Submission to the Senate Inquiry into Accessibility and Quality of Rural and Remote Mental Health services

Review of Accessibility and Quality of Rural and Remote Mental Health Services

Australian College of Mental Health Nurses

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1. Introduction

The Australian College of Mental Health Nurses (ACMHN) is the peak professional organisation representing mental health nurses in Australia. A primary objective of the ACMHN is to enhance the mental health of the community through the pursuit of efforts to improve service and care delivery to those affected by mental illness and disorder. The ACMHN also sets standards of practice for the profession and promotes best practice in mental health nursing.

The Australian College of Mental Health Nurses (ACMHN) welcomes the opportunity to provide a submission to the Senate Inquiry Review of Accessibility and Quality of Rural and Remote Mental Health Services. This submission will focus on a number of key issues that are relevant to the Terms of Reference.

2. The nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate; the higher rate of suicide in rural and remote Australia; and the challenges of delivering mental health services in the regions

Consistent with the existing evidence base (‘Social Determinants of Mental Health’; World Health Organisation, 2014), ACMHN members identified a range of factors contributing to poor mental health and high rates of suicide in rural and remote Australia.

“When farmers and people on the land are losing their properties (many families have had them for many generations), they not only feel depressed; but, shame is a major factor.”

“The higher suicide rate [in this region] is often due to the high number of aboriginal people who complete suicide [in the context of] substance misuse and intoxication….Aboriginal communities who have experienced intergenerational trauma and where there is no hope of employment prospects to break the cycle of welfare have a higher rate of substance misuse, domestic violence and incarceration.”

Factors identified by ACMHN members included:

- social isolation and loneliness (due to distance and time constraints – i.e. work and agricultural responsibilities mean there is not enough time to socialise)
- social determinants (lower household incomes, poor financial security, domestic violence, drug and alcohol misuse, homelessness/lack of safe and stable housing)
- cumulative stress and/or trauma (e.g. from harsh weather conditions, financial stress, relationship breakdown etc)
- Regional differences – For example:
  - demographic differences in different locations (areas with larger populations where English is not the first or even second language);
  - in some states there is a loading for rural and remote workers and services, but in other states there is no loading, meaning there is no incentive for the workforce to move to rural and remote locations.
- Stigma (though more nuanced than traditional mental health stigma, see comment below).
ACMHN Recommendation: Increase the availability of integrated mental health and alcohol and drug services, including facilitating the development of a workforce with the relevant skills (see workforce recommendations).

ACMHN Recommendation: Increase flexibility in the mental health service access requirement to have a GP Mental Health Care plan in areas where access to a GP is limited or non-existent (restrictions apply to some non MBS-funded services currently in some regions as well as those that are MBS funded).

ACMHN Recommendation: Provide grants-based funding to support local community initiatives aiming to reducing social isolation and loneliness in rural and remote Australia.

Stigma

Members also referred to a particular rural and remote ‘culture’ or attitude, suggestive of traditional mental health stigma potentially being more nuanced in rural and remote Australia. Specifically, members referred to a common belief among people living in rural and remote Australia that they should be able to manage on their own and should avoid becoming ‘someone else’s problem’. One member suggested this belief often had broad application, regardless of whether the problem was a broken piece of farming equipment, or the person’s own feelings of mental distress. It was this belief that some members suggested was reflective of a stigma or perception relating to asking for help more generally, rather than mental health stigma specifically.

“One member also highlighted that in circumstances where abuse is involved (e.g. domestic violence or sexual abuse) – and particularly in a small community – feelings of shame about the abuse itself can prevent people from seeking professional help.

This barrier to asking for help (regardless of what help is needed) and concern about being a burden on others is something that is important for health professionals in rural and remote Australia to consider in the context of service delivery.

Barriers due to funding arrangements

A past review has indicated rates of people with GP Mental Health Care Plans were much higher in metropolitan areas compared to regional, rural and remote Australia (ACSQHC and NHPA, 2015). Despite these findings, there remains a requirement to have a GP Mental Health Treatment Plan to access mental health services (including some mental health services funded outside of the MBS in some regions). This creates a significant barrier to service access as it makes access to services delivered by a mental health professional contingent on having access to a GP, which presents a barrier for many in rural and remote Australia.

The creation of a GP Mental Health Care Plan also takes considerably more time than GPs in rural and remote Australia (either resident or locum GPs) may have available to spend with a single patient, particularly when they are in such short supply. Furthermore, the often significant out of pocket costs of mental health care treatment, such as that provided through a GP Mental Health Care Plan subsidised under the MBS, poses a significant barrier to access for many. This financial barrier is exacerbated in rural and remote Australia where average incomes are lower,
unemployment is higher and cash supply can be limited due to reliance on welfare or income being tied up in non-liquid assets (e.g. agricultural equipment and livestock).

Members suggested this leads to a heavy reliance in rural and remote Australia on the limited program-based services typically delivered under short term (12-24 month) funding commitments. These services are frequently subject to changes in government policy direction and priorities, causing significant service and workforce disruption. The funding uncertainty represents a significant barrier to skilled and qualified mental health clinicians considering a move to rural and remote Australia, particularly those clinicians who already have limited access to Medicare funded services (e.g. mental health nurses). Currently, members of the largest and most geographically distributed clinical mental health workforce in the country (mental health nurses) who are considering work in private practice in a rural and remote location are expected to do so in the context of very limited funding available to support their services.

Funding sources for mental health nursing services is so limited that often there is not enough funding to support a full time equivalent position, despite significant unmet need and workforce capacity. The ACMHN was recently contacted by a credentialed mental health nurse in rural Australia who stated that there was enormous unmet demand in their community, which the only allied health professional at the service was unable to meet. The credentialed mental health nurse also employed at the service under a small amount of program-based funding was unable to increase their hours (despite having the relevant qualifications, skills and capacity to do so) due to there being no supplementary funding mechanism available to support the additional services they could provide (such as that which is available to allied health professionals via the MBS).

This occurrence is being repeated around the country. It is the position of the ACMHN that these funding limitations operate as a strong disincentive to Australia’s most geographically dispersed and largest clinical mental health workforce (National Rural Health Alliance Mental Health Factsheet, 2017) seriously considering employment in private practice rural and remote Australia (or more broadly for nurses considering specialising in mental health). Unfortunately it is Australians living in rural and remote communities who are among the most significantly impacted by this missed opportunity.

**ACMHN Recommendation:** Establish greater access to mental health services with minimal or no out of pocket expenses to reduce the financial barrier in rural and remote areas with a low average household income.

**ACMHN Recommendation:** Address artificial funding boundaries that prevent and/or substantially limit the capacity of credentialed mental health nurses and mental health nurse practitioners who are already working from delivering mental health services in the primary mental health care setting in rural and remote Australia.

### 3. The nature of the mental health workforce

> “I am one of four Credentialed Mental Health Nurses in the [area] in primary health. That is a woefully low number for this region and one of the reasons people don’t access us is that we haven’t got enough appointments in the day for everyone.”
ACMHN members raised a number of issues relating to the mental health workforce in rural and remote Australia, including:

- Professional isolation, lack of opportunity for professional development or leave, lack of clinical supervision and training for people who might be interested in commencing a position in a rural and remote community on a trial basis.
- A need for more mental health professionals specially trained in therapies in which people learn practical, evidence-based strategies that support sustained recovery (e.g. more mental health nurses and allied health professionals with specific qualifications and training in mental health).
- Suggestion that bonded placements occasionally create situations where clinicians are not as invested in the community they are working in.
- The credentialed mental health nursing and mental health nurse practitioner workforces are being underutilised. This means that mental health nurses in rural and remote communities are unable to increase their service offering, even though they may have capacity to and there is unmet demand. It also means few MHN are willing to consider work in rural and remote Australia outside of the crisis driven public mental health services due to uncertainty surrounding the ongoing service funding.
- Criticism of the “generalist” approach to the health workforce in rural and remote Australia, which some members were sceptical would facilitate access to the evidence based interventions people need.

“Most of us (mental health nurses at the service) provide psychotherapy and that requires a longer term commitment....short sessions of CBT help (sic) some of the people some of the time. Longer ongoing psychotherapy helps more people for longer.”

Mental Health Nurses represent the largest and most geographically dispersed clinical mental health workforce in Australia (Mental health services in Australia, AIHW, 2017; National Rural Health Alliance Mental Health Factsheet, 2017). Mental health nurses already deliver services to people living in rural and remote Australia in general and specialist settings in community and primary care, Aboriginal health services, aeromedical and outreach services, emergency departments and inpatient units. They are trained in mental health assessment and evidence based therapeutic interventions to identify and treat mild, moderate and severe mental health conditions. The size, geographical distribution, qualifications and skillset of the mental health nursing workforce creates enormous opportunity to provide timely identification and treatment of mental health conditions in rural and remote Australia.

Mental health nurses also offer a unique service model that has high utility in rural and remote Australia, in that they are not only specially trained mental health clinicians but are also Registered Nurses. As such, in addition to providing therapeutic evidence-based psychological interventions, mental health nurses can identify and respond to physical health needs – including chronic physical health conditions, pain management – and social factors. Barriers which could reduce or interfere with clinical mental health treatment outcomes (such as co-occurring poor physical health, medication side effects and/or social factors) can be identified by the mental health nurse and addressed in collaboration with the broader care team.

The mental health nursing workforce also has the knowledge and skills to educate and support improved knowledge and practice of all rural health workers in relation to mental health needs in the communities they service.
Furthermore, mental health nurse practitioners have access to a limited range of MBS items and are qualified to provide additional services, such as making diagnoses, as well as prescribing and reviewing relevant medications, which can be particularly beneficial in rural and remote Australia where psychiatrists are scarce.

“Innovative mental health nursing service models have the potential to increase access to high quality mental health care in rural and remote Australia. However, to date these models only operate under time-limited program funding and/or, access to a very limited number of items under the Medicare Benefits Schedule.

- In Western NSW, mental health nurses deliver services through the local Aboriginal Health Services and general practices from a number of locations (e.g. Walgett, Cobar) – a model developed by the NSW Outback Division of General Practice.
- In 2017, an aboriginal health service in a metropolitan location has established a mobile outreach mental health nursing service with the assistance of a Mental Health Nurse Practitioner. The model provides an integrated mental health and drug and alcohol outreach service. Consideration should be given to whether this model can be successfully adapted to rural and remote locations.
- In regional Victoria, a mental health nurse practitioner has setup their own fully nurse-led private mental health practice which employs a mix of mental health nurse practitioners and credentialed mental health nurses to deliver mental health services to the region. The service works closely with and receives referrals from GP and psychiatry practices and other services across the region.

Another model which holds great potential for attracting and retaining the workforce and improving care integration involves shared employment arrangements, whereby mental health nurses work across different settings under a single employment agreement (e.g. part time in community mental health and part time in primary care; or part time in community MH and part time in the emergency department).

The ACMHN has also just commenced a project to review the mental health content in undergraduate/pre-registration nursing courses in Australia with a view to informing the Australian Registered Nurse Accreditation Standards Review. This project will be very relevant to responding to the identified need to develop the knowledge and skill of the whole nursing workforce in relation to mental health, regardless of the service setting or geographical location in which they work.

**ACMHN Recommendation:** Develop an integrated and fully funded workforce development plan to increase the number of appropriately qualified and skilled mental health professionals in rural and remote Australia, including areas such as: transition to specialty practice programs, scholarships, including those that support transition to specialty practice, mentorship/clinical supervision, online communities of practice to address professional isolation, rural and remote loading etc (as recommended by Humphreys et al, 2017).

**ACMHN Recommendation:** Facilitate broader adoption of double major nursing degrees at Australian universities and provide scholarship incentives to students from rural and remote Australia, so that nursing students from rural and remote Australia have the option of choosing mental health as a second major.
ACMHN Recommendation: Establish supported pathways to mental health nursing for registered nurses already working in rural and remote Australia, so the nursing workforce in these areas become more equipped to respond to both the mental and physical health needs in their community.

ACMHN Recommendation: Trial and evaluate nurse-led clinics in selected regions of rural and remote Australia (mobile outreach and hub-based), that utilise a combination of mental health nurse practitioners and credentialed mental health nurses, general practice/bush nurses as well as other nurses with experience working in a mental health setting who can be supported to work towards becoming formally qualified credentialed mental health nurses.

Cultural Safety and Growing the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Workforce

The ACMHN supports the position of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives to embed cultural safety into regulation and accreditation of health professionals and services and to actively support the development of the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing workforce.

“Engaging aboriginal people takes a long time; can be facilitated by aboriginal health workers. It may take numerous sessions gaining trust for the client to open up and discuss their issues and often funding does not allow for this to occur so impact is limited.”

“Poor development and support for the Aboriginal health workforce and lack of a comprehensive scheme and implemented activities for growing the Aboriginal and Torres Strait Islander health workforce. Lack of workforce means people needing services are expected to communicate and express their feelings/distress in what is often a third, forth or fifth language for them. Language and cultural barriers place limitations on accuracy of mental health and risk assessments. Assumption from health workers that verbal fluency in English translates to contextual understanding.”

Member feedback in relation to this area was extensive, with one of the most themes coming back to a need for formal implementation of cultural safety across all health and mental health services. Specifically, members identified:

- Care quality and outcomes for individuals being compromised due to frequent engagement of a workforce (mental health and general health) that may have completed some basic ‘cultural competency’ training, but is not trained nor has a sufficient understanding of culturally safe practice.
- The amount of time that is often needed to develop trust with members of Aboriginal and Torres Strait Islander communities is often not support by service delivery models and funding.
- Cultural and language barriers impacting on the quality of care provided, hindered by the lack of concerted effort to grow the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Workforce.
**ACMHN Recommendation:** Implement evidence based initiatives to actively grow the Social and Emotional Wellbeing Workforce, with the aim of reaching a target of Aboriginal and Torres Strait Islander Social and Emotional Wellbeing workers proportionate to at least 3% of the Australian health workforce. This should be reflected, with tangible actions as part of any initiative developed to support the development of the broader mental health workforce in rural and remote Australia.

**ACMHN Recommendation:** Make the necessary amendment to the National Law and providing funding to support the provision of accredited cultural safety training for all health professionals working in Australian health services.

### 4. Opportunities that technology presents for improved service delivery

Technology provides opportunities to improve access to mental health care in rural and remote communities. This includes providing a treatment modality that helps to address privacy concerns which may pose a barrier for some people accessing services in small communities. Feedback from one member noted that the use of videoconference, Facetime, Skype can interrupt the isolation experienced by people in remote locations. Mobile and web based programs can improve access, and may also be a useful adjunct to face to face care, particularly among youth. The mental health workforce in rural and remote communities also utilises technology to access clinical supervision, continued professional development and to consult with other members of the care team.

> “The clinician sitting behind the computer cannot fully appreciate the impact of drought, job losses in the community as well as impacts from relationship breakdown in small communities etc”

> “MHTAL often entails long waiting times for telephone access” (Note: MHTAL is a NSW Mental Health Telephone Access Line)

> “Opportunities for increased use of telehealth, but need to acknowledge the limitations of bandwidth issues and the need for reimbursement schemes to make service provision commercially viable and also recognise that patients frequently need support at the other end of the screen where they sit as well.”

> “It is true that some clients can access online help and improve their wellbeing. But it is also true that clients need to be financially able to access the technological novelties and also cognitively well enough to do it.”

However, it is important to note the limitation of technology and the risk of relying on technology to fill gaps in care, or replace, face to face service delivery, as was indicated in the member feedback the ACMHN received:

- Mobile and web based mental health programs are not appropriate for all. Many people in need of mental health care may have symptoms such as avolition (i.e. the desire to complete a task but experience an inability to initiate the necessary behaviours to carry it out). For such individuals, models of care that centred on self-directed treatment such as many mobile and web based programs may not be clinically inappropriate. These models may also not be culturally safe or effective tools for some minority groups.
Face to face and/or home visits can provide important clinical information less likely to be identified using a phone or web based platform. Non-verbal cues play a significant role in clinical mental health assessment and review, such as body language and physical indicators that may not be visible from the visual display on a computer or phone. Face to face and/or home visits can also provide information such as whether someone has stopped looking after their personal hygiene, or are no longer managing domestic/agricultural duties etc.

Connection speed is often not adequate to support a video consultation in rural and remote Australia.

Members have reported long waiting times for people needing support to access the mental health telehealth service, yet highly qualified mental health nurses are presently excluded from providing these services via the Commonwealth funded telehealth service.

Members viewed technology as an important adjunct to rural and remote mental health service delivery, but not a direct replacement for face to face care for many people experiencing mental illness. The need for access to face to face mental health care was emphasised as particularly important for people with more moderate and severe mental health concerns.

ACMHN Recommendation: Develop clinical guidelines outlining appropriate use of technology-based mental health services, including clear guidance for determining when such services are clinically appropriate; how they should be used (e.g. as an adjunct to face-face contact with a clinician or self-directed); whether connection speed/reliability will pose a barrier to access; consideration of cultural relevance and cultural safety of the service platform etc.

ACMHN Recommendation: Address structural barriers impacting on mental health service access in rural and remote Australia (improve internet access and reliability of connection speeds; provide public/community transport for people to attend appointments; increase outreach services).

5. Other Issues

Maintaining service quality and workforce competency in areas of workforce shortage

The ACMHN would like to also draw particular attention to the challenge to delivering mental health services in rural and remote Australia, while balancing the need for service quality with the need for service access. Some College member referenced situations in which they perceived service access was being emphasised and prioritised at significant cost to service quality, particularly when it came to maintaining workforce skills and competency. Specific reference was made to employers substantially reducing the minimum qualifications and experience at the outset to increase the likelihood of a vacancy being filled quickly. Further investigation is needed to evaluate this and whether similar emphasis is also reflected in the priorities, activities and guidance set by government and other funding bodies.

“(for mental health professionals) to be overbooked and unable to fit in people that they know need more care than they can physically give is disheartening. You know that you are pushing people to either seek help from the less capable (or disinterested) or worse to not seek help at all.”

“If you have (a) transient workforce there is no continuity of care and clients prefer to “soldier on” than spill out their soul to constantly new persons who don’t look like they care at all.”
Members suggested that the practice of reducing minimum standards of workforce qualifications and skills in rural and remote Australia:

- Led to positions being filled by people who are not specially qualified mental health professionals, who are then also not being provided with adequate training and clinical supervision upon recruitment to deliver a high quality mental health service and strong outcomes for individuals.
- Resulted in members of the community trying multiple providers before finding someone with the right skills to help them; or disengaging from services altogether because their attempt to seek help resulted in them getting a poor quality service that they perceived to be a ‘waste’ of their time.
- Highlights a specific need for workforce growth amongst those who are trained and qualified to offer “more than just scripts for psychotropic medications and someone to listen to their problems/concerns”, as one member commented (that is the need to develop the workforce that is trained and qualified to provide evidence based therapeutic interventions that promote and support recovery).
- Emphasises providers’ need to be supported with funding and resources in order to create the option of supporting successful job applicants to ‘work towards’ obtaining the necessary qualifications and developing their skills over time (e.g. funding/resources to support clinical supervision, scholarships, workforce cover to attend professional development/study leave etc). Successful models to grow the workforce in rural and remote Australia are often multi-dimensional or involved a range of ‘bundled’ strategies (Humphreys et al, 2017).

The ACMHN also wishes to note the range of mechanisms available to assure quality in mental health nursing services, including:

- The Nursing and Midwifery Code of Conduct and professional standards (general standards applicable to all registered nurses, regardless of where they are employed)
- The ACMHN Standards for Mental Health Nursing (2010) specifies the minimum level of performance standards required for a registered nurse practising in any mental health setting.
- The ACMHN Scope of Practice (2013) further articulates more specifically the range of activities and services mental health nurses are trained to engage in or deliver.
- Credentialing demonstrates to employers, professional colleagues, consumers and carers that an individual nurse has achieved the professional standard for practice in their area of speciality (e.g. in mental health nursing)
- Continuing Professional Development (CPD) – Events, courses and other material provided by the ACMHN or through a range of other sources.

**ACMHN Recommendation:** Upskill the broader health workforce in rural and remote Australia to better identify mental health needs and know when referral to a specialist mental health professional is required.

**ACMHN Recommendation:** Improve funding certainty relating to mental health programs and services that sit outside of the MBS so that uncertainty does not contribute to the lack of qualified and skilled mental health clinicians. However efforts should also be made to ensure any decisions to extend funding periods are based on independent evaluation and clear evidence of service effectiveness.
ACMHN Recommendation: The ACMHN supports the recommendation of Mental Health Australia for:

- The COAG Health Council to develop a rural mental health strategy, informed by a collation prepared by the National Mental Health Commission of the PHN service mapping in rural and remote areas and other key data that identifies service shortfalls.
- The National Mental Health Commission to monitor and oversee implementation of the strategy, reporting back directly to the COAG Health Council.

6. Conclusion

An opportunity exists to provide an integrated approach to mental and physical health care for people living in rural and remote health Australia through the mental health nursing workforce. Despite being the largest and most geographically distributed clinical mental health workforce, mental health nurses are currently a significantly underutilised workforce due to a range of factors. Supporting sustainably-funded employment opportunities for mental health nurses in rural and remote Australia will not only attract even more nurses into mental health, but has enormous potential to benefit both the mental and physical wellbeing of people in rural and remote Australia. Addressing these workforce issues alongside the social, cultural structural and factors that impact on access to quality mental health care in rural and remote Australia offers an important opportunity to substantially improve mental health care access and quality for people in rural and remote Australia. The Australian College of Mental Health Nurses is happy to be contacted should the Committee require further information.
Appendix A: Summary of recommendations:

ACMHN Recommendation: Increase the availability of integrated mental health and alcohol and drug services, including facilitating the development of a workforce with the relevant skills (see workforce recommendations).

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- The National Mental Health Commission to monitor and oversee implementation of the strategy, reporting back directly to the COAG Health Council.
References


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