

Chapter 3

Barriers to accessing mental health services

3.1 Throughout this inquiry, the committee heard there were numerous barriers specific to rural and remote communities which restricted or prevented people from accessing mental health services.

3.2 The Australian Mental Health Commissions submitted that there are many factors unique to rural and remote communities which impact their ability to access mental health services, as well as increase their likelihood of experiencing mental illness:

Although social features of rural and remote communities are protective of mental health, for example resilience and a sense of community, people living in rural and remote areas can also be exposed to a variety of risk factors that contribute to mental ill-health. These are often tied to their location and include environmental adversity, geographic isolation, poorer socioeconomic circumstances, and restricted access to services. For Aboriginal and Torres Strait Islander peoples, the above risk factors associated with living in rural and remote Australia are compounded by the historic and cultural experiences of intergenerational trauma and socioeconomic deprivation.¹

3.3 This chapter will outline the rates at which rural and remote Australians access mental health services and the factors which contribute to the availability of these services. It will consider the practical effects of distance and other social determinants of health which are felt by rural and remote communities. Finally, this chapter will consider the continuing impact of stigma and concerns regarding privacy and confidentiality, which are pertinent to small communities.

Access rates of mental health services

3.4 While the prevalence of mental illness is similar across Australia, evidence provided to the committee suggested that people living in rural and remote areas access mental health services at a much lower rate than people living in major cities and inner regional areas.²

3.5 In 2016–17, people living in major cities accessed Medicare Benefits Schedule (MBS) funded mental health services at a rate of 495 encounters per 1000 people. The rate of encounters decreases the more remote the location, with 297 encounters per 1000 people for outer regional areas, 145 per 1000 people for remote areas and 81 encounters per 1000 people for very remote areas.³

1 Australian Mental Health Commissions, *Submission 52*, p. 9.

2 See, for example: Department of Health, *Submission 30*, p. 12; Royal Flying Doctor Service (RFDS), *Submission 22*, Attachment 1, p. 9; National Rural Health Alliance, *Submission 37*, p. 7.

3 Department of Health, *Submission 30*, p. 13.

3.6 The rate of encounters with MBS funded mental health services decreases rapidly by remoteness across the range of mental health service providers available including psychiatrists, psychologists, general practitioners (GPs) and allied health professions, as demonstrated in Table 3.1 below.

Table 3.1—Medicare-subsidised mental health services, by provider type and remoteness area, per 1000 population (2016–17)

Remoteness area	Psychiatrists		Clinical psychologists		Other psychologists		General practitioners		Allied health professionals	
	Rate	Comparison	Rate	Comparison	Rate	Comparison	Rate	Comparison	Rate	Comparison
Major cities	114.0	0	100.3	0	120.0	0	146.2		14.9	0
Inner regional	72.5	1.6 times lower	77.0	1.3 times lower	115.3	1.0 (same)	150.1	1.0 (same)	21.9	1.3 times higher
Outer regional	46.1	2.8 times lower	42.4	2.4 times lower	76.4	1.6 times lower	116.1	1.3 times lower	15.4	1.0 (same)
Remote	28.5	4.0 times lower	18.8	5.3 times lower	27.8	4.3 times lower	63.2	2.3 times lower	6.8	2.2 times lower
Very remote	18.9	6.0 times lower	11.1	9.0 times lower	16.6	7.2 times lower	32.9	4.4 times lower	2.3	6.5 times lower

Source: RFDS.⁴

3.7 As a percentage of the population, 10.2 per cent of people in major cities accessed MBS subsidised mental health services, compared to only 8.1 per cent in outer regional areas, 4.8 per cent in remote areas and 2.8 per cent in very remote areas.⁵

3.8 The committee heard that the low rate of encounters with MBS funded mental health services is of concern as lower access to early intervention services can result in intensification of need, comorbidity, chronic conditions and greater rates of hospitalisation.⁶

Are services available when and where they are needed?

3.9 As noted in Chapter 2, one of the goals of Primary Health Networks (PHNs) is to ensure patients are receiving the right care, in the right place, at the right time.⁷ However, evidence provided to the committee suggested that people in rural and remote communities are not accessing mental health services as often as people in urban locations, in part because the right care is not available at all, or it is not open when people need it most. The following discussion outlines these issues.

4 RFDS, *Submission 22*, p. 4.

5 Department of Health, *Submission 30*, p. 12.

6 Department of Health, *Submission 30*, p. 9.

7 Department of Health, *Submission 30*, pp. 4–5.

Availability of mental health services

3.10 Numerous submitters and witnesses indicated that the low rate of access to mental health services could be partially attributed to the limited number of practicing mental health professionals in rural and remote Australia.⁸

3.11 In regional areas, the per capita number of psychiatrists, mental health nurses and psychologists in 2015 were, respectively, 36 per cent, 78 per cent and 57 per cent of those in major cities, with even poorer comparisons in remote areas, as demonstrated in Table 3.2 below.⁹

Table 3.2—Number of mental health professionals (clinical FTE per 100 000 population) by remoteness, 2015

	Major cities	Inner regional	Outer regional	Remote	Very remote
Psychiatrists	13	5	4	5	2
Mental health nurses	83	74	46	53	29
Psychologists	73	46	33	25	18

Source: Department of Health.¹⁰

3.12 The Royal Flying Doctor Service (RFDS) submitted that in 2015, 201 local government areas (LGA) did not have any psychologists registered within the area, representing approximately 36 per cent of all 564 LGAs in Australia, many of which were in rural and remote areas.¹¹

3.13 The Victorian Government explained that attracting qualified mental health professionals to rural and remote areas limits the availability of mental health services:

In many cases, the availability of appropriately skilled staff can be the single biggest contributing factor limiting the ability to provide a broader range of services in rural communities, particularly where around-the-clock care is required.¹²

3.14 The factors which contribute to the low number of mental health professional in rural and remote communities around Australia will be explored further in Chapter 5.

8 See, for example: RFDS, *Submission 22*, pp. 2–3; Department of Health, *Submission 30*, p. 13; Victorian Government, *Submission 100*, p. 4.

9 National Rural Health Alliance, *Submission 37*, p. 14.

10 Department of Health, *Submission 30*, p. 13.

11 RFDS, *Submission 22*, p. 2.

12 Victorian Government, *Submission 100*, p. 4.

Outreach and fly-in-fly out services

3.15 The committee heard that often fly-in, fly-out (FIFO) services and outreach services are provided in rural and remote communities in an attempt to address the lack of mental health services and professionals available in rural and remote communities.¹³

3.16 Mr Brendan Morrison from the Kununurra Waringarri Aboriginal Corporation told the committee that communities are often not receptive towards FIFO workers as they only visit for short periods and have not built relationships within the community.¹⁴

3.17 Mrs Danielle Dyall from the Aboriginal Medical Services Alliance Northern Territory (AMSANT) also described how FIFO workers do not build relationships with the community and the impact this has on service delivery:

Sometimes there is no cultural safety awareness. There's also the flying in and flying out and not having access to actual community members on the ground. They might not be there for appointments or they might not show up. What we find is that, when people are within the community and have those relationships, they're able to drive around and find the people that they're meant to be meeting with and meeting in a safer environment. The people who fly in and fly out may not necessarily have that sort of relationship with community members to be able to have an understanding of where to meet and that sort of thing.¹⁵

3.18 Similarly in Whyalla, Dr Jennifer Cleary from Centacare Catholic Country SA informed the committee that FIFO services lack important local knowledge:

Service in remote communities often relies on fly-in fly-out visits, and FIFO as we know it creates less-individualised approaches around delivery. In the area of supporting those with a mental health challenge, which obviously can significantly range in severity or impact, those early intervention opportunities are often lost as people disengage or don't engage in the first place. Organisations which are not local often don't have the appropriate connections, knowledge or historical background and so can often struggle to engage appropriately.¹⁶

13 See, for example: RFDS, *Submission 22*, pp. 4–6; Western Queensland Primary Health Network (PHN), *Submission 125*, p. 3; Ms Vanessa Harris, Executive Officer, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 9 July 2018, p. 14; Dr Jennifer Cleary, Chief Executive Officer, Centacare Catholic Country SA, *Committee Hansard*, Whyalla, 20 July 2018, p. 43.

14 Mr Brendan Morrison, Social and Emotional Wellbeing, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 4.

15 Mrs Danielle Dyall, Team Leader Trauma Informed Care and Social Emotional Wellbeing, Aboriginal Medical Services Alliance Northern Territory (AMSANT), *Committee Hansard*, Darwin, 9 July 2018, p. 10.

16 Dr Jennifer Cleary, Centacare Catholic Country SA *Committee Hansard*, Whyalla, 20 June 2018, p. 43.

3.19 Conversely, the committee also heard in Whyalla that some members of the community would prefer to see a FIFO mental health worker as this minimises the risk to their privacy and concerns regarding confidentiality in small communities.¹⁷ The concerns regarding privacy and confidentiality will be discussed further later in this chapter.

3.20 In Mount Isa, the committee heard that outreach services face similar criticisms to those of FIFO mental health professionals, as the amount of time outreach services spend in communities is infrequent or inadequate:

I think one of the issues when you're talking about remote communities is that most services are outreach to the communities, and it's what's happening between those visits. We speak with communities all across Australia where the psychologists might come for a day and a half once a month, and it's impossible to get time with them because of their availability.¹⁸

3.21 The Royal Australian and New Zealand College of Psychiatrists submitted that while FIFO and outreach services offer an alternative where specialist services are otherwise unavailable, they 'should not be seen as permanent solutions' or replacements for a workforce based on the location.¹⁹

3.22 The committee heard that FIFO workers may be successful in building a rapport with the community if they come regularly over a long period of time. Dr Krista Maier, a GP from the Nunyara Aboriginal Health Service told the committee that it took her three years of coming to the community on a regular basis to develop the community's trust:

It took me three years of regularly coming up to Nunyara before I started to feel that I was an accepted and trusted member of the community, and to establish that trust... Over the years of my service, particularly at Nunyara, I have seen the beneficial effects, particularly on people's mental health, of having a constant person to touch base with by not having to tell their story over and over again but also the relationship that we develop means that they are much more likely to come in to see me when they start to struggle with their mental health.²⁰

3.23 Dr Maier noted that developing this relationship required FIFO staff committing to long-term relationships with the communities that they seek to serve.²¹

17 Ms Jane Dodding, Psychologist and Director, MindPlus, *Committee Hansard*, Whyalla, 20 June 2018, p. 41.

18 Mr Tony Cassidy, Group Manager, Wesley LifeForce, Wesley Mission, *Committee Hansard*, Mount Isa, 29 August 2018, p. 19.

19 Royal Australian and New Zealand College of Psychiatrists, *Submission 95*, p. 6.

20 Dr Krista Maier, General Practitioner, Nunyara Aboriginal Health Service, *Committee Hansard*, Whyalla, 20 July 2018, p. 35.

21 Dr Krista Maier, Nunyara Aboriginal Health Service, *Committee Hansard*, Whyalla, 20 July 2018, p. 34.

Lack of appropriate 24 hour support services

3.24 A number of submitters and witnesses told the committee that rural and remote communities lacked appropriate mental health services outside of standard business hours.²² This is particularly problematic for mental health patients as acute episodes can often occur at night when people cannot sleep or feel socially isolated.

3.25 For example in Albany, Ms Jo Brown from the Depression Support Network Albany explained that mental health services are not available overnight:

If you're suicidal between 8.30 am and 4.30 pm, you can go to the community mental health service. If you're suicidal after 4.30 pm and before 10.30 pm you can go to the emergency department, but you have to wait for the doctor before you can see the mental health nurse. The problem with this is, if you are having a mental health moment, you just give up and go away, because it can take up to three hours. If you're suicidal after 10.30 pm, you then have to wait for the mental health people to come back in, if you are deemed in need. We shouldn't have to be visibly distressed to convince them that we need help. A small community means people know everyone and don't want the world to know their business, so they don't go in for help.²³

3.26 The committee heard that it is common for people experiencing mental health issues to present to their local emergency department. For example in Mount Isa, the three highest presentations to the emergency department for mental health issues included: behavioural disturbances; suicide ideation; and anxiety.²⁴

3.27 However, submitters and witnesses informed the committee that often emergency departments in rural and remote communities were not conducive for mental health patients who present to the emergency department, particularly after hours when mental health specialists are not on duty.²⁵

3.28 Dr Niall Small, Chair of the Rural Regional and Remote Committee for the Australasian College for Emergency Medicine, explained that emergency departments are not suitable environments for mental health patients:

22 See, for example: Ms Cheryle Kaesler, Manager, Social Emotional Wellbeing Unit, Yura Yungi Medical Service, *Committee Hansard*, Halls Creek, 5 July 2018, p. 1; Tammy, Member, Carers Tasmania, *Committee Hansard*, St Helens, 6 September 2018, p. 50; Ms Lyn English, Consumer Deputy Co-Chair, National Mental Health Consumer and Carer Forum, *Committee Hansard*, Canberra, 19 July 2018, p. 25; Western Australia Association for Mental Health, *Submission 34*, pp. 5 and 20.

23 Ms Jo Brown, President/Coordinator, Depression Support Network Albany Inc, *Committee Hansard*, Albany, 5 June 2018, p. 27.

24 Ms Sandra Kennedy, Director Mental Health and Alcohol Tobacco and Other Drug Service, North West Hospital and Health Service, *Committee Hansard*, Mount Isa, p. 42.

25 See, for example: Dr Stephanie Trust, Principal GP, Kununurra Medical, *Committee Hansard*, Kununurra, 5 July 2018, pp. 14–15; Dr Roland Main, Area Director for Mental Health, Adults and Older Adults, WA Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 2; Roses in the Ocean, *Submission 7*, p. 4; Western Australia Association for Mental Health, *Submission 34*, p. 20; Wesley Mission, *Submission 38*, p. 15.

There are many examples of patients who present with acute mental health issues in peripheral regional and rural hospitals who are seen and assessed but who then wait many hours or even days for transfer to a mental health facility. While these patients wait, they're being cared for in a busy ED environment with constant activity, noise and lighting. Treatment options are severely limited in this situation, and these patients require specialist care in a specialist unit, not to be left in a busy emergency department. Given this scenario, patients often escalate in their behaviours and require sedation. This cycle may be repeated more than once until eventually the patient is transferred to the specialist mental health facility they require.²⁶

3.29 The committee heard that where specialist mental health staff are not on duty, hospitals in rural and remote locations may be able to contact mental health specialists in a regional centre or capital city for consultations on patients who may present to emergency departments outside of business hours. For example, the Kimberley Mental Health and Drug Service explained that emergency departments across remote locations in the Kimberley can contact staff in Broome:

We have very good relationships with our emergency departments, and we have 24/7 on-call psychiatrist support after hours as well to our clinicians that work in hospital. So we can advise and assess any presentation either by videoconference or in person if necessary. It may well be that an assessment is made in the emergency department that they can go home with family.²⁷

3.30 However, the committee heard that on other occasions, patients experiencing a mental health crisis who present to the emergency department at their local hospital are not assessed by a mental health specialist nor admitted to hospital:

There are numerous stories of suicide attempts being treated in hospital and accident and emergency departments, where the person is held for the minimum six hours observation only to be released back into the situation that led them to the attempt on their life without assessment by psych services whilst in A&E or treatment in the ward or follow-up by psych services after release.²⁸

3.31 Dr Small explained to the committee that emergency department clinicians are skilled in the provision of urgent medical treatment and crisis interventions, but are not trained in the ongoing care and support of mental health patients and are dependent upon other components of the mental health system to provide the ongoing support required by patients.²⁹

26 Dr Niall Small, Chair, Rural Regional and Remote Committee, Australasian College for Emergency Medicine, *Committee Hansard*, Townsville, 30 August 2018, p. 34.

27 Dr Renee Bauer, Clinical Director, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 22.

28 Mr David Brennan, Chief Executive Officer, Carers Tasmania, *Committee Hansard*, St Helens, 6 September 2018, p. 48.

29 Dr Niall Small, Australasian College for Emergency Medicine, *Committee Hansard*, Townsville, 30 August 2018, p. 34.

3.32 The Western Australia Association for Mental Health submitted that emergency response services in rural and remote communities required better facilities and training to appropriately respond to acute mental health conditions 24 hours a day.³⁰

3.33 Witnesses told the committee that this should include greater consideration of the design of emergency departments and how they are equipped to respond to patients experiencing psychosis, particularly where it is drug induced.³¹ Dr Roland Main of the WA Country Health Service explained:

I think we need a capacity to more safely look after people who've got that combination of acute behavioural disturbance and psychiatric symptoms as far as possible in the local setting. This is a problem which besets the whole of the country. It's more acute in rural areas because our emergency departments just don't have the capacity to contain those sorts of behavioural disturbance....

The design of emergency departments is relevant as well. Methamphetamine has changed the game in that respect. Many more people are coming in with really severe behavioural disturbance due to the effects of methamphetamines. So the design and staffing have an effect on the morale and the energy of the staff in emergency departments to look after such patients.³²

3.34 The WA Country Health Service also told the committee that the employment of psychiatric liaison nurses in regional emergency department had improved patient care, supported skill development of emergency department staff and improved connection with the community and patient's families.³³ Similarly, the committee heard that the local hospital in Whyalla has employed a mental health nurse as well as peer support works with lived experience of mental illness to better support mental health patients in emergency departments.³⁴

Culturally appropriate services

3.35 For many Australians, there is the added need for mental health services to be culturally safe and to recognise the needs of diverse groups of people, including people from culturally and linguistically diverse (CALD) backgrounds, people who identify as lesbian, gay, bisexual, transgender and/or intersex (LGBTI) and Aboriginal and Torres Strait Islander peoples.

30 Western Australia Association for Mental Health, *Submission 34*, p. 20.

31 See, for example: Dr Roland Main, WA Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 3; Ms Jo Brown, *Committee Hansard*, Albany, 5 June 2018, p. 30; Ms Elizabeth Little, Chief Executive Officer, Rural Alive and Well Inc., *Committee Hansard*, St Helens, 6 September 2018, p. 33.

32 Dr Roland Main, WA Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 3.

33 Dr Roland Main, WA Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 2.

34 Ms Lee Martinez, Secretary, Whyalla Suicide Prevention Network, *Committee Hansard*, Whyalla, 20 July 2018, p. 22.

3.36 The National Mental Health Consumer and Carer Forum submitted that two key communication barriers exist for people from CALD backgrounds. Information about services is often not available in accessible formats for these groups, compounded by poor communication and cultural differences between consumers and clinicians.³⁵

3.37 The committee received evidence that for people who identify as LGTBI, a fear of discrimination from mental health staff can result in a lower take up rate of mental health services and this is felt more keenly in rural and remote areas.³⁶ Submitters also pointed to the higher suicide rates for people who identify as LGBTI as a reason that culturally appropriate services are critical to ensure people at risk can access appropriate therapeutic services.³⁷ The committee heard this need was not met in services, with the National LGBTI Health Alliance reporting that the LGBTI community has 'incredibly poor or non-existent' culturally safe access to mental health care.³⁸

3.38 In rural and remote Australia, the numbers per capita of Aboriginal and Torres Strait Islander peoples are significantly higher than other groups with culturally diverse needs. One-fifth of Aboriginal and Torres Strait Islander persons live in remote or very remote areas (7.7 per cent in remote and 13.7 per cent in very remote), compared to only 1.7 per cent of non-Indigenous Australians.³⁹

3.39 The committee heard that Aboriginal and Torres Strait Islander peoples in rural and remote areas face a number of barriers to access mental health services, most notably a lack of culturally appropriate services, leading to Aboriginal and Torres Strait Islander peoples accessing mental health services at a far lower rate than non-Indigenous Australians.⁴⁰

3.40 In recognition of the far greater numbers of Aboriginal and Torres Strait Islander peoples in Australia's rural and remote communities and the unique circumstances they face, Chapter 4 will focus on the need for culturally competent services for Aboriginal and Torres Strait Islander peoples.

35 National Mental Health Consumer and Carer Forum, *Submission 84*, p. 3.

36 Mission Australia, *Submission 80*, p. 4.

37 Victorian Council of Social Service, *Submission 107*, p. 2.

38 National LGBTI Health Alliance quoted in National Mental Health Consumer and Carer Forum, *Submission 84*, p. 3.

39 National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 128*, p. 2.

40 Aboriginal and Torres Strait Islander Healing Foundation (Healing Foundation), *Submission 39*, p. 5; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, *Submission 74*, p. 3; NACCHO, *Submission 128*, p. 3.

Services under the National Disability Insurance Scheme

3.41 As discussed in Chapter 2, many rural and remote communities are facing uncertainty, confusion and lack of services due to the rollout of the National Disability Insurance Scheme (NDIS). In some regions, the introduction of the NDIS has in turn introduced new barriers to accessing mental health services, rather than increasing the accessibility of services.

Barriers related to the NDIS rollout

3.42 In Albany, where the NDIS had not yet been rolled out at the time of the committee's hearing, witnesses described how people moving to the Great Southern region of Western Australia (WA) were struggling to access the mental health services they require under their NDIS package, as very few organisations in the region had registered as NDIS providers.⁴¹

3.43 The Western Australian Association for Mental Health noted that even if there are organisations registered with the NDIS in an area, they may not be able to provide mental health services:

One of the problems in those situations is that in areas there are often no psychosocial disability services currently registered under the NDIS. We heard of one situation where a person was referred to a disability agency that had no connection with mental health, because that was the only registered provider in that region, because the NDIS hadn't been rolled out.⁴²

3.44 A committee member of the Depression Support Network Albany also told the committee that there were issues in renewing NDIS packages in these areas:

...I do know that there have been some that...have brought their package down because they've moved. They were allowed to bring their package with them, but if their package were due to be renewed, it couldn't happen down here, because it doesn't happen down here. So it's very, very hard and tricky for a lot of people. They're finding it quite a struggle.⁴³

Inappropriate NDIS services

3.45 In regions where the NDIS has rolled out, there are concerns that plans are being designed and written for the services which are available in the community rather than the services genuinely needed by the individuals on plans.

3.46 Service provider selectability provided the committee with a case study of Palm Island, an island off the coast of Far North Queensland classed as 'very remote' by the NDIS. selectability noted that that the NDIS packages on the island cost

41 Samuel Rose, Program Coordinator, Richmond Wellbeing, *Committee Hansard*, Albany, 5 June 2018, p. 34.

42 Mr Colin Penter, Projects Lead and Policy Officer, Western Australian Association for Mental Health, *Committee Hansard*, Albany, 5 June 2018, p. 49.

43 Mrs Penny Carpenter, Committee Member, Depression Support Network Albany, *Committee Hansard*, Albany, 5 June 2018, p. 34.

significantly less than those seen on the mainland, because they are drafted as a reflection of limited service availability in remote communities, as opposed to being a reflection of the actual needs of people with disability. selectability further noted that if packages correctly identified needs, that would mean services could afford to come to remote communities such as Palm Island:

The average cost of a plan on the mainland is \$35,000. On Palm it's much lower, and that's because the plans have been written for what services are available rather than what the person actually needs—but that's separate. If there are 5,000 people living on Palm Island and if 10 per cent of them were eligible for an NDIS plan, that's 500 people. If they were actually given a plan that was at least at the average level of \$35,000, that's \$17 million a year of economic benefit that should be actually going into Palm Island. What does that \$35,000 plan equate to in a year? If you work out how many hours that equates to, it works out to providing an additional 200 full-time equivalent jobs on Palm Island.

We raise that as a case study because if you think about the people on Palm Island who have a disability, whether it's mental health or another disability, and if the NDIS was rolled out in full—at 100 per cent—and rolled out to a time line, and if the plans were written as they should be written for what the person actually needs, the service providers would come. That would actually provide ongoing economic benefit for Palm Island, which means jobs and better lives for the people who actually have a mental illness.⁴⁴

3.47 People who are ineligible or who have not yet received a package are also facing barriers to accessing NDIS-based services. The committee heard at its Darwin hearing that 'massive gaps' have opened in some areas because funding moved from service-level or block funding from the Department of Social Services to the insurance model of NDIS funding before alternative arrangements for continuity of support were made:

The funding has gone in and people haven't been getting an NDIS plan. So there have been a lot of gaps. We heard stories of cases of suicide where they were waiting on a plan but didn't have any other service because the services had been shut down because all the funding had already gone over to the NDIS.⁴⁵

3.48 In Townsville, a service provider described that people who require chronic mental health care have gone through the process of applying to the NDIS 'only to find out they're not eligible...so they get no service whatsoever.'⁴⁶ Another service

44 Mrs Debra Burden, Chief Executive Officer, Selectability, *Committee Hansard*, Townsville, 30 August 2018, p. 47.

45 Ms Lorraine Davies, Executive Officer, Mental Illness Fellowship of Australia (NT), *Committee Hansard*, Darwin, 9 July 2018, p. 20.

46 Mrs Erica Buttigieg, Social and Emotional Wellbeing Program Manager, Townsville Aboriginal and Islanders Health Services, *Committee Hansard*, Townsville, 30 August 2018, p. 29.

provider in Whyalla described that there are barriers to even getting to the NDIS assessment processes if doctors don't understand psychosocial disability:

Initially [the applicant] will receive an access request form, which they have to take to their GP or any other medical professional, where the doctor will fill out the form. Then that is any other information—their diagnosis or when they're not able to show their impairment impacts on their everyday living. They need evidence of their disability. All the reports evidence we submit over to the NDIS. Then that which we have had have come back that they might request more evidence, so therefore the consumer will have to go back to the doctor or find evidence elsewhere. We're finding that some of the doctors don't want to know about it, don't have time. One particular consumer was told by the doctor that she didn't have a disability—she wasn't in a wheelchair and she could walk—so he wouldn't even look at the paperwork for her. We've had consumers that have got quite upset. One in particular last week cried because she was rejected. So it is impacting a lot on the consumers. We can appeal, but what happens after that we don't really know.⁴⁷

3.49 These concerns were similarly raised in Townsville, where a service provider suggested that people with physical disability, when compared to those with psychosocial or intellectual disability, are 'probably coming out of [the assessment process] okay and getting their needs met' as disability services have been designed around their needs.⁴⁸

3.50 The Western Australian Association for Mental Health suggested that a 'lack of assessor, planner and service provider expertise in psychosocial disability' has resulted in 'significant variations' in assessed eligibility and approved packages in WA.⁴⁹

3.51 Some witnesses also raised concerns that the insurance-based disability model of the NDIS is at odds with some of the recovery-based mental health supports previously offered by service providers, and that this is having detrimental effects on supporting capacity building for individuals. The Queensland State Manager of service provider Neami National told the committee that:

The NDIS is really a disability model. In people's plans, what we're finding is that there's only a very small amount, if any, of capacity building, which is where we would see the work that Neami has done traditionally—in the capacity building [of] people—to drive self-efficacy for people. That's very, very small in people's plans. The bulk of people's plans have been core support, which is the driving to the shops, helping somebody to learn to cook and that sort of level of support. That is actually diminishing. What

47 Mrs Jan Barr, Project Officer, UnitingSA, *Committee Hansard*, Whyalla, 20 July 2018, pp. 19–20.

48 Ms Catherine Crawford, Coordinator, North Queensland Combined Women's Services, *Committee Hansard*, Townsville, 30 August 2018, p. 29.

49 Western Australian Association for Mental Health, answers to questions on notice, 5 June 2018 (received 13 August 2018), p. 3.

we've seen over the last four years is that the capacity-building element is diminishing in people's packages as time goes on, as well as support coordination, which is often a really essential part in addressing, I guess, the issue around access for people and coordinating their wellbeing support.⁵⁰

3.52 The Chief Executive Officer of selectability raised similar concerns and told the committee that her experience has shown NDIS plans for psychosocial disability are not being written with these necessary capacity-building services in mind.⁵¹

Committee view

3.53 The committee is concerned that rural and remote Australians are accessing mental health services at a much lower rate than Australians in major cities and urban areas, and is concerned about the detrimental effect this may have on their mental health.

3.54 The committee believes there is a strong relationship between the proportionally low number of mental health professionals working in rural and remote communities and the low access rates of services by rural and remote Australians.

3.55 The committee is concerned by reports that people in rural and remote communities experiencing a mental health crisis do not have access to appropriate 24-hour care, particularly within local hospital emergency departments which often lack appropriate staff or facilities to support these patients.

3.56 The committee notes that while FIFO and outreach services provide an opportunity to offer mental health services in rural and remote communities where services may not otherwise exist, unless they are reliable and regular, that is, every couple of weeks with the same trusted practitioner, they should not be seen as a permanent solution to regular and ongoing mental health services with local knowledge and relationships with their community.

3.57 The committee believes that culturally appropriate services are essential to meet the mental health needs of a culturally diverse Australia and that the importance of these services should not be discounted simply because rural and remote communities are small or because specific skills are required to deliver culturally competent mental health services.

3.58 The committee acknowledges the significant concerns held by witnesses and submitters to this inquiry that the introduction of the NDIS has inadvertently created further barriers to accessing mental health services in many rural and remote areas.

3.59 The lack of expertise and understanding of psychosocial disability within the National Disability Insurance Agency, as well as among health professionals, is something that has been acknowledged by the Commonwealth Government in recent months.

50 Ms Karen Thomas, Queensland State Manager, Neami National, *Committee Hansard*, Townsville, 30 August 2018, p. 18.

51 Mrs Debra Burden, selectability, *Committee Hansard*, Townsville, 30 August 2018, p. 54.

3.60 The committee is pleased to see the announcement of a dedicated psychosocial disability stream within the NDIS and hopes that the introduction of this stream will start to resolve some of the concerns raised during this inquiry and others.

3.61 The committee is concerned about barriers to services for those who are not eligible for the NDIS.

Transport, telecommunications and the tyranny of distance

3.62 One of the biggest barriers to accessing services in rural and remote Australia is the tyranny of distance. The geography of Australia means that many rural and remote communities are literally thousands of kilometres from their nearest capital city and hundreds of kilometres from a regional centre.

3.63 This distance impacts not only on the availability of mental health services on the ground in rural and remote areas, as discussed in the section above, but on the ability for people to travel to those services. Distance from major centres is also a factor in access to reliable telecommunications infrastructure, which is necessary to access telehealth mental health services where travel is not possible or desirable.

Transport and travel

3.64 Transport was raised as a significant barrier to accessing mental health services in rural and remote Australia by witnesses at every hearing and in over half of the submissions received by the committee.

3.65 Submitters and witnesses noted that transport was only an issue because often, rural and remote communities lack sufficient local mental health services. Uniting Care Australia described that for consumers whose only mental health service option 'is to travel to another location, it may mean a whole day or two off work rather than a lunch hour appointment, as would be possible for a city dweller'.⁵²

3.66 Anglicare Southern Queensland submitted that '[e]ven where services exist, access may necessitate travelling long distances with implications for time, costs and managing family responsibilities',⁵³ while Dr Sabrina Pit, who has conducted research into rural GPs' experiences and perceptions of depression management and factors influencing effective service delivery, found that:

Patient's limited ability to travel was perceived as a significant barrier, identified by nine of the ten GPs. This was due to various factors, including geographic isolation, reduced mobility, financial constraints, and lack of public transport in the area.⁵⁴

3.67 Surveys conducted by mental health peak bodies and organisations have shown that many mental health consumers consider transport both as a major barrier to their accessing mental health services and is itself a cause of mental health issues. In Tasmania, 50.4 per cent of people described transport as one of the main challenges

52 Uniting Care Australia, *Submission 18*, p. 2.

53 Anglicare Southern Queensland, *Submission 126*, p. 1.

54 Dr Sabrina Pit, *Submission 112*, p. 2.

for seeking support in rural and remote areas and 47.15 per cent cited access to transport as a contributing factor affecting their mental health.⁵⁵ Similarly in WA, 51.79 per cent of people reported access to transport as affecting mental health in regional areas.⁵⁶

3.68 The Western Australian Association for Mental Health also described how lack of transport prevents access not only to mental health services and supports, but to suitable accommodation and housing options, for example more affordable housing, which is one of the key social determinants of mental health in regional areas.⁵⁷

3.69 The National Rural Health Alliance explained that transport concerns are particularly compounded for Aboriginal and Torres Strait Islander peoples, as:

...there [are] on average ten times fewer vehicles per person, a tendency to have older and inappropriate vehicles, the need to travel long stretches of unsealed roads, and effectively half of the population not having access to public transport or air transport at all.⁵⁸

Public and private transport

3.70 Submitters and witnesses described the transport difficulties faced by consumers in trying to get from a rural or remote community to a regional or metropolitan area to receive mental health services.

3.71 For many, the lack of public transport in rural and remote areas was raised as a concern for those without access to, or who cannot use, personal vehicles. The Executive Officer of CORES Australia, a community-based program for suicide prevention, told the committee that public transport does not meet the needs of consumers who need to attend appointments in town:

When we were working on the community action plans for suicide prevention, they talked about transport. And there are more and more issues with transport. Even in Tasmania, they found that often the buses left early in the morning. For people with mental health issues who wanted services in the city, like Launceston, Devonport or anywhere like that, the services that were there didn't fit them, because often people with mental health issues don't want to get out of bed before lunchtime. So people tended to disconnect from services.⁵⁹

3.72 One psychiatric nurse submitted that public transport is often not available in rural and remote areas and, if it is available, it can take a considerable amount of time and transfers to get to an appointment.⁶⁰ COTA Australia also noted that travel over

55 Community Mental Health Australia, *Submission 16*, p. 7.

56 Western Australian Association for Mental Health, *Submission 34*, p. 11.

57 Western Australian Association for Mental Health, *Submission 34*, p. 9.

58 National Rural Health Alliance, *Submission 37*, p. 11.

59 Ms Sharon Jones, Executive Officer, CORES Australia, *Committee Hansard*, Devonport, 5 September 2018, pp. 1–2.

60 Name withheld, *Submission 114*, [p. 3].

long distances to access services is a significant issue for older people who may no longer drive and rely on community or public transport.⁶¹

3.73 Others described how, even where consumers have access to their own transport, the cost and time required to travel to appointments can impact on attendance. The Mental Illness Fellowship of Australia made the point that consumers can face significant additional costs in attending services due to transport over distances.⁶² This point was echoed by Uniting Care Australia, which reported:

One family accessing a UnitingCare service advised that they had to drive hundreds of kilometres in a year to access mental health support for their child, spending almost \$20,000 on fuel.⁶³

3.74 A consumer representative in Devonport told the committee that some people who own their own car may not be able to drive safely to and from appointments due to the nature of their mental illness or the distress of an appointment, and therefore may choose not to attend.⁶⁴

3.75 Orygen, the National Centre of Excellence in Youth Mental Health, explained that when there is no public transport, a reliance on someone else to help a consumer travel to appointments may raise issues of anonymity. This may be of particular concern in areas where there is a high level of stigma about mental health issues.⁶⁵

Patient transport programs and assistance

3.76 To counteract the lack of readily-available public transport in rural and remote areas, some service providers are working to offer transport as part of their service.⁶⁶ The committee heard that transport was desperately needed in the Kununurra region to ensure that people, particularly those with large families and caring responsibilities, could attend social and emotional wellbeing services. Social and Emotional Wellbeing representative of the Kununurra Waringarri Aboriginal Corporation told the committee that:

A lot of the people we work with don't have vehicles, so we need to go out, pick them up and bring them into town so that they can go to their appointments or go to our appointments.⁶⁷

61 COTA Australia, *Submission 64*, p. 4.

62 Mental Illness Fellowship of Australia, *Submission 20*, [p. 2].

63 Uniting Care Australia, *Submission 18*, p. 2. See also: Youth Affairs Council of South Australia, *Submission 49*, p. 6.

64 Ms Rosemary Boote, Consumer Representative, Flourish Tasmania Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 49.

65 Orygen, *Submission 44*, p. 2.

66 See, for example: Western Australian Local Government Association, *Submission 104*, p. 11.

67 Mr Brendan Morrison, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 5.

3.77 In Tasmania, Youth, Family and Community Connections Inc described how providers have had to transfer some mental health clients from regional areas to Hobart at the providers' own expense, as the medical transport programs provided by the state work on a booking system which don't necessarily match with a client's needs:

Where you're trying to seize an opportunity, if you like, to get that person the assistance they need at that time, it's often just more practical to drive the client to Hobart to get treatment.⁶⁸

3.78 Rural Alive and Well, another Tasmanian service provider, also submitted that its workers have 'become involved in transporting clients to attend appointments given a lack of viable alternatives'.⁶⁹

3.79 Primary Health Tasmania explained to the committee is not in a position to fund transport, but described how it was trying to address the transport and distance concerns:

...within our contracts we do work with our providers to look at how we can best meet outreach needs so that we're not having a provider that's based in Devonport and only delivering service in Devonport. So we articulate in the contracts that we require them to provide outreach into the smaller communities. The reality is that Tasmania, unlike a lot of other states, has a very diverse population scattered across a fairly big area. I don't know if we've got that right at the moment. We're hoping, through the regional planning process and applying the mental health planning framework taxonomy, that we'll get a better picture and a better mix of where services should be, and we can fund to that.⁷⁰

3.80 The committee also heard that in some areas transport may be available for acute or emergency mental illness, but not for day-to-day attendance of necessary appointments.⁷¹ For example, HelpingMinds submitted that while the WA Country Health Service provides some support through the Patient Assisted Travel Scheme, 'this is restricted to appointments with psychiatrists. Access to preventative services such as psychological or psychosocial services is therefore restricted'.⁷²

3.81 The National Rural Health Association noted in its submission that 'funding transport in rural and remote areas has been an ongoing challenge – who funds it, how

68 Ms Roslyn Atkinson, Chief Executive Officer, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 34.

69 Rural Alive and Well, *Submission 90*, p. 6.

70 Mr Grant Akesson, Health Stream Lead, Mental Health and Alcohol and Other Drugs, Primary Health Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 13.

71 Ms Amanda Bresnan, Chief Executive Officer, Community Mental Health Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 24. See also: Benevolent Society, *Submission 71*, p. 5.

72 HelpingMinds, *Submission 98*, p. 9.

much, how often and who pays' in terms of return of investment.⁷³ Some submitters recommended that greater funding should be invested in outreach programs to reach people who do not have transport,⁷⁴ while others recommended that greater emphasis be placed on patient travel assistance schemes, transport vouchers or community drivers.⁷⁵

3.82 The Goulburn Valley Area Mental Health Service recommended that improvements to public transport in regional Australia, such as more reliable train and bus services in rural Victoria, would not only improve consumers' access to mental health services but would 'enable skilled clinicians to travel more easily to rural areas'.⁷⁶

3.83 Services for Australian Rural and Remote Allied Health submitted that the solution to transport for some clients may also have a therapeutic benefit, although this would require flexibility in program funding:

Some clients have benefited from obtaining support to purchase other modes of transport, such as a bicycle. This also serves to improve their mental and physical health through behavioural activation and promotes a sense of purpose and empowerment for them. The limitations of this, however, include extreme heat in summer, where many communities experience conditions where it is simply too hot to ride a bicycle during the day.

Enabling Mental Health workers to approve the purchase of a bicycle for a client, or to approve access to travel vouchers for bus or taxi travel are other possible options for consideration to support client access to the mental health services they need.⁷⁷

Emergency transport

3.84 The committee heard that methods of acute and emergency transport for mental illness in rural and remote areas appear to present other challenges for consumers and providers, primarily caused when there are no appropriate local services. The committee further heard that this can cause people to refuse to access the mental health services they need. The Australian Psychological Society submitted that

73 National Rural Health Alliance, *Submission 37*, p. 11. See also: Mental Health Victoria, *Submission 51*, p. 5.

74 Western Australian Association for Mental Health, *Submission 34*, p. 9; Australian College of Mental Health Nurses, *Submission 82*, p. 9.

75 Consumers of Mental Health WA, *Submission 31*, p. 20; Royal Australian and New Zealand College of Psychiatrists, *Submission 95*, p. 1; Services for Australian Rural and Remote Allied Health, *Submission 21*, p. 4; Australian Rural Health Education Network (ARHEN) Mental Health Academic Network, *Submission 76*, p. 11.

76 Goulburn Valley Area Mental Health Service, *Submission 63*, p. 2. See also: Australian College of Mental Health Nurses, *Submission 82*, p. 9.

77 Services for Australian Rural and Remote Allied Health, *Submission 21*, p. 4.

some people will not seek treatment for mental illness due to a fear of being sedated for transport and then being detained a long distance from home.⁷⁸

3.85 The Australasian College for Emergency Medicine submitted that its members had raised significant concerns about the delays in assessing and transporting patients presenting with mental illness to emergency rooms in rural and remote areas:

ACEM members report being actively discouraged from scheduling mental health patients in rural and remote emergency departments due to known delays with review by mental health telehealth teams (in the absence of face-to-face review). For young patients, this means they can be forced to wait in an isolated room in an emergency department for two to three days until transport is available to send them to an appropriately declared mental health facility, depending on the relevant jurisdictional legislation.⁷⁹

3.86 Other witnesses and submitters also described the distress felt by patients because of how they are treated during the transfer process to access services not available locally. A representative of the National Mental Health Consumer and Carer Forum told the committee that:

When it does happen and someone gets transported, the RFDS has a policy of sedating people who are mental health clients. They sedate them and restrain them. I remember two ladies in particular, both around 25 or 26 years of age. I nearly cried because they spoke about feeling like criminals. When they came around and they woke up in our Royal Adelaide Hospital, they thought they must have committed a crime because they were aware of how they were being treated and they were aware of how they felt. I'm not judging the staff that managed them at all; I understand the need for doing that. But that's the reality.⁸⁰

3.87 The Australasian College for Emergency Medicine noted in its submission that mental health patients in rural and remote areas are more likely to be transported to a hospital emergency department in a police or correctional vehicle than people with other conditions.⁸¹ The Victorian Council of Social Service submitted that, while police may have good intentions, they have 'limited ability to provide an appropriate therapeutic response' for a person experiencing crisis.⁸²

3.88 The WA Country Health Service told the committee of the situation which exemplified many of these concerns which had been recently experienced by one young Aboriginal man in regional WA. In this situation, the young man, who had a

78 Australian Psychological Society, *Submission 103*, p. 11. See also: National Mental Health Consumer and Carer Forum, *Submission 84*, p. 3.

79 Australasian College for Emergency Medicine, *Submission 91*, p. 4.

80 Ms Lyn English, National Mental Health Consumer and Carer Forum, *Committee Hansard*, Canberra, 19 July 2018, p. 25.

81 Australasian College for Emergency Medicine, *Submission 91*, p. 3.

82 Victorian Council of Social Service, *Submission 107*, p. 5.

history of substance abuse, presented to a regional emergency department describing suicidal thinking. He was assessed by an on-call psychiatrist but absconded from the hospital twice, requiring first responders and police to retrieve him. In the end, it was determined that:

... to safely perform a full assessment on that person required his transfer to Perth. To transfer him to Perth required involvement of the flying doctor. It required a level of sedation to allow his safe transfer on the plane....He arrived in Perth and he was seen, by sheer coincidence, by a psychiatrist who actually used to work in the region as well, so he knew of the family. It was a remarkable kind of circumstance. The Mental Health Act under which he was referred couldn't be applied to make him an involuntary patient, and he came home. So he presented to the hospital and was triaged, assessed, treated, transferred to the city and then sent home, back to the regional centre again....He didn't want to stay, and there weren't sufficient grounds under the Mental Health Act to force him to stay as an involuntary patient, and so he's back in the community.... That's caused some ructions in terms of the family and their confidence in the mental health service, and so we'll have to rebuild that trust again. That's not an unusual story.⁸³

3.89 The Western Australian Government submitted that a post-implementation review of the state's *Mental Health Act 2014* conducted in March 2018 had highlighted concerns about 'the relationship between limited access to specialist mental health care in regional areas and the high demand for transfers of mental health consumers to the metropolitan area' as well as delays in 'timely access to transportation by police and the Royal Flying Doctor Service'. The Western Australian Mental Health Commission and Western Australian Department of Health are now conducting work to 'identify causes and potential solutions to reduce delays in regional mental health transfers'.⁸⁴

3.90 The RFDS submitted that between July 2013 and June 2016, it provided aeromedical retrievals of 2567 patients experiencing acute mental health episodes requiring emergency treatment in a tertiary hospital. The RFDS expressed the view that 'many of these emergency retrievals could be avoided if more appropriate and comprehensive mental health services were available in more remote and rural areas'.⁸⁵

Telecommunications

3.91 Telehealth, as discussed in Chapter 2 of this report, is becoming an increasingly popular method of service delivery in rural and remote areas to combat the lack of available local services.

83 Dr Roland Main, WA Country Health Service, *Committee Hansard*, Albany, 5 June 2018, pp. 2–3.

84 Government of Western Australia, *Submission 35*, pp. 26–27.

85 RFDS, *Submission 22*, p. 6.

3.92 However, a lack of telecommunications infrastructure is limiting telehealth as a viable option to address the barriers of distance, travel cost, availability of services for many consumers and health professionals in these areas. The Western Australian Association for Mental Health submitted that:

...rural and remote areas lack stable, predictable and reliable infrastructure. Internet and mobile coverage are sporadic and intermittent, so services delivered through technology are not always reliable or available.⁸⁶

3.93 A large number of witnesses and submitters described telecommunications infrastructure in rural and remote areas, including landline telephones, mobile telephones and internet access, as poor, intermittent and unreliable.⁸⁷ Access to the internet in particular was described as a major issue, as many mental health services now have online or video-capable offerings such as telehealth or web-based services and there is an assumption that consumers will be able to access these if they are unable to use face-to-face services.⁸⁸ However evidence suggests that access to the internet for telehealth varies widely in rural and remote areas across the country.⁸⁹

3.94 Census data released in October 2018 shows that 23 per cent of households in remote and very remote locations in Australia do not have internet access, compared to only 12 per cent of households in major cities.⁹⁰ In some locations and demographics, the proportion of people without access to the internet is even higher.

3.95 The Western Queensland PHN reported that 27.3 per cent of people in their catchment area have no internet access,⁹¹ while the Victorian Council of Social Service observed that people on low incomes are even more likely to not have a

86 Western Australian Association for Mental Health, *Submission 34*, p. 21.

87 For example: Mrs Danielle Dyll, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 8; Frontier Services, *Submission 4*, p. 2; Butterfly Foundation, *Submission 110*, p.14; Mental Health Association of Central Australia, *Submission 27*, p. 6; Being, *Submission 92*, p. 13; Australian Mental Health Commissions, *Submission 52*, p. 17.

88 Mrs Connie Digolis, Chief Executive Officer, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 41; Western Australian Association for Mental Health, *Submission 34*, p. 23; Roses in the Ocean, *Submission 7*, p. 5; Benevolent Society, *Submission 71*, p. 12; Western Queensland PHN, *Submission 125*, p. 3.

89 Mr Michael Tunnecliffe, Clinical Psychologist, Ashcliffe Psychology, *Committee Hansard*, Albany, 5 June 2018, p. 38; Mrs Danielle Dyll, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 8; Ms Amanda Bresnan, Community Mental Health Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 22; Anglicare Southern Queensland, *Submission 126*, p. 5; Community Mental Health Australia, *Submission 16*, p. 10; Uniting Care Australia, *Submission 18*, p. 9; Orygen, *Submission 44*, p. 9.

90 Australian Bureau of Statistics (ABS), *8146.0 - Household Use of Information Technology, Australia, 2016-17*, March 2018, <http://www.abs.gov.au/ausstats/abs@.nsf/PrimaryMainFeatures/8146.0> (accessed 19 November 2018).

91 Western Queensland PHN, *Submission 125*, p. 3.

connection, noting that two thirds of people who received Salvation Army emergency relief could not afford an internet connection at home.⁹²

3.96 Sane Australia submitted that while online mental health support can bridge some of the gaps in mental health services in rural and remote areas:

...further work is needed to promote digital inclusion for the approximately 2.5 million Australians who, for health, geographic, education or socio-economic reasons, are not online.⁹³

3.97 The adequacy of the internet connection being accessed was also of concern to submitters, with one cited study finding that 48 per cent of people surveyed living outside of capital cities described the internet access they had as inadequate or not meeting their current needs.⁹⁴

3.98 OzHelp described in its submission that the quality of internet access in rural and remote areas is in part based on the technology available and that good connections may not be affordable or accessible to those who are disadvantaged; for example, in one 2016 survey, fibre-to-the-premise or fibre-to-the-node technology was found to be available to 88 per cent of people in the most socio-economically advantaged outer regional areas compared to only 12 per cent of those in the least advantaged areas.⁹⁵ The Local Government Association of Queensland also noted that many rural property owners and satellite towns will not get access to these technologies but will remain reliant on satellite internet access.⁹⁶

3.99 The Royal Australasian College of Physicians submitted that an 'obvious technical barrier to the greater use of telehealth' is access to a reliable broadband internet connection, which was ranked as the number two priority in the 2016 Australian Medical Association's Rural Health Issues Survey.⁹⁷ The joint submission from the Queensland Association of Mental Health and the Northern Territory Mental Health Coalition expressed the view that:

It's no good providing these [telehealth] services if internet accessibility is so bad that it doesn't allow a continuous connection, or if it becomes too expensive for people to get access to adequate internet services.⁹⁸

3.100 The Mental Health Academics Network of the Australian Rural Health Education Network shared these concerns about the expensive of internet access, submitting that:

92 Victorian Council of Social Service, *Submission 107*, p. 9.

93 SANE Australia, *Submission 130*, p. 5.

94 HealthWise, *Submission 68*, p. 2.

95 OzHelp, *Submission 11*, p. 5.

96 Local Government Association of Queensland, *Submission 19*, p. 6.

97 Royal Australasian College of Physicians, *Submission 78*, p. 5.

98 Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, *Submission 26*, p. 12.

The cost of access to a reliable internet connection is ongoing an issue, particularly in remote areas where there is no competition or where only one service provider has reliable coverage.⁹⁹

3.101 The committee heard that it is not only consumers who require reliable internet access to facilitate mental health services and access in rural and remote areas.

3.102 The National Rural Health Association submitted that web-based continuing professional development, a requirement for ongoing registration, is important for health professionals working in remote areas and that 'accessing webinars is dependent on a quality and reliable internet services so they can participate'.¹⁰⁰ Health professionals also described their frustrations with the quality of internet access in their work in rural and remote locations. Dr Vladislav Matic, Board Chair of the Northern Queensland PHN, told the committee:

The other thing is that my experience, at least having done some locums in some really remote places, is it only takes a couple of people in the community to be watching Netflix and the bandwidth has gone. And all of a sudden the surgery computers slow down and there's no access to My Health Record or anything else.¹⁰¹

3.103 While some submitters and witnesses discussed the need for internet connections of a quality that supports the use of videoconferencing for telehealth,¹⁰² others noted that, where this is not possible, low-bandwidth options such as mobile apps, online forums and webchat can still play an important role in early intervention and peer support-based mental health services, as well as promoting social inclusion.¹⁰³

3.104 The committee received evidence that some providers are trying to find solutions to the internet access barrier: Grow, a provider of mental health and wellbeing support groups, told the committee that some members of its online groups are unable to participate due to lack of personal internet access or the additional cost of using mobile data. To overcome this barrier, Grow has started to provide these participants with tablets with a data plan for use at no cost.¹⁰⁴

99 ARHEN Mental Health Academic Network, *Submission 76*, p. 13.

100 National Rural Health Alliance, *Submission 37*, p. 20.

101 Dr Vladislav Matic, Board Chair, Northern Queensland PHN, *Committee Hansard*, Townsville, 30 August 2018, p. 15.

102 For example: Ms Lyn English, National Mental Health Consumer and Carer Forum, *Committee Hansard*, Canberra, 19 July 2018, p. 34; Mr Dylan Lewis, Private capacity, *Committee Hansard*, Katherine, 9 July 2018, p. 23.

103 Ms Georgina Harman, Chief Executive Officer, beyondblue, *Committee Hansard*, Canberra, 19 July 2018, p. 42. See also: On The Line, *Submission 58*, p. 5; OzHelp, *Submission 11*, [p. 4]; SANE Australia, *Submission 130*, p. 5; Being, *Submission 92*, p. 12 and Interrelate, *Submission 77*, [p. 4].

104 Grow, *Submission 29*, p. 6.

3.105 The overwhelming recommendation from submitters to solve the telecommunications barriers to accessing mental health services was that there should be investment in infrastructure, such as the National Broadband Network and mobile phone networks, to ensure reliable phone and internet access in all rural and remote communities.¹⁰⁵

3.106 Suicide Prevention Australia further recommended:

...greater development of online communication and information technologies to greatly reduce the barriers of distance that typically disadvantage communities in rural areas. This must be matched by a commitment from government to collaborate with telecommunications service providers to improve parity of access to cost competitive broadband internet networks and infrastructure across rural and remote areas of Australia.¹⁰⁶

Committee view

3.107 In the face of limited services 'on the ground' in many rural and remote communities, transport and telecommunications are vital to accessing services based in regional and metropolitan areas. However, these obvious solutions to the barrier of distance can create new barriers in and of themselves.

3.108 The committee recognises that public transport is not available in many rural and remote locations and notes the efforts made by communities and service providers to transport consumers to the mental health services they require. The committee considers that service providers in these locations need flexibility within their funding models to provide transport services and solutions to overcome lack of transport.

3.109 The committee is concerned to hear that the methods of acute and emergency transport for mental illness in rural and remote communities, particularly in relation to the sedation of patients, are deterring some people from seeking help for their mental health. While aeromedical retrievals play a vital role in emergency medicine across the country, the committee strongly agrees with the view of the RFDS that such retrievals for mental health could be avoided if there were more appropriate and comprehensive mental health services in rural and remote areas.

3.110 The committee is aware that the lack of telecommunications infrastructure, particularly reliable access to the internet, is limiting the use of telehealth in rural and remote Australia. This must be addressed if telehealth is to be considered a viable option to address the barriers of distance, travel, and availability of services.

105 For example: beyondblue, *Submission 85*, pp. 16–18; Queensland Nurses and Midwives' Union, *Submission 36*, p. 14; AMSANT, *Submission 129*, pp. 6–7; Australian Association of Social Workers, *Submission 102*, p. 7; Western Australian Association for Mental Health, *Submission 34*, p. 21; Flourish Australia, *Submission 50*, p. 4.

106 Suicide Prevention Australia, *Submission 86*, p. 14.

Other social determinants of health

3.111 Submitters and witnesses explained to the committee that some of the biggest barriers to overcome in accessing mental health services are social determinants of health, which can be different in rural and remote communities to those felt in urban locations.¹⁰⁷ These barriers are often difficult to overcome as social determinants of health can be a result of structural disadvantage.¹⁰⁸

3.112 Social determinants of health include the circumstances in which people are born, grow up, live, work and age, and the healthcare available to treat any illness.¹⁰⁹ The World Health Organisation's *Commission on Social Determinants of Health 2005–2008* found that:

There is a social gradient in health such that the lower a person's socioeconomic position, the worse their health, including their mental health, is likely to be. The Commission broadly identified the cause of inequity as unequal access to health care, schools and education, conditions of work and leisure, housing, and their chances of leading a healthy life.¹¹⁰

3.113 The Australian Psychological Society informed the committee that social determinants of health have a strong impact on mental health and social and emotional wellbeing, and that people with a mental health illness are more likely to have experienced disadvantage and be on a low income, with many living in poverty.¹¹¹

3.114 The committee heard that the impacts of social determinants of health can be twofold: firstly people may be more likely to experience a mental illness and secondly, they are less likely to be able to access mental health support services due to their circumstances.

Socioeconomic status

3.115 Many submitters and witnesses informed the committee that socioeconomic status will impact on the availability and effectiveness of mental health services in rural and remote areas, as well as the likelihood of a person experiencing a mental illness or psychological distress.¹¹²

3.116 Research Australia submitted that people living in areas classified as having the lowest level of socioeconomic status had the highest rate of mental health-related

107 See, for example: Central Australian Aboriginal Congress, *Submission 55*, pp. 8 and 12; Western Australian Association of Mental Health, *Submission 34*, pp. 9–12; Australian Psychological Society, *Submission 103*, p. 8; Australian Research Alliance for Children and Youth, *Submission 81*, pp. 7–8.

108 Australian Psychological Society, *Submission 103*, p. 8.

109 Australian Psychological Society, *Submission 103*, p. 8.

110 Australian Psychological Society, *Submission 103*, p. 8.

111 Australian Psychological Society, *Submission 103*, p. 8.

112 See, for example: RFDS, *Submission 22*, Attachment 1, p. 19; WA Primary Health Alliance, *Submission 33*, p. 3; Orygen, *Submission 44*, p. 2; Australian Psychological Society, *Submission 103*, p. 8; Research Australia, *Submission 117*, p. 6.

presentations to hospital emergency departments, representing 26.8 per cent of presentations.¹¹³ Emergency department presentations gradually decrease as socioeconomic status increases, with the highest socioeconomic status making up 13.8 per cent of mental health-related presentations.¹¹⁴

3.117 Furthermore, young people (aged 10–15 years old) from low socioeconomic backgrounds are two and a half times more likely to be diagnosed with anxiety and depressed moods than those with high socioeconomic status.¹¹⁵

3.118 The National Rural Health Alliance informed the committee that the rate of suicide is also correlated with socioeconomic status.¹¹⁶ Between 2011 and 2015, the rate of suicide per 100 000 population was 14.5 for the lowest level of socioeconomic status, significantly higher than the highest level of socioeconomic status at 8.3 per 100 000 population.¹¹⁷

3.119 The most recent Census of Population and Housing in 2016 found that people with the highest level of socioeconomic status tend to live in capital cities, whereas people within the lowest level of socioeconomic status tend to live in regional and rural areas.¹¹⁸

3.120 As rural and remote areas generally have a higher proportion of people with socioeconomic disadvantage, the evidence put to the committee suggests that socioeconomic status is one factor which contributes to the high rate of suicide in rural and remote communities in Australia.¹¹⁹

3.121 However, there are many factors which contribute to a persons' socioeconomic status such as employment, level of income and housing security, which subsequently impacts on their ability to access and afford mental health services. These factors are discussed further below.

113 Research Australia, *Submission 117*, p. 7. See also: AIHW, *Mental Health Services in Australia*, 'Hospital emergency services', Table ED.6: Mental health-related emergency department presentations in public hospitals, by patient demographic characteristics, 2016–17, updated 11 October 2018.

114 Research Australia, *Submission 117*, p. 7.

115 National Mental Health Consumer and Carer Forum, *Submission 84*, p. 2.

116 National Rural Health Alliance, *Submission 37*, p. 13.

117 National Rural Health Alliance, *Submission 37*, p. 13. See also: AIHW, *Mortality Over Regional and Time (MORT) books*, 'Socioeconomic group 2012–2016', Table 2: Leading causes of death, by sex, 2012–2016, updated 18 July 2018.

118 ABS, *2071.0 - Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016*, 'Socio-economic Advantage and Disadvantage', 6 November 2018, <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Socio-Economic%20Advantage%20and%20Disadvantage~123> (accessed 19 November 2018).

119 See, for example: National Mental Health Consumer and Carer Forum, *Submission 84*, p. 2.

Employment and income level

3.122 The committee heard that employment and income level can impact a person's ability to access mental health services as well as their likelihood of experiencing mental illness during their life, and that this is particularly relevant in rural and remote communities where there is often a lower employment rate than in urban locations.¹²⁰

3.123 The National Survey of Mental Health Wellbeing found that education, employment and income are closely related to a person's socioeconomic status.¹²¹ The survey found that people who are unemployed are more vulnerable to mental illness and they are more likely to experience insecurity, feelings of hopelessness and risk to their physical health.¹²²

3.124 Of the survey respondents who were unemployed, 29 per cent experienced a mental illness within the preceding 12 months, compared to 20 per cent of people who were employed.¹²³

3.125 The National Mental Health Consumer and Carer Forum also submitted that mental health can be impacted by the employment status and the income of individuals and households.¹²⁴ A survey conducted by the Mental Health Council of Tasmania for the purpose of this inquiry found that 74 per cent of respondents identified unemployment as an issue affecting their mental health and 67 per cent identified lack of income.¹²⁵

3.126 A number of witnesses also told the committee that unemployment was a problem in their community which impacted on the rate of mental health illness.¹²⁶ For example, Mr John Singer from the Nganampa Health Council, told the committee that in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, only 30 per cent of people aged between 16 and 30 years old were employed.¹²⁷ As noted below, unemployment can greatly affect a person's mental health if it impacts on their sense of purpose and self-worth.

120 See, for example: National Mental Health Consumer and Carer Forum, *Submission 84*, p. 2.

121 ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 13.

122 ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 13.

123 ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, pp. 14 and 31.

124 National Mental Health Consumer and Carer Forum, *Submission 84*, p. 2.

125 Community Mental Health Australia, *Submission 16*, p. 7.

126 See, for example: Mr Simon Dann, Senior Medical Health Worker (Psychologist) and Alcohol and Drug Coordinator, *Committee Hansard*, Kununurra, 5 July 2018, p. 1; Ms Maureen Robertson, Social and Emotional Wellbeing Unit Manager, Provisional Psychologist, *Committee Hansard*, Derby, 6 July 2018, pp. 2–3; Mrs Trish O'Duffy, Manager, St Helen's Neighbourhood House; Member, *Committee Hansard*, St Helens, 6 September 2018 pp. 14–15.

127 Mr John Singer, Executive Director, Nganampa Health Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 23.

3.127 The Aboriginal and Torres Strait Islander Healing Foundation (Healing Foundation) attributed the high unemployment in some remote communities to a combination of poor educational outcomes and trauma experienced by Aboriginal and Torres Strait Islander peoples, which continues to undermine their ability to engage in employment.¹²⁸ The impact of trauma on Aboriginal and Torres Strait Islander will be explored further in Chapter 4.

3.128 While social security benefits may be available to some people who are unemployed, the committee heard that these payments are insufficient to pay for daily essentials such as food, fuel and housing as the cost of living in rural and remote areas is significantly higher than in major cities, yet recipients receive the same amount as their city counterparts.¹²⁹

3.129 The National Mental Health Consumer and Carer Forum explained that it is unlikely that an individual on a low income will be able to afford specialist support and treatment, particularly in rural and remote Australia where the costs of these services can be higher.¹³⁰ Furthermore, it is also common for people who are unemployed to experience feelings of insecurity and hopelessness which subsequently has a negative impact on their mental health.¹³¹

Self-worth and sense of purpose

3.130 Some submitters and witnesses attributed the negative impact of unemployment and low income levels to the sense of purpose and self-worth which comes from employment. For example, Dr Martin Kelly from the Nganampa Health Council explained to the committee that providing some community members of the APY Lands meaningful activity had improved their mental outlook:

I think another broader question is the question of work or at least structured, meaningful activity. Too many of our younger people don't have opportunities or hope. 'Where there is no vision, the people perish' is an old saying. That's what I'm afraid happens to lots of males in particular. Women in our communities have child raising, and that sort of stuff is an activity that families rally around and support, and it has meaning, it gives meaning, it's worthwhile and everybody knows that. I think a lot of men don't have as much of that going for them. ...But I think, having seen a number of people in our communities who have meaningful activity, not necessarily paid employment, and sometimes doing out-of-the-box kind of stuff that gives their life meaning, it has often turned their lives around.¹³²

3.131 In Albany, a peer support network has been established to provide information and support services to people in the region experiencing depression. The Depression

128 Healing Foundation, *Submission 39*, p 5.

129 Yura Yungi Medical Service Aboriginal Corporation, *Submission 70*, [p. 1].

130 National Mental Health Consumer and Carer Forum, *Submission 84*, p. 2.

131 National Mental Health Consumer and Carer Forum, *Submission 84*, p. 2.

132 Dr Martin Kelly, Senior Medical Officer, Nganampa Health Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 22.

Support Network Albany provides links to support services, education sessions on mental illness, craft sessions, walking groups and eat meals together.¹³³ The peer support network is run by people who have a mental illness as well as volunteers who do not have full-time employment:

You're enabling them to have purpose. They feel as if they are contributing. It's very much about using the skills of the people who are in the groups and saying, 'What have you got to contribute?' So they'll have art groups and people will have a skill there. It's very much about finding purpose. People's self-esteem improves, and there is that feeling of not being alone—that there is someone who you can talk to.¹³⁴

Housing security

3.132 Many submitters and witnesses identified housing security and overcrowding as a barrier which impacted the mental health of people in rural and remote communities.¹³⁵

3.133 Ms Cheryle Kaesler from the Yura Yungi Medical Service in Halls Creek told the committee that there is a limited supply of public housing in the community and there are virtually no private rental properties.¹³⁶ Ms Kaesler explained that this often leads to overcrowding in the available housing:

There's often in excess of five families living in a one-bedroom or two-bedroom home. There have been housing homes here but they are often only two- or three-bedroom homes and there are a lot more people than that within the family so, therefore, I feel they are far too small. There's an extensive waiting list on the housing commission, up to four to eight years. What we find is that this builds frustration. I honestly think it has sometimes led to suicide, because people are frustrated, they can't get out of it and there are arguments and things like that within families.¹³⁷

133 Ms Jo Brown, Depression Support Network Albany, *Committee Hansard*, Albany, 5 June 2018, p. 30.

134 Mrs Penny Carpenter, Depression Support Network Albany, *Committee Hansard*, Albany, 5 June 2018, p. 31.

135 See, for example: Healing Foundation, *Submission 39*, pp. 4 and 13; Northern Territory PHN, *Submission 54*, p. 2; Yura Yungi Medical Service, *Submission 70*, [p. 1]; Mr Simon Dann, *Committee Hansard*, Kununurra, 5 July 2018, p. 1; Miss Mary Moloney, Wellbeing Manager and Registered Mental Health Nurse, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 11.

136 Ms Cheryle Kaesler, Yura Yungi Medical Service, *Committee Hansard*, Halls Creek, 5 July 2018, p. 1.

137 Ms Cheryle Kaesler, Yura Yungi Medical Service, *Committee Hansard*, Halls Creek, 5 July 2018, p. 1.

3.134 Mr Jake Hay from the local council in Halls Creek advised that for young people, feelings of anxiety and depression are often a product of their home environment:

There are no services that exist in the overnight period, and this is a time where a lot of these traumatic episodes happen for young people, such as not knowing who's going to be there when they go home—their house might be overcrowded, there might be family coming in from all sorts of places and suddenly you've got 20 people in a three-bedroom home. You might also have issues such as excessive noise and excessive alcohol consumption which scare a lot of the young people away from their homes at night.¹³⁸

3.135 The committee also heard that overcrowded housing can increase the risk of sexual assault, particularly for young people, which is often an underlying cause of mental illness.¹³⁹

3.136 In some rural and remote communities, housing is unaffordable (particularly for people receiving social security benefits) and there are extensive waitlists for public housing.¹⁴⁰

3.137 The National Survey of Mental Health and Wellbeing found that homelessness was a significant risk factor for mental illness.¹⁴¹ The survey found that of the respondents who had ever been homeless, 54 per cent experienced a mental illness in the preceding 12 months, compared to only 19 per cent of people who had never been homeless.¹⁴²

Drug and alcohol addiction

3.138 Submitters and witnesses told the committee that drug and alcohol addiction was often comorbid with mental health issues.¹⁴³ The National Mental Health and Wellbeing Survey found that people who drank nearly every day were more likely to experience mental health issues than those who drank less than once a month:

People who reported that they drank nearly every day had more than 10 times the prevalence of 12-month Substance Use disorders compared

138 Mr Jake Hay, Regional Program Manager Youth, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 14.

139 Ms Brenda King, Sexual Assault Counsellor, Anglicare WA, *Committee Hansard*, Kununurra, 5 July 2018, p. 20.

140 Ms Jo Brown, Depression Support Network Albany, *Committee Hansard*, Albany, 5 June 2018, p. 27.

141 ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 14.

142 ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, pp. 14 and 32.

143 See, for example: Mr Benjamin Hedlam, Manager, Great Southern Community Alcohol and Drugs Service, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 17; One Door Mental Health, *Submission 122*, [p. 10].

with people who reported that they drank less than once a month (10.5% and 1.0% respectively).¹⁴⁴

3.139 The statistics do not, however, identify whether the relationship between alcohol and mental health is causal or correlational. The National Mental Health and Wellbeing survey finds that people who are diagnosed with alcohol dependence are more likely to have other mental health problems and that people with mental health problems were at greater risk of experiencing problems related to alcohol.¹⁴⁵

3.140 The National Mental Health and Wellbeing survey also found that 63 per cent of respondents who misused drugs nearly every day in the 12 months prior to the survey reported experiencing a mental illness.¹⁴⁶

3.141 The Alcohol and Drug Coordinator for the Ord Valley Aboriginal Health Service told the committee that the correlation between mental health and alcohol and drug issues may be related to self-medication:

I believe that, quite often, alcohol and drug use is self-medication for underlying mental health disorders and psychological distress.¹⁴⁷

3.142 Submitters and witnesses told the committee which drugs they were most concerned about in their communities. Palmerston Association Inc told the committee that methamphetamine was emerging as the drug of greatest concern in the Great Southern region of WA:

Patterns of drug use have shifted significantly in recent years. Historically, alcohol has been the primary drug of concern for Palmerston clients. However, in the 2016-17 aggregated data across the organisation, methamphetamine emerged as the primary drug of concern. In the Great Southern, we see a very similar picture, however cannabis has long featured heavily in the Great Southern.¹⁴⁸

3.143 The Ord Valley Aboriginal Health Service in Kununurra and the Nganampa Health Council in Alice Springs told the committee that they were concerned about the high level of cannabis use in their communities.¹⁴⁹

144 ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 18.

145 ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 17.

146 ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 18.

147 Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 1.

148 Mr Benjamin Hedlam, Great Southern Community Alcohol and Drugs Service, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 17.

149 Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 1; Mr John Singer, Nganampa Health Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 23.

3.144 The Central Australian Aboriginal Congress told the committee that alcohol was a significant contributor to mental ill health and wellbeing:

Alcohol is also a related and major contributor to mental ill health and poor social and emotional wellbeing, risky behaviour and is a precursor for suicide. Alcohol abuse is directly associated with at least 8 per cent of the burden of disease and injury borne by Aboriginal people, including through homicide, violence, and suicides.¹⁵⁰

3.145 This view was supported by the committee's visit to the Barkly Work Camp in Tennant Creek where the committee heard that alcohol and violence were often present in the prisoner's home environments.¹⁵¹

3.146 The North West Hospital and Health Service explained that significantly more people presented for alcohol related issues than for other drugs:

In terms of the drug and alcohol side of things, around 79 per cent is alcohol related only. Second to that is cannabis and the third is amphetamine use, which is three per cent.¹⁵²

3.147 Submitters noted it is important to address both mental health issues and substance abuse issues simultaneously. The Program Coordinator for Richmond Wellbeing and the Manager of the Great Southern Alcohol and Drug Service at the Palmerston Association Inc told the committee that specialist services need to be offered that can deal with alcohol and drug issues and mental health.¹⁵³

3.148 The Central Australian Aboriginal Congress explained that it is necessary to have a service that treats mental health and substance abuse issues together to stop the people being moved around the health system without addressing all of their issues:

Whether it's physical health or mental illness, it's all beginning in early childhood and we need service systems that can deal with people in that way. So we're not shuttling people between. 'Oh, you've got a grog problem; you go there,' and then the alcohol says, 'Oh, hang on; you've got a bit of psychosis. Even though you've got an alcohol issue, you've also got this, so go over to mental health.'... We've got to stop all that. We don't have that [at] congress—we treat the whole person.¹⁵⁴

150 Central Australian Aboriginal Congress, *Submission 55*, p. 11.

151 See Appendix 3.

152 Ms Sandra Kennedy, Director of Mental Health and Alcohol Tobacco and Other Drug Service, North West Hospital and Health Service, *Committee Hansard*, Mount Isa, 29 August 2018, p. 42.

153 Mr Benjamin Hedlam, Great Southern Community Alcohol and Drugs Service, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 17; Samuel Rose, Richmond Wellbeing, *Committee Hansard*, Albany, 5 July 2018, p. 30.

154 Associate Professor John Boffa, Chief Medical Officer Public Health, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 2.

Incarceration

3.149 The National Mental Health and Wellbeing Survey reported an increased rate of mental disorder among respondents who had been incarcerated. The survey reported that 41 per cent of respondents who have ever been incarcerated had a mental disorder in preceding 12 months compared to only 19 per cent of people who had never been incarcerated.¹⁵⁵

3.150 The Healing Foundation considered that the circumstances that lead to the incarceration of Aboriginal and Torres Strait Islander peoples are often caused by trauma:

The disproportionate levels of incarceration of Aboriginal and Torres Strait Islander people is both symptomatic of, and a cause of trauma, with a strong correlation between criminogenic risk factors, the social determinants of health, and the prevailing symptoms of trauma.¹⁵⁶

3.151 Miss Nawoola Newry told the committee that the trauma that led to incarceration was a perpetual cycle because parents do not know how to deal with it:

There's definitely a link between incarceration of young people and the lack of mental health services. Because there's so much trauma in most of our families up here, the parents don't know how to deal with that, and the parents are so traumatised themselves that the young people are seeing really bad behaviour, experiencing bad behaviour, experiencing their own trauma as well, which is leading them into all the crime, which is ending them up in jail.¹⁵⁷

3.152 The Healing Foundation told the committee that the mental health issues of Aboriginal and Torres Strait Islander peoples may not be diagnosed until the person is at a crisis point or is incarcerated.¹⁵⁸

3.153 The committee heard a similar perspective during its visit to the West Kimberley Regional Prison in Derby. The committee spoke with two prisoners who explained that their mental illnesses had not been effectively diagnosed or treated in their respective communities. However, the mental health services they received at West Kimberley Regional Prison had shown them how their mental illness had contributed to their offending and equipped them with strategies to modify their behaviour and improve their mental health.¹⁵⁹

3.154 Danila Dilba Health Service told the committee that when children end up in the juvenile justice system they are still not provided with adequate supports even though it is clear what support is required:

155 ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 30.

156 Healing Foundation, *Submission 39*, p. 4.

157 Miss Nawoola Newry, *Committee Hansard*, Broome, 6 July 2018, p. 28.

158 Healing Foundation, *Submission 39*, p. 6.

159 See Appendix 3.

When we look at the kids in the juvenile justice system, we see that every single one of those children is suffering from some form of trauma. They are affected by trauma. Even the people who run the facility say, 'We know that all of these children are affected by trauma,' and yet the system is not providing those children with a comprehensive, high-quality mental health service while they are incarcerated or while they're on parole. There are very limited mental health interventions available in the youth detention facility. We have a team that is funded to provide some input, mainly in the form of social support, but we've snuck a bit of therapeutic support in as well. We're providing some therapeutic group stuff in the centre, but the children do not get the level of mental health support that they need.¹⁶⁰

3.155 The Healing Foundation told the committee that the New South Wales Prison Inmate study found that the rates of mental illness among Aboriginal and Torres Strait Islander inmates was higher than for non-Indigenous inmates.¹⁶¹

3.156 The Western Australia Association for Mental Health relayed that the impact of incarceration away from country can also have an effect on mental health:

...the resultant impact of incarceration, often away from Country, on Aboriginal people's connection to family, land and community all of which impacts negatively on mental health.¹⁶²

3.157 Aarnja Ltd reminded the committee that Aboriginal and Torres Strait Islander peoples continue to be incarcerated at a higher rate than non-Indigenous Australians and considered that the role of mental illness and the effects of trauma need to be considered:

The factors that cause mental health are known...Aboriginal people are not predisposed; it's not in our genetics or DNA to be criminals, yet we make up the highest rate of people incarcerated...Illness doesn't see colour. We're all the same; we're human beings. We operate the same way.¹⁶³

Committee view

3.158 The committee notes that there is a strong relationship between social determinants of health, the likelihood of developing a mental illness and the accessibility of mental health services, and that the negative impacts of social determinants of health are more prevalent in rural and remote communities.

3.159 The committee acknowledges the relationship between mental health issues and substance abuse and believes that these issues must be addressed simultaneously to adequately address both the cause and symptoms of mental illness and psychological distress.

160 Ms Joy McLaughlin, Senior Officer, Strategy, Research and Policy, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p. 26.

161 Healing Foundation, *Submission 39*, p. 7.

162 Western Australian Association for Mental Health, *Submission 34*, p. 12.

163 Mr Martin Sibosado, Chairperson/WKEC Leader, Aarnja Ltd – Empowered Communities, Aarnja Ltd, *Committee Hansard*, Broome, 6 July 2018, p. 3.

3.160 The committee notes that overcoming these social determinants of health is challenging as they are often the product of unequal access to health care, brought about by structural disadvantage and social and economic policy. However, the committee believes that to address mental health in regional, rural and remote areas these social determinants must be improved.

Attitudes to mental health

3.161 Throughout the inquiry, the committee received evidence about how attitudes to mental health in rural and remote communities may influence decision making about whether to seek professional assistance for mental health issues. This section considers a number of the factors that witnesses and submitters raised with the committee.

Stigma

3.162 As noted above, while mental health issues are experienced at similar rates across Australia, mental health services are accessed at lower rates in rural and remote areas. Royal Australian College of General Practitioners Rural told the committee that while the principal driver of lower rates of access was the reduced availability of mental health services in rural and remote areas, a range of socio-economic and cultural factors, specific to rural and remote communities, that affect attitudes toward mental health services may also contribute to lower rates of access.¹⁶⁴ The Royal Australian College of Physicians, Being, the Northern Territory PHN and others told the committee that stigma was one of the factors that may explain lower rates of access in rural and remote communities.¹⁶⁵

3.163 Submitters told the committee that people with a lived experience of mental illness had told them that a number of factors, including their fear of stigma and a lack of confidentiality or anonymity when accessing services, led to decisions not access mental health services in their community. The Australian Mental Health Commissions told the committee that:

Anecdotal evidence from engagement with local communities has indicated that discrimination due to mental illness is a factor which affects whether a person seeks services in their town. People living with mental illness tell us that stigma and discrimination are very common experiences for them. This acts as a barrier to people receiving the support they need, when they need it. For some, anonymity is important and they will travel to the next town or regional centre to get the support they need, if it is available and they are seeking help or know where to seek help from.¹⁶⁶

164 Royal Australian College of General Practitioners Rural, *Submission 24*, [p. 4]. See also: One Door Mental Health, *Submission 122*, [p. 6].

165 See, for example: Neami National, *Submission 40*, p. 3; NT PHN, *Submission 54*, [p. 2]; Royal Australian College of Physicians, *Submission 78*, p. 5; Being, *Submission 92*, p. 4.

166 Australian Mental Health Commissions, *Submission 52*, p. 16.

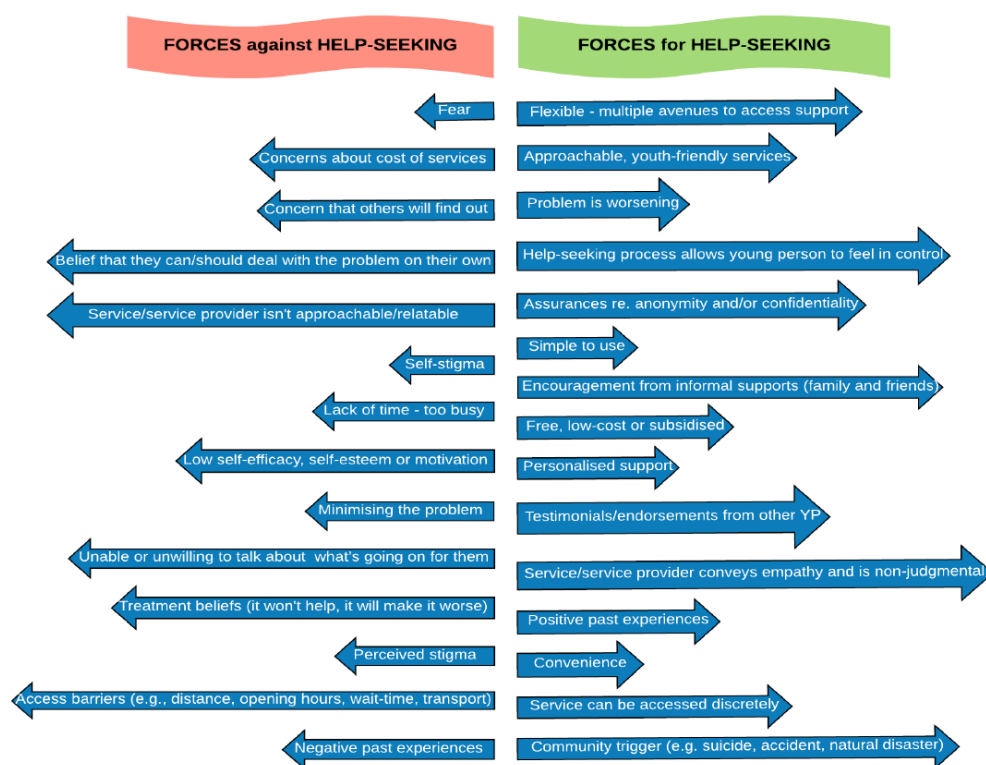
3.164 The Queensland Alliance for Mental Health and the Northern Territory Mental Health Coalition told the committee that they had received similar feedback regarding stigma from communities they had consulted:

The issue of stigma was one that was constantly raised in our discussions with members regarding this inquiry. Rural communities have a culture of self-sufficiency and self-reliance which does not lend itself to openly seeking treatment when it might be required. The lack of anonymity in small rural settings often creates barriers to access due to stigma and privacy.¹⁶⁷

Other factors

3.165 The committee received evidence that there was a complex array of factors that contributed to whether a person sought to access mental health services.¹⁶⁸ ReachOut described the forces that were faced by younger people deciding whether to access services as a 'tug of war' for and against seeking help, as demonstrated in Figure 3.1.¹⁶⁹

Figure 3.1—Forces for and against seeking help



Source: ReachOut.¹⁷⁰

167 Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, *Submission 26*, p. 3 (footnotes omitted).

168 Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, *Submission 26*, p. 3; ReachOut, *Submission 72*, p. 6.

169 ReachOut, *Submission 72*, p. 6.

170 ReachOut, *Submission 72*, p. 6.

3.166 Submitters who work in youth mental health, such as yourtown, told the committee that young people it worked with had expressed concerns about being judged if they accessed a mental health service. yourtown told the committee that the concerns raised by young people included a fear of being seen as incapable, being brushed off or being considered or labelled as an attention seeker.¹⁷¹

3.167 A number of submitters told the committee that they considered one of the factors that may act as a barrier to access was a preference for self-reliance to manage issues, which was sometimes described to the committee as 'rural stoicism'.¹⁷² The Queensland Nursing and Midwifery Union told the committee there was some academic evidence that this preference for self-reliance may lead to lower rates of access:

In a recent study, Brew et al. (2016) found attitudes to treatment were the greatest barriers to seeking help for all rural workers. Of these, 'I prefer to manage myself' was by far the most common and this was similar for farmers and non-farm workers. Overall...75% preferred to manage themselves rather than access help for mental health needs (Brew et al., 2016). These results could indicate a high level of self-sufficiency, however distance from services and inability to leave rural properties for any length of time are other relevant factors.¹⁷³

3.168 The Queensland Nursing and Midwifery Union noted, however, that in addition to self-sufficiency, these results may also indicate that an inability to leave rural properties for any length of time and distance to services may also serve as barriers to access.¹⁷⁴ The committee received similar evidence from other submitters, such as the Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, who considered that caring obligations and the requirements of running a property may influence whether a person accesses mental health services.¹⁷⁵

Privacy and confidentiality

3.169 Some submitters recognised that being part of a small community with a 'community spirit' or close social connections can be a potential protective factor for people experiencing a mental illness.¹⁷⁶ However, ReachOut, Suicide Prevention

171 Yourtown, *Submission 101*, p. 5.

172 See for example: Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 2; Mrs Chez Curnow, Manager Mental Health Alcohol and Other Drugs, Country SA PHN, *Committee Hansard*, Whyalla, 20 July 2018, p. 53; Northern Territory PHN, *Submission 54*, [p. 2]; One Door Mental Health, *Submission 122*, [p. 2]; Western Queensland PHN, *Submission 125*, p. 3; SANE Australia, *Submission 130*, p. 4.

173 Queensland Nursing and Midwifery Union, *Submission 36*, p. 13. See also COTA, *Submission 64*, p. 7.

174 Queensland Nursing and Midwifery Union, *Submission 36*, p. 13.

175 Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, *Submission 26*, p. 3.

176 Reach Out, *Submission 72*, p. 8; Suicide Prevention Australia, *Submission 84*, p. 8; One Door Mental Health, *Submission 122*, pp. 7–8.

Australia and One Door Mental Health also noted that the same connectedness can also lead to stigma and a perception that 'everyone knows everyone's business'.¹⁷⁷ Submitters told the committee that in a community with a small population some people may be concerned about being able to protect their privacy while accessing the service.¹⁷⁸

3.170 Witnesses told the committee that some people had concerns about being recognised or seeing a service provider with whom they would prefer not to have a 'dual relationship'.¹⁷⁹ MindsPlus explained that by 'dual relationship', it meant that a person may not wish to discuss their personal lives with 'someone their sister plays netball with or someone they may see socially'.¹⁸⁰

3.171 Some submitters advised the committee that people living in rural and remote communities told them that in some cases they were concerned about accessing services in case they were recognised while accessing the service.¹⁸¹ In some cases, submitters told the committee that they were aware of people who travelled to different towns or took certain steps, such as parking further from the service, because they were concerned about being recognised.¹⁸² Orygen noted that this could be a particular issue for young people who are concerned about being stigmatised if they were seen attending a headspace or another mental health service.¹⁸³

3.172 The National Mental Health Consumer and Carer Forum and Neami National told the committee that concerns about confidentiality could be even more acute for people from vulnerable groups, such as LGBTI people, CALD populations or Aboriginal and Torres Strait Islander peoples.¹⁸⁴ The Black Dog Institute noted that

177 Reach Out, *Submission 72*, p. 8; Suicide Prevention Australia, *Submission 84*, p. 8; One Door Mental Health, *Submission 122*, pp. 7–8.

178 See, for example: Mr Benjamin Hedlam, Great Southern Community Alcohol and Drugs Service, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 25; Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 11; Mrs Nicola Herriot, Chief Executive Officer, Northern Territory PHN, *Committee Hansard*, Darwin, 9 July 2018, p. 6; Ms Roslyn Atkinson, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 32; Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation Ltd, *Committee Hansard*, Canberra, 19 July 2018, p. 67; Mrs Anne Bainbridge, Chief Executive Officer, Youth Affairs Council of South Australia Inc, *Committee Hansard*, Whyalla, 20 July 2018, pp. 45–46; MindSpot, *Submission 5*, p. 3; Mental Health Carers Tasmania, *Submission 6*, p. 2; Government of Western Australia, *Submission 35*, p. 20.

179 MindsPlus, *Submission 15*, p. 1; National Mental Health Consumer and Carer Forum, *Submission 84*, p. 4.

180 MindsPlus, *Submission 15*, p. 1.

181 Orygen, *Submission 44*, p. 8; Helping Minds, *Submission 98*, p. 9.

182 Grow, *Submission 29*, p. 4.

183 Orygen, *Submission 44*, p. 8.

184 Neami National, *Submission 40*, p. 3; National Mental Health Consumer and Carer Forum, *Submission 84*, pp. 3–4.

some people in these groups may not engage with professional services for fear of not being understood or facing stigma.¹⁸⁵ The Black Dog Institute noted that similar concerns were also expressed by veterans groups who considered that veterans were reluctant to engage with professionals who may not be able to understand their unique experiences.¹⁸⁶

Reducing stigma

3.173 Some submitters suggested that co-locating health services in one place could help to address some of the issues surrounding stigma. The Central Australian Aboriginal Congress told the committee that by providing wrap-around services in one location, stigma was reduced by having the same door for physical and mental health services.¹⁸⁷ OzHelp noted that engaging clients with a focus on physical health and wellbeing would present an opportunity to discuss topics such as mental health and suicide.¹⁸⁸

3.174 Some submitters told the committee that there were effective ways to reduce stigma in a community. The Australian Mental Health Commissions told the committee that promotional campaigns and training have demonstrated the capacity to reduce stigma and recommended that such a campaign could be effective in combatting mental illness in rural and remote communities.¹⁸⁹

3.175 Being, a state-wide peak mental health consumer organisation based in New South Wales, told the committee that it believed that peer workers, a trained group of people with lived experience of mental illness, could help to educate the community:

Peer workers may be able to provide support with regard to a number of the challenges to mental health help seeking noted above. Peer workers can be an excellent source of education. Raising health literacy in schools, universities and workplaces, could very effectively be carried out by peer workers who themselves embody the message that getting help and learn to strategies to live with mental health issues can only start with the ability to recognise when something might be wrong.¹⁹⁰

3.176 ConnectGroups told the committee that peer support groups could play a significant role in promoting health and wellbeing and reduction of stigma.¹⁹¹ Others, such as the Depression Support Network Albany, told the committee that a peer workforce could be effective in breaking down stigma in the community:

185 Black Dog Institute, *Submission 47*, p. 11.

186 Black Dog Institute, *Submission 47*, p. 11.

187 Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 2.

188 OzHelp, *Submission 11*, [p. 3].

189 Australian Mental Health Commissions, *Submission 52*, p. 14.

190 Being, *Submission 92*, p. 10.

191 ConnectGroups, *Submission 3*, [p. 3].

I think getting out into the community and doing activities in the community, whether it be yoga or whether it be tennis, and joining in with those community groups and saying, 'Hey, we've got mental illness but we're not different to you,' has been a really good positive way. I talk a lot with various doctors and people around town, and they've gotten to know me and realised, 'Yes, she's got a mental illness but she's not that different from anybody else.'¹⁹²

3.177 Some submitters advised the committee that they were offering or developing technological supports that may allow individuals to access mental health services from the privacy of their computer. For example, Grow developed an online mutual support group using videoconferencing that catered for people around Queensland to provide support from people who were not in geographic proximity to other members of the group.¹⁹³ Similarly, OzHelp is developing its digital capacity to try to reduce barriers to access that might be faced by groups who may otherwise be reluctant to seek help face-to-face.¹⁹⁴ However, as noted above, technological solutions, while providing benefit to some people, are not the answer to the overall accessibility of rural and remote services.

Concluding committee view

3.178 In recent years in Australia there has been an increased national focus on mental health issues which has improved the diagnosis, treatment and community acceptance of mental health conditions across Australia. However, the committee heard compelling evidence that the different causes and service difficulties felt in rural and remote communities has meant the improvements driven by the national focus has mostly been felt in urban locations.

3.179 The committee recognises that many complex factors influence whether a person decides to seek help from professional mental health services, including the availability of those services, whether they believe their confidentiality can be protected and whether they believe they will be labelled or stigmatised for accessing those services if they are recognised. The committee considers that these factors are barriers to accessing mental health services that need to be addressed to make people more likely and willing to engage with professional services when they need them.

3.180 The committee heard that some communities and service providers are working to decrease stigma by educating the public about mental health and/or by co-locating physical and mental health services. The committee commends groups that are actively working to combat stigma, but considers that more needs to be done in rural and remote communities around Australia to improve attitudes toward accessing mental health services.

192 Ms Jo Brown, Depression Support Network Albany Inc, *Committee Hansard*, Albany, 5 June 2018, p. 31.

193 Grow, *Submission 29*, p. 4.

194 OzHelp, *Submission 11*, [p. 3].

3.181 The committee heard that the impacts of social determinants of health, which contribute to mental health conditions and impact on the delivery of mental health services, are felt significantly in rural and remote communities. The committee believes that addressing the social determinants of health must be considered in any reform to improve the accessibility of mental health services in rural and remote communities.

3.182 The committee is concerned that mental health services are not available when and where they are needed in rural and remote communities. The committee believes that more needs to be done to address the shortfall in mental health professionals in these areas and overcome the barriers of distance, transport and lack of reliable telecommunications infrastructure. A catalyst to drive mental health service improvements in rural and remote locations is clearly necessary to address the different needs of these communities.

