

MHYFVic Submission on mental health services in rural and remote Australia

MHYF Vic is a mental health advocacy group for consumers, professionals, and the public with a specific focus in enhancing services provided to children, adolescents, and their families.

Accessibility to services, irrespective of location, is a major focus of our work. Quality of services is also high among our priorities. To achieve our goals, we speak on relevant issues, provide forums, and support research efforts to ensure services are available to as many families as possible. We seek to influence service delivery across all the domains impacting families. Our annual Oration has had speakers with backgrounds in law and economics, as well as youth work, social work, psychiatry, and psychology.

MHYF Vic has existed under the current title since 2000, but most of us were part of a former organization from 1988 (Coalition of child and adolescent mental health professionals). We are primarily concerned with service provision in Victoria but believe our observations would apply across much of Australia and would like to see partner organizations formed in other States and Territories. We can offer commentary on each of the terms of reference for this Senate Committee Inquiry. We will be making comments that apply to children and families, and these include adults with diagnosed mental health conditions, but our focus is not upon lone adults and their particular challenges.

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

Access is affected by availability of service, obstacles to service access, and stigma. MHYF Vic has project groups working on these issues. These obstacles and availability issues are magnified by rural location although they also apply to urban areas. Families with troubled children find it difficult to recognize and then to respond effectively to such troubles, worsened by problems of acceptance into and travel to a quality service with experienced professionals. In the absence of well-organized referral pathways, families may not even seek help. The problems may then worsen and magnify the effects of isolation.

In our experience, stigma is a particularly pernicious issue with respect to adolescents and adults. **Stigma** directly affects attendance at mental health services in rural centres because there is high community visibility of people attending services. One of our committee members was recently working in Alice Springs and found that stigma made attendance by Aboriginal adolescents at the local Headspace service a rare event because of the high visibility associated with attendance, even though this service is run by the Central Australian Aboriginal Congress.

In urban areas, there is often a distance between the place of attendance and the homes and community of the potential service users, but service utilization is still common knowledge. Of course, in the bush, distances can be much greater, but members of the same community can observe the comings and goings of relatives. As it is not possible to disguise attendance at mental health services it is essential for service provision to be normalized through integration within non-stigmatized services and by community education countering stigma.

Stigma is an obstacle to attendance, but there are many others. Distance and opening hours also affect attendance. Parents are often reluctant to take their children out of school to attend and the children, usually, do not like to be seen to be absent. This applies especially to adolescents. Occasionally, adolescents may attend in order to avoid school, which may add to their problems. In some disorders such as 'school refusal' it is necessary to implement a team approach with other services such as the school; the high degree of anxiety experienced by school and family can be an impediment to providing appropriate help.

The service delivery system can create **obstacles to attendance**. The way cases are referred can be problematic because uncertain parents may not recognize a problem early enough and then not know how to find an appropriate service for their family's needs. Schools can provide a pathway to services, but often try to help with the problem first and can delay the finding of appropriate treatment. This problem is likely to occur more in rural settings where services may be felt to be too far away for parents to take their children.

General practitioners can help in smoothing the pathway for referral, if they are aware of services. Similarly, others could aid the referral process. Specific training of GPs who are interested in delivering mental health services may be a desirable goal. One of our members has had good outcomes with a family therapy training program designed and delivered to rural GPs.

The reception of the parents or children at the service can be a problem wherever it may be. In the community there are private services that are made accessible through Medicare or ATAPS but can only offer a limited amount of government supported sessions and usually involve a significant co-payment, which precludes attendance by less affluent families. There are public agencies and not-for-profit agencies (Headspace, Relationships Australia, local council counselling services, community health centres, and CAMHS/CYMHS) that provide appropriate services, but again these can supply services that involve out of pocket expenses beyond the means of the families with greatest need.

Receiving service at public agencies requires commitment from parents to support the attendance of their children and consent to service provision. This can involve a process of disclosure of personal information about the child which may be felt to reflect poorly on the referring parent and others. In some cases, if the young person is being abused or bullied by a family member they are less likely to self-refer. Self-referral can be difficult for children in need of help but who are under age. The people who receive the initial information at both urban and rural centres are usually not trained mental health professionals and may not be particularly capable as listeners and sorters of priority and need. These people are usually hired to the role of Receptionist and are expected to be able to receive referrals. Supervision of such work may not exist or may not be appropriately supportive or facilitative of skilful receipt of referral information.

When referral is sought to a CAMHS or CYMHS, there is usually a qualified mental health professional receiving the referral, but the primary role of Intake workers in such places is to assess if a referral is appropriate to the service. These specialist services are keen to work with those in greatest need and who will attend. Families in crisis are often not seen because they are not in a situation to attend with consistency. The Intake role can be a filter to prevent wastage of clinical time, but, in doing so, can exclude families with real and urgent needs.

Real and urgent needs may be manageable through telephone counselling services or online counselling services. Certainly, such services do claim success in preventing suicide and in helping troubled children work out the next step to seeking assistance, or in just settling down the caller so that what might have seemed a big challenge can be placed in context and a plan developed for discussing the problems with family or friends or school staff or others.

Families seeking mental health service need to be patient; often there are waiting times that are extremely long. This can be discouraging and excluding. Further, delays can mean unwell and disorganized young people progress not to health centres but to juvenile justice. Incarceration of unwell young people can add to the troubles and to isolation from the family.

Another factor that is likely to affect attendance is the quality of staff, including other staff factors like seniority, length of experience, and gender. Those among our organization who have worked in rural settings confirm that rural services are often places where beginning professionals attend. Some people do not like to talk to people younger than themselves and some people have preference for talking with a woman or a man. These are problems across the board but are magnified in rural settings. As those employed in Mental Health or ancillary services are also part of the community's social network there may be fears about confidentiality being kept.

One of our committee has noted the particular difficulties of LGBTQI youth in rural locations of seeking help and retaining anonymity. These young people can be truly isolated in bush communities and are very susceptible to suicide. The availability of staff with skills and without judgement was almost lethal in one case of hospitalization.

Complementary to the problems of obstacles to attendance, is the problem of **availability** of service. Services are funded on the basis of expectations of service need and these are usually calculated on a population basis. But when populations are dispersed distance can be a real barrier to attendance. Access to quality and specialist services is made more difficult by distance. In such instances, attendance for a one-hour appointment can involve the parents and children being absent from work and from school for a whole day, rather than the two hours that might be involved with urban families.

Quote from Shelley. "Often when people attend at professional services in rural areas they are intimately known by staff through association, such as being a family member, aunty Betty's brother's uncle that they drink with on Friday night, etc. due to the nature of the community. We have found for our 'Early Matters' program that the fear of attending a place where they may be known stops them attending at all. It is for parenting support, not medical or health support, where perhaps the stigma is increased or different. Further to this, many people cannot afford the time to be away from their land to attend such an appointment. If they are not there, jobs simply don't get done, the cows wait for no-one, so support to manage competing time constraints is not available in rural communities, particularly if the work they do is not seen as beneficial or important to others. I grew up in a very rural area and you only travelled to town once a month for groceries, so to book in to see someone on a more regular basis would not have been viable, and financially affording this extra travel and expense would have been out of the question."

Remoteness is not just a geographic problem. People can be housebound, socially isolated, or live on the urban fringe or just a little further out. The feeling of remoteness is probably more compelling and more constraining than the actual geography.

The best way to improve referral and attendance is through improving the pathway with support from other professionals and agencies (including GPs and schools). In turn this needs to involve education of referrers about services through provision of accurate information to the potential referrer and provision by the referrer of supportive pamphlets or other letters to some body seeking referral for their family. Such information could be accredited by a government body to be of a standard and form that did encourage referral. Brochures written by local agencies can be very useful, but sometimes lack comprehensiveness or sufficient focus.

Some of the problems of access can be addressed with the siting of services in locations that do not raise stigma; locating nearby a hospital might be one such strategy. Signage may help but needs to be clear but not obtrusive.

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

Suicide rates are affected by access to services and by the availability of a means to kill. Rural Australia has more guns than urban Australia. There are stretches of road that can involve high speeds and no other traffic, with trees or bridges that can lead to death. But, the lack of services can enhance the sense of distance from community and from others who might care.

Isolation is not recommended for anyone contemplating self-harm. Telephone counselling services can provide support to troubled persons and they always encourage connection with others at the finish of any telephone call. But in isolated settings, such connection with another may not be felt to be possible.

Research has demonstrated, in the past, that publicising suicide can increase rates of attempt, but there does need to be a way to discuss this suicide that does not promote it. This seems more urgent for rural communities given the higher rates of success. The higher rates of success probably reflect the availability of lethal means. Any public discussion of the issue in rural communities needs to include discussion of safe storage of weapons and safe driving.

The higher rates can also be indicative of isolation, the absolute lack of any other options, a profound sense of failure and disappointment to others, especially in a small community.

The availability of lethal means is less relevant when looking to young people, including women. Hanging is by far the most popular means, for both males and females, with firearms being about the third most popular for males (<http://www.mindframe-media.info/for-media/reporting-suicide/facts-and-stats>)

The fact that discussion may increase rates of attempt, needs to be a central part of any such discussion. Also, the contagion effect of death of a peer or family member needs discussion. This can be especially a problem in remote Aboriginal communities (such as Hermannsburg in late 2017).

Visiting services, or the local bush nursing facility, can be helpful at times of vulnerability, especially following death by suicide. The aim would be to calm things down and to make contact with the vulnerable.

(c) the nature of the mental health workforce;

Mental health professionals are usually trained in urban settings, come from urban settings, and prefer to live their lives in urban settings. Young professionals may go bush for their first job but are likely to return to their city of origin when they start their own families. General experience gained in the bush helps with employment in the more specialist services in town. There is the same level of need per head of population for specialist services in the bush, but much reduced likelihood that a suitably experienced specialist will respond to a mental health need.

Further, the support and supervision provided to remotely-located young professionals is likely to be from less qualified local professionals than might be accessible in town. Maintaining confidentiality within the smaller more isolated communities may also be of concern to staff seeking supervision as much as it can be for clients. Outreach consultancies to rural services and to groups of professionals can help with this training and support function (MHYF Vic committee members have been recipients and providers of such services in the past). But only certain experienced professionals are willing to expend the effort and time for remote travel.

Staffing appropriate outreach services to remote communities is another problem where lifestyle and need clash.

There are advantages of a changed perspective that comes from working outside the major urban areas. This can aid the maturity of the younger employee and extend the career of older employees.

While practitioners are aware of their inexperience, this may not be as great a problem for the client. The client lives in the region and understands that they may encounter young professionals, or else they trust the education system to produce qualified professionals, or they are too desperate to quibble over the quality of the practitioner. They need help and bring with this a strong wish to recover which is very helpful for the overall process. This might be client determination, or it might even be a placebo effect of help-seeking. Lack of experience should not be a reason to not provide funding for services based on population serviced.

Supervision is the answer to many workforce issues and visiting consultation services can provide this, but this can also be gained by technological means and visits to urban areas. Included here should be supervision of support staff; especially those on Reception. As indicated earlier, if the pathway works well, better outcomes are likely to arise. The role of the Receptionist in smoothing the path to service cannot be over-estimated. Investment in the training and support of such staff is important.

Urban based services should partner with rural services to provide training and consultation. This can be a condition of contract for urban services to provide and rural services to receive such training and consultation. There needs to be training programs in provision of remote consultation by visit, by video link, by telephone, and by online exchange.

Professional courses need to include observation or longer-term placements to rural centres. Again, this should be a contracted condition tied directly to funding. Health departments need to allocate funds to enable such contractual relationships.

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

Office-based service delivery is the most efficient way to provide mental health services. The professional is able to optimize the time spent with consumers if travel is not required. Mental health service also requires continuity of attendance and any cause of a cancellation can make for ineffective service. In the bush, monthly service interrupted by a cancellation can lead to gaps of two months or more in attendance.

However, travel can be a considerably greater impost on families in rural areas entailing day-long absences from work and school. Outreach services can help with remote communities, but continuity is a problem and visibility and stigma become greater problems. Travel may cause inefficiencies but be more informative for the professionals and more motivating for the clients. It is an extra burden for the professionals, and, therefore, can only be attractive to certain people, who may not have breadth and depth of experience. Although it is difficult, it should be an option for certain cases.

Most people do enjoy periods of work in the bush; there are challenges, but also enjoyment in the new environment and landscape. Time away can have a maturing effect for young people and a re-focusing effect for more experienced people.

(e) attitudes towards mental health services;

At a general level, and in parallel to attitudes that drive stigma, mental health services are seen by some as wasteful or scary places or places that make things worse or do not produce cures. Basically, the premise that talking can help is questioned. There is also widespread dissatisfaction with the pace of change. People would prefer solutions to personal problems being as rapidly delivered as the fixing of a leaky pipe, perhaps reflecting perceptions by service seekers of a cultural gap between potential clients and service providers.

There are also problems at the interpersonal level. Mental health professionals tend not to hear about the problems with their service. They are usually working with people who value what is offered and quality is perceived to be delivered. However, one does hear of the failures of other services and other professionals. In the bush, such feedback can create problems between services and may be based on particular cases where particular circumstances conspired to produce a negative attitude for one former client, which can create a loss of confidence in one of the few alternative services. This happens in town, as well, but the disenchanted client can find alternatives and the professional who learns of the disenchantment is less likely to worry about the state of other services.

(f) opportunities that technology presents for improved service delivery

Recently, one of our committee worked for four months in Central Australia, he maintained his private clinical psychology practice (clients and supervisees) by using the Internet system known as Zoom. Previously, he and a client presented to a Rural and Remote Mental Health conference (Geelong, 2013) on the use of Skype for counselling.

Zoom has the advantage over Skype of being encrypted in and encrypted out so that interception in transmission would involve a scrambled version of the message. Further, because the encryption has to be decoded at the receiving end, the sound and vision have to travel together and so loss or distortion of sound or image is much rarer the common pixilation encountered with Skype.

Supervisees found no problems with the medium. Supervision is very much based on words spoken and not on more subtle body movements and facial gestures. Back in Melbourne, some of the supervisees still prefer Zoom because they do not need to travel.

Clients had mixed feelings about using Zoom. Some felt it perfectly good; others felt that it lacked a feeling of warmth that came from being in the same room. Certainly, with clients, the non-verbal communications are important, and Zoom is a head and shoulders image, usually.

Other technologies already exist, such as telephone and online counselling. Relationships Australia Victoria is expanding its online service, currently. Such technologies are better suited to supporting those in crisis and to assist with decision-making. Longer term contact is usually better in person, but a mix of video and face-to-face, as funded under Medicare's Better Access program can work well and would probably be applicable to telephone and online counselling options.

In turn, the availability of such solutions would require public and professional education and the provision of well written, authorised brochures.

(g) any other related matters.

Rural services are a bit like a canary in a coal mine; they show up where the dangers are for all services: access, availability, information sources (brochures), risk, stigma, training, supervision, technology, support staff, networks, and pathways. But, as has been commented upon, these are challenges rather than deterrents; many people in need will find help, inexperienced professionals will find a way to help. Rural locations can aid professional development.

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