



**Submission to the Senate Community Affairs References Committee inquiry into  
Accessibility and quality of mental health services in rural and remote Australia**

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## Preface

The Mental Health Council of Tasmania (MHCT) is a member based peak body. We represent and promote the interests of community managed mental health services and have a strong commitment to enabling better mental health and wellbeing outcomes for every Tasmanian. MHCT welcomes the opportunity to respond to the Senate Community Affairs References Committee's inquiry into the accessibility and quality of mental health services in rural and remote Australia.

MHCT's submission is based upon consultation with our members and the broader public, both in direct response to this inquiry, and through previous consultations. To ensure a broad range of input from all regions of Tasmania, MHCT developed and distributed an online survey as our primary consultation method. This method has allowed for feedback from consumers, carers and family members, service providers, and other community members with direct or indirect involvement with the mental health sector, such as emergency service responders, teachers, nurses etc. MHCT wishes to emphasise that whilst our submission is based upon targeted consultation and discussion with direct reference to the current inquiry, many of the concerns and recommendations raised have been previously articulated through earlier inquiries and consultation mechanisms.

Finally, we note that the submission is structured to reflect the terms of reference of this inquiry, but some grouping has taken place to reflect the difficulty of separating out certain themes and issues as they pertain to rural and remote Tasmanian communities.

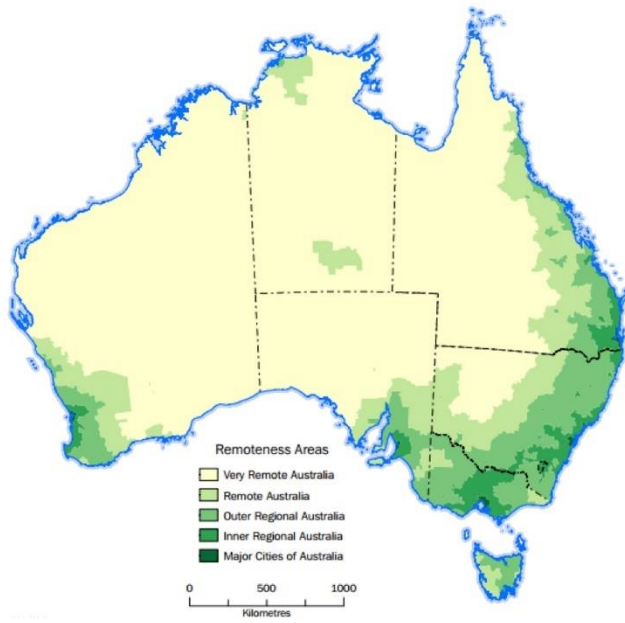
## Determination of the term 'rural and remote' for the purpose of this submission

In line with the Australian Bureau of Statistics document, 'ASGC Remoteness Classification: Purpose and Use' for the purpose of this submission, MHCT has classified the entire state of Tasmania as rural and remote, in line with Tasmania being regarded as rural or remote when considered within the context of the whole of Australia.

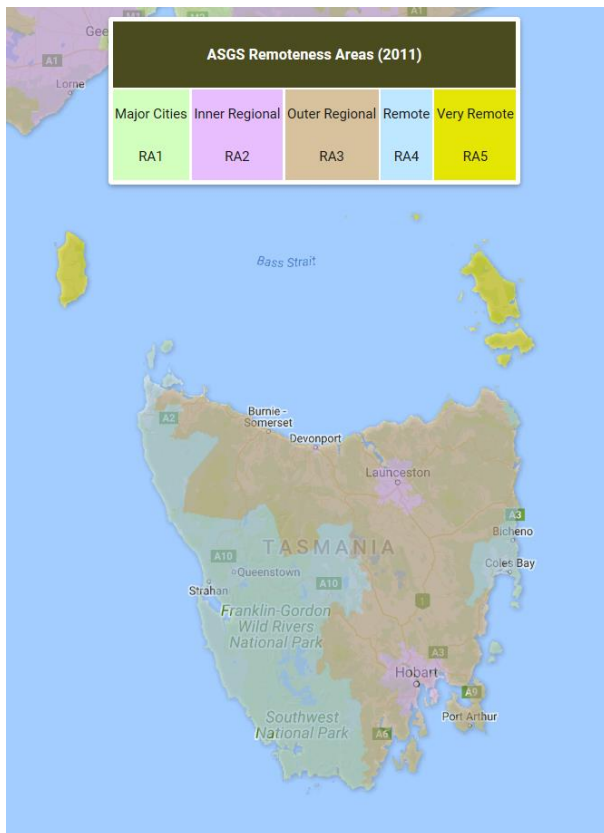
The ABS asserts:

*There is no widely accepted standard which determines just exactly where the 'city' becomes the 'country', i.e. how remote is remote. The boundary between RA classes is therefore relatively arbitrary. The ASGC Remoteness classification simply groups areas into classes where all members of a class have similar, but not identical, characteristics of remoteness. The underlying measure of relative remoteness is also an all of Australia view. Thus remote parts of Tasmania are remote because of their location in the context of Australia not their location within Tasmania.<sup>i</sup>*

Within the framework of a national inquiry, Tasmania's rural and remoteness in the context of the whole of Australia is important to represent. Organisations such as The Royal Flying Doctor Service (RFDS) use the term 'rural and remote' to describe all areas outside Australia's major cities. This includes areas that are classified as inner and outer regional (RA2 and RA3 respectively) and remote or very remote (RA4 and RA5 respectively) under the Australian Statistical Geography Standard (ASGS).<sup>ii</sup> The entirety of Tasmania falls under these categories, as represented in figure 1 and 2 below.



**Figure 1.**  
2011 Australian Statistical Geography  
Standard remoteness structure<sup>iii</sup>



**Figure 2.**  
2011 Australian Statistical Geography  
Standard remoteness areas – Tasmania<sup>iv</sup>

## Section One

### Terms of reference addressed:

- a) 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
  - e) Attitudes towards mental health services
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Many factors influencing the mental health of people in rural and remote locations are intensified by qualities unique to their local environments. A lack of access to mental health services within these areas can then further increase the severity and prevalence of mental health conditions. Our consultation has shown that social isolation is a highly influential factor, impacting on the mental health of rural and remote Tasmanians, with 83% of respondents indicating social isolation as a key contributing factor impacting on the mental health of individuals within Tasmania. Whilst social isolation rated highly, it was also closely followed by concerns such as stress (76.42%), alcohol and other drug use (75.61%), unemployment (73.98%), lack of income (67.48%), and trauma (61.79%). Further factors highlighted included negative community attitudes about mental health issues (stigma), lack of community support, lack of housing, violence, and limited access to transport. Additionally, other respondents highlighted further occupational and environmental factors which can be considered unique to rural and remote environments, such as, “adverse seasonal conditions”, “some farmers can do excessive hours of work per day – [impacting on] lifestyle balance,” and “high risk occupations, climate change factors and easy access to [fatal means] ... eg. firearms.”

These additional influences unique to, or exacerbated by, rural and remote locations also provide invaluable insight into factors that may contribute to the higher rates of suicide in rural and remote Australia. When asked about their thoughts on the reasons suicide rates are higher in rural and remote areas, many within our consultation group emphasised social isolation as a significant factor

in higher suicide rates. Our consultation received a large amount of feedback highlighting the complexities of this issue, further emphasising that for many rural and remote communities, the impact of suicide is intensified due to the size of communities. One individual in response to our consultation reinforced this perception, stating:

*“Rural and remote suicides rates are complex and [require] a multi-dimensional approach. Social isolation and the socio-economic marginalisation of rural and remote communities are contributing factors requiring upstream preventative and public health approaches rather than the downstream curative psycho-medical approach. The legal and social implications of suicide are further exacerbated in rural and remote contexts.”*

Further to social isolation, other factors contributing to the higher rates of suicide included unemployment, stigma in accessing mental health services, and geographical distance from, and a lack of access to, mental health services. One consumer consulted explained how geographical distance can be a huge barrier alone, but for many people located within a rural or remote area, there are a combination of other circumstances also influencing their ability to access services:

*“I have to travel 230km return to see a psychologist. I'm very disabled and it takes a lot to get ready and travel the three-hour return trip for a 1 hour appointment. Most people can't do this, especially without a support person to help them.”*

Survey respondents have highlighted a number of reasons why rural and remote Tasmanians access mental health services at a much lower rate. Whilst geographical location is an obvious barrier for many, 82% of respondents also identified having limited access to a range of services as a challenge, with another 78% of respondents highlighting the challenge of knowing what supports are available. Additionally, over 50% of our respondents indicated other impediments including service costs,

admitting and recognising a need for support, and transport to services as other stated challenges. Further to this, anecdotal evidence from our consultation suggests that often access to GPs in rural and remote areas may be limited, and that GPs who are available may not always be equipped and skilled to deal proactively with mental health concerns.

Our consultation has highlighted how often barriers to accessing services, and factors contributing to higher rates of suicide, are rarely experienced in isolation of one another, and how many respondents experience a combination of these challenges. This combination can result in some individuals having no access to services, whilst also being more susceptible to influences that are known to contribute to a higher risk of suicide. Due to this combination, rural and remote communities face an increased level of vulnerability.

## Section Two

### Terms of reference addressed:

#### c) the nature of the mental health workforce

#### d) the challenges of delivering mental health services in the regions

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Other than Hobart and surrounds, all of Tasmania is classified as a district of workforce shortage for psychiatry in accordance with The Australian Government's Department of Health Doctor Connect resource (figure 3). When asked about the challenges in delivering services within rural and remote locations, respondents within our consultation groups indicated that gaining initial access to services in Tasmania is challenging, and may involve significant waiting periods, with one consumer stating:

*"There are not enough psychologists to see the number of people who are needing help. Waiting lists are too long and if someone is already reluctant to seek help, being told that a mental health provider is not taking new patients, it makes them shy away from asking for help again."*



**Figure 3.**

Districts of Workforce Shortage for Psychiatry,  
ASGC-RA (2006) <sup>v</sup>



In addition to already acknowledged workforce shortages, MHCT members have previously raised significant concerns about the impact of NDIS rollout on the nature of the Tasmanian mental health workforce. This issue was raised consistently again by providers of mental health services during our consultation for this inquiry. During discussion surrounding the main challenges in delivering and accessing mental health services in rural and remote Tasmania, one provider asserted:

*“Having access to good quality and consistent mental health services. Psychiatrists and psychologists often change and then the person has to start all over again. Also gaining access can be an issue and there are only so many appointments they can attend. Programs are now closing due to the NDIS and people are more likely to fall through the gaps if they are unsure as to whether they can apply or be accepted by the NDIS.”*

Within previous consultations on the impact of the NDIS, individuals who discussed this topic with us indicated that as the funding for current community- delivered psychosocial support programs dries up – namely, Partners in Recovery (PIR), Personal Helpers and Mentors Scheme (PHaMS), Day to Day Living (D2DL) and Mental Health Respite: Carer Support (MHR:CS) – there is an equivalent and increasing loss of staff. In fact, a number of our members say they expect most program staff to turn over completely and that they will require an entirely new workforce to come on board in order to deliver supports under the NDIS.

Other workforce impacts include the shift to casualisation, reflecting the fact that organisations can only afford to pay staff per unit of care that they deliver, and the loss of professional development opportunities, supervision, and career pathways within the sector. These are significant structural and cultural shifts for individual workers and organisations to grapple with, but they also present very real challenges for the mental health sector as whole. Without the introduction of targeted strategies to retain staff and sustain organisations through this period of transformative change, we

risk losing much of the acquired skill and expertise within Tasmania's community mental health workforce.

The NDIS is also impacting on the nature of the mental health workforce with specific reference to isolated Tasmanians through not adequately considering the direct and indirect travel costs of consumers or providers within plans. This creates a number of difficulties for both consumers within rural and remote areas of the state already limited in their access options, and also for providers who are either having to operate at a loss to provide services to these consumers, or are simply unable to provide any supports at all.

The NDIS is quickly becoming one of the biggest challenges to delivering mental health services in particular to rural and remote communities, and can also be considered to be one of the most influential factors that is impacting on the nature of the mental health workforce within Tasmania. We are beginning to see the impact of this on the future of Tasmania's already limited sector, with some specialist mental health service providers reporting that they have elected not to offer NDIS services, others indicating they will reduce the number or type of services they offer, and still others considering merging with generalist disability providers. This leaves a question mark hanging over the survival and viability of many individual service providers, but also over the sector as a whole, as a reduction in individual organisational service capability inevitably means a reduction in overall sector capacity.

## Section Three

### Terms of reference addressed:

#### f) opportunities that technology presents for improved service delivery

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Our consultation has indicated initial positive attitudes towards using technology to support access to mental health services, with 68.03% of respondents indicating they would be comfortable in doing so. Of these, respondents indicated video link or skype from home, mental health web-pages and live chat as the most appealing options. Whilst this is positive feedback, many also emphasised the importance of technology being utilised in conjunction with traditional face to face services, rather than a standalone support option, with one respondent asserting:

*“Maybe for maintenance appointments but initial assessments and initial appointments need to be in person to build rapport.”*

Whilst this initial feedback does indicate that there are potential opportunities for technology to be used to improve service delivery, 22.13% of respondents did not feel comfortable using technology to access mental health services, naming concerns such as:

*“The internet in Tasmania does not necessarily make using a technology based service delivery enjoyable. Drop outs and lagging can make an interaction unenjoyable.”*

*“These services are a great idea, but are not necessarily viable for a large portion of vulnerable people in remote areas due to lack of access to technology, or lack of knowledge on how to utilize it properly.”*

*“It sounds like a grand idea, though here we operate on 3 G, yes 3G not 4G, the internet is VERY unreliable and drops out often, there are no more ports for people to get internet so the options are very expensive which does not make it any more reliable, the library is open*

*less than 10 hours a week, and we can often go all weekend with no internet and did I say it is very slow. It is not a good idea because it is not reliable.”*

Whilst our member consultation survey did indicate positive responses towards the use of technology for improved service delivery, MHCT wishes to highlight that this was an online survey, therefore only sampling populations which do have internet access. As such, we believe it is important to emphasise that within Tasmania, access to the internet, particularly in rural and remote areas of the state, is limited and in some cases, non-existent.

The 2016 Australian census indicated that 19.5% of Tasmanians did not have internet accessible from their home, and whilst these statistics do show that 78% of Tasmanians do have access to the internet from their home<sup>vi</sup>, this data does not take into consideration access reliability, affordability or individual digital ability, which are all factors that impact on the realistic usability of these potential technological opportunities for improved service delivery.

A more in-depth indicator of Tasmania’s digital divide is the Australian Digital Inclusion Index. In 2017, Tasmania’s Australian Digital Inclusion Index (ADII) score was 49.7, with Tasmania’s score being the lowest of any state or territory in Australia. This score was consistently the lowest nationally across all three sub- indices, with these being:

Access (Tasmania scored 63.2, against Australia’s national average of 69.6),

the Affordability measure (45.8, against 52.7 nationally), and;

Digital Ability (39.9, against 47.3 nationally)<sup>vii</sup>

As such, whilst there is some initial positivity from our sample group surrounding the potential opportunities that technology presents for improved service delivery, there is also significant digital

disadvantage state-wide and MHCT would urge this to be a key consideration in any future initiatives.

## Conclusion

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Our consultation has identified a number of consistent challenges for Tasmanians in regards to their mental health and access to support services in rural and remote locations, as well as a number of recommendations and considerations. The key concerns raised consistently throughout our consultation include:

1. Lack of available services
2. Lack of knowledge of appropriate and available services – particularly amongst consumers, carers and families
3. Stigma attached to accessing mental health services, particularly in smaller communities
4. Combined barriers when attempting to access services, including but not limited to, geographical barriers, transport challenges and cost concerns
5. Social and geographical isolation particularly in relation to higher rates of suicide
6. Digital, meaning potential opportunities that technology presents for improved service delivery are reduced

These key concerns have been raised consistently throughout our consultation, by consumers, carers and family members, service providers and other community members. Combined, these challenges not only contribute to increased vulnerability for rural and remote communities, but also to an alarming level of individuals who find that they unable to access services in areas that are already experiencing higher rates of suicide.

## Recommendations

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In response to the diverse and valuable feedback we received during our consultation period, MHCT writes to make the following recommendations:

1. Implement strength and capacity building programs to empower rural and remote communities to respond and support the improvement of mental wellbeing and minimise social isolation.
2. Identify successful technological supports that can be adapted to cater for communities which experience digital disadvantage while ensuring that any technological initiatives are not implemented in isolation of traditional support methods.
3. Adopt targeted initiatives to increase individual capacity to access supports, to lessen the impact of direct and indirect obstacles experienced by rural and remote communities. Eg increased costs, transport needs, the need to take time off work to travel etc, that are often experienced by rural and remote communities.
4. Develop and implement professional and community education strategies specifically tailored for rural and remote communities, to decrease stigma and increase community knowledge - including information on various mental health conditions, available service options, access options, wait times and alternatives.
5. Ensure a range of step-up and step-down supports are available within rural and remote locations to provide consumers, carers and families with individualised supports. This should

be delivered in conjunction with processes that will identify the changing level of support needs within these communities, and then respond to these accordingly.

6. Consider the need for improved infrastructure such as localised service directories and client centred records to provide both professionals and consumers with the tools and knowledge to make individualised choices about their care, allowing a streamlined transition between services and an overall strengthening of care pathways.
7. Implement a workforce strategy tailored to suit the unique needs and environments of rural and remote communities. This strategy should include tailored solutions to addressing specialist workforce shortages, whilst also upskilling the existing workforce.



## References

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- <sup>i</sup> ABS . Census Paper 03/01 . ASGC Remoteness Classification: Purpose and Use: Remoteness Area Classes "How Remote Is Remote?"  
[http://www.abs.gov.au/websitedbs/d3110122.nsf/0/f9c96fb635cce780ca256d420005dc02/\\$FILE/Remoteness\\_Paper\\_text\\_final.pdf](http://www.abs.gov.au/websitedbs/d3110122.nsf/0/f9c96fb635cce780ca256d420005dc02/$FILE/Remoteness_Paper_text_final.pdf)
- <sup>ii</sup> Royal Flying Doctor Service (RFDS) Defining Rural and Remote <https://www.flyingdoctor.org.au/what-we-do/research/defining-rural-remote/>
- <sup>iii</sup> Australian Bureau of Statistics. (2013a). Australian Statistical Geography Standard (ASGS): Volume 5—Remoteness Structure, July 2011. ABS cat. no. 1270.0.55.005. Canberra: Australian Bureau of Statistics.
- <sup>iv</sup> Australian Bureau of Statistics. (2013a). Australian Statistical Geography Standard (ASGS) Area: Tasmania: Volume 5—Remoteness Structure, July 2011. ABS cat. no. 1270.0.55.005. Canberra: Australian Bureau of Statistics.
- <sup>v</sup> Australian Government Department of Health: Districts of Workforce Shortage for Psychiatry, ASGC-RA (2006)
- <sup>vi</sup> 2016 ABS Census, 2901.0 - Census of Population and Housing: Dwelling Internet Connection  
[http://www.censusdata.abs.gov.au/census\\_services/getproduct/census/2016/quickstat/6?opendocument](http://www.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/6?opendocument)
- <sup>vii</sup> Thomas, J, Barraket, J, Wilson, C, Ewing, S, MacDonald, T, Tucker, J & Rennie, E, 2017, Measuring Australia's Digital Divide: The Australian Digital Inclusion Index 2017, RMIT University, Melbourne, for Telstra.