Charles Sturt University

Submission to the Mental Health and Suicide Prevention Agreement Review – Productivity Commission

Considerations for rural, regional and remote communities

Rural Health Research Institute

For further information please contact

Dr Hazel Dalton

Contents

Suggested citation:

Dalton H, & Allan J (2025) Submission to the Mental Health and Suicide Prevention Agreement Review (Productivity Commission) – consideration for rural, regional and remote communities. Rural Health Research Institute, Charles Sturt University, Orange NSW, Australia.

About the Rural Health Research Institute

Located at Charles Sturt University in Orange NSW, the Rural Health Research Institute (RHRI) was established in 2022 to conduct research that addresses the rural health gap in communities across regional and remote Australia and internationally.

The RHRI upholds the values of Charles Sturt University.

Yindyamarra Winhanganha' - The wisdom of respectfully knowing how to live well in a world worth living in

We pay our respect to all First Nations elders both past and present from the lands where Charles Sturt University students reside. In particular, we acknowledge the Wiradjuri, Ngunawal, Gundungurra, and Birpai peoples of Australia, who are the traditional custodians of the land where Charles Sturt University campuses are located.

Submission to the Mental Health and Suicide Prevention Agreement Review – consideration for rural, regional and remote communities

Introduction

We have reviewed the National Mental Health and Suicide Prevention Agreement using the framework within the Orange Declaration on rural and remote mental health [1], and the International Declaration on Rural Mental Health Research [2], and considered the National Mental Health and Suicide Prevention Agreement 2022-2023 Annual National Progress Report. From the themes arising, we have then reached to further evidence for rural and remote mental health. We have also considered the regional planning for mental health and suicide prevention by Primary Health Networks (PHNs) and their corresponding Local Health Networks (LHNs). The areas of the Agreement that refer to rural, regional and remote communities are noted in the Appendix.

1. Community Engagement and Cultural Sensitivity

The annual progress reports highlights efforts to engage rural communities in regional planning. There should be consideration given to how this engagement threads together over time to build a coherent narrative, strategic focus and iterative development of services, or whether these activities remain ad hoc and disconnected. For example, in considering this review, has the agreement been successful in encouraging maturation of regional planning capability, capacity and implementation success (building on from plans developed in line with the Fifth National Mental Health Plan [3])? There is an additional engagement opportunity cost for regional PHNs that have responsibilities over large geographical regions but small and unevenly distributed populations. Communities often have lower trust from prior poor experiences with engagement and trials of services that are not sustained, especially for Aboriginal and Torres Strait Islander communities. There is a trust cost to engagement work that doesn't lead to real change such as additional or more appropriate services locally.

Recommendation – assess whether the resourcing and time allocated for regional PHNs to engage with their dispersed populations is adequate and sustained to build trust and genuine participation.

2. Sustainable and Equitable Funding

The annual progress report highlights additional funds to rural and remote communities, however equity of access to services varies highly by geography. Consider cost-shifting in the opportunity costs (travel, time and family/carer responsibilities) experienced by rural and remote residents in accessing care. Those in remote communities face significant challenges, and whilst they can be supported to access acute services for mental health and suicidal ideation, they are often faced with challenges (logistically and financially) returning home from care that has been delivered at significant distances from their home. This is not faced by those living in metropolitan settings.

Recommendation – assess the resourcing and support to provide equity of access to mental health and suicide prevention support.

Funding models are not well aligned to the realities of rural service provision [4]. Funding models exacerbate market failure in rural and regional areas – time-limited contract commissioned services, and fee-for-service/activity-based-funding all contribute to system instability and fail to recognise that the populations are too small and the ability of services and practitioners to meet small and variable demand.

Recommendation – assess if more flexible funding models have been enabled or trialled – that acknowledge market failure, prioritise workforce recruitment and retention, invest in longer term sustainable and integrated care.

3. Workforce Development and Stability

The rural metal health workforce remains overstretched, with staff fulfilling different roles than that in metropolitan areas. Since numbers of qualified staff are low clinicians have to cover a wide scope of practice, often with poor access to clinical supervision and managerial support. This makes such jobs unattractive and in some cases career-limiting [5].

Health workforce recruitment, retention, development and support remain crucial areas for focus and investment. Workforce shortages across medicine (especially GPs), nursing and allied health, there needs to be sustained and increased investment across the workforce development pipeline. There are promising models that consider the social determinants of rural health workforce retention [6] in the form of the Whole-of-person retention framework [7]. Such approaches take a community engagement and co-design approach to recruiting and retaining staff as needed in place. With the dominant discourse around the shortage of GPs in primary care, there are additional challenges in recruiting the nursing and allied health workforce, and using to their maximal scope of practice, new models of care and funding should be considered [8].

Recommendation – To maximise rural primary care and its ability to meet mental health needs, consider nurse-led models of care (e.g. [9]), multidisciplinary team arrangements (e.g. [10, 11]) and maximising the role of community-controlled health services such as Aboriginal Community Controlled Health Services and Primary care Rural Integrated Multidisciplinary Health Services (as advocated by the National Rural Health Alliance [12]). Consider how maximising the capacity of primary care to support mental health has been prioritised in the agreement and its implementation.

4. Service Accessibility and Integration

The pandemic facilitated a rapid expansion of telehealth services, which has improved access to mental health care in remote areas. To ensure the long-term sustainability of telehealth services and addressing technological barriers, such as limited internet connectivity, are ongoing issues. The digital divide persists, and technological access is but one dimension, digital literacy, acceptability and affordability are other factors. Moreover, telehealth services should be seen as a complement and not a substitute.

Recommendation – support the evolution of telehealth support for rural mental health by considering how it connects to and works with local services, and the acceptability to local users, including cultural safety.

Mental health service models designed for large populations, which assume medical models focusing on specialist providers (e.g. psychiatrists) not available or resident in rural communities. Scaling down these models to fit smaller rural communities does not enable efficient or responsive services. Rather rural communities are served by primary care and community-based models which should form the basis of rural mental health services. Often these services, such as general practices and multi-purpose services focus on the care of physical problems and are not well equipped to address mental health problems.

Recommendation – supporting primary care to better integrate the mental health care of rural and remote residents, through training and additional resourcing (funding incentives). Consider how the agreement has prioritised integration of mental and physical health care in the primary care setting (see also Clause 47 (j)).

5. Data Collection and Outcome Measurement

Context: Rural Communities are not simply the other category which excludes capital cities. These communities vary in geography, demography, economy industry and amenity. This variance or heterogeneity exemplifies rural and remote areas and thus needs to be a feature of analysis, not noise to be ignored [13]. It follows that one size will not fit all. There are challenges with the use and application of the National Mental Health Service Planning Framework to address needs in rural areas, with a need to tailor to local areas [14]. The Framework requires tailoring to meet local needs.

Many of the systemic problems are exacerbated by the absence and poor use of data about the needs of communities, activities of services and outcomes of rural services. The collection, analysis and use of conventional and new data sources is possible, but investments made have not yet been sufficient. Data is often collected and not used or incompatible, incomplete and of limited value.

There are additional challenges of data heterogeneity and how to deal effectively with low numbers, other than omission. There is a need for more comprehensive data collection methods and better use of data to measure progress and identify areas for improvement. Infrastructure to support this regional planning can and should be national, to drive new opportunities for consistency, data collection and benchmarking, we applaud ongoing efforts to improve this. But rural residents need to lead local planning processes. In rural and remote areas, the need to gather and incorporate qualitative data becomes more important given the limits of quantitative data for small populations.

Recommendation – continue investing in national infrastructure to support regional planning, but account for the challenges of data heterogeneity that is a feature of rural and remote areas not a bug.

Recommendation – support PHNs to ensure collection of rich qualitative information on local challenges through its engagement activities in needs assessments and regional planning.

Appendix – Specific consideration of rural, regional and remote communities in the National Mental Health and Suicide Prevention Agreement

PART 2 — PRINCIPLES, OBJECTIVES, OUTCOMES AND OUTPUTS

(d) Support and enhance the capability of the mental health, suicide prevention and broader health and related workforce to meet current and future needs, particularly **in rural, regional and remote communities** and priority populations;

(i) Ensure the particular needs of Australia's **rural, regional and remote communities are equitably addressed**;

(k) Enable effective regional and national cooperation between providers, systems and governments that facilitates local responses to address the unique needs of communities, particularly in **rural, regional and remote areas**

Shared roles and responsibilities

Clause 47. Under this Agreement, the Commonwealth and the states agree to be jointly responsible for:

(h) Co-designing place-based approaches at a local level with affected communities ensuring:

   i. The voices of people with lived experience are embedded in the planning, design and evaluation of services to enable person-centred care that addresses the needs of priority populations and **rural, regional and remote communities**.

   ii. **Rural, regional and remote areas** where there is limited access to health and related services have new models of care, or refinement of existing models of care, developed to address equity of access and improve outcomes for that local community

Increase reporting and transparency, and drive system improvement

Clause 96. The Parties agree to:

(b) Develop specific KPIs for vulnerable cohorts and **regional, rural and remote areas** to ensure that outcomes for these groups are a priority focus.

Clause 111. Implementation of initiatives under this Agreement or associated Schedules will consider and support the mental health and wellbeing of the following priority populations groups, at a minimum, noting that a person may fall into one or more of the below groups:

(g) People living in **regional, rural and remote areas** of Australia

 Clause 120. To improve effectiveness, access and equity of care, the Parties agree that reform activities implemented under this Agreement will:

(d) be available in varied geographic locations, including **rural, regional remote areas**.

(e) be accessible to priority cohorts (refer Clause 111 for priority populations (**111 g**)).

Workforce

Clause 149. The Parties commit to support workforce development and sustainability across sectors, including those sharing the mental health and suicide prevention workforce (i.e. aged care, disability, alcohol and other drugs) and seek opportunities to address areas of thin markets (including **rural, regional and remote settings**).

Workforce Attraction, Training, Retention, Optimisation and Distribution

Clause 157. The Parties agree that there will be an increase in effort to support the expansion of vocational undergraduate and post graduate scholarships, specialist training posts, and clinical placements across all settings (private and public, and acute and primary care) for mental health and suicide prevention professions with identified shortages, with a particular focus on sub-specialities in shortages, and on **regional, rural and remote locations**.

References

1. Perkins, D., J. Farmer, L. Salvador-Carulla, H. Dalton, and G. Luscombe, *The Orange Declaration on rural and remote mental health.* Australian Journal of Rural Health, 2019. **27**(5): p. 374-379.
2. Roberts, R., S.-A. Munoz, K. Thorpe, H. Dalton, L. Deacon, D. Meredith, . . . L. Grattidge, *International declaration on rural mental health research: 10 guiding principles and standards.* Australian Journal of Rural Health, 2024. **32**(4): p. 611-616.
3. Department of Health, *The Fifth National Mental Health and Suicide Prevention Plan*. 2017, Australian Government: Canberra.
4. Rosenberg, S. and R. Roberts, *Models of Service Delivery and Funding of Mental Health Services*, in *Handbook of Rural, Remote, and very Remote Mental Health*, T.A. Carey and J. Gullifer, Editors. 2020, Springer Singapore: Singapore. p. 1-28.
5. Cosgrave, C., R. Hussain, and M. Maple, *Retention challenge facing Australia's rural community mental health services: Service managers' perspectives.* Aust J Rural Health, 2015. **23**(5): p. 272-6.
6. Cosgrave, C., C. Malatzky, and J. Gillespie *Social Determinants of Rural Health Workforce Retention: A Scoping Review*. International Journal of Environmental Research and Public Health, 2019. **16**, DOI: 10.3390/ijerph16030314.
7. Cosgrave, C. *The Whole-of-Person Retention Improvement Framework: A Guide for Addressing Health Workforce Challenges in the Rural Context*. International Journal of Environmental Research and Public Health, 2020. **17**, DOI: 10.3390/ijerph17082698.
8. Malatzky, C., C. Cosgrave, A. Moran, S.A. Waller, and H.E. Dalton, *It's more than just a rural GP shortage: challenging a dominant construction of the rural health workforce 'problem'.* Rural Remote Health, 2024. **early abstract/8734**.
9. Dalton, H., C. Cosgrave, and D. MacKinnon, *Teen Clinic - An integrated primary healthcare model that improves access for young people in rural communities.* Aust J Rural Health, 2023. **31**(6): p. 1050-1059.
10. Fitzpatrick, S., D. Perkins, T. Luland, D. Brown, and E. Corvan. *The effect of context in rural mental health care: understanding integrated services in a small town*. in *Small Countries PHC Meeting (Robert Wood Johnston Foundation)*. 2017. Royal College of Surgeons, Edinburgh, Scotland (Plenary): International Foundation for Integrated Care.
11. Fitzpatrick, S.J., D. Perkins, T. Handley, D. Brown, T. Luland, and E. Corvan, *Coordinating Mental and Physical Health Care in Rural Australia: An Integrated Model for Primary Care Settings.* International Journal of Integrated Care, 2018. **18**(2): p. 1-9.
12. National Rural Health Alliance. *Primary care Rural Integrated Multidisciplinary Health Services*. 2025 [cited 2025 March 12]; Available from: https://www.ruralhealth.org.au/primary-care-rural-integrated-multidisciplinary-health-services/.
13. Rock, D. and S.P. Cross, *Regional planning for meaningful person-centred care in mental health: context is the signal not the noise.* Epidemiol Psychiatr Sci, 2020. **29**: p. e104.
14. Wright, E., E. Leitch, K. Fjeldsoe, S. Diminic, K. Gossip, P. Hudson, and H. Whiteford, *Using the National Mental Health Service Planning Framework to support an integrated approach to regional mental health planning in Queensland, Australia.* Aust J Prim Health, 2021. **27**: p. 109-115.