NATIONAL MENTAL HEALTH CONSUMER ALLIANCE

Out of Sight, Out of Mind

Enduring barriers to mental health care in regional and remote Australia

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PRELIMINARIES: LANGUAGE

The National Mental Health Consumer Alliance uses the term mental health consumer throughout this submission. Mental health consumers to refer to people who identify as having a past or present lived experience of psychological or emotional distress, irrespective of whether they have received a diagnosis of mental illness or accessed services. Other ways people may choose to describe themselves include “peer”, “survivor”, “person with a lived experience” and “expert by experience”. This definition is based on consumers’ call for respect, dignity, and choice in how we choose to individually identify. As individuals we choose different ways to name and describe our experiences that may confirm or trouble ideas about ‘mental illness’.

This paper describes barriers to access ‘mental health supports’, which is here used to describe access to clinical and nonclinical supports outside of hospital that help make up a person’s recovery journey, including (but not limited to) psychiatrists, psychologists, recovery coaches, peer workers, step-up step-down residential facilities, support groups, counsellors, occupational therapists and other allied health professionals, and a broad range of community supports that do not fall within the above neat categories. The term ‘access’ is used to convey both voluntary access led by the consumer, or involuntary referral to a service driven by a clinician or other third party.

INTRODUCTION

Accessing mental health supports in regional, rural, or remote communities poses unique challenges compared to a metropolitan context. In policy and legislation, the distinctions between metro and regional/remote areas are often flattened, resulting in recommendations that fit the needs of the dominant majority residing in cities, but which continue to marginalise people living outside of these areas. This two-tiered system offers substantial (though not by any means exhaustive) options to people who happen to live in one locale, but presents severely restricted options for others, meaning that holistic, person-centred care is inconsistently available in certain geographical locations. Accordingly, the *Evaluation of the Better Access Initiative* report found that the Better

Access Initiative 'disproportionately favour[s] people on relatively higher incomes in major cities'[1].

This paper outlines the position of the National Mental Health Consumers Alliance on equitable access to mental health supports that are recovery-oriented, person-centred, affordable and culturally appropriate to people living in regional or remote communities across Australia. Our position begins with a discussion of the barriers specific to regional or remote communities, considering that the categories themselves of 'regional', 'rural' and 'remote' are not homogenous and have varying needs according to size, location, population, and culture, as well as the intersectional identities of individuals who live there. We recognise, for example, that a discussion of regional community need for mental health and community supports in Western Australia (or indeed within specific regional districts within the state) will be very different to discussing the needs of a community in Victoria. This paper examines the role of social determinants of mental health and stigma as factors that contribute to mental health challenges, and also as barriers to seeking help.

We examine case studies in Western Australia, Victoria, South Australia, Tasmania and Queensland that demonstrate best practice strategies and approaches to meet unique needs in regional areas. These case studies highlight the immense value of community-driven responses to community need, and the importance of place-based services and supports that approach mental health holistically. Notably, the case studies highlighted here are not purely clinical services and instead focus on community connection and addressing the social determinants of mental health including access to food, community and family support, affordable and accessible housing and a culturally safe environment.

We close by making recommendations that would improve the quality, effectiveness, and accessibility of mental health support in regional and remote areas. Our recommendations include: place-based supports driven by and for community need; a broader range of options for support

[1] Pirkis, J. Currier, D. Harris, M. Mihalopoulos, C. et al. (2022) 'Evaluation of Better Access: Conclusions and Recommendations'. University of Melbourne. https://www.health.gov.au/sites/default/files/2022-12/conclusions-and-recommendations-evaluation-of-the-better-access-initiative.pdf

including non-clinical approaches; culturally appropriate service provision for Aboriginal and Torres Strait Islander people, elevating and supporting the peer workforce in regional areas, and addressing problems within current strategies that represent a top-down approach to mental health care without adequate consultation or co-design/co-production with people with lived experience of mental health challenges in those communities.

DEFINING THE ISSUES

The lack of locations, variety and availability of support services in remote and regional communities

For Australians in regional, rural and remote communities, an ongoing concern has been the location of support services available within reasonable transport distance, the variety of services that can be accessed within this range, and the availability of these services in relation to opening times and capacity. The lack of available services in regional and remote areas is captured, to an extent, by the data from the Australian Institute for Health and Welfare (A.I.H.W.) on mental health appointments that have utilised the *Medicare Benefit Schedule*. This data indicates that outer regional, remote, and very remote communities have made far less use of subsidised mental health care, possibly because the services were not present.[2] Larger regional centres tend to have the most resources allocated to address entire community clusters, leaving more remote consumers reliant upon considerable travel or infrequent visits from regional centres to obtain support. As one person living in regional WA surveyed by CoMHWA noted:

'There is a lack of knowledge of what services are available and how to access them. It can be difficult to find out eligibility requirements and the costs involved in fees and transport can be ridiculous.' – WA consumer

[2] Australian Institute of Health and Welfare. (2022) 'Mental Health Online Report: Medicare-subsidised mental health-specific services.' https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia

Even before considering the dearth of available mental health services, issues with accessing General Practitioners (GPs) pose a significant initial barrier to beginning that journey. The increasing inaccessibility of bulk billing will impact rural and remote areas more because of the lower average incomes of those living in these areas[3]. For those consumers who can afford the gap, many clinicians including GPs have closed books in regional, rural and remote areas. Furthermore, as GPs often function as a gateway to further services, the GP must have good local knowledge and the capacity to refer consumers to good quality supports, and regional consumers report that this is frequently not the case.

Beyond the issues of finding services and gaining access to them, the limited range of options in regional and remote settings can also lead to frustration if the person seeking help finds a service or provider to be unsuitable:

'In terms of reaching out for psychologists, it has been very difficult. It almost feels like you have to settle for sub-par service. I can easily list two that I would not go back to. If you find a psychologist there is a lengthy waiting list, if there is availability at all.' – WA consumer

Victorian consumers have also expressed their concerns about the significant shortage of mental health professionals, even when it comes to counsellors in schools – where there is money for staff. A lack of mental health professionals means services are stretched. There is a perception among consumers that this leads to lower rates of compliance with completing training modules around the Act and with supporting processes such as the Your Experience of Service (YES) survey.

"It is very hard in the regions to have your gender and the trans experience respected. Psychiatrists have views and beliefs they can put forward, and these are often considered ahead of the patient. They can access telehealth with more gender-affirming services in Melbourne, but nothing locally (Latrobe Valley)." – Victorian consumer

[3] National Rural Health Alliance. (2017) 'Poverty in Rural & Remote Australia.' https://www.ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-povertynov2017.pdf

From the perspective of consumers with a physical disability there is an additional layer of inaccessibility in rural areas. One Victorian consumer mentioned having to have their regular psychiatrist appointment in a local café with no privacy, because the psychiatrist's office was not wheelchair accessible.

"There are minimum requirements made for accessibility but none of these can be enforced– if they can't be enforced then what is the point? Public transport does also not allow access to all the places you need to go – where we live means that there are costs in our location. People are even turned away at public hospital." – Victorian consumer

Lack of resourcing is a central issue that engenders some of the difficulties of delivering supports in regional and remote areas. While the recent recommissioning of NGO provided Mental Health Supports in South Australia allocated more services to Regional Local Health Networks, the overall funding envelope was capped at 2022 levels. No substantial provisions were made to address the higher costs of providing face to face supports across large geographical areas.

Lack of social support in regional/remote areas, and community stigma or lack of education surrounding mental health and accessing support.

A consistent theme that emerges from consultation with people living regionally and remotely is a concern about the stigma they face when attempting to engage with support services. In small communities, there is little opportunity to maintain privacy about mental health treatment, in particular if a person requires help with transport to access care.[4] This issue was adroitly summarised by a surveyed CoMHWA member living in regional WA:

[4] National Rural Health Alliance. (2021) 'Mental Health in Rural and Remote Australia' https://www.ruralhealth.org.au/sites/default/files/publications/nrha-mental-health-factsheet-july2021.pdf p. 4
Singh-Peterson, Shoebridge, Amanda. Lawrence, Geoffery. (2013) 'Food Pricing, Extreme Weather and the Rural/Urban Divide: A Case Study of Northern NSW, Australia' Journal of Food Security, Vol. 1:2, p. 46

'[There is] No confidentiality. Everyone knows everyone. You have to be willing for everyone to know your story…[Professional] Boundaries are hard, in a small town, everything becomes blended. Work is not just work. It is common to regularly see clients at the shops, events, etc. Privacy doesn't exist.' – WA consumer

Additionally, people from regional and remote communities have emphasised that they would benefit from having increased access to non-clinical social supports within their communities, which would focus on day to day wellbeing, using informal socialisation to help address the impact that isolation has on mental health and assist in the process of recovery.[5] Given the various kinds of stigma and understanding of what mental health distress is in different communities, responses to addressing stigma should be employed by state and territory governments to ensure that there is a flexible content for delivery depending upon local circumstances.

Consumers have indicated a lack of support beyond 'monitoring and surveillance', as one South Australian consumer puts it:

"When I was accessing mental health services forcefully in rural location as a result of ITO [involuntary treatment order] and then CTO [community treatment order] - the lack of continuity of care and adequate support beyond monitoring and surveillance was appalling. My family were unsupported and not referred to additional supports that would have made them better equipped and less harmful towards me whilst they had legal guardianship over me as an adult. I was left to recovery mostly on my own beyond mandated telehealth with a psychiatrist and occasional visits from a travelling social worker who was not recovery oriented and caused more harm to me in how they treated me than any benefit. When I was discharged from the CTO, I was not referred to any further services or supports and eventually had to return to living in the city away from family to try find support to access and recover on my own." – South Australian consumer

[5] Centre for Social Impact. (2023) 'Going the Distance: Making mental health support work better for regional communities' https://assets.csi.edu.au/assets/Regional-Report_online-version-June-2023.pdf pp. 69-70

The above story conveys a dearth in recovery-oriented supports, but also a lack of nuanced understanding as to how supports could or should be connected – for example, supports their family needed in order to ensure the safety of the consumer in a guardianship situation, or service navigation upon discharge from community treatment orders.

Place-based supports, particularly in remote and very remote communities, could help to address irregular contact with clinical spaces and the challenge of travelling long-distance to receive support.

People in regional and remote communities have expressed frustration with having to intermittently travel to access mental health support in both informal and clinical settings, rather than having place-based options within their local communities to help them. The issue is both one of access to transport, and the cost of travel related expenses including fuel, and the time lost from work/day to day life.[6] One surveyed WA consumer expressed their dissatisfaction as follows:

> ***'There are some really good services, but it also is difficult especially for people without a [drivers] license to access or attend these services. This results in services not getting the numbers they need to continue.'*** – WA consumer

While larger towns in regional areas have a better chance of having designated community centres that provide support services, this approach needs to be expanded to more remote locations to ensure that as many people as possible have access to support that does not require arduous travel. Additionally, as noted in the quote above, this would help to address the vicious cycle of good services lasted briefly due to difficulties in commuting to the service location.

Although place-based services are preferable, ensuring equitable access to transport would ameliorate the lack of local supports in the short term. Possible considerations for improving

[6] Royal Australian College of General Practitioners. (2022) ' Mental health care and the tyranny of distance' https://www1.racgp.org.au/newsgp/professional/mental-health-care-and-the-tyranny-of-distance

transport to mental health services, especially in a clinical setting, could include:

- A dedicated mental health retrieval service where the aircraft is tailored to the needs of mental health patient transport and potentially allows less invasive measures for safe flight. This could potentially be national/cooperative or a trial to be assessed to begin with.
- Reciprocity in state mental health legislation to facilitate transfers across state lines to the most appropriate/available hospital and to allow flexibility in community treatment orders to adapt to a person's wishes to move interstate as their circumstances may require from time to time.

It is important to ensure that, where possible, local leaders and community members are deeply enmeshed with support services and help develop programs to train local peer workers to provide additional support.

The engagement of local leaders and people with support services is a crucial step towards addressing the disconnection between current clinical services and the people that need their support.[7] By ensuring a community-driven approach to delivering support services and building rapport within remote and regional communities, it may be possible to reduce broad stigmas and effectively adapt services to the needs of these communities. The inclusion of local leadership should be extended to the development and planning for new support services, allowing for local customisation to meet the concrete needs of regional/remote communities.

Leadership and connection require relationship building in regional areas. Certain people and places hold importance for communities, and potential partners must understand this. First Nations people have a leadership hierarchy and have appointed people who act as delegates to communicate and negotiate on behalf of the First Nation community of the area. Other local leaders are often not found in traditional roles, and include: The local pub, sporting group, business owners, landowners, multigeneration family groups – they are well respected and have long standing connections with

[7] Centre for Social Impact. (2023) 'Going the Distance: Making mental health support work better for regional communities' https://assets.csi.edu.au/assets/Regional-Report_online-version-June-2023.pdf pp. 10, 60.

the community. Reputation and trust are extremely powerful in regional areas, and the local leaders act as the safeguards to a kind of quality checking. Without trust and a good reputation within the community that is affirmed with the support of local leaders, the community is very unlikely to be on board.

Moreover, training peer workers from local populations will allow for general supports such as community day-centres to operate and perform outreach far more successfully. The importance of developing a peer workforce to address the challenges of regional and remote mental health care has been recognised in the recent *Review of Rural Mental Health Services in South Australia*, which recommends that South Australia hasten the implementation of a trained peer workforce as soon as possible to help engage with consumers and ensure rigorous evaluations of regional providers are conducted.[8] Importantly, while peer workers can add significant value to these services, successful peer work programs require state or territory support for the peer worker including access to peer supervision, appropriate remuneration that accounts for any additional costs of living associated with living in regional and remote areas, connection with other peer workers and opportunities for professional development in their field.[9]

By ensuring that community leaders are involved with promoting the training of peer workers and offer support for training and suitable peer guidance, situations such as the following story from a WA consumer could be made better or avoided altogether:

'[There is a] Lack of guidance. No one understands the peer role, so you can't get any proper guidance. I have been a peer worker for 3+ years now, and it has only been in the last six months that I have been allowed to access peer specific supervision. In fact, any supervision at all.' – WA consumer

[8] Coleman, M. Roberts, R. English, L. (2023) *Review of Rural Mental Health Services in South Australia*. pp. 64-65 https://s3-ap-southeast-2.amazonaws.com/sahealth-ocp-assets/general-downloads/SA-Review-of-Rural-Mental-Health-Services-Report-Final-May.pdf

[9] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., et al. (2021) *National Lived Experience Workforce Guidelines*. National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/a33cce2a-e7fa-4f90-964d-85dbf1514b6b/NMHC_Lived-Experience-Workforce-Development-Guidelines

The employment of peer workers should, wherever possible, be developed through already established and successful mental health services in the community—not only does this provide a less arduous path to find local staff but would also allow peer-led community supports to harness the already established relationships that extant services share with their community.

One South Australian peer worker notes that peer work has the capacity to be a central solution in bridging the service gap:

"What stood out to me the most from what I heard from them [people with a lived experience of mental health in rural areas], and my own rural experiences, is that access to a peer worker locally and face to face whilst they were on extensive wait lists or accessing the only available services (most often clinically focused) would have made a world of difference to their experience of so called rural 'care'". – South Australian consumer

In the South Australian context, a major issue impacting consumers in regional and remote areas are lack of access to supports from a lived experience workforce. The SA Office of the Chief Psychiatrist (OCP) review of Regional Mental Health Services recommends this be addressed as part of any changes. Related to this is a lack of lived experience voices at governance level, service evaluation and design. This recommendation was accepted by the OCP, however it has addressed this by making the inclusion of Lived Experience a requirement of new programs without outlining a clear strategy of how the OCP will support the development of this workforce or the capacity of the lived experience community to contribute at all levels of the system.

Planning and funding arrangements for regional mental health services should account for the impact that population fluctuations from tourism and transitory population groups will have on the accessibility of services in the region.

Many regional towns experience profound seasonal shifts in population, typically driven by tourism at certain times of the year. This population expansion places additional stress on local resources, including Health and Mental Health services. For example, the WA town of Esperance normally has

~13,500 residents, however for months of the year the town hosts over 28,000 people,[10] more than doubling the potential demand on mental health services. Exmouth, another regional WA town, sees its population shift from 3 000 to 18 000 due to tourism, with recent reports indicating that this surge in people has resulted in extensive barriers to accessing both Health and Mental Health Services.[11]

The availability and accessibility of Mental Health services in regional and remote population centres can also be vitally important for Aboriginal and Torres Strait Islander peoples who regularly travel between different familiar locations without rigid schedules. Accounting for the transitory population of Aboriginal and Torres Strait Islander peoples is difficult, largely due to the lack of adequate data collected to this date on the practice.[12]

Accordingly, a key step towards ensuring that regional and remote locations have an appropriate range of available and accessible Mental Health support services will involve expanding data collection efforts for this transitory population to determine what services are needed. Additionally, mental health services should be prepared for the additional demand that may occur from transitory population groups and should be funded to proactively engage with visiting groups and individuals.

IMPROVING ACCESS FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE LIVING REGIONALLY/REMOTELY

There is a lack of focused data about Aboriginal and Torres Strait Islander needs and circumstances from isolated regional and remote communities.

There is a clear need for dedicated studies to be conducted to determine the needs and circumstances facing Aboriginal and Torres Strait Islanders in regional and remote communities: studies such as the Evaluation of the Better Access Initiative, and the forthcoming Going the Distance

[10] https://www.afr.com/companies/esperance-on-a-wave-20031218-ka8cm
[11] https://www.abc.net.au/news/2024-03-29/thousands-of-tourists-strain-health-service-resort-town-crisis/103640878
[12] Dockery AM and Colquhoun S. (2012) Mobility of Aboriginal and Torres Strait Islander people: A literature review. CRC-REP Working Paper CW004. Ninti One Limited, Alice Springs.

report both acknowledge having gaps in their data with regard to First Nations communities.[13] Additionally, most reports are presently using the Kessler 10 (K10) scale to determine the level of distress for those surveyed, which may not facilitate the most culturally appropriate framework through which to measure mental health for Aboriginal and Torres Strait Islander communities.[14] Going forward, it is imperative that funding is made available to design culturally appropriate studies that focus on the wellbeing of regional and remote First Nations people.

The support services for remote and regional First Nations people should be tailored to the needs of their communities and be culturally appropriate for the specific community being served.

The aforementioned issues of availability and variety of support services are compounded for Aboriginal and Torres Strait Islander communities, who would benefit most from services that are culturally sensitive, representative, and tailored to address the specific needs of these communities. For example, support services for First Nations communities should accommodate for language differences and have a clear awareness of the cultural circumstances and history of the particular group they are engaged with and their unique connection to country.[15] The challenge in providing suitable access to regional and remote First Nations communities is compounded by the issue of insufficient data outlined above—simply put, in order to provide evidence-based services, there must be a suitable quantity and quality of data harvested. Data aside, it is not a controversial or unsubstantiated argument that First Nations Communities know what is needed and should be resourced to co-produce appropriate services.

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[13] Pirkis, J. Currier, D. Harris, M. Mihalopoulos, C. et al. (2022) 'Evaluation of Better Access: Main Report' https://www.health.gov.au/resources/publications/main-report-evaluation-of-the-better-access-initiative?language=en p. 159, Centre for Social Impact. (2023) 'Going the Distance: Making mental health support work better for regional communities' https://assets.csi.edu.au/assets/Regional-Report_online-version-June-2023.pdf p. 14

[14] Australian Institute for Health and Welfare. (2009) 'Measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples' https://www.aihw.gov.au/getmedia/5b75be10-49ee-4d9c-baf0-5092936c585e/msewatsip.pdf.aspx?inline=true , for an example of culturally informed metrics see: Brinckley, M. et al. (2021) 'Reliability, validity, and clinical utility of a culturally modified Kessler scale (MK-K5) in the Aboriginal and Torres Strait Islander population' https://doi.org/10.1186/s12889-021-11138-4

[15] Commonwealth of Australia. (2017) 'National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing' pp. 6, 12-14

UNDERSTANDING CLIMATE CHANGE AS A CO-DETERMINANT OF MENTAL HEALTH

Another critical feature of rural mental health to consider—In relation to developing future access—Is the profound impact that the effects of climate change are having on the mental health of people in regional and remote communities. A range of studies released since 2022 have expounded on the negative mental impact of climate change for people in regional areas, especially the impact of droughts and bushfires on agricultural communities.

An example of the recent studies into the effects of climate change on regional consumers is the 'Concerns about climate change among rural residents in Australia' article in the *Journal of Rural Studies*.[16] In this qualitative study, people living in regional and remote NSW were questioned about their view of climate change, leading to four key themes of concern emerging—the suffering that climate change may bring, the causes of climate change, extreme events that may occur because of climate change, and finally the quality of leadership and actions taken to address climate change.[17] These concerns mirror concerns laid out in older studies, that consider how the effects of climate change entail high degrees of mental stress and subsequent mental distress.[18] The impact of extreme weather that is promulgated by climate change is a key driver of profound mental health distress, and has been linked to an increased rate of suicide in regional and remote centres.[19]

This year, the Climate Council released a report into the effects of climate disasters on Australians, which paid particular attention to how these effects are felt more acutely by people living in

[16] Austin, Emma K., Rich, Jane L., et al. (2020) 'Concerns about climate change among rural residents in Australia' *Journal of Rural Studies*. Vol. 75 https://www.sciencedirect.com/science/article/pii/S0743016717307805
[17] *Ibid*.
[18] Padhy SK, Sarkar S, Panigrahi M, Paul S. (2015) 'Mental health effects of climate change' Indian Journal of Occupational and Environmental Medicine. 19(1):3-7 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4446935/
[19] Hanigan, Ivan Charles. Vyas, Aditya. Butler, Colin D. Kuruppu, Natasha. (2022) ' Drought increases rural suicide, and climate change will make drought worse' The Conversation. https://theconversation.com/drought-increases-rural-suicide-and-climate-change-will-make-drought-worse-185392

regional and remote locations.[20] The report showed that, by and large, people living in regional and remote communities were far more likely to have had an experience of living through an emergency connected to climate change, such as floods or bushfires.[21] Elsewhere in the report, the impact of experiencing such a disaster was outlined, showing that 21% of affected people felt that the experience had impacted their mental health in a moderate or severe fashion.[22] Accordingly, it is highly likely that people living in regional and remote locations, as the people most at risk of experiencing future climate disasters, will experience significant negative impacts on their mental health at a higher rate than those people living in cities and metropolitan suburbs.

One recent study considered the steps regional and remote communities can take to build up resilience against the deleterious psychosocial impact of climate change, identifying community-based collective actions as the approach that most regional and remote people felt supported with their psychosocial wellbeing.[23] The positive news, then, is that the most effective path towards mitigating the negative psychosocial impact of climate change is also deeply congruent with other solutions to offer better access to people living in regional and remote communities.

PROBLEMS WITH CURRENT STRATEGIES TO PROVIDE ACCESS TO REGIONAL/REMOTE COMMUNITIES

While helpful for some consumers, there is a need to recognise the limitations of telehealth as a sole solution to remote and regional access.

The increase in telehealth options has provided more opportunity for contact with support services for those living in regional and remote communities, however the medium of online consultation

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[20] Climate Council (2023) *Climate Trauma: The growing toll of climate change on the mental health of Australians*. Climate Council of Australia Limited. https://www.climatecouncil.org.au/wp-content/uploads/2023/02/Report-Climate-Change-and-Mental-Health.pdf
[21] *Ibid*.
[22] *Ibid*.
[23] Longman, Jo. Braddon, Maddy et al. (2023) 'Building resilience to the mental health impacts of climate change in rural Australia' *The Journal of Climate Change and Health* Vol. 12. https://www.sciencedirect.com/science/article/pii/S2667278223000408

has fundamental issues that can render it suboptimal in relation to reaching the members of isolated communities. One key issue is whether remote and rural communities will have the appropriate communications infrastructure to access telehealth services. A 2023 report from the ABC News has highlighted this very issue, noting that some regional residents have lost telecommunications to their area for months at a time.[24] For example, due to distance and travel times, people living remotely or in regional areas will often have less contact with health service providers, leading to a desire for more thorough, face to face contact to discuss health concerns.[25]

In addition to infrastructural problems, people living in regional, remote or rural areas may lack appropriate computer hardware, or may struggle to learn how to use the software involved in participating in telehealth. Issues relating to telehealth and online access to information are especially noteworthy given that those people who have the greatest need for services are also often the least well-resourced in various ways, including in relation to the digital divide. The latest Australian Digital Inclusion Index[26] reports that areas outside capital cities recorded a 2023 Index score of 69.8, 3.4 points less than the national average, and 5.0 points less than capital cities. Central to this score is the Digital Ability gap, which has increased from 2022 from 7.0 to 7.7 points, meaning that people living in regional, rural and remote areas are less likely to have the necessary ability to make use of technology such as telehealth.

Similarly, a vast majority of consumers experiencing psychosocial distress prefer a face-to-face meeting to discuss their concerns, especially if they have not used this service previously. Respondents to the 2020 findings in 'Increasing & Improving Community Mental Health Supports in WA' claimed that telehealth options were letting community-based support options get

[24] Connor, Coquohalla. (2023) 'Warning of remote communities being left behind as telecommunications services go online' ABC News. https://www.abc.net.au/news/2023-09-11/telecommunications-roadshow-warn-communities-being-left-behind/102839714
[25] Centre for Social Impact. (2023) 'Going the Distance: Making mental health support work better for regional communities' https://assets.csi.edu.au/assets/Regional-Report_online-version-June-2023.pdf pp. 42, 64-65
[26] https://www.digitalinclusionindex.org.au/key-findings-and-next-steps/

overlooked.[27] Another study investigating the perspectives of clinical staff delivering telehealth revealed that, while useful as a supplementary service, telehealth consultations are ill suited to serve as the primary method of service delivery.[28] This view is mirrored beyond the sphere of consumers, with mental health researchers, academics, service providers, managers and commissioners coming together in 2019 to produce the Orange Declaration—An identification of ten key problems facing people in regional and remote locations with a call to act to address these issues. Telehealth features prominently as one of the ten issues, with the problem phrased as 'Telehealth alone is not the answer.'[29]

Additionally, some consumers will find the task of soliciting telehealth consultations confronting, a sentiment that was captured in a survey response from a CoMHWA member:

'…telehealth/online services are available - but so many people don't know how to access those or where to start. Engaging with a service like that requires an individual to be proactive in their care, and the majority of people are not.' – Regional consumer

However, it is important to recognize that, for a significant number of consumers, telehealth has provided significant access to support that was previously unavailable:

'Before 2016, I found considerable difficulties accessing services appropriate to my needs. I've lived remote east Pilbara, remote Midwest, Capel, Donnybrook and now Bencubbin. I've been able to continue my clin. psych appointments, by phone or Zoom.' – WA consumer

Accordingly, while telehealth is a valuable addition to efforts to provide access to regional and

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[27] Kaleveld, L. Bock, C. Seivwright, A. (2022) 'Increasing & Improving Community Mental Health Supports in WA' https://assets.csi.edu.au/assets/research/Final-report-Increasing-and-Improving-Community-Mental-Health-Supports-in-Western-Australia.pdf p. 49

[28] Mathew, Supriya. Fitts, Michelle S. Et al. (2023) 'Telehealth in remote Australia: a supplementary tool or an alternative model of care replacing face-to-face consultations?' BMC Health Serv Res. 23: 341. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10074370/

[29] Perkins, David. Farmer, Jane. Et al. (2019) *The Orange Declaration on rural and remote mental health.* Aust. J. Rural Health. 27: 374–379. https://onlinelibrary.wiley.com/doi/10.1111/ajr.12560

remote consumers, it cannot be relied upon as a silver bullet and should not result in less funding for place-based community supports.

Non-clinical, trauma-informed and holistic approaches to community support would provide important benefits for remote and regional consumers.

While access to clinical supports for consumers in regional and remote areas is notably more difficult, there is also a desire in these communities for psychosocial supports to include non-clinical services and groups, particularly community-based support groups.[30] The WA-based 'Going the Distance' report offers a supporting argument for expanding regional and remote supports beyond a clinical focus, providing data that reveals getting medication was the intervention those surveyed thought would be *least* helpful to help improve their mental health.[31] The frustration with an over-emphasis on clinical treatment and pharmacological intervention is captured in the following comment from a CoMHWA member:

'[Mental Health] needs do not fit into one box. Not all of us are in crisis, or psychotic or out of work. Many of us manage to work even if we change jobs regularly.' – Regional consumer

The establishment of non-specialised community support centres in towns could provide services beyond the clinical framework of traditional medical support, potentially offering peer support services and other holistic approaches ideally provided by members of the community.

Acknowledge and take steps to address the impact of declining bulk-billing options and increased co-pays for clinical services.

A crucial issue for regional and remote access is managing the spiralling costs of seeking out mental

[30] Centre for Social Impact. (2023) 'Going the Distance: Making mental health support work better for regional communities' https://assets.csi.edu.au/assets/Regional-Report_online-version-June-2023.pdf p. 10

[31] *Ibid*. p. 68

health support. The Better Access Review highlighted a concerning and continuing trend where support services are ending their practice of bulk-billing while simultaneously increasing co-payment costs.[32] People living in remote and regional communities face higher costs and financial pressures than people living in large cities,[33] and thus the cost increases to mental health support can make an inordinate impact on remote and regional communities. The impact of the lack of affordability in regional and remote communities is adroitly captured in the following response to CoMHWA's consultation with members:

'There are no doctors in Albany that bulk bill. That is a barrier. I pay top level private health insurance to assist me with covering all of these costs above. It is ridiculous - so much of my pay goes to 'keeping well'.' – WA consumer

Even when consumers can access services, the costs are onerous and cause a great deal of stress. To help consumers in regional and remote settings, more needs to be done to ensure or, at the very least, strongly encourage through policy, bulk billing and less burdensome co-payments by service providers for regional and remote consumers.

PATHS TOWARDS BETTER REGIONAL/REMOTE ACCESS

Consumers in remote communities would benefit from the presence of adequately supported peer-led services, especially those that operate in local spaces.

In order to address the lack of community supports, especially access to local place-based groups and in-person support, there should be a commitment to develop community centres that are led by, or at the least incorporate, peer workers. Access to peer-run support services was seen as an

[32] Pirkis, J. Currier, D. Harris, M. Mihalopoulos, C. et al. (2022) 'Evaluation of Better Access: Main Report' https://www.health.gov.au/resources/publications/main-report-evaluation-of-the-better-access-initiative?language=en p. 46

[33] National Rural Health Alliance Inc. (2017) 'Poverty in Rural and Remote Australia: Fact Sheet' https://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-povertynov2017.pdf

important option for several respondents in the 'Going the Distance' report.[34] Including local people with lived experience at the most accessible first port of call could help smooth the path to accessing further services as required, alongside helping to alleviate the isolation and stigma consumers face in engaging with support services in regional and remote communities. In order to encourage people with a lived experience of mental health distress to take up these vitally important and effective positions, it will be important to ensure that supports are made available for peer workers to help them navigate the stress of this position, and the potential effects of local stigma about the role. The difficulties that can emerge in regional peer work have been captured in the response from the following CoMHWA member:

'Workplaces aren't exposed to previous peer workers - so you have to do a lot of hard, groundwork - educating teams and workplaces. Facing stigma, bullying, and all that comes with it. - You are isolated. You are a colleague, but you don't quite become the friend. At times it feels labels are placed on us as peers, it's not quite 'safe' enough to become friends with us.' – WA consumer

Community centres would benefit from additional support that focus on the challenges of remote and regional communities such as privacy, travelling demands, and co-ordination with other services.

The development of services utilising peer workers in remote and regional communities will face challenges that are exacerbated by the remoteness of these settings. For example, one key issue outlined above is the lack of privacy (especially for remote communities), where the community is so small that everyone becomes aware quickly of who is reaching out for support. This issue can be compounded by an enduring attitude of 'Rural Stoicism' held by some in these communities: the view that people living in the country should be self-sufficient and do not require support for mental health issues.[35] In order to help overcome this attitude, remote and regional communities would

[34] Centre for Social Impact. (2023) 'Going the Distance: Making mental health support work better for regional communities' https://assets.csi.edu.au/assets/Regional-Report_online-version-June-2023.pdf p. 41
[35] National Rural Health Alliance. (2021) 'Mental Health in Rural and Remote Australia' https://www.ruralhealth.org.au/sites/default/files/publications/nrha-mental-health-factsheet-july2021.pdf

benefit from support services that have specialised peer training or run community events, to allow for the demystification and open discussion of the services they provide, and to promote community contact without the stigma of needing support.

Another challenge for remote and regional peer work would be ensuring that there are travel options made available to help facilitate the attendance of those who need support services.

'…there are some really good services/programs out there…But often those who really need it are unable to attend, due to poor public transport often they cannot get there.' – Regional consumer

Additionally, there are extra barriers to transport for young people face who cannot drive and may not be able to ask their parents, guardians, or carers for lifts.

Finally, support should be provided to help link and co-ordinate remote and regional peer supports with other services, allowing for the sharing of strategies and more effective paths to refer struggling community members.

It is important to acknowledge the profound differences between regional towns and remote communities and ensure that strategies for regional hubs are not unduly prioritised over the challenges in establishing remote services.

A key focus of further planning to improve access to mental health services should be to acknowledge the radical difference between the needs of regional and remote communities. A remote town with a population of 50 people has vastly different needs to a regional town of 30 000 people, so the strategies to provide better access must keep these differences in view during planning. Extending this point further, the challenges facing remote communities are different both between, and within, Australia's States and Territories—a remote community in Victoria can face extremely distinct levels of isolation from, for example, a remote community in Western Australia's

inland Pilbara. Reports such as 'Going the Distance' from the Centre for Social Impact reveal a consumer view that larger regional towns have tended to receive most of the new services and funding to improve access, relying on consumers to travel to these larger towns or providing mobile services to more remote communities with varying amount of frequency.[36]

'I am actually lucky, I live in Albany which is a [Regional] City, and is relatively well serviced. Outside of Albany, there is nothing. Eg, patients in Cranbrook, Mt Barker, Narrogin. Anywhere like this only has outreach community mental health workers, and to access care patients are required to travel significant distances. Most just fall under the radar' – WA consumer

While this concentration of resources has a pragmatic utilitarian logic of the greatest good for the greatest number, it is crucial that place-based services for remote communities should not be overlooked in favour of regional concentrations. Or, as a CoMHWA member concisely noted:

'Take the services out of the bigger towns and spread it out more. Make sure to ask us [consumers] about what services to put where, don't ask organisations.' – Regional consumer

OTHER CONSIDERATIONS: MENTAL HEALTH ACTS

While this paper broadly addresses the barriers and enablers to accessing mental health supports in the community and tends to focus on how individuals and their families can voluntarily seek support, mental health legislation for involuntary treatment has a significant role to play in shaping the landscape of mental health care in regional, rural and remote Australia. Mental Health Acts are governed by each State, but there are broad systemic issues across several State Acts that pose challenges for regional areas which can lead to increased coercive practice, restraint

[36] Centre for Social Impact. (2023) 'Going the Distance: Making mental health support work better for regional communities' https://assets.csi.edu.au/assets/Regional-Report_online-version-June-2023.pdf

(including chemical, emotional/psychological, and environmental) and decreased levels of care, which can in turn lead to iatrogenic harm, disengagement from supports and an unwillingness to seek help in the future.

Common issues include:

a) People under the MH Act must be transported to the nearest authorised facility for specialist care, often requiring 24/7, 1:1 nursing and police attendance until they are picked up for transportation, for which regional and rural areas are often not equipped or resourced. This can result in:

   i) Reluctance to certify a patient, when their condition genuinely warrants specialist care;

   ii) Undue burden on “staff on the ground” in small local hospitals and increased use of police staff;

   iii) Structural difficulties contributing to horizontal violence between staff and agencies;

b) Prolonged periods of chemical sedation and restraint, leading to increased physical risk to patients (airway compromise; aspiration of gastric contents; deep vein thrombosis).

c) Increased chance of other medical interventions such as the use of urinary catheters (particularly traumatic for childhood sexual abuse survivors) and compromised therapeutic relationships, personal dignity and self-determination.

d) Evacuation / retrieval issues include:

   i) Mental health retrievals compete with medical retrievals, which often leads to underestimating the urgency of transport for a mental health patient. Escalating risk to the patient of delaying specialist support (to patient and care staff) may be ignored.

ii) Currently, many mental health retrievals require a patient to be intubated and ventilated (essentially life support or a general anaesthetic) to ensure that everyone on the flight is safe because the patient is immobilised, and the patient is safe because their airway is secure and will not be at risk of obstruction or regurgitation/aspiration.

e) Regional members of Queensland's MHLEPQ (Mental Health Lived Experience Peak Queensland) described the poor functioning of the Mental Health Review Tribunal and

f) the difference between its purpose and the lived experience of it for consumers, including:

i) Clinical, professional and the decision-making authority holds disproportionate weight and influence on a person's experiences resulting in a process that is disempowering, unsuccessful and harmful to those it is designed to protect.

ii) Personal information and records are withheld, inaccessible, or inaccurate despite the seriousness of the outcome.

While Federal Governments cannot alter State Mental Health Acts, it is important to consider how the Acts compound lack of access to good quality, safe and recovery-oriented care in regional areas, and how better low-barrier access to safer, non-clinical, peer-led supports can reduce the need for involuntary intervention.

CASE STUDIES

Lamp

Lamp is a community-led mental health organisation based in Busselton (which supports people living with mental health challenges and their families and carers. Lamp provides recovery-based, psychosocial and living skills programs, centre-based supports such as day programs; supports for carer and family groups (face-to-face and online); cooked meals and in-home supports; Aboriginal and Culturally and Linguistically Diverse (CALD) youth and family supports; youth centre-based social and counselling programs; community education and training programs; family counselling and homelessness housing support for people with mental health issues; in-school programs; and NDIS plan coordination. Lamp delivers mental health services and supports in Margaret River, Cowaramup, Augusta, Harvey, Capel and Manjimup, and provides outreach support across the Warren Blackwood and surrounding South West region. It is funded by State and Commonwealth Governments and philanthropic providers and is an accredited service provider for Disability Service Commission and the NDIS.

Mindful Margaret River

Mindful Margaret River was developed as a communitywide response to mental ill-health, psychological distress, and community trauma. Activities they have initiated include mental health awareness programs, a Health Hub for professionals, and an ongoing community mental health collaboration of health practitioners, sporting and community groups. Mindful Margaret River emphasises the importance of supporting mental health by promoting connection, wellbeing and resilience. This approach was informed by a community consultation as well as research by the Centre for Rural and Remote Mental Health at the University of Newcastle. Mindful Margaret River employs several staff members and is funded by the Shire of Augusta Margaret River and Lotterywest. Key partners include local government, government agencies, NGOs, community groups and other local stakeholders such as sporting clubs, arts and cultural groups and environmental initiatives. This is one of the few examples of a local government in WA playing a

significant leadership and funding role in responding to the mental health needs in their community.

Tasmania

Tasmania has one of the most rural and remotely dispersed populations of any state or territory with 10% of the population living outside major population centres of Hobart, Launceston, Burnie and Devonport. Over half of Tasmanian's population lives outside of the capital city and greater Hobart area, where most mental health services are concentrated.

The Tasmanian Mental Health Reform's newest services including the Mental Health Emergency Response service and Hospital in The Home were rolled out in the south, with the North West of the state having to wait two years for the Mental Health Emergency Response service to be trialled in that area.

The Head to Health Centre, co-located with the Acute Care Team in Launceston, is a peer-led model and offers an integrated approach to mental health services for the Launceston Community. Tasmania looks forward to the development of further satellite Head to Health Centres in regional communities over the next two years. These services offer a genuine alternative to travelling long distances to access emergency departments for people in acute emotional distress.

MHWB LOCALS

VMIAC have heard from consumers during consultations that Mental Health and Wellbeing Locals can be positive support experiences and aid cultural change around common responses to mental health and distress. Consumers we spoke with at consultations would like to see Mental Health and Wellbeing Local sites and programs expanded in regional areas as some locals do not currently provide equitable wrap around referral and social prescription offerings across the region.

"It is so much better that staff at Locals ask "how can we help you?"…and they support people not focusing on what someone's diagnosis is" – Victorian consumer

"We need Mental Health and Wellbeing Local services urgently in Wodonga. They have cut them from sixty to fifty. Seymour, Kilmore, Wallan. Mitchell shire also lost Head to Health…the Alpine also struggles." – Victorian consumer

Connect Mt Gambier

The South Australian Office of the Chief Psychiatrist funded a peer-led and delivered pilot in Mount Gambier. The model used was built on a proof of concept delivered by Mind Australia, evaluated by LELAN and funded by the Northern Adelaide Local Health Network in 2022/23. The pilot built on the learnings from the proof of concept to provide a peer-delivered response to people in distress with multiple referral pathways including Emergency Departments, Community Mental Health Teams, GPs and other local service providers. Support is offered face to face for up to 12 weeks with an emphasis on supporting people to make sense of their distress and then connecting them with a range of formal and informal supports.

An initial evaluation showed high levels of satisfaction with the intentional peer supports provided and a decrease in program consumers accessing acute services such as the Emergency Department. Peer workers' use of a relational approach to supports were identified by program consumers as vital in allowing them to discuss their distress without feeling judged our invoking a risk-based response to their distress. The program staff were also instrumental in convening a reflective practice group for peer workers across a range of services in Mount Gambier to provide peer to peer support. Ongoing funding has not been confirmed for the pilot.

Research

Professor Sharon Lawn from Flinders University and her team are running a research project currently in regional South Australia where GPs can refer people seeking a Mental Health Plan to a peer worker for support as part of the plan. The utilisation of a lived experience workforce in this primary health centre is underdeveloped and this research will add to the evidence base on the efficacy of formal lived experience supports.

Thirrili

Thirrili[37] is a Queensland not-for-profit that resources First Nations Persons' communities to determine their own local solutions for social wellbeing. One example is told in the story of a small rural far-north Queensland township whose Elders worked with the Thirrili team to determine their cultural responses to suicide postvention. The importance of mob connections in this small community was a reason why people trusted and welcomed the Thirrili advocate, and this relationship forged a path to stronger community relationships with other services. The foundation of those relationships was built on a mutual connection to local culture and traditions. Thirrili applies grassroots, community capacity-building approach that builds resilience and focuses on reducing suicide through relationship-building and Community Innovation Action Plans; facilitating Family Healing Camps and establishing Lived Experience Groups.

Stanthorpe peer art group

A small peer art group is having success with the community in Stanthorpe and the hospital has started referring people as part of their discharge plan. It is well received for the following reasons:

a. There is no prescribed mental health programming – just space for authentic connection.

b. People come and go as they like and have flexibility.

c. It is not designed to be therapeutic or clinical, so power is balanced.

[37] https://thirrili.com.au/who-we-are/

d. It was established by a local resident from local need. The resident experienced first-hand that the area had no nonmedical or structured programs in the area to engage in after a hospital admission. Relationships and support were identified as critical to preventing crisis, but they felt isolated, with nowhere to connect with others. They established an art group, as art was something that helped articulate their journey and invited others to connect and support each other in the journey together.

"This is an ongoing program, that despite efforts receives no funding from government or non-government organisations - the resources are funded by the participants through donation of goods, or purchasing their own materials, and from the personal funds of the person who established the group" – *Lived experience member of MHLEPQ and former regional / remote GP.*

RECOMMENDATIONS

- *<u>Recommendation 1</u>: Prioritise the development of place-based supports within interested communities by fast tracking funding for locally run centres, rather than focusing on supporting clinical outreach that operates from regional hubs.*

- *<u>Recommendation 2</u>: The Federal and State/Territory governments should develop a range of education programs to combat discrimination, tailored to the differences of the communities they are delivered to. National and state peak bodies for mental health and consumers should be funded to help provide this community education and develop innovative methods of engaging the public.*

- *<u>Recommendation 3:</u> Develop the capacity to train community members as peer workers, with the help of community leaders to help facilitate better care from local community centres.*

- *<u>Recommendation 4</u>: Resource First Nations communities to identify issues and design their own solutions and responses.*

- *<u>Recommendation 5:</u> Provide additional place-based support services for remote and regional Aboriginal and Torres Strait Islander communities, that are culturally appropriate for, and tailored to, the needs of their particular communities.*

- *<u>Recommendation 6</u>: Provide financial assistance for consumers who are unable to manage the lack of bulk-billing and surging rates of co-payments to service providers.*

- *<u>Recommendation 7</u>: Ensure that telehealth is included in, but not central to, strategies to provide better regional and remote access.*

- *<u>Recommendation 8</u>: Provide peer-led support for community centres that help manage the challenges of remote and regional communities such as privacy, travelling demands, and co-ordination with other services.*

- *<u>Recommendation 9</u>: Develop incentives to promote non-clinical, trauma-informed and holistic approaches to community support in remote and regional communities.*