



Senate Standing Committees on Community Affairs

Accessibility and quality of mental health services in
rural and remote Australia

beyondblue submission

May 2018

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Introduction

beyondblue's focus and approach

beyondblue is a national, independent and bipartisan not-for-profit organisation working to promote good mental health, prevent suicide and improve the lives of individuals, families and communities affected by depression, anxiety and suicide.

beyondblue welcomes the opportunity to make this submission to the Inquiry by the Senate Standing Committees on Community Affairs into the accessibility and quality of mental health services in rural and remote Australia. *beyondblue* congratulates the Government on recognising the need for inquiry in this area to better understand the challenges of delivering services in rural and remote communities and the opportunities for reform.

This submission focuses on policy recommendations to improve the access and quality of mental health services for people living in rural and remote Australia to ensure they can achieve their best possible mental health. Having worked with rural and remote Australian communities for the last 18 years, we recognise that delivering services and reaching people with the support they need, when they need it, is no easy task. This submission draws on our experience in delivering supports and services in rural and remote communities, including the *beyondblue* Support Service; the KidsMatter and MindMatters initiatives for early childhood centres, primary and secondary schools; online forums; digital mental health solutions; NewAccess;¹ and The Way Back Support Service.² It also draws on our extensive engagement with rural and remote communities, through local events and activities, social and traditional media and campaigns, and the *beyondblue* Roadshow. Our roadshow travelled over 53,000km over 15 months in 2014 and 2015, stopping in 360 rural towns, regional centres, capital cities and suburban neighbourhoods. We attended 528 community events and started conversations about mental health with 100,000 people, many of whom were in rural and remote communities.

In preparing this submission, we have consulted with blueVoices – our online community of more than 8,000 people who have a personal experience of anxiety, depression or suicide, or support someone who does. blueVoices members from across Australia who are currently living, or have previously lived, in a rural or remote area responded to our call for insights and suggestions on what would make a difference to themselves, their families, and their communities. Their views and ideas are expressed throughout this submission.

Submission 'in a nutshell'

The central tenets of this submission are:

- At present, access to mental health services is significantly poorer in rural and remote areas. **Just 3.5 per cent of the psychiatric workforce services outer regional, remote and very remote areas nationwide.** Mental health services in rural and remote communities are at-capacity, leaving many people to travel significant distances to access traditional approaches to support and treatment.
- Suicide is unacceptably high in rural and remote communities. The suicide rate increases with remoteness – in 2010 – 2014 **the suicide rate was 23.7 per 100,000 people in very remote regions, compared to 9.8 per 100,000 in major cities. Aboriginal and Torres Strait Islander peoples are also twice as likely to die as non-Indigenous Australians.**
- Attempts to address quality and access to services to date have been ad hoc, with little widespread or long-term planning done to address the gaps in mental health services.

¹ NewAccess is an early intervention coaching program designed for people with mild to moderate depression and anxiety.

² The Way Back Support Service delivers psychosocial care, practical support and follow up designed for people who have been discharged from hospital following a suicide attempt.

- There are three major opportunities to improve outcomes for people living in rural and remote communities:
 - **Digital technology.** We need to build the capacity, capability and culture of health professionals and community members to expect digital mental health services to be a core component of our mental health system. This is currently not being done, and it is a lost opportunity – the recent ‘Invest to Save’ report conducted by Mental Health Australia and KPMG report that **using digital health solutions to deliver early intervention mental health services to one million Australians could create \$442 million in short term savings.** We also need to recognise that many people in rural and remote communities continue to have difficulties accessing good quality mobile and internet services, so this isn’t a solution for everyone.
 - **Long-term investment to Primary Health Networks.** Primary Health Networks can commission mental health services that fill gaps in the system and respond to local needs. However, they need to be supported to do so. PHNs have many competing priorities. Long-term funding to PHNS is critical to developing long-term solutions.
 - **Workforce reform.** Our current, traditional mental health workforce will never have enough capacity to meet demand. We need to develop new workforces, that focus on training local community members to deliver support – such as peer workers, coaches and support coordinators.
- **We need to work together to improve mental health in rural and remote communities.** Some initiatives, such as filling service gaps, should be driven locally, through Primary Health Networks, local Aboriginal and Torres Strait Islander leaders and community members. Other initiatives, such as scaling up digital health services and reforming our workforce, should be led nationally. We also need to combine our efforts on the most complex problems, such as preventing suicide, which need buy-in from the Commonwealth, State and Territory Governments and local communities.

The nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate

beyondblue's blueVoices members provided in-depth insights into the reasons people living in rural and remote areas don't access mental health services as readily as urban populations. Reasons include: lack of awareness of services; a lack of services; existing services being at capacity; difficulties accessing transport to attend appointments; extensive travel time to reach services; concerns about privacy; and constant changes in staffing, which means it is difficult to build a relationship with the provider.

What blueVoices members told us:

Transport and travel time

"My situation meant that I needed to access services in the private sector, so obviously there was a cost to bear, however initially I had to travel 5 hours one way to see a psychiatrist as those closer had closed their books. I then managed to shorten that by transferring to a doctor 2 hrs away and thankfully have only been 1 hour away from the majority of my treatment team for several years now."

"...if the health professionals can't be enticed to the rural/remote communities then if people need and are willing to travel, there needs to be greater assistance available to facilitate it and reimburse for it; acknowledging and accounting for such things as poor public transport and that driving at certain times of day is unsafe on country roads, let alone the distances."

"It's difficult when you have limited access due to transport restrictions. I would have to spend large amounts of time waiting to get to our return from treatment services or therapy. For example, a 60-minute trip by car to access a 30-minute psychiatry appointment might take me 8+ hours."

"I have to drive over an hour each way to see a psychologist... I could not get an appointment to see a recommended psychologist as I wasn't in 'her area', despite the fact that there isn't a psychologist in MY area."

Stigma and privacy

"[I would like] more free services that can be accessed without stigma and that are anonymous. There is no one size fits all for rural mental health must be based on the needs of the community."

"Create privacy! Reducing the stigma about mental illness is a long-term goal. But right now, stigma exists. So, people need to know they have the ability to seek medical help without being outed locally."

Access to services

"My experience was dismal... I had to wait for my psychiatrist to fly in every two to three weeks. At one point I was hospitalised after having a breakdown and attempting suicide, I was admitted on Friday morning and as per hospital policy I couldn't leave the hospital until I was cleared by a psychologist. The psych had to be flown in, however she didn't get there until Wednesday."

"My experience of access to mental health support in rural and remote areas varies as I have lived in several such [places]. My [main] experience has been one of delay; that doctors are booked out as much as six weeks in advance, and that whilst this is do-able once in the system (make a booking six weeks ahead as I leave the current appointment) it is very difficult to get in in the first place. It is also impossible to make an emergency visit for a mental health issue. A+E [accident and emergency] at the local hospital can deal with physical trauma and bleeding, but there is no capacity for an emergency arrival who is panicked or overwhelmed by emotion and cognitive dissonance."

"There are very few services where I live. When people are acutely unwell they can go to the hospital but no groups or further mental health services are offered."

Data recently released by the Australian Institute of Health and Welfare (AIHW) describes a similar picture. The *Survey of Health Care* (2016) presents data from Australians living in four of the five remoteness groups from inner regional to very remote areas. The results show that generally people living in a rural or remote area were less likely to have a usual GP, more likely to attend an emergency department because no GP

was available, and more likely to indicate that not having a specialist nearby was a significant barrier to seeing one.ⁱ

These findings support data from the *Regional Wellbeing Survey* (2016) conducted by the University of Canberra, in which **nearly 45 per cent of respondents (n=11,775) rated access to mental health specialist services as poor**, and nearly as many (>40 per cent, n=9,960) reported access to mental health services as poor.ⁱⁱ

To add to this, we know that **around half of people who experience poor mental health do not seek support or treatment from a health professional**.ⁱⁱⁱ The reasons for this are varied and are likely to be as significant, if not more so, for people living in rural and remote areas as for urban populations. In addition to factors such as cost, lack of available services, and the need to obtain a GP referral, lower levels of mental health literacy can also be a cause of low service use – both in recognising the need to seek support, as well as knowing what services are available.

Anonymity is recognised in the literature as a significant barrier to help-seeking in smaller communities. As such, people may be inclined to delay or avoid seeking help for fear of everyone finding out. Coupled with this is the characteristic common to many people in rural areas of self-sufficiency, self-reliance and stoicism.^{iv} These cultural factors must be reflected in any solutions proposed to improve uptake of mental health services. For some people, this may mean seeking support in a way that allows them to maintain anonymity, such as via online forums.

"I received some fantastic responses to my post that helped me reframe the situation that I was/am in. It's so important to me as I live in a regional area to be able to reach out in an anonymous fashion and be able to have others relate to my issues. It's a great comfort knowing that being diagnosed with depression/anxiety that I can interact with others who are kind, empathetic and understanding, and can offer their advice and experiences. Knowing that I'm not alone means a great deal to me and the forums are a great way to reach out whilst staying anonymous." beyondblue Online Forum user

beyondblue recommends:

1. Provide long-term, certain funding to Primary Health Networks to commission appropriate mental health services and supports within rural and remote communities, with a focus on those services that can be delivered by local community members in settings outside health care centres.
2. Targeting people in rural and remote communities, increase their knowledge of available mental health services and supports, including online e-therapies and the ability to access telepsychiatry services through the Medicare Benefits Schedule.

The higher rate of suicide in rural and remote Australia

What blueVoices members told us:

"How to reduce suicide in rural communities? INVEST in them! Rural communities have so much to offer. Look at how many people living in metropolitan areas escape to rural areas. For adventure. For experiences. For connection to nature. For relaxation. The pace of life is slower in rural areas... Rural areas are worth investing in... Asking communities what they need. What they would use. What is value for money. What can be sourced locally? What can be fundraised for? At heart I think a lot of suicides are because we have no hope. No one cares. Nothing changes. Feeling trapped and isolated and not listened to."

"Foster local support groups via existing and specialised community organisations."

"I think, much like urban areas, that feeling of isolation can be overwhelming. The difference is that you have limited interactions with others, if you had an ability to interact in person with someone that would be great. It was often that feeling of being alone, but not wanting to reach out for assistance that is hard to overcome. Having access to a phone based service means nothing when you have no desire to call, so what do you do? I think that a way to feel more connected is to have meaningful interaction with those in similar circumstances, be it in person or online. It's a help anyway."

"Education programs such as Mental Health First Aid for all community members but definitely in workplaces and for education staff."

Data shows that suicide rates for rural communities are consistently higher than in urban areas.^v Remoteness is a major risk factor contributing to suicide and the likelihood that someone will die by suicide appears to increase the further away they live from a city.^{vi} Data from 2010-2014 shows that, out of five zones of residence, **residents of 'Major cities' had the lowest rate of suicide deaths per 100,000 people (9.8 per 100,000) while residents of the 'Very remote' zone had the highest rate every year (23.7 per 100,000).**^{vii} Factors that may contribute to this high rate of suicide are: geographic and social isolation, unemployment and economic issues, the misuse of alcohol and other drugs,^{viii} greater access to lethal means such as firearms and pesticides, together with a relative lack of accessible mental health services in these communities.^{ix}

The Fifth National Mental Health and Suicide Prevention Plan commits all governments to a systems approach to suicide prevention, which is one of the most effective ways to reduce suicide. It draws on the World Health Organisation's *Preventing suicide: A global imperative*, and includes:

- Means restriction – Reduce the availability, accessibility and attractiveness of the means to suicide (e.g. firearms, high places). Reduce toxicity/lethality of available means.
- Awareness – establish evidence-informed community suicide prevention awareness campaigns, tailored for rural and remote communities. Increase public and professional access to information about all aspects of preventing suicidal behaviour.
- Stigma reduction – change attitudes and beliefs about suicide through awareness. Promote and normalise the use of mental health services, services for the prevention of substance abuse and suicide, and reduce discrimination against people using these services. Implement research and campaigns to provide people with knowledge, tools and permission to talk openly about suicide, while being careful not to inadvertently normalise this behaviour.
- Training and education – implement mental health and suicide literacy programs for the broader community. Maintain comprehensive, targeted training programmes for identified gatekeepers (e.g. educators, workplace health and safety officers, community leaders, policy and emergency services). Improve the competencies of mental health and primary care providers in the recognition and treatment of vulnerable persons and deliver specialised suicide prevention training to general practitioner and other frontline health workers.
- Crisis interventions – ensure that communities have the capacity to respond to crises with appropriate interventions and that individuals in a crisis situation have access to emergency mental health care, including through telephone and/or online support.

- Postvention – provide supportive care and services to family, friends and carers impacted by suicide attempts.

This systems-based approach should be implemented in all rural and remote communities, to ensure that the high rate of suicide in these communities decreases.

The population group most at risk of dying by suicide is those people who have attempted suicide. **15-25 per cent of those who have attempted suicide re-attempt, and 5-10 per cent will die by suicide.** The highest period of risk is the three months following a suicide attempt. To respond to this risk, *beyondblue* developed and trialled – using non-government funding from fundraising and philanthropic grants – **The Way Back Support Service.** The Way Back Support Service provides psychosocial, assertive outreach, follow-up care and practical support to individuals directly after a suicide attempt or suicidal crisis. The Way Back partnering hospitals assess and refer people to the service. Specially-trained Support Coordinators then contact the person within 24 hours and deliver one-on-one, psychosocial care and practical support, helping people stay safe, connected with their support network and engaged with health and community services.

The Way Back Support Service is currently operational in seven sites. In the 2018/19 Commonwealth Budget the Government committed \$37.6 million to expand The Way Back, with *beyondblue* also contributing a further \$5 million towards the expansion. The Way Back Support Service works because it brings together every necessary player: PHNs, hospitals, local community-based service providers, the Commonwealth, and State and Territory Governments. Interested States and Territories will be invited to contribute funding to the expansion of The Way Back Support Service to ensure that people and their families in rural communities are supported to find a way back from suicide.

There are a significant number of suicide prevention trial sites currently operating across the country. These include the Commonwealth-funded National Suicide Prevention Trial, which was recently extended to a further four rural sites; the Lifespan trials; and State and Territory-based suicide prevention trials, such as the Victorian place-based trial sites. It is important that lessons learnt from each rural and remote trial site is shared, to allow other communities to adopt ideas and learn from these experiences, where possible.

***beyondblue* recommends:**

3. Fund Primary Health Networks to deliver the systems-based approach to suicide prevention in all rural and remote regions.
4. Learn from what is happening around the country through trials and then build what works to scale. PHNs and States and Territories must be involved in this process.

The nature of the mental health workforce

What blueVoices members told us:

"People I know find it very hard as a psychiatrist comes only once every 6 weeks or longer to our town."

"Initially it took me about 2 years to get in to see a psychiatrist and that was only because a new guy moved to town and was seeing new patients. Who knows how long the wait would have been otherwise. I went in initially seeking a diagnosis for ADHD, but no one locally can diagnose that and I was told I had to go to Sydney (4 hours away) or Canberra (3.5 hours away) to get that."

"Rural and remote Australia is largely ignored when it comes to provision of mental health services. In these areas, more often than not, mental health services are only provided at hospitals by nursing staff. Nursing staff are not usually specialists in mental health, and more needs to be done to get specialist mental health workers into rural and remote areas."

"[To improve mental health services in my community], build a strong consumer consultant and peer support worker workforce."

"My GP keeps changing as they're hard to come by in the country and they move about a bit. The services I currently receive are inadequate and I remain very, very unwell."

"It was difficult having to travel to a city to see a Psychiatrist. The experience was made harder by constant changeover of staff so the service didn't have continuity."

"Identifying individuals living within regions and upping training and skills is a better option than fly in, fly out. Identifying local staff and those prepared to volunteer in communities may help establish hubs, groups, social or learning opportunities geared to mental health."

The current mental health workforce

The existing mental health workforce will never be able to meet the needs of people in rural and remote communities, due to issues such as recruiting and retaining people in these areas. Research undertaken by Reach Out and EY (*Crossroads: Rethinking the Australian mental health system*, 2014) demonstrates that **if we continue to implement a 'business as usual' approach to mental health services, the mental health system, across both rural and urban regions, would require at least 8,800 additional mental health professionals, at a cumulative cost of \$9 billion over the next 15 years, to meet demand.**^x This is likely to be exacerbated in rural and remote communities.

For example, based on most recent data (2015), nearly nine in ten psychiatrists (88 per cent) were employed in major cities. A further eight per cent were employed in inner regional areas, leaving **just 3.5 per cent of the psychiatric workforce to service outer regional, remote and very remote areas nationwide.**^{xi} Similarly, disparate results were found for mental health nurses and registered psychologists, with 76 and 83 per cent respectively, employed in major cities.

We must fundamentally change the structure and nature of the mental health workforce, to better meet people's needs and to deliver mental health services in a sustainable manner. Reaching more people living outside capital cities will require a commitment to expanding the available workforce, developing new types of roles, and redefining existing roles, complemented by the integrated use of high volume, wide reach technology-based solutions. The Fifth Plan recognises the need to grow and develop the mental health workforce.

In addition to the core mental health workforce, rural and remote areas often experience workforce gaps in other relevant services like counselling for drug and alcohol misuse, family support, women's issues, sexual abuse and crisis support. It is often the generalist primary care worker who is relied upon to fill these gaps, yet they are also an underrepresented workforce. This can place additional strain on these key health workers. There is evidence to suggest that doctors and nurses experience higher psychological distress than the general community. Young doctors, medical students (particularly Aboriginal and Torres Strait Islander students) and doctors working in rural and remote areas appear to be particularly vulnerable to poor mental health.^{xii} Ensuring they have sufficient supports, opportunities for leave and professional connection

is important. The recent budget announcement of funding and initiatives through the *Stronger Rural Health Strategy* will hopefully bolster rural GP numbers in these areas, as well as more highly skilled GPs through the rural generalist stream of speciality training.

What health professionals have told us:

“It’s a very stressful environment, not just for patients. It is hard to avoid mental health issues just from the work alone; add to this any other stresses or risk factors and you’re a sitting duck.” Midwife, Victorian regional health service ^{xiii}

“Mental health affects everything and everyone. Healthcare professionals need to look after their mental health as much as the next person. We can only care for others effectively when we are also caring for ourselves.” Nurse, South Australia ^{xiv}

“Mental health should be recognised as a focus in every workplace – especially a health service environment where stress is always present.” Dental assistant, Queensland ^{xiv}

New workforces

New workforces, that can deliver specific types of mental health treatment and support, are critical to improving the accessibility of mental health services, particularly in rural and remote communities. New roles may include peer workers; low intensity coaches; support coordinators; and training those people who come into regular contact with community members (such as those working in schools, banks, employment and housing support services) to identify and respond to people who may be experiencing mental health challenges.

Peer workers

The peer workforce is growing, albeit slowly, in Australia and could make a significant difference if it were scaled up and supported as a recognised profession.

Peer workers are people who have an experience of a mental health condition, either personally or as a family member or supporter. This workforce is a viable and sustainable workforce solution for rural and remote communities.

The peer workforce has significant benefits, at a range of different levels: ^{xiv,xv,xvi}

- for the **individuals receiving peer support** – there is reduced social isolation, improved social functioning, better access to services, better quality of care, greater feelings of hope and empowerment, and reduced hospitalisation rates
- for the **individuals providing peer support** – employment as a peer worker can be a meaningful career option, and be an important component in maintaining recovery and enabling participation (for example, through providing a career structure, a salary, and professional development)
- for **health services and systems** – peer workers can bring about positive cultural changes in the organisations in which they work (for example, reduced stigma, greater empathy and understanding), improved practices (for example, reduced use of seclusion and restraint), achieve outcomes that are equivalent to other health professionals (for example, hospitalisation rates, access to hard-to-reach clients), and reap significant economic and social benefits through increased participation and employment.

The Council of Australian Governments has committed to the development of the Peer Workforce Development Guidelines under the Fifth Plan. *beyondblue* believes this work to expand the infrastructure and recognition for peer workforces will be particularly important for rural and remote areas.

beyondblue has demonstrated the acceptability and effectiveness of receiving online peer support in rural and remote communities through the *beyondblue* online forums. These forums provide an anonymous, moderated space for people with an experience of depression, anxiety or suicide. There are more than 100,000 visits to the forums every month. **People in rural and remote communities access the forums at a proportionally higher rate than people living in metro regions – 45 per cent of forum users live outside metro areas, while only 35 per cent of the population live in these regions.**

The online forums use Community Champions – people with the time, skills and empathy to support other members and who are regularly and actively engaged with the forum, helping to set the tone of the community as a place of hope and recovery. These roles are separate from the clinical moderation also used on the forums. Community Champions are appointed to their roles based on their demonstrated experience, and they remain in these roles for as long as they feel comfortable and have wisdom and positivity to offer. *beyondblue* supports the Community Champions with regular opportunities to debrief or receive clinical support and each Champion is required to draft a wellbeing plan that considers how the role may impact their own mental health. Retention is reasonably high for Champions, with most staying in the role for a few years. Further information about the forums is available in the ‘*Opportunities that technology presents for improved service delivery*’ section of this submission.

“I know for sure that some people have told me in no uncertain terms that connecting with me and not only me but with other champions, you receive a post saying that helped, I’m feeling better now. That makes it all worthwhile.” Community Champion, *beyondblue* online forum

Coaches

beyondblue has demonstrated the effectiveness of training local community members to deliver low intensity cognitive behavioural therapy, through the NewAccess program. NewAccess is a low intensity coaching service for people with mild to moderate depression or anxiety. It provides up to six free, accessible, low intensity cognitive behavioural therapy sessions with a trained NewAccess coach. Sessions can be delivered by coaches either face-to-face or over the phone or skype. The program aims to engage people early, before symptoms worsen, to teach skills and strategies they can draw on to recover and stay well. Evaluation of the service found that people felt more comfortable meeting with a Coach when they didn’t have to attend a health practice setting. This reduced the stigma they felt and the perceived risk of experiencing shame if other people saw them entering a psychologist’s office. Other results of the trial showed that:

- **People recover:** 67.5 per cent of people who participated in the trial were below the clinical threshold for anxiety and depression when they finished treatment. Recovery rates in current services are now lifting to 70 per cent and above
- **People like NewAccess:** 88 per cent of all people referred to the program proceeded to treatment and 72 per cent continued treatment to completion
- **The program is cost effective:** the indicated cost-benefit ratio was 1.5. In addition, there are savings made through early intervention reducing strain on downstream services
- **Men like NewAccess:** traditionally harder to reach, 39 per cent of all referrals were men (increasing to 48 per cent at the rural pilot site).

Coaches are not required to have any previous mental health experience, but are recruited for their ability to relate and empathise with others. They operate under clinical supervision. A 12-month training program, which includes eight weeks of intensive training followed by regular supervised work, is delivered to all coaches. **NewAccess is available in 11 regions to date, reaching more than 8 million people. Almost half of these services are in rural areas** – in Queensland, NewAccess has been established by the Western Queensland and the Darling Down West Moreton PHNs, and in New South Wales, NewAccess sites are in North Coast, Murrumbidgee and Hunter New England and Central Coast PHN regions. All of South Australia currently has access to NewAccess, including rural and remote areas. This service is due to close on 30 June 2018.

Expanding new workforces like the NewAccess coaches provides both employment opportunities for people living in rural and remote areas, as well as a chance to increase access to mental health supports for people living in a rural or remote area.

Example: NewAccess commissioned by Western Queensland Primary Health Network

Western Queensland Primary Health Network (PHN) covers a region around three times the size of Victoria and has a population of just 76,000. This sparse distribution of people is amongst small towns, with few service providers operating in the area. There is a large population of Aboriginal and Torres Strait Islander people living in the region.

In 2017, Western Queensland PHN opted to commission NewAccess to fulfil the region's low intensity mental health service needs. To overcome the geographical challenges of service delivery, the PHN divided their catchment into three nominal sub-regions and identified service providers already working in each area. The PHN was able to coordinate each service provider to recruit, train, and launch their service concurrently, to support collaboration between the services. Most of the coaches incorporate their role as a NewAccess coach alongside work in other roles, ensuring the sustainability of their workforce. Local media has been supportive, promoting the services when they launched to increase uptake.

Demonstrating the success of using trusted community organisations, there has been an immediate uptake of the program and one service is increasing their coaching staff by 50 per cent after just eight weeks of operation.

Support Coordinators

The Way Back Support Service Support Coordinators provide psychosocial care and practical support to people in the first three months following a suicide attempt. In particular, they help individuals to stay safe, connect with essential services, and reconnect with support networks. They work alongside others who are providing support, including family, carers and friends. Their role complements existing services, by supporting attendance at appointments, which deliver follow-up care and support. Key requirements for Support Coordinators is their ability to be relate well to others, be approachable, and non-judgemental.

Example: The Way Back Support Service commissioned by Murrumbidgee Primary Health Network

Murrumbidgee Primary Health Network covers four regional areas, bordering the ACT on the East and the Murray Region on the South. The four areas included in its catchment are: Riverina, Western, Wagga Wagga and Border.

The Way Back Support Service delivers psychosocial care, practical support and follow up designed for people who have been discharged from hospital following a suicide attempt. The service has been commissioned by Murrumbidgee PHN.

In establishing the service, the workforce is geographically spread across the region to meet the needs of clients. Phone calls and text messaging is incorporated by the support coordinators to connect with clients remotely between face-to-face support. A flexible team approach has been developed to account for time spent travelling and working in isolation. The service has identified one challenge is retention of both support workers and clinical supervision staff. The service has effectively engaged the community on suicide prevention by attending different community events, such as sports matches, to raise awareness and reduce stigma. They have reported the positive impact of having these conversations where they don't usually occur.

What participants of The Way Back Support Service have told us:

"It is a very valuable service. Definitely the personal connection is what makes a difference."

"I'm back working now. It was a pretty hard hit to lose your business and have nowhere to go to. They really helped me pull myself up and get back on track. I travel now for work which I never thought I'd be able to do again."

beyondblue recommends:

5. Governments prioritise the development of the Peer Workforce Development Guidelines outlined in the Fifth Plan.
6. Develop a national workforce plan for rural and remote Australia, which includes:
 - Continued support for young people from rural and remote areas who wish to study a health profession and return to their region, through scholarships and workforce placements
 - Subsidised access to the Certificate IV in mental health peer support
 - Expansion of new workforces (such as NewAccess coaches and The Way Back Support Service support coordinators) to ensure people living in rural and remote areas have both access to services and employment opportunities
 - Redefined roles for existing services, including greater promotion of the Rural Generalist pathway for General Practitioners through the *Stronger Rural Health Strategy*, as well as expanded roles for practice nurses and mental health nurses
 - Established programs of support for health professionals working in rural and remote regions to reduce burnout and improve retention.
7. Primary Health Networks should develop regional mental health workforce plans, as part of the annual needs assessment and planning process. These regional plans should align with the proposed national workforce plan.

The challenges of delivering mental health services in the regions

What blueVoices members told us:

"It is difficult to access mental health services. I am only able to see my psychologist and psychiatrist every 3 months because they are extremely booked up. There is no support in emergency care. I have been sent home when suicidal because nobody in the emergency room has the appropriate skills to deal with mental health."

"I think the biggest limitation to people in rural communities in regards to mental health, is the lack of services and options."

"Mental Health services were only accessible during 'office hours'."

"Improvement needs to be done; very often there are no mental health services available, and if they are they are either many hours' drive away. Or the services are simply stretched beyond the capacity. In some cases, mental health workers have to cover vast territories, and this cuts into available time for clients. More training for current health workers should be considered, as well as enticing more professionals to move to country areas."

"To be able to visit a mental health [service] isn't that easy, and no they aren't easy to contact. The psychologists are fully booked so you have to go to the hospital and then it's difficult."

"Psych services are never available when needed. In a crisis, [it] can take up to 4-6hrs to be seen by duty worker. Once seen, very rarely is there follow up; either [you] become an inpatient at a facility 2hrs away or be sent home with maybe a phone call the next business day."

There are a number of features that rural and remote areas share – often dispersed and small populations, with varying access to health services and technology, and a range of challenging factors unique to living outside an urban area (e.g. social isolation, livelihood impacted by natural disasters). However, the diversity of rural and remote communities should not be forgotten – there is no single culture, typical community profile, or single definitive description that aptly describes a rural or remote community.^{xvii} As such, figuring out what works best where and for whom must be a consideration for each distinct area. Building and sustaining a strong workforce is central to improving mental health service access regionally.

Primary Health Networks (PHNs) offer the infrastructure to overcome some of these challenges but need time and funding certainty to deliver the structural and service reforms that the community, quite rightly, expect. PHNs are required to undertake comprehensive regional mental health planning; identify primary mental health care service gaps within the stepped care model; and commission mental health services. They must also establish governance arrangements that allow and support them to engage with the community and health professionals, to ensure that the services they commission respond to local needs. These functions mean that PHNs are ideally placed to respond to the challenges of delivering mental health services in their regions and their role in achieving integrated regional planning and service delivery is the opening priority of the Fifth Plan.

It is critical that PHNs are well supported to fulfil their commissioning role, and improve mental health outcomes in rural and remote communities. One particular risk associated with the PHN commissioning model is that the service system may become uneven, and gaps may emerge between what Australians in one region or jurisdiction experience versus those in another, thereby inadvertently exacerbating service fragmentation and making supports and services more difficult for people to navigate. This risk can be managed through a national oversight and coordination role. The regionalised approach to health service commissioning should continue to be supported, and PHNs provided guidance and funding appropriate to their community's needs.

In recognising the broader issues and social determinants that influence mental health, the *Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016-18*, offers a truly whole-of-government approach. A range of departments beyond the Ministry of Health are responsible for achieving a range of goals, including providing access to kindergarten in remote state schools and supporting primary producers to recover from natural disasters through disaster support and resources. While these things are clearly

separate from the delivery of mental health services, they are just as important in promoting and protecting health in rural and remote Australia, and this cross-government approach demonstrates real commitment to improving mental health.

***beyondblue* recommends:**

8. Provide long-term funding to Primary Health Networks to ensure that they can build the infrastructure and workforce required to respond to the mental health needs of rural and remote communities.

Attitudes towards mental health services

What blueVoices members told us:

"I think the reality is... the stigma of mental illness is, in some ways, worse than the illness itself. Unless the stigma can be removed to such a degree that it does not become a barrier to acknowledgement, treatment and hope for the future, the reduction of some mental illnesses will be nothing but a pipe dream."

"[The best approach to suicide prevention in the community is] culturally appropriate support [with a] community driven focus."

"There is a gulf between metropolitan mental health and remote and rural services. It felt that my life was worth considerably less, my two degrees and specialist employment in disability services could not be possible if I had "real" mental illness, that my contribution to the communities I lived in was of no consequence and my voice was not heard, let alone considered."

"By ridding society of the taboos, making mental health understood and accepted, it is enabling those suffering to put up their hands and seek help without recriminations."

"Talk about it more openly. Start early, at school. De-stigmatise depression, anxiety, mental illness in general."

"Technology is so expensive to learn to communicate. If every household does not have the funds for online communication, what hope have those in rural areas have to be able to access mental health services when it counts?"

People with mental health conditions must be treated with equity, respect and dignity, to ensure that everyone can participate and be included in society, free from discrimination.

beyondblue assessed experiences of discrimination among a broad community sample of 2,650 Australians, through the *beyondblue* Depression and Anxiety Monitor (2015). This research showed that **nearly one quarter of people who sought help for a physical health problem, and 15 per cent of those who saw a mental health professional, felt they had been treated unfairly by their health provider in the past year.** Stigma may be exacerbated in rural and remote communities, as people report strong concerns about a lack of privacy in accessing mental health services.

Research shows that the most effective way to reduce stigma is through first-hand interactions with people who experience depression and anxiety – this is no different in rural and remote areas. Interactions allow inaccurate stereotypes to be challenged and overcome, and for people to develop a more accurate understanding of what it is like to experience a mental health condition. ***beyondblue's* Speakers and Ambassadors program was established to provide avenues for people with an experience of depression or anxiety to share their stories.** Roughly 20 per cent of current speakers live outside a capital city, with this proportion increasing regularly. Further information on effective ways to reduce stigma and discrimination is available in *beyondblue's* [Information Paper](#) and [Position Statement](#) on Stigma and Discrimination.

Health services must also consider their cultural competency in order to meet the needs of the community. This is particularly important for health services supporting Aboriginal and Torres Strait Islander people, but may also include services delivered in communities who are culturally and linguistically diverse.

***beyondblue* recommends:**

9. Support local stigma-reduction initiatives, which enable local community members to share their experience of living with, or supporting someone with, a mental health condition. These initiatives should be implemented in the community and within health services.

Opportunities that technology presents for improved service delivery

What our blueVoices members told us:

"There is scope for more use of face-to-face technologies...Where I was able to access video conferencing, from my regional hospital to the capital city, I found that very helpful. To see a person even on a screen, to hear her and have her see and hear me was so much better than having a voice on a phone."

"I like technology and use it. Not all can or want to. Any move to more services for remote/rural via internet requires FIRST secure, affordable, efficient internet connection or mobile tower access. This has not happened yet. Many areas are woefully serviced by telecommunications. The things I use are not a substitute for access to real time, face to face access to a mental health professional when symptoms are acute."

"It's OK for those who know how to use it, but nothing beats face to face contacts. Talking to someone on a screen is no substitute for one on one contact, which is how rural people like to communicate."

"I know a Tele-health/video link service already exists in many places, but I think it has promoted the assumption that everyone can use that method of service delivery. Personally, I hate talking to people over screens let alone about deeply personal stuff. I'm anxious enough and struggle to open up when I'm in the same room as someone."

"[Use technology to] give nurses in emergency rooms training to deal with mental health."

"Online options have a significant part to play in accessing support. In the flood of technical advances, it irritates me that services via phone or internet are not more readily available."

"[You need to] Train people to not only have the equipment, but be comfortable enough to use the equipment to access these services electronically. Most people have either not got the equipment or find the equipment complicated to use - so just give up!"

"I think it can be a wonderful way to access services, however, not everyone has access to it or is familiar with using it. Often remote areas have poor or unreliable service. Teleconferencing is fantastic. Technology allows for immediate access to help in some cases."

Technology and digital approaches are fundamentally changing the way people live their lives, interact with others, and engage with support and health services. Digital developments are 'disrupting' the way almost everything in society works (e.g. Netflix, uber), and mental health supports and services will be affected by this disruption. It is critical that mental health policy, funding, service delivery and research reflects and responds to this constantly evolving digital landscape.

The National Mental Health Commission's Review (2014) stated that: *"E-mental health offers one of the greatest invest-to-save opportunities for government and the community in mental health. E-mental health is clinically effective and huge cost savings can be gained by integrating it into a fully functional mental health system of stepped care."*^{xviii} A recent report by KPMG and Mental Health Australia (2018) suggests **using e-health solutions to deliver early intervention mental health services to one million Australians could create \$442 million in short term savings**. This intervention is estimated to provide a \$1.60 short-term return on every dollar spent.^{xix}

Digital mental health approaches are relevant across the spectrum of mental health needs – for the well population, at-risk groups, people with mental health conditions, and those in crisis situations. They provide an opportunity to not just match the clinical outcomes that can be achieved through traditional face-to-face services, but to exceed these outcomes, as it can enable the systematic provision of effective, evidence-based services and support.

Despite the potential benefits of digital approaches to mental health, evidence suggests that they are currently considerably underutilised, and the individual and population-level mental health benefits that could be achieved through these tools and services are not being realised. The workforce must be informed

and supported to adapt to new digital mental health platforms, and the community must be made aware of the options available.

Digital mental health approaches have the potential to improve access to culturally appropriate and evidence-based social and emotional wellbeing supports for Aboriginal and Torres Strait Islander communities. There has been promising progress in the development of Indigenous-specific digital mental health tools (for example, iBobbly) and the inclusion of Indigenous pilot sites in the e-Mental Health Practice (eMHPrac) project. The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP, 2016) also identifies e-health services/internet/crisis call lines and chat services, as an important 'success factor' for universal/Indigenous community-wide suicide prevention initiatives.^{xx}

Example: technology for suicide prevention

One of the key benefits of digital tools for suicide prevention, is that it provides another way to identify and reach people at-risk of suicide, particularly those who may not otherwise engage with services. Incorporating digital approaches into the suite of suicide prevention services that are available, are therefore important.

beyondblue's BeyondNow safety planning app, for people experiencing a suicidal crisis, has had strong levels of uptake – over 42,000 unique visitors have searched BeyondNow related web pages and around 20,000 individuals have downloaded the BeyondNow app, with almost a third of those completing their safety plan since the app was released in March 2016.

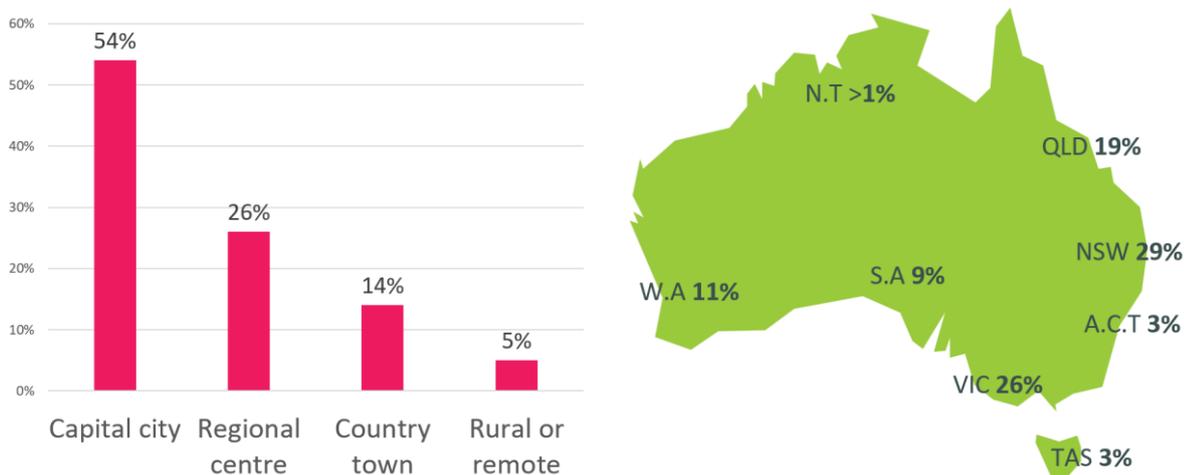
Online forums offer another avenue of care and are growing in their prevalence and use. ***beyondblue's* online forums are a safe place for people who have an experience of depression, anxiety or suicide**, or caring for someone, to connect and receive and offer support to one another, no matter the time of day or night. By registering for the forums, there is no obligation to post, with many people seeking support purely from reading the support of others.

"It is awfully hard in rural areas to even find the support that is needed so being able to jump onto a forum 24 hour a day is such an awesome way to reach out to chat about what may be troubling us. ... For me being able to tell my story whether it be via an online forum or face to face forum made a huge difference to my wellness and lifestyle and from the response I still receive walking around my town it was sorely needed. The more we promote forums on any mental health issue the more people will come out and realise that sharing/taking can be that 1 key that unlocks the door." *beyondblue* Online Forum user

A number of factors are important to the success of this platform:

- anonymity encourages participation and open engagement
- moderation processes maintain the forums as a safe space for participants
- a dedicated mental health focus, including specific categories for different issues.

Data on forum users suggests that a greater proportion of people living outside a capital city use this technology. Nearly half of forum users are not from a capital city – this is significant given around 65 per cent of the population inhabit a capital city. This disproportionately higher usage of the forums by people living in regional, rural and remote areas of the country demonstrates how important this platform is in providing support they may not otherwise be able to access. The graph and map below describe the regions that users come from.



This resource demonstrates the combined benefit that peer support and technology can have for the population. There are currently more than 80,000 users registered for the forums, of which around one tenth are regular users – the forums receive in excess of 100,000 visits per month. User research completed in 2016 found that as a direct result of interaction with the forums: two thirds felt less depressed or anxious; more than a third contacted a health professional; and 69 per cent made a positive lifestyle change.

“I think for myself, I prefer to type to someone – as in live chat. It’s not always easy to talk aloud if others are around. I also don’t think it’s helpful when mental health services say you need to see a Dr; it just makes me instantly shut down. I’ve found beyondblue to offer this assistance.” blueVoices member

Telephone and web chat helplines also play a role in connecting people with the care they need. The **beyondblue Support Service** aims to provide people in Australia with free, immediate, short-term, solutions-focused support and referral services for individuals and their families and friends affected by depression, anxiety and suicidality. The national service operates via a 24/7 telephone service (1300 22 4636), a web chat service from 3pm to midnight each day (via www.beyondblue.org.au/getsupport), and an email response service. *beyondblue* offers this support and information to every person in Australia, regardless of their age, gender, background or location. These confidential conversations focus on addressing a person’s immediate concern, as well as providing people with information and advice on getting further help and support. **In 2017, over 168,000 people contacted the support service, with a representative number of rural and remote callers using the service.** Even with advancements in technology, and the introduction of webchat and email support, telephone continues to remain the most preferred channel that people use to connect with the Support Service, demonstrating the value of reaching people in this way.

Technology also presents an opportunity to deliver training and support to health professionals living in rural and remote areas. Often sole practitioners, the chance to maintain and grow their skills and connect with peers is important for many professionals and could be facilitated through technology.

beyondblue recommends:

10. Continue to invest in infrastructure to support better mobile phone and internet access across Australia.
11. Increase the acceptance and use of digital mental health programs by:
 - Funding initiatives such as the eMHPrac project, that increase the capability of health professionals to use and refer people to digital mental health programs
 - Embedding digital mental health services into health professional training courses.
 - Alongside these, increase the community’s understanding of, and wiliness to, use digital mental health programs and supports.
12. Fund the delivery of national digital mental health programs across the stepped care model, rather than devolving this responsibility to Primary Health Networks.

Meeting the needs of Aboriginal and Torres Strait Islander people

What blueVoices members told us:

"I am a family violence case worker for remote Aboriginal communities across NT and WA. I visit regularly. The number of suicide attempts I am aware of is so significant... [it] is at a critical point. Many community members have significant mental health issues and or experience/live in dire circumstances. Rarely do mental health services visit. When they do, it's a very "white" experience. The community medical clinic experiences a high turnover in staff. Numbers are minimal and staff are burnt out. The same for police services."

Around two thirds of Aboriginal and Torres Strait Islander people live outside a major city.^{xxi} As with physical health, a significant gap exists between the mental health of Aboriginal and Torres Strait Islander people and non-Indigenous people. National research, survey and health services data shows that Aboriginal and Torres Strait Islander people are around:

- three times as likely to report high/very high levels of psychological distress as non-Indigenous Australians
- two and a half times more likely to be hospitalised for intentional self-harm than non-Indigenous Australians
- **twice as likely to die by suicide as non-Indigenous people in Australia.**^{xxii}

Increased efforts are required to reduce this gap and to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

beyondblue believes that action must take a holistic approach that recognises the interconnectedness of individuals, families and communities in achieving and maintaining wellbeing. Action is needed on five fronts:

- Strong people: support individuals to build and protect their mental health across the lifespan with an emphasis on efforts to build cultural identity and self-belief as well as mental health literacy and resilience.
- Strong families: build on the strengths of Aboriginal and Torres Strait Islander family and kinship groups to promote safe, nurturing and protective home and family environments that are free of violence.
- Strong communities: address racism and discrimination, ensure equitable access to cultural, social and economic opportunities that overcome exclusion and disadvantage and promote the importance of connection to land, sea, language, family, community and culture.
- Strong organisations: increase the Aboriginal and Torres Strait Islander workforce, support the capacity of community controlled health and social services, and continue to improve the capability of mainstream services to provide equitable access to culturally safe and relevant supports and services.
- Strong voice: address the impacts of colonisation by promoting self-determination, community empowerment and by building the capacity of Aboriginal and Torres Strait Islander leadership and advocacy bodies

Aboriginal and Torres Strait Islander leadership in design, implementation and evaluation of strategies is critical for success, as is adequate time and resourcing for initiatives to take shape, achieve impact and become sustainable. Consequently, formal partnerships need to be developed or increased between government and Aboriginal and Torres Strait Islander people, communities and organisations.

***beyondblue* recommends:**

- 13.** Empower Aboriginal and Torres Strait Islander leaders and communities to co-design and deliver policies and services for their communities.
- 14.** Invest in mental health services in Aboriginal Community Controlled Health Organisations.
- 15.** Fund the implementation and monitoring of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*.
- 16.** Require mainstream services to deliver culturally appropriate care in a safe environment and embed trauma-informed staff in mental health services to serve Aboriginal and Torres Strait Islander communities.

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