3 April 2025

Review of the National Mental Health and Suicide Prevention Agreement
Productivity Commission
GPO Box 1428 Barton
CANBERRA ACT 2600
mentalhealthreview@pc.gov.au

Dear Commissioner,

Final Review of the National Mental Health and Suicide Prevention Agreement

The National Rural Health Alliance (the Alliance) is pleased to provide a submission to the Productivity Commission's Final Review of the National Mental Health and Suicide Prevention Agreement (the National Agreement).

The Alliance is the peak body for regional, rural and remote (hereafter rural) health in Australia, comprising 53 member organisations, which include healthcare professionals, service providers, health and medical educators, researchers, medical and health practitioner students and the Aboriginal and Torres Strait Islander health sector.

Our vision is for healthy and sustainable rural communities, which make up the over 7 million people residing outside our major cities, or approximately 30% of the Australian population. It is of note that close to 60% of Australia's First Nations people – representing the world's longest continuous living culture of over 50,000 years – live in rural Australia. We are focused on advancing rural health reform to achieve equitable health funding to that of urban per capita spending and equitable health outcomes for rural communities.

Mental health costs the economy billions a year, with recent data from the Australian Institute of Health and Welfare (AIHW) reporting an increase in spending from $11.8 billion in 2018-19 to $13.2 billion in 2022-23 on mental health-related services. However, only 7% of total government health expenditure goes to mental health, far below the 15% total burden of disease it represents, and second only to cancer (17%).[1,2]

As the Commission reported in its Mental Health Report 2020, mental illness contributes significantly to lost productivity and is estimated at up to $39 billion per year. The lost productivity is expected to increase as more and more people are incapacitated due to mental health conditions.

Indeed, recent research by the Australian National University (ANU) indicates ongoing challenges within Australia's mental health system, highlighting significant lack of supported accommodation, hospital beds, and trained specialists for people experiencing chronic severe mental health conditions.[3] In rural areas, lives are being lost due to lack of available, appropriate and consistent mental health support. Many are not being supported to achieve a state of optimal mental health and wellbeing that allows them to live fulfilling lives and contribute fully to society. This is a strong imperative for change.

Rural health is both unique and complex, highlighting the need for tailored policies and flexible funding that recognises the distinct aspects of rural culture, the type and quantity of access to services. This review provides an opportunity to enhance the effectiveness of the National Agreement for priority population groups and consider further changes to implement systemic, whole-of-government mental health and suicide prevention reforms.

The Alliance's submission addresses the following terms of reference (ToR) and highlights some of the key complexities associated with supporting the mental health and wellbeing of rural Australians:

a) *the impact of mental health and suicide prevention programs and services delivered under the National Agreement to Australia's wellbeing and productivity*
b) *the effectiveness of reforms to achieve the objectives and outcomes of the National Agreement including across different communities and populations*
c) *the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved*
d) *the extent to which the National Agreement enables the preparedness and effectiveness of the mental health and suicide prevention services to respond to current and emerging priorities*

As a country, we need to ensure everyone, no matter where they live, has access to coordinated, accessible and patient-focused mental health services. As a priority population for the National Agreement, people living in rural Australia make significant contributions to the Australian economy, society and productivity performance of Australia. The gross value of agricultural, fisheries and forestry production was $100 billion in 2022-2023[4]. Over 90% of the food and drinks we consume are grown or made in rural Australia[5], and nearly half of the nation's tourism expenditure of 46% or $107 billion occurs in regional Australia.[6]

With the current $6.55 billion (or approximately $850 per person) per annum health underspend in rural Australia, this population deserves at least the same health expenditure and investment. A good start would be equitable access to healthcare and life expectancy, better health outcomes and improved mental health.

Further action to address the health funding, service and outcome inequities they face would ensure both social justice and economic prosperity for Australia.

I would be pleased to provide further information on any of the information contained in this submission if required.

Yours sincerely,

Susi Tegen
Chief Executive
National Rural Health Alliance
Ph 02 6285 4660
www.ruralhealth.org.au

National Rural Health Alliance

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

March 2025

… healthy and
sustainable rural,
regional and remote
communities

National
Rural Health
Alliance

Postal Address:	PO Box 475 Curtin ACT 2605
Address:	10 Campion St Deakin ACT 2600
Phone:	02 6285 4660
Fax:	02 6285 4670
Email:	nrha@ruralhealth.org.au

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

Table of Contents

People living in regional, rural and remote areas - a priority population for the National Agreement

The National Rural Health Alliance (the Alliance) notes that one of the key outcomes of the National Agreement is to improve the mental health and wellbeing and reduce suicide, suicidal distress and self-harm in the Australian population, with a focus on identified priority populations, including people living in regional, rural and remote areas of Australia.

We welcome the Review's focus on this priority population to ensure improved access and equity to mental health and suicide prevention programs and services delivered under the National Agreement. Living in rural areas offers numerous benefits, with people often enjoying a stronger sense of community and a healthier environment, surrounded by natural beauty. Individuals have access to fresh, local produce and tend to report higher satisfaction with relationships. Research indicates that people living in rural communities tend to have a greater sense of belonging, usually experience less loneliness, are more likely to volunteer in their community, and have significantly greater satisfaction with sense of community connectedness and personal safety.[7,8,9]

However, there remain continuing challenges for people who call rural and remote Australia home. They continue to experience the triple disadvantage that contribute to poorer health outcomes compared to people living in urban communities: **poorer social determinants of health**; **poor access to health care, including mental health services**; and **higher access and delivery costs**. In addition, they bear the brunt of extreme weather patterns that contribute to droughts, floods and wildfires, and are expected to bounce back from these disasters and remain resilient. This is despite climate uncertainty and risk and lack of funding and service provision being their reality.

Of note is that rates of self-harm and suicide increase with remoteness and people who experience suicidality are more likely than the general population to have a mental health disorder or condition. In addition, Indigenous populations experience higher rates of psychiatric morbidity and two-thirds of this population live in rural and remote areas of Australia. They require support in the areas of depression, post-traumatic disorders and comorbidity (with either substance misuse or a physical condition). Rates of schizophrenia and bipolar disorders are similar to those in the non-Indigenous population, but suicide rates are on average three times higher.[10]

The Alliance also seeks to highlight that the mental health crisis disproportionally affects farmers and those working in agriculture, and their welfare needs a whole-of-government approach if we as a nation are to address this critical issue in a truly meaningful way. A rural coalition comprising the National Farmer's Federation and more than 30 rural and health organisations is calling on the Federal Government to invest $50 million over 5 years to support farmers with their mental health and wellbeing.

These and many other impacts are discussed further in this submission in the context of supporting the diverse needs of people with mental health conditions living in rural and remote communities.

The Alliance considers that the differences in healthcare access and outcomes based on location of residence highlight significant inequity and deficiencies within our healthcare and social support systems as well as flexibility and consistency of funding. In this regard, we support the *National Suicide Prevention Strategy 2025–2035* call "to better understand the factors which cause suicidal distress in Australia, and to double our efforts in addressing them".[11]

From the rural perspective in particular, we support the findings of the *Outside the city: Designing suicide prevention for regional, rural, and remote communities* workshops undertaken by the Manna Institute. The report proposes "a call to action that seeks change in the way suicide prevention in regional, rural, and remote communities can be enhanced by place-based intervention, postvention, involvement of people and communities."[12]

Changes proposed to the next National Agreement

The Alliance notes that the National Agreement is supported by Bilateral Schedules with all States and Territories, which include funding to implement and deliver specific initiatives at the state level, with varying levels of commitment between the states and territories. The joint Commonwealth and state investments focus on providing community-based services to address gaps in the mental health and suicide prevention system, and includes varying commitments such as adult, youth and child mental health services, perinatal measures and suicide prevention services.[13]

We note also that while there have been notable achievements reported by the National Mental Health Commission, implementation progress against the Bilateral Schedule initiatives has been mixed. In part, this has been due to the Bilateral Schedules being signed late in the 2021-22 financial year.[13]

The Alliance proposes a number of changes to the next National Agreement to improve the mental health and suicide prevention systems.

Addressing social determinants of health in mental health and suicide prevention systems

Health outcomes are known to be poorer in populations that are socially or economically disadvantaged, with many fundamental quality of life factors deteriorating with increasing remoteness. There are a range of stressors unique to living outside major cities which contribute to poorer health outcomes such as a greater prevalence of some chronic conditions and disability, tyranny of distance, cost of services and lack of workforce.

Many factors are at play, rather than a single isolated cause. These include: **social determinants** (such as income, education, employment, housing, social inclusion, and access to health care); **individual factors**, including contextual factors (such as stressful life events, trauma, abuse and discrimination); **structural factors,** including what is available at a local community level, flexibility of funding, whether it is ongoing, **clinical factors** (for example, mental illness, drug and alcohol use, chronic physical illness); **personality factors**; **genetic factors**; and **demographic factors** (such as age, gender, geographic location, sexual orientation, cultural heritage).[14]

Physical illnesses that occur with mental health conditions, known as comorbidities, can worsen mental health and are strongly associated with early mortality and severe illness.[3] There is also a well-recognised relationship between mental illness, particularly severe mental illness, and substance use. Rates of smoking, risky drinking and illicit drug use are higher among people living in rural and remote communities. Dependence is common, with almost half of people with a severe mental health condition exhibiting current substance abuse or dependence.

In rural areas, lower employment opportunities, limited social support and less financial stability along with housing stress can also lead to increased mental ill health. The psychological impact of financial stress in the cost-of-living crisis is increasing demand for mental health support, where choices about eating are made against the cost of rent and mortgage versus healthcare costs. Recent research by the ANU which surveyed 4,200 Australians found that over 30% of respondents are finding it “difficult” or “very difficult” to get by on their current income, and this is impacting their mental resiliency.[3]

Distress relating to housing availability and cost is especially pertinent for families in rural and remote areas where the cost-of-living pressures are compounded by their need to travel further, lower income, which is some 15-20% lower than that of families in the major cities. The ANU research indicates that secure supported accommodation is the critical foundation for people to recover and prevent further deterioration and need for additional supports.[3]

Environmental stressors such as drought, flood and bushfire can have a heavy impact on mental health and wellbeing, especially in areas of primary industries. The impacts of these disasters often persist for many years. Some communities have lost their homes and livelihoods several times in the past 5 years. Yet, insurance premiums have quadrupled, compounded by insurance claims taking many years to settle. In addition, the mental health consequences of regional economic recession, services, Australia Post and the Big 4 banks withdrawing their services from rural towns can be long-lasting and are not felt by city populations.

Social care services help individuals navigate barriers by offering, among other things, housing support, education and training, job finding assistance, which help reduce the impact of factors that are known to lead to poor health.

Key points

- There is now compelling evidence that the risk of developing any mental health condition is inextricably linked to life circumstances. Accordingly, **preventive strategies addressing social determinants of mental health and wellbeing should sit alongside existing evidence-based strategies in clinical psychiatry that have proved effective in treating individuals**.[1]
- In this regard, reform activities should be informed by **the specific needs of people living in rural Australia** as one of the many priority population groups.
- Considering they make up 30% of the population, have worse health outcomes and are dying early from diseases that are preventable, **we have a social contract to our fellow rural Australians to close the urban and rural divide**.

Improving access to mental health care and psychosocial supports

Data on Medicare-patient subsidised mental health services in regional, rural and remote areas shows a clear pattern of lower use in these areas. There is a shortage of health services of all kinds in rural areas, and particularly in specialist areas such as aged care, disability and child psychiatry.[10] This is due to a persistent, ongoing maldistribution of health professionals in Australia – rural and remote areas have fewer providers (per capita) across most registered professions, e.g. doctors, dentists, pharmacists and allied health professionals. As well as these professionals, more Aboriginal health, ageing and disability professionals are needed in remote, rural and underserved areas.

Figure 1 shows the decrease in the number of health professionals with increasing remoteness, while **Figure 2** shows decreasing service availability (in particular GPs and specialists) with increasing remoteness.

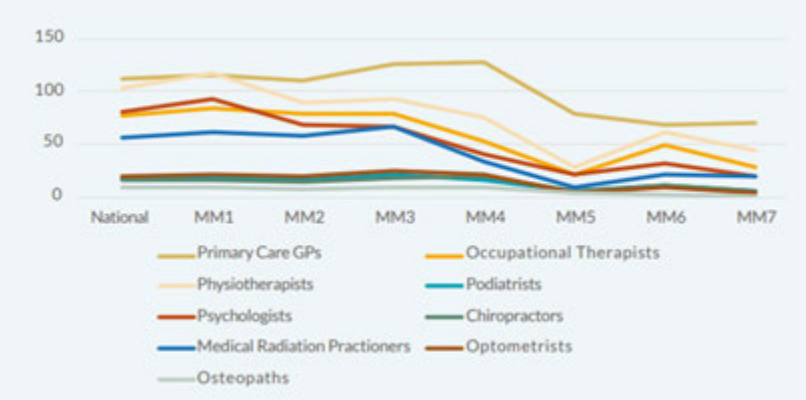

Figure 1. Health professionals by Remoteness: MM1 to MM7 FTE per 100,000 population, 2023 (Source Department of Health and Aged Care)

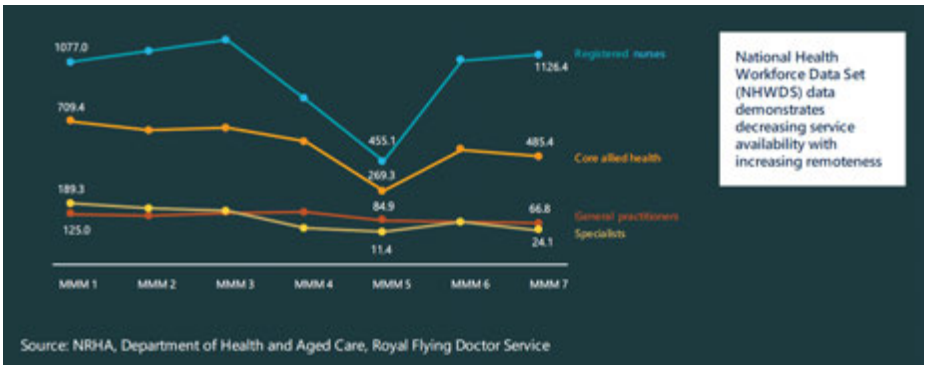

Figure 2. Lower expenditure on services reflects lower health practitioner availability

As a result, there is significant unmet population need for services and supports, challenges to the provision of a suitable and sustainable workforce, and multiple barriers to access in the area of mental health and wellbeing in rural Australia. Lack of timely access to services, diagnosis, treatment and ongoing management of a mental health condition in rural and remote areas is likely to occur later or not at all, resulting in increased utilisation of the acute care sector and sometimes leading to the most tragic of outcomes – self-harm and suicide.[15] In addition, inflexible and start-stop nature of some programs which are inflexible and not suitable to local needs, set communities and clinicians up to fail.

The Alliance welcomes the recent Victorian Government announcement to provide 24/7 clinical care in a home-like setting for young people aged 16-25 across Ballarat and surrounding areas experiencing mental health challenges, recognising that this will reduce pressure on hospitals by offering an alternative to acute hospital admission. In addition, there is a need to expand such programs to the populations of MMM 4, 5 and 6 areas, where there is the largest gap in services and funding.

For a substantial proportion of people with the most chronic severe mental health conditions – schizophrenia, bipolar disorder and severe depressive disorders – there is evidence that these people do not receive adequate care, if they receive care at all. This is because the care required to manage all aspects of their illness involves not only psychiatric and psychological treatment, but treatment of commonly associated physical conditions and substance use problems.[10]

In addition, the Alliance has received feedback indicating that even where equity of access is intended, people in rural areas may still be disadvantaged. Rates of subsidised and co-payment supplied medicine for mental health-related conditions are lower in remote and very remote regions, which suggest that people in those areas are not being prescribed or are not collecting their medicine to treat their mental health condition.

Another aspect of medicine use that varies with remoteness is the annual number of prescriptions per patient. The rate for major cities and inner/outer regional is 10 prescriptions per patient, compared to remote and very remote areas which is 8-9 prescriptions per patient. Assuming that a single prescription supply is for one month, a lower number of prescriptions indicates that patients are less adherent to a prescribed medicine regimen over a year, which might be due to accessibility, adherence or both.[16]

As noted by the Productivity Commission report of 2020, psychosocial supports are "… a key facilitator of recovery, can help alleviate some risks of illness relapse and support people as they develop skills to self-manage the effects of variations in their mental health. Psychosocial services typically include respite services, building social skills and relationships in a culturally supportive way, assistance with transport, tenancy or household management and finances, and coordination and support in complying with clinical treatment needs."[17]

Psychosocial support can reduce avoidable hospital presentations, for example, mental health outreach programs can help manage conditions like anxiety and depression before they escalate into crises requiring hospitalisation. Many of these recommended structures are just not available in rural Australia.

In this regard, the Alliance commends the recent Federal Government announcement to fund the roll out of a free digital psychosocial recovery program for adults experiencing complex mental illness and trauma, as well as for their family, carers and kin. Digital mental health services, in general, should be digitally inclusive and bridge the digital divide between urban and rural populations. These services should, however, be in addition to face-to-face services, not instead of, and need to be linked with the patient's regular primary care clinician to ensure continuity of care.

The Alliance supports Mental Health Australia's *Vision Statement: A mentally healthy Australia*, funding for mental health services should match the scale of the problem and community expectation. That is, mental health expenditure for rural areas needs to be commensurate with the level of psychosocial disability and mortality caused by mental ill-health in this population group. We need to embed an equitable, inclusive, human rights-based approach to care and support.[18]

Moreover, mental health supports need to be delivered in a way that is geographically and local needs appropriate, rather than trying to fit a city-centric model into environments that do not match. Indeed, inflexible funding models result in rural communities losing or underutilising their funding allocation and need to be reversed.

Key points

- **Reorientation of the mental health and wellbeing and suicide prevention system towards prevention and early intervention is essential** - given the workforce and access constraints in rural Australia – to allow efficient use of limited resources. This requires alignment of services with geographic, structural and delivery needs and capabilities, and alignment of supports and interventions with consumer and community need.
- Furthermore, there is an urgent need to **ensure equitable and appropriate levels of funding for and access to mental health promotion, preventive mental health, and early intervention programs and services** for people living in rural communities.
- **Digital mental health services should be expanded** as an addition to face-to-face consults to ensure rural and remote communities have equitable access to mental health care – this will also improve include connectivity and digital inclusion in these communities.
- Effective care of patients with chronic severe mental health conditions is complex and multifaceted. The next Agreement must include approaches not only to ensure access to mental health services, but also **address any shortfalls in funding and access to a range of psychological treatments, as well as psychosocial care**, as they can improve the quality of life for people with mental illness.
- Funding should be **commensurate with the level of psychosocial disability and mortality**, taking into account the way it can be delivered in that environment.
- The **allocation of rural funding must be kept separate in a rural health fund**, to ensure it is redistributed to rural health activities and services, rather than reallocated to urban Australia.

Strengthening workforce availability and capacity

As noted previously, the maldistribution of health professionals in rural and remote areas and poor access to healthcare services is resulting in unmet need in these communities. The latest National Health Workforce Dataset indicates that the availability of psychologists declines as remoteness increases, with the lowest in MM7 (26.1 FTE per 100,000 population), compared to MM1 and MM2 (126.70 and 91.00 FTE per 100,000 population, respectively). Services provided by a psychiatrist reduce dramatically once outside of major cities, as do those provided by clinical psychologists.[19]

Table 1 and **Figure 3** below show the generalist mental health workforce, FTE per 100,000 population, by MMM 2023-24. **Table 2** and **Figure 4** show the specialist mental health workforce, rate (per 100,000 population), by remoteness 2022-23.

Table 1: Generalist workers – mental Health, FTE per 100,000 population by MMM, 2023-24				
	Primary Care General Practitioner	**Paramedicine Practitioner**	**Aboriginal and Torres Strait Islander Health Practitioner**	**Total**
MMM1	112.20	77.20	0.80	190.20
MMM2	110.30	115.90	5.00	231.20
MMM3	126.70	122.60	7.60	256.90
MMM4	126.70	176.20	6.70	309.60
MMM5	78.60	113.70	2.00	194.30
MMM6	68.20	192.50	43.10	303.80
MMM7	71.40	236.30	57.30	365.00

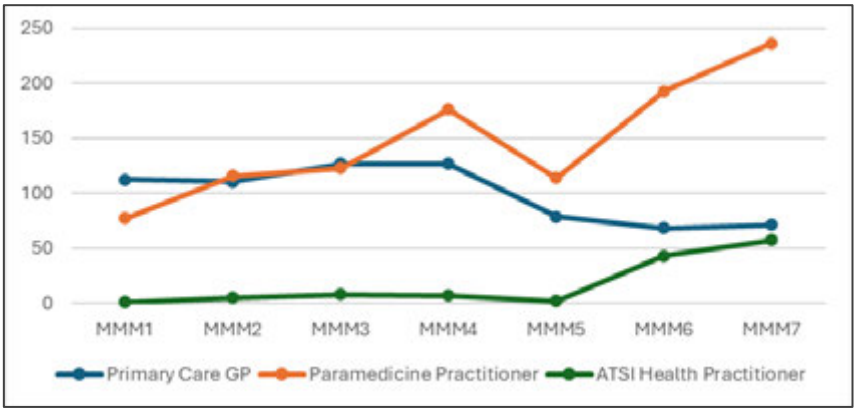

Figure 3. Generalist mental health workforce, rate (per 100,000 population), by MMM 2023-24 (Source: AIHW)

Table 2: Specialist workers – mental health, rate (per 100,000 population), by remoteness, 2022-23						
Remoteness	**Psychologist**	**Psychiatrist**	**Mental health nurse**	**Mental health occupational therapist**	**Accredited medical health social worker**	**TOTAL**
Major Cities	886	112	638	71	65	1,772
Inner Regional	487	38	486	36	84	1,131
Outer Regional	395	40	394	36	76	941
Remote	202	22	207	31	21	483
Very Remote	47	6	157	0	8	218

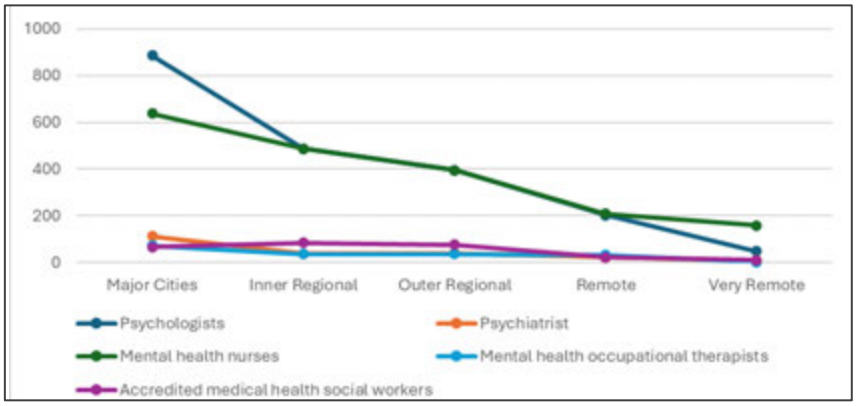

Figure 4. Specialist mental health workforce, rate (per 100,000 population), by remoteness 2022-23 (Source: AIHW)

The modelling used in the National Mental Health Workforce Strategy 2022-2032 reports a 32% overall shortfall in the mental health workforce compared to targets, with the shortfall likely to increase to 42% by 2030.[20]

For a range of reasons, access to GPs and primary care in many rural and the majority of remote communities is often limited and, therefore, is not always the usual entry point to primary mental healthcare systems for community members. In these instances, the first point of entry and coordinators of multidisciplinary, collaborative and integrated care may be nurses, Remote Area Nurses, nurse practitioners, Aboriginal Health Workers and Aboriginal Health Practitioners. Regardless of the practitioner providing or coordinating care, it remains essential that all practitioners have good skills and training in mental health and wellbeing and suicide prevention.

It is also important that all health practitioners are utilised according to their scope of practice. This includes medical specialists, psychologists and other allied health professionals, nurses, pharmacists and paramedics. The Alliance reaffirms the need for consistency and alignment across jurisdictions to prevent cross-border barriers which unnecessarily reduce health practitioners' scope of practice. For example, the Alliance is aware that, where an Aboriginal health worker is able to work in one jurisdiction, this may not be the case across the border, despite the shortage of Aboriginal and Torres Strait Islander mental health workers. Such cross-border limitations contribute to the underutilisation of this workforce, exacerbates workforce shortages and further limits access to culturally safe services.

Reduced access to primary care also places pressure on state-based health services, often the provider of last resort for vulnerable communities. Indeed, one of the significant unintended consequences of reduced access to primary care is an increase in preventable hospitalisations arising from an increase in demand for primary healthcare services, which can hamper these services from managing preventative health and chronic disease. This is particularly the case where there are thin or failed markets, often but not always in rural areas, and when the continued provision of primary care relies on a small number of providers.[9] Mental health reform must, therefore, ensure that the workforce is adequate to meet demand, not only for the mental health aspects of provision of care, but also for physical health needs and alcohol and other drug services.

The Alliance supports full implementation of rural generalist pathways to increase the capacity of rural practitioners to provide care to people with mental health concerns and suicidality, where specialised services are not available. It is of note that recent research indicates there are a number of barriers to employment models to attract and retain rural generalists, including housing, schooling and childcare support. The research concludes that state-wide, coordinated regional and local levels of strategy, planning and implementation are needed to achieve employment models that attract and sustain rural generalists.[21]

Research also indicates that good quality rural and remote placements are a predictor for rural practice. However, these placement opportunities can come at a significant financial burden, requiring flights, accommodation, and time away from paid employment activities. In addition, training often results in students being away from their partner and children, as well as having to face many other challenges such as shouldering multiple accommodation, unsuitable or lack of housing availability, and lack of support for trainees and other health staff. These challenges highlight the need to cultivate opportunities for rural placement and education pathways, and to include equity measures to ease the financial burden of undertaking rural placements. We have plenty to learn from the defence and mining industry.

In addition, the Alliance has received feedback relating to shifts in workforce distribution due to state-funded incentives aimed at attracting allied health clinicians to rural and remote areas. Although these incentives have eased recruitment issues in hospitals, they have created vacancies in other areas, namely, the not-for-profit, Aboriginal Community Controlled Health Organisations (ACCHO), and private sectors, and caused rifts in pay inequity and benefits between state vs primary care, as primary care often does not have scale.

Key points

- Given the complexities of managing people living with chronic severe mental health conditions, **Governments must work in partnership with mental health stakeholders and communities** in building a better mental health and suicide prevention system for all rural and remote Australians.
- The Alliance supports strategies to ensure **equitable access to GPs as an essential source of primary mental health care in rural areas.** Linkage of rural GPs and allied mental health staff within primary and secondary care, with **more specialised services via clear, integrated pathways** is critical to ensure best outcomes for rural people.
- There is a strong case for investing in rural training pathways for people from, and living in, rural areas and creating opportunities for rural experiences during placements. Support should be provided to ease the **financial burden, lack of housing infrastructure and child care needed while undertaking rural placements, as well as support to move to and from these placements**, just as any organisation would for its employees if they were required to move for work.
- Equally important are strategies to **increase access to psychiatrists and psychologists in rural Australia**.
- **Removing barriers to recruitment and retention of mental health professionals**, such as **cross-border arrangements that prevent them from working to full scope of practice** if they so wish, and **monitoring the shifts in workforce distribution** are particularly important in rural Australia, given the constraints of the system.
- There should also be **no gap in training and development opportunities** for the mental health workforce.

Addressing the fragmentation in mental health care

Australia's fragmented approach to mental health care has led to a confusing and problematic system and has been the subject of many inquiries. The split funding model, where the Commonwealth subsidises Medicare mental health services (e.g. GP mental health plans, psychologists), while States and Territories fund hospitals, community mental health services, and crisis care, creates gaps, duplication and fragmentation in healthcare.

From a patient perspective, this fragmentation in delivery makes it hard for individuals to navigate the system. Ultimately, a patient just expects to access a health service as an Australian and should not need to know about state vs federal service arrangements. From a service provider perspective, the Mental Health Commission has stated that the fragmentation often contributes to poor communication between service providers, role ambiguity and a disinclination to take on additional roles.[22]

In addition to a lack of integration between different levels of healthcare (e.g., primary, secondary and tertiary), there is also a disconnect across different systems causing many people to become neglected due to poor integration between mental health, NDIS, primary care, and social services. Indeed, people with complex mental health needs often fall through the cracks when transitioning between different services. Integrating mental health and alcohol services, for example, would deliver more streamlined and effective care for individuals dealing with harmful drinking habits, complement broader efforts to reduce alcohol-related harm, and provide person-centred support.

In instances where patients are discharged from hospitals, ongoing support is essential to prevent readmissions and reduce the impact of bed block on hospital emergency departments. Follow-up care, community-based support, medication management, and education on disease prevention and management can help to ensure patients adhere to treatment plans and promote long-term health outcomes, as well as reduce unnecessary hospital visits.[23]

Furthermore, as mental health services operate separately from housing, employment, justice, and education systems, it is a challenge for people to access holistic, wraparound support. The lack of holistic support leaves many vulnerable groups, such as rural Australians and First Nations communities, without tailored support.

The development and implementation of policies to reduce suicide rates in rural Australia needs to be grounded in an understanding that isolated initiatives and actions are less likely to be as effective as an integrated approach. Research suggests that a multifaceted public health approach has a greater likelihood of yielding reductions in suicide attempts than single interventions, however well-designed they may be.[24,25]

Key points

- **Strengthened collaboration and coordination between governments** rather than blame, is needed to improve the delivery of mental health care and achieve true reform of the mental health sector.
- The review should consider better coordination between state-funded and federally funded services, to ensure **smoother transitions between primary care, specialist care, and crisis response**.
- **Primary care should be integrated with mental health, aged care, community and disability services**.
- It is imperative that mental health and wellbeing and suicide prevention services, supports and interventions **are coordinated and carefully aligned to consumer and community need**, **indeed the setting.** This will support person-centred, integrated, evidence-based care across the continuum of care needs, including clinical and non-clinical services, with best use of limited resources (including workforce): the right care in the right place at the right time.[26]

Addressing other barriers to access and emerging issues

Various other issues influence access to mental health and wellbeing services and support from the demand side in rural Australia, including attitudinal factors, travel, cost, and digital access, among others. The following attitudes were prevalent among a sample of rural people including farmers: preference for self-management, lack of confidence that anything will help or be funded long enough before it is no longer funded, and trust. Concerns about privacy is also a barrier, as stigma related to mental health perpetuates privacy concerns for rural people, where health professionals are embedded within local communities and might be known to individuals.[27]

Structural barriers, such as the need to travel vast distances to access care, and costs related to travel, accommodation and time away from work and families are also a significant concern. While access to digital care and support services may ameliorate some of these barriers, reduced digital literacy in consumers and health professionals, lack of access to digital infrastructure (including reliable and affordable internet and mobile phone connectivity, hardware and interoperable software), presents challenges to equitable access outside of major cities, where the potential for benefit is large.

A Beyond Blue survey found that people are delaying seeking support or waiting until they are in severe distress. The top barriers to taking action included long waitlists, affordability of treatment and people thinking their problem was not serious enough to seek support.[28] Interventions that promote help-seeking behaviour are necessary for enhancing prevention, early detection, timely treatment and recovery from mental health problems.

More Australians are struggling in silence, not wanting to reveal their money woes. With the cost-of-living crisis, many are reaching out to psychologists, which means it has never been more important for the mental health workforce to understand the relationship between financial struggles and mental health. The Beyond Blue Survey of more than 5,000 people around Australia found that 46% of respondents named financial pressure as a key factor in their distress.[28]

Addressing the effects of exposure to rapid onset extreme weather events (e.g. bushfires, floods, cyclones) and slow-onset extreme weather events (e.g. droughts) on the mental health of children and young people must become a priority. Australian and international research has highlighted the need for better understanding of effective interventions and resources to support children and young people through the various psychological effects of extreme weather and disasters that are responsive to their local contexts. For example, geographic location is one of several factors that may amplify the level of psychological risk.[29]

Key points

- **Overcoming the different types of barriers** is key to helping more people access mental health services to deal with psychological distress.
- **Encouraging and promoting help-seeking behaviour**, which includes engaging with mental health services to communicate the need for advice and support when experiencing symptoms, should be **complemented with increased availability of mental health support** for people who may not otherwise seek the help they need.
- Programs that **build an integrated mental health and suicide prevention system** need to be attuned to the needs and experiences of people affected by mental health issues. Such programs are important for rural and remote communities to help **break down the barriers that often prevent them from reaching out** (e.g. farmers).
- Interventions to address emerging mental health issues such as **impacts of climate, cost of living pressures and economic or global market downturn on mental health** must be grounded in, and be responsive, to local contexts.

Improving data and performance information for assessing progress against the Agreement

Evidence based data is essential for understanding the prevalence of suicide, suicidal behaviours, suicide risk factors and the social determinants of suicide, such as rates of long-term unemployment and homelessness.

According to the Mental Health Commission, within the mental health and suicide prevention systems, significant data and information limitations restrict the type and level of analysis that can be performed to understand the true impact of health reform efforts. These challenges include but are not limited to data collection and reporting processes being largely activity-focused, an absence of metrics to measure key reform priorities, and a lack of specific targets and timeframes to promote accountability and assess progress.[30]

As noted by the National Mental Health Commission, more meaningful data needs to be captured to enable assessment of what is happening across the mental health system and facilitate new insights. While there is a lot of information on state and territory specialised mental health services, far less is known about outcomes of nationally funded initiatives, and even less on rural initiatives. In addition, little data is available on the impact and efficacy of the billions of dollars invested by governments across the system each year, or the experiences and outcomes of people who receive support through the system, and their families, carers and kin.[30]

Data on the mental health outcomes of various priority population groups, including people living in regional, rural and remote areas of Australia (noting that a person may fall into one or more of the priority groups and have many different attributes) need to be made more widely available.

Importance of dedicated funding for rural and remote mental health research

Poor mental health affects productivity. For all the reasons outlined in this submission, it is crucial that dedicated funding is set aside for rural and remote specific research to help address the unique issues and challenges experienced by rural communities in relation to mental health and suicide prevention strategies. As mental health solutions developed for cities often do not work in rural settings, research can inform tailored solutions to inform localised, community-driven programs that consider the rural realities.

The Alliance is pleased to be a partner in a specific rural and remote research study funded through the Medical Research Future Fund (MRFF). This project is in partnership with Monash University and is titled *Consumers' preferences for telehealth psychology in rural and remote areas.* This research will focus on the barriers and enablers that make telehealth options (which we consider should be a supplement or augmentation of the option of face-to-face consultations in most cases) work or not work well in rural Australia. This is the kind of research that needs to be encouraged as it recognises that there are unique issues for addressing the mental health needs of rural populations and tackles directly what make health options work better for these communities.

In addition, the Alliance urges all levels of government to work collaboratively to appropriately share findings from research and data analysis with relevant stakeholders, to assist in identifying gaps, improving supports provided. A new National Agreement should provide for better visibility and sharing of state-specific mental health and suicide prevention research

Key points

- The Alliance agrees with the National Mental Health Commission regarding the critical need for a whole-of-system view of mental health in Australia—across governments, portfolios, jurisdictions and providers —**that brings the key data together and describes the impact and efficacy of the mental health system holistically**.[30]
- The Alliance strongly urges data collected on mental health to be aggregated based on the priority population groups, and **in the case of people living in regional, rural and remote areas of Australia, broken down by geographic location**.
- Considering the mental health challenges of rural and remote areas, investing in mental health research for rural and remote Australia is essential to **reduce health disparities, improve access to care, and save lives.**
- Data collected for the National Agreement should be **broken down by geographical area** to facilitate clear assessment of the impact of mental health and suicide prevention services in rural and remote areas.
- A **dedicated pool of funding is required for rural and remote research** and the findings from research and data analysis, whether Commonwealth or state-funded, **should be shared with stakeholders.**

Proposal to improve access to healthcare services and health equity for rural Australia

The Alliance notes that The Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025 recommended that a shared plan of action focused on equity of access in rural and remote areas form a Schedule to the new National Health Reform Agreement. The Schedule would include priority actions and milestones, national datasets, minimum access standards, socioeconomic considerations and appropriate rurality weightings in funding formulae.[31]

In its 2025-26 Pre-Budget Submission, the Alliance has advocated for a **National Rural Health Strategy (the Strategy)**, whether as a Schedule to the new National Health Reform Agreement, or a standalone compact between the Commonwealth and State and Territory governments to address equity of access and deliver improved health outcomes for people living in rural Australia. Such a Strategy would address health disparities, supported by models of care that can function where workforce, funding and infrastructure is limited. Indeed, it would underpin a rural Mental Health Strategy.

Of note is that a component of the proposed Strategy is '**funded and coordinated delivery of mental health services'**. In this regard, the Strategy would support the implementation of the National Agreement through agreed programs of work that address rural health priorities. It would also facilitate the objective of delivering landmark mental health and suicide prevention reform, with the aim of moving towards a unified and integrated mental health and suicide prevention system.

An example of a viable model of care for addressing service gaps across the health system, including mental health, and sustaining primary healthcare services in the community is the place-based Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS) model, developed by the Alliance. The PRIM-HS model is an evidence-based solution that is intended to build the rural primary healthcare workforce and improve access to affordable, high-quality, culturally safe care when and where it is needed. The on-the-ground collaboration facilitated through the PRIM-HS model makes the model truly community-led, facilitating a grassroots approach to meeting primary care needs in rural populations through secure, ongoing employment of the workforce.

The Alliance has also advocated for a $1 billion **National Rural Health Fund (the Fund)** over 4 years, (ongoing), a dedicated, flexible rural and remote funding stream to support the objectives of the Strategy half for blended or block funding for communities where market has failed, and half for needs-based health infrastructure projects to address housing and increase access or service delivery, to administered by the Department of Health and Aged Care. A significant proportion of the blended or block funding should augment MBS fee for service, based on population health needs.

Ongoing commitment from the Commonwealth for the Fund would address the significant shortfall in healthcare funding and services, particularly for primary care, in rural Australia.

Key points

- The Alliance advocates for measures to support improved access to healthcare services and health equity for people living in rural areas of Australia: a **National Rural Health Strategy**, a compact between the Commonwealth and State and Territory governments to drive coordinated, transparent and sustained investments in rural health; and a **National Rural Health Fund**, in recognition that there needs to be a fundamental shift towards blended or block funding models where the market has failed or where there is no market.
- Under the Strategy, s**ervice delivery for mental health would be part of, and alongside, hospital and primary and community health care services**. It would support collaboration between Primary Health Networks (PHNs), Local Health Networks (LHNs), ACCHOs, and health providers **to integrate specialist and hospital services with primary care**.
- Models of care that can **identify and respond to emerging gaps in service systems and that make the best use of scarce resources** are needed, with **equitable and sustainable funding attached**.

Conclusion

The Alliance welcomes the clear commitment from government to prioritise mental health and wellbeing for all Australians through increased funding for services to respond to the mental health impacts across the country.

To maximise these investments, the Alliance calls for **strong national leadership and an agenda of action and measurable change, coupled with adequate resources, workforce innovations, local service planning and collaborative partnerships**. Building on existing capacity, there is potential for mental health and wellbeing to be managed holistically and promote better social and emotional wellbeing in rural Australia.

Australia's next phase of mental health and suicide prevention reform will require action at several levels, spanning not just **workforce growth and sustainability, but also better and more flexible system integration, stronger prevention efforts and data-driven responses**, to ensure Australia's mental health system is prepared and effective for both current and future challenges. This work must reflect the rural and remote versus urban diversity of Australia.

Supporting population health need, flexibility in funding and delivery, adapting new models of care, supporting multidisciplinary teams and leveraging digital technologies are all important for improving patient outcomes in rural, remote and regional Australia.

As more people move from the cities to regional and rural areas to find a better lifestyle, it is essential that these areas are supported by accessible and equitable healthcare to maintain a productive and holistic lifestyle for Australia.

References

1 Australian Institute of Health and Welfare. *Mental health*. Data last updated 25 February 2025. Available from: https://www.aihw.gov.au/mental-health/topic-areas/expenditure

2 Australian Institute of Health and Welfare. *Australia Burden of Disease Study 2023*. Last updated: 14 December 2023. Available from: https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2023/contents/summary

3 J. Looi, N. Robinson, S Robson. *Don't Walk By…Unmet Need in Chronic Severe Mental Health Conditions*. Australian National University December 2024. Available from: https://medicine-psychology.anu.edu.au/research/research-projects/dont-walk-unmet-need-chronic-severe-mental-health-conditions

4 Australian Government Department of Agriculture, Fisheries and Forestry. Snapshot of Australian Agriculture 2024. Australian Bureau of Agriculture and Resources Economics and Sciences. [Internet] March 2024 [cited 2024 Nov 20]. Available from: https://daff.ent.sirsidynix.net.au/client/en_AU/search/asset/1035603/0

5 Australian Government Department of Agriculture, Fisheries and Forestry. Food [webpage]. 2023 Mar 30 [cited 2023 July 14]. https://www.agriculture.gov.au/agriculture-land/farm-food-drought/food

6 Australian Regional Tourism Ltd. About ART [webpage]. 2024 [cited 26 Nov. 2024]. Available from: https://regionaltourism.com.au/

7 Health Research Institute. 2023 Regional Wellbeing Survey data tables. The University of Canberra; 2024 September [cited 2024 Nov 20]. Available from: https://www.canberra.edu.au/research/centres/hri/research-projects/regional-wellbeing-survey/regional-wellbeing-results-reports

8 Australian Unity Real Wellbeing. What is Real Wellbeing? The location effect: why where you live matters [Internet]. 19 July 2021 [cited 2024 Nov 21]. Available from: https://www.australianunity.com.au/wellbeing/what-is-realwellbeing/why-where-you-live-matters

9 AHURI. *The benefits and challenges of regional living: a case study of five regional cities. Policy Evidence Summary* [Internet]. May 2022 [cited 2024 Dec 6]. Available from: https://www.ahuri.edu.au/sites/default/files/documents/2022-05/PES-377-The-benefits-and-challenges-of-regionalliving-a-case-study-of-five-regional-cities.pdf

10 The Royal Australia Australian and New Zealand College of Psychiatrists. *Communities in rural Australia*. Last updated 24 February 2025. Available from: https://www.ranzcp.org/college-committees/key-areas-of-focus/rural-psychiatry/about-rural-psychiatry/communities-in-rural-australia

11 National Suicide Prevention Office. *The National Suicide Prevention Strategy 2025-2035*. Canberra: 2025. ISBN: 978-1-7636173-1-5 ©Australian Government, Department of Health and Aged Care, January 2025

12 Manna Institute. *Outside the City: Designing Suicide Prevention for Regional, Rural, and Remote Communities*. Available from: https://static1.squarespace.com/static/632ce2632eea76173d772316/t/668240575eee29446174e563/1719812191315/Manna+Outside+the+City+Report.pdf

13 National Mental Health Commission. *National Mental Health and Suicide Prevention Agreement 2022-2023*, *Annual National Progress Report Summary.* Sydney: NMHC; 2024.

14 Pirkis J, Gunnell D, Hawton K, Hetrick S, Niederkrotenthaler T, Sinyor M, et al. *A Public Health, Whole-of-Government Approach to National Suicide Prevention Strategies*. 2023. DOI: 10.1027/0227-5910/a000902.

15 National Rural Health Alliance. *Fact Sheet - Mental Health in Rural and Remote Australia*. July 2021. Available from: https://www.ruralhealth.org.au/publication/fact-sheet/mental-health-in-rural-and-remote-australia/

16 Pharmaceutical Society of Australia. *Medicine safety: rural and remote care*. Canberra: PSA; 2021. At: www.psa.org.au/wp-content/uploads/2021/03/PSA-Medicine-Safety-Rural-and-remote-care-report.pdf

17 Commonwealth of Australia. *Productivity Commission. Mental Health, Inquiry Report. Volume 1. No. 95*, 30 June 2020.

18 Mental Health Australia. *2024 Vision Statement: A mentally health Australia*. Webpage. Available from: https://mhaustralia.org/our-work/vision-statement

19 Australian Institute of Health and Welfare. *Mental health services in Australia. Medicare subsidised mental health-specific services*. Canberra, ACT; 2021 [cited 2021 Jun]. www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/medicare-subsidised-mental-health-specific-services

20 ©Commonwealth of Australia as represented by the Department of Health and Aged Care 2022. *National Mental Health Workforce Strategy 2022-2032*. P.16 Available from: https://www.health.gov.au/resources/collections/national-mental-health-workforce-strategy-2022-2032

21 O'Sullivan B, Boyer S, Stratton A, Philips J. *Employment Models to Attract and Sustain Rural Generalist Doctors: Barriers and Enablers.* 14 March 2025. Australian Journal of Rural Health. Volume 33. https://doi.org/10.1111/ajr.70019

22 National Mental Health Commission. *Submission for the Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025*. May 2023. Available from: https://www.mentalhealthcommission.gov.au/sites/default/files/2024-04/submission-for-the-mid-term-review-of-the-national-health-reform-agreement-addendum-2020-25.pdf

23 Burdack M. *Integration of Health and Social Care a Key to Improving Rural Health.* 14 March 2025. Available from: https://www.linkedin.com/pulse/integration-health-social-care-key-improving-rural-mark-7w7gc/

24 Torok M, Calear A, Shand F et al. *A systematic review of mass media campaigns for suicide prevention: understanding their efficacy and the mechanisms needed for successful behavioral and literacy change*. Suicide Life Threat Behav. 2017;47(6):672–87. doi.org/10.1111/sltb.12324

25 National Mental Health Commission. *Report of the National Review of Mental Health Programmes and Services Volume 2*. 2014 Nov 30 [cited 2021 May 21]. Available from: www.mentalhealthcommission.gov.au/Monitoring-and-Reporting/national-reports/2014Contributing-Lives-Review

26 National Rural Health Alliance. *Submission to the House Select Committee on Mental Health and Suicide Prevention*. 24 March 2021. Available from: https://www.ruralhealth.org.au/policy/submission/house-select-committee-on-mental-health-and-suicide-prevention/

27 Brew B, Inder K, Allen J, Thomas M, Kelly B. *The health and wellbeing of Australian farmers: a longitudinal cohort study*. BMC Public Health. 2016;16

28 Beyond Blue. *New Beyond Blue data reveals people struggle for years before getting mental health support*. 5 October 2024. Webpage. Available from: https://www.beyondblue.org.au/about/media/media-releases/beyond-blue-data-reveals-distress

29 Godden, Naomi J, Farrant, Brad M, Farrant, Jaime Yallup, Heyink, Emma, Collins, Eva Carot, et al. *Climate change, activism, and supporting the mental health of children and young people: Perspectives from Western Australia* First published: 18 November 2021 https://doi.org/10.1111/jpc.15649

30 National Mental Health Commission. *Monitoring the performance of Australia's mental health system, National Report Card 2023.* Sydney: NMHC; 2024.

31 Huxtable, R. *Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025, Final Report 24 October 2023*. Available from: https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf