



Submission:

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

The Centre for Excellence in Child and Family Welfare (the Centre) is the peak body for child and family services in Victoria. For over 100 years we have advocated for the rights of children and young people to be heard, to be safe, to access education and to remain connected to family, community and culture. We represent over 150 community service organisations, students and individuals throughout Victoria working across the continuum of child and family services, from prevention and early intervention to the provision of out-of-home care.

Many of our member organisations work with children and families who present with multiple, co-occurring complex needs, including mental ill-health. The Centre welcomes this opportunity to provide a submission on this important topic and is particularly interested in how outcomes for children and young people can be improved. In our submission we have focused on the nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate; the higher rate of suicide in rural and remote Australia and suggestions for improving mental health.

The prevalence of mental ill-health

In 2014-15, around 17.5% of Australians suffered from a mental illness.¹ People living alone, lone parents, the unemployed, those in the first quintile of Relative Socio-Economic Disadvantage and those with a co-occurring physical disability, all report higher rates of mental illness than other cohorts.² Aboriginal and Torres Strait Islander and Torres Strait Islander people also report much higher than average rates of mental illness (29.3%)³, as do LGBTI Australians.⁴ The national Child and Adolescent Survey of Mental Health and Wellbeing revealed worrying trends of depression, self-harm and suicidal thoughts among Australia's teenagers, with 10% having self-harmed at some point in their life.⁵

Nature and underlying causes of mental ill-health in rural and remote Australia

Rural and remote Australians fare worse in relation to a range of risk factors for mental ill-health – physical disability,⁶ chronic disease,⁷ unemployment and socio-economic deprivation.⁸ Rural and

¹ ABS (2016) [National Health Survey: Mental Health and co-existing physical health conditions, Australia, 2014 - 15](#), Accessed 18/04/18.

² ABS(2015) [National Health Survey, First Results 2014-15](#), Table 4: Long-term health conditions by population characteristics. Accessed: 18/04/18.

³ ABS (2016) [National Aboriginal and Torres Strait Islander and Torres Strait Islander Social Survey, 2014-15](#), Accessed: 18/04/18.

⁴ Rosenstreich, G. (2013) [LGBTI People: Mental Health & Suicide, 2nd ed.](#), National LGBTI Health Alliance, p. 3.

⁵ Lawrence, D., Johnson, S., Hafekost, J., Boterhoven de Haan, K., Sawyer, M., Ainley, J. & Zubrick, S. (2015) [The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing](#), pp. iii-iv.

⁶ ABS (2016) [Disability, Ageing and Carers, Australia: First Results, 2015](#). First Results Tables. Accessed: 19/04/18.



remote Australians are also more likely to smoke, be overweight or obese, partake in little exercise and exceed the lifetime risk guideline amounts for alcohol consumption.⁹

Rates of substance abuse of the highly addictive meth-amphetamine (Ice), which has been strongly associated with chronic mental and physical problems, are more than twice the national average in remote communities than in cities or regional areas.¹⁰ Studies show that around a third of Ice users experience psychosis at some point during a 'high', and 30% of those who experience this kind of psychosis while taking the drug go on to develop a long-term psychotic illness.¹¹

These risk factors for mental illness that coalesce with rurality are more acutely felt among Aboriginal and Torres Strait Islander communities, not least because the majority of Aboriginal and Torres Strait Islander Australians live outside of major cities.¹² The inter-generational trauma experienced by Aboriginal and Torres Strait Islander communities following years of genocide, the Stolen Generations, displacement, disadvantage and discrimination is reflected in significantly higher rates of unemployment, socio-economic disadvantage, physical ill-health,¹³ Child Protection involvement and removal,¹⁴ substance abuse¹⁵ and, crucially, mental illness. Almost a third of Aboriginal and Torres Strait Islander Australians self-report as having high rates of psychological distress.¹⁶

Children and adolescents living in low-income families, with low parental educational attainment or unemployment, record higher rates of mental disorders and these higher rates also correlate strongly with increasing remoteness.¹⁷ In Victoria, outer regional areas have the highest rates of substantiated Child Protection reports.¹⁸ Many of the Centre's child and family services member agencies operating in Victoria's outer regional areas report that their referrals from Child Protection are presenting with increasingly complex issues of mental health, substance abuse and family violence year after year.

Given its strong correlations with poor physical health, substance abuse, deprivation, unemployment and Child Protection issues, it is probable that mental distress rates are higher than we are currently aware for rural and remote Australians. For some, fear of stigmatisation and a reluctance to seek help, particularly by rural men, may be masking the true extent of their mental distress, because mental health services are accessed at much lower rates by rural and remote Australians than by

⁷ Bishop, L., Ransom, A. & Laverty, M. (2017) [Health Care Access, Mental Health and Preventative Health: Health priority survey findings for people in the bush](#), RFDS, p. 13.

⁸ Ibid, p. 17.

⁹ ABS (2015) [National Health Survey, First Results 2014-15](#), Table 6: Health risk factors by population characteristics. Accessed: 18/04/18.

¹⁰ National Rural Health Alliance (2015) [Illicit Drug Use in Rural Australia](#), p. 2.

¹¹ Arunogiri, S. (2018) [Ice psychosis: what is it, and why do only some users get it?](#) Accessed: 20/04/18.

¹² ABS (2013) [Estimates of Aboriginal and Torres Strait Islander and Torres Strait Islander Australians, June 2011](#), Estimated resident Aboriginal and Torres Strait Islander and Torres Strait Islander and Non-Indigenous population, Remoteness Areas, single year of age, 30 June 2011.

¹³ ABS (2016) [National Aboriginal and Torres Strait Islander and Torres Strait Islander Social Survey, 2014-15](#), Table 1: Selected characteristics, by remoteness and Indigenous status — 2002 to 2014-15, 1.3 Proportion.

¹⁴ AIHW (2018) [Data Tables Child Protection Australia 2016-17](#) Data tables: Child protection Australia 2016-17.

¹⁵ Catto, M. & Thomson, N. (2008) [Review of illicit drug use among Indigenous people](#). Australian Indigenous Health Bulletin 8(4).

¹⁶ ABS (2016) [National Aboriginal and Torres Strait Islander and Torres Strait Islander Social Survey, 2014-15](#), Table 23: Health risk factor indicators, by state, remoteness area and Indigenous status — 2014-15, 23.3 Proportion.

¹⁷ Lawrence et al (2015) p. iv.

¹⁸ AIHW (2018) [Data Tables Child Protection Australia 2016-17](#), Table S11. Accessed: 30/04/18.

those in the cities,¹⁹ but the suicide rate for those in rural and remote areas is considerably higher.²⁰ Dedicated and innovative targeting of resources and services would allow rural and remote Australians to access support when needed.

Suicide Rates

For Aboriginal and Torres Strait Islander peoples, the majority of whom live regionally or remotely, the five-year suicide rate for 2012-16 was more than twice that of the non-Indigenous population.²¹ For young people aged between 15 and 24 nationwide, suicide accounted for over a third of all deaths in 2016,²² and, as with the age-adjusted trend, suicide rates among young people also increase with remoteness and with socio-economic disadvantage.²³

Research on the causes and nature of the higher suicide rates of rural and remote communities has identified isolation, stoicism, inequitable gender relations, population decline and the unpredictable nature of climate variability and natural disasters as factors contributing to more rural and remote men being in crisis than those in urban areas.²⁴ There is an undeniable link between mental illness and suicide.²⁵ For young men in particular, the nuances present in rural communities (recreational boredom, risk-taking culture, easier access to firearms²⁶) can exacerbate feelings of desperation, mental distress and increase the risk of suicide.²⁷

Certain rural and remote communities are more susceptible to long-term, negative consequences from natural disasters such as bush fire, flood and drought which cause mass economic and social damage. Similarly, whole towns in rural areas are often built around one industry such as mining, and the unpredictable nature of this industry, featuring fly-in/fly-out workers and large fluctuations in employment and prices, can have a dramatic impact on population, prosperity and health. Farmers are also entirely reliant on the fortunes of the seasons. Basic necessities of life such as water access and provision can be hotly contested issues in outback rural and remote communities and cause prolonged stress and ill-health.²⁸ It is necessary to keep these complexities in mind when considering people's increased vulnerability to suicide in certain rural and remote communities and when assessing how best to intervene early to address mental distress before it reaches a crisis point.

For Aboriginal and Torres Strait Islander communities, the nature of suicide presents differently than for the non-Indigenous population. Unpacking the causes, nature and solutions to high suicide rates in

¹⁹ Bishop, L. Ransom, A. Laverty, M. & Gale, L. (2017) [Mental health in remote and rural communities](#), RFDS, p. 10.

²⁰ ABS (2017) [Causes of Death, Australia, 2016](#), Intentional self-harm (suicide). Accessed: 20/04/18.

²¹ Ibid.

²² Ibid.

²³ McNamara, P. M. (2012) Adolescent suicide in Australia: Rates, risk and resilience, p. 354 in *Clinical Child Psychology and Psychiatry* 18(3) pp. 351-9.

²⁴ Collins, J., Ward, B., Snow, P., Kippen, S. & Judd, F. (2017) Compositional, Contextual and Collective Community Factors in Mental Health and Well-Being in Australian Rural Communities, in *Qualitative Health Research* 27 (5) p. 678.

²⁵ Meyers, L. (2006) [World Mental Health Day emphasizes the link between suicide and mental illness](#). Accessed: 02/05/18.

²⁶ McNamara, P. (2012) Adolescent suicide in Australia: Rates, risk and resilience, in *Clinical Child Psychology and Psychiatry* 18(3) p. 355.

²⁷ Bourke, L. (2003) Toward understanding youth suicide in an Australian rural community, in *Social Science & Medicine* 57 p. 2357.

²⁸ Hazell, T., Dalton, H., Caton, T. & Perkins, D. (2017) [Rural Suicide and its Prevention: a CRRMH position paper](#), Centre for Rural and Remote Mental Health, University of Newcastle, Australia, pp. 4-7.



Aboriginal and Torres Strait Islander communities needs to be community-led, with Government efforts to improve outcomes focused on self-determination and the strengthening of connection to culture and identity, particularly for young people.²⁹

Youth suicide in Australia has its own nuances of cause and nature. Traumatic childhood experiences, school disengagement and poor academic performance, bullying, substance misuse, family violence and neglect all correlate strongly as indicators of suicidal ideation, intent or behaviour.³⁰ In rural and remote communities young people, particularly same-sex attracted, or gender diverse, can often feel heightened levels of oppression, isolation and fear, without somebody to turn to for help.³¹ Lack of acceptance and frequent discrimination, abuse and violence for being 'different' can sometimes prove too much, reflected in cross-international data showing considerably higher than average rates of suicidal thoughts, attempts and deaths amongst LGBTI youth.³²

Mental Health Services in rural and remote Australia

While rates of mental ill-health and suicide increase as remoteness increases, the reverse trend can be seen in data on access to mental health services. In Australia's cities and inner regional areas, 10% of the population accessed mental health specific services in 2016-17, but this figure fell to 8%, below 5% and below 3% respectively for outer regional, remote and very remote populations.³³ Higher proportions of regional and remote Australians with a lifetime mental health disorder reported that they had no need for information about mental illness, treatment and services, no need for talking therapy and no need for social intervention compared with those with a lifetime mental health disorder who were living in cities or inner regions.³⁴

Many young people in regional and rural areas carry additional worries that their disclosures to mental health practitioners or GPs will not be kept confidential from parents or teachers and for some young women in rural and remote areas, a lack of female GPs or mental health practitioners can further deter them from seeking help.³⁵

In addition to perceived community attitudes and cultures that may prevent early help-seeking in rural and remote communities, the high costs of travelling to and from services, and of the services themselves, are common barriers to seeking help in rural and remote areas. An evaluation of the Commonwealth's youth mental health service, Headspace, highlighted that the majority of its clients live within 10km of a Headspace centre and that the service is much less accessible for rural clients who cannot access the centres within the limited opening hours.³⁶

²⁹ Dudgeon, P. & Holland, C. (2016) [The Context and Causes of Suicide among Aboriginal and Torres Strait Islander and Torres Strait Islander People](#), pp. 3-8.

³⁰ McNamara, P. (2012) Adolescent suicide in Australia: Rates, risk and resilience, in *Clinical Child Psychology and Psychiatry* 18(3) p. 354.

³¹ McNamara, p. 357.

³² Skerrett, D. (2014) [Mental Health and Suicidal Behaviours in LGBTI Populations and Access to Care in Australia: A Literature Review](#), pp. 2-4. Queensland AIDS Council.

³³ AIHW (2018) [Mental health services in Australia](#), Medicare services 2016-17 tables. Table MBS.6. Accessed: 23/04/18.

³⁴ Craze, L. & Reddy, P. (2014) [Specific challenges for regional, rural and remote mental health services: challenges, inequities and opportunities](#), p. 17. University of Newcastle. Mental Health Commission.

³⁵ Boyd, C., Aisbett, D., Francis, K. & Newnham, K. (2006) [Issues in rural adolescent mental health in Australia](#), pp. 4-5. *Rural and Remote Health* 6.

³⁶ Hilferty, F., Cassells, R., Muir, K., Duncan, A., Christensen, D., Mitrou, F., Gao, G., Mavisakalyan, A., Hafekost, K., Tarverdi, Y., Nguyen, H., Wingrove, C. & Katz, I. (2015) [Is headspace making a difference to young people's](#)



The Centre supports the mental health sector in their concerns over the National Disability Insurance Scheme (NDIS) and its ability to better serve and empower those living with psychosocial disabilities. The NDIS scheme has a clear focus on permanent disability, with eligibility being assessed based on the existence of a diagnosed psychiatric condition, rather than the extent to which one's disability affects daily functioning. Such a model does not prioritise or promote early intervention as many people's mental ill-health is episodic and does not have a formal diagnosis. Similarly, assessing against a notion of permanency and severity means that many people living with psychosocial disabilities such as personality disorder, anxiety or depression may not be entitled to receive help for their condition under the scheme. Analysis based on data from the National Mental Health Commission, the Commonwealth Government and the NDIA suggests that, at best, NDIS will meet the needs of less than a third of those who have a severe mental illness requiring ongoing support.³⁷ People with psychosocial disabilities have numerous barriers impeding entry to the scheme; such as a highly complex paperwork process, trouble securing specialist assessments to prove eligibility, inappropriate assessments and advice, lack of cultural sensitivity for Aboriginal and Torres Strait Islander clients and a general lack of knowledge amongst clients about the scheme and what it means for existing services.³⁸ These barriers to accessing NDIS are exacerbated in rural and remote areas, where a large proportion of NDIS funding is spent travelling to access services, with little reflection of these costs in the scope of their funding. If individuals do not access services over time because these services are difficult to reach or are not meeting their needs, they risk losing their funding altogether because not purchasing funding is taken by NDIS case planners as evidence that the support is not needed.³⁹

This is concerning, because the financial, geographical and cultural barriers to early help explain the significantly higher rates of hospitalisation for mental illness in rural and remote areas compared to cities and inner regions.⁴⁰ The Royal Flying Doctors Service (RFDS) provides aeronautical retrieval of people experiencing acute mental health crises across regional and remote Australia. While the majority of retrievals relate to instances of schizophrenic psychosis, the next most common diagnosis in patients retrieved was a depressive disorder, suggesting that earlier therapeutic services and pharmacological assistance are needed to keep people from reaching a crisis situation.⁴¹

Mental health services are provided at strikingly lower rates per head of population in remote areas compared with major cities, from 49 service places per 100 people in major cities to only eight per 100 people in very remote areas.⁴² Almost 95% of all of Australia's psychiatrists and psychologists are based in a major city or inner region, meaning that early promotion of positive mental health, intervention services, diagnosis and prevention is difficult to achieve for people even if they want to

[lives? Final report of the independent evaluation of the headspace program](#), University of New South Wales, p. 112.

³⁷ Hancock, N., Gilroy, J., Llewellyn, G. & Yen, I. (2018) [Mind the Gap: The National Disability Insurance Scheme and Psychosocial Disability - Final Report](#), University of Sydney. Community Mental Health Australia, p. 8.

³⁸ Ibid.

³⁹ Warr, D., Olney, S., Karanikolas, A., Katsikis, G., Peters, D., Wilcox, M., Dickinson, H., Hargrave, J., Kasidis, V., Ozge, J. & Wheeler, J. (2017) [Choice, Control and the NDIS: Service users' perspectives on having choice and control in the new National Disability Insurance Scheme](#). University of Melbourne. Melbourne Social Equity Institute.

⁴⁰ National Rural Health Alliance (2017) [Mental Health in Rural and Remote Australia](#), pp. 1-2

⁴¹ Bishop, L., Ransom, A., Laverty, M. & Gale, L. (2017) [Mental health in remote and rural communities](#), RFDS, pp. 57-60.

⁴² Ibid, Table MBS.14.

access services, resulting in higher rates of acute crisis ending in hospitalisation than in cities and inner regions.⁴³

Access to mental health specialists such as psychiatrists and psychologists is increasingly difficult the more remote an area becomes, because recruitment and retention of specialists in such areas is notoriously challenging. Rural mental health workers report heavier workloads and higher levels of distress, causing more burnout.⁴⁴ Researchers note that schemes meant to entice workers to rural areas, like the remote area allowance and Medical Specialist Outreach Assistance Program (MSOAP), have little impact in reality.⁴⁵

In Australia's major cities, the per-person Medicare funding for mental health services is over six times more than the funding in rural and remote areas.⁴⁶ Submissions detailed in the Mental Health Commission's 'Contributing Lives, Thriving Communities' review paper highlighted that aggregated data masks the true extent of inequality of service provision.⁴⁷ Some areas that are deemed 'regional' are within an hour of a major town or city, making 'regional' areas appear to be well resourced, while other areas categorised as 'regional' are highly remote and isolated and do not benefit from anywhere near the same provisions, despite appearing to.⁴⁸

This inequity in provision appears to worsen under NDIS, as some organisations providing mental health services in rural and remote areas have opted not to be registered under the scheme as they feel they cannot provide quality service within the new pricing structure.⁴⁹ With block funding for agencies replaced by individualised client NDIS payments, services in rural and remote areas are struggling to stay viable and some are ceasing to operate entirely if there is no other agency to merge with. Often the needs of their clients are no longer met under NDIS, leaving agencies effectively unfunded to provide these services and running at a loss if they do.⁵⁰ It represents an unsustainable system that threatens the existence of the usually lone service that is available to rural and remote community members in mental distress. Findings from a survey conducted by the Australian Medical Association reveal that the majority of GPs believe that their Primary Health Network (PHN) has not effectively facilitated mental health care for patients not eligible for NDIS, and had not ensured sufficient psycho-social supports for clients in a timely manner even if they were eligible.⁵¹

The Commonwealth's response paper to 'Contributing Lives, Thriving Communities' pushed the importance of fewer, but larger, PHNs to replace Medicare Locals in order to deliver more effective,

⁴³ National Mental Health Commission (2014) [Report of the National Review of Mental Health Programmes and Services Volume 2](#), p. 100.

⁴⁴ Moore, T., Sutton, K. & Maybery, D. (2010) [Rural Mental Health Workforce Difficulties: a management perspective](#), in *Rural and Remote Health* 10, p. 2.

⁴⁵ Ibid.

⁴⁶ National Mental Health Commission (2014) [Report of the National Review of Mental Health Programmes and Services Volume 2](#), p. 96.

⁴⁷ Ibid, p. 98.

⁴⁸ Ibid, p. 98.

⁴⁹ Hancock, N., Gilroy, J., Llewellyn, G. & Yen, I. (2018) [Mind the Gap: The National Disability Insurance Scheme and Psychosocial Disability - Final Report](#), University of Sydney. Community Mental Health Australia, p. 27.

⁵⁰ Hancock et al., p. 33.

⁵¹ Australian Medical Association (2017) [AMA submission to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry into the Transitional arrangements for the National Disability Insurance Scheme](#), p. 3.



collaborative health services that are responsive to the community needs of their region.⁵² Knowing that mental ill-health is a challenging problem to address in rural and remote areas, there was concern more broadly at the outset of the PHN transfer over what level of priority mental health services would have under the new model.⁵³ Those concerns appear to be well founded as, under the new funding structures, PHNs are no longer required to employ community mental health nurses under the Mental Health Nurse Incentive Program. The Murray Primary Health Network (which encompasses wide areas of outer regional Victoria such as Ballarat, Mildura, Wangaratta and others) is proceeding with considerable redundancies in this specialist role, raising concerns over the viability of continuing quality care for thousands of patients who had established trusted relationships with their mental health nurses.⁵⁴ The program was previously utilising GPs in providing co-location in rural and remote areas for mental health nurses, psychologists and psychiatrists to work together. Mental Health Nurses under the program provided co-ordinated care, from identifying early need and referring on to other medical or dental services or advocating for NDIS eligibility, through to interventions in the acute stage.⁵⁵ In rural areas where mental ill-health is considerably under-recognised, the loss of mental health nurses could remove one of the already scarce options available for those who need services.

Strategies for Improvement

The Centre supports calls from the RFDS, Mental Health Commission and other organisations for greater, more sustained and targeted federal investment in solution-focused, early intervention based mental health services in rural and communities.

Specific focus should be paid to the most at-risk cohorts – Aboriginal and Torres Strait Islanders, young people and communities faced with harsh, turbulent economic and climatic environments. Given that so much of the presentation of mental illness in remote and rural areas is at the crisis end of the spectrum (suicide and hospitalisation), there is a strong need to focus attention on the public promotion of good mental health and on early intervention counselling and psychotherapy.

Government policy must promote good mental health practices on an individual level (by seeking to promote exercise, healthier food and decreased smoking and alcohol/drug consumption) and in the community, through public campaigns that encourage talking more openly about mental health and promoting the pathways people can take to seek help.

We welcome the Victorian Government's commitment to prioritising mental health in its 2018/19 budget, although it remains unclear how much of the record \$705m state-wide investment boost will be allocated towards strengthening resilience and providing early intervention in Victoria's outer regional and remote areas. Much of the investment is focused on the acute end of mental illness care – in drug rehabilitation facilities, new emergency department hubs, 89 inpatient beds, expanding post suicidal outreach services and improving clinical care. These acute services are in need throughout Victoria and the investment is welcomed, however a greater focus on early and preventative help is

⁵² Department of Health (2015) [Australian Government Response to 'Contributing Lives, Thriving Communities' - Review of Mental Health Programmes and Services](#), pp. 5-7.

⁵³ National Rural Health Alliance (2014) [Ensuring that new Primary Health Networks will work well in rural and remote areas](#), pp. 5-7.

⁵⁴ Australian Nursing and Midwifery Federation (2018) [Thousands of 'invisible' Victorians at risk](#), Accessed: 26/04/18.

⁵⁵ Australian Nursing and Midwifery Federation (2018) [Thousands of 'invisible' Victorians at risk](#), Accessed: 26/04/18.

critical in preventing mental health crises (such as suicide and self-harm) that require acute care in the first place, particularly in rural and remote areas.

The Victorian Government also needs to compensate within its budget for the issues arising from the nationwide roll-out of NDIS. Rural services are frequently faced with threats to their sustainability through inadequate funding, but the NDIS roll out and transition from Medicare Locals to PHNs across Australia need to recognise their impact on the viability of existing services. Programs such as Partners in Recovery, Day2Day Living and Support for Families and Carers need to be retained where possible, as many clients may not be eligible for NDIS but are still dependent on these services.

The Centre suggests the following strategies could help make NDIS and non-NDIS funded services more viable in rural and remote areas:

- **Enhancing culturally appropriate pathways into mental health services** for Aboriginal and Torres Strait Islander clients who are over-represented in statistics relating to mental illness, suicide and crisis hospitalisations. Services need to be culturally responsive, promote self-determination and have a workforce that is appropriately trained and, where possible, links to other Aboriginal services
- **Rejecting a one-size-fits-all approach** to rural mental health services, particularly under the new PHNs. Rural and remote communities are highly diverse and face vastly different macroeconomic and social conditions that determine the health of their communities. Mental health services, and the promotion of good mental health, should work in with existing primary care services and employment industries. For example, The Australasian Centre for Rural and Remote Mental Health runs a 'Minds in Mines' program in Western Australia aimed specifically at providing mental health strategies to miners. PHNs throughout Australia should liaise closely with the local communities in rural and remote areas to determine what their needs are in providing more effective, earlier help⁵⁶
- **Factoring in the additional costs of travel** and time under funding structures in both NDIS and non-NDIS services to make services more financially viable
- **Investing heavily in e-Health and tele-health models of delivery**. Evidence shows that tele-psychiatry services provide effective solutions to service provision in rural and remote areas, that telehealth promotes equity in accessing good mental health, empowers patients and has strong satisfaction rates.⁵⁷ Telehealth has the potential to circumvent issues of confidentiality and geography that are common barriers to rural Australians seeking early help. We support the Commonwealth government's initiative in providing tele-health as an option for rural and remote Medicare Better Access mental health clients and wish to see this expanded to more than the ten sessions currently available per client, per year. Given the uncertainty surrounding NDIS eligibility and suitability for many people with a psychosocial disability in rural and remote areas, telehealth services can, and should, be utilised in early intervention initiatives within and outside of the scheme.
- **Promoting good mental health to young people online**, through multiple mediums. The Government's online version of its youth mental health service – eheadspace – has been

⁵⁶ National Mental Health Commission (2014) [Report of the National Review of Mental Health Programmes and Services: Volume 2 - Every service is gateway](#), pp. 105-6.

⁵⁷ Chakrabarti, S. (2015) [Usefulness of videoconferencing tele-psychiatry: A critical evaluation of videoconferencing based approaches](#), p. 298 in World Journal of Psychiatry 5(3) pp. 286-304.

positively assessed by users and clinicians. While headspace was criticised in earlier evaluations for being inaccessible to many cohorts, eheadspace can circumvent the geographic barriers to counselling and consultation faced by young, rural Australians. It has provided interim assistance to young people while they wait to access face-to-face services and has been a spring-board into other services for those who are nervous about face-to-face interaction.⁵⁸ Using positive self-care messaging and promoting mental health through social media can point young people towards earlier help. Just as young people report negative experiences and interactions on social media, they also report gaining support and comfort from people online in challenging times.⁵⁹ Social media can provide safe spaces for young people to express their identities, something which is very valuable to those in rural and remote areas who may feel ostracised or alone, such as LGBTI youth. We support calls by researchers in the UK for social media platforms to have in-built alert systems that keep users informed of how much time they have been online, warn them of the dangers of too much use and provide links to information and resources on mental health.⁶⁰

- **Making rural and remote work more attractive for new psychologists** under the Better Access program by making certain benefits, scholarships and other incentives contingent upon providing services in rural and remote areas.⁶¹
- **Upskilling the existing workforce within primary care in rural and remote areas.** Allied health workers, GPs and nurses can all play a larger role in the promotion of good mental health and the provision of services to those in mental distress. It has been suggested by the Australian Nursing and Midwifery Foundation (ANMF) that there is greater scope for using advanced nursing practice roles to initiate earlier assessment, diagnosis and treatment for people with mental illness without the need to wait for a doctor's sign off. This could be highly beneficial in rural and remote areas where getting another appointment to see a GP prior to treatment being initiated may be challenging because of time and distance. Allowing locum mental health nurses greater authority to treat earlier with pharmacology may prevent some hospitalisations and improve health outcomes.⁶² There is also scope for more innovative models of investing in community members to upskill and provide peer/mentoring and mental health 'first aid' within the community, particularly where community members already have experience of mental illness and recovery.
- **Focusing federally on improving the social determinants of ill-health** that are higher in rural and remote areas (unemployment, poverty and particularly substance abuse) and decreasing co-morbidities associated with mental distress. The promotion of good mental and physical health can be addressed by primary care and public health as one, holistic approach to a better life. The intergenerational trauma and disadvantage faced by Aboriginal and Torres Strait Islander communities that further increase the risk of mental distress and co-morbidities requires thoughtful, ongoing solutions based around self-determination and hope.

⁵⁸ Hilferty, et al., pp. 83-5.

⁵⁹ RSPH (2017) [#StatusOfMind - Social media and young people's mental health and wellbeing](#), Young Health Movement, pp. 13-16.

⁶⁰ Ibid, p. 24.

⁶¹ National Mental Health Commission (2014) [Report of the National Review of Mental Health Programmes and Services: Volume 2 - Every service is gateway](#), p. 107.

⁶² Australian Nursing and Midwifery Federation (2017) [Lean on me: The challenges and opportunities facing mental health nursing](#), Accessed 26/04/18.