



The Chair
Senate Standing Committees on Community Affairs
Parliament House
Canberra ACT 2600

Dear Senator

Accessibility and quality of mental health services in rural and remote Australia

We welcome the Committee's inquiry into these significant issues. I am pleased to tender this submission on behalf of Rural and Remote Mental Health Ltd to the Committee.

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1. Introduction

Although this inquiry is primarily focused on the accessibility and quality of *clinical* mental health services, Rural and Remote Mental Health's submission identifies and focuses on the significant gap that now exists between clinical mental health services and community-based prevention services. Prevention services are crucial for all rural and remote Australians, especially sub-groups which have been identified at high risk of mental ill-health and suicide. This submission outlines the statistics and risk factors associated with living and working in rural and remote Australia and the rationale for prevention programs linked to early interventions which alleviate the demand for clinical services. It provides examples of solutions which have significant, positive impact and outcomes.

2. About Rural and Remote Mental Health Ltd

Rural and Remote Mental Health's (RRMH) programs and services are for people who live and work in rural and remote Australia. RRMH champions proactive, preventative and culturally-tailored initiatives for rural and remote communities.

RRMH is committed to developing, delivering and evaluating practical outcomes by raising awareness and focusing on mental health, suicide prevention and early interventions for those who are vulnerable and at risk in rural and remote Australia.

RRMH focuses on expanding the reach and impact for those whose social, health or economic circumstances expose them to a higher risk of suicide by providing evidence-based interventions thereby increasing their knowledge, resilience and help-seeking behaviour.

RRMH is a not-for-profit public company limited by guarantee with deductible gift recipient status. It is a virtual organisation with staff, consultants, trainers and presenters spread across each state and territory.

The key programs developed and delivered by RRMH are:

- **Rural Minds** – for agricultural and farming communities
 - **Rural Minds for Resourceful Communities**
- **Deadly Thinking** – for Indigenous communities
 - **Deadly Thinking Youth**
- **Resource Minds** – for the mining, quarrying, resources and remote construction sector
- **Mental Health for Leaders**

RRMH's programs:

- Deliver comprehensive and demonstrably effective prevention programs linked directly to early interventions (in this context 'early' includes interventions not only targeted at young people but anyone with minimal but detectable symptoms of psychological distress) ;
- Raise awareness, reduce mental ill-health stigma and prevent suicides;
- Have been measured, evaluated and the outcomes translated;
- Educate, train and empower the local workforce, natural helpers and community leaders, to embed skills and knowledge in their communities where access to health and/or mental health clinicians is either severely limited or non-existent; and
- Inform individuals, families and communities about self-help strategies and pathways to help.

Summary of Outcomes from RRMH Programs

All RRMH programs have and continue to be independently evaluated. The results of this research have been used to inform the enhancement of the programs and to advocate for their value in rural and remote Australia. Further, the results will continue to be analysed and published in the future.

Rural Minds

Key evaluation findings:

- The majority of participants agreed that they felt they were more comfortable talking about mental health issues (88%) and that they could use the information to help others (93%).
- The percentage of participants who indicated they would seek help for mental health issues from a mental health professional (i.e. a psychologist) increased from 6% to 31% for trainers and from 19% to 36% for the community participants.
- Approximately 90% of the Train-the-Presenter participants were confident they knew about the early warning signs of mental distress and 85% were confident they would know how to support others experiencing a mental health crisis.
- Preliminary results indicate that commonly identified barriers towards help seeking among participants were reduced following workshop participation.

Deadly Thinking

Key evaluation findings:

- More than half of respondents identified family worries as the most common source of stress and a more than a third were concerned with racism, loss of culture and violence in the community.
- Overall 95% of all survey respondents indicated that the Deadly Thinking training changed their attitudes to social and emotional wellbeing.
- Deadly Thinking training - and trainers specifically - were highly rated by survey respondents, with 96% reporting that Deadly Thinking overall was helpful.
- The most commonly endorsed take home message among trainers and community participants was that it helps to have a yarn about mental health issues.

Resource Minds

Key research findings which have informed the development of and provided the evidence base for Resource Minds are contained in Bowers, et al, Psychological distress in remote mining and construction workers in Australia to be published in the Medical Journal of Australia on 14th May

Key evaluation findings:

- An overwhelming number of workers believe that mental health is an issue in the mining industry and should be addressed like physical health and safety. More than that, over 95% of workers believe that there is a stigma surrounding mental health in the workplace.
- The majority “took away” something positive from the mental health program, in particular they understood that mental health issues were more common than they realised, that there is nothing to be ashamed of if they had an issue and it really helps if they talk to someone.
- Everyone thought that having essential information on mental health and emotional wellbeing helped them understand and better deal with their own mental health.
- Most workers believed that the toolbox talks including the videos were very engaging, effective and helpful.
- Over 70% indicated that they had recently spoken to a family member or a workmate about mental health - either their own or their family or mates.
- Over 80% of participants thought that the company which had committed to the program and facilitated the roll-out was a better employer as a result of addressing mental health and suicide prevention in the workplace.

3. Summary of challenges and statistics

It is well known and widely cited in the published literature that Australians living and/or working in rural and remote Australia are at greater risk of completing suicide and this increases with remoteness. Not only do they face individual, historical and environmental risk factors such as:

- A family history of mental illness
- Personality factors (e.g. having low self-esteem, being self-critical)
- A lack of social support
- Substance abuse
- Certain medications
- Stressful or traumatic life events, including:
 - A history of child abuse
 - Physical or sexual assault
 - Major injury or illness
 - Chronic pain
 - Death of a loved one
 - Relationship difficulties
 - Separation and divorce
 - Child Custody issues

- Financial problems
- Legal problems
- Bullying
- Being lesbian, gay, bisexual or transgender in an unsupportive environment

There are often work-related risk factors including:

- A lack of access to communications
- A lack of social support from the workplace or community
- High workloads
- Time pressures and pressure to produce
- Long periods of concentration
- Fatigue
- Long working hours
- Shift work
- FIFO induced “split-lifestyles” – including long periods of separation from family and friends
- High risk work locations (e.g. heights, over water, underground)
- Harsh climatic conditions
- Exposure to a traumatic event
- A male dominated workplace
- Workplace bullying, discrimination and harassment
- A culture that stigmatises mental illness and help-seeking
- Job insecurity resulting from changes to commodity prices and demand

As a result of these challenges, therefore, they have a higher prevalence of mental distress, they experience more stigma surrounding mental health, they are stoic and exhibit poor help seeking behaviour and they have greatly reduced access to clinical services when compared to Australians living in our cities.

Around 29% of the Australian population live and work in rural and remote Australia [1].

While the prevalence of mental disorders is similar throughout Australia, **rates of suicide and self-harm are higher in remote and rural areas and rise with increasing remoteness [2, 3]. Suicide rates are 40% higher than that of major capital cities [4].**

Farmers, young men, older people, and Aboriginal and Torres Strait Islander Australians in remote areas are at greatest risk of completing suicide [5], due to the compounding social determinants of health of these demographics and geographic location [3].

Men in rural and remote areas experience higher levels of psychological distress [1,6]. The rate of suicide among men aged 85 years and over who live outside major cities is around double that of those living within them [5].

In rural areas there is often apprehension around help-seeking and a fear of the stigma associated with mental illness - particularly in smaller communities where individuals are more visible, and confidentiality may be less assured [7]. Hence a localised ‘whole of community’ educational approach is essential.

It is acknowledged that, to date, there is a paucity of evidence in terms of a return on investment (RoI) and impact and outcomes of primary and secondary prevention programs. However, PWC [12] is helpful in assessing the economic returns for prevention programs for at risk groups in the workplace and estimated that for every \$1 an organisation invests in workplace mental health,

there is, conservatively, a \$2.30 return and in the mining sector the RoI can be \$15 for every dollar spent.

As outlined above, rigorously and ethically obtained evidence is emerging from RRMH's prevention programs targeted at "at risk" sectors of rural and remote Australia. The evidence to date indicates the programs have significant positive outcomes which include improved early help-seeking behaviour and attitudes, greater confidence in talking to professionals, family and friends and ultimately reducing stigma thereby indicating the potential for returns on investment in these programs.

4. Solutions - Prevention programs and early interventions for rural and remote Australians

Rationale

As a result of working in rural and remote Australia for over 11 years, RRMH believe a significant gap has emerged in the delivery of primary and secondary prevention initiatives which target respectively:

1. Entire population groups e.g. rural and remote Australians; and
2. Subgroups of this population who are at a heightened risk of developing a mental disorder, including high-risk people who are identified as having minimal but detectable symptoms and signs and vulnerable groups such as Indigenous communities, farming and agricultural communities and mining and resource sector workers.

The gap in prevention has been heightened following systemic service reforms by both Commonwealth and State Governments, including cost shifting and role changes between governments. There now appears to be limited government priority placed on and resources directed towards comprehensive primary or secondary mental ill-health and suicide prevention programs for these target groups particularly in rural and remote areas.

The Primary Health Networks commissioning and reporting is focusing on primary care and tertiary prevention, with limited funding allocated to secondary prevention, in particular [8].

There is also limited acceptance of responsibility for or understanding of the economic and productivity impact of mental health in the many government portfolios related to rural and remote Australia.

The impact of these portfolio challenges needs to be recognised more broadly, outside the mental health sector. This would improve co-ordination, a continuum of services and address the current gap in services, particularly prevention.

Further, RRMH believes that rural communities deserve services across all levels of the care spectrum from prevention and early intervention through to primary and tertiary care services. Rural communities deserve accessible, face-to-face programs to raise awareness about mental health and wellbeing and to promote the local (as well as online) support pathways available.

Solutions

Prevention programs

Rural and remote communities vary and have different societal concerns and environmental issues which require culturally-tailored, awareness-raising and prevention programs to improve early help-seeking behaviour. Programs need to embed capacity within communities, thereby reducing the pressure on the limited primary care and mental health services as well as improving access to suitable services for high risk individuals. RRMH programs are specifically tailored to help rural communities with these challenges.

RRMH considers that there needs to be greater emphasis on disseminating knowledge and education to mitigate developing a mental illness in rural and remote Australia and to support those experiencing the stigma associated with mental illness. This emphasis can be re-enforced by ensuring there is a seamless transition of prevention programs to early-interventions via e-mental health and suicide prevention services.

RRMH supports the urgent need for clinical interventions through to tertiary care for those experiencing mental ill-health and those at risk of suicide. RRMH applauds the initiatives announced in the 2018/19 Budget to increase the funding for clinical services through the RFDS and the commitment to recruit, teach, train and retain additional doctors and nurses for rural and remote areas.

However, we consider that promotion and prevention linked to an early intervention are critical to addressing and alleviating the ever-increasing demand on primary care and rural mental health services. A greater focus on preventative strategies will ensure a seamless, continuum of service from an early intervention through to clinical care and support.

Local community knowledge and awareness is also essential for encouraging support and safety in the absence of accessible, local mental health services.

Early Interventions

RRMH considers that face-to face education and services in rural areas are ideally suited to breaking down stigma, starting community conversations and improving help-seeking behaviour.

However, we acknowledge the importance of linking prevention programs with culturally tailored e-health interventions for ongoing and accessible support for rural and remote Australians. Multiple studies have shown that e-health interventions either online or via an app can be as effective as traditional therapies [9, 10, 11]. Additionally, computer-aided psychotherapy has been shown to:

- Be as effective as face-to-face psychotherapy.
- Expedite access to care.
- Break down barriers to help-seeking (e.g. stigma of face-to-face services, saving in traveling time).
- Sustain engagement.

Online opportunities exist for connecting people on their mobile phone, tablet or computer with wellbeing programs, counsellors or mental health professionals.

E-mental health can reduce mental health inequities, by targeting at risk population groups that have limited, local access to treatment and may most benefit from services. Governments, service organisations and communities also benefit from e-mental health programs, due to the low cost and efficiency of this mode of service delivery. Of course, this depends on the availability of accessible, reliable internet access.

5. Advocates for prevention services and strategies

The approach RRMH has adopted produces a significant impact that is consistent with the expert views outlined below from the National Mental Health Commission (NMHC), the Royal Flying Doctor Service (RFDS), The Black Dog Institute and many others.

- The National Mental Health Commission indicated the need to shift funding away from Disability Support Pensions, acute care, carer payments and MBS payments towards self-help, prevention and early intervention, psychosocial/non-clinical supports, and primary and

community mental health services [8, 14].

- RFDS identified that health promotion and prevention are areas where money should be spent to improve health outcomes for remote and rural communities as there is good evidence that health promotion and prevention activities can improve health outcomes [3]. Mental health and social and emotional and wellbeing programs in rural and remote Australia need to incorporate ten key components recommended by RFDS:
 1. “Be provided in identified areas of need;
 2. Focus on prevention and early intervention;
 3. Be evidence-based and evaluated;
 4. Be locally relevant, address community risk factors and include input from the community, consumers, carers and Indigenous Australians in decisions about new services;
 5. Take a social determinants of health approach and be holistic;
 6. Be implemented in collaboration with other organisations delivering mental health and Social Emotional Wellbeing services;
 7. Be implemented in collaboration with consumers, families and carers;
 8. Be culturally appropriate and safe;
 9. Be provided with a comprehensive primary health approach; and
 10. Facilitate access by all members of the local community.”
- The Black Dog approach [13] to the successful implementation of suicide prevention activities is contingent on the PHNs sourcing, selecting, and commissioning appropriate services. In summary, their approaches, which do not preclude the delivery of mental health prevention programs and early interventions, propose:

Identify existing programs - Collaborate with communities as repeated exposure to a message is likely to have a greater impact on information retention.

Ensure accurate and targeted messaging – This can be delivered by prevention programs delivered through community engagement processes and linkages to community suicide prevention networks.

Encourage effective marketing – Information about the causes and treatments for suicide risk increase community knowledge. Awareness messages include suicide warning signs, resources for referral and help within the local community.

Incorporate lived experience – Interventions aimed at reducing mental health stigma and discrimination are most effective when they involve individuals with lived experience of mental illness [13].

6. Recommendations

1. ***There must be a greater commitment to prevention services which can engage with rural and remote Australians in a culturally sensitive way to:***
 - a. *mitigate developing a mental illness;*
 - b. *support those experiencing stigma; and*
 - c. *connect those at risk with suitable support services.*
2. ***Mental health promotion and suicide prevention strategies are critical to addressing and alleviating the ever-increasing demand on primary care and rural mental health services and to promote the services that are most suitable.***

- 3. *Through e-mental health and related technologies there is now the opportunity to ensure a seamless transition from prevention to early-identification and interventions through to clinical services.***
- 4. *The COAG Health Council should be tasked with commissioning the development of a rural and remote mental health strategy to, for example, map existing services, identify gaps, clarify jurisdictional responsibilities between governments and engage with portfolios associated with rural and remote industries.***
- 5. *The National Mental Health Commission should be tasked with monitoring and overseeing implementation of the strategy, reporting directly to the COAG Health Council.***
- 6. *In summary, there are currently insufficient mental health services in rural and remote Australia. However, with the initiatives announced by the Government in the 2018/19 Budget, long-term strategies are now in place to alleviate the deficit of clinicians and services. It is now the responsibility of all governments to bridge the gap for at risk groups with culturally relevant prevention programs and timely, accessible early interventions.***

Yours sincerely

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