Rural & Remote
Mental Health

Submission by Rural and Remote Mental Health Ltd

**Australian Government Productivity Commission
Inquiry into the economic impacts of mental ill-health**

April 2019

Executive Summary

A largely overlooked and systemically challenging issue relating to the economic, social and individual burdens of mental ill health, is that of service provision and funding in rural and remote Australian communities. It is imperative that any robust and strategic discussion on the state of mental health in Australia incorporate the experiences of service providers, consumers and every day community members, living and working in these communities. Rural and Remote Mental Health (RRMH) has approached this submission to the Australian Government Productivity Commission Inquiry, from this perspective.

RRMH calls for the development of a National Rural and Remote Mental Health Strategy to address systemic challenges in providing mental health information, supports and services to rural and remote communities. This is in light of well documented gaps in the availability and funding of, adequate and accessible, clinical services and effective mental health, suicide prevention and intervention programs, to meet local level demand.

The many contributing factors that compound risk and preclude service access, such as demographic, geographic, economic, social and cultural factors, often culminate in rural and regional communities. This is particularly evident for high priority rural and remote cohorts such as: people working in primary and resource industries, and high risk workforces; Indigenous Australians; young people; isolated people; people with psychosocial disability; and those who have experienced the impacts of community and environmental crises. RRMH highlights the need for year-round attention, funding, and access for these individuals and communities as a preventative measure – not just in times of peak distress, such as prolonged drought or the aftermath of a natural disaster.

A key consideration is the appropriate allocation of scarce funding and resources to rural and regional mental health initiatives. RRMH advocates for a greater emphasis on long-term, sustainable research and evaluation, and for prioritisation of evidence-based initiatives with proven efficacy. Furthermore, RRMH highlights the need for the Commonwealth Government to reconsider the balance and direction of funding policy and allocations for prevention and early intervention in rural and remote Australia.

Our submission highlights challenges and barriers, while drawing on collective experience and evaluations for 'what works'. The extensive work and pioneering research of RRMH has clearly shown that the best impact is produced from localised solutions in addressing workforce shortages in rural and remote areas through: prioritising the role of in-community training and capacity building initiatives; enhancing the use of non-clinical Community Care Coordinators; and rewarding targeted innovations that support culturally relevant approaches, and the promotion of community connectivity and linkages.

Given the clinical, social and economic complexities of mental ill health, RRMH appeals for an improved notion of 'gold star' best practice in program delivery, and the direction of funding to rural and remote mental health programs to: ensure programs with the greatest impact are given precedence; allow for proven programs to be scaled, thus reaching more people in need; avoid duplication and competition for limited funding; generate the greatest financial and social return on investment; and have the greatest long-term, sustainable impact on individual lives and community wellbeing.

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Summary of Recommendations

Recommendation 1

A section in the Inquiry report be devoted to:

- issues associated with the delivery of information, support and services to rural and remote Australians; and
- the development of a National Rural and Remote Mental Health Strategy, which addresses systemic challenges in providing mental health information, support and services to rural and remote communities.

Recommendation 2

Long-term, sustainable research and evaluations be commissioned to determine the return on investment from delivery and promotion of prevention and early intervention programs for rural and remote communities or industries (particularly those with high risk workforces) – with an emphasis on productivity and participation.

Recommendation 3

The Commonwealth Government commit to redressing the imbalance in funding for prevention and early interventions particularly for rural and remote Australians.

Recommendation 4

PHNs and Government agencies target their investment into programs - particularly national prevention/early interventions - which have been piloted, successfully delivered and have a strong evidence base.

Recommendation 5

The professional health workforce be complemented by the recruitment, training and support of locally-based, non-clinical Community Care Co-ordinators (CCCs) – to address health workforce shortages and availability of psychosocial supports in rural and remote areas.

Recommendation 6

Higher priority be given to alternative and innovative, culturally-relevant initiatives and events in rural and remote areas, to generate social inclusion, connectivity and participation. This should not just be considered in times of environmental stress e.g. drought or floods, but as an ongoing strategy to ensure the maintenance of networks, relationships and community resilience.

Recommendation 7

Priority be given to the integration of culturally-specific, comprehensive information about stigma and the challenges faced by young people regarding mental health, wellbeing and suicide prevention within school curricula - especially for those in rural and remote areas.

Recommendation 8

That "gold standard" guidelines and/or regulations be developed for the content of prevention programs, including those that address: stigma, risk factors, signs of mental distress and suicidality, pathways to information, support and care specifically for rural and remote workplace settings, which differ considerably from the metropolitan concept of a workplace.

Recommendation 9

Special consideration needs to be given to the commissioning and funding for the delivery of national programs, especially for rural and remote Australia, to ensure impact, reach and sustainability.

1. Introduction

Rural and Remote Mental Health Ltd (RRMH) is a not-for-profit public company limited by guarantee with deductible gift recipient status. It is a national organisation with its Board, staff, and program trainers and presenters spread across each state and territory.

Through the delivery of evidence informed mental health, suicide prevention and early interventions, RRMH has developed an understanding of the unique needs, challenges, strengths and preferences of rural and remote communities, with regard to the delivery of mental health information, services and supports.

It is through the voice and experience of rural Australians, constantly challenged by droughts and adverse climatic events, stigma, isolation and remoteness, lack of support, and access to services, that the design and mode of delivery of the following mental health and suicide prevention programs emerged:

Deadly Thinking - a social and emotional wellbeing program designed by and for Indigenous people to 'have a yarn' about challenging topics in a culturally safe way.

Deadly Thinking Youth – a timely, new addition to RRMH programs, it starts the conversation for 12 to 20 year olds. It is designed for flexible delivery in settings ranging from schools to remote communities.

Rural Minds – Rural Minds workshops include practical information and encourage participants to connect and have 'life-saving' conversations about mental health and suicide. Complemented by SafeTALK and ASIST to add value.

Resource Minds – the most comprehensive, evidence-based mental health and suicide prevention program available for the mining and resource sectors, which can be delivered on site and in head office.

Rural Minds for Resourceful Communities – a hybrid program designed specifically for rural and agricultural communities with mining or resource industries nearby where the 'clash of cultures' can be volatile at times.

Mental Health for Leaders – a comprehensive, down-to-earth program suited to community leaders, small business owners, local government representatives and rural community workforces.

Fisher Minds - currently being developed to address the mental health and wellbeing of the seafood industry workforce, and the needs of the fishers whose livelihood can be one of hardship, risk and uncertainty.

These programs are predicated on identifying and training presenters to deliver the workshops from within each community or workplace. The programs have local and cultural relevance and they fit before and with the early stages of the stepped care model adopted by the Primary Health Networks (PHNs). Further, training programs developed from experience gained in rural and remote areas have now been designed to fulfil the need for non-clinical community care co-ordinators, identified through the transition to the NDIS.

RRMH welcomes the broad scope of this inquiry and, through the lens of rural and remote Australians, will provide an outline of key issues they face, as well as the outcomes from the prevention programs delivered by RRMH. These will inform the recommendations of this submission.

We appreciate that the inquiry will take an inclusive and overall social and economic view, however, this submission will reference impacts that eventuate from the lack of essential preventative information and access to early, non-clinical interventions for the entire population of rural and remote Australia. In particular, it will reference the subgroups who are at a heightened risk of developing a mental disorder, experiencing mental ill-health, and/or suicidality - including: Indigenous communities; farming and agricultural communities; the mining and resource sector workers; and fishers and seafood sector workers.

Key issues and facts relating to rural and remote mental health

Around 29% of the Australian population live and work in rural and remote Australia (AIHW 2016). While the prevalence of mental disorders is similar throughout Australia, rates of suicide and self-harm are higher in remote and rural areas, and increase with relative remoteness (Bishop, et al, 2017; Harrison and Henley 2014). Suicide rates in rural and remote communities are 40% higher than that of major capital cities (AIHW, as cited by NRHA 2017).

Farmers, young men, older people, and Aboriginal and Torres Strait Islanders in remote areas are at greatest risk of completing suicide (Arnautovska, et al, 2015), due to the compounding social determinants of health of these demographics and geographic locations (Bishop, et al, 2017).

Men in rural and remote areas experience higher levels of psychological distress than their metropolitan counterparts (AIHW 2008; ABS 2006). The rate of suicide among men aged 85 years and over who live outside major cities, is around double that of those living within them (ABS 2006).

In rural areas there is often apprehension around help-seeking and a fear of the stigma associated with mental illness - particularly in smaller communities where individuals are more visible, and confidentiality may be less assured (Judd, et al, 2006; Hoolahan 2002). Hence a localised 'whole of community' educational approach is essential. Building the capacity for locals to understand and respond to mental ill health in the context of their own communities is key.

The Gaps

RRMH considers that there needs to an be an increased emphasis on disseminating knowledge and education to mitigate developing a mental illness in rural and remote Australia, and to support those experiencing stigma associated with mental illness (either at a personal level or as a carer).

We support the urgent need for adequate primary care through to tertiary clinical care for those experiencing mental illness. However, we consider that promotion and prevention is

critical to addressing the ever-increasing demand on clinicians and service providers, especially within rural mental health services. Community knowledge and awareness, alongside support for informal community care models, is essential for promoting support and safety in the absence of accessible and clinical mental health services. As a result of working in rural and remote Australia for over 12 years, RRMH believes there is a significant gap in the provision of funded prevention initiatives that support seamless transition and linkages to early interventions and primary care when required.

RRMH advocates for preventative strategies from primary through to tertiary and secondary prevention. However, primary (illness prevention) and secondary (early diagnosis and intervention) prevention are the vital strategies missing and are the strategies most in need for at risk rural and remote Australians.

RRMH has observed that in rural and remote areas, early interventions are generally not available for *any* age cohort - not just young people - due to lack of awareness of risk factors, knowledge of symptoms and signs, stigma, and the historic paucity of services.

RRMH supports the view "that Australia has focused resources largely on reducing the duration of mental disorders through provision of more treatment and has neglected reducing the incidence of disorders through prevention" (Jorm 2014).

2. Assessment approach and scope of Inquiry

Acknowledgement of scope

RRMH commends the Productivity Commission for the broad and comprehensive scope of the inquiry. While the wellbeing and mental health of Australians living in rural and remote communities is of particular significance to RRMH, we would also like to draw attention to the often overlooked need to target specific, high risk cohorts – such as those working in specific industries or sectors. Examples of sectors operating in rural and remote areas, outside the scope of this inquiry include, various agricultural, primary production and farming sectors, forestry, fisheries, maritime, mining, resources, defence and defence industries, and tourism. RRMH highlights the need to invest in workforce based mental health initiatives, as a means of reaching Australians who may 'slip through the cracks' of generalist mental health supports, and furthermore in realising the impact that these industry environments can have on mental health and wellbeing.

3. The importance of the rural and remote experience with mental health

In addition to the prevalence of mental health concerns and high levels of suicidality in rural and remote Australia, there are many other challenges and experiences that impact on the mental health of individuals and families and their ability to work productively and efficiently. They include:

- Isolation and loneliness;
- economic fluctuations and financial pressures;

- limited and/or unreliable communication facilities;
- barriers and low rates of access to services;
- workforce shortage and high turnover;
- stigmatisation of mental illness and help-seeking;
- limited access to public transport;
- cultural and language challenges;
- Governments' regulatory changes;
- extreme weather events and natural disasters; and
- all the social determinants of mental health specific to rural and remote areas.

Further, the population in regional Australia is increasing, for example, between 2007 and 2017 the population outside major cities grew by 10.6% and it is predicted by the ABS that between 2007 and 2026 the population will grow by 26% (ABS 2018).

It is, therefore, of concern that the unique issues and systemic challenges facing rural and remote Australians has not warranted a major heading and section in the Productivity Commission's Issues Paper. As the Senate Inquiry (2018) recommended, a national, rural and remote mental health strategy which addresses these issues, should be implemented as they are vital to any discussions about systemic changes in mental health in Australia in a broader sense (The Senate 2018).

<u>Recommendation 1</u>

A section in the Inquiry report be devoted to:
- issues associated with the delivery of information, support and services to rural and remote Australians; and
- the development of a National Rural and Remote Mental Health Strategy, which addresses systemic challenges in providing mental health information, support and services to rural and remote communities.

Challenges and issues in key rural and remote industries

RRMH believes it is imperative to capture and appreciate the gravity of the following challenges and issues experienced within key industries and workforces operating in rural and remote Australia. These issues are presented within the context of the experiences and information gained through our program delivery and evaluation.

Mining and Resource Sector – Resource Minds
Resource Minds is a flexible, innovative, evidence-based mental health and suicide prevention program that creates sustainable and positive changes in workplace culture, behaviours and attitudes towards mental health. Resource Minds consists of:

- Mental Health for Leaders - training for managers, supervisors, WHS and HR staff;
- Suite of 13 Toolbox Talk presentations including videos;
- Toolbox Talk Presenter's Training and Presenter's Guide;
- *A Passport to Mental Health in Mining and Resources* booklet for every employee;

- Site visits by RRMH staff to deliver training and presentations;
- Onboarding handbook for new employees;
- Posters and flyers promoting key mental health messages;
- Dedicated RRMH Program Manager providing on-going support to your management team, WHS staff and presenters; and
- Survey and evaluation of the Program's outcomes.

Results from research associated with the development and delivery of RRMH Resource Minds (Bowers, et al, 2018) A cross-sectional, anonymous Wellbeing and Lifestyle Survey was administered at ten mining sites in South Australia and Western Australia to 1,754 respondents providing a final sample of 1124 employees at remote construction, and open cut and underground mining sites who completed the survey**.**

- 28% of fly-in, fly-out (FIFO) workers in remote mining and construction sites rated their psychological stress as high or very high, compared with just 10.8% of the general population;
- Significant and most frequently reported stressors were missing special events (86%), relationship problems with partners (68%), financial stress (62%), shift rosters (62%), and social isolation (60%);
- High psychological distress was significantly more likely in workers aged 25–34 years, and workers on a 2-weeks-on/1-week-off roster;
- Workers who were very or extremely stressed by their assigned tasks or job, their current relationship, or their financial situation were significantly more likely to have high/ very high stress scores than those not stressed by these factors;
- Workers who reported stress related to stigmatisation of mental health problems were at the greatest risk of high/very high psychological distress;
- Most importantly, the strongest predictor of psychological distress overall was fear of stigmatisation for mental health problems - workers who reported being stressed by this factor were 20 times more likely, and those who were extremely stressed about it were 24 times more likely, to have high or very high levels of distress values; and
- Given that 40% of respondents rated stigma a source of stress, this finding is alarming, and highlights the importance of early interventions and suicide prevention.

Commercial Fishing Sector – Information for "Sustainable Fishing Families - Developing industry human capital through health, wellbeing, safety and resilience" (King, et al, 2018)

- 22.2% of commercial fishers had high or very high levels of psychological distress, being significantly higher than the population as a whole;
- The most common risk factors identified for commercial fishers related to:
  - Physical health (24%) of which over a third related to fatigue;
  - Fisheries management (22%) which related to regulatory burden and change;
  - Mental health (17%) which linked stress, anxiety and depression with isolation, uncertainty and insecurity; and

  o Financial burdens (12%) which related to level of remuneration and entitlements, governance costs and running costs of a fishing business.

Agricultural, Primary production and farming sectors – Statistics derived from "Rural Minds Evaluation Report" (Orygen 2019)

- Approximately 1 in 7 (14%) reported having attempted suicide at some point in their lives with 11% being considered at a moderate-high risk of suicide at the time of the evaluation;
- Alcohol consumption was 1.5 times higher than national rates for exceeding single occasion consumption guidelines; and
- Participants were 13 times more likely to have used amphetamines in the past 3 months than the population average.

These findings:

a) provide a compelling basis to more accurately assess the productivity losses associated with stigma, mental distress and the related risk factors in industries operating in rural and remote regions;

b) demonstrate the need for culturally-specific prevention programs and early interventions that address stigma, risk factors, mental distress and suicide in rural and remote workplaces; and

c) inform the development of safety policies and practices directly relating to the risk factors associated with each sector.

Although there is limited research, analysis shows that there is variance in returns on investment (ROI) in prevention programs across industries. The average ROI across all industries for investing in a mental health initiative in the workplace is 2.3. However, there are potentially higher returns on investment of 15 in industries such as small to large mining organisations (PWC and Beyond Blue 2014). Recent research by Street (et al, 2018), confirm that in order to achieve a high ROI in this sector, health promotion needs to be strategically targeted in order to engage stressed employees with reduced productivity and a low desire to seek help. As other studies in the UK and European Union have demonstrated, there is great potential and there can be positive returns on investment in mental health prevention programs for the funder (Knapp, et al, 2011).

Further research needs to be long-term and transcend election cycles and traditional, short-term impact expectations and funding. Attitudes, behaviours and culture take years to transform, as evidenced by the long-term nature and impact of the "quit smoking" and "slip, slop, slap" campaigns.

Traditional time-limited funding for program research and evaluation ensures that they are often unsustainable and, therefore, leads to their demise. To ensure there is translational value, the research must take into account the cultural context, and ensure skills and capacity are integrated within the community or industry.

It is clear there are sufficient reasons to mitigate high levels of risk outlined above, to invest in the research of promotion and prevention programs, even though the mental health or

fiscal benefits will not be realised until some future time and may accrue to different funders from industries or levels of government.

Recommendation 2

Long-term, sustainable independent research and evaluations be commissioned to determine the return on investment from delivery and promotion of prevention and early intervention programs for rural and remote communities or industries (particular those with high risk workforces) – with an emphasis on productivity and participation.

4. Effective mental health care in rural and remote communities

The case for promotion, prevention programs and early interventions in rural and remote Australia.

Structural weakness/uncertainty

Given that the first two aims of the 5th National Mental Health and Suicide Prevention Plan (COAG Health Council 2017) are to: "promote the mental health and well-being of the Australian community and, where possible, prevent the development of mental health problems and mental illness"; and "reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community" there is limited understanding about where within Governments the responsibility for these key policy areas lie. The Commonwealth Government has the most to gain from establishing a national policy framework and receiving a return on investment from these aims over the long term. However, as with any structural reform, there must be understanding and commitment by all tiers of Government and key stakeholders to each element of the overall structure.

Target population for prevention programs

The mentally well population in rural and remote Australia

Distribution of mental health among the Australian population (Productivity Commission 2019) shows that 15 million Australians are mentally well and as at June 2017, 32.7% of Australia's population (a little over 8 million people) resided outside greater capital city areas (ABS 2018). **This equates to 5 million mentally well people outside greater capital city areas.**

The at-risk population in rural and remote Australia
This data also indicates that there are 5.8 million Australians at risk. If the risk factors for those residing in rural and remote areas are equal (which in some industries is clearly not the case) it is concluded that **at least 1.9 million people are at risk in rural and remote Australia.**

The first step of the Stepped Care Model (NMHC 2014, as cited by Productivity Commission 2019) is, therefore, targeted at 6.9 million Australians in rural and remote Australia. A proportional investment in programs and initiatives - such as those described by RRMH in

this submission - must be made to reach this significant and growing population in rural and remote populations.

In order to redress the imbalance in funding, it has been proposed by the NMHC that funding should be shifted from Disability Support Pensions, acute care, carer payments and MBS payments towards self-help, prevention and early intervention, psychosocial/ non-clinical supports, and primary and community mental health services.

Recommendation 3

The Commonwealth Government commit to redressing the imbalance in funding for prevention and early interventions, particularly for rural and remote Australians.

Improving responses to mental ill health and suicide – the vital role of prevention and early interventions.

The need for structured, independently evaluated prevention programs

Although there are many ways of communicating with people living and working in rural and remote Australia, including various tele-health and internet-based platforms, there is and will continue to be a need for face-to-face communication. Many Australians live and work in isolation and the opportunity to get together in a safe and congenial environment to 'have a yarn' about sensitive topics, such as mental distress and suicide, will continue to be popular. In vivo, conversation based mental health programs, have proven efficacy in their ability to break down stigma and normalise discussions around difficult subject matter such as mental illness and help seeking. In rural and remote communities, these conversations result in the creation of a "safe environment" and the formation of local networks based on a shared trust.

 While tele-health and digital based applications and online platforms are increasingly a positive information touch point, and a complement to mental health services, there will always be a need to build local community capacity and peer-to-peer engagement, in order to create more resilient and connected communities – as an important factor in early intervention and prevention. There is also a duty-of-care in the delivery of mental health and suicide prevention information to isolated individuals e.g. farmers at home or miners in their donga.

There is a substantial amount of information about mental health and suicide prevention available to anyone across many platforms, including broadcast media, publications, social media, websites, online tools and applications, local networks, events, and through groups and workplaces - among other channels. This is both positive and negative. As dialogue around mental health increases it can be difficult for people to know where to access quality information that is relevant to them. Not all information available is constructive, evidence-based and developed in consideration of the unique needs of different audience groups. Australians living and working in rural and remote areas are diverse. Each community and workplace have a unique situation based on geography, socio-economic factors, demographics, and local cultural profile. The people living and working in these communities, are as humans, just as diverse in their experiences, needs, risks, strengths and

capabilities. Mental health programs and information must contain an element of tailoring or customisation to the specific audience they are aimed at in order for them to engage and digest essential, preventative information.

RRMH has consulted, designed and delivered, culturally-tailored, comprehensive mental health and suicide prevention programs, which ensure engagement and have proven, positive impacts. Our experience has demonstrated the effectiveness of programs that contain the following two elements:

1. The core program, facilitated by a trained presenter, utilising distinct, unique and culturally-specific terms of language and imagery. The essential mental health and suicide prevention content is similar in each one but the length and form of delivery of the program is designed to suit each individual sector/community. The programs include: a suite of videos, Participants' Workbooks; and Passports to Mental Health (a passport-sized booklet with essential information) designed specifically for each program; and

2. A separate train-the-presenter program is delivered on a flexible basis to leaders and elders who are generally credible, respected members of communities and organisations. The train-the-presenter provides training in the delivery of the program and access to the suite of videos, Presenter's Guide and other program specific material.

This model ensures that the materials, skills and knowledge are embedded in communities by being delivered face-to-face by locals who know the unique community culture, issues and services.

Examples of evaluation results provide insights into community and individual challenges and evidence for the success and acceptance of selected programs. These are summarised below:

Deadly Thinking

Deadly Thinking is a social and emotional wellbeing program targeted at rural and remote Aboriginal and Torres Strait Islander communities to improve emotional health literacy, psychological wellbeing, and attitudes toward help seeking associated with emotional ill-health.

The independent ethically-approved evaluation findings (n=377 with an average response rate of 80%) provide a valuable insight into the lives and mental health of Indigenous people living in rural Australia (Orygen 2018b). They include:

- Racism and loss of culture (both 41%) remain key stress factors but family issues (57%) are the most prevalent stress factors;
- Stress is more prevalent in younger people;
- Approximately 1 in 7 (14%) reported having attempted suicide at some point in their lives with 3% being considered at high risk of suicide at the time of the evaluation;
- More than half the participants reported previously seeking help for an emotional health or wellbeing issue;

- Participants reported significantly greater help seeking intentions towards partners, friends, parents, community leaders and health professionals;
- The research shows that Deadly Thinking is both highly acceptable to participants and well received;
- Trainers reported that they felt there was a change in their attitudes toward mental health as a result of the workshop (94.1%), and that the workshop would help them to understand and deal with their own worries (98.9%);
- Participants reported that they were more comfortable talking about social and emotional wellbeing than before the workshop (96.2%).

- Take home messages and comments (Orygen 2018b) from train-the-presenters and community participants include:
    - "Mental health issues happen no matter what skin colour / race /culture,"
    - "Working together helps!"
    - "Empowered me to keep going."
    - "Together we are deadly."
    - "I felt I was not alone."
    - "An enjoyable and rich day – laughter and sharing"
    - "The two facilitators were awesome and kept us on track."

Rural Minds

Rural Minds was developed by RRMH to address the psychological wellbeing, substance use, mental health literacy and suicidality risk in men and women living and working in rural and remote agricultural communities.

The independent, ethically-approved evaluation findings (n=697 with over 70% response rate) from Rural Minds (Orygen 2018a) provide a valuable insight into the lives and mental health of many people living in rural Australia. They include:

- More than half of participants reported previously seeking help from a mental health professional, with females more likely to have sought help than males (58% vs. 48%);
- Finance and relationships with partners and/or children were the biggest causes of stress; and
- Males are much less likely to attend programs and get the required support through established channels.

Following the workshops:

- Community group attitudes toward mental ill-health changed, with participants reporting significantly higher agreement on statements such as 'mental illness is an illness like any other';
- Participants reported that they were most likely to seek help from their partners and there were significant increases in help-seeking intentions from a friend, other relative mental health profession, phone help line and family doctor were reported by presenters and participants;

- Participants reported perceiving fewer barriers to help than their view prior to the session;
- Men reported more barriers to help-seeking than females in pre- and post- surveys.
- The majority of participants following the presenter's workshop reported good to high 'confidence in their ability to deliver Rural Minds workshop' (81%);
- The highest rated aspect of the program was the increased awareness of 'the risks associated with my lifestyle' (78%);
- Participants reported high confidence on statements e.g.
  - 'I feel confident to communicate with others about mental health problems.'
  - 'I am confident that I would know what to do in a mental health emergency.'
  - 'I know about mental health issues.'
  - 'I know about treatment services.'
- with less than 6% of participants reporting low confidence.

Resource Minds (program description above)

Key findings from a sample evaluation (n=168) following the delivery of Resource Minds on-site include:

- Seven months after the first toolbox presentation, participants have attended an average of three toolbox presentations.
- The two most common take-home messages from the toolbox presentations were:
  1. mental health issues are common (n= 133, 79.2%),
  2. mental health is as important as physical health and safety (n=130, 77.4%).
- When asked to rate the toolbox presentations, more than three quarters (n=126, 85%) strongly agreed or agreed, that they were satisfied with the way the toolbox talks were presented.
- More than three quarters (n=118, 77.6%) of participants either strongly agreed or agreed that they had a better understanding of the signs and symptoms of mental health problems.
- More than half (n=91, 57.3%) of participants strongly agreed or agreed that they feel more confident about starting a conversation with someone who might need help.
- Over ninety percent (n=134,91.8%) of participants either strongly agreed or agreed they know where to find information about mental health support services and helplines.
- In relation to changes in their workplace, one third (n=46, 33.1%) of participants strongly agreed or agreed that their workplace has changed for the better since the toolbox talks started.
- Participants reported a significantly higher likelihood of helping others than seeking help for themselves.

The results of this evaluation indicate that participants believe that the Resource Minds mental health program has made positive changes in relation to their understanding and knowledge of mental health issues, mental health literacy and workplace change. Employees see value in the toolbox presentations, including the real life stories and relatable presenters and report they would like this to continue.

Investing in and scaling evidence-based programs

Mental illness and suicidality in Australia are significant health, social and economic concerns. The efforts to respond to these issues with timely, effective and appropriate services and supports, requires a multi-agency, collaborative approach, that recognises investment into complementary programs and services. However, duplication, competition for scarce funding and resources, and ill-fitting programs that lack an evidence base or proven results, can threaten to undermine the work of other agencies and organisations.

Due to the cost incurred by service providers who undertake research and evaluation of their programs, and due to their greater likelihood of impact, it is important to allocate resources to programs that have strong impact metrics and proven efficacy. Funders should acknowledge evaluated programs with demonstrated success as "preferred providers" over those that are unable to provide evidence of impact. The exception is, of course, in the piloting of new, innovative programs – particularly those that aim to support priority or hard to reach cohorts and emerging needs - but these should not be funded at the exclusion of programs that will 'actually work' in communities, and should be delivered by capable providers.

RRMH has invested more than $600,000 over a four-year period from various grants, including the Movember Foundation, to commission Orygen, the National Centre of Excellence in Youth Mental Health, Edith Cowan University and the University of Adelaide to contribute to the development of an independent and rigorous evidence-base for each program.

There are significant challenges and barriers to securing sufficient resources to demonstrate the success of any intervention or initiative and this, therefore, precludes significant numbers of small, local providers with limited funding from being able to independently evaluate programs. In order to rectify this, they should either be supported with additional evaluation funding and/or encouraged to collaborate with experienced organisations and/or research organisations, to measure program outcomes (and not just outputs).

For service providers like RRMH that have made that commitment and investment, it is proposed that policies and processes that allow for priority funding to scale and disseminate the successful, evaluated programs more broadly, be developed. For example:

- Development of a national register of well-governed NGOs delivering programs and services who do not have to continually justify their existence or sustainability for short-term tenders; and
- A more concerted effort within and by the sector to ensure collaboration and reduce duplication of services and programs.

These changes would ensure that:
- NGOs on the national register are not dependent on short-term, political 'sponsorship';
- Governments could more readily identify the most capable, culturally-relevant organisations for service provision; and
- Innovative and creative adaptations of existing evidence-based, programs can meet identified or emerging needs, for example, RRMH Rural Minds for Resourceful Communities.

The role of funders in valuing innovative, evidence-based initiatives

Funding opportunities available through governments, philanthropic organisations and corporate partners often site criteria such as "evidence base", "demonstrated outcomes", and "innovation" as requirements. There appear to be some challenges in consistently and sustainably supporting organisations who can meet these claims. Notable issues appear to be:

- The tendency to value new, progressive programs, which are robustly supported through the seed funding and pilot stage, but left to 'fend for themselves' for scale-up or expansion;
- The availability of funds for scale-up or expansion appears to favour organisations who have more prominent "public" brands or profiles, possibly due to expenditure of marketing, or programs that appear more "attractive" – not always those with sound evidence-base or proven results;
- Innovation for innovations sake – the tendency to place a premium on programs which claim to be modern, new, exciting and innovative, creates greater competition for already scarce funding. While strong innovation to meet emerging needs is positive – not all new programs are created equal. There should be a greater emphasis on recognising the value of existing or past programs that have had success, or re-tooling and adapting existing programs. Not only is this more cost effective, and lower in risk, but it also has the potential to ensure more programs remain sustainable, for longer;
- The challenge for proven programs to remain financially viable is a central issue. Aside from fee for service initiatives, not-for-profit organisations frequently rely on short-term political or philanthropic 'sponsorship' style arrangements to fund proven programs. The onus is put onto providers to demonstrate how their programs are sustainable, and to justify their existence, even when they have strong proven impact. Invariably when short-term funding for programs run out, these initiatives will go back into the competitive funding pool, to compete against other existing and emerging programs. This limits the potential for programs to gain real traction in communities and maximise their true potential; and
- Programs should be selected for funding based on their value and metrics, alongside the capacity for the provider organisations to manage funds to deliver best practice results - not on the ability of the organisation to lobby or attract endorsement.

Recommendation 4

PHNs and Government agencies target their investment into programs - particularly national culturally-tailored and locally-relevant prevention/early interventions - which have been piloted, successfully delivered and have a strong evidence base.

Aligning the health workforce with informal community care

The recent Senate Committee Report on the accessibility and quality of mental health services in rural and remote Australia (2018) provided substantial and relevant evidence of the need for initiatives that address the significant service gaps for people requiring early interventions, and those with psychosocial disability who do and do not qualify for the NDIS.

Although "provider lists" are available on NDIA websites, experience demonstrates that service organisations do not have workers on the ground in the areas listed "due to a lack of workforce and capacity in the region" (Rutherford 2018, as cited by the Senate 2018). This paucity of capacity is due not only to the lack of availability of appropriately trained people, but the logistics and significant financial costs (often not recognised), associated with workers fulfilling their role in remote locations.

Research indicates that implementation meetings with Local Area Coordinators (LAC's), both partnered and NDIA employed, often provide NDIS participants with a non-workable list of providers.

Additional evidence of the gap in supports was outlined by the Report as the committee was "concerned by the accounts it received that many rural and remote Australians have experienced issues applying for the NDIS and accessing appropriate mental health services through their NDIS plan. These issues included: a deficit of knowledge about the NDIS by health professionals; assessors, planners and service providers inexperienced in psychosocial disability; and a lack of appropriate support services" (the Senate 2018, p. 167).

Further, Recommendation 4 of the Report states "that the National Disability Insurance Agency ensure that the implementation of the psychosocial disability stream takes into account the issues facing rural and remote communities, including barriers to accessing mental health services and the lack of knowledge and experience in both psychosocial disability and the National Disability Insurance Scheme."

RRMH advocates for the recruitment, training and support for locally-based, non-clinical community care co-ordinators (CCC) who would go some way to redressing these current support deficits in rural and remote communities by providing linkages to local agencies and ensuring more choice and control for practical support.

The role of CCCs would involve identifying supports required; co-ordination and implementation of care plans; referrals; monitoring of progress; and advocacy and promotion. RRMH proposes that each community with a CCC will host a Rural Minds and safeTALK workshop to embed an informal community care approach, and build community mental health literacy, thereby increasing the propensity towards help-seeking behaviours and suicide safety. The events organised by the CCCs could also be used as community education and the opportunity to begin networking in the community.

There is potential for training and professional supervision to be delivered remotely by tele-support by the managing agency. This ensures a cost-effective means to maintain contact with even the most remote communities.

The development of a 'non-clinical' workforce and the investment into the prevention programs such as those delivered by RRMH would not only reduce the burden on primary care providers, but also services such as emergency services. By enabling local people to play an active role in the mental wellbeing and suicide prevention support model there is an emphasis on community capacity building that will incrementally, and more sustainably

improve mental health and wellbeing networks within rural and remote Australian communities.

Recommendation 5

The professional health workforce be complemented by the recruitment, training and support of locally-based, non-clinical Community Care Co-ordinators (CCCs) – to address health workforce shortages and availability of psychosocial supports in rural and remote areas.

Facilitating social participation and inclusion

Tailoring prevention and early intervention programs and services that engage specifically and culturally to rural and remote cohorts is important. Models that utilise local representatives, champions, 'natural helpers', and the community at large - through strategies such as 'train-the-presenters' or training of CCCs - enable discussion to be targeted and relevant to local community interests, experiences, language, culture and norms. This encourages peer to peer support, and participation in healthy discussions and behaviours about mental health. It allows an element of natural co-design in the adaptation and delivery of existing course content and information, to meet new audiences at a local level.

Events and initiatives that encourage social participation and inclusion in Indigenous and rural communities have been shown to improve mental wellbeing, improve help-seeking behaviour and prevent suicides. Examples of positive initiatives that RRMH has been engaged with include:

- "Roadshows" featuring musicians, performers and speakers who promote mental health. The overall objective of the roadshows was to increase awareness surrounding mental health through an enjoyable participatory event. The evaluation responses, both formal and informal, were overwhelmingly positive. There were many requests to repeat the exercise. The roadshows achieved the objectives and the benefits to the communities were evident in many ways.

  > **"***There were people who hadn't been off their properties for years who came to the show and they had fun for the first time in a long time. They reconnected with their community, picked up some information and some of them actually contacted some local mental health service providers. That is a very big breakthrough."*
  > (RRMH 2012)

- Art-based activities in Indigenous communities, which encourage participation of all interested community members. Participants don't have to have a background in art, feel artistic or plan to be an artist in the future. RRMH "Creative Livelihoods" is a workshop that demonstrates how Indigenous culture, heritage, creativity and arts– based activities can improve mental health and social and emotional wellbeing, whilst simultaneously creating potentially viable enterprises.

"You can't put a value on the expression on his face when he saw his painting and his image on the cover of the exhibition catalogue." - **A visiting mental health clinician in Lockhart River** (RRMH 2011).

'You should have seen his smile, that slow grin he has. I saw pride." - **Community Elder** (RRMH 2011).

There is often an increased impetus on the provision of community engagement and social connection activities during or after periods of community crisis or distress, such as after natural disasters in rural and remote communities. This is warranted, however, it would be beneficial if these initiatives were not considered as 'after thoughts' or temporary responses, but rather as ongoing contributions to community health and wellbeing. A greater emphasis on positive activities that build community participation around mental health and wellbeing, will have a preventative impact and should form part of a broader suite of programs to improve mental health awareness and help seeking, and reduce stigma towards these issues.

Recommendation 6

Higher priority be given to alternative and innovative, culturally-relevant initiatives and events in rural and remote areas, to generate social inclusion, connectivity and participation. This should not just be considered in times of environmental stress e.g. drought or floods, but as an ongoing strategy to ensure the maintenance of networks, relationships and community resilience.

Investing in mental health training in rural and remote communities, schools and workplaces

The wellbeing needs of students must be addressed before any academic outcomes can be achieved. Any mental health or suicide prevention programs run in schools will also be educating the staff as there has has been a significant lack of exposure to relevant mental health and suicide prevention professional development for teachers until recently. Due to the stigma associated with these topics in rural schools and communities, exposure to information or support has been limited at best.

The school curriculum is already jam-packed, so programs developed have to be specifically designed to fit in with the existing education environment for the long term. For example. the sessions should be lesson length and spread out over time in order to change the culture and behaviours of students.

In addition to the delivery of Rural Minds described above, RRMH has extensively delivered SafeTALK in rural and remote areas, including schools. Kingaroy High School evaluation indicated that:

"The feedback from the students was overwhelmingly positive and supportive of a greater rollout to their peers. The students' comments were in the main positive. The students found the training useful and indicated that they believed the training needs to be provided across all senior secondary students." (Kingaroy High School SafeTALK Participant 2018)

Based on the above information and feedback, RRMH have designed "Mental Health Briefings". Each Briefing is a comprehensive, abbreviated, hour-long session of essential information on mental health and suicide prevention for students attending schools in rural and regional Australia.

Indigenous Young People – Deadly Thinking Youth (DTY)

The particular experiences of Indigenous young people living in rural and remote communities has been captured through consultation followed by the development and trialling of DTY. Indigenous young people face a myriad of exacerbating factors which contribute to their heightened risk of mental ill health, suicidality and disconnection from clinical or other support services. This program is outlined below.

The DTY program is adapted from the adult program, based on feedback from Indigenous facilitators and youth involved in *Deadly Thinking* groups run with younger participants. DTY aims to help young Indigenous people in rural and remote communities to:

- Learn the importance of yarning with family and friends;
- Be more aware and understanding about what causes depression, anxiety and suicide;
- Understand how life changes can contribute to stress;
- Understand their own worries and how to deal with them (topics covered include cyber-safety, bullying and body image);
- Develop plans to help deal with challenges to their social and emotional wellbeing; and
- Connect to culture and country as a source of strength.

The DTY program has been designed for flexible, group-based delivery, either as a single one-day workshop, 2-3 half-day workshops or as individual units over a number of days or weeks. Although designed primarily for Indigenous youth, the DTY program is open to anyone aged 12-20 years. In most communities, DTY can run separately for younger (12-15) and older (16-20) age-groups.

As with the adult program, DTY involves a train-the-trainer model, including:

- A two-day training for potential DTY facilitators
- Trained DTY facilitators running the 12-unit DTY program in an open, comfortable and culturally-appropriate forum
- Various hard copy and online resources for DTY program participants, including videos and workbook.

Deadly Thinking Youth is currently being delivered by RRMH experienced, Deadly Thinking Trainers and evaluated by the Sax Institute, Sydney. Examples of preliminary results include:

In response to *"How much do you agree with the following statements?*
1. *Deadly Thinking Youth is culturally-appropriate for young people in my community*
2. *There is a real need for something like Deadly Thinking Youth in my community*
3. *Deadly Thinking Youth could make a positive difference for young people in my community"*
On a scale of one to ten, the mean response was 9.75 to each question.

When asked if there was anything else you'd like to say about Deadly Thinking Youth:

> *"I think the program is excellent and well over due needed in our community, its great as an Aboriginal Education Officer who works in schools to have these resources to pick up and help guide me to run the Deadly thinking with my students and it can be changed to suit age appropriate. Presenters were excellent and very engaging with us around group discussions"* (Sax Institute Deadly Thinking Youth Evaluation, in preparation, 2019).

Recommendation 7

That priority be given to the integration of *culturally-specific* comprehensive information about stigma and challenges faced by young people, mental health, wellbeing and suicide prevention, within school curricula - especially for those in rural and remote areas.

Mentally healthy workplaces

There is a clear need and appetite for relevant mental health information and training from workplaces and businesses across Australia. This is evidenced by: the massive cost of untreated mental health conditions in Australian workplaces; the number of programs emerging to meet demand; and the evaluation results of the RRMH programs outlined in this submission.

RRMH finds the following principles to be a valuable guide to the development of programs for any workplace. Programs should be:

- Culturally-specific in terms of language, imagery, topics e.g. inclusion of different risk factors and topics such as Succession in our Rural Minds Program for farmers;
- Comprehensive - inclusive of information about breaking down stigma and how to start a conversation, risk factors, mental ill-health symptoms and signs, signs of suicide, local and other sources of help, support and care;
- Integrated into occupational health and/or safety programs and delivered over the long term, as stigma and entrenched cultures take time and persistence to be broken down;
- A proactive not reactive approach, that is, preventative, taking the initiative to deliver programs, and speak to someone;
- Information is relevant and presented in an engaging manner;
- Presentation:
    - Must allow for conversation and participation, enable yarning and not too formal;
    - Must build a safe environment and trust among participants to share experiences;
    - Enable the creation of a local network for ongoing support;
    - Can be cathartic, uplifting, positive;
- Provides choices and access to services and support – locally and online; and
- Embedded particularly into rural and remote communities/workplaces by being delivered face-to-face by locals who know the unique culture and issues as well as services and supports.

It is also clear that there are significant personal and productivity benefits in the widespread commitment to improving mental health and wellbeing in the workplace. The real challenge is the ad hoc approach to selecting, funding and delivering the programs. For the most part, businesses and industry take responsibility for the safety of employees in the workplace and this includes physical and mental health. There is significant variability in the programs in terms of content, evidence-base, cultural fit and cost (depending on whether the program is subsidised by Government or not).

Peak industry bodies are making significant commitments to raising awareness and supporting various programs, however, there is still a long way to go despite the progress to date via the various Government inquiries into the mining sector and FIFO workforce (for example, the Western Australian Government's parliamentary Inquiry into Mental Health of Fly-in, Fly-out Workers in 2014 and the Queensland Government's parliamentary inquiry into FIFO and other long distance commuting work practices in regional Queensland, including mental health impacts.)

Some mining and resource companies have made significant investment in mental health in their workplace and, will over time, reap the rewards. However, there are other companies which recognise that it is a significant issue but take a short-term, limited investment approach that means they can "tick the mental health compliance box".

There are many family companies and small businesses which are run by and for the purpose of primary production. This includes farmers and fishers who work often in harsh conditions and in isolation (referenced above). Although some of the conditions and risk factors might be similar, their access to information, support and care are not the same as those in other industries. It is therefore challenging to make some "workplaces" more mentally healthy when they are so inaccessible.

Recommendation 8

That "gold standard" guidelines and/or regulations be developed for the content of prevention programs, including those that address: stigma, risk factors, signs of mental distress and suicidality, pathways to information, support and care specifically for rural and remote workplace settings, which differ considerably from the metropolitan concept of a workplace.

5. Framework to enhance mental health and improve workforce participation and contribution

Integrating services and programs in rural and remote Australia

Integration of mental health services in rural and remote Australia can be significantly enhanced by following the ten steps listed below:

- Be provided in identified areas of need/ at risk groups;
- Focus on prevention and early intervention;
- Be evidence-based and evaluated;

- Be locally relevant, address community risk factors and include input from the community, consumers, carers and Indigenous Australians;
- Take a social determinants of health approach and be holistic;
- When possible, implemented in collaboration with other or local organisations delivering mental health and Social Emotional Wellbeing services;
- Be implemented in collaboration with consumers, families and carers;
- Be culturally appropriate and safe;
- Links provided to early interventions and comprehensive primary healthcare; and
- Embed the information and knowledge of the programs into communities through local presenters (Bishop, et al, 2017).

Issues with current funding arrangements

The commissioning arrangements and tendering processes through the PHNs are gradually being implemented and improving. This is a topic currently being discussed between the PHNS and the NGO mental health sector, led by Mental Health Australia. However, it will be sometime before these processes are resolved to the satisfaction of all parties.

There are key issues from the perspective of a national NGO working in rural and remote Australia which has programs that can be tailored to local needs and delivered by local leaders and they include:

- the capacity and cost of engaging with at least 15 PHNs with rural and remote constituents, and
- how and who to inform about the value of prevention programs e.g. who is responsible for workforce, Indigenous programs.

Given that there are almost 7 million Australians in rural and remote Australia who would benefit from awareness raising and preventative information, there would be economies of scale if there was one commissioning body that understood the challenges and issues facing rural and remote Australians. Some of those challenges not previously highlighted in this submission include:

- every person the programs are targeted at and tailored for does not have the capacity or willingness to pay, therefore, unless there is an ongoing commitment over the long-term, the design and delivery of such programs will not be sustainable;
- once designed the train-the-presenter model ensures that the skills and information is retained in the community;
- the limiting factor may be the ability to pay a fee to the trained presenter to continue to deliver the program, in many cases, this can be voluntary but not always;
- the delivery of awareness and prevention programs are traditionally seen as a Government responsibility;
- the cost of accessing, training and supporting community leaders and non-clinical workers in rural and remote areas;
- the cost of transport and access to meeting points be they in regional towns or cities for those living and working in rural and remote areas;
- the lack of understanding or allowances made by funding bodies to accommodate the challenges of distance and remoteness; and

- balancing the need to use internet and phone connections versus personal contact. a

Recommendation 9

Special consideration needs to be given to the commissioning and funding for the delivery of national programs, especially for rural and remote Australia to ensure impact, reach and sustainability.

6. Conclusion

It is acknowledged that the mental health system is extraordinarily complex with a huge number of competing demands on human and fiscal resources. Further, with increasing levels of awareness and expectations from consumers, carers and the community generally, the challenges of structural reform are immense. That said, The Senate Inquiry (2018) and other submissions along with this one, will make the case for, not only for the implementation of a national prevention strategy, but for a focus on the 6.9 million rural and remote Australians who contribute selflessly and so significantly to Australia's GDP and prosperity.

7. Contact Details

Rural and Remote Mental Health invites any further discussion around the issues and recommendations addressed in this submission. Please direct contact to:

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