

CHAPTER 16

SERVICES FOR RURAL, REMOTE AND INDIGENOUS AUSTRALIANS

Introduction

16.1 People with mental illness in rural and remote communities, including many of Australia's Indigenous people, often are living in communities which offer high levels of social support. However, they also face great challenges in accessing effective health care. This was touched on in Chapter 6, which highlighted the low numbers of mental health professionals in rural and remote Australia, and this chapter looks at some of the issues in more depth.

16.2 In rural and regional areas stigma can be as socially isolating as the experience of mental illness itself, as this case study shows:

...wife on farm with depressed and angry husband, combination of alcohol and isolation fuels deteriorating capacity for communication or appropriate decision making—husband will not ring anyone, husband will not go to visit anyone, "they are all useless anyway and what would they know"—wife doesn't go out because she's scared to leave him alone, and she's embarrassed by his drinking when out.¹

16.3 The tyranny of distance on remote farms and stations, means being attended in a crisis by rural police officers, with very expansive geographical and policing responsibilities, and poor knowledge of mental disorders.² It can also mean long waits for the flying doctor service, and being sedated, or going out into the paddock with a gun.

16.4 For Indigenous Australians it can entail being taken far away from your country among strangers to an alienating clinical environment or, if you are lucky, connecting with an Indigenous health worker who can mediate your cultural and clinical needs with sensitivity. This chapter will assess the service requirements for Indigenous Australians in particular, after first surveying the situation of people with mental illness in rural and remote locations generally.

Rural and remote services

16.5 The challenges faced by people with mental illness in rural and remote areas are well known; they are a subset of those negotiated by all country people to obtain timely and appropriate health assistance at distance from hospitals and other specialist

1 NSW Farmers Association, *Submission 410*, p. 4.

2 Health Consumers of Rural and Remote Australia (HCRRA), *Submission 106*, p. [3].

services. In a situation where health services generally, and mental health services in particular, are under extreme pressure to meet urban population needs, the capacity of state governments to fund specialist services to people with mental health problems outside the cities is much diminished:

Rural and remote areas remain under-serviced. Even rural specific services are generally run from the larger regional centres and service provision declines as distance from the centre increases. While some of this is going to be difficult to overcome—population based funding will always focus on putting workers where there are more people to see—outreach services need to be specifically funded to reach more isolated populations.³

16.6 The difficulty of attracting medical and health professionals to rural areas remains a perennial problem:

There is also poorer access to mental health support in rural and remote areas. It remains difficult to attract and retain health workers in rural / remote areas, and mental health workers are no exception. Doctor and psychiatrist to population ratios are low, and there are fewer charity services to offer support. Members of the [NSW Farmers] Association have suggested that rural mental health support, from prevention through to crises care, is “virtually non-existent”.⁴

16.7 Living in connection with the land can be stressful. Rural organisations reported that the hardships for country people after long years of drought compound those arising from the restructuring of the economy and other social changes.⁵ Farmers end up in debt and rural support industries are squeezed. The cumulative effect of this 'financial drought' will last a decade or more, putting some rural families under unsustainable pressure to keep afloat.⁶

16.8 While the closeness of rural communities and their networks of support can assist some who are 'not coping', stigma against mental illness, underpinned by strong cultural pressures to show independence and resilience in the face of adversity, means that many of those affected will suffer silently.⁷ For those with low prevalence disorders such as schizophrenia or bipolar disorders, which generally onset during the teens to early adulthood, mental illness in rural communities can be particularly dispiriting:

In a big city it is easy to hide if you want to. In the country it is impossible. It is impossible to go the local doctor without the whole town knowing, so some patients are even more reluctant to seek treatment. Parents feel

3 SA Division of General Practice, *Submission 88*, p. 9.

4 New South Wales Farmers Association, *Submission 410*, p. 3.

5 HCRRA, *Submission 106*, p. [5].

6 Mr Alan Brown, Board Member and Chair, Rural Affairs Committee, NSW Farmers Association, *Committee Hansard*, 2 August 2005, pp. 15–16.

7 National Rural Health Alliance Inc (NRHA), *Submission 181*, p. 3.

isolated as well, and become unable to have social relationships. I understand from speaking to people in Long Reach that their chances of finding accommodation or care near there home is very slight.⁸

16.9 The very public consequences of untreated depression and anxiety in country areas were widely recorded in the evidence: unemployment, family breakdown, domestic violence, mysterious accidental deaths by car or gunshot, homelessness, increases in substance abuse, showdowns with police and imprisonment.⁹

16.10 The prevalence of these factors may support speculation that the incidence of mental illness in rural communities is higher than in urban ones.¹⁰ The relationship between unrelieved stress, lack of knowledge about mental illness, and limited service options are widely acknowledged catalyst to the high incidence of suicide among rural males (effectively double that of the rest of the population)¹¹, although this has not been empirically verified.¹² The National Rural Health Alliance (NRHA) referred to research indicating that it is the lower use of services rather than the prevalence of mental disorder which contributes to high suicide rates in rural and regional Australia.¹³ This suggests that service access, not the incidence of mental illness, is the key issue for country people.

16.11 The isolation of remote communities exacerbates service delivery problems and decreases the likelihood that problems such as depression will be diagnosed. A factor contributing to poor health outcomes for rural and remote Australia is the higher proportion of Indigenous people living there. While Indigenous people suffer the same problems as other Australians in rural and isolated areas, namely reduced access to timely and continuous specialised services, the invidiousness of their situation is exacerbated by additional historical and cultural factors.¹⁴ Indigenous Australians in cities also have discrete service access problems.¹⁵ For these reasons, Indigenous service issues are covered in detail in the next section dedicated to them.

16.12 The two outstanding issues for urgent attention addressed in this section apply to rural and remote communities generally, and are:

- stigma and lack of information; and

8 National Council of Women of Australia Inc Ltd, *Submission 435*, p. 5.

9 NSW Farmers Association, *Submission 410*, p. 3; NRHA, *Submission 181*, p. 10.

10 Health Consumers of Rural and Remote Australia, *Submission 106*, p. 5.

11 NSW Farmers Association, *Submission 410*, p. 4.

12 NRHA, *Submission 181*, p. 9.

13 Professor Brian Hickie, 'Reducing the Burden of Depression: Are We Making Progress in Australia?', *Medical Journal of Australia*, 181 (7), 4 October 2004, pp. S4, 5. Quoted in NRHA, *Submission 181*, note ix, p. 9.

14 NRHA, *Submission 181*, p. 10.

15 See discussion of the findings of the Western Australian Aboriginal Child Health Survey (WAACHS), below.

- poor service access, with a particular focus on GP, carer and community support services.

Getting it out in the open: stigma in rural communities

16.13 Stigma against mental illness, and lack of willingness to talk about it was identified as a major obstacle to early intervention, treatment and preventative approaches for people with mental illness and their families in rural communities. In absence of adequate services to seek people out, a lack of willingness to seek treatment means no treatment is received.¹⁶ For men and particularly young men, being 'tougher than John Wayne'¹⁷ reaps the outcomes above; for women having to be 'the strong one' under conditions of adversity can mean having 'a lot of responsibility and no control', with serious psychological consequences.¹⁸

16.14 The National Rural Health Alliance conjectured that the effects of stigma have broad implications, setting up a vicious circle between under identification and under servicing of rural mental health need:

There is a long history of shame and stigma being associated with mental illness, partly due to people not understanding its nature, causes and effects. There are lower general levels of education in rural and remote areas, suggesting that these problems might be worse there than in major cities. Shame, stigma and associated ignorance may contribute to the relatively low level of resources devoted to mental health in Australia, and to the low level of priority that mental health care seems to attract, including in rural and remote areas.

These attitudinal factors contribute to a reluctance to seek help. Consequently it is important to implement innovative ways to reach out to people under stress or facing early stages of mental illness. Barriers to seeking help are complex and may include issues of confidentiality and trust in a small community. Also there may be little expectation of help, leading to a tendency not to seek it.¹⁹

16.15 In recognition of these problems, the beyondblue depression initiative has made rural stigma a target:

One of our great challenges, particularly with men and with people in rural Australia, is to have them talk about their illness and seek help and treatment in order to return to as healthy a condition as possible. We are championing the cause to have this illness recognised as any other illness.

16 HCRRA, *Submission 106*, p.[1].

17 Mr Jeff Kennett, Chairman, beyondblue, *Committee Hansard*, 5 July 2005, p. 9.

18 Dr Simone Fulgar, *Submission 235*, Women's Recovery from Depression Research Project 2004-05, Attachment 1, p. 1.

19 NRHA, *Submission 181*, p. 26.

Whether it be AIDS, breast cancer or a broken arm, an illness is an illness and it is not a crime to be sick.²⁰

16.16 Rural and regional organisations considered that campaigns like beyondblue's have positive results in the bush.²¹ Submissions advised that leadership by a well-known figure like beyondblue Chairman Jeff Kennett had attracted unprecedented media attention to the issue at the drought summit, held in Parkes in May 2005. It had also made 'depression' acceptable talk:

—It was good to have Jeff Kennett there and to be talking so openly about depression—the fact that it was a figurehead and someone people recognised and that it was okay to talk. When you go to follow-up meetings, not even on drought, it is interesting to hear people say, ‘Did you see Jeff Kennett?’ They are actually talking by accident about depression. The media gave it a great run, and they gave a great run to the fact that we did not just have a session talking to politicians about what we needed from drought; we had a session called ‘bugger the drought’—about how we actually manage the human side of things. The fact that the media picked it up and ran with it was, I thought, historic, really.²²

16.17 The drought summit itself was an important mechanism to get rural mental health on the agenda, having both a cathartic and therapeutic effect:

Grown men stood up in an audience of 2,000 farmers with tears streaming down their face and talked about how close the end can seem, how desperate farming can be and how bad they felt that this one drought summit, which was about getting a political result, was the only reason they had left the farm in three months.²³

16.18 The personal story has great power to dispel prejudice and increase understanding of mental illnesses in rural situations. The committee heard from a number of individuals who had dedicated themselves to reducing stigma in rural communities, using their own experience to bring things out into the open, and to build empathy and understanding. One approach is through public speaking. Mr Noel Trevaskis, a Regional Manager Agricultural company and Rotary District Governor, reported:

Just over twenty years ago I suffered from severe depression and spent over 5 months in hospital as a result. I found the hardest thing for me to do was

20 Mr Jeff Kennett, Chairman, beyondblue, *Committee Hansard*, 5 July 2005, p. 1.

21 NSW Farmers Association, *Submission 410*, p. 5; HCRRA, *Submission 106*, p. [4].

22 Mr Alan Brown, Board Member and Chair, Rural Affairs Committee, NSW Farmers Association, *Committee Hansard*, 2 August 2005, p. 20.

23 Ms Brianna Casey, Senior Policy Manager, Rural Affairs, NSW Farmers Association, *Committee Hansard*, 2 August 2005, p. 19.

to go back to a small rural area to live with my wife and three small children because of the stigma that is attached to mental illness.²⁴

16.19 During the last six years Mr Trevaskis has spoken of his experiences in a voluntary capacity to over 15 000 people at over 180 public forums, seminars and conferences across Australia for organisations such as the DPP and NSW Bar Association, NSW Farmers, Landcare, farmer drought meetings, Vincent Fairfax Foundation, Women in Agriculture, NSW Agriculture, Rotary Clubs, Community Mental Health Awareness Forums, Area Health Services, Road Transport Association and many others.²⁵

16.20 Publishing your story is another method. HCRRA reports how a young woman with bipolar disorder decided to 'normalise' her illness after moving to a new town by raising awareness in rural Australia:

She wrote an article for a newsletter of a prominent women's agricultural organisation. As a result many local people who also suffer from mental illness or who have family members similarly afflicted, have approached her. She reports the benefits of this 'outing' as enormous as a support network has developed.²⁶

16.21 The need for broader information campaigns targeted at youth and the aged were noted in particular.²⁷ Rotary clubs, with government sponsorship and the assistance of the Australian Rotary Health Research Fund and beyondblue, has the capacity to launch more far reaching education campaigns.²⁸ But the funding of larger campaigns is beyond most rural organisations, despite the good ideas and rich personal experience to be drawn on in rural communities. The NSW Farmer's Association advised that its work on depression, for example, could not be expanded to a 'whole of mental health campaign' without funding assistance.²⁹

16.22 The care support depression group blueVoices saw education initiatives as integral to capacity building of rural health services generally, and particularly to community and outreach services.

16.23 Of particular concern to us is the funding in rural Australia where services at best are mediocre, and in a number of instances they are non-existent. Funding should be made available not just for institutional-based services but a significant portion of

24 Mr Noel Trevaskis, *Submission 523*, p. 1.

25 Mr Noel Trevaskis, *Submission 523*, p.1.

26 HCRRA, *Submission 106*, p. [3]

27 Australian Rotary Health Research Fund, *Submission 68*, p. 2.

28 Rotary's rural van has travelled the outback and convened over 350 rural fora focussing on depression and mental illness since 2000, Australian Rotary Health Research Fund, *Submission 68*, p. 1.

29 Ms Brianna Casey, Senior Policy Manager, Rural Affairs, NSW Farmers Association, *Committee Hansard*, 2 August 2005, p. 19.

funding should be allocated to the funding of community services, outreach services and educational programs within local communities. Groups such as Lifeline for example should be funded significantly to address the mental health activities which they perform.³⁰

16.24 Carer organisations could play an important role but capacity is largely determined by available funding:

ARAFMI Hunter offer workshops on stigma, educational materials on mental illness, group programs on family sensitive practices for mental health professionals and they distribute information on mental illness throughout local shopping centres and at community functions. However due to a lack of funding ARAFMI Hunter can only educate on a small scale and this means that they cannot greatly impact upon negative attitudes about mental illness as much as they would like to.³¹

16.25 New technologies are a very promising means of increasing knowledge about mental illness in rural communities, proving immediate access to the web-based information such as that on the beyondblue website³² and the Reach Out! youth website developed by the Inspire Foundation.³³ The potential of the internet to widely disseminate information in rural and remote communities is entirely dependent however on connection availability and speed of access, something quite uncertain in many rural communities.³⁴ The use of technology as a clinical tool is discussed below.

Comprehensive country wide services

16.26 As already mentioned, comprehensive data on the true levels of unmet need for mental health services in rural communities is not available; there is little epidemiological data to inform local priorities for mental health interventions, and there are no benchmarks to determine what constitutes the best mix of services.³⁵ However anecdotal evidence, supported by hard statistics relating to the high incidence of suicide, of accidental gun and vehicle deaths, and the social breakdown in small communities across Australia, suggests there is 'something seriously wrong' in the bush³⁶ and that a holistic response is required.

30 blueVoices, *Submission 259*, p.20.

31 ARAFMI [Association of Relatives and Friends of the Mentally Ill] Hunter, *Submission 231*, pp. 5–6.

32 blueVoices, *Submission 259*, pp. 20-21.

33 The Inspire Foundation, *Submission 491*, p. 4.

34 HCRRA, *Submission 106*, p. [1].

35 See discussion of the population health model below.

36 Mr Jeff Kennett, Chairman, beyondblue, *Committee Hansard*, 5 July 2005, p. 11.

Service gaps and pressures

16.27 Rural and remote communities reported chronic shortages of services and health professionals to staff them. They asserted that the obstacles to comprehensive management and continuous care are obvious once you step outside of any regional centre: medical health practitioners find themselves working long hours isolated in small communities with high levels of need; psychiatrists are in short supply; nurses are underprepared for growing problems such as dual diagnosis; and community support services to help people of all ages keep healthy are underdeveloped compared with other areas. Pressure and isolation encourage high staff turnover, militating against continuity in care.³⁷

16.28 This results in a situation where services gaps affecting more well supported communities open out dangerously, as the Burdekin Report noted:

The irony is that in many of the areas where the need is greatest the services are fewest. This is particularly the point in small country communities where mental health services—and certainly mental health services for children and adolescents—are almost entirely non-existent.³⁸

16.29 The West Australian Child and Adolescent Mental Health Services Advisory Committee (CAMHSAC) provided insight into the implications for children and youth in rural and remote communities and their families in WA:

Models for the funding of adequate rural and remote services should be based on a population weighted formula as rural and remote area services frequently perceive that little consideration is given to the needs of rural and remote services for young people. Tertiary “state-wide” services are not really accessible to rural and remote families as the programs only cater for people who live in metropolitan WA or who can readily access the statewide facilities which are metropolitan Perth based and are run on a Monday to Friday basis. There is little or no suitable accommodation provided for rural family members to be near their children who have been admitted to inpatient facilities. That inpatient beds in the state wide inpatient facilities (PMH and Bentley hospital) are limited (3 authorised beds at Bentley) resulting in young people being admitted to adult facilities. Recent funding for more authorised beds only went to the adult sector. CAMHSAC would like to see appropriate “youth friendly” beds made available for the 13-25 year olds.³⁹

37 Rural training and staffing issues are discussed in more detail in Chapter 6.

38 Quoted in Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA), *Submission 83*, p. 20.

39 The West Australian Child and Adolescent Mental Health Services Advisory Committee, (CAMHSAC), *Submission 24*, p. 2.

16.30 The shortage of locally-based psychiatrists and psychologists in rural and remote areas considerably increases the burden. Only 7.5 per cent of all psychiatrists, for example, are based in rural and remote areas, while 90 per cent of those practising in non-metropolitan areas are located in major regional centres.⁴⁰ Consumers and Carers from the NSW Far South reported:

There is a severe shortage of all mental health professionals but we particularly feel the shortage of psychiatrists in our area. At present our sector (including Bega Valley and Eurobodalla Shires which stretch for more than 250 kms in 6 major centres along the coast and includes about 70 000 people) has funding for 38 hours per week of visiting psychiatrists' time (including aged, child and adolescent and adult), however 4 to 5 hours of this time is taken in travel. There is no substitute for a psychiatrist living in the area and we believe more could be done to attract psychiatrists to rural areas. It is essential that funding and appropriate incentives be provided for a psychiatrist to reside in the area.⁴¹

16.31 Lack of appropriate crisis and acute care services in communities, and of private hospital services, puts unsustainable pressures on rural public hospitals ill-prepared to meet demand:

There is no crisis service after 10 pm in our area, and people are forced to utilize the emergency departments at local hospitals without adequate expertise or training for the nurses who deal with these problems. We have an emergency department Clinical Nurse Consultant however he must cover 7 hospitals over Monaro, Bega Valley and Eurobodalla shires. The shortage of acute care hospital beds in the Southern Area causes many problems. The only resource for this purpose is at Chisolm Ross Centre at Goulburn, which is up to 7 hours travel by road for patients and carers, and contains only 15 beds available to people from the old Southern Area. On a per capita basis we should have 45 acute care beds to cater for this population according to present policy.⁴²

16.32 On the same theme, NSW Farmers Association advised:

Wagga base hospital has around 20 mental health beds available for a catchment of 180,000 people. If you have that part of the state and draw in 180,000 people, it is a massive area. Most of those areas do not have access to mental health facilities within a reasonable distance.⁴³

16.33 These hospitals offer the only possibility for respite care. This poses particular problems as the care is rarely remedial and is particularly unsuccessful for Indigenous people.⁴⁴ The inadequate spread of community-based support services more generally

40 HCRRA, *Submission 106*, p. 5.

41 Consumers and Carers from the NSW Far South Coast, *Submission 5*, p. 2.

42 Consumers and Carers from the NSW Far South Coast, *Submission 5*, p. 1.

43 *Committee Hansard*, 2 August 2005, p. 13.

44 HCRRA, *Submission 106*, p. [2].

puts immense pressure on families unlucky enough to live in or near towns without any support systems:

In our rural town...There is simply no accommodation service and the rehabilitation service comprised only irregular visits by a case worker.

This is why we have had to relocate our son (after his second psychosis) to another town so we could get him admitted to a program which does offer rehabilitation and accommodation services. And despite assurances from our local Community Health and the Area Health Service, our experience was that our son could not get an admission to this other service unless he had an address in this other town. So we had to tear around and find him a flat to live in this other town to facilitate this admission. He lived here for a number of months while still acutely unwell, until he was deemed to be “a local”, was assessed and then he had to wait for a place at the accommodation facility to become available.⁴⁵

16.34 Community 'drop in' centres or other social support networks reduce the burden of stigma and make people feel more positive and less isolated, but are not available in rural areas.⁴⁶ The lack of services to treat the growing number of people with dual diagnosis in rural areas⁴⁷ is compounded by a total absence of support services common in the city:

I live thirty minutes away form Albury/Wodonga and find travelling major cost...and time to get the support and help I need to maintain some sort of normality in my life...I wish that a group could be set up for people like me...I am amazed to find many other people suffering from mental illness and substance abuse.⁴⁸

16.35 The general practitioner is usually the first person to diagnosis a mental illness in a rural setting.⁴⁹ However rural and remote communities can struggle to find and retain sufficient GPs for their local population. The committee met doctors and community members in Port Hedland. Members were struck by their dedication, but also by the heavy workload that came from having fewer doctors in the practices there than were needed.

16.36 Despite the promise of the Better Outcomes initiative, rural and remote GPs are rarely able to get away to do the prerequisite training to participate. SA Divisions of General Practices advised:

The more remote Divisions report considerable difficulty accessing the required training for their GPs to participate in the BOiMHC [Better Outcomes] scheme, and difficulty attracting appropriately qualified and

45 Name withheld, *Submission 244*, p. 4.

46 Brotherhood of St Laurence, *Submission 97*, p. 3.

47 HCRRA, *Submission 106*, p. [2].

48 Albury Wodonga Anxiety and Depression Support Group, *Submission 151*, p. 13.

49 NSW Farmers Association, *Submission 410*, p. 6.

experienced personnel. Training of GPs to do counselling themselves (Level 2 under BOiMHC) is likewise difficult as it requires the GP to do 20 hours of training – not available in the country thereby necessitating the GP to leave their practice unattended for a number of days. With the lack of available locum coverage to backfill, and rural doctors required to provide after-hours emergency care, this may leave entire towns and regions without any medical care.⁵⁰

16.37 Consequent to the lack of specialist support, attendant work pressures and problems of distance GPs tend to follow a medical model of treatment for conditions such as depression. Submitters identified a number of problems with this approach. Changes in medication can have unpredictable outcomes, such as unforeseen medical or psychological affects.⁵¹ The availability of guns at home can increase the risk of suicide or violence.⁵² Referral to a mental health caseworker brings other attendant risks given the long waiting lists.⁵³

16.38 In remote locations this combination of factors can be even more risky. There may be access to a GP or specialist on a fly-in fly-out basis but follow up by case workers and social workers and maintenance programs are not usually accessible.⁵⁴ Further, the transport and treatment of individuals in acute states can be complicated by different mental health regulations, for example, in the Northern Territory:

People suffering psychotic episodes in a remote area, are required to be sedated to be evacuated by air. To travel by aircraft, these people require sedation. From the time they are sedated, travel to a health facility and recover from their sedation, the period of time a person can be kept against their will has expired. This means a seriously ill person can leave a health care facility without having received any treatment for their mental condition.⁵⁵

16.39 Even if relocation of people for treatment is feasible, it can also be disruptive, and work against recovery. At Port Hedland the committee heard how specialist treatment could involve relocation thousands of kilometres to Perth. Such distances make it difficult for any family to maintain contact and support; for Indigenous families and consumers it can be particularly traumatic. Service provision in places like the Pilbara/ Kimberley region can also bring jurisdictional issues into focus. It would frequently make more social and economic sense for consumers to get specialised care in Darwin rather than Perth, but crossing jurisdictional boundaries can make this difficult or impossible.

50 SA Divisions of General Practices, *Submission 88*, p. 9.

51 HCRRA, *Submission 106*, p. [3].

52 Mr Alan Brown, Board Member and Chair, Rural Affairs Committee, NSW Farmers Association, *Committee Hansard*, 2 August 2005, pp. 16–17.

53 NSW Farmers Association, *Submission 410*, p. 4.

54 HCRRA, *Submission 106*, p. [3].

55 HCRRA, *Submission 106*, p. [4].

16.40 In rural and remote absence of adequate follow-up and maintenance programs increases the likelihood of relapse. Carers may be isolated with very unstable family members and have to travel long distances to gain treatment and support. A focus on developing more adequate relapse prevention and respite support for people in rural areas is necessary, and may include ensuring that carers are aware of available pension support and travel assistance allowances.⁵⁶ Information and training for police, who attend and manage crisis situations without specialist advice across vast geographical areas is also essential.⁵⁷ Mandatory mental health first aid training or programs such as Living Works which have a 'train the trainer' aspect were recommended to dispel misunderstandings and enhance skills among rural police, ambulance drivers and crisis carers.⁵⁸

Technology—clinical services and counselling

16.41 Technological developments including teleconferencing and video conferencing were cited as having significant potential to improve services to rural and remote communities. Telepsychiatry is one of the newer technologies which is being used to deliver better mental health care services to rural and remote communities:⁵⁹

In rural and remote mental health services a programs approach has been adopted with the CAMHS program being run within a generic mental health service usually managed by adult mental health team leaders/managers/psychiatrists with only CAMHS specialists available by video conference only. This is likely to result in a broad range in the capacity of services to provide specialist CAMHS clinical services particularly in rural and remote areas.⁶⁰

16.42 Ms Jenine Bailey, an Indigenous researcher who provides mental health counselling through the correctional centre at Townsville, reported the usefulness of teleconferencing to establish continuing treatment plans and to make important personal introductions to released Indigenous people to health workers back in their home country:

I did teleconferences to introduce the people. I actually referred them to services or workers to meet them once they got there, to basically start that. Before that, you would discuss and co-case what I had done with the person within the facility and, once they were released, in the community. You put the strategies in place before they get out. You have a fair idea of their

56 HCRRA, *Submission 106*, p. [4].

57 HCRRA, *Submission 106*, p. [3].

58 Consumers and Carers from the NSW Far South, *Submission 5*, p. 5; HCRRA, *Submission 106*, p. [3], and see Professor Anthony Jorm and Ms Betty Kitchener, *Submission 47*.

59 blueVoices, *Submission 259*, pp. 20–21.

60 CAMHSAC, *Submission 24*, p. 2.

release date, so you make sure that things are in place so the person is not left out in the cold and lost and therefore may get up to mischief again.⁶¹

16.43 Access to training and referral advice for health professionals in remote and regional Australia is one important benefit provided by internet access. The Northern Territory Government reported that its on-line mental health program site is a training reference and resource tool to clinicians.⁶² The development of cognitive behavioural therapy sites, as a subset of e-mental health and information services discussed above, also has great potential for rural and remote consumers. BlueVoices commented:

There are a number of cognitive behaviour therapy programs online to assist people, and whilst these should not be seen as being able to take the place of direct service intervention in rural or remote communities, they can offer a service where none currently exists. Web-based services can also be used to offer education and we cite the beyondblue website as well as our virtual network as examples of how technology can be used to increase education and support for persons in rural and remote communities as well as urban communities.⁶³

16.44 While the relative benefits of on-line services and other counselling approaches have not yet been evaluated, there are positive cost and service efficiencies:

Since 1997, Australia has been leading the world in the delivery of e-mental health services; however, no consistent investment has been made by Government in these emerging technologies, and little research has been done into the comparative benefits of web-based service delivery over phone-based and face-to-face service delivery. The research that has been undertaken indicates that web-based services that provide mental health information and support can significantly improve mental health outcomes. New developments in technology mean that cognitive behavioural therapies can be adapted into an online environment and be delivered without a counsellor, while still providing the same mental health outcomes at a fraction of the cost.⁶⁴

16.45 The clear success of online services like that provided by depressionNet, which runs a peer-based 24 hour online information, counselling and chatroom facility for

61 Ms Jenine Bailey, Indigenous Researcher, Rural Health Research Unit, James Cook University, *Committee Hansard*, 5 August 2005, pp. 38-39.

62 Northern Territory Government, *Submission 393*, p. 36.

63 blueVoices, *Submission 259*, pp. 20-21.

64 The Inspire Foundation reports that a recent review of telecounselling found that the average cost of delivering counselling to one person via a phone service ranged from \$19.87 to \$58.89. By contrast, during the 12 months to the end of June 2005, the cost of one person accessing the Reach Out! website, which provides mental health information and may provide comparable benefits, was \$1.12. See Inspire Foundation, *Submission 491*, pp. 4-6.

depression sufferers,⁶⁵ demonstrates the need for these types of services, and argues for more reliable and efficient online capacity in country areas.⁶⁶

16.46 The Inspire Foundation's Reach Out! for example, fills a niche for rural youth, not covered by the telephone counselling service Kids Help Line, which assists the under 18 years, or Lifeline, which receives only 10 per cent of calls from the 14 to 18 age group. Inspire reports that, in the financial year ending 2005, there were 760 000 individual visits to Reach Out! The service currently attracts 75 000 plus individual visits each month.⁶⁷

16.47 At the same time, online services must complement not replace an early human response in a crisis. This advocates for increased mental health and crisis support services in the bush, including support for telephone counselling services like the Kids Help Line which focuses on 8 to 18 year olds in rural and regional Australia, on the premise that these kids are at greater risk of mental illness than those living in cities.⁶⁸

A 'population health' response

16.48 A piecemeal approach to mental health reform will not, it was argued, be sufficient to address the considerable obstacles imposed by distance and culture in rural and remote communities. Instead, a holistic model of service is required. In this regard, rural stakeholders expressed disappointment that the National Mental Health Plan 2003-2008 has failed to acknowledge the specific needs of rural, regional and remote communities. Moreover, as the National Rural Health Alliance (NRHA) noted, two of the Plan's most relevant priorities—'increasing service responsiveness' and 'strengthening [service] quality'—remain distant goals for most rural communities, given chronic service and staff shortages.⁶⁹

16.49 Drawing on the template of its *Healthy Horizons Outlook 2003-07* policy document, the NRHA proposed that the Government immediately implement a 'population health' approach to rural and remote mental health.⁷⁰ This holistic model aims to breakdown intersectoral service barriers and build partnerships between social, community and health services. Based on the Department of Health and Ageing's *National Action Plan for Promotion and Prevention and Early Intervention*

65 depressionNet, *Submission 475*, p.1 reports that depressionNet.com.au was the most visited Australian health website within four months from conception with no promotion or advertising.

66 HCRRA, *Submission 106*, p. [1].

67 Inspire Foundation, *Submission 491*, p. 4.

68 The program trains rural and remote young people to respond to calls from their peers, Boystown, *Submission 107*, p. 10.

69 NRHA, *Submission 181*, p. 11.

70 National Rural Health Alliance and National Rural Health Policy Forum, 'Healthy Horizons', 1999 and update sub-committee 2002.

for *Mental Health*, the model has an early intervention emphasis, but assesses problems across seven priority age groups. This program of attack necessarily relies on sustained and judiciously allocated funding to achieve 'appropriate treatment and continuing care services, and [a] comprehensive approach to prevention'.⁷¹

16.50 Project-based funding was heavily criticised by rural commentators as being particularly onerous for overburdened rural health professionals. The HCRRA noted that staff burnout is a serious issue in the country because of the hours, large caseload and geographical area to be covered. 'Application burnout' becomes endemic as these overworked rural staff struggle to retain project-based grants'.⁷² Non health trained staff who play an important role as mental health lightning rods in rural communities, also fall prey to the problem. One important player during the drought years has been the Rural Financial Counsellor, as the NSW Farmers Association advised:

The Rural Financial Counsellors...are often the first to receive a farmer in despair. Whilst these counsellors provide financial assistance, they are skilled in identifying farmers with emotional need and referring them on. The services these counsellors provide are absolutely essential for the wellbeing of farmers, particularly during times of hardship such as drought, something their long waitlists attest to. Unfortunately the Rural Financial Counsellors continue to face uncertainty in their positions as they must regularly reapply for funding through an arduous administration process.⁷³

16.51 The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) and others that argued that the many proven 'innovative' approaches to service delivery and training in rural and remote areas now deserve Government's commitment.⁷⁴ To achieve this result, and support the revitalisation of rural communities, the NRHA advocated that funding to support continuous care should be based on the population health calculation, under which rural communities at 30 per cent of the population, should receive proportionate health budget increases. Moreover this funding should be recurrent and subject to monitoring and reporting requirements. This should be achieved as part of an increase in overall health funding to 12 per cent of national expenditure.⁷⁵

Indigenous Australians

16.52 During this inquiry, health outcomes for Indigenous Australians were described as 'completely inadequate'.⁷⁶ The National Rural Health Alliance stated:

71 NRHA, *Submission 181*, pp. 13–14.

72 HCRRA, *Submission 106*, p. [3].

73 NSW Farmers Association, *Submission 181*, pp. 6–7.

74 AICAFMHA, *Submission 83*, p. 20.

75 NRHA, *Submission 181*, p. 17.

76 AMA, *Submission 167*, p. 1.

The appalling health of Aboriginal Peoples and Torres Strait Islanders is a major contributor to the overall poorer health of people living in rural and remote communities.

This group must be given priority in improving mental health outcomes.⁷⁷

16.53 The Royal Australian and New Zealand Congress of Psychiatrists (RANZCP)⁷⁸ and the Royal Australian College of General Practitioners (RACGP) have both issued clear position statements on Indigenous health. The RACGP submission stated:

The RACGP has a clear position statement on Aboriginal and Torres Strait Islander health that recognises improving the health of Aboriginal and Torres Strait Islander people is one of Australia's highest health priorities.⁷⁹

16.54 Data set out in evidence before the committee establishes the uncontrovertible truth that Indigenous Australians have neither the life expectancy, the emotional or psychological security, nor level of material comfort other Australians enjoy:

- the perinatal mortality rate for babies born to Indigenous women is twice as high as that for babies born to non-Indigenous women;⁸⁰
- Indigenous Australians have at birth a life expectancy of twenty years less than other Australians;⁸¹
- Indigenous people have much higher rates of premature death due to external causes, 16 per cent of all deaths compared with 6 per cent for other Australians. Death due to deliberate self harm was 33 per cent for men and 15 per cent for women;⁸²
- Indigenous people have a significantly higher risk of experiencing major life stressors than other Australians, which affects their mental health and general wellbeing. Indigenous children are at higher risk of clinically significant emotional or behavioural difficulties; at 24 per cent

77 NRHA, *Submission 181*, p. 23.

78 The Royal Australian and New Zealand Congress of Psychiatrists (RANZCP), Position statement 2002.

79 Royal Australian College of General Practitioners (RACGP), *Submission 311*, p. 6.

80 Australian Government, *Submission 476*, Attachment 24, p. 1.

81 Australian Government, *Submission 476*, Attachment 24, p. 1.

82 Australian Bureau of Statistics for 1998–2001, quoted in Association for Australian Rural Nurses, *Submission 321*, p. 12.

compared with an equivalent figure of 15 per cent in the general population;⁸³

- Indigenous people are twice as likely to die of alcohol attributable diseases, despite the fact that alcohol intake is equivalent to that of the general population;⁸⁴
- Indigenous youth self-harm and suicide rates are much higher compared with other Australian youth. Of Indigenous youth 12 to 24 years, 31.1 per cent per 100 000 intentionally self harmed, compared with 6.4 per cent in a 100 000 of other Australian youth.⁸⁵ More than one in six, 16 per cent, of Indigenous young people aged 12–17 years had seriously considered ending their own life in the 12 months before the survey; of these, 39 per cent had attempted suicide.⁸⁶
- Indigenous Australians have higher rates of unemployment, poorer educational outcomes and lower rates of home ownership;⁸⁷ and
- at June 2002, Indigenous people were 11 times more likely than non-Indigenous people to be in gaol.⁸⁸

16.55 The marginalisation of people with mental illness is therefore compounded in the lived experiences of Indigenous peoples, making them potentially, as the United Nations recently suggested, the most disadvantaged community in the world today.⁸⁹

Policy responses

16.56 With these circumstances unimproved after many years of various policy approaches, the Government has recognised that overturning poor Indigenous health outcomes requires attention to the full spectrum of Indigenous life experience. This

83 Western Australian Aboriginal Child Health Survey (WAACHS)—The Social and Emotional Wellbeing of Aboriginal Children and Young People found that 20 per cent of Indigenous children had experienced seven or more of life stresses during the previous 12 months, compared with 0.2 per cent of non indigenous children. Life stresses assessed included family death, hospitalisation, a family member being imprisoned and loss of employment. 'Aboriginal Health'—*Health Report ABC*, 7 November 2005, p. 5, and see Auseinet, *Submission 441*, p. 12.

84 One contributing factor is that 20 per cent of Indigenous drinkers consume at higher risk levels compared with 10 per cent of other drinkers. Department of Psychiatric Medicine Children's Hospital Westmead and Tamworth (CAMHS), *Submission 99*, p. 6.

85 Department of Psychiatric medicine Children's Hospital Westmead and Tamworth (CAMHS), *Submission 99*, p. 1.

86 WAACHS, Australian Government, *Submission 476*, pp. 53–56.

87 Australian Institute of Health, 2004, quoted in Auseinet, *Submission 441*, p. 12.

88 Office of Aboriginal and Torres Strait Islander Health (OATSIH), Australian Government *Submission 476*, Attachment 24, pp. 7–8.

89 Ms Leanne Knowles, Manager, Social Health Unit, Wuchopperen Health Service, *Committee Hansard*, 5 August 2005, p. 42.

was first acknowledged in The National Aboriginal Health Strategy (1989), which defines Indigenous health as:

Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.⁹⁰

16.57 The Office of Aboriginal and Torres Strait Islander Health (OATSIH) reports further advances on this holistic agenda, with the development of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Social and Emotional Wellbeing and Mental Health 2004–2009 (the SEWB Framework). OATSIH advised:

The SEWB Framework aims to broadly address the social and emotional wellbeing and mental health needs of Aboriginal and Torres Strait Islander people. The document acknowledges that a range of government policies and practices has impacted on the social and emotional wellbeing of all Aboriginal and Torres Strait Islander peoples, including the ‘terra nullius’ policy, protection and assimilation policies, as well as the removal of children from their families. The document aims to provide a framework for action by all governments and communities to improve Social and Emotional Wellbeing in Aboriginal and Torres Strait Islander communities over the next five years.⁹¹

16.58 However, despite being due for release in March 2005, OATSIH reports that arrangements are just now being made for the publication and dissemination of the Framework.⁹² The tendency to delay the rollout and implementation of important components of Indigenous mental health policy—which have been agreed to and supported by Aboriginal people—was strongly criticised in submissions.⁹³ The Aboriginal Health and Medical Research Council of New South Wales stated:

The National Aboriginal Health Strategy (1989) is the foundation national document for policy, resource allocation and service delivery to Aboriginal people in health and health related matters and it has to be noted that many of the recommendations defined in that document are yet to be implemented. The Ways Forward and Bringing Them Home Reports documented and validated issues that Aboriginal people have been

90 National Aboriginal Health Strategy Working Party, A National Aboriginal Health Strategy, 1989, quoted in the Aboriginal Health and Medical Research Council of New South Wales, *Submission 406*, p. 3.

91 The framework was agreed to out of session by the Australia Health Ministers Advisory Council in 2004. See OATSIH, Australian Government *Submission 476*, Attachment 24, p. 7.

92 The Human Rights and Equal Opportunity Commission, *Submission 368*, Attachment 1, p. [7] for release date and OATSIH, Australian Government *Submission 476*, Attachment 24, p. 7.

93 The National Aboriginal Health Strategy- An Evaluation, Evaluation Committee, December, 1994 stated that the NAHS was ‘never effectively implemented’ and that ‘governments have grossly under-funded NAHS initiatives in remote and rural areas.’ Quoted in the Human Rights and Equal Opportunity Commission, *Submission 368*, Attachment 1, p. [3].

constantly raising, and the needs and strategies addressed in these reports continue to be relevant.⁹⁴

16.59 The consequence, as National Rural Health Alliance observed, is that Indigenous health needs remain largely unaddressed:

The National Aboriginal Mental Health Policy and Plan, published in 1995, canvasses extensively issues relating to mental health for this vulnerable group and included strategies and goals. Despite this the mental health of Australia's Indigenous Peoples remains poor.⁹⁵

16.60 With the policy framework further refined to better acknowledge the extent of damage inflicted by the history of colonisation and the past policies of family separation and assimilation, submitters exhorted the committee to urge adherence to key policy commitments made in the framework, principally that services be:

- Culturally appropriate—responsive to the diversity of Indigenous peoples and their beliefs, and delivered by trained Indigenous health workers of the appropriate sex; and
- Community-controlled health services—funded and operated by communities.

Culturally appropriate services

16.61 Indigenous people with mental illness experience extremes of social and psychological divorcement. Alienated from their families and country of origin, and hence from their identity, many are out of touch with traditional networks of help. This has important implications for the nature of services to be provided:

Primary prevention requires a greater focus on the social determinates of mental illness amongst Aboriginal people. This includes the need to recognise and address the historical trauma created by the experience of colonisation and dispossession as well as the specific trauma of the Stolen Generations. It has been suggested that the extent of this trauma is such that many Aboriginal people are suffering from symptoms suggestive of Post Traumatic Stress Disorder. This has been more extensively described for Aboriginal people in Canada but is almost certainly true in Australia as well.⁹⁶

16.62 As indicated here, research on the extent of this damage and on the most effective means of addressing Indigenous mental health needs is underdeveloped in

94 Aboriginal Health and Medical Research Council of New South Wales, *Submission 406*, p. 3.

95 NRHA, *Submission 181*, p. 23.

96 The Central Aboriginal Congress, *Submission 486*, p. 5.

Australia.⁹⁷ For example, diagnostic tools for assessment of mental illness among indigenous are underdeveloped.⁹⁸ The Human Rights and Equal Opportunity Commission noted that while the Western Australian Aboriginal Child Health Survey (WAACHS), quoted above and below, provides a watershed: 'A first step in any address to Indigenous mental health is to address the paucity of data collections in this area'.⁹⁹

16.63 Notwithstanding this, the major contention in the evidence was that the situation has not improved because the long espoused commitment to deliver culturally appropriate services has not received full government support.¹⁰⁰ In this regard, Indigenous researcher Ms Jenine Bailey, a Jagara woman from Brisbane now resident in Townsville, told the committee that the key message to mainstream health providers is: 'You are not listening to me; Aboriginal mental health is different'.¹⁰¹ She explained:

As an Aboriginal mental health worker, I have experienced first-hand the frustrations related to access and/or deliver of culturally appropriate mental health services to the community, when continually confronted by obstacles, gaps or lack of capacity in service delivery that hinder my work practice. These obstacles include lack of funding and/or inappropriate recognition for Aboriginal mental health, inadequate support from mainstream mental health workers and services, the stigmas associated with Aboriginal mental health, misunderstanding that Aboriginal mental health and the concept of health is different to western concepts of health and therefore there are different needs, and no recognition for cultural mental health differences between different Aboriginal communities.¹⁰²

16.64 One myth exploded by the WAACHS findings was that living in rural and remote communities confers poorer health outcomes on Indigenous people. Submissions referred to WAACHS data indicating that the environmental safety and health (ESH) of Indigenous children actually improved with isolation, that is, in

97 The NHMRC noted in 2002, mental health research on Aboriginal and Torres Strait islanders features in only 1 per cent of mental health research publications and attracts only two per cent of mental health research funding, despite the high and growing incidence of mental health problems and associated negative social outcomes. See OATSIH, Australian Government *Submission 476*, Attachment 24, p. 3.

98 See for example, Victorian Institute of Forensic Mental Health, *Submission 306*, pp.8–9.

99 The Human Rights and Equal Opportunity Commission, *Submission 368*, Attachment 1, p. [9]; Catholic Health Australia, *Submission 276* p. 13.

100 Combined Community Legal Centres Group NSW, *Submission 232*, p. 14.

101 Ms Jenine Bailey, Indigenous Researcher, Rural Health Research Unit, James Cook University, *Committee Hansard*, 5 August 2005, p. 31.

102 Ms Jenine Bailey, Indigenous Researcher, Rural Health Research Unit, James Cook University, *Committee Hansard*, 5 August 2005, p. 32.

remote communities. Children living in Perth had significantly poorer (five times worse) ESH than those living in very remote communities.¹⁰³

16.65 While Indigenous people are the largest group as a proportion of remote and rural populations and experience problems consequent to that isolation.¹⁰⁴ The important realisation arising from these findings is that culturally appropriate assistance to urban Indigenous people is urgently needed.¹⁰⁵ It was suggested that urban-based services must recognise the psychological effects of cultural dislocation, such as through the stolen generations policy,¹⁰⁶ and still be responsive to the different Indigenous cultural expectations, linking back to the particular beliefs of the client's country of origin:

There are those complexities in our culture. It depends where that person is from. The same applies to a woman speaking with a male psychiatrist; she would not feel right. There were times when I had the whole extended family, including an aunty, an uncle and cousins, because they take it all on. It is not just a one on one with the psychiatrist, it is a very big family group, and they will have a family meeting about it. It is just that understanding that it is just not one person going through the mental illness; it actually involves the family, and therefore it ripples out into the community. It just depends on the person who walks through the door. You must be aware of that. Torres Strait Islanders are different from Aboriginals, and it depends where the community is from. Just because they are an Aboriginal does not mean that way of treating and therapy, or applying strategies for care or whatever, will work for them as it does for somebody in Alice Springs, for instance.¹⁰⁷

16.66 Because the Indigenous concept of health is quite different to European understandings, the cultural nuances of diagnosis are complex.¹⁰⁸ Self harming can be part of ritual observances for mourning, or an expression of depression or other grief;¹⁰⁹ hearing voices can be seen as communication with ancestors, a men's business matter. Trained Indigenous workers of the right sex with appropriate cultural

103 See The Human Rights and Equal Opportunity Commission, *Submission 368*, Attachment 1, p. [10].

104 See NRHA, *Submission 181*, p. 10, and as discussed below and in the previous section on Rural and Remote.

105 See 'Aboriginal Health'—*Health Report ABC*, 7 November 2005, p. 6.

106 It has been suggested that in remote settings, traditional family connections have remained comparatively intact, with fewer individuals had been subject, or exposed thorough family connections, to forcible removal policies See 'Aboriginal Health'—*Health Report ABC*, 7 November 2005, p. 6.

107 Ms Jenine Bailey, Indigenous Researcher, Rural Health Research Unit, James Cook University, *Committee Hansard*, 5 August 2005, pp. 34–35.

108 Dr Roger Crib, *Submission 261*, pp. 3–5.

109 *Submission 261*, p. 5.

knowledge are essential to assess, interpret and assist. Mainstream psychiatrists in urban settings have little capacity to do this.¹¹⁰ At the same time shortages of psychiatrist in rural settings ensure that access to these services is even more limited for remote Indigenous communities.¹¹¹ The Central Australian Congress provided its template for more responsive care:

There needs to be greater attention given to the language and cross cultural barriers that arise when psychiatrists are employed who have English as a second language...there is also a need to address the shortage in mental health nurses working in remote areas. Acute care facilities need to have access to interpreters and Aboriginal liaison officers who can ensure that there is good communication between inpatients and their families. There also needs to be close liaison with the primary health care sector and many patients should have pre-discharge care plans developed with their primary health care provider to ensure that follow up is collaboratively planned. Congress has re-developed the job description of our mental health worker position to make this the prime focus of his job and we hope this will lead to better coordination of care and follow up of our patients who are in and out of ward.¹¹²

16.67 Indigenous health workers carry much of the load in building bridges in communities, although this is currently not recognised. Service providers argued that the key to improving Indigenous health outcomes relies on handing over control for design and delivery of these services to those who know best:

...we need to recognise the clinical and cultural capacity of Indigenous mental health workers within [the] mainstream to direct and guide service delivery for Indigenous users.¹¹³

16.68 Mr Jonathan Link is of Australian Aboriginal and Maori descent¹¹⁴ with health program qualifications. He is a Community Liaison and Development Officer with the Royal Flying Doctor Service, working in remote areas of the northern Cape

110 Ms Jenine Bailey, Indigenous Researcher, Rural Health Research Unit, James Cook University, *Committee Hansard*, 5 August 2005, p. 35.

111 For shortages in rural and remote areas see HCRRA, *Submission 106*, p. 5.

112 The Central Aboriginal Congress, *Submission 486*, p. 7.

113 Ms Leanne Knowles, Manager, Social Health Unit, WuChopperen Health Service, *Committee Hansard*, 5 August 2006, p.

114 Descendent of the Kuku Uulangi tribe, between Mosman and Cooktown (on his father and grandmothers side), and the Ngapuhi Te Autu of Auckland NZ (from his grandmother on his mother's side). Mr Jonathan Link, Community Liaison and development Officer, Royal Flying Doctor Service, *Committee Hansard*, 5 August 2006, p. 47.

York where services are spread thin.¹¹⁵ His experience resonates the important role of Indigenous health workers in bridge building in these communities:

I have been travelling to these communities for two years now and through meeting people in their homes, at the clinic, whatever the organisation, we try to express that individuals need to take control of their community, especially in their homes. For example, if I was going to your place, you would not expect me to come and invade your home. It is the same principle of us coming into a community and trying to tell them how to be. My role is to give them an opportunity to see that there is support. You are not going to always have the answer within communities, especially around raising awareness issues. Mental health is a stigma in Indigenous communities, so my role is to just be a person who will listen. That is a very important factor there. The communities tend to be reactive rather than proactive; if there is an issue there they tend to act on it straight away without actually coming together as a group. Listening to them, showing that you are transparent and not promising things that you cannot deliver are important. I believe I have made inroads there.¹¹⁶

16.69 Mr Link considers that lack of services and employment are major catalysts to mental illness in Indigenous communities, particularly among men and boys.¹¹⁷ He advocated a two-pronged approach: development of social and cultural infrastructure; and attention to the training and working conditions of local Indigenous health workers:

I would like to see cultural schools. I would like to see drop-in centres for youth, elders and people in the middle age groups. I would like to see traditional healers and elders having a bit more input into the way people feel. There is a big gap in the way our people interact with each other. Also I would like to see more money for health workers and a health worker exchange program. When nurses have holidays, there is always a replacement, but there is nothing there for Indigenous health workers. If you could implement and fund that particular initiative, that would be great.¹¹⁸

16.70 The depression initiative, *beyondblue* endorsed the view that social mentoring activities have potential to address mental health issues in Indigenous communities.

115 He flies fortnightly services to four Indigenous communities, taking a medical officer on a weekly run, a psychiatrist on three monthly visits, and delivers a psychologist who services eleven communities in total. See *Committee Hansard*, 5 August 2006, pp. 47–48.

116 Mr Jonathan Link, Community Liaison and Development Officer, Royal Flying Doctor Service, *Committee Hansard*, 5 August 2006, pp. 48.

117 Mr Jonathan Link, Community Liaison and Development Officer, Royal Flying Doctor Service, *Committee Hansard*, 5 August 2006, pp. 53–56.

118 Mr Jonathan Link, Community Liaison and Development Officer, Royal Flying Doctor Service, *Committee Hansard*, 5 August 2006, p. 51.

Mr Kennett referred to the copycat suicides of a dozen young Aboriginal men Swan Hill in Victoria as an indicator of urgent unmet need.¹¹⁹

...the Aboriginal community does respond very well to peer influences and particularly to footballers. Most Aboriginal communities are involved in football. We are actually looking at the moment at incorporating one or two of these people, properly trained—and there are a number who have suffered depression but who are very good communicators—to try to lift self-respect amongst some of the communities. The important thing is not to go in and conduct a program and then leave them. We have to have a method of going back every three months, six months and 12 months. That is fairly costly, but it has to be done. You cannot just go in once and think that you have educated someone.¹²⁰

16.71 Submissions confirmed that the difficulty of obtaining and retaining skilled locally-based Indigenous health workers, particularly male workers, in all areas is a major obstacle to delivery of continuous culturally appropriate mental health care.¹²¹ Studies show that Indigenous people are discouraged by hierarchal and 'silo' structures in the medical health industry and have a lack confidence in negotiating the education process,¹²² leading to low rates of retention in both instances.¹²³

16.72 Indigenous only education venues have proven successful in providing the type of collaborative culturally affirming learning environments essential to achieve positive outcomes for Indigenous people.¹²⁴ Mr Link achieved his qualifications at the Bachelor Institute Indigenous College which he suggested should have support.¹²⁵ Ms Leanne Knowles, Manager, Social Health Unit, WuChopperen Health Service proposed the introduction of scholarships for Indigenous health professionals, and incorporation of Indigenous Health curriculum in mainstream courses would assist.¹²⁶

119 Mr Jeff Kennett, Chairman, beyondblue, *Committee Hansard*, 5 July 2005, p.11.

120 Mr Jeff Kennett, Chairman, beyondblue, *Committee Hansard*, 5 July 2005, p. 10

121 Mr Jonathan Link, Community Liaison and development Officer, Royal Flying Doctor Service, *Committee Hansard*, 5 August 2006, p. 49, and see for example, Consumers and Carers from the NSW Far South Coast , p. 3.

122 See discussion of 'Seasonal Worker Syndrome' in Tom Brideson and Len Kanowski, 'The Struggle for Systemic' adulthood' for Aboriginal Mental Health in the Mainstream: the Djirruwang Aboriginal and Torres Strait Islander Mental Health Program' in Jane Havleka, Charles Sturt University, *Submission 438*.

123 *No Shame Job, Careers in Health*, Department of Education, Science and Training, 2002.

124 *Indigenous Vocational Education and Training: at a Glance*, National Centre for Vocational Education Research, November 2005, www.ncver.edu.au/publications/1630.html (accessed 16 March 2006).

125 Mr Jonathan Link, Community Liaison and development Officer, Royal Flying Doctor Service, *Committee Hansard*, 5 August 2006, p. 52.

126 Ms Leanne Knowles, Manager, Social Health Unit, WuChopperen Health Service, *Committee Hansard*, 5 August 2005, p. 41.

16.73 A ray of hope in both respects is the Djirruwang Program at Charles Sturt University which offers a Bachelor of Health Science (Mental Health) Degree to Aboriginal and Torres Strait Islander people. The Program adheres to the *National Practice Standards for the Mental Health Workforce 2002*, to ensure graduates are imbued with the skills and ethical values of the profession while maintaining 'a deep sense of cultural integrity'.¹²⁷ The submission recommended the *Djirruwang Program Clinical Handbook and Course Competencies* be adopted as the standard for national accreditation in Indigenous mental health practice to promote culturally supportive practices in the mainstream health system.¹²⁸

16.74 The inadequacy of available treatment for people with dual diagnosis is a matter of national concern addressed elsewhere in the report. The lack of specialised services to assist Indigenous communities to deal with co-occurring disorders was raised in submissions as a cause for shame. The Probation and Community Corrections Officers' Association Incorporated (PACCOA) advised:

A PACCOA member recently reported that there is a significant problem in Aboriginal communities concerning the issue of both mental illness and "undiagnosed" mental illness due to inadequate resources in these communities. These are often people being treated for addictions, and fall under the dual diagnosis umbrella. Often these communities do not have basic drug and alcohol services. At one Probation and Parole District Office, there are over 30 offenders with significant drug and alcohol issues, but no counsellor. Even though every effort is made to fill the gap by bringing in the services from outside the communities, wherever possible, the responsibility falls to health services. It has been recommended that, given there is a dual diagnosis treatment trial under way, such trials should be extended to poorly resourced Aboriginal communities where the treatment is so urgently needed.¹²⁹

16.75 The effect on Indigenous children and young people has not been fully counted in the equation of need, having been limited to addressing single issues such as the petrol sniffing epidemic.¹³⁰

Services for Aboriginal Australians continue to be acutely under funded, struggling to meet basic needs. Breakdown of traditional family structures and the loss of virtually entire generations due to substance abuse means parenting skills have been lost putting Aboriginal children in a situation of crisis. Community resources are reduced, leaving just the old struggling to care for the young as they handle their own ill health and poverty related

127 Brideson and Kanowski, 'The Struggle for Systemic' adulthood' for Aboriginal Mental Health in the Mainstream: the Djirruwang Aboriginal and Torres Strait Islander Mental Health Program' in Jane Havleka, Charles Sturt University, *Submission 438*.

128 See for example, Ms Jane Havleka, Charles Sturt University, *Submission 438*, [np].

129 The Probation and Community Corrections Officers' Association Incorporated (PACCOA), *Submission 503*, p. 4.

130 Currently the subject of an inquiry by the Senate Community Affairs References Committee.

issues. Mental health programs need to be integrated and integral to the overall health, social and emotional wellbeing programs that need to be funded for Aboriginal people, implemented in a culturally appropriate and socially acceptable manner.¹³¹

Community-controlled services

16.76 Building self esteem and a sense of empowerment is an important element in recovery-based models for care of all people with mental illness, and is particularly important for Indigenous people. This fact was recognised in the National Aboriginal Health Strategy:

The greater the degree of control a person has over their life and the greater the degree they feel they can participate in (influence) the way their social environment operates, the better their physical and mental health will be.¹³²

16.77 It was cogently argued in the evidence that the best way to manage and ameliorate the levels of distress in Indigenous communities, and so to achieve progress with mental health and social outcomes, is to give these communities the power to determine the nature, scope and presentation of services to their own people:

In certain areas Aboriginal mental health workers are placed in mainstream health services (or an Aboriginal staff member is designated that role), giving rise to problems of access and appropriateness when Aboriginal people won't utilise services for cultural and historical reasons. NCOSS strongly supports the placement of Aboriginal mental health workers in Aboriginal community-controlled organisations, from where they would work in conjunction with mainstream services to provide mental health services to the Aboriginal community. This would be consistent with the National Aboriginal Health Strategy, which has been agreed to by the NSW government and recognises that Aboriginal community controlled organisations are the best means for delivering health services to Aboriginal communities.¹³³

16.78 The committee received a number of reports of community controlled models and partnerships which are achieving results:

One such program is the Aboriginal Primary Health Care Access Program (APHCAP) which has considerable acceptance within the communities in regional SA and actively engages with Divisions of General Practice, is setting up Aboriginal controlled health centres on a “one stop” model. Workforce development for Aboriginal health workers in mental health is

131 SA Division of General Practice, *Submission 88*, p. 8.

132 National Aboriginal Health Strategy Working Group, National Aboriginal Health Strategy, AGPS, Canberra, 1989, p. ix, quoted in HREOC, *Submission 368*, Attachment 1, pp. 9–10.

133 NCOSS —Council of Social Service of New South Wales, *Submission 274*, p. 8.

much needed, as well as these workers being able to easily access specialist support.¹³⁴

16.79 However, there were very grave concerns that the funding needed for community controlled Indigenous health services, despite the rhetoric, is not ending up in Aboriginal hands. The experiences of the Central Aboriginal Congress are indicative:

...in 1997 when Alice Springs began experiencing a major upsurge in the rate of youth suicides Congress called a meeting of all Aboriginal organisations in Alice Springs and established an Aboriginal youth committee to discuss the problem and help to develop potential solutions. In spite of this process Congress was unable to access any of the national youth suicide prevention funds to establish programs in accordance with community proposals because all of this money had been given to the states and territories.¹³⁵

16.80 The Congress was later informed that all the youth suicide prevention money had been given to the Northern Territory Government for redistribution to community organisations, such as the Congress. The funds, however, were transferred to a non-Aboriginal mental health NGO. The Congress commented:

...given that the principal need is in the Aboriginal community we do not think this is the best option. Aboriginal community controlled organisations have the best chance of providing such programs in a manner which will meet the needs of their communities and achieve health outcomes. Because of the difficulties that Aboriginal people are experiencing in accessing funding for social and emotional well being services and programs OATSIH are having to primarily use their PHC resources to fund the delivery of social and emotional well being services within Aboriginal community controlled PHC services. Such services should be funded with mainstream Mental Health specific funds.¹³⁶

16.81 Congress maintains that Indigenous-controlled community services are best placed to build capacity to deliver targeted and culturally appropriate services to youth and remote communities.¹³⁷ Denial of direct funding to Indigenous organisations is contrary to the principles of community ownership and control espoused as Australian Government policy, notwithstanding the insult to the Indigenous committee fora convened especially to consult over suicide prevention. The draining of dedicated OATSIH funds to support identified *national* mental health priorities, seems ill

134 SA Division of General Practice, *Submission 88*, p. 8.

135 The Central Aboriginal Congress, *Submission 486*, p. 7.

136 *Submission 486*, p. 7.

137 There are no services, for example, to support itinerant indigenous youth with social and emotional well being disorders in Alice Springs; there are no such services in existence. See *Submission 486*, p. 7.

considered given the high level of complex unmet need among Indigenous communities.¹³⁸

16.82 Government evaluations have shown that only 38 per cent of Aboriginal Community-controlled organisations have a dedicated mental health or social and well being worker.¹³⁹ To foster genuine and effective local community-based mental health services around the country, submissions asked that the Government honour both the letter and the spirit of its commitments. Aboriginal Health and Medical Health Services advised that national leaders must:

- require all stakeholders to comply with existing Aboriginal health agreements, policies and processes at state, regional and local level;
- support those programs and providers currently providing services which the Aboriginal community value and utilise;
- enhance culturally appropriate services targeting Aboriginal children and adolescents, either directly or indirectly;
- support dedicated Aboriginal Health funding being directed to Aboriginal community health services to administer the development, implementation and evaluation of programs;
- secure effective implementation of state and local policy to Aboriginal Mental Health Workers in the public, private and Aboriginal community controlled health sectors; and
- promote effective coordination and support of local mental health services.¹⁴⁰

16.83 To be effective, these core recommendations must be underpinned by a full commitment at federal level, in terms of recurrent funding, policy development and support for implementation of Indigenous emotional and wellbeing program. Submitters argued that this must be more than just rhetoric, backed up by the politics of mutual obligation. It must be based on genuine respect for what traditional cultures offer, and recognition that self determination of Indigenous people over conditions of life in all states and territories will be the foundation of real progress in Indigenous health.

138 The committee notes in this regard Department of Health and Ageing advice that its Indigenous Mental Health program, comprising Social and Wellbeing Regional Centre, and the Bringing Them Home programs are not funded beyond annual allocations. Funding for some Social and Wellbeing programs are supplied annually 'subject to previous compliance'. The Link Up program, an integral response to the 'stolen generations', is now another program to be resourced by OATSIH Answers to Questions on Notice, *Submission 476A*, p. 5.

139 *Consultation Paper for the Development of the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well Being 2004-2009*, Canberra, 2003, p. 11.

140 Aboriginal Health and Medical Research Council of New South Wales, *Submission 406*, pp. 9–10.

Other groups: Gay, Lesbian, Bisexual and Transgender

16.84 The AIDS Council of NSW (ACON) told the committee that mental health problems are more common among gay, lesbian, bi-sexual and transgender (GLBT) people than among the population in general.¹⁴¹ This relationship is related to society's response to homosexual and transgender people, many of whom experience discrimination and stigmatisation.¹⁴²

16.85 Discrimination impacts not only on the mental wellbeing of GLBT people, but on their ability to access mental health services. Further, multiple discrimination, on the basis of both mental illness and sexuality, can seriously affect GLBT people's access to wider support services, such as housing, employment, law enforcement and general health services.¹⁴³ Training is required to ensure appropriate service delivery:

It is important that all state and national strategies and policies recognize this and work to eliminate homophobia and discrimination on the basis of sexuality and gender identity.¹⁴⁴

16.86 ACON suggested that community-based organisations are well positioned to provide culturally appropriate health services and support for GLBT, but note that funding is currently limited.¹⁴⁵

141 The Aids Council of NSW Inc (ACON), *Submission 531*, p. 3.

142 *Submission 531*, pp 3-4.

143 *Submission 531*, p. 6.

144 *Submission 531*, p. 5.

145 *Submission 531*, p. 6.

