



Position Statement: Provision of mental health services in rural Australia

March 2015



Strategic objective

The RACGP recognises that GPs, as part of a multidisciplinary team, play a crucial role in the provision of mental health services for all Australians. The RACGP is committed to ensuring the profession is well supported in providing quality mental health care in general practice.

The rural context provides a challenging setting for those providing mental health care. The GP may be the only available health professional providing the first contact for mental health presentations. Service deficits, including lack of specialists and support services, impact significantly on access to support for both patient and the profession. Through recent consultation with rural members, RACGP Rural has sought to clarify the key challenges in meeting patient need in mental health which forms the basis of this Position Statement.

Position summary

RACGP Rural strongly advocates for policies that provide supportive structures to enable the required service integration to facilitate quality GP-led patient-centred mental healthcare in rural and remote communities. Primary Health Networks (PHNs) have the potential to facilitate collaboration and simplification of referral pathways helping to build the required service connections. But to meet the vast under supply of mental health care in many rural areas more flexibility within policy is required which includes addressing the many complexities through stronger integration of funding streams.

The required connectedness between the available funding streams is currently lost in policy. Instead, GPs and healthcare teams need to work through a complexity of different supports – Medicare, Better Access, ATAPS, State Health, Headspace – most working in isolation of the other and often limited in application due to a narrow objective or focus to fix just one service component. Innovative localised service solutions can be coordinated to lift this burden which would provide for more flexibility and support falling more in line with the workings of the multidisciplinary team and shared care arrangements. Supports must expand beyond the confines of the MBS and private practice should be supported in packaging available funding streams to enable service expansion and service continuity in rural areas.

Barriers and enablers

Key factors contributing to disparities in service utilisation in rural and remote include poor service integration, insufficient workforce numbers, restrictive funding approaches and high number of socio-economically disadvantaged people. Enabling comprehensive team-based care with strong coordination among providers requires flexibility of service funding relevant to need, including consolidation of funding schemes and service innovations in addressing the distance barrier including telehealth.¹

The **key principles** outlined below are considered vital to addressing need in rural communities and enabling access to mental health care.

1. Facilitating stronger integration and coordination of care

The patient journey and outcomes can be improved through coordination and integration of care. A seamless continuum of care in the rural and remote context relies on flexibility and local responsiveness. GPs need to access a range of supports to facilitate localised solutions and build partnerships and service connections required for shared care arrangements.

1.1 Meeting need through flexibility within policy

Access and care for acute and chronically unwell patients are complex and cannot be devolved to one funding formula. A **flexible approach** is needed which includes stronger integration of existing funding streams, beyond the “Better Outcomes” framework to meet need in rural communities. Funding needs to support shared care arrangements and provide the necessary supports and service links.

RACGP Rural recommends that flexibility be built into program design parameters to fit the complex and challenging context of rural practice and to facilitate shared care arrangements.

1.2 Enabling Innovative localisation solutions

Improving collaborative care through **innovative models of healthcare** is imperative to address need. Flexibility to support the structure and functions of a multidisciplinary team includes providing supports to expand the care team beyond current confines of the MBS. This would enable the expansion of teams working within private practice to include private psychologist and other allied health professions. The utility and centrality of technology as an enabler of care cannot be understated either. It is through telehealth that more psychiatrists can access rural clients and rural clinicians can be supported to deliver care to the upper limit of their scope of practice in a generalist framework.

RACGP Rural recommends the further investments in policy which enables innovative localised solutions which help to reduce the distance burden in rural and remote communities.

2. Workforce Support

Stronger investments are needed in mental health training and education to support GPs in upskilling to meet patient-driven need. Medicare-subsidised mental health related services must reflect the complexity of the service provided. Both the training incentives and payment structures require attention and expansion to reflect demand and particular expertise required within certain patient population groups.

2.1 Support to upskill to meet patient need

Options for practising GPs to re-engage, re-skill or re-train in mental health advanced skill practice are limited. Enabling the training opportunity requires equitable support for the acquisition and maintenance of advanced skills for rural GPs. This requires expansion of current incentives to capture essential non-procedural advanced skills including Mental Health.

RACGP Rural calls for stronger investments in advanced skills, procedural and non-procedural, for the existing workforce to address need in rural communities.

2.2 Remuneration and recognition

In order to capture service complexity there is a need to ensure remuneration more adequately reflects the services provided. Incentivised support for GPs to access additional training in mental health, which enables access to various mental health related MBS item numbers is required. Funding arrangements are also required for long term care for people with serious or complex mental illness.

RACGP Rural recommends a review of MBS item numbers to ensure payments accurately reflect service complexity.

The following Position Statement expands on these important principles and outlines a preferred policy approach utilising existing policy levers which allow for flexibility and choice.

Background

Mental health conditions have a significant impact on rural and remote communities who face unique challenges in accessing mental health services. While mental health is a critical public health issue nationally, it is argued that the impacts of mental illness are greater in rural and remote areas for the following three reasons:

- (i) Social attitudes to health and a culture of self-efficiency and resilience
- (ii) Fewer mental health professionals and/ or lack of access to services, delaying diagnosis and intervention
- (iii) A combination of the two points above, whereby stigma (perceived and real), guilt and shame are attached to seeking help in small, close-knit communities where confidentiality is more difficult to safeguard.²

Patient-centred care

GPs play a crucial role in the provision of mental health services for all Australians. In a rural or remote context, the GP may be the only available health professional, providing the first contact for mental health presentations in an environment where other specialist support is not immediately available and access to other mental health professionals may be severely limited. As the first port of call for the majority of patients presenting with mental health issues GPs must be able to diagnose and manage a wide range of mental health problems both acute and chronic across the all ages, referring to other health practitioners only on an as needs, rather than routine basis.³

Mental illness often presents with physical symptoms or coexists with another physical condition at the same time, and research has shown that mental health related comorbidity increases with socioeconomic disadvantage thus affecting already vulnerable people.⁴ These patients will need generalists, who are best placed to deal with complex multimorbidity and who have access to a strong multidisciplinary referral network.

A focus on patient groups

A **population health** approach to planning will ensure a more targeted approach investing in the strategies which will support improved health outcomes for rural and remote communities. A number of subgroups within rural and remote communities are particularly vulnerable to poor mental health outcomes. It is important that any policies be congruent with the needs of all patients with mental health problems but there are some immediate policy interventions required for the particularly vulnerable patient population groups. These specific groups and required interventions are briefing discussed below.

Child and Adolescent

There is evidence to suggest that rural adolescents are at significantly greater risk of major depression, anxiety disorders, nicotine dependence, substance abuse and suicide attempts.⁵ However, mental health services for this particular cohort are limited in rural and remote areas and upskilling opportunities for rural GPs scarcely available. Headspace are well funded to provide mental health care for this cohort, but are geographically limited in coverage across rural Australia and outreach is virtually non-negotiable.

The high incidence of Attention Deficit Hyperactivity Disorder as per DSM-V also requires a particular focus in rural and remote areas. Not all children require treatment with stimulants (Methylphenidate, Ritalin and Concerta, and Dexamphetamine) but for those who do it is essential that regulations concerning prescription of stimulants, which currently vary between the states and territories, are extended to enable GPs to initiate stimulants in children where there is a lack of access to other Specialists (Paediatricians or Child Psychiatrists).

Adolescent and Adult Males

Male youth in rural and remote areas have a suicide rate twice that of their metropolitan counterparts.⁷ Farmers over 55 years of age are also of particular concern, with evidence suggesting older males in these areas are more likely to experience depression than those living in cities.⁶ There is a need for specific investments to provide preventative strategies and supports for these cohorts.

Aboriginal and Torres Strait Islander population

Aboriginal and Torres Strait Islander people, for whom suicide rates are almost twice that of non-Indigenous Australians,⁷ experience depression in rural and remote areas at a significantly higher rate than the general population in major cities.⁶ Suicide rates among Aboriginal and Torres Strait Islander youth living in rural and remote communities are up to six times as high compared to non-Indigenous Australians.⁷

A range of complex factors contribute to the mental health burden in the Aboriginal and Torres Strait Islander population, and it is vital that **culturally appropriate mental health services** are readily accessible. Aboriginal and Torres Strait Islander people are less likely to seek mental health care from mainstream health services,⁸ and as a result may delay seeking help until problems are more serious or acute. The provision of quality mental health for Aboriginal and Torres Strait Islander people requires a deep understanding of cultural practices, traditions, values and history, as well as an understanding of the cultural context, Indigenous holistic concepts of social and emotional wellbeing, and the broader social determinants impacting on mental health.

GP-led coordination of care

Integration and coordination of care

To enable access to mental health care in rural and remote communities, flexibility is key. Funding must be flexible enough to encourage coordination and integration of care. Stronger integration of funding streams is imperative if access issues are to be addressed. It is through consolidating these funding schemes, thereby lifting the key barriers that comprehensive team-based care can occur. This will encourage the required coordination among providers and lead to localised solutions. Collaborative care arrangements must be supported in policy which includes provision for innovations within private general practice to enable the expansion of teams which expand beyond the practice nurse to include private psychologists and other allied health professions.

Medicare-subsidised mental health related services

The *Better Access to Psychiatrists, Psychologists and GPs under the MBS* (Better Access) represents the most significant investment to mental health in Australia, enabling individuals with mental illness to access a level of care not readily attainable in the past. It has been instrumental in fostering collaboration between GPs, psychiatrists, psychologists, and eligible allied health professionals in the care of patients with mental illness. Two key issues exist for the *Better Access* program:

- Firstly, **access issues** exist for patients with mental illness who do not easily fit within existing programs, or require a level of care, which is not commensurate with a single MBS payment.
- Secondly, **remuneration** currently provided does not adequately reflect the services provided, particularly for Mental Health Treatment Plans (MHTP).

An effective MHTP has the ability to act as a shared-care agreement, used to **integrate, coordinate and support** shared care rather than simply being a referral template. Shared care MBS items are currently available for cancer treatment, where GPs and specialists have MBS item numbers allocated specifically to conduct a case-conference to agree on roles and responsibilities, discuss treatment and methods of communication. To support GP-led coordination of care a similar approach is recommended. That is, separating out MHTP item numbers from 'assessment' to increase their focus on 'planning' and setting goals to allow a greater focus on mechanisms for shared care.

These enhanced features would be particularly useful in rural and remote communities, where the various practitioners providing care may be separated by significant geographical distance and the use of technology to communicate is essential. The current funding parameters fail to sufficiently consider case complexity, as well as the time taken to plan and coordinate patient care, liaise with other mental health providers and complete paperwork. These elements of care need to be incorporated into program funding without losing the additional, valuable aspects that are recommended for a MHTP, such as crisis planning, relapse prevention and carer involvement. Funding arrangements are also required for long term care for people with serious or complex mental illness.

Innovative localised solutions

In addition to the service innovations through flexibility within policy described above, **technology has great capacity** to reduce the distance barrier impacting both patients and professionals in rural and remote communities, enabling innovative, localised solutions for patients requiring mental health care. Through strong primary care and specialist networks, GPs can provide and coordinate mental health care for patients facing access barriers such as distance, lack of culturally appropriate services, socioeconomic disadvantage and mobility. The Government currently provides incentive for the provision of telehealth services for populations with greatest need, through access to MBS item numbers for eligible patients. It is imperative that this support is continued into the future, to enable patients in rural and remote areas to access mental health care.

Workforce Support

Training enablers – opportunity, access and incentive

In a rural or remote context, where professional support may not be immediately available, GPs must have access to the ongoing training and education they need in order to competently, confidently and safely address the mental health needs of their rural community. Recent research confirms this need, with rural GPs perceiving mental health advanced skills to be among the skills most prominently acquired and practised to address patient or service need in their rural community.⁹ Through the provision of **ongoing training opportunities** to rural GPs, more mental health conditions can be managed locally at significantly less cost to Government. This allows patients to access mental health closer to home, and visiting psychiatrists more time to deal with most unwell patients for whom they may be the best service provider.

However, these skills are currently undervalued in the sector and excluded from current workforce policy both in terms of support and recognition. Incentives to support rural GP upskilling are currently limited to procedural skills, excluding non-procedural skills such as mental health. Options for practising GPs to re-engage, re-skill or re-train in mental health advanced skill practice are also limited. Equitable incentivised support for GPs to build, develop and/or refresh skills in mental health and training opportunities, which are accessible to rural and remote GPs, are urgently required.

Remuneration and recognition

In order to capture service complexity there is a need to ensure remuneration more adequately reflects the services provided. Adequate recognition and remuneration for GPs who have acquired additional mental health training, including Focused Psychological Strategies (FPS) and Advanced Rural Skills Training (ARST), is also an important upskilling incentive.

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