National Mental Health Commission
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Submission to the Senate Standing Committees on Community Affairs inquiry into the provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians

Australian Government
National Mental Health Commission

The mental health perspective on the provision of primary care in rural and remote Australia

General practitioners and related primary care professionals play a crucial role in the delivery of mental health care and those working in rural and remote communities in Australia face unique challenges. These challenges affect the provision of mental health care in rural and remote communities resulting in inequity in mental health outcomes for many Australians.

Key summary points

The need for structural reform

There has been a long history of national policy work in primary health care reform as the primary health care system attempts to adapt to changing needs of the Australian population. The current system has structural and funding weaknesses that are exacerbated by unique challenges the rural and remote context presents. These challenges include fewer options for referral and lack of specialist services; and for the workforce, inadequate staffing levels, lack of career opportunities, and long hours with on-call requirements.

Current reforms are trying to bring in a focus on population health, system integration, prevention and flexible funding approaches to address the needs of Australians and the primary care professionals who support their health. In August 2019, the Australian Government announced Australia's Long Term National Health Plan, including a 10-year Primary Health Care Plan. A goal stipulated in the Plan is a person-centred system that fully integrates mental health care into the health system. Additionally, key findings from the Productivity Commission's Inquiry into Mental Health have highlighted the need for General Practitioners (GPs) to be delivering person-centred care with the recognition of personal recovery in addition to clinical improvement. While GPs are often the first point of contact for people accessing the mental health system and will refer patients to specialist services, it is important they play a key role in the continued coordination of care and treatment of their patients. They are particularly well placed to do this as they have established relationships and built trust with patients, especially for patients requiring longer-term supports.

The rural and remote context brings additional challenges for GPs and primary care professionals. Lack of services and workforce mean many professionals have roles and responsibilities that require additional knowledge, training, skills and competencies compared to their metropolitan counterparts. The National Mental Health Workforce Strategy (currently in development) will need to consider the specific workforce needs of GPs and primary health care professionals in the rural and remote context. In addition, in its National Report 2020, the Commission recommended the development of a National Rural and Remote Mental Health Strategy that looks holistically at the issues faced across diverse communities in regional and remote Australia.

Connections and Vision 2030

In 2019, the Commission undertook a national tour, called the Connections project, to hear first-hand from Australians what their experiences of the mental health and suicide prevention system were. As part of this project, the Commission visited 26 communities, 11 of which were regional and five were remote. The Commission also conducted an online survey and findings from the project clearly highlighted that accessibility issues are exacerbated for those living in rural and remote communities. Service integration was a common theme with communities calling for services that are joined up, talk to each other, and that provide people with the full breadth of services they require, at the time they require them.

The Connections project informed the development of Vision 2030, a long-term blueprint for an effective, connected, and well-functioning mental health and suicide prevention system that meets the needs of the whole community. One of the central pillars of Vision 2030 is the balanced community-based care approach. It follows well-established expert consensus that mental health services should be placed within communities, closely linked or co-located where possible

with primary health care, and functionally integrated with hospital-based services. The implementation of balanced community-based care within rural and remote locations will need to consider ways to provide reliable, regular, and local services that have relationships and trust within the community. GPs and primary care professionals play a crucial role in this.

Workforce capacity and capability

There are a number of workforce challenges that impact GPs and primary care providers in rural and remote Australia. Critical workforce shortages are evident across the mental health workforce in rural communities including mental health nurses, psychologists and psychiatrists. As a result, GPs who also face workforce shortages in rural and remote areas, are relied upon to provide crucial frontline mental health services, despite many not feeling adequately trained, equipped, or supported to do so. It is critical that workforce shortages are addressed in order to increase workforce capacity and therefore the availability of, and access to, mental health services and supports for people in rural and remote areas.

In addition, there is a need to bolster the capability of both GPs and other primary care professionals to better respond to the mental health challenges faced by people in rural and remote communities. GPs should be better equipped to provide mental health support in collaboration with broader primary care professionals such as allied health, practice nurses or nurse practitioners, and Aboriginal health workers. This broader approach needs to include consideration of appropriate training or upskilling in mental health capabilities across primary care professions, and greater flexibility in the provision of funding that allows communities to address local needs and gaps.

There is significant potential for communities, who understand local needs, and Lived Experience (peer) workers, who understand personal experience, to play a greater role in mental health care in rural and remote settings. However, this requires appropriate resourcing and support.

Prevention and early intervention

The Commission views prevention and early intervention as a crucial component in the delivery of quality health and mental health services. In Vision 2030, early intervention refers to coordinated multidisciplinary care programs provided early in the onset or early in the episode of mental health concerns and should be readily available and provided in a sustained manner. This requires cross-sector investment into actions that promote mental health and wellbeing and support early intervention across the life course.

GPs and primary care providers play an integral role in the prevention and early intervention of mental ill-health. Primary care providers can also increase access to mental health supports for people who experience, or fear the experience of, stigma. Some people in rural and remote communities may feel more comfortable seeking mental health care from a primary care provider as they are not associated with any specific health conditions.

Accessibility was the most raised concern during the Connections tour, with affordability the most described issue within accessibility. The integration of mental health services into primary health care makes supports more financially accessible and therefore more accessible to those who need help.

A number of challenges exist in the integration of mental health care into primary health care. Careful consideration needs to be given to training and continuing professional support, which in a rural and remote context are already key challenges, and significant investment is required.

About the National Mental Health Commission

The National Mental Health Commission (the Commission) was established in 2012 and is an executive agency in the Australian Government Health Portfolio. The Commission is a listed entity under the *Public Governance, Performance and Accountability Act* 2013 with the Commission's purpose set out in clause 15 of Schedule 1 of the *Public Governance, Performance and Accountability Act* 2014.

The Commission's purpose is to monitor and report on investment in mental health and suicide prevention initiatives; provide evidence-based policy advice to Government; disseminate information on ways to continuously improve Australia's mental health and suicide prevention systems; and act as a catalyst for change to achieve those improvements. This includes increasing accountability and transparency in mental health through the provision of independent reports and advice to the Australian Government and the community.

The Commission monitors and reports on the mental health of people living in regional and remote Australia through mechanisms such as the Commission's National Report, promoting issues in submissions, and presenting at rural and remote forums. In 2018, the Commission made a joint submission to the Senate Standing Committees on Community Affairs inquiry into the accessibility and quality of mental health services in rural and remote Australia. Both the joint submission by the Australian Mental Health Commissions (submission reference number 52) and the Final Report of the Committee address in further detail many of the issues pertaining to the provision of GP and related primary mental health services to people living in rural and remote Australia.

The Commission seeks to contribute the mental health and suicide prevention perspective in response to this inquiry into issues relating to the provision of GP and related primary health services to outer metropolitan, rural and regional Australians. As such, we have not responded to b. ii and b. iv of the specified terms of reference.

Introduction

Primary health care is often the first point of contact for people seeking support for their health and wellbeing, regardless of their mental health status. The primary care workforce extends beyond just GPs and includes practice nurses, nurse practitioners, allied health professionals (including psychologists, occupational therapists, social workers, and physiotherapists), midwives, pharmacists, dentists, dietitians, and Aboriginal health workers. This workforce has a crucial role in recognising distress, promoting health and wellbeing, conducting assessments, delivering primary mental health interventions, and connecting individuals with specialists and mental health services as required. They also play a key role in continued coordination of care, including for people with comorbidities who may be accessing both physical and mental health supports.

Critical opportunities exist to strengthen the contribution of the primary care workforce to play a key role in mental health and suicide prevention in rural and remote communities. This includes bolstering the capacity of the workforce to respond to mental health and wellbeing issues and a greater involvement of communities and the Lived Experience (peer) workforce across primary care.

People living in rural and regional Australia are disproportionally affected by poor mental health compared to people living in urban areas. Differing levels of disadvantage related to education, income and employment are also faced by people living in rural and remote areas compared to people living in metropolitan areas. In addition to these challenges, unique factors such as the occurrence of natural disasters and geographical and social isolation can further impact on mental health and wellbeing. While prevalence rates of mental illness in rural and remote regions is commensurate to that of metropolitan areas (20%)[1], the same cannot be said for the provision of funding and services to rural and remote regions, who make up 30% of the Australian population.[2]

While many people living with a mental illness lead healthy lives, approximately 80% of people with a mental illness also have a mortality-related physical health condition. This is due to a complex range of factors including poor access to health services, stigma and discrimination, lifestyle factors and the side effects of medication. In rural Australia, the rate of early death for people living with a mental illness is tripled compared to the general population (doubled compared to people living with a mental illness in Australia in general). This could be due to compounding factors specific to rural and remote areas such as geographical distances and a shortage of health and screening services.[3] This highlights the importance of holistic assessment and treatment of people with mental illness in rural and remote areas.

Additionally, the impact of suicide is more pronounced for rural and remote communities, where population size is lower than metropolitan areas. Further, rates of self-harm and suicide have been found to increase with remoteness. In 2019, self-harm and suicide rates in regional and remote areas was 17.5 compared to 10.8 in greater capital cities.[4]

Aboriginal and Torres Strait Islander people (two thirds of whom live in rural, regional or remote areas) are almost three times as likely as non-Indigenous people to report mental and behavioural conditions. However, prevalence of high or very high levels of psychological distress in Aboriginal and Torres Strait Islander people is slightly lower in remote areas (28%) than non-remote areas (31%).[5]

Terms of reference

(a) the current state of outer metropolitan, rural, and regional GPs and related services

For many people who begin to experience symptoms of mental-ill health, a visit to the GP is the first step in accessing support. The recent *Productivity Commission's Inquiry into Mental Health* has estimated that in 2018-19 at least five million people (or 1 in 5 Australians) had a consultation with their GP about their mental health, and around 1 in 8 GP consultations (around 20 million a year) relate to mental health problems. These statistics highlight the crucial role GPs, amongst other primary care professionals, can play in supporting mental health. For example, 6 in 10 people presenting to their GP with mental-ill health are prescribed medication, 3 in 10 receive counselling, education or advice from the GP and 2 in 10 receive a referral (about half to a psychologist and 10-20% to a psychiatrist).[6]

A GP's role in the provision of mental health care is relied on more so in rural and remote areas where typically there are fewer mental health clinicians GPs can refer to for mental health services. The Australian Medical Association has pointed out that around 80% of all community based mental health care in Australia is provided by GPs, however in rural areas this figure rises to 95%.[7] Despite reliance on GPs, access to GPs is generally more limited in rural and remote areas.[6] In 2016, people in remote areas were more likely to report barriers accessing GPs and specialists than those in major cities.[8]

In recognising the skills and requirements needed of GPs in regional, rural and remote areas, including the provision of mental health care, the Australian Government launched the National Rural Generalist Pathway. This pathway seeks to improve the availability of health care in rural and remote areas, providing GPs with a defined and supported pathway to undertake generalist training in rural and remote areas. The rollout of the pathway is underway with new junior doctor rotations due to commence in the second half of 2021. At this stage it is too early to comment on effectiveness. Evaluation of the pathway is currently being conducted by Australian Healthcare Associates, which aims to assess the short-term (within 2 years) outcomes of the pathway reforms.[9]

Mental health care for people in rural and remote communities is often provided through community health centres, hospitals in major regional centres and GPs. However, many communities have no resident mental health services and must rely on visiting services, relocate or travel long distances to access services. Often this requires travel away from families and communities. This can become an additional stressor and denies an important source of social support.[10] These challenges in accessing appropriate support services for people in rural and remote areas are driven by maldistribution of the mental health workforce which is skewed towards urban areas.

Rural and remote communities in Australia have an overall lower rate of service provision (lower number of mental health service encounters),[11] as well as more limited access to specialist psychological care.[12] The rate of Medicare-subsidised mental health specific services is highest in major cities and inner regional areas (11.1%), with rates decreasing by remoteness.[13] This pattern is consistent across health provider types and could be a result of the increased stigma and limited access to a mental health workforce in rural and remote areas.

It is also worth noting that while well-funded to provide mental health care for adolescents, headspace's coverage across rural Australia is limited.[14] This is a significant issue given evidence suggesting rural adolescents are at greater risk of major depression, anxiety disorders, nicotine dependence, substance abuse and suicide attempts.[15] Greater support for the primary care workforce to provide mental health support for young people in rural and remote areas is also needed.

There are a number of issues pertaining to the equitable access and provision of GP or related primary care services in rural and remote areas that the Commission views as key challenges. These include current service system structures and governance; funding provision and models; workforce issues; and the emergence of service provision via digital technologies.

Service system structures and governance

The delivery of health services across a nation as geographically large and as culturally diverse as Australia is extremely complex. This complexity is combined with the differing health responsibilities across three levels of government in Australia (federal, state and local). In several rural locations, service provision crosses state and territory jurisdictional boundaries.

This split of responsibilities across governments and sectors prevents the delivery of coordinated community-based care and the expansion of evidence-based services to scale. This results in programs and services that are disconnected, reactive, not coordinated, and difficult to navigate.

Currently, there is a gap in service provision between primary and tertiary care. Many people with complex or chronic mental illness with moderate intensity care needs are left with limited appropriate service options because their needs are beyond the scope of care offered by a GP, yet not suitably dealt with in an acute setting either. There is a lack of clarity as to which government should fund this gap resulting in a plethora of community-based services that are often inaccessible due to geographical restrictions, affordability, or both.

While primary care is considered the entry point into the mental health system, often care pathways result in a jump from primary to tertiary care. A lot of the time, the tertiary care system is not where people need to be directed to, and not where they need to start from. Better integration with and coordination between primary and tertiary health settings is therefore needed, including greater integrative support for people with high prevalence and/or complex mental illness. The Commission views a stepped care approach as one way of achieving better integration and coordination. A stepped care approach is a system of identifying needs and delivering treatment so that the right level of care is provided to an individual at the time it is needed.

In its position statement on the provision of mental health services in rural Australia, the Royal Australian College of General Practitioners (RACGP), likewise emphasises the need to facilitate stronger integration and coordination of care. The statement calls for a seamless continuum of care that enables GPs to access a range of supports that facilitate localised solutions and build partnerships and service connections required for shared care arrangements.[16]

Central to achieving this level of integrated mental health care and embedding stepped care approaches, is the role of Primary Health Networks (PHNs) in close alignment with Local Hospital Networks (LHNs). This is recognised under the *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) where integrated regional planning and service delivery is a key priority area. The Fifth Plan notes the role of PHNs and LHNs as the core structural foundations to support integration at the regional level. Addressing the mental health needs of rural and remote Australia requires an understanding of the specific challenges these areas face and an innovative approach to addressing them — one which maximises available local resources and expertise and adopts a regional or community specific approach.

PHNs have the ability to undertake local gaps analysis and needs assessments, regionally plan with Local Hospital Districts and commission primary mental health services that match individual and local population needs. This can reduce fragmentation, improve coordination, efficiency and effectiveness of care. However, the Productivity Commission has found that cooperation and joint regional planning between PHNs and LHNs is not operating in this way on the ground, with current processes providing limited clarity as to how joint regional planning can be best achieved and limited accountability mechanisms to ensure appropriate processes are being followed. In addition, findings from the Commission's 2020 Consumer and Carer Survey (an extension of the Commission's Fifth Plan reporting responsibilities) has highlighted that the intended benefits of improving integrated regional planning and service delivery under the Fifth Plan have not yet been realised for a significant proportion of consumers and carers.

To address these challenges the Productivity Commission has therefore recommended the establishment of regional commissioning authorities to administer mental health funding as an alternative to PHN-LHN joint regional planning and cooperation. The Commission supports a funding system that allows mental health and suicide prevention services to be commissioned regionally, where local needs are better understood.

Primarily, people living with severe and persistent mental illness receive the majority of their services from within the public health system. With PHNs having responsibility for the commissioning of primary mental health services, it is critical for these two sectors to be working in partnership. It is also crucial that PHNs, public health services and other sectors that provide social and welfare supports/services work collaboratively to plan, commission and provide services. In addition, commissioned services or programs should complement existing government services to ensure a system wide coordinated response. To support PHNs in catering for rural needs, governments need to invest long-term in community-based approaches and retention of mental health professionals.

These service system structures and governance issues are applicable for the mental health system in general, however are particularly exacerbated for people in rural and remote regions.

Funding provision and models

Existing funding models are impacting on service provision in rural and remote regions. The provision of free primary care services (via bulk billing) are disproportionately available in metropolitan areas.[17] This means both primary care and specialist services in rural and remote areas are less affordable and therefore less accessible than those in metropolitan areas, particularly for people with lower socio-economic backgrounds. In effect, where you live, coupled with your financial means will determine your access to services. This is not equitable access.

The use of activity-based funding models is particularly concerning in rural and remote areas because they increase the challenges in attracting and retaining workforce. There is a need for flexible funding to allow communities to address local gaps and needs. Unlike activity-based funding, flexible funding acknowledges and caters to the unpredictability and variability of mental health care costs. The RACGP position statement on the provision of mental health services in rural Australia emphasises the need for greater flexibility of funding that supports shared care arrangements and provides the necessary supports and service links.

Additionally the Orange Declaration on rural and remote mental health has highlighted the tendency of public funding to favour outreach, telehealth and city-centric models over local public, private and non-government organisation services from medical, allied health, nursing, peer and care partners. This, along with short term funding constraints offered by PHNs, deters providers from making investments in rural and remote communities.[18]

To assist with the development of the Primary Health Care 10-Year Plan, the Primary Health Reform Steering Group have provided a number of recommendations around funding reform for primary health care services. This includes the establishment of funding models that support integrated health care to match local needs such as flexible funding for individual service providers including block and blended payments models and bundled payment approaches that link financial incentives to high quality care and improvement at the individual and population level. The need for innovative funding models that are equitably funded for a range of primary health care services and rural and remote communities has also been emphasised.[18] Many of these recommendations are aligned with the funding approach outlined in the Commission's Vision 2030 in support of a move towards a complex blended model of funding, removing deficiencies in the system and addressing population mental health needs.

Workforce challenges

The primary health care workforce, including the mental health workforce face a number of workforce challenges in rural and remote areas. Recruitment of rural health professionals is particularly challenging in the context of global, state and national shortages of suitable workers and competition with metropolitan and larger regional centres.

The latest annual Primary Health Workforce Needs Assessment report by the New South Wales Rural Doctors Network (RDN) has identified a number of primary health workforce challenges in the areas of access; quality and sustainability; and innovative sector approaches. Some key findings include:

- continuing GP shortages and overdependence on locums, exacerbated by disasters and emergencies
- continuing supply shortages for most health care and medicals roles, specifically in regional and rural Australia
- prevalence of short-term contracts, part-time positions and lack of visible career pathways are deterring applicants for allied health positions in rural and remote locations
- the health needs of refugee populations have placed increasing demand on the health workforce, resulting in barriers to their health access
- natural disasters and emergencies in recent times have put pressure on the system highlighting the need for changes
- primary care providers and PHNs are not systemically included in health emergency response and disaster management planning, despite generally being the main point of contact with the health system, having valuable local knowledge and strong connections with the communities they support.

As a subset of the primary care workforce, the Commission notes psychiatrists play a crucial role in the assessment, management and care coordination of people living with mental illness and are a vital component of multidisciplinary approaches to care. However, there is a lack of psychiatrist expertise with no existing psychiatrist sub-speciality for GPs[19] like there are for other specialities such as GP obstetricians and GP anaesthetists. There is also a lack of incentives in the MBS for GPs to take up more work in this area. The issue of access to an appropriately trained, retained, and incentivised workforce to take up regional and rural work, and to offer support to the rural workforce, has been the subject of significant recent discussion at a national level. The *Productivity Commission's Inquiry into Mental Health* found that there are ongoing shortages of psychiatrists in rural and regional parts of Australia and recommended the development of a national plan specifically to increase the number of psychiatrists in clinical practice, particularly outside major cities and in those specialities suffering shortages, such as child, adolescent and older people psychiatry. The Productivity Commission has noted that this national plan should form part of the broader Australian Government medical workforce strategies currently being developed.

Rural psychiatrists also play an important role in providing support to rural GPs, including supervision of GPs undertaking advanced skills in mental health. A stronger, more stable rural psychiatry workforce will provide better foundations for rural generalist GP training and supervision in mental health. The recently released Rural Psychiatry Roadmap 2021-31 will work towards enhancing equitable and sustainable delivery of mental health services in rural areas.[20]

Pharmacists are the most visited healthcare professionals in Australia, and in rural and remote communities are often more readily available and accessible than other healthcare professionals. Therefore, there is significant potential for pharmacists to play a greater role in supporting people with mental illness particularly in rural and remote communities. However, for many pharmacists this potential is not realised due to a lack of knowledge and confidence in mental health. Supporting pharmacists to feel confident and equipped with the knowledge to respond to and assist people with mental ill-health is another important avenue for increasing the provision of mental health support for people in rural and remote communities. The New South Wales Government is currently working with the Pharmacy Guild of Australia - New South Wales Branch to upskill pharmacists and pharmacy support staff via the Mental Health Community Pharmacy Program 2020.[21]

As part of the development of Vision 2030, the Commission held a rural and remote specific roundtable that included discussion on workforce issues. Roundtable participants agreed the 2018 Senate Community Affairs Reference Committee Inquiry into the accessibility and quality of mental health services in rural and remote Australia (Senate Inquiry)[22] had already identified many solutions to the challenges of recruiting and developing a sustainable rural and remote workforce. The Senate Inquiry was well received by the sector and provides 18 recommendations for action. The Australian Government has agreed its support for the majority of these. However, participants identified that implementing these recommendations requires time and funding certainty, which has been a barrier to acting on a number of solutions identified in the Senate Inquiry's report. Facilitating change for rural and remotes communities will be achieved by the implementation of these actions.

Roundtable discussion also identified structural design issues for recruitment and retention that is based on urban assumptions, as was the importance of career support and development opportunities (including supervision and mentoring opportunities) for individual workforce participants. Emphasis was placed on the need for development of a self-sufficient 'home-grown' workforce that does not rely on locums.

Participants particularly emphasised that the allocation of additional service funding without consideration for the available workforce in those rural and remote communities can be problematic and is likely to result in redistribution of the existing mental health workforce without increasing their overall capacity.

Addressing key workforce issues, such as workforce shortages, recruitment and retention issues and limited training and development pathways, is crucial to increasing the provision and access to quality and appropriate services. The Senate Inquiry recommended the development of a national rural and remote mental health strategy, which included addressing the workforce issues in rural and remote communities. While the Government supported the recommendation, the inclusion of a rural and remote focus was instead incorporated under the broader National Mental Health Workforce Strategy currently in development. This is discussed in more detail under terms of reference item (b).

Suicide prevention

Evidence suggests that many suicidal persons will engage with a GP or primary health care professional ahead of other services and possibly at earlier stages in their emerging suicidality. Therefore, the provision of training and development for GPs and primary health care professionals on suicide prevention is a key priority. The effectiveness of training GPs in earlier and more specific identification of suicidality (and forms of depression that are relevant) has been documented in many studies, in particular the effectiveness of 'gatekeeper training' for GPs and primary health care professionals.[23]

The role of primary health care in achieving 'systems approaches' to suicide prevention has also been recognised. The European Alliance Against Depression project provides measurable results on the importance of community-based communication and education linked to improved primary health care capacity for suicide prevention and treatment of depression.[24,25] Further, the LifeSpan model developed by Black Dog Institute reinforces the importance of primary health care.[26] However, despite inclusion as a priority area in the Fifth Plan, there are limited strategies or policies surrounding primary health care and 'systems approaches' to suicide prevention in the Australian context. The Commission supports greater recognition of evidence-based primary health care in suicide prevention reforms in primary mental health policies.

Several jurisdictions are pursuing suicide prevention reforms in healthcare, notably New South Wales, Queensland, South Australia and Tasmania, using the Zero Suicide Healthcare framework and working towards greater consistency and evidence-based care for suicidal persons. Victoria is likely to pursue similar reforms in healthcare, in line with the Royal Commission into Victoria's mental health system recommendations. These reforms include the adoption of more comprehensive psychosocial assessments for service and care planning, use of suicide safety planning and means restriction counselling, provision of suicide-specific psychological therapies such as Cognitive Behaviour Therapy for Suicide Prevention (CBT-SP) and Dialectical Behaviour Therapy (DBT), and smoother pathways to aftercare – with boosted aftercare services such as The Way Back Support Service and others. Further work is required as to how these reforms in suicide related healthcare can involve primary healthcare, including consideration of commensurate upskilling, capacity building and improved service and communication processes to enable primary healthcare professionals to complement broader reforms.

Given that rates of self-harm and suicide have been found to increase with remoteness, greater consideration and use of effective suicide prevention measures is particularly important for GP and related primary health care services in rural and remote settings. The Commission encourages ongoing efforts and prioritisation of suicide prevention in rural and remote areas.

Digital and telehealth provision

The Commission's National Report 2020 emphasises the use of digital technology for remote service provision and as an adjunct to the workforce in rural and remote areas, including as a method of providing distance education and training, and e-supervision to health professionals. In addition, emerging research has identified the potential for social media to facilitate the establishment of social connections and the receipt of online social support for young people in particular.[27] This can be particularly important for those who do not have access to communities of similar peers otherwise, such as LGBTQI communities, people with disabilities, and those who are geographically isolated.

However, there are significant barriers to accessing digital technology for many living in rural and regional areas and as such these services should not be a substitution for face-to-face care. Barriers can include limited access to an internet connection or digital technologies such as laptops, tablets and smartphones as well as significantly lower internet speeds in some rural areas.[28] In addition, there is a need to ensure that the online care and supports being accessed are evidence based and that the use of these are incorporated as part of the broader mental health system.

The Commission welcomes the use of digital technologies and telehealth as a way of increasing access to services for people in rural and remote areas, however this is just one aspect alongside broader issues of workforce shortages and capacity that need addressing in rural and remote areas.

(b) current state and former Government reforms to outer metropolitan, rural and regional GP services and their impact on GPs

Australian Government Primary Health Care 10-Year Plan

The Australian Government has committed to primary health care reform as part of its Long Term National Health Plan. The development of a Primary Health Care 10-Year Plan is being informed by a Primary Health Reform Steering Group. In August 2021, the Primary Health Reform Steering Group released its draft recommendations, which included the prioritisation of structural reform in rural and remote communities. This recommendation aims to support a community connected approach built around the strengths of rural and remote communities, where the community has equitable access to care and providers trust a system that supports and empowers delivery of high value care. Several of the draft recommendations are aligned to Vision 2030 and the Commission commends the Senate Standing Committee on Community Affairs to follow the Primary Health Reform Group's progress to assist in informing this inquiry.

Stronger Rural Health Strategy

The Commission welcomes the aims of the Stronger Rural Health Strategy to build a sustainable, high quality health workforce that is distributed across the country according to community need. However, criticisms from the health sector[29,30] have ensued in relation to the strategy's primary focus on the medical workforce, the focus of which is too narrow given the increased collaboration required across disciplines in rural areas, and the need to include the entire primary care workforce (nursing, allied health, dentistry and other primary care professionals) in addressing health care workforce shortages. The largest workforce gap exists in allied health rather than those workforces addressed by the strategy. Rural communities have around half the number of psychologists, occupational therapists, medical imaging clinicians and physiotherapists (45%, 47%, 54% and 58%, respectively) that major cities have.[31]

The Commission views the primary health care workforce as being more than just GPs, notwithstanding their sizeable contribution to the provision and coordination of mental health care, particularly in rural areas. This broader understanding is reflected in Vision 2030, with a focus on integration that considers the capacity building needs across sectors, particularly in primary care and allied health, to enable joined-up approaches to mental health. Any strategy that addresses rural health needs to ensure a broader consideration of workforce shortages, capacity building, training and resources for the entire primary care workforce including, and beyond GPs.

Lived Experience (Peer) Workforce Development Guidelines

Taking a broader approach to the provision of primary mental health care presents a unique opportunity for the Lived Experience (peer) workforce and greater involvement of communities. Lived Experience (peer) workers have a

particularly important role in rural settings, where geographic isolation may be more intense and the opportunity to share personal experience more limited. There should be investment in improving the capacity of community members, especially those with a personal experience of mental illness, to provide peer and/or mental health first aid services and supports to augment the existing workforce. Expansion of the Lived Experience (peer) workforce will require increased training and appropriate levels of peer supervision. This was also recommended in the Commission's submission to the Senate Inquiry into accessibility and quality of mental health services in rural and remote Australia.

The Commission is currently leading the development of the National Lived Experience (Peer) Workforce Development Guidelines and has conducted extensive consultation and co-design processes to ensure the guidelines are grounded in lived experience. The guidelines are intended to support ongoing growth and development of the Lived Experience (peer) workforce by providing employers and sector leaders with detailed guidance on how to implement structures, policies and practices that support sustainable and effective growth of this workforce. The guidelines have significant potential to guide expansion and development efforts of the Lived Experience (peer) workforce in rural and remote communities.

National workforce strategies

There are two key strategies in development that will address issues pertaining to the mental health and primary care workforce. These are the National Medical Workforce Strategy, which will include considerations for psychiatrists and general practice; and the National Mental Health Workforce Strategy, which will address many of the barriers and opportunities for the mental health workforce into 2030, many of whom offer primary care services.

Strategic thinking around quality, supply and distribution of the mental health workforce is currently progressing through the National Mental Health Workforce Strategy, which is being developed by the Australian Government Department of Health. Development of the strategy was a key recommendation within the Fifth Plan and is supported by a skilled national taskforce. Amongst other key priority areas, the taskforce is looking closely at rural and remote workforce needs.

Although work under the National Mental Health Workforce Strategy will address the mental health workforce in rural and remote communities, the Commission's National Report 2020 has recommended the Australian Government develop a National Rural and Remote Mental Health Strategy that looks holistically at the issues faced across diverse communities in regional and remote Australia. It is recommended that development of the strategy should commence once the National Mental Health Workforce Strategy is finalised.

Productivity Commission Inquiry into Mental Health

Mental health is in the midst of a huge reform agenda with a strong focus on whole-of-government and cross-sectoral approaches, and the need for early intervention and prevention. A significant piece of work has been the Productivity Commission's Inquiry into Mental Health, which has made broad sweeping recommendations across all areas of mental health and suicide prevention. In its final report, the Productivity Commission has noted the important role of GPs in relation to mental health along with a number of areas for improvement including:

- limited training specific to mental health, particularly non-pharmacological interventions
- the need to recognise the importance of personal recovery in addition to clinical improvement
- the need to operate more 'person-centred', advising of possible mental health treatment options and providers and discussing together to assist the individual to decide which option is most suited to their needs.

The Productivity Commission has recommended improving GP gateways for consumers with GPs to do more to support consumer choice as well as calls for the Mental Health Treatment Plan to be replaced amidst findings these currently do little to assist consumer needs. Again, while the inquiry has been nationally focussed, it is important to note many of these issues are often amplified for rural and remote communities due to higher reliance on GPs in these areas to provide mental health care and support.

The Australian Government's 2021-22 Budget included an investment of $15.9 million to provide specialised training and resources to enhance the capacity of GPs and other medical practitioners to address mental health concerns of patients. Depending on how training and resources are distributed across metropolitan, regional and rural areas, this could be a welcome investment for rural and remote communities, enhancing the skills of their GPs to respond to mental health issues. Whilst an important step, issues of workforce shortages for rural and remote communities still persist. The Commission will continue to monitor implementation of a number of mental health related budget items.

(c) the impact of the COVID-19 pandemic on doctor shortages in outer metropolitan, rural, and regional Australia

For many rural communities, the COVID-19 pandemic has coincided with the ongoing stress of prolonged periods of drought and recovery from the recent devastating 2019-2020 summer bushfires.

The Commission's National Report 2020 included a specific focus on the impact of the COVID-19 pandemic on mental health and mental health service provision. The impacts on rural and remote communities, many of whom rely on fly-in fly-out (FIFO) services, was highlighted. Strict and multi-layered travel restrictions during 2020 resulted in significant practical, administrative and financial challenges to local service provision. For example, although mental health services were covered by exemptions allowing the entry of essential services, FIFO staff had to be provided with accommodation and allowances while in quarantine, often in private accommodation. This meant costs were often higher as a result of inadequate quantities and qualities of staff housing in some communities.[32] As a result, many Aboriginal Community Controlled Health Services were paying for staff who were unable to work to full capacity, making it even more difficult for communities to access mental health support when it was most needed.

The development and implementation of new technologies such as telehealth has been instrumental in continuing the provision of mental health care for rural and remote communities during the pandemic. The Commission has observed new digital models of mental health service delivery being embraced through its role in working with a range of key national organisations throughout the pandemic. Recent data shows that MBS mental health services delivered via telehealth increased from 3% in March 2020 to an average of 32.1% over the 9 months to January 2021.[33] This may indicate some potential for further innovation and extending the reach of specialist services. In some areas, tele and virtual psychiatry models have helped to bridge the access gap experienced by people in remote areas or areas poorly supported by specialist workforce.

The New South Wales RDN 2019-20 Annual Report has further highlighted how COVID-19 impacted the rural health workforce including: workforce resilience issues being amplified, particularly in areas still recovering from drought, bushfires and floods; escalation of mental health, wellbeing and financial stressors for practitioners; increased risks to the health and wellbeing of Aboriginal communities, including changes to accessing health and support services; perceived risks to primary care practices and NGOs maintaining financial viability; and education and training impacts, including limited physical access to courses and exams as well as course delays and deferments.[34]

These impacts suggest the critical need for increased support of the rural health workforce during crises, in particular those impacted by previous disasters and those working with Aboriginal and Torres Strait Islander communities. It also highlights the need to support the mental health and wellbeing of the health workforce itself during crises, whose own physical, mental and financial challenges are particularly exacerbated during these times. Further, such measures should be embedded in system design instead of resorting to a surge response once a crisis has occurred, increasing the local workforce's ability to adequately respond to the needs of rural communities.

The Commission's National Disaster Mental Health and Wellbeing Framework (yet to be released) notes the difficulties ensuring an appropriately located and skilled health and mental health workforce for disaster-affected communities, particularly in the context of existing workforce shortages in the rural and remote areas where disasters primarily occur. As such, the Framework has highlighted consideration of the sharing of temporary workers to disaster-affected communities as increasingly important. Planning for the deployment of the local primary health care workforce needs to be included as part of broader mental health disaster workforce planning.

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