

Thursday, 18th April 2019

Productivity Commission
Parliament House
Canberra ACT 2600

Submitted online

Dear Secretary,

Re: inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth

Thank you for the opportunity to provide a submission to the Productivity Commission (the Commission) inquiry into the *role of improving mental health to support economic participation and enhancing productivity and economic growth*. This submission represents the collective voice of the Mental Health Academic (MHA) Network, a staff network of the Australian Rural Health Education Network (ARHEN). ARHEN is the peak body for the 16 University Departments of Rural Health (UDRH) which are in every state and the Northern Territory (MHAs are listed by state, with affiliated UDRH, in Appendix B). Further information about ARHEN is appended (see Appendix A).

MHAs are uniquely situated in UDRHs in rural and remote communities across Australia to flexibly respond to local community needs. The MHA Network also contributes to the national conversation on rural and remote mental health through research and other collective projects. This current submission focuses on shared concerns about the deteriorating mental health of Australians, with a specific focus on rural and remote regions. The key recommendations made in our submission are summarised in the executive summary.

Additionally, the MHA Network would encourage members of this inquiry to access the published records and outcomes of the recent *Senate inquiry into the accessibility and quality of mental health services in rural and remote Australia*¹, where some of the issues being considered by this inquiry have been deliberated. The MHA Network submission to the Senate inquiry is available as a public record (Submission 76²), as is the evidence given by members of the MHA Network at a public hearing in Canberra (16 July 2018³) and at public hearings in other locations across rural and remote Australia⁴.
Yours sincerely,

The ARHEN Mental Health Academic Network

¹ https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices

² <https://www.aph.gov.au/DocumentStore.ashx?id=7b72885c-3c7e-46d8-9352-9a2b60972d8f&subId=612889>

³ <https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id:%22committees/commsen/22540fe5-52fd-4eb4-900d-8cedf3ba4a15/0000%22>

⁴ https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Public_Hearings

EXECUTIVE SUMMARY

1. Improving mental health to support economic participation and enhancing productivity and economic growth requires the inclusion of broader individual, socio-economic and community factors. For a comprehensive understanding of the true impact of mental illness on the economy it is critical to include social capital, community and individual resilience, social and emotional wellbeing, and other determinants of health in any economic impact calculation.
2. Mental health promotion, early intervention and universal approaches are an investment in mental health and wellbeing. Education and early intervention have been found to reduce distress (e.g., stress, anxiety, depression) through education and skill acquisition, reduce suicide, and provide an opportunity to identify individuals who may need more intensive support provided by more traditional mental health services.
3. It is essential to address the fragmentation of the system, where interventions are driven by funding models and not needs of the community or consumer. It is essential to move towards consumer driven mental health systems that are codesigned by the communities they serve. Interprofessional education (IPE) frameworks support collaboration between health professionals and ensure the consumer health journey is considered in funding and program decisions.
4. Key recommendations include:
 - Broaden the scope of this inquiry from a biomedical view of mental health and wellbeing to a more holistic social and emotional wellbeing view.
 - Actively engage with consumers and consumer groups to enable the consumer stories and service gap experiences to be heard.
 - Review the evidence presented during the Senate inquiry into *the accessibility and quality of mental health services in rural and remote Australia* in 2018.
 - Base funding models on investment models rather than cost-effectiveness models. Investment models take a longer-term view and include broader constructs, such as social capital and social and emotional wellbeing, and can better address the determinants of health.
 - Adopt service and program co-design principles that create a sense of agency for the community and individuals.
 - Address disparities between medicine remuneration packages and other health professional remuneration packages offered for difficult to fill vacancies. Equal remuneration will make it more attractive for other health professionals to work in rural and remote locations. Include opportunities for emerging mental health workers (student placement, exchange program) in rural and remote settings.
 - Incorporate IPE principles in policy and funding models. Psychology undergraduate degrees need to be reviewed to ensure students can be included in IPE training and placement opportunities.
 - Make a commitment to invest in the Arts, as a preventative measure, and as a form of social engagement for those who are experiencing mental illness or emotional distress.
 - Develop a climate change national response plan based on (and responsive to) local community needs. Ensure the inclusion of consumers, carers, communities, and academics in the development of an evidence-based and community led response.

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RESPONSE TO QUESTIONS

The following submission addresses the questions raised by the Commission, with a focus on the needs of Australians living in regional, rural and remote areas.

1. Response to Questions on Assessment Approach

1.1. Assessment Approach for the Inquiry

- Mental illness does not occur in isolation of biological and environmental, factors. Therefore, when assessing the cost of mental illness, it is important to also consider social determinants of health (World Health Organization [WHO] Regional Office for Europe, 2012)
- The Commission has focused predominantly on the measurement of deficits with very little focus on social capital, community resilience and social and emotional wellbeing as factors that impact on mental and physical health.
- Research investigating the links between social capital and mental health is well documented, as is research that focuses on the social determinants of health (e.g., McPherson et al., 2014; WHO Regional Office for Europe, 2012).
- It is important to understand that in any calculation of the cost of mental illness to the community where mild and moderate mental health conditions are considered to be an important focus, the economic costs and solutions need to be addressed within the social, cultural (including workplace culture and systemic racism and sexism), family, and community systems (McPherson et al., 2014).

1.2. Recommendations: Assessment Approach

1. Consider the impact of the social determinants of health in
2. Include broader individual and community factors when calculating the economic impact of mental illness. These would include: social capital, community and individual resilience, and social and emotional wellbeing.

2. Response to Questions on Structural Weaknesses in Healthcare

2.1. Addressing and Improving the Structural Weaknesses in Healthcare

- There is evidence from the recent *Senate inquiry into the accessibility and quality of mental health services in rural and remote Australia* that questions the validity of a stepped care approach as the most appropriate approach for Australians living in rural and remote locations (Senate Community Affairs References Committee, 2018). From theoretical and fiscal viewpoints this model appears to have face validity, however the evidence is mixed about the model's soundness and its true cost savings (van Straten, Hill, Richards, & Cuijpers, 2015).
- Further, from a consumer perspective the stepped care model continues to stigmatise mental health concerns and creates a larger divide between levels of service provision and access to services. For example, organisations in the lower steps of care are funded on an "open door" policy (self-referral process); whereas to gain access to the higher steps of care (moderate and severe) individuals often need to change service provider, be referred by a medical practitioner, and access different funding sources, such as the Medicare Better Access program or the public mental health system.

- This example highlights the stepped care model's focus on *funding (cost)* and *severity* rather than on the *consumer's* health journey, resulting in a model that is not responsive to consumer need. Ideally, if a stepped care model is utilised the consumer should be able to step up and down the levels of care with the same provider and/or clinician if they choose. Consumer choice and sense of agency within any health system is critical for recovery. Support for this view is found in the wealth of evidence that demonstrates that the therapeutic alliance is as important as the intervention, and in the stories of consumers that have been shared at other inquiries (e.g., Dunster-Page, Haddock, Wainwright, & Berry, 2017).
- Further, the focus on assigning funding to services based on the cost per session rather than the value they add (investment) results in some services struggling to compete with services who recruit mental health staff with less education and training, and who are not regulated under the Australian Health Practitioner Regulation Agency (AHPRA).
- Arguably, recruiting staff who are not regulated under AHPRA removes the restrictions of the legislative requirements which regulated health professionals work under. The implications for not regulating all health professionals working in mental health (social workers and counsellors) can already be seen in workforce participation in rural and remote areas. If it can be argued that Psychologists need to be regulated as a measure to protect the public from possible harm, then the argument can be extended to any mental health professional and creates a case for regulating social workers and counsellors through AHPRA, with minimum ethical, education and training standards set as a protection for the consumer. The Australian Association of Social Workers (AASW) has been lobbying for Social Workers to be regulated under AHPRA since the introduction of the national health regulation system.

2.2. Recommendations: Structural Weaknesses in Healthcare

1. The Commission actively engages with consumers and consumer groups to enable the consumer stories to be heard.
2. The stepped care model is reviewed, with a focus on consumer health journeys to better understand the mechanisms by which they enter and exit systems of health care, and the barriers to access when severity of mental illness becomes an issue.
3. The Commission reviews the evidence presented during the *Senate inquiry into the accessibility and quality of mental health services in rural and remote Australia* in 2018.
4. Funding models are based on investment models rather than cost-effectiveness models. Investment models take a longer-term view and include broader constructs, such as social capital and social and emotional wellbeing (also refer to section 1).
5. All mental health professionals are regulated by AHPRA to ensure accountability and consumer safety is paramount.

3. Response to Questions on Specific Health Concerns

3.1. Mental Health Promotion, Early Intervention and Universal Approaches

- There is a rich body of evidence indicating that early intervention and universal approaches are efficacious as a first line of defence for mental health disorders, and they provide an opportunity for communities and groups to identify where more specific and targeted interventions are required (e.g., Blair & Raver, 2016).
- Universal interventions have been found to be linked with improved outcomes in the areas of mental health, resilience, attention, executive functioning, and behavioural concerns. For

example, a number of infants and parents who routinely attend primary care services are identified at risk of developing mental health problems. Integrating mental health promotional activities within the primary care setting assists with raising awareness, decreasing stigma and working towards a decrease in the number of mental health problems in adult life (Bayer, Hiscock, Morton-Allen, Ukoumunne, & Wake, 2007). These improvements have been found to be significant across behavioural and neuroscientific studies, yet social and emotional curriculums are not included in our National education system (Blair & Raver, 2016).

- It is also important that any early intervention and universal approach is considered within a more holistic framework, and links to policies and supports that address issues such as childhood trauma, inter-generational trauma, stress and poverty. Prevention and early intervention can be the more cost-effective investment for creating longer-term and meaningful change at the individual, family, community and societal levels (Johnson, Riis, & Noble, 2016).

3.1.1. Mental health promotion, early intervention and universal approaches summary

- With the persuasive evidence available it is important that Australia moves towards investing universally in social and emotional wellbeing across the lifespan, with mental health and social and emotional wellbeing curriculums included in primary, secondary, and tertiary education.
- Mental health promotion, early intervention and universal approaches are seen as an investment in mental health and social and emotional wellbeing. It is recognised that they also provide an opportunity to identify individuals who may need more intensive support provided by more traditional mental health services.

3.2. Suicide Prevention

3.2.1. General discussion

- Despite significant funding injections over the past decade suicide prevention has not been successful in reducing planned self-harm deaths in Australia, with recent statistics showing that death by intentional self-harm is increasing at an alarming rate (Australian Bureau of Statistics [ABS], 2018a). Concerningly, these rates are significantly higher for Aboriginal and Torres Strait Islander peoples, with the average rate of death by intentional self-harm approximately twice that of non-Indigenous Australians (ABS, 2018b).
- Investing more money into suicide prevention without understanding why current models and interventions are not working is of greatest concern. It has been argued that the focus on cause and symptoms is flawed when trying to understand suicide, and that a broader sociology perspective that looks at societal and disruptive factors to explain changes in suicide rates over time is required (Abrutyn & Mueller, 2016).
- Furthermore, suicide continues to be treated predominantly as a mental health issue rather than as a primary health concern, despite intentional self-harm being linked to health conditions (eg., cancer, cardiovascular disease, chronic pain, sleep disorders), life events (e.g., chronic unemployment, retrenchment, relationship breakdown, child custody, domestic violence), government policies (systematic racism, mining, disconnection from and loss of culture), environment factors (e.g., climate change, pesticides, extreme weather conditions, natural disasters). Evidence from large scale education and awareness campaigns (with a focus on suicide prevention, mental health awareness, and resilience and wellbeing) has consistently demonstrated successful outcomes in improving mental health and reducing suicide (David-

Ferdon, 2016; Evans, Scourfield, & Moore, 2016; Knox, Conwell, & Caine, 2004; Macdonald, 2016; Russell et al., 2019).

- For example, a large multi-centre cluster-randomised study targeting youth mental health and youth suicide assigned youth to four types of groups: youth mental health awareness program (YAM); question, persuade and refer manualised program (QPR); screening by a professional program (ProfScreen); and a control group (Wasserman et al., 2015). For ethical reasons, the control group were able to see materials from the YAM program throughout their classroom and had access to mental health support. The outcome variables were suicide attempts and new cases of suicidal ideation. At the 12-month follow-up, the only significant reduction in suicide attempts and suicide ideation was found for the YAM group when compared to the control group. These results were also found in a US study that applied a peer driven education program to mental health awareness, building a strong case for mental health and suicide to be treated as primary health concerns (Wasserman et al., 2015).
- In a study looking at factors related to suicide risk for people with affective disorders, a link was found between increased numbers of psychiatric beds available and increases in suicide rates (König, 2018). Although the link was not causal it was identified that inpatient care is higher in countries where quality outpatient care was not available, suggesting the link was quality of outpatient care available in the community.
- Studies such as these demonstrate the need for a population and primary health response to suicide prevention; however, we do argue that mental health and front-line services are a critical part of the solution. For example, a systematic review of studies that looked at contact with primary and mental health services prior to suicide found that contact with primary health and mental health care was highest within the 12-months prior to suicide, with many consumers contacting mental health services within three months of suicide and some consumers reaching out to health care providers through to four weeks before suicide (Stene-Larsen & Reneflot, 2019).
- These results also demonstrate that many at-risk consumers continue to seek help and engage with primary and mental health services, providing a case for brief interventions at the acute presentation stage that target wellbeing and protective factors. For example, a combination of brief interventions administered both during and after the emergency department (ED) visits decreased post-ED suicidal behaviour (Miller et al., 2017); research that focused on the targeting of positive cognitions and emotions showed promising results and concluded that symptom reduction does not automatically increase wellbeing (Huffman, 2014); a study established that high health efficacy had a negative correlation with suicidal ideation independent of gender, age, education, marital status, substance abuse, psychological distress, poor mental and physical health (Isaac, Wu, McLachlan, & Lee, 2018). Research conducted in the U.K. has also demonstrated there can be an economic benefit to mental health and social and emotional wellbeing interventions (including behavioural) at all levels of care (Knapp, McDaid, & Parsonage, 2011).
- Finally, any approach to suicide prevention needs to be integrative to ensure that the bigger picture – resilient and thriving individuals and communities – is not lost, and it is essential to involve co-design principles that create a sense of agency for the community and the individuals (Steen, Manschot, & De Koning, 2011).

3.2.2. *Suicide and First Nation Peoples*

- As previously discussed, the suicide rates for Aboriginal and Torres Strait Islander peoples are increasing at alarming rates. Despite significant funding being injected into this area no real progress has been made, suggesting we need to rethink our approach and pay closer attention to what the evidence is telling us. For example, a Canadian study that looked at cultural interventions found that “culture as treatment” was positively linked to reduced suicide risk; other studies have found a positive link between social and emotional well-being and cultural practice and identification (Lines & Jardine, 2019). These findings have been replicated in other first nations cultures who were subject to theft of land, dispossession and removal of rights, abuse, slavery, systemic racism, “white” policies, loss of language and culture, loss of oral histories and elder practices and knowledge, and the teaching of false histories that has created a sense of shame for the surviving peoples (e.g., Raphael, Swan, & Martinek, 1998).
- Currently, First Nation peoples in Australia and internationally continue to experience the corollaries of history through high rates of incarceration, inter-generational trauma, poverty, higher rates of alcohol and substance abuse, and a sense of hopelessness for the future that is compounded by pervasive racism experienced at the community level and within government policies that are discriminative and culturally insensitive. The repercussions of these experiences for Aboriginal and Torres Strait Islander peoples can be seen in the rising suicide rates, despite extensive research and intervention (e.g., Zubrick, 2004); highlighting the importance of understanding the outlined issues and concerns from an Aboriginal and Torres Strait Islander peoples’ cultural perspective.
- The recent inquest into the 13 deaths of children and young people in the Kimberley region outlines these issues and concerns clearly with 42 recommendations being advised. The recommendations covered health, public health, mental health, culture, poverty, employment, training and the right to self-determination and empowerment of Aboriginal and Torres Strait Islander peoples⁵. The Coroner notes that although a significant number of services were being provided within the Kimberley region, they were mainstream services that were “adapted” for the region rather than purpose built, were not culturally appropriate and did not involve co-design with the community. We urge the Commission to read the Coroner’s findings and take into consideration the recommendations that have been made.

3.2.3. *Suicide prevention summary*

- Overall, the findings from the current body of research suggests to successfully prevent suicide in non-Aboriginal and Aboriginal populations, a framework incorporating cultural, sociological, community, individual and systems factors needs to be developed. The framework needs to also include other factors such as addressing poverty and employment opportunities; with funding being invested in communities, non-health areas, primary health and mental health to enable a holistic model of suicide prevention to be developed.
- To address the increasing suicide rates in Aboriginal and Torres Strait Islander populations, interventions and solutions to suicide prevention should incorporate and demonstrate understandings of the Aboriginal and Torres Strait Islander people’s history and cultural. Interventions based on the needs of First Nation peoples, rather than from political or research agendas, are critical to addressing the increasing suicide rates.

⁵ See https://www.coronerscourt.wa.gov.au/_files/inquest-2019/13-Children-and-Young-Persons-in-the-Kimberley-Region-Finding.pdf

- Co-design principles need to be utilised when developing services for local communities, with an integrative approach to service provision to enable communities and individuals to maintain or develop a sense of agency.

3.3. *Methamphetamines and Mental Health*

- The social and economic costs of methamphetamine in Australia in 2013/14 was estimated to be \$5.0 billion (Tait & Allsop, 2017; Whetton et al., 2017). Although the authors were unable to estimate these impacts in differing settings across Australia, a simple proportional calculation by population would suggest that the social and economic impact of methamphetamine use in rural and remote Australia in 2013/14 was \$1.5 billion.
- However, Roche and McEntee (2017) reported that the lifetime and recent methamphetamine use was significantly higher in rural Australians aged 18-29 years compared to peers from metropolitan settings, and a national increase in methamphetamine related *treatment*-episodes was proportionally smaller in rural areas.
- Mental health problems experienced by methamphetamines users include depression, anxiety and psychotic disorders (Baker & Dawe, 2005; Darke et al., 2008; Hall et al., 1996; McKetin et al., 2006; McKetin et al., 2008; Zweben et al., 2004).
- It has been estimated that a quarter of methamphetamine users suffer psychiatric symptoms severe enough to merit inpatient treatment (Zweben et al., 2004).
- Use of methamphetamine has also been associated with suicide and violent behaviour (Darke et al., 2008; Hall et al., 1996). McKetin et al. (2008) found that the level of mental health harm was not related to the route of methamphetamine administration. Lee, Harney, and Pennay (2012) found an association between problematic methamphetamine use and the onset of mental health problems. It has also been found that recreational methamphetamine use in the context of polysubstance use, is associated with a two- to threefold increase in the likelihood of developing psychotic symptoms (McKetin, Hickey, Devlin, & Lawrence, 2010). The enduring impact of experiencing psychosis as a result of methamphetamine use is not clear.
- A number of studies reported that methamphetamine psychosis ameliorates with a week; however, other studies reported 16-40% of first episode methamphetamine related psychosis will suffer enduring psychotic symptoms despite abstinence from methamphetamine (Glasner-Edwards & Mooney, 2016). However, approaches to treating co-occurring methamphetamine use disorder and mental health problems are poorly understood (Glasner-Edwards & Mooney, 2015; Hellem, Lunberg & Renshaw, 2015).
- Furthermore, Hall et al. (1996) found that about a quarter of psychostimulant users have a lifetime history of attempted suicide, a rate that is substantially higher than the general population.
- Although methamphetamine use is characterised as a significant issue in rural areas, few studies have examined the methamphetamine use and access to alcohol and drug and mental health services within a rural context (Judd et al., 2006). Many rural communities in Australia suffer isolation, economic disadvantage and have limited service access, particularly to mental health and drug and alcohol services.
- For example, in the USA, Grant et al. (2007) found that the proportion of methamphetamine users reporting a methamphetamine related-psychosis was higher in the rural cohort compared to their urban counterparts. While Wallace et al. (2009) found that the majority of a rural cohort of Australian methamphetamine users had moderate to severe mental disability on the

Short Form-12 (SF-12). Interestingly, the majority of this cohort self-reported being diagnosed with a major mental health disorder and being prescribed psychotropic medication.

3.3.1. Methamphetamines and mental health summary

- Overall, key research in this area exposes an urgent need to develop a better understanding of the pathways to mental health support in methamphetamine users, particularly in rural and remote regions where access to services is limited and methamphetamine is reportedly higher.
- Gaps in research need to be addressed to ensure that interventions targeting methamphetamine use and mental health are evidence based and community focused.

3.4. Recommendations: Specific Health Concerns

1. Invest in social and emotional wellbeing across the lifespan, with mental health and social and emotional wellbeing included in the national curriculum.
2. Develop a holistic framework for suicide prevention that incorporates cultural, sociological, community, individual and systems factors, and other factors such as poverty and employment opportunities.
3. Ensure that suicide prevention interventions are culturally appropriate, demonstrate a clear understanding of the history of Aboriginal and Torres Strait Islander peoples, and are based on current needs driven from the local community.
4. When developing any intervention, utilise co-design principles within an integrative approach to enable communities and individuals to have a sense of agency.
5. Invest in research that looks at the pathways to mental health support in methamphetamine users, with a focus on rural and remote communities.

4. Response to Questions on Health Workforce and Informal Carers

4.1. Professional Health Workforce

- There is a need to adopt an interprofessional education (IPE) approach to the development of the health professional workforce; where all health professionals are trained in mental health regardless of the context in which they work. IPE approaches drive consumer focused and collaborative care, creating integrative systems that support the consumer through their entire health journey and limit systems and policies that are focused solely on the needs of the organisation rather than the consumer (Herbert, 2005; Olson & Bialocerkowski, 2014).
- However, IPE approaches require a system and culture shift that is often neglected when IPE models are trialled within organisations (Herbert, 2005; Olson & Bialocerkowski, 2014). Importantly, this shift needs to be driven by management, with IPE principles being embedded in the policies, procedures and actions of the organisation (Herbert, 2005). Additionally, embedding IPE across health disciplines will require implementation via mandatory requirements specified in all health profession accreditation standards that training institutes need to adhere to (Olson & Bialocerkowski, 2014).
- Furthermore, the structure of psychology degrees creates a professional divide from other health professionals where opportunities for IPE are missed during undergraduate study⁶. This is primarily because the focus of undergraduate psychology training is on knowledge acquisition rather than practical skills, a decision that is out of alignment with other

⁶ See https://www.psychologycouncil.org.au/sites/default/files/public/Standards_20180912_Published_Final_v1.2.pdf

disciplines. The argument for a focus on knowledge rather than practical skills is based on public safety and the focus of the psychology discipline primarily on mental health; however, there is an argument for practical skills to be developed in the undergraduate degree from an allied health perspective to enable foundation skills to be developed from an interprofessional perspective.

- Further, other health professionals working in the mental health space, such as medical practitioners, social workers, occupational therapists, speech and language pathologists, and counsellors, all develop practical skills and complete placements in their undergraduate degrees. Placement and IPE opportunities in third- and fourth-year studies of psychology would also open up opportunities for rural and remote placements, creating connection to rural and remote communities and providing opportunities for rural and remote practice. Reviewing psychology within the context of the health workforce and consumer needs, as well as public safety, would be important moving forward.
- Significantly, the separation of mental health from public health is not supported by the evidence and continues to perpetuate the stigma associated with accessing mental health services. The early research that postulated that mental illness could be explained by chemicals and neurotransmitters in the brain is pervasive and dangerous rhetoric that has not been supported in current research (e.g., Lacasse & Leo, 2015; Valenstein, 2002); with the evidence being clear that mental health is difficult to separate from psychical and emotional health, and that the biomedical model cannot explain the complexity of presentations or aetiology of the disorders. This is important to note because the current mental health workforce is separated from other health professionals working in physical health areas, creating an artificial divide that places significant strain and stress on mental health professionals and perpetuates the stigma associated with mental health.

4.1.1. Professional health workforce summary

- To create a consumer-focused service that promotes collaborative care, IPE principles need to be incorporated in the policies, procedures and actions of all health organisations.
- Additionally, IPE needs to be embedded within all health profession accreditation standards that training institutes need to adhere to. Particular focus will need to be placed on reviewing undergraduate and graduate psychology training ensure that IPE frameworks are placed within the curriculum.
- Including mental health services within primary and community health services will help reduce the stigma of mental health and enable a more collaborative model of care to be provided to consumers. This will also include the isolation and stress experienced by the mental health workforce, and they will be able to draw on a larger peer support network.

4.2. Stress and Turnover of the Mental Health Workforce

- Intervention strategies are conceptualized within two broad categories: programs designed to improve burnout by targeting change strategies at individual workers, and those that are designed to change the work environment. We suggest that interventions and programs that target both the individual and the work environment are equally important; including addressing organisational systems, process, and expectations that contribute to burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). This is particularly important in rural and remote regions where the workload is usually higher, and the work demands are greater, with lower levels of support. Although there is an argument that individual interventions do not address the issues that led to ‘burnout’, it is important to understand that

combining organisational strategies to reduce burnout with individual strategies and skills to help health professionals manage stressors, can result in a more resilient workplace.

- For interventions to be successful, an organisational commitment would need to be made that addressed organisational cultural change and implemented organisational practices that may help decrease or prevent burnout. These could include increasing social support for employees, especially by teaching communication and social skills to supervisors (Burke & Richardsen, 1993; Halbesleben & Buckley, 2004); increasing individual employee autonomy and involvement in decision-making (Morse et al., 2012); reducing role ambiguity and conflicts for employees (Stalker & Harvey, 2003); providing regular supervision, including peer supervision (Feingold, 2005); and decreasing workloads and promoting self-care as a value (Feingold, 2008).
- We would also encourage you to refer to sections (a) and (c) of the MHA Network submission to the *Senate inquiry into the accessibility and quality of mental health services in rural and remote Australia* for our previous response to government regarding workforce issues and workforce retention⁷. The MHA main submission is provided in Appendix C. Key issues identified included:
 - Short-term contracts are a significant problem in rural and remote regions. Additionally, organisations are often not notified their contract is renewed until the “11th hour” if they are fortunate. Many organisations report they are not told of funding success until months after their current funding has expired or they are told the funding will not be renewed, only to have the program re-funded 2-3 months later. The cost to job stress, workforce turnover, and in recruitment and training costs is substantial.
 - Funding of initiatives to address the maldistribution of the workforce and rural and remote experience disproportionately targets the medical profession in comparison to allied health and allied health programs
 - This can also be reflected in disparities between remuneration packages for allied health versus medicine for the same difficult to fill vacancies. This type of approach devalues the contribution that allied health professions can make in the mental health service space
 - Numerous interventions have been implemented to redress the inequitable distribution of healthcare professionals to rural and remote areas, and can generally be grouped into educational strategies (e.g. targeted admission policies to graduate programs, establishment of university campuses in rural areas, rural and remote placements), financial incentives (e.g. scholarships linked to service obligations in rural and remote areas), regulatory strategies (e.g. mandatory periods of service in rural and remote areas, and supportive strategies (e.g. professional development and mentoring programs). There is currently limited reliable evidence regarding the effects of these interventions, although the implementation of educational strategies, financial incentives and supportive strategies may have value (e.g., Grobler, Marais, & Mabunda, 2015; Wilson et al., 2009).
 - The factors impacting recruitment and retention in the rural and remote mental health workforce are multifaceted and dynamic and likely include a metro-focused higher education system, demanding working conditions, professional and personal isolation, insufficient resources, inadequate financial remuneration, inadequate opportunities for

⁷ <https://www.aph.gov.au/DocumentStore.ashx?id=7b72885c-3c7e-46d8-9352-9a2b60972d8f&subId=612889>

personal and professional development, limited career opportunities, poor organisational leadership, service funding issues, safety concerns, a lack of anonymity, and lack of job opportunities for spouse and educational opportunities for children.

- Recognise that positive engagement with the local the community is linked with service success and health professional job satisfaction.

4.2.1. *Stress and turnover summary*

- Interventions targeting stress and burnout in the workplace need to target the individual and the work-place.
- Rural and remote regions experience higher rates of stress and burnout associated with workload complexity and volume, requiring more support to be provided in the areas of workload balance, supervision and role clarity.
- In rural and remote regions, short-term contracts place significant stress on health professionals, contribute to staff turnover, and place a high administrative burden on organisations in recruitment and training activities. Additionally, organisations require adequate notice of funding outcomes to provide job security to current employees or to plan for changes associated with funding changes. Funding needs to also allow for community engagement activities.
- Address disparities between allied health professions and medicine remuneration packages offered for difficult to fill vacancies, making it more attractive for allied health professional to work in rural and remote locations. Include opportunities for emerging mental health workers (student placement, exchange program) in rural settings.
- Provide funding to develop and deliver mental health skilling programs in rural and remote areas, instead of these trainings only being available in major cities. Recognise not only training, but also supervision and peer support and review for all disciplines working in rural and remote regions. Recognise and map the gaps in staff training needs.

4.3. *Peer Workforce and Lived Experience*

- The peer workforce provides a role in mental health services but is often under-valued, with peer workers experiencing role confusion and low support for the value their role has within the service (Byrne, Roennfeldt, Wang, & O'Shea, 2019).
- Confounding this issue is that there is very little national consistency for training and professional development of the peer workforce. Local and regional frameworks have been developed to try and address these gaps but there has been a strong need for evidence-based National guidelines for peer workers within Australia that is being addressed by the National Mental Health Commission⁸.

4.3.1. *Peer workforce and lived experience summary*

- The development of the National Framework and the professionalisation of the peer workforce is a welcome change that will have a positive impact on peer workers, including an expectation that there will be clear role descriptions, a fair salary structure, access to training and development, opportunities for career progression, including support to pursue further study if desired.

⁸ See <http://www.mentalhealthcommission.gov.au/our-work/mental-health-peer-work-development-and-promotion.aspx>

4.4. Informal Carers

- In a Deloitte Access Economic report commissioned by Carers Australia (2015) it was reported that more than 2.86 million Australians are estimated to be providing informal care, with over 0.825 million Australians reporting they are the primary carer (Carers Australia, 2015).
- Over the next decade the demand for carers will be greater than the care available, placing burden on formal carer systems. The replacement value of this care is calculated to be \$60.3 billion, equivalent to 60% of the health and social work industry (Carers Australia, 2015).
- Developing a deeper understanding of the current and changing needs of the informal carer workforce and the formal carer workforce will enable us to be able to adequately prepare for the increasing demand on the formal carer workforce in the future (Carers Australia, 2015).
- A carer led group would be best placed to inform the Commission regarding this issue, but we would like to propose that although a national response is required, localise community solutions addressing carers' needs would be more beneficial than a centralised "one size fits all" response. Further, we would like to propose that the MHA Networks rural and remote focus places them in a unique position to contribute to the national and local conversations on future carer needs, and other workforce issues (including recruitment and retention) for Australians living in rural and remote regions.

4.4.1. Informal carers summary

- It is essential that a national and community level analysis of consumer needs, and the needs and roles of their formal and informal carers, is undertaken to enable the government and communities to prepare for the predicted changes in the carer workforce.
- It is recommended that a community national response plan is developed based on (and responsive to) community needs. Ensure the inclusion of consumers, carers, communities, and academics in the development of an evidence-based and community led response.

4.5. Recommendations: Health Workforce and Informal Carers

1. It is recommended that mental health workforce be placed within community and primary health services, as the artificial separation of mental health from health is not supported by evidence.
2. Imbed IPE frameworks within all health profession accreditation standards that training institutes need to adhere to. Review undergraduate and graduate psychology training ensure that IPE frameworks are placed within the curriculum across all education facilities. Ensure IPE is implemented using atop down model.
3. Extend all regional, rural and remote funding contracts to a minimum of two years to help reduce staffing costs and staff turnover and increase retention.
4. Provide remuneration incentives to rural and remote practice through training pathways, educational opportunities and professional recognition. Ensure that financial remuneration is role dependent and not profession dependant, to address the inequities in pay between professions (for the same job).
5. Address stress and burnout with the mental health profession by targeting organisational policies as well as individual strategies.
6. Develop a peer workforce framework that is implemented through policy and monitored through funding requirements. A peer workforce framework needs to include educational

pathways and clear scope of practice. Remuneration and accreditation standards also need to be addressed. Include peer workers in management teams and on boards.

7. Respond to the growing crisis in the reduction of the informal carer workforce through research, consumer and carer led advisory groups, and education and training (of future formal carer workforce).

5. Response to Questions on Social participation and inclusion

5.1. The Arts, Culture, Sport and the Natural World

- There is significant evidence that engagement in the Arts increases wellbeing and can be a protective factor for neurocognitive disorders and mental illness (Parkinson, 2009; Suckey & Nobe, 2010; Wilson, Bryant, Reynolds & Lawson, 2015; Young, Camic, & Tischler, 2016). The Arts has also been found to address social justice issues such as stigma, prejudice and racism, with it being recommended that investment in the Arts as a preventative measure, and as a form of social engagement for those who are experiencing mental illness or emotional distress (Corbett, 2016; Harris, Barnett, & Bridgman, 2018; Jensen & Bonde, 2018; Lamb, 2009).
- Importantly, the Arts can be invested in across all levels of policy and intervention, with the Arts demonstrating efficacy in enhancing wellbeing through participation; enhancing social and emotional wellbeing through individual/clinical and universal interventions in mental health; enhancing recovery in health; and in building community resilience.
- Further, research investigating interactions with the natural world (including natural spaces and developing spaces that are aesthetically pleasing) and with interactions and relationships with animals (wild and domestic), has demonstrated that investment in these areas has health benefits that go beyond the individual and extend into community (Cox et al., 2017; Lambert, Betts, Rollins, Sonke, & Swanson, 2015).
- These findings suggest there is an urgent need for serious investment in this area, especially in rural and remote communities, to improve social participation and improve wellbeing across the lifespan, particularly with our aging population (Hanna, Noelker, & Bienvenu, 2015). Although it could be argued that a strength of rural and remote communities is natural spaces, the effects of water scarcity, drought and economic factors has reduced access to natural spaces that could be considered to promote wellbeing.
- Councils investing in edible and aesthetically pleasing community gardens would be a good first step towards addressing these issues both rurally and in urban spaces. Additionally, although we have a National Arts and Health Framework it is not clear how well this has filtered down to policy and primary and mental health care, suggesting a need for targeted funding and practical implementation support in resource stretched communities (Davies, Pescud, Anwar-McHenry, & Wright, 2016; Department of Communications and the Arts, 2013).
- Finally, research that has explored engagement in the arts, culture, and sport has shown that regular engagement in sports and art activities generates positive benefits to wellbeing, and that art events can also provide these benefits regardless of frequency (Wheatley & Bickerton, 2017). This further supports investment in these areas to promote wellbeing and mental health within individuals and communities.

5.1.1. Arts, culture, sport and the natural world summary

- There is a body of both peer reviewed and anecdotal evidence highlighting that art in all its forms plays a valuable role in engaging people who may be marginalised due to having a mental illness. It allows participants to switch off from issues that may be distressing them, promoting wellbeing and social inclusion.
- The participation in art related activities, provides individuals with a purpose, feelings of engagement and achievement. research has contributed to the evidence base of how arts and mental health can strengthen community connections and decrease stigma. Investing in the Arts across all levels of policy and interventions will enhance social and emotional wellbeing through individual/clinical and universal interventions in mental health; enhancing recovery in health; and in building community resilience (Davis, Knuiman, Rosenberg, 2016).

5.2. Recommendations: The Arts, Culture, Sport and the Natural World

- Investment in the Arts as a preventative measure, and as a form of social engagement for those who are experiencing mental illness or emotional distress (Corbett, 2016; Harris, Barnett, & Bridgman, 2018; Jensen & Bonde, 2018; Lamb, 2009).
- Future research to extend on current findings via more robust study designs (e.g. prospective cohort studies).
- Enablers and barriers to the arts-mental health relationship should also be investigated, as should the influence of art form (e.g. visual arts, performing arts, etc.), type (i.e. active versus receptive engagement), and mode of engagement (e.g. attendance, participation, etc.) to determine which elements have the most impact on mental well-being.
- Further research is needed to quantify and explore the arts-social health and the arts-physical health relationship.

6. Response to Questions on Funding Arrangements

6.1. Mental Health and Economic Growth

- In a U.S. study, Davlasheridze, Goetz, and Han (2018) explored the effects of mental health on economic growth. Their modelling of the impact of poor mental health days (PMHD) on economic growth demonstrated that “one additional PMD is associated with a 1.84 percentage lower per capita real income growth rate” (p 155). They also concluded that the average number of PMHDs are statistically higher in less wealthy counties compared to wealthy counties.
- The higher prevalence of poor mental health in low-income earners was also found to have reduced income growth for this population. Reduced income growth in this population was further compounded by fewer job opportunities due to reduced job opportunities, and lack of education and specialised skills.
- When considered in the Australian context, these data have significant implications for rural remote communities. Results highlighted the correlation between poverty, economic growth, employment opportunities, educational outcomes and mental health.
- These results demonstrated that solutions need to target economic, social and health systems. It would be important to conduct longitudinal Australian research that investigates these links in the Australian context. Although the National Mental Health Commission is targeting this

research area, they appear to be focusing on the costs of mental illness rather than the more complex relationship between mental health and the economy⁹.

6.1.1. Mental health and economic growth summary

- There is a negative relation between PHMD and income growth rate and job opportunities.
- A positive relationship exists between poor mental health and low socio-economic status.
- Poor mental health is also linked to poor education outcomes, perpetuating the negative cycle associated with income growth and job opportunities.

6.2. Mental Health and Climate Change

- In 2007 the government commissioned the Garnaut Climate Change Review to investigate the impact of climate change on the Australian economy, with a final report being released in 2008, and an issues paper that focused on rural mental health impacts of climate change also being commissioned that year (Garnaut, 2008a, 2008b). Garnaut was later commissioned in 2010 to provide an updated review that was released in 2011 (Garnaut, 2011).
- It is important to understand that the Garnaut reviews in 2008 and 2011 were comprehensive reviews that focused on presenting the available scientific evidence and predicting industry and economic changes that would be driven by climate change. At the time, Garnaut (2008a, 2008b, 2011) also raised concerns about political and social agendas that were being driven by belief systems that served current economic paradigms, with the disadvantaged paying the highest price for Australia's inaction on climate change. The following discussion will only focus on the implications that climate change has on mental health and propose actions that need to be addressed through public policy and action.
- Climate change is postulated to have indirect and direct effects on mental health through extremes in temperatures (eg., heat exhaustion, reduced physical activity and increased reliance on transport), trauma from repeated exposure to major events (eg., floods, cyclones, drought, fire), and community wellbeing (erosion of physical environments results in erosion of social and community environments; Berry, Bowen, & Kjellstrom, 2010; McMichael, Blashki, & Karoly, 2007).
- This is especially true for regional, rural and remote (RRR) environments where the climate can be harsh, and the accelerated climate related changes are resulting in "once in a 100-year events" occurring more often with longer term consequences due to their frequency. The lack of leadership and clear policy direction in this area has made it a neglected issue when assessing mental health, community wellbeing, and resilience in RRR areas; despite the government spending a significant amount of funding on responding to major climate events and building community resilience.
- Without this direct leadership most communities make sense of these events within their own frames of reference, including drawing on cultural and societal beliefs (eg., stoicism) to form part of their coping strategies (Morrissey & Reser, 2007). This has led to key organisations in RRR areas, including UDRHs, developing strategies that have focused on psychological preparedness and service engagement and responsiveness.
- However, other outcomes related to climate change are not as easily addressed. In RRR communities, economic security and participation is impacted by extreme weather events that can co-occur. For example, a 10-year drought and a major flood resulting in the loss of a

⁹ See <http://www.mentalhealthcommission.gov.au/media-centre/news/economics-of-mental-health-in-australia.aspx>

significant number of livestock from primary producers who had already experienced significant losses from the drought.

- Other economic concerns relate to housing security, access to affordable and sustainable power and food sources and increased household expenses from a rising cost of living. Coupled with remoteness and the economic burden of accessing specialised health care from urban centres, rural communities are struggling to cope with the economic burdens experienced as a result of climate change. Further, climate change has caused a rise in involuntary migration to other centres where a sense of isolation and displacement is experienced by migrating people.
- The emotional distress caused by concerns about climate change, and perceived courses of action that need to be taken, has created social anxiety in some cases, and in other cases social apathy (Fritze, Blashki, Burke, & Wiseman, 2008). It is in this space that health and mental health funding can have the largest impact.
- By building awareness of climate change and its impact and creating practical and community driven strategies that focus on what can be done, communities are better able to adapt and respond to the changing climate demands (Wheatley & Bickerton, 2017).
- There are opportunities for services and health professionals across public and mental health to play a mitigating role on the health impacts of climate change through health promotion and monitoring, and for services to respond by planning for adverse effects of climate change (e.g., quality of air monitoring) through advocacy, infrastructure and resources within and across communities (Horton, Hanna, & Kelly, 2010).
- There are also opportunities for Aboriginal and Torres Strait Islander peoples to contribute to the national conversation on climate change through their knowledge and experience of caring for country that is holistic and involves caring for wildlife, waterways and their ancestral lands. Research that has investigated the effects of caring-for-country projects has demonstrated a causal link between these projects and increased social capital, which in turn has resulted in increased social and emotional wellbeing (Berry et al., 2010). Non-Indigenous Australians have a lot to learn from Aboriginal and Torres Strait Islander peoples about country and how to respond to the current crisis.
- Future research and funding models will need to address the relationship between ecological, economic and social justice principles and objectives to develop a more comprehensive understanding of the consequences and implications of climate change; creating an opportunity to “build social and economic relationships that are based on sustainable and just patterns of growth and consumption” (p. 9; Wheatley & Bickerton, 2017).

6.2.1. *Mental health and climate change summary*

- Climate change is contributing to the mental health of all Australians, both directly and indirectly. The severity of the impact is greater in regional, rural, and remote regions (RRR).
- There needs to be strong leadership and government policy that addresses climate change in a proactive rather than reactive manner.
- Opportunities also exist to include Aboriginal and Torres Strait Islander peoples in the discussions and decision making on the impact of climate change and the actions that can be taken.

- Services and healthcare professionals can play a part in mitigating the effects of climate change through health promotion, awareness, monitoring and responding to climate change events (e.g., air quality from ongoing bush fires).

6.3. Recommendations: Funding Arrangements

1. Mental health needs to be addressed within the context of economic resources and opportunities. The most disadvantaged in society often have the poorest outcomes and most difficulties accessing services. Lower income growth rates result in intergenerational consequences.
2. Develop policies and actions that address the impact of climate change in a proactive way. Include Aboriginal and Torres Strait Islander peoples in the discussions and decision making on the impact of climate change.
3. Build awareness of climate change and its impact in communities and create practical and community driven solutions that focus on positive action.
4. Fund research that will contribute to a deeper understanding of the relationship between ecological, economic and social justice principles and objectives to develop a more comprehensive understanding of the consequences and implications of climate change.

7. Response to Questions on Monitoring and Reporting Outcomes

7.1. Mental Health and Wellbeing as an Investment

- For an individual and community to thrive they need access to a basic standard of living, infrastructure and programs, and a sense of agency over their future direction and current conditions (WHO Regional Office for Europe, 2012).
- There is a clear relationship between economic status and mental health disorders, with low income and limited employment opportunities placing significant stress on communities, particularly in rural and remote locations (WHO, 2014).
- It is important to be able to understand that good mental health is an investment and cannot be measured and monitored within a biomedical framework alone.
- To measure mental illness at an individual and community level without also including broader measures of wellness and social capital will limit the conversation and continue to provide false data, as the underlying issues are not being addressed.
- Examples of the concepts/types of data to measure would be: of measures of industry, employment and training opportunity, social disadvantage, racism, quality of healthcare, environmental stressors (e.g., effects of climate change; natural disasters; drought etc), social capital, wellbeing, community resilience and resources. Developing a measurement model that could utilise multiple sources of data to understand the complexity of the issues would be important.

7.1.1. Mental health and wellbeing as an investment summary

- Mental health is an investment and not a cost and needs to incorporate social and emotional wellbeing. Changing the conversation from cost to investment will ensure that broader measures are used to calculate the benefit of investing in other areas such as employment, education, and the arts.

7.2. *Mental Health and Rurality*

- Social geographers are challenging our understanding of rural and remote landscapes, and the experience and concept of mental health within the rural context. They are encouraging a deeper understanding of rural mental health through three major areas of work: rural geography (challenging the idea of the “rural idyll”); mental health geography (artificial geographies that underlie social exclusion and stigma – “us” and “them” dichotomies); and social geographies of caring (socio-spatial relationship that can be influenced by self-stigma and mental health geography; Boyd & Parr, 2008).
- Understanding rural mental health within these constructs helps us to understand the greater impact that mental illness can have within these communities, where there are fewer services and a perceived increase in stigma (e.g., Gamm, Stone, & Pittman, 2010).
- There is also a need for consumer driven service models to be co-designed with local communities to help communities have their voices heard and to develop a sense of agency about mental health within their community.
- Urbanised models when applied within rural and remote environments result in a disconnection between the services offered and the consumer, even when there appears to be a saturation of services (see Appendix C for further discussion of this issue).
- Addressing this issue is critical when considered within the context of higher suicide rates and lower access to health professionals and services (National Rural Health Alliance, 2017). Further, employing a social ecology framework to rural and remote mental health will help services to contribute to and draw from the unique social capital profiles of each community, creating a flexible and responsive mental health and health service that is suitable for rural and remote contexts, and able to meet the needs of rural and communities (Wilson, Wilson, & Usher, 2015).

7.2.1. *Mental health and rurality summary*

- It is important to develop a deeper understanding of rurality that goes beyond geographic borders and extends to a social and ecological understanding. To do this it is important to consider the evidence presented by social geographers that describes how rural and remote people understand their mental health within their communities.
- It is important that consumer driven service models are co-designed with local communities to help develop a sense of agency about mental health services within their community.
- Employing a social ecology framework to rural and remote mental health will help services to contribute to and draw from the unique social capital profiles of each community.

7.3. *Recommendations: Monitoring and Reporting Outcomes*

1. Broaden the monitoring tools for mental health to ensure they include measures of social capital, social and emotional wellbeing and socioeconomic factors that are linked to poor mental health outcomes.
2. Include measures of industry, minimum wage, educational outcomes and other indicators of social disadvantage such as racism, quality of health care and environmental factors.
3. Include social geographic models to create a more comprehensive understanding of mental health landscapes within rural and remote communities.

4. Involve consumers and communities in the development of services designed to address their mental health needs.
5. Use a social ecology framework to understand the unique social capital resources available within communities, and to better understand where the gaps in service may be.

8. Conclusions

- It is commendable that the Productivity Commission is investigating the effect of mental health on social and economic participation, and that sectors beyond mental health are being considered in the scope of this review.
- Mental health is a complex problem that needs to be considered within the broader sectors and broader social and emotional constructs, with social determinants of health playing a large role in the aetiology of mental health disorders.
- Moving away from a bio-medical approach to mental health and towards a broader socio-ecological model will help build health systems that are integrative and consumer focused, and community led and co-developed.
- Socio-economic disadvantage needs to be understood and addressed within all sectors its impacts, with an understanding that the positive link between low socio-economic status and mental health has wide reaching implications.
- Aboriginal and Torres Strait Islander peoples continue to experience the repercussions of intergeneration trauma, displacement through land theft and forced removal, and systemic racism. Including Aboriginal and Torres Strait Islander peoples in the National and local conversations about how to address the current health issues associated with this disadvantage is critical. Any intervention that is not co-designed and community led will not be successful.
- This submission focused on the main issues being addressed by the Commission and provides specific and key recommendations for action, across seven of the key areas being addressed by this inquiry.

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APPENDICES INCLUDED IN SUBMISSION

Appendix A

Australian Rural Health Education Network (ARHEN)

ARHEN's role

ARHEN (www.arhen.org.au) is the peak body for UDRHs. It was established in 2001 and is funded by membership contributions from each UDRH. It is a representative, non-government organisation whose role is to provide a united and strong voice as well as integrative functions for university departments of rural health.

ARHEN's functions include:

- facilitating a national focus and profile for UDRHs and a shared strategic direction
- leading and initiating the rural and remote health agenda in areas of education and research
- advocacy and representation to government and other decision makers
- providing advice to governments, UDRHs and the rural health sector
- sector consultation and coordination with UDRHs and other rural clinical education
- capacity building to enable more effective functioning of UDRHs and delivery on policy goals
- building evidence in related research and for policy development
- information sharing and dissemination among UDRHs and within the rural health sector.

In view of its role and that of the UDRHs, ARHEN has a particular interest in the Review. As well as contributing this submission, ARHEN would welcome the opportunity to be involved further in the process as the Committee develops its report and recommendations.

The role of UDRHs

University Departments of Rural Health (UDRHs) are funded under the Commonwealth Department of Health's Rural Health Multidisciplinary Training Program (RHMTTP). UDRHs have been a cornerstone of the rural health workforce strategy since the late 1990s. With representation in every state and the Northern Territory (www.arhen.org.au), they focus on expanding and enhancing the rural and remote area health workforce through in-situ inter-disciplinary education and training, research, professional support and service development.

UDRHs respond in diverse and complementary ways to the needs of their regions and have a significant academic role in building the knowledge base in rural and remote health and establishing and supporting clinical training placements.

Within defined geographic regions, UDRHs:

- coordinate and provide clinical placements in rural and remote areas for undergraduate and postgraduate health science students from Australian universities
- provide and support learning experiences which expose students to rural and remote area practice and prepare and encourage students to establish careers in these settings
- function as rurally based academic units that work with all health disciplines at undergraduate and postgraduate levels and with the existing workforce
- enhance expertise and the knowledge base in rural and remote health through research and by developing and testing solutions that inform the development of rural and remote healthcare work with communities and health networks to support and meet the current and future health workforce needs and respond to challenges in rural and remote health including Aboriginal and Torres Strait Islander health.

The role of MHAs

The MHA Staff Network supports their UDRH to meet the program funding parameters set out in the RHMTF Program Framework. Although aspects of the MHA role have a local focus, specific to the needs of their UDRH region, there are broad objectives the MHA Staff Network meets:

- participation in the experiences of students and rural health professionals through supervision, training and/or placement support;
- supporting local health professionals and collaborating with community, state/territory/federal health organisations and other stakeholders to support a sustainable mental health workforce in rural and remote Australia.
- maintaining and progressing an evidence base and rural and remote mental health agenda.
- leadership in the area of Aboriginal and Torres Strait Islander mental health.
- leadership in the areas of mental health workforce recruitment and retention, and workforce training.

There are many examples of important rural mental health initiatives. Mount Isa, Broken Hill, Launceston, Lismore, Alice Springs, Shepparton, Tamworth and Moe have focused on increasing the number and range of rural mental health placements and increasing training and supervisory support so that health professionals are attracted to work in rural and remote communities and supported to stay there. Whyalla, Shepparton, Geraldton and Warrnambool have placed an emphasis on enhancing community awareness of mental health issues, and in particular on engaging the community in suicide prevention strategies. Moe, Lismore and Geraldton have developed important community engagement initiatives to enhance the wellbeing of local Aboriginal and Torres Strait Islander peoples. Other MHA strategies e.g. the development of online training programs, have had national as well as regional significance.

What is common to all the MHAs is that they provide the kind of linkage between different services, and between services, university and community, which was unavailable before the commencement of the MHA program. With their university background and clinical credibility from their involvement in local services (90% have part-time clinical roles), MHAs are uniquely placed to provide training and supervision in regions that are often severely lacking in appropriate local resources. Moreover, as academics, they have reported the results of these initiatives in national and international journals so that their creative endeavours may be available for others working in similar situations.

In summary, the MHA program has noticeably contributed to enhancing recruitment and retention of mental health professionals; creating a better trained and supported health workforce; and facilitating community engagement in strategies to enhance mental health awareness, including suicide prevention strategies.

Appendix B

Membership of the Mental Health Academic Network

Victoria

Kate Schlicht (Deakin Rural health, Deakin University, Geelong)
Keith Sutton (Department of Rural Health, Monash University, Newborough)
Tegan Podubinski (Department of Rural Health, The University of Melbourne, Wangaratta)

New south Wales

Fiona Little (University of Newcastle Department of Rural Health [collaboration between Hunter New England Health and the University of New England], Tamworth)

South Australia

Lee Martinez (Deputy Chair of the MHA network; Department of Rural Health, University of South Australia, Whyalla Norrie)
Vivian Isaac (Flinders Rural Health South Australia, Flinders University, Renmark)

Northern Territory

Tanja Hirvonen (Centre for Remote Health, Flinders University and Charles Darwin University, Casuarina)

Queensland

Sharon Varela (Chair of the MHA network; Centre for Rural and Remote Health, James Cook University, Longreach and Mount Isa)
Dayle Osborn (Southern Queensland Rural Health, Toowoomba [collaboration between The University of Queensland, University of Southern Queensland, Darling Downs Health and South West Hospital and Health Service])

Western Australia

Chantal Crinquand (Western Australian Centre for Rural Health, University of Western Australia, Geraldton)

Tasmania

Heather Bridgman (Centre for Rural Health, University of Tasmania, Launceston)

Appendix C

MHA Main Submission response to Senate Inquiry

The following submission addresses the specific concerns identified by the committee about accessibility and quality of mental health services in rural and remote Australia.

(a) The nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate:

1. While 'Access' has been conceptualised in many different ways, it can essentially be defined as the degree of 'fit' between consumers and health care systems; the better the fit, the better the access (Penchansky & Thomas, 1981). Furthermore, access can be viewed as the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services and to actually have service needs fulfilled (Levesque, Harris, & Russell, 2013). Thus, access is influenced by both user and provider characteristics (Levesque et al., 2013; Penchansky & Thomas, 1981).
2. Ensuring access to mental health services in rural and remote Australia is dependent on having a suitably qualified mental health team (Perkins, Larsen, Lyle, & Burns, 2007; Russell, 2017). Access is restricted if available resources are unevenly distributed around a country (Levesque et al., 2013). Unfortunately, increasing rurality and remoteness is associated with a decrease in the number of mental health professionals (e.g. psychiatrists, mental health nurses and psychologists). For instance, in 2015 almost nine 9 out of 10 Full-Time-Equivalent (FTE) psychiatrists (88.1%) were employed in major cities, over three-quarters of FTE mental health nurses (76.2%) were employed in major cities and over eight 8 in 10 FTE registered psychologists (82.6%) were employed in major cities (Australian Institute of Health and Welfare [AIHW], 2015). Thus, to increase consumer access to mental health services and promote better mental health outcomes in rural and remote regions, it is imperative that the maldistribution of the mental health workforce is addressed.
3. Compounding the maldistribution issue in the mental health workforce are recruitment and retention challenges, with many mental health services reporting chronic staffing issues as a major concern (Cosgrave, Hussain, & Maple, 2015). Recruitment and retention problems challenges can also cause consumers and other service providers to report 'service fatigue,' where high staff turnover creates a disengagement from the service itself, even if the consumer or service has experienced positive outcomes. Consumers often report that high turnover in staff makes it difficult for them to trust the longevity of a service. This can also be true when funding models change, and consumers are faced with new barriers to access a service (such as requiring a mental health treatment plan to access a funded service). Consumers will often disengage from a service, or not engage at all, rather than comply to the new access rules. These concerns highlight the complexity of the access issue and demonstrate the need to develop a clearer understanding of the barriers to the recruitment and retention of mental health workers in rural and remote Australia, and the need to implement targeted strategies that are responsive to the region they are designed for, and economically sustainable in the longer term (Segal, 2018).
4. The factors impacting recruitment and retention in the rural and remote mental health workforce are multifaceted and dynamic and likely include a metro-focused higher education system, demanding working conditions, professional and personal isolation, insufficient resources, inadequate financial remuneration, inadequate opportunities for personal and professional

development, limited career opportunities, poor organisational leadership, service funding issues, safety concerns, a lack of anonymity, and lack of job opportunities for spouse and educational opportunities for children (e.g. Chisholm, Russell, & Humphreys, 2011; Conomos, Griffin, & Baunin, 2013; Cosgrave et al., 2015; Durey et al., 2015; Fisher & Fraser, 2010; Humphreys et al, 2009; Keane, Smith, Lincoln, & Fisher, 2011; Lehmann, Dieleman, & Martineau, 2008; Moore, Sutton, & Maybery, 2010; O'Toole, Schoo, & Hernan, 2010; Perkins et al, 2007; Salvador-Carulla, 2018).

5. Another point to consider is that the funding of services on the stepped care model needs to be equitable and transparent across the levels of care offered (Department of Health [DoH], 2015). Currently, the stepped care model appears to be community based, with an 'open door policy', for consumers at the lower level of the model (mild and mild-moderate), but once consumers are in need of services at the moderate level and higher they are required to navigate restrictive access rules, with the funding model rules being the 'gatekeeper' to these services. These decisions seem to have been made on metropolitan funding equations where more expensive services are restricted and less expensive services are easier to access. In metropolitan regions this can work quite well as there are numerous options across the stepped care model; however, in rural and remote where there are fewer service options this can create a barrier to accessing services, with consumers thinking assuming they do not have enough services to meet their needs.
6. Salvador-Carulla (2018) urges that to better understand the service needs of rural and remote communities there needs to be an investment in health ecosystems research, with the development of an international framework of rural and remote mental health.
7. There is an absence of rural and remote mental health service delivery models that reflect the intrinsic differences in rural and remote health and mental health (McCord et al., 2012; Salvador-Carulla, 2018). Consequently, services are overwhelmingly implemented using inappropriate urban-centric models of mental health care (Schmidt, 2000; Bourke, 2012). Funding reporting rules are also biased towards an urban model where services need to collect demographic data at the personal rather than the aggregate level. In urban areas consumers can maintain anonymity by travelling to another service area, but in rural and remote regions the collection of this data can be seen as stigmatising and can become a barrier to accessing services. Inherently this funding reporting can also be culturally biased, with anecdotal evidence suggesting that there is a mistrust about why the government may require this level of information and, consequently, a withdrawal from service. These concerns could be alleviated if more general information could be collected about who engaged in certain services, or where services were funded to also engage with their community and other services through health promotion activities such as health hubs, or general men's health checks (e.g., PitStop), community awareness activities (such as radio segments about mental health or attending local shows to provide information on mental health and engage the community in the conversation), and community training such as Mental Health First Aid or providing mental health information to a cardiac recovery group. In the past, these activities made services visible and available to community members and helped with inter-agency relationships and referrals. It also gave the service a presence in the community that was positive and helped with stigma and, service fatigue (when there is was staff turnover). Currently, only some services are funded to engage with the community outside a clinical/therapy room.
8. Access to mental health services for Aboriginal and Torres Strait Islander peoples also requires a special consideration. Aboriginal and Torres Strait Islander people experience higher rates of mental health issues than other Australians with deaths from suicide twice as high; hospitalisation

rates for intentional self-harm 2.7 times as high; and rates of high/very high psychological distress 2.6 times as high as for other Australians (P&MC, 2017). “While Indigenous Australians use mental health services at higher rates than other Australians, it is hard to assess whether this use is as high as the underlying need.” Access to specialist psychiatry in rural and remote Australia is particularly problematic (Hunter, E, 2007). In 2014, for clinical psychologists, there were 31 FTE per 100,000 people in remote/very remote areas compared with 102 per 100,000 in major cities. In 2015-16, Indigenous Australians were less likely than non-Indigenous Australians to have claimed through Medicare for psychologist care (133 compared with 200 per 1,000) and also psychiatric care (52 compared with 97 per 1,000). In addition, Indigenous Australians utilised the Access to Allied Psychological Services programme at 3.5 times the rate of non-Indigenous Australians (AIHW, 2016).

9. Finally, the need to review the use of mental health treatment plans (MHTP) to access mental health services, rather than a GP referral as is the case for psychiatrists, needs to be reviewed in the context of stigma and other concerns such as employment (e.g., defence force) and insurance (e.g., travel insurance). This additional barrier also places a burden on the health system that is considerable, particularly when within the MHTP scheme clinical psychologists are treated differently based on their specialisation. This is not the case for psychiatrists, and within a rural and remote context is not supported by the literature where a generalist model is seen as important in meeting the needs of the community. It can also amplify access difficulties due to increased financial burden (to access services or in the rebate available from MBS), time constraints (needing to see a GP before accessing a mental health professional can be seen as a deterrent), as well as distance travelled to access a service (rural and remote regions are very diverse and large in area). For more complex presentations it is acknowledged that the GP has the potential for longer term involvement and should therefore be a part of the treatment planning. In these cases, it would be beneficial if the patient could have three funded psychological sessions before the MHTP is required or signed off. This would enable the MH clinician and the GP to collaborate on the complex needs of the client; whereas with simple presentations, three sessions can often be all that’s required.

Recommendations for Section (a)
<p><i>Based on the discussion points raised, the following recommendations are made:</i></p> <ol style="list-style-type: none"> I. Recognise and prioritise accessibility gaps in rural and remote service provision and develop a strategy to fill those gaps. II. Funding for research programs into the recruitment and retention of rural and remote mental health workers, with a focus on whether targeting individuals who have grown up in the area or in a rural and remote setting has long term retention benefits – developing the workforce in and for the region, “Growing our own”. III. Continued funding of UDRHs to encourage rural placements. In addition, supporting emerging mental health professionals to complete placements or take locums in rural and remote areas through scholarships, bursaries and student placements targeted for the mental health workforce. Currently there is a gap in financial support for students who choose to travel to rural and remote locations to complete a longer placement, particularly if they have a partner and children who also need to relocate for the duration of that placement. This financial gap sometimes results in students choosing not to complete a rural and remote placement due to affordability. There is also a gap for rural

and remote external students to travel to university to complete on-campus requirements.

- IV. Funding models for service provision need to:
 - a. be reviewed and adjusted for the region they are being implemented in.
 - b. increase the visibility of a service through community engagement and activities at all levels of the stepped care model, not just at the lower end.
 - c. be reviewed in the context of their cultural acceptability across regions, with it being recognised that a “one size fits all” model is not appropriate.
- V. Aboriginal and Torres Strait Islander peoples need to be a part of the consultation for local service provision, and more funding needs to be invested in increasing the Aboriginal and Torres Strait Islander health workforce.
- VI. There needs to be an emphasis on developing locally tailored rural and remote sustainable models of service delivery. These models require development from a local context using codesign involving service providers, local community, government and academics, within a participatory action research or similar framework.
- VII. An investment in health ecosystems research, with the development of an international framework of rural and remote mental health, would help policy developers understand the unique needs of each region, within a broader framework.
- VIII. Mental health treatment plans (MHTP) need to be evidence based and developed from local context using a co-design approach which involves service providers, local community, government and academics.
- IX. MHTPs need to be reviewed in the context of stigma and service access, as well as the insurance and employment implications that they may place on an individual. It would be important to consider a model where adults can access up to three psychological sessions before a MHCP is required to be finalised.

(b) The higher rate of suicide in rural and remote Australia:

1. The prevalence of mental disorders in rural and remote Australia is reported as being the same as that in major cities, making mental illness one of the few illnesses that do not have higher prevalence rates in rural and remote Australia compared to city areas (ABS, 2007). However, these statistics are over a decade old and should not be relied on to make decisions regarding mental health in rural and remote Australia.
2. Point b(1) is particularly pertinent as the rate of suicide in rural and remote Australia was reported as being over 50 percent higher in 2016 than in capital cities, at 15.3 per 100,000 compared to 10.0 per 100,000 (ABS, 2016a).
3. Suicide is one of the most common causes of death among Aboriginal and Torres Strait Islander people. On average, over 100 Aboriginal and Torres Strait Islander end their lives through suicide each year, with the rate of suicide twice as high as that recorded for other Australians.
4. Between 2011 and 2012, 7.6 percent of urban residents accessed mental health services under the Medicare Benefit Schedule (MBS), compared to three percent in rural and remote areas and 1.5 percent in very remote areas (Centre for International Economics, 2015).
5. We do not know if the prevalence statistics quoted above are still valid. We also do not know if the increase in the rate of suicide is related to external pressures (such as a drought) or service access

issues, or other factors (such as a reduction in community initiatives and education). We need more responsive and up-to-date statistics to better understand what is occurring within our communities.

6. Continued lack of coordination of services or awareness/education activities for suicide prevention results in duplication of service provision and available activities for the community. This can create confusion and fatigue within the community and is financially inefficient.
7. Since the first national mental health plan, there has been a concerning trend to mainstream mental health services, with crisis/emergency mental health funding being utilised to place more beds in general wards with staff who are not specialised mental health professionals (Grace et al., 2017). In addition, the successes of these reforms have been measured by narrowly focused empirical data that is urban biased and does not currently include community consultation or stakeholder feedback (Grace et al., 2017).

Recommendations for Section (b)	
<i>Based on the discussion points raised, the following recommendations are made:</i>	
I.	Our knowledge of prevalence of mental illness in rural and remote locations is based on data that is over ten years old. It is recommended that there is an investment in timeseries data, repeating the National Survey of Mental Health and Wellbeing (ABS, 2007) on a regular basis (at least every 10 years).
II.	There needs to be a community-based approach with a focus on community and individual resilience, as well as suicide prevention. This is also true for programs that target Aboriginal and Torres Strait Islander people. It is important there is a focus on social and emotional wellbeing for community, family and individuals. Programs need to be funded to support Aboriginal and Torres Strait Islander people within their broader family systems, with outreach models being prioritized over clinic room models.
III.	It is critical to develop an Aboriginal and Torres Strait Islander cultural framework for suicide prevention services and programs and use the ATSIPEP website and recommendations to forward plan work in this area (http://www.atsispep.sis.uwa.edu.au/).
IV.	Better coordination between agencies providing suicide prevention programs and awareness/education programs. A requirement of funding should be that organisations would collaboratively in defined catchment areas.
V.	There needs to be discrete funding allocated for acute (crisis/emergency) Mental Health services in rural and remote areas (Psychiatric emergency teams and MH hospital/unit), with emphasis placed on <i>accredited</i> mental health professionals employed in specialist and support roles. Accredited mental health professionals are recognised by their professional body as having met the requirements to practice as a mental health professional.
VI.	Regular Enhanced capacity to provide continuing professional development for front line health professionals (e.g., GPs and nurses), that focuses on mental health and suicide prevention, as well as available services in the health professional's region.
VII.	To ensure that time limited projects will have enough time and funding to fully evaluate outcomes, suicide prevention/intervention and postvention funding may benefit from having a centralised, ongoing funding base at the national level.

(c) The nature of the mental health workforce:

1. As discussed in section (a), the maldistribution of the mental health workforce has direct implications on the nature of the mental health workforce in rural and remote areas. Numerous interventions have been implemented to redress the inequitable distribution of healthcare professionals to rural and remote areas, and can generally be grouped into educational strategies (e.g. targeted admission policies to graduate programs, establishment of university campuses in rural areas, rural and remote placements), financial incentives (e.g. scholarships linked to service obligations in rural and remote areas), regulatory strategies (e.g. mandatory periods of service in rural and remote areas), and supportive strategies (e.g. professional development and mentoring programs). There is currently limited reliable evidence regarding the effects of these interventions, although the implementation of educational strategies, financial incentives and supportive strategies may have value (e.g., Grobler, Marais, & Mabunda, 2015; Wilson et al., 2009). There is an urgent need to find out what really works in regard to the recruitment and retention of mental health professionals to rural and remote regions, so as to identify the strategies that can guide future practice and policy.
2. One strategy that does appear to have some success in recruitment and retention is targeting individuals who have grown up in the area or in a rural and remote setting. There is a bigger push in more recent times to attempt to track a person's time living in rural and remote areas in their younger years, and their experience in living and working in rural and remote areas in their adult life. An increase in available data about who works rural and remote, and who stays in rural and remote regions long-term, will help us better understand how recruitment and retention policies can be adjusted to target these individuals. Further to this, working towards a coordinated and systematic approach in developing a rural and remote peer workforce across the sector would increase capacity and skill development of local people. Engaging individually at this level can lead to country people further developing an allied health, nursing or medical career in rural mental health.
3. Funding of initiatives to address rural and remote recruitment disproportionately targets the medical profession in comparison to allied health and allied health programs.
4. This can also be reflected in disparities between remuneration packages for allied health versus medicine for the same difficult to fill vacancies. This type of approach devalues the contribution that allied health professions can make in the mental health service space.
5. Implications of current funding models –
 - a. A concerning trend in funding models in rural and remote is based on economic formulas of cost-benefit that do not account for social capital, and the long-term benefits (psychological and emotional) of quality services that are embedded within a community model (Fitzpatrick, Perkins, Luland, Brown, & Corvan, 2017; Segal, 2018). There has been a concerning trend of financing 'cheaper' services over 'more expensive' services without consideration for what makes a service cheaper or more expensive, and what the implications are for the community. Services that pay for more experienced staff with higher qualifications will cost more than services that employ people with limited qualifications, with a significant number of staff being in professions that are not registered under AHPRA. This raises concerns about standards and accountability that anecdotal

evidence suggests are generally not met in practice, with consumers left vulnerable, and ignores the link between quality services and better long-term health outcomes (Segal, 2018). Certainly, the evidence demonstrates that a higher investment in quality services can reduce the financial burden on the health system in the future (Segal, 2018).

- b. Despite repeated data being provided over an extended period of time, funding continues to be offered to organisations on a twelve-month contractual basis. If the organisation has to recruit to the position they are then only able to offer a contract for the time left before the funding contract expires. Some recruitment processes can take 3-6 months, due to the difficulties in attracting talent to short-term contracts. The data supports rural and remote funding being a minimum of 2 to 3 years, with an expectation that an organisation would know six months prior to the end of the contract whether the funding will be renewed. Currently organisations are informed at the 11th hour (6-1 week prior to funding end date) about the continuation of their funding program, with some organisations reporting they are informed after the contract end date. Other organisations have also reported they have been told they have lost their funding, only to have the decision reversed a couple of months later. This has not improved under the new PHN model of funding distribution who themselves have cyclic funding. The implications for organisations continues to be high staff turnover, difficulties in recruiting to short-term positions, local staff having to move from one service to another when the provider changes under the current tender arrangements, local families leaving the region because of job uncertainty, and uncertainty in about what services they organisations can continue to offer consumers.
- c. There has been a dangerous and false rhetoric about talent not being able to be attracted to rural and remote areas, with this proving a justification for funding fly-in-fly-out services rather than services embedded within a community. The belief that talent can only reside in metropolitan areas is not supported by the literature and is contrary to research that demonstrates that mental health services embedded in a community help reduce stigma and improve the mental health literacy of the local community. It is also contrary to the Australian Government’s response paper to the Contributing Lives, Thriving Communities report, where it is proposed that local responses are paramount to the success of mental health services within rural and remote regions (DoH, 2015).
- d. Support the training, recruitment and retainment of Aboriginal and Torres Strait Islander peoples in the workforce in fields related to suicide prevention, early intervention and social and emotional wellbeing. Projects need to be sustainable both in terms of building community capacity and in terms of being ongoing, rather than the usual ‘one off’ funding models that are frequently applied. However, within project and research planning it is important that there is capacity within the funding arrangements to also work in a way that the community becomes empowered. For example, providing Aboriginal and Torres Strait Islander workforces and community members with ways of training others, supervision, mentorship and links to outside stakeholders to ensure longevity for this work.

Recommendations for Section (c)	
<i>Based on the discussion points raised, the following recommendations are made:</i>	
I.	Invest in funding of initiatives to address recruitment of allied health professionals in rural and remote regions.

- II. Increase investment into an Aboriginal and Torres Strait Islander peoples workforce in the fields related to suicide prevention, early intervention and social and emotional wellbeing through the provision of training, skills and professional qualifications at all levels.
- III. Address disparities between allied health professions and medicine remuneration packages offered for difficult to fill vacancies, making it more attractive for allied health professional to work in rural and remote locations. Include opportunities for emerging mental health workers (student placement, exchange program) in rural settings.
- IV. Funding to develop and deliver mental health skilling programs to be delivered in rural and remote areas, instead of these trainings only being available in major cities. Recognise not only training but also supervision and peer support and review for all disciplines working in rural and remote regions. Recognise and map the gaps in staff training needs.
- V. Acknowledge and value research for informing decision making and to better understand the diversity of our rural and remote regions. Support a local research culture through grants and funding programs at a local level, with centralised research support being provided.
- VI. Help immerse health professionals into the local community through community engagement and education activities that are included in funding models.
- VII. Review current funding models with a view to allowing funding to be issues issued over a period of at least two years to support recruitment and retention and reduce the burden and cost of staff turnover. Services to be provided with reasonable (three-six months) notice about the future of their current funding for each program they deliver.

(d) The challenges of delivering mental health services in the regions:

1. Rural regions are often centres for a mobile workforce and tourists, which can result in marked changes in population and service demands during these peak times. It can also make it difficult to follow-up and provide and consistent services to individuals.
2. Large distances to cover to deliver Mental Health services can make it difficult to offer face-to-face and personalised/community-based services for each community within a service's region.
3. Rural and remote communities face the financial burden and challenge of being able to attend appointments across health and mental health. The lack of public transport is a major contributor to individuals not attending their appointments. There are often no public transport available and limited taxi services (if any). Funding support for transport (to appointments) is no longer available for many services or programs. Financial hardship regarding petrol can also be a reason why individuals do not attend their appointments, obtaining fuel vouchers can be a complex process and perhaps these could be centralised. It is not only the cost of the petrol or access to a vehicle, it is also the time involved in attending (significant travel distances and times) and the potential loss of income.
4. Stigma towards mental illness is pervasive in rural areas (Boyd and Parr, 2008; Larson et al., 2012; Judd et al., 2006; Nicholson, 2008; Gamm et al., 2003). Larson et al (2012) suggest that the degree of stigma varies across rural communities. Smaller communities are reported to hold more stigmatising attitudes (Larson et al., 2012; Robeiro Gruhl et al., 2012), particularly in remote First

Nations communities where mental illness can be associated with the stigma and shame of bad medicine or curse (Schmidt, 2000). The fear and social stigma associated with mental illness in rural communities influences familial attitudes to addressing mental health problems (Larson et al., 2012), inhibits help seeking (Larson et al., 2012; Boyd and Parr, 2008), and can result in people with obvious mental health problems being ostracised and excluded (Aisbett et al., 2007; Parr et al., 2004). Stigma influences the general rural mores towards mental illness and increases the risk of self-stigmatisation for rural people experiencing mental health problems. This risk is compounded by social visibility (Aisbett et al., 2007), unemployment, level of education, and economic status (Larson et al., 2012). Anti-stigma/anti-discrimination interventions aim to change attitudes and misconceptions and mitigate the impact of prejudice and discrimination on individuals with mental health problems. The most effective interventions that have emerged are approaches, which involve active learning combined with direct social contact with people with mental illness who are in recovery (Stuart, 2016). The evidence for other interventions such as awareness raising, mass media, and mental health literacy programs (including Mental Health First Aid) is poor at best (Stuart, 2016). Stuart (2016) recommends that anti-stigma programs be tailored to the local context in which they are delivered. Locally tailored anti-stigma interventions need to be informed by theory and evidence, target the behavioural outcomes of stigmatisation at both individual and communal levels, and be objectively evaluated, ideally through community-university alliances (Stuart, 2016).

5. Stand-alone mental health services can reinforce stigma and negative connotations and consequently make accessing services problematic. In urban centres community mental health will often collocate with community health with a shared administration and access process. This needs to be replicated in rural and remote regions.

Recommendations for Section (d)	
<i>Based on the discussion points raised, the following recommendations are made:</i>	
I.	Fund a study on the impact of a mobile workforce and tourism on mental health service demand in rural and remote regions.
II.	Improve multidisciplinary telehealth funding models across remote and rural Australia
III.	Invest in funding locally-tailored anti-stigma programs. This could also benefit from a co-design approach, as discussed in section (a), recommendation VII.
IV.	Provide transport funding to deliver mental health services rurally/remotely, possibly based on a “field day” model for more remote locations (e.g., https://www.flyingdoctor.org.au/news/rfds-field-days-day-remember/).
V.	If public transport options are not available funding for community transport services e.g., community drivers, and or family) needs to be available and easy to access.
VI.	Liaise with key rural community members to identify how challenges of service delivery can be addressed and develop a plan to address these.
VII.	Increase collaboration (across services) and service access by funding community-based buildings that services can share, such as a local health centre or community centre.

(e) Attitudes towards mental health services:

1. Some rural and remote areas do not value mental health services as there is a lack of knowledge and awareness of what these services can offer (refer to the discussion on stigma in section (d), point 4).
2. There is a segregation of mental health from physical health, despite the evidence demonstrating they are linked. Since the first national mental health plan in 1988 there has been a move towards mainstream mental health services and co-locating these services with other health services. Although it is arguable about the success of mainstreaming mental health services (Grace et al., 2017), co-location of mental health services with other health services has proven to be a successful strategy for improving community attitudes towards mental health services.
3. Communities want mental health services to be able to respond to their community's needs and can become frustrated when funding models do not allow for such a more flexible response. This needs to be considered within the larger context of rural and remote service models, discussed in (a), point 76. Anecdotal evidence suggests some mental health workers are providing services in their own time to develop trust in their community as current funding restrictions don't allow them to support their community through health related activities that meet their community's needs. Long-term this type of individual sacrifice leads to burnout and mental health professionals leaving rural and remote practice.
4. The system may appear complex to those who are trying to access it, with access rules varying across funded services despite there being a national focus on "no wrong door." Consumers find it confusing and see access rules as barriers to getting the help they would like. Supporting consumer advocate roles or 'lived experience' roles can often help reduce these difficulties.

Recommendations for Section (e)	
<i>Based on the discussion points raised, the following recommendations are made:</i>	
I.	Develop innovative ways in which to promote mental health services to the community in an aim to reduce stigma. For example, consumer and community engagement in the planning and delivery of services can increase positive community attitudes towards mental health services.
II.	As discussed previously, there needs to be greater community involvement from health care services to increase their visibility in the community (refer to section (a) recommendations and discussion).
III.	Promote mental health service awareness in schools, the community and the local health services.
IV.	To continue to develop the role of a Lived Experience Work force in Public Mental Health. To develop national policies and procedures and national accreditation to be in line with all other health professionals.
V.	Extend the comprehensive primary health care model that works well within remote and rural locations.
VI.	To develop systems and cultures that enable organisations/services to respond to all referrals/walk-ins, enabling the consumer to access a service they require and allowing the organisations/services to transition the consumer to a more appropriate service

if/when required. This would reduce the confusion a consumer can often have about what services are available for them to access.

(f) Opportunities that technology presents for improved service delivery:

1. Digital mental health (d-MH) provides a helpful alternative mental health option for people living in rural/remote communities, particularly where issues of stigma and confidentiality may prevent access to local services. Research shows that d-MH far more effective if supported by a mental health professional. Mindspot has proved to be a particularly effective evidence-based service in this regard, providing a free service throughout Australia with weekly support from psychologists (Titov et al., 2015, 2107).
2. Stand-alone d-MH may have limited value without practitioner support. It should not be seen as a solution but as an adjunct to existing services to support access to evidence-based programs when travel is an issue, or to assist local providers to provide ongoing support between face-to-face sessions.
3. It needs to be acknowledged that internet connections continue to be unreliable and this becomes complex particularly at clinical reviews.
4. The cost of access to a reliable internet connection is also ongoing an issue, particularly in remote areas where there is no competition or where only one service provider has reliable coverage.
5. Technology skills and technology support can also be a limitation to accessing d-MH services, with an investment into basic technology skills and technology support needing to be funded for professionals and consumers.
6. There needs to be clarity around where d-MH fits into the stepped model of care, and how it is funded on an ongoing basis. Funding of d-MH has a bias to the remoteness of where of where a consumer lives; however, it needs to be acknowledged that consumers who are rural rather remote can also have challenges about attending appointments and accessing d-MH.

Recommendations for Section (f)
<p><i>Based on the discussion points raised, the following recommendations are made:</i></p> <ol style="list-style-type: none">I. To ensure all rural and remote mental health services have access to fast, reliable and high-quality connectivity to ensure d-MH can be a reliable option.II. To research where d-MH fits within a stepped model of care, and mechanisms to integrate d-MH within a stepped model of care is urgently required.III. To enhance awareness of available d-MH resources (e.g. Head to Health, Mindspot).IV. To fund health hubs in more rural or remote areas where someone can access d-MH programs through the hub at no cost. These hubs would also have a person with mental health training who can assist the consumer if needed and encourage a referral to a mental health professional if needed.V. Funding for training of consumers and professionals needs to be provided to ensure optimal utilisation of d-MH.

(g) Any other related matters: *The importance, and contribution, of the Mental Health Academic Role within each University Department of Rural and Remote Health*

1. The Mental Health Academic (MHA) project is funded by the Australian Government (Department of Health) and was established in 2007 as a component of the University Departments of Rural Health (UDRH) program (Pierce et al., 2016), which has transitioned to the Rural Health Multidisciplinary Program. The MHA's role has been found to successfully meet the needs of the community, and to help bridge the service gaps and professional development needs (Pierce et al., 2016). Professionals in various sectors look to MHAs for advice and consultation. Due to the lack of resources, inadequate Mental Health professional development and the high turnover of health care staff, the MHA role is essential in providing continuity in Mental health promotion through research and projects in rural and remote health. The link between the services and challenges on the ground and policy and protocol is invaluable.
2. MHAs have a unique role which helps to provide inclusiveness, they have the ability to respond to local community need quickly and flexibility and also via the Australian Rural Health Education Network (ARHEN) have a voice in Canberra. The strength of the MHA network is through a local and regional focus, within a national footprint.

Recommendations for Section (g)
<p><i>Based on the discussion points raised, the following recommendations are made:</i></p> <ol style="list-style-type: none">I. To continue to support targeted funding to ensure the continuation role of the MHA position in all existing UDRHs, and in the newly developed UDRHs, through funding allocation to the MHA position. Consider extending the role of the MHAs to help address some of the professional development and retention concerns in rural and remote regions. This will result in a continued national voice on mental health for rural and remote areas.II. Provide seed funding to enhance collaborative projects between rural and remote research hubs and UDRH MHAs. Encourage international research collaborations that will help enrich our knowledge of the unique needs of rural and remote regions.

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