

Productivity Commission Issues Paper

The Social and Economic Benefits of Improving Mental Health



Centre for
Rural & Remote
Mental Health

About the CRRMH

The Centre for Rural and Remote Mental Health (CRRMH) is based in Orange NSW and is a major rural initiative of the University of Newcastle and the NSW Ministry of Health. Our staff are located across rural and remote NSW.

The Centre is committed to improving mental health and wellbeing in rural and remote communities. We focus on the following key areas:

- the promotion of good mental health and the prevention of mental illness;
- developing the mental health system to better meet the needs of people living in rural and remote regions; and
- understanding and responding to rural suicide.

As the Australian Collaborating Centre for the International Foundation for Integrated Care, we promote patient-centred rather than provider-focused care that integrates mental and physical health concerns.

As part of the University of Newcastle, all of our activities are underpinned by research evidence and evaluated to ensure appropriateness and effectiveness.



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Introduction

The Centre for Rural and Remote Mental Health (CRRMH) is based in Orange NSW and receives a major grant from the NSW Health Mental Health Branch. The CRRMH addresses three key objectives:

- the promotion of good mental health,
- improving rural mental health services, and
- working with rural communities to prevent suicide.

The CRRMH is a leader in rural and remote mental health expertise and research in Australia. It has an exceptional track record of conducting high-quality research and delivering exceptional evidence-based programs and services that improve mental health and wellbeing. The CRRMH has a small research team that works collaboratively with the University of Newcastle colleagues and others in Australia and overseas. The CRRMH publishes widely in local and international journals, and presents regularly at conferences and in 2017, the CRRMH brought in more than \$700,000 in new direct research funding. Our research focus areas map to our priorities and include community wellbeing collaboratives, low-intensity mental health services, integrated care and understanding and preventing rural suicide.

The programs we run are based on the best available research and evaluated to determine their effectiveness. For more information see www.crrmh.com.au

The CRRMH provides two major programs: the Rural Adversity Mental Health Program (RAMHP) and Good SPACE, a rural Suicide Prevention Program. These programs are unique, developed in response to rural needs and are evidence-based.

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This submission does NOT represent the views of the New South Wales Government, who provide an operating grant to the CRRMH.

About the Rural Adversity Mental Health Program



The aim of RAMHP is to support rural and remote communities in a number of ways: linking people to mental health services and resources; training workplace and community members to recognise and provide support to someone who they think may be experiencing a mental health problem; informing and raising awareness around mental health and wellbeing; responding in times of severe adversity, such as drought; and partnering with services and organisations in rural NSW to increase RAMHP's impact in rural communities. RAMHP has an extensive geographic reach across all rural NSW Local Health Districts, with 19 RAMHP coordinators based across the state. RAMHP has also built strong partnerships with various government bodies and non-government organisations including the Department of Primary Industries, Country Women's Association, The Land, NSW Farmers and Local Land Services. Figure 1 provides an overview of RAMHP's achievements in 2018.

Figure 1 Overview of RAMHP's Achievements

In 2018, we helped
3,385
people

find the right type of support
This was a **74% increase** from 2017

In 2018, we trained
9,998
people

to look after their own mental
health and to support others
This was a **17% increase** from 2017

Our RAMHP
Coordinators shared
information by attending
464 community events
and meetings
across the state

About Good SPACE



Good SPACE is an evidence-based suicide prevention project that aims to prevent suicide through community and clinical education. It offers workshops and training sessions, including an Aboriginal Suicide Prevention Workshop (We-Yarn) and a suicide prevention community workshop. The overarching goal of the Good SPACE Suicide Prevention Program is to help community members recognise suicidal behaviour and provide practical help in their communities and workplaces.

QUESTIONS ON ASSESSMENT APPROACH

What suggestions, if any, do you have on the Commission's proposed assessment approach for the inquiry? Please provide any data or other evidence that could be used to inform the assessment.

- Rural communities across Australia are diverse in their economic and social makeup, the assessment approach undertaken by the Productivity Commission should not simply draw comparisons between metropolitan and rural areas. Each rural community is unique and solutions proposed need to allow local tailoring and input.
- The assessment approach also needs to recognise that from a social and economic perspective rural communities are not starting from the same position as many metropolitan communities. There are many social factors that are impacting on both the physical and mental health outcomes of rural people. Figure 2 outlines some of these social determinants and how they impact on health outcomes.

Figure 2 Social Determinants of Health and the Health Status of Rural Australians



- Further information on considerations for assessment in rural and remote locations is provided in the Rural Suicide and its Prevention: a CRRMH position paper.¹

QUESTIONS ON STRUCTURAL WEAKNESSES IN HEALTHCARE

Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?

What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?

Market Driven Responses are Not Sufficient in Rural Areas

- Over the past two decades, Australia's physical health, mental health and disability sectors have undergone considerable reforms, all with the ultimate objective of improving the efficiency and effectiveness of achieving health

outcomes for Australians. All reforms, including the most recent reform to the mental health system, have placed a strong emphasis on the introduction of funding mechanisms that drive efficiencies through a market-driven response. The major structural weakness which has been overlooked is that this approach to reform assumes a well-functioning and mature market of mental health services exists in rural areas.

- Unfortunately, rural mental health services are exposed to a number of market failures, including:
 - There are small numbers of service providers that can effectively service rural areas, this creates a non-competitive market environment
 - The ability for PHNs to commission services in an effective manner relies on PHNs having a solid understanding of the evidence behind interventions and the outcomes achievable. There is a paucity of evidence surrounding the effectiveness of many mental health interventions in rural areas. Simply assuming interventions that work in metropolitan areas will be effective in rural areas is not sufficient for making value for money commissioning decisions
 - PHNs are highly variable in their maturity and ability to commission mental health services effectively and on a value for money basis. Many rural PHNs have found it difficult to recruit the skills needed to lead regional mental health planning and this recruitment is not made easier by short term funding.
- Likewise, the availability of a suitably trained workforce is a constant challenge and barrier for many service providers trying to deliver mental health services in an efficient manner.
- The end result of overlooking these market failures, and simply assuming a market-driven response will work in rural areas is significant fragmentation and duplication of rural mental health services.

Suggested Solution

- A suggestion to alleviate at least one of the above-mentioned market failures is the provision of longer-term contracts to both PHNs, NGOs and State-wide programs that deliver mental health services in rural areas (minimum contract term 3 years). This will provide some consistency and certainty to service providers, enabling them to build trust with community members and make investments which allow them to deliver services efficiently in rural areas.
- Australian governments, funders and providers should adopt the policy and practice of parity of esteem for mental health problems and practices which means 'valuing mental health equally with physical health'.²

Implications of valuing mental health equally with physical health

- Equal access to the most effective and safest care and treatment
- Equal efforts to improve the quality of care
- The allocation of time, effort and resources on a basis commensurate with need
- Equal status within healthcare education and practice
- Equally high aspirations for service users
- Equal status in the measurement of health outcomes⁵

*The combination of **local mental health service planning/service commissioning** and **parity of esteem for mental health problems** has much to offer rural communities but it will require agreement from all levels of government, health service funders and providers. This will have implications for legislation, regulation of health insurance providers, the education and training of clinicians, and the measurement and reporting of health service performance and population health more broadly.*

QUESTIONS ON SPECIFIC HEALTH CONCERNS

Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?

Which forms of mental health promotion are effective in improving population mental health in either the short or longer term? What evidence supports this?

What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?

What healthcare reforms do you propose to address other specific health concerns related to mental ill-health? What is the supporting evidence and what would be some of the benefits and costs?

What overseas practices for supporting mental health and reducing suicide and comorbidities should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

- The Rural Adversity Mental Health Program is an early intervention and mental health promotion program that has been operating in rural NSW since 2007. The RAMHP Program was specifically developed for the unique needs of rural people and is evidenced based.
- The aim of RAMHP is to ensure rural and remote people that are struggling with their mental health are connected with appropriate services and support. Recognising that successful early intervention programs in rural areas need to go well beyond service access information, RAMHP provides four main strategies. These strategies of link, train, inform and partner are outlined in Figure 3.

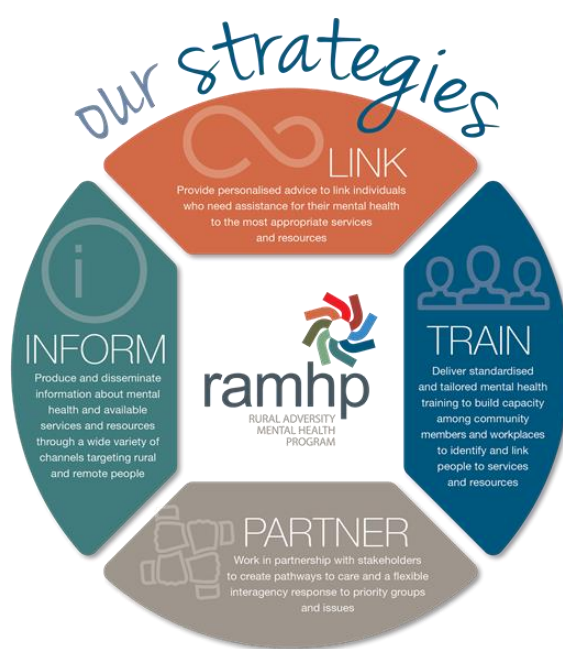


Figure 3 Overview of RAMHP's Strategies

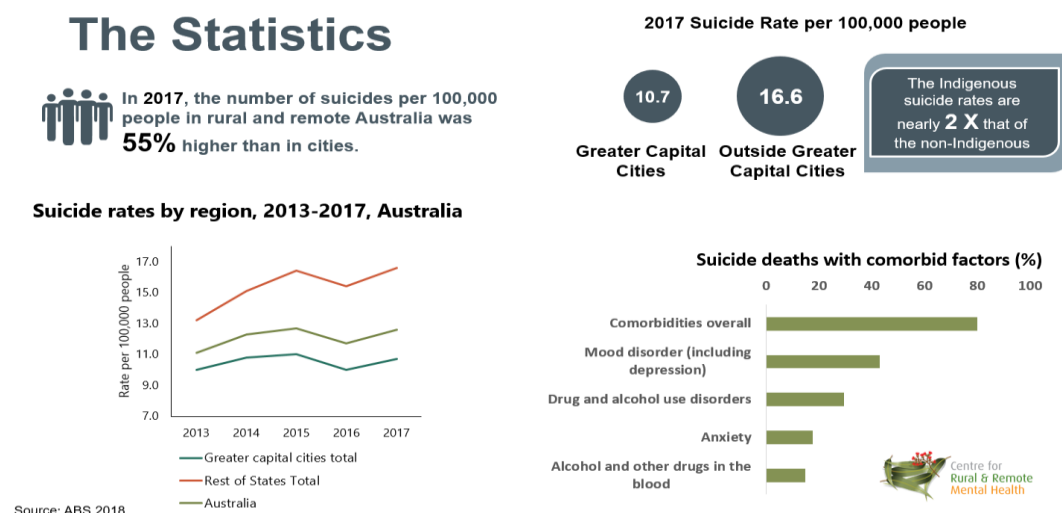
- A comprehensive evaluation framework (see attached evaluation summary) measures the outcomes achieved by the program, builds the evidence base and enables continuous quality improvement and refinement of RAMHPs activities.
- Much of RAMHP's success stems from the fact our 19 RAMHP Coordinators live, work and genuinely understand the needs of their communities, and tailor their approach accordingly. Furthermore, our most recent funding contract spans five years. This has provided employment certainty and the ability for RAMHP Coordinators to build and gain the trust of their rural communities. Trust is an essential element of any rurally based early intervention program.

- In April 2017, the CRRMH hosted a Rural Suicide Prevention Forum at the Royal Sydney Easter Show, where 60 key stakeholders met to discuss rural suicide prevention. These stakeholders included politicians, policy makers, industry representatives and non-government and government organisations. These stakeholders were given the opportunity to discuss their thoughts and voice their concerns regarding the higher rates of suicide among those living outside of capital cities, and even more so in rural and remote areas.

From this Forum and informed by the literature, the CRRMH developed a Position Paper on Rural Suicide and its Prevention. The paper addresses the key issues of higher rates of suicide in rural and remote areas of Australia.

An update on the regarding suicide in Australia 2017, including rural and remote rates is shown in Figure 4.

Figure 4: 2017 suicide rates in Australia, consideration for rural and remote regions.



- Drawing from data from 2017, the number of suicides in rural and remote areas per 100, 000 people, was 55% higher than that in greater capital cities.
- Additionally, data from 2012 to 2016, found the rate of suicide for the Indigenous population was 23.7 per 100,000 people; more than twice that of non-indigenous Australians over the same period, 11.6 per 100,000 people.
- Research from the United Kingdom has shown a consistent decrease in the number of suicides involving paracetamol since legislation to reduce pack sizes was introduced. By reducing pack sizes to 32 tablets in pharmacies, and 16 tablets in other retailers, it is estimated that 765 suicides were prevented between 1998 and 2009.³

- It is a complex question, aggregate figures for rural suicide are higher than in major capital cities but numbers vary over time and between communities. It appears that metropolitan strategies are not working in rural and remote communities. The rates of death by suicide have been coming down in greater Sydney and greater Melbourne but not in rural Australia.

Suggested Solution

- Our analysis suggests that we must focus on both short and medium-term strategies to prevent rural suicide. Figure 5 outlines suggestions to reduce and prevent rural suicide that is included in our position paper¹, based on evidence and consultation.

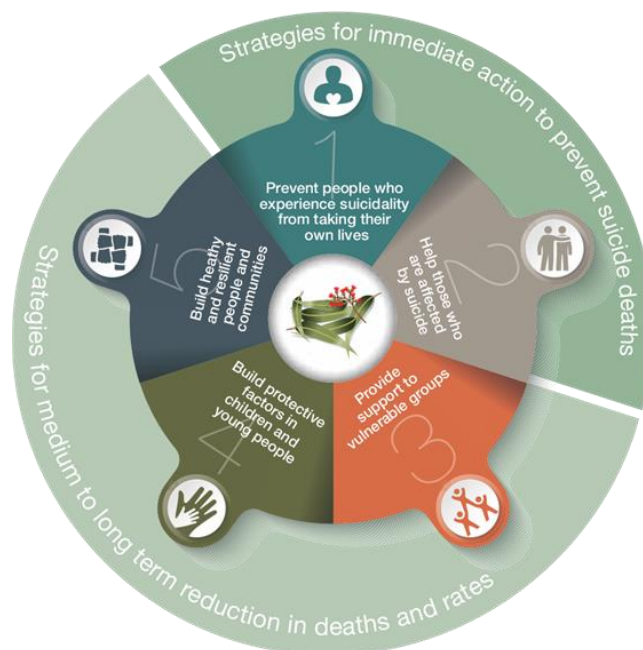


Figure 5: Rural Suicide Prevention Focus Areas

QUESTIONS ON HEALTH WORKFORCE AND INFORMAL CARERS

Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity?

What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and telehealth services be suitable? What prevents greater remote provision of services to address the shortages?

What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these

restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?

What could be done to reduce stress and turnover among mental health workers?

How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?

What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would be some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?

- We conducted a [major review of workforce issues](#) for the National Mental Health Commission in 2014.⁴ We do not believe that the numbers have changed significantly.
- Our broad recommendations were as follows:

Recommendations for the mental health workforce
1. Retrain general nurses as mental health nurses
2. Undertake a study of the psychologist workforce
3. Build the capacity of primary care services to increase access to mental health care and promote prevention and early intervention
4. Co-locate a proportion of Community Mental Health Staff within Primary Care
5. Support the development of the peer support mental health workforce
6. Establish the infrastructure for competency-based workforce planning and development for mental health services.

- This approach focusses on building mental health capabilities within GP and community health services and emphasising prevention and early intervention.

Diversify Scope of Practice

- Substantial workforce shortages exist across the mental health nurses, psychologists and community nurse roles in rural and remote Australia. For many years remote workforce incentives have purely relied on financial benefits to entice and retain health professionals in rural Australia.
- In rural areas, with distance you need to create depth of skills and diversity of practice. The most effective decisions occur when made by someone that truly understands the situation and environment. RAMHP has recognised this need and ensured RAMHP Coordinators not only have the qualifications and experience to make appropriate decisions for their rural communities but that they feel empowered to do so. Instead of relying on the commonly used financial remuneration incentive, we also built considerable diversity into the

RAMHP Coordinator's primary tasks and responsibilities. The challenge and learning opportunities available through this diverse role increases its attractiveness substantially and has resulted in a strongly retained workforce.

- Adequate professional development opportunities are not provided to mental health professionals employed by government agencies. This limited opportunity for support and growth negatively impacts on staff retention.

Suggested Solution

- From an industry-wide perspective, we need to pay greater attention to empowering our workforce and creating diverse roles. That is, the more remote the workforce, the greater the need for autonomy and diversity. Sometimes decisions made in capital cities can have ongoing negative implications for rural communities.
- There needs to be locally-relevant influence on how the workforce is retained since place-based social processes affect retention in rural and remote areas.⁹ Thus, incentives need to provide local support, clinical support that is appropriate, and training and skills-retention opportunities, including resourcing time away such as the provision of locums to back-fill, while away.
- There is currently substantial variability in how peer workers are used alongside the clinical mental health workforce. Further consultation with the sector is required to agree on an appropriate scope of practice for peer workers across the inpatient, community and disabilities sectors. Indeed due consideration needs to be given, including training and ongoing support for the peer workforce that exists and into the future.

QUESTIONS ON SOCIAL SERVICES

How could non-clinical mental health support services be better coordinated with clinical mental health services?

Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?

What continuity of support are State and Territory Governments providing (or plan to provide) for people with a psychosocial disability who are ineligible for the NDIS?

Are the disability support pension, carer payment and carer allowance providing income support to those people with a mental illness, and their carers, who most need support? If not, what changes are needed?

Is there evidence that mental illness-related income support payments reduce the propensity of some recipients to seek employment?

How could mental illness-related income support payments better meet the needs of people whose capacity to work fluctuates over time?

- The effectiveness and coverage of the NDIS psychosocial disability support is incredibly variable across rural NSW, due to the market-driven challenges mentioned previously. Our remotely based RAMHP Coordinators (whose primary role is to link people to support services) have anecdotally reported substantial gaps in access to NDIS services for rural people suffering a complex mental illness.
- There is also substantial confusion amongst rural community members on what complex mental illnesses are qualify for NDIS support. This burden of assisting community members to navigate the NDIS system is falling to existing local health and welfare staff, such as RAMHP Coordinators.

QUESTIONS ON SOCIAL PARTICIPATION AND INCLUSION

In what ways are governments (at any level) seeking to improve mental health by encouraging social participation and inclusion? What evidence is there that public investments in social participation and inclusion are delivering benefits that outweigh the costs?

What role do non-government organisations play in supporting mental health through social inclusion and participation, and what more should they do?

Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?

What indicators are most useful to monitor progress in improving mental health outcomes through improved social participation and inclusion?

- Research from the Australian Rural Mental Health Study (ARMHS) has consistently shown longitudinal evidence that social support and participation contribute to positive mental health outcomes. This includes a reduction in the likelihood of depression,⁴ psychological distress,⁵ post-traumatic stress disorder,⁶ and suicidal thoughts and behaviours.^{7,8}

Community Wellbeing Initiatives

The CRRMH was supported by the Mental Health Commission of NSW to conduct a review of community wellbeing initiatives, which entailed a review of the literature and case study approaches. The model for such approaches that we have drawn together involves a public health approach, that is community-led and supported by local government and services. This has involved working with the following communities [Our Healthy Clarence](#) (Grafton), [Muswellbrook Healthy & Well](#), Lithgow,

Margaret River, and various [Act-Belong-Commit](#) initiatives to both learn from their experience.



Muswellbrook
HEALTHY & WELL



Suggested Solution

- We see these collaborative approaches to community wellbeing as a necessary step towards the prevention of mental illness and promotion of positive mental wellbeing.

QUESTIONS ON EDUCATION AND TRAINING

What are the key barriers to children and young people with mental ill health participating and engaging in education and training, and achieving good education outcomes?

Is there adequate support available for children and young people with mental ill health to re-engage with education and training?

Do students in all levels of education and training have access to adequate mental health-related support and education? If not, what are the gaps?

How effective are mental health-related supports and programs in Australian education and training settings in providing support to students? How effective are programs in educating staff, students and families, on mental health and wellbeing? What interventions are most effective? What evidence exists to support your assessment?

Do teachers and other staff in schools and education facilities receive sufficient training on student mental health? Do they receive sufficient support and advice, including on the quality and suitability of different approaches, to adequately support students with mental ill-health?

What overseas practices for supporting mental health in education and training should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

- Health literacy is key in rural and remote areas, it is known that some residents have high levels of distress and but do not realise that this may constitute poor mental health⁵

- In order to achieve better mental health outcomes through training and education, it needs to reach a broad range of community members to lift mental health literacy across the population.
- For example, CRRMH's RAMHP team provided a comprehensive training program for St Vincent de Paul staff and volunteers in Western NSW comprising Mental Health First Aid for managers, Workplace support Skills for staff, and Community Support Skills for volunteers. This is described in the [RAMHP 2018 Annual Report](#), p. 7-8.
- Our position on building skills and resilience in young people through education and training is described in Focus Area 4 of the CRRMH Position Paper on Rural Suicide¹

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