Private Mental Health
Consumer Carer Network (Australia)
engage, empower, enable choice in private mental health

Senator Penny Wright,
Australian Greens Senator for South Australia,
L13, 100 King William Street,
ADELAIDE SA 5000

Sent via email: senator.wright@aph.gov.au

Dear Senator Wright,

SUBMISSION

RURAL MENTAL HEALTH SERVICES CONSULTATION

Thank you for the opportunity to provide direct input into your inquiry into '**Improving mental health services in country Australia.'**

The *Private Mental Health Consumer Carer Network (Australia)* (hereafter Network) represents Australians who have private health insurance and/or who receive their treatment and care, and those that care for them, from private sector settings for their *mental illnesses or disorders.* As our title implies, the Network is the authoritative voice for consumers and carers of private mental health settings.

The Network is committed to working with you and the Australian Greens in addressing the needs of people with a mental illness from regional, rural or remote areas. We bring to this Submission, a mental health consumer and carer perspective.

Mental health brings with it many challenges. As a consumer and carer organisation we are in a position to provide direct 'lived' experiences to your Inquiry and would welcome the opportunity to engage in further discussions.

Whilst our Network is primarily focussed on mental health delivered in private sector settings such as private hospitals and private providers in their own practices, we nonetheless consider this an opportunity to focus on the whole of the mental health system far more broadly than just the private sector.

We would like to comment on the 5 areas specifically raised by you:

1. Problems or barriers to accessing mental health services, and current gaps in service delivery.

Your Discussion Paper quite rightly articulated many issues, but in particular we would like to raise the following:

- There is a very limited number of Australian psychiatrists who practice outside metropolitan cities. In South Australia for example, to our knowledge there are no **resident** psychiatrists in country SA. Throughout country Australia, mental health delivery by psychiatrists is via a limited number of Consultant Psychiatrists flying in/flying out for a limited period of usually one day. This does not allow for timely follow up in crisis situations, close monitoring, or long term psychological therapies.

Whilst psychologists are more accessible in regional areas, a similar situation applies regarding rural and especially remote locations.

The recent Federal Government incentive for Psychiatrist Office based IT or web teleconferencing goes some way to address these needs, however there is evidence that the uptake has been slow. Prioritising the roll out of the National Broadband Network to regional and rural areas would facilitate these services.

- The mental health needs of people in rural/remote areas are currently catered for by small community mental health teams. These clinicians provide much needed mental health care though in a limited capacity and can consist of one clinician working in isolation, or two or more working as a team. The more remote the location, the less number of clinicians. Whilst the workforce consists of mental health nurses, sometimes Occupational Therapists, sometimes psychologists and/or Social Workers, the ability to administer and monitor psychotropic medications, to provide crisis interventions, long term therapy etc is limited.

We would recommend an incentive payment to the mental health workforce similar to that which applies to teachers. We would recommend an upfront payment to relocate, followed by an additional payment once employment has reached 18 months and a final payment once the term of employment has reached 36 months.

- People in rural and remote communities should be encouraged to make greater use of government, non-government, community mental health services, resources and support groups where available. Stigma also plays a huge part in impeding mental illness identification and treatment. Both men and women in small communities often seek assistance from health professionals outside of their local community, especially for mental health issues, for fear of the reaction of others within their small social environ.

  This heightened stigma in rural and remote communities remains an obstacle to the utilisation of mental health services partly due to the size of the communities and the close association people have with each other in social, community and employment situations.

We would recommend a specific media campaign normalizing mental illness and to tackle stigma targeted to country Australia.

We would recommend a heightened awareness campaign targeting the local geographic area of government, non-government, resources and support group availability.

- A mental health consumer's condition is highly sensitive and any disclosure can, and indeed often does, result in discriminatory practices. These can range from not gaining employment in the first place, to struggling to cope with the mental illness and work commitments, often resulting in an inability to retain employment.

  Therefore unemployment is a real issue for people in country Australia. Further, long drought conditions experienced a few years ago shattered crops, livestock etc and the ability of many to gain or maintain meaningful employment.

We would recommend as part of the media campaign tackling stigma, that a focus on employing people with a mental illness is achievable, acceptable and a good thing to do.

Increasingly, significant numbers of Culturally and Linguistically Diverse (CALD) and refugee groups are being re-located in regional and rural areas. Specific refugee populations are now being relocated to specific areas ie Afghan refugees to Rockhampton for employment within the local abattoir. These geographic areas need to have mental health services which are user friendly and appropriate to address specific cultural and language needs. The question arises, are services being delivered and designed to attract local CALD or refugee communities, if not, then we would recommend that they are.

The Network believes that policy should be developed around ensuring that mental health services cater to their respective local geographic CALD and/or refugee communities.

We would recommend that where local CALD and/or Refugee communities are significant in number, that policy be developed to ensure the design and provision of mental health services meet their cultural and language needs.

2. How we can address gaps in the delivery of mental health services

People needing mental health services in rural and remote areas of Australia are severely disadvantaged due to the unavailability of services. The result is often that the first point of call for someone in crisis is the GP, ambulance, or police. The GP often takes responsibility for the ongoing management of people with a mental illness. There is an argument that these providers should have a higher level of training in the management of people suffering from a mental illness than their city counterparts.

There is also an argument that we need to consider the mental health of rural based GP's in an environment which sees great demand on their services. Peer support from urban-based GP's or the Royal Australian College of General Practitioners is strongly recommended.

Greater integration of urban-based psychiatrists and rural-based GPs, consumers and their carers can be achieved by use of tele-psychiatry. Governments need to take responsibility and put in place the necessary measures to enable the provision of this type of service more broadly. Whether this requires an increase the Medicare rebate for their time must be considered.

We would recommend the strengthening of the Mental Health Professionals Network's capacity to deliver training opportunities and to offer peer support targeted to regional, rural and remote area staff including GPs, psychologists, mental health nurses, Occupational Therapists and Social Workers.

The Mental Health Nurses Incentive Program offers the capacity of credentialed mental health nurses to undertake mental health care. Unfortunately, the Federal Government has frozen funds at the current level.

There are barriers to credentialed mental health nurses providing mental health care under this Program as individuals. Current eligibility requires a mental health nurse to work within the practice of an 'organisation'. Individual mental health nurses are unable to obtain their own Eligible Organisation Number. Eligible organisations must be community based and have the services of a general practitioner with a Medicare Australia provider number or a psychiatrist registered with Medicare Australia.

Eligible organisations may include:

- general practices

- private psychiatry practices and
- Aboriginal and Torres Strait Islander Primary Health Care Services funded by the Australian Government through the Office for Aboriginal and Torres Strait Islander Health.

Until 31 December 2009, eligible organisations could engage or retain either:

- mental health nurses currently credentialed with the Australian College of Mental Health Nurses (ACMHN) and/or
- registered nurses with current registration who have obtained, or are working towards obtaining, specialist qualifications in mental health (such as a Graduate Diploma in Mental Health Nursing or a Masters in Mental Health Nursing) and have three years recent experience in mental health nursing.

From 31 December 2009, eligible organisations can only access payments through this program if they engage or retain the services of a mental health nurse currently credentialed with the ACMHN.

Should a nurse not be credentialed by 31 December 2009, the practice will not be able to claim reimbursement of sessions undertaken by the mental health nurse after this date.

We would recommend the expansion of the MHNIP in country Australia and the removal of barriers inherent in the scheme to allow credentialed mental health nurses a greater capacity to work as individuals in the delivery of mental health services in rural and remote areas.

3. Appropriate policy responses and solutions

In terms of recruitment of psychiatrists to fill the needs of mental health consumers in rural and remote areas the following are currently in place.

- Overseas Trained Psychiatrists are required to undertake additional education. The Specialist Pathway of the RANZCP is a pathway to College Fellowship and only suitable for Overseas Trained *Specialists* (OTS) with a recognised Specialist Qualification who wish to remain and work in Australia permanently. Given that mental health is largely about 'talking therapy' language and strong accents by OTS can be an issue for consumers.

  The other pathway to RANZCP College Fellowship is to recruit to an Area of Need. Areas of Need are declared by the States and Territories for rural and remote areas when the jurisdictional governments offer employment. The Overseas Trained psychiatrists in these positions are often unsupported by the Governments where they are required to practice often in isolation within a mental health system which is complex and foreign. This can act as a deterrent in recruitment and retention.

We would recommend greater peer support for Overseas Trained Psychiatrists and greater education about the Australian mental health system provided by the relevant state or territory Government.

4. Best practice approaches to suicide preventions

The Network is concerned about the increased rate of suicide in rural and regional areas. It is common knowledge that these areas have a much higher rate of suicide than metropolitan areas. Increasingly, the results of drought, natural disasters, loss of properties held in

families for generations, lack of employment and social networks all compound on the health of people, particularly men, in these areas.

Suicide rate higher in men

Men often refuse to get help and treatment for mental health issues, failing to either recognise a problem exists or to admit there may be something wrong. Data detailed in the Australian Bureau of Statistics Report of 2007 shows that the age-standardised suicide rate in 2005 was 16.4 per 100,000 for males against 4.3 per 100,000 for females. The Report therefore vividly illustrates that through the 10 year period to 2005, male suicide death rate remained roughly four times higher than for females.

How often do we hear of single male accident fatalities in country Australia. Clearly, men must be a more highly targeted group for suicide promotion strategies especially in regional, rural and remote areas.

Greater education and training to front line staff including ambulance, police and administrative staff about suicide awareness is needed.

We would recommend targeted suicide prevention strategies for men in country Australia.

We would recommend the funding of training and education to country staff including ambulance, police and administrative staff of suicide awareness.

These could be funded under the Suicide Prevention Strategy.

5. Australian Greens' approach

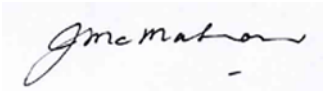
The Network strongly supports the Australian Green's approach to improving mental health in country Australia.

The five points articulated within the Discussion Paper outlines in our opinion the key points about mental health provision in country Australia.

Your Discussion Paper clearly articulates that access to health care is a basic human right and certainly in Australia in 2012. This includes access to high quality mental health care, provided in an accepting and respectful environment by skilled multi-disciplined clinicians.

We believe that greater financial incentives are required to attract a skilled workforce to practice in country areas. If this is what is needed in the first instance, then we must do what is required to recruit and retain clinicians.

Thank you for the opportunity of providing our views and perspectives. We would be very pleased to have further discussions with you.



Janne McMahon OAM
Independent Chair
19th December, 2012