

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

VCOSS submission to the Senate Standing
Committee on Community Affairs

May 2018



About VCOSS

The Victorian Council of Social Service (VCOSS) is the peak body of the social and community sector in Victoria. VCOSS members reflect the diversity of the sector and include large charities, peak organisations, small community services, advocacy groups, and individuals interested in social policy. In addition to supporting the sector, VCOSS represents the interests of vulnerable and disadvantaged Victorians in policy debates and advocates for the development of a sustainable, fair and equitable society.

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VCOSS acknowledges the traditional owners of country and pays its respects to Elders past and present.

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Introduction

VCOSS welcomes the opportunity to provide a submission to the senate Standing Committee on Community Affairs inquiry into accessibility and quality of mental health services in rural and remote Australia.

VCOSS is the peak body for social and community services in Victoria. VCOSS members reflect the diversity of the sector and include large charities, peak organisations, small community services, advocacy groups and individuals interested in social policy. In addition to supporting the sector, VCOSS represents the interests of vulnerable and disadvantaged Victorians in policy debates and advocates for the development of a sustainable, fair and equitable society.

Rural and regional Victorians experience mental health issues and psychological distress at a similar rate to people living in the city.¹ However, they are much less likely to access supports, and the services they do access are often provided by professionals with less training. The tragic consequences of this gap are higher rates of suicide and poorer life expectancy.² Rates are even higher among some groups, including Aboriginal and Torres Strait Islander people and lesbian, gay, bisexual, transgender and intersex (LGBTI) people.

These health inequities for rural Victorians are unfair and largely preventable. They are primarily the result of isolation, socio-economic disadvantage, lack of healthcare providers and barriers to service access. One of the reasons for lower engagement with mental health services is the lack of services and specialists physically available in rural and remote communities. Targeted strategies and funding are needed to improve access and reduce barriers to mental health services for rural and remote Australians.

In addition, too often mental health services and systems are designed without considering the needs of rural and remote people, and without engaging them in design and delivery. A stronger commitment to co-designing with communities is needed to ensure services are appropriately meeting the needs of diverse communities across the country.

Community organisations play a vital role in supporting the mental health of rural Victorians and preventing mental ill-health. Current reforms, including the ongoing implementation of the NDIS, is putting the future of community managed mental health rehabilitation services at risk. The role of community organisations in addressing mental illness in the community must be recognized and valued, and their funding restored.

¹ Victorian Department of Health and Human Services, *Victorian Population Health Survey*, 2015, p 125.

² State Government of Victoria, *Victorian Suicide Prevention Framework 2016-25*.

Recommendations

Mental health services in rural Victoria

- Increase funding for rural mental health services providing clinical care
- Improve case coordination between hospital and community based mental health services, and between mental health and other community services
- Ensure clinical mental health services are required to engage in local planning processes, to improve integrated care outcomes
- Identify and address funding gaps in specialist mental health services in rural and remote areas.
- Expand mental health professional development training for rural GPs and primary health professionals
- Ensure community organisations in rural and remote areas receive have adequate and sustainable funding levels
- Use existing community advisory and place-based groups to co-design services that fit the needs of local communities
- Undertake comprehensive rural mental health workforce planning, incorporating the government, not-for-profit and private sector workforces
- Review the NDIS pricing structure to ensure it supports a highly qualified mental health workforce
- Continue investigating options for expanding online information provision and support
- Recognise the impacts of the digital divide on rural and low-income communities

Mental health services and the NDIS

- Work with the state and territory governments to continue providing funding for psychosocial rehabilitation services outside the NDIS.
- Monitor the continued delivery of successful programs for people in rural and remote areas, including the Personal Helpers and Mentors (PHaMs) program.
- Collect and publish detailed data on provision of services and service gaps at the local level, to identify thin markets.
- Ensure there is adequate and appropriate supply of services to meet demand, particularly in regional, rural and remote areas.
- Maintain diversity in the market to support participants' choice.
- Amend NDIS prices to reflect the components of quality service delivery
- Adequately fund travel costs for high quality, equitable service delivery

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- Work with the NDIA to ensure the NDIS model provides capacity for organisations to reach out to isolated people and communities.
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Mental health services in rural Victoria

Strengthen clinical mental health services

Recommendations

- Increase funding for rural mental health services providing clinical care
- Improve case coordination between hospital and community based mental health services, and between mental health and other community services
- Ensure clinical mental health services are required to engage in local planning processes, to improve integrated care outcomes

Clinical mental health services provide expert support to people with serious mental health issues. They include hospital inpatient units, crisis assessment teams and community based care, including Prevention and Recovery Care Services (PARCs) and clinical outpatient services.

VCOSS members from rural and regional Victoria report many clinical mental health services across the state cannot meet demand. Too often only the most unwell, or those assessed as a risk to others, can get immediate help.

Rather than reducing pressure, members report the NDIS rollout, and the resultant loss of community managed rehabilitation services is increasing reliance on clinical services to support people with mental illness.

Under-resourced and over-stretched acute services put people's lives at risk. Several VCOSS members report people being repeatedly turned away from regional hospitals and acute care facilities, despite demonstrating suicidal ideation. In small rural and regional communities, there are often no other options besides the local hospital. Community organisations report feeling their only option when people is experiencing a crisis is to call police, who despite good intentions have limited ability to provide an appropriate therapeutic response.

When people do receive treatment in hospital, issues often arise at the time of discharge, in coordination of care between hospitals and community based teams. This can be a particular problem when people are released from hospital in a large regional centre, without appropriate resources, linkages with community care or even transport to return to their more rural local community.

VCOSS members also report inadequate communication and case planning between clinical providers and other community based supports (for example drug and alcohol and allied health providers) who can help people remain well in the community. Past investment in building dual

diagnosis capacity in organisations and strengthening relationships between mental health and drug and alcohol treatment services has been welcome, but without ongoing funding, momentum and expertise is rapidly being lost.

The policies of some clinical services act as an unacceptable barrier to disadvantaged people getting help. For example, one VCOSS member reports that in their local region the clinical mental health service would not provide treatment to homeless people without a fixed address. When clinical services cannot provide support, the burden falls back on already stretched community services, who may not have specialist mental health expertise.

VCOSS members also report difficulties engaging clinical mental health services in local community planning and broader system engagement. For example, members report mental health services often do not attend local monitoring and governance groups driving the implementation of ambitious state-level reforms related to the Victorian Royal Commission into Family Violence, despite having an important role to play.

Address gaps in specialist service types

Recommendations

- Identify and address funding gaps in specialist mental health services in rural and remote areas.

As well as general clinical services, VCOSS members highlight service gaps making it difficult for people with specific mental health problems to get the help they need. Additional funding is needed in these areas, to improve access to specialist expertise.

Perinatal depression services

Federal Government cuts to perinatal depression services have left some areas with no services for new mothers experiencing or at risk of perinatal mental health issues. For example, the Shepparton region experiences high rates of disadvantage and family complexity, but parents in this area must seek support through the mainstream mental health system, or travel to the city.

Eating disorder services

Similarly, funded services for people with eating disorders are very limited. Many people report having no choice but to pay significant out of pocket costs for private treatment.

VCOSS members also report difficulties getting secondary consults from people with expertise in eating disorders, and not enough allied health professionals (for example, dieticians) to refer people to, to help manage their health.

Legal assistance

A lack of legal assistance services in regional and rural Victoria means people are being forced to appear before the Mental Health Tribunal unrepresented. When people appear before the tribunal on their own, it may be more difficult to have their views heard and taken into account, possibly resulting in involuntary treatment orders that could have been avoided with appropriate advocacy.

Mental health services for farming communities

Community consultations by the Primary Health Networks in Victoria have identified farmers as at particular risk of poor mental health, highlighting the impacts of drought, extreme weather events and market changes on mental health outcomes.³

Investment by the Victorian government in targeted support for farmers, including mental health first aid training are welcome. However, these programs are not always co-designed with service users, to meet the community needs. For example, VCOSS members report training sessions are often held at times and locations that are inconvenient for farming families, placing additional stress on them.

Child and adolescent mental health services

Regional organisations report services for children and young people are particularly stretched, despite evidence early intervention for young people can make a big difference to their lives, and prevent mental illness escalating. Waiting lists in some places are apparently so long that some young people are not receiving help until they age out of CAMHS and become eligible for adult services.

Strengthen primary and community health services

Recommendations

- Expand mental health professional development training for rural GPs and primary health professionals
- Ensure community organisations in rural and remote areas receive have adequate and sustainable funding levels
- Use existing community advisory and place-based groups to co-design services that fit the needs of local communities

There are far fewer mental health professionals in rural and remote areas than in major cities. For example, there are four psychiatrists for each 100,000 people in outer regional areas, compared with 13 in major cities.⁴ This shortage can also lead to higher fees being charged by available specialists, further locking out low-income people.

As a result, VCOSS members report primary care workers, like GPs, are increasingly a main support for people with mental illness in their communities. While some have training and expertise in supporting people with mental illness, this is inconsistent. A professional development program to expand the mental health expertise of rural GPs, nurses and other primary health professionals is needed.

³ For example, Western Victoria PHN, *Needs Assessment; Mental Health*, November 2016.

⁴ National Rural Health Alliance, *Mental Health in rural and remote Australia*, December 2017.

People's mental health is affected by a range of social determinants, including financial stress, poor or insecure housing, family violence and physical health issues. Co-occurrence of mental illness with drug dependency or disability is also common. Community health and other community organisations support people through the many complex and interrelated issues they experience, especially where there are few specialist mental health services available. They can reduce costs on the health system of more expensive acute care, by helping people recover or preventing crisis.

To strengthen the mental health of rural and remote communities, community organisations providing family violence, housing, family, financial and other support need to be well-funded and supported. However, many rural and regional community organisations report sustainability challenges, including increased competition from outside providers, tendering processes that prioritise the 'bottom line' without recognising local knowledge and connections, and ageing and inappropriate infrastructure.

Community organisations also need access to specialist mental health expertise, via secondary consultations. Many clinical and specialist mental health services are simply too busy to provide this kind of support.

Rural and remote communities are also different from each other. A better understanding is needed of the different experiences of communities. Many community organisations, as well as the Primary Health Networks have established community advisory committees that provide an opportunity to tap into local knowledge and co-design services that best meet the specific needs of local communities.

Build the rural mental health workforce

Recommendations

- Undertake comprehensive rural mental health workforce planning, incorporating the government, not-for-profit and private sector workforces
- Review the NDIS pricing structure to ensure it supports a highly qualified mental health workforce

Rural and regional services across the mental health system (and related sectors) are experiencing a critical shortage of highly skilled workers. Isolation, limited access to professional development, inadequate management and professional support and family challenges, including access to high quality education for children, spousal employment and housing all contribute to difficulties recruiting and retaining workers. VCROSS members report some rural and regional health services are forced to use large numbers of agency staff. This leads to issues with local engagement, building trusting relationships with consumers, and continuity of care.

Strategies to address workforce shortages have often been uncoordinated and piecemeal. VCROSS supports the call from mental health peak bodies for comprehensive rural and remote workforce

planning, that includes clinical and community based mental health workers, peer workers and non-mental health specialists, including GPs.⁵

The NDIS pricing model is also contributing to the challenge of securing a highly skilled workforce. Recent survey data from the sector indicates half of disability service providers are considering reducing service quality because of NDIS pricing.⁶

Community-managed mental health organisations report that the community-based rehabilitation services they provide do not fit well into the pricing structures of the NDIS. Before the implementation of the NDIS, 90 per cent of the community-managed mental health sector held a diploma or higher qualification.⁷ The NDIS pricing system does not support the continued employment of appropriately qualified mental health workers at the rates at which they were previously paid, or the attraction of new workers.

Expand telehealth

Recommendations

- Continue investigating options for expanding online information provision and support
- Recognise the impacts of the digital divide on rural and low-income communities

E-mental health services are increasingly cited as a way to improve service access for rural and remote Australians. This can involve psychologists, psychiatrists and other specialists providing services via video-conferencing from their city bases to people in rural areas. There is also a growth in e-mental health programs, delivered through website, apps and online support hubs.

E-mental health has potential for engagement, delivery and facilitation of treatment, especially for young people who are most likely to be comfortable engaging with these kinds of new technologies. However, e-mental health is not a replacement for face-to-face services. Some risks of e-health services include reliability, the need for digital literacy skills, difficulty in finding services that are evidence-based, and challenges to establishing a therapeutic relationship remotely.⁸

E-health services are also not appropriate for people without access to the internet. Victoria's 'Capital-Country' gap is the largest of all states, with rural Victorians having significant less digital inclusion than people living in Melbourne.⁹ People on low-incomes in particular are being left behind. For example, among people using the Salvation Army's emergency relief services in 2017, 61 per cent did not have access to an internet connection, and two thirds could not afford an internet connection at home.¹⁰

⁵ For example, Pro Bono Australia, *New strategy needed to address rural mental health crisis*, January 2018.

⁶ National Disability Services (NDS), *State of the Disability Sector Report 2017*.

⁷ Community Mental Health Australia, *NDIS Costs – Productivity Commission Issues Paper*, 2017.

⁸ Orygen the National Centre of Excellence in Youth Mental Health, *Research Bulletin: E-mental health: The future of youth mental health*.

⁹ J Thomas, J Barraket, C Wilson, S Ewing, T MacDonald, J Tucker and E Rennie, *Measuring Australia's Digital Divide: The Australian Digital Inclusion Index 2017*, 27-29.

¹⁰ Salvation Army, *The Hard Road: National Economic & Social Impact Survey 2017*, 52.

Mental health services and the NDIS

The NDIS is a major shift in service provision for people with disability, including psychosocial disability. VCOSS strongly supports the NDIS' goals – to provide eligible people with greater choice and control over their services and improve social and economic inclusion for all people with disability, their families and carers – however, as with any large social reform, there are emerging issues. While some are 'teething' issues likely to disappear over time, others are more substantial and require action to be taken.

There are particular issues for people with mental illness and for mental health services.

VCOSS has been engaging with NDIS service providers, consumers and carers over the last several years, to understand the implications and challenges of the NDIS rollout. Below we highlight some of the significant issues impacting on rural and regional communities and mental health services providers.

Restore community-managed mental health services

Recommendations

- Work with the state and territory governments to continue providing funding for psychosocial rehabilitation services outside the NDIS.

Victoria has diverted all existing funding from community-managed mental health services into the NDIS. Assumptions have been made that people with mental illness who need support will transition from community-managed mental health services, to the NDIS.

However, a significant number of people with mental illness will not be eligible for individual funding packages, but will still require some support. The Victorian peak body for mental health services estimates about 10,000 Victorians living with mental illness will be ineligible for the NDIS and at risk of not getting the support they need to manage their mental health and recovery.

Community managed mental health services provide psychosocial rehabilitation and support, helping people with a range of mental health issues stay well, and able to work, study, care for their children and families and participate in community life. Prior to the introduction of the NDIS, many community mental health services had a strong social support focus, and didn't require a clinical diagnosis to provide treatment and care.

General community health services in rural Victoria are already reporting increased demand for care from people who previously accessed community mental health services. It is likely that this gap will continue to place pressure on community services

VCOSS understands that in the 2017-18 budget the Federal Government allocated \$80million to fund the gap in psychosocial support services, if matched by the states and territories. The state government has yet to commit to matching this funding.

Continue successful programs

Recommendations

- Monitor the continued delivery of successful programs for people in rural and remote areas, including the Personal Helpers and Mentors (PHaMs) program

Existing programs that are benefiting people in rural and remote areas may be unavailable to people who have transitioned to the NDIS.

For example, peer programs like the Personal Helpers and Mentors program (PHaMs) has been successful in helping people with mental illness navigate the system and get access to services. With PHaMs services progressively transitioning to the NDIS, VCOSS members expressed concern about the future support needs of the people supported through this program.

While many PHaMs clients will be eligible for the NDIS, the data is already demonstrating that many will not receive individual support plans.¹¹ There is also no guarantee that existing PHaMs providers will continue to offer this kind of peer support through the NDIS. Even if rural Victorians are eligible for individual support plans, and choose to include peer support in their plans, there may be no providers in their region.

As far as we are aware, no one is tracking the availability of peer support, and other successful models of support, through the NDIS.

¹¹ Parliament of Australia, Senate Estimates, *Hearing date 1 March 2018, Questions No. NDIA SQ18-000005*

Address market failure in rural Victoria

Recommendations

- Collect and publish detailed data on provision of services and service gaps at the local level, to identify thin markets.
- Ensure there is adequate and appropriate supply of services to meet demand, particularly in regional, rural and remote areas.
- Maintain diversity in the market to support participants' choice.

In rural and regional areas, VCOSS members report there are not enough local services to provide people with funded supports, let alone choice of providers. The intermediate NDIS evaluation found NDIS participants living in rural or remote areas are 15 per cent more likely to experience unmet demand for supports, compared with participants living in metropolitan areas.¹² This is a particular issue for people with specialist or complex needs. In these cases, participants must travel to services, or pay extra for service staff to travel.¹³

It is necessary for the government or NDIA to intervene in thin markets, to guarantee access to essential services for rural and remote people living with mental illness. Depending on the circumstances, different approaches may be required, such as block funding core services, retaining a 'provider of last resort', and leveraging or building the capacity of established community organisations, such as community health services.

Review NDIS pricing

Recommendations

- Amend NDIS prices to reflect the components of quality service delivery
- Adequately fund travel costs for high quality, equitable service delivery

Service providers report that the NDIS is failing to recognise the significant travel costs associated with providing services in rural and remote areas.

Failing to adequately cover the costs of travel can act as a disincentive to organisations providing services in these areas. VCOSS welcomes the NDIA's acceptance of the Independent Pricing Review's recommendation to increase the travel allowance from 20 minutes up to 45 minutes in rural areas¹⁴ as a good start, however notes that since providing services in rural areas often

¹² K Mavromaras, M Moskos, S Mahuteau, *Evaluation of the NDIS, Intermediate Report*, National Institute of Labour Studies, Flinders University, Adelaide, September 2016, p.31.

¹³ D Warr, H Dickinson, S Olney et. Al. *Choice, Control and the NDIS*, Melbourne, University of Melbourne, 2017, p.8

¹⁴ NDIA, *Independent Pricing Review: NDIA Response*, 2 March 2018.

requires travelling more than 45 minutes. Organisations should be able to claim their total travel costs.

Build outreach capacity

Recommendations

- Work with the NDIA to ensure the NDIS model provides capacity for organisations to reach out to isolated people and communities.

VCOSS members continue to advise that many people eligible for the NDIS will not engage in the scheme without active assistance.^{15,16} These people may be isolated, not accessing existing services or have multiple or complex needs. For instance, up to a third of people experiencing severe mental health issues are unlikely to engage with services.¹⁷ People experiencing homelessness are also likely to face many difficulties accessing the NDIS.¹⁸ Undertaking assertive outreach can help identify and reach isolated people and communities who cannot otherwise engage in the NDIS, especially those not currently accessing services. This requires funding for skilled and experienced workers, and can take substantial time to effectively

¹⁵ VCOSS, *Submission to NDIS Joint Standing Committee inquiry into Transitional Arrangements for the NDIS*, August 2017.

¹⁶ Jesuit Social Services, *Submission to the Productivity Commission study into the NDIS costs*, March 2017.

¹⁷ T Slade, A Johnston, M Teesson, H Whiteford, P Burgess, J Pirkis and S Saw, *The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing*, May 2009, p.15.

¹⁸ Council to Homeless Persons, *Homelessness and the National Disability Insurance Scheme – Challenges and solutions*, 2017.

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