FIT FOR PURPOSE

IMPROVING MENTAL HEALTH SERVICES FOR YOUNG PEOPLE LIVING IN RURAL AND REMOTE AUSTRALIA

ACKNOWLEDGMENTS

Orygen consulted members of its Youth Advisory Council and Youth Research Council in the development of an earlier document contributing to this policy paper. Orygen acknowledges the contribution made by council members in support of this project.

KEY STAKEHOLDERS

Orygen would like to recognise a number of key organisations and individuals who made a substantial contribution during the drafting of this policy report through participation in a critical reference group and the provision of information, advice, peer-review and feedback. Please note: the final report reflects Orygen's analysis and independent conclusions. It may not necessarily reflect all the opinions or conclusions of key contributors.

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SURVEY

A workforce survey was conducted by Orygen in January 2020. This survey included service providers, the largest responding group. Orygen acknowledges the time taken by services to respond to this survey. Please note: the final report reflects Orygen's analysis and independent conclusions. It may not necessarily reflect opinions or experiences of service providers.

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EXECUTIVE SUMMARY

People living in rural and remote areas face unique mental health risk factors and have more limited access to mental health services. Service provision and workforce issues have been the subject of many reviews, inquiries and policy development.

The extent of mental ill-health experienced by young people living in rural and remote Australia is unknown. What is known, is that young people experience high rates of suicide and the rate of suicide increases with remoteness.

A critical reference group was convened to understand the issues that need to be addressed to improve delivery of mental health services for young people in rural and remote Australia.

There are three key areas in rural and remote mental health requiring new policy solutions. This policy paper presents solutions to address workforce gaps, enhance service models and identify how technology can play a role.

DEVELOPING SOLUTIONS

Attracting and retaining mental health professionals to rural and remote Australia continues to be a challenge. The Productivity Commission has identified that working in rural and remote areas is 'less attractive from both a professional and personal perspective'.

For many young people living in rural and remote Australia primary health professionals are the only health providers they have access to. Professional support and development are required to equip them for these expanded roles. Where a doctor is not available the lead primary health care providers needs to be accredited to provide referrals to specialist mental health care.

A number of barriers exist in providing supervision and professional development in rural and remote health services. The practice of inter-professional supervision needs to be supported by professional bodies and coordinated at a service level. Existing inter-professional practices provide an example for the development of such initiatives in rural and remote contexts.

An ageing workforce in rural and remote areas highlights the need to educate and train the future workforce. There is evidence that undertaking education and training in rural and remote areas leads to continuing practice. Trialling bonded scholarships for allied health students would provide an incentive to practice in rural and remote areas.

Technology present a means to help solve some - but not all - of the barriers to delivering mental health services for young people in rural and remote communities. While digital service delivery is a focus of health policy (with telehealth and mobile applications expanded in response to the coronavirus/COVID-19 pandemic) it is important new service models and platforms are designed with young people.

Orygen supports the Productivity Commission's draft recommendation [5.1] for an MBS item for psychiatrists to provide advice to GPs over the phone and suggests that it be expanded to include expert advice on alcohol and other drug disorders in young people.

Innovative responses to support primary health services provide mental health care are required to enable improved access for young people. A trial of new initiatives in local contexts provides an opportunity to test ideas and identify solutions that can then be implemented more widely.

KEY POLICY SOLUTIONS

A number of policy solutions are proposed in this policy paper that address workforce challenges, service innovation and the role of technology. Three key solutions have been identified that build on existing policies and have the potential to improve mental health care for young people.

HEADSPACE OUTREACH SERVICES	PERMANENT TELEHEALTH MBS ITEMS	ACCREDITED TREATMENT PLANNING
headspace centres in regional centres provide a ready service platform for trailing outreach services into smaller population centres in partnership with local health professionals.	Make permanent telehealth MBS items for young people aged 12-25 years of age developed to enable service delivery during coronavirus restrictions.	Lead primary care providers (i.e. nurse practitioners, Aboriginal health workers) be accredited in the absence of a GP to write mental health treatment plans.

INTRODUCTION

People living in rural and remote areas face unique mental health risk factors, including isolation and environmental events such as droughts and bushfires.[1] They also have limited access to specialist mental health services. The issues are particularly pertinent for young people (12-25 years) as the majority of mental ill-health begins during these years.[2]

POLICY CONTEXT

The gaps in mental health services in rural and remote areas and the challenges to removing identified barriers has been the subject of numerous reviews, inquiries and policies. Policy solutions proposed in this paper have been developed in the context of existing research and past and present initiatives.

- The 2018 Senate Community Affairs Reference Committee inquiry into Accessibility and quality of mental health services in rural and remote Australia (Senate inquiry).[3] The report identified many of the issues raised by critical stakeholders engaged for this policy project. These issues centred around: service funding and provision; barriers to access; culturally appropriate services; and workforce issues.
- The Productivity Commission is currently undertaking an inquiry into mental health services. In its 2019 draft report the Commission identified issues with workforce training, recruitment, supervision and practicing numbers in rural and remote areas.[1]
- The Stronger Rural Health Strategy aims to build a sustainable, high quality health workforce of doctors, nurses and allied health professionals distributed according to community need particularly in rural and remote communities. The strategy includes a range of incentives, targeted funding and bonding arrangements.[4]
- The Rural Health Outreach Fund is a Commonwealth funding initiative to improve access to medical specialists, general practitioners (GPs), allied and other health professionals in rural, regional and remote areas of Australia. Delivery of mental health services is one of four priorities of the program. Funding is distributed through state and territory agencies.[5]
- The National Rural Generalist Pathway was a collaboration between the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine led by the Rural Health Commissioner, Emeritus Professor Worley. The report outlined a continuous training pathway for students, junior doctors and registrars.[6]
- The Health Workforce Scholarship Program provides funding for post-graduate studies for health professionals (including doctors, nurses and allied health professionals) working in rural and remote areas. The program is delivered through state and territory Rural Workforce Agencies.[7]
- The National Strategic Framework for Rural and Remote Health was prepared in 2011 to promote a national approach to policy, planning, design and delivery of health services in rural and remote communities.[8]
- The National Rural and Remote Health Workforce Innovation and Reform Strategy was developed to advance an appropriate, skilled and well supported health workforce that meets the needs of the local communities.[9]

CRITICAL REFERENCE GROUP

A critical reference group was convened to inform Orygen's understanding of the issues faced in delivering mental health services for young people in rural and remote Australia. The group was made up of a diverse range of stakeholders including the National Rural Health Commissioner, members of Orygen's youth councils and representatives from peak bodies and service providers, practitioners and academics.

A round table meeting was held in Adelaide in November 2018 and a follow up teleconference with participants unable to attend the meeting. Issues discussed at the meeting included service promotion and access, workforce barriers, government policy and the use of technology. These issues and initial policy options were further explored at the subsequent teleconference.

SURVEY OF SERVICE PROVIDERS

A survey of youth mental health service providers which primarily operate in regional, rural and remote areas was conducted in January 2020. The survey focused on workforce supply and need. There were 42 survey responses, of which the majority were from headspace centres (n=25).

DEFINING LOCATION

The Australian Bureau of Statistics (ABS) has defined five classes of remoteness based on relative access to services. The five classes are; major cities, inner regional, outer regional, remote and very remote.[10]

The Department of Health uses the Modified Monash Method (MMM) which is based on the ABS classes of remoteness with a further differentiation between inner and outer regional Australia based on town size.[11]

The term rural and remote is used in this discussion paper to best reflect the differences that young people can experience based on population size and service availability.

The policy paper begins by outlining what is known about the prevalence of mental ill-health for young people in rural and remote Australia. Policy solutions are then developed to address workforce gaps and challenges, service design and the role of technology. These solutions have been developed in the context of existing policies and were informed by engagement with the critical reference group.

YOUTH MENTAL HEALTH

There is a lack of detailed public data on the prevalence, severity and complexity of mental ill-health among young people living in rural and remote Australia. Patchy prevalence data for this group is a barrier to developing and delivering services and support. The last national survey of mental health and wellbeing conducted in 2007 did not identify differences in mental ill-health based on location.[12] A more recent survey found that reported experiences of mental disorders was 16.4 per cent outside of capital cities (compared with 12.6 per cent), but the surveyed group was children and adolescents (4–17 years).[13] Young people living outside capital cities have identified that greater data on access to mental health care in rural and remote areas is required to address their needs.[14]

The Royal Flying Doctor Service has reported an increase in aeromedical retrievals for young people with mental ill-health symptoms. While retrieval data is not indicative of prevalence, being limited to acute presentations it is remarkable given the lack of available data. The most frequent diagnosis for 15-24 year olds who were retrieved for a was alcohol and other drug related mental and behavioural disorders (24 per cent), followed by a diagnosis of schizophrenia (16 per cent), unspecified nonorganic psychosis (13 per cent) and depressive episodes (12 per cent).[61]

POLICY SOLUTIONS	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
FILLING MENTAL HEALTH DATA GAPS			
Prevelance data collected by Primary Health Networks be centrally collated to develop a national prevelence dataset for youth mental health in rural and remote areas. Oversampling be undertaken for the Intergenerational Health and Mental Health Study to enable analysis of the mental health expereicnes of young people living in rural and remote areas.	There is a lack of available data on the prevalence, severity and complexity of mental ill-health, service utilisation and outcomes among young people living in rural and remote Australia to guide service planning and policy development.	Evidence based service level and funding decisions.	Commonwealth Department of Health

Delivery timeline: 1-2 years nationally coordinated publishing of PHN collected data
2-5 years oversampling for Intergenerational Health and Mental Health Study

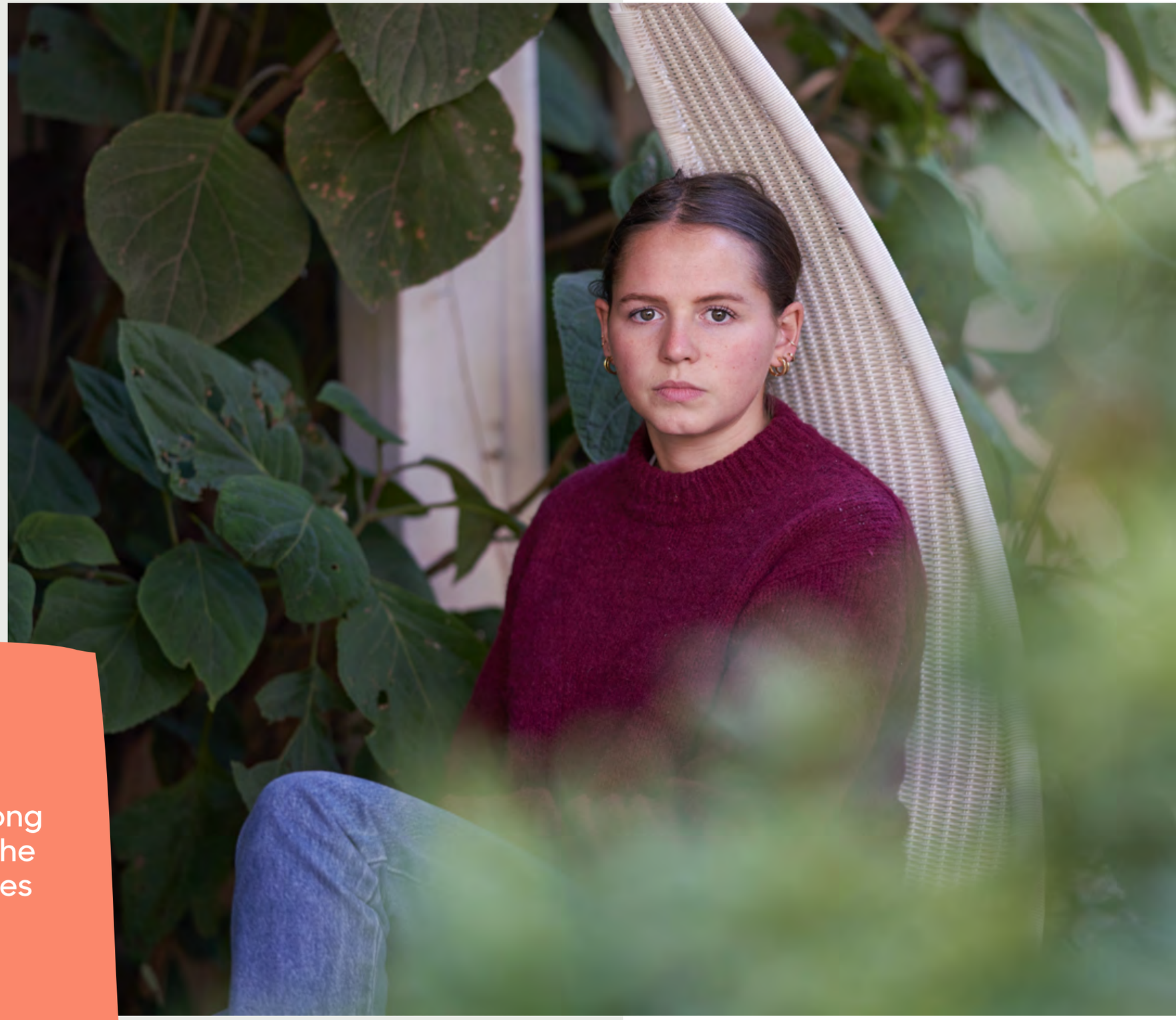
HIGHER RATES OF SUICIDE

Suicide was the leading cause of death for 15-24 year olds in Australia in 2015[15] and the rate of suicide increases with remoteness.[3] Young people aged 12-17 living outside greater capital cities who had experienced a major depressive disorder have been found to be at greater risk of suicide.[13] The rate of intentional self-harm (suicide) resulting in death of children and adolescents (aged 5-17 years) from 2012-2016 was 3.2 per 100,000 outside of greater capital cities, compared with 1.8 in greater capital cities.[16] Approximately one in seven young people living in rural and remote Australia reported being very or extremely concerned about suicide.[14]

SUMMARY

There is a lack of data on the prevalence of youth mental health in rural and remote areas which limits the evidence available to develop and fund services.

The rate of suicide among young people increases with remoteness.



> “Suicide is a leading cause of death among young people and the suicide rate increases with remoteness.”

THE MENTAL HEALTH WORKFORCE

Attracting and retaining mental health professionals to rural and remote Australia continues to be a challenge. A “fundamental lack of appropriately trained and supported staff” has been identified as a key barrier to service delivery in rural and remote Australia.[3] For many young people living in rural and remote Australia, primary health professionals are the only health providers they have access to. Specialist services, such as psychologists and psychiatrists are not universally available. Workforce shortages in rural and remote Australia add to the barriers faced by young people trying to access mental health services.[17]

GPs, nurse practitioners and Aboriginal health workers need to be equipped to provide mental health care. They need to understand the particular risks faced by young people and be able to provide the level of care they need.

Existing policies and policy advice to address workforce gaps include recruitment and retention, incentives, professional supervision and development, education and training and expanded roles for primary health professionals. Policy solutions that build on past advice and present policies are identified.

WORKFORCE GAPS

There are fewer mental health professionals available in rural and remote Australia compared with major cities. A majority of services responding to a workforce survey conducted by Orygen reported that current medical (72.1 per cent) and allied health (75.8 per cent) staffing levels was inadequate to meet service need. Services were asked to prioritise which professions the service most needed more of. Psychologists, psychiatrists, GPs and social workers were identified as the number one priority in approximately equal numbers.

In regional and rural areas mental health workforce availability across the mental health service system is in high demand and supply is not adequate to support the existing system of mental health care. - Survey response

The Productivity Commission has highlighted a shortage in practicing psychiatrists.[18] The Productivity Commission has drafted a recommendation [Draft recommendation 11.2] that Commonwealth and state and territory governments develop a national plan to increase the number of psychiatrists in clinical practice, in particular practicing outside major cities and in sub-specialities with significant shortages, such as child and adolescent psychiatry.

There are proportionally more primary care health professionals employed in remote / very remote areas compared with major cities (e.g. clinically practicing registered medical practitioners[19] and registered nurses[20]). These health professionals represent the most available workforce. The population threshold for providing equitable access to primary health professionals with mental health skills differs between rural and remote areas. A lower threshold has been identified in remote areas (101-500 people) compared with rural areas (501-1000).[21] To better enable the available primary health orientated workforce to meet the mental health needs of young people they need professional development, supervision and support.

For Aboriginal and Torres Strait Islander young people Aboriginal health workers provide culturally safe option for clinical and primary health services. Aboriginal health workers also have the ability to adapt roles to a local context. Available data shows that in 2011 there were 229 Aboriginal health workers per 100,000 Aboriginal and Torres Strait Islander people.[22] There were 337 working in remote areas and 408 in very remote areas.

RECRUITMENT AND RETENTION

The challenge of recruiting and retaining mental health professionals in rural and remote areas is not a new issue. The appeal of working in rural and remote areas, capacity to offer incentives and short-term funding models are barriers to recruitment and retention.

The Productivity Commission was straightforward in identifying that working in rural and remote areas ‘has been less attractive from both a professional and personal perspective’. Professionally; isolation from peers, higher workloads and limited access to professional development activities are deterrents. Improved support and opportunities for peer interaction are identified as opportunities to make rural and remote practice more attractive.[1]

The Productivity Commission has drafted a recommended [Draft recommendation 11.7] that within two years Commonwealth and state and territory governments should implement initiatives (e.g. reducing professional isolation, increasing opportunities for professional development, and improving the scope to take leave) to increase recruitment and retention.

Personal challenges include fewer job opportunities for partners, schooling options for families, a lack of housing and general lifestyle differences.[1, 3] These barriers are not new, the Productivity Commission previously identified that ‘remuneration levels, professional demands and, more generally, lifestyles and isolation’ are barriers to health professionals applying for rural and remote positions.[23] The labelling of financial and in-kind incentives as “hardship payments” reinforce prevailing negative perceptions. Orygen heard during consultations with stakeholders that promised conditions and benefits sometimes do not materialise.

Service funding models are also a barrier to recruitment and retention. Short-term funding and contract roles, working in isolation and a lack of support have been identified as issues in recruiting and retaining primary and mental health professionals, including Aboriginal health workers.[24] Turnover of mental health support services is a contributing factor in youth disengagement from services.[3] Compounding these issues, workforce shortages are often addressed by a revolving workforce, including locum doctors and nurses. Constantly changing staff makes it difficult for young people to develop the rapport often needed to broach the subject of mental health.

The Senate inquiry report recommended that Commonwealth and state and territory governments should develop:

- longer minimum contract lengths for commissioned mental health services in regional, rural and remote locations [Recommendation 5]; and
- policies to allow mental health service contracts to be extended where a service provider can demonstrate the efficacy and suitability of the services provided, and a genuine connection to the local community [Recommendation 6].

In a survey of service providers pay and conditions were the main challenge in recruiting and retaining mental health professionals. The challenge faced by a service is shaped by the funding model it uses. The headspace model is based on a private practitioner model that is funded by Medicare rebates. This model has issues related to the comparative competitiveness (pay and job security) compared with private practice and state health department positions. Changes to the Medicare Benefits Schedule (MBS) provides a mechanism for targeted reforms and incentives to increase delivery of youth mental health services and treatment.

INCENTIVES

Incentives are used to attract and retain health professionals in rural and remote practice. The focus of incentive programs has historically been to encourage doctors to work in rural and remote areas.

The Stronger Rural Health Strategy includes a Workforce Incentive Program. The program replaces two incentive programs for practice nurses and doctors, but retains separate streams. The practice stream is intended to support practices to employ a single health professional or a combination from allied health professions, nurses and Aboriginal health workers. A rural loading will be applied for practices located in MMM areas 3-7. An annual payment to GPs will be available, with the amount dependent upon location.[25]

Incentives are also provided through the MBS to encourage private providers to practice in rural and remote areas. Concerns were heard through consultation with stakeholders, however, that current MBS incentives were insufficient to make practicing in many rural locations financially viable. This issue was also identified in survey responses from services in regional, rural and remote areas. Combining MBS payments with subsidised service delivery payments to provide higher pay was suggested by stakeholders as a mechanism to incentivise practicing in remote communities.

The Productivity Commission cited existing financial incentives (together with other draft recommendations to expand services and fund more local positions) as a reason for not making any recommendations for financial incentives in its draft report. However, Orygen heard during consultations for this project that incentives are not one-size-fits-all and that a range of incentive options need to be available. A range of incentives are required to attract mental health professionals to rural and remote areas. The Commonwealth, state and territory governments and PHNs need to work together to increase mental health services provided to young people by salaried health professionals, GPs in primary practice and mental health professionals in private practice is required.

POLICY SOLUTIONS	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
TARGETED MBS INCENTIVES			
Implement a higher rebate in MBS item numbers for mental health services provided to people aged between 12 and 25 years by practitioners practicing in rural and remote areas.	A range of policy mechanisms are used to provide incentives to attract and retain health professionals in rural and remote areas. MBS based incentives would enable targeted incentives to encourage a broader range of primary health professionals, allied health professionals and psychiatrists to practice in rural and remote areas. Paying a higher rebate for mental health services provided to young people would enable increased rates of service delivery and sufficient time to provide these services.	Increased youth mental health services delivered in rural and remote areas.	Commonwealth Department of Health, MBS Review Taskforce.

Delivery timeline: 1-2 years

PROFESSIONAL SUPERVISION AND DEVELOPMENT

A number of barriers exist in providing professional supervision and development in rural and remote health services. These barriers include; a small local workforce, restrictions in how formal professional development is delivered, who can provide supervision and a lack of mentoring. Priority recommendations identified in the National Rural and Remote Health Workforce Innovation and Reform Strategy focused on enhancing education, clinical training and career opportunities for the rural and remote workforce and the need to support leadership and optimise the available skill base in workforce planning.[9]

A study of allied health professionals in rural South Australia found the smaller numbers of allied health professionals made matching supervisors with clinicians difficult.[26] The potential for visiting clinicians to provide training or support for local health professionals is often missed due to the demands on available time to provide patient-facing services.[27]

The accreditation standards for training and professional development is often too impractical or onerous to enable delivery in a rural or remote setting.[9] The National Rural and Remote Health Workforce Innovation and Reform Strategy previously identified the restrictions of registration and accreditation requirements on providing supervision. This requirement can be a barrier to innovative responses, such as inter-professional supervision and development. The strategy included a strategic action to encourage "National Boards to review their supervision requirements to enable inter-professional supervision models".[9] Five years later the Senate inquiry report made a similar recommendation – indicating no or little progress had been made.

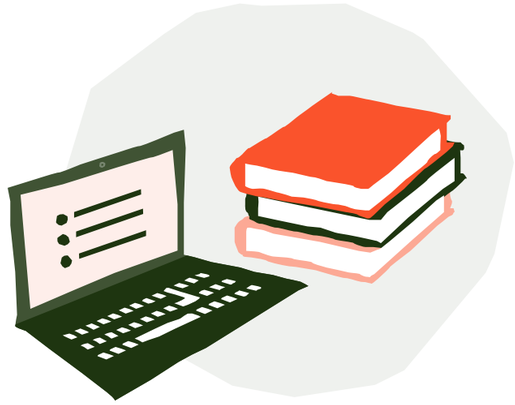
The 2018 Senate Community Affairs Reference Committee inquiry heard from medical colleges that they recognised their responsibility to meet supervision needs and to be flexible in how supervision is provided. The report documented the role health professional colleges have in supporting the rural and remote workforce through the developing programs to provide increased support and providing continuing professional development. The committee recommended "the Commonwealth Minister of Health work with health professional colleges to develop strategies for the immediate improvement of professional supports and clinical supervision" [Recommendation 13].

INTER-PROFESSIONAL SUPERVISION

Although the option of inter-professional supervision faces barriers, lessons learned from where it has been practiced, inter-professional clinical placements and multidisciplinary teams suggest that such an approach could be beneficial and provides direction for how it might be implemented. In the context of medical student placements in rural hospitals, exposure to inter-professional practices positively affected attitudes toward this approach.[28] The implementation of inter-professional practice in a youth mental health service in Tasmania resulted in greater understanding of other's roles.[29] Inter-professional practice increases health professionals understanding of the role played by colleagues from other professions.

Inter-professional supervision can also benefit supervisors. A small study of inter-professional supervision of students in a two rural hospitals found the practice challenged professional boundaries and supervisors updated their clinical skills and reflected on clinical practice rather than routine practice.[30] Interviews with health professionals from rural New South Wales who provided inter-professional clinical supervision of students found that participation increased awareness of issues and improved communication.[31]

Introducing inter-professional supervision is likely to be more successful where inter-professional practices are already in place. In rural contexts where formalised practices have not been implemented a degree of informal practice is likely to already be practiced potentially increasing receptiveness to inter-professional supervision. While inter-professional practices are facilitated by staff knowing each other in rural contexts[32], research is needed to explore whether staff familiarity would be an enabler or barrier to inter-professional supervision.



POLICY SOLUTIONS	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
REMOVING BARRIERS TO INTER-PROFESSIONAL SUPERVISION			
Trial of inter-professional supervision to determine efficacy and acceptability. A two-year trial and evaluation be conducted in four rural health services. Research themes for the trial include: • barriers and enablers to working across professions; • identifying requisite skills to inform the development of guidelines; and • co-design of program presentation to enable program acceptance.	A number of barriers exist in providing supervision and professional development in rural and remote health services. The accreditation standards for training and professional development is often to impractical or onerous to enable delivery in a rural or remote setting. Evidence shows that inter-professional practices are beneficial. Benefits include increased awareness of other roles and workplace or practice issues and improved communication. The National Rural and Remote Health Workforce Innovation and Reform Strategy previously encouraged professional bodies to review requirements to enable inter-professional supervision. Medical colleges have acknowledged the need to be flexible in how supervision is provided.	Supported and implemented model for inter-professional supervision.	Health departments, professional bodies.

Delivery timeline: 2-5 years

TECHNOLOGY

The option of providing supervision via teleconferencing previously reported by the Senate inquiry report[3] was also recommended by the Productivity Commission in its draft report [Draft recommendation 11.2] [18].

Although online professional development options are available, some professionals working in rural and remote areas experience the same barriers of limited bandwidth that young people face in accessing online services.

EDUCATION AND TRAINING THE FUTURE WORKFORCE

An ageing health workforce in rural and remote areas[9] highlights the need to educate and train the future workforce. There is evidence that undertaking education and training in rural and remote areas increases the likelihood new graduates will work in this setting.[3, 9] This approach is an existing workforce development policy. Policies have, however, focused on educating and training doctors. For example, the Commonwealth provides up to 100 Commonwealth-supported medical school places annually to increase the number of doctors working in rural and remote Australia.[33] Recipients of a supported place are contracted to work in a rural or remote area for six years.

In the 2018-19 budget, the Australian government provided funding to establish five new rural medical schools through the 'train in the regions, stay in the regions' program. Part of the Stronger Rural Health Strategy the program included the establishment of a new Department of Rural Health at La Trobe University to increase clinical training opportunities for nursing and allied health students in rural Victoria. This initiative is an extension of the Rural Health Multidisciplinary Training Program.[34]

The available evidence for pathways from training to practice in rural and remote areas led the Productivity Commission to draft a recommendation [Draft recommendation 11.2] that the number of trainee psychiatrists be increased and that states and territories consider determining the number of scholarships supporting nurses to attain specialist post-graduate mental health qualifications by workforce need.[1]

The use of Commonwealth funded scholarships for medical students that bond recipients to periods of rural service is well established. Expanding Commonwealth funded bonded scholarships schemes to all health professions has been suggested in the past.[9] Financial incentives and accessible opportunities to study can encourage students to consider or select rural and remote education and training opportunities, from which a positive experience increases the potential of a longer-term career in rural and remote practice. While scholarships assist with the cost of study and provide assurance of a graduate employment, financial incentives alone are seldom a motivator for applying for scholarships.[35] Scholarships should be considered one component of a broader support structure for students and graduates that includes mentoring, supervision and professional development.

Increasing Aboriginal and Torres Strait Islander student numbers and completion rates are part of the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023.[22] Policy initiatives are required to attract Aboriginal and Torres Strait Islander people to undergraduate and vocational health courses to achieve strategy aims. Providing culturally safe workplaces are also an enabling factor for career pathways in health services[24] that requires strategic support.[22]

POLICY SOLUTIONS	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
ALLIED HEALTH SCHOLARSHIPS			
Trial scholarships with a service requirement in a rural or remote placement be made available for allied health students. Scholarships be made availabe to final year students in a range of roles and disciplines based on identified service need. A three year trial and evaluation of bonded scholarships in a Primary Health Network with existing teaching facilities be implemented and evaluated.	There is evidence that undertaking education and training in rural and remote areas increases the likelihood new graduates will work in this setting. This approach is an existing workforce development mechanism for recruiting doctors. The need for increased access to allied health services with mental health skills in rural and remote Australia warrants providing scholarships to these professions to support development of a future rural and remote workforce.	Increased allied health workforce recruitment and retention.	Commonwealth Department of Health, state and territory health and education departments

Delivery timeline: 2-5 years

EXPANDED ROLES

Primary health professionals are required to fill the gap in specialist mental health services in many rural and remote areas. Professional support and development is required to equip them for this role.

The development of a National Rural Generalist Pathway is an example of the support and development required. The project is a collaboration of the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine.[6] Through the project GPs working in rural and remote Australia will be equipped with advanced skills to provide secondary and tertiary level care. The National Rural Generalist Pathway report includes a recommendation to make available funding and leave for professional development as an incentive for working in rural and remote Australia.[36]

Nurses are an integral provider of primary health services in rural and remote areas. Commonwealth funding has been allocated through the Stronger Rural Health Strategy to promote and develop the nursing workforce. The initiative is made up of a training and mentoring program for nurses transitioning to primary health care; raising awareness of the Nurse Practitioners and an independent review of preparation of nurses entering the workforce.[37] Training and mentoring will be provided to nurses to support transition to primary health care and training in clinical areas of need for nurses in rural areas. The strategy aims to provide an additional 3,000 nurses in rural general practice over 10 years through changes to incentives programs for rural and remote general practices. The benefits, profile, and role of nurse practitioners as providers of primary health care will be promoted.

Nurse practitioners are authorised to function autonomously and provide an alternative to medical practitioners. A cost-benefit analysis estimated that ten nurse practitioner roles could conservatively improve access to care for 10,000 Australians in rural and remote areas or a similar number, or if located in specifically targeted areas provide access to services for more than 6,000 Aboriginal and Torres Strait Islander People with limited access. The report found similar barriers to recruitment and retention identified for health professions generally, including the need for professional support and mentoring.[38]

The Health Workforce Scholarship Program provides funding for post-graduate studies for nurses (as well as doctors and the allied health professionals). This program is delivered through state and territory rural workforce agencies.[37] Scholarships are available as an incentive for both recruitment and retention of staff in areas experiencing shortages.

Aboriginal health workers have an important role to play in supporting the mental health of Aboriginal and Torres Strait Islander young people. The Stronger Rural Health Strategy also provides investment for Aboriginal and Torres Strait Islander health professional organisations to support their work increasing the number of people in the Aboriginal and Torres Strait Islander health workforce and supporting them in their careers.[39]

Training Aboriginal health workers in low intensity mental health interventions has been identified as one option in equipping them for this role.[3] Another option is to permit Aboriginal health workers (and nurses) to refer young people for specialist care under the Better Access program. This option was recommended in the Senate inquiry report (Recommendation 9). Where a GP is not available Aboriginal health workers need to be able to provide or refer a young person to the care they need.

POLICY SOLUTIONS	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
ACCREDITED MENTAL HEALTH TREATMENT PLANNING			
Accrediting nurse practitioners and Aboriginal health workers to write Medicare Mental Health Treatment plans. An accreditation model would include: • an appropriate training module be developed for accreditation; and • accreditation be reviewed annually. • A telephone advice line be provided to support planning.	Nurses and Aboriginal health workers are an integral provider of primary health services in rural and remote areas. Government policies support and promote the role these health professionals can play. Where a doctor is not available a nurse or Aboriginal health worker needs to be able to provide pathways to specialist mental health care.	Ensuring pathways to specialist mental health care.	Commonwealth Department of Health and professional bodies
Delivery timeline: 2-5 years			

BROADENING THE SUPPORT NETWORK

In a context where primary health professionals are required to provide more specialised services there is an opportunity for other professions working with young people to provide early responses to mental health needs. This broader support network includes teachers, police and social services and community members who have contact with young people. For example, the acceptability of school-based counsellors as a first contact for young people accessing mental health care has previously been identified.[40] If the responsibility for providing mental health support is to be broadened then awareness and support will be required to fulfil the role.

A ROLE FOR OTHER PROFESSIONS

In many cases teachers and police are already providing early stage mental health support. This role needs to be acknowledged so that appropriate support and training can be provided. Teachers at boarding schools will come into contact with students from rural and remote areas and should be included in training initiatives. The Be You program is the Australian government's schools based mental health program. The program includes professional learning modules for teachers. Links with local mental health services provide a local option for knowledge transfer and also makes service contacts for teachers and police. Regularly meeting with a primary health professional would also serve to establish and strengthen health care pathways. Recognition of this training could also be incorporated into job descriptions and remuneration.

Policy opportunities previously developed by Orygen to increase the access and acceptability of mental health services also identified people in leadership roles with young people.[41] Australian research has found that sports coaches frequently performed activities which promote young people's mental health.[42] If non-health professionals are to play a role in providing early stage mental health support in rural and remote Australia they will need to be trained and supported for this role. A review of existing evidence for mental health training programs for non-mental health professionals found that follow up is needed to maintain the attained benefits.[43] Annual training and refresher courses could be implemented to ensure new staff are trained and continuing staff benefit from reinforcement.

COMMUNITY MEMBERS

The size of rural and remote populations can mean that community members are more likely to know who is in need of care. Recognition of a community preceptor role or participation in training may better enable connections to be made between a young person and health services. Community members who have regular contact with young people could potentially play this role (i.e. hairdresser, café/take-away shop owners). Training can provide mental health literacy to equip community members in identifying a young person's need for support.

Training programs to equip individuals, including community members to provide help to someone who is developing or experiencing mental ill-health are available. For example, the Mental Health First Aid program has been found to be effective in improving mental health literacy and ability to provide appropriate support, with improvements still present six months after training.[44] It is unknown, however, how effective the intervention is in positively affecting help-seeking behaviours.[45] A training course focused on supporting young people for school staff, parents, sports coaches, community group leaders and youth workers is available. Other programs established to train community members include the Rural Adversity Mental Health Program and the Rural Minds Project.

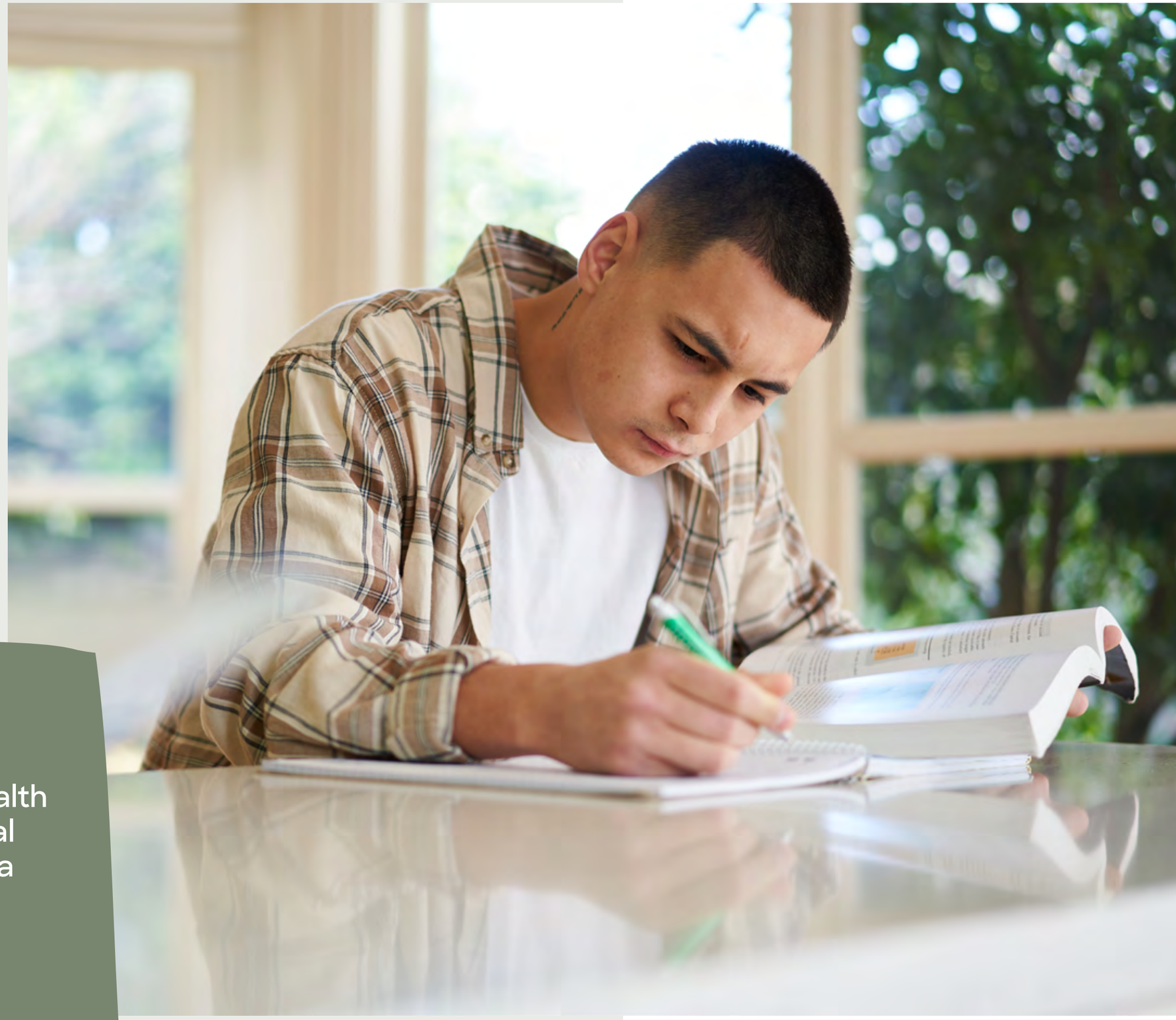
While community members can provide a valuable resource and link, if they are not supported there is a risk that expectations of their role will not be sustainable. In some communities, including Aboriginal communities there is a risk they will be burdened with additional support roles.[3]

SUMMARY

Workforce recruitment and retention is an ongoing issue.

New and expanded initiatives are needed to educate and train the future workforce and to provide professional supervision and development for the existing workforce.

There is scope for a broadened role for non-health professionals and community members.



> “Attracting and retaining mental health professionals to rural and remote Australia continues to be a challenge.”

SERVICE MODELS

Rural and remote areas lack the population base necessary to support independent health teams at primary, secondary and tertiary levels. While ideally the mental health care a young person receives is appropriate to their need, this service reality means that primary care is often the only locally available care.

The National Rural and Remote Health Workforce Innovation and Reform Strategy has previously identified the need to prioritise workforce development to enable health professionals to work across the continuum of care.[9] The National Mental Health Service Planning Framework is intended to assist in the planning, coordinating and resourcing of mental health services in Australia based on population needs. Priorities identified for the tool include refining the care profiles to better account for the needs of people living in rural and remote areas.[46] Opportunities to improve services include identifying gaps in service availability, improving communication, workforce innovation and the potential use of technology.

CULTURAL AWARENESS

The cultural awareness of a health service and health professionals can influence a young person's access and acceptance of care and the potential beneficial outcomes. A young person's initial experience of a health service will inform their future involvement. For example, a lack of cultural appropriateness has been identified as a barrier to help-seeking at headspace centres.[47] What an appropriate service looks like will differ for different population groups, including Aboriginal and Torres Strait Islander young people, young people from new and emerging populations and majority population young people.

The Senate inquiry report recommended that all mental health service providers ensure their workforces are culturally competent and that any training is endorsed by and delivered in partnership with the communities into which they are embedded [Recommendation 14].

Training in low intensity interventions for Aboriginal and Torres Strait Islander community members to provide care in local context has also been suggested as another avenue for improving access to culturally safe care. Local delivery of such training is required as leaving an individual's community can be a barrier to participation.[3]

The challenges of recruiting and retaining mental health professionals effects the ability to train and maintain a culturally responsive workforce. Workforce movement means that training and relationships need to be constantly renewed. In addition to cultural awareness training developing relationships with staff, community leaders and young people will enhance a health clinician's cultural responsiveness.

Working with local Aboriginal and Torres Strait Islander health workers can support other health professionals develop their cultural responsiveness. In remote contexts, improving communication between nurses and Aboriginal health workers has been identified as an enabler for collaboration.[48] At a local level collegial activities have been suggested as one way to increase understanding and communication. More broadly, greater promotion of the role of Aboriginal health workers among the broader health workforce and to managers and employers is required.[24]

GAPS NOT OVERLAP

There is enormous variability in the level of service available in rural and remote areas. To identify gaps in mental health services PHNs have commissioned integrated mental health atlases to identify gaps and inform planning.[3]

State and territory provided community mental health services have responsibility for a geographical region. A lack of sufficient resourcing can limit the provision of adequate services to rural and remote areas. Potential gaps in community mental health services highlights the need for greater service structure flexibility in how rural and remote services operate.

Orygen heard during consultations that it is important to understand what is and is not working in terms of delivering services and why. The independence and autonomy of Aboriginal Medical Service and Aboriginal Controlled Community Health Organisations enable local decisions to be made about the development and delivery of services. The transfer of control of health services to local communities was given as an example by the critical reference group of the type of reform that could transform rural and remote health services.

HEADSPACE OUTREACH

Towns in rural and remote areas do not have a sufficient population base to support a headspace centre. headspace centres in regional areas provide a service platform for an outreach service to these areas. In collaboration with local partners (e.g. schools, teachers, GPs) headspace staff would provide outreach services. This outreach model is an extension of existing headspace service model which is built on local partnerships and establishing and strengthening community connections.

POLICY SOLUTIONS	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
OUTREACH HEADSPACE SERVICES			
Trial an outreach headspace service model. A regionally based headspace centre with a proven capacity to build local service partnersips, community links and service delivery be identified to trial the outreach model over two years. Funding to employ support staff and outreach service equipment and resources would be required	Rural and remote towns do not have the population base to support a headspace centre. An outreach model provides an opportunity to extend the service reach of existing regional headspace centres and increase access for young people.	Greater geographic reach of existing headspace services and increased population access to services.	Commonwealth Department of Health and Primary Health Networks

Delivery timeline: 2.5 years

AEROMEDICAL SERVICES

Access to mental health services in remote communities can be limited to aeromedical services. The gap between visits can mean a young person experiences extended gaps between appointments. In extremely remote areas visits are infrequent making the delivery of all but the most general mental health care impractical. There are examples of innovative approaches to youth mental health being used within aeromedical services. For example, CountrySA Primary Health Network has funded a Royal Flying Doctor Service nurse to provide community engagement alongside the clinical component of their work during visits.

A number of aeromedical services operate in Australia, however, due to the high cost of these services they are dependent upon operational funding. The Senate inquiry report recommended that long-term investment be provided to aeromedical mental health services to enable reliable and regular services [Recommendation 15]. The Royal Flying Doctor Service for example, has been allocated $20.4 million in Commonwealth funding to increase the provision of psychologist and social worker outreach clinics (and telehealth capacity) from January 2019.[49, 50] This recommendation also stated that providers of aeromedical services invest in long-term support for mental health professionals to ensure consistency of staff.

COMMUNICATION

Communication between health professionals is important in supporting a young person's transition between services. In the context of rural and remote services communication within an area can often be more integrated than in urban settings, however, communication beyond the local area becomes critical due to the distance between services and appointment availability.

Greater flexibility is required to better enable communication between health professionals in rural and remote settings. For example, communication between providers of specialist services (i.e. telehealth delivered psychiatry) and tertiary services with local primary health services. In Tasmania the PHN has implemented referral software for GPs populated with available specialist services to provide referral pathways for a young person. During consultations for this project Orygen heard that referral and discharge communication between tertiary services and rural and remote primary health services is problematic. To address this issue CountrySA PHN has undertaken a trial communication model for referrals in and out of state tertiary mental health services.

CASE CONFERENCING

Case conferences are intended to enable communication between health professionals to ensure a patient's multidisciplinary care needs are met through a planned and coordinated approach. This option is well suited to rural and remote contexts. There are, however, barriers to implementing case conferences. For example, only a medical practitioner can claim a rebate for coordinating a conference.[51] Limiting rebates restricts the option for case conferencing in rural and remote areas. For example, where an Aboriginal health worker or nurse is the primary health care provider. Rebates are limited to coordinating a conference and are not paid for participating. This restriction does not recognise the time required for preparation or participation. While this may not be a barrier for salaried staff working in a hospital, or community mental health service, it will likely be a barrier to participation for private providers.

These barriers may prevent participation of the requisite three health professionals required for a conference meaning the coordination rebate cannot be claimed. The limitation of MBS rebates for case conferencing need to be removed in rural and remote contexts. This policy opportunity could be implemented as part of the Stronger Rural Health Strategy or through the MBS Review Taskforce.

POLICY SOLUTIONS	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
ENABLING CASE CONFERENCING			
MBS items for case conferencing in rural and remote areas be expanded to include coordination by lead primary care providers (this may be a nurse or Aboriginal health worker). A register of approved primary care coordinators in rural and remote areas be established. MBS item numbers for case conference participation be available for non-salaried allied health professionals working in rural and remote areas.	Case conferences are intended to enable communication between health professionals. Case conferences are a potential solution for communication barriers in rural and remote contexts. The existing MBS model presents barriers to coordinating and participating in case conferences for a range of health professionals. Broaden MBS case conferencing items in rural and remote areas to increase communication between health professionals.	Increased communication between primary and specialist health providers working in rural and remote areas.	Commonwealth Department of Health, MBS Review Taskforce.

Delivery timeline: 1-2 years

INNOVATION

Innovative responses to support primary health services to provide mental health care are required to enable improved access for young people. Responsibility needs to be given to those living and working in rural and remote areas to create the solutions that will meet the particular needs they face. Support from health departments and PHNs will be required to trial locally created solutions.

The Tasmanian PHN provides an example of tailoring service delivery approaches for a local context. Different approaches have been taken in the north and the south of the state for the Youth Enhanced Services to best match the geographic distribution of the population. In the north, staff have been located in a number of locations reflecting the dispersed population, whereas the comparatively concentrated population in the south has seen an assertive outreach approach taken for seeing young people living outside Hobart.

New approaches and initiatives to enable services need to be trialled to test new ways to improve services for young people. A smaller initial investment permits evaluation to determine program efficacy and the funding required for scaling up successful models for national implementation.

COMMUNITY

The potential of applying community development strategies to youth mental health and the role of rural health professionals has previously been explored.[52] The model emphasised social assets within a community strengthening rural communities to develop responses to improve support for young people. Firstly, young people with a lived experience and community mental health 'champions' are brought together to guide the project. Secondly, a network of associations and community groups that could contribute are identified. This network is then expanded to include agencies and services providing mental health and related support services. This network of social assets forms a local, support network for young people at risk of or experiencing mental ill-health.

SHARING THE ROLE(S)

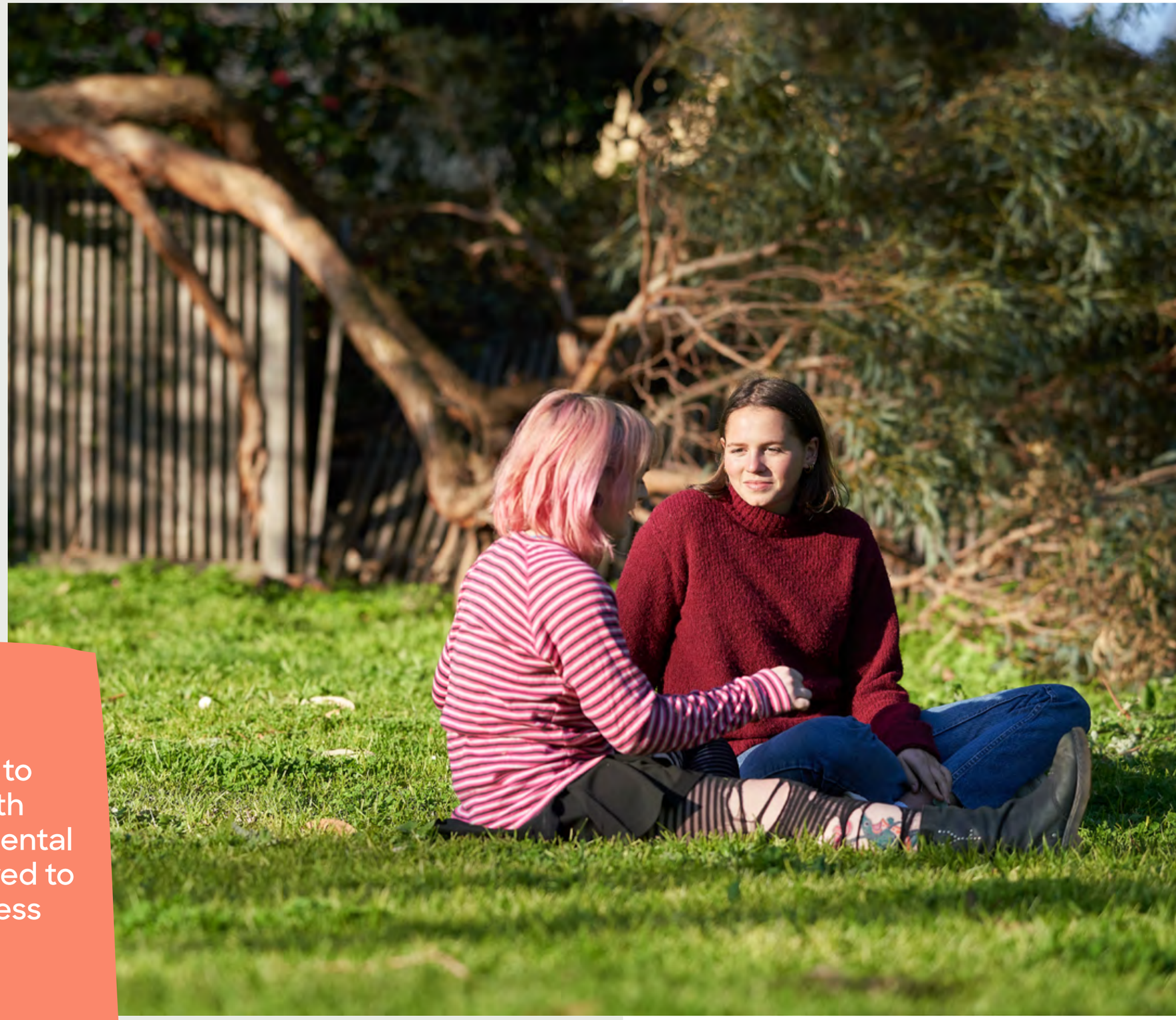
Enabling primary and mental health professionals to practice across services can maximise available resources and recruitment opportunities. One option is to allocate the funding for a full-time mental health placement across different professions to enable a dedicated proportion of practice time for mental health services. This would extend coverage of mental health services. To ensure quality service provision this model would require planned recruitment or training of professionals with advanced capacity to provide mental health care and treatment.

Alternately, a full-time position for a specific discipline could be funded through a combination of part-time roles. Structurally this approach would require multiple services working together or one service taking responsibility and potentially the financial liability of coordinating such a position. Recruitment processes would have to ensure that skills and experience in multiple domains were present.

SUMMARY

Programs to support communication between health professionals need to be reviewed to remove barriers.

Trial an outreach headspace model from regional centres with local partnerships.



> “Innovative responses to support primary health services to provide mental health care are required to enable improved access for young people.”

TECHNOLOGY

Technology platforms present a means to help solve some - but not all - of the barriers to delivering mental health services for young people in rural and remote communities. Technology (e.g. videoconferencing and web-based services) are considered an alternative to face-to-face service delivery by government and policy makers. In response to the coronavirus/ COVID-19 pandemic the utilisation of telehealth has been extended. There remain, however, barriers to implementation and take-up of technology (i.e. poor network connectivity, acceptability) based services models.

BEING CONNECTED

Opportunities for technology to complement existing services is reliant on access to adequate internet connectivity and mobile networks. Access to these communication options remains an issue in rural and remote Australia. The Senate inquiry reported that a 'large number of witnesses and submitters described telecommunications infrastructure in rural and remote areas, including landline telephones, mobile telephones and internet access, as poor, intermittent and unreliable.'[3] Anecdotal evidence from the critical reference group meeting illustrated this point: online access for one young person working on a remote station was only available through their employer's email address.

A range of mental health services can be delivered remotely via telephone, online and through videoconferencing platforms - where accessible. Each of these platforms provide different elements of mental health services.

- Telephone helplines are used to provide information and emergency crisis support. Specialist advice can also be provided for primary health professionals through a professional helpline.
- eHealth is a broad category of services delivered through mobile apps or online sites and include information, brief interventions, online modules and support communities.
- Telehealth services include the provision of consultations, education and supervision from a distance using videoconferencing platforms or similar online services.

TELEPHONE HELPLINES

Telephone helplines exist for the public and health professionals, providing access to support and advice.

Telephone helplines are an established form of support for people experiencing mental ill-health and their family and friends. The support provided may be information or access to a crisis services. The anonymity of telephone services was identified by the critical reference group as a positive feature for young people in rural and remote Australia who may otherwise find it difficult to access confidential mental health advice.

Telephone advice services for primary health professionals are also available. When working with complex cases access to a psychiatrist or psychologist can assist practitioners in making treatment decisions. Bush Support Services, a national psychology service provided for remote health workers is an example of this type of service. Through this service a team of psychologists (including two Aboriginal and Torres Strait Islander psychologists) provide around-the-clock telephone support. A similar national service for GPs was previously funded by the Australian government, but low use and high costs were an issue. The Productivity Commission has drafted a recommendation [Draft recommendation 5.1] for an MBS item for psychiatrists to provide advice to GPs over the phone. Orygen supports this draft recommendation and suggests that it be expanded to include expert advice on alcohol and other drug disorders in young people.

EHEALTH

Online services, such as eheadspace provide links to online health practitioners that may not be available for young people in rural and remote areas. Despite the potential role, usage data indicates these services are predominantly used by young people in metropolitan areas.[53, 54] Online therapeutic services are ideally used in connection with face-to-face care, rather than as a replacement.[55] While eHealth platforms are generally acceptable to young people and there is suggestive evidence supporting its use for anxiety and depression, more research is needed to establish the conditions for effective delivery and treatment.[56] An advantage cited for eHealth is the possibility for a specialist living in an urban centre to provide treatment to a young person in rural and remote Australia.[57] However, the acceptability of eHealth services for rural and remote young people being staffed and located in urban centres was questioned by stakeholders participating in a critical reference group for this project. National policy and funding initiatives for eHealth for young people need to provide acceptable content and support that reflects the experiences of young people living outside of urban centres.

TELEHEALTH

Telehealth is often cited as a solution to the shortage of specialist mental health services in rural and remote Australia. In addition to the potential to deliver specialist services not otherwise available in rural and remote areas, cost advantages are also cited as benefits. A review of evidence for telehealth services found that mental health communication, counselling and monitoring, management can be delivered through telehealth and that the research agenda should now be focused on implementation.[58] The potential for telehealth to be delivered by a specialist living in an urban centre to provide treatment to a young person in rural and remote Australia has been identified as a policy solution for a lack of specialist mental health services in rural and remote Australia.[57] Telehealth services compliment face-to-face services and are not intended to replace existing services.

In 2017, the Australian government expanded the Better Access program to include telehealth services for people living in remote areas (MMM 4-7).[59] An initial requirement that one of the first four sessions was delivered through a face-to-face consultation was subsequently removed. The Mental Health Reference Group recommended to the MBS Review Taskforce that these changes to the provision of mental health services via telehealth under Better Access be assessed in two years to determine whether it had delivered the hoped-for outcomes.[60]

In response the coronavirus pandemic temporary MBS telehealth service items were established. Access to these items should be made permanent for young people.

Data requirements for telehealth services are a potential barrier to access. Services should be encouraged to use platforms that have lower data requirements. Data use for telehealth services should be unmetered for service users. Internet providers are able to identify when a telehealth platform is being used. The Department of Health should determine the most effective method for funding telehealth data use.

Not all young people living in rural and remote areas will have access to adequate internet services to support video-based platforms. Telephone services need to be available alongside video-based services.

Concern was expressed during stakeholder engagement that telehealth services are being marketed and provided to people in remote areas by health professionals living in urban areas. The opinion was expressed that professionals living and working in rural and remote areas would better understand the context of remote living and, therefore, be better placed to provide appropriate services. A requirement that health professionals delivering telehealth services live in a rural or remote area, or have experience working in this context was suggested by the group. This requirement would have the additional benefit of providing further employment options, potentially increasing practice viability for health professionals.

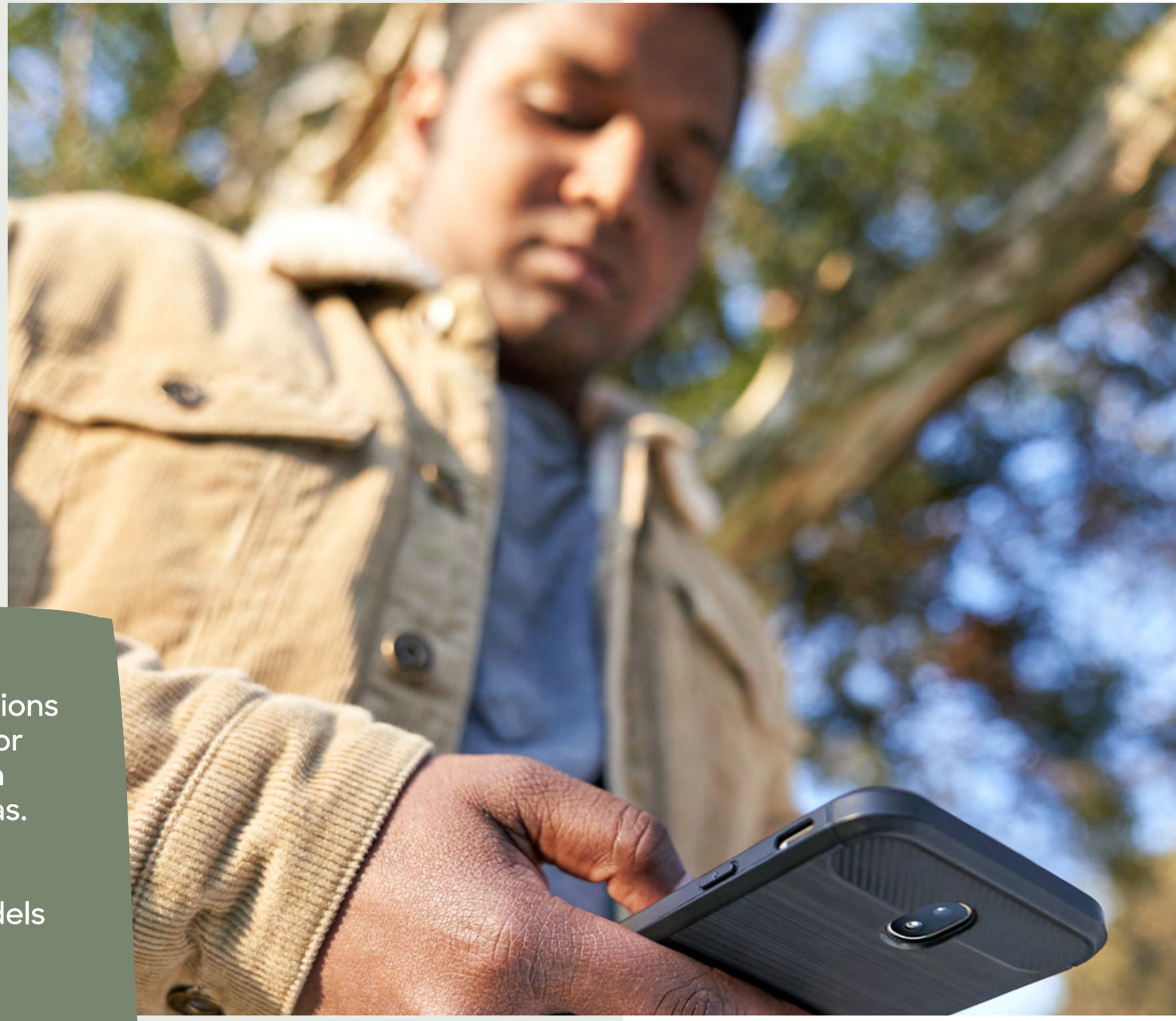
POLICY SOLUTIONS	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
MAKE PERMANENT TELEHEALTH MBS ITEMS FOR YOUNG PEOPLE			
Make permanent telehealth MBS items for young people aged 12-25 years of age. Service users should not be charged for data useage for telehealth services. Internet providers can identify when telehealth services are being used. These servies should be unmetered. The Department of Health.	In response the the coronavirus pandemic temporary MBS telehealth services have been established. Telehealth services enable the delivery of specialist services not otherwise available in rural and remote areas. A review of evidence for telehealth services found that mental health communication, counselling and monitoring, management can be delivered through telehealth and that the research agenda should now be focused on implementation.	Improved access to mental health services.	Commonwealth Department of Health

Delivery timeline: Immediate permancy of telehealth services, 6 months for negotioation of unmetered data use for telehealth services

SUMMARY

Technology provides an opportunity for enhancing service delivery options for mental health care in rural and remote areas.

Services utilising technology need to be part of a broader policy approach to rural and remote mental health service delivery.



> “There are policy solutions to improve services for young people living in rural and remote areas. Solutions to address workforce gaps, enhance service models and identify the role for technology.”

FIT FOR PURPOSE

Mental health services need to be appropriate and acceptable for young people living in rural and remote areas. Services need to reflect the issues young people face, including the increase of suicide rates with remoteness. The workforce challenges faced by health services require innovative responses and funding to enable sufficient support for young people.

To deliver fit for purpose mental health services for young people policy solutions are required to address workforce gaps, enhance service models and identify the role for technology.

WORKFORCE GAPS

Trained and experienced mental health professionals are required to provide youth mental health services. Opportunities to develop this workforce, include education and training, work experience and supervision. For example, scholarships used to attract medical students could be extended to allied health students. Exploring broader supervision opportunities, including development of inter-professional supervision is potentially part of the solution. The expanded role of rural and remote positons also has to be recognised. For example, accrediting nurse practitioners and Aboriginal health workers in remote settings to write Mental Health Treatment Plans to enable access to mental health services.

SERVICE MODELS

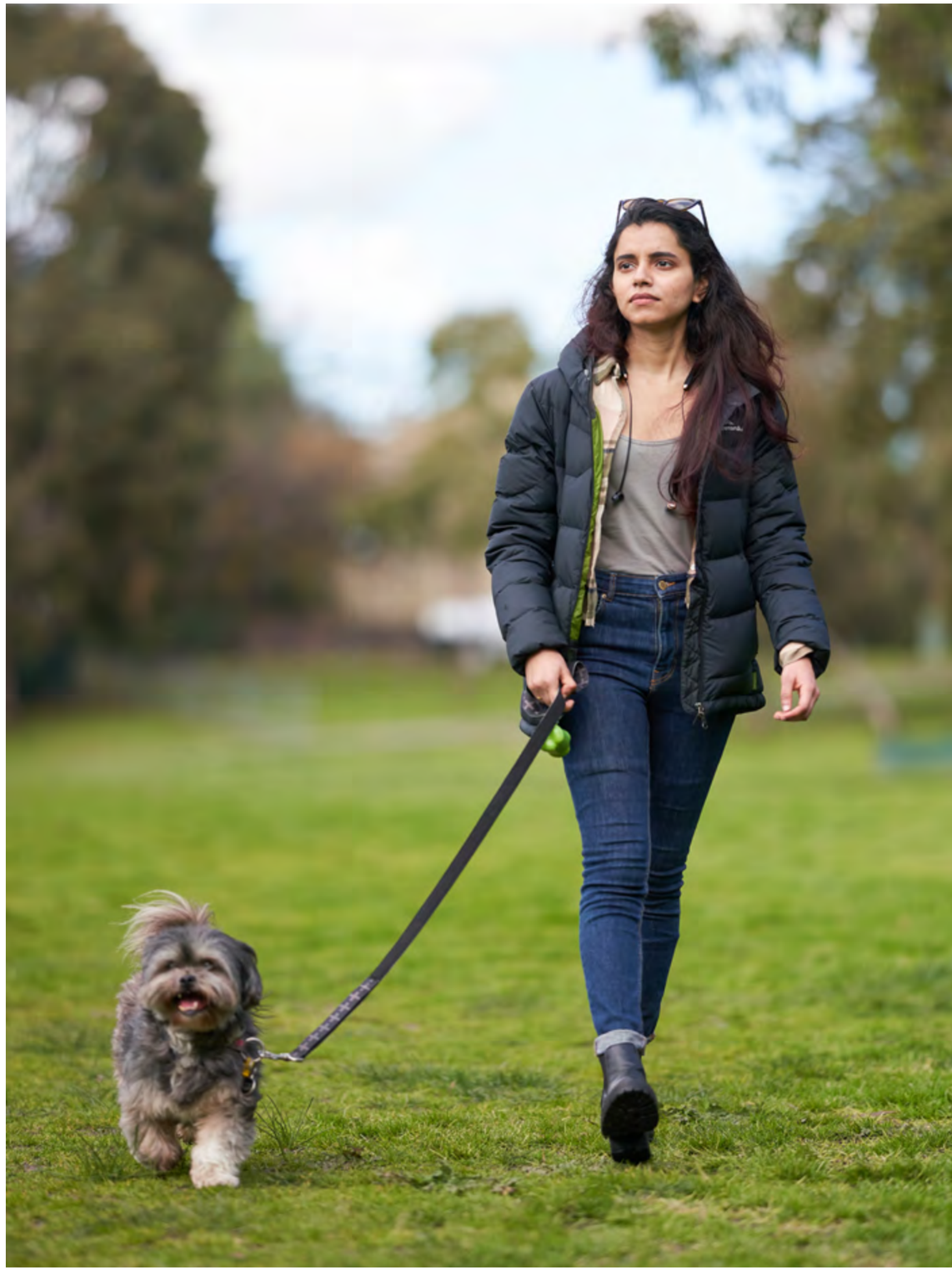
Independent primary, secondary and tertiary level mental health services are not feasible in rural and remote areas. Service delivery and workforce sustainability in rural and remote areas will be strengthened through a higher rebate in MBS item numbers for mental health services provided to people aged 12 and 25 years.

An outreach model from regionally based headspace centres could establish and develop local partnerships to enable the expansion of this youth mental health service model into rural areas.

To enable involvement of appropriately qualified mental health professionals in the provision of care for a young person requires communication channels with the in situ health professional. MBS items for case conferencing in rural and remote areas need to be expanded to include coordination by lead primary care providers and rebates for participation of non-salaried allied health professionals. Flexibility in youth mental health roles across services or shared between staff could also maximise the available workforce.

TECHNOLOGY

Telephone helplines, online eHealth platforms and telehealth services are all existing technology options for different forms of service delivery. These platforms continue to be pursued in government policy and in response to changing social circumstances (i.e. the 2019-20 bushfires, and coronavirus pandemic). The potential of these platforms to expand mental health services for young people is dependent



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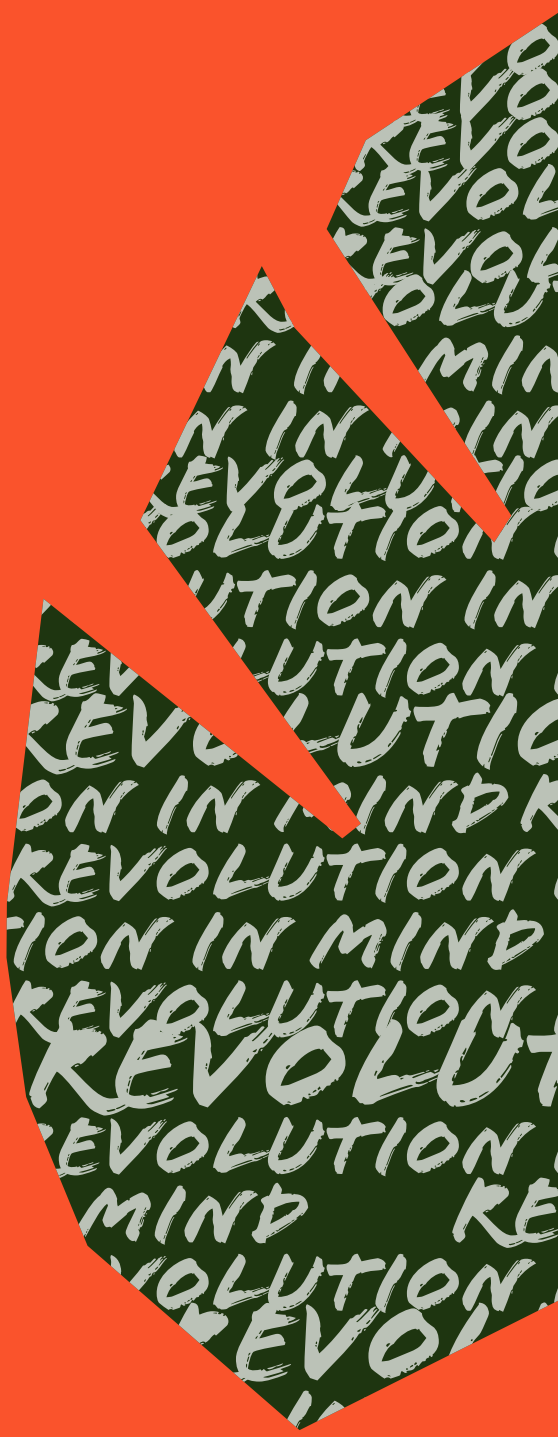

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