**CoMHWA**

Consumers of Mental Health WA (Inc)

## Submission to Senate Community Affairs Reference Committee

## Accessibility and Quality of Mental Health Services in Rural and Remote Australia

24th May 2018

Consumers of Mental Health WA

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# Introduction

## About this Submission

CoMHWA is Western Australia's independent mental health consumer peak organisation in Western Australia. We strengthen and advance the voice, leadership and expertise of people with lived experience of mental health issues.

Consumers of Mental Health WA (CoMHWA) welcomes the opportunity to make a submission on the quality and accessibility of mental health services in Western Australia. The terms of reference for the Inquiry are included in *Appendix 1.* We are happy to be take part in a hearing for the Inquiry.

We appreciate notification of the outcomes of our submission to the Senate Community Affairs Reference Committee to assist us to confirm and communicate the difference made through our work.

**Language**

CoMHWA uses the term mental health consumer throughout this submission to collectively refer to people where needed, such as "Consumer Representative or Consumer Advisory Group". Mental health consumers are defined by our Constitution as people who identify as having a past or present lived experience of psychological or emotional distress, irrespective of whether they have received a diagnosis or accessed services. Other ways people may choose to describe themselves as a collective include "peers", "survivors", "people with lived experience" and "experts by experience".

## Consultative Sources Used

We base our submission on consultative evidence gathered from rural and remote West Australians to assist with this inquiry, including consultations undertaken by CoMHWA, Carers WA, HelpingMinds and a consultation undertaken by the WA Association for Mental Health[1].

The primary source of feedback used for this submission is a survey conducted in April 2018 by CoMHWA, Carers WA and HelpingMinds with questions aligned to the Terms of Reference of the Commonwealth Senate Inquiry. The survey was distributed both online and hard copy versions and received 235 responses.

Approximately 45% worked for a mental health service, 22% were of Aboriginal and/or Torres Strait Islander background, 63% had a lived experience of mental health issues, and 71% were a family member or friend of someone with a lived experience of mental health issues. Respondents were located across all major rural regions of Western Australia[2].

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[1]WAAMH, 2018.

[2] This included 11.3% from the Kimberley, 25.8% from the Pilbarra, 15.5% from the Midwest/Gascoyne region, 7.2% from the Goldfields, 6.2% from the Wheatbelt, 25.8% from the Great Southern and 8.2% from the South-West.

# Rural and Remote Communities in Western Australia: Key Statistics

Western Australia is particularly affected by rural and remote mental health issues due to lower population density, vast land area, socio-economic disadvantage in rural communities and high numbers of remote Aboriginal communities facing additional hardships:

- Western Australia accounts for 34.3% of the land area of all of Australia.

- WA has the second lowest population density of all states and territories, with 1.0 persons per km2 compared with 3.0 persons per km2 national average[3].

- 32% of remote communities, and 31% of very remote communities, are in Western Australia[4].

- 60% (approximately 52, 588 members) of the Aboriginal population live outside WA's metropolitan area[5]. 38% of Aboriginal and/or Torres Strait Islander people live in remote and very remote parts of Western Australia, compared with 18.4% of Aboriginal community members living in remote and very remote areas in Australia, overall[6].

- WA has 274 remote communities, including 110 smaller communities that do not receive special state provision or support as remote communities[7]

- 41% of WA's rural population (217,941) live in areas classified 1 or 2 out of 5 (most socio-economic disadvantaged) areas.

- In 2016, public mental health services in rural areas in Western Australia were significantly below KPIs for timely community intervention. Rates of contact with community mental health services in the 7 days preceding admission, an indicator of timely intervention to prevent hospital admission, were 47.3%, compared with a target of at least 70% and a state average of 64.1%.

- WA's Country Primary Health Network is the largest geographically in Australia, and covers 548,185 people.

- Suicide rates among Aboriginal children and youth aged 5-17 years were 18.0 per 100,000 from 2012-2016, the highest in Australia, and 9 times higher than non-Aboriginal children and youth over the same period[8].

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[3] ABS, 2016b.
[4] ibid
[5] WACHS, 2017.
[6] ABS, 2016a.
[7] Regional Services Reform Unit, 2017.
[8] ABS, 2017.

# Terms of Inquiry

## Lower Rates of Access to Mental Health Services

**Inquiry Terms of Reference:**

**(a)The Nature and Underlying Causes of Rural and Remote Australians Accessing Mental Health Services at a Much Lower Rate**

**In Summary**

There are major and multiple barriers to accessing mental health services and these are playing a major role in lower rates of access to mental health services. Lack of availability of services was the mostly frequently reported barrier and for the majority of people (64%).

Lack of available services, lack of out of hours services, confidentiality challenges, lack of choice in services and inability to transport to services are common barriers to accessing mental health services. Community attitudes and understanding about mental health needs and how to access support, and variable experiences of services, create additional barriers to service access.

**Facts About the Gap in Access to Services for Rural and Remote Communities**

- 7.6% of city residents accessed MBS mental health services in cities, compared to 3.0% in remote areas and just 1.5% in very remote areas[9]
- Per 100,000 population based on AIHW 2014 data, there are 3.0 psychiatrists and 29.6 psychologists in remote and very remote areas, compared with 16.6 psychiatrists and 92.4 psychologists in major cities[10].

**Feedback Received**

- 64% of people (n=151) felt services were not available
- 65% of people (n=154) felt services were not available when needs, such as on weekends or evening.
- 63% of people (n=149) felt people aren't comfortable speaking to a work who they may also know socially in their local town
- 53% of people (n=126) felt there was a lack of choice in services
- 41% of people (n=98) felt that lack of transport to get to services was a barrier to access.
- 40% of people (n=95) can't travel to the service due to work or family obligations.

Other frequently reported barriers included:

- Confidentiality (16.5% of people)

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[9] Royal Flying Doctor Service,
[10] ibid

- Community Attitudes and Understanding: stigma and lack of knowledge about services (33% of other reasons raised)
- Service quality and reputation (33% of other reasons): People reported mixed or negative perceptions of the quality of services, such as due to turnover, lack of diversity inclusion, gatekeeping and staff attitudes.
- In the WAAMH survey, 35.5% of respondents saw costs of mental health services as a challenge for access[11].

The Patient Assisted Travel Scheme (PATS), which is designed to overcome travel-related cost barriers to accessing essential services in metropolitan areas, has numerous gaps and carries significant out-of-pocket costs[12]. Uneven coverage, out of pocket costs, and fragmented policies between states, territories and Commonwealth arrangements for PATS adversely affect rural communities[13].

**What People Shared for the Inquiry**

> *"It takes time to get an appointment even in an emergency mental health situation. The after hours/weekend services area terrible. Untrained people on the end of the telephone".*

> *The mental health system cannot help our people recover as it is not holistic, culturally suited".*

> *"Waitlists in the country means often by the time you get an appointment the crisis has passed or you feel under valued and disheartened."*

> *"People are not made aware enough of mental health and don't know how to deal with their depression, anxiety etc. Talking and opening up to a stranger is not easy."*

> *"Service providers go to community and don't do follow ups with other service providers that attend remote places, there is a lack of shared care arrangements"*

> *"People have a lack of confidence in the service."*

> *"For small town like where I live gossip spreads faster to air."*

> *"Some services are great, but some are also appalling".*

> *"Many people were in the gap between what community services handle and what mental health handle… me included".*

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[11] WAAMH, 2018
[12] WACHS, n.d.
[13] NRHA, 2014.

# Higher Suicide Toll and Greater Risk of Suicide

**Inquiry Terms of Reference:**

**(b)The Higher Rates of Suicide in Rural and Remote Western Australia**

**In Summary**

Lack of access to mental health supports and fewer social, economic and community opportunities contribute to the higher suicide toll in Western Australian communities. This couples with a range of other factors including the impact of isolation, lack of cultural healing programs, lack of access to other health and community services, stigma and reluctance to seek help and lack of youth opportunities.

**Facts About Increased Suicide Risk in Rural and Remote Communities**

- While 29.6% of Australians live in rural and remote areas, rural and remote suicides accounted for 42% of all suicides in Australia in 2016[14].
- Suicide rates consistently increase as the remoteness of a community increases[15].
- Suicide rates in rural and remote communities are increasing at a higher rate than in metropolitan communities. For the past 4 years (2012-2016) suicide rates rose by 9.2% in rural and remote areas compared to 2% in major cities[16].
- While rates of mental health are currently considered to be similar between metropolitan, rural and remote areas nationally, rates vary between communities, and individuals living in rural communities face greater impacts due to limits and gaps in availability of services[17]. Self-harm and alcohol and other drug use are also higher in rural and remote areas[18].

**Feedback Received**

- 70% of people (n=165) saw lack of access to mental health support as contributing to higher rates of suicide. This includes services such as access to low-cost psychiatrists, psychologists, access to GPs with mental health competency and access to community mental health supports.
- 72% of people (n=169) felt that people in rural and remote areas have fewer opportunities, such as job opportunities, housing opportunities and access to community activities, programs and services. Reduced socio-economic prospects due to limited employment opportunities increases risks of homelessness and housing insecurity, isolation, inability to afford key services, lack of access to education as an employment pathway, risks of mental health issues and substance use, despair/hopelessness and domestic violence. At the same time, rural and remote communities have a more limited range of community and social services to address and respond to these needs.

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[14] Hazell, Dalton & Caton, 2017.
[15] ibid
[16] ibid
[17] Commonwealth of Australia. 2017.
[18] ibid

People identified a range of other factors contributing to increased suicide risk.

- 20% (n=48) identified a gap in young people's access to mentors, supports and leaders
- 31% (n=72) felt that life is harder for people in rural and remote communities
- 32% (n=76) felt that there is a lot of sadness within rural and remote communities.

Other issues affecting the wellbeing of rural and remote communities shared by community members included:

- Isolation, with lack of community activities, programs, work of an isolating nature (e.g. farming) and geographic isolation from others having an impact on wellbeing.
- High financial risks of farming due to weather events impacting crops
- Barriers to using services (such as stigma and lack of confidence in services)
- Limited cultural safety and security within mental health services to meet the needs of Aboriginal and Torres Strait Islander communities;
- Limited access to culturally appropriate trauma and healing programs
- Limited access to youth mentoring and activities
- Cultures that value and expect stoicism, self-reliance and devalue disclosure, which inter-relate with mental health stigma and traditional stereotypes about mental illness to create community intolerance, avoidance and shame.

In WAAMH's survey of rural and regional consumers, families and providers, the following factors were seen to be impacting mental health in rural and regional areas. Mental health challenges and risk of suicide are closely interlinked, with an estimated 87.3% of those who suicide having had a mental health diagnosis[19]. For this reason, we include these as likely factors contributing to suicide directly or indirectly through their adverse impact on mental health.

**Table 1. Factors adversely impacting mental health in regional areas[20]**

| % of participants reporting this factor | Factor |
|---|---|
| 83% | Alcohol and other drug use |
| 77% | Social isolation |
| 77% | Stress |
| 67.5% | Unemployment |
| 64% | Stigma |
| 57% | Lack of income |
| 52% | Stigma |
| 52% | Trauma |
| 52% | Lack of community support |
| 52% | Lack of transport |
| 47.5% | Lack of housing |
| 19% | Violence |

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[19] Suicide Prevention Australia. 2018.

[20] WAAMH, 2018.

**Views Shared for the Inquiry**

*"The lack of employment opportunities, and cost of everyday living is higher keeping a lot of people in poverty".*

*"Not enough things to do. Especially for the youth".*

*"Past history, trauma, against our people. And there are not cultural healing programs for our people, people are not presenting (to services)".*

*"Personal resilience and resistance is tested more in small communities. People are not comfortable to talk about their issues if it just leads to bigger ones".*

*"There is a significant amount of trauma present in a lot of remote communities and this is not being addressed according to each community's needs."*

*"Families in rural communities tend to get up and get on with it, avoid is such…rather than accepting sadness, acknowledging it's okay to fail"*

*"The heaviness sadness in communities all day every day is hard to beat".*

# Service Challenges and Workforce Characteristics

**Inquiry Terms of Reference:**

**(d) The Nature of the Mental Health Workforce**
**(e) The Challenges of Delivering Mental Health Services in the Regions**

**In Summary**

Rural mental health services and their staff face numerous challenges to service delivery. This includes difficulty retaining staff, travel distances involved, time pressures, housing and living costs, lack of privacy for staff. Under-funding and under-resourcing has an impact on the quality, availability, retention and wellbeing of staff, and the capacity of services to appropriately and adequately assist communities, which has follow on adverse impacts for the wellbeing of community members in regions.

**Feedback Received**

People were asked to indicate challenges faced by rural mental health services:

| Challenges- rural mental health services | Responses | |
|---|---|---|
| Staff Retention | 68% | 157 |
| Staff living and housing costs | 45% | 103 |
| Travel distances | 59% | 135 |
| Privacy for people living in the same town | 42% | 96 |
| Staff time pressures | 53% | 122 |
| Other challenges | 39% | 89 |
| | **Answered** | **230** |

People who shared comment on other challenges faced by mental health services raise a number of issues. These include: under-funding and under-resourcing; high workloads, lack of on-referral pathways, and working with communities and services who have limited awareness and understanding among the community and other services about how to provide informal mental health support and assistance and how to access mental health services. Services experience difficulty attracting as well as retaining staff, as well as difficulties attracting and retaining more qualified and experienced staff relative to metropolitan areas. Some of the reported effects of rural workforce attraction and retention difficulties, which are linked to funding and resourcing issues, were high turnover, associated difficulties sustaining engagement and trust with community members due to constantly changing staff, staff shortages, excessive workloads and poorer quality services.

Staff face considerable role strain that may lead to difficulty in retaining staff and may increase risks of burnout or emotional stress at work. This includes high workloads and lack of other services involved with the person to assist with support. Staff comments highlight the emotional impact of working with individuals who are facing poverty and lack of opportunities in the regions, and that staff living in the regions face the same pressures as those they are supporting- pressures such as isolation, lack of community activities and opportunities, living costs and the emotional toll of suicide on local communities. Some people shared a preference for more opportunities for people living locally to work in the mental health sector, which would require access to qualification opportunities. The need to ensure services were culturally appropriate- both in staff understandings and in what services are available- was also seen as important.

**Views Shared for the Inquiry**

*"[Government] agencies want more fees to come in…from youth, people who are on Centrelink, young sine parents on a pensions, people despairing because there is no work".*

*"Distance between appointments, services suffer from perception and suspicion of drive in drive out staff. Services need to present in town not just in regional centres".*

*"Constantly changing staff….a need to repeat your story time and again. The difficulty of building a rapport when faces are constantly changing."*

*"Too low staff numbers so staff are just spread too thin on the ground".*

*"Volume [of work], variety and the need of individuals who travel large distances if they have transport. Trying to help clients who have no money or transport to services. The general isolation causes loneliness for clients."*

*"No real support for mental health services- no real resources- no where people can be referred to"*

*"Limited other services to refer to and work alongside for wrap around support"*

*Overworked and under-supported"*

*"Can lack cultural awareness"*

# Community Attitudes to Mental Health Services

> **Inquiry Terms of Reference:**
>
> **(e) Attitudes towards mental health services**

**In Summary**

Our survey highlights that stigma may not be as great a factor in help-seeking compared to other factors such as the poor quality, availability and suitability of mental health services. 94% of people would use a mental health service if they were very sad or upset and the majority would access, and want their family members or friends to access, mental health services if they needed them. However, the majority of people's comments revealed adverse experiences or mixed experiences of services because of problems of quality and/or availability of care. There is a need to improve service quality, accessibility and availability so that people can have better mental health supports in rural communities.

| What are your feelings towards mental health services? | Responses | |
|---|---|---|
| I wouldn't use a mental health service even if I was really upset or sad | 6% | 14 |
| I would want a family member or friend to use a mental health service if I was worried about them | 76% | 177 |
| I would use a mental health service if I thought the staff were good | 64% | 149 |
| I would use a mental health service if it was private and no one else knew | 50% | 116 |
| People I know didn't get any better after going to a mental health service | 17% | 40 |
| People I know got a lot of help from the mental health service | 35% | 81 |
| Other (please specify) | 24% | 55 |
| **Answered** | | **233** |

Of the 55 people who shared comments about how they feel about mental health services, these were classified into positive feedback, mixed feedback, or negative feedback about services.

Only 16% of people described positive experiences of services. The vast majority were ambivalent or negative towards services. 32% of people having mixed feelings about services and 52% of people having negative feelings about services. No people commented that they would not access services because of stigma.

Reasons for negative feedback were similar to reasons for mixed feedback. This included: lack of choice, medication and clinical only model, being knocked back from services in the past when seeking help for themselves or their family members, being disrespected by the service, and not being able to access the service for reasons of cost,

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distance and lack of service presence within the community. Some mixed feedback involved recognition that some services are helpful and others aren't, but more commonly, a person giving mixed feedback was *willing to access the services but unable to, or not confident they would receive the assistance they need.*

**Views Shared for the Inquiry**

*"[I] have witnessed miscommunications between service providers and consumers, consumers not feeling head and carers not having a fully understanding of the consumer's treatment plan"*

*"My son sees his clinician only 15 minutes every month. That is not enough to support his wellness improvement"*

*"I would want to use mental health services…if I felt that they were going to be cared about as an individual. And I'm not sure people are. People are fobbed off, moved on, referred through".*

*"Regional acute services are understaffed and say they can't help with crisis situations and refer onto Perth"*

*"People have an appointment and then they get told just go back to your GP"*

*"Mental health staff never seem to have time to listen to anyone they are always too busy with what????"*

*"I would use mental health services if they were lower-cost [and] if the ones I require were available locally without travelling to the city".*

*"There is too much emphasis on medicate and poor counselling services".*

*"Publicly I wasn't seen as urgent and there was a long wait to see someone, and then I saw a different person every time. It was not ideal and they were just reviewing my medication. There are fewer options for private treatment as practitioners have left town or are already at capacity."*

*"Still old school of approach of psychiatrist knows best and not promoting autonomy and choice of client"…respect them as an individual who is trying their best to overcome challenges, not lazy, slack (e.g. due to side effects of medications)"*

*"Help is only generally available publicly if you are a danger to yourself or others. There is also a lack of follow up."*

# Community Views about Technology

**Inquiry Terms of Reference:**

**(f) Opportunities that technology presents for improved service delivery.**

**In Summary**

Responses we received indicate that technology can sometimes be used as a complement to existing services but cannot replace services. Attempts to replace face to face services and supports with technology are likely to create further inequalities for rural and remote Western Australians, particularly Aboriginal communities, people in financial hardship and those who are not engaged with specific technologies for reasons of literacy, preference, privacy concerns or disability.

**Feedback Received**

- 60% had, or knew someone who had, internet connection at home.
- People were asked if they would be willing to use, or know people who might be willing to use, the following technologies. Telehealth options for mental health were only likely to benefit some people:

| I am willing to use, or someone I know might be willing to use: | YES |
|---|---|
| Video link or Skype from home | 58% |
| Video link or Skype from a community mental health services | 54% |
| SMS service | 44% |
| Live chat e.g. facebook, website, messenger | 54% |
| Emails | 33% |

- 37% (n=82) provided one or more comments about use of technologies. These were categorised as follows. Of all comments:
  - 28 were about access barriers, including higher costs of internet and phone in rural areas, lack of connection or poor quality connection, and other barriers
  - 28 preferred face to face, or felt it was the only method that would work
  - 11 said technology could enhance, but should not replace, face to face supports
  - 6 preferred basic phone calls
  - 10 thought it might be helpful to others
  - 3 had found it helpful for themselves or others
  - 4 were concerned about privacy (data security).

Three people suggested removing cost barriers to technology, such as free phone calls. There was a significant number of comments that face to face rather than technological approaches were often preferred by Aboriginal communities. Technology use was also seen to be easier and more appropriate for young people compared to other ages. Several people felt that technology can worsen, rather than reduce, a sense of isolation.

**Views Shared for the Inquiry**

*"Remote areas are still in a black hole, useless having these options when they don't work in your home area!!!"*

*"No credit, no internet no privacy in Aboriginal homes. Might work for the white fella over time again not ideal or liked."*

*"You can miss a lot about a person's body language with IT. A computer cannot comfort you when you're upset."*

*"Some people but not all could use these options."*

*"This can greatly assist people…but it cannot replace having a physical worker on the ground".*

*"A lot of services that use modern technology often isolate some members of the community further as a lot of my clients can't even read"*

# Strategies to Improve the Mental Health Outcomes, and Prevent Suicide, in Rural and Remote Communities

**Inquiry Terms of Reference:**

**(g) Other related matters.**

## Part A: General Feedback Received

**In Summary**

The overarching theme of feedback shared was the need for rural communities to be better supported through adequately available and suitable services, and to have greater opportunities to sustain their wellbeing through enhanced socio-economic prospects, facilities and associated services in regional areas. It is clear that there is a need for greater access to the spectrum of mental health and suicide prevention and intervention services.

There is also a need for rural and remote community members to be better supported with service navigation (to know about services and how to access them), as well as stigma reduction and education on mental health recovery. This is an important finding as it may be assumed that services may be better known to communities when the number of services are limited, but these comments highlight that that is not the case.

Some services are not being delivered in ways that best meet community needs. Examples include the need for more out of hours options, for a regular local community presence and relationships of trust between services and communities, outreach to where people work and live, and for multi-purpose community facilities where people

can access mental health support discretely and informally. This highlights the need for consultation with communities to ensure service models are appropriate to local needs.

Based on the range of underlying factors contributing to higher rates of suicide shared with CoMHWA, a dual strategy to improve mental health outcomes and prevent suicide is needed that focuses on, firstly, improving availability of mental health and suicide prevention programs and services, and secondly, building support social, cultural and economic resilience through access to the holistic range of infrastructure, services and supports that assist people to sustain quality of life and overcome hardships.

**Feedback Received**

Our survey invited people to share what they felt were the most important things that should be done to improve access to the right mental health and suicide prevention assistance in their community. People could list up to three suggestions and a total of 541 suggestions were received.

The following summarises key themes of feedback received:

- **More Services (71% of suggestions):**

  All Services (45%):

  Requests for increases in mental health services (without specification of type of program) made up 45% of all responses. This included improved quality and retention of staff, which is linked to funding levels.

  People wanted to see increased affordability of services (such as through increased Medicare subsidies) reduced wait times, increased access, more skilled and experienced staff, increased support and greater continuity of support as a result of growth in availability of services.

  Specific Services and Approaches (55%):

  55% of responses described a need for increased availability of specific mental health service types or approaches. Frequent themes included a preference in approaches for more out of hours services, more outreach for home visits and a greater local presence in communities outlying regional centres, more discrete settings (such as co-location of mental health supports with other services) and improved access to mental health crisis and emergency response.

  Of specific mental health services, suggestions were evenly distributed across different types of supports- from prevention and early intervention, to community services, to primary care and counselling, to acute services. Some people shared that they felt there were only acute services in their area with lack of follow up and lack of continuity of support for recovery after a suicide attempt or mental health emergency.

  This need for general investment to increase availability of a range of services to address individual needs is similar to the findings of the WAAMH survey, as shown in the table below[21].

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[21] WAAMH, 2018.

| Table X: WAAMH Survey Extract | |
|---|---|
| % of participants reporting this shortage | Service Shortages |
| 73% | Community mental health services |
| 72% | Preventative mental health services |
| 66% | Emergency mental health services |
| 32% | Doctors |
| 59.5% | Support services |
| 40.5% | Housing Services |

Other Supports:

Some suggestions were about building social capital, informal supports and regional infrastructure (9%). These included more community groups, support groups, events and activities to foster connections between community members, and reducing financial burdens (such as financial assistance with travel to services, relocation assistance and improved telecommunications access and affordability).

**Stigma reduction, awareness raising and education (18% of suggestions):**

Among suggestions for stigma reduction, awareness raising and education, the most commonly raised suggestion (8% of all suggestions) was improved service navigation (to know more about services available and how to access them). Several people felt that services were better known by residents of regional centres compared to outlying towns. Remaining suggestions were greater community education, stigma reduction and improved education of health and community service workers, including GPs.

**Improving service delivery approaches (11% of suggestions)**

These suggestions included greater consultation with local communities by government and services, improved service coordination and more culturally appropriate and recovery-focused services.

## Part B: Additional Feedback Received: Consumer Voice and Advocacy Projects

CoMHWA regularly undertakes systemic advocacy to government regarding the importance and benefits of strengthening people's health care rights and improving their experiences as they navigate and interface with mental health services, systems and the broader community.

Core to strengthening people's rights and improving experiences, in addition to adequate investment in the right mental health supports, are the following pillars of support:

1.Adequate access to independent, individual advocacy services to resolve issues, such as barriers to accessing services.

2.Adequate information, advice and education to assist people to understand their options, to make informed decisions and to seek further support if they wish

to, such as in managing stigma and discrimination by services, in communities and in the workplace.

3.Adequate representation by and for mental health consumers in decision making settings where consumers' interests are at stake. This is a necessary system component to enable the voices of people using services to be heard and to have an influence on decisions made, including through representation within services, and through representation to government at local, regional, state and territory and federal levels of government, on matters relating to mental health and suicide prevention. This must be accompanied by an adequate infrastructure and investment in mental health consumer representative networks, training, coordination and support. It must also include collective forums and by consumer representatives to advocate with services at various levels of the system, which are commonly known as Consumer Advisory Group s(CAGs), Lived Experience Advisory Groups (LEAGs) and Consumer-led Organisatoins. These bring together consumers in an ongoing group setting to explore and air issues affecting mental health consumers and to offer robust representation and advice as a consultative group to services and/or

The need for these initiatives is equally present in rural areas based on state-wide research we have conducted on consumer engagement and mental health advocacy issues[22]. All of the above strategies are inadequately resourced in both metropolitan and rural areas of Western Australia (as with other states and territories). However, this inadequate resourcing is more pronounced and has additional impacts in rural areas. This includes, for example:

- This submission has shown significant problems with the quality, accessibility and availability of services that indicate many consumers are experiencing sub-optimal care and rejection from services, which indicates the need for access to more individual advocacy and a stronger voice for communities over the design and delivery of mental health supports;
- Waitlists, lack of resourcing and lack of specialist training and skills for mental health advocacy, are significant barriers to accessing individual advocacy services, as with other types of services in rural communities;
- Lack of progress in the peer workforce (workers deployed on the basis of lived experience of recovery, to directly support individual recovery or advance rights and recovery approaches within services);
- Lack of consumer participation, limited and ineffective consumer participation arrangements due to lack of resourcing for dedicated staff, for travel costs of consumers and for consumer training and support;
- Limited representation of rural consumers on state-wide committees due to travel, training and support costs not being accommodated. This leads to lack of opportunity for rural consumers to have a voice in raising rural community concerns at a state and national level;
- Very limited and uneven availability of peer groups (mutual support groups) for people to access mutual support, social connection and informal advocacy. This is seen as an essential component for people with disabilities in the National

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[22] CoMHWA, 2017 and additional consultations undertaken from 2014-2016 in relation to NDIS and mental health in rural areas.

Disability Insurance Scheme but is minimally available in rural areas, and for people with mental health issues who do not identify with disability.

Lack of opportunities for consumer to connect and act together for change can create an ongoing cycle of stigma, disempowerment and isolation. Overcoming stigma in communities relies on key members of the community championing more contemporary understandings of mental health and it is easier to do so in numbers, rather than in isolation. We have been supporting individual consumer leaders in several major regional centres who are unable to secure funding for people with lived experience to connect with one another, such as peer support groups and consumer advisory groups. These leaders are at high risk of burnout due to the over-reliance of both consumers and services to provide them with advice, support, advocacy and representation, and are under immense pressure to be the sole person 'out, open and approachable' about mental health in their communities. They need greater support to be part of a local movement of lived experience leaders for change.

# <u>Recommendations</u>

## Rural Equity

Across all other recommendations, below strive to maximise equal quality of life and opportunity for members of rural communities through:

    i. Funding allocations for programs that are sufficient, adequate, and rationally and transparently distributed to take into account rurality of each state, territory and regional area;

    ii. Adequate consultation with regional and local communities as part of commissioning and planning of services to ensure these meet community needs.

## Funding for Mental Health and Suicide Prevention and Intervention Services and Supports

1. **Increase funding across the spectrum of mental health and suicide prevention and intervention services and supports.**

   Based on community feedback we recommend investment in:

       iii. Psychosocial community services particularly for people not eligible for the NDIS;

       iv. Greater access to free or low-cost counselling and psychology services;

       v. Recovery-focused and trauma informed crisis support services, with a focus on faster response and more out-of-hours support options. Example types of crisis support services are the ALIVE program, step up step down facilities, peer hospital to home programs, clinical outpatient outreach services, and Hospital in the Home;

       vi. Community hubs, programs, groups, activities and outreach that assist people to stay socially connected, learn about wellbeing issues and strategies, navigate service options, sustain mental health and emotional wellbeing and access counselling and referrals to relevant services and supports;

       vii. Ongoing cultural healing programs for Aboriginal communities;

       viii. Individual advocacy services, including culturally secure mental health advocacy services, to assist people who may face stigma, discrimination and cultural and other barriers to service access;

       ix. Alcohol and other drug treatment and support services, in addition to mental health services;

       x. Improved service navigation supports and greater access to education and training that equips services and community members to reduce stigma and assist people to recognise and seek appropriate supports for mental health wellbeing and recovery;

       xi. Improved recovery-focused culture initiatives (e.g. policies, core training and leadership initiatives, uptake of the peer workforce) in public clinical mental health services;

## Transport Assistance

2. **Review, identify and resource evidence-based and cost effective solutions to overcoming transport barriers to service access within rural and remote areas.**

   This includes to:
   i.   Provide for individualised transport funding subsidies within, or similar to, Patient Assisted Travel Schemes (PATS) that can be accessed for non-medical mental health services, such as psychology, counselling and psychosocial community services and support groups.
   ii.  Expand PATS eligibility to access to public mental health services other than psychiatry, such as psychologists, day programs and other rehabilitation programs;
   iii. Increased subsidies through PATS to reduce the significant out-of-pocket expenses that are still incurred within the PATS scheme;

## Supporting Resilience and Recovery in Rural Communities

3. **Support the conditions for social, cultural and economic resilience though greater access to the range of infrastructure, opportunities, services and supports that assist people to sustain quality of life and overcome hardships.**

   Based on community feedback, this includes to:

   i.   Work proactively across all levels of government to regularly engage with communities to identify emerging issues and locally relevant solutions in the area of regional community social, cultural and economic resilience, such as unemployment and job creation, droughts/floods and financial relief.

   ii.  Increase availability and access to the holistic range of health, social and community services that assist in providing community (emergency) relief, financial advice, assistance with training, employment and small business, family supports and community and social connections.

## Voice and Partnership with Rural Communities (Mental Health)

4. **Adequately resource and support local (regional and sub-regional) mental health and suicide prevention lived experience advisory groups through which individuals, families and carers affected by mental health and/or suicide can shape improved solutions and responses suited to local community needs.**

   Resourcing should enable advisory groups to undertake the following activities:

i. Consulting on, identifying and advocating for local needs and appropriate local responses to mental health and suicide prevention issues;

ii. Undertaking local awareness raising, navigation assistance and stigma reduction initiatives

iii. Alerting funders to resilience and suicide risks and emerging patterns of suicide within their region for promote timely prevention n and intervention;

iv. Partnering with community stakeholders and services in the design and delivery of quality, effective and locally suitable mental health and suicide prevention initiatives.

v. Championing and influencing recovery and acceptance within communities and services through lived experience education to services and the general community.

vi. Liaison, coordination and support relationships with state and federal consumer and carer representative bodies to inform appropriate policy and commissioning responses to rural issues at state and national level.

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# Appendix 1. Information about the Senate Inquiry

***Accessibility and Quality of Mental Health Services in***

***Rural and Remote Western Australia***

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

On 19 March 2018, the Senate referred the following matter to the Senate Community Affairs References Committee for inquiry and report:

The accessibility and quality of mental health services in rural and remote Australia, with specific reference to:
(a) the nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate;
(b) the higher rate of suicide in rural and remote Australia;
(c) the nature of the mental health workforce;
(d) the challenges of delivering mental health services in the regions;
(e) attitudes towards mental health services;
(f) opportunities that technology presents for improved service delivery; and
(g) any other related matters.

Submissions are sought by **11 May 2018**. The reporting date is **17 October 2018**.

While the committee has requested that submissions to the inquiry be received by **11 May 2018**, it will continue to consider and accept submissions after this date. As a large number of submissions may be received for this inquiry, including many of a sensitive and personal nature, there may be a delay between your submission being received and it being considered and approved for publication by the committee. This process may take a number of weeks. Thank you for your patience in this matter.