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UnitingCare Australia Submission to the Senate Committee Inquiry on Accessibility and Quality of Mental Health Services in Rural and Remote Australia

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UnitingCare Australia is pleased to provide a response to the Senate Inquiry into accessibility and quality of mental health services in rural and remote Australia.

UnitingCare Australia is the national office representing the network of community service organisations of the Uniting Church in Australia (network). Our network operates nationally across more than 1,300 sites in metropolitan, rural and remote Australia, delivering services to people across the life course. Network experience in delivering mental health services in rural and remote Australia provides us with on the ground visibility of the challenges to accessibility and quality of mental health services in these locations. Comprehensive input to this submission was provided by the following organisations from our network:

- Uniting Country SA
- Uniting SA
- UnitingCare Queensland (including Australian Rural and Remote Community Services - ARCCS)
- Uniting NSW.ACT
- Frontier Services
- ARDS Aboriginal Corporation

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

Evidence shows that the prevalence of people experiencing mental illness (at approximately 20 percent) is consistent across Australia, regardless of whether they live in metropolitan, rural or remote locations. However, the uptake of mental health services differs immensely, with people in rural and remote locations accessing services at a much lower rate. The National Rural Health Alliance states that in 2015-16 there were 482 mental health encounters per 1,000 people in metropolitan locations, compared with 382 in rural locations and only 108 in remote areas[1].

Our network's experience is that access to mental health services in rural and remote locations is limited. The face-to-face services that are available are often visiting services which may only be provided one day per fortnight or even one day per month. These services are frequently fully booked months in advance and have long waiting lists, which is

[1] National Rural Health Alliance, "Mental Health in Rural and Remote Australia" December 2017, available at http://ruralhealth.org.au/factsheets/thumbs

not helpful for people who need more immediate help. Additionally, these services often do not continue past their funding period which is sometimes only two or three years. This limited number of services often means that there is poor information about what actually is available and whether there is any ongoing support for people. Frontier Services are aware of one incidence where a woman had to wait nine months to see a psychologist for grief counselling in remote Queensland after losing her child and husband.

Services are sometimes provided via telephone or are web based to supplement the lack of face-to-face services. While our agencies observe that there is definitely a place for these services in rural and remote Australia, they do not fully replace face-to-face consultations.

Statistics in the table below from the Australian Institute for Health and Welfare support this on the ground experience that regional and remote areas are poorly serviced by mental health professionals:

Prevalence of Mental Health Professionals by Remoteness, 2015[2]

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Clinical FTE per 100,000 population					
Psychiatrists	13	5	4	5	2
Mental Health Nurses	83	74	46	53	29
Psychologists	73	46	33	25	18

This reduced access to care is reflected in the Medicare expenditure on mental health services in regional and remote areas. The figures show that 74 percent less is spent per capita in regional areas and 21 percent less in remote Australia (see table below):

Per Capita Medicare Expenditure on Mental Health Services 2015-2016[3]

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
All pofessionals	$50.94	$42.18	$28.09	$13.15	$7.44

Lack of transport options and long travelling distances to services are also challenges. Access to public transport or roadworthy vehicles, as well as the cost of taxis or petrol, can be barriers to service access. If the only 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. 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.

[2] Australian Institute of Health and Welfare, available at https://www.aihw.gov.au
[3] Australian Institute of Health and Welfare, available at https://www.aihw.gov.au

Concern about confidentiality is an issue in small communities, including Aboriginal and Torres Strait Islander communities. There is the perceived risk of being seen to access a service in a particular location, or of having information about a visit shared. Individuals accessing services may thus be subjected to stigma from within their communities, compounding mental health problems.

While there are some significant challenges and barriers to access, our network of services advised that some models are working well in rural and remote Australia.

Frontier Services Bush Chaplaincy Program[4]

Frontier Services provides on the ground practical, pastoral and spiritual care directly to people within remote communities. In their experience, those who are in greatest need and the primary users of their services are graziers, fly-in-fly-out (FIFO) workers and First Peoples.

Frontier Services Bush Chaplains live and work in their communities which gives them unique insight and credibility not achievable by outsiders. The Bush Chaplaincy Program providers holistic care for each individual who needs support, both in an immediate crisis and over the long term. The Chaplains are highly valued members of their community and integral to that community as they are also chaplains for the Police, SES, Schools and Hospitals.

There is currently a network of 11 skilled Bush Chaplains spaced across the country in remote areas. These areas vary in size, some larger than states, and are made up of different communities.

Demand for Bush Chaplains is high, currently exceeding Frontier Services' ability to sustainably fund these positions. Frontier Services estimates that there is a need for an additional 14 Bush Chaplains to address the critical mental health needs of the most marginalised people in remote Australia.

Mental Health Matters Toolkit – Uniting Church in NSW.ACT[5]

The Uniting Church, in collaboration with its agencies, has developed a toolkit titled Mental Health Matters. The purpose of the document, which is publicly available, is to educate and equip congregations to support people with mental health issues.

[4] Frontier Services Bush Chaplaincy Program available at: https://frontierservices.org/how-we-help/bush-chaplaincy/
[5] Mental Health Matters Toolkit for Congregations, available at: http://ume.nsw.uca.org.au/wp-content/uploads/2014/12/mental-health-matters-final.pdf

The Mutitjulu Partnership Model[6]

ARCCS have cited their Mutitjulu Partnership Model as one that has delivered good outcomes in a remote Aboriginal community.

This is a generational integration model where community care, aged care and childcare services are provided in a community space. This model provides an example of an inclusive partnership in action, enabling transparency and inclusivity for that community.

The Model reduces stigma because people attending the community space could be there for many purposes, not necessarily to access a mental health professional. It also provides the opportunity to educate the community in what services are available to them and how to access them.

b) The higher rate of suicide in rural and remote Australia

While the incidence of mental illness does not appear to be impacted by location, the incidence of suicide does increase with remoteness. The rate of suicide is 40 percent higher in regional areas and it doubles in remote locations as shown in the table below:

Incidence of Suicide by Remoteness 2010-2014[7]

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Age standardised rate per 100,000 population					
Males	14.9	21.3	22.9	28.3	29.7
Females	n.p.	n.p.	n.p.	9.5	13.0
Persons	9.9	13.1	14.4	19.6	22.3

np – not published

Our network observes that lack of access to, and knowledge of, mental health services contribute to the higher prevalence of suicide in rural and remote Australia. Our services also note that access to means, such as firearms, is easier in these areas, thus heightening safety risks associated with poor mental health. Drought, income insecurity (often dependent on the variability of seasons) and isolation are other contributors. Families often separate when young people move to the city for study or work opportunities. This can create isolation for those left behind, particularly if they are living on remote properties.

[6] ARCCS http://www.arrcs.org.au/
[7] Australian Institute of Health and Welfare, available at https://www.aihw.gov.au

Country Callback for drought affected and isolated communities

In recognition that access to mental health service was an issue in remote areas during drought, UnitingCare Queensland was originally funded to provide a Country Call Back service. As local services are normally only available during business hours this often precludes farmers or other workers from accessing appointments. The Country Callback service is available 24/7 so clients can make a time for the service to call them when it is convenient to talk, whether that is late at night or during the weekend. The service is aimed at early intervention and provides counselling, support and links to resources.

While the service no longer receives any government funding now that drought funding has ceased, UnitingCare Queensland is now self-funding this important service. However, sustainability remains a challenge.

The rate of suicide among Aboriginal and Torres Strait Islander people is almost twice that of non-Indigenous people. Aboriginal and Torres Strait Islander people are more at risk of self-harm or suicide, particularly if they feel disconnected from their culture, their land and their identity.[8]

> *"Our people have strong culture. We are artists and storytellers, we are sporting legends and skilled hunters, we are musicians and dancers and uncles and aunties and grandmothers and grandfathers. Most of all we are teachers, and we are teaching our children to find their way in a modern world. Our kids need a guide to find their way … they need to take our culture with them…. to bring both worlds into one." (Aboriginal Mental Health Worker)*[9]

Purple House Model[10]

In Aboriginal communities in the Northern Territory the high incidence of renal disease has had a huge impact, with significant numbers of Elders having to move off country into locations such as Alice Springs for treatment. Communities fear for their future wellbeing as Elders are no longer on country to pass on their cultural knowledge and provide mentoring and leadership to those communities. Young Aboriginal people aspire to be recognised in their community, to belong. The health and wellbeing of those communities is essential for a healthy future generation.

The Purple House has been a leader in changing the model of renal dialysis services in Central Australia. By physically locating dialysis chairs in regional and remote communities they have made it possible for Elders to stay in their home countries.

Purple House aims to provide culturally appropriate service delivery to enable cultural continuity, leadership and strength in community. "*At the core of Purple House's success is a spirit of hope, a celebration of country and family, and an aspiration to live well".*

[8] Lifeline Toolkit - Suicide Prevention Information for Aboriginal & Torres Strait Islander people, available at: https://www.lifeline.org.au/get-help/facts-and-information
[9] Lifeline Toolkit - Suicide Prevention Information for Aboriginal & Torres Strait Islander people, available at: https://www.lifeline.org.au/get-help/facts-and-information
[10] Memmott, P Keys, C and Kane J; 2017 'The Purple House – A good practice profile'

c) The nature of the mental health workforce

Our network advises that it can be difficult to recruit skilled people in rural and remote areas. As a result, the workforce often consists of older people who have been working in the area for some time. It is hard to attract younger, more recently skilled workers who provide the opportunity for succession planning. Frontier Services notes that in remote Australia you are often an outsider, and not well accepted, until you have lived in a community for generations.

In our experience mental health professionals, such as clinical psychologists, are given contracts of only three months. As a result, it is difficult for them to gain acceptance in a community and they are not able to build good relationships with their clients before they move on. This forces clients to retell their story, risk re-living trauma, commence a new process of building rapport and experience disruption to continuity of support.

Funding often does not recognise the distances that workers need to travel to support their clients. These distances also mean that workers can themselves become isolated and at risk, particularly when mobile network coverage is not always available.

Given the limited resources in rural and remote locations, it is difficult for workers to focus on prevention and early intervention. They spend much of their time responding to crises.

Providing professional development for staff is challenging, as training is often only available in cities, making access expensive and time consuming.

Finally, our agencies advise that burnout is very common in rural and remote mental health staff due to the factors listed above. As one agency stated, burnout is common because staff are working as hard as they can in a challenging environment with limited resources.

UnitingCare Australia has trialled a recruitment and employment model in the disability and aged care area which has significant potential for effective application in in the mental health space. We recognize that the program is aimed at lower skilled workers such as mental health support workers. However, given the overall shortage of staff across mental health services in rural and remote locations we believe it would be a good fit.

UnitingCare Australia Employment Model

UnitingCare Australia has successfully developed and trialled, with three Uniting Church community service providers, a values-based recruitment model for the community service sector. This pilot was undertaken in collaboration with the Department of Employment (now Department of Jobs and Small Business) and has informed the development of the Government's national workforce initiative – *Launch Into Work*.

The pilot successfully trained, mentored and employed 36 people who had previously been struggling to get a foothold in the job market, a number of them long term unemployed. Candidates were selected for their attributes, capability and life experience rather than skills and work experience. The program is designed to teach them the skills and expertise they need for the role and support them as they learn.

d) The challenges of delivering mental health services in the regions

Many of the challenges of delivering mental health services in rural and remote Australia have already been stated in this submission.

Our network advises that there is a lack of understanding by funding bodies of the need for secure, long term funding to adequately establish and resource quality services. Agencies need to be able to recruit quality staff and provide them with a secure role, professional development, adequate travel time and a reasonable case load to allow them to deliver the service their clients deserve. The funding must recognise the challenges and costs of serving a vast geographical area, rather than just a population size.

The risks of uncertainty of funding for services were highlighted during our consultation, with a story of a mental health worker who was met at their car by a gentleman:

> *"'crying and telling me his family had left him – he had the gun out and was about to drive down the paddock. I was able to get him support immediately because we had a drought counsellor in the district. As soon as the drought was declared over, this support was withdrawn. Unfortunately the impact of the drought doesn't cease overnight when the rain arrives".*

Our agencies observe that the model of mental health service delivery provided in metropolitan areas does not suit rural and remote areas. Uniting NSW.ACT advise that Community Consultations have been very powerful in rural areas to enable communities to identify ways to support each other and inform the models of care that work for them.

ARDS highlight the success of an Aboriginal controlled mental health service based in North-East Arnhem Land in the Pathways in Mental Health resource available at: https://vimeo.com/267162539.

The Malparara Way[11]

In remote Aboriginal and Torres Strait Islanders communities, no matter what the service is, it must be an inclusive partnership for it to be effective. The Malparara Way from the NPY Women's Council is a model that has worked well.

The basis of the Malparara Way is "two staff who are working together on a program, one of whom is an Anangu woman or man, and the other who is the partner staff member, employed for his/her specific professional skills. The Malparara Way recognises and values the knowledge, skills and resources of the local people while assisting them in gaining access to services which are delivered in a culturally appropriate and effective way."

Building on this model, our network observes that mental health practitioners working in a respectful way alongside traditional Aboriginal mental health healers, such as Ngankari Traditional Healers, brings about the best results for people in remote Aboriginal communities.

[11] NPY Women's Council – strong culture, strong women, strong communities http://toolkit.aigi.com.au/case-studies/npy-womens-council-strong-culture-strong-women-strong-communities

e) Attitudes towards mental health services

A strong theme in our consultation across our services is the stigma around mental illness in rural and remote communities. There is often a culture in these communities of being self-reliant. Rural stoicism makes it more likely that rural people will withdraw rather than seek help from appropriate mental health services. This stoicism is a significant contributor to the stigma and shame in reaching out to the medical professional for mental health support when it is needed.

As stated earlier in this submission, confidentiality and anonymity are an issue. This, combined with the stigma of accessing mental health services, means that people are resistant to seeking help. Add to this the long waiting lists and limited number of services available and it is easy to see why people in these communities are disillusioned with services and not seeking help.

ARDS Aboriginal Corporation – Yolngu Radio[12]

The fear of sorcery is so widespread among the Yolngu population, in particular the youth, that even discussing it is perceived to draw negative attention to yourself. It is spoken about in private.

Over 10 years ago, ARDS identified the increased use of sorcery in the communities. It was suggested that this was due to the reduced ability to practice traditional systems of law and punishment, leaving Yolngu no other option than to resort to sorcery (which is unlawful).

Increasingly, sorcery is blamed for illness or misfortune – this is due to the level of confusion about the way the contemporary world works.

The fear of sorcery adds burden to the already high allostatic load experienced by Yolngu people. The impact on mental health has not been researched to our knowledge, but this underlying fear is possibly only enhanced by drug induced paranoia.

Even committed Christians sadly, do not feel free from the effects of sorcery.

While the belief in and fear of sorcery is widespread, it is not an easy subject to discuss. It needs to be done sensitively with very experienced cross-cultural facilitators. It is not a topic for the visiting worker to engage in.

However, our view is that unless the impact of sorcery is understood and culturally competent ways of discussing it are developed, many mainstream interventions will not result in the benefits hoped as they are not addressing one of the core issues.

Several of our agencies observed that there has been a focus on delivering both Mental Health First Aid and Aboriginal Mental Health First Aid[13] training courses recently which is a good start at educating the community on the issue and reducing the stigma.

[12] ARDS Aboriginal Corporation http://ards.com.au/
[13] Mental Health First Aid, available at: https://mhfa.com.au/

Uniting NSW.ACT noted the success of the NSW Ability Links program in working in partnership with the community and other organisations to break down stigma around mental health[14].

f) Opportunities that technology presents for improved service delivery

There is an appetite and strong case for services provided through technology in rural and remote Australia. This model of service delivery can provide the possibility of better confidentiality to the client as it can be accessed from home. It can also be cost effective and give access to skilled professionals who may only normally be available in metropolitan areas.

However, we note some of the challenges that our agencies have identified in relation to utilising technology to deliver mental health services:

- The internet is not always available, reliable or affordable for people in rural and remote areas.
- The best model is to build rapport and trust with a client face-to-face in the first instance and then consultations can be moved to an IT platform.
- Staff must be skilled in delivering services through IT – it is not the same as delivering services face-to-face.
- Clients need good training in IT so they know how to make use of it effectively and the system must be easy to use and reliable.
- Some models of online delivery are delivered from the premises of the service provider – however, in our experience this takes additional resources as there must be a person present to assist and support the client on site, as well as the mental health professional online.

We are aware that a number of services utilising technology are working effectively and providing positive results for people in rural and remote Australia including Beyond Blue's NewAccess Coaching Model[15], Lifeline's Crisis Support Chat[16] and SA Regional Access counselling service[17].

g) other

Our network has expressed concern around the future of mental health services for people outside the NDIS going forward. We note that funding for mental health services is reducing as it is put towards the NDIS. While we are supportive of the NDIS and the important service it is providing for those who qualify, we recognise that not all people with mental health issues will be eligible for an NDIS package.

An example of a gap that is opening up with the transfer of services out of block-based funding into the consumer directed care model of NDIS is in relation to the Personal Helper

[14] Ability Links NSW, available at: https://www.abilitylinksnsw.org.au/about_us.html
[15] Beyond Blue NewAccess program, available at: https://www.beyondblue.org.au/get-support/newaccess
[16] Lifeline Crisis Support Chat service, available at https://www.lifeline.org.au/get-help/online-services/crisis-chat
[17] https://saregionalaccess.org.au/

and Mentors (PHaMs) program. This program is currently funded by the Commonwealth Department of Social Services but is in the process of fully transitioning into the NDIS. This means that people who have not qualified for an NDIS package, but have to date been accessing the PHaMs service, are going to be unable to access this support in the future.

PHaMs' success has been its ability to keep people out of hospital and clinical services. People do not need to have a formal clinical diagnosis of a severe mental illness to be able to access the service[18]. Our agencies advise that its success has been significant due to it being a service outside the health sector. As a result, there is less stigma attached to it, less power imbalance and it is more accessible. We are concerned that without this service many of our clients will become more unwell and will need an NDIS package at some point in the future. This will mean they will need to be classed as having a 'permanent' disability.

We thank the Committee for the opportunity to provide feedback and would be pleased to provide more information on any of the points covered in this submission.

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UnitingCare Australia

UnitingCare Australia is the national body for the network of Uniting Church community service organsiations, one of the largest providers of community services in Australia. With over 1,600 sites, the network employs 40,000 staff and is supported by the work of over 30,000 volunteers. We provide services to children, young people and families, Indigenous Australians, people with disabilities, the poor and disadvantaged, people from culturally diverse backgrounds and older Australians in urban, rural and remote communities.

UnitingCare Australia works with and on behalf of the UnitingCare network to advocate for policies and programs that will improve people's quality of life. UnitingCare Australia is committed to speaking with and on behalf of those who are the most vulnerable and disadvantaged.

[18] Department of Social Services, Personal Helper and Mentors Program available at: https://www.dss.gov.au/our-responsibilities/mental-health/programs-services/personal-helpers-and-mentors-phams