

Issues Paper:

Exploring key issues for better access to mental health and substance misuse clinical services in rural and remote Queensland¹

Purpose of this paper

This issues paper is intended to promote discussion and consultation with key stakeholders about the priority areas for improving access to mental health and alcohol and drug clinical services for people living in rural and remote Queensland.

Rather than offering a comprehensive analysis of all matters affecting rural and remote mental health or problematic substance use, the paper focusses on key issues raised during the Queensland Mental Health Commission's (the Commission) consultations during the development of the Commission's whole-of-government mental health and drug strategic plan, as well as ideas identified by key stakeholders servicing rural and remote Queensland. The paper also refers to matters raised at the Queensland Ministerial Roundtable on Rural and Remote Mental Health held in Charleville on 13 March 2014, with specific focus on response to the current drought.

The key issues highlighted within this paper will form the basis for further discussion and future action. Any other relevant issues brought to the Commission's attention will also be considered, however responses to many of the issues may be the responsibility of agencies other than the Commission.

Background

The Commission was established to drive system-wide reform of the mental health and drug and alcohol systems in Queensland. As part of its legislative mandate¹ the Commission will promote the best interests of people living with mental illness or problematic substance use as well as their families, carers and support persons. This mandate includes a specific focus on the unique and diverse circumstances of individuals living in rural and remote communities.

One of the Commission's first priorities is to develop a whole-of-government strategic plan to identify priorities and commitments to help improve mental health and minimise the impact of substance misuse across the state. The strategic plan must ensure due consideration and attention is given to addressing mental health issues experienced by many rural Queenslanders. To this end, the Commission held regional stakeholder forums in Toowoomba, Rockhampton, Cairns and Townsville in September and October 2013 to inform the strategic plan's development. Additionally, the Queensland Mental Health Commissioner met with local organisations and networks to hear their concerns and proposed solutions for making the systems better.

¹ Current at 30 April 2014

Key messages heard from the Commission's consultations was that rural and remote Queenslanders need better **access** to mental health and alcohol and drug services and better prevention and early intervention supports, particularly in the face of natural disasters such as drought and flood.

What we know

The needs of individuals and families living in rural and remote areas are intertwined with issues affecting their broader communities. There are many benefits of living in rural and remote areas including a sense of community, connectedness, a clean living environment, slower pace of life, family enterprise, less regulation of life, caring personally-known services and free parking,

However, this can be challenged by the social, financial and environmental impacts experienced from issues such as limited employment and education opportunities; ageing populations; itinerant and fly-in fly-out workforces; economic hardship driven by high levels of debt, fluctuations in livestock, produce and commodity prices; prolonged drought conditions and natural disasters can contribute to high levels of stress for many individuals and communities. These stresses are not only for primary producers but also for the many local small and medium businesses whose owners must contend with the economic stress of their own personal circumstances as well as the impact on their employees, and their employees' families.

Attention to these socio-economic determinants of health and wellbeing are critical to improving mental health and wellbeing, as well as to minimising problematic substance use.

A culture of self-reliance which values 'toughness' and personal resilience while useful in many circumstances can affect people's help seeking behaviour. This culture combined with living in small communities where privacy may be compromised can lead to help being sought only when a crisis point has been reached. Social stigma and discrimination may also serve to discourage disclosure of mental health and problematic substance use problems to peers, support networks and services, thereby magnifying the experience of social (and geographic) isolation.

The Australian Institute of Suicide Research and Prevention reports that agricultural workers, particularly men, are at higher risk of suicide and that contextual stressors connected with the agricultural industry, relationship breakdown and Aboriginal and Torres Strait Islander populations were associated with greater risk of suicide in remote populations. The quality of available health services and stigma were also associated with help-seeking and highlighted as influences on rural suicide².

- *Suicide rates among agricultural workers are 2.2 times in the general population and the rates of suicide for Aboriginal and Torres Strait Islander Queenslanders were on average 25.7 per 100,000, which was about 70 per cent higher than in non-Indigenous Australians³. And despite the tough times, suicide rates in rural Queensland have not increased over the last few years.*

Access to alcohol and drug treatment services can be difficult with barriers including limited access to drug treatment options, particularly for withdrawal and detoxification services, and needle and syringe programs⁴. The 2010 National Drug Strategy Household Survey found that people living in remote and very remote areas were more likely to drink at risky levels (for both lifetime and single occasion risk) than those living in other areas⁵.

Given the spread of population and services in Queensland the cost of delivering services using traditional models of service tends to be more expensive in rural and remote areas. This must

be considered in funding decisions for the provision of services by local Hospital and Health Boards, private providers, community based organisations and the Commonwealth government.

Meeting diverse needs

Delivering services that meet the diverse needs of a wide-ranging mix of consumers, their families and carers, across their life course is a challenge for service providers in rural and remote areas. Given the diversity of Queensland's communities the need for locally designed and planned services, taking a needs based approach, is essential to deliver sustainable, effective and efficient services for all.

All groups need:

- Local trusted services
- Informal network support
- Confidential services
- Visiting expert services either directly or by tele-consultation

Some particular population groups experience disadvantage in relation to health and social indicators, as well as access to information and services. These inequalities often predispose individuals and communities to a higher degree of risk for developing a mental illness or problematic substance use, as well as suicide. For these vulnerable and marginalised population groups⁶ the experience of stigma and/or social exclusion is compounded by geographic isolation. Language and cultural differences for people from cultural and linguistically diverse backgrounds are additional barriers requiring culturally competent staff and service provision. Focussed attention addressing the needs of these groups by the provision of targeted services and promotion, prevention and early intervention programs is essential.

In recognition the diversity of need and barriers to access to interventions there have been a range of innovative online programs developed. For example, OnTrack⁷ aims to support mental and physical health and wellbeing by the provision of free online mental health, alcohol and drug information, programs and tools prepared by psychologists. Headspace (the National Youth Mental Health Foundation) has developed eheadspace⁸ to address the needs of young people in rural and remote areas. eheadspace is a confidential, free and secure online space developed for young people aged 12 to 25 years or their family to contact a qualified youth mental health professional via chat, email or telephone. Headspace is also expanding their use of telepsychiatry to complement their web based services.

Aboriginal and Torres Strait Islander Queenslanders

The majority of Aboriginal and Torres Strait Islander people live in regional and remote Queensland and experience disproportionately high levels of mental health issues and suicide. For example Aboriginal and Torres Strait Islander hospitalisation rates for mental illness related to substance use in Queensland were four times higher than non-Indigenous people. Between 2007–11 in Queensland, the *Report on Government Services: Indigenous Compendium 2014* reported that the rate of suicide amongst Aboriginal and Torres Strait Islander people was 21.5 per 100,000 compared to 11.9 per 100,000 for non-Indigenous people. In 2012–13, almost one-third of Aboriginal and Torres Strait Islander Australians aged 18 years and over reported high or very high levels of psychological distress — almost three times the rate experienced by non-Indigenous people. The rate of psychological distress was more likely to be experienced by those living in non-remote areas.⁹

The evidence for addressing the unique needs of Aboriginal and Torres Strait Islander people is overwhelming. The combination of geographic isolation and higher rates of social and emotional wellbeing problems creates complex challenges requiring dedicated attention. To address the

high levels of mental health, problematic substance misuse and suicide, services need to adopt a holistic, whole-of-life view of health inclusive of the social, emotional and cultural wellbeing of a whole community.

Key access issues

Several specific access issues have emerged during the Commission's consultations. The issues are explored in brief below. Acknowledging that it is not possible to replicate services across the breadth of Queensland, equity of outcomes as opposed to equal services was discussed, during the consultations, as an important factor in the planning and delivery of responsive, accessible services.

Clinical Service Delivery

The provision of clinical services is a critical aspect of supporting the mental health and wellbeing of rural and remote Queenslanders. There is a need to explore innovative, flexible and collaborative models of service delivery that meet the local needs of communities.

Telehealth

The use and expansion of telehealth or telepsychiatry (video consultation) is promoted as a key tool to improve access to healthcare, especially after hours. The Queensland Government's Blueprint for better healthcare in Queensland identified telehealth as a mainstay of remote area healthcare. Flowing from this, the Queensland Department of Health's Strategic Plan 2012–16¹⁰ includes access to safe and sustainable care for rural and remote communities through a statewide network of telehealth facilities as a key strategy to support access to health services. Key actions to progress this strategy include the development, expansion and coordination of the network of telehealth facilities to improve services to patients in rural and remote communities; the creation of six trial sites for Rural Telehealth Service in 2013; and an action to ensure the activity based funding model for telehealth supports continued expansion of services.

The Commission supports these strategic directions and notes that it remains the responsibility of each HHS to consider the best ways to maximise the use of telehealth to support service delivery.

Telehealth is an effective tool that enhances access to health care however it should be considered as complementing, rather than replacing face-to-face clinical contact. For example the first psychiatric assessment may be conducted face-to-face and followed up by telehealth appointments, with subsequent face-to-face assessments at least once every six months. There are however challenges with the availability of face-to-face appointments in rural and remote areas due to clinical workforce constraints (i.e. distance, time and the number of full time equivalent psychiatrists available within the Hospital and Health Service (HHS) area.

To meet the needs of Aboriginal and Torres Strait Islander people and their respective communities flexible, culturally capable models of telehealth service delivery need to be developed and implemented. For example to build a trusting relationship between the clinician and consumer, telehealth will need to be complemented by face-to-face appointments. Additionally, Aboriginal and Torres Strait Islander consumers may need to be supported to use telehealth services by Aboriginal and Torres Strait Islander health workers or other community respected professionals.

The Commission also notes that on 27 February 2014 the Queensland Parliament's Health and Community Services Committee announced an inquiry into telehealth services in Queensland. It will consider the implementation of telehealth, including the Rural Telehealth Service. The

Committee has invited submissions by 5 May 2014 and will be holding public hearings commencing on 21 May 2014. It intends to report to Parliament by September 2014.

Despite the strategic directions and development of resources and tools to support the delivery of telehealth, the Office of the Chief Psychiatrist (Department of Health) reports only minimal uptake of telehealth or telepsychiatry as a mental health and/or alcohol and other drugs service delivery option across Queensland. Nonetheless, compared with general health, the uptake of telehealth by mental health professionals is relatively good. It is noted that Children's Health Queensland mental health services and the Mater Child and Youth Mental Health Service both deliver telepsychiatry (eCYMHS) to rural and remote child and youth mental health teams.

To complement the available resources and tools to support the delivery of telehealth/telepsychiatry the Commission has been advised of a need for clearly defined local protocols in its use to support quality and safety for both consumers and clinicians. Specifically, the development of follow up protocols; referral practices and information sharing between clinical and local support services to promote continuity of care; and onsite support from local clinical staff for consumers at their telehealth appointment.

The National Rural Health Alliance has recently noted the growing use and uptake of telehealth for specialist appointments and recommended the identification and support of local coordinators to ensure that patients and health professionals make the best use of specialist visits or telehealth consultations¹¹. It is anticipated by local people that some telehealth services will be delivered not only in rural clinics but also directly into the homes of people who live on remote stations.

Medicare Benefit Schedule payment incentives for the use of telehealth are available to consultant psychiatrists, consultant physicians, specialists and some health workers¹² who provide support to a consumer located in an eligible telehealth area during a video consultation. Currently, mental health worker¹³ services are ineligible for the incentive payments. This may act as a disincentive for mental health workers and inhibit access for people in rural and remote areas.¹⁴

Proposed actions — Telehealth:

1. The Commission will work with the Hospital and Health Services and the Department of Health to:
 - a. explore the development of clearly defined local protocols to support the delivery of telehealth to mental health and alcohol and drug consumers; and
 - b. examine improvements that can be made to support high quality access to telehealth services for mental health and/or alcohol and other drugs.
2. The Commission will participate in the Queensland Parliament's Health and Community Services Committee Inquiry into telehealth services in Queensland.

Clinical workforce

A sustainable, skilled and appropriate clinical workforce is fundamental to the mental health of rural and remote Queenslanders. Much attention has been provided to the issues around workforce development, both at a national and state level.

It is important to engage and continually up-skill local service providers as they have the trust of the community. It is equally important to engage key local community members and develop

resources that make it easier for local service providers to access more people through property visits and community events. Clinical staff who can work with other trusted local organisations such as financial counselling services are more likely to connect with people in communities.

Both the Department of Health and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) recognise the difficulties in attracting and retaining skilled staff to rural and remote mental health services. A high turnover of staff and reliance on short term locums results in consumers (and carers) needing to retell their story, re-establish a trusting relationship, changing treatment plans and potentially missed opportunities for support and referrals if the locum does not have knowledge of local services.

RANZCP notes the shortage of consultant psychiatrists and identifies the following as factors influencing recruitment and retention¹⁵:

- professional isolation (e.g. lack of locum support, peer support and review)
- social and family factors (e.g. difficulties with spouses gaining employment)
- lack of career opportunities
- size of patient base
- burden of travel to outreach services
- lack of specialist positions at regional hospitals
- remuneration (inadequate financial incentives)
- access to ongoing education and professional development opportunities.

These have much in common with recruitment issues faced by solo rural doctor arrangements that are being increasingly replaced by dual positions to allow relief and collegiate support and avoid facing the on-call and isolation inherent in a solo position.

Recruitment of junior psychiatrists is a major challenge for mental health services in rural, regional and remote areas. In 2012 RANZCP removed the mandatory rural rotation from the training curriculum resulting in a significant decrease in trainees undertaking rural rotations and gaps in filling rural registrar positions. Overseas trained doctors have been recruited to enable the continuation of clinical mental health services in some rural areas. While bringing valuable skills, other matters such as cultural issues, have emerged especially in rural areas. New South Wales Health has responded to the recruitment challenges by making rural rotation for psychiatry trainees mandatory. Collaboration between the Department of Health and the RANZCP (Queensland branch) is required to ensure that all psychiatry trainees are rotated through rural mental health services unless some other solution can be identified to address this inequity for rural and remote Queenslanders. The Commission is liaising with the Department of Health to facilitate a solution.

The Commission has also heard that full time equivalent positions in the public health system are allocated on the basis of population rather than taking into account the distances that must be travelled to deliver community based services. This requires further exploration if mental health and alcohol and other drug services are to be delivered in the community and as close to home as possible.

The attraction and retention of the broader mental health and alcohol and other drug workforce (for example addiction medicine specialists, psychologists, mental health nurses, allied health professionals, community sector workers) remains a continual challenge for similar reasons as the RANZCP has identified for its members.

The uptake of training and ongoing professional development opportunities can be difficult for many workers who are often in services with very few staff. Access to offsite training is curtailed by the negative impact on the delivery of local services. On-line learning or the use of telehealth as methods of delivery may assist. The Queensland Centre for Mental Health Learning currently delivers a range of inter-disciplinary training programs that focus on the core requirements of Queensland Health mental health staff. Training programs are delivered either face-to-face in regional (for example Toowoomba, Rockhampton, Maryborough), or occasionally rural/remote (for example Bamaga), areas or via on-line learning. Similarly, there are online professional development opportunities for alcohol and other drug staff through InSight Clinical Support Services¹⁶. These types of programs need to be expanded.

The Medicare Locals have played a role in providing professional development opportunities for primary health care providers, with many offering mental health specific training. It has been reported to the Commission that the Medicare Locals active support of the upskilling of general practitioners has been very important in rural and remote areas where these opportunities might otherwise be scarce. The Commonwealth Government is currently conducting a review of Medicare Locals and is due to receive a report in March 2014.

Incentives such as good quality housing, peer support and supervision, access to locum relief to allow participation in professional development activities are some of the ideas to support recruitment and retention of the mental health workforce.

Attention to development of the Aboriginal and Torres Strait Islander mental health workforce will enhance mental health service provision to Aboriginal and Torres Strait Islander people in rural and remote Queensland. Queensland Health has lead responsibility for workforce development and cultural capability training. A Cultural Information Gathering Tool (CIGT)¹⁷ was developed by Queensland Health for all staff involved in the delivery of mental health services to Aboriginal and Torres Strait Islander peoples. The CIGT is a tool designed to be completed by Aboriginal and Torres Strait Islander Mental Health Workers to capture cultural information to be provided to clinicians to inform care, treatment and discharge planning. The use of the CIGT will enhance the cultural capability of the mental health workforce through the provision of education, support and information sharing through its use. The Commission supports its continued use and promotion to all health services in Queensland, especially in rural and remote populations.

An emerging workforce with a national priority is the peer workforce, which is mental health peer workers in paid roles that require them to bring expertise to the position based on their lived experience of mental illness, either personally or as a family member or supporter. The National Mental Health Commission has recommended the development of a National Mental Health Peer Workforce Development Framework¹⁸. The development of a peer workforce is likely to have positive flow on effects to rural and remote areas by providing professionally trained mental health workers with a lived experience to work alongside clinicians.

At the request of the Intergovernmental Committee on Drugs, a National Alcohol and other Drug Workforce Development Strategy is being developed. The strategy development is being undertaken by the National Centre for Education and Training on Addiction and is due to report in mid-2014.

Proposed actions — Clinical workforce:

3. The Commission will work with:

- a. Generalist colleges (Australian College of Rural and Remote Medicine/Royal Australian College of General Practitioners) to ensure that rural general practitioners are properly trained.
- b. the Office of AHP to ensure that mental health professionals are supported.
- c. the Hospital and Health Services, the Department of Health and key professional bodies such as the Royal Australian and New Zealand College of Psychiatrists and the Royal College of Physicians to enhance the mental health and alcohol and drug workforce, including the expansion of professional development opportunities and training models.
- d. the Department of Health and the Royal Australian and New Zealand College of Psychiatrists to revisit mandatory rural rotation requirements for psychiatry trainees.
- e. the Department of Health to encourage the use and monitoring of the Cultural Information Gathering Tool, in particular to Hospital and Health Services servicing rural and remote populations.

Queensland Health Clinical Networks

Queensland Health's Statewide Clinical Networks are formally recognised groups, mainly comprising clinicians, established to address problems in quality and/or efficiency of health care. Current Queensland Health Clinical Networks relevant to this work include the:

- Statewide Mental Health Alcohol and Other Drugs Clinical Network and a range of specialist clinical groups (for example child and youth, older persons, alcohol and other drugs); and
- Statewide Rural and Remote Clinical Network which provides advice to the Minister for Health, Queensland Health and the Hospital and Health Services.

In mid-2013 Queensland Health released the draft *Queensland Rural and Remote Health Service Framework*. The framework was developed by the Department of Health and the Statewide Rural and Remote Clinical Network in collaboration with other external stakeholders to assist Hospital and Health Service to undertake needs based health service planning in rural and remote communities. Planning is intended to be done in collaboration with communities, Medicare Locals and other service providers. The framework seeks to describe in easily understandable terms the function of district hospitals, rural and community hospitals and community clinics. This needs to be considered with respect to mental health

The Mental Health Alcohol and Other Drugs Branch within Queensland Health, is finalising the development of a Mental Health Alcohol and Other Drugs Clinical Governance Framework to guide mental health alcohol and other drugs services in the development of clinical governance strategies for the provision of the best possible quality healthcare and support services to develop coordinated, consistent and sustainable approaches to improving safety and quality.

Both networks provide opportunities for clinicians and network members to engage in planning, priority setting, information sharing and system improvement.

The ability of individual HHSs to develop and implement clinical governance mechanisms varies according to the resource availability. Health services operating in rural and remote areas tend to have fewer resources to meet their areas needs therefore statewide or cross HHS partnerships would be beneficial.

Proposed action — Clinical Networks:

4. The Commission will work with:

- a. the Statewide Rural and Remote Clinical Network, the Rural Doctors Association, Medical Colleges and the Department of Health to ensure mental health and alcohol and drug issues are integrated into the Queensland Rural and Remote Health Service Framework.
- b. the Statewide Mental Health Alcohol and Other Drugs Clinical Network to ensure that rural and remote mental health and problematic substance use becomes an integral part of their agenda.

Transport

Transport to and from services pose a significant challenge in rural and remote areas. In collaboration with HHSs, the Queensland Ambulance Service, the Queensland Police Service and other key stakeholders, the Mental Health Alcohol and Other Drugs Branch (Department of Health) is developing a statewide interagency agreement regarding safe transport of people with a mental illness, including those under the *Mental Health Act 2000*. The statewide agreement will clarify each agency's role and responsibilities, and provide a framework for the development and review of local agreements and protocols to support interagency collaboration in ensuring safe mental health patient transport. A draft agreement was disseminated for broad consultation across the agencies in late 2013. It is expected to be finalised early 2014.¹⁹

The Commission supports initiatives that reduce the unnecessary transport of people who could access mental health or drug and alcohol services via alternative means such as telehealth. This flexible model of service delivery may support access to services and reduce impacts such as dislocation from support networks and community, cost, time and frequency of travel and loss of income from time away from work.

The agreement supports the use of telehealth services to improve access to specialist mental health and drug and alcohol assessment and treatment services in regional, rural and remote areas. This promotes earlier access to assessment and treatment, and allows a greater number of patients to be assessed and treated locally, thereby reducing the demand for transport.

Community support, communication and awareness

Local community members know their community the best and are well placed to advise on appropriate interventions and to lead and coordinate local events.

Ready access to reliable useful information was raised at the Ministerial Roundtable on Rural and Remote Mental Health in Charleville on 13 March 2014. In response to this, the Department of Health is coordinating a communication strategy with an individual and community approach that has the potential to incorporate a number of elements including:

- an online repository of all support services, legal, financial and health

- sponsorship of community events that incorporate information about mental health with more general information
- use of publications such as Queensland Country Life and other forms of media to promote material and information
- the use of local champions to promote positive messages
- community support mechanisms are also provided through a range of other agencies such as the Department of Communities, Child Safety and Disability Services and local government.

Coordinated service delivery

Coordinated service delivery that is underpinned by cross sectoral, cross discipline collaboration is essential in areas where resources are stretched and/or scarce. High quality referral practices, clear information exchange protocols and active partnerships are essential ingredients for integrated service delivery. Hospital and Health Services predominately serving rural and remote areas could pool resources to overcome staff shortages and to integrate the provision of services.

Mental health services need to be more closely connected to general health services.

Lack of coordination within and between service providers has been identified as a barrier to access for mental health care in some rural and remote areas.²⁰ This may result in long waiting lists, additional travel costs and time away from support networks over multiple days for consumers, their families, carers and support persons to receive support from different service providers. People also report multiple assessments by different service providers which is frustrating for them and seen to be an unnecessary duplication of effort.

Similarly, the need for a joined up approach around program delivery from local, state and Commonwealth programs is required. A balanced approach would ensure that programs delivered by all levels of government were provided in a complementary way with minimal overlap, no major gaps and seamless interagency communication. The Commonwealth government's Partners in Recovery initiative is an example of a program designed to provide systems level collaboration at a local level. Non-clinical support programs such as the Queensland government funded Service Integration Coordinators and the Commonwealth funded Personal Helpers and Mentors Program (PHaMs) are also important aspects of the service delivery system.

Medicare Locals were established by the Commonwealth government to support the integration and coordination of primary health care within selected geographical boundaries. Driven by local communities' needs analyses the work of the Medicare Locals varies. However they all aim to improve interagency collaboration, in particular the interface between hospital-based services and primary health care which is crucial in rural and remote areas.

Services delivered by visiting providers may not have established relationships and/or trust in the community and may need to be reviewed to ensure that they meet local community needs. Being part of a coordinated service and program delivery may mitigate some of the reluctance by people to use such services. Conversely, in small close communities some people want the choice to access services staffed by people outside their close neighbourhood networks.

In rural and remote areas it is likely that psychiatrists will need to liaise extensively with primary health care providers, such as general practitioners, and community based organisations. General practitioners are often the first point of contact for consumers experiencing mental health difficulties or problematic substance use. However, many rural areas are under-

resourced in the primary care sector with access inhibited by limited numbers of general practitioners, particularly those trained or experienced in mental health. Additionally, a lack of bulk-billing general practitioners can serve as a barrier to both the physical and mental health care of mental health consumers.

Better transparency and accountability

In a tight fiscal environment consideration of how to maximise the available resources is a priority for both government and non-government service providers. Improved coordination and integration of service delivery may lead to greater efficiencies however equally important is the identification of service delivery gaps.

Through the Commission's consultations stakeholders have identified the need for funding models that support statewide services that enable access to expertise and equity of outcomes across Queensland. Flexible, local, needs-based planning for investment across the continuum of care (from prevention to tertiary treatment) and the whole service system (government, non-government and community managed sectors) is required especially in rural and remote areas.

Considerable work has gone into service planning at both a state and national level. It is anticipated that the National Mental Health Service Planning Framework will provide guidance for investment as it provides parameters for the mix and level of the full range of mental health services, including those in rural and remote areas.

The Commission, via the whole-of-government mental health and drug strategic plan, will be working to encourage a more robust service system that is transparent and accountable to all stakeholders for both investments and outcomes. This will have a direct flow on effect to rural and remote service delivery.

Our actions

Throughout this paper key areas for the Commission's attention and action are highlighted. A summary of the proposed actions are at Attachment A.

A part-time senior consultant psychiatrist is working with the Commission to focus on (among other issues) what better access to rural and remote mental health services would look like, and to identify with key stakeholders solutions to known impediments to service delivery. He will consult with key stakeholders such as the Statewide Rural and Remote Clinical Network, the Royal Australian and New Zealand College of Psychiatrists, and the Mental Health Alcohol and Other Drugs Branch, Queensland Health.

The Queensland Mental Health and Drug Advisory Council (the Council) will be briefed and have input into this work area.

Further discussions with both clinical and non-clinical service providers as well as consumers, their families, carers and support persons (who are valued partners in identifying practical things that can be done to improve mental health and wellbeing in Queensland's rural communities) will continue. In recognition of the diversity of rural Queensland and the unique circumstances within each community, the Commission intends to conduct further visits throughout rural Queensland in 2014 to inform development of the Commission's whole-of-government mental health and drug strategic plan.

The Commission will continue its partnership in an Australian Research Council Linkage Project to examine influences on farmer suicide in Queensland and New South Wales. The project aims to determine the individual and environmental risk factors related to suicide in farmers of

Queensland and New South Wales. The prevention of suicide, particularly amongst rural and remote communities, Aboriginal and Torres Strait Islander people, and children and young people will be a priority within the Commission's whole-of-government mental health and drug strategic plan.

The Commission will continue to monitor emerging issues and any matters raised by key stakeholders. The Commission will take action on recommendations made by the Queensland Mental Health and Drug Advisory Council.

Updates on our work will continue to be provided on the Commission's website — www.qmhc.qld.gov.au

Prepared April 2014

This paper has been prepared in accordance with the functions outlined in the Queensland Mental Health Commission Act 2013, Section 11(1)(d) — to review, evaluate, report and advise on – (i) the mental health and substance misuse system; and (ii) other issues affecting relevant persons; and (iii) issues affecting community mental health and substance misuse.

Attachment A: Summary of proposed actions

Telehealth

1. The Queensland Mental Health Commission will work with the Hospital and Health Services and the Department of Health to:
 - a. explore the development of clearly defined local protocols to support the delivery of telehealth to mental health and alcohol and drug consumers; and
 - b. examine improvements that can be made to support high quality access to telehealth services for mental health and/or alcohol and other drugs.
2. The Commission will contribute to the Queensland Health Queensland Parliament's Health and Community Services Committee Inquiry into telehealth services in Queensland.

Clinical Workforce development

3. The Queensland Mental Health Commission will work with:
 - a. Generalist colleges (Australian College of Rural and Remote Medicine/Royal Australian College of General Practitioners) to ensure that rural general practitioners are properly trained.
 - b. the Office of AHP to ensure that mental health professionals are supported.
 - c. the Hospital and Health Services, the Department of Health and key professional bodies such as the Royal Australian and New Zealand College of Psychiatrists and the Royal College of Physicians to enhance the mental health and alcohol and drug workforce, including the expansion of professional development opportunities and training models.
 - d. the Department of Health and the Royal Australian and New Zealand College of Psychiatrists to revisit mandatory rural rotation requirements for psychiatry trainees.
 - e. the Department of Health to encourage the use and monitoring of the Cultural Information Gathering Tool, in particular to Hospital and Health Services servicing rural and remote populations.

Clinical networks and frameworks

4. The Queensland Mental Health Commission will work with:
 - a. the Statewide Rural and Remote Clinical Network, the Rural Doctors Association and the Department of Health to ensure mental health and alcohol and drug issues are integrated into the Queensland Rural and Remote Health Service Framework.
 - b. the Statewide Mental Health Alcohol and Other Drugs Clinical Network to ensure that rural and remote mental health becomes an integral part of their agenda.

Emerging Issues

5. The Queensland Mental Health Commission will continue to monitor emerging issues and any matters raised by key stakeholders. Action will be taken on any recommendations made by the Queensland Mental Health and Drug Advisory Council.

References

- ¹ *Queensland Mental Health Commission Act 2013*
- ² Queensland Mental Health Commission Strategic Planning Issues Papers, Better Suicide Prevention in Rural and Remote Queensland, Australian Institute of Suicide Research and Prevention, Griffith University. See <http://www.qmhc.qld.gov.au/our-work/queensland-mental-health-and-drug-strategic-plan/issue-papers/>
- ³ Suicide in Indigenous populations in Queensland; Diego De Le et al. 2011
- ⁴ See <http://ruralhealth.org.au/sites/default/files/publications/fact-sheet-33-illicit-drug-use-rural-australia.pdf>
- ⁵ Australian Institute of Health and Welfare 2011. 2010 National Drug Strategy Household Survey report. Drug statistics series no. 25. Cat. no. PHE 145. Canberra: AIHW.
- ⁶ Vulnerable and at risk groups include, but are not limited to, Aboriginal and Torres Strait Islander people; people from culturally and linguistically diverse backgrounds; refugees; lesbians, gays, bisexuals, transgender and intersexed persons; people with disabilities and/or intellectual impairments; people who are, or who are at risk of homelessness; prisoners; children and young people; and the aged.
- ⁷ <https://www.ontrack.org.au/web/ontrack>
- ⁸ See: <https://www.eheadspace.org.au/>
- ⁹ <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4727.0.55.0012012-13?OpenDocument>. See Table 2.1 Selected health characteristics by Remoteness Area – 2012–13, Aboriginal and Torres Strait Islander persons (estimate).
- ¹⁰ See: http://www.health.qld.gov.au/about_qhealth/strat_plan/12-16/
- ¹¹ Better in the Bush? Annual face-to-face meeting of the National Rural Health Alliance 2013 Communiqué, 2 December 2013. See: <http://ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/policy-development/nrha-councilfest-communique-2013.pdf>
- ¹² Medical practitioners, nurse practitioners, midwives, practice nurses and Aboriginal health workers. See <http://www.medicareaustralia.gov.au/provider/incentives/telehealth/information-for-health-professionals.jsp>
- ¹³ Mental health workers, as defined in the *Medicare Benefits Schedule — Allied Health Services 1 March 2014*, are services provided by psychologists, mental health nurses, occupational therapists, social workers, Aboriginal and Torres Strait Islander health practitioners/Aboriginal health workers. See [http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/2F8294726E8247C8CA257C70001292AD/\\$File/201403-Allied.pdf](http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/2F8294726E8247C8CA257C70001292AD/$File/201403-Allied.pdf)
- ¹⁴ <http://www.abc.net.au/news/2014-02-21/video-conferencing-effective-in-mental-health-services-delivery/5274426?>
- ¹⁵ Position Statement 65, Rural Psychiatry, Royal Australian and New Zealand College of Psychiatrists
- ¹⁶ <http://www.dovetail.org.au/insight/index.php>
- ¹⁷ See: <http://www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-365-3.pdf>
- ¹⁸ National Mental Health Commission, 2013: A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention. Sydney: NMHC
- ¹⁹ Department of Health, February 2014: Issues related to mental health and alcohol and other drug service delivery in rural and remote areas
- ²⁰ Queensland Mental Health Commission Strategic Planning Issues Paper: Too Much, Too Little, Too Late!; Goddard, M: 2013. See <http://www.qmhc.qld.gov.au/our-work/queensland-mental-health-and-drug-strategic-plan/issue-papers/>