The Senate

Community Affairs
References Committee

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

December 2018

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Suicide Call Back Service
1300 659 467
www.suicidecallbackservice.org.au

beyondblue
1300 224 636
www.beyondblue.org.au

headspace
1800 650 890
www.headspace.org.au

Open Arms
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1800 011 046
www.openarms.gov.au

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45th Parliament

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ABBREVIATIONS

Aboriginal Mental Health Framework	*National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023*
ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
AHMRC	Aboriginal Health and Medical Research Council of NSW
AIHW	Australian Institute of Health and Welfare
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ANU	Australian National University
AOD	alcohol and other drugs
APY	Anangu Pitjantjatjara Yankunytjatjara
ARHEN	Australian Rural Health Education Network
ARIA	Accessibility and Remoteness Index of Australia
Better Access initiative	Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS
CALD	culturally and linguistically diverse
CATSINaM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CEO	Chief Executive Officer
Chairs of the National Boards	Chairs of the Nursing and Midwifery Board of Australia, Medical Board of Australia, Aboriginal and Torres Strait Islander Health Practice Board of Australia and the Psychology Board of Australia
COAG	Council of Australian Governments
Committee	Senate Community Affairs References Committee
ConnectGroups	ConnectGroups Support Groups Association WA
DESDE-LTC	Description and Evaluation of Services and Directories in Europe for Long-Term Care

FIFO	fly-in, fly-out
Fifth National Plan	*Fifth National Mental Health and Suicide Prevention Plan*
GP	General Practitioner
GPMHSC	General Practice Mental Health Standards Collaboration
Healing Foundation	Aboriginal and Torres Strait Islander Healing Foundation
KALACC	Kimberley Aboriginal Law and Cultural Centre
KAMS	Kimberley Aboriginal Medical Services
LGA	local government area
LGBTI	lesbian, gay, bisexual, transgender and/or intersex
MBS	Medicare Benefits Schedule
MMM	Modified Monash Model
NACCHO	National Aboriginal Community Controlled Health Organisation
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NISPS	National Inuit Suicide Prevention Strategy
NSW	New South Wales
NT	Northern Territory
PBS	Pharmaceutical Benefits Scheme
PHaMs	Personal Helpers and Mentors
PHN	Primary Health Network
PHN Stepped Care Guidance	*PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care*
PIR	Partners in Recovery
Queensland Health	Queensland Department of Health
RFDS	Royal Flying Doctor Service
SA	South Australia

SEWB	social and emotional wellbeing
VACCA	Victorian Aboriginal Child Care Agency
WA	Western Australia

LIST OF RECOMMENDATIONS

Recommendation 1

6.9 The committee recommends the development of a national rural and remote mental health strategy which seeks to address the low rates of access to services, workforce shortage, the high rate of suicide, cultural realities, language barriers and the social determinants of mental health in rural and remote communities.

Recommendation 2

6.10 The committee recommends that the national rural and remote mental health strategy is subject to an implementation and monitoring framework which includes regular reporting to government and that these reports are tabled in Parliament.

Recommendation 3

6.17 The committee recommends an overarching approach is taken by all parties to guarantee that the design of mental health and wellbeing services starts with local community input to ensure that all rural and remote mental health services meet the measure of 'the right care in the right place at the right time'. This needs to be informed by best practice and international knowledge.

Recommendation 4

6.22 The committee recommends that the National Disability Insurance Agency ensure that the implementation of the psychosocial disability stream takes into account the issues facing rural and remote communities, including barriers to accessing mental health services and the lack of knowledge and experience in both psychosocial disability and the National Disability Insurance Scheme.

Recommendation 5

6.27 The committee recommends that Commonwealth, State and Territory Governments should develop longer minimum contract lengths for commissioned mental health services in regional, rural and remote locations.

Recommendation 6

6.29 The committee recommends that Commonwealth, State and Territory Governments should develop policies to allow mental health service contracts to be extended where a service provider can demonstrate the efficacy and suitability of the services provided, and a genuine connection to the local community.

Recommendation 7

6.34   The committee recommends that Commonwealth, State and Territory Governments consider the reestablishment of block funding for mental health services and service providers in regional, rural, and remote areas.

Recommendation 8

6.37   The committee recommends that the Commonwealth Government review the role of Primary Health Networks in commissioning mental health services under the stepped care model to ensure effective and appropriate service delivery in regional, rural and remote areas.

Recommendation 9

6.42   The committee recommends that the Commonwealth Government consider pathways for allied health professionals and nurses in rural and remote Australia to refer patients under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* (Better Access) initiative.

Recommendation 10

6.45   The committee recommends that the Commonwealth Government prioritise the development of implementation and evaluation plans for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023*.

Recommendation 11

6.51   The committee recommends the Commonwealth Government implement measures to ensure that services commissioned by Primary Health Networks embody the action plans of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* and are delivered by, or in genuine long-term partnerships with, Aboriginal Community Controlled Health Services and other Aboriginal and Torres Strait Islander community organisations.

Recommendation 12

6.52   The committee recommends that all Primary Health Networks have an Aboriginal and Torres Strait Islander member on their board.

Recommendation 13

6.57   The committee recommends the Commonwealth Minister for Health work with health professional colleges to develop strategies for the immediate improvement of professional supports and clinical supervision for registered health practitioners working in rural and remote locations.

Recommendation 14

6.63   The committee recommends that all mental health service providers, including government and community sector, ensure their workforces are culturally competent and that such training be endorsed by and delivered in partnership with the communities into which they are embedded.

Recommendation 15

6.66   The committee recommends that all providers of fly-in, fly-out mental health services ensure that mental health professionals are supported by long-term investment to enable them to provide reliable and regular support services to rural and remote communities, with consistency of personnel an essential requirement for any service provider.

Recommendation 16

6.69   The committee recommends that peer support workers be given appropriate training to enable them to continue their role in helping people experiencing mental health issues. The committee further considers that peer support workers should be recognised as a valuable support service by being paid to perform this role in rural and remote communities.

Recommendation 17

6.77   The committee recommends that Commonwealth, State and Territory Governments, as well as mental health service providers and local communities, continue to educate rural and remote communities about mental health and advertise local and digitally-available support services, with a view to reducing the associated stigma.

Recommendation 18

6.78   The committee recommends that Commonwealth, State and Territory Governments work with mental health service providers and local communities to co-design appropriate educational materials to reduce the stigma surrounding mental health in rural and remote communities.

Chapter 1
Introduction

1.1   One in five Australians will experience mental illness in any given year, no matter where in Australia they live.[1] Over a lifetime, almost half of all Australians will experience a mental illness.[2]

1.2   However, Australians living in rural and remote communities are less likely to seek mental health treatment than their city dwelling counterparts.

1.3   In 2016–17, people living in remote areas accessed Medicare-subsidised mental health services at a rate of three times less than people living in major cities. In very remote areas the rate of access decreased even further, with people accessing services at a rate of six times less than in major cities.[3]

1.4   The reduced access to mental health services is reflected in the high rate of suicide in rural and remote communities. In 2016, 47 per cent of all suicides occurred outside capital cities, even though these areas account for only 32 per cent of Australia's total population.[4]

1.5   The Royal Flying Doctor Service (RFDS) released a major report in March 2017 which sparked a national conversation about the state of mental health in remote and rural communities.[5]

1.6   *Mental Health in Remote and Rural Communities*[6] described how even though Australians living in rural and remote areas are impacted by mental disorders at the same rate as people living in major cities, they experience unique barriers to receiving care.[7] The report outlined data about the mental health services provided by the RFDS, including mental health and social and emotional wellbeing programs and

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1   Department of Health, *Submission 30*, p. 9, citing Australian Bureau of Statistics (ABS), *National Survey of Mental Health and Wellbeing: Summary of Results*, 23 October 2008, pp. 7 and 27, http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/ 4326.02007?OpenDocument (accessed 11 November 2018).

2   Department of Health, *Submission 30*, p. 9, citing ABS, *National Survey of Mental Health and Wellbeing: Summary of Results*, 23 October 2008, p. 1.

3   Department of Health, *Submission 30*, p. 12.

4   Department of Health, *Submission 30*, p. 21.

5   See, for example: Norman Hermant, 'Flying Doctors fight barriers to treat mental illness in rural Australia', *ABC News*, 3 June 2017, https://www.abc.net.au/news/2017-06-03/isolation-remains-huge-barrier-to-treating-mental-illness/8579560 (accessed 20 November 2018).

6   Royal Flying Doctor Service (RFDS), Mental Health in Remote and Rural Communities, March 2017. Received by the committee as: RFDS, *Submission 22*, Attachment 1.

7   RFDS, *Submission 22*, Attachment 1, p. 9.

aeromedical retrievals, in order to describe the impact of mental disorders on rural and remote Australians receiving those services.[8]

1.7   In January 2018, the Chief Executive Officers of the RFDS, Dr Martin Laverty, and of Mental Health Australia, Mr Frank Quinlan, expressed the view that a lack of coordination and funding in the sector had led to rural and remote patients missing out on services. Dr Laverty described the low rate of people accessing mental health services in rural and remote areas as a crisis.[9] In response to this, the Minister for Health, the Hon. Greg Hunt MP, stated that he believed there to be a 'very significant challenge' for mental health services in regional areas.[10]

1.8   In March 2018, the Senate referred an inquiry into the accessibility and quality of mental health services in rural and remote Australia to the Senate Community Affairs References Committee (committee).[11] The terms of reference for the committee's inquiry are outlined below:

(a)   the nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate;

(b)   the higher rate of suicide in rural and remote Australia;

(c)   the nature of the mental health workforce;

(d)   the challenges of delivering mental health services in the regions;

(e)   attitudes towards mental health services;

(f)   opportunities that technology presents for improved service delivery; and

(g)   any other related matters.[12]

Defining rural and remote

1.9   There are a number of classifications used by government health programs which seek to measure the remoteness of a particular community, such as the Australian Bureau of Statistics (ABS) Remoteness Areas, the Modified Monash Model (MMM) and the Accessibility and Remoteness Index of Australia (ARIA). A 'remoteness classification' refers to a set of geographic boundaries that define the areas contained within them and assigns them to a specific remoteness category.

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8   RFDS, *Submission* 22, Attachment 1, pp. 14–15.

9   Lucy Barbour, 'Royal Flying Doctors warn rural mental services in "crisis" due to funding shortage', *AM, ABC Radio News and Current Affairs*, 22 January 2018, https://www.abc.net.au/radio/programs/am/rfds-warns-rural-mental-services-in-crisis/9347960 (accessed 20 November 2018).

10   Sabra Lane, 'Mental health a "universal challenge" for Australia: Greg Hunt', *AM, ABC Radio News and Current Affairs*, 22 January 2018, https://www.abc.net.au/radio/programs/am/mental-health-universal-challenge-for-australia-greg-hunt/9348308 (accessed 20 November 2018).

11   *Journals of the Senate*, No. 88, 19 March 2018, p. 2787.

12   *Journals of the Senate*, No. 88, 19 March 2018, p. 2787.

1.10 Each of these remoteness classifications rely on data from the ABS and information collected during the five-yearly Census of Population and Housing. Effectively, each classification uses the distance from an urban centre as an indicator of whether an individual may or may not have access to particular services.

1.11 For example, the ABS Remoteness Areas classifies each area in Australia as:

- Major City;

- Inner Regional;

- Outer Regional;

- Remote; or

- Very Remote.[13]

Figure 1.1—Map of the 2016 ABS Remoteness Areas
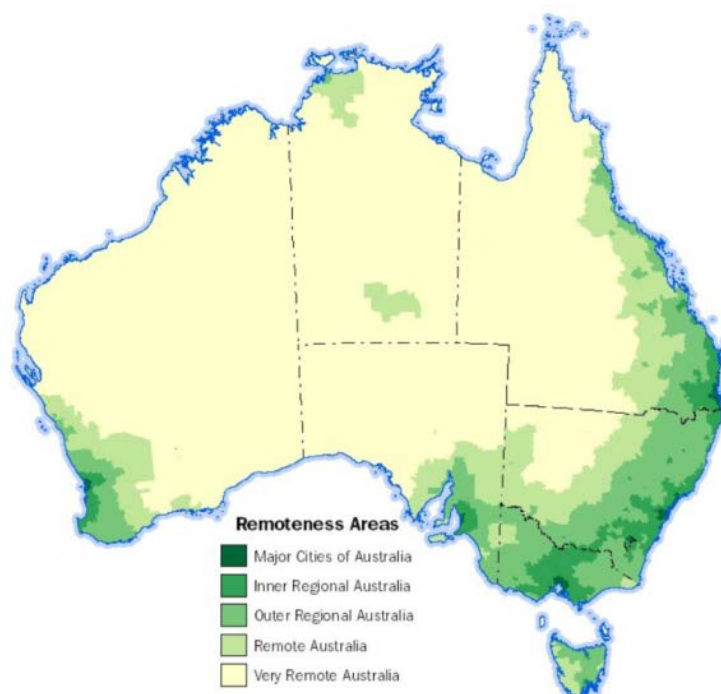
Source: ABS.[14]

1.12 Remoteness classifications are used in a wide variety of settings, such as to determine a person's eligibility for telehealth, identify areas with a workforce shortage or to analyse statistical data.

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13   ABS, *Defining Remoteness Areas*, 16 March 2018, http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/1270.0.55.005Main%20Features15July%202016?opendocument&tabname=Summary&prodno=1270.0.55.005&issue=July%202016&num=&view= (accessed 11 November 2018).

14   ABS, *Map of 2016 Remoteness Areas*, 16 March 2018, http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/1270.0.55.005Main%20Features5July%202016?opendocument&tabname=Summary&prodno=1270.0.55.005&issue=July%202016&num=&view= (accessed 11 November 2018).

1.13   The committee has not chosen to limit itself to one particular remoteness classification or to strictly enforce these definitions in the course of its inquiry. This report refers to particular remoteness classifications where relevant, and uses the term 'rural and remote' to refer generally to regional and remote communities.

1.14   The committee held public hearings in a number of locations which may be considered a regional town. This was in recognition of the fact that often mental health services for residents of rural and remote areas are located in regional hubs which have the population to sustain the services. These regional hubs can also act as a base for outreach services to smaller rural and remote communities.

Prevalence of mental illness and suicide in rural and remote Australia

1.15   Mental health is defined as 'a state of emotional and social wellbeing where the individual can cope with the normal stresses of life and achieve their life potential. It includes being able to work productively and contribute to community life'.[15]

1.16   Mental illness refers to a clinically diagnosable disorder which affects a person's cognitive, emotional and social abilities, and interferes with the lives and productivity of people.[16] Mental illness covers a spectrum of disorders that vary in severity and duration and include disorders such as anxiety, depression and addiction.[17]

1.17   The most recent National Survey of Mental Health and Wellbeing was conducted in 2007. The survey found that approximately 45 percent of Australians aged 16–85 years will experience a diagnosable mental illness in their lifetime.[18] The survey also found that the prevalence of mental illness outside capital cities and major urban areas was marginally lower than in capital cities.[19]

1.18   However, the same cannot be said for the prevalence of suicide in Australia's rural and remote communities. As remoteness increases, so too does the rate of suicide.

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15   Department of Health, *Submission 30*, p. 9.

16   ABS, *National Survey of Mental Health and Wellbeing: Summary of Results*, 23 October 2008, p. 4; Department of Health, *Submission 30*, p. 9.

17   ABS, *National Survey of Mental Health and Wellbeing: Summary of Results*, 23 October 2008, p. 4; Australian Institute of Health and Welfare (AIHW), *Mental health services in Australia: in brief 2018*, 11 October 2018, p. 1, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia-in-brief-2018/contents/table-of-contents (accessed 12 November 2018).

18   ABS, *National Survey of Mental Health and Wellbeing: Summary of Results*, 23 October 2008, p. 7. See also: National Rural Health Alliance, *Submission 37*, p. 7.

19   ABS, *National Survey of Mental Health and Wellbeing: Summary of Results*, 23 October 2008, p. 30. See also: RFDS, *Submission* 22, Attachment 1, p. 9; National Rural Health Alliance, *Submission 37*, p. 7.

Figure 1.2—Percentage of avoidable deaths from suicide and self-inflicted injuries (persons aged 0–74 years), 2010–2014
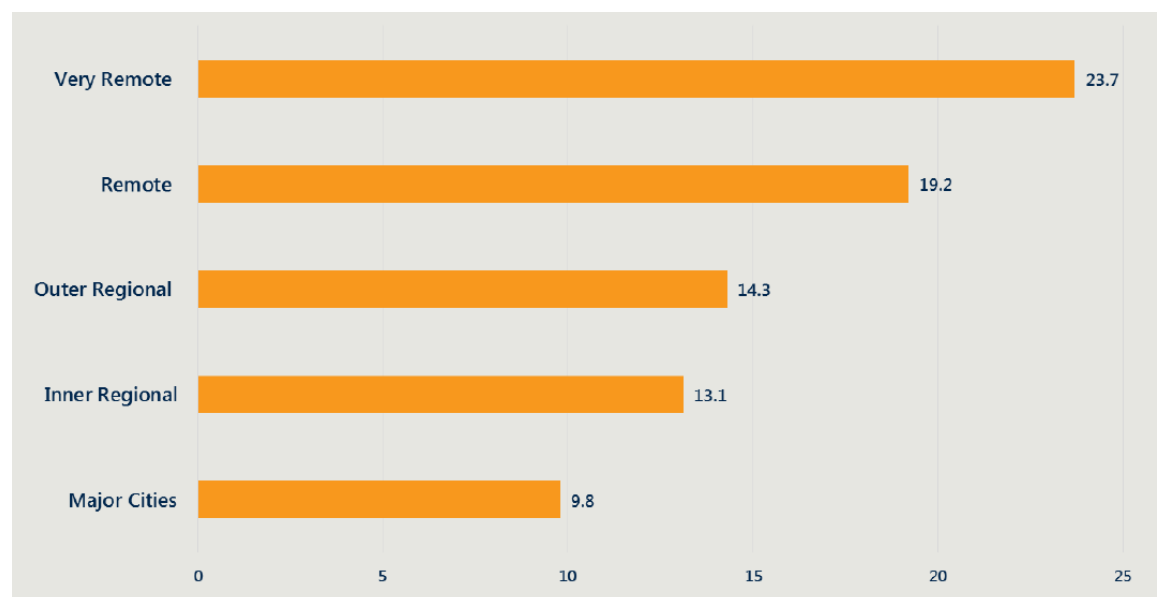
Source: Department of Health.[20]

1.19   As shown above, between 2010 and 2017, the rate of suicide in remote areas was almost double that of major cities, while the rate in very remote regions was almost 2.5 times that of major cities.

1.20   The high rate of suicide in rural and remote communities is in part driven by the increased rate of suicide amongst Aboriginal and Torres Strait Islander peoples.[21]

1.21   Statistics show that Aboriginal and Torres Strait Islander peoples are 1.2 times as likely to die from mental illness as non-Indigenous Australians and 1.7 times as likely to be hospitalised for mental illness. Furthermore, Aboriginal and Torres Strait Islander peoples aged 12–24 years are three times as likely to be hospitalised with a mental illness as non-Indigenous young persons of the same age.[22]

1.22   While the prevalence of mental illness does not differ across Australia, the impact of mental illness is far greater in rural and remote communities.

Living in rural and remote communities

1.23   Approximately 10 per cent of Australia's population, or 2.6 million people, live in outer regional, remote and very remote areas.[23]

1.24   While people living in rural areas report high levels of civic participation, social cohesion, social capital, volunteering and informal support from friends,

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20   Department of Health, *Submission 30*, p. 22.

21   Department of Health, *Submission 30*, pp. 22–23.

22   RFDS, *Submission 22*, p. 2.

23   AIHW, *Australia's Health 2018*, p. 8, https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents (accessed 12 November 2018).

neighbours and the community, they experience unique circumstances such as flood, fire, drought, as well as economic variability and population downturn, which can impact on their health and wellbeing.[24]

1.25   Residents of rural and remote communities face a unique combination of factors which are believed to contribute to low rates of access to mental health services and the high rate of suicide. These include poor access to primary and acute health care, social and geographical isolation, limited mental health services, funding restrictions, ongoing stigma surrounding mental illness and the cost of travelling to and accessing mental health services.[25] In addition, Aboriginal and Torres Strait Islander peoples face cultural barriers and a lack of mental health services which are culturally appropriate.[26]

1.26   The barriers which impact upon the availability and accessibility of mental health services in rural and remote communities will be explored further throughout this report.

Aboriginal and Torres Strait Islander communities

1.27   Aboriginal and Torres Strait Islander peoples are more likely to live in rural and remote communities with approximately 20 per cent of all Aboriginal and Torres Strait Islander peoples living in remote or very remote areas, compared to only 1.7 percent of non-Indigenous Australians.[27]

1.28   Aboriginal and Torres Strait Islander peoples make up approximately three per cent of Australia's population but continue to be disproportionately represented on almost every indicator of social, health and wellbeing outcomes.[28]

1.29   Social determinants of health and historical factors such as intergenerational trauma, racism, social exclusion, and loss of land and culture are commonly recognised as factors which contribute to these ongoing disparities in health care.[29]

1.30   The level of psychological distress for Aboriginal and Torres Strait Islander peoples over 18 years old is nearly three times the rate of non-Indigenous people across Australia.[30]

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24   RFDS, *Submission 22*, Attachment 1, p. 15; One Door Mental Health, *Submission 122*, [pp. 2 and 5].

25   RFDS, *Submission 22*, p. 2; Department of Health, *Submission 30*, p. 23; Australian Mental Health Commissions, *Submission 52*, p. 6.

26   RFDS, *Submission 22*, p. 2; Australian Mental Health Commissions, *Submission 52*, p. 16; National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 128*, pp. 2–3.

27   NACCHO, *Submission 128*, p. 2.

28   NACCHO, *Submission 128*, p. 2.

29   Aboriginal and Torres Strait Islander Healing Foundation (Healing Foundation), *Submission 39*, p. 3; NACCHO, *Submission 128*, p. 2.

30   National Rural Health Alliance, *Submission 37*, p. 8.

1.31   The alarmingly high rate of suicide amongst Aboriginal and Torres Strait Islander peoples has led to the development of a number of state and national strategies which seek to address the over representation of Indigenous Australians in the mental health system as a priority.[31]

National framework for mental health

1.32   Mental health services, like most other health services in Australia, are funded through a combination of federal, state and territory, and private health insurance spending and delivered by a combination of public, private and non-government sector providers.

1.33   Public mental health services include psychiatric hospitals, psychiatric units in general hospitals, community residential units and community mental health services, which are funded by both the Commonwealth and state and territory governments.[32]

1.34   At a federal level, the Commonwealth Government has established 31 Primary Health Networks (PHNs) which are responsible for the coordination and commissioning of health care, including mental health services, in their local areas.[33] PHNs are expected to work with state and territory Local Hospital Networks to ensure that the national approach to mental health service delivery is effective at the local level.[34]

1.35   Mental health services are provided in the private sector by private psychiatrists, general practitioners, private psychiatric hospitals and private allied health professionals. However, the Commonwealth Government also contributes to these services through Medicare Benefits Schedule rebates and private health insurance rebates.[35]

1.36   Non-government organisations include not-for-profit and community managed organisations, which promote independence and mental wellbeing, provide support and advocacy, or provide specialised information, accommodation and rehabilitation services.[36]

Fifth National Mental Health and Suicide Prevention Plan

1.37   In 2014, the National Mental Health Commission conducted a review into mental health services and programs across Australia. The review found that

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31   NACCHO, *Submission 128*, p. 2.

32   Department of Health, *Submission 30*, pp. 3–4.

33   Department of Health, *Submission 30*, p. 4.

34   Department of Health, *Submission 30*, p. 16.

35   Department of Health, *Submission 30*, p. 4.

36   Department of Health, *Submission 30*, p. 4.

Australia's mental health system was poorly planned, fragmented, badly integrated and lacked accountability.[37]

1.38   In response, the Council of Australian Governments (COAG) released the *Fifth National Mental Health and Suicide Prevention Plan* (Fifth National Plan) in August 2017. The Fifth National Plan aims to achieve reform and improved outcomes in eight identified priority areas:

- Priority Area 1: Achieving integrated regional planning and service delivery;

- Priority Area 2: Suicide prevention;

- Priority Area 3: Coordinating treatment and supports for people with severe and complex mental illness;

- Priority Area 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention;

- Priority Area 5: Improving the physical health of people living with mental illness and reducing early mortality;

- Priority Area 6: Reducing stigma and discrimination;

- Priority Area 7: Making safety and quality central to mental health service delivery; and

- Priority Area 8: Ensuring that the enablers of effective system performance and system improvement are in place.[38]

1.39   Notably the Fifth National Plan is the first national mental health strategy to include a national suicide prevention plan.[39] Under the suicide prevention priority area, governments will establish a new Suicide Prevention Subcommittee which will develop a National Suicide Prevention Implementation Strategy.[40]

1.40   The National Suicide Prevention Implementation Strategy will include a focus on Aboriginal and Torres Strait Islander suicide prevention and a draft version of the

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37   Department of Health, *Submission 30*, p. 4; National Mental Health Commission, *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services–Summary*, 30 November 2014, p. 8, http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributing-lives-review.aspx (accessed 12 November 2018).

38   Council of Australian Governments (COAG), *Fifth National Mental Health and Suicide Prevention Plan* (Fifth National Plan), p. 4, https://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf (accessed 12 November 2018).

39   COAG, Fifth National Plan, p. 2.

40   COAG, Fifth National Plan, pp. 24–25.

strategy is expected to be released in mid-2019 for public consultation, prior to release of the final strategy by 2020.[41]

1.41   The Fifth National Plan committed all governments to work together to achieve integration in the planning and delivery of mental health services and placed consumers and carers at the centre of how services are planned, delivered and evaluated.[42]

Overview of state government services and strategies

1.42   State and territory governments provide funding for public sector and community services and set legislative, regulatory and policy frameworks for mental health service delivery within their jurisdiction.[43]

1.43   The main government bodies delivering mental health services to rural and remote areas in each state and territory and the key strategies for mental health in these areas are outlined below.

Western Australia

1.44   Public mental health services in rural and remote Western Australia (WA) are delivered by the WA Country Health Service, part of the WA Department of Health. Health services are organised by a hub and spoke model, with services based in larger regional and metropolitan centres, and specific rural services funded to address locational disadvantage.[44]

1.45   The WA Mental Health Commission is responsible for commissioning of state-government funded mental health services from government and non-government providers, and also provides and has responsibility for commissioning mental health, alcohol and other drug prevention and health promotion programs. Investment has been directed to the implementation of a comprehensive suicide prevention program (*Suicide Prevention 2020*), public education campaign initiatives, and the expansion of community-based bed and treatment services.

1.46   Mental health services in WA are guided by the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025*.[45]

1.47   The committee held five public hearings in WA, in recognition of the vast rurality of the state and high number of remote communities. WA encompasses 32 per cent of Australia's remote communities and 31 per cent of very remote communities.[46]

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41   COAG, *Fifth National Mental Health and Suicide Prevention Plan*: *Implementation Plan*, pp. 10–11, https://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan_Implementation%20Plan.pdf (accessed 20 November 2018).

42   COAG, Fifth National Plan, p. v.

43   COAG, Fifth National Plan, p. 9.

44   Government of Western Australia, *Submission 35*, p. 4.

45   Government of Western Australia, *Submission 35*, p. 2.

46   Consumers of Mental Health WA, *Submission 31*, p. 3.

1.48   The committee held its first public hearing in the south-west regional town of Albany on 5 June 2018. The committee held its next four public hearings across the remote Kimberley region in northern WA, visiting Kununurra and Halls Creek on 5 July 2018 and Derby and Broome on 6 July 2018.

Northern Territory

1.49   The Northern Territory (NT) makes up approximately 18 per cent of Australia's land mass, but only one per cent of the total national population. Approximately 33 per cent of the NT population live in areas considered remote or very remote.[47]

1.50   Public health services in the NT, including mental health services, are delivered by the Top End Health Service (Darwin metropolitan and the northern part of the territory) and the Central Australia Health Service (Alice Springs and the southern part of the territory).[48]

1.51   Key strategies relating to mental health services and suicide prevention in the NT include the *Northern Territory Suicide Prevention Strategic Framework 2018–2023,* which was recently launched in September 2018, the *Northern Territory Mental Health Strategic Plan 2015–2021* and the *Northern Territory Health Aboriginal Cultural Security Framework 2016–2026.*

1.52   Provision of funding to non-government organisations is managed by the Mental Health Alcohol and Other Drugs Branch of the NT Department of Health.[49] This funding supports services such as subacute care, mental health promotion, support and advocacy, primarily in Darwin and Alice Springs, with a small number of providers in Katherine and Tennant Creek.[50]

1.53   The committee held three public hearings in the NT: two on 9 July 2018 in Darwin and Katherine and a further hearing in Alice Springs on 10 July 2018.

South Australia

1.54   SA Health provides mental health services for South Australians through community health centres, public hospitals and in-home care.[51] SA Health is also

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47   Northern Territory Government, *Northern Territory Mental Health Strategic Plan 2015–2021*, 2015, p. 8, http://hdl.handle.net/10137/988 (accessed 5 November 2018).

48   NT Department of Health, *About NT Health*, https://health.nt.gov.au/health-governance/about-nt-health (accessed 12 November 2018).

49   NT Department of Health, *Mental health information for health professionals*, https://health.nt.gov.au/professionals/mental-health-information-for-health-professional (accessed 12 November 2018).

50   Northern Territory Government, *NT Mental Health Strategic Plan 2015–2021*, 2015, p. 13.

51   SA Health, *Mental health services*, https://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+services/Mental+health+services/ (accessed 6 November 2018).

responsible for implementation of the *South Australian Suicide Prevention Plan 2017–2021*.[52]

1.55   The South Australian Mental Health Commission was established in 2015 to strengthen mental health and wellbeing in the state.[53] Subsequently, the commission released the *SA Mental Health Strategic Plan 2017–2022* which recognised the need to target support for rural and remote communities.[54]

1.56   The committee held one public hearing in South Australia in Whyalla on 20 July 2018.

Queensland

1.57   Approximately 33 per cent of Queensland's 5 million residents live in rural and remote areas, with 95 per cent of Queensland's land mass classified as rural or remote.[55]

1.58   The committee held two public hearings in Queensland: Mount Isa on 29 August 2018 and Townsville on 30 August 2018.

1.59   The Queensland Department of Health (Queensland Health) is responsible for the overall management of public health in the state. Public health services, including mental health services, are provided through service agreements with 16 independent Hospital and Health Services, each governed by its own board and chief executive.[56] Queensland Health also commissions non-government organisations to provide mental health services.

1.60   The Queensland Mental Health Commission was established in 2013 to provide ongoing reform towards an integrated, evidence-based, recovery-oriented mental health and substance misuse system.[57] The commission is responsible for preparing, monitoring, reporting and reviewing the *Queensland Mental Health, Drug*

52   SA Health, *South Australian Suicide Prevention Plan 2017-2021*, 2017, https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+services/mental+health+services/suicide+prevention+plan+feedback (accessed 12 November 2018).

53   Australian Mental Health Commissions, *Submission 52*, p. 5.

54   South Australian Mental Health Commission, S*A Mental Health Strategic Plan 2017–2022*, 14 December 2017, p. 36, http://samentalhealthcommission.com.au/the-plan/downloads/ (accessed 12 November 2018).

55   Queensland Mental Health Commission, *Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016–18*, p. 3, https://www.qmhc.qld.gov.au/about/publications/browse/strategy-and-action-plans/queensland-rural-and-remote-mental-health-and-wellbeing-action-plan-2016-18 (accessed 5 November 2018).

56   Queensland Health, *Queensland Health organisational structure*, https://www.health.qld.gov.au/system-governance/health-system/managing/org-structure (accessed 12 November 2018).

57   Australian Mental Health Commissions, *Submission 52*, p. 5.

and Alcohol Strategic Plan 2014–2019.[58] In 2016, the Queensland Government and the Queensland Mental Health Commission released the *Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016–18*.

New South Wales

1.61   New South Wales (NSW) Health is the provider of public hospital and health services in NSW, including specialist mental health services. NSW Health operates seven rural and regional local health districts, each of which has 'the flexibility to tailor services where most needed and using methods most appropriate to their communities'.[59] Two specialty networks, Justice Health and Forensic Mental Health Network and Sydney Children's Hospitals Network, also provide specialist mental health services to rural and remote areas.[60]

1.62   The NSW Ministry of Health Mental Health Branch funds non-government organisations to deliver treatment, psychosocial rehabilitation and recovery/disability support programs. It also invests in the Centre for Rural and Remote Mental Health to support the mental health of rural and regional residents through research and evidence-based service design, delivery and education.[61]

1.63   The Mental Health Commission of NSW is an independent statutory agency responsible for monitoring, reviewing and improving mental health and wellbeing for people in NSW.[62] The Mental Health Commission developed *Living Well: A Strategic Plan for Mental Health in NSW 2014–2024*, which was adopted by the NSW Government and informed the development of a new strategic framework for mental health in the state.[63]

1.64   The *NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022* was released in September 2018.[64] Other relevant key plans and strategies for mental health and rural health more broadly include the *NSW Rural Health Plan Towards 2021* and the *NSW Aboriginal Health Plan 2013–2023*.[65]

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58   Mr Ivan Frkovic, Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Mount Isa, 29 August 2018, p. 49.

59   NSW Government, *Submission 106*, p. 5.

60   NSW Government, *Submission 106*, p. 7, 13–15.

61   NSW Government, *Submission 106*, p. 6–7.

62   Australian Mental Health Commissions, *Submission 52*, p. 5.

63   NSW Government, *Submission 106*, p. 9. See also: Mental Health Commission of New South Wales, *Living Well reforms*, https://nswmentalhealthcommission.com.au/living-well-agenda/living-well-reforms (accessed 12 November 2018).

64   NSW Health, *NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022*, 27 September 2018, https://www.health.nsw.gov.au/mentalhealth/publications/Publications/mh-strategic-framework.pdf (accessed 12 November 2018).

65   NSW Government, *Submission 106*, pp. 6 and 10.

Victoria

1.65   The Victorian Government Department of Health and Human services is responsible for mental health care in the state of Victoria. The Victorian Government funds a range of primary, community-based and hospital mental health services.[66]

1.66   The Mental Health Complaints Commission is an independent, specialist body established to resolve complaints about Victorian public mental health services, safeguard patient's rights and recommend improvements to services.[67]

1.67   In November 2015, the Victorian Government launched *Victoria's 10-year mental health plan*, outlining the government's long term strategy to improve mental health outcomes for Victorians with a mental illness, their families and carers.[68]

1.68   Major strategies developed under the plan include the *Victorian suicide prevention framework 2016–25*, the *Mental Health Workforce Strategy*, and the *Aboriginal Social and Emotional Wellbeing Framework*.

Tasmania

1.69   The Mental Health, Alcohol and Drug Directorate, within the Tasmanian Department of Health and Human Services, is responsible for the provision of mental health services throughout the state.[69]

1.70   Statewide Mental Health Services is the provider of care for people with a severe mental illness in inpatient facilities and in the community. In addition, Mental Health Services works with the community sector to provide support to people with a moderate to severe mental illness.[70]

1.71   In October 2015, the then Minister for Health launched the *Rethink Mental Health Better Mental Health and Wellbeing – A Long-Term Plan for Mental Health in Tasmania 2015–25* which identified a reform agenda to improve the mental health of Tasmanians and priority action areas.[71]

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66   Victorian Government, *Submission 100*, p. 1.

67   Mental Health Complaints Commissioner, *Our Role*, https://www.mhcc.vic.gov.au/about-the-mhcc/our-role (accessed 6 November 2018).

68   Victorian Government, *Submission 100*, p. 1.

69   Department of Health and Human Services, *Statewide Mental Health Services*, https://www.dhhs.tas.gov.au/mentalhealth (accessed 12 November 2018).

70   Department of Health and Human Services, *Mental Health Services in Tasmania*, https://www.dhhs.tas.gov.au/mentalhealth/mhs_tas (accessed 12 November 2018).

71   Department of Health and Human Services, *A Long-Term Plan for Mental Health in Tasmania 2015–25*, October 2015, p. 11 https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/202496/DHHS_Rethink_Mental_Health_WEB.pdf (accessed 12 November 2018).

1.72   Approximately 40 per cent of Tasmanian's live outside of Hobart and Launceston in areas classified as outer regional, remote and very remote.[72]

1.73   The committee held two public hearings in Tasmania: one in the north-west town of Devonport on 5 September 2018 and one on the east coast in St Helens on 6 September 2018.

Australian Capital Territory

1.74   ACT Health provides mental health services in hospital and community settings for residents of the Canberra region.[73] However, the committee did not receive any evidence relating to the accessibility of mental health services in the Canberra region.

1.75   The committee held three public hearings in Canberra on 19 July 2018, 18 September 2018 and 16 October 2018 to hear from peak representative bodies of the mental health sector, non-government organisations, academics, and relevant Commonwealth government departments.

Structure of the report

1.76   This report is presented in six chapters:

- This first chapter provides background and context to the committee's inquiry.

- Chapter 2 outlines mental health services funding and provision in Australia, the model of practice on which these services are based and commissioned, and examines opportunities to utilise technology in the provision of mental health services.

- Chapter 3 explains the numerous barriers people in rural and remote areas face when accessing mental health services, including attitudes towards mental health.

- Chapter 4 considers the role and impact of culturally appropriate services on Aboriginal and Torres Strait Islander peoples.

- Chapter 5 outlines the issues facing the mental health workforce and how these issues are intensified in rural and remote communities.

- Chapter 6 provides the committee's conclusions and recommendations.

Conduct of the inquiry

1.77   On 19 March 2018, the Senate referred the inquiry into the accessibility and quality of mental health services in rural and remote Australia to the committee for

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72   Department of Health, *Tasmania PHN Profile*, Tasmania PHN Factsheet, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Tasmania (accessed 12 November 2018).

73   ACT Health, *Mental Health Services*, https://health.act.gov.au/services-and-programs/mental-health/mental-health-services (accessed 12 November 2018).

inquiry and report by 17 October 2018.[74] The Senate subsequently granted the committee extensions of time to report until 4 December 2018.[75]

1.78   The committee advertised the inquiry on its website and wrote to relevant individuals and organisations inviting submissions by 11 May 2018. The committee continued to accept submissions after that date.

1.79   The committee received 138 submissions. A list of submissions received by the committee is available at Appendix 1 and copies of public submissions can be accessed via the committee's website.

1.80   During the inquiry, the committee travelled across Australia to hear from state government bodies, mental health service providers, academics, peak representative organisations, local PHNs and community members about the quality and accessibility of mental health services in rural and remote areas.

1.81   In total, the committee held sixteen public hearings. A list of the witnesses who appeared at each hearing is available at Appendix 2.

1.82   The committee also conducted two site visits in the course of its inquiry. The committee visited the West Kimberley Regional Prison in Derby on 6 July 2018 and the Barkly Work Camp in Tennant Creek on 10 July 2018. Reports on the committee's sites visits are at Appendix 3.

Acknowledgements

1.83   The committee thanks all of the individuals and organisations who submitted to the inquiry and appeared as witnesses.

1.84   The committee also thanks the WA Department of Justice and the NT Department of the Attorney-General and Justice for facilitating the committee's site visits. The committee extends its gratitude to the staff and prisoners of the facilities who were generous with their time and willingness to discuss their experience with mental health.

Notes on references

1.85   References in this report to *Committee Hansard* are to proof transcripts. Page numbers may vary between the proof and official transcripts.

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74   *Journals of the Senate*, No. 88, 19 March 2018, p. 2787.

75   *Journals of the Senate*, No. 121, 20 September 2018, p. 3845; *Journals of the Senate*, No. 131, 27 November 2018, p. 4261.

Chapter 2

Funding and mental health service models

2.1   Throughout the inquiry, the committee heard that the way mental health services in Australia are funded and commissioned can be complicated, confusing and frustrating for many service providers and consumers in rural and remote Australia.

2.2   This chapter will outline mental health services funding and provision in Australia and the stepped care model of practice on which these services are based. This chapter also explores concerns about how services are commissioned and some of the ways in which technology is being used to deliver and inform mental health service provision.

2.3   According to the Australian Institute of Health and Welfare, the total amount of national spending on mental health was almost $9 billion in 2015–16. Of that, about 60 per cent of spending ($5.4 billion) was by state and territory governments, 35 per cent ($3.1 billion) by the Commonwealth Government, and the remaining 5 per cent ($466 million) by private health insurance funds (see Figure 2.1).[1]

Figure 2.1—National spending on mental health services 2015–16
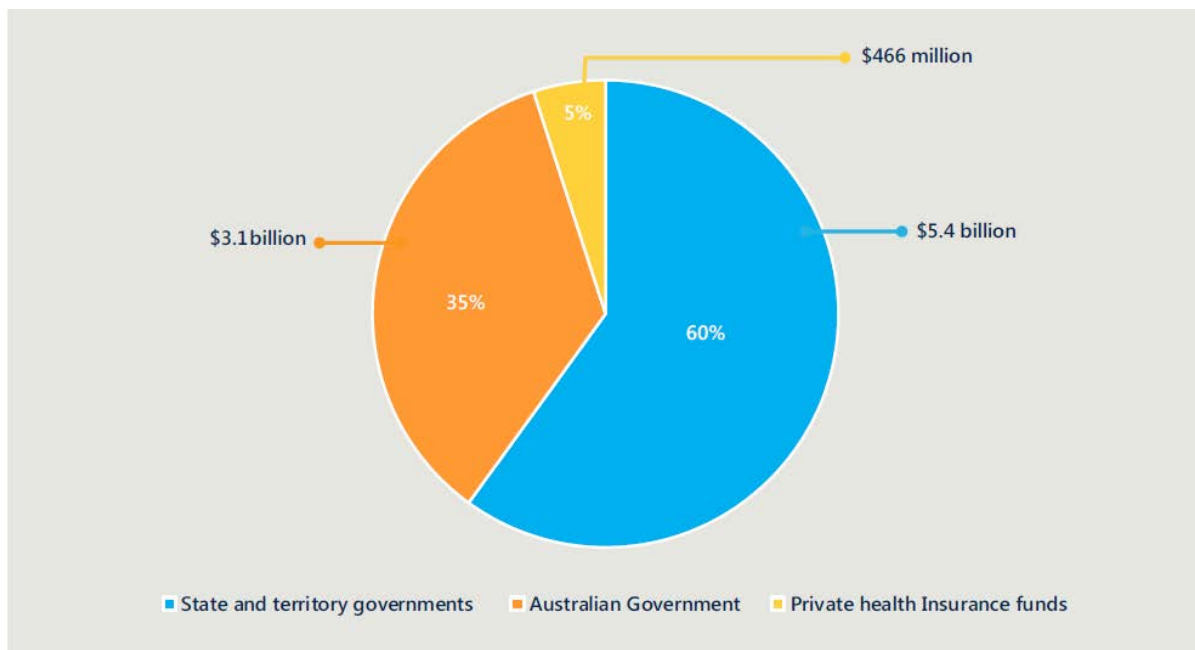
Source: Department of Health.[2]

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1   Australian Institute of Health and Welfare (AIHW), *Mental health services in Australia: Expenditure on mental health services*, 11 October 2018, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services (accessed 25 October 2018). See also: Department of Health, *Submission 30*, p. 3.

2   Department of Health, *Submission 30*, p. 3.

State and territory funding for mental health

2.4　　As discussed in Chapter 1, state governments play a significant role in the provision of mental health services in rural and remote Australia. State and territory governments account for the largest proportion of all mental health spending in Australia. State and territory governments fund and deliver mental health services though:

- public psychiatric hospitals;

- psychiatric units or wards in public hospitals;

- community mental health services;

- residential mental health services; and

- commissioning of non-government organisations to deliver services.[3]

2.5　　In addition, several states have an independent mental health commission, each with different operating and reporting structures and responsibilities, but with a common goal of mental health reform.[4]

2.6　　State and territory governments also provide school psychologists, counsellors, guidance officers and nurses through their departments of education. These professionals can have a significant role in identifying young people with psychosocial, mental health or substance use issues and providing follow-up care, particularly in remote communities.[5]

Federal funding for mental health

2.7　　The Commonwealth Government is not a direct provider of mental health services but provides a significant amount of funding to the sector through:

- Medicare Benefits Schedule (MBS) services for mental health;

- Pharmaceutical Benefits Scheme (PBS) prescriptions for illness related to mental health;

- the federal share of public hospital funding for mental health services;

- the proportion of private health insurance rebates used for mental health services;

3　　AIHW, *Mental health services in Australia: Expenditure on mental health services*, 11 October 2018, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services (accessed 25 October 2018).

4　　Australian Mental Health Commissions, *Submission 52*, p. 5.

5　　Ms Nicole Cockayne, Director of Discovery and Innovation, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 11; Ms Elizabeth Foley, Federal Professional Officer, Australian Nursing and Midwifery Federation, *Committee Hansard*, Canberra, 19 July 2018, p. 18; Alannah and Madeline Foundation, *Submission 73*, p. 8; Mr Nicholas William Newman, Mental Health Coordinator, Ngaanyatjarra Health Service, *Committee Hansard*, Alice Springs, 10 July 2018, p. 20.

- mental health research through the National Health and Medical Research Council;

- the National Mental Health Commission; and

- mental health program funding.[6]

2.8   In 2017–18, the Commonwealth Health Portfolio's estimated total mental health expenditure was \$4.3 billion, of which \$778 million, or around 18 per cent, was for mental health programs.[7] The Commonwealth operates a number of grants-based mental health programs through five program areas: national leadership; primary mental health care; promotion, prevention and early intervention in mental health; psychosocial support; and suicide prevention.

2.9   Funding for mental health programs is generally provided either directly to service providers for specific programs (for example, to beyondblue for the Way Back Support Service and to Lifeline Australia for telephone crisis services) or to Primary Health Networks (PHNs) as a flexible primary mental health care funding pool for commissioning of mental services.[8]

Primary Health Networks

2.10   PHNs play a significant role in commissioning and coordinating federally-funded mental health and suicide prevention programs at a local level in regional, rural and remote Australia.

2.11   PHNs were established in 2015 with the objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.[9] The Department of Health described that PHNs are about 'thinking nationally and acting locally'.[10]

2.12   PHNs receive and distribute both quarantined funding for specific mental health services and a flexible funding pool for planning, integrating and commissioning other mental health services in each PHN's local community in accordance with the needs of that community. In 2018–19, the flexible funding pool represents around 59 per cent of mental health funding to PHNs, while 32 per cent of

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6   Department of Health, *Submission 30*, p. 3; Department of Health, answer to question on notice No. 312, 2018–19 Budget estimates, 30 May 2018.

7   Department of Health, answer to question on notice No. 312, 2018–19 Budget estimates, 30 May 2018.

8   Department of Health, *Submission 30*, p. 5; Commonwealth of Australia, *Budget Measures: Budget Paper No. 2 2018–19*, p. 122–124.

9   Department of Health, *Submission 30*, pp. 4–5. See also Department of Health, *PHN Background*, 19 July 2018, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background (accessed 2 November 2018).

10   Dr Alison Morehead, First Assistant Secretary, Primary Care and Mental Health Division, Department of Health, *Committee Hansard*, Canberra, 18 September 2018, p. 1.

funding has been quarantined for youth psychosis and headspace initiatives and 9 per cent has been quarantined for Aboriginal and Torres Strait Islander mental health.[11]

2.13   Fifteen out of the 31 PHN regions are predominantly non-metropolitan and represent around 33 per cent of the Australian population (see Table 2.1).[12] Mental health and suicide prevention funding to these regions is weighted by the Commonwealth Government to account for rurality, Indigenous status and socioeconomic status, as these factors are associated with higher levels of need and lower rates of access in rural and remote regions; this means that the funding per capita in these non-metropolitan PHN regions is around double that of metropolitan regions.[13]

Table 2.1—Mental health flexible funding to PHNs (2018–2019 estimate)

PHN region type	Number of regions	% of Australian population	% of PHN funding	Per capita funding
Non-metropolitan*	15	33%	50%	$24.70
Metropolitan**	16	67%	50%	$11.95
Total	31	100%	100%	$16.14

* predominantly (>50%) non-major city populations

** predominantly (>50%) major cities populations

Adapted from: Department of Health.[14]

2.14   Three PHNs in rural and remote areas – Murrumbidgee, North Coast New South Wales (NSW) and Tasmania – have also been established as mental health lead sites. The Department of Health explained that:

> Those PHNs were provided with additional funding to enable them to accelerate implementation, trial innovative approaches and share their learnings with the other PHNs. The sorts of things they are doing range from piloting innovative clinical supports for young people to a formal evaluation of clinical care coordination for people with severe and complex mental illness.[15]

2.15   PHNs are also responsible for leading the implementation of the National Suicide Prevention Trial. The National Suicide Prevention Trial was launched in 2016, providing $36 million over three years to fund suicide prevention programs in

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11   Department of Health, *Submission 30*, pp. 4–5.

12   A map of the Primary Health Networks (PHNs) in Australia is included in Appendix 4.

13   Department of Health, *Submission 30*, pp. 5–6.

14   Department of Health, *Submission 30*, p. 7.

15   Dr Alison Morehead, Department of Health, *Committee Hansard*, Canberra, 18 September 2018, p. 2.

12 sites across Australia in identified priority areas, including a number of rural and remote locations. In May 2018, a further $1 million was allocated to each trial site to extend the trial through until 30 June 2020. These trial sites are led by the local PHN, in consultation with local community members and service providers, to design and deliver services that are tailored to the needs of each community.[16]

2.16   Evidence received by the committee suggests that the efficacy of the PHN-based approach to commissioning mental health services in rural and remote areas varies widely from network to network and is a major contributing factor to service access and delivery. These concerns, relating particularly to flexibility, contract length, and commissioning of services which understand local communities' needs, are detailed later in this chapter.

Aboriginal Community Controlled Health Services

2.17   Aboriginal Community Controlled Health Services (ACCHSs) also play a significant role in providing federally-funded mental health services in rural and remote Australia. ACCHSs are primary health care services initiated and operated by local Aboriginal and Torres Strait Islander communities to deliver comprehensive and culturally-appropriate health care to their communities, and are controlled through a locally-elected board of management.

2.18   ACCHSs receive federal funding via the Department of Health and Department of Prime Minister and Cabinet, such as grants for the operation of the service, specific grants for targeted programs (such as child and maternal health), Medicare rebates, and other program funding through PHNs.[17] ACCHSs also receive some grant funding through state and territory programs, for example NSW Health funds 16 ACCHSs for mental health projects in 17 locations.[18]

2.19   The committee heard about the frustration faced by ACCHSs in seeking funding directly from governments to provide mental health services. The Central Australian Aboriginal Congress explained that accessing grants and other funding for mental health services as an ACCHS has 'taken a long time' due to confusion about whether funding should be provided from the state/territory or federal government:

> For many, many years we just kept getting told, 'The states fund mental health and the Commonwealth don't. Go to the state.' The state never funded mental health through Aboriginal health services; they funded through their own system.[19]

2.20   The National Aboriginal Community Controlled Health Organisation (NACCHO), the peak body representing ACCHSs, explained in its submission that it

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16   Department of Health, *Submission 30*, p. 24.

17   Department of Health, *Submission 30*, p. 8.

18   NSW Government, *Submission 106*, p. 13.

19   Associate Professor John Dominic Boffa, Chief Medical Officer Public Health, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 1.

is in the interest of government to invest in the ACCHS sector to reduce the economic burden of mental illness:

> There is a strong argument for optimising government investment in areas where populations are most at risk and most vulnerable to mental illness, and for directing investment to facilitate effective mental health, and consequent fiscal gains.[20]

2.21   For the three financial years 2016–17 through 2018–19, PHNs have received $85.7 million from the Commonwealth Government through the Indigenous Australian's Health Programme to provide Aboriginal and Torres Strait Islander people with access to effective, high quality mental health care services across Australia. The Department of Health explained in its submission that this funding is provided to ACCHSs 'wherever possible and appropriate', as well as to mainstream services.[21]

2.22   NACCHO described that the redirection of mental health funding away from direct grants and into PHN administration 'is having a deleterious and inequitable impact on Indigenous Australians accessing appropriate and effective services', emphasising in its submission that:

> …if Government is serious about closing the gaps in health and mental health services, positively directing funding for Aboriginal service delivery to the ACCHS sector is imperative.[22]

2.23   The Aboriginal Medical Services Alliance Northern Territory (AMSANT), an organisation which is also one of three company members of the Northern Territory PHN, told the committee at its Darwin hearing that PHNs in the territory had prioritised the Aboriginal primary healthcare sector, however:

> …in other jurisdictions funding was provided to mainstream organisations—rather than to Aboriginal providers in many cases. We believe this is flawed and will result in suboptimal outcomes.[23]

2.24   The Western Queensland PHN has also taken an active step in ensuring that PHN funding is meeting the service requirements of local Aboriginal and Torres Strait Islander peoples through the Nukal Murra Alliance which comprises four ACCHSs in the region. At the committee's hearing in Mount Isa, Western Queensland PHN's Executive Manager of Service Provider Commissioning described that:

> Western Queensland PHN does not make decisions on behalf of Aboriginal and Torres Strait Islander people. We draw on the cultural authority and intelligence from the members of the Nukal Murra Alliance.[24]

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20   National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 128*, p. 6.

21   Department of Health, *Submission 30*, p. 8.

22   NACCHO, *Submission 128*, pp. 3–4.

23   Mrs Danielle Dyall, Team Leader Trauma Informed Care and Social Emotional Wellbeing, Aboriginal Medical Services Alliance Northern Territory (AMSANT), *Committee Hansard*, Darwin, 9 July 2018, p. 7.

2.25   Western Queensland PHN is further supporting primary care service integration between mainstream and ACCHS services through its tripartite agreement with Gidgee Healing and the North West Hospital and Health Service and the introduction of an integrity framework to guide cultural competency of commissioned providers.[25]

2.26   However, Ms Vanessa Harris, Executive Officer of the Northern Territory Mental Health Coalition and board member of Danila Dilba Health Service, contended that even with a commitment to community controlled services, it is important for Aboriginal and Torres Strait Islander peoples to have choice in mental health services from a variety of providers:

> …if you're living in this sort of situation in the Northern Territory, in Darwin or Katherine or wherever, and there are health boards and Aboriginal health services throughout the NT, people still have the opportunity for a choice of service. If they feel that Danila Dilba gives them the choice of a certain type of service, they can go there, absolutely—or to TeamHEALTH or to MIFANT, if they give them another type of service. I think it's their right to have a choice in where they go for what supports them in their life and where they are at that point in time, and I think that's really important.[26]

2.27   The issues around culturally competent services for Aboriginal and Torres Strait Islander peoples are explored in detail in Chapter 4 of this report.

National Disability Insurance Scheme

2.28   The National Disability Insurance Scheme (NDIS) plays a significant role in facilitating access to mental health services funded by the Commonwealth Government for some people with mental health and psychosocial disability.

2.29   There has been ongoing criticism of the provision of services for people with psychosocial disabilities related to a mental health condition under the NDIS. In 2017, the Joint Standing Committee on the NDIS conducted an inquiry which examined these issues in detail.[27] That committee made 24 recommendations to strengthen the effectiveness of the NDIS and ensure that people with psychosocial disabilities are appropriately supported.[28]

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24   Ms Sandy Gillies, Executive Manager, Service Provider Commissioning, Western Queensland PHN, *Committee Hansard*, Mount Isa, 29 August 2018, p. 5. See also Western Queensland PHN, *Submission 125*, p. 3.

25   Western Queensland PHN, *Submission 125*, pp. 3–4.

26   Ms Vanessa Harris, Executive Officer, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 9 July 2018, p. 19.

27   Joint Standing Committee on the National Disability Insurance Scheme, *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*, August 2017.

28   Joint Standing Committee on the National Disability Insurance Scheme, *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*, August 2017, pp. xi–xvi.

2.30   A new NDIS stream for psychosocial disability was announced on 10 October 2018.[29] This stream is designed to improve the process of accessing the NDIS and to provide dedicated support for people with severe and persistent mental health issues. The stream will include the employment of specialised planners and Local Area Coordinators; better linkages between services, National Disability Insurance Agency (NDIA) staff and NDIA partners; focus on recovery-based planning and episodic needs; connecting people, including those found to be ineligible for the NDIS, with appropriate supports; employing and/or funding mental health peer workers; and psychosocial disability awareness training for staff and coordinators.[30]

2.31   As part of the roll-out of the NDIS around Australia, a number of federally-funded mental health and support programs are now part of or in the process of transitioning to the NDIS. Some of these programs include Personal Helpers and Mentors (PHaMs),[31] Mental Health Respite: Carer Support,[32] Partners in Recovery (PIR)[33] and Day to Day Living.[34] For each of these programs, the Commonwealth Government has outlined a timeline for transition to the NDIS ahead of the full roll-out on 1 July 2019. After this date, funding under a 'continuity of support' measure has been allocated to support people who are assessed as ineligible and those who are eligible but have not yet finalised their package:

> …PHNs will have funding through [the continuity of support] measure and through the National Psychosocial Support Measure to be able to continue to support people through PIR and Day to Day Living while they are waiting on their packages.[35]

2.32   During the course of this inquiry a number of concerns were raised about this process.

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29   Dr Gerry Naughtin, Strategic Advisor, Mental Health and Psychosocial Disability, National Disability Insurance Agency, *Committee Hansard*, Canberra, 16 October 2018, p. 3; The Hon Paul Fletcher MP, Minister for Families and Social Services, and the Hon Sarah Henderson MP, Assistant Minister for Social Services, Housing and Disability Services, 'Government announces improved NDIS mental health support', *Media release*, 10 October 2018.

30   National Disability Insurance Agency, answers to questions on notice, 16 October 2018 (received 7 November 2018).

31   Department of Social Services, *Personal Helpers and Mentors (PHaMs)*, https://www.dss.gov.au/our-responsibilities/mental-health/programs-services/personal-helpers-and-mentors-phams (accessed 5 November 2018). Note: a person does not need to have a formal clinical diagnosis of a severe mental illness in order to participate in PHaMs.

32   Department of Social Services, *Mental Health Respite: Carer Support,* https://www.dss.gov.au/our-responsibilities/mental-health/programs-services/mental-health-respite-carer-support (accessed 5 November 2018).

33   Department of Health, *About Partners in Recovery*, http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pir-about (accessed 5 November 2018).

34   Department of Health, *Support for Day to Day Living in the Community*, http://www.health.gov.au/internet/main/publishing.nsf/content/mental-d2dl (accessed 5 November 2018).

35   Ms Emma Wood, Assistant Secretary, Mental Health Services Branch, Primary Care and Mental Health Division, Department of Health, *Committee Hansard*, Canberra, 16 October 2018, p. 4.

Eligibility to transition

2.33   Evidence received by the committee indicates that a high percentage of the people who accessed services such as PIR, PHaMs, Day to Day Living and Mental Health Respite: Carer Support in the past will not be eligible under the NDIS and that continuity of support funding is not addressing these gaps in the communities where the NDIS has already rolled out. The Mental Health Council of Tasmania described its concern with the NDIS transition during the hearing in Devonport:

> What the federal government decided was that everybody who was accessing those services would be transitioning to the NDIS. Therefore it seemed logical to roll that funding for those programs into the NDIS. What they hadn't realised at the time was that not everybody who was in those programs would be deemed eligible for NDIS.[36]

2.34   Witnesses told the committee that their experience has shown that a significant number of people in regional areas are not, or will not be, transitioning to the NDIS. The Mental Health Council of Tasmania estimated that at least 30 per cent of people in Tasmania who have been a part of the aforementioned federally-funded programs will not be eligible for the NDIS, with up to 90 per cent of PHaMs participants ineligible.[37] The Northern Queensland PHN told the committee that only 10–25 per cent of PIR and 15 per cent of PHaMs participants in their area have been identified as eligible, while service provider Neami National estimated that only 30 per cent of their PIR and PHaMs participants would be transitioning.[38]

Continuity of support and other funding concerns

2.35   The National Psychosocial Support measure was announced in 2017 to maintain community-based, non-clinical support services outside of the NDIS; the Commonwealth Government has committed $80 million over four years to be matched by state and territory governments.[39] While the Department of Health explained that the intention of the National Psychosocial Support measure is to provide psychosocial support to people who are not currently participating in PIR, Day to Day Living and PHaMs, the committee heard that some service providers are unsure if this funding will adequately support new clients.[40]

2.36   The committee heard how the shift of funding for mental health programs from states to the NDIA ahead of the NDIS roll-out is contributing to gaps in service

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36   Mrs Connie Digolis, Chief Executive Officer, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 39.

37   Mrs Connie Digolis, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, pp. 40 and 41.

38   Ms Karen Thomas, Queensland State Manager, Neami National, *Committee Hansard*, Townsville, 30 August 2018, p. 14.

39   Department of Health, answer to question on notice no. 7, 16 October 2018 (received 12 November 2018).

40   Mrs Connie Digolis, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 40.

which are not being adequately met by continuity of support funding.[41] Consumers of Mental Health WA explained that:

> The NDIS is an example where the Commonwealth has invested in servicing people who have severe mental health issues, and there are still issues with what the state has been doing. In the complexity of the NDIS there are people who have significant mental health issues who aren't eligible, but the funds for state based programs have been shifted across into the NDIS. So, you have a group that the NDIS is servicing who now have got access to programs that have been taken away from people who, for whatever reason, aren't eligible or choose not to be in the NDIS.[42]

2.37   A broad range of witnesses told the committee that one of the most significant concerns about continuity of support for this cohort was impact of the loss of 'block funding' for the service providers which had previously delivered those programs being transitioned to the NDIS, which would impact on those organisations' ability to meet overhead costs.[43] Selectability told the committee that some estimates suggest that the number of NDIS provider organisations in Australia is estimated to drop from 2600 to 400 over the next five years due to loss in block funding to cover overhead costs.[44] The issue of lost block funding in the broader mental health sector is discussed later in this chapter.

2.38   The committee also heard that the inability to meet overhead costs, even when taking into account loadings for rural and remote areas,[45] is deterring some providers from entering into or continuing NDIS service provision. Neami National, a service provider in Queensland, reported that the cost to deliver NDIS services in some remote communities was 180 per cent higher than in an urban location.[46] In mid-western NSW, the Benevolent Society has decided not to continue to provide psychosocial disability supports under the NDIS because it is not financially viable and resulted in a significant financial loss to the organisation. However, there are no

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41   For example: Ms Amanda Bresnan, Chief Executive Officer, Community Mental Health Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 24; Mr Jeremy Audas, Member, Queensland Alliance for Mental Health, *Committee Hansard*, Townsville, 30 August 2018, p. 49.

42   Ms Shauna Gaebler, Chief Executive Officer, Consumers of Mental Health WA, *Committee Hansard*, Albany, 5 June 2018, pp. 47–48.

43   Mr Ivan Frkovic, Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Mount Isa, 29 August 2018, p. 52; Ms Helen Egan, Chief Executive Officer, TeamHEALTH, *Committee Hansard*, Darwin, 9 July 2018, p. 20.

44   Mrs Debra Burden, Chief Executive Officer, selectability, *Committee Hansard*, Townsville, 30 August 2018, p. 51.

45   For further detail about loadings, see: National Disability Insurance Agency, answers to questions on notice, 16 October 2018 (received 7 November 2018).

46   Ms Karen Thomas, Neami National, *Committee Hansard*, Townsville, 30 August 2018, p. 9.

other service providers in the region and it is unclear who will be able to take over these supports.[47]

2.39   Other organisations expressed concerns that funding received for staff under the NDIS has been significantly reduced from what was provided for programs previously. The Mental Health Council of Tasmania observed that the anticipated reduction in funding by nearly half has also meant a 'shift in the level of qualifications of staff' providing supports such as PIR since their transition to NDIS.[48] Other witnesses across the country agreed that this will have a major impact on the quality and appropriateness of service provided.[49]

2.40   Consumers of Mental Health WA explained that as it becomes difficult for local non-government organisations to afford to maintain services under the NDIS 'there's a tendency…for the larger NGOs to move into the region' and that this can cause distress for members of the community and the smaller service providers.[50]

2.41   The Victorian Council of Social Service recommended in its submission that NDIS pricing should be amended to 'reflect the components of quality service delivery' to ensure access to essential mental health services for people in rural and remote areas:

> Depending on the circumstances, different approaches may be required, such as block funding core services, retaining a 'provider of last resort', and leveraging or building the capacity of established community organisations, such as community health services.[51]

2.42   Barriers to people accessing mental health services in rural and remote Australia, including mental health services provided through NDIS, are addressed in Chapter 3 of this report.

The stepped care model for service planning and delivery

2.43   Mental health services in Australia, particularly those funded through Commonwealth grants or PHN flexible funding, are predominantly commissioned based on the stepped care model of mental health service delivery. The Department of Health submitted that the inclusion of the stepped care model 'at the core of PHN

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47   Benevolent Society, *Submission 71*, p. 11.

48   Mrs Connie Digolis, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 41.

49   Mrs Debra Burden, selectability, *Committee Hansard*, Townsville, 30 August 2018, p. 47; Mr Colin Penter, Projects Lead and Policy Officer, Western Australian Association for Mental Health, *Committee Hansard*, Albany, 5 June 2018, p. 49; Ms Helen Egan, TeamHEALTH, *Committee Hansard*, Darwin, 9 July 2018, p. 25.

50   Ms Shauna Gaebler, Consumers of Mental Health WA, *Committee Hansard*, Albany, 5 June 2018, p. 49.

51   Victorian Council of Social Service, *Submission* 107, p. 12.

regional planning, funding and commissioning' is an important measure in improving quality service delivery.[52]

2.44   The stepped care model, as set out in the Department of Health's *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care* (PHN Stepped Care Guidance), is defined as 'an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs'. The PHN Stepped Care Guidance is designed for all PHNs across Australia and describes how:

> In a stepped care approach, a person presenting to the mental health system is matched to the intervention level that most suits their current need. An individual does not generally have to start at the lowest, least intensive level of intervention in order to progress to the next 'step'. Rather, they enter the system and have their service level aligned to their requirements.[53]

2.45   The stepped care model, as set out in the *Fifth National Mental Health and Suicide Prevention Plan*, is summarised in Figure 2.2 below. According to the PHN Stepped Care Guidance, the multiple levels within a stepped care approach do not operate in silos or as one directional steps, but rather 'offer a spectrum of service interventions' for mental health consumers.[54]

2.46   While witnesses and submitters to the inquiry were broadly supportive of the stepped care model for planning, commissioning and delivering mental health services, evidence received by the committee has shown that the availability and appropriateness of stepped services can vary widely when the model is implemented in regional, rural or remote locations.

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52   Department of Health, *Submission 30*, p. 16.

53   Department of Health, *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care* (PHN Stepped Care Guidance), p. 2.

54   PHN Stepped Care Guidance, p. 2.

Figure 2.2—Mental health stepped care levels of need and services

WELL POPULATION

Mainly publically available information and self-help resources

AT RISK GROUPS (early symptoms, previous illness)

Mainly self-help resources, low intensity interventions including digital mental health

23.1% of population

MILD MENTAL ILLNESS

Mix of self-help resources including digital mental health and low intensity face-to-face services

Psychological services for those who require them

9.0% of population

MODERATE MENTAL ILLNESS

Mainly face-to-face clinical services through primary care, backed up by psychiatrists where required

Self-help resources, clinician-assisted digital mental health services and other low intensity services for a minority

4.6% of population

SEVERE MENTAL ILLNESS

Clinical care using a compination of GP care, psychiatrists, mental health nurses, and allied health.

Inpatient services

Pharmacotherapy

Psychosocial support services

Coordinated, multiagency services for those with severe and complex illness

3.1% of population

* Adapted from Australian Government Response to Contributing Lives, Thriving Communities—Review of Mental Health Programmes and Services (November 2015).

* Estimates of prevalence derived from National Mental Health Service Planning Framework modelling (unpublished).

Source: Council of Australian Governments.[55]

Stepped care not designed for rural and remote areas

2.47   Professor Luis Salvador-Carulla, Centre Head of the Australian National University (ANU) Centre for Mental Health Research, explained to the committee that rural mental health is different from urban mental health and the problem with the stepped care model is how it was developed for urban areas:

> This model was developed in a highly urbanised area in the Netherlands. It has been tested in the southern part of Norway. It has been tested in urban areas in the UK. My feeling is that it does not work for rural areas. This is just one example of many of how just translating and adapting what has been developed in cities in urban mental health does not work in rural health. We have to develop a new understanding of these services, if we want to change the problems we have in this area.[56]

2.48   Professor Salvador-Carulla proposed that mental health care in rural Australia should not be compared with Sydney but rather global locations with similar population densities and needs, such as the northern part of Scandinavia, Greenland, the Labrador Peninsula in Canada, and some areas in Latin America. The ANU Centre for Mental Health Research is currently conducting a comparison of healthcare in the

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55   Council of Australian Governments, *Fifth National Mental Health and Suicide Prevention Plan*, p. 20.

56   Professor Luis Salvador-Carulla, Centre Head, ANU Centre for Mental Health Research, *Committee Hansard*, Canberra, 18 September 2018, pp. 18–19.

Pilbara and Kimberly with the Lapland region of northern Finland and developing partnerships with Canada and Denmark to help understand 'what is happening with our rural system'.[57]

2.49   The WA Primary Health Alliance also commented that the National Mental Health Service Planning Framework (which is used to guide stepped care service commissioning by PHNs[58]) is not suited to respond to the mental health needs of 'sparse and disparate populations' in rural and remote Australia and that refinement of that framework for rural and remote settings is 'several years away'.[59]

2.50   Dr Sharon Varela, a mental health academic from the James Cook University Centre for Rural and Remote Health and chair of the North West Queensland Mental Health Network, told the committee that the stepped care model has an 'urban-centric bias' and that:

> The stepped care model itself is actually a really good model. The limitations are on how it's funded in rural and remote regions, and the stipulations on that funding.[60]

2.51   The Mental Health Academic Network, a staff network of the Australian Rural Health Education Network, observed that while the stepped care model can fund community-based services for consumers at the mild–moderate level with an 'open door policy', moderate–high level services in rural and remote areas may be more restricted due to strict access rules, such as requiring a consumer to have a mental health treatment plan, being a condition of the service funding:

> These decisions seem to have been made on metropolitan funding equations where more expensive services are restricted and less expensive services are easier to access. In metropolitan regions this can work quite well as there are numerous options across the stepped care model; however, in rural and remote where there are fewer service options this can create a barrier to accessing services, with consumers assuming they do not have enough services to meet their needs.[61]

General Practitioners in the stepped care model

2.52   The PHN Stepped Care Guidance states that the role of General Practitioners (GPs) is critical to the stepped care approach as GPs are 'typically the first point of clinical contact for people seeking help for mental health problems and mental illness

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57   Professor Luis Salvador-Carulla, ANU Centre for Mental Health Research, *Committee Hansard*, Canberra, 18 September 2018, p. 19.

58   PHN Stepped Care Guidance, p. 11.

59   Dr Daniel Rock, Principal Adviser and Research Director, WA Primary Health Alliance, *Committee Hansard*, Albany, 5 June 2018, p. 14; WA Primary Health Alliance, *Submission 33*, [p. 2].

60   Dr Sharon Varela, Mental Health Academic, Centre for Rural and Remote Health, James Cook University, *Committee Hansard*, Mount Isa, 29 August 2018, p. 31.

61   Australian Rural Health Education Network (ARHEN) Mental Health Academic Network, *Submission 76*, pp. 3–4.

and are gatekeepers to other service providers'. The PHN Stepped Care Guidance anticipates that access to primary mental health services commissioned by PHNs will require referral from GPs or other health professionals.[62] However, the committee found that during the inquiry that access to GPs can be difficult and further that views differed about what the role of GPs should be in providing stepped care mental health services in rural and remote Australia.

2.53   General Practice Mental Health Standards Collaboration (GPMHSC), a multi-disciplinary body managed by the Royal Australian College of General Practitioners, observed that limited availability of specialist services in rural and remote regions means that patients are more likely to seek help for mental distress from their GPs. However, GPMHSC explained that the PHN Stepped Care Guidance does not recognise GPs as having a role in the health promotion or early intervention steps and, as GP referral is not required for low intensity care in some PHNs, this may run the risk of fragmenting care.[63]

2.54   The Rural Doctors Association of Australia submission called for 'team-based models of care and telehealth' in rural and remote areas, wherein aspects of stepped care are undertaken by practice staff, community support staff or mental health professionals, but coordinated by GPs to ensure continuity of care.[64]

2.55   In contrast, the Queensland Alliance for Mental Health described that in its experience many PHNs have remained too 'doctor-focused' in their approach, stating that while GPs 'do a fantastic job in community… sometimes the care the person needs might be a therapy assistant or a community arrangement, not a GP' and that one of the challenges of accessing PHN funding is that it is sometimes controlled by people who want to keep a medical focus on services.[65]

Between the steps

2.56   The committee also heard that one of the concerns about the stepped care model in rural and remote areas is the lack of accessible 'steps'. The Australian Psychological Society submitted that despite development of the stepped care model, many Australians in rural and remote areas:

> …have limited access to fully stepped mental health care, leaving many with little to no intervention until the severity of their mental illness requires tertiary level mental health care.[66]

2.57   The committee heard that while some areas lack these early intervention services, meaning that people cannot access care until they are at crisis point, others instead lack acute care services.

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62   PHN Stepped Care Guidance, p. 5.

63   General Practice Mental Health Standards Collaboration (GPMHSC), *Submission 23*, p. 3.

64   Rural Doctors Association of Australia, *Submission 79*, p. 10.

65   Ms Simone Finch, Acting Chief Executive Officer, Queensland Alliance for Mental Health, *Committee Hansard*, Townsville, 30 August 2018, p. 52.

66   Australia Psychological Society, *Submission 103*, p. 11.

2.58   Orygen, the National Centre of Excellence in Youth Mental Health, submitted that a lack of workforce and vast distances in more rural and remote areas can affect the fidelity of the early intervention step, while:

> Parts of Australia may not have the population size or workforce to set up full services, particularly those that cater to moderate to severe mental health needs.[67]

2.59   Country and Outback Health, a service provider in South Australia (SA), described how across its services (including headspace in Whyalla and Port Augusta) the organisation is 'holding onto' high-risk and chronic clients longer than the stepped care model would recommend because of the lack of appropriate severe or acute care services:

> …because there aren't necessarily people with capacity to hand them on to in the state-based system. So, whilst we are working as closely as we can within the parameters, we are still seeing and holding onto clients that, if we were in a metropolitan setting with access to a greater number of services, we would automatically refer on; whereas we tend to hold onto them longer here.[68]

2.60   The committee also heard that lack of prevention and early intervention services can lead to people accessing emergency services as their only option. Mental Health Carers Tasmania argued that:

> …we should not be allowing people to become so unwell that the only option they have is to go to emergency. We need to be having those preventative and prevention opportunities for people to access within communities before they become so unwell that they end up in emergency.[69]

2.61   The availability of appropriate mental health services, including the role of emergency departments in the management of acute mental health, is discussed in further detail in Chapter 3.

PHNs working to make the model fit

2.62   The committee received evidence about how a number of PHNs with rural and remote catchment areas are working to make the stepped care model meet the needs of the local population.

2.63   The Country SA PHN informed the committee of its approach in administering the stepped care model, explaining that it is 'trying to identify the missing gaps within communities to enable [stepped care] within communities and regional areas'. It indicated that stepped care is 'an evolution and a staged approach'

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67   Orygen, *Submission 44*, p. 6.

68   Ms Andrea Triggs, Operations Manager, Country and Outback Health, *Committee Hansard*, Whyalla, 20 July 2018, p. 13.

69   Ms Maxine Griffiths AM, Chief Executive Officer, Mental Health Carers Tasmania, *Committee Hansard*, St Helens, 6 September 2018, p. 53.

and emphasised the importance of keeping services in communities, rather than creating gaps by defunding existing services.[70]

2.64   Primary Health Tasmania, the PHN responsible for the entire state of Tasmania, told the committee that it had taken a different approach to many other PHNs, by first commissioning providers 'to get services on the ground' and then later developing its stepped care plan. It is currently working to develop a regional application of the stepped care model, using Commonwealth Government guidance to identify the steps of care needed but 'putting a Tasmanian spin on it, to ensure that the steps are something that the community will adopt and appreciate'. Public consultation on the regional plan is due in late 2018 in anticipation of the plan being in place by 2020.[71]

2.65   The WA Primary Health Alliance procured a new model of primary mental health delivery in 2017, Integrated Primary Mental Health Care, based on the principles of stepped care and designed to meet the needs of people across the state.[72] The WA Primary Health Alliance told the committee:

> …this approach targets patients with mild to moderate conditions and functionally referred by a GP and includes the use of a virtual clinic, telephone and face-to-face modalities. The virtual clinic has the capacity and capability to reach most of the main populated areas of each region across WA, improving equity of access to those most at risk of poor health outcomes. The approach utilises existing distribution systems technology; however, where this is not available or not appropriate for the population subgroups, increased focus is based on building local capacity.[73]

'No wrong door' to receiving care

2.66   The 'no wrong door' approach within the stepped care model—i.e. assisting consumers to receive the appropriate mental health care for their needs no matter their entry point into the health system—was discussed as a solution to meeting the needs of mental health consumers in rural and remote areas. However, the committee heard that consumers see access rules around the mental health system as confusing[74] and this was supported in evidence from the Katherine hearing, where Mr Dylan Lewis, an individual with lived experience of mental health issues, described the difficulty of navigating the mental health system:

70   Mr Reg Harris, Director Mental Health and Alcohol and Other Drugs, Country SA Primary Health Network, *Committee Hansard*, Whyalla, 20 July 2018, p. 50.

71   Mr Grant Akesson, Health Stream Lead, Mental Health and Alcohol and Other Drugs, Primary Health Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 11.

72   WA Primary Health Alliance, *Submission 33*, [p. 7]; WA Primary Health Alliance, *Integrated Primary Mental Health Care*, https://www.wapha.org.au/primary-health-networks/mental-health/ipmhc/ (accessed 6 November 2018).

73   Ms Lesley Pearson, Regional Manager, WA Primary Health Alliance, *Committee Hansard*, Albany, 5 June 2018, p. 13.

74   ARHEN Mental Health Academic Network, *Submission 76*, pp. 3–4.

> If you're sick, break your arm or anything, you go to the hospital. I can't see why it should be any different for mental health.[75]

2.67   The Central Australian Aboriginal Congress has a highly-praised 'no wrong door' policy in Alice Springs[76] which allows patients to access integrated services for all of their health concerns, rather than requiring separate specialists, diagnoses or services for each concern. This is model has been particularly important when managing complex care needs, including trauma, in the region.[77] The committee heard that the 'no wrong door' approach has also been successful in other ACCHSs, such as Gidgee Healing in Mount Isa[78] and Cyrenian House Milliya Rumurra Outreach Service in the West Kimberley region.[79]

2.68   The Central Australian Rural Practitioners Association made the point that while the 'no wrong door' approach has been successful for self-contained organisations such as Congress, it does not work so well when remote patients are referred from a point of contact which is unable to meet their needs to a specialist with a two-year waiting list, even if that specialist is 'happy to see them'.[80]

2.69   The committee heard that some organisations are trying to meet the needs of patients through a 'no wrong door' approach by pushing the boundaries of the services for which they are funded. For example, Youth, Family and Community Connections Inc, a service provider in the north-west and west coast of Tasmania, explained that their approach to 'no wrong door' is to use a holistic assessment and case management process to support anyone who visits the service, 'even though they might not neatly fit into [the] funding streams'.[81]

2.70   Northern Queensland PHN has funded a 'no wrong door' referral service to improve access to stepped care in the region. Connect to Wellbeing, run by provider Neami National, commenced in June 2018 and provides a single point of entry to allied health and psychological services following referral from GPs, state health funded services and primary health workers. The service provides intake, assessment and triage, contacting the individual to determine their needs and the relevant

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75   Mr Dylan Lewis, Private capacity, *Committee Hansard*, Katherine, 9 July 2018, pp. 21–22.

76   Professor Paul Worley, National Rural Health Commissioner, Department of Health, *Committee Hansard*, Canberra, 19 July 2018, p. 82.

77   Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, pp. 2 and 4.

78   Mrs Renee Blackman, Chief Executive Officer, Gidgee Healing, *Committee Hansard*, Mount Isa, 29 August 2018, p. 3.

79   Ms Sally Malone, *Submission 127*, p. 1.

80   Mrs Lynette (Lyn) Byers, Secretary, Central Australian Rural Practitioners Association, *Committee Hansard*, Alice Springs, 10 July 2018, pp. 28–29.

81   Ms Roslyn Atkinson, Chief Executive Officer, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 31.

available services for them.[82] At the hearing in Townsville, Neami National told the committee that Connect to Wellbeing receives approximately 30 referrals per day, of which a number are from remote locations. Although there is a lack of providers in certain regions, Connect to Wellbeing is able to identify alternatives such as phone counselling to ensure that people get support.[83]

2.71   However, the committee also heard that having 'no wrong door' approach is not always enough to meet the needs of the community. Witnesses in Whyalla described that although the 'no wrong door' approach is one of the strengths of the headspace centres in the region, it can be difficult for people to get an initial appointment to get their foot through that door.[84] In Albany, Palmerston Association Inc explained that seeking services in the first place can still be a major barrier for individuals who need help:

> The well-worn concept of 'no wrong door' has not created the ease of access to services that was intended. Services need to move away from the expectation that their clients must come to them. For people experiencing mental health problems, those who feel isolated and alone, those contemplating suicide, the easier it is to think it is too hard to get help, the less likely they are to get it.[85]

2.72   Community Mental Health Australia emphasised the need for 'no wrong door' in accessing all health and disability services in rural and remote Australia, noting the significant intersections between mental health and disability, and recommended that PHNs, the NDIA, state governments and other funding agencies should work more closely with remote communities to meet their specific needs.[86]

2.73   Some of the challenges of understanding and navigating the mental health system are discussed in Chapter 3.

Committee view

2.74   While the committee supports the aims of the stepped care model to provide a spectrum of service interventions for mental health, it holds significant concerns that

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82   Neami National, answers to questions on notice, 30 August 2018 (received 20 September 2018), p. 1; Connect to Wellbeing, https://www.connecttowellbeing.org.au/faq (accessed 13 November 2018). See also: Queensland Nurses and Midwives' Union, *Submission 36*, p. 7.

83   Ms Karen Thomas, Neami National, *Committee Hansard*, Townsville, 30 August 2018, pp. 9 and 13–14. See also: Neami National, answers to questions on notice, 30 August 2018 (received 20 September 2018), p. 1.

84   Ms Andrea Triggs, Country and Outback Health, *Committee Hansard*, Whyalla, 20 July 2017, p. 9; Dr Krista Maier, General Practitioner, Nunyara Aboriginal Health Service, *Committee Hansard*, Whyalla, 20 July 2017, p. 37.

85   Mr Benjamin Headlam, Manager, Great Southern Community Alcohol and Drugs Service, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 18.

86   Ms Amanda Bresnan, Community Mental Health Australia, *Committee Hansard*, Canberra, 19 July 2018, pp. 24–25.

this spectrum is not being made appropriately available to people in rural and remote Australia.

2.75   The committee questions whether the stepped care model can be adequately implemented in areas where the local population is small and cannot support a workforce or service spread of a suitable size to deliver all of the model's steps. The committee also holds concerns that, even where all steps are available, consumers are unsure of how to access these services.

2.76   In light of this, the committee is strongly supportive of the no wrong door approach to service delivery. The committee was particularly impressed by the example set by the Central Australian Aboriginal Congress in meeting the needs of its consumers in this way, but recognises the challenges for smaller service providers which do not have the benefit of being self-contained and still rely on referrals to outside services when supporting consumers to access other levels of care.

2.77   The committee notes that commissioning of services, particularly through PHNs, appears to be vital in filling the gaps between steps in communities in rural and remote Australia and ensuring that all consumers can access the right service at the right time.

Commissioning services for community needs

2.78   Evidence throughout this inquiry emphasised the need for funders of mental health services in Australia to work collaboratively with rural and remote communities to commission appropriate services for the specific needs of those communities.[87]

2.79   Identifying and commissioning for the needs of the local community is one of the key functions of PHNs and the Department of Health submitted that this function:

> …is vital for mental health and suicide prevention services in rural and remote communities, where most people do not have access to local mental health specialist services, and local GPs are the first (sometimes only) available service.[88]

2.80   However there have been significant challenges faced by PHNs in realising this role since their establishment in 2015.

2.81   The Australian Psychological Society and Australian College of Rural and Remote Medicine both submitted that PHNs with regional, rural and remote catchments across large geographical areas have been tasked with building regionally-tailored stepped care services for what can be a wide range of community needs with a limited amount of funding.[89]

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87   For example, see: Mental Health Victoria, *Submission 51*; beyondblue, *Submission 85*; COTA Australia, *Submission 64*; Sane Australia, *Submission 130*.

88   Department of Health, *Submission 30*, p. 5.

89   Australian Psychological Society, *Submission 103*, p. 11; Australian College of Rural and Remote Medicine, *Submission 43*, p. 6. See also: Rural Doctors Association of Australia, *Submission 79*, p. 3.

2.82   Beyondblue submitted that PHNs 'must…establish governance arrangements that allow and support them to engage with the community and health professionals, to ensure that the services they commission respond to local needs' but need time to overcome the challenge of working out 'what works best where and for whom'. beyondblue recommended that PHNs require long-term funding to build the infrastructure and workforce required to meet the needs of rural and remote communities.[90]

2.83   The Centre for Rural and Remote Health described PHN and local mental health service commissioning arrangements as 'immature' and reported that:

> Many rural PHNs have found it difficult to recruit the skills needed to lead regional mental health planning and this is not made easier by short term funding which impacts on the duration of contracts with mental health service providers. This, in turn, weakens rural service providers who face particular challenges in building and retaining a skilled workforce. Thus PHNs need time and support to mature, and to work with local services to commission effective mental health services fit for the needs of rural communities.[91]

2.84   The Australian Mental Health Commissions joint submission discussed the importance of PHNs working in partnership with local hospital networks, public health services and other social and welfare support providers to plan, commission and provide services which match population needs. However, the Australian Mental Health Commissions also made the significant point that services need to be made available in rural and remote areas for the PHNs to commission and that this will require federal, state and territory governments to 'invest [in] community-based approaches and retention of mental health professions'.[92]

2.85   PHNs with regional, rural and remote catchment areas also provided evidence to the committee about how they view their roles in leading community coordination.[93] Country SA PHN, responsible for all country regions of SA, described that identifying gaps in communities is 'not an instantaneous process' and that it is committed to sustainability of services and market growth to address those gaps. It told the committee that:

> We also acknowledge that the process isn't just about service procurement, it's actually about the PHN being a leader and trying to better coordinate the sector and, in some cases that we've heard from communities, it's not

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90   beyondblue, *Submission 85*, pp. 13–14.

91   Centre for Rural and Remote Mental Health, *Submission 87*, p. 5.

92   Australian Mental Health Commissions, *Submission 52*, pp. 7–8; see also Rural Doctors Association of Australia, *Submission 79*, p. 11; Consumers Health Forum of Australia, *Submission 10*, p. 6.

93   See, for example, WA Primary Health Alliance, *Submission 33*, [p. 9]; Mr Grant Akesson, Primary Health Tasmania, *Committee Hansard*, Devonport, 5 September 2018, pp. 10–11.

necessarily always about a service gap: it's about the interaction of the service providers at that level.[94]

2.86   The Western Queensland PHN made a similar point, stating that evidence from its commissioned service providers indicates 'the increased need for collaboration between services to facilitate shared care planning'. However, the PHN also noted that an aversion among service providers in the region to collaboration, as well as perceived market competition, feared loss of intellectual property and branding, and other structural, financial and organisational barriers, are contributing to fragmentation and duplication within that region.[95]

Inadvertent duplication of services

2.87   Many submitters and witnesses reported that lack of coordination from service providers and funding streams from multiple sources are causing inadvertent duplication in commissioned mental health services in rural and remote areas and contributing to consumers' difficulty in accessing the right service at the right time.[96]

2.88   The Mental Health Council of Tasmania told the committee that there 'isn't any coordination at a regional level' in Tasmania to ensure that funding from multiple sources, such as the PHN, state and federal governments, is used effectively and efficiently.[97]

2.89   AMSANT submitted that having multiple sources of Social and Emotional Wellbeing and suicide prevention funding for the Northern Territory (NT) (i.e. PHNs, Department of Health, Department of Prime Minister and Cabinet) is causing duplication and confusion and recommended that it would 'increase efficiency and equity of funding' to direct this through a central body, such as the Commonwealth Department of Health.[98]

2.90   Dr Beryl Buckby, acting coordinator of the Clinical Psychology Program at James Cook University, told the committee at the Townsville hearing that duplication in suicide prevention programs, particularly for veterans, has also occurred in that region.[99]

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94   Mr Reg Harris, Country SA Primary Health Network, *Committee Hansard*, Whyalla, 20 July 2018, p. 50.

95   Western Queensland PHN, *Submission 125*, p. 8. See also Mr Benjamin Headlam, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 17.

96   For example: Wesley Mission, *Submission 38*, p. 9; Royal Far West, *Submission 42, Attachment 1*, p. 5; Australian College of Rural and Remote Medicine, *Submission 43*, p. 6; Central Australian Aboriginal Congress, *Submission 55*, p. 14; ARHEN Mental Health Academic Network, *Submission 76*, p. 6; National Farmers Federation, *Submission 83*, p. 7; Rural Doctors Association of Australia, *Submission 79*, p. 3.

97   Mrs Connie Digolis, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 38.

98   AMSANT, *Submission 129*, p. 4.

99   Dr Beryl Buckby, Coordinator Clinical Psychology Program (Acting), James Cook University, *Committee Hansard*, Townsville, 30 August 2018, p. 37.

2.91   Similarly, the Western Australian Government submitted that funding from multiple sources is contributing to overlaps in suicide prevention programs in that state and that 'there is scope to consider alternate funding models such as through coordinated commissioning, pooling of resources and expertise'.[100]

2.92   MindSpot, a digital mental health service provider, also recommend that greater national coordination is required to reduce duplication of resources and services in the digital mental health sector to avoid confusing consumers and health professionals.[101]

2.93   Marathon Health, a service provider in western NSW and the ACT, described how there is not necessarily a trusted partner for organisations to approach to confirm whether establishing a service in an area will 'run into somebody else'. Marathon Health explained that for independent organisations, there is a business risk in sharing plans with 'the competition', i.e. other service providers, due to the small amount of funding available.[102]

2.94   However, coordination failure between services is not necessarily deliberate. During the hearing in Katherine, Miss Mary Maloney from Wurli-Wurlinjang Health Service described working five months to establish a perinatal program in a remote community east of Katherine, only to learn by chance that representatives of another agency had been attempting to establish a similar program in the same community. Miss Maloney told the committee:

> [The program] was about to start and, by happenstance, I was talking to some people from another agency. I happened to be sharing a donga with them one night and found out that they were also about to start a new mothers group in the same community. So how onerous, time consuming, confusing for people in the community. We really need to collaborate more efficiently is my opinion. Perhaps one way of doing that is to support increased community control, so community members are actually involved in who comes into their community and delivers what service and how and when.[103]

Competitive tendering for services

2.95   Meeting the needs of the community in rural and remote areas is as much about commissioning the right provider as it is about commissioning the right service. The committee heard a number of examples throughout the inquiry of providers which are ill-suited to the needs of the community being commissioned through competitive tendering processes, in some instances taking the service away from an existing local provider.

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100   Western Australian Government, *Submission 35*, p. 13.

101   MindSpot, *Submission 5*, p. 5.

102   Mr Stephen Jackson, Chief Executive Officer, Marathon Health, *Committee Hansard*, Canberra, 19 July 2018, p. 73.

103   Miss Mary Maloney, Wellbeing Manager and Registered Mental Health Nurse, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 8.

2.96   In the Kimberley, the current funded service to develop the Halls Creek suicide network is based in Queensland, with an outreach worker based in Darwin, and in Kununurra the suicide network is managed on a fly-in, fly-out (FIFO) basis by an organisation in Sydney. The Shire of Halls Creek described that suicide prevention services in that town have little connection to local families.[104]

2.97   AMSANT observed a similar situation in the NT, expressing a view that providing mental health funding to mainstream organisations with weak links to Aboriginal communities operating services on a FIFO basis is not effective.[105] Central Australian Aboriginal Congress shared this view, explaining that 'competitive tender doesn't lead to quality or access' and that large corporations delivering services in small communities 'is not going to work; you need a regional approach'.[106] The Northern Territory PHN explained that:

> …where services target Aboriginal people we tend to prefer Aboriginal community controlled health services, or similar, to be the service providers where that is possible—which of course is not always possible—depending on the particular service.[107]

2.98   The committee also heard of instances where city-based mainstream organisations which were successful in securing contracts in rural and remote areas were unable to deliver services due to a lack of workforce and capacity in the region.[108]

2.99   The Australian College of Mental Health Nurses described a 'noticeable trend' of funding being taken away from small, locally-based and trusted providers, contracts instead being awarded to larger organisations 'with substantially greater capacity to develop a strong tender application'. In some instances, these larger organisations have not had the workforce on the ground which they claimed and have struggled to recruit a new workforce to provide the service for which they are funded.[109]

2.100   The Royal Australian College of General Practitioners echoed concerns about smaller providers in rural areas failing to secure contracts, with Dr Caroline Johnson,

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104   Mr Jake Hay, Regional Program Manager Youth, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12; Mr Simon Dann, *Committee Hansard*, Halls Creek, 5 July 2018, p. 7.

105   Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 7.

106   Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 6.

107   Mrs Nicola Herriot, Chief Executive Officer, Northern Territory PHN, *Committee Hansard*, Darwin, 9 July 2018, p. 15.

108   Ms Peta Rutherford, Chief Executive Officer, Rural Doctors Association of Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 6.

109   Australian College of Mental Health Nurses, answers to questions on notice, 19 July 2018 (received 17 August 2018); Adjunct Associate Professor Kim Ryan, Chief Executive Officer, Australian College of Mental Health Nurses, *Committee Hansard*, Canberra, 19 July 2018, p. 20.

Clinical Lead for Mental Health, observing that many mental health nurses in Victoria have lost positions 'they weren't part of more sophisticated commissioning services'. Dr Johnston told the committee that it was too soon to assume that the commissioning model is a failure, noting that PHNs have to commission services at an affordable rate, but described:

> …what has definitely happened, as a secondary consequence, is some existing relationships that were very well-established, particularly between general practice and mental health nurses, have been severely threatened, and in some cases probably irreparably harmed, and that is a great tragedy of the reform process.[110]

2.101   The Central Australian Aboriginal Congress made a link between duplication of services and competitive tendering, submitting that competitive tendering for short-term funding creates a culture of competition between providers, rather than one of collaboration and that:

> Government funding, policies and processes based on competitive tendering have unfortunately been a major driver of the disconnected, inefficient and hard-to-navigate mental health and social and emotional wellbeing system for Aboriginal communities.[111]

2.102   Service providers also told the committee about how onerous applying and reapplying for tenders can be, particularly for small organisations which are unable to dedicate a staff member to the task.[112] Derby Aboriginal Health Service described that the amount of time it takes for the organisation to tender for funding requires nearly one full-time staff member to be taken off service provision.[113] This is of particular concern due to short funding cycles, as providers need to spend considerable time in applying to maintain their services within the community.

2.103   Danila Dilba Health Service also described that the limitations on what funding is available means that some smaller organisations are being pushed to design programs which meet the requirements for tender, rather than the requirements of the community.[114]

2.104   Many submitters made the point that there is not necessarily a sufficient market for financial viability in providing mental health services in rural and remote areas, either for general mental health services or for more specialised disability

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110   Dr Caroline Johnson, Clinical Lead, Mental Health, Royal Australian College of General Practitioners, *Committee Hansard*, Canberra, 19 July 2018, p.11.

111   Central Australian Aboriginal Congress, *Submission 55*, p. 14.

112   Ms Joy McLaughlin, Senior Officer, Strategy, Research and Policy, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p. 25.

113   Dr Prue Plowright, Senior Medical Officer, Derby Aboriginal Health Service, *Committee Hansard*, Derby, 6 July 2018, p. 7.

114   Mr Malcolm Darling, Acting Chief Executive Officer, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p. 24.

mental health under the NDIS, which can also impact on who tenders to deliver a service.[115]

Contracts and funding insecurity

2.105   The committee was concerned by the large number of providers who gave evidence about the impact of short-term funding contracts on their ability to deliver long-term mental health services in rural and remote communities.

2.106   At the committee's first hearing in Albany on 5 June 2018, several local service providers had not yet received confirmation of ongoing PHN funding for the 2018–19 financial year, commencing three weeks later. Providers told the committee that, if they did receive funding from that date, it would likely be granted for another 12 months only and that they would face ongoing uncertainty.[116] The committee heard that this situation was common across the country, with providers in many other locations also facing the uncertainty of receiving only 12 months' worth of funding at a time.[117] The impact of short funding cycles on workforce recruitment and retention in particular was a common theme throughout the inquiry and is explored in Chapter 5.

2.107   The committee heard that short, year-to-year contracts from PHNs to providers have been a run-on effect of similarly short-term funding from the Commonwealth to the PHNs.[118] Primary Health Tasmania explained that:

> Unfortunately, we have to [give 12 month contracts] because that's the length of the funding we receive from the Commonwealth as PHT. Our understanding is that there is work underway to address that and that will

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115   Australian Psychological Society, *Submission 103*, p. 15; Community Mental Health Australia, *Submission 16*, p.10; Flourish Australia, *Submission 50*, [p.1]; Mental Health Victoria, *Submission 51,* p. 7; Benevolent Society, *Submission 71*, p. 3; Australian Services Union, *Submission 94*, pp. 5–6. See also: Mr Stuart Gordon, Chief Executive Officer, Western Queensland PHN, *Committee Hansard,* Mount Isa, 29 August 2018, p. 6; Mr Luke Butcher, Area Manager, Western New South Wales and Special Projects, Mission Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 69; Mr John Mendoza, Director, ConNetica; and Adjunct Associate Professor, Brain and Mind, University of Sydney, *Committee Hansard*, Canberra, 18 September 2018, pp. 21–22.

116   Dr Andrew Wenzel, Manager, Headspace Albany, *Committee Hansard*, Albany, 5 June 2018, p. 20; Ms Alison Woollard, Mental Health Manager, Amity Health, *Committee Hansard*, Albany, 5 June 2018, p. 20; Ms Fiona-Marie Kalaf, Chief Executive Officer, Youth Focus, *Committee Hansard*, Albany, 5 June 2018, p. 21.

117   Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 8; Mr Grant Akesson, Primary Health Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 13.

118   Mr Benjamin Headlam, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 21; Mr Reg Harris, Country SA Primary Health Network, *Committee Hansard*, Whyalla, 20 July 2018, p. 51; ARHEN Mental Health Academic Network, *Submission 76*, p. 9. See also: Australian Association of Social Workers, *Submission 102*, p. 6.

go into longer-term contracts. Our intent would be that when we get longer-term contracts we'll provide longer-term contracts for our providers.[119]

2.108   For this reason, beyondblue recommended to the committee that PHNs should receive long-term funding in order to commission and develop long-term solutions for mental health in communities.[120]

2.109   A significant number of submitters and witnesses recommended that service providers be commissioned with longer minimum contract lengths, generally three or five years, to ensure that communities and providers alike have long-term security in mental health services.[121] Others suggested that three or five years is still insufficient time in terms of continuity of care for patients, employment security for staff and establishment of infrastructure[122] and recommended that Australia consider adopting even longer contract terms of 10 years or more for mental health service provision.[123]

Finding flexibility in funding

2.110   Another major challenge in commissioning services is allowing sufficient flexibility to meet the needs of the community within the funding granted to service providers.

2.111   A consistent recommendation throughout the inquiry was that service funding, particularly in rural and remote locations, should be provided as part of a 'block funding' model to allow organisations greater flexibility in service delivery to meet the needs of their community. The Royal Flying Doctor Service summarised the benefits and flexibility of block funding:

> The benefit of block funding as opposed to fee for service is that it allows for flexibility for the clinician to spend more time with the individual patient and to tailor the interface with the patient around the patient's needs rather than the service provider's needs. But it also provides the flexibility to us as the service provider to determine which skill best suits the individual or the community that we are serving. Is it a psychiatrist, a psychologist, a mental health nurse, a community worker or an allied health

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119   Mr Grant Akesson, Primary Health Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 13.

120   beyondblue, *Submission 85*, p. 3. See also: Ms Georgina Harman, Chief Executive Officer, beyondblue, *Committee Hansard*, Canberra, 19 July 2018, p. 42.

121   For example: Ms Roslyn Atkinson, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 33; MindSpot, *Submission 5*, p. 5; Western Australian Association for Mental Health, *Submission 34*, p. 14; Wesley Mission, *Submission 38*, p.12.

122   Western Australian Association for Mental Health, *Submission 34*, p. 22; Australian College of Rural and Remote Medicine, *Submission 43*, p. 4; Central Australian Aboriginal Congress, *Submission 55*, p. 15; Australian Services Union, *Submission 94*, p. 11.

123   Yura Yungi Medical Service Aboriginal Corporation, *Submission 70*, [p. 2]; Dr Andrew Wenzel, Headspace Albany, *Committee Hansard*, Albany, 5 June 2018, p. 21.

worker? That is determined by the circumstances of the individual patient or that community.[124]

2.112 Witnesses have described that a loss of block funding and a movement towards grants-based and fee-for-service funding makes it difficult to provide mental health services, particularly for organisations providing services under the NDIS.[125] Mr Ivan Frkovic, the Queensland Mental Health Commissioner, explained how, without block funding, organisations providing mental health services under the NDIS do not receive adequate funding for the kinds of overhead costs of keeping an organisation running, as the 'funding model is solely designed on the services delivered to the individual'. He told the committee that:

> The margins for organisations to have adequate funds to be able to put back into training into quality, into governance and all those things are minimal, marginal…[The NDIS funding model] doesn't think about the survival of the organisation that actually has to deliver [services]. More and more we're moving into these funding models that are much more focused on the individual, which is important, and individual needs, choice and control— and I'm certainly very supportive of that. At the same time, we've seen these funding models having major impacts on organisations to be able to train these staff, retain their staff, meet quality standards, improve their reporting, improve their IT systems, HR systems et cetera.[126]

2.113 The committee also heard that, for a person-centred or client-driven approach to mental health services to be successful, a level of flexibility will be needed, as mental health is difficult to compartmentalise and people sometimes require treatment across multiple health and social areas.[127] For example, the Australian College of Mental Health Nurses explained that it can be difficult to determine whether people with a mental illness are using drugs and alcohol to self-medicate or whether the drug and alcohol problems are causing the mental health problems.[128] The significant relationship between mental health and substance use and abuse is discussed in Chapter 3 of this report.

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124 Dr Martin Laverty, Chief Executive, Royal Flying Doctor Service of Australia, *Committee Hansard*, Townsville, 30 August 2018, p. 6.

125 See, for example: Ms Heather Alexander, Director, Rural and Remote, Centacare North Queensland, *Committee Hansard*, Mount Isa, 29 August 2018, p. 19; Mr Ivan Frkovic, Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Mount Isa, 29 August 2018, p. 52; Ms Helen Egan, TeamHEALTH, *Committee Hansard*, Darwin, 9 July 2018, p. 20; Mr Phil Ihme, Senior Director Mental Health Services, Northern Australia Primary Health Limited, *Committee Hansard*, Townsville, 30 August 2018, p. 18.

126 Mr Ivan Frkovic, Queensland Mental Health Commission, *Committee Hansard*, Mount Isa, 29 August 2018, p. 52.

127 Ms Roslyn Atkinson, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 33.

128 Adjunct Associate Professor Kim Ryan, Australian College of Mental Health Nurses, *Committee Hansard*, Canberra, 19 July 2018, p. 15.

2.114   The Northern Queensland PHN advocated for flexible, consolidated funding for regions, rather than multiple funding streams, with more focus on outcomes. Dr Vladislav Matic, Board Chair of the Northern Queensland PHN, expressed the view that PHNs could get 'better bang for the buck' with 'regional tailoring, client focus, community focus, regional focus, flexibility, lengths of funding terms and less bureaucracy'.[129] Danila Dilba Health Service, based in Darwin, also recommended that funding could be provided to an organisation as a single 'bucket of money' for mental health which could then be distributed as determined by the service provider to deliver a range of services and outcomes.[130]

2.115   This 'bucket of money' approach, allowing flexibility in how money can be spent to meet the needs of communities, has been one of the successes of the National Suicide Prevention Trial in Tasmania. Relationships Australia Tasmania described that the trial site approach:

> …provides a great opportunity for communities to have a direct say in the types of interventions they would like to have delivered on the ground to address the issues they're acutely aware of and grapple with on a day-to-day basis….It turns the funding approach around a little bit. Often we'll see funding that says 'We have X amount of money to deliver these particular programs; tell us how you might do that,' whereas this approach is: 'Tell us about the issues. How do you think you might address those? How much money might need you [sic] to do that work?' and then applying that.[131]

2.116   Finding flexibility to meet community needs within the PHN funding model as it stands, however, appears to be difficult for some service providers. The committee heard of one instance where a very successful Aboriginal mental health literacy program, Uti Kulintjaku administered by the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council in central Australia, was defunded because it did not neatly fit into the PHN's definition of suicide prevention and there was 'a very limited amount of funds available for that particular program area'.[132]

2.117   North and West Remote Health told the committee that service providers also lack the flexibility to use PHN block funding, even when it is available, to run mental health programs which complement MBS mental health services as this would result in non-compliant Medicare billing due to shared overhead costs of these services. Section 19(2) of the *Health Insurance Act 1973* prohibits the payment of Medicare benefits where other Commonwealth, state, territory or local government funding is provided for that service:

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129   Dr Vladislav Matic, Board Chair, Northern Queensland Primary Health Network, *Committee Hansard*, Townsville, 30 August 2018, p. 13.

130   Ms Joy McLaughlin, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p. 25.

131   Dr Michael Kelly, Chief Operating Officer, Relationships Australia Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 43.

132   Miss Christine Williamson, Director, Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 16.

> The simple way to put it is, if we see 10 people and three of those have got GP referrals and care plans, we can't see this person who has the GP referral and charge that to MBS and then see the next person who doesn't have that, who are block funded. We can't see them all together because of the whole transparency around the Medicare guideline.[133]

2.118 These issues are also not exclusive to PHN funding, with the committee hearing that other grants or business sponsorship of mental health programs are often very limited in what they can be used for. Depression Support Network Albany told the committee:

> A really hard thing with going for grants is: if you don't fit smack bang in the middle of what they're asking for, you might as well not bother applying. Often, if you do fit smack bang in the middle of what they're asking for, they'll go, 'We'll pay for a telly.' I might not need a telly, but I might need to pay the insurance. Having something that would cover running costs would be a huge difference.[134]

Committee view

2.119 The committee is concerned by the number of service providers facing uncertainty in funding for mental health services in rural and remote Australia. The committee believes that the year-to-year and other short-term funding from the Commonwealth Government to the PHNs is having an adverse run-on effect for service providers who already struggle to provide services in some regions without the added uncertainty of whether they will have ongoing funding.

2.120 The committee also holds serious concerns about the impact of competitive tendering processes on local service providers that are unable to dedicate the resources required to compete for big contracts. These local service providers have an understanding of their communities that cannot be matched by large city-based organisations with little if any connection to the state, let alone the region.

2.121 The committee recognises that there are significant difficulties faced by funding providers to identify and meet the needs of diverse communities in rural and remote Australia and to commission services to meet those needs within their funding allocation. However, it is clear that further dedication to understanding these needs is absolutely necessary to ensure that appropriate mental health services are available to all consumers in Australia.

2.122 The committee considers that block funding of some services for rural, regional and remote areas should be reconsidered.

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133 Mrs Evelyn Edwards, Chief Executive Officer, North and West Remote Health, *Committee Hansard*, Townsville, 30 August 2018, p. 12. See also: Mr Stuart Gordon, Western Queensland PHN, *Committee Hansard,* Mount Isa, 29 August 2018, p. 6.

134 Ms Johnette Brown, President/Coordinator, Depression Support Network Albany, *Committee Hansard*, Albany, 5 June 2018, pp. 31–32.

Technology and service provision

2.123   Throughout this inquiry, the committee received extensive evidence about how technology can deliver, augment and inform mental health service provision in rural and remote Australia.

2.124   Submitters and witnesses told the committee how telehealth can be an important method of service delivery for many people in rural and remote locations,[135] but cannot replace the genuine need for other mental health services, particularly face-to-face services.[136]

Telehealth

2.125   Telehealth is defined as 'use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance' and was the term generally used by witnesses and submitters to this inquiry to refer to the provision of mental health services via telephone and video.[137] The committee heard how telehealth is being used to provide services in rural and remote locations where other services are inaccessible because of factors such as distance, travel cost or lack of available health professionals.[138]

2.126   While some telehealth services are funded through state and territory initiatives[139] or accessed on a private patient basis, the most significant telehealth service for mental health is the federally-funded Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative. The Better Access initiative was expanded by the Department of Health in 2017 to

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135   Australian Psychological Society, *Submission 103*, p. 16; Consumers Health Forum of Australia, *Submission 10*, p. 6; Western Queensland PHN, *Submission 125*, p. 7; NACCHO, *Submission 128*, p. 7; AMSANT, *Submission 129*, p. 7; National Rural Health Alliance, *Submission 37*, p. 20; Northern Territory PHN, *Submission 54*, [p. 5]; Central Australian Aboriginal Congress, *Submission 55*, pp. 15–16; Royal Australasian College of Physicians, *Submission 78*, p. 5; Rural Doctors Association of Australia, *Submission 79*, p. 13.

136   Mental Illness Fellowship of Australia, *Submission 20*, p. 1; Centre for Mental Health Research, Australian National University, *Submission 1*, [p. 1]; Western Queensland PHN, *Submission 125*, p. 9; AMSANT, *Submission 129*, p. 7; Services for Australian Rural and Remote Allied Health, *Submission 21*, [p. 4]; Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, *Submission 26*, p. 12; Western Australian Association for Mental Health, *Submission 34*, p. 21; National Rural Health Alliance, *Submission 37*, pp. 20–21; Australian College of Rural and Remote Medicine, *Submission 43*, p. 8; Australian Rural Health Workforce Agencies, *Submission 48*, p. 8; Central Australian Aboriginal Congress, *Submission 55*, pp. 15–16; Occupational Therapy Australia, *Submission 65*, p. 16; Australasian College for Emergency Medicine, *Submission 91*, p. 7; Royal Australasian College of Physicians, *Submission 78*, p. 7.

137   Department of Health, *Telehealth*, http://www.health.gov.au/internet/main/publishing.nsf/content/e-health-telehealth (accessed 13 November 2018).

138   These barriers to access are discussed in detail in Chapter 3.

139   See, for example: Victorian Government, *Submission 100*, p. 7; NSW Government, *Submission 106*, pp. 17–18; Western Australian Government, *Submission 35*, pp. 22–24.

include a measure for telehealth provision of mental health services for people in rural and remote Australia from allied health professionals only.[140]

2.127   At the time of the referral of this inquiry to the committee, the Better Access initiative had a requirement that one of the first four Better Access sessions be delivered 'face-to-face to facilitate a personal connection with the treating allied health professional'.[141] This was widely criticised by witnesses and submitters, who noted that barriers which lead to people accessing telehealth can prevent them from seeking face-to-face services.[142] Others criticised that GPs were unable to access the MBS items for the telehealth measure for people in rural and remote locations.[143]

2.128   However, in acknowledgement of these concerns, the Department of Health removed the requirement for face-to-face sessions from 1 September 2018[144] and the Better Access initiative was expanded from 1 November 2018 to allow GPs to also provide telehealth services to the rural and remote population.[145]

2.129   The committee also heard that while telehealth plays an important role in service provision in rural and remote Australia, access to telecommunications infrastructure is still a major barrier for many people. These barriers to access are addressed in further detail in Chapter 3.

Online platforms and apps

2.130   The committee also heard how websites, online platforms and apps are being used for mental health literacy and to deliver mental health services for people in rural and remote locations, particularly at the 'early intervention' level of the stepped care approach. Many of these products are designed to deliver sub-clinical self-help services, or act as a referral to appropriate care, while others provide clinical services. Some key examples include:

- Head to Health, a federally-funded digital mental health gateway, which links consumers to early intervention and lower-level mental health services. This website has a dedicated page of information for people in rural and remote

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140   Department of Health, *Submission 30*, pp. 39–40.

141   Department of Health, *Submission 30*, pp. 39–40.

142   Mr Michael Tunnecliffe, Clinical Psychologist, Ashcliffe Psychology, *Committee Hansard,* Albany, 5 June 2018, pp. 38–39; Ms Christine Franklin, Member, Services for Australian Rural and Remote Allied Health, *Committee Hansard*, Mount Isa, 29 August 2018, p. 37; Australian Psychological Society, *Submission 103*, p. 3; MindsPlus, *Submission 15*, p. 3; National Rural Health Alliance, *Submission 37*, p. 5; Royal Far West, *Submission 42*, [p. 3]; Orygen, *Submission 44*, p. 10; National Centre for Farmer Health, *Submission 56*, p. 5; Regional Australia Institute, *Submission 53*, p. 7; Northern Territory PHN, *Submission 54*, [p. 5].

143   GPMHSC, *Submission 23*, p. 5; Royal Australian College of General Practitioners Rural, *Submission 24*, [p. 5]; Australian College of Rural and Remote Medicine, *Submission 43*, p. 9.

144   Dr Alison Morehead, Department of Health, *Committee Hansard*, Canberra, 18 September 2018, p. 2.

145   Ms Emma Wood, Department of Health, *Committee Hansard*, Canberra, 16 October 2018, p. 11.

areas, a search function that includes a regional filter, and a decision support 'chatbot' tool.[146]

- The Black Dog Institute's numerous 'e-mental health' programs, such as StepCare, a mobile tablet-based screening tool which detects symptoms of depression, anxiety and suicide risk among patients in the GP waiting room and provides evidence-based stepped care recommendations to the GP to assist in discussing results with the patient; and iBobbly, a suicide prevention app for young indigenous Australians.[147]

- ReachOut's tools and programs, including Next Step, a tool that recommends customised support options based on a young person's symptoms and how significantly the symptoms are affecting them; apps for managing sleep, worry and anxiety; and ReachOut Orb, a digital game designed for use in Year 9 and 10 classrooms which aims to improve understanding of mental fitness and wellbeing.[148]

- beyondblue's Support Service via web chat and telephone, and online forums for people who have an experience of depression, anxiety or suicide, which offer an avenue for peer support and are moderated to maintain a safe space for participants.[149]

- The eheadspace service, which provides the headspace model of mental health services for young people via web chat, email and by telephone. 25.5 per cent of serviced clients accessing eheadspace were in rural and remote locations.[150]

2.131   Some submitters have cautioned that platforms and apps such as these should be used only in certain circumstances, with the Australian Psychological Society commenting that the use of technology should be considered in the context of stepped care and 'not be used to substitute for appropriate monitoring and interventions where the severity of an individual's mental health symptoms are regarded as moderate to severe'.[151]

2.132   NACCHO further submitted that, although mental health apps have great potential, there is an increasing importance that they are inclusive and culturally appropriate for Aboriginal and Torres Strait Islander consumers.[152] Black Dog

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146   Department of Health, *Submission 30*, p. 39; Department of Health, answers to questions on notice, 18 September 2018 (received 11 October 2018).

147   Black Dog Institute, *Submission 47*, pp. 12–13.

148   ReachOut, *Submission 72*, p. 4.

149   beyondblue, *Submission 85*, p. 17.

150   Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation Ltd, *Committee Hansard*, Canberra, 19 July 2018, pp. 67–68; Department of Health, *Submission 30*, pp. 41–42.

151   Australian Psychological Society, *Submission 103*, p. 16.

152   NACCHO, *Submission 128*, p. 7. See also: Aboriginal Health and Medical Research Council of NSW, *Submission 99*, p. 8.

Institute told the committee that its mobile app iBobbly is the first suicide prevention app specifically designed for young indigenous Australians and was developed in partnership with Aboriginal communities in the Kimberley region.[153]

2.133   The Queensland Nurses and Midwives' Union also noted the importance of clinical guidance in developing these tools and the need for reliable infrastructure.[154] As with telehealth, access to telecommunications infrastructure is a barrier for people in rural and remote locations accessing web- or mobile-based mental health tools and services.

Mapping and data for service design and delivery

2.134   The committee received evidence about projects which are using information and data about mental health services and the prevalence of suicide to inform planning and commissioning of services in rural and remote areas.

2.135   For example, the Primary Mental Health Care Minimum Data Set has been designed to allow PHNs and the Department of Health to monitor the quality and quantity of mental health service delivery by commissioned providers. This data is also intended to inform future improvements in planning and funding of mental health services though the PHNs.[155]

2.136   The Department of Health submitted that:

> While it will take up to a decade to consolidate a robust database to inform national policy and decision-making, this information is already available to PHNs to support them in their planning.[156]

2.137   The Centre for Rural and Remote Mental Health told the committee that the establishment of this data set is a 'positive step' and recommended that the opportunity should be taken to more widely link this data with other health and social data sets.[157]

2.138   Case studies of two major projects using health and social data—the integrated atlases of mental health and the LifeSpan suicide prevention trials—are detailed below.

Case study: Integrated atlases of mental health

2.139   While it is a role of all PHNs to undertake a degree of service mapping to identify gaps in services and the needs of their local communities, the committee heard that several PHNs have taken the step of commissioning integrated atlases of mental health to inform their planning and understanding of the region.

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153   Ms Nicole Cockayne, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 12.

154   Queensland Nurses and Midwives' Union, *Submission 36*, p. 13.

155   Department of Health, *Submission 30*, p. 20.

156   Department of Health, *Submission 30*, p. 20.

157   Centre for Rural and Remote Mental Health, *Submission 87*, p. 5.

2.140   An integrated atlas of mental health is a service assessment and decision support tool which collects information about mental health services in an area. In Australia, these atlases are produced through the University of Sydney, the ANU and ConNetica, a mental health and suicide prevention social enterprise, and have so far been produced for mainly metropolitan regions.[158]

2.141   An integrated atlas of mental health is built using a standardised classification system, known as the Description and Evaluation of Services and Directories in Europe for Long-Term Care (DESDE-LTC), which allows data to be compared between different geo-demographic areas. The DESDE-LTC was originally designed to map health issues which require long term care, but has been applied to mental health in Australia to include services across a wide range of care intensities and durations. Services are classified in the atlas by the main care structure or activity, as well as the level of availability and utilisation.[159] Mr John Mendoza, Director of ConNetica and Adjunct Associate Professor, Brain and Mind at the University of Sydney, who has been involved in the development of many of the atlases, described for the committee that:

> What these give us is a quite unparalleled visual understanding of what are the population needs in each of those regions, but also what is the capacity and, if you like, the spectrum of care that is available and whether they are located where the population needs are.[160]

2.142   Professor Luis Salvador-Carulla, Centre Head of the ANU Centre for Mental Health Research and coordinator of the DESDE-LTC project, told the committee that developing data of this kind means that it is possible to compare what is happening with rural and remote mental health in other countries with similar regions in Australia; this is how the ANU Centre for Mental Health Research is able to compare mental health services in the Pilbara and the Kimberley with those in the Lapland region of Northern Finland.[161]

2.143   The WA Primary Health Alliance and the Mental Health Commission of WA partnered with ConNetica to produce the first atlas of this nature to map an entire state of Australia. The WA atlas is split into four stand-alone atlases: Metropolitan Perth; Country WA; the Kimberley Region; and Perth North PHN. The WA Primary Health Alliance told the committee how this project would help to identify gaps and

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158   ANU Centre for Mental Health Research, *Atlas of Mental Health Care*, https://rsph.anu.edu.au/research/projects/atlas-mental-health-care (accessed 13 November 2018).

159   Luis Salvador-Carulla et al for DESDE-LTC Group (editors), *DESDE-LTC*: *Evaluation and classification of services for long term care in Europe*, Psicost and Catalunya Caixa , Spain, 2011; ConNetica Consulting, *Integrated Atlas of Mental Health and Alcohol and Other Drugs of Western Australia: Volume 2, Country WA 2017,* pp. 3–4.

160   Mr John Mendoza, ConNetica and University of Sydney, *Committee Hansard*, Canberra, 18 September 2018, p. 17.

161   Professor Luis Salvador-Carulla, ANU Centre for Mental Health Research, *Committee Hansard*, Canberra, 18 September 2018, p. 19.

duplication across mental health services in the state and to help make comparisons with other similar locations. Dr Daniel Rock, Principal Adviser and Research Director for the WA Primary Health Alliance, described that:

> Looking at the data at the moment, it's fascinating. We have in the rural areas some rather unusual service distributions compared to other places in the world and notable gaps. The atlas doesn't say whether that's good or bad; it just says that that's different.[162]

2.144   Community Mental Health Australia told the committee that the kind of detail offered by these atlases is needed in many regions to get a comprehensive understanding of service availability.[163]

Case study: The LifeSpan trials and suicide prevention data

2.145   The committee heard how one of the most significant suicide prevention programs in Australia, the Black Dog Institute's LifeSpan, is using scientific modelling to implement evidence-based, integrated suicide prevention trials across the country.

2.146   The LifeSpan program uses nine strategies, ranging from an individual level to the whole population, shown in evidence from international studies to reduce suicide. These strategies, which have a focus on a community-led approach to suicide prevention, are demonstrated in Figure 2.3.[164]

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162   Dr Daniel Rock, WA Primary Health Alliance, *Committee Hansard*, Albany, 5 June 2018, p. 16.

163   Ms Amanda Bresnan, Community Mental Health Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 30.

164   Black Dog Institute, *Submission 47*, p. 1; Black Dog Institute, *LifeSpan strategies and components,* https://www.blackdoginstitute.org.au/research/lifespan/lifespan-strategies-and-components (accessed 13 November 2018).

Figure 2.3—LifeSpan strategies
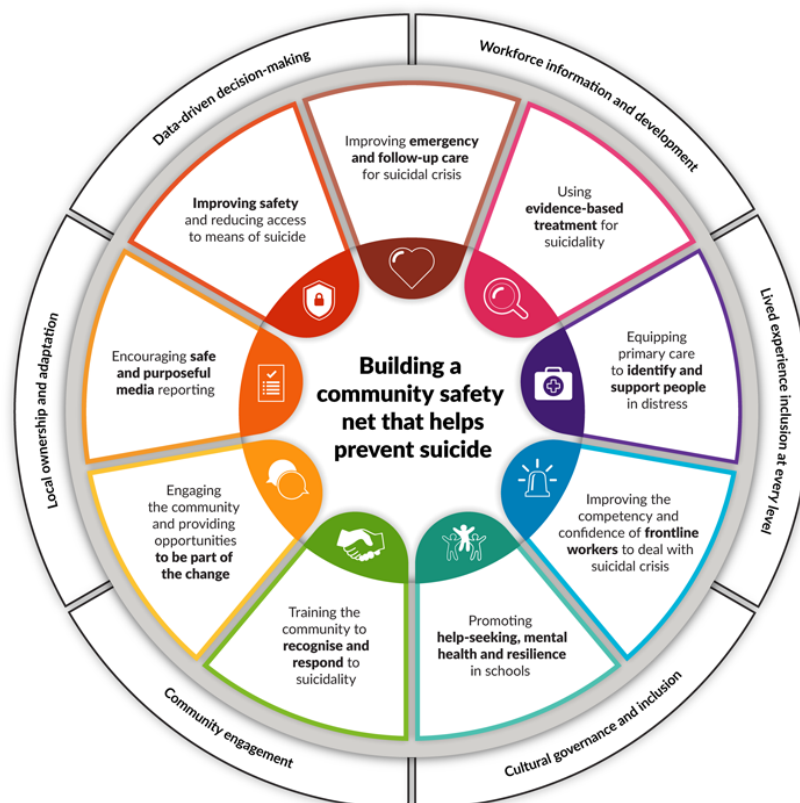
Source: The Black Dog Institute.[165]

2.147   LifeSpan was initially developed on behalf of the NSW Mental Health Commission by the Black Dog Institute and the National Health and Medical Research Council Centre for Research Excellence in Suicide Prevention. Black Dog received grant funding from the Paul Ramsey Foundation to deliver and evaluate LifeSpan in four regional NSW trial sites.[166] A fifth trial of LifeSpan, funded by the ACT Government, has recently commenced in Canberra.[167]

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165   Black Dog Institute, *LifeSpan,* https://www.blackdoginstitute.org.au/research/lifespan (accessed 13 November 2018).

166   Black Dog Institute, *Submission 47*, p. 1; Black Dog Institute, *LifeSpan sites,* https://www.blackdoginstitute.org.au/research/lifespan/lifespan-sites (accessed 13 November 2018); Ms Nicole Cockayne, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 11.

167   ACT Health Office for Mental Health and Wellbeing, *LifeSpan – Integrated Suicide Prevention*, https://www.health.act.gov.au/about-our-health-system/office-mental-health-and-wellbeing/lifespan-integrated-suicide-prevention (accessed 14 November 2018).

2.148   The Black Dog Institute is also using the LifeSpan approach to support the 12 federally-funded National Suicide Prevention Trial sites and a further 12 place-based trials in Victoria funded by the state government.[168]

2.149   The Black Dog Institute submitted that LifeSpan has been informed by 'Big Data used Intelligently for Suicide Prevention' through a partnership with the ANU and the SAS Institute.[169] Ms Nicole Cockayne, Director of Discovery and Innovation at the Black Dog Institute, told the committee that this means that:

> Black Dog's data team can link previously unrelated datasets from the coroner's office, police, ambulance and hospitals. We can incorporate additional data from health workforce and mental health services, socioeconomic factors, geographical profile and other social risk factors— all of this to build a comprehensive picture to assist a community's early intervention and prevention strategies.[170]

2.150   Ms Cockayne described that this approach to data is a 'powerful tool to enable policymakers, government, planners and health professionals to provide targeted services, supports and means to prevent and reduce suicide' which also allows the Black Dog institute to measure the impacts of the prevention program trials.[171]

2.151   However, the committee heard about the frustrations faced by Black Dog Institute, as well as other organisations, in accessing the necessary data sets to make suicide prevention tools like this a reality. Evidence to the committee demonstrated that there can be a significant lag, sometimes of years, in receiving up-to-date data about suspected suicides.[172] Orygen also noted the need for improved national data sets for the mental health experience of Australians in general.[173]

Concluding committee view

2.152   The committee recognises that the frameworks by which mental health services are funded, commissioned and delivered in rural and remote Australia are incredibly complex, that the concerns of rural and remote communities about the

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168   Black Dog Institute, *Submission 47*, p. 1; Black Dog Institute, *LifeSpan sites,* https://www.blackdoginstitute.org.au/research/lifespan/lifespan-sites (accessed 13 November 2018); Ms Nicole Cockayne, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 11.

169   Black Dog Institute, *Submission 47*, p. 3.

170   Ms Nicole Cockayne, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 11.

171   Ms Nicole Cockayne, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 11.

172   Ms Paula Chatfield, Executive Director for Mental Health, WA Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 4; Ms Wendy French, Managing Consultant, Talking about Suicide; Member, Break O'Day Suicide Prevention Trial Working Group, *Committee Hansard*, St Helens, 6 September 2018, p. 2; Ms Nicole Cockayne, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 14.

173   Orygen, *Submission 44*, p. 3.

services available to them are great, and that the challenges for local mental health service providers are many.

2.153   It is essential that the mental health services commissioned and delivered in a rural or remote community not only meet the needs of that community, but also are welcomed and trusted. Allowing for longer-term service provision contracts for local providers could be the key to building service capacity, enticing a workforce and developing meaningful, productive relationships with the local community. Greater flexibility in that funding is required for providers to adequately meet the unique and changing needs of each rural and remote community.

2.154   Identifying the needs of a community is a major challenge for all funding providers and the committee is pleased to see that work is being done to use data and mapping to inform this process. However, the committee wishes to emphasise that, in the same way as telehealth cannot replace face-to-face mental health services, data about a community cannot replace the need for face-to-face consultation with members of that community.

2.155   The committee is of the view that the way mental health services are planned and commissioned needs serious review at a national, strategic level. It is not the role of any one PHN, government or organisation to be solely responsible for the planning and coordination of all mental health services in rural and remote Australia. Instead, frequent collaboration is needed between all stakeholders, including representatives of the community, to ensure that the right mental health services are available in the right place at the right time.

Chapter 3
Barriers to accessing mental health services

3.1   Throughout this inquiry, the committee heard there were numerous barriers specific to rural and remote communities which restricted or prevented people from accessing mental health services.

3.2   The Australian Mental Health Commissions submitted that there are many factors unique to rural and remote communities which impact their ability to access mental health services, as well as increase their likelihood of experiencing mental illness:

> Although social features of rural and remote communities are protective of mental health, for example resilience and a sense of community, people living in rural and remote areas can also be exposed to a variety of risk factors that contribute to mental ill-health. These are often tied to their location and include environmental adversity, geographic isolation, poorer socioeconomic circumstances, and restricted access to services. For Aboriginal and Torres Strait Islander peoples, the above risk factors associated with living in rural and remote Australia are compounded by the historic and cultural experiences of intergenerational trauma and socioeconomic deprivation.[1]

3.3   This chapter will outline the rates at which rural and remote Australians access mental health services and the factors which contribute to the availability of these services. It will consider the practical effects of distance and other social determinants of health which are felt by rural and remote communities. Finally, this chapter will consider the continuing impact of stigma and concerns regarding privacy and confidentiality, which are pertinent to small communities.

Access rates of mental health services

3.4   While the prevalence of mental illness is similar across Australia, evidence provided to the committee suggested that people living in rural and remote areas access mental health services at a much lower rate than people living in major cities and inner regional areas.[2]

3.5   In 2016–17, people living in major cities accessed Medicare Benefits Schedule (MBS) funded mental health services at a rate of 495 encounters per 1000 people. The rate of encounters decreases the more remote the location, with 297 encounters per 1000 people for outer regional areas, 145 per 1000 people for remote areas and 81 encounters per 1000 people for very remote areas.[3]

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1   Australian Mental Health Commissions, *Submission 52*, p. 9.

2   See, for example: Department of Health, *Submission 30*, p. 12; Royal Flying Doctor Service (RFDS), *Submission 22*, Attachment 1, p. 9; National Rural Health Alliance, *Submission 37*, p. 7.

3   Department of Health, *Submission 30*, p. 13.

3.6   The rate of encounters with MBS funded mental health services decreases rapidly by remoteness across the range of mental health service providers available including psychiatrists, psychologists, general practitioners (GPs) and allied health professions, as demonstrated in Table 3.1 below.

Table 3.1—Medicare-subsidised mental health services, by provider type and remoteness area, per 1000 population (2016–17)

Remoteness area	Psychiatrists		Clinical psychologists		Other psychologists		General practitioners		Allied health professionals	
	Rate	Comparison	Rate	Comparison	Rate	Comparison	Rate	Comparison	Rate	Comparison
Major cities	114.0	0	100.3	0	120.0	0	146.2		14.9	0
Inner regional	72.5	1.6 times lower	77.0	1.3 times lower	115.3	1.0 (same)	150.1	1.0 (same)	21.9	1.3 times higher
Outer regional	46.1	2.8 times lower	42.4	2.4 times lower	76.4	1.6 times lower	116.1	1.3 times lower	15.4	1.0 (same)
Remote	28.5	4.0 times lower	18.8	5.3 times lower	27.8	4.3 times lower	63.2	2.3 times lower	6.8	2.2 times lower
Very remote	18.9	6.0 times lower	11.1	9.0 times lower	16.6	7.2 times lower	32.9	4.4 times lower	2.3	6.5 times lower

Source: RFDS.[4]

3.7   As a percentage of the population, 10.2 per cent of people in major cities accessed MBS subsidised mental health services, compared to only 8.1 per cent in outer regional areas, 4.8 per cent in remote areas and 2.8 per cent in very remote areas.[5]

3.8   The committee heard that the low rate of encounters with MBS funded mental health services is of concern as lower access to early intervention services can result in intensification of need, comorbidity, chronic conditions and greater rates of hospitalisation.[6]

Are services available when and where they are needed?

3.9   As noted in Chapter 2, one of the goals of Primary Health Networks (PHNs) is to ensure patients are receiving the right care, in the right place, at the right time.[7] However, evidence provided to the committee suggested that people in rural and remote communities are not accessing mental health services as often as people in urban locations, in part because the right care is not available at all, or it is not open when people need it most. The following discussion outlines these issues.

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4   RFDS, *Submission 22*, p. 4.

5   Department of Health, *Submission 30*, p. 12.

6   Department of Health, *Submission 30*, p. 9.

7   Department of Health, *Submission 30*, pp. 4–5.

Availability of mental health services

3.10   Numerous submitters and witnesses indicated that the low rate of access to mental health services could be partially attributed to the limited number of practicing mental health professionals in rural and remote Australia.[8]

3.11   In regional areas, the per capita number of psychiatrists, mental health nurses and psychologists in 2015 were, respectively, 36 per cent, 78 per cent and 57 per cent of those in major cities, with even poorer comparisons in remote areas, as demonstrated in Table 3.2 below.[9]

Table 3.2—Number of mental health professionals (clinical FTE per 100 000 population) by remoteness, 2015

	Major cities	Inner regional	Outer regional	Remote	Very remote
Psychiatrists	13	5	4	5	2
Mental health nurses	83	74	46	53	29
Psychologists	73	46	33	25	18

Source: Department of Health.[10]

3.12   The Royal Flying Doctor Service (RFDS) submitted that in 2015, 201 local government areas (LGA) did not have any psychologists registered within the area, representing approximately 36 per cent of all 564 LGAs in Australia, many of which were in rural and remote areas.[11]

3.13   The Victorian Government explained that attracting qualified mental health professionals to rural and remote areas limits the availability of mental health services:

> In many cases, the availability of appropriately skilled staff can be the single biggest contributing factor limiting the ability to provide a broader range of services in rural communities, particularly where around-the-clock care is required.[12]

3.14   The factors which contribute to the low number of mental health professional in rural and remote communities around Australia will be explored further in Chapter 5.

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8   See, for example: RFDS, *Submission 22*, pp. 2–3; Department of Health, *Submission 30*, p. 13; Victorian Government, *Submission 100*, p. 4.

9   National Rural Health Alliance, *Submission 37*, p. 14.

10   Department of Health, *Submission 30*, p. 13.

11   RFDS, *Submission 22*, p. 2.

12   Victorian Government, *Submission 100*, p. 4.

Outreach and fly-in-fly out services

3.15   The committee heard that often fly-in, fly-out (FIFO) services and outreach services are provided in rural and remote communities in an attempt to address the lack of mental health services and professionals available in rural and remote communities.[13]

3.16   Mr Brendan Morrison from the Kununurra Waringarri Aboriginal Corporation told the committee that communities are often not receptive towards FIFO workers as they only visit for short periods and have not built relationships within the community.[14]

3.17   Mrs Danielle Dyall from the Aboriginal Medical Services Alliance Northern Territory (AMSANT) also described how FIFO workers do not build relationships with the community and the impact this has on service delivery:

> Sometimes there is no cultural safety awareness. There's also the flying in and flying out and not having access to actual community members on the ground. They might not be there for appointments or they might not show up. What we find is that, when people are within the community and have those relationships, they're able to drive around and find the people that they're meant to be meeting with and meeting in a safer environment. The people who fly in and fly out may not necessarily have that sort of relationship with community members to be able to have an understanding of where to meet and that sort of thing.[15]

3.18   Similarly in Whyalla, Dr Jennifer Cleary from Centacare Catholic Country SA informed the committee that FIFO services lack important local knowledge:

> Service in remote communities often relies on fly-in fly-out visits, and FIFO as we know it creates less-individualised approaches around delivery. In the area of supporting those with a mental health challenge, which obviously can significantly range in severity or impact, those early intervention opportunities are often lost as people disengage or don't engage in the first place. Organisations which are not local often don't have the appropriate connections, knowledge or historical background and so can often struggle to engage appropriately.[16]

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13   See, for example: RFDS, *Submission 22*, pp. 4–6; Western Queensland Primary Health Network (PHN), *Submission 125*, p. 3; Ms Vanessa Harris, Executive Officer, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 9 July 2018, p. 14; Dr Jennifer Cleary, Chief Executive Officer, Centacare Catholic Country SA, *Committee Hansard*, Whyalla, 20 July 2018, p. 43.

14   Mr Brendan Morrison, Social and Emotional Wellbeing, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 4.

15   Mrs Danielle Dyall, Team Leader Trauma Informed Care and Social Emotional Wellbeing, Aboriginal Medical Services Alliance Northern Territory (AMSANT), *Committee Hansard*, Darwin, 9 July 2018, p. 10.

16   Dr Jennifer Cleary, Centacare Catholic Country SA *Committee Hansard*, Whyalla, 20 June 2018, p. 43.

3.19   Conversely, the committee also heard in Whyalla that some members of the community would prefer to see a FIFO mental health worker as this minimises the risk to their privacy and concerns regarding confidentiality in small communities.[17] The concerns regarding privacy and confidentiality will be discussed further later in this chapter.

3.20   In Mount Isa, the committee heard that outreach services face similar criticisms to those of FIFO mental health professionals, as the amount of time outreach services spend in communities is infrequent or inadequate:

> I think one of the issues when you're talking about remote communities is that most services are outreach to the communities, and it's what's happening between those visits. We speak with communities all across Australia where the psychologists might come for a day and a half once a month, and it's impossible to get time with them because of their availability.[18]

3.21   The Royal Australian and New Zealand College of Psychiatrists submitted that while FIFO and outreach services offer an alternative where specialist services are otherwise unavailable, they 'should not be seen as permanent solutions' or replacements for a workforce based on the location.[19]

3.22   The committee heard that FIFO workers may be successful in building a rapport with the community if they come regularly over a long period of time. Dr Krista Maier, a GP from the Nunyara Aboriginal Health Service told the committee that it took her three years of coming to the community on a regular basis to develop the community's trust:

> It took me three years of regularly coming up to Nunyara before I started to feel that I was an accepted and trusted member of the community, and to establish that trust... Over the years of my service, particularly at Nunyara, I have seen the beneficial effects, particularly on people's mental health, of having a constant person to touch base with by not having to tell their story over and over again but also the relationship that we develop means that they are much more likely to come in to see me when they start to struggle with their mental health.[20]

3.23   Dr Maier noted that developing this relationship required FIFO staff committing to long-term relationships with the communities that they seek to serve.[21]

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17   Ms Jane Dodding, Psychologist and Director, MindPlus, *Committee Hansard*, Whyalla, 20 June 2018, p. 41.

18   Mr Tony Cassidy, Group Manager, Wesley LifeForce, Wesley Mission, *Committee Hansard*, Mount Isa, 29 August 2018, p. 19.

19   Royal Australian and New Zealand College of Psychiatrists, *Submission 95*, p. 6.

20   Dr Krista Maier, General Practitioner, Nunyara Aboriginal Health Service, *Committee Hansard*, Whyalla, 20 July 2018, p. 35.

21   Dr Krista Maier, Nunyara Aboriginal Health Service, *Committee Hansard*, Whyalla, 20 July 2018, p. 34.

Lack of appropriate 24 hour support services

3.24   A number of submitters and witnesses told the committee that rural and remote communities lacked appropriate mental health services outside of standard business hours.[22] This is particularly problematic for mental health patients as acute episodes can often occur at night when people cannot sleep or feel socially isolated.

3.25   For example in Albany, Ms Jo Brown from the Depression Support Network Albany explained that mental health services are not available overnight:

> If you're suicidal between 8.30 am and 4.30 pm, you can go to the community mental health service. If you're suicidal after 4.30 pm and before 10.30 pm you can go to the emergency department, but you have to wait for the doctor before you can see the mental health nurse. The problem with this is, if you are having a mental health moment, you just give up and go away, because it can take up to three hours. If you're suicidal after 10.30 pm, you then have to wait for the mental health people to come back in, if you are deemed in need. We shouldn't have to be visibly distressed to convince them that we need help. A small community means people know everyone and don't want the world to know their business, so they don't go in for help.[23]

3.26   The committee heard that it is common for people experiencing mental health issues to present to their local emergency department. For example in Mount Isa, the three highest presentations to the emergency department for mental health issues included: behavioural disturbances; suicide ideation; and anxiety.[24]

3.27   However, submitters and witnesses informed the committee that often emergency departments in rural and remote communities were not conducive for mental health patients who present to the emergency department, particularly after hours when mental health specialists are not on duty.[25]

3.28   Dr Niall Small, Chair of the Rural Regional and Remote Committee for the Australasian College for Emergency Medicine, explained that emergency departments are not suitable environments for mental health patients:

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22   See, for example: Ms Cheryle Kaesler, Manager, Social Emotional Wellbeing Unit, Yura Yungi Medical Service, *Committee Hansard*, Halls Creek, 5 July 2018, p. 1; Tammy, Member, Carers Tasmania, *Committee Hansard*, St Helens, 6 September 2018, p. 50; Ms Lyn English, Consumer Deputy Co-Chair, National Mental Health Consumer and Carer Forum, *Committee Hansard*, Canberra, 19 July 2018, p. 25; Western Australia Association for Mental Health, *Submission 34*, pp. 5 and 20.

23   Ms Jo Brown, President/Coordinator, Depression Support Network Albany Inc, *Committee Hansard*, Albany, 5 June 2018, p. 27.

24   Ms Sandra Kennedy, Director Mental Health and Alcohol Tobacco and Other Drug Service, North West Hospital and Health Service, *Committee Hansard*, Mount Isa, p. 42.

25   See, for example: Dr Stephanie Trust, Principal GP, Kununurra Medical, *Committee Hansard*, Kununurra, 5 July 2018, pp. 14–15; Dr Roland Main, Area Director for Mental Health, Adults and Older Adults, WA Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 2; Roses in the Ocean, *Submission 7*, p. 4; Western Australia Association for Mental Health, *Submission 34*, p. 20; Wesley Mission, *Submission 38*, p. 15.

There are many examples of patients who present with acute mental health issues in peripheral regional and rural hospitals who are seen and assessed but who then wait many hours or even days for transfer to a mental health facility. While these patients wait, they're being cared for in a busy ED environment with constant activity, noise and lighting. Treatment options are severely limited in this situation, and these patients require specialist care in a specialist unit, not to be left in a busy emergency department. Given this scenario, patients often escalate in their behaviours and require sedation. This cycle may be repeated more than once until eventually the patient is transferred to the specialist mental health facility they require.[26]

3.29   The committee heard that where specialist mental health staff are not on duty, hospitals in rural and remote locations may be able to contact mental health specialists in a regional centre or capital city for consultations on patients who may present to emergency departments outside of business hours. For example, the Kimberley Mental Health and Drug Service explained that emergency departments across remote locations in the Kimberley can contact staff in Broome:

We have very good relationships with our emergency departments, and we have 24/7 on-call psychiatrist support after hours as well to our clinicians that work in hospital. So we can advise and assess any presentation either by videoconference or in person if necessary. It may well be that an assessment is made in the emergency department that they can go home with family.[27]

3.30   However, the committee heard that on other occasions, patients experiencing a mental health crisis who present to the emergency department at their local hospital are not assessed by a mental health specialist nor admitted to hospital:

There are numerous stories of suicide attempts being treated in hospital and accident and emergency departments, where the person is held for the minimum six hours observation only to be released back into the situation that led them to the attempt on their life without assessment by psych services whilst in A&E or treatment in the ward or follow-up by psych services after release.[28]

3.31   Dr Small explained to the committee that emergency department clinicians are skilled in the provision of urgent medical treatment and crisis interventions, but are not trained in the ongoing care and support of mental health patients and are dependent upon other components of the mental health system to provide the ongoing support required by patients.[29]

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26   Dr Niall Small, Chair, Rural Regional and Remote Committee, Australasian College for Emergency Medicine, *Committee Hansard*, Townsville, 30 August 2018, p. 34.

27   Dr Renee Bauer, Clinical Director, Kimberley Mental Health and Drug Service, *Committee Hansard,* Broome, 6 July 2018, p. 22.

28   Mr David Brennan, Chief Executive Officer, Carers Tasmania, *Committee Hansard*, St Helens, 6 September 2018, p. 48.

29   Dr Niall Small, Australasian College for Emergency Medicine, *Committee Hansard*, Townsville, 30 August 2018, p. 34.

3.32   The Western Australia Association for Mental Health submitted that emergency response services in rural and remote communities required better facilities and training to appropriately respond to acute mental health conditions 24 hours a day.[30]

3.33   Witnesses told the committee that this should include greater consideration of the design of emergency departments and how they are equipped to respond to patients experiencing psychosis, particularly where it is drug induced.[31] Dr Roland Main of the WA Country Health Service explained:

> I think we need a capacity to more safely look after people who've got that combination of acute behavioural disturbance and psychiatric symptoms as far as possible in the local setting. This is a problem which besets the whole of the country. It's more acute in rural areas because our emergency departments just don't have the capacity to contain those sorts of behavioural disturbance….
>
> The design of emergency departments is relevant as well. Methamphetamine has changed the game in that respect. Many more people are coming in with really severe behavioural disturbance due to the effects of methamphetamines. So the design and staffing have an effect on the morale and the energy of the staff in emergency departments to look after such patients.[32]

3.34   The WA Country Health Service also told the committee that the employment of psychiatric liaison nurses in regional emergency department had improved patient care, supported skill development of emergency department staff and improved connection with the community and patient's families.[33] Similarly, the committee heard that the local hospital in Whyalla has employed a mental health nurse as well as peer support works with lived experience of mental illness to better support mental health patients in emergency departments.[34]

Culturally appropriate services

3.35   For many Australians, there is the added need for mental health services to be culturally safe and to recognise the needs of diverse groups of people, including people from culturally and linguistically diverse (CALD) backgrounds, people who identify as lesbian, gay, bisexual, transgender and/or intersex (LGBTI) and Aboriginal and Torres Strait Islander peoples.

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30   Western Australia Association for Mental Health, *Submission 34*, p. 20.

31   See, for example: Dr Roland Main, WA Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 3; Ms Jo Brown, *Committee Hansard*, Albany, 5 June 2018, p. 30; Ms Elizabeth Little, Chief Executive Officer, Rural Alive and Well Inc., *Committee Hansard*, St Helens, 6 September 2018, p. 33.

32   Dr Roland Main, WA Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 3.

33   Dr Roland Main, WA Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 2.

34   Ms Lee Martinez, Secretary, Whyalla Suicide Prevention Network, *Committee Hansard*, Whyalla, 20 July 2018, p. 22.

3.36   The National Mental Health Consumer and Carer Forum submitted that two key communication barriers exist for people from CALD backgrounds. Information about services is often not available in accessible formats for these groups, compounded by poor communication and cultural differences between consumers and clinicians.[35]

3.37   The committee received evidence that for people who identify as LGTBI, a fear of discrimination from mental health staff can result in a lower take up rate of mental health services and this is felt more keenly in rural and remote areas.[36] Submitters also pointed to the higher suicide rates for people who identify as LGBTI as a reason that culturally appropriate services are critical to ensure people at risk can access appropriate therapeutic services.[37] The committee heard this need was not met in services, with the National LGBTI Health Alliance reporting that the LGBTI community has 'incredibly poor or non-existent' culturally safe access to mental health care.[38]

3.38   In rural and remote Australia, the numbers per capita of Aboriginal and Torres Strait Islander peoples are significantly higher than other groups with culturally diverse needs. One-fifth of Aboriginal and Torres Strait Islander persons live in remote or very remote areas (7.7 per cent in remote and 13.7 per cent in very remote), compared to only 1.7 per cent of non-Indigenous Australians.[39]

3.39   The committee heard that Aboriginal and Torres Strait Islander peoples in rural and remote areas face a number of barriers to access mental health services, most notably a lack of culturally appropriate services, leading to Aboriginal and Torres Strait Islander peoples accessing mental health services at a far lower rate than non-Indigenous Australians.[40]

3.40   In recognition of the far greater numbers of Aboriginal and Torres Strait Islander peoples in Australia's rural and remote communities and the unique circumstances they face, Chapter 4 will focus on the need for culturally competent services for Aboriginal and Torres Strait Islander peoples.

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35   National Mental Health Consumer and Carer Forum, *Submission 84*, p. 3.

36   Mission Australia, *Submission 80*, p. 4.

37   Victorian Council of Social Service, *Submission 107*, p. 2.

38   National LGBTI Health Alliance quoted in National Mental Health Consumer and Carer Forum, *Submission 84*, p. 3.

39   National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 128*, p. 2.

40   Aboriginal and Torres Strait Islander Healing Foundation (Healing Foundation), *Submission 39*, p. 5; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, *Submission 74*, p. 3; NACCHO, *Submission 128*, p. 3.

Services under the National Disability Insurance Scheme

3.41   As discussed in Chapter 2, many rural and remote communities are facing uncertainty, confusion and lack of services due to the rollout of the National Disability Insurance Scheme (NDIS). In some regions, the introduction of the NDIS has in turn introduced new barriers to accessing mental health services, rather than increasing the accessibility of services.

Barriers related to the NDIS rollout

3.42   In Albany, where the NDIS had not yet been rolled out at the time of the committee's hearing, witnesses described how people moving to the Great Southern region of Western Australia (WA) were struggling to access the mental health services they require under their NDIS package, as very few organisations in the region had registered as NDIS providers.[41]

3.43   The Western Australian Association for Mental Health noted that even if there are organisations registered with the NDIS in an area, they may not be able to provide mental health services:

> One of the problems in those situations is that in areas there are often no psychosocial disability services currently registered under the NDIS. We heard of one situation where a person was referred to a disability agency that had no connection with mental health, because that was the only registered provider in that region, because the NDIS hadn't been rolled out.[42]

3.44   A committee member of the Depression Support Network Albany also told the committee that there were issues in renewing NDIS packages in these areas:

> …I do know that there have been some that…have brought their package down because they've moved. They were allowed to bring their package with them, but if their package were due to be renewed, it couldn't happen down here, because it doesn't happen down here. So it's very, very hard and tricky for a lot of people. They're finding it quite a struggle.[43]

Inappropriate NDIS services

3.45   In regions where the NDIS has rolled out, there are concerns that plans are being designed and written for the services which are available in the community rather than the services genuinely needed by the individuals on plans.

3.46   Service provider selectability provided the committee with a case study of Palm Island, an island off the coast of Far North Queensland classed as 'very remote' by the NDIS. selectability noted that that the NDIS packages on the island cost

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41   Samuel Rose, Program Coordinator, Richmond Wellbeing, *Committee Hansard*, Albany, 5 June 2018, p. 34.

42   Mr Colin Penter, Projects Lead and Policy Officer, Western Australian Association for Mental Health, *Committee Hansard*, Albany, 5 June 2018, p. 49.

43   Mrs Penny Carpenter, Committee Member, Depression Support Network Albany, *Committee Hansard*, Albany, 5 June 2018, p. 34.

significantly less than those seen on the mainland, because they are drafted as a reflection of limited service availability in remote communities, as opposed to being a reflection of the actual needs of people with disability. selectability further noted that if packages correctly identified needs, that would mean services could afford to come to remote communities such as Palm Island:

> The average cost of a plan on the mainland is $35,000. On Palm it's much lower, and that's because the plans have been written for what services are available rather than what the person actually needs—but that's separate. If there are 5,000 people living on Palm Island and if 10 per cent of them were eligible for an NDIS plan, that's 500 people. If they were actually given a plan that was at least at the average level of $35,000, that's $17 million a year of economic benefit that should be actually going into Palm Island. What does that $35,000 plan equate to in a year? If you work out how many hours that equates to, it works out to providing an additional 200 full-time equivalent jobs on Palm Island.

> We raise that as a case study because if you think about the people on Palm Island who have a disability, whether it's mental health or another disability, and if the NDIS was rolled out in full—at 100 per cent—and rolled out to a time line, and if the plans were written as they should be written for what the person actually needs, the service providers would come. That would actually provide ongoing economic benefit for Palm Island, which means jobs and better lives for the people who actually have a mental illness.[44]

3.47   People who are ineligible or who have not yet received a package are also facing barriers to accessing NDIS-based services. The committee heard at its Darwin hearing that 'massive gaps' have opened in some areas because funding moved from service-level or block funding from the Department of Social Services to the insurance model of NDIS funding before alternative arrangements for continuity of support were made:

> The funding has gone in and people haven't been getting an NDIS plan. So there have been a lot of gaps. We heard stories of cases of suicide where they were waiting on a plan but didn't have any other service because the services had been shut down because all the funding had already gone over to the NDIS.[45]

3.48   In Townsville, a service provider described that people who require chronic mental health care have gone through the process of applying to the NDIS 'only to find out they're not eligible…so they get no service whatsoever.'[46] Another service

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44   Mrs Debra Burden, Chief Executive Officer, Selectability, *Committee Hansard*, Townsville, 30 August 2018, p. 47.

45   Ms Lorraine Davies, Executive Officer, Mental Illness Fellowship of Australia (NT), *Committee Hansard*, Darwin, 9 July 2018, p. 20.

46   Mrs Erica Buttigieg, Social and Emotional Wellbeing Program Manager, Townsville Aboriginal and Islanders Health Services, *Committee Hansard*, Townsville, 30 August 2018, p. 29.

provider in Whyalla described that there are barriers to even getting to the NDIS assessment processes if doctors don't understand psychosocial disability:

> Initially [the applicant] will receive an access request form, which they have to take to their GP or any other medical professional, where the doctor will fill out the form. Then that is any other information—their diagnosis or when they're not able to show their impairment impacts on their everyday living. They need evidence of their disability. All the reports evidence we submit over to the NDIS. Then that which we have had have come back that they might request more evidence, so therefore the consumer will have to go back to the doctor or find evidence elsewhere. We're finding that some of the doctors don't want to know about it, don't have time. One particular consumer was told by the doctor that she didn't have a disability—she wasn't in a wheelchair and she could walk—so he wouldn't even look at the paperwork for her. We've had consumers that have got quite upset. One in particular last week cried because she was rejected. So it is impacting a lot on the consumers. We can appeal, but what happens after that we don't really know.[47]

3.49   These concerns were similarly raised in Townsville, where a service provider suggested that people with physical disability, when compared to those with psychosocial or intellectual disability, are 'probably coming out of [the assessment process] okay and getting their needs met' as disability services have been designed around their needs.[48]

3.50   The Western Australian Association for Mental Health suggested that a 'lack of assessor, planner and service provider expertise in psychosocial disability' has resulted in 'significant variations' in assessed eligibility and approved packages in WA.[49]

3.51   Some witnesses also raised concerns that the insurance-based disability model of the NDIS is at odds with some of the recovery-based mental health supports previously offered by service providers, and that this is having detrimental effects on supporting capacity building for individuals. The Queensland State Manager of service provider Neami National told the committee that:

> The NDIS is really a disability model. In people's plans, what we're finding is that there's only a very small amount, if any, of capacity building, which is where we would see the work that Neami has done traditionally—in the capacity building [of] people—to drive self-efficacy for people. That's very, very small in people's plans. The bulk of people's plans have been core support, which is the driving to the shops, helping somebody to learn to cook and that sort of level of support. That is actually diminishing. What

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47   Mrs Jan Barr, Project Officer, UnitingSA, *Committee Hansard*, Whyalla, 20 July 2018, pp. 19–20.

48   Ms Catherine Crawford, Coordinator, North Queensland Combined Women's Services, *Committee Hansard*, Townsville, 30 August 2018, p. 29.

49   Western Australian Association for Mental Health, answers to questions on notice, 5 June 2018 (received 13 August 2018), p. 3.

we've seen over the last four years is that the capacity-building element is diminishing in people's packages as time goes on, as well as support coordination, which is often a really essential part in addressing, I guess, the issue around access for people and coordinating their wellbeing support.[50]

3.52   The Chief Executive Officer of selectability raised similar concerns and told the committee that her experience has shown NDIS plans for psychosocial disability are not being written with these necessary capacity-building services in mind.[51]

Committee view

3.53   The committee is concerned that rural and remote Australians are accessing mental health services at a much lower rate than Australians in major cities and urban areas, and is concerned about the detrimental effect this may have on their mental health.

3.54   The committee believes there is a strong relationship between the proportionally low number of mental health professionals working in rural and remote communities and the low access rates of services by rural and remote Australians.

3.55   The committee is concerned by reports that people in rural and remote communities experiencing a mental health crisis do not have access to appropriate 24-hour care, particularly within local hospital emergency departments which often lack appropriate staff or facilities to support these patients.

3.56   The committee notes that while FIFO and outreach services provide an opportunity to offer mental health services in rural and remote communities where services may not otherwise exist, unless they are reliable and regular, that is, every couple of weeks with the same trusted practitioner, they should not be seen as a permanent solution to regular and ongoing mental health services with local knowledge and relationships with their community.

3.57   The committee believes that culturally appropriate services are essential to meet the mental health needs of a culturally diverse Australia and that the importance of these services should not be discounted simply because rural and remote communities are small or because specific skills are required to deliver culturally competent mental health services.

3.58   The committee acknowledges the significant concerns held by witnesses and submitters to this inquiry that the introduction of the NDIS has inadvertently created further barriers to accessing mental health services in many rural and remote areas.

3.59   The lack of expertise and understanding of psychosocial disability within the National Disability Insurance Agency, as well as among health professionals, is something that has been acknowledged by the Commonwealth Government in recent months.

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50   Ms Karen Thomas, Queensland State Manager, Neami National, *Committee Hansard*, Townsville, 30 August 2018, p. 18.

51   Mrs Debra Burden, selectability, *Committee Hansard*, Townsville, 30 August 2018, p. 54.

3.60   The committee is pleased to see the announcement of a dedicated psychosocial disability stream within the NDIS and hopes that the introduction of this stream will start to resolve some of the concerns raised during this inquiry and others.

3.61   The committee is concerned about barriers to services for those who are not eligible for the NDIS.

Transport, telecommunications and the tyranny of distance

3.62   One of the biggest barriers to accessing services in rural and remote Australia is the tyranny of distance. The geography of Australia means that many rural and remote communities are literally thousands of kilometres from their nearest capital city and hundreds of kilometres from a regional centre.

3.63   This distance impacts not only on the availability of mental health services on the ground in rural and remote areas, as discussed in the section above, but on the ability for people to travel to those services. Distance from major centres is also a factor in access to reliable telecommunications infrastructure, which is necessary to access telehealth mental health services where travel is not possible or desirable.

Transport and travel

3.64   Transport was raised as a significant barrier to accessing mental health services in rural and remote Australia by witnesses at every hearing and in over half of the submissions received by the committee.

3.65   Submitters and witnesses noted that transport was only an issue because often, rural and remote communities lack sufficient local mental health services. Uniting Care Australia described that for consumers whose only mental health service option 'is to travel to another location, it may mean a whole day or two off work rather than a lunch hour appointment, as would be possible for a city dweller'.[52]

3.66   Anglicare Southern Queensland submitted that '[e]ven where services exist, access may necessitate travelling long distances with implications for time, costs and managing family responsibilities',[53] while Dr Sabrina Pit, who has conducted research into rural GPs' experiences and perceptions of depression management and factors influencing effective service delivery, found that:

> Patient's limited ability to travel was perceived as a significant barrier, identified by nine of the ten GPs. This was due to various factors, including geographic isolation, reduced mobility, financial constraints, and lack of public transport in the area.[54]

3.67   Surveys conducted by mental health peak bodies and organisations have shown that many mental health consumers consider transport both as a major barrier to their accessing mental health services and is itself a cause of mental health issues. In Tasmania, 50.4 per cent of people described transport as one of the main challenges

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52   Uniting Care Australia, *Submission 18*, p. 2.

53   Anglicare Southern Queensland, *Submission 126*, p. 1.

54   Dr Sabrina Pit, *Submission 112*, p. 2.

for seeking support in rural and remote areas and 47.15 per cent cited access to transport as a contributing factor affecting their mental health.[55] Similarly in WA, 51.79 per cent of people reported access to transport as affecting mental health in regional areas.[56]

3.68   The Western Australian Association for Mental Health also described how lack of transport prevents access not only to mental health services and supports, but to suitable accommodation and housing options, for example more affordable housing, which is one of the key social determinants of mental health in regional areas.[57]

3.69   The National Rural Health Alliance explained that transport concerns are particularly compounded for Aboriginal and Torres Strait Islander peoples, as:

> …there [are] on average ten times fewer vehicles per person, a tendency to have older and inappropriate vehicles, the need to travel long stretches of unsealed roads, and effectively half of the population not having access to public transport or air transport at all.[58]

Public and private transport

3.70   Submitters and witnesses described the transport difficulties faced by consumers in trying to get from a rural or remote community to a regional or metropolitan area to receive mental health services.

3.71   For many, the lack of public transport in rural and remote areas was raised as a concern for those without access to, or who cannot use, personal vehicles. The Executive Officer of CORES Australia, a community-based program for suicide prevention, told the committee that public transport does not meet the needs of consumers who need to attend appointments in town:

> When we were working on the community action plans for suicide prevention, they talked about transport. And there are more and more issues with transport. Even in Tasmania, they found that often the buses left early in the morning. For people with mental health issues who wanted services in the city, like Launceston, Devonport or anywhere like that, the services that were there didn't fit them, because often people with mental health issues don't want to get out of bed before lunchtime. So people tended to disconnect from services.[59]

3.72   One psychiatric nurse submitted that public transport is often not available in rural and remote areas and, if it is available, it can take a considerable amount of time and transfers to get to an appointment.[60] COTA Australia also noted that travel over

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55   Community Mental Health Australia, *Submission 16*, p. 7.

56   Western Australian Association for Mental Health, *Submission 34*, p. 11.

57   Western Australian Association for Mental Health, *Submission 34*, p. 9.

58   National Rural Health Alliance, *Submission 37*, p. 11.

59   Ms Sharon Jones, Executive Officer, CORES Australia, *Committee Hansard*, Devonport, 5 September 2018, pp. 1–2.

60   Name withheld, *Submission 114*, [p. 3].

long distances to access services is a significant issue for older people who may no longer drive and rely on community or public transport.[61]

3.73   Others described how, even where consumers have access to their own transport, the cost and time required to travel to appointments can impact on attendance. The Mental Illness Fellowship of Australia made the point that consumers can face significant additional costs in attending services due to transport over distances.[62] This point was echoed by Uniting Care Australia, which reported:

> One family accessing a UnitingCare service advised that they had to drive hundreds of kilometres in a year to access mental health support for their child, spending almost $20,000 on fuel.[63]

3.74   A consumer representative in Devonport told the committee that some people who own their own car may not be able to drive safely to and from appointments due to the nature of their mental illness or the distress of an appointment, and therefore may choose not to attend.[64]

3.75   Orygen, the National Centre of Excellence in Youth Mental Health, explained that when there is no public transport, a reliance on someone else to help a consumer travel to appointments may raise issues of anonymity. This may be of particular concern in areas where there is a high level of stigma about mental health issues.[65]

Patient transport programs and assistance

3.76   To counteract the lack of readily-available public transport in rural and remote areas, some service providers are working to offer transport as part of their service.[66] The committee heard that transport was desperately needed in the Kununurra region to ensure that people, particularly those with large families and caring responsibilities, could attend social and emotional wellbeing services. Social and Emotional Wellbeing representative of the Kununurra Waringarri Aboriginal Corporation told the committee that:

> A lot of the people we work with don't have vehicles, so we need to go out, pick them up and bring them into town so that they can go to their appointments or go to our appointments.[67]

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61   COTA Australia, *Submission 64*, p. 4.

62   Mental Illness Fellowship of Australia, *Submission 20*, [p. 2].

63   Uniting Care Australia, *Submission 18*, p. 2. See also: Youth Affairs Council of South Australia, *Submission 49*, p. 6.

64   Ms Rosemary Boote, Consumer Representative, Flourish Tasmania Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 49.

65   Orygen, *Submission 44*, p. 2.

66   See, for example: Western Australian Local Government Association, *Submission 104*, p. 11.

67   Mr Brendan Morrison, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 5.

3.77   In Tasmania, Youth, Family and Community Connections Inc described how providers have had to transfer some mental health clients from regional areas to Hobart at the providers' own expense, as the medical transport programs provided by the state work on a booking system which don't necessarily match with a client's needs:

> Where you're trying to seize an opportunity, if you like, to get that person the assistance they need at that time, it's often just more practical to drive the client to Hobart to get treatment.[68]

3.78   Rural Alive and Well, another Tasmanian service provider, also submitted that its workers have 'become involved in transporting clients to attend appointments given a lack of viable alternatives'.[69]

3.79   Primary Health Tasmania explained to the committee is not in a position to fund transport, but described how it was trying to address the transport and distance concerns:

> …within our contracts we do work with our providers to look at how we can best meet outreach needs so that we're not having a provider that's based in Devonport and only delivering service in Devonport. So we articulate in the contracts that we require them to provide outreach into the smaller communities. The reality is that Tasmania, unlike a lot of other states, has a very diverse population scattered across a fairly big area. I don't know if we've got that right at the moment. We're hoping, through the regional planning process and applying the mental health planning framework taxonomy, that we'll get a better picture and a better mix of where services should be, and we can fund to that.[70]

3.80   The committee also heard that in some areas transport may be available for acute or emergency mental illness, but not for day-to-say attendance of necessary appointments.[71] For example, HelpingMinds submitted that while the WA Country Health Service provides some support through the Patient Assisted Travel Scheme, 'this is restricted to appointments with psychiatrists. Access to preventative services such as psychological or psychosocial services is therefore restricted'.[72]

3.81   The National Rural Health Association noted in its submission that 'funding transport in rural and remote areas has been an ongoing challenge – who funds it, how

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68   Ms Roslyn Atkinson, Chief Executive Officer, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 34.

69   Rural Alive and Well, *Submission 90*, p. 6.

70   Mr Grant Akesson, Health Stream Lead, Mental Health and Alcohol and Other Drugs, Primary Health Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 13.

71   Ms Amanda Bresnan, Chief Executive Officer, Community Mental Health Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 24. See also: Benevolent Society, *Submission 71*, p. 5.

72   HelpingMinds, *Submission 98*, p. 9.

much, how often and who pays' in terms of return of investment.[73] Some submitters recommended that greater funding should be invested in outreach programs to reach people who do not have transport,[74] while others recommended that greater emphasis be placed on patient travel assistance schemes, transport vouchers or community drivers.[75]

3.82   The Goulburn Valley Area Mental Health Service recommended that improvements to public transport in regional Australia, such as more reliable train and bus services in rural Victoria, would not only improve consumers' access to mental health services but would 'enable skilled clinicians to travel more easily to rural areas'.[76]

3.83   Services for Australian Rural and Remote Allied Health submitted that the solution to transport for some clients may also have a therapeutic benefit, although this would require flexibility in program funding:

> Some clients have benefited from obtaining support to purchase other modes of transport, such as a bicycle. This also serves to improve their mental and physical health through behavioural activation and promotes a sense of purpose and empowerment for them. The limitations of this, however, include extreme heat in summer, where many communities experience conditions where it is simply too hot to ride a bicycle during the day.
>
> Enabling Mental Health workers to approve the purchase of a bicycle for a client, or to approve access to travel vouchers for bus or taxi travel are other possible options for consideration to support client access to the mental health services they need.[77]

Emergency transport

3.84   The committee heard that methods of acute and emergency transport for mental illness in rural and remote areas appear to present other challenges for consumers and providers, primarily caused when there are no appropriate local services. The committee further heard that this can cause people to refuse to access the mental health services they need. The Australian Psychological Society submitted that

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73   National Rural Health Alliance, *Submission 37*, p. 11. See also: Mental Health Victoria, *Submission 51*, p. 5.

74   Western Australian Association for Mental Health, *Submission 34*, p. 9; Australian College of Mental Health Nurses, *Submission 82*, p. 9.

75   Consumers of Mental Health WA, *Submission 31*, p. 20; Royal Australian and New Zealand College of Psychiatrists, *Submission 95*, p. 1; Services for Australian Rural and Remote Allied Health, *Submission 21*, p. 4; Australian Rural Health Education Network (ARHEN) Mental Health Academic Network, *Submission 76*, p. 11.

76   Goulburn Valley Area Mental Health Service, *Submission 63*, p. 2. See also: Australian College of Mental Health Nurses, *Submission 82*, p. 9.

77   Services for Australian Rural and Remote Allied Health, *Submission 21*, p. 4.

some people will not seek treatment for mental illness due to a fear of being sedated for transport and then being detained a long distance from home.[78]

3.85   The Australasian College for Emergency Medicine submitted that its members had raised significant concerns about the delays in assessing and transporting patients presenting with mental illness to emergency rooms in rural and remote areas:

> ACEM members report being actively discouraged from scheduling mental health patients in rural and remote emergency departments due to known delays with review by mental health telehealth teams (in the absence of face-to-face review). For young patients, this means they can be forced to wait in an isolated room in an emergency department for two to three days until transport is available to send them to an appropriately declared mental health facility, depending on the relevant jurisdictional legislation.[79]

3.86   Other witnesses and submitters also described the distress felt by patients because of how they are treated during the transfer process to access services not available locally. A representative of the National Mental Health Consumer and Carer Forum told the committee that:

> When it does happen and someone gets transported, the RFDS has a policy of sedating people who are mental health clients. They sedate them and restrain them. I remember two ladies in particular, both around 25 or 26 years of age. I nearly cried because they spoke about feeling like criminals. When they came around and they woke up in our Royal Adelaide Hospital, they thought they must have committed a crime because they were aware of how they were being treated and they were aware of how they felt. I'm not judging the staff that managed them at all; I understand the need for doing that. But that's the reality.[80]

3.87   The Australasian College for Emergency Medicine noted in its submission that mental health patients in rural and remote areas are more likely to be transported to a hospital emergency department in a police or correctional vehicle than people with other conditions.[81] The Victorian Council of Social Service submitted that, while police may have good intentions, they have 'limited ability to provide an appropriate therapeutic response' for a person experiencing crisis.[82]

3.88   The WA Country Health Service told the committee of the situation which exemplified many of these concerns which had been recently experienced by one young Aboriginal man in regional WA. In this situation, the young man, who had a

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78   Australian Psychological Society, *Submission 103*, p. 11. See also: National Mental Health Consumer and Carer Forum, *Submission 84*, p. 3.

79   Australasian College for Emergency Medicine, *Submission 91*, p. 4.

80   Ms Lyn English, National Mental Health Consumer and Carer Forum, *Committee Hansard*, Canberra, 19 July 2018, p. 25.

81   Australasian College for Emergency Medicine, *Submission 91*, p. 3.

82   Victorian Council of Social Service, *Submission 107*, p. 5.

history of substance abuse, presented to a regional emergency department describing suicidal thinking. He was assessed by an on-call psychiatrist but absconded from the hospital twice, requiring first responders and police to retrieve him. In the end, it was determined that:

> … to safely perform a full assessment on that person required his transfer to Perth. To transfer him to Perth required involvement of the flying doctor. It required a level of sedation to allow his safe transfer on the plane….He arrived in Perth and he was seen, by sheer coincidence, by a psychiatrist who actually used to work in the region as well, so he knew of the family. It was a remarkable kind of circumstance. The Mental Health Act under which he was referred couldn't be applied to make him an involuntary patient, and he came home. So he presented to the hospital and was triaged, assessed, treated, transferred to the city and then sent home, back to the regional centre again….He didn't want to stay, and there weren't sufficient grounds under the Mental Health Act to force him to stay as an involuntary patient, and so he's back in the community…. That's caused some ructions in terms of the family and their confidence in the mental health service, and so we'll have to rebuild that trust again. That's not an unusual story.[83]

3.89   The Western Australian Government submitted that a post-implementation review of the state's *Mental Health Act 2014* conducted in March 2018 had highlighted concerns about 'the relationship between limited access to specialist mental health care in regional areas and the high demand for transfers of mental health consumers to the metropolitan area' as well as delays in 'timely access to transportation by police and the Royal Flying Doctor Service'. The Western Australian Mental Health Commission and Western Australian Department of Health are now conducting work to 'identify causes and potential solutions to reduce delays in regional mental health transfers'.[84]

3.90   The RFDS submitted that between July 2013 and June 2016, it provided aeromedical retrievals of 2567 patients experiencing acute mental health episodes requiring emergency treatment in a tertiary hospital. The RFDS expressed the view that 'many of these emergency retrievals could be avoided if more appropriate and comprehensive mental health services were available in more remote and rural areas'.[85]

Telecommunications

3.91   Telehealth, as discussed in Chapter 2 of this report, is becoming an increasingly popular method of service delivery in rural and remote areas to combat the lack of available local services.

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83   Dr Roland Main, WA Country Health Service, *Committee Hansard*, Albany, 5 June 2018, pp. 2–3.

84   Government of Western Australia, *Submission 35*, pp. 26–27.

85   RFDS, *Submission 22*, p. 6.

3.92   However, a lack of telecommunications infrastructure is limiting telehealth as a viable option to address the barriers of distance, travel cost, availability of services for many consumers and health professionals in these areas. The Western Australian Association for Mental Health submitted 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.[86]

3.93   A large number of witnesses and submitters described telecommunications infrastructure in rural and remote areas, including landline telephones, mobile telephones and internet access, as poor, intermittent and unreliable.[87] Access to the internet in particular was described as a major issue, as many mental health services now have online or video-capable offerings such as telehealth or web-based services and there is an assumption that consumers will be able to access these if they are unable to use face-to-face services.[88] However evidence suggests that access to the internet for telehealth varies widely in rural and remote areas across the country.[89]

3.94   Census data released in October 2018 shows that 23 per cent of households in remote and very remote locations in Australia do not have internet access, compared to only 12 per cent of households in major cities.[90] In some locations and demographics, the proportion of people without access to the internet is even higher.

3.95   The Western Queensland PHN reported that 27.3 per cent of people in their catchment area have no internet access,[91] while the Victorian Council of Social Service observed that people on low incomes are even more likely to not have a

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86   Western Australian Association for Mental Health, *Submission 34*, p. 21.

87   For example: Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 8; Frontier Services, *Submission 4*, p. 2; Butterfly Foundation, *Submission 110*, p.14; Mental Health Association of Central Australia, *Submission 27*, p. 6; Being, *Submission 92*, p. 13; Australian Mental Health Commissions, *Submission 52*, p. 17.

88   Mrs Connie Digolis, Chief Executive Officer, Mental Health Council of Tasmania, *Committee Hansard,* Devonport, 5 September 2018, p. 41; Western Australian Association for Mental Health, *Submission 34*, p. 23; Roses in the Ocean, *Submission 7*, p. 5; Benevolent Society, *Submission 71*, p. 12; Western Queensland PHN, *Submission 125*, p. 3.

89   Mr Michael Tunnecliffe, Clinical Psychologist, Ashcliffe Psychology, *Committee Hansard*, Albany, 5 June 2018, p. 38; Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 8; Ms Amanda Bresnan, Community Mental Health Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 22; Anglicare Southern Queensland, *Submission 126*, p. 5; Community Mental Health Australia, *Submission 16*, p. 10; Uniting Care Australia, *Submission 18*, p. 9; Orygen, *Submission 44*, p. 9.

90   Australian Bureau of Statistics (ABS), *8146.0 - Household Use of Information Technology, Australia, 2016-17,* March 2018, http://www.abs.gov.au/ausstats/abs@.nsf/PrimaryMainFeatures/8146.0 (accessed 19 November 2018).

91   Western Queensland PHN, *Submission 125*, p. 3.

connection, noting that two thirds of people who received Salvation Army emergency relief could not afford an internet connection at home.[92]

3.96   Sane Australia submitted that while online mental health support can bridge some of the gaps in mental health services in rural and remote areas:

> …further work is needed to promote digital inclusion for the approximately 2.5 million Australians who, for health, geographic, education or socio-economic reasons, are not online.[93]

3.97   The adequacy of the internet connection being accessed was also of concern to submitters, with one cited study finding that 48 per cent of people surveyed living outside of capital cities described the internet access they had as inadequate or not meeting their current needs.[94]

3.98   OzHelp described in its submission that the quality of internet access in rural and remote areas is in part based on the technology available and that good connections may not be affordable or accessible to those who are disadvantaged; for example, in one 2016 survey, fibre-to-the-premise or fibre-to-the-node technology was found to be available to 88 per cent of people in the most socio-economically advantaged outer regional areas compared to only 12 per cent of those in the least advantaged areas.[95] The Local Government Association of Queensland also noted that many rural property owners and satellite towns will not get access to these technologies but will remain reliant on satellite internet access.[96]

3.99   The Royal Australasian College of Physicians submitted that an 'obvious technical barrier to the greater use of telehealth' is access to a reliable broadband internet connection, which was ranked as the number two priority in the 2016 Australian Medical Association's Rural Health Issues Survey.[97] The joint submission from the Queensland Association of Mental Health and the Northern Territory Mental Health Coalition expressed the view that:

> It's no good providing these [telehealth] services if internet accessibility is so bad that it doesn't allow a continuous connection, or if it becomes too expensive for people to get access to adequate internet services.[98]

3.100   The Mental Health Academics Network of the Australian Rural Health Education Network shared these concerns about the expensive of internet access, submitting that:

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92   Victorian Council of Social Service, *Submission 107*, p. 9.

93   SANE Australia, *Submission 130*, p. 5.

94   HealthWise, *Submission 68*, p. 2.

95   OzHelp, *Submission 11*, p. 5.

96   Local Government Association of Queensland, *Submission 19*, p. 6.

97   Royal Australasian College of Physicians, *Submission 78*, p. 5.

98   Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, *Submission 26*, p. 12.

> The cost of access to a reliable internet connection is ongoing an issue, particularly in remote areas where there is no competition or where only one service provider has reliable coverage.[99]

3.101   The committee heard that it is not only consumers who require reliable internet access to facilitate mental health services and access in rural and remote areas.

3.102   The National Rural Health Association submitted that web-based continuing professional development, a requirement for ongoing registration, is important for health professionals working in remote areas and that 'accessing webinars is dependent on a quality and reliable internet services so they can participate'.[100] Health professionals also described their frustrations with the quality of internet access in their work in rural and remote locations. Dr Vladislav Matic, Board Chair of the Northern Queensland PHN, told the committee:

> The other thing is that my experience, at least having done some locums in some really remote places, is it only takes a couple of people in the community to be watching Netflix and the bandwidth has gone. And all of a sudden the surgery computers slow down and there's no access to My Health Record or anything else.[101]

3.103   While some submitters and witnesses discussed the need for internet connections of a quality that supports the use of videoconferencing for telehealth,[102] others noted that, where this is not possible, low-bandwidth options such as mobile apps, online forums and webchat can still play an important role in early intervention and peer support-based mental health services, as well as promoting social inclusion.[103]

3.104   The committee received evidence that some providers are trying to find solutions to the internet access barrier: Grow, a provider of mental health and wellbeing support groups, told the committee that some members of its online groups are unable to participate due to lack of personal internet access or the additional cost of using mobile data. To overcome this barrier, Grow has started to provide these participants with tablets with a data plan for use at no cost.[104]

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99   ARHEN Mental Health Academic Network, *Submission 76*, p. 13.

100   National Rural Health Alliance, *Submission 37*, p. 20.

101   Dr Vladislav Matic, Board Chair, Northern Queensland PHN, *Committee Hansard*, Townsville, 30 August 2018, p. 15.

102   For example: Ms Lyn English, National Mental Health Consumer and Carer Forum, *Committee Hansard*, Canberra, 19 July 2018, p. 34; Mr Dylan Lewis, Private capacity, *Committee Hansard*, Katherine, 9 July 2018, p. 23.

103   Ms Georgina Harman, Chief Executive Officer, beyondblue, *Committee Hansard*, Canberra, 19 July 2018, p. 42. See also: On The Line, *Submission 58*, p. 5; OzHelp, *Submission 11*, [p. 4]; SANE Australia, *Submission 130*, p. 5; Being, *Submission 92*, p. 12 and Interrelate, *Submission 77*, [p. 4].

104   Grow, *Submission 29*, p. 6.

3.105   The overwhelming recommendation from submitters to solve the telecommunications barriers to accessing mental health services was that there should be investment in infrastructure, such as the National Broadband Network and mobile phone networks, to ensure reliable phone and internet access in all rural and remote communities.[105]

3.106   Suicide Prevention Australia further recommended:

> …greater development of online communication and information technologies to greatly reduce the barriers of distance that typically disadvantage communities in rural areas. This must be matched by a commitment from government to collaborate with telecommunications service providers to improve parity of access to cost competitive broadband internet networks and infrastructure across rural and remote areas of Australia.[106]

Committee view

3.107   In the face of limited services 'on the ground' in many rural and remote communities, transport and telecommunications are vital to accessing services based in regional and metropolitan areas. However, these obvious solutions to the barrier of distance can create new barriers in and of themselves.

3.108   The committee recognises that public transport is not available in many rural and remote locations and notes the efforts made by communities and service providers to transport consumers to the mental health services they require. The committee considers that service providers in these locations need flexibility within their funding models to provide transport services and solutions to overcome lack of transport.

3.109   The committee is concerned to hear that the methods of acute and emergency transport for mental illness in rural and remote communities, particularly in relation to the sedation of patients, are deterring some people from seeking help for their mental health. While aeromedical retrievals play a vital role in emergency medicine across the country, the committee strongly agrees with the view of the RFDS that such retrievals for mental health could be avoided if there were more appropriate and comprehensive mental health services in rural and remote areas.

3.110   The committee is aware that the lack of telecommunications infrastructure, particularly reliable access to the internet, is limiting the use of telehealth in rural and remote Australia. This must be addressed if telehealth is to be considered a viable option to address the barriers of distance, travel, and availability of services.

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105   For example: beyondblue, *Submission 85*, pp. 16–18; Queensland Nurses and Midwives' Union, *Submission 36*, p. 14; AMSANT, *Submission 129*, pp. 6–7; Australian Association of Social Workers, *Submission 102*, p. 7; Western Australian Association for Mental Health, *Submission 34*, p. 21; Flourish Australia, *Submission 50*, p. 4.

106   Suicide Prevention Australia, *Submission 86*, p. 14.

Other social determinants of health

3.111   Submitters and witnesses explained to the committee that some of the biggest barriers to overcome in accessing mental health services are social determinants of health, which can be different in rural and remote communities to those felt in urban locations.[107] These barriers are often difficult to overcome as social determinants of health can be a result of structural disadvantage.[108]

3.112   Social determinants of health include the circumstances in which people are born, grow up, live, work and age, and the healthcare available to treat any illness.[109] The World Health Organisation's *Commission on Social Determinants of Health 2005–2008* found that:

> There is a social gradient in health such that the lower a person's socioeconomic position, the worse their health, including their mental health, is likely to be. The Commission broadly identified the cause of inequity as unequal access to health care, schools and education, conditions of work and leisure, housing, and their chances of leading a healthy life.[110]

3.113   The Australian Psychological Society informed the committee that social determinants of health have a strong impact on mental health and social and emotional wellbeing, and that people with a mental health illness are more likely to have experienced disadvantage and be on a low income, with many living in poverty.[111]

3.114   The committee heard that the impacts of social determinants of health can be twofold: firstly people may be more likely to experience a mental illness and secondly, they are less likely to be able to access mental health support services due to their circumstances.

Socioeconomic status

3.115   Many submitters and witnesses informed the committee that socioeconomic status will impact on the availability and effectiveness of mental health services in rural and remote areas, as well as the likelihood of a person experiencing a mental illness or psychological distress.[112]

3.116   Research Australia submitted that people living in areas classified as having the lowest level of socioeconomic status had the highest rate of mental health-related

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107   See, for example: Central Australian Aboriginal Congress, *Submission 55*, pp. 8 and 12; Western Australian Association of Mental Health, *Submission 34*, pp. 9–12; Australian Psychological Society, *Submission 103*, p. 8; Australian Research Alliance for Children and Youth, *Submission 81*, pp. 7–8.

108   Australian Psychological Society, *Submission 103*, p. 8.

109   Australian Psychological Society, *Submission 103*, p. 8.

110   Australian Psychological Society, *Submission 103*, p. 8.

111   Australian Psychological Society, *Submission 103*, p. 8.

112   See, for example: RFDS, *Submission 22*, Attachment 1, p. 19; WA Primary Health Alliance, *Submission 33*, p. 3; Orygen, *Submission 44*, p. 2; Australian Psychological Society, *Submission 103*, p. 8; Research Australia, *Submission 117*, p. 6.

presentations to hospital emergency departments, representing 26.8 per cent of presentations.[113] Emergency department presentations gradually decrease as socioeconomic status increases, with the highest socioeconomic status making up 13.8 per cent of mental health-related presentations.[114]

3.117   Furthermore, young people (aged 10–15 years old) from low socioeconomic backgrounds are two and a half times more likely to be diagnosed with anxiety and depressed moods than those with high socioeconomic status.[115]

3.118   The National Rural Health Alliance informed the committee that the rate of suicide is also correlated with socioeconomic status.[116] Between 2011 and 2015, the rate of suicide per 100 000 population was 14.5 for the lowest level of socioeconomic status, significantly higher than the highest level of socioeconomic status at 8.3 per 100 000 population.[117]

3.119   The most recent Census of Population and Housing in 2016 found that people with the highest level of socioeconomic status tend to live in capital cities, whereas people within the lowest level of socioeconomic status tend to live in regional and rural areas.[118]

3.120   As rural and remote areas generally have a higher proportion of people with socioeconomic disadvantage, the evidence put to the committee suggests that socioeconomic status is one factor which contributes to the high rate of suicide in rural and remote communities in Australia.[119]

3.121   However, there are many factors which contribute to a persons' socioeconomic status such as employment, level of income and housing security, which subsequently impacts on their ability to access and afford mental health services. These factors are discussed further below.

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113   Research Australia, *Submission 117*, p. 7. See also: AIHW, *Mental Health Services in Australia*, 'Hospital emergency services', Table ED.6: Mental health-related emergency department presentations in public hospitals, by patient demographic characteristics, 2016–17, updated 11 October 2018.

114   Research Australia, *Submission 117*, p. 7.

115   National Mental Health Consumer and Carer Forum, *Submission 84*, p. 2.

116   National Rural Health Alliance, *Submission 37*, p. 13.

117   National Rural Health Alliance, *Submission 37*, p. 13. See also: AIHW, *Mortality Over Regional and Time (MORT) books*, 'Socioeconomic group 2012–2016', Table 2: Leading causes of death, by sex, 2012–2016, updated 18 July 2018.

118   ABS, *2071.0 - Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016*, 'Socio-economic Advantage and Disadvantage', 6 November 2018, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~ 2016~Main%20Features~Socio-Economic%20Advantage%20and%20Disadvantage~123 (accessed 19 November 2018).

119   See, for example: National Mental Health Consumer and Carer Forum, *Submission 84*, p. 2.

Employment and income level

3.122   The committee heard that employment and income level can impact a person's ability to access mental health services as well as their likelihood of experiencing mental illness during their life, and that this is particularly relevant in rural and remote communities where there is often a lower employment rate than in urban locations.[120]

3.123   The National Survey of Mental Health Wellbeing found that education, employment and income are closely related to a person's socioeconomic status.[121] The survey found that people who are unemployed are more vulnerable to mental illness and they are more likely to experience insecurity, feelings of hopelessness and risk to their physical health.[122]

3.124   Of the survey respondents who were unemployed, 29 per cent experienced a mental illness within the preceding 12 months, compared to 20 per cent of people who were employed.[123]

3.125   The National Mental Health Consumer and Carer Forum also submitted that mental health can be impacted by the employment status and the income of individuals and households.[124] A survey conducted by the Mental Health Council of Tasmania for the purpose of this inquiry found that 74 per cent of respondents identified unemployment as an issue affecting their mental health and 67 per cent identified lack of income.[125]

3.126   A number of witnesses also told the committee that unemployment was a problem in their community which impacted on the rate of mental health illness.[126] For example, Mr John Singer from the Nganampa Health Council, told the committee that in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, only 30 per cent of people aged between 16 and 30 years old were employed.[127] As noted below, unemployment can greatly affect a person's mental health if it impacts on their sense of purpose and self-worth.

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120   See, for example: National Mental Health Consumer and Carer Forum, *Submission 84*, p. 2.

121   ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 13.

122   ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 13.

123   ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, pp. 14 and 31.

124   National Mental Health Consumer and Carer Forum, *Submission 84*, p. 2.

125   Community Mental Health Australia, *Submission 16*, p. 7.

126   See, for example: Mr Simon Dann, Senior Medical Health Worker (Psychologist) and Alcohol and Drug Coordinator, *Committee Hansard*, Kununurra, 5 July 2018, p. 1; Ms Maureen Robertson, Social and Emotional Wellbeing Unit Manager, Provisional Psychologist, *Committee Hansard*, Derby, 6 July 2018, pp. 2–3; Mrs Trish O'Duffy, Manager, St Helen's Neighbourhood House; Member, *Committee Hansard*, St Helens, 6 September 2018 pp. 14–15.

127   Mr John Singer, Executive Director, Nganampa Health Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 23.

3.127 The Aboriginal and Torres Strait Islander Healing Foundation (Healing Foundation) attributed the high unemployment in some remote communities to a combination of poor educational outcomes and trauma experienced by Aboriginal and Torres Strait Islander peoples, which continues to undermine their ability to engage in employment.[128] The impact of trauma on Aboriginal and Torres Strait Islander will be explored further in Chapter 4.

3.128 While social security benefits may be available to some people who are unemployed, the committee heard that these payments are insufficient to pay for daily essentials such as food, fuel and housing as the cost of living in rural and remote areas is significantly higher than in major cities, yet recipients receive the same amount as their city counterparts.[129]

3.129 The National Mental Health Consumer and Carer Forum explained that it is unlikely that an individual on a low income will be able to afford specialist support and treatment, particularly in rural and remote Australia where the costs of these services can be higher.[130] Furthermore, is also common for people who are unemployed to experience feelings of insecurity and hopelessness which subsequently has a negative impact on their mental health.[131]

Self-worth and sense of purpose

3.130 Some submitters and witnesses attributed the negative impact of unemployment and low income levels to the sense of purpose and self-worth which comes from employment. For example, Dr Martin Kelly from the Nganampa Health Council explained to the committee that providing some community members of the APY Lands meaningful activity had improved their mental outlook:

> I think another broader question is the question of work or at least structured, meaningful activity. Too many of our younger people don't have opportunities or hope. 'Where there is no vision, the people perish' is an old saying. That's what I'm afraid happens to lots of males in particular. Women in our communities have child raising, and that sort of stuff is an activity that families rally around and support, and it has meaning, it gives meaning, it's worthwhile and everybody knows that. I think a lot of men don't have as much of that going for them. …But I think, having seen a number of people in our communities who have meaningful activity, not necessarily paid employment, and sometimes doing out-of-the-box kind of stuff that gives their life meaning, it has often turned their lives around.[132]

3.131 In Albany, a peer support network has been established to provide information and support services to people in the region experiencing depression. The Depression

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128   Healing Foundation, *Submission 39*, p 5.

129   Yura Yungi Medical Service Aboriginal Corporation, *Submission 70*, [p. 1].

130   National Mental Health Consumer and Carer Forum, *Submission 84*, p. 2.

131   National Mental Health Consumer and Carer Forum, *Submission 84*, p. 2.

132   Dr Martin Kelly, Senior Medical Officer, Nganampa Health Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 22.

Support Network Albany provides links to support services, education sessions on mental illness, craft sessions, walking groups and eat meals together.[133] The peer support network is run by people who have a mental illness as well as volunteers who do not have full-time employment:

> You're enabling them to have purpose. They feel as if they are contributing. It's very much about using the skills of the people who are in the groups and saying, 'What have you got to contribute?' So they'll have art groups and people will have a skill there. It's very much about finding purpose. People's self-esteem improves, and there is that feeling of not being alone— that there is someone who you can talk to.[134]

Housing security

3.132   Many submitters and witnesses identified housing security and overcrowding as a barrier which impacted the mental health of people in rural and remote communities.[135]

3.133   Ms Cheryle Kaesler from the Yura Yungi Medical Service in Halls Creek told the committee that there is a limited supply of public housing in the community and there are virtually no private rental properties.[136] Ms Kaesler explained that this often leads to overcrowding in the available housing:

> There's often in excess of five families living in a one-bedroom or two-bedroom home. There have been housing homes here but they are often only two- or three-bedroom homes and there are a lot more people than that within the family so, therefore, I feel they are far too small. There's an extensive waiting list on the housing commission, up to four to eight years. What we find is that this builds frustration. I honestly think it has sometimes led to suicide, because people are frustrated, they can't get out of it and there are arguments and things like that within families.[137]

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133   Ms Jo Brown, Depression Support Network Albany, *Committee Hansard*, Albany, 5 June 2018, p. 30.

134   Mrs Penny Carpenter, Depression Support Network Albany, *Committee Hansard*, Albany, 5 June 2018, p. 31.

135   See, for example: Healing Foundation, *Submission 39*, pp. 4 and 13; Northern Territory PHN, *Submission 54*, p. 2; Yura Yungi Medical Service, *Submission 70*, [p. 1]; Mr Simon Dann, *Committee Hansard*, Kununurra, 5 July 2018, p. 1; Miss Mary Moloney, Wellbeing Manager and Registered Mental Health Nurse, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 11.

136   Ms Cheryle Kaesler, Yura Yungi Medical Service, *Committee Hansard*, Halls Creek, 5 July 2018, p. 1.

137   Ms Cheryle Kaesler, Yura Yungi Medical Service, *Committee Hansard*, Halls Creek, 5 July 2018, p. 1.

3.134   Mr Jake Hay from the local council in Halls Creek advised that for young people, feelings of anxiety and depression are often a product of their home environment:

> There are no services that exist in the overnight period, and this is a time where a lot of these traumatic episodes happen for young people, such as not knowing who's going to be there when they go home—their house might be overcrowded, there might be family coming in from all sorts of places and suddenly you've got 20 people in a three-bedroom home. You might also have issues such as excessive noise and excessive alcohol consumption which scare a lot of the young people away from their homes at night.[138]

3.135   The committee also heard that overcrowded housing can increase the risk of sexual assault, particularly for young people, which is often an underlying cause of mental illness.[139]

3.136   In some rural and remote communities, housing is unaffordable (particularly for people receiving social security benefits) and there are extensive waitlists for public housing.[140]

3.137   The National Survey of Mental Health and Wellbeing found that homelessness was a significant risk factor for mental illness.[141] The survey found that of the respondents who had ever been homeless, 54 per cent experienced a mental illness in the preceding 12 months, compared to only 19 per cent of people who had never been homeless.[142]

Drug and alcohol addiction

3.138   Submitters and witnesses told the committee that drug and alcohol addiction was often comorbid with mental health issues.[143] The National Mental Health and Wellbeing Survey found that people who drank nearly every day were more likely to experience mental health issues than those who drank less than once a month:

> People who reported that they drank nearly every day had more than 10 times the prevalence of 12-month Substance Use disorders compared

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138   Mr Jake Hay, Regional Program Manager Youth, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 14.

139   Ms Brenda King, Sexual Assault Counsellor, Anglicare WA, *Committee Hansard*, Kununurra, 5 July 2018, p. 20.

140   Ms Jo Brown, Depression Support Network Albany, *Committee Hansard*, Albany, 5 June 2018, p. 27.

141   ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 14.

142   ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, pp. 14 and 32.

143   See, for example: Mr Benjamin Hedlam, Manager, Great Southern Community Alcohol and Drugs Service, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 17; One Door Mental Health, *Submission 122*, [p. 10].

with people who reported that they drank less than once a month (10.5% and 1.0% respectively).[144]

3.139   The statistics do not, however, identify whether the relationship between alcohol and mental health is causational or correlational. The National Mental Health and Wellbeing survey finds that people who are diagnosed with alcohol dependence are more likely to have other mental health problems and that people with mental health problems were at greater risk of experiencing problems related to alcohol.[145]

3.140   The National Mental Health and Wellbeing survey also found that 63 per cent of respondents who misused drugs nearly every day in the 12 months prior to the survey reported experiencing a mental illness.[146]

3.141   The Alcohol and Drug Coordinator for the Ord Valley Aboriginal Health Service told the committee that the correlation between mental health and alcohol and drug issues may be related to self-medication:

> I believe that, quite often, alcohol and drug use is self-medication for underlying mental health disorders and psychological distress.[147]

3.142   Submitters and witnesses told the committee which drugs they were most concerned about in their communities. Palmerston Association Inc told the committee that methamphetamine was emerging as the drug of greatest concern in the Great Southern region of WA:

> Patterns of drug use have shifted significantly in recent years. Historically, alcohol has been the primary drug of concern for Palmerston clients. However, in the 2016-17 aggregated data across the organisation, methamphetamine emerged as the primary drug of concern. In the Great Southern, we see a very similar picture, however cannabis has long featured heavily in the Great Southern.[148]

3.143   The Ord Valley Aboriginal Health Service in Kununurra and the Nganampa Health Council in Alice Springs told the committee that they were concerned about the high level of cannabis use in their communities.[149]

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144   ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 18.

145   ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 17.

146   ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 18.

147   Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 1.

148   Mr Benjamin Hedlam, Great Southern Community Alcohol and Drugs Service, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 17.

149   Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 1; Mr John Singer, Nganampa Health Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 23.

3.144   The Central Australian Aboriginal Congress told the committee that alcohol was a significant contributor to mental ill health and wellbeing:

> Alcohol is also a related and major contributor to mental ill health and poor social and emotional wellbeing, risky behaviour and is a precursor for suicide. Alcohol abuse is directly associated with at least 8 per cent of the burden of disease and injury borne by Aboriginal people, including through homicide, violence, and suicides.[150]

3.145   This view was supported by the committee's visit to the Barkly Work Camp in Tennant Creek where the committee heard that alcohol and violence were often present in the prisoner's home environments.[151]

3.146   The North West Hospital and Health Service explained that significantly more people presented for alcohol related issues than for other drugs:

> In terms of the drug and alcohol side of things, around 79 per cent is alcohol related only. Second to that is cannabis and the third is amphetamine use, which is three per cent.[152]

3.147   Submitters noted it is important to address both mental health issues and substance abuse issues simultaneously. The Program Coordinator for Richmond Wellbeing and the Manager of the Great Southern Alcohol and Drug Service at the Palmerston Association Inc told the committee that specialist services need to be offered that can deal with alcohol and drug issues and mental health.[153]

3.148   The Central Australian Aboriginal Congress explained that it is necessary to have a service that treats mental health and substance abuse issues together to stop the people being moved around the health system without addressing all of their issues:

> Whether it's physical health or mental illness, it's all beginning in early childhood and we need service systems that can deal with people in that way. So we're not shuttling people between. 'Oh, you've got a grog problem; you go there,' and then the alcohol says, 'Oh, hang on; you've got a bit of psychosis. Even though you've got an alcohol issue, you've also got this, so go over to mental health.'…We've got to stop all that. We don't have that [at] congress—we treat the whole person.[154]

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150   Central Australian Aboriginal Congress, *Submission 55*, p. 11.

151   See Appendix 3.

152   Ms Sandra Kennedy, Director of Mental Health and Alcohol Tobacco and Other Drug Service, North West Hospital and Health Service, *Committee Hansard*, Mount Isa, 29 August 2018, p. 42.

153   Mr Benjamin Hedlam, Great Southern Community Alcohol and Drugs Service, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 17; Samuel Rose, Richmond Wellbeing, *Committee Hansard*, Albany, 5 July 2018, p. 30.

154   Associate Professor John Boffa, Chief Medical Officer Public Health, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 2.

Incarceration

3.149   The National Mental Health and Wellbeing Survey reported an increased rate of mental disorder among respondents who had been incarcerated. The survey reported that 41 per cent of respondents who have ever been incarcerated had a mental disorder in preceding 12 months compared to only 19 per cent of people who had never been incarcerated.[155]

3.150   The Healing Foundation considered that the circumstances that lead to the incarceration of Aboriginal and Torres Strait Islander peoples are often caused by trauma:

> The disproportionate levels of incarceration of Aboriginal and Torres Strait Islander people is both symptomatic of, and a cause of trauma, with a strong correlation between criminogenic risk factors, the social determinants of health, and the prevailing symptoms of trauma.[156]

3.151   Miss Nawoola Newry told the committee that the trauma that led to incarceration was a perpetual cycle because parents do not know how to deal with it:

> There's definitely a link between incarceration of young people and the lack of mental health services. Because there's so much trauma in most of our families up here, the parents don't know how to deal with that, and the parents are so traumatised themselves that the young people are seeing really bad behaviour, experiencing bad behaviour, experiencing their own trauma as well, which is leading them into all the crime, which is ending them up in jail.[157]

3.152   The Healing Foundation told the committee that the mental health issues of Aboriginal and Torres Strait Islander peoples may not be diagnosed until the person is at a crisis point or is incarcerated.[158]

3.153   The committee heard a similar perspective during its visit to the West Kimberley Regional Prison in Derby. The committee spoke with two prisoners who explained that their mental illnesses had not been effectively diagnosed or treated in their respective communities. However, the mental health services they received at West Kimberley Regional Prison had shown them how their mental illness had contributed to their offending and equipped them with strategies to modify their behaviour and improve their mental health.[159]

3.154   Danila Dilba Health Service told the committee that when children end up in the juvenile justice system they are still not provided with adequate supports even though it is clear what support is required:

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155   ABS, *National Survey of Mental Health Wellbeing: Summary of Results*, 23 October 2008, p. 30.

156   Healing Foundation, *Submission 39*, p. 4.

157   Miss Nawoola Newry, *Committee Hansard*, Broome, 6 July 2018, p. 28.

158   Healing Foundation, *Submission 39*, p. 6.

159   See Appendix 3.

> When we look at the kids in the juvenile justice system, we see that every single one of those children is suffering from some form of trauma. They are affected by trauma. Even the people who run the facility say, 'We know that all of these children are affected by trauma,' and yet the system is not providing those children with a comprehensive, high-quality mental health service while they are incarcerated or while they're on parole. There are very limited mental health interventions available in the youth detention facility. We have a team that is funded to provide some input, mainly in the form of social support, but we've snuck a bit of therapeutic support in as well. We're providing some therapeutic group stuff in the centre, but the children do not get the level of mental health support that they need.[160]

3.155 The Healing Foundation told the committee that the New South Wales Prison Inmate study found that the rates of mental illness among Aboriginal and Torres Strait Islander inmates was higher than for non-Indigenous inmates.[161]

3.156 The Western Australia Association for Mental Health relayed that the impact of incarceration away from country can also have an effect on mental health:

> …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.[162]

3.157 Aarnja Ltd reminded the committee that Aboriginal and Torres Strait Islander peoples continue to be incarcerated at a higher rate than non-Indigenous Australians and considered that the role of mental illness and the effects of trauma need to be considered:

> The factors that cause mental health are known…Aboriginal people are not predisposed; it's not in our genetics or DNA to be criminals, yet we make up the highest rate of people incarcerated…Illness doesn't see colour. We're all the same; we're human beings. We operate the same way.[163]

Committee view

3.158 The committee notes that there is a strong relationship between social determinants of health, the likelihood of developing a mental illness and the accessibility of mental health services, and that the negative impacts of social determinants of health are more prevalent in rural and remote communities.

3.159 The committee acknowledges the relationship between mental health issues and substance abuse and believes that these issues must be addressed simultaneously to adequately address both the cause and symptoms of mental illness and psychological distress.

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160 Ms Joy McLaughlin, Senior Officer, Strategy, Research and Policy, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p. 26.

161 Healing Foundation, *Submission 39*, p. 7.

162 Western Australian Association for Mental Health, *Submission 34*, p. 12.

163 Mr Martin Sibosado, Chairperson/WKEC Leader, Aarnja Ltd – Empowered Communities, Aarnja Ltd, *Committee Hansard*, Broome, 6 July 2018, p. 3.

3.160   The committee notes that overcoming these social determinants of health is challenging as they are often the product of unequal access to health care, brought about by structural disadvantage and social and economic policy. However, the committee believes that to address mental health in regional, rural and remote areas these social determinants must be improved.

Attitudes to mental health

3.161   Throughout the inquiry, the committee received evidence about how attitudes to mental health in rural and remote communities may influence decision making about whether to seek professional assistance for mental health issues. This section considers a number of the factors that witnesses and submitters raised with the committee.

Stigma

3.162   As noted above, while mental health issues are experienced at similar rates across Australia, mental health services are accessed at lower rates in rural and remote areas. Royal Australian College of General Practitioners Rural told the committee that while the principal driver of lower rates of access was the reduced availability of mental health services in rural and remote areas, a range of socio-economic and cultural factors, specific to rural and remote communities, that affect attitudes toward mental health services may also contribute to lower rates of access.[164] The Royal Australian College of Physicians, Being, the Northern Territory PHN and others told the committee that stigma was one of the factors that may explain lower rates of access in rural and remote communities.[165]

3.163   Submitters told the committee that people with a lived experience of mental illness had told them that a number of factors, including their fear of stigma and a lack of confidentiality or anonymity when accessing services, led to decisions not access mental health services in their community. The Australian Mental Health Commissions told the committee that:

> Anecdotal evidence from engagement with local communities has indicated that discrimination due to mental illness is a factor which affects whether a person seeks services in their town. People living with mental illness tell us that stigma and discrimination are very common experiences for them. This acts as a barrier to people receiving the support they need, when they need it. For some, anonymity is important and they will travel to the next town or regional centre to get the support they need, if it is available and they are seeking help or know where to seek help from.[166]

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164   Royal Australian College of General Practitioners Rural, *Submission 24*, [p. 4]. See also: One Door Mental Health, *Submission 122*, [p. 6].

165   See, for example: Neami National, *Submission 40*, p. 3; NT PHN, *Submission 54*, [p. 2]; Royal Australian College of Physicians, *Submission 78*, p. 5; Being, *Submission 92*, p. 4.

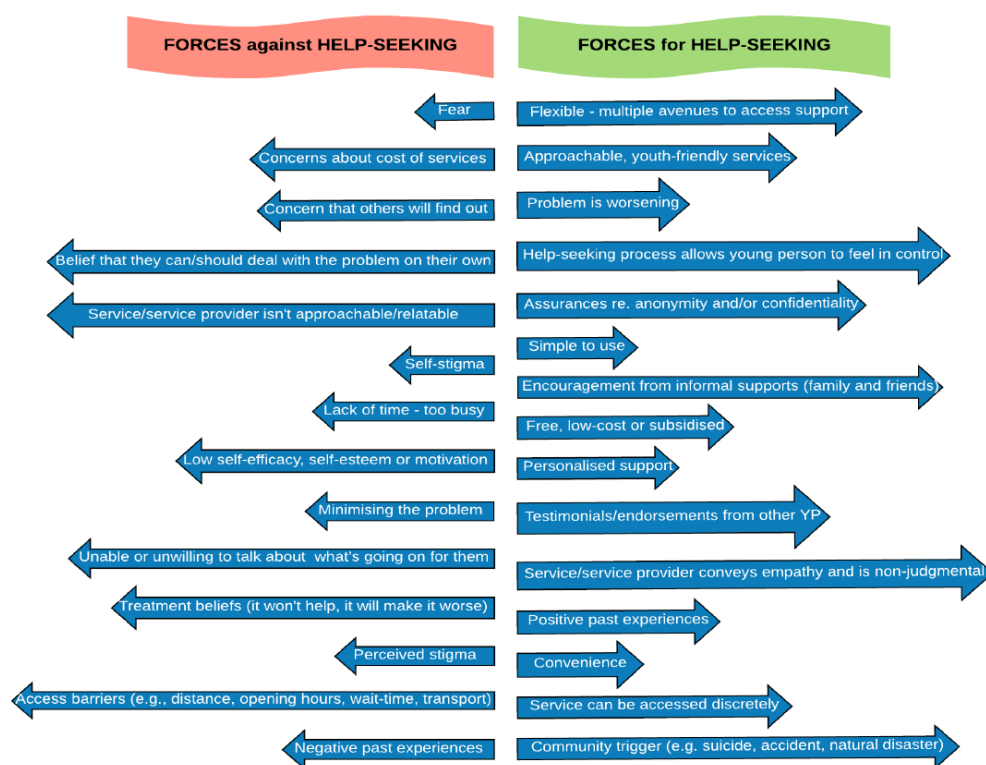166   Australian Mental Health Commissions, *Submission 52*, p. 16.

3.164   The Queensland Alliance for Mental Health and the Northern Territory Mental Health Coalition told the committee that they had received similar feedback regarding stigma from communities they had consulted:

> The issue of stigma was one that was constantly raised in our discussions with members regarding this inquiry. Rural communities have a culture of self-sufficiency and self-reliance which does not lend itself to openly seeking treatment when it might be required. The lack of anonymity in small rural settings often creates barriers to access due to stigma and privacy.[167]

Other factors

3.165   The committee received evidence that there was a complex array of factors that contributed to whether a person sought to access mental health services.[168] ReachOut described the forces that were faced by younger people deciding whether to access services as a 'tug of war' for and against seeking help, as demonstrated in Figure 3.1.[169]

Figure 3.1—Forces for and against seeking help

Source: ReachOut.[170]

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167   Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, *Submission 26*, p. 3 (footnotes omitted).

168   Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, *Submission 26*, p. 3; ReachOut, *Submission 72*, p. 6.

169   ReachOut, *Submission 72*, p. 6.

170   ReachOut, *Submission 72*, p. 6.

3.166   Submitters who work in youth mental health, such as yourtown, told the committee that young people it worked with had expressed concerns about being judged if they accessed a mental health service. yourtown told the committee that the concerns raised by young people included a fear of being seen as incapable, being brushed off or being considered or labelled as an attention seeker.[171]

3.167   A number of submitters told the committee that they considered one of the factors that may act as a barrier to access was a preference for self-reliance to manage issues, which was sometimes described to the committee as 'rural stoicism'.[172] The Queensland Nursing and Midwifery Union told the committee there was some academic evidence that this preference for self-reliance may lead to lower rates of access:

> In a recent study, Brew et al. (2016) found attitudes to treatment were the greatest barriers to seeking help for all rural workers. Of these, 'I prefer to manage myself' was by far the most common and this was similar for farmers and non-farm workers. Overall…75% preferred to manage themselves rather than access help for mental health needs (Brew et al., 2016). These results could indicate a high level of self-sufficiency, however distance from services and inability to leave rural properties for any length of time are other relevant factors.[173]

3.168   The Queensland Nursing and Midwifery Union noted, however, that in addition to self-sufficiency, these results may also indicate that an inability to leave rural properties for any length of time and distance to services may also serve as barriers to access.[174] The committee received similar evidence from other submitters, such as the Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, who considered that caring obligations and the requirements of running a property may influence whether a person accesses mental health services.[175]

Privacy and confidentiality

3.169   Some submitters recognised that being part of a small community with a 'community spirit' or close social connections can be a potential protective factor for people experiencing a mental illness.[176] However, ReachOut, Suicide Prevention

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171   Yourtown, *Submission 101*, p. 5.

172   See for example: Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 2; Mrs Chez Curnow, Manager Mental Health Alcohol and Other Drugs, Country SA PHN, *Committee Hansard*, Whyalla, 20 July 2018, p. 53; Northern Territory PHN, *Submission 54*, [p. 2]; One Door Mental Health, *Submission 122*, [p. 2]; Western Queensland PHN, *Submission 125*, p. 3; SANE Australia, *Submission 130*, p. 4.

173   Queensland Nursing and Midwifery Union, *Submission 36*, p. 13. See also COTA, *Submission 64*, p. 7.

174   Queensland Nursing and Midwifery Union, *Submission 36*, p. 13.

175   Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, *Submission 26*, p. 3.

176   Reach Out, *Submission 72*, p. 8; Suicide Prevention Australia, *Submission 84*, p. 8; One Door Mental Health, *Submission 122*, pp. 7–8.

Australia and One Door Mental Health also noted that the same connectedness can also lead to stigma and a perception that 'everyone knows everyone's business'.[177] Submitters told the committee that in a community with a small population some people may be concerned about being able to protect their privacy while accessing the service.[178]

3.170   Witnesses told the committee that some people had concerns about being recognised or seeing a service provider with whom they would prefer not to have a 'dual relationship'.[179] MindsPlus explained that by 'dual relationship', it meant that a person may not wish to discuss their personal lives with 'someone their sister plays netball with or someone they may see socially'.[180]

3.171   Some submitters advised the committee that people living in rural and remote communities told them that in some cases they were concerned about accessing services in case they were recognised while accessing the service.[181] In some cases, submitters told the committee that they were aware of people who travelled to different towns or took certain steps, such as parking further from the service, because they were concerned about being recognised.[182] Orygen noted that this could be a particular issue for young people who are concerned about being stigmatised if they were seen attending a headspace or another mental health service.[183]

3.172   The National Mental Health Consumer and Carer Forum and Neami National told the committee that concerns about confidentiality could be even more acute for people from vulnerable groups, such as LGBTI people, CALD populations or Aboriginal and Torres Strait Islander peoples.[184] The Black Dog Institute noted that

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177   Reach Out, *Submission 72*, p. 8; Suicide Prevention Australia, *Submission 84*, p. 8; One Door Mental Health, *Submission 122*, pp. 7–8.

178   See, for example: Mr Benjamin Hedlam, Great Southern Community Alcohol and Drugs Service, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 25; Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 11; Mrs Nicola Herriot, Chief Executive Officer, Northern Territory PHN, *Committee Hansard*, Darwin, 9 July 2018, p. 6; Ms Roslyn Atkinson, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 32; Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation Ltd, *Committee Hansard*, Canberra, 19 July 2018, p. 67; Mrs Anne Bainbridge, Chief Executive Officer, Youth Affairs Council of South Australia Inc, *Committee Hansard*, Whyalla, 20 July 2018, pp. 45–46; MindSpot, *Submission 5*, p. 3; Mental Health Carers Tasmania, *Submission 6*, p. 2; Government of Western Australia, *Submission 35*, p. 20.

179   MindsPlus, *Submission 15*, p. 1; National Mental Health Consumer and Carer Forum, *Submission 84*, p. 4.

180   MindsPlus, *Submission 15*, p. 1.

181   Orygen, *Submission 44*, p. 8; Helping Minds, *Submission 98*, p. 9.

182   Grow, *Submission 29*, p. 4.

183   Orygen, *Submission 44*, p. 8.

184   Neami National, *Submission 40*, p. 3; National Mental Health Consumer and Carer Forum, *Submission 84*, pp. 3–4.

some people in these groups may not engage with professional services for fear of not being understood or facing stigma.[185] The Black Dog Institute noted that similar concerns were also expressed by veterans groups who considered that veterans were reluctant to engage with professionals who may not be able to understand their unique experiences.[186]

Reducing stigma

3.173   Some submitters suggested that co-locating health services in one place could help to address the some of the issues surrounding stigma. The Central Australian Aboriginal Congress told the committee that by providing wrap-around services in one location, stigma was reduced by having the same door for physical and mental health services.[187] OzHelp noted that engaging clients with a focus on physical health and wellbeing would present an opportunity to discuss topics such as mental health and suicide.[188]

3.174   Some submitters told the committee that there were effective ways to reduce stigma in a community. The Australian Mental Health Commissions told the committee that promotional campaigns and training have demonstrated the capacity to reduce stigma and recommended that such a campaign could be effective in combatting mental illness in rural and remote communities.[189]

3.175   Being, a state-wide peak mental health consumer organisation based in New South Wales, told the committee that it believed that peer workers, a trained group of people with lived experience of mental illness, could help to educate the community:

> Peer workers may be able to provide support with regard to a number of the challenges to mental health help seeking noted above. Peer workers can be an excellent source of education. Raising health literacy in schools, universities and workplaces, could very effectively be carried out by peer workers who themselves embody the message that getting help and learn to strategies to live with mental health issues can only start with the ability to recognise when something might be wrong.[190]

3.176   ConnectGroups told the committee that peer support groups could play a significant role in promoting health and wellbeing and reduction of stigma.[191] Others, such as the Depression Support Network Albany, told the committee that a peer workforce could be effective in breaking down stigma in the community:

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185   Black Dog Institute, *Submission 47*, p. 11.

186   Black Dog Institute, *Submission 47*, p. 11.

187   Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 2.

188   OzHelp, *Submission 11*, [p. 3].

189   Australian Mental Health Commissions, *Submission 52*, p. 14.

190   Being, *Submission 92*, p. 10.

191   ConnectGroups, *Submission 3*, [p. 3].

> I think getting out into the community and doing activities in the community, whether it be yoga or whether it be tennis, and joining in with those community groups and saying, 'Hey, we've got mental illness but we're not different to you,' has been a really good positive way. I talk a lot with various doctors and people around town, and they've gotten to know me and realised, 'Yes, she's got a mental illness but she's not that different from anybody else.'[192]

3.177   Some submitters advised the committee that they were offering or developing technological supports that may allow individuals to access mental health services from the privacy of their computer. For example, Grow developed an online mutual support group using videoconferencing that catered for people around Queensland to provide support from people who were not in geographic proximity to other members of the group.[193] Similarly, OzHelp is developing its digital capacity to try to reduce barriers to access that might be faced by groups who may otherwise be reluctant to seek help face-to-face.[194] However, as noted above, technological solutions, while providing benefit to some people, are not the answer to the overall accessibility of rural and remote services.

Concluding committee view

3.178   In recent years in Australia there has been an increased national focus on mental health issues which has improved the diagnosis, treatment and community acceptance of mental health conditions across Australia. However, the committee heard compelling evidence that the different causes and service difficulties felt in rural and remote communities has meant the improvements driven by the national focus has mostly been felt in urban locations.

3.179   The committee recognises that many complex factors influence whether a person decides to seek help from professional mental health services, including the availability of those services, whether they believe their confidentiality can be protected and whether they believe they will be labelled or stigmatised for accessing those services if they are recognised. The committee considers that these factors are barriers to accessing mental health services that need to be addressed to make people more likely and willing to engage with professional services when they need them.

3.180   The committee heard that some communities and service providers are working to decrease stigma by educating the public about mental health and/or by co-locating physical and mental health services. The committee commends groups that are actively working to combat stigma, but considers that more needs to be done in rural and remote communities around Australia to improve attitudes toward accessing mental health services.

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192   Ms Jo Brown, Depression Support Network Albany Inc, *Committee Hansard*, Albany, 5 June 2018, p. 31.

193   Grow, *Submission 29*, p. 4.

194   OzHelp, *Submission 11*, [p. 3].

3.181   The committee heard that the impacts of social determinants of health, which contribute to mental health conditions and impact on the delivery of mental health services, are felt significantly in rural and remote communities. The committee believes that addressing the social determinants of health must be considered in any reform to improve the accessibility of mental health services in rural and remote communities.

3.182   The committee is concerned that mental health services are not available when and where they are needed in rural and remote communities. The committee believes that more needs to be done to address the shortfall in mental health professionals in these areas and overcome the barriers of distance, transport and lack of reliable telecommunications infrastructure. A catalyst to drive mental health service improvements in rural and remote locations is clearly necessary to address the different needs of these communities.

Chapter 4
Culturally competent services

> A culturally safe health system is as important as a clinically safe health system. As evidence shows, when people experience culturally unsafe health care encounters they will not use health services or they will discontinue treatment, even when this maybe life threatening.[1]

4.1   The focus of this inquiry, the accessibility and quality of mental health services in rural and remote Australia, is of particular importance to Aboriginal and Torres Strait Islander peoples. As noted in Chapter 3, Aboriginal and Torres Strait Islander peoples are much more likely to live in these areas than non-Indigenous Australians.

4.2   The health outcomes for Aboriginal and Torres Strait Islander peoples is far poorer compared to non-Indigenous people and addressing this health disparity is the goal of many close-the-gap programs. Aboriginal and Torres Strait Islander peoples are have disproportionately low outcomes on almost every scale of social, health and wellbeing.[2] Of relevance to the health focus of this inquiry, the rate of admissions to specialised psychiatric care for Aboriginal and Torres Strait Islander peoples is double that of non-Indigenous Australians.[3]

4.3   The previous chapter outlined key barriers to the accessibility and quality of mental health services in remote communities of Australia. These included 'tyranny of distance' issues, workforce shortfalls and a lack of appropriate support services, among others.

4.4   For Aboriginal and Torres Strait Islander peoples, there is the added need for those services to be culturally competent in order to provide an appropriate, and adequate, service that does not re-traumatise people through the denial of their cultural needs. An overwhelming body of evidence presented to this inquiry shows that the lack of culturally competent and safe mental health services results in significantly lower rates of Aboriginal and Torres Strait Islander peoples accessing the mental health services they need.[4]

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1   Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), *Submission 74*, p. 5.

2   National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 128*, p. 2.

3   NACCHO, *Submission 128*, p. 2.

4   NACCHO, *Submission 128*, pp. 2–3. Other submitters who argued that a lack of cultural competency in mental health services is a key factor in lower use of mental health services by Aboriginal and Torres Strait Islander peoples include: Aboriginal and Torres Strait Islander Healing Foundation (Healing Foundation), *Submission 39*, p. 7, NACCHO, *Submission 128*, p. 2, Aboriginal Medical Services Alliance Northern Territory (AMSANT), *Submission 129*, pp. 4–5, CATSINaM, *Submission 74*, p. 3.

4.5   This chapter will outline the frameworks of culturally competent mental health service delivery in rural and remote locations, discusses the improved health outcomes when services are culturally competent, and explores the barriers to culturally competent service delivery. Although services which target alcohol and other drugs (AOD) services are often co-located with mental health services, this chapter will focus on clinical mental health services and social and emotional wellbeing (SEWB) programs, as well as suicide prevention strategies.

Service contexts

4.6   An overwhelming majority of submitters and witnesses cited the causes of mental health problems for Aboriginal and Torres Strait Islander peoples as being significantly different to non-Indigenous Australians, in that the causes are primarily poor social determinants of health[5] which leave families and whole communities in crisis, combined with the trauma caused by historical factors. A wide body of research has found that these historical factors include intergenerational trauma, racism, social exclusion, and loss of land and culture.[6]

4.7   The Aboriginal Health and Medical Research Council of NSW (AHMRC) submitted that the compounding impact of removal from families, racism and loss of culture through past assimilation policies left communities with high levels of disadvantage and ill health.[7]

4.8   A General Practitioner from Kununurra discussed the range of causative factors leading to mental health problems that she encounters as being intergenerational trauma, sexual abuse and 'a whole breakdown of cultural values, cultural connections, that we see; it's all absolutely contributing to that.'[8]

4.9   The National Aboriginal Community Controlled Health Organisation (NACCHO) submitted that:

> [I]t is not possible to consider best practice mental health models of service for Indigenous people without considering culture, including an understanding of the multi-faceted impact that intergenerational trauma has on Indigenous people and its inextricable link to mental health, and social and emotional wellbeing.[9]

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5   The World Health Organization defines the social determinants of health as …*the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life*. See: https://www.who.int/social_determinants/sdh_definition/en/ (accessed 13 November 2018).

6   NACCHO, *Submission 128*, p. 2.

7   Aboriginal Health and Medical Research Council of NSW (AHMRC), *Submission 99*, p. 4.

8   Dr Stephanie Karen Trust, Principal GP, Kununurra Medical, *Committee Hansard*, Kununurra, 5 July 2018, p. 11.

9   NACCHO, *Submission 128*, p. 4.

4.10   Prior to discussing the cultural competence of mental health service delivery, it is important to outline the context in which those services are being delivered. The following sections outline key service delivery factors within Aboriginal and Torres Strait Islander communities.

Dispossession and colonisation

4.11   Evidence to this inquiry from a range of organisations noted that the colonisation of Australia involved the disruption and severing of many of the connections that are at the heart of social and emotional wellbeing and good mental health for Aboriginal people.

4.12   Witnesses noted that these impacts are still felt in Aboriginal and Torres Strait Islander communities today. The Aboriginal Medical Services Alliance Northern Territory (AMSANT) noted that the current delivery of mental health, SEWB and AOD services, generally without local input and governance, replicates some of the harmful aspects of colonisation and has significant implications for accessibility of services.[10]

4.13   The Medical Director of Wurli-Wurlinjang Health Service made a similar observation:

> The wellbeing of the community is affected by dispossession, by poverty, by all these other things, by lack of respect from the Australian government …which has disempowered and continues to do that on a fairly spectacular basis.[11]

4.14   Miss Nawoola Newry, a local advocate, pointed out that the direct outcomes of colonisation occurred in Kununurra in living memory, which meant the trauma was still fresh within that community.[12]

Collective and intergenerational trauma

4.15   The Aboriginal and Torres Strait Islander Healing Foundation (Healing Foundation) submitted that intergenerational trauma, where the impacts of trauma continue down through multiple generations, is complex in its impacts as it is both collective and cumulative. It is collectively experienced across communities, it is cumulative over a life-span and can be passed from one generation to the next.[13]

4.16   The Healing Foundation further submitted that the impacts of collective trauma can be devastating, as it can cause whole community breakdown and a loss of connection to community. This emphasises the need to provide collective healing responses, as individual treatment interventions alone cannot address this collective factor. The failure thus far to tailor healing efforts at a community level means

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10   AMSANT, *Submission 129*, pp. 4–5.

11   Dr Peter Fitzpatrick, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 14.

12   Miss Nawoola Selina Newry, *Committee Hansard*, Kununurra, 5 July 2018, p. 27.

13   Healing Foundation, *Submission 39*, p. 3.

families continue to live in vulnerability without the strength of a community to assist them to heal.[14]

4.17   The Central Australian Rural Practitioners Association told the committee that the collective trauma of the stolen generation continues to impact decisions to access mental health services, as 'there is a very strong fear now still alive for Aboriginal people that welfare will be involved in your family and you might lose your children. That does have an effect.'[15]

4.18   The committee also heard of the build-up of collective grief, where communities were dealing with multiple instances of crisis and loss. A psychologist for the Ord Valley Aboriginal Health Service described this as:

> …people being in a constant state of grief and loss. They have relatives dying consistently. We are talking about people attending a funeral every week. They are almost in a cycle of grief and loss continuously.[16]

4.19   AMSANT submitted that the combination of these historical and present day experiences of trauma result in the disconnections in aspects of life that keep people well and strong and underlie the complex mental health, SEWB and AOD issues that impact Aboriginal and Torres Strait Islander communities.[17]

Social determinants of health

4.20   Many submitters and witness argued that the provision of mental health services will not alone address the mental health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians, as many of the causes of poor mental health and wellbeing for Aboriginal and Torres Strait Islander peoples are the social determinants of health, such as housing access, adequate food and educational and job opportunities.[18]

4.21   The Manager of the Social Emotional Wellbeing Unit for Yura Yungi Medical Service told the committee that housing was a significant factor in stress-related mental health issues:

> There's an extensive waiting list on the housing commission, up to four to eight years. What we find is that this builds frustration. I honestly think it

14   Healing Foundation, *Submission 39*, p. 4.

15   Mrs Lynette Byers, Secretary, Central Australian Rural Practitioners Association, *Committee Hansard*, Alice Springs, 10 July 2018, p. 26.

16   Mr Simon Dann, Senior Medical Health Worker (Psychologist) and Alcohol and Drug Coordinator, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 1.

17   AMSANT, *Submission 129*, p. 4.

18   Yura Yungi Medical Service Aboriginal Corporation, *Submission 70*, p. 1. Multiple organisations argued that many mental health issues in Aboriginal and Torres Strait Islander peoples were caused by social determinants of health including: Central Australian Aboriginal Congress, Central Australian Rural Practitioners Association, Danila Dilba Health Service, Kimberley Aboriginal Medical Services, Shire of Halls Creek and Wurli-Wurlinjang Health Service among others.

has sometimes led to suicide, because people are frustrated, they can't get out of it and there are arguments and things like that within families.[19]

4.22   Townsville Aboriginal and Islanders Health Services told the committee that many instances of clients with depression or anxiety are found to have external stressor causes:

> When the doctor talks to them, or even the health worker, in their yarning they usually find out that it's more of a social thing. It might be overcrowded at home or dad's not working—he's unemployed—or Billy might be running off all the time and not going to school.[20]

4.23   The Social and Emotional Wellbeing support worker from the Kununurra Waringarri Aboriginal Corporation discussed the levels of crisis that individuals deal with on a regular basis, which leads to feelings of being overwhelmed, such as dealing with 'housing, Centrelink, the courts, juvenile justice and all that kind of stuff. A lot of them find it quite daunting and hard to deal with.'[21]

4.24   The AHMRC argued that mainstream mental health services are not capable of addressing the social determinants of wellbeing.[22] Mrs Gillian Yearsley, the Executive Director of Clinical Governance and Performance with the Northern Queensland Primary Health Network (PHN) affirmed this view and told the committee that:

> Current mental health service models are based upon models of care which are culturally inappropriate and which do not target the underlying systemic issues within those communities. This impacts upon the health and wellbeing of all community members, such as housing, employment, education, access to healthy food and the areas which link to the social determinants of health.[23]

4.25   The AHMRC pointed to the need for 'equitable funding and resource allocation towards the determinants of health and wellbeing such as safe and affordable housing, access to affordable nutritious food, and vocational and educational opportunities.'[24]

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19   Ms Cheryle Ann Kaesler, Manager, Social Emotional Wellbeing Unit, Yura Yungi Medical Service, *Committee Hansard*, Halls Creek, 5 July 2018, p. 1.

20   Mrs Erica Buttigieg, Social and Emotional Wellbeing Program Manager, Townsville Aboriginal and Islanders Health Services, *Committee Hansard*, Townsville, 30 August 2018, p. 25.

21   Mr Brendan Morrison, Social and Emotional Wellbeing, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 2.

22   AHMRC, *Submission 99*, p. 5.

23   Mrs Gillian Yearsley, Executive Director, Clinical Governance and Performance, Northern Queensland Primary Health Network, *Committee Hansard*, Townsville, 30 August 2018, p. 8.

24   AHMRC, *Submission 99*, p. 4.

Impacts of trauma on child development

4.26   The committee heard a range of evidence that showed the social and historical determinants of health for Aboriginal and Torres Strait Islander peoples often has a more sharply felt negative impact on children.

4.27   The Healing Foundation submitted that the impact of trauma on children can effect emotional regulation, attachment, aggressive behaviour and developmental competencies.[25] This can be compounded by other risk factors experienced by Aboriginal and Torres Strait Islander children, such as family disruption, family violence, economic disadvantage, poor living standards, disengagement from school and overcrowded housing.[26]

4.28   The Healing Foundation further submitted that medical research has also shown that trauma interferes with childhood neurobiological development, impacts responses to stress and increases a child's later engagement in correctional, social and mental health services.[27]

4.29   The Youth Program Manager for the Shire of Halls Creek outlined that there is higher than average presentation of youth with neurodevelopmental disorders in that region which is generally undiagnosed until after they have engaged youth justice services and these children 'are more likely than their peers to have other mental disorders, such as anxiety, depression and antisocial behaviour.'[28] The youth worker went on to detail other findings from diagnostic tools used on this youth cohort:

> Young people in the Olabud Doogethu program consistently present with low baseline scores when tested against the Rosenberg self-esteem scale, the Oxford happiness questionnaire, the social identification scale, which relates to belongingness, and the Kessler psychological distress scale. This indicates that clients have very little to no resilience skills.[29]

4.30   The Senior Medical Officer for the Nganampa Health Council told the committee that the experiences of poverty, malnutrition, chronic stress and exposure to violence damage the vulnerable minds and brains for children and that this could cause physical changes:

> The stresses are an ongoing thing. The high cortisol levels not only change how your body works and ages more quickly from a cardiovascular point of view but also the way the brain develops.[30]

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25   Healing Foundation, *Submission 39*, p. 12.

26   Healing Foundation, *Submission 39*, p. 13.

27   Healing Foundation, *Submission 39*, p. 1.

28   Mr Jake Hay, Regional Program Manager Youth, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12.

29   Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 11.

30   Dr Martin Kelly, Senior Medical Officer, Nganampa Health Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 12.

4.31   A psychologist for the Ord Valley Aboriginal Health Service bluntly told the committee that 'we've got kids who probably have the same circulating stress hormones as people living in a combat zone—and that's what they're going back home to.'[31] He further informed the committee that many of these children, some as young as 10 years old, self-medicate with cannabis to deal with their stress.[32]

4.32   The Mental Health Coordinator of the Ngaanyatjarra Health Service, a mental health nurse, told the committee of child behaviour cases he sees, with a range of possible causes such as 'alcohol, drugs, genes, genetics and in utero stuff' and further told the committee it was things he had 'never seen before within a city setting, the behaviours. A lot of it could be learnt behaviours as well, plus the beginning of mental health behaviours.'[33]

4.33   One of the traumas experienced by Aboriginal and Torres Strait Islander children in higher rates than non-Indigenous children is sexual assault. The committee was told this can be caused in part by one of the social determinants of health, overcrowded housing, which leads to children to being more vulnerable to sexual assault because the 'protective factors of family being able to provide safety are compromised.'[34]

4.34   A psychologist working for the Ord Valley Aboriginal Health Service told the committee of the high rates of sexual abuse encountered among their client population, which can be children as young as five to eight years of age:

> Also, regarding seeing clients who are survivors of child sexual abuse, I've never seen so many as in the Kimberley. I might have three sessions a day sometimes that are survivors of childhood sexual abuse. So I know we definitely need the services and skilled clinicians to help people recover from that devastating history.[35]

4.35   The psychologist further stated that generally the presentation he sees is an older female adolescent who is dealing with past trauma, who goes on to being a long-term therapy client.[36]

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31   Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 7.

32   Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 7.

33   Mr Nicholas Newman, Mental Health Coordinator, Ngaanyatjarra Health Service, *Committee Hansard*, Alice Springs, 10 July 2018, pp. 20–21.

34   Ms Brenda King, Sexual Assault Counsellor, Anglicare WA, *Committee Hansard*, Kununurra, 5 July 2018, p. 20.

35   Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, pp. 2 and 8.

36   Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 9.

4.36   The Sexual Assault Counsellor for Anglicare WA told the committee of the impacts that child sexual assault can have on development:

> Child sexual abuse can have a very significant impact on a person's mental health both as a child and later on when they become an adult. Child sexual abuse is often a factor in people experiencing mental illness. It is identified as a factor in suicide and often results in personality disorders.[37]

4.37   The Sexual Assault Counsellor for Anglicare WA further discussed the lack of cultural competency in services to address issues of disclosure, including training for local Aboriginal Health Workers:

> There is a strong taboo against, and shame for, victims speaking about sexual abuse, and this is especially the case for Aboriginal people. There is a need for culturally appropriate education and resources to be rolled out by people who are adequately trained. It is my opinion that we need staff from both Aboriginal and non-Aboriginal backgrounds engaged in this work. Aboriginal workers may require training and mentoring to overcome the taboo associated with talking about sexual abuse.[38]

4.38   AMSANT told the committee that the only child and adolescent mental health services in the Northern Territory are in Darwin and Alice Springs and said that children are only receiving psychiatric care at crisis point from mainstream services that are not culturally safe for them.[39] Jesuit Social Services pointed out that this is compounded in the Northern Territory, where clinical psychologists used to be provided in schools but that service is no longer funded.[40]

Drug and alcohol issues

4.39   Aboriginal and Torres Strait Islander communities often have high rates of drug and alcohol use, which compounds and increases the complexity of mental health service delivery. The Ord Valley Aboriginal Health Service told the committee that the use of cannabis was 'linked to psychosis' but that clients reported they used cannabis as a coping strategy:

> What we see also is people almost in a perpetual state of grief and loss, continuously, with many of their relatives passing. So I believe that, quite often, alcohol and drug use is self-medication for underlying mental health disorders and psychological distress.[41]

4.40   A local advocate in Kununurra also raised the issue of self-medication, often to deal with undiagnosed mental health issues:

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37   Ms Brenda King, Anglicare WA, *Committee Hansard*, Kununurra, 5 July 2018, p. 19.

38   Ms Brenda King, Anglicare WA, *Committee Hansard*, Kununurra, 5 July 2018, p. 19.

39   Mrs Danielle Dyall, Team Leader Trauma Informed Care and Social Emotional Wellbeing, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 7.

40   Mr John Adams, General Manager, Central Australia, Jesuit Social Services, *Committee Hansard*, Alice Springs, 10 July 2018, p. 35.

41   Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 1.

> Because so many [in the] community have these illnesses that are undiagnosed they turn to alcohol and drugs to mask their issues. When people are self-medicating on such a level in town it creates all these extra issues out in community. There can be violent outbursts and everything, which the family have to deal with, and then that can create further dysfunction in the family, trying to deal with that as well.[42]

Kinship and family structures

4.41   The different notions of kinship held by Aboriginal and Torres Strait Islander peoples, alongside the increased cultural obligations to family, was raised as an important service delivery context that was often overlooked by non-Indigenous service providers. The Provisional Psychologist for the Derby Aboriginal Health Service outlined that carer duties can impact on a client's ability to attend appointments:

> An Aboriginal person might book an appointment with me for 10 o'clock, but they don't rock up because Nan has said to them, 'I need to go to Woolies at 10 o'clock.' I'm not prioritised. And why aren't I prioritised? I'm not prioritised because they don't have to live the rest of their life with me; they're going to live it with Nan, and Nan won't forget that they didn't take her to Woolies at 10 o'clock when she needed to go…funders have difficulty getting their heads around it.[43]

4.42   The committee was also told that Aboriginal families tended to be larger, and for Aboriginal women with many children they found it difficult to attend appointments while caring for their children.[44]

4.43   The committee was also told that the different family structures found within Aboriginal communities can result in older Aboriginal women running informal safe houses for children with limited resources, often funded by a pension and under great stress:

> These safe houses, which they run and organise and where they've given their heart and their soul to the preservation of their children, are really where the duty of care, in my view, shines…These are receiving places within their community, built on a strong cultural base and on strong relationships, either personal or otherwise….That's where the rubber hits the road in this context. You asked the question: what are the cultural solutions? There is one.[45]

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42   Miss Nawoola Selina Newry, *Committee Hansard*, Kununurra, 5 July 2018, p. 25.

43   Ms Maureen Robertson, Social and Emotional Wellbeing Unit Manager, Provisional Psychologist, Derby Aboriginal Health Service, *Committee Hansard*, Derby, 6 July 2018, p. 3.

44   Mr Brendan Morrison, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 5.

45   Mr Wayne Barker, Festival and Cultural Events Coordinator, Kimberley Aboriginal Law and Cultural Centre (KALACC), *Committee Hansard*, Broome, 6 July 2018, p. 8.

Committee view

4.44   It is clear that the mental health service contexts for rural and remote Aboriginal and Torres Strait Islander communities are greatly different to those for predominantly non-Indigenous communities. These differing contexts include both the causes of mental illness, as well as barriers to the service delivery itself.

4.45   The committee heard compelling evidence directly from rural and remote Aboriginal and Torres Strait Islander people of the environments in which they live, work and raise families and the impacts these environments have on social and emotional wellbeing. Aboriginal and Torres Strait Islander communities are often operating in crisis mode, dealing with the continuing impacts of past traumas such as colonial dispossession and the stolen generation, compounded by ongoing traumas caused by high suicide rates and extremely poor social determinants of health.

4.46   The committee also heard from a range of experts that those social determinants of health have a far greater impact on individual mental health outcomes for Aboriginal and Torres Strait Islander peoples than that felt in non-Indigenous communities.

4.47   It is clear to the committee that health and mental health services which do not reflect these contexts are not only destined to fail, in the worst cases these services traumatise and retraumatise the very people for whom they are supposed to provide therapeutic treatment.

Culturally competent services

4.48   The Implementation Plan for the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* outlines the importance of health services being culturally competent.[46] The Implementation Plan states an intention that 'mainstream health services are supported to provide clinically competent, culturally safe, accessible, accountable and responsive services to Aboriginal and Torres Strait Islander peoples in a health system that is free of racism and inequality.'[47]

4.49   The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) submitted that for Aboriginal and Torres Strait Islander peoples, cultural wellbeing is inextricably linked to health outcomes, and pointed to the National Aboriginal Health strategy definition of health:

> Health is not just the physical wellbeing of the individual, but the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community.[48]

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46   Cultural competence is often also described as cultural safety, cultural awareness, cultural sensitivity, cultural security and culturally appropriate.

47   *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, Strategy 1B*, quoted in CATSINaM, *Submission 74*, p. 5.

48   National Aboriginal Health Strategy Working Party, quoted in CATSINaM, *Submission 74*, p. 4.

4.50   NACCHO also discussed the importance of culturally competent health services and submitted that this competency directly impacts the health outcomes of Aboriginal and Torres Strait Islander peoples accessing those services:

> Aboriginal people identify culture as key to mental wellbeing and evidence highlights that programs and services which provide culturally safe early intervention and prevention are the most effective in reducing the likelihood of poor mental health and suicide.'[49]

4.51   However, NACCHO submitted that access to culturally secure mental health services, particularly in rural and remote locations, is inconsistent and in many cases is non-existent.[50]

What is cultural competence?

4.52   Before evaluating the cultural competence of mental health service provision, it is useful to outline what cultural competence is and the impact that cultural competence can have on the clinical outcomes of mental health services for Aboriginal and Torres Strait islander peoples.

4.53   The Centre for Cultural Competence provides a definition of cultural competence in an operational context as 'the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes.'[51]

4.54   The Tangentyere Council provided a commonly used definition of cultural safety as:

> An environment that is spiritually, socially and emotionally safe, as well as physically safe for people, where there is no assault, challenge or denial of their identity, of who they are and what they need.[52]

4.55   The committee was told that culturally competent service provision is fundamental to the mental health outcomes of Aboriginal and Torres Strait peoples. NACCHO submitted that the lack of culturally competent services is a major barrier to Aboriginal people seeking the mental health care they need, and that in 2012–13 seven per cent of Aboriginal and Torres Strait Islander peoples reported avoiding seeking health care because they had been treated unfairly by medical staff.[53]

4.56   It was also acknowledged to the committee that cultural competence in the Aboriginal and Torres Strait Islander service setting is not a one size fits all solution.

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49   NACCHO, *Submission 128*, p. 3.

50   NACCHO, *Submission 128*, p. 2.

51   Centre for Cultural Competence, *Information Pack: Imagine a culturally competent Australia*, p. 4, https://www.ccca.com.au/Frontend/Content/Course/InfoPack/ c25a38a984eb4feba83149 53e3581ca8.pdf (accessed 18 September 2018).

52   Ms Maree Corbo, Program Manager, Tangentyere Family Violence Prevention Program, Tangentyere Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 33.

53   NACCHO, *Submission 128*, p. 3.

Each community will have different needs and a different cultural context and traditions.[54]

Trauma informed and strengths based care

4.57   The interrelated nature of trauma informed care and culturally competent care was raised by submitters and witnesses across a number of contexts. It was contended that without cultural competency, services for Aboriginal and Torres Strait Islander communities could not be considered trauma informed, as they often inflicted additional trauma on the very people using the service.

4.58   AMSANT submitted that the mainstream models of trauma informed care, considered best practice in non-Indigenous settings, could not be considered best practice for Aboriginal and Torres Strait Islander peoples. AMSANT argued it can in fact be harmful, because of the differences between non-Indigenous and Aboriginal and Torre Strait Islander communities' belief systems and historical experiences of colonisation.[55] AMSANT pointed to Culturally Responsive Trauma Informed Care as an approach of best practice, which requires the service approach to be contextually tailored and localised to the nuances of each location.[56]

4.59   The Healing Foundation contended that many mental health staff lack education about the nature and impact of trauma on the mental health of Aboriginal and Torres Strait Islander peoples. The Healing Foundation submitted that despite an increasing awareness of trauma informed care in mainstream health services, there is a significant gap in the accessibility of genuinely trauma-informed mental health services for Aboriginal and Torres Strait Islander peoples.

4.60   The use of fly-in, fly-out (FIFO) services can be particularly problematic if people are encouraged to talk about traumatic life events, and then the service is unavailable for over a month leaving the community to manage the distress of the individual, and in some case suicide attempts.[57]

4.61   The issue of FIFO services was raised by many other witnesses. The Kununurra Waringarri Aboriginal Corporation told the committee that many people will not engage with a FIFO service because the periodic nature of the service raises trauma and then leaves it unresolved:

> They're thinking: 'What's the point of going and speaking to someone who's only to be [here] for a week? We're not going to see them again.'…If they're supporting a person who's going to be permanently based here in town and they can put a face to a name and know that that person is going to be here

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54   Dr Denise Riordan, Chief Psychiatrist, Northern Territory Department of Health, *Committee Hansard*, Darwin, 9 July 2018, p. 1.

55   AMSANT, *Submission 129*, p. 5.

56   AMSANT, *Submission 129*, p. 5.

57   Healing Foundation, *Submission 39*, p. 6.

for good, I think it will encourage them to come out and really speak about our story and talk about what issues they might be facing.[58]

4.62   The Consultant Psychiatrist with the Kimberley Mental Health and Drug Service described other health services which are standard for non-Indigenous patients but can be traumatising to Aboriginal and Torres Strait Islander peoples:

> If there is a compelling health reason to keep someone in hospital, then yes, of course we will do that. That's our duty of care and it's our ethical, personal and professional obligation…However, a hospital is an institution. It's a conventional western institution that's a traumatising place…that will often make things worse.[59]

4.63   The Consultant Psychiatrist also described how the usual approach to therapeutic questioning can also be traumatising for an Aboriginal and Torres Strait Islander patient:

> When I take a step back in the consulting room, rather than me driving that and rather than me being a top-heavy, medical-down practitioner, if I've asked a local person who can build a bridge between me and the distressed person rather than me inadvertently retraumatising that person by grilling them with interrogative questions, the person who's there building the bridge, the Aboriginal person, makes it a safe interaction and allows that person and their family to buy in to the strategies that will most likely make a more meaningful and enduring difference.[60]

4.64   CATSINaM pointed to strengths-based approaches being linked to wellbeing in Aboriginal and Torres Strait Islander health, as they assist in changing perspectives of Aboriginal and Torres Strait Islander health and provide alternative ways to approach social and emotional wellbeing.[61]

4.65   AMSANT pointed to a review conducted for the Closing the Gap Clearinghouse, which found that programs that show positive results for Aboriginal and Torres Strait Islander peoples' social and emotional wellbeing are those that are strengths-based, in that they 'encourage self-determination and community governance, reconnection and community life, and restoration and community resilience.'[62]

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58   Mr Brendan Morrison, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 4.

59   Dr Huu Duy Tran, Consultant Psychiatrist, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 23.

60   Dr Huu Duy Tran, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 23.

61   CATSINaM, *Submission 74*, p. 5.

62   P Dudgeon and C Holland, 'Recent developments in suicide prevention among the Indigenous peoples of Australia', *Australasian Psychiatry*, vol. 26, no. 2, 2018, pp. 166–169, quoted in AMSANT, *Submission 129*, p. 3.

Cultural competency in non-Indigenous services

4.66   As outlined above, a key concern raised regarding the cultural competency of non-Indigenous service providers is the prevalence of the FIFO model used to service remote communities.

4.67   The Regional Youth Program Manager for the Shire of Halls Creek discussed how this model is incompatible for Aboriginal and Torres Strait Islander adolescent mental health, which favours a drop-in model. The FIFO model means that '[r]apport building with clientele is difficult, and intensive therapeutical intervention is almost impossible.'[63]

4.68   AMSANT said that FIFO services often do not have access to community members who do not show up for an appointment–as discussed early in this chapter this can often be for competing family duty issues. Services run by local community members with relationships on the ground can have staff drive around and find those people and then conduct a meeting in a safe environment.[64]

4.69   The Acting Chief Executive Officer (CEO) of Jungarni-Jutiya Indigenous Corporation gave a similar example, where a non-Indigenous service refused to find a young man in need of mental health intervention, requiring him to visit the service or attend hospital:

> They waited four weeks until he went off his head. The system doesn't work for people here because there's no real prevention on the ground. They're all in these flash offices with the air conditioning and everything else, but they're not on the ground out there where people can see them just having a yarn with people. Mental health doesn't have to be that bad. If you just go and have a yarn with somebody, you could stop those people from being what they are in some cases.[65]

4.70   The Healing Foundation further submitted that government-funded services need to reframe their thinking to recognise that service delivery failures are due to a failure to build trust and safety with clients, rather than viewing Aboriginal and Torres Strait Islander clients as being 'hard to reach.'[66]

4.71   Mr Nathan Storey, the chair of the Kununurra Region Economic Aboriginal Corporation, told the committee that a lack of cultural awareness was also felt in children's counselling services, where children did not engage because the services were delivered 'in a little sterile room.' Mr Storey outlined how a culturally competent children's service should engage with Aboriginal and Torres Strait Islander children:

> Take them out bush to hunt a kangaroo. Everyone will cook the kangaroo and sit around eating damper and even marshmallows, if you want. We will

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63   Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 11.

64   Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 10.

65   Mrs Sharon Bambling, Acting Chief Executive Officer, Jungarni-Jutiya Indigenous Corporation, *Committee Hansard*, Halls Creek, 5 July 2018, p. 1.

66   Healing Foundation, *Submission 39*, p. 12.

all sit, dance and sing. We will go to sleep and when we wake up we will go fishing. We will come back. Eventually you'll get those kids opening up.[67]

4.72   The Youth Program Manager of the Shire of Halls Creek described how external service providers continue to win service contracts, despite a low success rate:

Services like this are not successful, and have not been able to mobilise community buy-in; however, they continue to be funded. CAMHS—Child and Adolescent Mental Health Services—have closed open cases on multiple occasions due to little or no engagement with the client. So they've had a referral, but when they come to Halls Creek every two to three weeks, they can't find the client or the client does not want to engage, making rapport building extremely difficult.[68]

4.73   The Healing Foundation contended that successful non-Indigenous service models not only acknowledge Aboriginal and Torres Strait Islander culture, but value it as a fundamental cornerstone.[69] This issue was raised by many witnesses, who argue that a lack of service co-design with local communities resulted in poor services which were not utilised by the local community:

Little consultation occurs with our communities with regard to identifying the level of need and service design. Decisions about operating models are often focused on budget constraints rather than the number requiring access to the service.[70]

4.74   The CEO of Aarnja Ltd, pointed out that too many service decisions impacting Aboriginal and Torres Strait Islander peoples are made by non-Indigenous people:

So when you look at, for example, some of our decision-making in the Kimberley—no disrespect to the organisations or departments here—when we sit in discussions on Aboriginal people, it's predominantly non-Aboriginal managers who sit in that space. They're getting direction and some information from their Aboriginal staff, but the Aboriginal staff aren't at that decision-making table. That needs to be changed if we're going to get any traction within the current system.[71]

4.75   Submitters and witnesses argued that not only are many mainstream services in remote locations not culturally competent or responsive, they do not appear to take action to address this issue. Many services do not provide cultural awareness

67   Mr Nathan Storey, Chair, Kununurra Region Economic Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 31.

68   Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12.

69   Healing Foundation, *Submission 39*, p. 8.

70   Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12.

71   Ms Maureen O'Meara, Chief Executive Officer, Aarnja Ltd, *Committee Hansard,* Broome, 6 July 2018, p. 4.

training.[72] Where it is provided, it is insufficient, ad-hoc and relies on online training modules.[73]

4.76   The CEO of Aboriginal Interpreting WA told the committee that addressing intergenerational and vicarious trauma will not happen 'if it's continually attempted in high English without regard for traditional Aboriginal languages.' The CEO informed the committee that English is not the first language for many Aboriginal people in Western Australia and many are missing out on services where no interpretation is offered.[74]

4.77   The Tangentyere Council pointed out that mental health services also include phone counselling services, such as Lifeline and beyondblue, which 'are frequently not appropriate for people where English is a second or third language or where the people on the end of the phone do not understand the cultural context of the people they are speaking to.'[75]

4.78   The Healing Foundation recommended that cultural competency should be tested with agreed criteria and standards, and that local community input should be required, with measurable outcomes relating to the client's experience used as the primary indicator of success.[76]

4.79   The Royal Flying Doctor Service (RFDS) told the committee that their model of ensuring they are culturally competent is based on building relationships with community controlled organisations:

> We visit and work in community controlled organisations only at the invitation of them. Over many years, those dynamics have developed such that, for many nurse-led outposts, we provide the medical backup over the phone and the emergency retrieval as required at the invitation of the community controlled organisation. That will continue as we expand our mental health service.[77]

4.80   The RFDS went on to say that the working model went beyond being invited to a community, but included:

> …the establishment of the service in response to local need…I can flag that, as part of that very long established dialogue with community controlled organisations, we'd only work where we're invited to do so with

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72   Miss Nawoola Selina Newry, *Committee Hansard*, Kununurra, 5 July 2018, p. 25.

73   Healing Foundation, *Submission 39*, p. 6.

74   Ms Deanne Lightfoot, Chief Executive Officer, Aboriginal Interpreting WA, *Committee Hansard,* Broome, 6 July 2018, p. 4.

75   Ms Maree Corbo, Tangentyere Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 34.

76   Healing Foundation, *Submission 39*, p. 6.

77   Dr Martin Laverty, Chief Executive, Royal Flying Doctor Service (RFDS), *Committee Hansard,* Townsville, 30 August 2018, pp. 6–7.

> Aboriginal communities and in the manner in which those communities want us to operate.[78]

4.81   Cyrenian House cited a similar approach, where that organisation provides a monthly written report to the community councils outlining its recent activities and seeking feedback from communities.[79]

Aboriginal community controlled services

4.82   The committee heard evidence from a range of organisations that the Aboriginal Community Controlled Health Service (ACCHS) model of comprehensive primary health care delivers better outcomes for Aboriginal people.[80]

> Without exception, where Aboriginal people and communities lead, define, design, control and deliver services and programs to their communities, they achieve improved outcomes.[81]

4.83   The AHMRC submitted that for the majority of Aboriginal people, their local ACCHS is their first point of contact with the health system and is their preferred provider of primary care services. The AHMRC argued that Aboriginal communities consider their ACCHS as integral to the wellbeing of the community, and provides a gathering place where families can safely attend to their physical and mental health needs.[82]

4.84   NACCHO also pointed to ACCHSs as best placed to deliver mental health services to Aboriginal communities, as the community-based model of care involves a sense of empowerment for Aboriginal people with mental illness.[83] Dr Denise Riordan, the Chief Psychiatrist of the Northern Territory, noted that ACCHSs are also particularly good at delivering SEWB services.[84]

4.85   In some cases, to improve the cultural competency of external mental health specific diagnostic tools, ACCHSs have rewritten the standard mental health screening tools to adapt to local culture. This included ensuring that the diagnostics were undertaken by health workers of the same gender as the client, as required under local cultural tradition.[85]

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78   Dr Martin Laverty, RFDS, *Committee Hansard,* Townsville, 30 August 2018, p. 7.

79   Ms Sally Ann Malone, Manager, Cyrenian House, Milliya Rumurra Outreach Team, *Committee Hansard*, Broome, 6 July 2018, p. 14.

80   See, for example: NACCHO, *Submission 128*, p. 1; Community Mental Health Australia, *Submission 16*, pp. 4–5; Central Australian Aboriginal Congress, *Submission 55*, p. 1.

81   NACCHO, *Submission 128*, p. 1.

82   AHMRC, *Submission 99*, pp. 1–2.

83   NACCHO, *Submission 128*, p. 3.

84   Dr Denise Riordan, Northern Territory Department of Health, *Committee Hansard*, Darwin, 9 July 2018, p. 3.

85   Ms Cheryle Ann Kaesler, Yura Yungi Medical Service, *Committee Hansard*, Halls Creek, 5 July 2018, p. 7.

4.86   In direct comparison to the clinical-setting services provided by many non-Indigenous providers, the Derby Aboriginal Health Service outlined the informal engagement methods they used to build rapport and trust with people needing mental health support:

> We have a community engagement model where a number of our workers—our youth worker, our perinatal worker and our Aboriginal mental health worker—actually spend a lot of time out in the community. So it's a more relaxed approach…Ash, our male Aboriginal health worker, may go footy training out of work hours and he may lean on the fence and have a yarn with someone. It's in a very relaxed environment where the client or the patient feels comfortable, but there's a consultation going on here. So we're reaching out.[86]

4.87   The Derby Aboriginal Health Service outlined that many Aboriginal people will not attend state mental health services because of the history of institutions for Aboriginal people.[87] The Danila Dilba Health Service made a similar observation, and pointed out that the co-location of mental health services in ACCHSs meant that people who are comfortable with their health service are more likely to access mental health services located within the same facility.[88]

4.88   The Tangentyere Family Violence Prevention Program described the informal environment they created to make clients feel safe:

> We are surrounded by Aboriginal artwork, and the atmosphere is welcoming and physically and emotionally safe. We understand that conducting outreach to people's homes assists them to feel more in control. Many conversations regarding challenging topics happen in the car.[89]

4.89   Dr Peter Fitzpatrick from the Wurli-Wurlinjang Health Service pointed out to the committee that federal funding which used to resource the ACCHS sector is now being diverted to fund PHNs, who then tender out services:

> NGOs are all putting in tenders for chunks of money that previously went to ACCHOs to provide services to Indigenous people, and that's a concern for us. We've seen that here in Katherine. We've seen NGOs applying for funding and winning the tender because they have access to great tender-writers because they're multinational companies.[90]

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86   Ms Maureen Robertson, Derby Aboriginal Health Service, *Committee Hansard*, Derby, 6 July 2018, p. 4.

87   Dr Lynette Henderson-Yates, Chief Executive Officer, Derby Aboriginal Health Service, *Committee Hansard*, Derby, 6 July 2018, p. 5.

88   Mr Malcolm Darling, Acting Chief Executive Officer, Danila Dilba Health Service, *Committee Hansard,* Darwin, 9 July 2018, p.26.

89   Ms Maree Corbo, Tangentyere Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 33.

90   Dr Peter Fitzpatrick, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 8.

4.90   Dr Fitzpatrick went on to state that ACCHSs have developed over time to be highly effective health service delivery organisations:

> There are 130-odd across Australia. They're a highly evolved structure. We're general practice accredited. We're ISO accredited. We get ticked off by ORIC and every other—we're, really, very organised organisations. We've got state bodies and national bodies. And we're all paid for by the Australian taxpayer, so use it. Use the structure that you've created instead of bypassing it.[91]

Improved outcomes when services are competent

4.91   The AHMRC pointed to the low numbers of Aboriginal people accessing non-Indigenous mental health services, resulting in crisis presentation at Accident and Emergency, resulting in admission for treatment and subsequent community follow-up after discharge, at a cost of $19 728 per person. The AHMRC submitted that evidence shows that better allocation of resources to the ACCHS sector would result in a redaction of hospital admissions and associated costs, because ACCHSs have made significant impact on the burden of illness in Aboriginal communities and provide good value for money.[92]

4.92   NACCHO agreed with this view, noting that the ACCHSs sector was able to deliver lower cost community-based mental health services and that these services were closer to where people live, which assists in keeping people healthy in the community and prevents hospital admissions.[93]

4.93   The AHMRC further submitted that although ACCHSs are making referrals to funded non-government organisations (NGOs) and mainstream mental health services, Aboriginal people are not presenting for those appointments, usually as a result of inflexible and culturally unsafe practices in the organisations.[94] NACCHO agreed with this view and submitted that mainstream services are unable to provide holistic and culturally competent care to Aboriginal people, particularly those living in rural, remote and very remote locations.[95]

4.94   The Townsville Aboriginal and Islanders Health Services put forward a similar view and told the committee:

> We do have clients that still go out to the hospital, but they don't ever return out there because of the way that they feel they're treated. There's not a lot of Indigenous staff to support them when they're out there, which, I

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91   Dr Peter Fitzpatrick, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 16.

92   AHMRC, *Submission 99*, pp. 2 and 4.

93   NACCHO, *Submission 128*, p. 3.

94   AHMRC, *Submission 99*, p. 5.

95   NACCHO, *Submission 128*, p. 3.

suppose, comes back to resourcing and having enough staff to help people.[96]

4.95   The Healing Foundation submitted that 'the most successful service models to address trauma, healing and indeed mental health balance best practice western methodologies with Aboriginal and Torres Strait Islander cultural and spiritual healing practices.'[97]

4.96   The Townsville Aboriginal and Islanders Health Services told the committee of the successful services they delivered using this model, where Queensland Health are co-located at their clinic. This enabled the services to establish trust before making a mental health referral, as they 'sometimes go through another channel instead of going straight to mental health.'[98]

4.97   The Executive Director of medical services at the Wurli-Wurlinjang Health Service agreed with this view and told the committee that:

> …the experts in Indigenous mental health are Indigenous people. They're not psychiatrists, they're not mental health nurses, they're not GPs, and we don't recognise that—we don't pay for it and we don't engage with that group. Those other groups come in and value-add to it but they can't actually resolve it.[99]

4.98   The CEO of Kimberley Aboriginal Medical Services (KAMS) provided the committee with an overview of all the positive outcomes that can be achieved when services are culturally competent, which go far beyond improved service delivery for individuals:

> It will build local Aboriginal community capacity and resilience through workers [being] trained and people feeling much more comfortable in dealing with their own community. It will improve access and coordination of care by having one-stop shops, so people don't have to try and navigate this complex system. It'll help increase cultural awareness and cultural safety of mainstream programs, because these workers can work with the mainstream services to make sure that their programs and services are appropriate. And it'll reduce costs of service delivery at the acute end if we can keep people healthy and out of the expensive hospital system.[100]

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96   Mrs Erica Buttigieg, Townsville Aboriginal and Islanders Health Services, *Committee Hansard,* Townsville, 30 August 2018, p. 25.

97   Healing Foundation, *Submission 39*, p. 7.

98   Mrs Erica Buttigieg, Townsville Aboriginal and Islanders Health Services, *Committee Hansard,* Townsville, 30 August 2018, p. 25.

99   Dr Peter Fitzpatrick, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 14.

100   Mr Robert McPhee, Chief Executive Officer, Kimberley Aboriginal Medical Services (KAMS), *Committee Hansard*, Broome, 6 July 2018, pp. 13–14.

4.99   Submitters and witnesses strongly argued that a culturally competent workforce is the foundation to delivering culturally competent services. These workforce challenges are discussed in detail in the following chapter.

Committee view

4.100   It is an accepted fact within various national health strategies and implementation plans that health services must be culturally competent in order to be effective. Cultural competency is not an optional extra. It is not a gold-standard. Cultural competency is a basic benchmark that health services must reach in order to meet the needs of the communities they serve, be they urban, remote, non-Indigenous or a predominantly Aboriginal and Torres Strait Islander client base.

4.101   The committee has heard overwhelming evidence that in rural and remote locations, mental health services lack the cultural competency and safety required to meet the most fundamental principle of medicine: *first, do no harm.*

4.102   The committee has also heard that the experts in cultural competency, the local communities, have very little input into service design or scope of practice. Clearly, until communities have greater say in what services are funded and how those services will operate, mental health services for Aboriginal and Torres Strait Islander peoples in rural and remote locations will continue to fail their patients.

Social and emotional wellbeing programs

4.103   The committee heard from many submitters and witnesses that SEWB programs are fundamental to improving the overall mental health of Aboriginal and Torres Strait Islander communities, both on an individual and a collective level.

4.104   The Social Health Reference Group, responsible for developing the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004–2009*, concluded that:

> The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment.

> The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual.[101]

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101   See: Department of Health, National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, '*Social and emotional wellbeing*', http://www.health.gov.au/internet/publications/ publishing.nsf/Content/mental-natsisps-strat-toc~mental-natsisps-strat-1~mental-natsisps-strat-1-soc (accessed 29 November 2018).

4.105 AMSANT stressed the importance of SEWB programs in Aboriginal and Torres Strait Islander cultures (see Figure 4.1) and submitted that 'First Nations Peoples of Australia maintained health and mental health through beliefs, practices and ways of life that supported their social and emotional wellbeing across generations and thousands of years'.[102]

Figure 4.1—Social and Emotional Wellbeing from an Aboriginal and Torres Strait Islanders' perspective
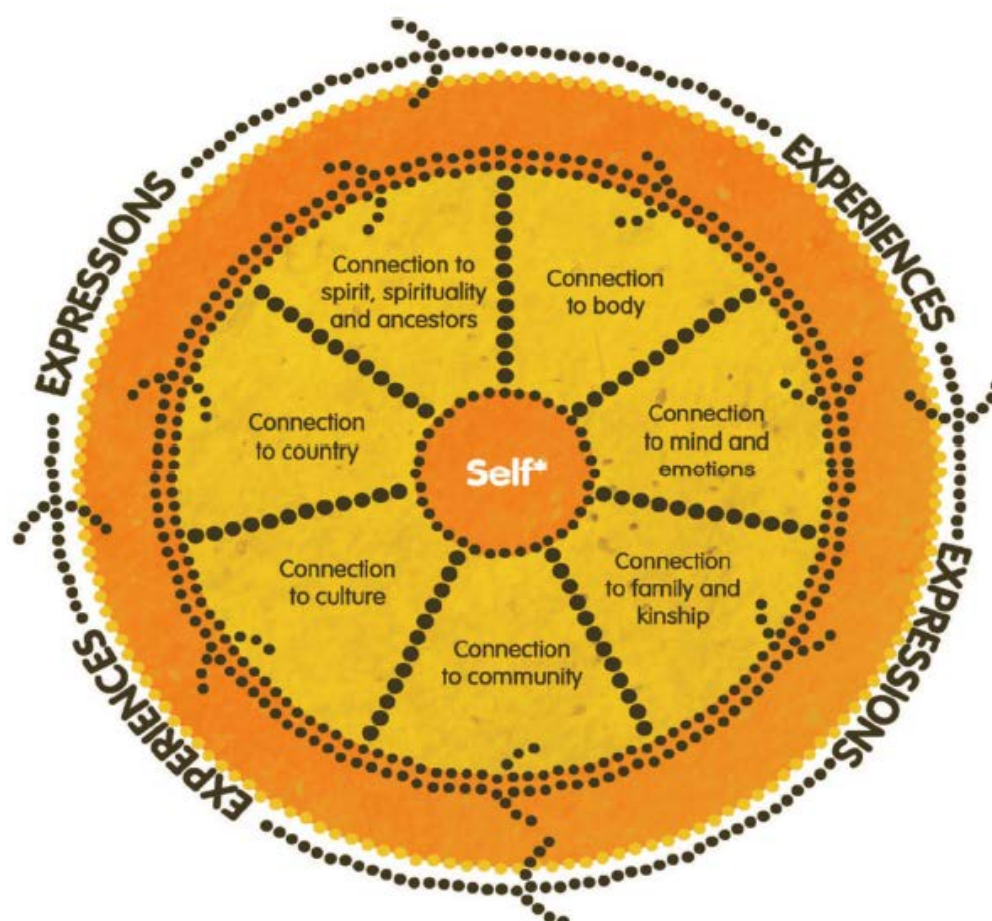
Source: AMSANT.[103]

4.106 The National Mental Health Commission's 2015 *Review of Mental Health Programmes and Services* concluded that mainstream mental health services had largely let down Aboriginal communities and recommended that integrated mental health and SEWB teams should be established in all ACCHSs.[104] The AHMRC made

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102 AMSANT, *Submission 129*, p. 2.

103 Model developed by the Australian Indigenous Psychologists Association. In: AMSANT, *Submission 129*, p. 3.

104 National Mental Health Commission, *Review of Mental Health Programmes and Services,* 16 April 2015, quoted in AMSANT, *Submission 129*, p. 3.

a similar recommendation to this inquiry, that all ACCHSs are funded to build and establish SEWB teams including Residential Rehabilitation and Healing Services.[105]

4.107   AMSANT recommended that integrating SEWB, mental health and AOD programs into primary health care services is the most cost-effective approach to the delivery of metal health services in rural locations. AMSANT stressed that this requires funding for multidisciplinary, culturally and trauma informed teams.[106]

4.108   AMSANT told the committee of a SEWB model developed by a working group of the Northern Territory Aboriginal Health Forum, based on a combination of a community based Aboriginal workforce and a mental health professional workforce. AMSANT told the committee this model includes both a clinical and community development prevention component and is particularly suited to remote communities. It provides access to therapy in a culturally safe environment, noting that the provision of cultural and social support is a crucial part of mental health care.[107]

4.109   The Healing Foundation cited research which indicates that healing programs are best delivered on country by people from the same cultural group as participants.[108]

4.110   The Queensland Alliance for Mental Health discussed the importance of early intervention SEWB programs in providing people with supports in the early stages of mental illness, resulting in the diversion of those people from more expensive hospitalisation or long term National Disability Insurance Scheme funding. The organisation went on to say that in rural and remote areas, one of the most effective interventions is community capacity building via informal programs in local communities.[109]

4.111   The Chief Psychiatrist of the Northern Territory stressed to the committee the need for a broad approach to mental health, and that while clinical mental health services are important components in addressing mental health related conditions, 'the promotion and maintenance of mental health in the community is influenced by many complex social factors and really is the responsibility of the whole of the government and the whole of the community.'[110]

Committee view

4.112   As outlined earlier in this chapter, the committee heard that the social determinants of health in rural and remote Aboriginal and Torres Strait Islander

105   AHMRC, *Submission 99*, p. 2.

106   AMSANT, *Submission 129*, p. 3.

107   Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 7.

108   Healing Foundation, *Submission 39*, p. 15.

109   Mr Jeremy Audas, Member, Queensland Alliance for Mental Health, *Committee Hansard,* Townsville, 30 August 2018, p. 49.

110   Dr Denise Riordan, Northern Territory Department of Health, *Committee Hansard*, Darwin, 9 July 2018, p. 1.

communities are not being adequately addressed and that these communities are often operating in a continual cycle of crisis. The committee also received evidence that the collective social and emotional health of the community is vital to individual mental health outcomes for Aboriginal and Torres Strait Islander peoples.

4.113   These service contexts, however, are not being taken into account in funding decisions and social and emotional wellbeing programs are not being delivered to the extent needed in remote communities. It is clear to the committee that increased focus on this form of early intervention would have a significantly beneficial therapeutic impact to entire Aboriginal and Torres Strait Islander communities.

Suicide prevention

4.114   Suicide is a major cause of Aboriginal and Torres Strait Islander peoples' premature mortality and is a contributor to the overall Aboriginal and Torres Strait Islander peoples' health and life expectancy gap. In 2014 suicide was the fifth leading cause of death among Aboriginal and Torres Strait Islander peoples, with the rate double that of non-Indigenous people.[111] In the 15–34 years age bracket, suicide is the leading cause of death[112] and those aged 15–24 are over five times more likely to commit suicide than their non-Indigenous peers.[113] The Healing Foundation submitted that gender should also be considered as a factor, as males represent a significant majority of completed Aboriginal and Torres Strait Islander suicides.[114]

4.115   NACCHO noted that while the prevalence of mental disorders is similar throughout Australia, the rates of suicide and self-harm are higher in rural and remote areas, and these rates get higher as areas become more remote.[115] Again, this is more relevant for Aboriginal and Torres Strait Islander peoples, as the majority of suicides among Aboriginal and Torres Strait Islander peoples occurred outside of capital cities.[116]

4.116   AMSANT discussed the findings of a review of suicide prevention strategies for Aboriginal and Torres Strait Islander peoples, which found:

> High Indigenous suicide rates arise from a complex web of interacting personal, social, political and historical circumstances. While some of the causes and risk factors associated with Indigenous suicide cases can be the same as those seen among non-Indigenous Australians, the prevalence and

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111   NACCHO, *Submission 128*, p. 4.

112   AHMRC, *Submission 99*, pp. 4–5.

113   NACCHO, *Submission 128*, p. 4.

114   Healing Foundation, *Submission 39*, p. 9.

115   NACCHO, *Submission 128*, p. 4.

116   NACCHO, *Submission 128*, p. 4.

interrelationships of these factors differ due to different historical, political and social contexts.[117]

4.117 AMSANT further noted that this review found that one of the quality indicators of suicide prevention services is culturally safe services and that such services were optimally provided by ACCHSs.[118]

4.118 The Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council agreed with this view of the non-mental health causes of suicide and told the committee of their internal suicide register, which shows that half of all suicides and attempted suicides have a clear link with domestic and family violence.[119]

4.119 The Chief Executive Officer of the Northern Territory PHN noted that culturally appropriate suicide prevention strategies need to be developed for each community:

> A prevention strategy that works on one community may have very little impact on another. Culturally appropriate services need to be developed, and community consultation and engagement is essential to this. Those approaches need to be community led.[120]

4.120 NACCHO submitted that efforts to reduce suicide in Aboriginal and Torres Strait Islander communities must do more than address social and economic disadvantage and health gaps, and must also promote healing and building the resilience of individuals, families and the whole community.[121] The Kimberley Aboriginal Law and Cultural Centre (KALACC) concurred with this view and quoted an expert in indigenous suicide, Professor Michael Chandler:

> [I]f suicide prevention is our serious goal, then the evidence in hand recommends investing new moneys, not in the hiring of still more counsellors, but in organized efforts to preserve Indigenous languages, to promote the resurgence of ritual and cultural practices, and to facilitate communities in recouping some measure of community control over their own lives.[122]

4.121 KALACC cited the Western Australia (WA) Parliamentary report into Aboriginal youth suicide, which found the need to focus more on a holistic approach

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117 P Dudgeon and C Holland, 'Recent developments in suicide prevention among the Indigenous peoples of Australia', *Australasian Psychiatry*, vol. 26, no. 2, 2018, pp. 166–169, quoted in AMSANT, *Submission 129*, p. 5.

118 AMSANT, *Submission 129*, p. 5.

119 Miss Christine Williamson, Manager, Youth Program, Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 14.

120 Mrs Nicola Anne Herriot, Chief Executive Officer, Northern Territory PHN, *Committee Hansard*, Darwin, 9 July 2018, p. 6.

121 NACCHO, *Submission 128*, p. 4.

122 KALAAC, *Submission 59*, p. 1.

than a simple clinical approach[123] and recommended restoring culture and a sense of identity as a key protective factor against Aboriginal and Torres Strait Islander suicide.[124] The CEO of KAMS also recommended that this report 'had a suite of recommendations that we need to start to act upon.'[125]

4.122   The AHMRC submitted that evidence shows that programs and services which provide culturally safe early intervention and prevention have proved to be the most effective in addressing suicide.[126]

4.123   The National Suicide Prevention Trial, outlined in Chapter 2, involves a number of trial sites, one of which is the Kimberley region of Western Australia and targets Aboriginal and Torres Strait Islander peoples. This trial is discussed below.

Kimberley suicide prevention trial

4.124   A decade-long audit quantified the suicide rate in the Kimberley among Aboriginal and Torres Strait Islander peoples as among the highest rates in the world.[127] The CEO of KAMS told the committee 'this means is that Aboriginal family members in the Kimberley are losing loved ones at rates that are among the highest in the world.'[128]

4.125   The trigger factors for suicide in the Kimberley region include alcohol and other drug use, relationship difficulties, family conflict or a previous suicide attempt, as well as other causal issues, including intergenerational trauma, loss of culture and other social determinants, such as employment, education, and housing.[129] KALACC argued that Aboriginal suicide in the Kimberley has very little to do with clinical mental health.[130]

4.126   A Consultant Psychiatrist with the Kimberley Mental Health and Drug Service concurred with this view and listed the causes of Aboriginal and Torres Strait Islander peoples suicide as the 'upstream factors' which also cause substance use, poverty, children in custody and incarceration, stating that 'suicide is almost never due to a mental illness. So it's is not due to something that we can diagnose and treat within a conventional Western model, within a Western framework of how our hospitals and our clinics are set up.' He went on to recommend that increased funding for clinical services was not the answer:

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123   WA Parliament Standing Committee on Health and Education, *Learnings from the message stick: The report of the Inquiry into Aboriginal youth suicide in remote areas*, November 2016, quoted in KALACC, *Briefing Paper submitted to the Kimberley Suicide Prevention Regional Trial Working Group*, additional information received 28 September 2018, [p. 2].

124   KALAAC, *Submission 59*, p. 4.

125   Mr Robert McPhee, KAMS, *Committee Hansard*, Broome, 6 July 2018, p. 14.

126   AHMRC, *Submission 99*, p. 5.

127   ConnectGroups Support Groups Association WA Inc., *Submission 3*, [p. 3].

128   Mr Robert McPhee, KAMS, *Committee Hansard*, Broome, 6 July 2018, p. 13.

129   Mr Robert McPhee, KAMS, *Committee Hansard*, Broome, 6 July 2018, p. 13.

130   Mr Wayne Barker, KALACC, *Committee Hansard*, Broome, 6 July 2018, p. 1.

> People who are at risk of or complete suicide have drowned at the end of the stream. If you give us more resources to catch more people with nets before they drown, then of course we will catch more people before they drown. However, that doesn't address the upstream factors.[131]

4.127   The committee was told that the National Suicide Prevention Trial was not culturally competent to factors in the Kimberley region. The CEO of KAMS told the committee that the National Suicide Prevention Trial needed to be more responsive to the local factors, and that the trial is 'looking at evidence from Europe, which senses depression as the centre of why people take their lives, and all of the evidence in Aboriginal suicides says that it's not depression; it's often all of the other crap that you're dealing with every day.'[132]

4.128   Both KALACC and Aarnja sit on the National Suicide Prevention Trial Kimberley community reference group. Both organisations discussed their frustration with the project, citing a lack of progress and a lack of community involvement in designing solutions:

> All we get, as the community reference panel—they said, 'We'll set the strategic plan and we'll bring it back to you.' What did we get? Two meetings in 12 months. No action. At the last meeting they came back and said, 'We'll just give the money out.' As community organisation we thought we were going to be consulted and involved in the establishment of the trial. It's just gone to a fixed interest group. I will be blunt about it, because that's what it is.[133]

4.129   Aarnja was so frustrated with the lack of progress and cultural competence of the National Suicide Prevention Trial, they designed their own suicide program, which is a family empowerment project for extended, rather than nuclear, families and based is on Bardi and Jawi cultural frameworks.[134]

Inuit suicide prevention program

4.130   The high rate of suicide among Aboriginal and Torres Strait Islander peoples is also found in other Indigenous peoples throughout the world.[135] The Canadian Inuit peoples' experience of colonisation is relatively comparable to that of Aboriginal and Torres Strait Islander peoples, both historically and also in the continued impacts of that colonisation in the form of collective and intergenerational trauma and the destruction of the protective factors of culture and a sense of identity.[136]

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131   Dr Huu Duy Tran, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 21.

132   Mr Robert McPhee, KAMS, *Committee Hansard*, Broome, 6 July 2018, p. 15.

133   Mr Martin Sibosado, Chairperson, Aarnja Ltd, *Committee Hansard*, Broome, 6 July 2018, p. 7.

134   Mr Martin Sibosado, Aarnja Ltd, *Committee Hansard*, Broome, 6 July 2018, p. 7.

135   AMSANT, *Submission 129*, p. 5.

136   Inuit Tapiriit Kanatami, *National Inuit Suicide Prevention Strategy,* 2016. https://www.itk.ca/national-inuit-suicide-prevention-strategy/ (accessed 27 November 2018).

4.131   The following case study is of a suicide prevention strategy developed for the Inuit Nunangat (homeland) regions in Canada by Inuit Tapiriit Kanatami, the national representational organisation of Inuit in Canada.

Case study: National Inuit Suicide Prevention Strategy

The National Inuit Suicide Prevention Strategy (NISPS) envisions suicide prevention as a shared national, regional, and community-wide effort that engages individuals, families, and communities. The NISPS is a tool for assisting community service providers, policymakers, and governments in working together to reduce the rate of suicide among Inuit to a rate that is equal to or below the rate for Canada as a whole.

The NISPS will promote the dissemination of best practices in suicide prevention, provide tools for the evaluation of approaches, contribute to ongoing Inuit-led research, provide leadership and collaboration in the development of policy that supports suicide prevention, and focus on the healthy development of children and youth as the basis for a healthy society.

Risk factors for suicide

The NISPS identifies the key risk factors for Inuit suicide as:

Historical Trauma: from the social and cultural upheavals tied to Canada's colonization of Inuit Nunangat, experienced by an entire group as a result of a cumulative and psychological wounding over a lifespan and across generations.

Social Inequity: Poverty and other indicators of social inequity translate into stress and adversity for families, disparities in health status and increased risk of suicide.

Intergenerational trauma: Unresolved symptoms of trauma can make it difficult for caregivers to provide a sense of safety and security to their children.

Childhood adversity: is linked to negative outcomes that are associated with suicidal behaviour, such as poor mental health, substance abuse, and poverty.

Mental Distress: there are greater rates of depression, personality disorder and substance misuse in Inuit who died by suicide.

Acute Stress: Mental health disorders or developmental adversity impair an individual's ability to cope with or adapt to life stress or change.

Strategy

The NISPS promotes an evidence-based, Inuit-specific approach to suicide prevention by identifying priority areas for intervention that would be most impactful in preventing suicide.

These priority areas are as follows: (1) creating social equity, (2) creating cultural continuity, (3) nurturing healthy Inuit children from birth, (4) ensuring access to a continuum of mental wellness services for Inuit, (5) healing unresolved trauma and grief, and (6) mobilizing Inuit knowledge for resilience and suicide prevention (see Figure 4.2).

The Strategy's evidence-based approach to suicide prevention considers the entire lifespan of the individual, as well as what can be done to provide support for families

and individuals in the wake of adverse experiences that we know increase suicide risk. Focusing our resources and efforts on supporting families and nurturing healthy Inuit children is the most impactful way to ensure that people never reach the point where they consider suicide.

Figure 4.2—Protective factors identified by the Inuit suicide prevention strategy

Evaluation

One of the implementation tasks will be to finalize an evaluation framework for the NISPS, by identifying key indicators for each action item, and processes for collecting necessary data in an ongoing way. Progress will be evaluated in two-year increments.

Source: Inuit Tapiriit Kanatami, *National Inuit Suicide Prevention Strategy*, 2016.

Committee view

4.132   The committee heard evidence from organisations and communities that suicide, both attempted and completed, has long since reached a crisis level in rural and remote Aboriginal and Torres Strait Islander communities. That this has been allowed to continue unchecked for so long is to Australia's shame.

4.133   The committee heard overwhelming evidence from mental health experts that in too many cases, the causes of suicide for Aboriginal and Torres Strait Islander peoples is not mental illness, but despair caused by the history of dispossession combined with the social and economic conditions in which Aboriginal and Torres Strait Islander peoples live.

4.134   The committee strongly recognises the Australian and international evidence that demonstrates the most effective suicide prevention strategies for Aboriginal and Torres Strait Islander peoples will be to restore strong, resilient communities who are able to raise children with the inherent protective factors that arise from safe homes, safe communities and strong culture.

National strategic framework

4.135   The Australian Minister's Health Advisory Council endorsed the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (Aboriginal Mental Health Framework) in February 2017.[137]

4.136   The stated purpose of the Aboriginal Mental Health Framework is to 'to guide and inform Aboriginal and Torres Strait Islander mental health and wellbeing reforms' and to 'to respond to the high incidence of social and emotional wellbeing problems and mental ill-health [of Aboriginal and Torres Strait Islander peoples]'. The purpose also declares that ' the Australian Government has committed to continue to seek advice from Aboriginal and Torres Strait Islander mental health and related areas leaders and stakeholders to shape reform at the national level.' [138]

4.137   The Aboriginal Mental Health Framework contains 5 key action areas, each with three outcomes. Of particular relevance to discussions of culturally competent mental health service delivery is the following action areas and associated outcomes:

> ACTION AREA 1: Strengthen the Foundations
>
> Outcome 1.1: An effective and empowered mental health and social and emotional wellbeing workforce.

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137   Commonwealth of Australia, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023,* October 2017 (Aboriginal Mental Health Framework), [p. 4], https://pmc.gov.au/resource-centre/indigenous-affairs/national-strategic-framework-mental-health-social-emotional-wellbeing-2017-23 (accessed 21 November 2018).

138   Aboriginal Mental Health Framework, p. 2.

Outcome 1.2: A strong evidence base, including a social and emotional wellbeing and mental health research agenda, under Aboriginal and Torres Strait Islander leadership.

Outcome 1.3: Effective partnerships between Primary Health Networks and Aboriginal Community Controlled Health Services.

4.138   The Aboriginal Mental Health Framework notes that a monitoring plan would need to be prepared, and noted it 'should be developed under the leadership of, and in partnership with, Aboriginal and Torres Strait Islander leadership bodies.'[139]

4.139   CATSINaM recommended that all planning and development of mental health services should follow the recommendations made in the Aboriginal Mental Health Framework and the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*, both of which 'were for and about Aboriginal and Torres Strait Islander peoples and demonstrated best practice in policy development.' CATSINaM noted however, that the Aboriginal Mental Health Framework did not yet have an implementation plan and required associated funding investment.[140]

4.140   The following discussion outlines some continued policy and funding concerns presented to the committee, which appear to show some inconsistency in the early implementation of the Aboriginal Mental Health Framework.

Framework failures

4.141   A consistent theme appeared in the evidence presented to the committee, that the lack of culturally competent mental health services for Aboriginal and Torres Strait Islander communities was due in part to the fragmentation of policy advice and funding arrangements across multiple jurisdictions. The funding framework for mental health services was discussed in detail in chapter two, including details on how the ACHHS sector is funded. This following section will focus on certain policy and funding issues that continue to impact the cultural competency of mental health services.

Policy fragmentation

4.142   The committee heard from a range of organisations that policy fragmentation, across different geographical regions and different levels of government, was a contributing factor to poor cultural competency of mental health service delivery for rural and remote Aboriginal and Torres Strait Islander peoples.

4.143   NACCHO submitted that policy fragmentation is also felt in how services operate, citing that a lack of coordination between government and non-government services impacts mental health service provision, particularly in addressing needs in a 'culturally appropriate and holistic way.'[141]

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139   Aboriginal Mental Health Framework, p. 33.

140   CATSINaM, *Submission 74*, p. 4.

141   NACCHO, *Submission 128*, p. 5.

4.144   The Danila Dilba Health Service made an overarching recommendation that all levels of government, as well as non-government service providers, should adopt a policy to move services to the Aboriginal community-controlled sector, starting with capacity building of the sector. This could be done by funding for services to Aboriginal communities including a requirement for non-Indigenous providers to develop an exit strategy and show progress in implementing that strategy. Danila Dilba Health Service cited the Jesuit Social Services in Victoria, who partnered with the Victorian Aboriginal Child Care Agency (VACCA) and managed a successful transition in the roles where VACCA is now the led agency in the partnership.[142]

4.145   When asked about this program, Jesuit Social Services told the committee that organisations must be prepared to allocate enough time within the program framework 'to enable Aboriginal and Torres Strait Islander people to strengthen their capacity so that in the long term they may develop the autonomy and skills required to manage these services.' Jesuit Social Services discussed a similar approach they took to service delivery in Santa Teresa, and noted that 'Business-wise, that work is difficult because, when you're continually operating to put yourself out of business, you have to work out how you stay in business too.'[143]

4.146   CATSINaM submitted that many areas of policy, such as economic and environmental policy, use impact assessments to predict and assess the consequences of a proposed policy, to assist in creating better outcomes. CATSINaM recommended that future policy decisions for mental health should include a social impact assessment to study the consequences on Aboriginal and Torres Strait Islander peoples and all peoples in rural and remote Australia. CATSINaM pointed to this being of particular importance for rural and remote Australia, as the emphasis on market driven solutions for human services has resulted in market failure in mental health services delivery in rural and remote locations.[144]

Funding implications for cultural competency

4.147   The committee was told that the complexity in funding arrangements for Aboriginal and Torres Strait Islander-specific health and wellbeing services impacts on the quality of those services.

4.148   NACCHO argued that the continual underfunding of ACCHSs to deliver mental health and SEWB services limits the capacity of ACCHSs to improve the mental health outcomes for Aboriginal people, leading to increases in hospital admissions for complex and chronic conditions.[145]

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142   Ms Joy McLaughlin, Senior Officer, Strategy, Research and Policy, Danila Dilba Health Service, *Committee Hansard,* Darwin, 9 July 2018, p.27.

143   Mr John Adams, Jesuit Social Services, *Committee Hansard*, Alice Springs, 10 July 2018, pp. 35 and 37.

144   CATSINaM, *Submission 74*, p. 5.

145   NACCHO, *Submission 128*, p. 6.

4.149   Organisations from the ACCHS sector told the committee there was a significant reduction in overall funding to the ACCHS sector after policy oversight of Aboriginal-specific health and wellbeing funding was transferred in 2013 from the Department of Health's Office of Aboriginal and Torres Strait Islander Health to the Department of the Prime Minister and Cabinet.[146]

4.150   The committee was also told this transfer has resulted in increasing the already confusing array of funding sources, which now includes the Department of Prime Minister and Cabinet, Commonwealth health funding disbursed by PHNs, as well as State and Territory funding. AMSANT recommended that at a Commonwealth level, SEWB, mental health and AOD program funding be placed back into the Indigenous Health Division of the Health Department, with input and advice on funding decisions from jurisdictional forums such as the Northern Territory Aboriginal Health Forum.[147]

4.151   The Northern Queensland PHN raised similar concerns, telling the committee that multiple funding streams, not just in the health portfolio, could be better coordinated to achieve improved outcomes with the same level of resources.[148]

4.152   Danila Dilba Health Service commented that the fragmentation of funding meant that an organisation could apply for capital works to build a facility, but they did not guarantee funding would be supplied from different areas of government to actually operate the service.[149] Danila Dilba Health Service also told the committee it takes a full time role to apply for funding and then complete funding reporting requirements and they had the capacity to do this only because they are a larger organisation.[150]

4.153   The Wurli-Wurlinjang Health Service noted that the funding fragmentation of Aboriginal and Torres Strait Islander health and wellbeing programs sometimes led to the duplication of services. It also noted that this ever-changing funding environment also meant that organisations have 'no real foundation in regard to infrastructure to work from. There's no stability; you're constantly on the move because it's so funding dependent.'[151]

4.154   AMSANT submitted that the small amount of overall funding available for health and wellbeing services to Aboriginal and Torres Strait Islander peoples often goes to large NGOs who lack local and cultural expertise. This leads to mental health

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146   AHMRC, *Submission 99*, p. 1 and NACCHO, *Submission 128*, p. 6.

147   AMSANT, *Submission 129*, p. 4.

148   Mrs Gillian Yearsley, Northern Queensland Primary Health Network, *Committee Hansard,* Townsville, 30 August 2018, p. 11.

149   Mr Malcolm Darling, Danila Dilba Health Service, *Committee Hansard,* Darwin, 9 July 2018, p.27.

150   Ms Joy McLaughlin, Senior Officer, Strategy, Research and Policy, Danila Dilba Health Service, *Committee Hansard,* Darwin, 9 July 2018, pp. 24–25.

151   Miss Mary Maloney, Wellbeing Manager and Registered Mental Health Nurse, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, pp. 8–9.

services designed and delivered without local Aboriginal input, which are usually ineffective and inappropriate for Aboriginal communities and results in people not accessing these services.[152] AMSANT noted that the Northern Territory PHN had prioritised funding of ACCHSs, but in other PHN areas this did not occur.[153]

4.155   The AHMRC raised a similar concern and submitted that current funding landscapes, which include commissioning models and competitive tendering, have resulted in a fragmentation of services where external NGOs are allocated funding to work with Aboriginal communities, whose preference is to seek services through their local ACCHS.[154]

4.156   The AHMRC pointed to recommendations from bodies such as the AMA and the National Aboriginal and Torres Strait Islander Leadership in Mental Health, which have recommended long term investment in the ACCHS sector by governments.[155]

4.157   The AHMRC submitted this could be implemented through a model where ACCHSs work with Local Health Districts to develop integrated models of care. The AHMRC argued that such partnership agreements would provide the framework to develop better referral pathways, pre-discharge planning and care coordination. This would also provide mainstream mental health workforces with the exposure to Aboriginal culture needed to work in a culturally safe manner with Aboriginal communities The AHMRC made further recommendations for reinvestment in community mental health services to provide clinical services in thin markets where specialist psychiatric services are scarce, such as child and adolescent services. [156]

4.158   Neami National raised concerns that funding is not provided up-front for service design, to ensure that organisations are 'working with people on the ground in co-designing what that service might look like.'[157]

4.159   KALAAC pointed to the lack of funding overall for any form of cultural programs, despite the findings on the important role of Aboriginal culture as a protective factor against suicide. KALAAC cited Productivity Commission statistics, that at present 0.74 per cent of Commonwealth and State Government funding for Aboriginal Affairs in Western Australia are allocated to culturally based programs.[158]

4.160   The Social and Emotional Wellbeing Manager for Aboriginal Interpreting WA told the committee that investment in Aboriginal-designed programs was the overarching solution:

152   AMSANT, *Submission 129*, pp. 4–5.

153   Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 7.

154   AHMRC, *Submission 99*, p. 5.

155   AHMRC, *Submission 99*, p. 2.

156   AHMRC, *Submission 99*, pp. 6–7.

157   Ms Karen Thomas, Queensland State Manager, Neami National, *Committee Hansard,* Townsville, 30 August 2018, p.11.

158   KALAAC, *Submission 59*, p. 5.

There should be investment and building of the solutions for our people. It's quite simple. We can have an overarching framework to sit with our community and talk about our own intergenerational cycles, hold our own people to accountability, create healing and be responsive and reflective of our own people's needs. A right delayed is a right denied. The investment and the solutions are before the government and before the decision-makers and the influencers who have that power. So, there should be no inquiry and there should be no royal commission; there should only be investment in the solutions for a better way.[159]

Concluding committee view

4.161 The committee recognises that the mental health service needs of Aboriginal and Torres Strait Islander peoples are different to those of non-Indigenous Australians. This is because the causes of mental illness and disorders are often very different, and the cultural framework for effective therapeutic outcomes is also very different.

4.162 What was made clear in the evidence presented to the committee is that those different health services needs are not being met, to devastating outcomes for whole communities.

4.163 What was also made clear from experts in mental health and the Aboriginal Community Controlled Health sector, is that the solutions are there, but are not being recognised, funded and supported to grow. The committee is strongly of the view that Aboriginal and Torres Strait Islander peoples mental health service challenges in remote communities will only be solved when Aboriginal and Torres Strait Islander peoples are given better opportunity to address them.

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159 Mr William Hayward, Social and Emotional Wellbeing Manager, Aboriginal Interpreting WA, *Committee Hansard*, Broome, 6 July 2018, p. 9.

Chapter 5
Mental health workforce

5.1   The previous chapters of this report have outlined the service settings for rural and remote mental health, considered the various service models used, and have discussed the key barriers to individuals seeking and receiving mental health services in rural and remote Australia.

5.2   For mental health service providers, many of the key barriers to delivering an effective service stem from workforce issues. The committee heard there is a fundamental lack of appropriately trained and supported staff to deliver mental health services in rural and remote communities in Australia. Chapter 4 noted the particular needs of Aboriginal and Torres Strait Islander peoples, which raise additional workforce challenges in delivering culturally competent services.

5.3   Evidence to the inquiry indicates that it can be difficult to attract appropriately trained clinical staff to remote areas and to then provide the professional support and ongoing professional development they require as part of their registration requirements. The tyranny of distance also poses challenges to providing training and other development opportunities when a local person has been identified as a potential mental health worker.

5.4   This chapter will examine the issues involved in maintaining an effective and sustainable mental health workforce and how these issues are exacerbated in remote communities. It will first consider some of the personal and professional challenges that face mental health professionals considering whether they and their families will move to a rural or remote community and which influence whether such professionals stay in a rural or remote community over the longer term. The second part of this chapter will examine how changes to training may help to build a sustainable and culturally competent mental health workforce for rural and remote Australia.

Challenges in attracting and retaining mental health professionals

5.5   Mental health service providers told the committee that, in order to provide appropriate levels of service, there is a pressing need for more mental health staff in rural and remote communities, but that service providers find it difficult to attract the staff they need.[1] The breadth of difficulties was outlined by the Victorian Council of Social Service:

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1   See for example: Dr Roland Main, Area Director for Mental Health, Adults and Older Adults, Western Australia Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 2; Mr Jake Hay, Regional Program Manager Youth, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12; Dr Renee Bauer, Clinical Director, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 25; Mr David O'Sign, Chief Executive Officer, Cornerstone Youth Services, *Committee Hansard*, Devonport, 5 September 2018, p. 23; MindSpot, *Submission 5*, p. 2; National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission* 128, p. 6.

Isolation, limited access to professional development, inadequate management and professional support and family challenges, including access to high quality education for children, spousal employment and housing all contribute to difficulties recruiting and retaining workers.[2]

5.6   These barriers are explored in greater detail below.

Personal factors

5.7   Of particular relevance to service delivery in remote communities is the challenge of attracting sufficiently qualified and experienced staff who are prepared to live and work in a remote community. As the Executive Officer of the Mental Health Fellowship of Australia (NT) told the committee:

> There are very few trained people willing to work in remote settings due to the tyranny of distance from friends and family and the lack of infrastructure and services.[3]

5.8   Some of the personal factors which make it difficult to attract and retain staff and which were raised with the committee include the lack of housing and quality schooling for children and family members, as well as general lifestyle differences between rural and urban locations. These are discussed below.

Housing

5.9   The Central Australian Rural Practitioners Association noted that secure housing is essential to attract skilled and qualified practitioners:

> …workers everywhere—and I think community people, too—demand things like safety and reasonable housing...There are reasons why people work in remote communities, but you have to have safe housing. You have to have housing where the locks actually work. There are a lot of dongas out there. They're old buildings on stilts, which need a lot of maintenance. People say, 'We don't…have to work like this. There are other opportunities—other work.'[4]

5.10   In the Northern Territory (NT), the committee heard that there were potentially hundreds of communities across the territory that had inadequate housing to support skilled workers.[5]

5.11   In some cases, service providers have been able to rent accommodation in order to provide stable and appropriate housing for trained staff, but for others

2   Victorian Council of Social Service, *Submission 107*, p. 8.

3   Ms Lorraine Davies, Executive Officer, Mental Illness Fellowship Australia (NT), *Committee Hansard*, Darwin, 9 July 2018, p. 16.

4   Mrs Lyn Byers, Secretary, Central Australian Rural Practitioners Association, *Committee Hansard*, Alice Springs, 10 July 2018, p. 29.

5   Ms Vanessa Harris, Executive Officer, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 9 July 2018, p. 19.

securing housing is more complicated.[6] TeamHEALTH, a provider in the NT, shared its experience trying to obtain secure housing for its staff in remote communities:

> From our experience, the services in Gunbalanya and Maningrida—it took us years to get appropriate housing so that we could have trained staff who were able to stay in community. We now rent one of the houses that we use so that we can provide that stability. Other times you rely on the teacher's partner, the childcare worker's partner, the policeman's wife—those sorts of people who have housing provided as part of their thing. They disappear because so-and-so gets transferred, and that really impedes. So housing for skilled workers that you want to bring in so that you can skill and pass on the culture and the mental health expertise into the community and help them build their capacity is one element.[7]

Education

5.12   Some witnesses expressed concern that the quality of schooling, especially in some remote communities, would deter prospective health professionals considering moving to a remote community if they had children.[8]

5.13   In other cases, the committee heard that it can be a challenge, even in regional locations like Whyalla, to retain health professionals who may consider moving away to more metropolitan centres to support their children's education.[9]

5.14   In Halls Creek, the Chairperson of the Jungarni-Jutiya Indigenous Corporation told the committee about the state of schooling in the community:

> The quality of schooling here is way behind the eight ball. Kids coming out of school in high school still can't read and write. We've been talking about these types of things for a number of years, and very little seems to change.[10]

Lifestyle

5.15   One rural social worker suggested to the committee that rural communities are not able to provide the lifestyle opportunities that city practitioners, their children and families may be used to.[11]

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6   Mr David O'Sign, Cornerstone Youth Services, *Committee Hansard*, Devonport, 5 September 2018, p. 22.

7   Ms Helen Egan, Chief Executive Officer, TeamHEALTH, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 9 July 2018, p. 19.

8   Mrs Sharon Bambling, Acting Chief Executive Officer, Jungarni-Jutiya Indigenous Corporation, *Committee Hansard*, Halls Creek, 5 July 2018, p. 6; Dr Stephanie Trust, Principal GP, Kununurra Medical, *Committee Hansard*, Kununurra, 5 July 2018, p. 16; Australian Rural Health Education Network (ARHEN) Mental Health Academic Network, *Submission 76*, p. 3.

9   Ms Andrea Triggs, Operations Manager, Country and Outback Health, *Committee Hansard*, Whyalla, 20 July 2018, p. 9.

10   Ms Robyn Long, Chairperson, Jungarni-Jutiya Indigenous Corporation, *Committee Hansard*, Halls Creek, 5 July 2018, p. 6.

11   Name withheld, *Submission 115*, [p. 4].

5.16   The Central Australian Rural Practitioners Association explained some of the challenges associated with living in a remote community:

> Very remote communities are inherently unhealthy places to live. It doesn't matter whether you grew up there or didn't. There are basic things that you need. Food is expensive. I've got resources to get good food—I've got credit cards and the ability to transport stuff—but other people don't. So food is expensive. The water won't taste as good and you'll have to dilute it with stuff—it's bore water. The air might not be as good because of the dust and so forth. It will be difficult to find places to exercise, because of dogs and so forth. It's inherently an unhealthy place to live.[12]

5.17   Another witness explained part of the challenge in living in a remote community in Western Australia is that common services, such as shops, may be limited:

> The problem is retaining staff that can live in that remote circumstance. There is one shop in Mulan; it's open six hours a day. Prices are very expensive. Besides that there's nothing to do except shopping.[13]

Mental health and stress

5.18   Some submitters told the committee that there was also a need to consider the mental health of the workforce living and working in rural and remote communities.

5.19   A midwife working for a regional health service explained that healthcare professionals need to manage their mental health to protect themselves from multiple sources of stress:

> It's a very stressful environment, not just for patients. It is hard to avoid mental health issues just from the work alone; add to this any other stresses or risk factors and you're a sitting duck.[14]

5.20   In many small communities, a health practitioner can be a high profile member of a local community. This means that the practitioner and/or their family could be subject to threats or harassment because of treatment they provide or decisions they are required to make.[15] The committee heard that this can be stressful for practitioners who may not have access to the supports that they require to maintain their own mental health or who may not be able to place emotional safety or professional distance between themselves and their patients.[16]

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12   Mrs Lyn Byers, Central Australian Rural Practitioners Association, *Committee Hansard*, Alice Springs, 10 July 2018, p. 28.

13   Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 15.

14   beyondblue, *Submission 85*, p. 9.

15   Australian College of Rural and Remote Medicine, *Submission 43*, p. 6; Outback Futures, *Submission 60*, p. 5; ARHEN Mental Health Academic Network, *Submission 76*, p. 3.

16   Outback Futures, *Submission 60*, p. 5.

5.21   The Australian College of Rural and Remote Medicine noted that potential threats and a lack of anonymity were especially concerning in rural and remote settings as:

> Many of these workplaces are very isolated, limiting access to personal and professional support for health professionals. Workforce shortages can make obtaining locum relief difficult. Lack of anonymity which makes it difficult to be 'off duty', and can increase pressure to meet community expectations and pressures. This makes them more susceptible to workplace violence and increases the likelihood that this violence might be serious.[17]

Professional factors

5.22   Some of the personal factors which make attracting and retaining staff difficult may also be either compounded or alleviated by the professional working environment.

Uncertainty regarding short-term funding cycles

5.23   As discussed in Chapter 2, many service providers in rural and remote Australia are facing uncertainty in funding. Submitters advised the committee that short-term funding cycles have posed a significant challenge to attracting and retaining staff.[18]

5.24   The Rural Doctors Association of Australia explained that it is hard to attract practitioners if their job is insecure:

> People will not relocate for a temporary job for one or two years. It is a huge upset to their own families and to their own professional lives if they're moving out to a community and there's no job security.[19]

5.25   Youth, Family and Community Connections Inc in Tasmania told the committee that short-term contracts were not conducive to providing staff with job security and made it harder to attract staff to the region:

> Short funding periods are not conducive to long-term employment, so that's a major issue. Also, as you'd be aware, it's not—if I can use this language— 'sexy'. It's not attractive to deliver services in some of these regions.[20]

5.26   Short-term contracts affect the ability of staff to have the certainty that would allow them to organise their families and personal affairs in a way that would allow them to make a longer term commitment to the community and the region.[21]

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17   Australian College of Rural and Remote Medicine, *Submission 43*, p. 8.

18   Dr Andrew Wenzel, Manager, headspace Albany, Youth Focus, *Committee Hansard*, 5 June 2018, p. 20; Mr Colin Penter, Projects Lead and Policy Officer, Western Australian Association for Mental Health, *Committee Hansard*, Albany, 5 June 2018, p. 47; Mr David O'Sign, Cornerstone Youth Services, *Committee Hansard*, Devonport, 5 September 2018, p. 23.

19   Mrs Peta Rutherford, Chief Executive Officer, Rural Doctors Association of Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 2.

20   Ms Roslyn Atkinson, Chief Executive Officer, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 33.

5.27   Youth, Family and Community Connections Inc explained that having staff on year-to-year funding cycles made it harder for them to have a mortgage or a personal loan and that the service was experiencing much higher staff turnover than when it had funding periods of three years or longer and could offer longer contracts.[22]

5.28   Mission Australia told the committee that the same issues arise for staff who are on funding cycles of three years or less:

> The issue with three-year funding cycles, or fewer-than-three-year funding cycles, is that as you get to the end of the funding cycle people have mortgages and ask, 'Can I stay in this community? Can I afford my rent or do I need to go back home?' which is particularly challenging. Longer-term funding is something that our organisation advocates for quite strongly.[23]

5.29   Service providers identified that providing longer-term funding arrangements, even by a few years, would assist them to provide services and to recruit staff to work in rural and remote communities:

> We're not sharing the knowledge of that good work. So, for me, some of the solutions to this would be around longer term funding agreements. If we look to moving towards a five-year agreement, for example, I think this would really enable outreach services and those that are place based to invest in these communities. When you know you're going to be there for five years, it makes it easier to recruit staff and you can truly invest in some place based options for those communities. I think there needs to be acknowledgement that this type of service delivery will be more expensive than delivering in a capital city, for example, and that numbers might be lower but the outcomes can be tremendous.[24]

5.30   A number of submitters agreed that minimum five-year funding would be preferable to provide staff with certainty that would allow them to plan for the future.[25] Mr Chris Cowley, the Chief Executive Officer of the Whyalla City Council,

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21   Mr Malcolm Darling, Acting Chief Executive Officer, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p. 24; Associate Professor John Boffa, Chief Medical Officer Public Health, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 1; Cr Clare McLaughlin, Deputy Mayor, Whyalla City Council, *Committee Hansard*, Whyalla, 20 July 2018, p. 5.

22   Ms Roslyn Atkinson, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 34.

23   Mr Luke Butcher, Area Manager, Western New South Wales and Special Projects, Mission Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 70.

24   Ms Roslyn Atkinson, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 33.

25   Dr Martin Laverty, Chief Executive Officer, Royal Flying Doctor Service (RFDS), *Committee Hansard*, Townsville, 30 August 2018, p. 2; Ms Evelyn Edwards, Chief Executive Officer, North West Remote Health, Northern Queensland Primary Health Network, *Committee Hansard*, Townsville, 30 August 2018, p. 10; MindSpot, *Submission 5*, p. 5; Wesley Mission, *Submission 38*, p. 12.

explained why he considered that the difference between two-year funding and five-year funding was so important:

> I know in my experience, certainly in my role, the provision of a five-year contract gives you a good three to four years before you start turning your mind to what is the future opportunity or am I going to be awarded a further contract. Whereas if you give out a two-year contract you're only going to be 12 months into the role and you're already creating uncertainty. It's not even particularly based on funding, but I know in the human psyche a five-year contract gives you certainty: do I relocate my family, do I invest, do I take the time to embed myself in this community or am I just a mercenary? That's the difference between a two and a five.[26]

5.31   Service providers such as the Royal Flying Doctor Service (RFDS) acknowledged that five-year funding would provide certainty for both staff and service providers and give both the best opportunity to succeed:

> As a result of our arrangements with the Commonwealth, this is funded for an initial five years, and we have every expectation of that becoming a permanent program. Five years is so terribly important because some of the existing programs of the Royal Flying Doctor Service and other community organisations have short contract lives—one year, two years or perhaps three years. That creates great uncertainty for the staff who work in them. It also creates more uncertainty for those in communities who are reliant on those services. The fact that we've got five years guaranteed resourcing to roll out this national program across underserved remote areas gives us great optimism that this service will be established and given the certainty that it needs to succeed.[27]

5.32   Longer funding cycles may also lead to better outcomes for patients in rural and remote communities if they mean that the practitioner can live and build relationships in the community for a period of time.

Professional reputation and rapport

5.33   Some service providers explained to the committee that the problem with only having staff stay for a short period of time is that it takes time for the practitioner to develop relationships with patients.[28] It is also problematic for patients who are required to re-tell their story to each new practitioner:

> …in regard to the turnover of staff, it takes a while for rural, regional and remote people because they're not that trusting of outside services and people they don't know. So when we have the turnover of staff which we have in our sector, then people just get to trust someone, and I hear time

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26   Mr Chris Cowley, Chief Executive Officer, Whyalla City Council, *Committee Hansard*, Whyalla, 20 July 2018, p. 5.

27   Dr Martin Laverty, RFDS, *Committee Hansard*, Townsville, 30 August 2018, p. 2.

28   Mr Luke Butcher, Mission Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 70; Ms Sharon Jones, Executive Officer, CORES Australia, *Committee Hansard*, Devonport, 5 September 2018, p. 2.

and time again, 'I've got to retell my story, and I'd rather kill myself than tell my story again.' That's a real issue.[29]

5.34   If there is a suggestion that the practitioner will not be there for a reasonable length of time, such as on a 'fly-in, fly-out' basis, there is the very real risk that community members will not engage with that service.[30]

5.35   Currently, some communities believe that younger, less experienced practitioners are coming to regional or remote locations for a short period of time to further their own careers.[31] The Regional Youth Program Manager for the Shire of Halls Creek explained that some practitioners only ever planned to stay in the town for a short period of time:

> …the first thing people say when they arrive here to work is, 'How long are you here for?' They don't see Halls Creek as their home; they see Halls Creek as a transitioning point for greater things.[32]

5.36   Service providers indicated to the committee that when practitioners are prepared to make a commitment to a community, then the members of the community are more willing to engage:

> If they're supporting a person who's going to be permanently based here in town and they can put a face to a name and know that that person is going to be here for good, I think it will encourage them to come out and really speak about our story and talk about what issues they might be facing.[33]

5.37   A GP working in Kununurra discussed the turnover of mental health support services in her region as being a cause of youth disengagement with the services they critically need:

> I saw a 14-year-old this morning who has been to two different organisations and seen five different counsellors about what happened to her when she was younger. She has now given up and is refusing to go to anymore because she's sick of seeing different people. She is not going to school and is now starting to drink, take drugs and have antisocial behaviour. If we don't stop that, she will end up in juvenile detention.[34]

5.38   The GP explained that in her area there were 10 different organisations with responsibility for a small portion of juvenile justice and health:

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29   Ms Sharon Jones, CORES Australia, *Committee Hansard*, Devonport, 5 September 20187, p. 2.

30   Mr Brendan Morrison, Social and Emotional Wellbeing, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 4.

31   Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12; Mrs Nicola Herriot, Chief Executive Officer, Northern Territory PHN, *Committee Hansard*, Darwin, 9 July 2018, p. 6; Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, *Submission 26*, p. 9.

32   Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 15.

33   Mr Brendan Morrison, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 4.

34   Dr Stephanie Trust, Kununurra Medical, *Committee Hansard*, Kununurra, 5 July 2018, p. 15.

It's so confusing for me sitting around the table after all my experience. You can imagine what it's like for parents and for kids.[35]

5.39   Miss Nawoola Newry told the committee that the high turnover can exacerbate a lack of cultural awareness and lead to communities having to deal with the consequences of service gaps:

They come here and we have such a high turnover of staff up here, but it takes people at least two to three years to build relationships in town. They don't come to our community and do cultural awareness training. They sit in their offices from eight to four, they go home at four o'clock and they shut their door—their job is done. It's our community that is dealing with it. It's our community that is trying to stop our family from hanging themselves in the trees.[36]

Remuneration and team support

5.40   As noted above, the cost of living in regional, rural and remote communities can be higher than in cities. However, remuneration packages may not be commensurate with the increased cost of living. Witnesses reported that some experienced mental health professionals had expectations of high remuneration which organisations described as being 'difficult to meet within funding levels'.[37]

5.41   In Tasmania, the committee received evidence that offering lower amounts of remuneration increased the difficulties in attracting qualified staff. The Mental Health Council of Tasmania told the committee that attracting qualified staff was an ongoing issue:

We're well below the national average for access to psychiatrists and GPs. A lot of people are receiving care from fly-in, fly-out locums. We don't have that continuity of care or those important relationships being built between patients, clients and clinicians. It is an ongoing challenge for Tasmania because, yes, we don't offer more—in fact, we'd be on the lower end of the pay scale for attracting those staff. Then we've got the additional isolation of being surrounded by a ring of water. You choose to come to a place like this and to work here. There are some difficulties in being able to attract people and keep them here.[38]

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35   Dr Stephanie Trust, Kununurra Medical, *Committee Hansard*, Kununurra, 5 July 2018, p. 15.

36   Miss Nawoola Newry, *Committee Hansard*, Kununurra, 5 July 2018, p. 25.

37   Mr Malcolm Darling, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p. 24; Dr Jennifer Cleary, Chief Executive Officer, Centacare Catholic Country SA, *Committee Hansard*, Whyalla, 20 July 2018, p. 43.

38   Mrs Connie Digolis, Chief Executive Officer, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 38.

5.42   This issue is compounded by the fact that service providers feel that they are not receiving sufficient funding for certain programs to employ staff with the qualifications actually required to deliver the service.[39]

5.43   Some witnesses in remote locations, such as Derby, expressed concern about attracting staff because they could not offer the same level of remuneration or other benefits as other regional organisations.[40]

5.44   The Central Australian Aboriginal Congress, which has developed a successful and self-sustaining practice, stressed that paying health professionals good salaries and supporting them with a collegiate team was key to attracting and retaining good staff to stay in rural and remote communities:

> I think the salaries that are offered are attractive. Psychologists are highly urbanised. This is an issue in rural Victoria. Most psychologists remain in the cities. To be able to get them to come out to a remote area you have to give them the right salary. It does not compete. If a psychologist wants to stay in private practice, they can make a lot more money. You do need to have a decent salary offered. I think also we have that reputation. We have other psychologists here, so psychologists feel supported.[41]

5.45   Associate Professor John Boffa, Chief Medical Officer Public Health at the Central Australian Aboriginal Congress, told the committee that psychologists should be remunerated by a form of blended payment, comprised of part salary and part Medicare Benefits Schedule payments.[42]

5.46   Associate Professor Boffa explained that the blended model was needed to ensure that psychologists could afford to stay in the community even if not all of their patients attended all of their appointments:

> The other challenge in remote areas is that people don't just turn up to appointments in the way they might in the city where people are motivated in that they might be paying a big gap fee to see their psychologist and they might want to turn up for six appointments. Here, people have major issues but the challenge is to keep people coming and to engage them. You might do that and people might come to their appointment and then not come to the next appointment and then maybe come to the third appointment. When you've got a salary you can cope with people not attending at times but it is

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39   See, for example: Mrs Connie Digolis, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 41; Ms Helen Egan, TeamHEALTH, *Committee Hansard*, Darwin, 9 July 2018, p. 25.

40   Dr Lynette Henderson-Yates, Chief Executive Officer, Derby Aboriginal Health Service, *Committee Hansard*, Derby, 6 July 2018, p. 8.

41   Dr Jon-Paul Cacioli, Social and Emotional Wellbeing Manager, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 4.

42   Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, pp. 2 and 5.

difficult when you're trying to fund it all through Medicare and through Medicare plus a gap fee.[43]

5.47   Associate Professor Boffa also noted that building a supportive team was critical to supporting practitioners and that it was also helpful in attempting to recruit practitioners because the prospective practitioner would know that they would be supported:

> The report of someone in the recruitment process is really important as well. If a psychologist rings up, it is important that they are able to talk to someone who is in their field and is already working there. That really helps. That person helps develop the JD. They can provide support. So there is external supervision and support. You have got to have a network.[44]

5.48   That view was supported by the Western Queensland Primary Health Network, which told the committee that it believes that having a network of professionals in a regional area creates a much more sustainable workforce:

> Another thing that is really important is creating those clinical hubs and networks and having professional advocacy within communities. Clinical leadership comes from a team. So it's about building those teams and supporting them. People can come into the country areas and really work to their scope and experience opportunities they don't experience in regional and metropolitan areas. They can get stretched and exposed to a whole range of different cultural, personal and professional experiences. I think that's often the hidden success, because it's more sustainable, you're working as a team, you're supported and you thrive professionally. Also you're in a network that has an interest in your family, your children and your own wellbeing.[45]

Clinical supervision

5.49   One of the key concerns expressed by practitioners and their representatives is that they may not receive adequate clinical supervision in a rural or remote community.[46]

5.50   However, the committee heard that providing clinical supervision for a trainee practitioner can place great stress on clinical practitioners who are already in high demand and have a high workload.[47]

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43   Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 2.

44   Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 4.

45   Mr Stuart Gordon, Chief Executive Officer, Western Queensland Primary Health Network, *Committee Hansard*, Mount Isa, 29 August 2018, p. 2.

46   Occupational Therapy Australia, *Submission 65*, p. 12; Australian College of Mental Health Nurses, *Submission 82*, p. 5; Australian Psychological Society, *Submission 103*, p. 15.

47   Royal Australian and New Zealand College of Psychiatrists, *Submission 95*, p. 4.

5.51   The medical colleges said they have identified that they have an obligation to assist practitioners who wish to work in these areas to obtain adequate supervision from metropolitan based practitioners if there is no supervisor in the non-metropolitan location. The Royal Australian and New Zealand College of Psychiatrists noted:

> …you may also have a limited number of psychiatrists who can supervise a psychiatric trainee, because there's only one regional psychiatrist. And that's where our college is trying to look at: 'How can metropolitan based supervisors perhaps fill in some of that gap?' until you get to a critical mass where you're then able to take on more positions.[48]

5.52   The Chairs of the Nursing and Midwifery Board of Australia, Medical Board of Australia, Psychology Board of Australia and the Aboriginal and Torres Strait Islander Health Practice Board (Chairs of the National Boards) told the committee that they were flexible about how clinical supervision was provided.[49] In some cases, supervision may be able to be provided via either videoconference or telephone.

5.53   For trainee psychologists, the committee was advised that off-site supervision was available, videoconference could be used for supervision sessions, and that teleconference supervision could be requested from the Psychology Board of Australia.[50] However, the coordinator of the clinical psychology program at James Cook University noted that external supervision requires greater input from supervisors:

> …the appropriate professional supervision or mentoring of people who go to the west is a massive issue. I can speak mostly about psychology: I've supervised many people who are working in Mt Isa. But it's a long way. You can't hold a person's hand from Townsville very easily, so those kinds of things are difficult. It's very challenging to work in mental health in Mt Isa.[51]

5.54   Some submitters advised the committee that incentives or additional remuneration may need to be provided to supervisors, including specialist psychologists, to ensure that they remain committed to supervising the student and to ensure that supervision does not impede their own clinical work.

5.55   This approach was supported by the Central Australian Aboriginal Congress, the Australian Psychological Society and the Centre for You.[52] The Centre for You

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48   Dr Matthew Coleman, Committee Member, Section of Rural Psychiatry, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, Canberra, 19 July 2018, p. 8.

49   Australian Health Practitioner Regulation Agency, answers to written questions on notice, pp. 1–2 (received 31 August 2018).

50   Australian Health Practitioner Regulation Agency, answers to written questions on notice, p. 2 (received 31 August 2018).

51   Dr Beryl Buckby, Coordinator Clinical Psychology Program (Acting), James Cook University, *Committee Hansard*, Townsville, 30 August 2018, p. 39.

52   Central Australian Aboriginal Congress, *Submission 55*, p. 13; Australian Psychological Society, *Submission 103*, p. 15; Centre for You, *Submission 57*, [p. 2].

currently trains Provisional Psychologists undertaking Masters Degrees in Clinical Psychology to provide clinical services in rural Victoria. However, the Centre for You noted that its current psychologist training pipeline may not be able to continue without some form of incentive payment because it is having trouble attracting qualified supervisors.[53]

5.56   Ms Brenda King, a sexual assault counsellor working for Anglicare WA in Kununurra, also told the committee that additional resources for expert clinical supervision were needed for Anglicare WA's service to continue in the area.[54]

Continuing Professional Development

5.57   Some submitters told the committee that it was difficult for practitioners based in rural and remote areas to access continuing professional development.[55]

5.58   The Chairs of the National Boards[56] advised the committee that the National Boards adopted a very flexible approach to continuing professional development to ensure that rural and remote practitioners were supported:

> Learning activities can be broad and varied. Health practitioners are able to use multimedia and multiple learning opportunities including simulation, interactive e-learning and self-directed learning. It is therefore possible for rural and remote practitioners to access CPD to support their practice and in some instances, may access CPD arranged for other professions if that CPD relates to their chosen scope of practice.[57]

5.59   The National Rural Health Alliance told the committee that multimedia and e-learning may not be possible because telecommunications, including for the transmission of teaching and learning materials, were poorer in non-metropolitan areas. This meant that to keep their professional registration and maintain and increase their skills there is a need for practitioners working in rural and remote locations to travel to access professional development opportunities.[58]

5.60   While the Australian Government has a Rural Locum Assistance Program to provide funding which should enable a locum to backfill positions to allow practitioners to attend professional development sessions, travelling to larger centres

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53   Centre for You, *Submission 57*, [p. 2].

54   Ms Brenda King, Sexual Assault Counsellor, Anglicare WA, *Committee Hansard*, Kununurra, 5 July 2018, p. 20.

55   Queensland Nursing and Midwifery Union, *Submission 36*, p. 4; Australian Psychological Society, *Submission 103*, p. 15.

56   The Chairs of the National Boards are the Chairs of the Aboriginal and Torres Strait Islander Health Practice Board of Australia, the Medical Board of Australia, the Nursing and Midwifery Board of Australia and the Psychology Board of Australia.

57   Australian Health Practitioner Regulation Agency, answers to written questions on notice, [p. 1] (received 31 August 2018).

58   National Rural Health Alliance, *Submission 37*, p. 18.

to access the professional development can be expensive for the healthcare professional or their organisation.[59]

5.61   The Australian Nursing and Midwifery Federation told the committee that it was difficult for nurses and midwives in rural and remote practice areas to access continuing professional development in mental health because a scholarship program for rural and remote nurses and midwives had been discontinued.[60] The Australian Nursing and Midwifery Federation noted that reinstating the funding would allow nurses and midwives working in rural and remote areas to maintain their skills in the mental health area:

> There needs to be attention to continuing professional development and postgraduate mental health program funding so that nurses in rural and remote areas can be upskilled, can continue the education that they received in their undergraduate programs and can remain relevant to the environment in which we're working today.[61]

5.62   There may also be a role for some of the medical colleges to upskill the general health workforce to provide them with greater skills to recognise and deal with mental health issues. The Australian College of Rural and Remote Medicine told the committee that it was currently reviewing its curriculum to ensure that its Fellows were properly equipped to meet the needs of the communities they serve:

> Rural and remote GPs have significant needs in terms of training and upskilling and many struggle to meet these needs. Mental health is a key component of the College's primary curriculum for GP registrars, and advanced skills training (AST) training option in mental health is available.

> The College is currently reviewing its primary curriculum and the upskilling and professional development courses it provides for its Fellows to ensure that these continue to meet the needs of rural and remote communities.[62]

5.63   Some potential proposals to address these concerns are discussed later in this chapter.

Committee view

5.64   The committee acknowledges that it is difficult for service providers to attract and retain a skilled mental health workforce in rural and remote communities. While the committee understands that practicing in a rural or remote community can be incredibly rewarding and provide interesting professional challenges, the committee

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59   Department of Health, *Submission 30*, p. 33; National Rural Health Alliance, *Submission 37*, p. 18.

60   Ms Elizabeth Foley, Federal Professional Officer, Australian Nursing and Midwifery Federation, *Committee Hansard*, Canberra, 19 July 2018, p. 18.

61   Ms Elizabeth Foley, Australian Nursing and Midwifery Federation, *Committee Hansard*, Canberra, 19 July 2018, p. 18.

62   Australian College of Rural and Remote Medicine, *Submission 43*, p. 7.

understands that there may be both personal and professional reasons practitioners do not move to and stay in rural and remote communities.

5.65   The committee notes that short funding cycles mean that service providers cannot offer mental health professionals the job security that is needed for them and their families to commit to living and working in a rural or remote community in the longer term. The committee notes that the length of the funding cycles is closely linked to staff turnover and that there is a connection between staff turnover and community engagement with mental health services. Some submitters consider that five-year funding would be preferable for service providers and practitioners. The committee considers that longer funding cycles would provide greater certainty for mental health service providers and their staff.

5.66   The committee understands that clinical supervision is problematic for some professionals to obtain in rural and remote areas. The committee welcomes the Chairs of the National Boards' flexibility towards supervision and considers that the colleges have a responsibility to match trainees in non-metropolitan areas with a metropolitan based supervisor if there is no supervisor on-site in the trainee's location.

5.67   The committee accepts that some form of incentive payment may need to be considered for supervisors to encourage a commitment to supervision and recognise the additional workload clinical supervision entails, over and above their own clinical work.

5.68   The committee considers that the colleges and other training providers should consider the professional development needs of practitioners working in rural and remote communities when they develop training materials. The committee understands that the withdrawal of some scholarship funding has made it harder for practitioners, such as nurses, to undertake additional professional development.

Training the workforce

5.69   Throughout the inquiry the committee received evidence that changes to what training is provided, who is provided with mental health training and where the mental health workforce is trained may help to build a more sustainable mental health workforce in rural and remote communities.

5.70   As discussed in Chapter 3, one of the issues affecting service delivery in rural and remote locations is the number of clinicians that practice in these areas. This section will consider the location of clinicians training and how that affects whether they elect to practice in a rural or remote area.

5.71   Improving mental health in rural and remote Australia requires a variety of skills and levels of training. In Chapter 3, the role of a peer workforce was discussed in supporting members of the community and breaking down stigma. This section will also consider the role that a peer workforce may play in both Aboriginal and non-Aboriginal communities.

5.72   Finally, this section of the chapter will consider the workforce training aspects of developing a culturally competent workforce. As discussed in detail in Chapter 4, mental health service delivery for Aboriginal and Torres Strait Islander peoples has a very different service context. The committee heard evidence that a culturally

competent workforce is essential to effective service delivery for Aboriginal and Torres Strait Islander peoples.

Training a workforce in rural and remote areas

5.73   Throughout the inquiry, submitters and witnesses identified the location of training as being important to the development of a mental health workforce that is likely to practice long term in a rural or remote area.

5.74   Training for medical practitioners is largely based in large metropolitan and regional hospitals which, as the Rural Doctors Association of Australia noted, does little to influence a practitioner to select a career in a regional or remote location:

> I think one of the big challenges for rural [areas] is that a lot of the training still happens in the metropolitan and large regional hospitals, and they are filled with the specialists of all the other colleges other than the RACGP or the Australian College of Rural and Remote Medicine. You've got your psychiatrists. You've got your surgeons. You've got your anaesthetists. The fellows of those colleges are doing constant recruitment to pick and choose the brightest to go into their college training pathways. Rural or general practice do not have that influence in the training hospitals.[63]

5.75   The committee heard that there is a growing evidence base that it is easier to recruit and retain staff if they are from, or undertake study in, a rural or remote area.[64] The Royal Australian and New Zealand College of Psychiatrists explained that there was evidence demonstrating that practitioners who began their careers in a rural area were more likely to become part of that community and to practice there long-term:

> It's part of the specialist training program. I can commend it to the committee. I think that this is a strategic way for both the college and state and federal stakeholders who fund these positions to get people from the beginning of their medical career into rural and remote communities so that they become part of a rural community. Hopefully they partner, get themselves a mortgage and have children in that community to become part of that community and then stay. It's a strategic way to train, recruit and retain both GPs and specialists. The evidence has been demonstrated over the past 10 to 15 years with rural clinical schools. The universities training medical students have been giving them longer term rural placements. I see in the Riverina that you'll be able to go from school into university and do

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63   Mrs Peta Rutherford, Rural Doctors Association of Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 8.

64   Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12; Marcella M S Kwan et al, 'The rural pipeline to longer-term rural practice: General practitioners and specialists', *PLoS ONE*, vol. 12, no. 4, 2017, https://doi.org/10.1371/journal.pone.0180394, in Australian Psychological Society, *Submission 103*, p. 12. See also: Therese Zink et al, 'Efforts to graduate more primary care physicians and physicians who will practice in rural areas: examining outcome from the University of Minnesota-Duluth and the Rural Physician Associate Program', *Academic Medicine*, vol. 85, no. 4, 2010, pp. 599–604; James TB Rourke, 'Relationship between practice location of Ontario family physicians and their rural background or amount of rural medical education', *Canadian Journal of Rural Medicine*, vol. 10, no. 4, 2005, pp. 231–240.

your medical undergraduate training in a rural location. The college's aim is that you can then remain as an intern and a junior medical officer and start your specialist training in a rural location. If you can start and complete your training in a rural location, you're more likely to stay there as a consultant specialist.[65]

5.76   The Chief Executive Officer of the RFDS also stressed the importance of requiring practitioners to complete their training in rural or remote areas:

The placement of mental health training facilities in remote or country areas is absolutely essential. The evidence is that you're more likely to have a doctor stay and work in a country community if (a) they grew up there or (b) they spent their medical training in a country area. We don't see too many schools of psychology or mental health nursing that are situated in the bush or in remote areas. They're certainly in regional centres, but the opportunity to place more training in remote Australia is an absolutely essential component of attracting your staff, just as it is to rethink the professional skill set of your individual staff.[66]

5.77   The committee received evidence from Dr Prue Plowright, a Senior Medical Officer with the Derby Aboriginal Health Service, who confirmed that doing her initial medical training in Derby was a significant contributing factor to why she decided to stay in the community.[67]

5.78   During the inquiry the committee heard about the development of a new National Rural Generalist Pathway. The National Rural Generalist Pathway will equip General Practitioners with advanced skills to also provide secondary and tertiary level care in a rural setting if needed.[68] These advanced skills will include mental health and alcohol and other drug services.[69] The Rural Doctors Association of Australia indicated that Queensland and New South Wales' experience in developing rural generalist pathways provided useful evidence that training in a rural location could lead to practitioners staying in those locations:

I think the early lessons learned from the Queensland and the New South Wales pathway will hold the national pathway in good stead, and they are about early recruitment, having positions at intern level, and the second year of the doctors' training, the third-year, and then their rural training all

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65   Dr Matthew Coleman, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, Canberra, 19 July 2018, p. 3. See also: Royal Australian and New Zealand College of Psychiatrists, *Submission 95.1*, [p. 2].

66   Dr Martin Laverty, RFDS, *Committee Hansard*, Townsville, 30 August 2018, p. 6.

67   Dr Prue Plowright, Senior Medical Officer, Derby Aboriginal Health Service, *Committee Hansard*, Derby, 6 July 2018, p. 8.

68   Professor Paul Worley, National Rural Mental Health Commissioner, Department of Health, *Committee Hansard*, Canberra, 19 July 2018, p. 79.

69   Mrs Peta Rutherford, Rural Doctors Association of Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 8; Professor Paul Worley, Department of Health, *Committee Hansard*, Canberra, 19 July 2018, p. 79.

happening in rural and regional areas. The reality is: if you train them in the bush, they're more likely to stay in the bush.[70]

5.79   The Department of Health advised the committee that some steps were already being taken in this area to train more health professionals in rural and regional areas, including the establishment of five rural medical schools in the Murray-Darling region:

There are a number of things that we are addressing through the Stronger Rural Health Strategy announced as part of the recent budget in terms of ensuring that we have training in rural and regional locations to ensure that people who fundamentally would like to work in rural and remote locations are able to train and then continue their employment in rural and regional Australia. There is a whole raft of things coming through out of that around training and retention in terms of trying to keep people training and working within those locations.[71]

Developing a peer workforce

5.80   Clinical mental health workers are not the only people who have the ability to assist members of the community who may be suffering with a mental illness; members of the community, including those with life experience of a mental illness, can be empowered to provide assistance.

5.81   The issue of empowering existing community members to become stronger supports in their community was discussed by many submitters and witnesses.[72] The issue was seen as complex, as while it is beneficial to include people with local knowledge and trust, if not properly resourced it can lead to burn-out of community leaders.

5.82   The Kununurra Waringarri Aboriginal Corporation outlined a training program it provides, where individuals 'get taught Aboriginal mental health first aid, youth mental health first aid, and techniques and tools to help people who might be in a crisis, especially if they're in a community, and have them as the go-to person'.[73]

5.83   A medical practitioner from Kununurra flagged some issues with this approach that need addressing when improving and supporting peer and community supports:

If you talk to any of the big families in the Kimberley, there's always one or two people that stand out from those families. Those people especially need support because often they're the strong ones in the family. And I guess

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70   Mrs Peta Rutherford, Rural Doctors Association of Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 8.

71   Ms Chris Jeacle, Assistant Secretary, Rural Access Branch, Health Workforce Division, Department of Health, *Committee Hansard*, Canberra, 16 October 2018, p. 8.

72   See, for example: Roses in the Ocean, *Submission 7*, p. 2.

73   Mr Brendan Morrison, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 6.

> there's a fine line between empowering them but also not setting those people up to then be the person that takes everything on.[74]

5.84   The Kimberley Mental Health and Drug Service pointed out that expecting Aboriginal and Torres Strait Islander peoples to volunteer to provide unpaid health and wellbeing support in their communities would be 'systemic institutionalised racism, by saying, "This service is essential, yet we're not going to place the same socioeconomic value on that essential service"'.[75]

5.85   Mental health first aid and a workforce of peers and community members is not just important for Aboriginal and Torres Strait Islander peoples, but for rural and remote communities as a whole.

5.86   In many communities there are already people who have established peer-based support networks. Where those networks exist, some organisations told the committee that they wanted to work with local practitioners to build local capacity, leadership and referral pathways.

5.87   ConnectGroups Support Groups Association WA (ConnectGroups) noted that transient service provision is rarely effective because of a lack of community context.[76] Instead, ConnectGroups advocated for building local capacity and to develop a peer workforce to provide social and emotional wellbeing support based on lived experience.[77] As noted in Chapter 3, these groups can be vital to breaking down stigma in a community.

5.88   Throughout the inquiry the committee heard from a number of organisations that were working to support their communities and educate them about mental health. Mr Dylan Lewis, the founder of Katherine Mental Mates, told the committee that his group was providing free training for anyone in the Katherine community that wanted to do it:

> The training is in mental health crisis support through nationally recognised training such as Mental Health First Aid and safeTALK. Through the hard work of volunteer trainers, we have seen around 350 people trained in Mental Health First Aid in the last 2½ years, and it's all been for free when this course normally costs about $160 per person.[78]

5.89   Mr Lewis explained to the committee that a survey of the program run by Mental Mates demonstrated that, on average, each participant had helped five people struggling with depression, anxiety or another mental illness.[79]

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74   Dr Stephanie Trust, Kununurra Medical, *Committee Hansard*, Kununurra, 5 July 2018, p. 13.

75   Dr Huu Duy Tran, Consultant Psychiatrist, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 25.

76   ConnectGroups Support Groups Association WA (ConnectGroups), *Submission 3*, [p. 8].

77   ConnectGroups, *Submission 3*, [p. 3].

78   Mr Dylan Lewis, *Committee Hansard*, Katherine, 9 July 2018, p. 18.

79   Mr Dylan Lewis, *Committee Hansard*, Katherine, 9 July 2018, p. 19.

5.90   Another example of a group helping to develop a peer workforce was the Depression Support Network Albany. The Depression Support Network Albany explained to the committee that it had been running a peer support network to support social activities that connected members of the community with resources and organised meals and activities to support mental health in the community.[80] The Depression Support Network Albany also raises awareness and works to break down stigma around mental illness.[81]

5.91   The committee received evidence throughout the inquiry that these groups of individuals were helping others who were experiencing a mental illness to find the help and support they needed.[82]

5.92   It is clear that people really value the support that can be provided by a peer workforce. Mr John Harper, a Lived Experience Member of Suicide Prevention Australia, told the committee that he frequently receives calls because he is a non-clinical person with a lived experience of working through an episode of mental illness that included a suicide attempt:

> I'm like a peer support worker. I get people ringing me up. This is what gets me: most people know what to do, but I get people ringing me up from North Queensland, Mount Morgan, Weipa or wherever, because I'm an ordinary joker. All I've got to talk about is my lived experience and what worked for me—that I went to the doctor, I did this, I did that. It seems to give people the confidence to take the next step. That's how important it is.[83]

Cultural competency

5.93   The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) explained the importance of a culturally appropriate workforce in stark terms: if a service is not culturally safe, Aboriginal and Torres Strait Islander peoples will not use it, even if their life is in danger.[84]

5.94   CATSINaM submitted that the presence of both an Aboriginal and Torres Strait Islander workforce and a non-Indigenous workforce are central to meeting the Closing the Gap targets for health outcomes and employment. CATSINaM contended that increasing the Aboriginal and Torres Strait Islander health workforce is important

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80   Ms Jo Brown, President /Coordinator, Depression Support Network Albany Inc, *Committee Hansard*, Albany, 5 June 2018, pp. 30–31.

81   Ms Jo Brown, Depression Support Network Albany Inc, *Committee Hansard*, Albany, 5 June 2018, p. 31.

82   Mrs Joanne Cooke, Lived Experience Advocate and Board Member, The Butterfly Foundation, *Committee Hansard*, Canberra, 19 July 2018, p. 49.

83   Mr John Harper, Member, Lived Experience, Suicide Prevention Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 48.

84   Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), *Submission 74*, p. 5.

in providing cultural safety training to support the capability of the non-Indigenous workforce.[85]

5.95   CATSINaM stressed in its submission that the non-Indigenous workforce must be culturally safe and responsive, must be interdisciplinary and must include and value Aboriginal and Torres Strait Islander health professionals.[86] Aboriginal Medical Services Alliance Northern Territory (AMSANT) also pointed to the need to provide culturally appropriate training from entry level to post graduate training, with entry level training to be available within communities and to be designed with Aboriginal input.[87]

5.96   The Director of Mental Health Services for Northern Australia Primary Health Limited discussed the difficulties mainstream health providers face in trying to develop a culturally competent workforce across multiple specialities, when clinicians often move away from rural areas:

> The workforce issue needs to be a coordinated regional approach with the PHN, the universities, government services and NGOs to come up with a plan to change that. This has been happening since I started, and nothing has changed. It is likely to get more difficult because more clinicians are moving down south, going away.[88]

5.97   AMSANT told the committee that a local workforce is well-placed to support incoming clinical specialists:

> A well supported local workforce is able to address these psychosocial and cultural aspects of care and can also support the mental health professional to provide therapeutic care.[89]

5.98   Associate Professor John Boffa of the Central Australian Aboriginal Congress supported this view, and told the committee that an Aboriginal Health Worker can provide a range of services that support therapy, but the therapy itself needs to be delivered by a highly skilled therapist. Associate Professor Boffa went on to say that where people experience poor treatment from low-level counsellors, they will not return as they think the treatment does not work.[90]

5.99   The RFDS pointed to the Aboriginal Health Worker model as a successful model of developing the skills of the allied health professional at a subclinical level and suggested the model should be adopted by mainstream care providers. The RFDS

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85   CATSINaM, *Submission 74*, p. 3.

86   CATSINaM, *Submission 74*, p. 2.

87   Aboriginal Medical Services Alliance Northern Territory (AMSANT), *Submission 129*, p. 6.

88   Mr Phil Ihme, Senior Director Mental Health Services, Northern Australia Primary Health Limited, *Committee Hansard,* Townsville, 30 August 2018, pp. 21–22.

89   Mrs Danielle Dyall, Team Leader Trauma Informed Care and Social Emotional Wellbeing, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 7.

90   Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 3.

went further to state that the model has been successful beyond training and has been successful in attracting and retaining health professionals in rural and remote locations:

> We will always need psychiatrist, [sic] psychologists, mental health nurses and allied health workers, but I think, in modelling the success of the Aboriginal health worker, which has been so successful not just in Alice Springs but across Australia, we've got to learn from that in the mental health sector. It's not out of necessity because we don't have enough staff but out of the opportunity because the Aboriginal health work has been so successful.[91]

Nature of cultural training

5.100 The committee heard examples from several service providers demonstrating that non-Aboriginal staff are not receiving culturally appropriate training to equip them to work in rural and remote communities. The Mental Illness Fellowship of Australia (NT) told the committee that in some cases non-Aboriginal staff are ill-prepared for their roles and to engage with the community when they arrive because their training has been poor and too generic:

> Most community services staff receive a generic, politically correct cultural-training course and then find the reality of living in remote communities is very different from the cultural training they have received.[92]

5.101 The Regional Youth Program Manager for the Shire of Halls Creek told the committee that, in some cases, staff did not have an adequate understanding of the geographic or cultural concerns of the people they were coming to serve:

> Staff do not have an adequate understanding of geographical and cultural concerns for Kimberley clientele. This has resulted in the township of Halls Creek going through extended periods of time without any Child and Adolescent Mental Health Service workers. This issue is even more problematic in our remote communities, mainly for Balgo, Mulan, Billiluna and Ringer Soak. Service delivery needs to be malleable towards Aboriginal cultural concerns; staff members need to learn the right language and the right approach to sensitive to cultural practice.[93]

5.102 Furthermore, cultural competence is dependent on the local community because Aboriginal culture and tradition is not homogenous—what is culturally appropriate varies between communities. It is therefore necessary for non-Aboriginal people to undertake cultural training specific to the area they are going to.

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91 Dr Martin Laverty, RFDS, *Committee Hansard,* Townsville, 30 August 2018, p. 6.

92 Ms Lorraine Davies, Mental Illness Fellowship of Australia (NT), *Committee Hansard*, Darwin, 9 July 2018, p. 16.

93 Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12.

5.103   The Central Australian Aboriginal Congress considered that all mental health staff ought to be equipped to understand and deliver programs specifically for Aboriginal communities and have knowledge of the available resources:

> …there is a need to ensure that all mental health staff (especially non-Aboriginal staff) working for Aboriginal people and communities are able to address the specific health and wellbeing needs of Aboriginal people. This means equipping health professionals with the knowledge, skills, attributes and cultural understanding to competently design and deliver health services and programs and policies for Aboriginal communities. It is particularly important for those service providers in remote areas (i.e. nurses/Aboriginal Health Workers and GPs) undertaking risk assessments to have the competency to manage and work with clients, and to have the knowledge of available resources.[94]

5.104   The Wurli-Wurlinjang Health Service told the committee that training should include practical advice on how to appropriately be in or visit a community:

> …within the delivery of services training, cultural training is crucial for non-Indigenous staff. It should include history, as well as practical tips on how to actually be in a community—things like visiting the elders to pay respect, asking if it's okay to be in community at this time and if there is anything that it may be helpful for me to know.[95]

5.105   Miss Nawoola Newry, a local advocate from the Kimberley, recommended that the Public Service Commission organise cultural awareness training for all services in the Kimberley region and that this training should be mandatory for every staff member who works in remote communities.[96]

5.106   CATSINaM recommended a practical contribution that Health Ministers could make would be to ensure that cultural safety is a legislated requirement for health professionals. CATSINaM suggested this could be achieved by amending the *Health Practitioner Regulation National Law Act 2009* to embed requirements for cultural safety into clinical practice, and further recommended that all health practitioners working in rural and remote Australia have access to cultural safety training and are also supported to undertake this continuing professional development.[97]

5.107   However, providing cultural awareness or cultural safety training can only extend so far. Some service providers, such as the Consultant Psychiatrist with the Kimberley Mental Health and Drug Service, told the committee that no amount of mental health training would provide the skills necessary to connect with Aboriginal

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94   Central Australian Aboriginal Congress, *Submission 55*, pp. 12–13.

95   Miss Mary Moloney, Wellbeing Manager and Registered Mental Health Nurse, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 8.

96   Miss Nawoola Newry, *Committee Hansard*, Kununurra, 5 July 2018, p. 25 and 26.

97   CATSINaM, *Submission 74*, p. 6.

and Torres Strait Islander persons on the same level that a person from the same community is able to do:

> No matter how hard I try, I won't be able to engage with someone sitting in front of me as well as someone who is local. No matter how kind, how compassionate or how skilled I am, I won't get the level of engagement with someone who is in distress that a local person will get.[98]

5.108   For that reason, it is vital to upskill the local Aboriginal and Torres Strait Islander workforce.

Aboriginal and Torres Strait Islander workforce

5.109   The Aboriginal and Torres Strait Islander mental health workforce is diverse: it includes clinicians, nurses, Aboriginal Health Workers, support staff for social and emotional wellbeing programs and volunteers. Aboriginal and Torres Strait Islander staff can be local to the area in which they are working, or can be from a culturally distinct different region.

5.110   CATSINaM submitted that a lack of Aboriginal and Torres Strait Islander peoples in the workforce was one of the factors that contributed to the lower rates of Aboriginal and Torres Strait Islander peoples accessing health services, compared to non-Indigenous Australians.[99] AMSANT agreed with this view and submitted that services which are governed, designed, delivered and staffed by a local Aboriginal workforce are more accessible and effective for Aboriginal people living in rural and remote areas.[100] The Chief Executive Officer of the Northern Territory PHN also agreed with this view, telling the committee that a 'well trained, well supported and well resourced Aboriginal mental health workforce is critical to the delivery of culturally engaged mental health care for Aboriginal people'.[101]

5.111   CATSINaM pointed to the current Australian Government benchmark to achieve representation in the Aboriginal and Torres Strait Islander workforce equivalent to population parity, which is 2.8 per cent. CATSINaM submitted that because the burden of disease experienced by Aboriginal and Torres Strait Islander peoples is 2–3 times higher than non-Indigenous Australians that goal should be higher, but as of 2016 only 1.03 per cent of all registered nurses and midwives identified as Aboriginal and Torres Strait Islander peoples.

5.112   CATSINaM stressed that the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* recommended focus on building the workforce including increasing the proportion of Aboriginal and Torres Strait Islander peoples working in mental health and wellbeing related fields. CATSINaM recommended this should be a

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98   Dr Huu Duy Tran, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 21.

99   CATSINaM, *Submission 74*, p. 3.

100   AMSANT, *Submission 129*, p. 6.

101   Dr Denise Riordan, Chief Psychiatrist, Northern Territory Department of Health, *Committee Hansard*, Darwin, 9 July 2018, p. 6.

priority in strategies to build cultural capacity and safety within Australia's mental health workforce.[102]

5.113   The National Aboriginal Community Controlled Health Organisation (NACCHO) submitted that the importance of Aboriginal Mental Health Workers is recognised in the inclusion of rights of consumers to access culturally competent services, including an Aboriginal Mental Health Worker in the mental health legislation in a number of Australian jurisdictions.[103]

5.114   NACCHO submitted that Aboriginal Health Workers and Health Practitioners acting as 'cultural brokers' between mainstream health services and Aboriginal and Torres Strait Islander peoples is a vital tool to bridging the cultural gap between those services and the consumers' access to mental health care, treatment and support.[104]

5.115   The Aboriginal and Torres Strait Islander Healing Foundation acknowledged that there is difficulty in attracting and training qualified Aboriginal and Torres Strait Islander staff in remote communities and recommended that the sector should develop a targeted staff retention strategy to reduce the issue of high staff turnover, which burdens clients with disrupted clinical relationships.[105]

5.116   Professor Sabina Knight from the Centre for Rural and Remote Health pointed out that the full capacity for Aboriginal Health Workers to act as referral pathways for mental health is limited by the fact that clinical psychologists cannot receive a Medicare rebate for services provided to people who are referred by an Aboriginal Health Worker or remote area nurse instead of a General Practitioner doctor.[106]

5.117   Associate Professor John Boffa told the committee there are other avenues for potential Medicare improvement, which could include expanding Medicare funding beyond Aboriginal Health Workers to other workers delivering social and emotional wellbeing programs.[107]

5.118   The Wurli-Wurlinjang Health Service pointed to the lower remuneration of Aboriginal Health Workers as a key barrier to workforce development:

> So we pay these people in our system—even in our ACCHO system, which is supposed to value culture—the least and give them the least in our organisation, and we expect the most. That's the dilemma that we face every day, even in our own structure. Why are we paying health workers, whether they're Aboriginal health workers, registered health workers or mental

102   CATSINaM, *Submission 74*, p. 3.

103   NACCHO, *Submission 128*, p. 2.

104   NACCHO, *Submission 128*, p. 2.

105   Aboriginal and Torres Strait Islander Healing Foundation, *Submission 39*, p. 8.

106   Professor Sabina Knight, Director, Centre for Rural and Remote Health, James Cook University, *Committee Hansard*, Mount Isa, 29 August 2018, p. 30.

107   Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 7.

health workers, the wages of kids leaving school and expecting huge amounts from them?[108]

5.119　The North Queensland Combined Women's Services said the difficulties in establishing a qualified Aboriginal Health workforce in mental health included the many specialities of the sector and that some roles also had a gender component, requiring only a female or male health professional.[109] The Sexual Assault Counsellor for Anglicare WA raised similar concerns regarding culturally appropriate gender roles, stating that a lack of a male sexual assault worker hinders the work of that organisation:

> [b]ecause of the cultural limitations—women's business and men's business—it's not comfortable or appropriate to talk about sexual things in mixed company, and probably uncomfortable for people to speak out about it. It limits my ability to really address the secrecy around child sexual abuse and sexual abuse in the hope of increasing reporting and empowering, and making links with, victims.[110]

5.120　The Central Australian Aboriginal Congress also pointed out that even Aboriginal clinical psychologists, if they were not from the community they are servicing, may not have the local cultural knowledge required for culturally competent service delivery.[111]

Challenges in building the Aboriginal workforce

5.121　Some communities indicated that they wanted to build and sustain their own capacity within the community to allow them to manage their own mental health issues.[112]

5.122　The Wurli-Wurlinjang Health Service told the committee that for a sustainable and culturally competent workforce to be developed, more needs to be done within communities to develop an Aboriginal and Torres Strait Islander mental health workforce:

> The greatest resource in Indigenous health is Indigenous people. But we just ignore that and bring in a psychiatrist or an ophthalmic surgeon or something like that to solve the eye problems. We keep missing the point

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108　Dr Peter Fitzpatrick, Executive Director, Medical Services, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 11.

109　Ms Catherine Crawford, Coordinator, North Queensland Combined Women's Services, *Committee Hansard,* Townsville, 30 August 2018, p. 27.

110　Ms Brenda King, Anglicare WA, *Committee Hansard*, Kununurra, 5 July 2018, p. 19.

111　Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 8.

112　Ms Helen Egan, TeamHEALTH, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 9 July 2018, p. 17.

that the greatest resource is sitting in front of us, largely underemployed and very available to help—and their own systems work against that.[113]

5.123 The Chairperson of the Jungarni-Jutiya Indigenous Corporation told the committee that one of the barriers to the development of this workforce is that training is not being offered to locals and this means that knowledge was not retained by the community when external workers left:

> There are a lot of outsiders who get employment here and they get all the incentives and everything to go with it, but they don't actually leave a lot behind. They take a lot of knowledge with them, and our people are not getting the training, even if it's only basic training. They talk about these crisis lines. While the crisis line is good sometimes, when you've got someone in your household going off, if you know there is someone in the community who might be able to settle that person, maybe they should be looking up those people.[114]

5.124 The Jungarni-Jutiya Indigenous Corporation told the committee that this capacity building may include providing members of the Aboriginal community with the opportunity to make a difference in their own community:

> If they're going to just put one coordinator in, and you've got so many people out of at [sic] Balgo, and none of those other people are going to be employed or going to take part in actually trying to make a difference, you're pretty much wasting your time, because those people need to be given jobs as well, if they want jobs, I guess. They should be encouraged to be the ones who make the difference.[115]

5.125 Some service providers are already working to increase community capacity by employing local Aboriginal staff.[116] For example, the committee received evidence that the Kimberley Mental Health and Drug Service was prioritising upskilling the local Aboriginal workforce in Broome:

> For us, in our service, our priorities are really about strengthening our Aboriginal workforce. Currently about 22 per cent of our workforce is Aboriginal, and we really want to try and provide leadership opportunities and further enhancement of the workforce. As Duy has mentioned, I think

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113   Dr Peter Fitzpatrick, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, pp. 14–15.

114   Ms Robyn Long, Jungarni-Jutiya Indigenous Corporation, *Committee Hansard*, Halls Creek, 5 July 2018, p. 4.

115   Ms Robyn Long, Jungarni-Jutiya Indigenous Corporation, *Committee Hansard*, Halls Creek, 5 July 2018, p. 4.

116   Dr Renee Bauer, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 25; Dr Roland Main, Western Australia Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 2.

that's where we find that local knowledge and that local expertise, and the trust that people have in them is exceedingly important for our service.[117]

5.126   The Chief Executive Officer of TeamHEALTH, a mainstream mental health service provider, considered that non-Indigenous and Aboriginal and Torres Strait Islander organisations should collaborate on training and workforce development to upskill some of the smaller community-based organisations.[118]

5.127   AMSANT considered that one option to develop a low intensity Aboriginal workforce could be to deliver entry-level training on country with Aboriginal input.[119] beyondblue explained that a 'low intensity' workforce was one that was trained to apply cognitive behavioural therapy techniques. beyondblue explained that it is currently developing supervising and training a low-intensity workforce to apply cognitive behavioural therapy techniques after 12 weeks and become fully qualified after 12 months.[120] beyondblue explained that the program is currently being trialled using local people in 11 metropolitan and regional Primary Health Networks.[121]

5.128   The Executive Director of Community Services for the Wurli-Wurlinjang Health Service told the committee that if programs are going to be run to upskill the local workforce, it is essential for the training programs to be adapted to the needs and educational background of the individual, to ensure that people identified with good potential are not set up to fail by training programs beyond their means.[122]

5.129   Currently, there is also some mental health first aid training that is being provided by the government. The Department of Prime Minister and Cabinet indicated that Aboriginal Mental Health First Aid training is available to provide community members with the ability to recognise mental health symptoms and that 112 communities so far have received one or both streams of the course.[123] The Department of Prime Minister and Cabinet advised that 41 local instructors had also been trained as part of the program.[124]

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117   Dr Renee Bauer, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 25.

118   Ms Helen Egan, TeamHEALTH, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 9 July 2018, p. 18.

119   AMSANT, *Submission 129*, p. 6.

120   Ms Georgina Harman, Chief Executive Officer, beyondblue, *Committee Hansard*, Canberra, 19 July 2018, p. 49.

121   Ms Georgina Harman, beyondblue, *Committee Hansard*, Canberra, 19 July 2018, p. 49.

122   Mr Darrell Brock, Executive Director, Community Services, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 8.

123   Department of Prime Minister and Cabinet, answers to written questions on notice, pp. 3–4 (received 2 November 2018).

124   Department of Prime Minister and Cabinet, answers to written questions on notice, p. 4 (received 2 November 2018).

Supporting a clinical Aboriginal workforce

5.130   Some submitters told the committee that there are a number of barriers to training a workforce of Aboriginal clinical psychologists.

5.131   AMSANT noted that for some Aboriginal and Torres Strait Islander peoples considering undertaking clinical training, there was cultural and family pressure for the young person not to leave country.[125] Even if Aboriginal and Torres Strait Islander peoples do leave country to train, the Townsville Aboriginal and Islanders Health Services pointed to the high cost of training qualifications as a major barrier to developing an Aboriginal and Torres Strait Islander health workforce:

> If you go and do even just a counselling course, that's $10,000-plus. I don't have $10,000 to pay for that myself. So that's what I'd like to see: when we do get new staff, being able to send them through and have the formal education side of it done so they get the qualifications that we actually need.[126]

5.132   AMSANT suggested that the high cost of training could be defrayed by providing scholarships to support Aboriginal people to study psychology and social work.[127] AMSANT told the committee that there were often language barriers that Aboriginal people needed to overcome to undertake clinical training.[128]

5.133   The Central Australian Aboriginal Congress noted that there are limited courses to become a clinical psychologist in the NT and that often people who become clinical psychologists do not come back to the NT.[129] The Central Australian Aboriginal Congress reiterated that this was another reason that it is vital to establish clinical training centres in rural and remote communities.[130]

Concluding committee view

5.134   The evidence the committee received demonstrates that if practitioners are trained in a non-metropolitan area or are from a non-metropolitan area, they are more likely to stay in those areas. The committee considers that creating five medical schools in regional locations represents a good initial investment in training the future rural and remote workforce, but notes that further development of training centres in rural and remote communities may help to develop a professional clinical workforce pipeline for rural and remote Australia.

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125   Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 10.

126   Mrs Erica Buttigieg, Social and Emotional Wellbeing Program Manager, Townsville Aboriginal and Islanders Health Services, *Committee Hansard,* Townsville, 30 August 2018, p. 29.

127   Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 7.

128   Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 10.

129   Dr Jon-Paul Cacioli, Australian Central Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, pp. 7–8.

130   Dr Jon-Paul Cacioli, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 8.

5.135   The committee acknowledges that a peer workforce can be a powerful and useful support for people who are experiencing a mental illness and plays a role in reducing stigma. The committee considers that these groups should be supported to continue their work supporting members of the community experiencing mental illness.

5.136   A culturally competent workforce is vital to deliver services to Aboriginal and Torres Strait Islander clients in rural and remote Australia. The committee considers that this requires a non-Aboriginal and Aboriginal workforce working together to promote understanding and to develop culturally safe services.

5.137   The committee was concerned by evidence that the non-Aboriginal workforce does not appear to be receiving adequate training to deliver culturally competent services to Aboriginal and Torres Strait Islander clients. The committee considers that all service providers who are moving into or working in a rural or remote community should engage with cultural training that is specific to the locality to ensure that they are able to provide culturally competent services.

5.138   The committee considers that it is essential to train and upskill the local Aboriginal workforce to allow them to play a part in the mental health of their own communities and to develop a sustainable capacity that will endure beyond the term of the next funding cycle. For that to happen, there is a need to support a clinical Aboriginal pathway and a need for non-Aboriginal organisations to partner with communities to train a low intensity workforce.

5.139   The committee understands that attracting and training a capable, sufficient and sustainable mental health workforce to serve rural and remote Australia will be challenging. There is a lot of work to be done to ensure that Aboriginal communities in particular are able to manage their own mental health challenges. The committee considers this requires a coordinated approach to ensure that the mental health workforce is developed as quickly as possible.

5.140   Mental health and wellbeing services are dependent on the quality of the workforce delivering those therapeutic services. Without a concerted effort by all stakeholders involved, the lack of cultural competency of the workforce will continue to cause these services to fail, which in turn has devastating effects on the health of individual Aboriginal and Torres Strait Islander persons, and more broadly on the entire communities in which they live.

Chapter 6
Conclusion and recommendations

6.1   Throughout this inquiry, the Senate Community Affairs References Committee (committee) heard how people living in Australia's rural and remote communities face a myriad of barriers to accessing quality mental health services.

6.2   These barriers range from the obvious, such as the actual presence or availability of services and health professionals in an area, to the more subtle, such as the attitudes towards mental health within the community or the effects of social determinants of health like socioeconomic status or employment.

6.3   Rural and remote mental health services across the country represent a patchwork of strategies, models and approaches funded by all levels of government. Few appear to be fully meeting the needs of the communities which they service.

6.4   The recommendations proposed by the committee in this chapter seek to address what it considers to be the most pressing and prevalent of concerns raised by submitters and witnesses to this inquiry.

A strategic response to deliver a complex service

6.5   The delivery of health services across a nation as geographically large and as culturally diverse as Australia is extremely complex. Added to that complexity are the differing health responsibilities of the three levels of government in Australia, combined with the reality that in many rural locations, service provision crosses state and territory jurisdictional boundaries.

6.6   In recognition of this complexity, a range of national, state and territory health strategies have been developed to assist in the design and delivery of health services. While there are strategies for mental health services, which make mention of the complexity of rural and remote service delivery, and strategies for rural and remote health service delivery, which mention mental health services, what has been lacking to date is a strategy specifically for mental health and wellbeing services delivered in the distinct service environments found in rural and remote Australia.

6.7   In rural and remote communities, the causes of mental illness are often different, the culture of communities is different and the service solutions must therefore be different to those found in urban centres. Until there is a strategy that acknowledges the different context of rural and remote communities, mental health service delivery in rural and remote locations will continue to be a fragmented approach with band-aid solutions.

6.8   The committee supports the recommendation endorsed by many expert organisations, including the Royal Flying Doctor Service, that the National Mental Health Commission should be funded and tasked with the development of a national rural mental health strategy. This strategy should be informed by Primary Health Network service mapping in rural and remote areas and other key data that identifies service shortfalls. The National Mental Health Commission should also be tasked with

monitoring and overseeing implementation of the strategy, reporting back directly to government.

Recommendation 1

6.9   The committee recommends the development of a national rural and remote mental health strategy which seeks to address the low rates of access to services, workforce shortage, the high rate of suicide, cultural realities, language barriers and the social determinants of mental health in rural and remote communities.

Recommendation 2

6.10   The committee recommends that the national rural and remote mental health strategy is subject to an implementation and monitoring framework which includes regular reporting to government and that these reports are tabled in Parliament.

6.11   Additionally, the committee considers that the development of a national rural and remote mental health strategy should take into account matters raised in this report, including but not limited to the improved outcomes seen by services offering a 'no wrong door' approach to service delivery, ensuring that patients are treated holistically and receive the support they need without entry barriers.

6.12   The committee believes that in order to be effective, a national rural and remote mental health strategy must also seek to address the social determinants of health identified in this report which are fundamental to improving mental health services and suicide prevention in regional, rural and remote communities around Australia.

6.13   Furthermore, the committee does not believe that work on a rural and remote mental health strategy should halt immediate progress to solve pressing concerns that could be addressed now, or that would not require a strategy to develop solutions. Some of these concerns and related recommendations are discussed below.

Putting the community at the centre of the approach

6.14   During the course of this inquiry, the committee travelled to rural and remote locations throughout Australia to gain an understanding of how mental health service delivery impacts different communities across Australia, each with different needs and a different service context. The committee spoke to locals from diverse backgrounds, including mental health consumers, farmers, miners, Aboriginal and Torres Strait Islander peoples, local councils, teachers, nurses, doctors, academics, and committed volunteers at the front lines of suicide prevention.

6.15   One clear message came from these very distinct communities. From small towns in Tasmania to Aboriginal communities in the Northern Territory and from mining towns in Queensland to agricultural regions in Western Australia, the committee heard that the voices and experiences of local communities are not being listened to in service design and delivery.

6.16   While there is often some level of community consultation, this is often at the tail-end of the process when a provider has been selected and the service has already

been commissioned and largely designed. This near universal lack of local input at the very start of the service commissioning process has resulted in mental health and wellbeing services that are designed in urban centres, by and for the needs of people who live in urban centres, and then tweaked to create the appearance of a local approach or to accommodate the travel needs of urban staff to deliver the service in a rural or remote context.

Recommendation 3

6.17 The committee recommends an overarching approach is taken by all parties to guarantee that the design of mental health and wellbeing services starts with local community input to ensure that all rural and remote mental health services meet the measure of 'the right care in the right place at the right time'. This needs to be informed by best practice and international knowledge.

The role of the National Disability Insurance Scheme

6.18   The committee is encouraged by the creation of a psychosocial disability stream within the National Disability Insurance Scheme (NDIS) to improve the process of accessing the NDIS and to provide support to people with severe and persistent mental health issues.

6.19   The committee notes that at the time of this inquiry, there was limited information available regarding the implementation of the psychosocial disability stream, and in particular how it will be rolled out in rural and remote Australia.

6.20   The committee is concerned by the accounts it received that many rural and remote Australians have experienced issues applying for the NDIS and accessing appropriate mental health services through their NDIS plan. These issues included: a deficit of knowledge about the NDIS by health professionals; assessors, planners and service providers inexperienced in psychosocial disability; and a lack of appropriate support services.

6.21   The committee believes that it is critical that the new psychosocial disability stream addresses these issues in rural and remote communities to ensure it meets its objective of improving access to the NDIS for people with a mental illness.

Recommendation 4

6.22 The committee recommends that the National Disability Insurance Agency ensure that the implementation of the psychosocial disability stream takes into account the issues facing rural and remote communities, including barriers to accessing mental health services and the lack of knowledge and experience in both psychosocial disability and the National Disability Insurance Scheme.

Funding services appropriately

6.23   The committee holds serious concerns about the short-term nature of funding cycles, noting the large number of mental health service providers facing uncertainty in funding. Limiting funding contracts for providers to 12 months at a time is having a detrimental impact on the provision and continuity of care in many rural and remote communities.

6.24   The committee also recognises that rural and remote communities are not suited to a competitive tendering process for service provision. The competitive tendering process favours city-based organisations with the capacity to provide rural and remote services at a financial loss. However, these organisations rarely have an understanding of communities and their needs and frequently do not have services 'on the ground' when they are awarded the contract. Local providers can't compete and the communities which they service lose out.

6.25   The committee is of the firm belief that funding cycles need to be of sufficient length to allow local service providers to develop infrastructure, attract and retain a suitable workforce, and build trust within a community, while also allowing for accountability and review processes within the contracted time period.

6.26   The committee therefore suggests that the minimum initial contract length be 5 years when funding mental health services in rural and remote communities and in the regional centres which service those communities. Furthermore, there should be options to extend a service provider's contract without additional tendering, following assessment of the efficacy and acceptability of the services provided to the local community.

Recommendation 5

6.27   The committee recommends that Commonwealth, State and Territory Governments should develop longer minimum contract lengths for commissioned mental health services in regional, rural and remote locations.

6.28   The committee also strongly believes that local knowledge and connection to the community should be major considerations when commissioning service providers in rural and remote areas. This could be demonstrated in a variety of ways, such as a high proportion of locally-based health workers, a local-workforce capacity-building strategy, and an ongoing community consultation forum with genuine input into design and decision-making.

Recommendation 6

6.29   The committee recommends that Commonwealth, State and Territory Governments should develop policies to allow mental health service contracts to be extended where a service provider can demonstrate the efficacy and suitability of the services provided, and a genuine connection to the local community.

Block funding

6.30   The committee recognises that restrictive fee-for-service models of funding combined with the loss of block funding, in many cases a result of the introduction of the Primary Health Network commissioning model and the implementation of the NDIS, has had a serious impact on the ability of small service providers in rural and remote areas to meet the overhead costs of running a service in these locations.

6.31   The committee believes that there has been market failure in rural and remote communities, making the current style of the NDIS rollout in these contexts a practical impossibility. The committee notes that the removal of block funding for long-established services creates significant risk for the individuals and communities who

have voiced genuine concern that no service will be available to them if rural or remote communities are forced to implement the current NDIS model.

6.32   Service providers in many rural and remote communities cannot offset overhead costs through other fee-based services as providers in urban centres are able to do and therefore rely on block funding for the long-term viability of their services. Without block funding, some providers have had to pull their trusted, established services out of rural and remote communities.

6.33   The committee agrees with the view that flexible block funding is also required for providers to adequately meet the unique and changing needs of each rural and remote community. What works in one community may not suit the next and providers need to be able to offer flexible services, such as community engagement, and supports, such as transport, to improve access and attendance.

Recommendation 7

6.34   The committee recommends that Commonwealth, State and Territory Governments consider the reestablishment of block funding for mental health services and service providers in regional, rural, and remote areas.

Stepped care

6.35   The committee received extensive evidence that the stepped care model of mental health service provision, while well-suited to urban centres, is failing in some rural and remote areas. For a number of communities visited by the committee, some of the 'steps' within the model are poorly accessible or missing entirely.

6.36   It is the role of Primary Health Networks to identify the needs of their local communities and commission services which address the gaps in the stepped care model. While the committee saw some excellent examples of regions where this has been successful, it holds concerns that not all Primary Health Networks are addressing the needs of their region adequately.

Recommendation 8

6.37   The committee recommends that the Commonwealth Government review the role of Primary Health Networks in commissioning mental health services under the stepped care model to ensure effective and appropriate service delivery in regional, rural and remote areas.

Improving access

6.38   The committee acknowledges the important role that telehealth plays in the delivery of mental health services to rural and remote areas, particularly through programs such as headspace and the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* (Better Access) initiative.

6.39   However, the committee strongly believes that access to telecommunications infrastructure in rural and remote locations needs to be improved if telehealth initiatives are to be a viable alternative or supplement for face-to-face services in these areas.

6.40   The committee also heard concerns from some submitters that the way the Medicare Benefits Schedule (MBS) funds certain mental health and primary care services is also restricting the flexibility of providers and practitioners to offer the care needed by consumers in rural and remote communities, both face-to-face and via telehealth.

6.41   The committee considers that thought should be given to allowing capacity for MBS-funded psychology referrals from allied health professionals and nurses, such as Aboriginal Health Workers and remote area nurses, and for greater exemptions under section 19(2) of the *Health Insurance Act 1973* (Cth) to allow provision of MBS mental health services alongside services funded from other sources.

Recommendation 9

6.42   The committee recommends that the Commonwealth Government consider pathways for allied health professionals and nurses in rural and remote Australia to refer patients under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* (Better Access) initiative.

Strengthening the strategic framework for Aboriginal and Torres Strait Islander mental health

6.43   Throughout the inquiry, the committee heard about the positive impact of Aboriginal Community Controlled Health Services and the role of an Aboriginal and Torres Strait Islander workforce in the delivery of mental health and wellbeing services for Aboriginal and Torres Strait Islander peoples.

6.44   The committee commends the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (Aboriginal Mental Health Framework) as an invaluable tool to improve mental health services and notes that it is in the early stages of implementation. However, the committee notes with some concern that there does not yet appear to be a specific implementation plan for this strategy, a monitoring plan has not been developed and there is no explicit associated funding.

Recommendation 10

6.45   The committee recommends that the Commonwealth Government prioritise the development of implementation and evaluation plans for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023*.

6.46   The committee notes that a key action area under the Aboriginal Mental Health Framework is to 'Strengthen the Foundations', in particular the development of effective partnerships between Primary Health Networks and Aboriginal Community Controlled Health Services.

6.47   Evidence received by this committee is that only a limited number of Primary Health Networks have worked towards establishing such a partnership with the Aboriginal Community Controlled Health Service sector, despite clear evidence that

the preferred model of health service delivery for Aboriginal and Torres Strait Islander peoples is by Aboriginal Community Controlled Health Services.

6.48   The committee notes that there is a large body of evidence about the value of Aboriginal Community Control across the health sector and recognises that some states and territories are actively pursuing pathways for community control and partnerships which build capacity in communities.

6.49   However, Aboriginal Community Controlled Health Services reported to the committee that they face funding difficulties as service contracts are frequently given to non-local organisations that then seek to sub-contact portions of the work to the local Aboriginal Community Controlled Health Service as a junior partner with limited if any input into service design.

6.50   The committee strongly agrees with the statements of the Aboriginal Mental Health Framework that Aboriginal and Torres Strait Islander leadership, engagement and partnership in the planning, delivery, evaluation and measurement of services and programs is critical in fostering greater trust, connectivity, culturally appropriate care and effective outcomes. The committee believes that not enough has been done to ensure that this principal is put into practice in funding and service design.

Recommendation 11

6.51   The committee recommends the Commonwealth Government implement measures to ensure that services commissioned by Primary Health Networks embody the action plans of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* and are delivered by, or in genuine long-term partnerships with, Aboriginal Community Controlled Health Services and other Aboriginal and Torres Strait Islander community organisations.

Recommendation 12

6.52   The committee recommends that all Primary Health Networks have an Aboriginal and Torres Strait Islander member on their board.

Increasing professional workforce support

6.53   The committee heard time and again throughout this inquiry that the workforce is the backbone of mental health service delivery, and without a well-educated and well-resourced workforce, any strategy for mental health service delivery will be destined to fail.

6.54   The committee heard there is already a desperate shortage of urban-trained mental health specialists who are available to work in rural and remote locations and that, conversely, there is a lack of training opportunities for people living in rural and remote locations to upskill and fill those roles. The committee further heard that the ongoing registration requirements for health professionals are often difficult to meet in rural and remote locations.

6.55   The committee therefore believes there is a role for health professional colleges to develop programs to provide increased support to the rural and remote workforce, encouraging rural and remote rotations, incentivising placements and

supervision of junior staff, and providing continuing professional development in these regions.

6.56   However, the committee believes that a strategic approach must be taken to workforce development, which needs a multi-pronged approach to develop a sustainable and effective workforce into the future.

Recommendation 13

6.57   The committee recommends the Commonwealth Minister for Health work with health professional colleges to develop strategies for the immediate improvement of professional supports and clinical supervision for registered health practitioners working in rural and remote locations.

Cultural competency

6.58   Furthermore, the committee believes that the mental health workforce must be appropriately trained to meet the needs of diverse communities in rural and remote Australia, including by providing culturally competent mental health and wellbeing services.

6.59   The committee acknowledges that a one size fits all approach cannot be applied to cultural competence and that every community in Australia will have different needs and a different cultural context.

6.60   The committee heard throughout its inquiry the importance of patients, particularly Aboriginal and Torres Strait Islander peoples, having a positive initial interaction with mental health professionals to ensure patients return and continue to access support services.

6.61   The committee notes that culturally competent mental health services directly impact the health outcomes of Aboriginal and Torres Strait Islander peoples and is concerned by reports that the level of cultural competency of mental health services is inconsistent in rural and remote communities.

6.62   The committee firmly believes that service providers should offer training and accommodate continuing professional development for their staff in culturally competence which is informed by, and relevant to, their local community.

Recommendation 14

6.63   The committee recommends that all mental health service providers, including government and community sector, ensure their workforces are culturally competent and that such training be endorsed by and delivered in partnership with the communities into which they are embedded.

Fly-in fly-out services

6.64   The committee understands that for some communities, fly-in, fly-out (FIFO) mental health professionals provide valuable support to rural and remote communities which may otherwise not have access to mental health services, due to the shortage of mental health professionals in these communities.

6.65   However, the committee notes that like any other mental health services, FIFO services must be designed to meet the needs of the local community and be

supported by long-term investment which enables FIFO mental health professionals to provide reliable and regular services and build relationships and trust within the local community. The presence of a service provider on any day in a community ensures neither service provision nor the necessary continuity of care known to be critical in developing the trust required to underpin the therapeutic relationships fundamental to good mental health care and positive patient outcomes.

Recommendation 15

6.66   The committee recommends that all providers of fly-in, fly-out mental health services ensure that mental health professionals are supported by long-term investment to enable them to provide reliable and regular support services to rural and remote communities, with consistency of personnel an essential requirement for any service provider.

Peer support workers

6.67   In many of the communities it visited, the committee heard about the important role played by peer support workers, who provide support to people experiencing mental illness and often fill a gap left by the shortage of mental health professionals in rural and remote communities.

6.68   The committee notes that generally these support services are provided by people who have had their own lived experience with mental illness but have received no formal training in mental health support and are not employed or paid for the support services they provide. Many rural and remote communities rely on these outstanding members of the community to provide support to people in times of crisis and connect them to mental health resources.

Recommendation 16

6.69   The committee recommends that peer support workers be given appropriate training to enable them to continue their role in helping people experiencing mental health issues. The committee further considers that peer support workers should be recognised as a valuable support service by being paid to perform this role in rural and remote communities.

Reducing stigma in rural and remote communities

6.70   While one in five Australians will experience a mental illness in any given year, the stigma associated with mental health is still pervasive in Australia's rural and remote communities. The committee believes that stigma plays a major role in rural and remote communities accessing mental health services at a low rate.

6.71   The committee acknowledges that there are many factors which contribute to the ongoing stigma surrounding mental health. Many people told the committee that they did not seek help for their mental health issues either out of fear of facing discrimination about experiencing mental illness or because of the culture of self-reliance in rural and remote communities.

6.72   The committee heard time and time again that concerns about confidentiality and privacy prevented people from seeking support from local mental health services. People in rural and remote communities don't always feel comfortable speaking about

their mental health to a person they may also see in a social setting, or if they are not confident in the mental health professional's ability to maintain confidentiality. This often results in people travelling to the next town or a capital city to access mental health support services, or simply not seeking support at all.

6.73   In some communities, visiting a particular location in town was conspicuous and people in the community could easily deduce when a person was seeing a mental health professional. The committee heard that some communities are seeking to combat this issue by implementing the 'one door' approach which co-locates mental health services with other physical medical services.

6.74   The committee supports the use of the 'one door' approach in an effort to improve access to mental health service in rural and remote communities, but also believes that more must be done to educate the community about mental health in order to reduce the associated stigma.

6.75   This is particularly the case for vulnerable groups of people such as lesbian, gay, bisexual, transgender and intersex people, cultural and linguistic diverse populations and Aboriginal and Torres Strait Islander peoples. The committee believes that separate communication strategies which are specific to these vulnerable groups should be developed in recognition of the ongoing role of education in reducing the stigma associated with mental health.

6.76   The committee believes that co-design with these communities is critical to enable ongoing review and adaption of relevant public health services and messaging.

Recommendation 17

6.77   The committee recommends that Commonwealth, State and Territory Governments, as well as mental health service providers and local communities, continue to educate rural and remote communities about mental health and advertise local and digitally-available support services, with a view to reducing the associated stigma.

Recommendation 18

6.78   The committee recommends that Commonwealth, State and Territory Governments work with mental health service providers and local communities to co-design appropriate educational materials to reduce the stigma surrounding mental health in rural and remote communities.

Senator Rachel Siewert

Chair

APPENDIX 1

Submissions and additional information received by the Committee

Submissions

1   Centre for Mental Health Research, Australian National University

2   Australian Human Rights Commission

3   ConnectGroups Support Groups Association WA Inc.

4   Frontier Services

5   MindSpot

6   Mental Health Carers Tasmania

7   Roses in the Ocean

8   Mental Health Australia

9   Department of Developmental Disability Neuropsychiatry, UNSW Sydney

10   Consumers Health Forum of Australia

11   OzHelp

12   Mental Health for the Young and their Families (Vic)

13   Exercise and Sports Science Australia

14   Deakin University

15   MindsPlus

16   Community Mental Health Australia

17   Mental Health Council of Tasmania

18   UnitingCare Australia

19	Local Government Association Queensland
20	Mental Illness Fellowship of Australia
21	Services for Australian Rural and Remote Allied Health
22	Royal Flying Doctor Service (plus an attachment)
23	General Practice Mental Health Standards Collaboration
24	Royal Australian College of General Practitioners Rural
25	National Rural Health Student Network
26	Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition
27	Mental Health Association of Central Australia
28	Mental Health Coalition of South Australia
29	Grow
30	Department of Health
31	Consumers of Mental Health WA
32	Mental Health Advocacy Service
33	WA Primary Health Alliance
34	Western Australian Association for Mental Health
35	Government of Western Australia
36	Queensland Nurses and Midwives' Union
37	National Rural Health Alliance
38	Wesley Mission (plus an attachment)
39	Aboriginal and Torres Strait Islander Healing Foundation

40   Neami National

41   Centre for Research Excellence in Integrated Quality Improvement

42   Royal Far West (plus an attachment)

43   Australian College of Rural and Remote Medicine

44   Orygen, The National Centre of Excellence in Youth Mental Health

45   Rural and Remote Mental Health Ltd

46   Australian Nursing and Midwifery Federation

47   Black Dog Institute

48   Australian Rural Heath Workforce Agencies

49   Youth Affairs Council of South Australia

50   Flourish Australia

51   Mental Health Victoria

52   Australian Mental Health Commissions

53   Regional Australia Institute

54   Northern Territory Primary Health Network

55   Central Australian Aboriginal Congress

56   National Centre for Farmer Health

57   Centre For You

58   On the Line

59   Kimberley Aboriginal Law and Cultural Centre

60   Outback Futures

61   Australian College of Nursing

62	Parent-Infant Research Institute
63	Goulburn Valley Area Mental Health Service
64	COTA Australia
65	Occupational Therapy Australia
66	CRANAplus
67	Isolated Children's Parents' Association of Australia
68	HealthWISE New England North West
69	Painaustralia
70	Yura Yungi Medical Services Aboriginal Corporation
71	Benevolent Society (plus an attachment)
72	ReachOut
73	Alannah and Madeline Foundation
74	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
75	Loddon Mallee Mental Health Carers Network
76	ARHEN Mental Health Academic Network
77	Interrelate
78	Royal Australasian College of Physicians
79	Rural Doctors Association of Australia
80	Mission Australia
81	Australian Research Alliance for Children and Youth
82	Australian College of Mental Health Nurses
83	National Farmers' Federation

84   National Mental Health Consumer and Carer Forum

85   beyondblue

86   Suicide Prevention Australia

87   Centre for Rural and Remote Mental Health

88   WayAhead - Mental Health Association NSW

89   Dr Tegan Podubinski and Professor Lisa Bourke

90   Rural Alive and Well

91   Australasian College for Emergency Medicine

92   Being

93   Carers WA

94   Australian Services Union (plus an attachment)

95   Royal Australian and New Zealand College of Psychiatrists (plus a supplementary submission)

96   Centre for Excellence in Child and Family Welfare

97   Centacare Catholic Diocese of Ballarat

98   HelpingMinds

99   Aboriginal Health and Medical Research Council of NSW

100   Victorian Government

101   yourtown

102   Australian Association of Social Workers

103   Australian Psychological Society

104   Western Australian Local Government Association

105   Confidential

106   NSW Government

107   Victorian Council of Social Service

108   Confidential

109   Healthdirect Australia

110   Butterfly Foundation

111   Name Withheld

112   Dr Sabrina Pit

113   Name Withheld

114   Name Withheld

115   Name Withheld

116   Dr Barry Jones (plus an attachment)

117   Research Australia

118   Name Withheld

119   Confidential

120   Confidential

121   Confidential

122   One Door Mental Health

123   Confidential

124   Wheatbelt Health Network Incorporated
         Adverse comment response from WA Primary Health Alliance
         Adverse comment response from Amity Health

125   Western Queensland Primary Health Network

126   Anglicare Southern Queensland

127   Ms Sally Malone

128   National Aboriginal Community Controlled Health Organisation

129   Aboriginal Medical Services Alliance NT

130   SANE Australia

131   Tristar Medical Group

132   Murrindindi Shire Council

133   North and West Remote Health

134   Adjunct Associate Professor John Mendoza

135   Meander Valley Council (plus an attachment)

136   Confidential

137   Australian Association of Developmental Disability Medicine

138   Name Withheld

Additional Information

1   Opening statement, from Central Australian Rural Practitioners Association, received 13 July 2018

2   Aboriginal Youth Suicide in Central Australia: Developing a consistent data system and referral pathway, Centre for Remote Health, 2013, from Central Australian Rural Practitioners Association, received 13 July 2018

3   Cyber Safety in Remote Aboriginal Communities, Final Report, RMIT University, June 2018, from Central Australian Rural Practitioners Association, received 13 July 2018

4   Generalist registered nurses caring for mental health clients in remote areas of Australia: An interpretive case study, Thesis, Scott Trueman, March 2016, from Central Australian Rural Practitioners Association, received 13 July 2018

5   Information booklet, from Rural Outreach Counselling Inc., received 19 July 2018

6   Business Plan 2017, from Rural Outreach Counselling Inc., received 19 July 2018

7   Opening statement, from Nunyara Aboriginal Health Service, received 22 July 2018

8   Submission made by the AMA(SA) to an SA Parliamentary inquiry into regional health services in 2016, from Australian Medical Association (South Australia) Inc, received 27 August 2018

9   Letter regarding the establishment of a headspace in Katherine, from Anglicare NT, received 7 September 2018

10 Briefing Paper submitted to the Kimberley Suicide Prevention Regional Trial Working Group, from Kimberley Aboriginal Law and Cultural Centre, received 28 September 2018

11 Correspondence supplementing evidence provided at the Committee's public hearing in Mount Isa on 29 August 2018, from Dr Sharon Varela, received 2 October 2018

Answers to Questions on Notice

1   Answers to Questions taken on Notice during 5 June public hearing, received from Ashcliffe Psychology, 6 June 2018

2   Answers to Questions taken on Notice during 5 June public hearing, received from WA Country Health Service, 3 July 2018

3   Answers to Questions taken on Notice during 5 June public hearing, received from Western Australian Association for Mental Health, 13 August 2018

4   Answers to Questions taken on Notice during 5 July public hearing, received from Shire of Halls Creek, 20 August 2018

5   Answers to Questions taken on Notice during 6 July public hearing, received from Kimberley Aboriginal Medical Services, 3 August 2018

6   Answers to Questions taken on Notice during 9 July public hearing, received from Danila Dilba Health Service, 2 August 2018

7   Answers to Questions taken on Notice during 9 July public hearing, received from Northern Territory Department of Health, 10 August 2018

8   Answers to Questions taken on Notice during 9 July public hearing, received from Aboriginal Medical Services Alliance Northern Territory, 13 August 2018

9   Answers to Questions taken on Notice during 10 July public hearing, received from NPY Women's Council, 19 July 2018

10 Answers to Questions taken on Notice during 19 July public hearing, received from Royal Australian and New Zealand College of Psychiatrists, 26 July 2018

11 Answers to Questions taken on Notice during 19 July public hearing, received from Australian Nursing and Midwifery Federation, 30 July 2018

12 Answers to Questions taken on Notice during 19 July public hearing, received from Marninwarntikura Women's Resource Centre, 30 July 2018

13 Answers to Questions taken on Notice during 19 July public hearing, received from Australian Rural Health Education Network, 6 August 2018

14 Answers to Questions taken on Notice during 19 July public hearing, received from beyondblue, 6 August 2018

15 Answers to Questions taken on Notice during 19 July public hearing, received from headspace National Youth Mental Health Foundation, 8 August 2018

16 Answers to Questions taken on Notice during 19 July public hearing, received from ReachOut, 14 August 2018

17 Answers to Questions taken on Notice during 19 July public hearing, received from National Farmers' Federation, 15 August 2018

18 Answers to Questions taken on Notice during 19 July public hearing, received from National Mental Health Commission, 17 August 2018

19 Answers to Questions taken on Notice during 19 July public hearing, received from Mission Australia, 17 August 2018

20 Answers to Questions taken on Notice during 19 July public hearing, received from National Rural Health Alliance, 17 August 2018

21 Answers to Questions taken on Notice during 19 July public hearing, received from Australian College of Mental Health Nurses, 17 August 2018

22 Answers to Questions taken on Notice during 19 July public hearing, received from Royal Australian College of General Practitioners, 24 August 2018

23 Answers to Questions taken on Notice during 19 July public hearing, received from National Rural Health Commissioner, 27 August 2018

24 Answers to Questions taken on Notice during 20 July public hearing, received from Country South Australia Primary Health Network, 13 August 2018

25 Answers to Questions taken on Notice during 20 July public hearing, received from Country and Outback Health, 17 August 2018

26 Answers to Questions taken on Notice during 20 July public hearing, received from Child Adolescent Mental Health Services Northern Country, 17 August 2018

27 Answers to Questions taken on Notice during 29 August public hearing, received from Gidgee Healing, 14 September 2018

28 Answers to Questions taken on Notice during 29 August public hearing, received from Anglicare North Queensland, 19 September 2018

29   Answers to Questions taken on Notice during 29 August public hearing, received from North West Hospital and Health Service, 20 September 2018

30   Answers to Questions taken on Notice during 30 August public hearing, received from selectability, 30 August 2018

31   Answers to Questions taken on Notice during 30 August public hearing, received from North and West Remote Health, 18 September 2018

32   Answers to Questions taken on Notice during 30 August public hearing, received from Neami National, 20 September 2018

33   Answers to Questions taken on Notice during 5 September public hearing, received from CORES Australia, 24 September 2018

34   Answers to Questions taken on Notice during 5 September public hearing, received from Relationships Australia Tasmania, 3 October 2018

35   Answers to Questions taken on Notice during 5 September public hearing, received from Primary Health Tasmania, 4 October 2018

36   Answers to Questions taken on Notice during 5 September public hearing, received from Cornerstone Youth Services, 5 October 2018

37   Answers to Questions taken on Notice during 16 October public hearing, received from National Disability Insurance Agency, 7 November 2018

38   Answers to written Questions on Notice and Questions taken on Notice during 16 October public hearing, received from Department of Health, 12 November 2018

39   Answers to Questions taken on Notice during 16 October public hearing, received from Department of Health, 26 November 2018

40   Answers to written Questions on Notice, received from Australian Health Practitioner Regulation Agency, 31 August 2018

41   Answers to written Questions on Notice, received from Department of Health, 11 October 2018

42   Answers to written Questions on Notice, received from Department of the Prime Minister and Cabinet, 2 November 2018

43   Answers to written Questions on Notice, received from Department of Social Services, 12 November 2018

44   Answers to written Questions on Notice, received from Department of Health, 26 November 2018

Tabled Documents

1   Derby Aboriginal Health Service (DAHS) and Winunngari Work-Strengths Program Report, November 2017, tabled by Derby Aboriginal Health Service, at Derby public hearing, 6 July 2018

2   Summary of Feedback from Western Australia's Closing the Gap Consultations, June 2018, tabled by Kimberley Aboriginal Law and Cultural Centre, at Broome public hearing, 6 July 2018

3   Mental Health and Suicide Prevention Service Review, 2017, tabled by Northern Territory Mental Health Coalition, at Darwin public hearing, 9 July 2018

4   Position statement of RANZCP, tabled by Royal Australian and New Zealand College of Psychiatrists, at Canberra public hearing, 19 July 2018

5   Opening statement notes, tabled by Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, at Canberra public hearing, 19 July 2018

6   Rural Suicide and its Prevention: a CRRMH position paper, tabled by Centre for Rural and Remote Mental Health, University of Newcastle, at Canberra public hearing, 19 July 2018

7   Rural Suicide and its Prevention: a CRRMH Prevention Paper, tabled by Centre for Rural and Remote Mental Health, University of Newcastle, at Canberra public hearing, 19 July 2018

8   Lifting the weight – Understanding young people's mental health and service needs in regional and remote Australia, tabled by Mission Australia, at Canberra public hearing, 19 July 2018

9   National Mental Health review information, tabled by Country SA Primary Health Network, at Whyalla public hearing, 20 July 2018

10   National Suicide Prevention Trial: Survey data report, April 2018, PHN Country SA, tabled by Country SA Primary Health Network, at Whyalla public hearing, 20 July 2018

11   Snapshot of activities and workshops undertaken during 2016 by the Break O'Day Mental Health Action Group, tabled by St Helens Neighbourhood House, at St Helens public hearing, 6 September 2018

12   Break O'Day Direct Mental Health Services Directory Version 11, tabled by St Helens Neighbourhood House, at St Helens public hearing, 6 September 2018

13   Letter from Break O'Day Mental Health Action Group to Tasmania Medicare Local, 3 August 2015, tabled by St Helens Neighbourhood House, at St Helens public hearing, 6 September 2018

Correspondence

1   Information relating to discussions during Darwin public hearing on 9 July 2018, received from Danila Dilba Health Service, 20 July 2018

2   Correspondence clarifying evidence given at Canberra public hearing on 16 October 2018, received from Department of Health, 19 November 2018

3   Correspondence clarifying evidence given at Canberra public hearing on 16 October 2018, received from Department of Health, 26 November 2018

APPENDIX 2

Public hearings

Tuesday, 5 June 2018

Albany Public Library, Albany

Witnesses

Western Australia Country Health Service

CHATFIELD, Ms Paula, Executive Director for Mental Health
MAIN, Dr Roland, Area Director for Mental Health, Adults and Older Adults

WACHS Great Southern, Mental Health Services

WELLS, Mr Matthew, Acting Regional Mental Health Manager
COLLINS, Dr Noel, Consultant Psychiatrist and Acting Clinical Director

WA Primary Health Alliance

ROCK, Dr Daniel, Principal Adviser and Research Director
PEARSON, Ms Lesley, Regional Manager

Youth Focus

KALAF, Ms Fiona-Marie, Chief Executive Officer
HARRIS, Mr Christopher, General Manager, Community Engagement
WENZEL, Dr Andrew, Manager, headspace Albany

Amity Health

WOOLLARD, Ms Alison, Mental Health Manager
HAGON, Mrs Janice, Integrated Care Manager

Palmerston Association Inc.

HEADLAM, Mr Benjamin, Manager, Great Southern Community Alcohol and Drugs Service

Depression Support Network Albany Inc.

BROWN, Ms Johnette (Jo), President/Coordinator
CARPENTER, Mrs Penny. Committee Member

Albany Halfway House Association

BROWN, Mr Geoff, Clinical Lead

Richmond Wellbeing

ROSE, Samuel, Program Coordinator

Ashcliffe Psychology
TUNNECLIFFE, Mr Michael, Clinical Psychologist

Western Australian Association for Mental Health
CONNOR, Ms Elizabeth, Systemic Advocacy Officer
PENTER, Mr Colin, Projects Lead and Policy Officer

ConnectGroups Support Groups Association WA Inc.
SEGRE, Ms Antonella, Chief Executive Officer

Consumers of Mental Health Western Australia
GAEBLER, Ms Shauna, Chief Executive Officer

Thursday, 5 July 2018

Shire of Wyndham / East Kimberley, Kununurra

Witnesses
Kununurra Waringarri Aboriginal Corporation
MORRISON, Mr Brendan, Social and Emotional Wellbeing

Ord Valley Aboriginal Health Service
DANN, Mr Simon, Senior Medical Health Worker (Psychologist) and Alcohol and Drug Coordinator

Kununurra Medical
TRUST, Dr Stephanie Karen, Principal GP

Anglicare WA
KING, Ms Brenda, Sexual Assault Counsellor

NEWRY, Miss Nawoola Selina, Private capacity

Kununurra Region Economic Aboriginal Corporation
STOREY, Mr Nathan, Chair

Thursday, 5 July 2018

Civic Hall, Halls Creek

Witnesses

Yura Yungi Medical Service
KAESLER, Ms Cheryle Ann, Manager, Social Emotional Wellbeing Unit

Jungarni-Jutiya Indigenous Corporation
BAMBLING, Mrs Sharon Elizabeth, Acting Chief Executive Officer
LONG, Robyn, Chairperson

Shire of Halls Creek
HAY, Mr Jake, Regional Program Manager Youth
DECKERT, Mr Steven, Acting Chief Executive Officer
EDWARDS, Mr Malcolm, Councillor and President

BARNES, Mr Stephen, Sole Proprietor, Taylor's Store

Friday, 6 July 2018

Derby Aboriginal Health Service, Derby

Witnesses

Derby Aboriginal Health Service
HENDERSON-YATES, Dr Lynette, Chief Executive Officer
SPRY, Miss Tara, Chairperson
ROBERTSON, Ms Maureen, Social and Emotional Wellbeing Unit Manager, Provisional Psychologist
PLOWRIGHT, Dr Prue, Senior Medical Officer
OZIES, Mrs Narelle, Senior Manager, Business Operations

Garl Garl Walbu Alcohol Association Aboriginal Corporation
ROBERTS, Ms Jean, Manager
HENDERSON, Ms Sharon, Administration Officer

Friday, 6 July 2018

Mercure Hotel, Broome

Witnesses

Kimberley Aboriginal Law and Culture Centre
BARKER, Mr Wayne, Festival and Cultural Events Coordinator

Aarnja Ltd
O'MEARA, Ms Maureen, Chief Executive Officer
SIBOSADO, Mr Martin (Marty), Chairperson/WKEC Leader, Aarnja Ltd –
Empowered Communities

Aboriginal Interpreting WA
LIGHTFOOT, Ms Deanne, Chief Executive Officer
HAYWARD, Mr William, Social and Emotional Wellbeing Manager

**Aboriginal Health Council of Western Australia; and Kimberley Aboriginal
Medical Services**
McPHEE Mr Robert, Member, AHCWA Network; and Deputy Chief Executive
Officer

Milliya Rumurra Aboriginal Corporation
AMOR, Mr Andrew, Chief Executive Officer

Cyrenian House Milliya Rumurra Outreach Team
MALONE, Ms Sally Ann, Manager

Kimberley Mental Health & Drug Service
TRAN, Dr Huu Duy, Consultant Psychiatrist
BAUER, Dr Renee, Clinical Director

Monday, 9 July 2018

Legislative Assembly of the Northern Territory, Darwin

Witnesses
Northern Territory Department of Health
RIORDAN, Dr Denise, Chief Psychiatrist

Northern Territory PHN

HERRIOT, Mrs Nicola Anne, Chief Executive Officer

SMITH, Ms Le, Executive Manager Regional Partnerships and Procurement

Aboriginal Medical Services Alliance Northern Territory

DYALL, Mrs Danielle, Team Leader Trauma Informed Care and Social Emotional Wellbeing

Northern Territory Mental Health Coalition

HARRIS, Ms Vanessa, Executive Officer

EGAN, Ms Helen, Chief Executive Officer, TeamHEALTH

COX, Ms Merrilee, Chief Executive Officer, Mental Health Association of Central Australia

Mental Illness Fellowship of Australia (NT)

DAVIES, Ms Lorraine, Executive Officer

RUSSELL, Mrs Bronwyn, President

Danila Dilba Health Service

DARLING, Mr Malcolm, Acting Chief Executive Officer

McLAUGHLIN, Ms Joy, Senior Officer, Strategy, Research and Policy

Monday, 9 July 2018

Katherine Town Council, Katherine

Witnesses

Katherine Town Council

MILLER, Councillor Fay, Mayor

Dolly's Dream

CURTAIN, Mr Tom

Sunrise Health Service Aboriginal Corporation

REEVES, Ms Helen, Registered Mental Health Nurse

Wurli-Wurlinjang Health Service

FITZPATRICK, Dr Peter John, Executive Director, Medical Services

BROCK, Mr Darrell Arthur, Executive Director, Community Services

MOLONEY, Miss Mary, Wellbeing Manager and Registered Mental Health Nurse

LEWIS, Mr Dylan, Private capacity

Tuesday, 10 July 2018

DoubleTree by Hilton Hotel, Alice Springs

Witnesses

Central Australian Aboriginal Congress

BOFFA, Associate Professor John Dominic, Chief Medical Officer Public Health
CACIOLI, Dr Jon-Paul, Social and Emotional Wellbeing Manager

Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council

WILLIAMSON, Miss Christine, Manager, Youth Program
SMITH, Ms Margaret, Director
NIPPER, Miss Theresa, Member and Project Worker

Ngaanyatjarra Health Service

NEWMAN, Mr Nicholas William, Mental Health Coordinator

Nganampa Health Council

SINGER, Mr John, Executive Director
KELLY, Dr Martin, Senior Medical Officer

Central Australian Rural Practitioners Association

BYERS, Mrs Lynette (Lyn), Secretary

Jesuit Social Services

ADAMS, Mr John, General Manager, Central Australia

Tangentyere Council

CORBO, Ms Maree, Program Manager, Tangentyere Family Violence Prevention Program

Thursday, 19 July 2018

Parliament House, Canberra

Witnesses

Royal Australian College of General Practitioners
JOHNSON, Dr Caroline, Clinical Lead, Mental Health

Royal Australian and New Zealand College of Psychiatrists
BALARATNASINGAM, Dr Sivasankaran (Siva), Chair, Aboriginal and Torres Strait Islander Mental Health Committee
RIORDAN, Dr Denise, Member, Faculty of Child and Adolescent Psychiatry
COLEMAN, Dr Mathew, Committee Member, Section of Rural Psychiatry

Rural Doctors Association of Australia
RUTHERFORD, Mrs Peta, Chief Executive Officer
RODRIGUES MACIAS, Ms Anita, Senior Policy and Research Officer

Australian College of Mental Health Nurses
RYAN, Adjunct Associate Professor Kim, Chief Executive Officer
CASEY, Mr Denis, Credentialed Mental Health Nurse, Uralba Clinic

Australian Nursing and Midwifery Federation
FOLEY, Ms Elizabeth, Federal Professional Officer

National Mental Health Consumer and Carer Forum
MEADOWS, Elida, Tasmanian Carer Representative and Deputy Carer Co-Chair
ENGLISH, Ms Lynette (Lyn), Consumer Deputy Co-Chair

Community Mental Health Australia
BRESNAN, Ms Amanda, Chief Executive Officer

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
GIBBS, Ms Colleen, Senior Policy Officer
GORDON, Ms Jennifer (Jennie), Membership Engagement Officer

The Healing Foundation
WESTON, Mr Richard, Chief Executive Officer
HILLAN, Ms Lisa, Director, Programs, Policy and Knowledge Creation

Marninwarntikura Women's Resource Centre
ELLIOTT, Professor Elizabeth, AM, Research Partner (University of Sydney)
CARTER, Ms Emily, Chief Executive Officer

beyondblue
HARMAN, Ms Georgina Kim, Chief Executive Officer

Suicide Prevention Australia
PIPEROGLOU, Mr Anastasios (Stan), Board Member (Director) and Chair, Policy Committee
HARPER, Mr John, Member, Lived Experience

The Butterfly Foundation
MORGAN, Ms Christine, Chief Executive Officer
COOK, Ms Frances, National Member, Knowledge, Research and Policy
COOK, Mrs Joanne, Lived Experience Advocate and Board Member

Centre for Rural and Remote Mental Health, University of Newcastle
PERKINS, Professor David, Director
DALTON, Dr Hazel, Research Leader and Senior Research Fellow

National Rural Health Alliance
DIAMOND, Mr Mark, Chief Executive Officer
PHILLIPS, Mr Andrew, Policy Adviser
STRATHIE, Mrs Lynne, Council Member

National Farmers' Federation
HARVEY-SUTTON, Mr Mark, General Manager, Rural Affairs
DOOLEY, Ms Corinne, Policy Adviser, Rural Affairs

Australian Rural Health Education Network
FITZPATRICK, Dr Lesley, National Director
HIRVONEN, Miss Tanja, Mental Health Academic
SCHLICHT, Ms Kate, Chair, Mental Health Academics Network

Mission Australia
BUTCHER, Mr Luke, Area Manager, Western New South Wales and Special Projects

ReachOut Australia
DE SILVA, Mr Ashley, Deputy Chief Executive Officer
BUHAGIAR, Dr Kerrie, Director of Service Delivery
CAIRNS, Dr Kathryn, Senior Evaluation Manager

Marathon Health
JACKSON, Mr Stephen, Chief Executive Officer

headspace National Youth Mental Health Foundation Ltd
TRETHOWAN, Mr Jason, Chief Executive Officer

National Mental Health Commission
LEWIS, Ms Maureen, Interim Chief Executive Officer
BROGDEN, Mrs Lucinda (Lucy), Chair

WORLEY, Professor Paul, National Rural Health Commissioner, Department of
Health

Friday, 20 July 2018

Whyalla City Council, Whyalla

Witnesses
Whyalla City Council
McLAUGHLIN, Councillor Clare, Deputy Mayor
COWLEY, Mr Chris, Chief Executive Officer

Country & Outback Health
SKELDON, Mr Zieco, Chief Executive Officer
TRIGGS, Ms Andrea, Operations Manager

UnitingSA
BARR, Mrs Jan Marie, Project Officer
DUNSTAN, Mr Brett, Community Support Worker

Whyalla Suicide Prevention Network
MARTINEZ, Ms Lee, Secretary
HARRISON, Mrs Karen Mary, Committee Member
ROBINSON, Mrs Trudy Ann, Committee Member

Child Adolescent Mental Health Services Northern Country
VOLVRICHT, Mrs Sandra, Acting Manager
WHITEHEAD, Mrs Kim, Acting Clinical Coordinator

Nunyara Aboriginal Health Service
MAIER, Dr Krista, General Practitioner

Rural and Remote Mental Health Limited
BOWERS, Dr Jennifer, Chief Executive Officer

MindsPlus
DODDING, Ms Jane, Psychologist and Director

Youth Affairs Council of South Australia Inc
BAINBRIDGE, Ms Anne, Chief Executive Officer

Centacare Catholic Country SA
CLEARY, Dr Jennifer, Chief Executive Officer

SA Mental Health Commission
TRAINO, Mrs Amelia, Executive Director

Country SA Primary Health Network
HARRIS, Mr Reg, Director Mental Health and Alcohol and Other Drugs
CURNOW, Mrs Chez, Manager Mental Health and Alcohol and Other Drugs

Wednesday, 29 August 2018

RedEarth Hotel, Mount Isa

Witnesses

Gidgee Healing
PHILLIPS, Mrs Mona, Deputy Chairperson
SHAW, Ms Leann, Board Member
BLACKMAN, Mrs Renee, Chief Executive Officer

Western Queensland Primary Health Network
GORDON, Mr Stuart, Chief Executive Officer
GILLIES, Ms Cassandra (Sandy), Executive Manager, Service Provider
Commissioning

Anglicare North Queensland
MARTYR, Ms Jodi, Program Manager
REGUNAMADA, Mr Sakiusa, Wellbeing Mentor

Wesley Mission
CASSIDY, Mr Tony, Group Manager, Wesley LifeForce
SUSSMAN, Mr Tim, Researcher, Wesley LifeForce
KERRIGAN, Mr David, Chair, Central West Suicide Prevention Network

Centacare North Queensland
ALEXANDER, Ms Heather, Director, Rural and Remote

Glencore Copper and Zinc North Queensland
WIPAKI, Ms Maryann, General Manager Health, Safety, Environment and Community

Centre for Rural and Remote Health, James Cook University
KNIGHT, Professor Sabina, Director
VARELA, Dr Sharon, Mental Health Academic

Services for Australian Rural and Remote Allied Health
SCHOLZ, Ms Karren, Member Psychologist
FRANKLIN, Ms Christine, Member
BROOKE, Ms Fiona, Director, Policy and Evidence

North West Hospital and Health Service
KENNEDY, Ms Sandra, Director Mental Health and ATODS
DHAMMIKA, Dr Herath, Clinical Director, Mental Health

Queensland Mental Health Commission
FRKOVIC, Mr Ivan, Commissioner

Thursday, 30 August 2018

Hotel Grand Chancellor, Townsville

Witnesses
Royal Flying Doctor Service of Australia
LAVERTY, Dr Martin, Chief Executive

Northern Queensland Primary Health Network
MATIC, Dr Vladislav, Board Chair
YEARSLEY, Mrs Gillian, Executive Director, Clinical Governance and Performance
EDWARDS, Mrs Evelyn, Chief Executive Officer, North and West Remote Health
THOMAS, Ms Karen, Queensland State Manager, Neami National

headspace
SEYMOUR, Ms Kirsten, Centre Manager

Northern Australia Primary Health Limited

IHME, Mr Phil, Senior Director Mental Health Services

Townsville Aboriginal and Islanders Health Service

BUTTIGIEG, Mrs Erica, Social and Emotional Wellbeing Program Manager, Townsville Aboriginal and Islanders Health Service

North Queensland Combined Women's Services

CRAWFORD, Ms Catherine, Coordinator

Australasian College for Emergency Medicine

SMALL, Dr Niall, Chair, Rural Regional and Remote Committee
MAHER, Ms Helena, Manager, Policy and Advocacy

James Cook University

LUTKIN, Dr Sarah, Clinic Manager/Lecturer, Clinical Psychology
BUCKBY, Dr Beryl, Coordinator Clinical Psychology Program (Acting)

Centacare North Queensland

LA ROSA, Ms Paula, Director Governance and Risk

Queensland Alliance for Mental Health

FINCH, Ms Simone, Acting Chief Executive Officer
AUDAS, Mr Jeremy, Member

selectability

BURDEN, Mrs Debra, Chief Executive Officer
FARRELL, Mr Aaron, Operations Manager

Wednesday, 5 September 2018

Paranaple Centre, Devonport

Witnesses

CORES Australia

JONES, Ms Sharon, Executive Officer

Tasmanian Transcultural Mental Health Network

BIRDAHIC, Ms Esta, Project Officer, Phoenix Centre, MRC Tasmania

Primary Health Tasmania

AKESSON, Mr Grant, Health Stream Lead, Mental Health and Alcohol and Other Drugs

Cornerstone Youth Services

O'SIGN, Mr David, Chief Executive Officer
FROST, Mr Wayne, Centre Manager, Headspace Launceston and Devonport

Youth, Family and Community Connections Inc.

ATKINSON, Ms Roslyn, Chief Executive Officer

Mental Health Council of Tasmania

DIGOLIS, Mrs Connie, Chief Executive Officer

Relationships Australia Tasmania

KELLY, Dr Michael, Chief Operating Officer

Flourish Tasmania Inc.

BAUR, Mr Klaus, Chief Executive Officer
BOOTE, Ms Rosemary, Consumer Representative

Thursday, 6 September 2018

Tidal Waters Resort, St Helens

Witnesses

Break O'Day Suicide Prevention Trial Working Group

WEBBER, Mrs Yvonne, Chairperson
FRENCH, Ms Wendy, Managing Consultant, Talking about Suicide; Member
O'DUFFY, Mrs Trish, Manager, St Helen's Neighbourhood House; Member
BARNES, Mr Gary, Manager, Fingal Valley Neighbourhood House; Member
SIMPSON, Ms Abbie Simpson, Mental Health Worker, Royal Flying Doctor Service; Member
JONES, Mr Stephen, President, Rotary Club of St Helens; Member

Break O'Day Mental Health Action Group

LeFEVRE, Councillor Barry, Councillor, Break O'Day Council; and Chair
McMURTRIE, Ms Leanne, Counsellor, Counselling and Consulting Services Tasmania

DRUMMOND, Councillor Janet, Councillor, Break O'Day Council

Rural Alive & Well Inc.
LITTLE, Ms Elizabeth, Chief Executive Officer
McMICHAEL, Mr Ian, President

Tasmanian Council of Social Service
GOODES, Ms Kym, Chief Executive Officer

Rural Health Tasmania Inc.
WATERMAN, Mr Robert, Chief Executive Officer

Carers Tasmania
BRENNAN, Mr David, Chief Executive Officer
Samantha, Member
Tammy, Member

Mental Health Carers Tasmania
GRIFFITHS, Ms Maxine, AM, Chief Executive Officer

Tuesday, 18 September 2018

Parliament House, Canberra

Witnesses

Department of Health
MOREHEAD, Dr Alison, First Assistant Secretary, Primary Care and Mental Health Division
RODDAM, Mr Mark, First Assistant Secretary, Indigenous Health Division
JEACLE, Chris, Assistant Secretary, Health Workforce Division, Rural Access Branch
GLEESON, Mrs Emma, Assistant Secretary, Mental Health for Children, Adolescents and Suicide Prevention Branch
WOOD, Mrs Emma, Acting Assistant Secretary, Mental Health Services Branch

Black Dog Institute
COCKAYNE, Ms Nicole, Director of Discovery and Innovation

MENDOZA, Mr John, Director, ConNetica; and Adjunct Associate Professor, Brain and Mind, University of Sydney

SALVADOR-CARULLA, Professor Luis, Centre Head, ANU Centre for Mental Health Research

Tuesday, 16 October 2018

Parliament House, Canberra

Witnesses

Department of Health

GLEESON, Ms Emma, Assistant Secretary, Mental Health and Suicide Prevention Branch, Primary Care and Mental Health Division
JEACLE, Ms Chris, Assistant Secretary, Rural Access Branch, Health Workforce Division
RODDAM, Mr Mark, First Assistant Secretary, Indigenous Health Division
WOOD, Ms Emma, Assistant Secretary, Mental Health Services Branch, Primary Care and Mental Health Division

Department of the Prime Minister and Cabinet

ARNAUDO, Mr Peter, Assistant Secretary, Health and Wellbeing Branch

Department of Social Services

McDEVITT, Ms Helen, Acting Deputy Secretary
STRAPP, Mrs Eliza, Branch Manager

National Disability Insurance Agency

NAUGHTIN, Dr Gerry, Strategic Advisor, Mental Health and Psychosocial Disability

APPENDIX 3

Summary of committee sites visits related to the inquiry

This appendix contains summaries of the committee's visits to the West Kimberley Regional Prison (Western Australia) and the Barkly Work Camp (Northern Territory).

Site visit to West Kimberley Regional Prison

Introduction

During the committee's public hearings in the Kimberley region of Western Australia (WA), the committee travelled to the West Kimberley Regional Prison (WKRP) on 6 July 2018 to receive a tour of the facility, a briefing from staff members and learn more about the mental health services available at the prison. Senators Siewert, O'Neill and Pratt participated in the site visit.

Profile of the WKRP

WKRP is located approximately 7 kilometres outside of Derby, a small town on the north-west coast of WA. Derby has a population of approximately 3511 people, with 49.4 per cent of people identifying as Aboriginal and/or Torres Strait Islander.[1]

The WKRP is considered a unique facility due to its design and operating philosophy which is premised upon Aboriginal cultures and values as far as is possible. The prison's philosophy includes recognition and acceptance of cultural, kinship, family and community responsibilities as well as spiritual connection to land.

Description of the facilities

The WKRP consists of numerous administration, facility and accommodation blocks which surround a central sports oval. The WKRP features two secure compounds, one which houses only women, and another which houses male prisoners who have recently been received into the prison or have a high security rating. The remaining accommodation blocks house men. The committee received a tour of the women's compound and one of the men's accommodation blocks.

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1   Australian Bureau of Statistics, *2016 Census QuickStats*, 'Derby (WA)', http://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/SSC50404 (accessed 4 September 2018).

The accommodation areas include several houses which each accommodate 8-11 prisoners on average, with a total capacity of approximately 223 prisoners. Prisoners are grouped according to their security rating as well as family ties and language where possible. The houses include a shared kitchen, living area and bathroom facilities, and 4-5 shared bedrooms. The houses are spread throughout a common outdoor space which features boab trees and native plants and grasses, mirroring the bushland which surrounds the WKRP.

Amongst other facilities, the WKRP also includes:

- Education and Program buildings;

- Workshop buildings;

- Main kitchen building;

- Spiritual Centre;

- Outdoor seating areas and recreation facilities;

- Health Centre (medical) building;

- Secure multi-purpose type building; and

- Administration area with staff offices.
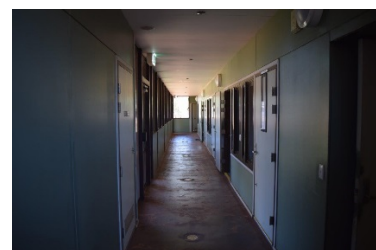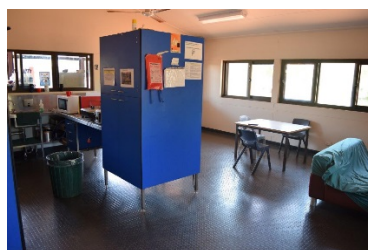
Description of services provided

Following the tour, the committee received a briefing from staff including the Clinical Nurse Manager, Clinical Nurse Specialist Mental Health, and Transitional Manager regarding the mental health and other services provided at WKRP. The committee

heard that three of the biggest factors which contribute to prisoners re-offending were drug and alcohol addiction, mental health issues and cognitive disability.

The WKRP has a doctor on site four days per week, a counsellor and a psychiatrist visits the facility for half a day every six weeks. A number of prisoners at WKRP receive mental health treatment including regular counselling, however, only prisoners in an acute state are seen by the visiting psychiatrist when necessary. The psychiatrist is also able to prescribe medication for a prisoner which is then administered by WKRP staff.

Staff explained that some prisoners have symptoms of psychosis when they arrive at the prison but that this is often as a result of drug use. Following approximately six weeks in the prison, symptoms improve as prisoners undergo detox and receive mental health treatment from staff. Staff reflected that for some prisoners, it is easier for them to find themselves in prison than receive mental health care in the community. At WKRP, prisoners receive treatment for their mental health issues, have an established routine, receive regular meals and are able to take a break from pressures in the community such as relationships or drug and alcohol addiction.

During the discussion, staff noted that a number of the prisoners' mental health illnesses related to a disability, such as an acquired brain injury or the effects of foetal alcohol spectrum disorder, but that the interaction of mental health services and disability services was complex. In particular, staff advised there was confusion regarding the roll out of the National Disability Insurance Scheme (NDIS) in the Kimberley region and how prisoners eligible for the NDIS would access services once in the community.

In addition to the mental health services provided, the committee also heard about transition arrangements for prisoners returning to their communities. The committee heard about a number of difficulties staff face when making arrangements for prisoners including a lack of wrap-around support services, changing Centrelink requirements and barriers to opening a bank account for prisoners. Where appropriate, prisoners are referred to the Kimberley Mental Health and Drugs Service to assist with their transition back into their community and to continue the mental health treatment received in prison.

Impact of services on prisoners

The committee met with two prisoners who spoke about their experience with mental illness and mental health services both inside and outside of the prison. Each of the prisoners the committee spoke with felt that the mental health treatment they had received whilst at WKRP was more effective than the limited mental health services they had been able to access in their respective communities.

Each of the prisoners reflected on how their history of mental illness affected their behaviour and had contributed to their offending. The committee heard that after accessing the mental health services available at WKRP, the prisoners had developed strategies for how to modify their behaviour and improve their mental health.

The committee heard that cultural understanding was integral to the treatment the prisoners had received for their mental health. The Clinical Nurse Specialist Mental Health at WKRP is of Maori heritage. The prisoners explained they had been able to establish a relationship built on trust and culture with the Mental Health Nurse by each sharing aspects of their Aboriginal and Torres Strait Islander culture and Maori culture. This mutual understanding enabled staff to tailor mental health treatment to each prisoner and that the prisoners were more receptive to the counselling they received.

Both prisoners were confident that they would seek ongoing support for their mental health when they returned to their communities. The prisoners explained that it can take time to find the right mental health service for an individual but that it is important to persevere and take the time to build a relationship and establish trust with a health professional.

Acknowledgements

On behalf of the committee, Senator Siewert thanked the prisoners and staff of the WKRP for speaking to the committee and facilitating their visit.

Site visit to Barkly Work Camp

Introduction

Before the committee's public hearing in Alice Springs on 10 July, the committee travelled to the Barkly Work Camp (BWC), Tennant Creek, to conduct a site visit of the facility.

The committee was greeted at the Tennant Creek airport by Kay Horsburgh, Officer in Charge and Chief Correctional Officer, and were provided with a briefing and tour of the BWC. Senators Siewert and O'Neill participated in the site visit.

Profile of the BWC

The BWC was opened in 2011 as a partnership between the Northern Territory Correctional Services and Tennant Creek and Barkly Region communities in conjunction with Native Title holders, the Patta Aboriginal Corporation.

The BWC is an open and low-security correctional facility for adult male prisoners, located less than 4 kilometres from the Tennant Creek town centre. It has a focus on rehabilitation and reparation instead of traditional forms of incarceration, giving prisoners opportunities to develop work readiness and life skills.

Originally built to house 50 prisoners, at time of the visit the BWC housed a total of 74 prisoners, with plans to expand capacity to 96 prisoners. The majority of prisoners who have transitioned through the BWC since its opening have been Aboriginal and Torres Strait Islander people.

The BWC aims to accommodate prisoners who have family or community ties to the Barkly region. At the time of the committee's visit, around 50 per cent of the prisoner population had family or community ties to the Barkly region.

Description of the facilities

The BWC consists of several structures surrounding a central recreational yard, including:

- accommodation blocks for prisoners, each of which consists of an air-conditioned shared space with kitchenette facilities, adjoined by several shared bedrooms with ensuite bathrooms;
- an Elders' visiting centre;
- a covered visiting space;
- kitchen building;
- laundry building;
- training and equipment sheds;

- vegetable garden; and
- an administration area with staff offices and accommodation.

Programs at BWC

The BWC provides opportunities for prisoners to reintegrate back into the community and provide reparation to the community for their offending behaviour.

Prisoners participate in paid employment, via the Sentenced to a Job program, and voluntary employment, including reparation works for the Barkly Regional Council and not-for-profit organisations, such as regional rodeos and shows. For those prisoners participating in Sentenced to a Job, some of their wage goes towards board and lodging for their place at the camp and any fines they owe, while 5 per cent goes to Victims of Crime Northern Territory. The rest of their wage is held in trust until they are released, or can be paid to their family.

Some of the work readiness and life skills programs offered by BWC include: training in chain saws and small motors; construction 'White Card'; AFL umpiring; pre-tertiary certificates delivered through University of Southern Queensland; and driver education. Prisoners also participate in the local football league.

While the BWC does not provide specific mental health services for prisoners, it does facilitate a number of support programs for social and emotional wellbeing, including:

- a men's therapeutic life skills program, delivered by Relationships Australia;
- Codes 4 Life, delivered by Desert Knowledge Australia;

- a family violence program; and

- a visiting Elders program.

Prisoners requiring mental health support, or complex medical support such as alcohol and other drugs programs, are transferred out of the BWC to receive those supports in the Alice Springs Correctional Centre.

Impact of the BWC programs on prisoners

The committee met with prisoners living and working the BWC. Prisoners described some of the social issues in their communities and the behaviours which led to their arrest and imprisonment.

Staff at the facility told the committee that living conditions at home are difficult or bad for many prisoners, with many communities in the Barkly region facing significant issues with alcohol and violence, and that there is a good culture within the BWC of prisoners encouraging each other to 'keep the peace' as they understand that placement at BWC is a privilege.

The committee heard how prisoners at the BWC benefit from being closer to their communities and enjoy more frequent visits from their families, compared to when they were in the Alice Springs Correctional Centre.

Prisoners who spoke with the committee explained that they hoped to use the skills they had learned in the BWC to find work in Tennant Creek, or in their home communities, once their sentences are served.

Acknowledgements

On behalf of the committee, Senator Siewert thanked the prisoners and staff of the BWC for warmly hosting the committee's visit.
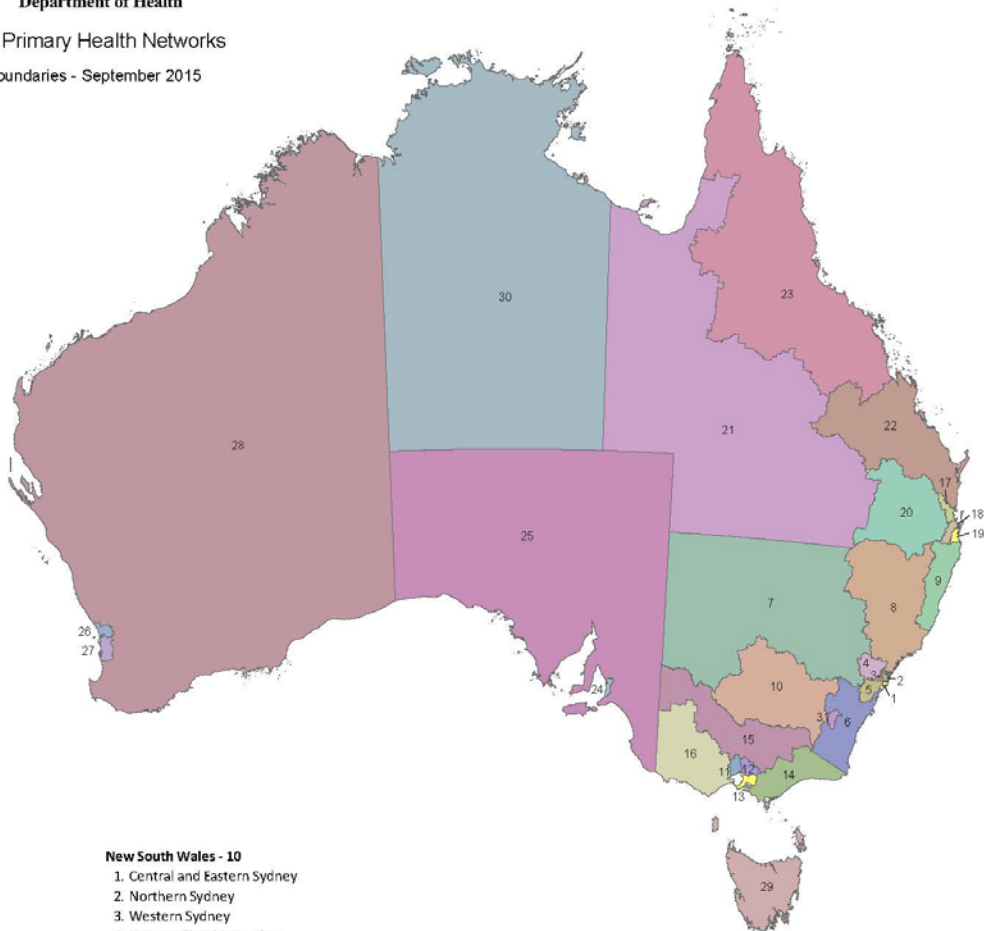
APPENDIX 4

Primary Health Networks in Australia

Australian Government

Department of Health

31 Primary Health Networks

Boundaries - September 2015

New South Wales - 10
1. Central and Eastern Sydney
2. Northern Sydney
3. Western Sydney
4. Nepean Blue Mountains
5. South Western Sydney
6. South Eastern NSW
7. Western NSW
8. Hunter New England and Central Coast
9. North Coast
10. Murrumbidgee

Victoria - 6
11. North Western Melbourne
12. Eastern Melbourne
13. South Eastern Melbourne
14. Gippsland
15. Murray
16. Western Victoria

Queensland - 7
17. Brisbane North
18. Brisbane South
19. Gold Coast
20. Darling Downs and West Moreton
21. Western Queensland
22. Central Queensland, Wide Bay, Sunshine Coast
23. Northern Queensland

South Australia - 2
24. Adelaide
25. Country SA

Western Australia - 3
26. Perth North
27. Perth South
28. Country WA

Tasmania - 1
29. Tasmania

Northern Territory - 1
30. Northern Territory

Australian Capital Territory - 1
31. Australian Capital Territory

Source: Department of Health, *Australia Primary Health Networks*, http://www.health.gov.au/internet/main/publishing.nsf/content/phn-maps-aust (accessed 29 November 2018).