

**Submission by Rural Alive and Well (RAW) to the
Senate Inquiry into Accessibility and Quality of Mental Health Services
in Rural and Remote Australia
May 2018**

RAW is an incorporated non-government organisation that is the only state-wide provider of mental health wellbeing and suicide prevention programs to rural Tasmania. RAW is an entirely mobile service delivering its programs via a fleet of SUV's that move around the state. We also deliver services on King and Flinders Islands in the Bass Strait. RAW is highly respected in the communities it services and makes a significant contribution to the sustainability and quality of life of rural communities across Tasmania. RAW has recently received a small amount of philanthropic funding to assist rural communities on the Australian mainland to establish similar programs.

Services delivered by RAW are low-cost, low-stigma mental health and suicide prevention programs that provide person-centred, non-clinical care and practical support through assertive outreach. The service aims to improve mental health and well-being and prevent repeat suicide attempts and suicide deaths. RAW adopts a culturally sensitive, strengths-based and collaborative approach to care. RAW workers are recruited from a range of backgrounds and receive training and ongoing support to provide evidence-informed care to people.

RAW currently delivers its services through two main programs.

Firstly, the RAW Outreach program provides support to individuals, families, and communities and currently covers all of rural Tasmania except for the metropolitan areas of Hobart, Launceston, Devonport and Burnie.

The Outreach program focuses on strengths based approaches, and building community connectedness. It is available 24/7 either face-to-face or through our 24/7 phone service, 1300 HELP MATE. The program involves assertive outreach including 'cold calling', going where people live & work and demonstrating genuine care with a proactive approach to providing ongoing physical and emotional support to individuals and their families and carers. The service also operates an out-of-hours crisis call-out capacity across the state. Safety management for this service is conducted in collaboration with Tasmania Police and other relevant emergency services.

Outreach staff conduct regular farm and house visits making contact with those who traditionally have been isolated or overlooked or are simply 'doing it tough'. The Outreach team focus on client engagement and take the time needed to connect with people, providing ongoing support or referral to key services. Their approach to client engagement is 'non-clinical' in style and presents as caring, confidential, non-intrusive, and available when and where the help is most needed. Following a referral to RAW, Outreach Workers contact the person and work with them to:

- identify risk and safety issues;
- set goals;
- provide support, coaching and motivation to encourage individuals to build skills and motivation to engage with family and community supports and to stay alive;

- stay connected to informal and formal supports and services that strengthen their mental health and promote recovery;
- provide warm referrals to and support engagement with support services that may include clinical care, safe and secure housing, financial or relationship counselling, getting back to study or work, and/or keeping in touch with family and friends.

Working in close partnership with government and non-government agencies and community groups has enabled RAW Outreach Workers to participate in and contribute to a very effective service network of caring and experienced people as a vital resource for individuals, families and communities. This combined with promoting events and activities creates a greater level of social inclusion and provides opportunities to promote suicide awareness and prevention education for a broad range of people across Tasmanian rural communities.

RAW's second program, the Healthy and Resilient Communities Program (HaRC) program aims to build capacity in order to enhance mental health and wellbeing community protective factors such as coping capability, resilience and connectedness, and to better equip rural Tasmanian communities to react to challenging life experiences and to recognise and support community members who may be 'at risk'. This program is characterised by the adoption of an evidence-based, "bottom-up" approach to empowering communities through harnessing their social, cultural, built and human capital to respond to events that challenge the overall wellbeing and health of the community such as an incidence of suicide or a natural disaster.

RAW operates in a 'step-up/step-down' model by providing systems navigation including facilitating engagement of rural people with clinical and specialist services as required, and by working in partnership with families and communities to support integration and reintegration of 'at risk' individuals into their local community networks including social and recreational programs.

The responses below are opinions stemming from the observations over time of RAW workers as well as discussions with many people across rural and remote Tasmania.

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

RAW workers experience first-hand the barriers inhibiting Tasmanians in remote and rural areas from accessing mental health services. RAW was established by rural Tasmanians in 2008 after farmer suicides at the end of a long drought in order to address these very issues. A core RAW function is to work with and support clients to identify and access appropriate services wherever they may be located.

Most mental health services are located in major urban centres and it is difficult for people in remote areas to know about or to access these services. A seeming lack of integration between primary and acute services providers in both government and non-government sectors also creates barriers and these are often exacerbated for people in rural and remote locations. The nature of Commonwealth and State funding of services may contribute to this lack of integration. It should be noted that many of these urban based regional services are based on the 'hub and spoke' model which assumes the capacity to deliver rural 'outreach' services from the urban 'hub'. However, the reality is that limited resources and the high demands on the hubs often do not leave sufficient

resources for adequate 'spoke' service delivery. Further, this model is sometimes resisted by rural communities because of the perceived 'fiffo' nature (fly-in/fly-out) and turnover of staff.

Rural Tasmanians and those living in relative isolation in remote areas often have to travel considerable distances to access services provided only in the major urban centres. It is our experience that rural Tasmanians are either unaware of the services that exist or are reluctant to access them due to the dislocation and expense involved in travel time and accommodation. It can also be argued that relocation to access services can exacerbate certain mental health conditions such as anxiety. An important function for RAW workers is to link rural people with the right services for their need and to support them in accessing these wherever they may be located.

There remains a significant stigma associated with mental illness and people in rural communities often do not wish others to know they have a mental health problem and will not access visiting services provided in their local area let alone be admitted to hospital or clinic based services.

It is our observation that some services are not provided in a way which is culturally appropriate and reflect a lack of understanding of the nature of people in rural and remote communities and their needs. This can apply to visiting services and other centre based services which are often approached with reluctance. Services provided in the major urban areas are often not seen as friendly places for people who must travel lengthy distances to access them. It is considered that generalist services provided in close proximity and utilising lay people with a good understanding of the needs and resources of their local communities will encourage a better engagement and utilisation rate. The approach of RAW workers for example, is to see people in a setting in which they feel comfortable and that is usually the family home. This model also allows for improved triaging with local solutions being sought for clients with lower intensity/complexity of needs.

Sub groups within rural and remote communities have particular issues. Men are often very reluctant to discuss mental health and to acknowledge they may have a problem that requires assessment and treatment. There is a perception and stereotype of the strong resilient male and this perpetuates a reluctance by men to seek help when needed.

An ageing population creates significant challenges and over 65's represent the fastest growing client group for the RAW Outreach Workers (currently 14.9% of our caseload). This group carries a significant health burden with concomitant pain issues, as well as experiencing high levels of social isolation, limited access to care and support, and lowered transport access.

At risk young people are another emerging group often accompanied by alcohol, drugs and difficult family and economic circumstances. Family violence is another factor which can have a devastating impact in rural and remote areas.

The RAW approach is to work directly with these groups to provide information and support services and to refer on to appropriate clinical or specialist services where available and support access to those services and treatment compliance as appropriate... RAW operates as a systems 'navigator' and 'enabler'.

Another significant issue is a lack of support for family, carers and supporters of people with a mental health problem with the focus usually on providing treatment for the person 'diagnosed' as having a problem. A more holistic approach which considers the ongoing importance and needs of carers and supporters (these are often family members) and integrates them and their needs into a care plan is required.

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

Tasmania has the second highest rate of suicide in Australia with 17 deaths/100,000 (age standardized) in 2016 (ABS – Causes of Death) and is the only state in Australia where the suicide rate is rising. Tasmania is particularly vulnerable to poor health outcomes in general and the most recent ABS information about suicide in the state is of particular concern:

- Males aged 85+ and living in rural Tasmania are the group most at risk of completing suicide in Australia... they do so at a rate more than three times the national average;
- In the period 2012 to 2017 suicide rates in Tasmania increased by 31%;
- While in general males complete suicide at three times the rate of females, this has changed in the age cohort 50 – 55 where it is double the rate.

Research by Flinders University and the ABS shows that on average people living in rural areas experience additional risk factors such as mental illness, substance abuse, chronic pain or illness at higher levels than their urban counterparts. Returned military service personnel, who complete suicide at higher than average rates, are also more represented in rural areas. Tasmanian rural areas have a higher saturation of risk factor cohorts than national averages in that:

- there is a higher male to female ratio than urban areas, in some places up to 38% more males than females;
- 2.7% of the Tasmanian population are aged over 85 (the group at highest risk of suicide) compared to 1.9 % of the overall Australian population. More than 1 in 5 of all Tasmanians aged over 85 live in rural areas;
- 40% of Tasmanians using mental health services live in rural Tasmania;
- Of the four primary chronic physical illness categories:
 - 37% of Tasmanians treated for heart conditions live in rural communities;
 - 38% of Tasmanians treated for cancer live in rural communities;
 - 36% of Tasmanians treated for kidney conditions live in rural communities; and
 - 40% of Tasmanians treated for chronic arthritis live in rural communities.

It is the experience of RAW that there are a number of factors that have contributed to the higher rate of suicide in rural and remote communities.

The stigma involved in accessing mental health services and a reluctance to engage and discuss problems are contributing factors. This leads to a lower rate of service utilisation as outlined above and a higher attrition rate in treatment access and compliance.

It is the experience of RAW however that death by suicide is not always the result of mental illness. People in rural and remote areas can be subject to extreme stressors on a daily and seasonal basis. The vagaries of natural disasters such as fire, flood, drought and disease, fluctuating prices and other economic pressures compounded with isolation and family pressures have a significant impact on the well-being of people in rural and remote communities. This can often lead to a sense of hopelessness and, with ready access to the means to complete suicide, such as guns, chemicals and rope, tragic outcomes arise.

The approach by RAW to these issues is to be available and known in rural and remote communities. Referrals are often received from people in rural communities who know someone who is struggling. RAW will contact that person and seek to visit them in their home to commence a process that will hopefully lead to recovery.

RAW runs training and education programs in rural and remote communities aimed at enabling community groups and individual to build resilience and capacity within their communities to identify and support those who need support.

In developing responses to suicide rates in rural and remote areas it is necessary to consider the range of occupational groups in these areas, the context of their work, and their particular issues and needs. There are groups such as farmers, miners, aquaculturalists, and orchardists and the range of businesses and enterprises that spin off and support these groups. Rural workforces also include field or outplaced essential service workers such as police and emergency services, electricity, water and other infrastructure services etc. When considering rural workforce profiles it is important to recognise that a number of these occupational groups have higher than average levels of suicide (eg farmers and agricultural workers).

It is also necessary to consider systemically and in the development of policy ways in which to build vibrant and sustainable rural communities with networks that maintain and support the people living in them. Good health and wellbeing requires conditions that allow all community members to pursue important personal goals, enjoy fulfilling relationships, and take part in their community. A healthy, thriving community is one in which members enjoy optimal health in an environment that actively promotes productive, rewarding and socially inclusive lives.

(c) The nature of the mental health workforce

There is a need for a skilled professional workforce to provide the range of acute through to primary mental health services. The health professionals working in these sectors should be trained to work in ways that meet the needs of people in rural and remote communities. Rotations to rural areas and working with lay people and peers in these communities would be ways in which to develop culturally appropriate approaches and to relate well to clients.

However it is unlikely that the mental health and well-being needs of rural communities can be met (or afforded) by simply importing and rotating clinical professionals. Instead it is appropriate to develop and support local networks of peer workers who have skills in community engagement and the capacity to work collaboratively with both clinical service providers and community members and networks. These workers should be selected for their capacity to engage with isolated individuals and to cope and hopefully thrive as 'isolated' workers. They should be supported with intensive supervision and case review resources and trained in core competencies such as strengths based and trauma informed approaches to counselling as well understanding the impact of grief on individuals and communities and community strengthening/capacity building approaches.

Partnerships with key rural professional training institutions need to be widened to facilitate the above with a focus on the co-design of collaborative training and service delivery models and practice. In 2017 RAW had a number of fruitful collaborations with the University of Tasmania. The first partnership with the School of Social Work led to the establishment of a six person RAW Student Unit to undertake a state-wide evaluation of the Outreach program – two of the six participating students have subsequently been employed by RAW. If resources were available in the future, this Unit could become a standing RAW training facility. The second partnership was with the Centre for Rural Health who were contracted by RAW to undertake a formative evaluation of the HaRC program in order to inform service development and improvement.

It should be noted that workforce safety management, particularly in relation to home visitation outreach services in isolated communities throw up particular challenges. RAW's safety monitoring of its staff including real time satellite tracking of all its vehicles requires a significant resource investment.

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

There are significant challenges inherent in the provision of mental health services in regional areas. Clearly economies of scale make it impossible to replicate the range of services provided in urban areas.

Providing services that are culturally appropriate for people in rural and remote communities is a challenge. It is our experience that people in such communities are often reluctant to access mental health services and consideration needs to be given to how and where these services are best delivered in order to ensure a willingness to access and engage. This also includes attracting the right workforce and in particular health professionals with an affinity for and a capacity to relate and engage with clients in these settings.

There is a level of stoicism associated with rural people and often this leads to a reluctance to recognise or acknowledge the stress that develops from the fluctuations of rural life, and the impact this can have on the individual and their family.

Access to transport is an ongoing issue and often RAW workers become involved in transporting clients to attend appointments given a lack of viable alternatives.

Developing more integrated approaches to enable seamless pathways for clients is a challenge. While great strides have been taken in the development of collaborative approaches and partnerships there is more to be done across both government and non-government services to ensure that clients can easily access and navigate seamlessly across services in either sector.

The cost of delivering services is challenging. For NGOs in particular sustainability is often an issue given the vagaries and timelines of funding bodies including the state and federal governments. There are clearly increased costs in providing services in remote areas as well as an investment cost in terms of establishing community trust. Funding continuity would allow the realisation of this investment over time, however, this is undermined by short term funding cycles. This impact has been exacerbated by the 'market' approach to human services purchasing adopted nationally by the PHN's.

(e) Attitudes towards mental health services

Visiting clinical services is often viewed with suspicion and there is stigma attached to being seen to visit a mental health service in a rural community. Models such as those employed by RAW workers break down the negative attitudes that persist in relation to accessing clinical services. With a largely non-clinical workforce RAW workers present as supportive, non-threatening, and are seen as "mates" who work with clients and their families to address their issues.

Much of the evidence based literature in this field draws a clear delineation between mental illness and suicide prevention. While it is clear that a significant proportion of those who complete suicide have experienced clinical depression, it is also clear that for many suicide is driven primarily by situational stressors that overwhelm the individual's capacity to cope in the present. While pharmacological interventions can help to alleviate the associated symptoms of depression and anxiety in the short term, it is the solution or alleviation of the exacerbating situational problems and the strengthening of the capacity of the individual to recognise what is happening to them and retake control of their life that reduces suicide risk in the longer term.

Designing rural mental health and well-being services, particularly suicide prevention, on a top-down medical paradigm focussing on 'illness' fails to acknowledge that 'doing it tough' can feel like hitting

a brick wall for some. Normalising what people are feeling and how they are reacting in such situations de-stigmatises what is happening to them and being able to access trusted others to ventilate their feelings and get information and services can help them to ground themselves in the present and see a pathway into their future. Rural people generally are pragmatic and solution focussed – they are not reluctant to do the hard work that is the pathway back to wellness, they just need the support and resources at a time and place they can access to do so.

Interestingly this approach is consistent with the latest ‘what works’ evidence available in relation to responding effectively to male help seeking behaviour.

(f) Opportunities that technology presents for improvements to service delivery

Looking after one’s self and self-agency are essential to meet needs and maintain good health as is accessing self-help when necessary, particularly in rural and remote areas. There is some argument that there are evidence based e-health interventions available to help people self-manage illnesses and challenges and that online access has the potential to make a difference, particularly for those who are remote or who prefer not to use face-to-face services due to stigma.

However, e-mental health is problematic in rural areas with limited network access and with certain cohorts such as older people who may lack experience in using digital media. Poor or no digital provision has negative effects on rural communities, as access to the internet may be the only possible solution to link people with health care services. To deliver successful online services organisations must consider:

- mapping internet access across communities – identifying digital exclusion areas;
- whether there are alternative means to deliver online services if areas are excluded; and
- tailoring online programs to suit different cohorts to enable them to utilise services.

There are substantial differences between rural and urban areas for digital inclusion. Research has found that it is principally wealthier, younger, educated urban Australians who enjoy greater digital access and there is a significant ‘spatial digital divide’ across three indices – access, affordability and digital ability. Rural areas in Tasmania such as Burnie, the West Coast, and north-eastern Tasmania rank as amongst the least digitally included areas in Australia, whilst Tasmania in its entirety is the lowest of any state or territory on the digital inclusion index. Age is a significant factor influencing digital inclusion with those over 65 years of age recording the lowest scores (Roy Morgan 2017).

Nevertheless, the use of Telehealth and related technologies are likely to assist in improving service delivery. Strategies aimed at young people are likely to be more effective given their familiarisation with technology. The opportunity to link with services such as Headspace that cannot be replicated in rural and remote areas would enable young people in rural and remote communities to access a user appropriate service.

The use of technology is not a panacea or substitute for the provision of good, relevant, local services. Older people often struggle with technology and there are still significant blackspots which create access issues.

There is also a plethora of online mental health and suicide prevention applications and ensuring their quality and relevance is an ongoing issue.