‘We need more than pamphlets.’

Mental Health Services in Rural and Remote Australia

While the terms of reference of the Select Committee on Mental Health are broad and wide ranging, the contribution to these deliberations by Health Consumers of Rural and Remote Australia (HCRRA) is to put before the Committee the views of a cross section of our members about mental health services in rural and remote Australia. These views relate to availability, access and appropriateness of mental health services in rural and remote areas of Australia. The second purpose of the submission is to present some proposals for developing services for future delivery.

About HCRRA

HCRRA is an incorporated, not-for-profit national organisation governed by a National Committee, which is elected by members at postal elections every two years. One committee member represents each State with 2 committee members representing Western Australia. The Australian Government Department of Health and Ageing provides funding for HCRRA. Membership subscriptions and donations from organisations, such as Meat and Livestock Australia, supplement this funding.

HCRRA canvasses the views of people in rural and remote areas about their health services and other related issues. HCRRA takes these views to State and Federal Governments directly and through their policy development forums as well as to the policy forums of non-government organisations. This ensures that the views and needs of people who live in Australia’s non-metropolitan areas are considered when policies and service delivery methods are being developed.

Mental Health Services in Rural and Remote Australia

The availability of information about mental health and available services in rural and remote areas can be enhanced and limited by the presence of structural health services, the versatility of outreach services and the willingness of people to be seen to be collecting material about this specific health issue. There is no doubt that various programs, such as Beyond Blue and Lifeline have well researched and readable information resources as a component of their programs. Internet information from these programs and about mental illness is dependent upon the availability of access to Internet services, the quality of the connectivity and the willingness and ability of the user.

Because of the combined complications of geography, distance, workforce issues and the availability of support networks, it is difficult to make general statements about the adequacy of various models of care for people with a mental illness who live in rural and remote areas of Australia.

As with most other illnesses, for people with mental illness, the support network of community is important. However, this support network through the extended community may be compromised by the lack of confidentiality. In fact feedback from HCRRA’s membership reports that the lack of confidentiality is a significant feature of life in small communities. The stigma of mental health is enormous. HCRRA research reports that most people, who are diagnosed with a short or long-term mental condition, hide their condition as much as possible rather than seek help and there are not the resources for help to seek them.

Confidentially is a two-edged sword however. We have evidence where a caregiver of an adult with a serious mental illness is not permitted to receive any news about an ongoing condition from a health practitioner because of confidentiality. This situation is most frustrating for the caregiver and can thwart care by a family member, costing the community in the long run.

Additionally the research reports that in the cases of diagnosed long-term mental illness, the resources to assist the family to cope with this issue are meagre or non-existent. In the northeast of WA for example, a visiting specialist and a mental health nurse do provide some services but they are required to cover an area of 1800 square kilometres. There are also 2 resident Indigenous Health Care Workers in the area who provide services for both Indigenous and non-Indigenous people.

In another particular isolated area in the south eastern region of WA, there is a community mental health service available during working hours but there is no after hours service, no supported accommodation and no supported employment programs available.

There are many familial stories that point to an absence of appropriate services to address particular circumstances.

- *in the north west of WA, there lives a family where an aged widow and her two adult sons, both with mental illness that makes them violent, find coping difficult. Currently, both are bound by restraining orders. When a mental episode occurs with one or both of the sons, because of the absence of appropriate care facilities, they are taken to Perth for treatment. Once the treatment is complete, the son returns to his hometown where his mother waits, sometimes in fear of her life, for the next episode to occur.*

  Police services are scant in the area and their geographic area of responsibility is huge. When violent episodes do occur and assistance is required to manage the situation, it is not always available.

  There is no support for either the mother or her sons. There is also the added concern about the ultimate fate of the sons as their mother is no longer able or willing to allow them back into her house.

- *From that same area is the story of a person with drug-related schizophrenia. This person lived in a group house, had no family support, did not seek community or other support following diagnosis of this condition. As time passed, the illness worsened and the person committed suicide. The responsibility for this death weighed on the community service providers who judged that failing to be able to adequately support this person and his mental condition led directly to his death.*

Access to Appropriate Respite Care

Appropriateness of Respite Care is another important issue. In many small communities, respite is provided in the local hospital. Reports from rural as well as isolated communities points to the view that this form of respite simply postpones the problem, the stay in 'respite' limited by a range of factors and the person is released into their community, condition and support levels unchanged. Often not considered is that this form of respite care is totally inappropriate for indigenous people, as they will not stay in a hospital. In the area there is a religious minister and his wife, both social workers, who provide the counselling services free and on a fee for service basis. They are both extremely busy and burnout, a common condition with health workforce in rural and remote areas, may become an issue.

It will come as no surprise to the Committee that depression related to changes to local economic and social conditions is prevalent in many communities. Feedback from a mental health professional who works in rural Queensland reports that, with the reconstruction of the dairying industry and the subsequent loss of profession and possessions, the number of people in the area that have been diagnosed with depressive illness has increased markedly. The suicide rate has also increased. Other States echo this observation in relation to the impacts of drought on their farming communities. In fact research undertaken by the National Rural Women's Coalition strongly supports this assertion. Copies of this research can be made available upon request.

It is worth noting that HCRRA's research concludes there is an increase in the occurrence of psychotic mental health illness related to drug use with no increase in the level of health workforce numbers, services or supported accommodation to provide services to or accommodate those who suffer from this condition. In locations where there is supported accommodation, it may close on weekends, which is a significant issue for the residents. This feedback has come from both NSW and Qld.

A peripheral but very important issue worthy of consideration is the importance of case management in patient care. Health professionals working together managing and co-ordinating care of their patients can facilitate the best possible and most cost effective care for individuals. For example, an elderly patient may present symptoms of mental illness as a side effect of some medication being taken for a

urinary tract infection. Case management of people in this situation would prevent inappropriate treatment options being taken up.

Normalising Mental Illness

The education campaigns to normalise 'mental illness', are of utmost importance in this regard. We have one member who lives in Western New South Wales who was diagnosed with a mental illness (bipolar disorder) at the age of 14 years. A series of life changing occurrences led her to settle with her family at their present location. There is one GP in the town and a visiting psychologist who does not charge the patient for his services.

The woman decided that normalising her illness was a positive way to raise awareness of mental illness 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.

Workforce Issues

Workforce issues will be a major part of any discussion about the provision of health services in rural and remote Australia, particularly the provision of mental health services. People with episodic depression have little or no support services in this area and the service providers who work with people suffering mental illness are stretched beyond their capacity in come cases.

A significant workforce issue in rural and remote areas is the lack of continuity of a reliable workforce. This has the power to seriously impact the operation and delivery of mental health programs. There are examples of where programs are operating successfully as a result of the tenacity and resilience of the mental health worker, nurse, general practitioner or allied health professional who is working at a particular health facility or in the immediate area just as there are examples of services folding because of the absence of such staff.

There is evidence that whilst the medical side of mental health care is tackled successfully in rural and remote areas by fly-in fly-out personnel, there is not the on-the ground support staff – case workers, social workers etc – to support these efforts. It seems that if the support services are not available then the good work done on the medical side of the illness unravels quickly. Additionally, maintenance programs cannot be accessed in many rural and remote areas.

As is the case with health care professionals in any sector in rural and remote areas of Australia, staff burnout is a serious issue because of the hours, large caseload and geographical area to be covered. However, another factor that contributes to staff burnout is the *Application cycle*. There are always a large number of pilot programs developed that health services must apply to for funds. This is admirable in that governments are always willing to try something new. What is often not considered is that personnel must spend valuable time researching and applying for funding under these programs that they eventually reach application burnout.

HCRRA advocates for the best use of the services of the health professionals that are available. To this end, it is important to ensure that training and information sharing is always be optimised to make best use of staff time and effort and to equip them to do their work with the least amount of stress.
It is also important to point out that, because they are often the first services called to a mental health episode or to a suicide, auxiliary services such as ambulance and police officers need to have competencies in handling the many and varied circumstances they may confront. Managing any violence is only one of the potential scenarios. The will most likely also confront person in various stages of distress because of their condition, they more than likely will face a medical situation where the patient is close to death or dead because of attempted suicide.

For the sake of the officers, the patients, the families and others they will com in contact with, these officers need to have up to date training in handling this wide variety of situations and still provide a professional and effective service. They also need to care for their own mental wellbeing.

Structural Support for Effective Case Management

Evidence from the Northern Territory points to a situation where one set of rules serves to undo another set of rules. 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.

Delivery of Programs Through Community Organisations

There are a large number of community organisations delivering mental health programs in many parts of Australia. The success of these initiatives is not an issue for this paper. What is an issue however is where there are administrative changes to service delivery with insufficient attention being given to the needs of their client group. A mentally ill person considering suicide who desperately needs to speak to a counsellor will be devastated to hear a recorded message about the closure of the service, a change of phone number, or, worse still, be confronted by an unanswered phone. These type of changes happen but more thought needs to be given to the transitional arrangements.

Alternative Therapies

There is no mention in the terms of reference of the use of alternative therapies to assist in the treatment of mental illness. Aromatherapy, relaxation techniques, massage, Tai chi, acupuncture and hypnotherapy may be beneficial. Additionally, exercise has shown to be positive in treating depression.

Indigenous Programs

It is reported that the Aboriginal Mental Health Worker program in the Northern Territory and run through the Top End Division of General Practice works very well. The issue of concern with the program has been the uncertain future of the program because of funding concerns. The program has been continued with innovative methods of funding but it does take away from the program's success when the continuity of funding is under constant pressure. An agreement between levels of government could ensure this successful program would continue.

What Works – Preventative Programs

In our research there was high praise for a program called 'Living Works' from both health service professionals and patients. The Program is costly but does have a 'train the trainer' component. HCRRA advocates for an increased allocation of funding for this program so that it can be made available to health professionals, police and ambulance officers and crisis carers.

Our research also revealed high praise for the initiatives of 'Beyond Blue', although evidence suggests it has yet to have measurable impact on people many rural areas. Those who commended the initiative saw it as a positive intervention rather than a 'bandaid' solution.

Relapse Prevention

Access to services and continuing care become an issue for people who live in rural and remote communities once they return from treatment episodes in the city or large regional centres. Because of the distance and isolation from treatments services and options and in a number of cases, the absence of support there is always the possibility of relapse. Normalising mental illness could mean that support in rural communities may be forthcoming. In the meantime, the potential of relapse remains a risk factor and strategies to address this risk must be incorporated in ingoing individual treatment plans.

This issue has been addressed at length in a paper produced by the Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet), a national project funded by the Australian Department of Health and Ageing under the Mental Health Strategy and the National Suicide Prevention Strategy. The paper is entitled *Pathways to Recovery: Preventing Relapse* and is available through HCRRA commends the paper to the Inquiry.

HEALTH CONSUMERS OF RURAL AND REMOTE AUSTRALIA

Mental Health – Low Level of Services in Rural and Remote Australia

POSITION STATEMENT – Health Consumers of Rural and Remote Australia will use its networks and representative opportunities to bring to the attention of policy developers in State and Commonwealth Governments that services for people suffering from mental illness in rural and remote Australia are not at a sufficient level to address the evidence that people in rural and remote areas have higher levels of mental illness than those living in urban areas.

Health Consumers of Rural and Remote Australia recognises that

- there is evidence that people in rural and remote areas have higher levels of mental illness than those living in urban areas;
- services of the 7.5% of psychiatrists located in rural or remote locations is not an appropriate service level for people who live in rural and remote areas;
- of psychiatrists practising in non-metropolitan areas, 90% are located in major regional centres. This is not an appropriate service level for people who live in rural and remote areas; and
- there are also shortages of clinical psychologists and social workers in rural and remote areas.

Health Consumers of Rural and Remote Australia advocates

- that all efforts to improve the development and implementation of flexible service delivery models that will increase the level of mental health services in rural and remote areas be fully supported by Health Consumers of Rural and Remote Australia;
- that governments acknowledge the implications and potential implications upon access to and delivery of mental health services, which are unintended consequences of policy decisions;
- increased availability, in locations such as schools, sporting clubs, social venues and businesses, of information on mental health issues and available services;
- that, wherever possible, consumer representative opportunities in mental health forums be offered to members of Health Consumers of Rural and Remote Australia who have a knowledge and understanding of the issues about mental illness; and
- HCRRA will use its networks to advocate for increased availability of mental health services in rural and remote Australia.

HCRRA – 7 April 2005