VOICES & EXPERIENCES

IMPROVING MENTAL HEALTH SERVICES IN COUNTRY AUSTRALIA

THE GREENS

CONTENTS

THE TOUR

During 2012 and 2013, Senator Wright, the Australian Greens' spokesperson for mental health, took to the road and toured regional Australia to discuss rural, regional and remote mental health service delivery. As well as visiting places in her home state of South Australia, Senator Wright travelled the continent from Launceston and Hobart in Tasmania, to Caloundra, Townsville and Innisfail in North Queensland, to meet with over 185 people, including service providers, individual consumers, carer groups and stakeholders. She and her team held over 55 meetings across six states and 24 Australian towns, and received 37 online submissions and 20 written submissions in response to her online discussion paper.[1]

The aim of this broad-based consultation process was to gain valuable practical feedback from those working on the frontline in rural, regional and remote mental health services, and to allow individuals and organisations to have a say about the provision of mental health services in their communities. We have used this feedback to shape a comprehensive mental health policy which reflects the unique needs of people living in rural, regional and remote Australia.

185 people
55 meetings
24 Australian towns
37 online submissions
20 written submissions

INTRODUCTION FROM SENATOR PENNY WRIGHT

Over a year ago my team and I set out to develop well-informed, responsive, practical policy to assist the many rural Australians who live with the challenges of mental ill-health. Since then, I've been on quite a journey!

As the Australian Greens spokesperson for Mental Health, I knew that 30 per cent of Australians live in rural areas and I also knew people living outside urban areas generally don't receive their fair share of services.

Mental health and fairness are both close to my heart and, although I have lived most of my life in cities, I was born and spent my early years in Red Cliffs — a small town near Mildura.

I have never lost the "country" values – of contributing and community — that my parents taught me. Rural communities are the backbone of our nation — important to our sense of who we are and our history, as well as being integral to our economy.

To put it simply, when it comes to mental health, we need to make sure country Australia receives its fair share of resources and services, to foster wellbeing and resilience, and to support those who need help and treatment.

My team and I have come away from this consultation with more information and understanding than we can hope to represent in this report. We have seen a wealth of programs and initiatives which have sprung from great need, been nurtured in communities and delivered with care and dedication.

We have shaped Australian Greens policy on the basis of what we have learned. But what I have heard and seen will continue to inform my work in improving the services and situation for Australians living in the bush.

I will continue to be a strong voice in the parliament for country people who experience the challenges of mental ill-health, their carers and those who work at the frontline.

I am very grateful for the hospitality and generosity I've received from people all over Australia. My sincere thanks to all of those who trusted me with their time, ideas and, often very personal, experiences.

Senator Penny Wright
Greens Spokesperson for Mental Health

EXECUTIVE SUMMARY

The Australian Greens consider adequate mental health care to be a basic human right. We are committed to improving access to quality mental health care for Australians living in rural, regional and remote areas. Rural Australians face unique challenges which impact upon their mental health, and therefore need robust, innovative responses locally.

At the moment, people living outside major cities do not receive the mental health support and services they need. The figures show that overall per-person health expenditure is much higher for those living in major cities, with the most remote Australians receiving only 8 per cent of the funding their city counterparts enjoy.[2] We know that some 20 per cent of Australians experience mental health issues each year.[3] We hear that rural Australians are often less likely to seek help because of the ongoing stigma surrounding mental illness in regional Australia.

The following report is the result of extensive consultation with frontline rural mental health workers, service providers, consumers and their families. Senator Penny Wright toured regional Australia during 2012 and 2013 to discuss the issues with such stakeholders.

The report highlights the concerns and ideas we heard during this tour:

• Stigma relating to mental health and accessing mental health care.

• Poor access to sub-acute services.

• The need for stronger community-based mechanisms.

• Better support for carers.

• Improved training and education for the rural mental health workforce.

These themes continually emerged as being important to those working in rural mental health service delivery. Our report aims to reflect what we heard from service providers and consumers across Australia, to bring rural, regional and remote Australians into the conversation about mental health policy. It is the voices and experiences of these people that cut through political rhetoric to the heart of our nation's wellbeing.

At the moment, people living outside major cities do not receive the mental health support and services they need. The figures show that overall per-person health expenditure is much higher for those living in major cities, with the most remote Australians receiving only 8 per cent of the funding their city counterparts enjoy.

SUMMARY OF RECOMMENDATIONS

COMMUNITY

Recommendation 1 — Increase funding to community-based initiatives, including neighbourhood houses, community wellbeing centres and outreach services.

Recommendation 2 — Provide better support for multi-disciplinary, community-based sub-acute services on a step-up, step-down model.

WORKFORCE

Recommendation 3 — Develop a rural and regional mental health workforce plan focusing on training and attracting mental health professionals, including those from Aboriginal and Torres Strait Islander and culturally diverse backgrounds, to rural practice. This plan should include key pathways and incentives for health professionals, as well as training, supervising and employing peer workers in paid and voluntary roles.

Recommendation 4 — Increased funding for training and research aimed at improving the mental health workforce, including greater investment in training and education about mental health and suicide prevention for frontline workers and community members.

Recommendation 5 — Increased funding and expansion of the Mental Health Nurse Incentive Program.

ONLINE & TELE-HEALTH SERVICES

Recommendation 6 — Recognise the crucial role to be played by online services and tele-health in improving access to mental health services in country Australia. Develop and fund a comprehensive strategy to provide the infrastructure, training and coordination necessary to ensure that these services are integrated with existing and alternative services.

STIGMA

Recommendation 7 — Implement a national social inclusion program centred on addressing mental health stigma. Use targets to track progress.

SUB-ACUTE CARE

Recommendation 8 — Provide increased support for existing prevention, early intervention and sub-acute services in rural, regional and remote areas.

CARERS

Recommendation 9 — Revise Centrelink's application form for the Carer Allowance, so it is appropriate where the relevant disability is psychiatric, as well as where the relevant disability is physical.

Recommendation 10 — The Commonwealth, states and territories should ensure privacy laws and policies in the mental health sector appropriately balance a consumer's privacy as a basic human right, with their nominated carer's need to give and receive information relevant to their caring role.

A UNIQUE SECTOR

Recommendation 11 — Provide increased, targeted investment in mental health services in regional, rural and remote Australia.

Recommendation 12 — Establish a whole-of-person approach to mental health service delivery, including greater resourcing for outreach services and community wellbeing centres where people can access:
• Mental health and general health services
• Housing assistance
• Financial counselling
• Centrelink- and employment-related services.

CORE CHALLENGES

Funding was the key theme threading each of our meetings together. Service providers seek more flexible and sustainable funding models. Feedback reflected strong support for community-based mental health services as a way of addressing stigma. Concerns about workforce shortages, staff retention and training also formed a large part of the narrative. Service providers talked about the need for preventative measures and sub-acute facilities to take the emphasis off crisis-driven services. Carers and consumers told us they want to be able to get timely advice, help and treatment when they need it, before a crisis hits.

COMMUNITY-BASED SERVICES & NEIGHBOURHOOD HOUSES

WORKFORCE TRAINING & SHORTAGES

PREVENTION

TRANSPORTATION

ONLINE SERVICES

RURAL, REGIONAL AND REMOTE MENTAL HEALTH

REMOVE EMPHASIS ON CRISIS-DRIVEN SERVICES

HOUSING & HOMELESSNESS

FUNDING FLEXIBILITY

ADDRESS STIGMA

OUTREACH

FIGURE 1 — Themes central to rural, regional and remote mental health service provision, as identified during the consultation process.

THE IMPORTANCE OF COMMUNITY

NEIGHBOURHOOD HOUSES AND COMMUNITY CENTRES

Feedback from service providers and consumers reflected strong support for community-based mental health services including wellness centres and neighbourhood houses. Whereas wellness centres are designed specifically around the needs of people who are living with mental illnesses and play a valuable role in providing advice and peer support, neighbourhood houses are open to the broader community and 'provide social, educational and recreational activities for their communities in a welcoming, supportive environment'.[4]

Stakeholders communicated that programs run from these centres and houses assist with social inclusion, by encouraging participation and a place of belonging, as well as providing information about mental health.

During consultations, it was explained that neighbourhood houses assist in combating the stigma associated with mental illness because they offer a friendly, inclusive welcome to all members of the community, and, while including programs focused on mental health more broadly, such as exercise, education, nutrition and social activities, they are not labelled as mental health facilities. As one stakeholder suggested, "It's about mental wellness – not mental illness."

We learned that in some cases, funding had been withdrawn or was likely to be withdrawn from community-based mental health services in the future. In Queensland's Lockyer Valley, the Laidley Community Centre has experienced ongoing funding uncertainty. The centre was forced to close its doors for a day in late 2012 as the renewal of their funding was delayed. The capacity of the centre is constrained by a lack of funding, despite reports of a growing need for flexible, community-centred approaches to mental health and wellness – especially in the aftermath of the Queensland floods in 2011 and 2013. The Laidley Community Centre is one of only two community centres in the Lockyer Valley – a region home to more

than 35,000 people. People referred to community centres and neighbourhood houses in the region as "the glue of these communities" – something community leaders tried to capture in their pursuit of further funding.

Throughout the consultation process, it consistently emerged that resources for community and neighbourhood centres are stretched – especially in the wake of extreme weather events. Bushfires, floods and droughts take an enormous toll on rural and regional communities and while we were told that there is often a rush of assistance at the time of the emergency, resources dwindle before many of the mental health effects of a crisis become known. Ongoing support to keep communities resilient and follow up for individuals affected by these events was requested.

The importance of neighbourhood houses and community centres in Queensland was outlined in a report by the Queensland Council of Social Service (QCOSS). It was found that 'poor levels of core funding place at risk the full scope of what community and neighbourhood centres could be doing to prevent isolation, link people to services and resources, and build stronger places of belonging capable of rising to any challenge, including crisis situations like Queensland's floods.'[5] It was further suggested that community and neighbourhood centres are cost effective, focusing on people's strengths and potential to help others to relieve pressure on other mental health services.[6]

CASE STUDY

We met a woman at the Port Lincoln Community House who was seriously traumatised by the Wangary bushfires that engulfed her property in 2005. For some time she hid away from people in a cupboard and was seeing a psychiatrist for assistance. A while after she began to attend the Community House, her psychiatrist told her she no long needed to see him as she was now in the process of healing, thanks to her participation at the centre. When we met her she attended regularly, confidently participating in programs and activities and feeling valued and valuable.

SUB-ACUTE, COMMUNITY-BASED CARE

The importance of step-up, step-down services was emphasised by many of the people we spoke to. Step-up care occurs when a person in the community is becoming unwell and involves early intervention in order to avoid a hospital stay. Step-down care focuses on transitional support when a person is discharged from an acute admission.[7] One participant spoke of her support for sub-acute services, saying "early intervention could reduce the [number of] people becoming acute and therefore needing a lot more resources and time to get well again."

REACHING OUT

During consultations we found that people value outreach services. Many of the people we spoke with talked about the important role of outreach services in preventing mental illness crises for those who live outside population centres. As one participant explained, "we need a mental health safety net, not an ambulance."

"We can learn from other countries where there is huge financial poverty but some communities have a deep sense of belonging - in community…to look at social connections, programs or institutions that offer relationships and support; distance can then be turned to advantage — providing people can connect to others in some meaningful way"

- *response to online discussion paper.*

In the central region of Tasmania, at Melton Mowbray, Rural Alive and Well (RAW) describe themselves as "Lifeline on wheels". Growing out of a community response to serious drought in the 1990s, there are now other pressures on people's wellbeing that include loss of employment and family breakdown.

RAW is focused on reaching out to people who may be at risk of suicide and relies on referrals, word of mouth and "tip-offs" from those who are concerned. As well as a 24-hour phone line and taking referrals from the police, hospital and community organisations, RAW practises "cold calling" on people who live on isolated properties to have a chat, have a cup of tea and offer a shoulder. This is outreach at its most immediate, but workers there could only recollect being turned away once in the five years the program has been operating in its current form.

The RAW staff believe that the secret of their success – and they have no doubt that there are people alive today because of their help – is their attention to follow up. They keep in touch.

Conversations with individuals and organisations showed that outreach services are valuable but often difficult to deliver. Poor weather and road conditions affect workers' ability to reach people in need. One mental health worker explained, "We have offered to travel to outer areas but found this to be less productive with one worker on the road for several hours in return trips." We often heard that the challenges were the costs and time involved in assisting people who live remotely and yet it is these very people who do not have easy access to services and are at risk of being seriously isolated.

We also learned that another benefit of outreach services – including those provided by visiting practitioners from urban areas – is that they can offer a solution to problems of privacy and conflict of interest in small communities where there are a limited number of qualified service providers.

"I used to live in a very small town (of no more than 1500 people) and there never seemed to be a high level of privacy maintained... I really do feel that if I was more confident in seeing professionals in my own home town, I'd have accessed help earlier and my illness mightn't have got to this stage."

- Participant in the Inspire Foundation's ReachOut.com conversation

WELLBEING AND STIGMA

During our travels we found that country communities implement a range of programs designed to engage people in activities and provide support and information to vulnerable people to help them function well and live healthy lives. People often spoke to us about the importance of respecting lived experience of mental ill-health and considering mental health in the context of a person's life. This was poignantly summarised by a participant who explained, "When you know a little about mental illness it is less scary to say maybe my son or daughter might be developing a mental illness…living proof – it's just like you and me; it's about normalising it."

Many of the people we spoke with emphasised the prevalence of stigma in rural, regional and remote areas – particularly in very small communities. Where the population is small, there may be unavoidable conflicts of interest, if mental health workers are related to, or very familiar with a consumer's family. Concerns about privacy were also raised and it was explained that in a town where there may only be one GP, "both men and women in small communities often seek assistance from health professionals outside their local community…for fear of the reaction of others." The reality of this concern was summarised by a service provider in Albany who said, "If your car is out the front of my service, everyone knows…if you become very unwell, people remember."

"The local headspace is located in the main street next to a pizza shop. The young people in my home town feel vulnerable in approaching it."

EDUCATING THE COMMUNITY

"We should have Mental Health first aid as first training for anyone going into any job, anywhere…"
– Participant, Townsville

From Townsville in the North, to Geraldton in the West, to Orange in the East, many of those we met told us they want to see greater investment in training and education about mental health and suicide in the community. Programs providing information about symptoms and signs of mental health concerns were considered valuable because they alert people to the early warning signs of mental ill-health and give them the skills to intervene in a productive and effective way.

It was suggested that there was a need for such education for teachers and local council workers, and in farming, mining and Indigenous communities, which are often inaccessible. Others proposed rolling out programs to stock and station agents and milk truck drivers, who may have contact with those who are at risk. Some suggested education should start with school nurses, guidance counsellors and parents.

Mental health first aid was very clearly seen as an important way to raise awareness of mental health issues in the broader community, both to decrease stigma and to help people seek and receive help as early as possible.

UNDERSTANDING STIGMA

Our consultations indicate that stigma around mental ill-health is widespread. People with persistent and severe mental illnesses, such as schizophrenia and bipolar disorders, people who have personality disorders and those experiencing depression and anxiety all experience stigma and discrimination. Further research into the causes and consequences of stigma and discrimination would shed light on the most effective means of overcoming it, enabling people to seek help more openly and effectively.

WORKFORCE: TRAINING AND SHORTAGES

Country areas experience shortages of mental health and medical workers. Statistics show that 89.5 per cent of psychiatrists and around two thirds of mental health nurses work in major cities.[8] Research suggests that the unavailability of GPs, infrequent GP travel to remote areas and transient nature of GPs in some areas affects referral pathways for people seeking mental health assistance in rural Australia.[9]

Those working in mental health care in rural, regional and remote areas are often stretched thin. Staff burnout is a concern in remote areas where demand for mental health services is high and support for employees is often unavailable.[10] A higher turnover of staff in rural, regional and remote areas also impacts consumers. In this context, many of the people we spoke to raised concerns about continuity of care for consumers. One person said, "When you become a ping pong ball it makes recovery much worse." Another consumer explained, "...they swap your worker every couple of weeks – nothing worse than when you pour your heart out to someone and then you have to do it again."

Stakeholders described the reluctance of staff to relocate to country areas, insufficient pay and career path opportunities and a perceived lower level of professional development as reasons for shortages of mental health professionals in rural and remote areas. People told us about the need to continue educating and training the rural mental health workforce, suggesting that they need professionals who can "hit the ground running." Service providers explained that staff are often "under-resourced and under-trained," with some nurses receiving just six weeks of mental health training before beginning work.

One program which was seen as assisting rural communities was the government's Mental Health Nurse Incentive Program (MHNIP). This program involves engaging mental health nurses in primary health care services through non-Medicare incentive payments. When visiting the Riverland in South Australia, we had the opportunity to meet two nurses in two different practices, both delivering high quality care to individuals, but also providing extensive community education programs and building mental health resilience within their own particular communities, which reflected local needs. Both were employed through General Practices and the GPs we met could not speak highly enough of the value and expertise they had brought to their practices.

PEER WORKERS

We also heard consistent support for the development and promotion of peer workers in the mental health workforce – in both paid and volunteer capacities. As a result of their own experience of mental ill-health, they are able to share their unique knowledge to empathise with others' experience and offer a sense of acceptance and hope. We were told that this is of special significance in regional Australia, offering new paths to employment for those who have valuable experience of not only mental illness, but of country life and an understanding of the rigours of life on the land. Consumers and service providers in Launceston strongly advocated for peer workers in Accident & Emergency departments and acute settings, where people are often frightened, confused and distressed. Appropriate training and supervision is required to ensure that peer workers are properly supported.

CULTURALLY APPROPRIATE WORKERS

Many described a need to "grow your own" mental health workers, discussing the idea of training people from their own communities to work in mental health because they are more likely to understand the needs and experience of their clients and to stay and provide continuity for clients and service providers.

This was also particularly relevant for service providers who talked about the importance of having Aboriginal and Torres Strait Islander health professionals to deliver culturally appropriate care. It has been found that Aboriginal and Torres Strait Islander health workers are instrumental in breaking down barriers and developing community acceptance of non-Indigenous mental health professionals.[11] Figures show that Indigenous Australians are up to two times more likely to be hospitalised for mental health-related concerns than their non-Indigenous counterparts, making culturally appropriate care essential.[12]

The Centre for Rural and Remote Mental Health in Orange described the acute shortage in this aspect of the workforce and called for more training and support for Aboriginal mental health professionals to develop culturally safe Aboriginal mental health services overseen by strong community governance.

In visiting various regions we also became aware of the needs of Australians from culturally and linguistically diverse (CALD) backgrounds – whose access to services was limited by language or cultural barriers. New arrivals and asylum seekers living in regional areas may experience mental ill-health related to traumatic experiences in their past, or be isolated and lonely, affecting their mental health and wellbeing. The Tasmanian Transcultural Mental Health Network made a strong call for mental health workers from diverse cultural backgrounds, the provision of adequate interpreters and telephone interpreting services and workforce training to enhance cultural sensitivity and respect. The point is well-made that mental health and wellbeing, and mental ill-health, are often experienced and viewed in a cultural context. This is particularly the case when dealing with suicide. The use of bicultural workers, where needed, is very important.

SUPPORT FOR CARERS

We also heard about the need for carers to be supported in their work. Carers play an integral role in mental health service delivery in rural, regional and remote areas. As one carer said, "...we only have small shoulders but they need to be huge." This was echoed by another participant who said, "...the carer needs to look after themselves otherwise they'll go down in a screaming heap." People we spoke with raised concerns about Centrelink's Carer's Allowance form, telling us there is no appropriate application form for people caring for those with a mental illness. Many carers explained that the paperwork was too complex and in one case, the form "didn't capture the experience" of what caring for someone with a mental illness involved.

Other carers raised the importance of respite care so they can have a break from ongoing caring responsibilities, knowing their loved one is safe and appropriately looked after. Another concern raised by a relatives and friends group in Newcastle was the need for accommodation for carers wishing to visit a family member who has been transferred away from home for inpatient care. They pointed out the cost of an overnight stay is prohibitive for many carers, who are often on low incomes, particularly when added to the cost of travel and time off work, and yet it is important that their loved one does not feel abandoned and can be supported.

BARRIERS TO ACCESSING CARE

LACK OF SERVICES

Everywhere we travelled we heard that there is a "crisis-driven" system, with a lack of treatment options for many people until their health is considered an emergency. In Murray Bridge, we were told, "Until something really bad happens to someone they don't do something about mental health. I got suicidal and was in and out of Glenside for two years. There was nowhere to send me until I was in the system. Until then, I couldn't get any help." In Townsville, a service provider told us: "It is a crisis-driven system, we don't intervene early enough. We need secure and safe housing and supports, which will reduce the number of admissions and is more cost effective. If we had supported accommodation, more respite...that crisis might not happen."

DISTANCES AND TRANSPORT

Even where services are available, we were frequently told that people were unable to use them because of the need to travel distances and a lack of reliable, affordable transport in rural Australia. From the Riverland in South Australia to towns in Western Australia, this was a common refrain. Many consumers and carers are on low incomes and do not own dependable cars. Fuel costs can be prohibitive too. Public transport is generally poor, even in regional centres, and there is very little available once those centres are left behind.

The Wellness Centre in Innisfail was a vital meeting point for consumers and carers in Innisfail but we heard that it cost some people in outlying towns $45 for the round trip, by bus. Others explained that transport options were limited due to irregular services at inconvenient hours and attending medical appointments often necessitated an overnight stay because the bus did not run again until the next day. In Tasmania, we were told that "transport is a massive issue" and in Western Australia the Country Women's Association told us that there are sometimes no buses to the city from country areas or they only run once or twice a week.

We heard many ideas including subsidies to individuals for transport costs, subsidies to companies providing services and making public transport free on one day per week, such as 'Transport Tuesdays'. The role of local government was highlighted as a potential provider of localised transport programs to build the resilience of their communities.

Our tour certainly reminded us that Australia is a huge country of vast distances and that transport will always be a challenge. Many of the people we met told us about the value of e-health as a way to overcome this challenge, where it is appropriate and users have access to the necessary technology. We were also reminded about the importance of sufficient funding for personnel, fuel and time, for on-the-ground outreach services where human contact is crucial.

CASE STUDY

In Caloundra, on the Sunshine coast, we heard about 'Comlink' - a very successful program that was set up to provide access to transport that is reliable and affordable, for the frail, elderly and people with disabilities (including mental ill-health conditions). Consumers are registered with the service and bookings can be made three working days in advance to take them to doctors and specialists, shopping and social engagements. The cost is based on a person's ability to pay.

Comlink is funded to provide 52,000 trips a year but is able to provide 102,000 trips, using some of its own vehicles and also engaging volunteers with their own cars. It's a wonderful example of a good idea that involves networking and sharing in the community. In 2012 Comlink were hoping to obtain a further $15,000 to extend the service to Goodna, a disadvantaged community. Only available on the Sunshine Coast when we visited, it was suggested the program could be scaled up and made national.

Source: http://comlink.org.au/about-us/about-suncoast-transport-and-care-association-inc-stac

SOCIAL DETERMINANTS OF HEALTH

Mental ill-health is often inextricably woven together with other social determinants of health, including homelessness, unemployment, poverty, isolation and social exclusion.[13] Service providers in country areas told us that they are often under-resourced in their pursuit of a whole-of-person approach to mental health.

One stakeholder said,

"We are trying to respond to the social impacts that complicate people's recovery… disability, poverty, unemployment… we want long term sustainable recovery, not bandaids."

CASE STUDY

One service provider in Bendigo has formed connections with TAFE to give opportunities to young people, helping them overcome issues which are associated with experiencing a mental illness. The service provider collaborated with TAFE to run a photography course and engage consumers in the TAFE environment. After attending a general community event about photography, and being asked to take photos, one of the participants commented, with surprise and a sense of being included: "They thought we were normal!"

HOUSING AND HOMELESSNESS

Many forms of accommodation are in demand for people with a mental illness. Stable accommodation, crisis accommodation, step-up, step-down services and residential care were all raised as important concerns in communities. As a participant told us, "no one can recover from mental illness unless they have something safe, affordable and decent to live in." A report by the Mental Health Council of Australia outlined the links between mental illness and homelessness and estimated that as many as 75 per cent of homeless people experience mental ill health.[14] We heard about the need for secure and safe housing as a cost effective mechanism to reduce hospital admissions and relieve pressure on crisis services. As one stakeholder suggested, "If we had supported accommodation, more respite – that crisis might not happen. A place to go, a safe house to go for a week instead of admission would be a better outcome… people are sometimes discharged into homelessness."

CASE STUDY

Service providers in Queensland's far north town of Innisfail explained that homelessness is an ongoing problem in the area. On a busy night, the local soup kitchen distributes up to 130 dinners. Figures from the 2011 Census showed that Queensland has a rate of 46 homeless persons per 10,000 of the population.[15] Additionally, Aboriginal and Torres Strait Islander people experience homelessness at a far higher rate than their non-Indigenous counterparts, with 24 per cent of Queensland's homeless population identifying as Aboriginal or Torres Strait Islander.[16]

FUNDING: FLEXIBILITY AND AVAILABILITY

FUNDING: FLEXIBILITY AND AVAILABILITY

Funding was the most salient issue affecting the service providers and consumers with whom we met. People frequently told us that existing methods of funding make the provision of ongoing and appropriate mental healthcare difficult.

We heard that where funding is inflexible, it is impossible to tailor programs to meet the needs of a particular community or individual. In Warragul, Victoria, a service provider expressed frustration with the current funding model: "how do we individualise a package of care and how flexible can we be tailoring that? When we have flexibility around funding, the care will be more suitable."

People we met with in Whyalla told us, "We continually struggle with our 'post code' allocation. Rural communities may fall under the post code but aren't getting the service. This comes about by funding 'post code' but not looking at geography and understanding the distances."

The government-funded Headspace program has been well-received in many rural communities. One service provider suggested that the reason for this lies within the flexibility of the model, "Having a loose template to stamp into the local terrain…thinking more creatively about what does and doesn't work in particular communities."

Service providers explained that funding uncertainty is disruptive to staff and communities and makes employee retention even more difficult. A service provider in Melton Mowbray in Tasmania told us that their funding is perpetually insecure, "We lurch from pillar to post; we're out there trying to raise money."

THE ROLE OF MENTAL HEALTH SERVICES
THE ROLE OF ONLINE MENTAL HEALTH SERVICES

A persistent theme of our consultations was the growing importance and utility of online, tele-health and e-health services, for people living in the bush. Whether as a way of overcoming the difficulties associated with remoteness, transport, workforce shortages or privacy, more and more people are choosing to access information, and treatment, via their computers.

Many people valued the fact that online services are self-directed; offering the power to choose when and where assistance can be sought. Immediate access to reliable information was considered very helpful as well as the use of online programs as alternatives, or in addition to, face to face treatment.

It was suggested that telehealth and e-health services are important tools which allow access to qualified practitioners, including psychiatrists and psychologists, who are in short supply in rural areas. However some expressed caution, explaining that online mental health services must be accompanied by thorough training for practitioners and staff, with proper preparation and follow up being a key to its success.

Some of those we met described very positive experiences with online treatments and valuing the privacy and convenience of being able to access help from home at the time they wanted. We were interested to hear that some members of an Aboriginal community in Northern New South Wales had found e-health and online services helpful and it was suggested that this is an option which should be more widely explored.

Other stakeholders expressed the view that it is relationships that really matter and they can't be replicated by using an online service. Some suggested that it was important to work out what online services are useful for and not expect them to meet every need – but be just "one tool in the toolkit". Following up initial online programs with face to face contact was proposed by others who felt that the relationships aspect of care and treatment could not be adequately met online.

Many stakeholders told us access to fast internet connections and a reliable computer is essential to the effective use of online services. In some cases poor equipment made it unattractive and frustrating.

RECOMMENDATIONS

COMMUNITY

"...places where people can gather and interact are likely to be enormously beneficial to mental health as preventative services."

– Online submission from service provider.

During our meetings with stakeholders, it emerged that community-based programs and initiatives are both relatively inexpensive and effective in assisting people to access the services they require. The importance of community was continually outlined by service providers, consumers and their families as central to the mental health and wellness of rural, regional and remote communities.

Many we spoke to also emphasised the importance of step-up, step-down services as a form of sub-acute, community-based care.

Recommendation 1
Increase funding to community-based initiatives, including neighbourhood houses, community wellbeing centres and outreach services.

Recommendation 2
Provide better support for multi-disciplinary, community-based sub-acute services on a step-up, step-down model.

WORKFORCE

"My worker has been there every step of the way and has been my biggest supporter and has helped me to find myself and be off medication for two years and out of the hospital for three, and I agree that the hospital system treats us like criminals when all we are looking for is understanding."

– Online submission from consumer.

Stakeholders and service providers frequently described the difficulties associated with recruiting and retaining staff with suitable mental health qualifications. Those we spoke to cited lack of professional development opportunities, reluctance to relocate, lack of support and insufficient pay as factors making it difficult to attract mental health professionals to rural areas.

Recommendation 3
Develop a rural and regional mental health workforce plan focusing on training and attracting mental health professionals, including those from Aboriginal and Torres Strait Islander and culturally diverse backgrounds, to rural practice. This plan should include key pathways and incentives for health professionals, as well as training, supervising and employing peer workers in paid and voluntary roles.

Recommendation 4
Increased funding for training and research aimed at improving the mental health workforce, including greater investment in training and education about mental health and suicide prevention for frontline workers and community members.

Recommendation 5
Increased funding and expansion of the Mental Health Nurse Incentive Program.

ONLINE & TELE-HEALTH SERVICES

Recommendation 6

Recognise the crucial role to be played by online services and tele-health in improving access to mental health services in country Australia. Develop and fund a comprehensive strategy to provide the infrastructure, training and coordination necessary to ensure that these services are integrated with existing and alternative services.

STIGMA

"When sufferers have been fighting their own battle for two or three decades with little support, they no longer present as well groomed, have lost the ability to 'pass' or hold a job. They rely on an increasingly small number of people in the community who accept them at face value - or perhaps understand their history and will support them, or recognise when they need help."
– Online submission by rural South Australian service provider.

We learned that the level of stigma surrounding mental health in rural areas is significant and profoundly affects the ways in which people choose to seek help or access services. Those we spoke to explained that people from small rural communities sometimes travel outside their home towns to access mental health services in the hope that no one will find out.

Recommendation 7

Implement a national social inclusion program centred on addressing mental health stigma. Use targets to track progress.

SUB-ACUTE CARE

"Our communities incubate crises then ship the unfortunate victims to Adelaide, placing an unreasonable burden on the ambulance service and Flying Doctor. There is very little effective practice in between 'everything's fine' and crisis…"
– Online submission by rural South Australian service provider.

Those we spoke with advocated for a move away from crisis-focused mental health care toward a well-rounded approach to mental health and wellness. Many people pointed to the Headspace model as one which encompasses a wide range of services for young people, including employment assistance, financial counselling and mental and general health services.

Recommendation 8

Provide increased support for existing prevention, early intervention and sub-acute services in rural, regional and remote areas.

CARERS

"We have two sons with mental health illness and over ten years we have had situations where both have been ill at the same time. The Centrelink Carers' allowance form is not appropriate for people with mental illness. We have never applied because it is so hard. We looked at it and couldn't fill out the form because it doesn't capture our experience. And they require us to provide forms from doctors but we can't do that without permission from our sons. It is impractical. Privacy laws are an issue or the way that they are administered by the government agencies."

-Carers in Ingham.

From our conversations with consumers and their families, we found that many carers feel unsupported in their role. This lack of support extends to a government level where carers explained that Centrelink do not offer a Carers' Allowance application form appropriate for those caring for a person with a mental illness.

Recommendation 9
Revise Centrelink's application form for the Carer Allowance, so it is appropriate where the relevant disability is psychiatric, as well as where the relevant disability is physical.

Recommendation 10
The Commonwealth, states and territories should ensure privacy laws and policies in the mental health sector appropriately balance a consumer's privacy as a basic human right, with their nominated carer's need to give and receive information relevant to their caring role.

A UNIQUE SECTOR

Senator Wright's rural mental health tour was premised on the need to improve mental health services in country Australia. Our findings have confirmed the need for increased and more targeted investment in mental health services in regional Australia.

Recommendation 11
Provide increased, targeted investment in mental health services in regional, rural and remote Australia.

It emerged that a whole-of-person approach to mental health service delivery is required.

Recommendation 12
Establish a whole-of-person approach to mental health service delivery, including greater resourcing for outreach services and community wellbeing centres where people can access:

• Mental health and general health services

• Housing assistance

• Financial counselling

• Centrelink- and employment-related services.

CONCLUSION

"So many people hide their mental illness; it takes courage to stand up and say this is my life and I can do it and others can do it and you can do it and you can be part of the solution"

The Australian Greens are committed to addressing the growing disparity between funding and access to mental health services in city and country areas. Approximately seven million Australians live outside major cities and have unique pressures, experiences and lifestyle factors which affect their mental health. The Greens have listened to, and consulted with, those working on the frontline in rural, regional and remote mental health. We have used their experiences and stories to shape a mental health policy which focuses on community-based, people-centred responses to mental health.

From our consultations with rural mental health stakeholders, we learned that community-based responses such as neighbourhood houses and community centres are cost effective, well received by locals and are central to addressing the loneliness and isolation experienced by people who have mental ill-health.

We recognise the importance of innovative and flexible community-based initiatives which are less crisis-driven and increasingly focused on prevention and early intervention. We note the need for greater investment and funding for the rural mental health workforce and emphasise the significance of ongoing education and training for mental health professionals and other members of community who may be in a position to intervene in a positive way.

We have learned much from listening to those with lived experience of mental ill-health in the course of our consultation and we thank all who took the time to share their views with us, in meetings or online.

We believe that, in developing policy, we must heed the voices of the "experts", those who live with the experience of mental ill-health every day. It is only in this way that we can achieve a responsive, accountable and ultimately effective mental health system for Australia.

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