WAAMH

Western Australian Association for Mental Health

Western Australian Association for Mental Health

Submission: Accessibility and quality of mental health services in rural and remote Australia Senate inquiry

May 2018

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SUMMARY

The following points provide a summary of the key findings and themes detailed in this submission in relation to the accessibility and quality of mental health services in regional areas of WA.

- Accessible and appropriate locally based services are needed in regional areas.
- Prevention, health promotion, and the social determinants of health are not sufficiently addressed in regional areas.
- Staffing issues and investment in workforce are key issues for service delivery in regional areas of WA.
- Addressing the needs of population groups at heightened risk is a priority for regional mental health in WA.
- Emergency response and acute care issues must be addressed to improve mental health service access in regional WA.
- Technology is not a panacea for mental health service provision in WA.
- Funding of mental health services is a key issue for mental health in regional WA.
- People in regional areas experience challenges trying to access the National Disability Insurance Scheme in relation to psychosocial disability.

Recommendations summary:

1	Strategy, policy and planning for mental health regional areas must prioritise locally-based and outreach services that are easy to access and provide people with appropriate assistance when they need it.
2	General Practitioners are a valuable resource in regional areas and investment should be made to ensure that mental health training and skills are provided and prioritised for General Practitioners in regional areas.
3	Increase investment in prevention and community-based services and supports, as outlined in the Western Australian Mental Health Alcohol and Other Drugs Services Plan 2015 – 2025.
4	Grow and develop the public and community mental health workforce and peer and lived experience workforce in rural and remote areas.
5	Actively address the mental health needs of priority groups in regional areas.
6	Invest in strengthening the capacity and appropriateness of emergency and acute inpatient facilities for mental health in regional areas.
7	Investment in infrastructure to ensure high quality internet access is needed for effective online services.
8	Online services for mental health must not be used as a substitute for quality, face-to-face services in regional areas.
9	Prioritise funding for mental health services in regional areas that are localised and tailored to the needs of the community.
10	Monitor the National Disability Insurance Scheme closely as it is rolled out in regional areas, with particular attention to addressing the needs of consumers, carers and families affected by mental health issues and psychosocial disability.

BACKGROUND

The Western Australian Association for Mental Health (WAAMH) welcomes the opportunity to contribute to the accessibility and quality of mental health services in rural and remote Australia senate inquiry consultation.

WAAMH is the peak body for the community mental health sector in Western Australia and exists to champion mental wellbeing, recovery and citizenship. WAAMH recognises a continuum of supports - built on principles of human rights, recovery, co-production, personalisation and choice, social inclusion and cultural connection - are essential to the promotion, protection and restoration of mental wellbeing. WAAMH promotes, advocates for and further develops this network of supports.

WAAMH's membership comprises community managed organisations providing mental health services, programs or supports and people and families with lived experience of mental health issues and suicide, with whom WAAMH engages in genuine partnership. WAAMH also engages a wide network of collaborative relationships at a state and national level with individuals, organisations and community members which share its values and objectives.

WAAMH consultation and submission process

In April 2018, WAAMH engaged in consultation with both members of the organisation and the wider community to inform this submission. This consultation was conducted to ensure that WAAMH presents a genuine and focused regional perspective on the Inquiry Terms of Reference.

The response to the consultation was significant, with 195 submissions to an online survey, approximately 20 face- to- face and telephone consultations, and 2 written submissions. Input was received from respondents from all regions of WA, with the following percentages for each region: Gascoyne 2%, Goldfields-Esperance 8%, Great Southern 16%, Kimberley 10%, Mid-West 6%, Peel 3%, Pilbara 5%, South West 22% and Wheatbelt 26%.

Respondents identified as either a person who uses mental health services (30.4%), a carer or family member of someone who uses mental health services (30.4%) or a provider of mental health services (35%).

The submission also draws on information collected by WAAMH through other activities. In 2017, WAAMH gathered information about issues in rural and remote areas for a Workforce Development Project. In July 2017 a consultation forum on rural and remote mental health was held with participants from rural and remote areas attending the WA Mental Health Conference. These two projects have also helped to inform this submission.

WAAMH would like to thank all participants in the consultation process and other projects who contributed to this submission.

CONTEXT: MENTAL HEALTH REFORM IN WA

Modelling undertaken to inform the Western Australian Mental Health Alcohol and Other Drugs Services Plan 2015 – 2025 (the Plan) (Western Australian Mental Health Commission [MHC], 2015) identified that only 1 in 5 people in Western Australia can access the community support they need. With most mental health funding caught up in crisis and hospital-based services, the Plan identified a pressing need to rebalance the system across all services types to improve mental health services access and outcomes.

Specifically, the Plan identified a need to increase community support from 842,000 support hours to 3.2 million hours of community support by 2020 and a total of 5.28 million support hours by 2025 at a modelled cost of approximately $245 million in state funding. The government's current Sustainable Health Review interim report also identifies the need for access to community-based support and earlier intervention across the health system, including in mental health.

While baseline community support hours at the Plan's commencement in 2015 are not available for regional areas, the increases in modelled support need is significant: with a total need for 639,000 hours by 2025 in northern and remote Western Australia, and 718,000 hours needed in southern country areas. Broken down by region, people in every region of Western Australia have a pressing need for significant increases in the community-based recovery support available. This total modelled need of 1.35 million community support hours for regional, rural and remote areas is significantly greater than the current 842,000 support hours currently available across the entire state – much of which we understand is provided in metropolitan areas.

The Plan's aim was to increase community support by 432,000 support hours by the end of 2017, with a particular focus on regional areas, children and youth. This has not been achieved and there is no projected funding in the state budget in the coming years to increase this support. WAAMH is concerned that the state government may be anticipating that the NDIS will provide this access, despite early experiences showing that the majority of mental health consumers will not be eligible for funded NDIS supports.

Similarly, the Plan identified a need to focus on preventing mental health problems. A key mechanism the Plan identified to achieve this was to increase the proportion of the Mental Health Commission budget spent on prevention dedicated to mental health from 1% to 2% by 2017, to 4% by 2020 and to 5% by 2025. But the recent State Budget shows a 12.7% cut to prevention spending this year and totalling a 41% cut from 2019-20.

WAAMH is informed that the cut is due to a lack of confirmation of federal funding for workforce development amongst other programs. Yet the Plan estimated that prevention funding would be allocated by the State, and the Budget identifies no increase in State Prevention funding over the forward estimates. Given the modelled needs set out in the Plan and the major needs identified by survey participants, WAAMH is extremely concerned about the State's lack of specific funding plans to increase prevention approaches in regional, rural and remote areas.

Despite this lack of progress in prevention and community support for people in rural and remote areas, WAAMH is pleased to report the government has made significant progress in establishing sub-acute Step Up Step Down services in major regional centres. These will go some way to preventing unnecessary hospital admissions and transitioning people effectively into the community after a hospital stay, but do not negate the need for community-based recovery supports.

This background provides important context for the following submission. The findings from the WAAMH consultation clearly reflect the needs identified in the Plan, and demonstrate ongoing deficits in areas such as prevention, community-based supports, child and youth services and drug and alcohol services and supports. WAAMH has consistently supported the Plan and continues to advocate for strong political commitment to the Plan as a framework for mental health investment in WA.

KEY THEMES

This submission addresses the accessibility and quality of mental health services in rural and remote Australia, based on the feedback from the WAAMH consultation process. It reflects these responses and provides an overview of the key themes and issues identified through the consultation (see Summary Table 1). Where appropriate, additional information and evidence has been included, and direct quotes have been provided as much as possible to demonstrate the heartfelt views and concerns of regional respondents.

Key Theme Summary Table 1.

Theme 1	Appropriate and accessible locally-based mental health services
Theme 2	Prevention, health promotion, and the social determinants of health
Theme 3	Staffing issues and investment in workforce
Theme 4	Addressing the needs of population groups at heightened risk
Theme 5	Emergency response and acute care services
Theme 6	Technology is not a panacea
Theme 7	Funding
Theme 8	NDIS in regional areas
Theme 9	Community Resource Centres

THEME 1: Appropriate and accessible locally-based mental health services

- *Relevant Term of Reference: a*

Western Australia is a state with several large regional cities and centres, hundreds of medium to small sized towns and highly remote small communities and a dispersed rural and remote population.

The challenge of delivering specialist and recovery-oriented mental health services across large distances and geographically sparse populations makes it difficult for people to access services in a timely and convenient manner when they are most needed.

The lack of accessible, appropriate, timely and contemporary locally based services in regional areas is a key theme from the WAAMH consultation. A lack of services generally in regional areas is consistently raised as an issue that affects people's ability to access mental health services and seek support for mental health issues. Notably, a lack of community-based services is explicitly identified as being the key barrier to seeking support for mental health issues in regional areas, with 73% of respondents to the WAAMH consultation survey highlighting this as an issue.

This finding is consistent with research undertaken by the Royal Flying Doctor Service, which found that people living in remote locations have access to mental health services at 1/5 the rate of city dwellers (Bishop, Ransom & Laverty, 2017) and work by the Country WA Primary Health Network which found that in all WA regions demand for mental health services far outweighs service capacity (Country WA Primary Health Network, 2016). The challenges are summed up by the Country WA Primary Health Network (2016), which said, “many remote communities rely in visiting services, digital health technologies or having to travel to major regional centres or the Perth metropolitan area for care. Integrated and coordinated care is difficult due to the limited availability and distances to be travelled, difficulties in delivering to outlying communities and methods of service delivery which may not reflect cultural security.”

> ***Why do community mental health services matter?***
> *A lack of community mental health services in regional areas is particularly relevant for WA, as the current Ten Year Mental Health Plan specifically details the need for more community-based supports for mental health, and to provide care in more appropriate places (MHC, 2015).*

Specifically, the lack of locally based services is major concern. Mental health services are not available when they are needed (for example, outside of business of hours, or 24 hours a day), and unreasonably long waiting times for accessing services create a barrier to people seeking support for mental health issues and accessing services in regional areas.

In a previous consultation undertaken by WAAMH on rural and remote mental health, participants identified a pressing need for locally based services, based on local knowledge and consultation and provided by local organisations. These can meet community-identified needs and contribute to capacity building of the community and residents (WAAMH, 2017).

A lack of choice of mental health services available in regional areas, and the lack of services for mild to moderate mental health issues also prevent people from accessing mental health services and seeking support for mental health issues. Related to accessibility, the cost of services in regional areas is also a key barrier to people accessing mental health supports.

1.1 Remoteness and distance

- *Relevant Terms of Reference: a, d*

Related to accessibility, the issue of remoteness and distance from services is consistently raised as an issue for accessing mental health services, seeking mental health supports,

and delivering mental health services in regional areas. Distance from services, lack of transport options (including access to transport assistance options like the Patient Accommodation and Travel Scheme) and the cost of travel are all barriers to accessing services and supports in regional areas. These are even more of a difficulty for people living in remote areas including Aboriginal communities.

Similarly, service providers identify remoteness and distance issues as key barriers to delivering services in regional areas. Distance from both clients and other service providers is identified as a key barrier for service delivery, and a lack of connection to other support services is another key issue for service delivery. A lack of transport options for delivering services is also a concern.

Funding to overcome the extra costs associated with travel should be embedded in funding. Too often funding provided to rural and remote services or funding provided to individuals does not cover the additional cost of travel.

1.2 Stigma and confidentiality

- *Relevant Terms of Reference: a, d, e*

Stigma was identified by 64% of respondents to the WAAMH consultation survey as being a barrier to seeking supports for mental health care in regional areas and was raised consistently over the consultation period. Similarly, service providers identified stigma around mental health issues as being in the top five barriers to delivering mental health services in regional areas.

Many participants spoke about the negative impact of stigma and the need to build the capacity of communities to speak openly about mental health and address stigma:

What people say:

“Shame and stigma- community led solutions are needed across the state for Aboriginal people.”

“The stigma of seeing a psychologist will stop people using the service we have in our nearest town as it is small and there is a fear of the psych knowing you socially or having your car spotted in the car park by friends or family. This stigma is slowly being broken down in our community, but it is still there for some.”

“The stigma in small towns is an issue. There is a counsellor in town, but nobody goes there because they don't want everyone knowing.”

“More discussion and awareness that mental health is not a taboo subject.”

“Due to stigma, people are afraid to access services.”

Concerns about confidentiality were raised in the WAAMH consultation, and a perceived lack of confidentiality when accessing mental health services in small towns is noted as a barrier to seeking support for mental health issues in regional areas.

1.3 General Practitioners

- *Relevant Terms of Reference: a, d*

Many people living with mental health conditions in rural and remote areas rely on their GP to provide assessment, treatment and referral. While participants in consultations recognise the important role of GPs, they report that few GPs in their local area have the skills, time and expertise to provide quality and recovery- oriented mental health assessment, treatment and support.

What people say:

"Stability of GPs- high turnover means lack of relationships and knowledge of your health issue."

"Very small community. GP comes to town once per week, high GP turnover, if they have one at all."

"Provide more services through our GP clinic."

Several initiatives have been announced to improve access to GP with mental health experience and skills in rural and remote areas, including the National Rural Generalist Pathway, and these are to be applauded.

However, the feedback from this consultation is that lack of access to GP's with mental health expertise remains a major problem.

During the consultations we heard that even in towns with a good supply of GPs, people with mental health conditions often travel long distances to nearby towns to see a GP who is known to be skilled and experienced in mental health assessment and treatment and makes time to build relationships with people with mental health conditions.

Example
The CEO of a community mental health agency in a large city in regional WA reported that some clients travel for over 1 hour to a smaller town to see a GP who is recognised as having specialist skills, expertise and willingness to work with people with complex mental health conditions.

Example
A mental health advocate in a medium sized regional town with several GPs told of a parent and client who drove over 200 kms to see a GP in a small town who was known to be skilled in working with complex mental health issues. The client was unable to get an appointment with a GP in their town of residence because the GP's already had a full list of patients and were not able to add the client to that list. It is also the case that in the same town that no GP works full time.

1.4 Outreach and localised services

- *Relevant Terms of Reference: a*

In most regions, mental health services and facilities are located in the main regional population centres, with few services accessible in outlying towns, settlements and communities. People must travel to the regional centres or to Perth to access specialist services.

What people say:

"In the main centres, Hedland, Karratha and Newman there are staff located so access to services is easy. If you reside in Tom Price, Paraburdoo, Onslow or Western desert communities, services are sporadic and not available on the ground due to small numbers and funding constraints."

"Adequate funding to support counselling services in Manjimup with adequate funding for outreach services to each town."

"*We literally are travelling over four hours to seek help each week as we have to see a psych in Perth as there is no one in our area it is very costly and impacts on our lives greatly. Please create services where there aren't any."*

"Small rural centres have nothing."

Providing more locally based and accessible services is identified as a key strategy to improve access to mental health services in regional areas. Increasing outreach services to towns and homes and increasing out of hours service availability are identified as being needed to improve mental health service access in regional areas

People call for increased funding of localised services and regular outreach mental health services from regional centres to smaller towns and communities, provided by skilled mental health practitioners through community resource centres (CRC), local GP practices (where they exist), hospitals and nursing posts. In addition, the need to invest in supporting and building the capacity of locally based and governed organisations is proposed.

What people say they need:

"Funding to employ outreach, non-residential support in the smaller communities, could run from hospitals, emergency centres or nursing posts'

"Outreach programmes are needed"

"Services are evaporating in local communities. What was there has been rolled into the NDIS. No NDIS funded plans means no services at all for people in small towns"

"Services provided in town on a regular basis and to accommodate working people"

"Visiting professionals to the town."

"We are too far away from larger centres and they all think we don't matter- not enough people living in the town."

The need for outreach services is seen by people in small and remote communities as a solution to the lack of transport between outlying towns and regional centres, the large distances they must travel, and the cost and time involved, which has the effect of limiting access to mental health services and support.

- **Recommendation 1:** Strategy, policy and planning for mental health regional areas must prioritise locally-based and outreach services that are easy to access and provide people with appropriate assistance when they need it.

- **Recommendation 2:** General Practitioners are a valuable resource in regional areas and investment should be made to ensure that mental health training and skills are provided and prioritised for General Practitioners in regional areas.

THEME 2: Prevention, health promotion, lived experience and the social determinants of health

- *Relevant Terms of Reference: a*

Mental health services are not enough to address mental health concerns and improve mental wellbeing in rural and remote communities. A key message from participants in consultations is the need for greater investment in locally driven, whole- of- community approaches, that include prevention, early intervention, lived experience involvement, community education and building the capacity and strengths of people with lived experience and rural and remote communities.

What people say they need:

“Long term action/funded plans needed for Federal and State Government to support the community-housing, emergency accommodation, hospitals, schools, rehabilitation.”

“More time and effort spend on working with individual communities in different ways.”

“Capacity building is needed so that carer and consumer voices can be heard.”

A key theme emerging from the WAAMH consultation is the lack of preventative services and resources. This includes a lack of health promotion and education related services, and an absence of services and resources addressing key social determinants of health.

Over 70% of respondents to the online survey identifed a lack of preventative services as a key barrier to people seeking support for mental health issues in regional areas. Lack of preventative services was also identified as a barrier to accessing services and was consistently raised as major area for action to improve mental health and access to mental health services in regional areas.

Why is prevention important for WA?
The lack of preventative services in regional areas is particularly relevant to WA, as the current Ten Year Mental Health Plan has specifically identified the requirement to increase investment in prevention from 1% to 5% of the Mental Health

> *Commission budget (dedicated to mental health) by the year 2025, a goal which is currently not on track (MHC, 2015).*

Increased access to health promotion resources and information about mental health services was identified as the third most important thing to address help improve mental health service access in regional areas, following addressing staffing issues and providing accessible, locally based services. Specifically, information about mental health services (through advertising and promotion) and increased community education about mental health are identified as key issues in this regard. Early intervention services and increasing opportunities for community connection were also identified as being needed to improve mental health service access, and the provision of support services was also highlighted.

A lack of recovery-oriented support-based services was identified as a key issue limiting access to mental health services, with almost 60% of respondents to the online survey identifying this as a key barrier to seeking support for mental health in regional areas. Increasing support services (including support workers, peer workers, support groups, and information and support for carers and families) were in the top ten suggestions for ways to improve mental health access in regional areas.

Similarly, increasing prevention services and increasing community-based services and resources that address the social determinants of health were major needs identified as being required in regional areas to improve mental health. The need for greater provision of psychosocial support services and community-based supports was consistently raised, and specifically the need for more employment related services and opportunities, and more flexible and appropriate accommodation options were the two main priorities in this area.

People with lived experience are an existing resource in rural and remote communities. To grow and realise both the experience and benefits of people with lived experience, and their carers and family members, local initiatives are needed to build the capacity of consumers and carers who do not have access to the training and development opportunities that exist in the metropolitan area. To support and enable lived experience expertise, capacity building and training is also needed for staff who work with consumers, carers and family members.

The development of Recovery Colleges and local recovery models of care and support must be a higher priority in rural and remote areas. Recovery Colleges are local education-based approaches to support mental health and wellbeing, which complement existing mental health services and support through the provision of co-designed and self-directed recovery and learning opportunities (WA Mental Health Commission, 2018).

The Recovery College of WA is currently supporting the development of Recovery Colleges in several rural sites across WA, and the example below illustrates the potential of Recovery Colleges in rural and remote areas:

> ***Example***
> Responding to the shortfall in the provision of training for Consumers and Carers in WA rural areas, the Esperance satellite of the Recovery College of WA (RCWA) conducted two courses that were co-produced and co-delivered by local Consumers and professionals in the areas of mental health and drug and alcohol but with

governance and educational oversight from RCWA. These unfunded courses could only be delivered because of the volunteer contribution of community members. Participant evaluation significantly demonstrated that education by locals provided information through a focus on connectedness, real experiences, and the shared leadership of educational facilitation but require funding to be sustainable.

2.1 The role of social determinants

- *Relevant Terms of Reference: a*

The poorer mental health of people in rural and remote areas (compared to people who live in major cities and towns) is linked to exposure to the socio-economic determinants of health (Hazell, Dalton, Caton and Perkins, 2017).

Throughout the WAAMH consultation the issue of social determinants and their role in mental health was frequently highlighted. Respondents to the online survey component of the consultation were asked to identify what factors affect mental health in regional areas. The following determinants were identified as the key issues in regional areas:

Factor	% of responses
Alcohol and other drug use	83.08%
Social isolation	76.92%
Stress	76.92%
Unemployment	67.69%
Stigma about mental health issues	64.10%
Lack of housing	47.69%
Lack of income	56.92%
Negative community attitudes about mental health issues	52.31%
Trauma	52.31%
Lack of community support	51.79%
Access to transport	51.79%
Violence	43.08%
Access to food	18.97%
None of these things affect mental health in my area	0.51%

Lack of transport is consistently highlighted as preventing access to mental health services and supports, and accommodation and housing options (for example, more affordable housing) are identified as being needed to improve mental health in regional areas. A lack of trauma informed services and the need to provide more contemporary, trauma-informed service options are also recurring concerns. In addition, environmental factors (such as weather variability and effect on farming communities and job security) are highlighted as being important for mental health in regional areas.

Feedback from Aboriginal people and the services that support them indicates that experiences of racism and discrimination continue to feature strongly in the experiences of Aboriginal people when trying to access both mental health and mainstream services.

Examples provided by Aboriginal families include less responsiveness in crisis situations to Aboriginal young people compared to their non-Aboriginal counterparts, resulted in lower service access and a lack of appropriate support in times of crisis, despite the higher risk of suicide. Other families have informed WAAMH about discriminatory action by police and justice agencies, contributing to the over-representation of Aboriginal people in prisons and across the justice system, and the resultant impact of incarceration, often away from Country, on Aboriginal people's connection to family, land and community all of which impacts negatively on mental health.

What people say:

"*Times are tough in the country. No disposable income, groceries are more expensive and poorer quality to the City. Lack of internet services. Education is not great."*

"A deficits, defects and weaknesses discourse that has served to perpetuate a paradigm of mainstream service delivery in which non – Aboriginal people deliver services to Aboriginal people."

In a group meeting in one regional centre, those present (including service providers and people with lived experience) made it very clear that socio-economic factors impacting on people's mental health should be the major issue requiring attention. These findings fit with research which shows that people in rural and remote areas are understood to be at increased risk of exposure to risk factors for mental health (Department of Health Australia (DoH), 2006), and that rural communities have more economic variability (GRF, 2015), higher unemployment rates, more domestic violence (DoH, 2006), and poorer physical health outcomes than urban areas (GRF, 2015). Increased exposure to environmental extremes (GRF, 2015), and lack of health services (AIHW, 2016) also impact on the mental health of people in rural and remote areas.

- **Recommendation 3:** Increase investment in prevention and community-based services and supports, as outlined in the Western Australian Mental Health Alcohol and Other Drugs Services Plan 2015 – 2025.

THEME 3: Staffing issues and investment in workforce

- *Relevant Terms of Reference: a, c, d, e*

Research has shown that people in rural areas are concerned about workforce shortages, staff retention and training in relation to mental health, and that resources for community mental health services are stretched (The Greens, 2014). Australian studies also indicate that people in regional Australia experience significant barriers to accessing services and effective treatment, in part due to the distribution of the health workforce across Australia (Jones, Kruger & Walsh, 2016).

These understandings are reflected in the findings from WAAMH consultations, with staffing issues being a key problem identified. Staffing issues in general were consistently in the top five themes identified as preventing access to mental health services, and are the biggest challenge identified by service providers for delivering mental health services in regional

areas. Staffing issues are also identified as the key area for improving access to mental health services in regional areas.

Under the umbrella of staffing issues in general, there are specific areas of concern. Insufficient staff skills, high staff turnover, and a lack of appropriately trained staff are key issues for accessing mental health services and supports, and for delivering services in regional areas. A perceived hostile care environment and lack of understanding from staff are also identified as other staffing issues that restrict access to mental health support. High workload and demand on staff are key issues for delivering services in regional areas.

In line with these concerns, increasing mental health staff and more training for staff are identified as the top priorities for improving access and supports in regional areas. Specifically, more psychiatrists and psychologists are repeatedly identified as being needed to improve service access.

The consultation demonstrates the urgent need to grow and develop the public and community mental health workforce in rural and remote areas.

What people say they need:

"More qualified workers. I find a lot of the employees for some agencies have only a Cert 4 in mental health and try to play the role of a psychologist which can be triggering for the patient and dangerous for the staff."

"More funding should be made accessible to local clinicians and medical services to employ relevant clinicians."

"Getting qualified staff in rural areas- need extra enticements."

"Lack of staff to provide counselling within community mental health."

"Retaining skilled staff."

"Availability of staff to provide these services."

"Continuity of staff within the Midwest Mental Health Service."

"More access to psychiatrists and psychologists with deep knowledge of chronic mental health illnesses."

The consultation findings are consistent with findings from other work WAAMH has completed. In 2017, WAAMH was commissioned by the WA Mental Health Commission to undertake a state-wide project to identify workforce development needs of the community mental health sector (and sectors beyond mental health that deliver mental health services) in the metropolitan and rural and remote areas. (Penter, McKinney & Jones 2017).

One hundred and thirty-three (133) representatives were consulted from 73 non-government organisations in Kalgoorlie/Goldfields/Esperance/the Lands, Albany, Bunbury, Busselton, Pilbara, Midwest and Perth metropolitan area. Three online surveys were completed, by 24 service users, 47 agency Chief Executive Officers (CEOs)/managers/co-ordinators and a third survey by 132 individual workers from all over the state. The project analysed 100 mental health job roles advertised in the NGO sector in Western Australia over an 8-week period.

Some major findings were:

- The community mental health sector is experiencing a period of significant uncertainty and change that is having a major impact on the workforce. National and state policy reforms emphasise an increasing role for the community mental health sector, however, this is occurring in a constricted fiscal environment, with additional funding uncertainty for many organisations with the roll out of the National Disability Insurance Scheme (NDIS). There is concern that the community health sector is vulnerable in its ability to develop and sustain a workforce sufficiently equipped to deliver services and support consistent with recovery, co-production, peer work and personalisation.

- The community mental health sector is experiencing rapid workforce growth and needs to increase in size and diversify in skills to meet service demand. Nationwide, demand for mental health services is expected to rise between 135% and 160% by 2027, which will require almost 9,000 extra mental health professionals. In addition, the WA 10-year Mental Health Plan envisages a 500% growth in the community mental health sector workforce. The full roll out of the NDIS will require an estimated 20,000 additional FTE workers in WA.

- The community mental health sector workforce is diverse, well qualified, highly skilled and experienced. The level of qualifications is high with most of the workforce holding a bachelor's degree or vocational qualification (primarily Certificate IV or III).

- There is a growing need to support and develop alternative employment models and other workforces, including the peer workforce (consumer and carer peer) and lived experience workforce, the generalist workforce, the rural and remote workforce and the Aboriginal workforce.

- Targeted strategies are needed to attract, recruit, retain and develop the workforce in rural and remote areas. Strategies include, improved remuneration; increased funding of training, development and supervision; provision of a wider array of employment incentives and conditions; development of alternative employment models; better quality and more attractive workplaces; measures to attract more younger workers and recruit staff with higher level clinical skills and experience; dissemination and sharing of good practice by employers.

- Many organisations are having trouble recruiting and retaining staff with the necessary qualifications, experience and skills. The most common contributing factor is low levels of funding, changing funding and uncertainty about funding which make it difficult to attract, recruit and retain staff. Action is needed by Governments and funders to ensure that:

    - Funding levels and contracts pay adequate salary levels and provide funding for training and workforce development activities.
    - Longer term funding is provided- 5-year contracts- to improve job security and continuity of employment.
    - Incentives are available to attract, recruit and retain staff in rural and remote areas.

- The community mental health sector workforce experiences work related pressures and stress not experienced by other sectors. Burnout and stress are common experiences due to client pressures, service pressures and an increasing administrative and bureaucratic compliance impost.

- Aboriginal workers are under-represented in the community mental health sector workforce in rural and remote areas. This is particularly important as mental health and social and emotional wellbeing issues have a disproportionate impact on Aboriginal people and Aboriginal communities in Western Australia.

- Rural and remote services face additional workforce challenges in terms of recruitment, retention, training, skills development and supervision of appropriately trained staff.

- The community mental health sector is responding to more people with co-morbidities and chronic conditions, particularly people with co-occurring drug and alcohol and mental health issues and intellectual disability and mental health issues. Responding to these challenges requires a highly skilled and competent workforce that can work collaboratively with the drug and alcohol sector and other sectors and agencies, such as disabilities, housing, health, education, child and family services and justice.

- Consumers indicated that workers in the non-government services they access provide information well, are good listeners, recognise social and cultural issues, recognise and support the roles of families and carers, routinely explain the rights and responsibilities of consumers, and are consultative. Consumers indicated that the two areas where there could be greatest improvement are increased access to peer support/peer workers and achieving the recovery goals of the individual consumer.

People with lived experience are a growing part of the workforce and work in a variety of roles. This is attributed to an increasing recognition of the value and benefit people with lived experience bring to services and the workforce and service delivery. The need for more peer workers and lived experience workers in rural and remote areas is seen as a high priority.

This issue was highlighted in a workforce development project undertaken in 2017 by WAAMH, which found that whilst the value and role of peer workers and the lived experience workforce is increasingly acknowledged by government and the sector, this has not been matched by the level of funding required to employ more peer workers and lived experience workforce and to train, support and supervise these workers, particularly in rural and remote areas

Increased funding is needed for the employment of peer workers and the lived experience workforce in rural and remote areas.

- **Recommendation 4:** Grow and develop the public and community mental health and peer and lived experience workforce in rural and remote areas.

THEME 4: Addressing the needs of population groups at heightened risk

- *Relevant Terms of Reference: a, b*

As previously described, a lack of appropriate and accessible mental health services in general was identified as a key issue in the WAAMH consultation. However, special mention should be made of the priority groups identified as being under-serviced in regional areas, as the lack of appropriate services for priority groups was a recurrent theme throughout the consultation.

4.1 Children and youth

- *Relevant Terms of Reference: a*

In particular, a lack of child and youth mental health services is repeatedly raised as an access problem and increasing access to child and adolescent youth services (including school-based services, community services and inpatient facilities) is in the top five areas identified for improving mental health service access in regional areas.

What people say:

"*As a parent it is disheartening to see when your child wants help and yet can't access it in our area."*

An anecdote was given of young people in small regional towns needing to be flown to larger centres for care in mental health crisis situations. For some this may be their first experience with mental health services, and patients have reportedly been transferred by plane under sedation and with a urinary catheter placed and may be sedated for a number of days waiting for a hospital bed. While these methods are used for the safety of the patient, this also can be a very traumatic experience for some people, and also takes them away from family and friends.

4.2 Alcohol and other drugs

- *Relevant Terms of Reference: a*

Lack of access to alcohol and other drug (AOD) services (including rehabilitation services), and services that cater for cooccurring mental health and AOD issues are a recurring theme in the consultation. This is particularly important, as AOD problems were identified as the top issue that affects mental health in regional areas, with 83% of respondents identifying this a problem in their area. Significantly, in a report release by the Royal Flying Doctors Service in 2017 the need to address alcohol and drug issues in regional communities was also identified in the top three priorities for improving health in regional areas in Australia, signifying the importance of this area (Bishop, Ransom & Laverty, 2017).

4.3 Cultural security for Aboriginal peoples

- *Relevant Terms of Reference: a, d, e*

Cultural security and appropriateness of services for Aboriginal and Torres Strait Islander people was identified as a barrier to service access and support access, as well as to delivering services.

Aboriginal and Torres Strait Islander people living in rural and remote areas are significantly impacted by the lack of mental health services. Despite areas such as the Kimberley having a very large population of Aboriginal peoples, there are few specific targeted approaches for people with mental ill-health.

"Pilbara Aboriginal people had avoidable death rates that were significantly higher (around 6 times) than non-Aboriginal people…. Suicide rates in the Kimberley and Goldfields are the highest in Australia" (Country WA Primary Health Network, 2016).

Aboriginal peoples have a broader understanding of mental health, incorporating concepts of well-being and connection to family, land and culture, that is only very rarely reflected in mainstream service delivery. There is a long-recognised and established need for culturally-based programs led by Aboriginal peoples and organisations, inclusive of the expertise of Elders, which WAAMH strongly endorses.

A lack of culturally safe services for Aboriginal and Torres Strait Islander people is identified as a barrier to seeking supports for mental health services in regional areas for Indigenous people. In addition, having access to culturally appropriate services for Aboriginal and Torres Strait Islander people, having more Aboriginal and Torres Strait Islander staff, having access to cultural training and translators, and access to multicultural services are also identified as being needed to improve access to mental health services in regional areas.

In its 2017 Workforce Development Report, WAAMH identified the need to grow the Aboriginal mental health workforce in rural and remote areas. This includes the workforce in agencies funded to provide services primarily to an Aboriginal population, including Aboriginal community-controlled health services.

WAAMH calls for much greater investment in Aboriginal community-controlled health services to enable them to provide more mental health and social and emotional wellbeing services and programs in rural and remote areas (Penter, McKinney & Jones 2017).

There is also a need to train, support and upskill staff in the community mental health sector to improve their cultural competence and capability to work with Aboriginal people.

What people say:

"Government needs to be investing in strong communities. And what is the number one asset or strength of Aboriginal people? CULTURE."

4.4 People at risk of suicide or non-suicidal injury

- *Relevant Terms of Reference: a, b*

Suicide is flagged by a significant number of respondents as an important issue in regional areas. Concern at a perceived failure to adequately address incidents of suicide in regional areas was expressed. Particularly, the need for more suicide-specific services for people at risk of suicide or self-harm was indicated, and the need for more appropriate inpatient and emergency services for people in this at-risk group was also flagged.

Concerns were also raised about the lack of longer term postvention services for rural and remote communities, particularly Aboriginal communities affected by suicide. Whilst critical response action immediately following an incident is generally adequate, long term postvention responses which assist individuals, families, friends and communities to deal with the aftermath twelve to twenty-four months after the incident are generally non-existent.

There are very high rates of suicide for Aboriginal young people in remote Western Australia. Professor Pat Dudgeon writes (in McKimmie, 2017), that although the causes of Aboriginal suicide are multiple and include discrimination and disadvantage, an important contributing factor to erosion of wellbeing is, “the dislocation, disruption and attempted destruction of connection to culture”.

The concerns raised in WAAMH’s consultation reflect findings identified in the 2016 WA inquiry into Aboriginal youth suicide in remote areas and the 2017 inquest into the suicides of 13 Aboriginal young people in the Kimberley (Western Australian Legislative Assembly, 2016). Amongst the significant and detailed findings of the 2016 inquiry were a lack of action on the recommendations of previous inquiries and a lack of government accountability for implementing the recommendations of Parliamentary inquiries, along with government reluctance to fund culturally based suicide prevention programs and the need to rectify this.

What people say:

“When [a] client is suicidal very limited options for crisis management, usually to present to hospital which has significant stigma and perceived lack of confidentiality.”

“KALACC believes that suicide is the act of a sick or distressed community.”

“The clear finding in the Message Stick Report is that nothing works better than culture.”

4.5 Farming Communities

- *Relevant Terms of Reference: a*

Participants expressed heighted concern about the extent of mental health issues among farming communities. Farming communities are hit hard by mental health issues and financial and family distress, as well as the social impact of the changing nature of farming. Recent events here in WA have demonstrated the severity of the crisis. Farming remains a physically and psychologically hazardous industry. Recent work by Kate Fennell shows that farmers are twice as likely to suffer a mental health disorder than other members of the rural population. Some 49% of farmers were likely to have mild or worse mental health disorders compared to 26% of the general rural population, and farmers have a high rate of suicide- about 1.6 times the general population (Fennell, 2017). Fennell (2018 notes that there is

something unique about farming that puts farmers more at risk of mental health conditions and requiring of specific help.

Participants spoke about the social impact of the changing nature of farming, the decline in family farms and trend towards bigger corporate run farms run with fewer people, which denudes many farming communities of population and leaves the remaining farmers and farming families more isolated and with reduced access to services and infrastructure. It also contributes to the decline of community groups which provide a sense of cohesion and community, such as sporting clubs, community groups and voluntary bodies.

What people say:

"Farming is very taxing business and somethings are so out of control, like the weather, grain prices, farm expenses, like fertilizer, chemicals etc. tis very stressful. I would like to write so much in this section, but it would take a long time. Sadly, we have had quite a few suicides in our area. As we know this is a very desperate measure to take but it is happening all too often. There has been much improvement in mental health but still a long way to go. Please come out and meet with our farming communities."

"Industry demands of agriculture. Long hours, financial stress, reliance on weather, business paperwork demands, stock mortality, employee retention and crop diseases/pests etc- volunteer fatigue burden. Community members run all emergency services, sporting clubs on a volunteer basis. As well as meeting demands of work, family etc, fire/ambulance calls can be particularly burdensome."

"All major farmers in our area are medicated for depression. It's an ongoing issue that is largely connected to the pressure of the farming industry and subsequent isolation."

4.6 Other priority groups

- *Relevant Terms of Reference: a*

While the WAAMH consultation identified the needs of a range of priority groups in regional areas, it should be noted that there are a number of other priority groups which require attention in regional areas, including LGBT+ youth and adults, older adults, culturally and linguistically diverse populations and people living with disabilities. It is understood that people identifying as being part of many of these priority groups may experience greater levels of social isolation in regional areas (Hazell, Dalton, Caton & Perkins, D, 2017), which can be a risk factor for poor mental health and suicide. The needs of these and other priority groups must also be prioritised in reforms to mental health services and access in regional areas.

- **Recommendation 5:** Actively address the mental health needs of priority groups in regional areas.

THEME 5: Emergency response and acute care services

- *Relevant Terms of Reference: a, b, d*

While respondents clearly identify the need for more community and preventative services in regional areas, a lack of emergency and acute services and the need for increased service provision in these areas is a recurring priority.

A shortage of emergency services is identified as the third most important barrier to seeking support for mental health services, with 66% of respondents to the WAAMH consultation survey identifying this as a problem in their area.

Emergency response services (such as emergency departments and crisis response teams), services and facilities that support people with chronic and acute needs and acute inpatient facilities are lacking in rural areas. Existing services are not always sufficient or well equipped to deal with mental health emergencies. Providing more acute services (including 24-hour services, emergency services and inpatient units or beds) was one of the top ten priorities identified in the WAAMH consultation as being needed to improve mental health care access in regional areas.

Participants stress the need for hospital emergency departments and first responders to have access to staff, facilities and knowledge to appropriately respond to patients with acute mental health conditions. Better training of emergency department staff in rural and remote hospitals so they can respond to people with mental health issues more appropriately, and provide recovery-oriented support and care is identified as an issue requiring attention:

What people say they need:

“An emergency response team would certainly help.”

‘’Acute psychiatric services are needed.”

“Money for beds and specialized staff.”

“Provision for staff at the local hospital who can deal with emergency mental health, especially if drugs are involved.”

“An inpatient unit or step up step down service in the Midwest”

‘An improved mental health care clinical and hospital facility in the region”

- **Recommendation 6:** Invest in strengthening the capacity and appropriateness of emergency and acute inpatient facilities for mental health in regional areas.

THEME 6: Technology is not a panacea

- *Relevant Term of Reference: f*

Technology offers considerable opportunities to improve access to services in rural and remote areas, through tele-health, online, e-services and apps, with the result that governments have begun to invest in technology based mental health services for people in rural and remote areas.

For example, in 2017, the Federal Government increased access to Medicare-rebated mental healthcare delivered by distance psychiatrists, psychologists and mental health clinicians through telehealth, online services and technology.

With regards to the use of technology to address mental health in regional areas, there are a mixed range of views identified in the WAAMH consultation. While some responses indicate a desire for more telehealth and online services, there are strong caveats to this position.

There is concern that there is an over-reliance on online services, at the expense of face-to-face services and quality mental health care service provision. Technology is often unreliable, compromising the utility and availability of online services like telehealth.

People who participated in the consultations recognise the potential of e- mental health, telehealth and other internet-based services, but point out that rural and remote areas lack stable, predictable and reliable infrastructure. Internet and mobile coverage are sporadic and intermittent, so services delivered through technology are not always reliable or available.

The cost of internet services is identified as a barrier to using online services. Similarly, there is concern around the presumption that people have access to online services. Consultation participants note that many people with mental health conditions do not have access to the internet and/or do not own a computer. This is particularly important, as disparate access to internet services (due to location, cost or functional capacity) can contribute to inequities in health care access, which already exist in regional areas.

Another concern raised is that services delivered through technology are individualistic and provide limited opportunities for people to build community connections and links.

People said technology can complement face- to- face services but it is not a replacement and services delivered through face-to-face interaction must remain the priority. Others said that policy makers must recognise that reliance on technology to deliver mental health services is not a panacea to the challenges of delivering face-to-face services across large rural and remote areas:

What people say:

"More one-on-one consults with patients- especially with mental health patients as over the phone or telehealth services do not work at all."

"Have a free service that you see quickly which is with the psychologist, but not over the phone."

Others are concerned that the reliance on technology is a cost saving initiative to reduce face- to- face service delivery, particularly for people with chronic and complex mental health issues:

What people say:

"Provide some mental health services to be accessed. Generally, just directed to online programs- but don't feel like there is any overall support and understanding."

"Retaining skilled staff, limit of clinical scope, service withdrawal and going online as a cheaper model of service delivery. This may work for prevention strategies but not for clinical needed supports. Programs being limited by funding windows i.e. 3 years then program disappears."

Respondents call for increased government investment in and commitment to online services to ensure that they work properly and provide a quality service to people in the regions. Similarly, the need for more affordable and reliable internet service in regional areas is expressed.

What people say:

"Quality service delivery is relational not technological. Too much faith placed in telehealth."

"Technology is not predictable and sometimes works well but also regularly fails."

"Faster internet with larger, cheaper data allowances would increase uptake of the vast range of online mental health services available. I would not do skype consults for fear of going over my data allowance that I need for my job."

"More one on one consults with patients - especially with mental health patients as over the phone or telehealth services do not work at all."

- **Recommendation 7:** Investment in infrastructure to ensure high quality internet access is needed for effective online services.

- **Recommendation 8:** Online services for mental health must not be used as a substitute for quality, face-to-face services in regional areas.

THEME 7: Funding

- *Relevant Terms of Reference: d*

A survey conducted by the Royal Flyer Doctors Service of Australia in 2017 (Bishop, Ransom & Laverty, 2017) found that people in country areas believed health expenditure should be prioritised towards expanding access to health services in country areas, with the top three priority areas being general health service access (32.2%), more expenditure on mental health (14.6%) and health prevention and promotion (8.6%) (p. 10).

In the same survey, mental health was identified as one of the five most important health related issues impacting remote and rural communities, and mental health was also identified as a key area where money should be spent to improve health outcomes, suggesting that more effort and resources are required to address mental health in these areas (Bishop, Ransom & Laverty, 2017).

The issue of insufficient funding of mental health is a concern across the board in the WAAMH consultation. Specifically, service providers identify funding as a key barrier to delivering mental health services in regional areas. Paucity of funding in general, partnered with the high cost of delivering services in regional areas, is felt to limit the capacity of mental health service providers in regional areas. Issues of inconsistent funding streams, and competitive tendering, in addition to a perceived lack of understanding from funders of the true cost of providing services in rural and remote areas is felt to contribute to the difficulty of delivering mental health services in the regions. The lack of funding and inadequate levels of existing funding and the need to increase funding for public mental health (adult, child and adolescent and youth mental health) and community mental health services across large regions with dispersed populations, is a major issue identified during consultations.

What people say they need:

“Supports for non-government agencies to offer services a bit further afield than the regional cities.”

“More funding should be made accessible to local clinicians and medical services to employ relevant clinicians, mental health support workers and to implement support therapy groups specific to the needs of the community.”

“Far more practitioners on the ground. Increase Medicare funding for longer term treatment, Greater access to free services as poverty a major issue in this area

“Increase resourcing of mental health services in the community.”

“Increased staff hours and therefore availability to individuals and other agencies who also support the clients.”

Public mental health services, community mental health services and hospital-based mental health services and facilities are the foundation of service responses in rural and remote areas, however inadequate levels of funding and staffing, funding and staffing reductions, uncertainty over the future of services and improvements to these services, and resultant service quality issues are identified as a major problem.

What people say they need:

“Increased allocation of resources towards rural and remote communities. At the very least an increase in CAMHS clinicians and Aboriginal mental health support workers.”

“Serious upgrade for Margaret River hospital to provide timely and efficient services to those that require mental health support.”

“Do not remove current mental health service (South West Mental Health). Reinstate SWMH ability to service more clients. Employ child and adolescent mental health practitioner in Margaret River or allow clinicians to travel to Margaret River to provide services when needed.”

Federal Government policy is increasingly looking to private clinicians- private psychiatrists, clinical psychologists and psychologists, social workers and allied mental health clinicians- to offer an alternative suite of services to people with mental health issues. However, the lack of private clinicians in rural and remote areas is a major issue. In most regional cities and towns there are not enough private clinicians with the skill and experience to work effectively with people with mental health issues and recruiting clinicians to work in rural centres and towns is difficult. The number of psychiatrists in regional areas is 1/3 (33%) of that found in major cities and the number of psychologists is over ½ (54%) of that found in major cities. (National Rural Health Alliance 2016).

In addition, private clinicians face significant challenges in rural and remote areas.

Example

A private clinician running a successful psychology practice in a medium sized town was unable to retain and recruit staff, resulting in the practice closing, because the costs and overheads of running the practice were too high to run as a single clinician practice. The failure to retain and recruit other clinicians, meant that income from a single clinician practice was inadequate to cover the cost of running the practice.

What people say they need:

“I would love to get another clinician up here, but FIFO costs are too expensive for a small business. Any help would be wonderful”

“More government funded programs for private practitioners that pay practitioners a decent amount of money for their service and for client base to receive free counselling.”

“Funding for access to clinical psychologists or private psychiatrists as CMHS WACHS is overworked”

Concern is also expressed about the way government funding, service delivery models and competitive commissioning and procurement approaches actively undermine the capacity of local communities and local agencies, as large state-wide and national providers with no local connections or linkages, little local presence or local knowledge and no local governance, win contracts to provide services in rural and remote areas and crowd out or take over smaller local providers, thereby undermining local governance, local community capacity and control over services delivered in the community.

- **Recommendation 9:** Prioritise funding for mental health services in regional areas that are localised and tailored to the needs of the community.

THEME 8: The NDIS in regional areas

- *Relevant Terms of Reference: a, g*

The National Disability Insurance Scheme is currently being rolled out in WA, and as such, some regional areas do not have access to NDIS services at this time. However, NDIS issues were raised during the WAAMH consultation, with regard to mental health service provision and psychosocial disability.

Of those people who had attempted to access disability services related to psychosocial disability through the NDIS, 76% reported experiencing challenges with this process. Being ineligible for disability services related to mental health needs under the new NDIS was the most common challenge (22.5%), followed closely by a lack of available services locally (20%). Lack of information about the NDIS, lack of assistance completing required NDIS documentation and lack of continuity of services were also problematic.

Concern about the inadequate knowledge and expertise of Local Area Co-ordinators (LACs) and planners in mental health and psychosocial disability is a significant issue in rural and remote areas. Most of the LACs and planners in rural and remote areas have worked with people with physical, intellectual, developmental and sensory disorders and have limited experience working with people with psychosocial disabilities and mental health issues.

- **Recommendation 10:** Monitor the National Disability Insurance Scheme closely as it is rolled out in regional areas, with particular attention to addressing the needs of consumers, carers and families affected by mental health issues and psychosocial disability.

THEME 9: Community Resource Centres

- *Relevant Term of Reference: g*

In light of recent cuts to funding for community resource centres (CRCs) in WA, their role in supporting mental health in regional areas is also worth addressing. This issue was raised in the WAAMH consultation process, with participants indicating the value of CRC's in their community and addressing concern at the impact of reduced funding on the functions of these centres.

CRCs are identified as places to provide community oriented, easily accessible mental health assistance, and free access to technology, and CRC's in some regional areas play a role in providing referrals to relevant government and non-government services for people with mental health challenges. However, funding cuts significantly decrease the capacity of CRCs to perform this function, and continued funding was highlighted by some participants as being required for regional areas.

What people say:

“Offer CRCs full funding and support to deliver confidential videoconferencing of specialists. Provide professional development for CRC staff to improve understanding and qualifications to address mental health issues”

“There is not enough assistance due to lack of funding. We are providing and referring what we can the community resource centre but us and other organisations cannot even afford printable brochures never mind face to face assistance.”

“A more casual, easy to access and maybe anonymous way of accessing help. Using places that aren't typically health services, such as Community Resource Centres, sporting clubs and pubs.”

“Full, continued funding for Community Resource Centres. Possibly training CRC staff in mental health fields.”

CONCLUSION

This submission draws heavily on the views of people living and working in rural and remote Western Australia, including people with lived experience of mental health issues, as well as carers, family members, service providers and community members. WAAMH was overwhelmed with the number of responses and the passion and frustration with which people contributed.

The findings presented in this submission are not new. They have been presented many times before to inquiries, consultations, reviews and research projects undertaken by Federal and State Parliamentary bodies, statutory authorities, government agencies, research bodies, consultancies and non-government organisations.

People in rural and remote areas told us that the issues are well known and have been documented and described many times. They are tired of inaction and talk. They want to see tangible action, not more reports, promises or broad directions.

As one participant told us:

“We’ve been promised so much but we haven’t actually seen any of it.”

We urge the Committee to take heed of this core message from people who live in rural and remote Western Australia. People want tangible action, not more talk.

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