GOING THE DISTANCE

Making mental health support work better for regional communities

A discovery Project to understand and document the need for mental health support across three regions of Western Australia

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Prepared by the Centre for Social Impact, The University of Western Australia

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Project Team

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The Centre for Social Impact (CSI) is a collaboration of four universities: The University of Western Australia, Flinders University, the University of New South Wales and Swinburne University of Technology. The purpose of CSI is to catalyse positive social change, and to enable others to achieve social impact. CSI achieves this through transformational research and education that is rigorous and purpose driven.

Western Australian Association for Mental Health

The Western Australian Association for Mental Health (WAAMH) is the peak body for the community mental health sector in Western Australia and exists to champion mental wellbeing, recovery and citizenship. WAAMH recognises that a continuum of supports – built on principles of human rights, recovery, co-production, personalisation and choice, social inclusion and cultural connection – are essential to the promotion, protection and restoration of mental wellbeing. WAAMH's membership comprises community managed organisations providing mental health services, programs or supports and people and families with lived experience of mental health issues and suicide, with whom WAAMH engages in genuine partnership. WAAMH also engages in a wide network of collaborative relationships at a state and national level with individuals, organisations and community members who share its values and objectives.

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Foreword

The personal and social impacts of mental illness and distress in Australia is experienced most intensely in rural and remote regions of the Country. It is these communities that have the greatest need yet are under-resourced and inadequately serviced. 'Going the distance: Making mental health support work better for regional communities', clearly highlights the drivers of mental distress in rural communities, the barriers in accessing services, and the increased need for support.

The Western Australian Association for Mental Health (WAAMH) and the Centre for Social Impact (CSI) visited communities across three regions in Western Australia (WA). WAAMH, being the peak body for community mental health in Western Australia, and the CSI, leaders in social research, have created a highly effective partnership utilising rigorous research tools with thoughtful analysis. The authors sensitively and inclusively engaged with communities enabling the reader to truly hear the voice of rural people. Personal, heartfelt stories have been shared, allowing an authentic description of the needs that exist in rural communities.

The report highlights challenges that are common to rural communities as well as the needs that are unique to individual places. Participants reported time and again the need for tailored, community specific services – be they community services that address the social determinants of mental health, peer support groups, education programs or treatment services.

As a GP who works and lives in a small rural community, I am acutely aware that the greatest strength in having a rural address is the community itself. This document highlights the power of community in all tiers of mental health care – awareness raising, education and destigmatisation; as well as the provision of therapeutic support.

The report not only describes the needs and inequities that exist between rural and metropolitan communities, it also provides a number of solutions. A place-based approach that addresses the unique context and needs of communities is inarguably the most therapeutically effective and fiscally sustainable option. Decision-making must be given back to the rural communities who are best placed to know and service their needs.

The report highlights the necessity for an urgent review of current funding models. We have repeatedly seen drive-in drive-out services failing. There are a multitude of reasons for this – a lack of understanding of the community's needs, inadequate consultation with local stakeholders and inefficiencies with large budgetary allocations being for travel. The cycle of mistrust and underutilisation of these (undoubtedly well meaning) services is perpetuated. State and Commonwealth Governments have recognised a need for increased services in rural areas, however the model of planning, commissioning and governance is ineffective.

For rural populations to receive the support they require, commissioning and servicing needs to be decentralised. The report identifies a large number of rurally-based mental health advocates who are committed to the wellbeing of their communities and who would ensure that services are context-driven, responsive and accessible.

Those of us who live and work in rural communities must be consulted in policy making and planning if the inefficiencies and the ineffectiveness of the status quo is to be addressed.

I thank the authors of the 'Going the distance' report for giving our rural communities a long overdue voice, for articulating the inequities that exist between rural and metropolitan communities, and for providing recommendations for policy makers and commissioning services for an alternative approach to funding mental health services in rural communities. It is time to make these changes – our communities are in need, and we are ready.

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Terminology – This section offers working definitions of terminology that are used in this report

Barriers: Factors that affect access to a support based on environmental circumstances. Low-barrier refers to ease in accessing support; there are no constraints that make it difficult to seek help. Where there are many barriers, accessing help is more difficult.

Community mental health support: Refers to various non-clinical options and services (both formal and informal) which respond to mental distress in a non-institutional or community setting. This may include grassroots, peer-led and family inclusive options. Some examples include safe spaces, peer support groups, Hearing Voices groups, and community-run family supports.

Drive-in drive-out service delivery: Drive-in drive-out refers to a model of service provision in regional areas where service providers travel to smaller towns to provide visiting services. Occasionally, for very remote areas, services may also be fly-in fly-out (e.g., in the case of the Royal Flying Doctor Service).

Family members and carers: Refers to people with a lived experience as a carer, family member, friend or other supporter of a consumer. The term acknowledges that not all family members wish to identify as a 'carer', and there may be other important relationships in a person's life or recovery process.

Fly-in fly-out / drive-in drive-out work: A mode of work in which employees fly or drive to regional work sites for temporary periods rather than permanently relocating. This method is often used to address shortages of workers in rural and remote Australia.

Lived experience: Refers to people who have personal experience, currently or in the past, that can provide insights, knowledge and understanding of that issue in order to inform service delivery and policy. Someone with a lived experience of mental health may include a person who is living with or has experienced a mental health condition, distress, or challenge.

Mental health: The World Health Organization defines mental health as a state of wellbeing that enables people to cope with stress, reach their potential, and live a meaningful, fulfilling life (World Health Organization, 2013). Understandings of mental health and social and emotional wellbeing vary among different cultures and communities, and some see distress or social and emotional wellbeing concerns as a response to adverse social conditions (Dudgeon et al., 2017).

Mental health supports: A term that encompasses a range of services and organisations that address mental health issues, such as mental health services, as well as community-based services including social supports, peer-led supports, activity-based supports and holistic informal supports.

Natural helpers: People who others naturally turn to in times of need and crisis. They might be a friend or even a teacher or colleague. Natural helpers are diverse, they can be skilled or unskilled, and formally educated or not formally educated. Often, natural helpers are positioned between those in need and the services that are available to meet that need. They have also been labelled 'lay educators' and 'lay health workers' (Drew, 2015).

Peer workforce: Refers to the (usually) paid workforce engaged specifically for their lived or living experience of concerns relating to social and emotional wellbeing, or of mental health difficulties, or of using mental health services. Roles within this workforce include but are not limited to peer support workers, lived experience academics, peer advocates and advisors. This workforce complements and is distinct from other clinical and professional roles.

Place-based: A collaborative, long-term approach to building a thriving community, delivered in a distinct location. A place-based approach responds to complex, interrelated, or challenging issues and is usually characterised by partnering, co-design, and shared accountability related to outcomes.

Social and emotional wellbeing: A multifaceted concept that refers to an individual's wellbeing determined by interrelated domains: body, mind, family, community, culture, Country and spirituality. This is a preferred term among many Indigenous Australians and indicates a broad approach to wellness (Dudgeon et al., 2017).

Social determinants of mental health: The social, economic and environmental factors which shape experiences of mental health among individuals and groups of people. This may include, for example, income, job security, housing, the built environment, access to support, and social connectivity.

Trauma-informed: An approach to service delivery whereby aspects of services are organised around acknowledging existing trauma throughout society and among individuals who may access the service(s). Trauma-informed services are aware of and sensitive to the dynamics of trauma that people may experience, and seek to mitigate harm from retraumatisation, and engage with people in a way that rebuilds trust and connection.

Executive summary

PURPOSE AND METHODOLOGY

People living outside of metropolitan areas experience consistently poor mental health outcomes (Perkins et al., 2019), and yet, often their needs are less visible or overlooked in critical decision-making processes. Policy-making, service planning, commissioning, resource allocation, and workforce development are all functions that flow out from capital city epicentres, often without a clear line of sight as to whether these processes truly serve rural, regional and remote communities.

This Project aimed to better understand what is different about living in regional areas that leads to poorer mental health and difficulties accessing support, and what further support is needed to improve the lives and wellbeing of people living in those communities.
We asked:

1. What are the lived experiences of individuals experiencing mental health issues at various levels of severity in regional areas?
2. What are the perceived gaps in need versus access to mental health supports in regional areas?
3. What are the unique factors of living regionally that affect experiences of mental health, service access and funding, and what do communities say needs to change?

Three geographical regions were chosen for in-depth consultation: the Midwest, South West and Wheatbelt. The consultation process involved forums, focus groups and other events to engage community members. Interviews with key stakeholders were conducted via video conferencing. Survey data was captured from across all regions in Western Australia (WA), providing the chance to analyse findings from the three study regions and extrapolate, to an extent, experiences across all nine regions of WA. Analysis involved synthesising qualitative and quantitative data across the three regions, and by size of community. An overview of the three main data collection methods and participation is provided in Table 1.

Table 1: Participation in data collection

Community consultations	One-on-one interviews	Survey
320 participants	14 interviewees	410 respondents
16 communities	12 communities	122 towns/113 postcodes
3 focus regions only	3 focus regions, plus stakeholders from metropolitan-based peak bodies with a knowledge of the focus regions	All 9 WA regions, with more respondents from the 3 focus regions

INDICATIONS OF UNMET NEED

Community members made observations about their community strengths, such as positive experiences of social cohesion and the ways that community members support one another in practical ways. However, **over half of survey respondents rated their community's overall mental health and social and emotional wellbeing as fair or poor**, suggesting that many people believe that mental health in their community could be improved.

> "Being a local ambulance officer within my community, I have noticed the amount of mental health issues increasing significantly over time with the rate of suicide to be on the incline"
>
> (Survey respondent)

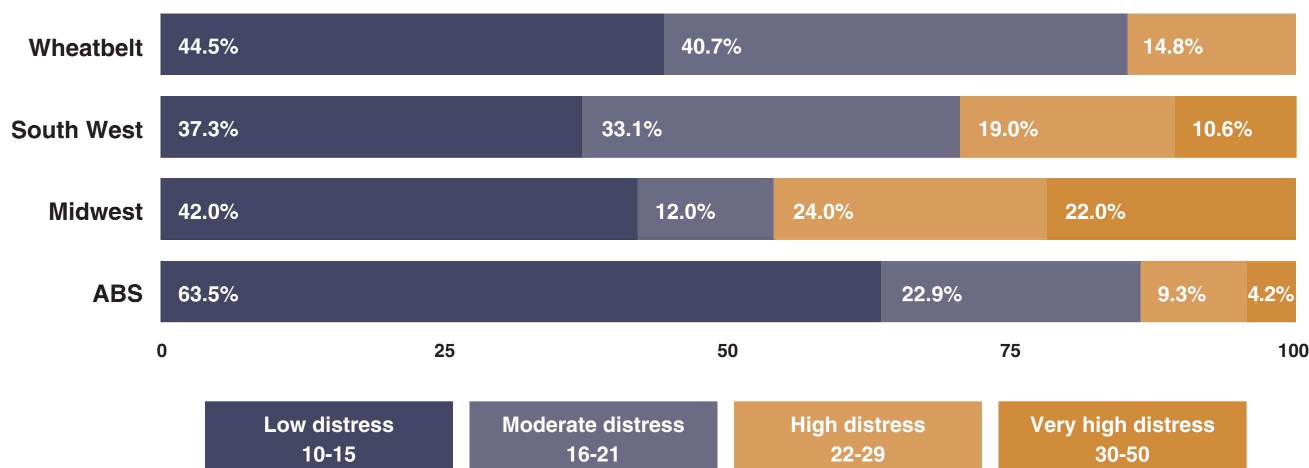
People consulted spoke about particular adversities faced by rural communities. They highlighted experiences of isolation, loneliness and lack of opportunities for activity or connection, distance from services and supports, issues with alcohol and other drugs (AOD), stigma around mental health and people's unwillingness to get care. They also spoke of the need for greater financial stability and employment options to help people feel optimistic about the future. The impacts of natural disasters, a changing climate and the destabilising effects of market dynamics on farming were felt acutely in some communities. Generally people did not see 'resilience' as an adequate solution to overcoming these difficulties.

Survey comments and consultations across many communities identified young people (primary school age to young adults) as having urgent mental health needs, both in terms of the symptoms and distress observed, as well as the lack of suitable supports available for them. Schools were seen as settings that could potentially make a difference to the mental health and wellbeing of communities.

> "Help with... emotional regulation and anxiety needs to be available in every school. In the community there are huge issues" (Survey respondent)

The survey included clinical measures of distress (World Health Organisation-Five Well-Being Index, WHO-5), psychological distress (Kessler Psychological Distress Scale, K10) to help understand the level of need for mental health support. **Over one third of survey respondents (34%) indicated they were in either high or very high psychological distress.** Half of survey respondents scored less than 50 on the WHO-5 measure, suggesting possible depressive symptoms (and, in a clinical setting, this would indicate a need for further assessment for clinical depression). Across the board, all regions were doing poorly compared to Australian population norms (Australian Bureau of Statistics [ABS], 2012), see Figure 1.

Figure 1: Levels of distress across regions and compared to ABS data (K10 categories)



These data suggest about a third to one half of survey respondents may have a mental health need to address. There is a population-level need to reduce distress, particularly in younger people.

MENTAL HEALTH EXPERIENCES IN REGIONAL SETTINGS

Evidence across multiple data sources demonstrates that people living in regional communities are not being adequately supported in a number of ways.

- **Social determinants:** **A quarter of survey respondents experienced challenges with housing, one in four also experienced financial stress and one in four reported physical health issues. One in five were struggling with social isolation or loneliness.** All are known social determinants with impacts on function and wellbeing. Interview data uncovered that in rural settings addressing these issues is more difficult because of the relative scarcity of jobs, housing and services. Thus, the effect of the social determinants on mental health is likely to be amplified in rural settings.
- **Social care and self-care:** **About one third of people surveyed were not getting as much social support as they felt they needed**, which is problematic because access to social supports is associated with lower distress. To care for their wellbeing, people identified the need to improve their eating, sleeping and exercise habits and asked for more support to be physically healthier.
- **Early help-seeking:** Stigma about mental illness prevented people living in regional and rural settings from getting help early (including internalised stigma as well as stigma observed in support services), as did transport and logistical barriers such as distance to travel, pressures of living and cost. **Both the cultural and logistical barriers to help-seeking were felt to be more acute in regional areas, and especially in smaller towns.**
- **Symptom reduction and coping:** **Seventy-six percent of people surveyed said that in the past 12 months there was a time when they wanted to talk to someone or seek help about stress, depression or problems with emotions.** However, 39% of these people reported that they did not get the care they needed.
- **Support for people in acute distress:** Consultations and survey comments strongly suggested that **people experiencing a mental health crisis were not adequately supported** in regional areas. This was particularly so in smaller towns. However, the issue also applied to larger regional centres where hospitals had staffing and capacity issues, and access to mental health beds, or specialists such as psychologists and counsellors, was also limited.
- **Healing and reintegrating:** In regional areas, **people experienced a lack of choice around social and recovery supports to keep them well and socially connected**. For recovery and reintegration, people consulted felt that locally-based community supports are ideal, but program funding is often piecemeal and limited, which impacts their effectiveness.

Access to support across the regions

Survey respondents were asked: *In the past 12 months was there a time when you wanted to talk to someone, or seek help about stress, depression, or problems with emotions?* and the follow-up question, *Did you get the support you needed?*. Results indicated significant unmet support need across all regions.

- **71%** of respondents surveyed from the Wheatbelt reported needing to seek support for their mental health in the last 12 months, however, **55%** of these people did not get the supports they needed.
- **72%** of respondents surveyed from the South West reported needing to seek support for their mental health in the last 12 months, however, **44%** of these people did not get the supports they needed.
- **79%** of respondents surveyed from the Midwest reported needing to seek support for their mental health in the last 12 months, however, **42%** of these people did not get the supports they needed.

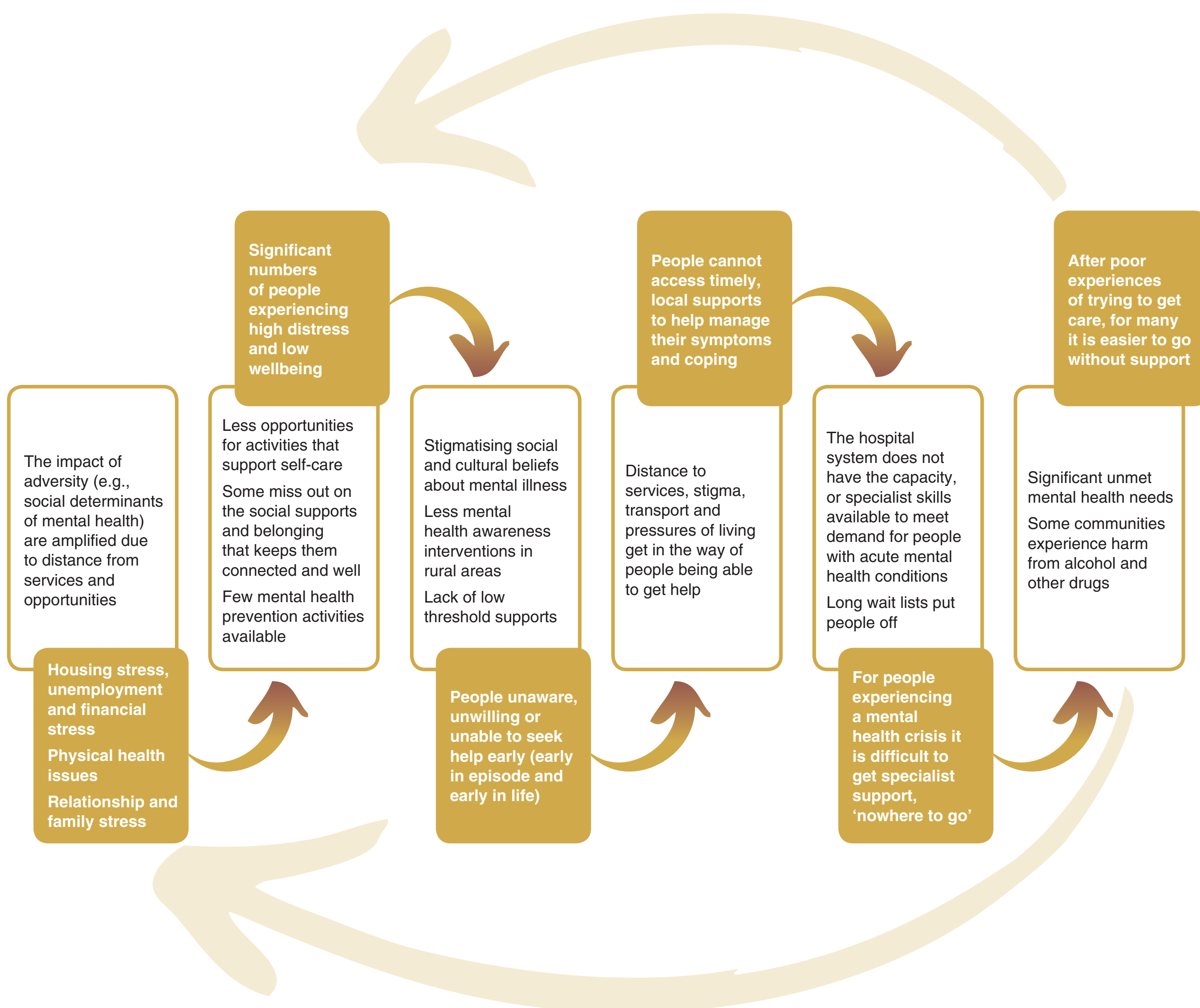
Survey respondents from the Wheatbelt seemed to experience greater difficulties getting the supports they needed, with over half of the respondents not being able to access supports. This may relate to the sparse population and lack of mental health supports funded in that region. People reported needing to drive up to three hours to access face-to-face mental health care, and telehealth is not always viable or preferred.

"There are a number of services, however the wait list is too long. A lot of state-wide NGO contracted services are not actually delivered or available state-wide. People without a car cannot access services. There is no public transport. There is a long wait list for services. The cost of private providers and gap fees are sometimes too much for a family to bear. The stigma of asking for help is very real" (Survey respondent)

The 'tyranny of distance' was mentioned often as a barrier to achieving social integration and having good-quality, easily accessible formal and informal supports for mental health, which compounds poor mental health, particularly among more isolated individuals and families such as farmers. In addition, the lack of options available, plus experiences of stigma or discrimination within the mental health system, further alienate people from services, and may mean for that some people in need it is easier to go without support.

The following diagram (Figure 2) summarises the issues people living regionally face in getting support for their mental health, the drivers for mental health conditions, and how failures to get support further compound the mental health vulnerabilities in a regional context.

Figure 2: Indicators and drivers of unmet mental health needs, and compounding effects, for people living in regional settings



THE EXPERIENCE OF REMOTE COMMUNITIES

Across all three regions a common pattern was observed. Mental health support is available to some extent in the large regional centres. On paper, the service providers based in these larger towns provide outreach supports to surrounding towns via drive-in-drive-out service delivery. From a service planning perspective, this makes sense given WA's sparsely populated geography and the lack of a specialist, qualified workforce in remote areas.

However, for various reasons outreach services do not always reach small towns. Sometimes there is no time allocated for promotion or community engagement and therefore the local community are not aware of the visiting service, it is underutilised and then eventually withdrawn. In other instances, outreach supports might reach small towns in such small supply that they are of little value. In effect, very little funded support is available beyond the regional centres, which highlights significant structural problems with the dominant funding model. These dynamics can leave towns without any supports, unless the communities make a strong commitment to fundraise or ensure other workarounds so that they have locally-based mental health supports.

FURTHER SUPPORT THAT PEOPLE ASKED FOR

Individuals involved in the consultation process and survey expressed a strong sense of what they needed. These needs were:

- **Community mental health supports:** **Thirty-nine per cent of survey respondents expressed a desire to seek community mental health support** (such as a program delivered at a drop-in centre, a neighbourhood centre or attending a peer support group).
- **Social supports:** Survey respondents felt that **the most important thing for making a difference to their mental health and social and emotional wellbeing was connection with others and developing a sense of belonging** (26% quite important; 55% very important). One survey respondent said that in their community, social supports would be just as important as clinical care, and yet there are no supports available where people can "interact, engage and participate in the community" or connect in groups with support from occupational therapists and social workers with mental health expertise.
- **Prevention and mental health awareness:** To address stigmatising beliefs about mental illness that exist in regional WA, people asked for **greater public mental health awareness campaigns, tailored to their community, including information about help-seeking and self-care.** According to one survey respondent, there is a "lack of understanding of when to access mental health [supports]/being able to identify this, and there is a huge stigma around accessing services when people need them".
- **Holistic 'non-mental health' supports that address whole of life needs:** Specialist clinical support is difficult to access, but not necessarily the answer and not always preferred. **Holistic non-clinical supports that do not necessarily focus only on mental health** were raised as a way to help people cope with living and reduce stresses, and also as a way to address the perceived stigma of mental health issues.
- **Activity-based, informal supports:** People also asked for **supports that provide opportunities for people to connect and participate in something for their wellbeing, including safe spaces where people come together and socialise**. The perceived advantages of activity-based supports are that they are low-threshold, holistic and non-stigmatising. These were also seen as suitable for young people. One survey respondent summarised it well: "There needs to be more facilities that are more relaxed and not so in your face about being 'mentally ill'… [to] help people get back on track to feeling good without the label".
- **Culturally appropriate and culturally safe supports:** People identified a need for **more innovative support models that can appropriately engage people of different cultural backgrounds and Aboriginal peoples**, such as, "More back to Country activities for Aboriginal people with mental health issues" as suggested by a survey respondent. To address mental health in Aboriginal communities, this would involve models that are culturally safe as well as culturally appropriate, non-stigmatising, non-discriminatory, accessible, and Aboriginal-led.
- **Support offered by peer workers, and for peer workers:** People with lived experience and service providers consulted as part of the Project called for **the development of more peer and lived experience-led responses** in regional and remote communities. This could include more peer workers and the use of peer navigators in both clinical

and non-clinical settings, as well as appropriate training for peer workers to support their own mental wellbeing and their efficacy.

- **Support for first responders:** The consultation process highlighted the **significant benefit that providing mental health-specific training and support to first responders would have in regional communities.** In smaller towns and communities, with the exception of the Police, first responders are usually local people who volunteer their time in roles such as ambulance drivers, bushfire brigades, fire and emergency personnel and paramedics. In small communities they are likely to have social connections to the people they assist. First responders receive minimal support in dealing with the possible trauma and emotional burdens of performing their volunteer functions in situations where they know the people affected.

LOCAL RESPONSES

Community-led responses have emerged in some communities, with examples presented including community collectives, place-based multipurpose mental health agencies, supports that encourage help-seeking, supports that address housing and financial stress, alternatives to hospital crisis care and supports designed for young people. One strength of these initiatives developed in regional communities is that they utilise existing community settings, such as ‘gathering places’ and community partners beyond the mental health sector, creating positive environments for delivering non-stigmatising and holistic support. The weakness of these community-driven supports is that they are not often successful at attracting formal mental health funding, they rely on the goodwill of community partners, and are rarely funded in a way that is sustainable.

KEY LEARNINGS

Communities’ experiences of mental health support were highly context-specific, varied with the size and location of a community, and were influenced by demographic and socioeconomic factors. What works for one regional community may not work for another, even if they are located close together or share similar characteristics. While change was called for by many people we listened to, it was not necessarily clear-cut in terms of what that might look like.

However, four key learnings cut across all regions and communities examined, and were supported by state-wide survey data:

- **Key learning 1: Levels of distress and extent of unmet needs are significantly high.** Mental health distress in regional communities is significant and communities have a range of unmet needs, including around social determinants, which are having a large impact on mental health and wellbeing.
- **Key learning 2: Regional communities need more supports around help-seeking.** Greater mental health literacy is required to reduce stigma, normalise getting support for mental health, and to encourage people to accept help – particularly early in life and at the onset of experiencing challenges with mental health.
- **Key learning 3: There is a need to improve accessibility of clinical supports and provide more options beyond clinical care.** Existing clinical services in the regions are necessary but not sufficient in terms of accessibility, quality and relevance, and communities would like more support options beyond clinical care.
- **Key learning 4: Local leadership needs to be engaged so that supports are effective and sustained.** Mental health support options need to be ‘place-based’; i.e., context-specific, and community-driven so that they respond to needs, are easily accessible and are utilised.

Importantly, locally-based solutions utilise the strengths and assets of a community, and give services the opportunity to work flexibly. Local leadership can inform and support adjustments to the location and timing of service hours, types of support models offered, the mix of group and individual supports, types of outreach, levels of brokerage and practical support, depending on the community. This could make a significant difference to people getting the help they need, as these are all issues that people told us must be considered to help people overcome barriers to seeking help and getting the sustained support that they need to stay well.

SUMMARY OF FINDINGS

Conversations with community members and survey data highlighted the need to improve mental health and wellbeing in regional communities.

While the need is recognised, there is also a feeling that people should be able to get by without help, as a necessary condition of rural life. This is amplified in smaller communities where often there are no funded mental health supports available. This assumption however is changing, and many communities are having conversations locally about how better to support people who are struggling, especially young people who many community members are concerned about.

Community supports (including social supports, peer-led supports, activity-based supports and holistic informal supports) are regarded as a viable solution, especially where there are difficulties finding a qualified workforce to deliver clinical services. Community supports are more holistic and less stigmatising, are typically low-barrier and low-threshold (less costly to implement and access), address social determinants and causes of distress, and can be delivered flexibly by peer workers in innovative settings. In these ways they align well with the needs identified by rural and remote communities.

Reviewing funding allocations and procurement models was out of scope for this Project, however it seemed impossible to have conversations with community members without the issue of funding coming up. At times there was a sense of hopelessness because larger towns seem to attract all the resources. On the other hand communities expressed pride in community-driven activities that were sustained largely by local money and goodwill.

An important learning from these conversations is that funding is not only about money. It is about sovereignty and all the decisions that are made in the commissioning process. Local leaders and mental health advocates must be able to help make these critical resourcing decisions according to their community context. Across all proposed actions, it is recommended to provide funding streams that are sustainable, long term and provide local communities with control and access to resources to make decisions based on their community's needs. The evidence presented in this report suggests that this single structural change alone could significantly improve access to support for mental health for people living in rural and remote communities in WA.

SECTION 1:
Introduction

1.1 Background

"We need to strengthen our community but are not sure what to do about that. Often everything happens in towns nearby with larger populations. Depression, drugs and alcohol are a big problem, but no-one is able to talk about it or make a plan to assist. It's too big a problem to manage without government or organisational intent and support"

(Survey respondent)

In 2021, the Western Australian Association for Mental Health (WAAMH) and the Centre for Social Impact (CSI) visited communities across three regions in Western Australia (WA) to ask about mental health experiences, and the extent to which the existing supports were meeting need. A mix of quantitative statistical and qualitative survey data, insights from key stakeholders and service providers and diverse stories of personal experience have provided a rich understanding of mental health needs that exist outside of metropolitan Perth.

The introductory quote may be the opinion of just one person, however it reflects a common sentiment across communities. While the need for more mental health support is recognised, there is also a sense of overwhelm and a feeling that people should get by without help, as a necessary condition of rural life. This is amplified in smaller communities where services can be seen as a luxury for people living in the distant, larger towns.

Stigma and shame surrounding mental illness, and the effects of experiences such as geographical and social isolation and economic hardship make it difficult for people to ask for support for their mental health. This applies to asking for help from formal services as well as from natural supports like family and friends. Talking to people allowed us to understand the value of natural supports in rural settings, due to the social cohesion of communities and resilience of individuals. On the other hand, the myth of the tough and resilient rural community where everyone supports one another effortlessly and adequately is also problematic. Through deeper conversations, we came to understand that there are many people who may be excluded socially from these 'tight-knit' communities; there are people whose struggles are not visible at all to others (until a crisis manifests); there are people who are exhausted from supporting others living with ongoing mental ill-health; and others whose support needs are more complex, requiring expertise that is beyond what the caring community members around them can provide. In some communities, although people are quick to lean in to help one another with all sorts of practical matters, talking among friends about mental health problems is still something that tends to be avoided.

While mental health needs in some towns may lack visibility, it was clear from the conversations we had that many people have been thinking about, and responding to, the issue of mental health and harm from alcohol and other drugs (AOD) in their communities for some time. When asked, community members could clearly articulate what is not working currently, and also offered ideas about practical ways that their community could overcome the limitations they face. A problem-solving approach was adopted in conversations so that possible solutions to help communities get 'unstuck' could be documented. It is hoped that these insights are captured in this report in a way that helps others to understand experiences of mental health in regional communities and the opportunities for change.

PURPOSE AND SCOPE OF THIS WORK

The purpose of this Project was to come closer to answering three key questions:

1. What are the lived experiences of individuals experiencing mental health issues at various levels of severity in regional areas?
2. What are the perceived gaps in need versus access to mental health supports in regional areas?
3. What are the unique factors of living regionally that affect experiences of mental health, service access and funding, and what do communities say needs to change?

Three geographical regions were chosen for in-depth consultations: the Midwest, South West and Wheatbelt. Although each region had a different demographic and historical profile – as did the communities within them – common threads of experience could be highlighted to help understand regional mental health. Survey data was captured from across all nine regions in WA, providing the chance to analyse findings from the three study regions and extrapolate, to an extent, to experiences across all WA regions. It should be noted that the in-depth consultations occurred in the three regions closest to Perth, therefore the experience in other WA regions may be further amplified with increasing distance from the capital and with increasing remoteness. Although some Aboriginal communities and towns were in scope in the three focus regions, this Project was also limited in the extent to which we could explore systematically, comprehensively, with proper consultation and with culturally-adequate depth and understanding, the needs of Aboriginal communities. It is hoped that this work will be conducted in the future, as a requisite for more comprehensively addressing the mental health needs of regional WA.

Structured participatory research methods were used (i.e., interviews, focus groups and a survey), as well as more natural engagement approaches such as yarning and informal conversation. Where possible, the consultation happened face-to-face in the communities, although there were also online discussions facilitated via video conferencing. These data were analysed to reveal personal and community experiences of mental health and wellbeing, and access to support. Analysis involved summarising data across the three regions, and by size of community.

WAAMH commissioned CSI as Project partners. WAAMH provided expertise in consultation, community engagement and navigating conversations about mental health informed by the strategic context, and also utilised their existing networks developed through its state-wide advocacy work. CSI provided expertise in designing a data collection methodology, conducting qualitative and quantitative analysis of data, interpretation, and presenting findings in this report.

FRAMEWORK FOR UNDERSTANDING MENTAL HEALTH SUPPORT NEEDS

Access to clinical supports for diagnosed mental health problems, and finding timely hospital care during a crisis, were notably important for regional West Australians, and top of mind in many conversations. However, the Project Team facilitated discussions that purposefully broadened the conversation around mental health support to also cover:

- Improving wellbeing and preventing mental health conditions;
- Improving mental health literacy and supporting help-seeking behaviours;
- Addressing the social determinants of mental health;
- Enhancing support opportunities and options for people who need support for a mental health condition; and
- Understanding the role of social connection and natural supports within communities for supporting mental health.

The following diagram (Figure 3) illustrates how the need to access clinical care for mental health was conceptualised as a 'tip of the iceberg' need, with conversations deliberately digging down to uncover other critical needs (or perhaps less visible needs) that contribute to the overall picture of mental health support needs.

Figure 3: Support needs beyond clinical care

Informed by this expanded conceptual framework, the Project Team facilitated targeted discussions about 'community mental health supports', i.e., non-clinical options for responding to mental distress. A range of services and formal/informal supports are included within the scope of community support. For example, services funded to support people with mental health issues in their community, as well as supports outside the mental health sector in areas such as housing, employment, training, education, income support, recreation and daily living activities. Community supports also include community groups that provide opportunities for people who may have a mental health issue to meet and connect with others who share similar interests. Some examples include safe spaces, peer support groups, Open Dialogue groups, Hearing Voices groups, and community-run family supports (Martin et al., 2020).

Community supports provide opportunities to better address the needs of people who may be otherwise marginalised from services or underserved by the mental health system, which includes people living in rural and remote settings (Kaleveld, Bock & Seivwright,

2020). The value of community supports for promoting positive mental health in regional settings has been documented but not extensively, and this Project was seen as a way to build on this work and these understandings.

From a purely pragmatic point of view, it is true that for some communities, hospital care is many miles away and a workforce of locally-based, qualified clinicians will be very limited. Thus, the problem-solving orientation of the conversations also lent itself to exploring community supports as a viable option for supporting mental health locally and in ways that are easy for people to access.

1.2 Strategic context

POOR MENTAL HEALTH OUTCOMES IN REGIONAL AUSTRALIA

People living outside of metropolitan areas experience consistently poor mental health outcomes. In 2018 a group of researchers and service providers in regional Australia came together to discuss and confront this issue, with their understandings and recommendations documented in the Orange Declaration on Rural and Remote Mental Health (Perkins et al., 2019). This Project responds to the Orange Declaration's call to better understand what is different about living in regional areas that commonly leads to poorer mental health.

ENHANCING THE VIEW TO REGIONAL AREAS

Enriching understanding is a critical starting point. As an ongoing policy agenda item, the government's commitment to rural mental health is already clearly mapped. Priority Area 1 of the Fifth National Mental Health and Suicide Prevention Plan is "achieving integrated regional planning and service delivery" (Mental Health Commission, 2017). The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 also stresses that regional areas of WA must be prioritised for access to mental health service and support (Mental Health Commission, 2019). These key strategic frameworks are clear in their call for increased investment in regional mental health as a matter of urgency, however they are not always accompanied by a detailed description of what that could look like across the diverse regions and communities in our state.

The paralysis around how to help regional communities (as was described by one community member: "we need to strengthen our community but are not sure what to do about that"), might exist just as much for policymakers in Perth as it does within communities themselves. Perth-based commissioners may also have limited understandings of existing community-led, informal supports that are already working well to prop up communities. For example, community supports run by regional non-government organisations, community groups, local governments and networks are often unknown outside these communities. Also overlooked is the extent to which local communities are having conversations about mental health and are committed to addressing this issue, although often without any formal government support or sustainable funding structures.

The Orange Declaration (Perkins et al., 2019) called out the damage done to rural communities when their decision-making power is taken out of their hands by centralised, metropolitan-based institutions. Centrally-controlled funding models, for example, can lead to service fragmentation and instability in rural areas, or can often mean that support fails to even reach the target communities in any effective or meaningful way. Service planning, commissioning, governance, and workforce development are all functions that flow out from capital city epicentres, without a clear line of sight as to whether these processes are truly serving those communities at a distance from metropolitan centres.

UNDERSTANDING DIVERSITY ACROSS COMMUNITIES

Another critical point highlighted by the Orange Declaration was that not all communities in regional or remote areas need the same types of support. Strategic frameworks and key planning documents often assume homogeneity outside of metropolitan centres, which is unhelpful when it comes to adequately addressing needs. For this Project, we were therefore mindful of capturing the diversity that exists between towns and regions.

The WA Primary Health Alliance (WAPHA), WA Country Health Service (WACHS) and several local government authorities have undertaken recent work to help understand mental health needs across regional WA. However, this work has focused on mental health as defined by the scope of current health planning frameworks, or has looked at specific communities only, or specific populations, such as youth. In WA, there has been limited work undertaken, if any, to uncover mental health support needs across diverse regional communities.

> Strategic frameworks and key planning documents often assume homogeneity outside of metropolitan centres

A SUSTAINABLE, BALANCED SYSTEM

Understanding the need for community-based mental health support in regional WA contributes to the wider strategy of balancing the mental health system away from its primary focus on acute care. For example, the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 suggests that investment in community support needs to increase to 22% of our overall investment in mental health in WA (in 2019, this was only 5%).

The value of increasing investment in community supports, for the system, is the opportunity to support people to stay well in the community, and to prevent people experiencing periods of crisis and escalating distress needing hospitalisation and acute care (Kaleveld, Bock & Seivwright, 2020). Hospital care, and especially mental health beds, are even less accessible to populations outside of metropolitan centres. Investing in community supports in regional areas has the potential to deliver even greater returns than in metropolitan areas – in terms of both improving the cost effectiveness of the service system, as well as improving access and better supporting mental health outcomes.

> Hospital care, and especially mental health beds, are even less accessible to regional populations. Investing in community supports in regional areas has the potential to deliver even greater returns – in terms of both cost effectiveness and improving mental health outcomes

1.3 Methodology

The Project Team utilised a mixed methods approach to collect data from the three focus regions. The Project was conceptualised as a consultation rather than an academic study or research piece. A flexible consultation approach based on what local representatives thought was appropriate enabled the Project Team to engage meaningfully with communities. Engagement methods were based as much as possible on natural interactions, and configurations of community members that would facilitate the most comfortable conversations. In this way, the visits were welcomed by communities, and a deep understanding of a community's needs could be gathered in a short time frame.

Alongside the consultation approach, established research methodologies and analytic techniques were employed. These research methods involved high levels of rigour. One-on-one interviews from a select and (as much as possible) representative sample were conducted, transcribed and analysed for themes. Additionally, a survey employing validated measures and a significant sample size provided evidence that could be triangulated with anecdotal evidence, increasing confidence in the findings. A more detailed description of the methods – community consultations, one-on-one interviews and the survey – is provided on the following page.

PARTICIPATION

An overview of consultation participants, across the three data collection methods is provided in Table 2.

Table 2: Participation in data collection

Community consultations	One-on-one interviews	Survey
320 participants	14 interviewees	410 respondents
16 communities	12 communities	122 towns/113 postcodes
3 focus regions only	3 focus regions, plus metropolitan-based peak bodies with a knowledge of the focus regions	All 9 WA regions, with more respondents from the 3 focus regions

The total number of participants is unknown, due to the potential for people to be involved across multiple data collection methods. However, we can say with confidence that at least 320 participants were consulted. Participants also came from a range of backgrounds and community sizes which was taken into account in the analysis of findings. The socioeconomic, demographic and geographical characteristics of communities varied. Intentional sampling to capture as much representation as possible was employed for interviews, although our ability to ensure diverse participation was limited in the community consultations and the survey. However findings were analysed with representation in mind. The greatest number of participants were Caucasian and lived in large or small regional centres, limiting our ability to comprehensively understand the needs of specific cohorts in regional areas. However, there were smaller numbers of participants from across many diverse communities: Culturally and Linguistically Diverse (CALD), LGBTQIA+, all age groups, and people experiencing acute mental health or AOD issues and living with disability, and carers and family members. Therefore, to an extent, people with diverse experiences and views were captured.

We can also say with confidence that, overall, the hundreds of people who participated were highlighy engaged and willing to share beyond the surface-level.

COMMUNITY CONSULTATIONS

Site visits in sample communities across three regions were a primary method of data collection, with over 320 people participating in various engagement events. In terms of the communities visited, the Project Team aimed to visit a sample of different communities across each region, with a particular interest in reaching smaller remote towns located a distance from main regional centres. As many of these towns had limited or no access to mental health supports, they were considered a priority.

The breakdown of towns visited and number of consultation participants across the three regions is provided in Figure 4.

Figure 4: Participation in consultations across the three regions and towns visited

Midwest n = 67	Wheatbelt n = 68	South West n = 166
Geraldton	Northam	Bunbury
Mullewa	Narrogin	Busselton
North Midlands	Narrambeen	Margaret River
	Moora	Collie
	Dalwallinu	Boyup Brook
	Pingelly	Manjimup
		Bridgetown

Local stakeholders played a key role in planning, promoting, and publicising events. In each regional centre and town, WAAMH collaborated with local agencies, including mental health services, WAPHA staff, WACHS staff, local government authorities and local community organisations to identify the best way to engage local people.

Face-to-face and video-conferencing meetings, focus groups, public forums, workshops, and semi-structured interviews were conducted during site visits. Forums were open to the public and were advertised locally, and some participants who attended sessions came from surrounding towns and communities within that region (some community stakeholders actively promoted the opportunity to people in surrounding towns).

Participants included people with lived experience of mental health issues; carers, family members and friends of people with lived experience; representatives of service providers; representatives of non-government agencies with an interest in mental health; representatives of Aboriginal Community Controlled Organisations; members of support and self-help groups; school principals and teachers; WACHS staff; WAPHA staff; members of Community Wellbeing Committees in towns where they existed; members of Consumer Advisory Groups (and other regional advisory structures); representatives of government agencies (WA Police, Department of Communities, Department of Education, Department of Corrective Services, Department of Fire and Emergency Services); Royal Flying Doctor Service (RFDS) staff; farmers and farming groups; local government councillors and staff; local business people; interested and concerned local citizens; former politicians and staff of local politicians; academics, community leaders and volunteers; General Practitioners (GPs) and psychiatrists; and members of local community groups such as Men's Sheds, Community Resource Centres, Family Centres, Returned and Services Leagues, Country Women's Associations, sporting clubs, and local ambulance and firefighter volunteers.

ONE-ON-ONE INTERVIEWS

One-on-one interviews were conducted by CSI and involved a purposeful sampling process, semi-structured questions systematically applied, and recording/transcription for more in-depth qualitative analysis. Fourteen semi-structured, 30-minute interviews were completed via video conferencing.

Interviewees were selected from metropolitan-based peak bodies and agencies, or regional organisations. All interviewees were selected for their experience and expertise in mental health support for regional and rural areas. This included people with lived experience as a consumer, carer, or family member.

Interviewees were sourced through contact with agencies, internet searches, prior connection to WAAMH or application to be part of the lived experience reference group for this Project, and snowball sampling. A matrix was used to ensure stakeholders interviewed were, as much as possible, a representative sample from the three regions, had experience in remote towns as well as regional centres, and represented various demographic characteristics. Interviewees included people who had experienced or could speak to (through personal connection in some way) experiences such as migrant status, being a young person, being Indigenous, experiencing financial or housing instability, having comorbid health conditions and/or AOD issues, being a fly-in fly-out (FIFO) worker, being a farmer, living in a large or small rural or remote centre, or having experienced a suicide in the community.

STATE-WIDE ONLINE SURVEY

A mental health and social and emotional wellbeing survey was developed to capture insights into the respondent's community's mental health needs, and their own individual needs. A total of 410 respondents completed the survey.

The survey was open to anyone living in WA and over the age of 12 years (respondents between 12 and 18 years of age were asked to seek a parent or guardian's permission before proceeding with the survey). We welcomed the voices of all people willing to share their views of mental health and wellbeing, irrespective of whether they had a lived experience, were a family member, carer, or service provider in mental health, or a community member who was interested in completing the survey. Respondents came from across all regions, although a large portion were from the site visit areas where the survey was promoted by the visiting Project Team.

SURVEY PARTICIPANTS

In total 410 people responded to the survey. Demographic breakdown totals, and the totals for survey questions, will not always sum to 410. This is because the survey questions were voluntary; we gave respondents the opportunity to skip questions they did not wish to answer.

Women were over-represented in the survey (81% were female, 18% male, and 1% identified another way). Most participants were aged between 35 and 64 years (71%) with a further 19% aged 18 to 34, and 10% aged 65 years or older. Approximately 99% of respondents reported speaking mainly English at home.

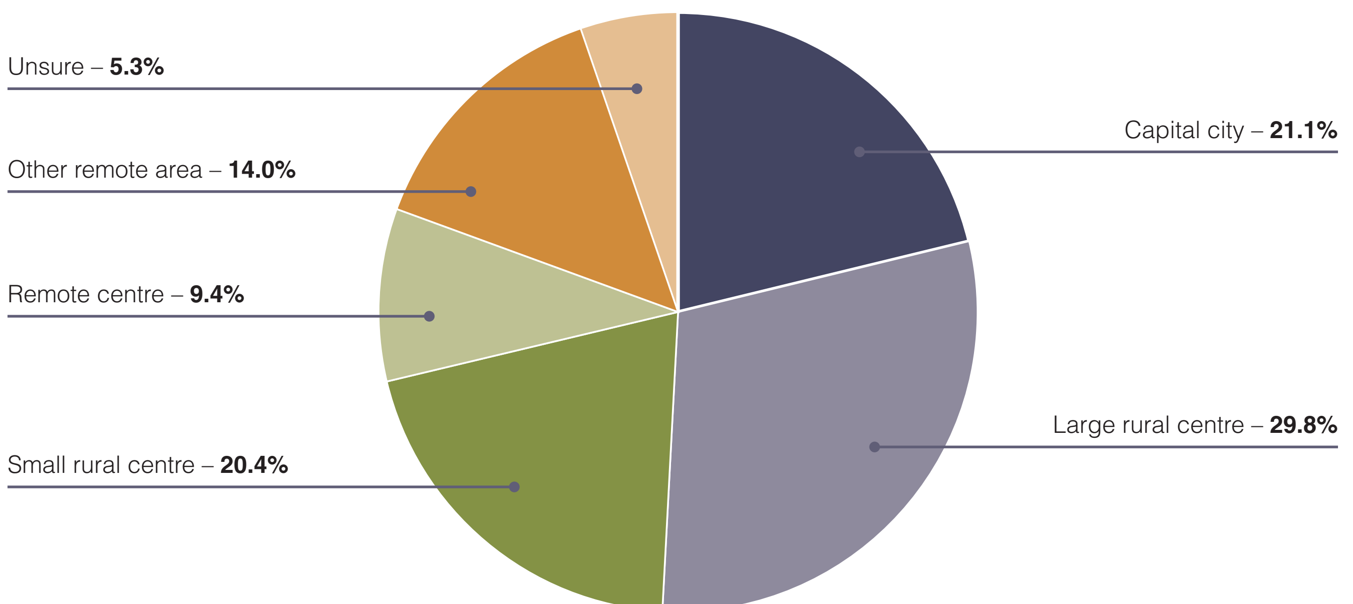
Respondents were from all regions of WA. The survey results were representative of mostly the South West (38%), the Perth metropolitan area (17%), and the Midwest (14%). Thirty-one respondents (8%) resided in the Wheatbelt. See Appendix A: Region and size of community of survey respondents, for representation across the nine regions.

Respondents outside metropolitan Perth were also asked about the size of the community they came from, with the question guided by the Australian Census classification for rural, remote and metropolitan areas:

1. Large rural centres – regional cities with a population of 25,000 or more
2. Small rural centres – towns with a population between 10,000 and 24,999
3. Remote centres – towns with populations between 5,000 and 9,999
4. Other remote areas – all other places that are under 5,000 people

Nearly one third of respondents were living in a large rural centre, and almost one quarter were living in a remote centre, or other remote area (see Figure 5).

Figure 5: Survey respondents by remoteness

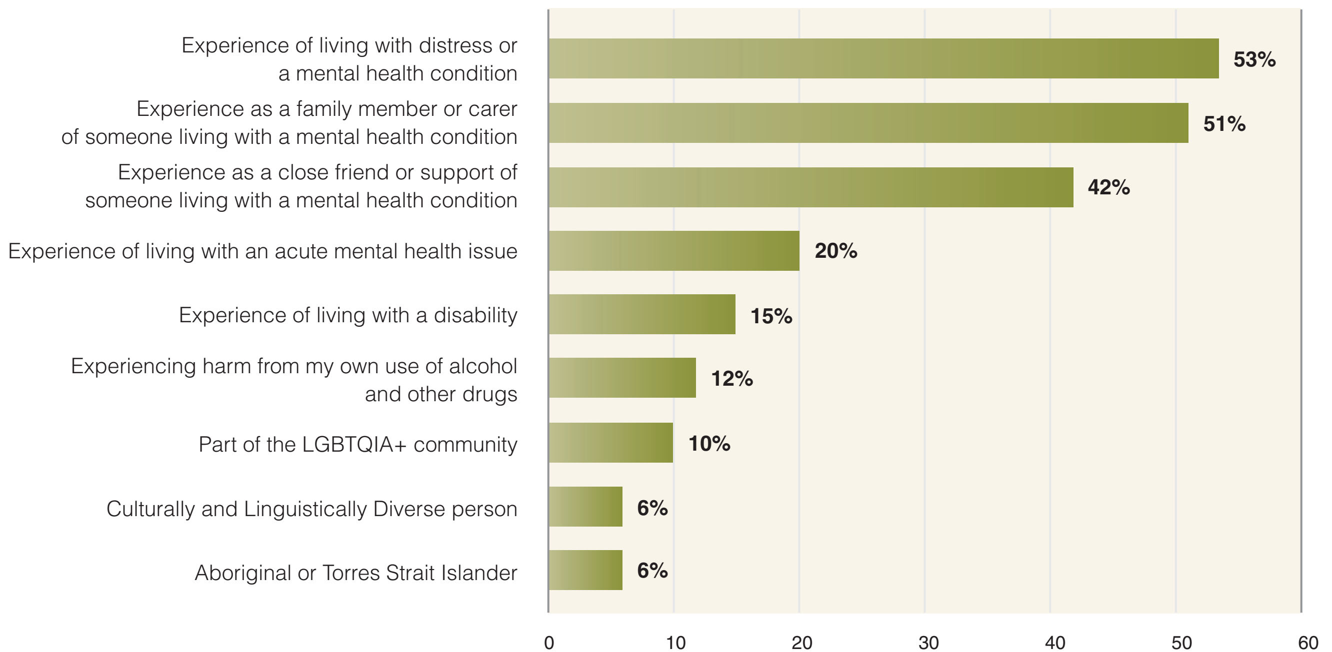


Approximately 12% of respondents reported that, within the last three months, they needed to travel away from home regularly, or lived in one place. This included for drive-in-drive-out (DIDO) work arrangements (5%), FIFO arrangements (2%), and other reasons (5%). Other reasons for regular travel were diverse, they included travel for family/relationships, medical care, and university requirements.

Survey respondents reported an array of life experiences and perspectives – see Figure 6. Approximately 6% of respondents identified as Aboriginal or Torres Strait Islander, a further 6% identified as being a CALD person, and 10% were a part of the LGBTQIA+ community.

Many respondents (40%) indicated that they were a service provider, staff member, peer worker or clinician working in mental health. Over half (53%) had a lived experience of psychological distress or a mental health condition and one in five (20%) had experience living with an acute mental health issue. Half of all survey respondents had experience as a family member or carer of someone living with a mental health condition, and 42% had experience as a close friend or support for a close friend living with a mental health condition. Approximately 15% of respondents had experience of living with a disability, and 12% had experienced harm from AOD.

Figure 6: Life experiences and perspectives of respondents



ANALYSIS

Quantitative analysis

Primary analyses were descriptive and considered participant demographics, including age, gender, locality, and lived experience. Additional analysis examined issues affecting mental health, adequacy of current supports, and perceptions of community supports. Validated measures assessed self-reported wellbeing (World Health Organisation-Five Well-Being Index, WHO-5), psychological distress (Kessler Psychological Distress Scale, K10), and social cohesion (Sampson et al., 1997). Reliability analysis revealed high internal consistency across all three of these standardised measures. Further analysis tested for differences between K10 and WHO-5 scores across the three focus regions (the South West, Midwest and Wheatbelt), however sample sizes varied significantly, ranging from 27 to 145. Considering the large discrepancies between the sample sizes across the three regions, region-level analysis and comparisons between the regions should be interpreted with some caution, as statistical power is likely to be reduced in this instance.

Qualitative analysis

Qualitative analysis of community consultation data, interview data and survey comments involved categorising comments into themes to illuminate the 'big picture', as well as localised experiences, of mental health and mental health support. Content captured by qualitative methods included participants' current and past experiences of accessing support for mental health (or being otherwise involved in mental health support), as well as their opinions and insights into support needs for the future. Comparing findings between regions, and between different communities within the same region, revealed context-specific differences in the way that communities have experienced mental health support so far and their ideas about the way forward for their community. Sometimes, consultation participants were clearer about what was not currently working than on the actual needs of the community, and in these instances, a certain degree of interpretation was required to understand what might help alleviate some of the issues raised.

1.4 Report structure

This report begins with exploring the need for mental health support in regional WA (Section 2). Initially, using clinical measures, as indicated through survey responses (e.g., levels of mental health distress), and additionally, with deeper understandings of the needs to address, as revealed through interviews, site visits and survey comments. Section 3 presents evidence of the extent to which supports can be accessed and describes the barriers to accessing help that are experienced outside of metropolitan areas. Section 4 delves into the impact of community size on experiences accessing mental health support. Through a focus on one region as a case study (the Midwest), this section unpacks how experiences in remote towns are dramatically different from the experiences of people living in regional centres, which raises questions about how effectively current funding models are working.

Through visiting and listening to community members, it came to our attention that several remote communities with limited or no access to mental health support are developing their own responses to supporting mental health. Some of these responses exist outside of mental health funding models. Section 5 captures examples of innovative, community-driven approaches to supporting mental health. Finally, Section 6 provides an analysis of key learnings, and suggests ways that the evidence presented in this report could potentially support action to improve the lives and wellbeing of people living in regional WA.

SECTION 2:

Indications of unmet need

2.1 Perceptions of the health and resilience of communities

People consulted seemed to have a strong sense of how their community was tracking in terms of mental health and wellbeing. They had observations about community strengths (such as social cohesion and positive perceptions of the way community members support one another in practical ways), and also had concerns for their community (such as loneliness and lack of opportunities for activity or connection, distances from services and supports, issues with AOD, stigma and unwillingness to get help, and the need for financial stability and employment to keep people well).

We combined these insights with survey data to unpack overall indications of how well communities felt they were doing in terms of mental health.

KEY FINDINGS AND NEEDS IDENTIFIED:

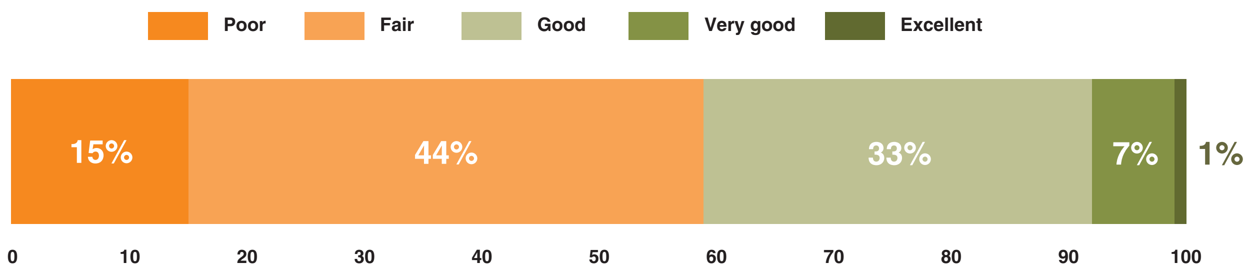
- Over half of survey respondents rated their community's mental health and social and emotional wellbeing as 'fair' or 'poor', suggesting that many people believed that mental health in their community could be improved.
- People consulted spoke about particular adversities faced by rural communities – isolation, natural disasters, impacts of climate and market dynamics on farming, and ongoing social issues such as unemployment. However, they did not see 'resilience' as an adequate solution to overcoming these difficulties.
- Many survey comments identified young people (primary school age to young adults) as having urgent mental health needs, both in terms of the symptoms and distress observed, as well as the lack of suitable supports available for young people. Schools were seen as settings that could make a difference to the mental health and wellbeing of communities.

RATING COMMUNITIES' MENTAL HEALTH AND WELLBEING

The survey asked respondents for their perception of their community's mental health and wellbeing: *Generally, how would you rate the overall mental health and social and emotional wellbeing of people in your community? (Excellent, very good, good, fair, or poor)*.

Only one per cent of people rated the overall mental health and wellbeing of the people in their community as excellent. Seven per cent rated it as very good, 33% good. Well over half of survey respondents perceived the mental health and wellbeing of their community to be fair (44%) or poor (15%; see Figure 7).

Figure 7: Survey respondents' perceptions of community wellbeing



A large proportion of people rated their community's wellbeing negatively, suggesting that for most people mental health and social and emotional wellbeing is an issue that needs addressing.

ISSUES IMPACTING MENTAL HEALTH AND RESILIENCE OF COMMUNITIES

In consultations participants noted that regional communities are greatly affected by 'macro' factors beyond their control, such as changes in the climate or sudden changes in market dynamics affecting farming communities, and the impact of natural disasters (such as the widespread damage caused by cyclone Seroja in the Midwest and Wheatbelt in April 2021 [Mitchell, 2021]). Community resilience and mental health are likely shaped by fluctuations in these dynamics over time. A series of cascading macro forces combined with no locally available mental health supports can easily wear down the collective health and resilience of any community.

Unaddressed mental health issues can have a significant impact across a community, where community members are left to cope with and manage the impacts of mental-ill health as best they can.

"There is a significant number of people who are untreated for major mental health issues, but who are supported by the community to live in the community, in spite of significant behavioural and safety issues. Many have tried and failed to access services. The nearest services are literally hundreds of kilometres away" (Survey respondent)

People with substance abuse problems (exacerbated by both underlying mental health issues and social isolation), and the knock-on effects of AOD issues on the overall wellbeing of a community, were mentioned. While efforts are made at the interpersonal level to support one another, some people consulted felt that they were up against greater forces, and that 'resilience' was not enough to address these issues.

"We are trying to support people to be resilient in a system that doesn't support people"

(Interview participant)

YOUNG PEOPLE AS A COHORT WITH URGENT UNMET NEEDS

Typically, much research in rural mental health points to males as a cohort that experiences significantly higher vulnerability to mental ill-health. However, when survey respondents were asked to comment on the need for support in their community, it was not so much men, but young people (12-25 years) and children (6-12 years) that were overwhelmingly mentioned as a priority group for urgent attention.

"...primary and secondary students are currently struggling with mental health issues more than they have in the past" (Survey respondent)

"Some children have an avoidant anxious response to certain traumas which are re-triggered daily [at school] – their need is not being met for a number of reasons, including the capacity of schools" (Interview participant)

It was young people and children that were overwhelmingly mentioned by community members as a priority group for urgent attention

People interviewed across all regions raised concerns around young people, relating to: AOD issues, un/underemployment, housing shortages, lack of choice in educational pathways (particularly in high school), boredom and loneliness, criminal activity, helplessness and frustration, lack of support and mentorship, cultural detachment among youth from Aboriginal or CALD backgrounds, and significant mental health distress and high suicide rates, which were often suggested to be a direct result of these situational factors.

When concerns for young people were expressed, strong language was often used:

"Young people in this region are in crisis" (Survey respondent)

"Help with... emotional regulation and anxiety needs to available in every school. In the community there are huge issues" (Survey respondent)

Survey respondents and consultation participants across all regions felt that young people needed greater and more timely support for their mental health within and beyond the school.

"Our one youth-based mental health service which is based in our town is over capacity and has a wait list..." (Survey respondent)

"As a school chaplain in two primary schools I am finding increasing need for mental health support for primary school aged children, including suicidal ideation, but there is no organisation that I know of that will see a child under 12 for mental health issues. I can only refer them to their GP, to refer them to a private counsellor or psychologist. Often the cost is prohibitive. Without this help for the child the parent themselves soon needs help for their own mental health" (Survey respondent)

Some consultation participants said there was a lack of mental health support for regional young people across all levels of severity, while others pointed out that it was certain types of support that were missing. The quotes below indicate that support gaps seem to vary (perhaps according to location). Some people called for more mental health promotion and early intervention for young people.

"The whole interactive dialogue... is absent. That learning space where kids ask questions and know that there's something called depression and something called anxiety – it's just not there. We need to open up the space of psychoeducation"

(Interview participant)

Others called for more supports for young people seeking moderate levels of care.

"What schools say is that the children who are at the really pointy end, that's ok, the services are in place, we know who to speak to, to access supports... Schools tend to struggle with the middle group: they know something is not right, they're trying to figure it out... Schools need to provide holistic and wraparound supports in a measured way. It's the middle group that are missing something" (Interview participant)

Others perceived gaps in supporting young people with severe mental health conditions.

"There's a serious gap for young people with severe and persistent mental health concerns and complex needs in our community – no services available who take these young people, and lack of free, accessible youth friendly counselling supports"

(Survey respondent)

These concerns applied to young people in large regional centres as well as small remote towns.

2.2 Measures of psychological distress and wellbeing

Asking people about the mental health and resilience of their community provided an overview of mental health and wellbeing challenges in regional communities, vulnerabilities and higher risk groups. Measuring *the extent* of the need through validated tools was also considered valuable (and helped to validate the perception data).

Clinical mental health measures were included in the survey as optional questions. Survey respondents' wellbeing and level of psychological distress were measured using the scientifically validated World Health Organization-Five Well-Being Index (WHO-5) and the Kessler Psychological Distress Scale (K10). These scales use self-report data, where people select the frequency or extent to which they have experienced wellbeing or feelings of distress, within the past two weeks (WHO-5), or four weeks (K10).

Clinical measures focus on signs and symptoms. However, we acknowledge that mental health, wellbeing, and personal recovery is much broader, and is about leading a good life. The results of these measures, applied to this survey sample, must be interpreted as indicative data only. However, despite these limitations, these two measures are standardised, and provide comparative data due to their use in other population-level studies (such as research conducted by the World Health Organization and the Australian Bureau of Statistics). For this reason, these results are considered useful in terms of understanding the mental health of a population.

KEY FINDINGS AND NEEDS IDENTIFIED:

- Over one third of survey respondents indicated they were in either high or very high distress.
- Half of survey respondents scored less than 50 on the WHO-5 suggesting possible depressive symptoms (or indicating a need for further clinical assessment).
- Data suggests a population-level need to reduce distress, particularly in younger people, and to address wellbeing.

PSYCHOLOGICAL DISTRESS

The K10 involves 10 statements representing depression and anxiety symptoms (e.g., "feeling nervous", "feeling hopeless"), rated on a scale of 1 (none of the time) to 5 (all the time). Scores range from 10 to 50 and are categorised based on severity of distress: low distress (10-15), moderate distress (16-21), high distress (22-29) and very high distress (30-50; ABS, 2012).

> Over one third of survey respondents indicated they were in either high or very high distress

Most respondents reported low or moderate distress (36% and 29% respectively), however one in five reported high levels of distress (21%) and a further 14% were in very high distress. This means that over one third of respondents surveyed were in either high or very high distress. Overall, the average K10 score of respondents was 19.8, suggesting moderate levels of psychological distress across the regions. There was a significant relationship between psychological distress and age. As psychological distress increased, age decreased. Younger respondents reported higher psychological distress than older respondents.

WELLBEING

The WHO-5 comprises five statements, for example, “I have felt relaxed and calm”, rated on a scale from 0 (at no time) to 5 (all of the time). Scores are summed and multiplied by 4. A score of 100 represents the best imaginable wellbeing and 0 represents the worst imaginable wellbeing. For a clinical population, a score equal to or less than 50 prompts a recommendation to screen for depression. In the general population, the European Quality of Life Survey, collected in 2012, found that mean scores for the WHO-5 ranged from 53.7 to 70.1 across different European countries (Topp et al., 2015).

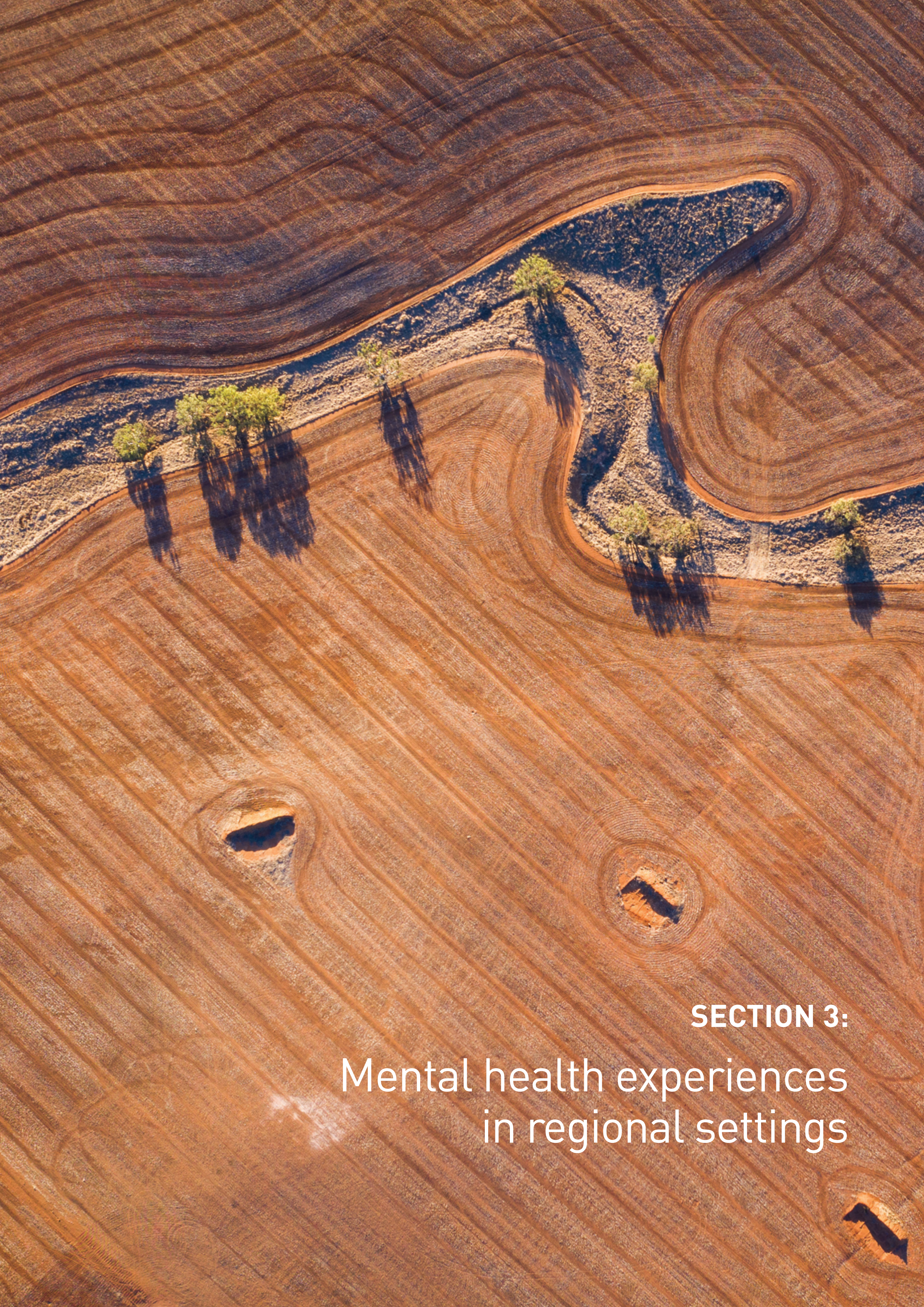
> Half of the survey respondents scored less than 50, suggesting possible depressive symptoms (or indicative of the need for further clinical assessment)

The average WHO-5 score of the survey respondents was comparatively low (48.5). Half of the respondents scored less than 50, suggesting possible depressive symptoms (or indicative of the need for further clinical assessment).

IMPLICATIONS

These data suggest that about a third to one half of survey respondents may have a mental health need to address.

There are limitations to these results, and we cannot say anything definitive about mental health in regional WA based on any one measure. However, the results of both measures, especially taken together, provide an indication that more support is needed in regional areas to reduce psychological distress and increase wellbeing.



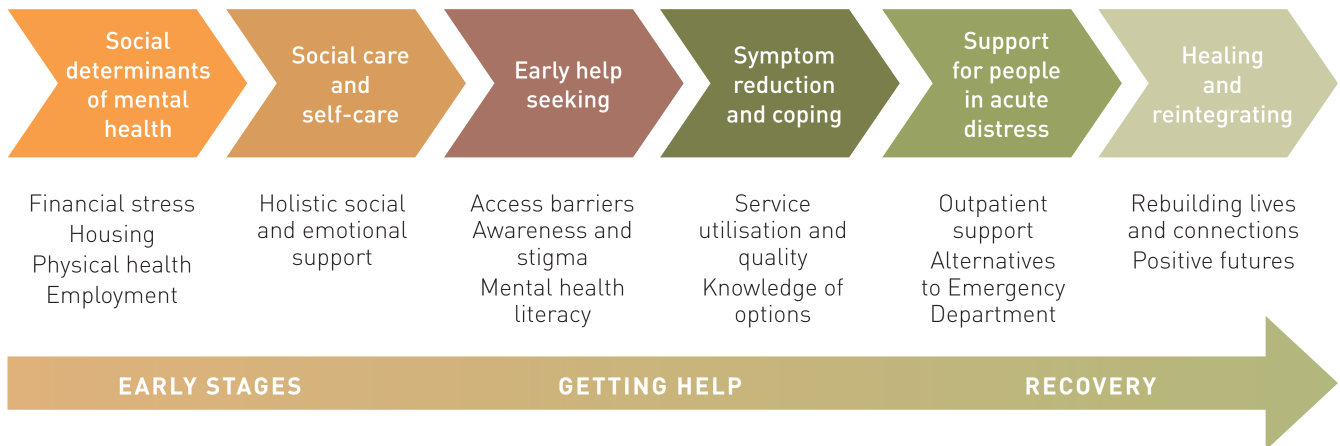
SECTION 3:

Mental health experiences in regional settings

3.1 Mental health experiences in regional settings

Section 2 presented qualitative and quantitative evidence to indicate the need for increased mental health support in regional areas. In this section we draw on a 'consumer journey' framework (Figure 8) to explore why regional populations may be experiencing poor mental health and wellbeing, and where there are opportunities to enhance support.

Figure 8: Framework for understanding regional mental health experiences and supports



The framework, adapted from a combination of existing mental health system maps and consumer journey frameworks, was created for the Project to help facilitate conversations with communities, to ensure that conversations could span the range of supports needed. Although this framework implies a linear, unidirectional journey, we recognise that this does not often reflect the real world experience of individuals living with mental health conditions. The framework does illustrate, however, that support needs do change, and failures to address need at one intervention point can lead to an escalation of a mental health condition and consequently, the intensity of support needed.

KEY FINDINGS ABOUT EXPERIENCES OF COMMUNITY MEMBERS ACROSS THE SPECTRUM OF SUPPORTS:

- **Social determinants**: A quarter of survey respondents experienced challenges with housing, one in four experienced financial stress and one in four reported physical health issues. One in five were struggling with social isolation or loneliness. All are social determinants of mental health, known to impact function and wellbeing. Interview data uncovered the particular dynamics of living in rural settings, where addressing these issues can be very difficult because of the lack of jobs, housing options and access to social services. Thus, the effect of the social determinants on mental health is likely to be amplified in rural settings.
- **Social care and self-care:** Psychological distress was found to significantly decrease with increased social supports. Survey results suggest that about one third of people were not getting as much social support as they felt they needed. To enhance their wellbeing, people identified the need to improve their eating, sleeping and exercise habits, and asked for more support to be physically healthier.
- **Early help-seeking:** Stigma about mental health (internalised stigma as well as perceived stigma in services) prevented people living in regional settings from getting help early. Transport and logistical barriers such as distance to travel, pressures of living and cost of services were also barriers to help-seeking. Both stigma and logistical barriers were felt to be significantly more acute in regional areas than in the city, and were especially heightened for people living in small towns.

- **Symptom reduction and coping:** 76% of people surveyed said that in the past 12 months there was a time when they wanted to talk to someone or seek help about stress, depression or problems with emotions. And 39% of these people who needed help said they did not get the care they needed.
- **Support for people in acute distress:** Consultations and survey comments strongly suggested that people experiencing a mental health crisis were not adequately supported. This was particularly so in smaller towns. However, the issue also applied to larger regional centres where hospitals faced staffing and capacity issues, and access to mental health beds, or specialists such as psychologists and counsellors, was also very limited.
- **Healing and reintegrating:** In regional areas, people experienced a lack of choice around psychosocial supports to keep them well and socially connected. For recovery and reintegration, people consulted felt that locally-based community supports were ideal, but program funding is often limited and not sustained, which impacts their effectiveness.

SOCIAL DETERMINANTS OF MENTAL HEALTH

Mental health is shaped to a great extent by the social, economic, and physical environments in which people live. The known social determinants of poor mental health outcomes include difficulties with housing, relationship and family problems, physical health issues, financial stress and unemployment. These are all circumstances that, in one way or another, are exacerbated by life in remote and rural areas. Physical distance from social connections and services to address specific issues such as health issues, and limited access to opportunities such as jobs, education and recreation, amplify the effects of social determinants on mental health outcomes.

When survey respondents were asked about the challenges they faced, one in four reported struggling with housing (25%), one in four experienced financial stress (25%) and one in four had physical health issues (25%). One in five reported struggling with social isolation or loneliness (21%). Sixteen per cent reported they have been the subject of discrimination, prejudice, or stigma, and 12% reported struggles with unemployment. In summary, the survey results indicate that a large proportion of people living in regional WA are facing challenges that are known to cause signficiant disruption to function and wellbeing.

Links between living conditions, access to opportunities and mental health is not just theoretical – they were observed and articulated by community members.

"What are the social determinants of people's mental health? What keeps them stable? Home ownership, financial security, and healthy relationships are the three main ones" (Interview participant)

"Adequate stable and affordable housing is a substantial issue impacting upon positive mental states" (Survey respondent)

According to one interviewee, most mental health problems are a result of situational factors, and therefore, the focus should be on prevention – specifically, addressing issues such as housing, financial insecurity and relationship problems, long before a person reaches crisis point.

"There is no point in working on their mental health when they cannot access stable housing or stable finances, because the government does not provide enough housing stock and makes the JobSeeker payments so ludicrously low!" (Survey respondent)

"People need to be supported before little problems become overwhelming" (Survey respondent)

All interviewees spoke of how different groups of people in the regions experienced different challenges (i.e., social determinants), and this necessitated targeted solutions. For example, as one interviewee commented, for people experiencing family and domestic violence, mental health is "also about housing and being able to leave if you need to leave; if your partner controls the house and finances, where do you go?". Another interviewee remarked that the poor mental health in their region (the Augusta-Margaret River region) was due to the interplay of housing shortages/unaffordable housing, a transient population, a higher migrant and refugee population with high levels of social isolation, and unemployment and underemployment among young people. These conditions mean that people trying to address their own mental health needs through building a life that sustains them physically and psychologically, may sometimes face very limited choices.

Other social determinants that were emphasised in interviews and considered especially relevant to regional communities were financial insecurity (e.g., due to precarious work, poorly paid work or debt), lack of personal safety (e.g., due to family and domestic violence or other abuse), the disruptive impact of harm from AOD on relationships and social connections, and belonging to a non-dominant cultural group where discrimination and isolation may be experienced. If these issues are not addressed as part of any mental health support, "we're simply not dealing with why this person is there [seeking help] in the first place", in the words of an interview participant.

Generational poverty and lack of economic mobility (for those living in low socioeconomic status conditions) were also discussed as significant determinants of poor mental health in regional areas, particularly when experienced without the protective factors that close-knit communities often afford and/or if they were experienced alongside AOD issues or unemployment.

Discussions revealed how stressful situational factors, such as those described above, often lead to 'downstream' consequences like relationship breakdowns, custody battles, housing problems, and even entry into the criminal justice system.

While people living in metropolitan Perth may also experience a similar devastating cascade of life-events, their city location affords them better access to a range of services and opportunities that can address multiple co-occurring needs, in a timely way. In contrast, living in regional areas may heighten one's vulnerability to the impacts of these spirals. The key message from conversations was that unaddressed social vulnerabilities are inseparable from experiences of poor mental health in the regions. Living regionally limits access to opportunities and services to address these issues, and that these vulnerabilities must be central to efforts to improve mental health outcomes.

> The key message... was that unaddressed social vulnerabilities are inseparable from experiences of poor mental health in the regions

SOCIAL CARE AND SELF-CARE

Social connection to others, wellbeing, and quality of life have significant impacts on mental health. Through the consultations, we heard that rural communities can be tight-knit, with strong social networks and good access to informal support providing people with natural supports for their mental health when they are in need. On the other hand, we also heard that is it common to feel lonely in some towns, and that it sometimes takes considerable, sustained effort on the part of an individual to experience belonging in a small community. Sometimes, or for some people, there are limited opportunities to participate or connect with others. Likewise, recreational activities that help to keep people physically fit and mentally stimulated are few and far between in some regional towns.

Community cohesion, social supports and indicators of wellbeing

Quantitative analysis of survey data considered the relationship between perceived psychological distress (K10 score) social supports (for details about how social support was measured see Appendix B: Perceived Functional Social Support Questions), and social cohesion (see Appendix C: Social Cohesion Questions). There was no significant relationship identified between distress and social cohesion. However, we found that K10 scores, and therefore psychological distress, significantly decreased with increased social support ($p<0.01$). This suggests that respondents with less social support were at risk of experiencing significantly greater distress.

> Survey results suggest that about one third of people were not getting as much social support as they felt they needed

Analysis also assessed the relationship between wellbeing (WHO-5), social supports, and social cohesion. There was no significant relationship found between wellbeing scores and perceived social cohesion, however, WHO-5 scores significantly increased where participants reported greater social supports ($p<0.01$). This suggests that respondents with more social supports had significantly better wellbeing.

Survey results suggest that about one third of people were not getting as much social support as they felt they needed, a finding emerging in qualitative findings as well.

"I am fortunate to be strongly connected to family, friends and community, which is not the case for a significant number of people who live here" (Survey respondent)

"When you're that geographically isolated, you become socially isolated and targeted by bullies" (Interview participant)

The 'tyranny of distance' experienced by geographically isolated farming families, for example, was frequently mentioned as a barrier to accessing good-quality, formal and informal social supports. However, geographical distance is not the only contributor to social isolation.

"I went there [to a small regional town] quite healthy but then [when I arrived] there was nobody there my age. It was a very different environment to where I grew up in the country... it was very, very hard to break into socially" (Interview participant)

"Trying to get community support has been really difficult... Over the past 10 years I've watched the community spirit decline. Social media has really disconnected people; community events and spirit used to happen a lot more... COVID-19 accelerated the division"

(Interview participant)

"So many people just don't care about others, or don't want to get involved" (Survey participant)

When social support systems work well, they are effective in supporting quality of life outcomes. However, we cannot assume that all regional communities are experiencing strong social cohesion, or that belonging and acceptance are extended to everyone in a way that meets their social support needs. Given the statistically significant relationship between social supports and wellbeing, and the impact of social isolation for many people living in regional WA, service responses that enhance social connection and participation may be important for preventing and addressing mental ill health.

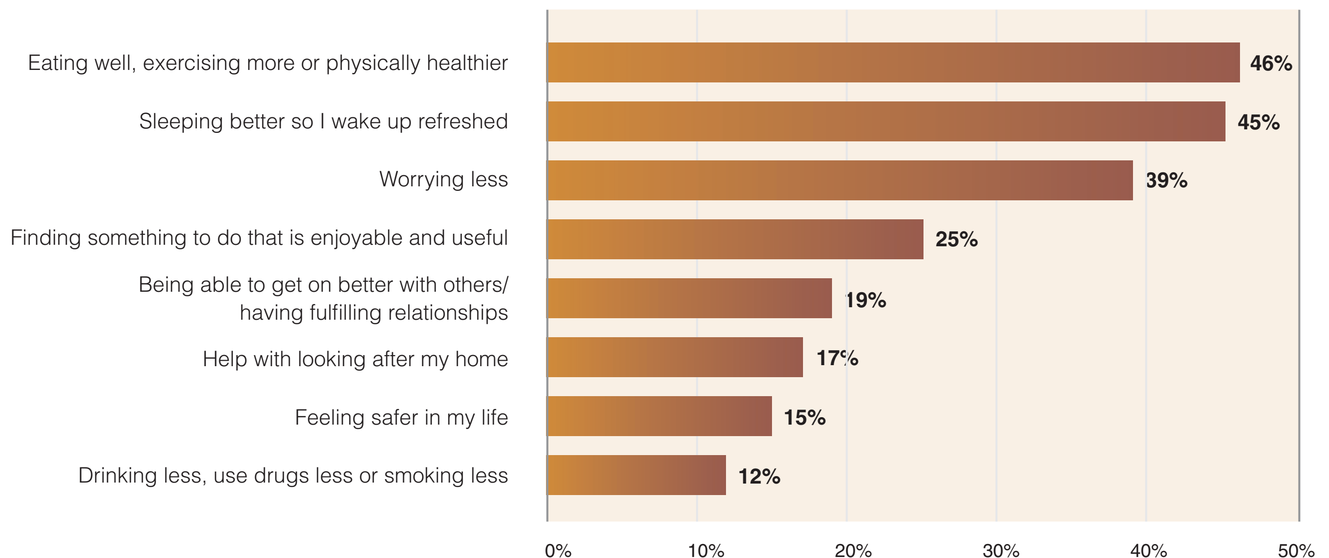
There are also limits to the role of social connection in addressing mental health. One survey respondent pointed out that there is a "very big difference between mental health and social and emotional wellbeing. They are not the same thing". This person goes on to say that, "In small towns like ours, our folk are generally well-connected and supported, but still have mental health issues." Thus, recognising the role of social support as a protective factor in mental health does not negate the need for more targeted mental health supports.

Support to improve wellbeing

The survey included a question about the respondent's priorities for improving wellbeing: *Below is a list of ways one can improve one's wellbeing. Is addressing any of the following a high priority for you? By high priority, we mean that these things may be affecting your ability to function well at home, at work or in your relationships. I think I would benefit from help and support with…*

The respondents were provided with options to select and multiple responses were permitted. The need most commonly identified as being high priority was 'eating well, exercising more, or being physically healthier' (47%). A further 45% selected 'sleeping better (and waking up more refreshed)'; 39% selected 'worrying less'; 25% selected 'finding something to do that was enjoyable and useful'; 19% selected 'getting on better with others and have more fulfilling relationships'; 17% selected 'help with looking after the home'; 15% selected 'feeling safer in their lives'; and a further 12% selected 'drink less, use fewer drugs, or smoke less'. These self-reported needs are displayed in Figure 9.

Figure 9: The most commonly identified wellbeing support needs



These findings demonstrate that assisting people with self-care to enhance their wellbeing does not need to be overly complex, with support to eat well, exercise more, and sleep better being the leading wellbeing interventions identified by survey respondents.

EARLY HELP-SEEKING

Early help-seeking for mental health issues for individuals, and community-wide mental health promotion and awareness raising activities were critical support gaps identified by regional communities.

"Early intervention doesn't exist" (Survey respondent)

Some communities still struggle to normalise conversations about mental health, and consequently, we heard anecdotes about people missing out on early intervention (which can reduce the severity and length of a mental health condition).

"Because I wasn't around my friends, I wasn't caught early enough. By the time I was sick, I was very sick" (Interview participant)

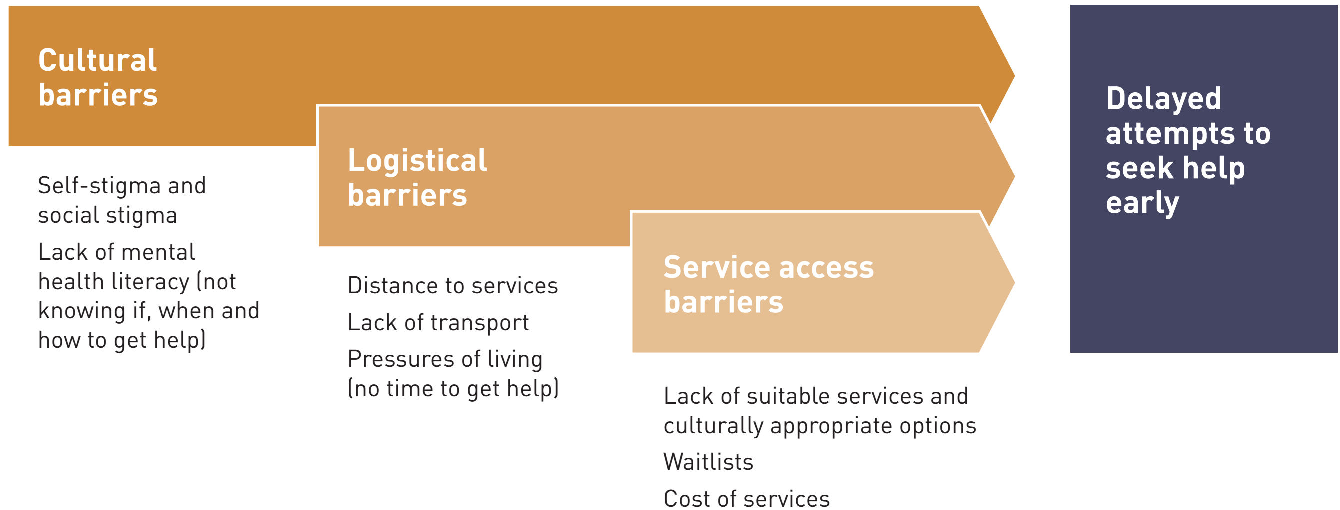
The consultation interviews and survey results found that even very basic awareness of the mental health supports available was lacking in some communities.

"It is getting better, but the community is closed-minded with the understanding of what must be done to help oneself. It's very open, everyone knows someone who is depressed or on pills etc., but then at the same time it's still a bit dirty to talk about how to get help. It's easier to talk about the issue but not how they get the help they need in the correct way" (Survey respondent)

"My community is displaced Aboriginal people – a homeless mob. Most of them don't know or don't care enough about their mental health to get help... most are just trying to get by and don't realise that there are people who seriously want to help them" (Survey respondent)

There are multiple reasons why a person living in a regional area might have trouble connecting to mental health services or feel that they don't want to. Interviews touched on the lack of options that people would be comfortable accessing (e.g., there are plenty of men, and women, who feel uncomfortable with the idea of seeing a psychologist). The effect of social stigma around accessing mental health support is exacerbated in smaller communities where 'everyone knows everyone'.

Figure 10: Commonly identified barriers to seeking support



Quantitative analysis of the survey data revealed that the top four barriers to accessing support were: transport, pressures of living, stigma, and lack of mental health literacy (i.e., problems individuals have identifying if and when they needed help). Thematic analysis revealed three broad kinds of barriers: cultural barriers, logistical barriers and service access barriers.

Cultural barriers

Interviews and the survey findings confirmed that both internalised and perceived stigma (i.e., self-stigma, and the stigma you believe others to have) about mental health impacts on people's ability to be aware of their own need for help, and to follow through with seeking support.

"Generally I think many people are confused about when and where to seek help, tending to dismiss their problems until they are very serious. Seeking psychological help is seen as too large a step, and asking friends for support is seen as 'burdening them'" (Survey respondent)

Over half of the survey respondents (55%) felt that stigma about mental health issues was a barrier in their community and that this impacted people's ability to seek help to a great extent, and over one third (36%) felt that people had problems with being able to identify if, and when, they needed help, and this was a barrier to seeking the mental health support that was needed.

"The stigma is as huge part of what's stopping most people I know reaching out to access mental health [services]. Plus, I've experienced in the past that there can even be judgement from the 'professionals'" (Survey respondent)

"I've always had depression. I've always had to contend with thinking of myself as the problem" (Interview participant)

"Many people are falling through the net and either don't know or are not informed or too scared to make contact with anything to do with mental health, as they are seen as 'nutters'" (Survey respondent)

Interviewees explained that stigma affects both the quality and consistency of support. For example, an individual may have felt ashamed to reveal any mental health concerns to people in their community and either relied heavily on natural supports/carers, avoiding existing local services due to fear of being 'seen', or avoided seeking help altogether, compounding feelings of isolation and potentially worsening their mental health and in some cases also their physical health. Anecdotally, people pointed out that avoidance strategies due to stigma can put pressure on clinical services and hospitals later due to lack of early intervention (both of which are less accessible in regional areas thus exacerbating the problem).

One interviewee stated that women from CALD backgrounds are taught not to seek help – "helplessness is sort of institutionalised" – and the high level of stigma around mental health in some cultures is a significant barrier to accessing support.

The relative isolation of living regionally adds another layer to the experience of mental health stigma and disconnection from clinical and non-clinical forms of support. It was notable how often people expressed that in rural communities many people (including health professionals) are somehow 'outdated' in their approach to mental health, leading to regional communities experiencing greater stigma compared to metropolitan centres where open and non-judgemental discussions about mental health may be more normalised.

"The way we judge people affects the way they get help or not" (Interview participant)

"There was a patriarchal male privilege attitude [in hospital]... there was an assumption that my issues were caused by me as a faulty human; there was no trauma-informed practice. Their reputation seemed to be more important than my health" (Interview participant)

The lack of culturally appropriate supports, and language barriers (i.e., no available translation services), were also raised as help-seeking barriers, particularly for Aboriginal and CALD communities. Inseparable from this is the perception that available supports are not trauma-informed, i.e., not sensitive to experiences of personal and intergenerational trauma, for example the specific experiences of Aboriginal and migrant communities or among those experiencing poverty and AOD issues.

The general lack of mental health literacy was a common theme in discussions and survey comments. Findings suggest that people living regionally may not have the same level of exposure to non-stigmatising mental health promotion messaging, or connections with professionals in their lives who informally communicate non-stigmatising messages, and therefore may miss out on normalising conversations about mental health in their everyday lives. This leads to people not having the understanding of what the early stages of a mental health condition might involve, and therefore when it is appropriate or beneficial to get help. One survey respondent described how the identification of a mental health issue was a challenge, even when there may be indications of "excessive alcohol use, avoidance of sorting out finances, hoarding or avoidance of social events" and that "stigma at all social levels" only exacerbates this.

Transport and logistical barriers

Consultations revealed how in some rural areas, such as smaller towns a long way from regional centres, it is untenable for people to access face-to-face, regular, support sessions with qualified mental health professionals. For most people living outside the larger regional centres, it was unrealistic to find time on a regular basis to drive an hour or two (sometimes more) for mental health care.

Survey data revealed that for 44% of respondents, transport, or distance to services, the pressures of living and not having enough time or resources, were barriers to seeking help.

"People can self-refer to specialist services and receive counselling for free locally but [the] availability is one day per week. There is no local transport or bus service. The regional bus service to access specialist services in [the] next towns run just twice a day" (Survey respondent)

"Most of our people are low income. The only transport they have is the train but it doesn't get there on time to see doctors" (Survey respondent)

"Some people have comorbidity issues and public transport is an issue for them" (Survey respondent)

This sentiment was echoed by participants across all community sizes and regions, although transport was a greater issue in smaller, more isolated towns and particularly among farming communities where the added pressure of taking time away from the farm to access support is unviable. If getting help for mental health concerns is considered unrealistic, this is likely to prevent someone seeking early help, or having early exploratory conversations with professionals about their mental health struggles.

Cost of services

The cost of services was raised as a significant barrier to accessing mental health support, affecting early help-seeking. The importance of providing low-threshold, low-barrier options for people so they can access care in the early stages of a mental health issue is critical, especially for diverse groups who may be less literate in mental health or navigating specialist service options.

"Mental health isn't a priority for CALD parents, they didn't factor it in to their plan... They come as migrants, they're trying to put food on the table;

then their child gets a condition, they don't know what to do... they don't understand what trauma is and they don't have the money to seek help" (Interview participant)

"The Indigenous younger generation don't tend to talk about feelings, and also they don't want to be away from family or Country. Accessing medical care on Country is much better for them" (Interview participant)

Beyond this, it was also evident that many of the regional communities consulted experienced a lack of timely services entirely, both clinical and non-clinical, and this was a significant reason that support was often not accessed early enough. As a rational response to these circumstances, people living in rural settings often wait until they are in crisis before they access the support they need.

Barriers to seeking early help for harm from alcohol and other drugs

Respondents felt that people struggling due to harm from AOD faced similar barriers to accessing mental health supports, but also reported that there is a need for greater literacy in identifying when support is needed for AOD use.

"There is a major cultural issue in Australia around alcohol abuse and people not accepting that this is a mental health issue. Alcohol needs to be seen as a drug that is harmful to our wellbeing. It needs to be treated with care and respect, not as means of dealing with the stresses of life or to help you have a good time. Alcohol abuse is a symptom of deeper mental health issues but it is making the situation worse" (Survey respondent)

While stigma and awareness about when to seek help can be overcome through better health promotion and awareness activities, the issue of transport and pressures of living are more difficult to address. People living in rural areas struggle to find time to travel long distances to regular appointments, and to schedule their care around existing commitments. Add to the equation any additional barriers imposed by services, such as long wait lists, high out-of-pocket costs or not being especially welcoming or culturally safe, and it seems even less likely that an individual will be able to successfully access help early in their mental health struggles.

SYMPTOM REDUCTION AND COPING

"It's taken me over eight months to get help seeing a counsellor for my 15-year-old daughter who is dealing with depression and self-harming"

(Survey respondent)

Problems accessing clinical care or support for a particular mental health condition when needed (whether diagnosed or not) was a common theme. To some extent, the same issues raised in section 2 apply here (stigma, transport, pressures of living and problems identifying if and when help is needed), but they are potentially exacerbated and there is greater pressure when a person's symptoms are causing distress, or they are struggling to cope without help. By the time people seek help, they are already struggling, and therefore sometimes need more intensive intervention.

76% of people surveyed said that in the past 12 months there was a time where they wanted to talk to someone or seek help about stress, depression or problems with emotions

"What we glaringly see in schools is that by the time services are available you need to be so unwell, and the families and child are so stuck that the service can't sustain the intensity of the requirement in any way that is helpful" (Interview participant)

Conversations with community members revealed that there were very limited options for getting support for mental health when distress escalates, especially in some communities. We used the survey to understand the extent to which people living in regional WA, a) felt the need to get support, and b) were able to successfully get the support they needed.

Survey respondents were asked, *In the past 12 months, was there was a time where you wanted to talk with someone or seek help for stress, depression, or problems with emotions?*

Seventy-six per cent of people said yes, however, 39% of these people reported that they did not get the care they needed. Of those who did not get the help they needed, two-thirds (67%) reportedly tried connecting with a service or support.

The survey participants who wanted to seek help were asked to select the reasons why they were unsuccessful in accessing a service, despite their attempt to do so (see Figure 11). Most sought help but were placed on a waitlist (41%). A further 39% tried to access help but felt that the support was not suitable for their needs, 30% did not have transport (or the service was not close enough), 23% were told they were ineligible, and 9% sought help but felt it would be too embarrassing to seek support.

Of the respondents who wanted to seek help and attempted to access a service, 30% did not have transport (or the service was not close enough)

Stakeholders with experience of regional services describe a system in very high demand, that requires knowledge, connections and sometimes even the 'luck of the draw' to access in a timely way.

"I have phone numbers for everyone in Bunbury but I have sat there for a couple of hours trying to get someone to help" (Consultation participant)

"Waiting times for new patients is enormous. It can be a couple of months to get to see a psychologist and having to wait six months+ to see a psychiatrist is not unusual" (Consultation participant)

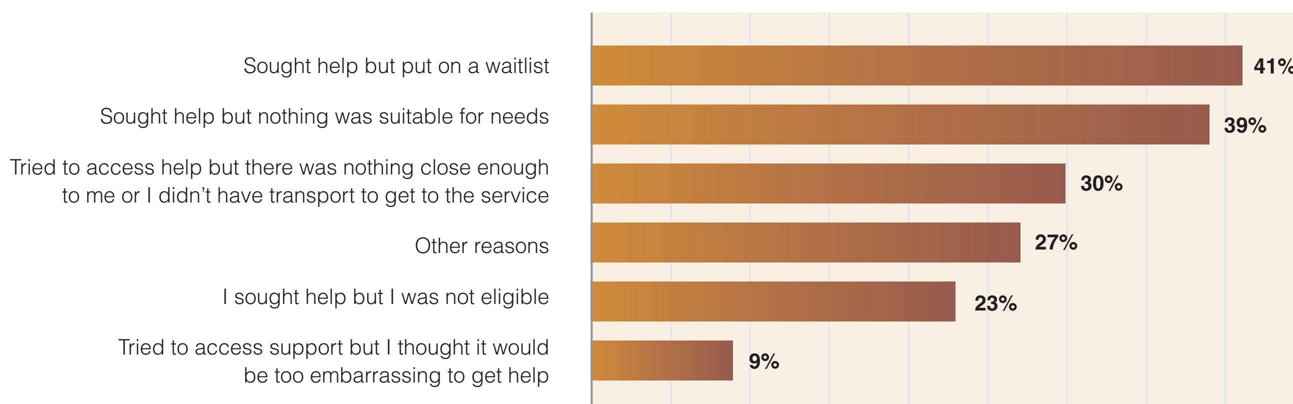
These experiences were echoed in survey comments.

"While community mental health supports e.g., Men's Sheds and community centres are good for prevention, if people do have a need for intervention there are wait times and delays at most mental health services in our region currently" (Survey respondent)

"Long waiting lists to be seen by the local hospital psychologist. I was referred three years ago and still have not heard from them. Thankfully I could afford to see someone privately but it is expensive and not accessible to everyone" (Survey respondent)

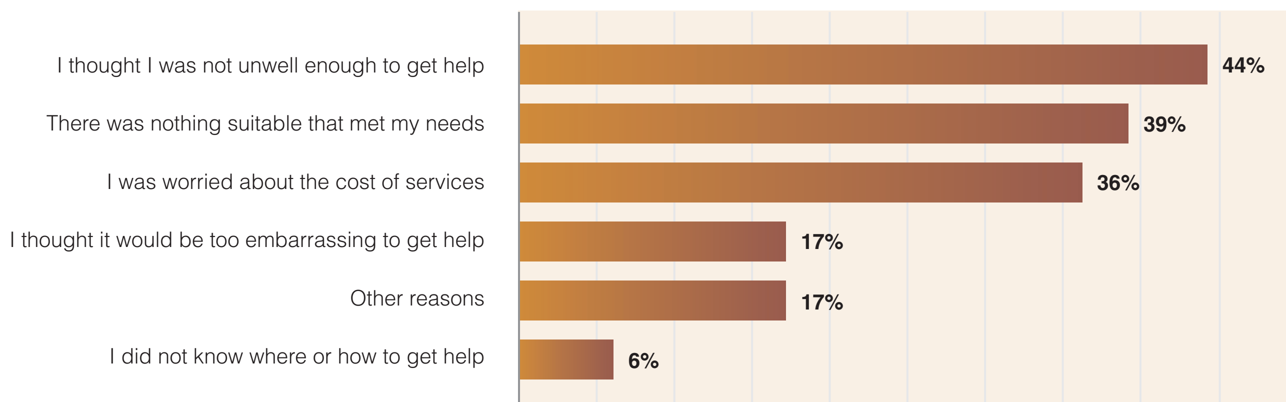
Of the survey respondents who wished to pursue help, but did not make any attempt to connect with a service or support, the primary barrier was feeling they were not unwell enough to seek support (44%). A further 39% felt that there was nothing suitable that met their needs, and 36% were worried about the cost of services. Seventeen per cent felt it would be too embarrassing to access help, and 6% did not know where to or how to get help. Figure 12 further illustrates the barriers associated with not attempting to access support.

Figure 11: Barriers experienced during an attempt to access support



Note. Multiple responses permitted.

Figure 12: Barriers that prevented people attempting to access support



Telehealth as a support option

Telehealth is often seen as a go-to option for people who do not have physical access to a clinician or mental health service. However, although Telehealth offers some people timely, high quality mental health support, it is not the answer for everyone. One in 10 survey respondents said they did not reliably have access to a computer or other device such as a tablet or phone (4% of survey respondents reported that they did not have any access to a computer or other device, and a further 6% had access only sometimes). Six per cent reported having inconsistent access to a mobile phone, 6% had no access to the internet, and 13% had access to the internet only sometimes.

Regardless of whether people have access to a device or internet, they may not have the privacy required for a consultation. Of the survey respondents, 29% did not always have access to a private space to make a video call in their homes. Additionally, some people may not feel comfortable utilising telehealth, or may prefer face-to-face support (for more detail about telehealth, see Section 5).

SUPPORT FOR PEOPLE IN ACUTE DISTRESS

"People need help NOW – appointments are not doing the job"

(Survey respondent)

Individuals in acute distress are not adequately supported in regional areas, especially in smaller towns or remote areas. Consultation participants and survey respondents indicated that there was a need for better crisis support for mental health. People in acute stages of a mental health condition need high quality, timely treatment options. Often, in more remote areas, people rely on FIFO services such as The Royal Flying Doctor Service, which, although of great value, is not always enough to safely support the number of people in acute distress in regional WA (due to logistical issues, timing, and staffing/capacity issues).

Support for people in acute distress in larger regional centres was not necessarily more reliable or accessible than in small towns, reportedly due to a lack of a qualified, skilled mental health workforce in local regional hospitals who can meet demand. A number of participants raised concerns around the quality of staff in hospitals and in other psychiatric care services, saying that staff may be under-trained (for example not being knowledgeable about trauma or even mental health care in general), judgemental, or otherwise unsupportive.

"Support for people in a mental health crisis is very limited with only the local hospital. There are no mental health staff at the local hospital and a telehealth consult is the only support for the person in a mental health crisis"

(Survey respondent)

"I have a family member that has had to wait two months to make a mental health appointment with their GP. Another family member was taken to hospital with self-harm and sent home with her partner who was told to hide the knives. She then went back in an ambulance after a cocktail of Valium and vodka. It needs to be taken seriously and it's getting better, but when you're in the depths being told you need to wait eight weeks [for an appointment], it feels like a lifetime" (Survey respondent)

"There are no longer psychiatric emergency teams. To get help for a suicidal person on the weekend or after hours is close to impossible, people who self-harm and suicidal people are turned away from our local Mental Health Unit at the hospital, the services inside the hospital once admitted aren't culturally safe or appropriate, doctors and nurses inside of this unit aren't trained in mental health or mental health first aid, holistic wraparound services aren't available, people on the phone lines for Crisis Care and Beyond Blue aren't trained well enough and can further isolate someone who rings them. There are so many gaps in the broken system and no beds" (Survey respondent)

This was the case not just for hospital admissions but for people accessing urgent care from clinical supports too, for example from a psychologist or psychiatrist, or specialist services (e.g., a child psychologist or someone specialising in eating disorders). Although such services may exist within a reasonably accessible distance (although often this was not the case in more remote communities), wait times and a lack of afterhours options were often prohibitive for people who needed immediate, specialist support when their condition becomes acute or even life-threatening.

"Mental health crises do not occur only during 9 to 5, evening and weekend support is needed. Having access to support when you need it, not waiting weeks when it's already too late" (Survey respondent)

In some cases, it was revealed that people in very high distress were actively turned away from services.

"Many won't accept a referral if suicidal ideation is present" (Survey respondent)

The lack of supports available for those in a mental health crisis is a particularly vexing issue for regional communities, who feel the fallout when people they care about cannot access specialist care.

"Where is there to go when there's nowhere to go?" (Interview participant)

"We have a significant number of people with serious mental health conditions who are only able to access the support they need when they are taken by police to the emergency department while experiencing significant psychosis... There is also a significant number of people who are untreated for their major mental health issues, but who are supported by the community to live in the community, in spite of significant behavioural and safety issues. Many have tried and failed to access services, but the nearest services are literally hundreds of kilometres away" (Survey respondent)

"Services are not easily available. With my Indigenous clients they would benefit from a service which is available at times of crisis rather than being referred for counselling and an appointment two weeks later. A lot of the work is single session which does not address the underlying causes of their distress, but is a band aid measure"
(Survey respondent)

Sadly, our findings suggest that many people living in regional communities who experience a mental health crisis are unlikely to find the immediate, quality support they urgently need. This is compounded by a lack of locally-based supports, limited access to a qualified, skilled workforce, and difficulties accessing telehealth.

HEALING AND REINTEGRATING

Looking at ways that people with experiences of mental ill-health could be supported to recover and heal was not always top of mind for people consulted, and less information was collected about how well supported people are in this sense. The Project Team wondered whether this was because these supports were so few and far between, or so difficult to access. In-depth interviews provided an opportunity to prompt key stakeholders about recovery supports in regional towns, and many people did comment on the inadequacy of recovery and reintegration efforts in regional settings, particularly for very isolated areas. Stakeholders said there was a lack of coordinated programs to support individuals and carers and assist with their rehabilitation and resocialisation back into 'everyday' life.

"People get discharged from hospital and say, 'well what next?'" (Interview participant)

Psychoeducational community programs were generally considered important among consultation participants, however the feedback about how effective these were in regional communities was mixed. For example, according to one interviewee, in one Wheatbelt community there had been programs of this type that had served as a comfort for some, but had ultimately failed to reach people in greatest need. In other areas, educational programs have been successful in bringing together those with lived and learned experience to offer a "transformational educational approach", in the words of an interviewee located in the South West.

Where these programs do exist and are working well, stakeholders also report that often the funding was time limited and when it ran out the programs were no longer available. The importance of peer led programs to support recovery (and lack of options for accessing peer supports) was also consistently raised.

IMPLICATIONS

In this section, the 'consumer journey' framework provided a structure for the analysis of findings, and in doing so revealed that people living in regional communities are not adequately supported in a number of ways. In summary, in regional communities:

- the effects of the social determinants of mental health (for example, unemployment) are felt more acutely and it is more difficult for people to find the resources, opportunities or services to resolve social vulnerabilities;
- high levels of social support, quality of life and wellbeing are not guaranteed due to limited opportunities for recreation or social connection, and the effects of social or geographical isolation may also be more difficult to resolve;
- mental health awareness and literacy is poor in many communities, and opportunities to have normalising conversations about mental health concerns 'early in life and early in episode' are limited by stigmatising beliefs about mental illness;
- accessing regular care to help manage a mental health issue in an ongoing way is effortful and at times not realistic for people living regionally, who face additional logistical barriers such as transport and cost. This also affects people's ability to access urgent help when in a crisis, sometimes leading to devastating consequences such as suicide; and
- conversations about supports for healing and recovery reveal there is some awareness of the need for support in this area, but this awareness is limited.

Unpacking support needs in this way shows that difficulties accessing appropriate care are compounded across the spectrum of need, as well as by distance from metropolitan centres.

3.2 System failures in meeting demand

"There are a number of services, however the waitlist is too long. A lot of state-wide NGO-contracted services are not actually delivered or available state-wide. People without a car cannot access services. There is no public transport. There is a long waitlist for services. The cost of private providers and gaps are sometimes too much for a family to bear. The stigma of asking for help is very real"

(Survey respondent)

Among consultation participants several points were raised that highlighted the failures of the mental health system to provide adequate mental health support to people living regionally. Services may not be available at all, there are capacity and workforce issues which limit access, services are often underfunded and overbooked, there are extremely long waitlists and a lack of services that are appropriate for diverse cohorts. The evidence for this was strong, across all data sources. People were keen to discuss their disappointment with how things were. Considering the stigma in regional communities around having conversations about mental health and help-seeking, reaching out for help is likely to involve a personal risk and/or logistical effort, and potentially devastation and helplessness if this call for help is unmet.

KEY FINDINGS AND NEEDS IDENTIFIED:

- Most of survey respondents (82%) agreed that there was a lack of funded services available for improving the mental health of their community, and the same number also agreed that the skills, staff, and capacity was limited locally for improving poor mental health.
- People reported needing to drive up to three hours to access face-to-face mental health care, and telehealth is not always viable or preferred.
- The lack of options available, and on top of that, experiences of stigma or discrimination within the mental health system further alienate people from services, and may mean that for some people in need it is easier to go without support.

Community members expressed concern for the people in their towns, and felt that despite having mental health challenges in the community (including harm from AOD), there was a **lack of funded services available for improving the mental health of the community** (38% agreed; 44% strongly agreed).

The impact of this plays out in several different ways. In some communities, people drive for over three hours to access in-person mental health support. Telehealth is not always an option for reasons that might include poor internet access or lack of privacy. Seeking support from clinical or non-clinical services is also less appealing if there is a high staff turnover or lack of collaboration between services: people are "tired of telling a story lots of times", said one interviewee. Reflecting on a town in the South West, another interviewee discussed the role of socioeconomic status in accessing support, suggesting that affluent families not only have more informal community supports, they are also more able, and more likely to, access services.

"The mental health support services provided in Geraldton, while they do great work and I have massive amounts of respect for the counsellors, are extremely underfunded and overbooked. There is an insane waitlist for free or discounted programs. To get in sooner than a few months you would have to pay a private practice which is incredibly expensive and out of reach for most of the community who need it most" (Survey respondent)

Language and cultural barriers were also raised as problematic in accessing supports for CALD and Aboriginal communities in particular. Services need to consider literacy levels, the translation of documents, and cultural appropriateness, in order to effectively reach people from diverse cultural backgrounds.

The number of factors that seemed to conspire against people in regional areas accessing high-quality, timely, consistent, and appropriate mental health care led some people to not bother with mental health support at all, and others to 'settle' for what they could get (often services which were inappropriately timed or not holistic in their approach). This appeared to be the case particularly when trying to access support in the early stages of mental health distress.

"To have options for mental health support in the community people need travel to the next town, which is 30 minutes' drive away, services there cost, [there are] limited sessions for counselling, long waitlists and often people cannot afford the travel for the fuel or service. Access to bus services are limited and fare is above a normal metropolitan price" (Survey respondent)

Survey respondents also overwhelmingly agreed that **the skills, staff, and capacity was limited locally for improving poor mental health** (36% agreed and 46% strongly agreed).

"I feel the mental health care workers are extremely overworked and under-resourced which negatively affects their practice and their reputation in the community"

(Survey respondent)

"The publicly-funded mental health system is at capacity and people aren't getting the help they need. The local hospital doesn't have a specific inpatient mental health unit and people in acute crisis can't access sufficient help"
(Survey respondent)

"I specialise in providing eating disorder services as a dietitian. The main issues I have noticed is that there is a lack of clinicians in the South West who are skilled/trained in this area so there is a huge lack of support services for eating disorders in particular. This includes dietitians, GPs, psychologists and psychiatrists. The other issue is cost – there are limited services who can provide long term support for public patients or those who cannot afford to pay for services and often those people are discharged early from services that they need" (Survey respondent)

This issue is reflected even in the larger regional centres.

"Recently I took a patient who was having issues, he was wanting to commit suicide. When we got to ED in Bunbury there was no bed, so we had to leave him in the main ED for the public. This situation is not uncommon. Bunbury hospital needs a dedicated place to take mentally ill patients, not through the main ED. With more than one bed"
(Survey respondent)

Knowing what we know about the stigma people may have to overcome, and logistical efforts needed in order to access help – the risks and efforts involved in asking for help – it seems a dire situation that this help would then be denied.

"I've had a 40-year-old man in my family acknowledge he needed help [for his mental health]. After much encouragement, he went to the GP. Was told to come back in two weeks and then she could write him a mental health care plan. He went back to her, only to be told the wait time to see a counsellor or psychologist is 10 weeks. This is someone who is severely depressed, who knows he could lose everything, who is trying to seek support, and feels more hopeless than ever"
(Survey respondent)

"The wait for mental health support is too long and in some cases, places close their books to new clients because they just don't have the capacity. This is very challenging if trying to refer people that you think need to access some help"
(Survey respondent)

People are put off by access barriers, and there is also evidence that these barriers deter people from engaging again.

"Seems to be lots of services available in the community, however to access them appears tricky. They are either at capacity or can only give three sessions. Referrals are lengthy and involve the person telling their story multiple times – when they are already at crisis point, this is a big turn off and adds to their feelings of being not important/ undervalued" (Survey respondent)

> "When I was unwell, I didn't bother trying to get a psychologist and psychiatrist appointment for myself because I knew it'd be months and all my problems felt so immediate"

"Low availability of psychologists and psychiatrists is a big problem. We just need more of them. The true demand is probably hidden to some extent because I know of people who've complained about how long it'd take to get an appointment and they just don't bother pursuing it. When I was unwell, I didn't bother trying to get a psychologist and psychiatrist appointment for myself because I knew it'd be months and all my problems felt so immediate, and ironically, I had to get to a slightly better place mentally (without help) to be able to think long term and realise 'well the wait will be long, but I might as well get the ball rolling'. That's a difficult mindset to get into when people are very unwell, so who knows how many people aren't even trying to access services" (Survey respondent)

Furthermore, some people reported experiences of discrimination within the mental health system.

"The mental health system seems to be on a 'doctor chooses' basis. If a person has a physical complaint, e.g., a brain tumour, it seems they get instant help. When the problem is mental health it appears the psychologists and psychiatrists can pick and choose who they wish to treat. Some people are considered too complex and are passed over" (Survey respondent)

"There are problems with racism in the medical field, and problems with how professionals treat fat people. There are also issues with homophobia/ transphobia, and a general lack of education and knowledge around LGBTQIA+ people" (Survey respondent)

Some respondents expressed views that diversity and inclusion practices may not be as extensively embedded in the culture and practice of service providers in regional areas compared to metropolitan centres.

There were many survey respondents (39%) who agreed that there were options for their community related to attaining mental health support *(People in my community have options for getting help for their mental health)*, however, the vast majority (80%) agreed that some groups of people are doing better than others in terms of their mental health. Further, respondents felt that *Some people are actually missing out on options to support their mental health* (39% agreed and 51% strongly agreed).

> "The cost is an issue too. Even with a Mental Health Treatment Plan, the price of accessing a psychologist has been a deterrent... And the gap fee to see a psychiatrist is enormous"

"For the aged there is very little, we are looked upon as past our use-by date" (Survey respondent)

"Mental health [support] in the community is very limited for youth and the main mental health counselling service is not able to provide support to under 16 years of age" (Survey respondent)

"The cost is an issue too. Even with a Mental Health Treatment Plan, the price of accessing a psychologist has been a deterrent for two of my friends who are students. Regularly paying a $40 gap fee is not affordable. I'm employed, but even so the gap fee has been a limit on how often I get to see a psychologist, and I have skipped it for months at a time when in financial distress. And the gap fee to see a psychiatrist is enormous: I see a psychiatrist twice a year but would really prefer to see them more often to fine tune medication and ask more questions. I just can't afford it" (Survey respondent)

Further analysis found that nearly three-quarters (72%) of respondents believed that, for certain groups in their community, mental health support seems completely inaccessible. These groups included young people, people living with a disability, Aboriginal peoples, CALD persons, those a part of the LGBTQIA+ community, the elderly, farmers, remote workers, people experiencing homelessness, and those of low socioeconomic status.

The mental health system is not adequately addressing mental health need in regional WA. Evidence, in both the survey findings and conversations, described failed attempts of individuals to get support, care and treatment, and groups and cohorts in the community that appear to be systematically overlooked or underserved. Similar systemic problems may also exist in metropolitan areas, however they appear to be intensified in regional communities where the number of options available is limited, skilled and specialist staff in short supply, and distance to travel and waitlists are likely to be longer. Importantly, consultation participants described how by the time a community member reaches out to a mental health service for help, it is likely that they have overcome significant social, cultural, internal and logistical barriers to seek help, and might not try again. Therefore potentially, in the rural context, meeting that call for help in a timely, responsive way becomes even more critical.

3.3 Variance across regions

Findings presented in Section 2 indicate that many people living in regional WA are struggling with high levels of psychological distress and low wellbeing. This section uses survey data to explore the extent to which respondents' experiences differ across regions, using the three focus regions to examine this question. We looked in particular at how psychological distress, wellbeing, access to mental health support and social cohesion varied across three regions.

In comparing regional data, it is important to note that there were significant differences in the sub-group sample sizes (South West n=142; Midwest n=50; Wheatbelt n=27), and therefore, the results should be interpreted with caution. Further, findings are limited in the extent to which they are representative of the region's whole population.

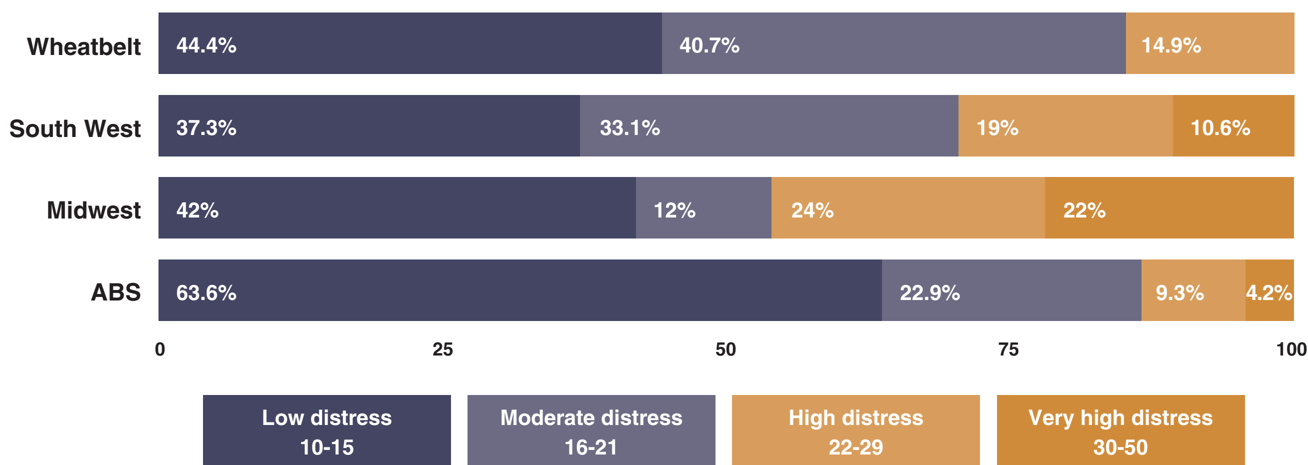
KEY FINDINGS AND NEEDS IDENTIFIED:

- Percentages of high and very high distress were considerably greater across all three regions, compared to the Australian norms.
- Possible depression (i.e., a WHO-5 score below 50) was indicated in 43% of Wheatbelt respondents, 49% of South West respondents, and 54% of Midwest respondents.
- Survey results indicate significant unmet need across all regions. Survey respondents from the Wheatbelt seemed to experience greater difficulties getting the supports they needed, with over half (55%) of the respondents not being able to access supports when needed. For the South West, 44% did not get support when needed, which was a similar proportion to the Midwest (42%).
- Scores indicate that social cohesion was low across the three regions.

PSYCHOLOGICAL DISTRESS BY REGION

The following diagram (Figure 13) compares aggregated K10 data from the three regions to 'normative data', or norms. For normative data we have used the Australian Bureau of Statistics' (ABS) National Health and Wellbeing Survey 2021-22 (2022). Percentages of high and very high distress were considerably greater in all three of the regions, compared to the ABS norms. This suggests that survey respondents in the Wheatbelt, South West and Midwest regions were experiencing greater psychological distress than the Australian norms. Statistical comparison across the three regions showed no difference between locality. These data suggest that all regions were facing psycholgical distress levels consistent with a mental health need.

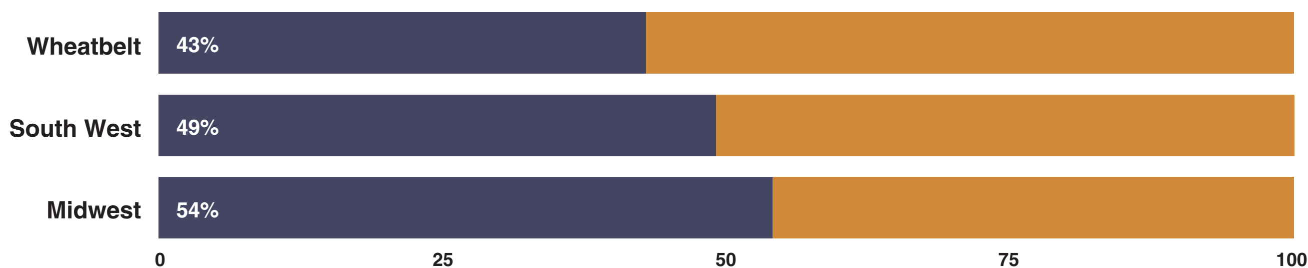
Figure 13: Levels of distress across regions and compared to ABS data (K10 categories)



WELLBEING BY REGION

The wellbeing measure used was the WHO-5, a screening tool for general wellbeing. A score of zero represents the lowest level of wellbeing, and a score of 100 is indicative of the best possible wellbeing. Scores below 50 suggest further, clinical assessment is warranted to assess for depression. Wellbeing was consistently low across the regions, which would indicate, from a clinical assessment point of view, that many people may be experiencing poor subjective quality of life, more negative mood, low energy, and less interest in life. Possible depression (i.e., a WHO-5 score below 50) was found in 43% of Wheatbelt respondents, 49% of South West respondents, and 54% of Midwest respondents (see Figure 14). Mean wellbeing scores did not differ statistically across the regions.

Figure 14: Wellbeing across the regions (percentage of respondents who scored below 50 on the WHO-5 measure)



SOCIAL COHESION ACROSS REGIONS

Social cohesion was measured using five related items. Survey respondents were asked to rate how strongly they agreed (5) or disagreed (1) with the following statements on a five-point scale: "people around here are willing to help their neighbours"; "this is a close-knit neighbourhood"; "people in this neighbourhood can be trusted". Two statements were reverse scored "people in this neighbourhood generally don't get along with each other"; and "people in this neighbourhood do not share the same values". The scores were summed to create a total score, with higher scores indicating greater social cohesion (Sampson et al., 1997). Comparisons made between the three regions found similar self-reported social cohesion across the South West (14.1), Wheatbelt (14.1), and Midwest (14.2). There are no current guidelines for interpreting mean social cohesion scores using the current measure, however, given all average scores were less than the mid-point of the scale (15), this would suggest that we cannot assume that social cohesion is always high in regional settings.

ACCESS TO SUPPORT ACROSS THE REGIONS

Survey respondents were asked: *In the past 12 months was there a time when you wanted to talk to someone, or seek help about stress, depression, or problems with emotions?* and a follow-up question, *Did you get the support you needed?*. Results indicated significant unmet support need across all regions. Survey respondents from the Wheatbelt seemed to experience greater difficulties getting the supports they needed, with over half of the respondents not being able to access supports. This may relate to the sparse population and lack of mental health supports funded in that region.

- **71%** of respondents surveyed from the Wheatbelt reported needing to seek support for their mental health in the last 12 months, and **55%** of these people did not get the supports they needed.
- **72%** of respondents surveyed from the South West reported needing to seek support for their mental health in the last 12 months, and **44%** of these people did not get the supports they needed.
- **79%** of respondents surveyed from the Midwest reported needing to seek support for their mental health in the last 12 months, and **42%** of these people did not get the supports they needed.

Qualitative data was not able to illuminate why people across the regions had differing experiences of accessing support, as not many people had experience of living in all three regions. However one stakeholder interview highlights the fact that the South West had more supports available.

"The South West has more alternative settings for support, not just for education but mental health services generally. There are some fantastic supports available, but for people to access them more generally and consistently (and with consistent staff) in other areas like the Wheatbelt and Midwest, it's more difficult" (Interview participant)

This analysis of variance across three regions is limited and not comprehensive. However, even this indicative analysis points to the fact that each region has different levels of mental health distress, wellbeing and access to supports, perhaps pointing to different drivers of distress, a range of vulnerabilities experienced across various demographic groups and communities, and different needs to address.

This analysis would support one of the key recommendations of the Orange Declaration (Perkins et al., 2019): that local level planning and leadership are required to deeply understand and unpack the dynamics that impact on mental health in different communities, and to develop considered responses and resource allocations based on these needs.

SECTION 4:

The experience of remote communities

4.1 The impact of community size on access to supports

One insight that emerged from the consultation was that the size of the community was a factor in how well supported people felt. While initially this finding was largely anecdotal, we aimed to substantiate this with further analysis. A typology was created utilising the Australian Census classification for rural, remote and metropolitan areas, to support analysis using community size as a factor:

1. Large rural centres – regional cities with populations of 25,000 or more
2. Small rural centres – towns with populations of between 10,000 and 24,999
3. Remote centres – towns with populations between 5,000 and 9,999
4. Other remote areas – all other places that are under 5,000 people

Experiences of accessing mental health support in large rural centres were found to be vastly different to experiences in remote centres, a finding consistent across all three study regions.

KEY FINDINGS AND NEEDS IDENTIFIED:

- People living in larger regional towns have greater access to locally-based services, whereas people in towns even just one hour away from these large regional centres often have to rely heavily on visiting services, with locally-based services spread thinly over a very large geographic area.
- Using the Midwest as a case study, we found that the regional centre of Geraldton had 33 services that were all locally-based, whereas nine smaller towns mapped as part of this analysis had a total of only 17 locally-based services. In addition, there were 28 visiting services shared across the nine towns.

ANALYSIS OF SIZE OF COMMUNITY BY ACCESS TO LOCALLY-BASED SERVICES

As outlined in the table below, the communities across the three study regions were classified into the four Census categories, using population statistics mostly based on data from ABS 2016 (the last available Census data): Statistical Area 2 (SA2); State Suburb (SSC); Urban Centre/Locality (UCL); or Local Government Area (LGA), depending on which was the most appropriate (note: numbers often jumped significantly when surrounding areas were included).

Table 3: Typology based on size of community as applied to the three study regions

	South West	Wheatbelt	Midwest
Large rural centre (regional city with a population of 25,000 or more)	Bunbury (31,683) – shire statistics, 2021 Busselton (40,333) – shire statistics, 2021		
Small rural centre (town with a population between 10,000 and 24,999)	Australind-Leschenault (17,592) – SA2, 2016 Margaret River (10,50) – shire statistics, 2021		Geraldton (11,790) – SA2, 2016
Remote centre (population of between 5,000 and 9,999)	Collie (7,587) – SSC, 2016 Dunsborough (5,320) – SSC, 2016 Capel (5,195) – SA2, 2016 Manjimup (5,538) – SA2, 2016	Northam (11,112) – LGA, 2016 Narrogin (5,162) – LGA, 2016	Carnarvon (5,160) – SA2, 2016
Other remote area (all other places that are under 5,000 people)	Augusta (1,788) – shire statistics, 2021 Boyanup (1,217) – SSC, 2016 Boyup Brook (911) – SSC, 2016 Bridgetown (2,812) – SSC, 2016 Greenbushes (385) – SSC, 2016 Cowaramup (1,902) – SSC, 2016 Donnybrook (2,824) – SSC, 2016 Dardanup (502) – SSC, 2016 Roelands (845) – SSC, 2016 Pemberton (974) – SSC, 2016 Nannup (936) – SSC, 2016 Yallingup (1,029) – SSC, 2016 All other towns	Bruce Rock (703) – SSC, 2016 Bindoon (1,183) – SSC, 2016 Corrigin (851) – SSC, 2016 Cunderdin (876) – SSC, 2016 Dalwallinu (787) – SSC, 2016 Gingin (852) – SSC, 2016 Lancelin (726) – SSC, 2016 Kellerberrin (972) – SSC, 2016 Narembeen (472) – SSC, 2016 Toodyay (1,408) – SSC, 2016 Williams (948) – SSC, 2016 Southern Cross (680) – SSC, 2016 York (2,535) – SSC, 2016 All other towns	Carnamah (405) – SSC, 2016 Coral Bay (207) – SSC, 2016 Cervantes (527) – SSC, 2016 Dandaragan (340) – SSC, 2016 Jurien Bay (1,761) – SSC, 2016 Exmouth (2,514) – SSC, 2016 Dongara (1,380) – SSC, 2016 Meekatharra (708) – SSC, 2016 Morawa (532) – SSC, 2016 Mount Magnet (470) – SSC, 2016 Mullewa (447) – SSC, 2016 Kalbarri (1,557) – SSC, 2016 Wiluna (720) – SSC, 2016 All other towns

Across all three regions, the size of a community had a substantial impact on support needs and access to available services. This was confirmed through conversations with service providers who travelled through the regions, or talking to people who had experiences living in different-sized communities.

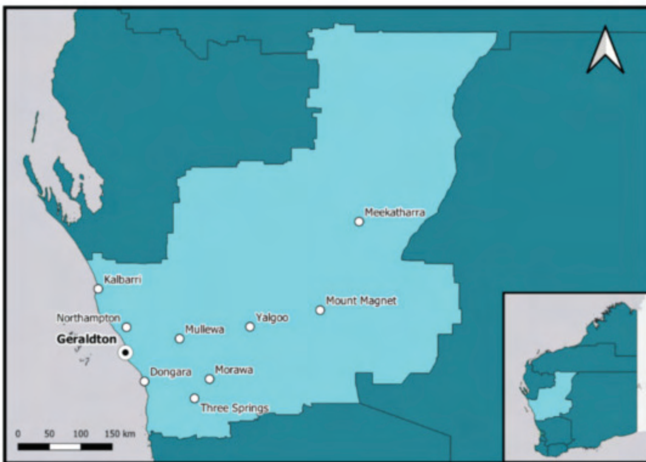
"Being a fly-in-fly-out worker in a remote community means that I don't have access to supports that I would normally have"
(Survey respondent)

When consulting with stakeholders from smaller towns, the differential access to support between larger and smaller towns was strongly observed and expressed. While this pattern was apparent in all regions, the Midwest is used as a case study area to help illustrate the differential access to support by size of towns, and to unpack the causes.

MIDWEST CASE STUDY AREA

The following map (Figure 15) outlines the Midwest region. Geraldton is the largest town in the region. Across the Midwest, 67 participants were engaged in conversations and forums, including people from Geraldton, Mullewa and the North Midlands. Two locations were selected as a point of comparison for understanding differential experiences of mental health support according to size of community: Geraldton, which is classified as a small rural centre and has a population of approximately 12,000 people; and Mullewa, which is a remote town with a population of approximately 500 people, and a one-hour drive from Geraldton.

Figure 15: Map of the Midwest region



OVERVIEW OF LOCALLY-BASED SERVICES ACROSS THE MIDWEST

WAAMH documented the services and supports available in the Midwest that were mentioned during conversations with local key stakeholders. CSI validated and refined this overview through internet searching. While this process is not as robust as a full environmental scan and service mapping exercise (which was outside the scope of this Project), this more limited process was still considered valuable for providing an indicative overview of the number and distribution of services and supports. The types of services and supports that were included in the analysis were those that provided mental health support, including both clinically and non-clinically oriented supports; for example hospitals with provision to provide mental health care as well as community mental health supports delivered by NGOs.

Services and supports were classified as either 'locally-based' or 'visiting' and then counted in both Geraldton and all other towns.

- A locally-based service is a service (or support, or program) with a physical premises in a fixed location that provides support in the local community in which it is based.
- A visiting service is a service (or support, or program) which travels throughout a number of smaller towns on a regular or semi-regular basis to provide a kind of 'travelling support'.

We recognise that there would be overlaps between these support models: for example, a locally-based service may also provide outreach to other surrounding towns. In instances such as these, some services were counted multiple times in this analysis, for example where a Geraldton-based service also provided support in Mount Magnet in the form of a visiting service.

Figure 16: Number of locally-based services across different towns in the Midwest

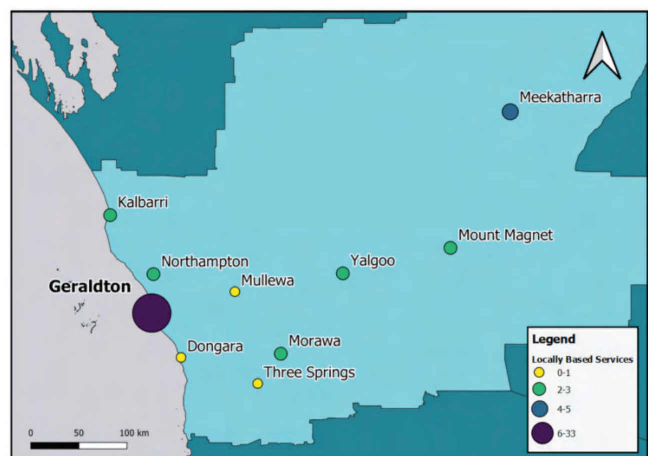
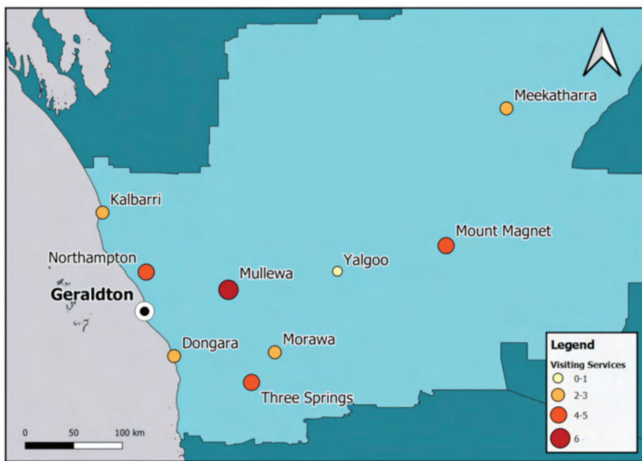


Figure 16 illustrates that the majority of locally-based services in the Midwest are focused in Geraldton, despite there being many communities well over 100 kilometres away from Geraldton. This finding was confirmed by anecdotal evidence.

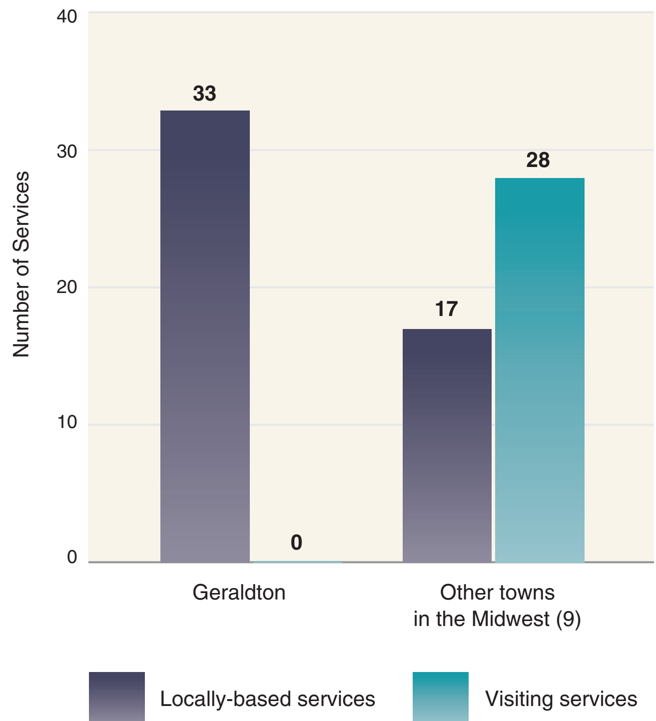
We recognise that services based in Geraldton do provide visiting services to remote towns. During the consultation process, we collected information about visiting services to understand the extent to which local communities were supported by these visiting services (see Figure 17). Again the data collection process was not as rigorous as a comprehensive mapping process would have been – it was point-in-time information, based on stakeholder knowledge provided at the time of consultation – however it does provide a picture that aligns with what we heard anecdotally.

Figure 17: Distribution of visiting services across the midwest



Overall, our analysis found that the regional centre of Geraldton had 33 services that were all locally-based, whereas all the other nine towns mapped as part of this analysis had a total of only 17 locally-based services (see Figure 18). In addition, there were 28 visiting services shared across the nine towns.

Figure 18: Number of locally-based and visiting services in Geraldton compared to other towns in the Midwest



What is immediately apparent from this analysis is that people living in larger regional towns have greater access to locally-based services, whereas people in towns even just one hour away from these large regional centres often have to rely heavily on visiting services, with locally-based services spread thinly over a very large geographic area. While this pattern has a logic from a service planning/population density viewpoint, the key question is whether visiting services are equally as effective and accessible as locally-based services. Stakeholders consulted in Mullewa helped us answer this question, based on their community's experience.

4.2 Accessing mental health support in a remote community

As outlined in our methodology, the Project Team made a particular effort to engage with remote towns and communities, many of which had very limited community mental health support or clinical mental health services. Mullewa was one such community, and in-depth consultation provided a rich understanding of how one small community experiences mental health support.

KEY FINDINGS AND NEEDS IDENTIFIED:

- Based on the experiences of one remote community, it is clear that visiting services, delivered for example through drive-in drive-out (DIDO) models do not adequately meet local needs.
- While on paper the DIDO service delivery model has a sound rationale, the dynamics of how it works in practice means that smaller towns often experience sporadic, unsustainable or non-existent/withdrawn service provision.

THE EXPERIENCE OF MULLEWA

Four-hundred and fifty kilometres from Perth, and 100 kilometres from Geraldton, Mullewa is classed as 'Other remote area' (fewer than 5,000 residents) with its population of approximately 500. Around one third of the workforce works in agriculture, and from 2003-2014 an iron ore mine was in operation in the district. As an agricultural centre, much of Mullewa's economy is based on grain production and pastoralism. Mullewa has several facilities and services within the town centre including a sports club, pharmacy, supermarket, hospital, doctor's surgery, recreation centre, Community Resource Centre (CRC) and police station. Mullewa is on the land of the Wajarri people of the Southern Yamatji nation.

Community members we listened to spoke of a long history of trauma in and around Mullewa and how this trauma is a major driver of mental health issues and self-harm challenges. The Mullewa Community Safety and Wellbeing Action Plan developed by the Geraldton Regional Aboriginal Medical Service (GRAMS) describes a community experiencing the "complex impact of social determinants such as intergenerational trauma, poverty, drug and alcohol abuse, dysfunctional family and community life, silent racism, discrimination, high unemployment, Geraldton-centric attitudes, poor education experiences, poor personal health choices and declining recreational options" (GRAMS, 2020).

The drivers of mental health issues, and their origins in historical events, are often left out of the picture in service planning and the design of supports, especially for Aboriginal people. Stakeholders told us that few programs in the area addressed these levels and layers of entrenched and intergenerational trauma.
As expressed by one local stakeholder in a focus group, the cry for mental health support is much larger than mental health itself: it is "like a lot of onion layers to be peeled".

Other issues experienced by the town that affect mental health and remain inadequately addressed include a lack of housing and the impact of AOD. These issues have an impact on children and young people but there are no programs and activities that really engage with those issues, for that cohort.

OVERVIEW OF AVAILABLE SUPPORTS IN MULLEWA

A consultation session was held in Mullewa with eight participants. One of the questions they were asked was: *What mental health community supports are available in Mullewa?* Respondents gave an overview of available mental health supports, which are presented below according to how localised their engagement with the community is (Table 4). As illustrated in the table, the most common kind of support model was a Geraldton-based organisation delivering a program locally (4 identified), followed by a Geraldton-based organisation providing a regular schedule of visits (3 identified). Note: this information may be subject to change and was not created with the rigour of a full system mapping exercise. Some services may have been missed, so this is presented as indicative data only.

Table 4: Available mental health support options in Mullewa, and their level of local connection, as identified by consultation participants

Telehealth with no local connection	Geraldton-based service that visits neighbouring town	Geraldton-based organisation that 'may' visit (sporadically, or as needed)	Geraldton-based organisation committed to a regular time slot for visits	Geraldton-based organisation delivering a program locally	Locally-based organisation delivering a program locally	Locally-based organisation providing ongoing access to support
1. WACHS based in Geraldton provides telephone counselling	**1.** Desert Blue Connect provides family counselling, based in Geraldton but visits Morawa (but not Mullewa)	**1.** WACHS public mental health and AOD service provides counselling and treatment for children and young people	**1.** WACHS Public mental health and AOD service supports people with AOD issues, visits on a fortnightly basis **2.** Ngala based in Geraldton but provides family counselling in Mullewa four sessions per fortnight **3.** Geraldton Regional Aboriginal Medical Service provides NDIS support through regular visits	**1.** WA Centre for Rural Health UWA delivers health-related programs locally (e.g., women's program) **2.** Geraldton Sporting Aboriginal Corporation delivers health and social and emotional wellbeing initiatives **3.** Centacare delivers programs such as school-based support, Yarning Circle, on-Country support for young people **4.** MEEDAC provides NDIS support, support for job seekers, support to help people clear fines, aged care	**1.** Mullewa Community Resource Centre delivers local community mental health awareness and promotion initiatives e.g. A night with the Blokes in partnership with Checkmate	**1.** WACHS Mullewa Hospital provides a 24-hour nursing station

Representatives from Mullewa were asked to identify any gaps or unmet needs in mental health support in their community. With Geraldton having a population of 12,000 and Mullewa having a population of 500, it seems reasonable that some services would be based in the larger centre one hour away, which the Mullewa community can access if they choose by travelling to Geraldton, or through visiting supports and programs delivered by larger Geraldton-based services.

However, stakeholders overall did not seem satisfied with the level of support received locally. They reported that Mullewa community members commonly express frustration with the City of Greater Geraldton for the lack of support they feel they receive. This frustration refers to both the local council, as well as other government agencies. Participants also suggested that these bodies perceive Mullewa as an Aboriginal town (and maybe not their responsibility) – which is a perception that is harmful for Aboriginal people, who feel forgotten.

"It is as if Mullewa's needs are ignored. The City's focus is on Geraldton"

(Consultation participant)

The Mullewa Community Safety and Wellbeing Action Plan argues that the mental health challenges faced by Mullewa are "compounded by the drive-in drive-out service model from Geraldton and the lack of place-based supports and services in Mullewa" (GRAMS, 2020). The Report identifies a suite of under-utilised community assets, including community groups, people assets, institutional assets, physical assets, historical and cultural assets and a number of strong organisations, such as the Yamaji Arts Centre, Mullewa Football Club and the Mullewa Community Resource Centre that can all contribute to community wellbeing and mental health.

According to those consulted, much more is required to respond to the needs of the community and promote community wellbeing. Participants were clear that DIDO models, in which service providers occasionally visit from the regional centres or come from outside the community, don't work for the community. They often do not have a strong enough presence in the local setting for people to understand who they are and what they offer, or to gain the trust and understanding of the community in order to effectively engage with people who are most in need of support.

Further, in very practical ways, this model of funding and service provision was experienced as problematic for various reasons. Firstly, money may be allocated for supports and services in Mullewa, but the providers are based in Geraldton, and in effect, might have no or very minimal presence in Mullewa, or much of the funding allocation is spent on travel to and from Mullewa. Secondly, supports that are provided by Geraldton-based services often do not fit in with what the community needs.

"There are too few NGO providers coming to Mullewa, and they rarely ask what is needed. They come with their own programs that don't fit the community" (Consultation participant)

Thirdly, reliance on visiting services is precarious because services are vulnerable to changes in staff, program allocations or changes to funding streams (changes often made based on the understandings of decision-makers living in larger centres). For example, services and supports may be provided in Mullewa, but if a staff member leaves, they may not be replaced (for example, this happened with the local Youth Centre).

The fact that local community members are often unaware of visiting services, plus the above practical implementation issues raised (i.e., small towns being overlooked by service providers in larger centres, being offered supports that do not fit in with needs and insecure services and supports that are often not sustained) were the key problems around service access and provision in Mullewa.

Due to the gap left by the visiting services model, people are expected to travel to Geraldton to access supports and services. However, many people are unable to get to Geraldton as they may not have a car or money for petrol, or cannot take time off work. In addition, telehealth does not work for people who don't have a computer, phone, reliable internet connection or a private space to make calls (see Section 5.1).

THE EXPERIENCE OF OTHER SMALL TOWNS

These issues did not apply only to Mullewa. They were common experiences in many small towns across the three focus regions.

"My Community includes Manjimup, Pemberton, Northcliffe and Walpole. Lack of appropriate mental health support across the region is a critical issue... with the majority of services being available only in regional city areas of Bunbury, Busselton and Albany... All between 1.5 and 2.5 hours away, one way. Outreach services are often a joke as the 1FTE has to include travel time and lunch on the day they visit and therefore often get to see three people only." (Survey respondent)

As this respondent indicates, the need in their local community is greater than can be met by visiting services.

The pattern observed by the Project Team was that mental health support tends to be available to some extent in the main regional centres, where funding for programs is often allocated to larger service providers based in these regional centres. However, funding does not always effectively flow through to the smaller towns in the catchment areas of the larger centres, even if that is the intention.

Stakeholders from remote communities often told us that there is a major disconnect between what is supposedly being funded and delivered and what is actually provided on the ground in towns some distance (usually over 30 kilometres) from the main regional centres.

Service providers based in larger towns may intend to provide outreach supports to surrounding towns, but for various reasons outreach services do not get there. Alternatively, outreach supports might be provided in such small supply that they are of little value to the community. Sometimes there is no time allocated for important locally-based promotion or engagement work, and therefore the local community are not aware of the visiting service, leading it to be underutilised, and then withdrawn. In effect the Project Team observed that very little funded support was available beyond the regional centres.

Inevitably, the disruption and disappointment that sporadic, unsustainable or non-existent/withdrawn service provision can cause to a population is a significant problem when it comes to supporting mental health.

This experience was common across all of the small towns visited, across all three regions, highlighting structural problems with the funding model. While on paper the DIDO service delivery model has a sound rationale, the dynamics of how it works in practice means that whole towns are left without any effective supports. Inevitably, the disruption and disappointment that sporadic, unsustainable or non-existent/withdrawn service provision can cause to a population is a significant problem when it comes to supporting mental health.

HOW PEOPLE LIVING IN REMOTE AREAS GET THE HELP THEY NEED

Most of the small rural and remote towns across all three regions had no formal mental health services. Some may have a GP (with varying abilities to respond to mental health needs). Support is often provided outside the mental health sector by people who live locally and understand local circumstances. NGOs and community organisations play a key role in providing mental health promotion activities, providing practical help (such as with housing, employment and financial stress) and facilitating social connections that help keep people well and help to prevent people from needing crisis and emergency services.

Depending on the community, these organisations might be family centres, neighbourhood centres, family support groups, Community Resource Centres, Men's Sheds, schools, senior centres and groups, sporting clubs, community or service hubs, arts and cultural spaces such as galleries, service organisations such as the Country Women's Association groups and Returned Services League branches, farming groups, community groups, food/meal centres, community spaces and recreation facilities, and in some cases local business groups.

Many of these organisations have created "gathering places", which are community-owned and operated places that provide opportunities for people to connect and access support, activities and services (Victorian Government, 2016; Kingsley et al., 2021). They may be effective in providing social and emotional and community wellbeing benefits, which is critical where there are no formal mental health services, and where clinical and emergency services are not available locally at all.

However, the organisations providing these supports often sit outside the mental health sector, and not generally considered as stakeholders in relation to the provision of mental health services and support. Often they do not receive mental health funding. They exist because communities have made a commitment to fundraise or use other workarounds to ensure they have permanent, locally-based centres where the social and emotional needs of communities can be addressed.

4.3 A spotlight on funding models

While this Project did not seek to examine funding allocations, or service planning modelling, consultation participants consistently steered the conversation towards how and why current funding approaches were not meeting the needs of regional WA, and especially remote towns. This section examines in more depth two key grievances highlighted by stakeholders: firstly, that mental health funding does not flow to the smaller towns, and secondly, that services in larger regional centres are not adequately resourced to meet needs locally, or across their geographically large catchment areas.

KEY FINDINGS AND NEEDS IDENTIFIED:

- Conversations with stakeholders consistently highlighted structural issues with how mental health services were funded, leading to resources not flowing into towns outside the larger rural centres, and also services within the larger centres not being adequately resourced to meet demand.
- Evidence is largely anecdotal but consistent across all regions, and further review into the impacts of funding approaches on regional communities is recommended.

FUNDING THAT DOES NOT FLOW TO SMALLER TOWNS

Stakeholders in small towns describe how they are locked out of mental health and other funding opportunities due to competitive pressures on government contacts. Government procurement approaches favour larger organisations, usually based in regional centres (or the metropolitan area). On paper large organisations are seen to have greater capacity and capability to deliver support and services across the region. While these providers may win the funding to provide mental health support in remote communities, they often end up having limited or no local presence (as detailed in Section 4.2). For instance, they may plan to visit regularly, but due to lack of utilisation by the community, they come less and less.

...despite being highly knowledgeable about local needs and the solutions that would work, they are rarely consulted by funders about issues affecting their communities, and feel unable to influence decisions about the funding that is supposed to benefit their communities.

Key stakeholders, perhaps people working in community organisations in smaller communities, become frustrated that despite being highly knowledgeable about local needs and the solutions that would work, they are rarely consulted by funders about issues affecting their communities, and feel unable to influence decisions about the funding that is supposed to benefit their communities.

As a result of the market forces at play, agencies or community-led mental health initiatives in smaller towns are often unable to access mental health funding, and, in effect, need to rely on funding from other non-mental health sources (e.g., donations, fundraising or philanthropic funding) – even in instances where they are the only provider of mental health support in that town.

CONSTRAINTS FACED BY ORGANISATIONS IN REGIONAL CENTRES

While remote communities often end up being overlooked by current funding frameworks, this does not necessarily mean that people in larger regional centres are over-serviced or even adequately serviced. In fact, NGO and community agencies in regional centres told us that access to sufficient and more secure funding was one of the largest constraints they faced in trying to meet the high demand for mental health support in regional WA.

"We need a mental health unit in Geraldton now! Unable to get to Perth when unwell. Told to use local services yet there are none for when in crisis"
(Survey respondent)

"I tried getting my son in to see a psychologist, but all had their books closed. This is a decently sized city. We went through Headspace and eventually he got an appointment. But it was an extended period. It made me understand why we have an issue with youth mental health. Further, there would be a great deal of people who could not afford a private psych, which means Headspace is it – and it is nowhere near enough" (Survey respondent)

"We're in a 'super town' and yet, still have no options?! It's no wonder suicide is such a huge issue…" (Survey respondent)

For agencies in regional centres who are also required to service smaller surrounding towns, often the extensive travel time involved is not sufficiently accounted for, and sometimes not accounted for at all.

These organisations tend to rely on multiple funding sources or short term funding which creates fragmentation. Sometimes insufficient funding means services need to be rationed or controlled (i.e., waitlists, relying on group programs rather than individualised supports, withdrawal of services from smaller towns or reduced presence in outlying towns).

Sometimes insufficient funding means services need to be rationed or controlled (i.e., waitlists, relying on group programs rather than individualised supports, withdrawal of services from smaller towns or reduced presence in outlying towns)

While this Project has not collected the bureaucratic evidence to validate these claims, patterns observed and survey respondents' perspectives do align with the widespread anecdotal evidence collected about this. It is recommended that more investigation is needed to ensure that the funding of mental health supports in regional areas is adequate, and to assess whether typical regional funding models (either a hub and spoke or satellite model, where the provider is based in regional centre and provides services/support through smaller satellite centres) are the most effective way to deliver services and support across large geographic and sparsely populated regions such as regional WA.

4.4 Implications for supporting remote communities

As outlined above, transient or DIDO services are common in smaller communities but largely seen to be unhelpful. Too often these services feel tokenistic. Large NGOs "pop in and pop out", according to one interviewee, with no real lasting effect (although one interviewee noted that travelling services can be preferable to some because they offer a greater level of anonymity).

To address the gaps left by current approaches, stakeholders, especially from smaller communities, spoke of the need to:

1. Improve how visiting services interact with the communities they visit;
2. Strengthen locally-based services and supports to improve mental health outcomes;
3. Engage local leaders from smaller communities more actively in service planning.

KEY FINDINGS AND NEEDS IDENTIFIED:

- Many people living in smaller towns are not aware of what services visit, and when and how to access them. It was suggested that visiting services need a dedicated budget and time to engage effectively with the towns they visit.
- For remote communities, locally-based services and supports were seen as preferred, as they help address logistical barriers, but also provide better quality care.
- Local leaders in smaller communities are often excluded from important planning processes and need more systematic ways to advocate for the specific supports needed across the diverse communities in regional WA.

IMPROVE HOW VISITING SERVICES INTERACT WITH THE COMMUNITIES THEY VISIT

Part of the reason that DIDO models of service provision are not effective is that community members are often not aware of them, as they are not present in small towns to do the ongoing promotion and engagement work.

"People in Mullewa and the wider district do not know what services visit Mullewa, what they provide, when and where they provide it and how people can access support/services"
(Consultation participant)

Stakeholders in many small towns spoke of the need to build in the time and resources for DIDO providers to communicate and engage with people who live in the smaller towns they visit. Improved communication would in turn improve take-up of services, and service coordination between local and visiting services.

Communication, promotion and engagement work needs to not only be well resourced (by funders and commissioners), but DIDO services should ensure this work is purposefully delivered and as critical as service provision.

One suggestion was to have a regular interagency forum/meeting involving all service providers based in small towns as well as those delivering DIDO services. Another idea was developing a calendar to outline which providers visit the town (who comes, when and where and what they provide), to allow for better coordination of those visits.

STRENGTHEN LOCALLY-BASED SERVICES AND SUPPORTS TO IMPROVE MENTAL HEALTH OUTCOMES

"We need to strengthen our community but... often everything happens in towns nearby with larger populations"

(Survey respondent)

While the DIDO model may provide advantages (for example access to specialist skills that are not available locally, and the opportunity to speak to someone outside the community if stigma is an issue), the limitations as described above must be acknowledged.

Rather than rely on a DIDO model, a better approach for regional mental health support based on the findings of this Project would be to make use of and strengthen services and supports that already exist in small towns, as well as create opportunities for new place-based and community-led solutions. Community members that were consulted for this Project by and large noted a preference for locally-based supports.

"There needs to be a different model for small remote communities. Local place-based services and groups need to be supported as they so very often fill the gap as there is nothing else"
(Survey respondent)

This could include running more programs locally, or increasing the capacity, skills and knowledge of local service providers, and ensuring they have support (including funding, training and supervision) to deliver more mental health supports.

Using Mullewa as an example, agencies and groups that are based in Mullewa whose capacity could be supported and strengthened to provide mental health support could include St John Ambulance service, sporting clubs, the Community Resource Centre, the Men's Shed (although this has been closed for some time), and schools.

"Kids my age need more. There's not much help. I have to travel over an hour if I want help. I can't always get there. The people who come to down don't understand what it's like to live here. I want to talk to someone local. Someone who knows my town. There are lots of support for places near the ocean but none where I live. We, as kids, need some help" (Survey respondent)

A local service is better able to engage with the community, develop lasting relationships, observe changes and concerns, see opportunities to connect, and encourage help-seeking in innovative ways that are appropriate for that community. All of these assets are significant for improving mental health outcomes.

Importantly, this includes opportunities for keeping people well (i.e., preventing mental health issues from developing in the first place) and catching people in the early stages of a mental health struggle, even before the help-seeking stage is reached. Locally-based supports may also involve addressing or at least acknowledging the role of the social determinants of mental health for an individual in the context of their community, networks, history and environment, which can help people feel supported and willing to access other wrap-around support with appropriate advice and encouragement.

A local service is better able to engage with the community, develop lasting relationships, observe changes and concerns, see opportunities to connect, and encourage help-seeking in innovative ways that are appropriate for that community.

"A lot of the help that we can get is online. Indigenous people here want to see someone face-to-face. Our area has one of the highest suicide rates in WA. The town has great issues with alcohol which contributes to the state of mental health and compounds [issues for] already struggling people" (Survey respondent)

"We have quite a number of services that attend our regional town, however they are usually 'satellite' services who only come once a week or fortnight. It can be difficult to remember when services are available and difficult to see someone in a timely manner when services only attend weekly/fortnightly" (Survey respondent)

What is also needed are programs and initiatives that build the capacity and capability of natural helpers and first responders – including family, friends, neighbours, community leaders, citizens, community members and volunteers – to provide support for people struggling with mental health issues and before, during and after a mental health crisis.

Some of this work is happening already through the activities of Regional Suicide Prevention Coordinators and the development and implementation of community wellbeing plans. For instance, in the grain growing areas of WA, Commercial Bulk Handling is partnering with several mental health services, including the Mental Illness Fellowship of WA and Lifeline, to roll out such training to local towns and communities.

ENGAGE LOCAL LEADERS FROM SMALLER COMMUNITIES MORE ACTIVELY IN SERVICE PLANNING

With service provision largely driven by organisations based in metropolitan or large regional centres, many small towns have limited or no opportunities to work together as a community (or with influential decision-makers outside their communities) to map out the needs they have and a plan for addressing them.

A mechanism is needed for leaders and key stakeholders in smaller communities to come together on a regular basis for planning purposes (i.e., more often than sporadic or one-off opportunities). Local leaders need to have a voice about what is needed in the community, and opportunities to shape the types of services and supports provided, "to enable people to mobilise the passion they have for their community" as one focus group participant said.

Given the learnings of this Project around the variance of need across different communities, and significant impact of social determinants of mental health which play out differently in each community context, it is increasingly clear that local leadership needs to be engaged more systematically, to ensure mental health efforts delivered in regional WA are relevant and effective.

SECTION 5:

Local responses and proposed solutions

5.1 Experiences with existing supports

The survey and consultation findings point to significant unmet mental health need and experiences of difficulty accessing timely mental health care across regional WA. This section outlines the ways that people are currently supporting themselves and each other, what people say they need and want for their communities, and describes the resourceful ways that the mental health challenges of living in regional WA are being addressed through locally-driven initiatives.

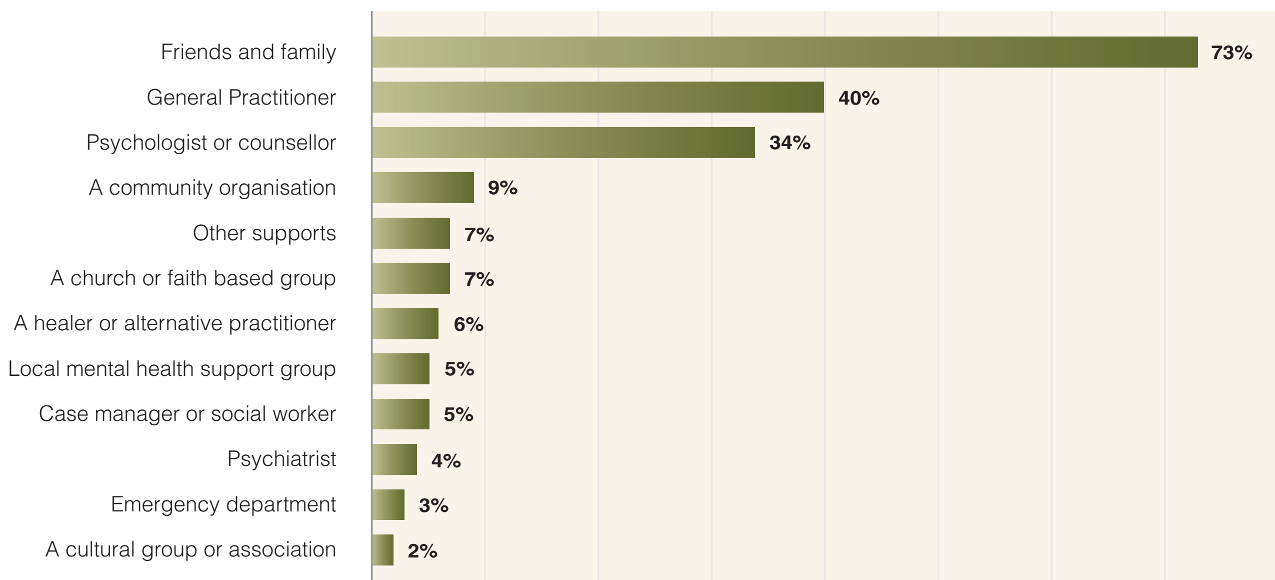
KEY FINDINGS AND NEEDS IDENTIFIED:

- Survey findings indicated that people in regional areas supported their mental health by using mostly informal supports (friends and family), their GP and psychologists or counsellors, and used other supports much less frequently. This may reflect the lack of options available.
- People reported that seeing their GP to access mental health support involved significant barriers, and although clinical supports were in short supply, they were not always preferred.
- Across all regions, online services, including telehealth, was not a realistic option for a significant portion of people – the survey indicated that in the South West and Midwest, at least one in six people experienced one or two major barriers to accessing telehealth. In the South West, about one in five people reported they could not consistently access the internet with the speed and data needed for telehealth. It is significant to note that in the Midwest one in six people could not access a private space to talk on the phone.
- In some small communities, group supports were available and worked well sometimes but they were not always the preferred option.

RELIANCE ON INFORMAL SUPPORTS, GPs AND PSYCHOLOGISTS AND COUNSELLORS

Survey respondents were asked, *In the past 6 months, which of the following supports have you accessed to help with your mental health and social and emotional wellbeing?* Seventy-three per cent accessed help from family and friends. A further 40% sought support from a GP and 34% from a psychologist or counsellor. After these top three supports, there was a drop off; other options were utilised at significantly lower rates, perhaps indicating they were less available as options. Figure 19 illustrates the range of mental health supports accessed by survey respondents.

Figure 19: Mental health supports accessed in the last six months



Note. Multiple responses permitted.

EXPERIENCES OF ACCESSING A GP

Although seeing a GP was a source of support for 40% of respondents, several people also expressed discontent with their experiences. General Practitioners were not seen as suitable for addressing mental health issues, in relation to perceptions about their lack of empathy about mental health, lack of training in understanding mental health, or inability to provide timely assistance:

"I went to a GP about my mental health post-pregnancy and I was sent away to come back to make a plan. I never went back"

(Survey respondent)

"People are accessing support through their GP but you need a double appointment to have a Mental Health Assessment which is taking up to three months to be able to be booked"
(Survey respondent)

The cost of seeing a GP was prohibitive for some:

"The cost of the GP for a medical appointment in relation to mental health is double that of a standard appointment. It really puts off my partner accessing help when he needs it, and he instead turns to drinking alcohol as it is more affordable in his view" (Survey respondent)

"Yes, there are bulk-billing GPs, but I only have one GP I feel comfortable with and they don't bulk bill, so I have to pay for two long consults to get 10 Mental Health Plan sessions. So in two years now my treatment has been delayed (/abandoned) by having this obstacle in the way. Sure, booking a long consult and paying another $80 or so is not a huge deal to a person functioning well, but when you're not functioning well all possible roadblocks (and costs) need to be removed" (Survey respondent)

Others expressed their discomfort with seeing a GP, due to discrimination.

"It is very hard for members of the LGBTIQA+ community here (in and around Geraldton) to access healthcare, let alone mental health support. Most GPs I have visited here are either extremely inexperienced (on rural placements straight out of university and likely to do more harm than good when presented with complex cases) or they are older/more experienced but also very prejudiced. These are the people responsible for making referrals and drawing up mental health care plans?!" (Survey respondent)

EXPERIENCES OF CLINICAL SUPPORT

Despite about one third of survey respondents seeing psychologists or counsellors in the previous six months, clinical support was not always seen as a suitable option for regional areas for reasons including distance to service, lack of access to professionals with the right experience and skills, stigma and extensive wait times and cost.

"If you walked into the emergency department struggling, there would be no doctor, and they'd likely tell you to fly to Perth... with your own money"
(Survey respondent)

Clinical supports were also not seen as an effective way to resolve the causes of mental health distress or provide the tools necessary for a successful reintegration back into everyday life after a period of acute distress.

Clinical support was not always seen as a suitable option for regional areas for reasons including distance to service, lack of access to professionals with the right experience and skills, stigma and extensive wait times and cost.

"In hospital they might give you temazepam but they don't solve your problems. You have temporary relief but then you go back into the toxic environment… you're not given the skills to get better" (Interview participant)

EXPERIENCES OF TELEHEALTH

Telehealth had been utilised by some consultation participants with varying levels of success. Sometimes telehealth was used because the local in-person clinical support available was seen as inadequate, and for other people it was due to logistical issues such as distance to clinics.

"When this is the standard of care that I can expect to receive for physical health problems in this town, how could I possibly trust any practitioner here with mental health issues? I don't feel safe. My partner sees a GP in Perth via telehealth because our experiences here in Geraldton have been so bad, and because there aren't enough doctors here who understand and care about the LGBTIQA+ community. Seeking help for mental health care here is completely out of the question" (Survey respondent)

Despite the benefits of telehealth, it was not generally considered an antidote to the problems associated with accessing clinical support. Findings suggest that for people living in regional WA, telehealth is not suitable everyone, and there need to be other solutions to getting people the care they need.

"It's really hard to find a trusted list of psychologists/counsellors who do telehealth. COVID-19 made this easier as everyone went online, and Medicare got easier to access. But it's hard to find someone and then trust they are actually reputable… there isn't anywhere private where people who don't have access to phone/ internet could make a telehealth call in town" (Survey respondent)

"Isolation is compounded by a lack of services and a lack of reliable, affordable internet access for online support for many members of the community" (Survey respondent)

"The doctors and professionals who do online sessions are not covered by the Medicare 'free' number of sessions, they are super expensive, on average $300 per session" (Survey respondent)

"I've been talking to my psychologist in Perth via telehealth, but I feel very disconnected from her in a way that I did not feel when I was having face-to-face appointments with her when I was living in Perth. It's no wonder that people here choose to drink or take drugs instead of working on their problems when real help is so inaccessible" (Survey respondent)

INFRASTRUCTURE FOR TELEHEALTH ACROSS REGIONS

Mental health and wellbeing supports and services are increasingly available online, but these are only an option for people and households that have suitable digital infrastructure.

"Most people in regional areas, especially males, will not access phone helplines. This is in part due to reception and internet factors" (Survey respondent)

The survey asked about access to internet with sufficient speed and data, and a private place to talk, and we analysed the results by region.

- **13%** of respondents from the Wheatbelt reported not having consistent access to an internet connection with the speed and data for telehealth, and **13%** did not have access to a private space to take a call, and a further **18%** had access to a private space only sometimes.
- **20%** of respondents from the South West reported not having consistent access to an internet connection with the speed and data for telehealth, and **13%** did not have access to a private space for a phone call, and a further **18%** had access to a private space only sometimes.
- **16%** of respondents from the Midwest reported not having consistent access to an internet connection with the speed and data for telehealth, and **16%** reported that they did not have a private space to take a phone call, and a further **13%** had access to a private space only sometimes.

Across all three regions, at least one in six people are likely to need to overcome one, possibly two major barriers to accessing telehealth. Across each of the three regions, 13% to 20% of respondents reported inconsistent or absent internet or data, and 13% to 16% of people reported not being able to access a private space for a phone call.

These data suggest that across all regions, online services, including telehealth, are not necessarily a realistic option for a significant number of people.

EXPERIENCES WITH GROUP SUPPORTS

Many consultation participants had personal experience of accessing group supports in their community or region. As with telehealth, people had varying degrees of success with group supports depending on a range of factors. This included the relevance of the group; the dynamics between people within the group; feelings of inclusion/exclusion; lack of anonymity; perceptions of stigma; quality of leadership; how safe the space was; the 'feel' of the group; types of activities; and the consistency of the group. Some people expressed groups to be "quite scary and not suitable for anyone with social anxiety", or also not appropriate for smaller towns if there is stigma around mental health and a concern about privacy.

"GROW has been trying for a year to get the support groups to work but people don't want to go to a group where people know them. There is not much interest in group supports" (Consultation participant)

"Manjimup can be very isolating and while it has a lot of group activities it does not have many options for people that aren't very social and/or are afraid of being stigmatised"

(Survey respondent)

Conversations revealed how sometimes non-clinical group supports can be compromised by exclusionary group dynamics or poor leadership, which may further isolate vulnerable individuals in small towns. This sentiment was very dependent on the particular community. Other people felt that the non-clinical group support options offered in regional towns (often for a specific group or purpose, such as cultural connection for Aboriginal youth) were making a significant positive difference in mental health.

In short, group supports were beneficial in some contexts but not in others, and also depended on personal preferences. Conversations helped us understand the added complexities about offering group supports in regional towns, compared with offering the same option in a metropolitan setting. Therefore group support should be provided in response to local needs, and preferably not be the only option available.

5.2 Support options to introduce and increase

Survey and consultation data suggest that there are multiple support needs to address, and that the most urgent needs do not necessarily involve specialist clinical support.

Addressing the social determinants of mental health was emphasised in conversations and was often top of mind in survey comments; perhaps people with an interest in regional mental health intuitively understood that the social context of living rurally significantly impacts on mental health and wellbeing.

"It's one thing to have the biomedical model... but that's quite limiting; it's a band aid approach. It's the underpinning social determinants of health and trauma – addressing those that will be able to assist people to go forward with life" (Interview participant)

People would like to see more practical help available in regional towns, and a variety of different approaches that are part of a broader support framework that considers the causes of distress rather than only the symptoms. A range of options, beyond GPs and psychologists, were proposed. These options are either completely missing from regional towns, or need to be increased in order to effectively address mental health support needs.

KEY FINDINGS AND NEEDS IDENTIFIED:

- 44% of survey respondents would benefit from additional support for their mental health and wellbeing, and when asked what they needed a broad range of options was proposed.
- A focus on locally-developed mental health awareness and literacy activities was seen as a missing piece in regional areas, and greatly needed, alongside more ways for people to find help for their mental health early, before they are in crisis.
- People spoke of the need for more community mental health supports in their communities, including social supports, holistic 'whole of life' supports, and activity-based supports. Such support models address wellbeing and healing, without an explicit, sole focus on 'mental health'. This was seen as suitable for regional ares, and needed for helping those who will not engage with clinical supports.
- The Project Team did not always specifically ask about culturally safe and appropriate mental health support in regional areas. Nonetheless this emerged as a gap that needs addressing. More consultation is needed to understand how to design new supports or improve existing ones, working in close partnership with regionally-based cultural groups and Aboriginal communities.

Survey respondents were asked: *Do you think you would benefit from additional support for your mental health and social and emotional wellbeing?* Forty-four per cent said they would benefit from additional support, 46% did not think they needed more support, and 10% were unsure. The survey also asked participants: *Is there anything else you would like to comment on, related to people in your community getting the help they need for their mental health?* Many responses to this question indicated that addressing the need would be an overwhelming task.

"There is so much need in our rural communities for a lot more on-the-ground staff like counsellors, with minimal waiting time" (Survey respondent)

Comments were analysed, with a summary of findings outlined below.

INCREASING MENTAL HEALTH AWARENESS AND LITERACY

To address stigmatising beliefs about mental illness that exist in regional WA, people asked for greater public mental health awareness campaigns, including information about help-seeking, and self-care.

"We have a lack of understanding of when to access mental health/being able to identify this, and there is a huge stigma around accessing services when people need them" (Survey respondent)

"Community need better health literacy and local governments need capacity building support by staff to upskill them in mental health promotion under their public health planning obligations" (Survey respondent)

It was apparent to community members that mental health awareness raising was rarely prioritised locally, even though, as one participant noted, research shows that developing messages at the grass roots level is most effective and using community media in regional areas is cost effective.

"Community members [need to] know what services are available... to improve mental health... At the very least helping local organisations tell their story about the community supports they provide is important... however funding for these projects is difficult" (Survey respondent)

Service providers also noted that they often hear from community members that 'we didn't know about this service'.

PREVENTION

Many of the interviews with knowledgeable stakeholders emphasised the importance of preventative measures, with some suggesting that ultimately this is where the solution lies.

"We don't need more medical support. We need more people prepared to talk about the situations that drive them to become depressed and anxious" (Interview participant)

"If people don't build up capacity and life skills to manage life and know how to recognise and get out of toxic situations, and skills to lead a happy life and get employment and have a home... we just keep making people mentally unwell" (Interview participant)

Several people spoke about the need for initiatives that provide the "resources, tools, and connections" to improve wellbeing, "rather than just attempting to fix it once things have already gone bad".

"If you had early intervention and community support, you wouldn't need to go to hospital and you wouldn't spiral" (Interview participant)

COMMUNITY MENTAL HEALTH SUPPORTS

Thirty-nine per cent of respondents expressed a desire to seek community mental health supports (such as a drop-in centre, peer support group, or neighbourhood centre). Only 8% were already accessing a community mental health support, and 2% were previously accessing this support, but reported it was no longer available to them.

Approximately half of the respondents felt that community mental health supports were very effective (49%), or effective (30%) in supporting mental health and social and emotional wellbeing. One reason for their appeal was that they are easier to access, without the usual barriers such as cost and lack of availability.

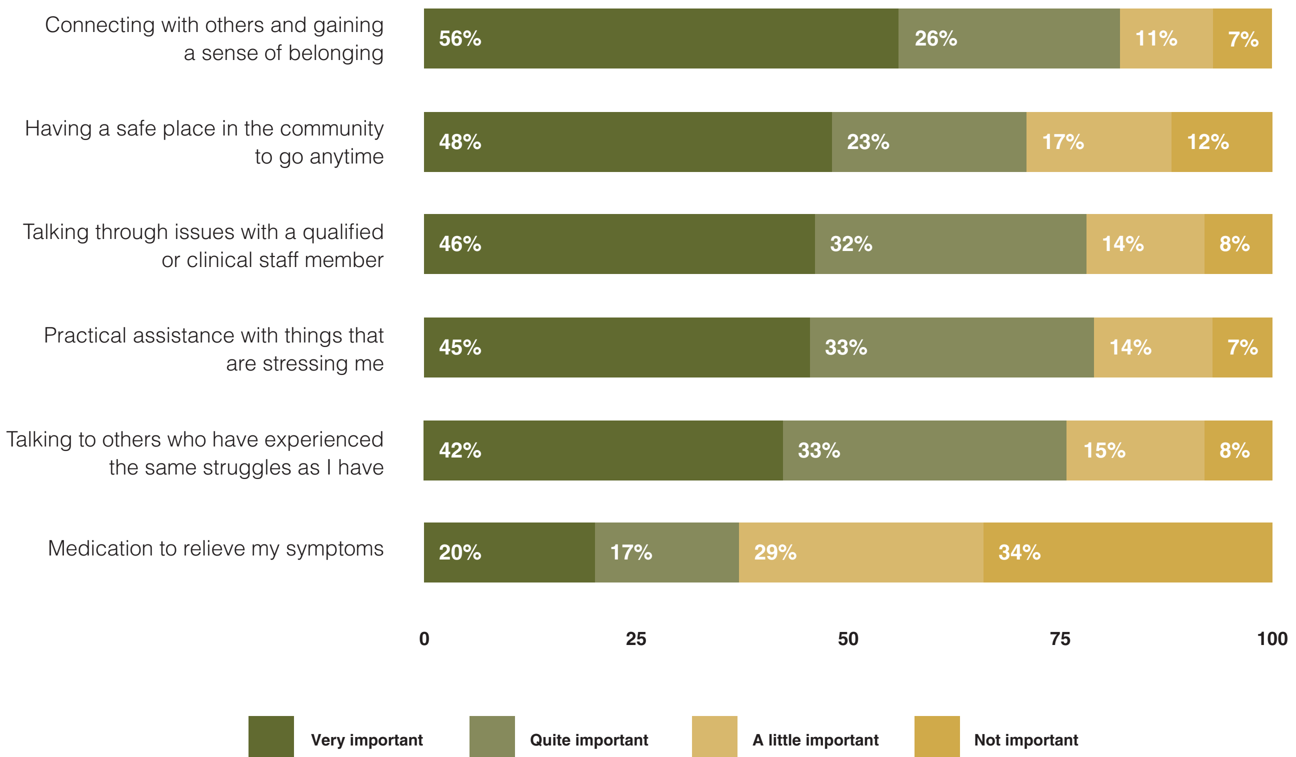
"Many people I know are using alcohol and/or drugs to deal with the stress of their lives, e.g., a high-pressure job. I can see that they need better psychological support and were unable to find it so they gave up. My friends are not able to afford a psych appointment as they mostly cost $100 or more per session. My parents are not willing to try a psych after initial efforts were unfruitful. I think we need a lot more options and for them to be free or cheap. This will help to make their use more widespread and in turn improve the stigma of going to a psych" (Survey respondent)

The following subsections describe more specific support models that were called for that can be delivered as community mental health supports.

Social supports

Social supports are seen to be needed to strengthen belonging and connection. We asked: *What kind of things (interventions) would be important in making a difference to your mental health and/or social and emotional wellbeing?* Most survey respondents felt that the most important thing was connection with others and developing a sense of belonging (55% very important; 25% quite important).

Figure 20: Interventions that survey respondents felt would make a difference to mental health and/or social and emotional wellbeing



The social supports that people asked for were not overly sophisticated, nor did they require specialist skills.

"A lot of people say 'I don't need a psychologist to tell me what to do and re-trigger the trauma. I don't want someone to fix me, I want someone to validate my feelings'"

(Interview participant)

"I think we need places for people to go and be for the day – 7 days a week. I would love to see churches open every day and have someone there to talk to others, give them a cup of tea, some bread or a meal, something to read, somewhere for them to relax" (Survey respondent)

"A women's/men's group would be of great benefit in each township within the Midwest for women and men to have access to go and interact with others, also a safe house for young people to have access to when they are feeling unsafe" (Survey respondent)

One survey respondent said that in their community social supports would be just as important as clinical care, and yet there are no supports available where people can "interact, engage and participate in community" or connect in groups with support from occupational therapists or social workers with mental health expertise.

Holistic 'non-mental health' supports that address whole of life needs

While specialist clinical support is difficult to access in regional WA, it is not necessarily the answer and not always preferred. Holistic, non-clinical supports (that do not necessarily focus only on mental health) are needed to help cope with the realities of rural living, while working around the mental health stigma that still exists in some communities.

"There needs to be more facilities that are more relaxed and not so 'in your face' about being 'mentally ill'" (Survey respondent)

"Loads of people are struggling to ask for help when you don't want to be called mentally ill going to a facility for mental health. Why not a wellbeing service? Help people get back on track to feeling good without the label" (Survey respondent)

"The stigma is as huge part of what's stopping most people I know reaching out to access mental health. Plus I've experienced in the past that there can even be judgement from the 'professionals'. It really doesn't help someone who is struggling and had swallowed their pride to reach out. 'Hiding' services within socially acceptable or even hub facilities is key to increasing uptake of services, in my opinion" (Survey respondent)

A wide range of needs emerged from discussions with regional community members – e.g., housing, financial, and relationship supports – indicating that it is not necessarily specialist services that are most urgently required (and often specialist services are more difficult to access). Providing practical support to unburden people going through tough times, flexible supports that can give comfort and nurturing for those experiencing difficult life transitions, and offering connections that provide a sense of hope in times of stress can be some ways that may better serve people's needs.

"Often what's most successful are those services that are able to provide the practical day-to-day support, getting them up and going, to appointments, to have some hope particularly to those low-income individuals who cannot access private services or travel to access services" (Survey respondent)

Survey respondents called for more support groups, drop-in centres and low-cost group therapy programs, which can address needs such as empowerment, authentic connection and belonging.

"Authentic relationships are of the utmost importance and the number one factor that will make or break any intervention" (Interview participant)

"More focus on empowerment, life skills, emotional regulation education/awareness training, programs to help work through areas where there are gaps in development/life skills especially where there is intergenerational mental illness or trauma" (Survey respondent)

At times people needed very basic supports to help them function and cope with their mental health condition.

"Practical help seems to be what is most needed. When I am overwhelmed by issues, I cannot complete tasks. These tasks then build up unfinished and make me feel worse" (Survey respondent)

Yet people reported that sometimes this was just as difficult to access as specialist mental health support.

"My physical health affects my mental health and after my psychologist and exercise, home help is the next most important help I need. I don't fit into the categories to get home assistance and I am financially able to pay for help, but being in a small town I can't get help with cleaning" (Survey respondent)

Holistic supports are seen as especially relevant in that they can address social determinants of mental health such as the effects of, for example, relationship breakdown, unemployment, financial stress and housing insecurity. When people seek help from clinical services, typically situational distress remains unaddressed, and this may perpetuate the problem(s) that underpin their experiences of poor mental health. One interviewee described how many farmers in the Wheatbelt who had experienced poor mental health saw GPs who "would simply prescribe an antidepressant, nothing more", and which often "went straight in the bin". Addressing symptoms in isolation from causes was generally not viewed as appropriate by the people with whom we consulted, even though this was the predominant approach of the few services that were available in the regions.

Activity-based, informal supports

People also asked for supports that provided opportunities for people to connect and participate in something for their wellbeing, or a safe space where people could 'hang out' together in an informal setting.

"More group support such as craft groups, art therapy, pet therapy would be very beneficial"

(Survey respondent)

"More youth centres for kids to hang out at in a safe environment and having things to do. More camp opportunities for over the school holidays" (Survey respondent)

As with the holistic and social supports, there were many advantages of activity-based models, because they are low-threshold and non-stigmatising. These were also seen as suitable for young people.

"Services should have gyms, people to talk to on a casual basis, cafes, cooking classes, short courses, yoga/meditation spaces, etc. All people are in need of holistic wellbeing but the resources are not available and can be intimidating for people" (Survey respondent)

"As a youth support worker we struggle trying to get mental health support and housing for youth who are using meth. Many of the youth attending the crisis refuge do not feel comfortable talking about their mental health in a formal setting. They are more likely to talk about it in an informal setting where they are participating in activities, walking, driving etc." (Survey respondent)

CULTURALLY APPROPRIATE AND CULTURALLY SAFE SUPPORTS

Twenty-six percent of survey respondents reported that 'Support to connect with and strengthen my culture' was very important. Related to the need for more holistic, activity-based, safe and informal supports is the need for innovative support models that can appropriately engage Aboriginal people. For example, "more Back-to-Country activities for Aboriginal people with mental health issues". This would involve models that are culturally safe as well as culturally appropriate, non-stigmatising, and Aboriginal-led.

The theme of needing innovative approaches based on culture also applied to people from CALD backgrounds.

"Men and people from different cultural backgrounds find it hard (from what I've been told by many) to show up to a service that is primarily for women and 'too Australian to understand me'"

(Survey respondent)

This theme was not explored in enough depth to do it justice, due to the methodological limitations of the Project. However, it should be noted that several survey comments pointed to the need to design more culturally-appropriate services for Aboriginal people as well as for people from CALD backgrounds. It is recommended that, going forward, these issues be explored with a more deliberate focus, and a dedicated consultation.

5.3 Developing mental health skills and capacity

A consistent theme to emerge through consultations were frustrated experiences with the mental health workforce in regional WA due to the lack of training, qualifications, skills, expertise and/or capacity. Finding 'the right person' who can offer a timely, highly individualised approach, with skilled support including clinical expertise if needed, and a personal connection that is authentic and non-stigmatising, may seem a big ask, but is also foundational to any effective mental health care.

The number of formally-qualified mental health experts and clinical leaders in regional WA is limited, and the staff that are available may be relatively inexperienced and transient. As one interviewee put it, there is "not the skill in the population to have services operating with consistent staff", even if the funding for services is there. As a result, consumers are unable to build relationships with adequately skilled staff, and mental health in the regions then remains un- or under-supported. Multiple sources of data for this Project suggest that this is particularly problematic in the Wheatbelt and Midwest.

Targeted investment in workforce development and training are aspects of the solutions that people called for. While noting that reviewing the regional mental health workforce is for others to do (and not in scope for this Project), in this section, rather than addressing workforce issues per se, we will present suggestions for potential 'easy wins' that regional communities believe would enhance the way that mental health supports are delivered, as well as mental health outcomes for regional WA.

DEVELOPING THE PEER WORKFORCE

People with lived experience and service providers consulted as part of the Project called for the development of more peer and lived experience-led responses in regional and remote communities. Several stakeholders advocated for greater investment in the peer and lived experience workforce in regional WA, calling for more people in peer and lived experience roles to be employed across services.

Consultation participants also indicated, however, that the culture of many agencies in regional and remote areas continues to view peer work and peer and lived experience workers as somehow of less value than professional and clinical staff.

The use of peer navigators, that is, people with similar experiences or backgrounds, who assist individuals, their families, and carers, to navigate services and other pathways, are also needed to promote mental and physical wellbeing. Several consumers consulted suggested this is a model they believe would have value in regional and remote areas, as there are often such limited options and so many access barriers.

MENTAL HEALTH TRAINING AND SUPPORT FOR FIRST RESPONDERS AND NATURAL HELPERS

In smaller towns and communities, with the exception of the Police, first responders are usually local people who volunteer their time in roles such as ambulance drivers, bushfire brigades, fire and emergency personnel and paramedics. As local members of small communities they often have pre-existing, personal relationships with the people they assist and their families. First responders receive minimal support in dealing with the trauma and mental and emotional distress that may result from performing their volunteer functions in situations that are sometimes tragic, and where they know the people affected. There would be significant benefit in providing mental health specific training to first responders, as well as structured, ongoing support.

In the absence of a mental health workforce in smaller towns and remote communities, natural helpers play an important role in providing support to people struggling with mental health. In efforts to improve mental health in rural settings, there is untapped potential in training and upskilling all interested local members of rural and remote communities to act as natural helpers and, where appropriate, to take on peer support roles. Training can be one way that mental health awareness and support (based on quality frameworks and informed approaches), can filter through informal networks, to reach more people in smaller towns and remote communities.

5.4 Community-led initiatives to strengthen

Many rural and remote communities across Australia have no access or limited access to mental health support (De Cotta et al., 2021), and as a result communities are developing their own place-based and community-led responses to the mental health challenges they face.

Western Australian examples that we heard about through consultation included locally-led activities to promote wellbeing, enhance awareness and help-seeking. There were also collaborations to enhance support pathways between services and mental health supports in neighbouring towns or in regional centres. We uncovered a diverse range of settings for mental health initiatives and partnerships, which may occur between primary health services (where they exist), and local service providers, local sporting and arts/cultural groups, schools, local government authorities, local businesses, and other civic and community organisations including Men's Sheds, Community Resource Centres, Country Women's Association groups and Returned Services League branches among others.

This section outlines examples of these responses in the three focus regions for this Project.

KEY FINDINGS AND NEEDS IDENTIFIED:

- Community-led responses to address mental health issues have emerged in some communities, and examples were captured for this Project. In some cases these initiatives were very well supported and sustained at the local level.
- Some examples presented include community collectives, placed-based multipurpose centres, supports that encourage help-seeking, supports that address housing and financial stress, alternatives to hospital crisis care and supports designed for young people.
- The strengths of these initiatives developed in regional communities, by the community, is that they utilise existing community settings, such as 'gathering places', and community partners who work outside the mental health sector, creating positive environments for delivering non-stigmatising and holistic support.

COMMUNITY COLLECTIVES

Community collectives aim to bring together community members and local stakeholders as a network to identify local mental health challenges and opportunities, test and develop local responses and take local action to support mental health and wellbeing.

The Victorian Royal Commission into the Mental Health System called for the establishment and resourcing of 'community collectives' in each local government area across the State of Victoria (2021). In WA this approach is happening organically in towns such as Boyup Brook, Bridgetown, Margaret River, Pingelly, Narrogin, and the North Midlands, however it is often on a small scale. Often these initiatives are not funded or only partially funded by the state or federal government, or they survive on small amounts of funding sourced from local government, local donors and fundraising and philanthropic funders. Mindful Margaret River and the Boyup Brook Community Mental Health Action Team are two examples of community collectives.

Mindful Margaret River (Margaret River, South West)

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

Boyup Brook Community Mental Health Action Team (Boyup Brook, South West)

The Boyup Brook Community Mental Health Action Team (CoMHAT) is a community-based organisation run by people who live in the town and surrounding district. CoMHAT employs a small number of part time staff, to help bring together all sectors and groups in town. Together, CoMHAT works to build awareness about mental health and wellbeing, improve community mental health and wellbeing, reduce harm associated with mental-ill health and AOD use, and facilitate pathways to formal mental health services and support. Activities include partnering with local groups to educate about mental health, intergenerational community activities, education workshops and training sessions for the community, and linking people to specialist mental health services. With support from the Mental Health Commission, CoMHAT has created a Community Wellbeing Plan which provides direction for their activities. Local schools, sporting clubs, farmers and farming groups, local businesses, the Shire of Boyup Brook, community health and the local GP, police and volunteer emergency groups, and music, arts and cultural groups are involved. Stakeholders can respond within their areas of expertise, but also work towards collective approaches.

PLACE-BASED MENTAL HEALTH AGENCIES PROVIDING A DIVERSE MIX OF SUPPORTS

Several examples emerged of mental health agencies operating in regional areas in flexible ways to accommodate the needs of their communities. They run as multi-purpose centres that provide a suite of supports that are both centre-based and outreach. This might include support for everyday living, housing-related support, group programs, recovery supports, clinical supports and day programs.

Lamp (Busselton and surrounds, South West)

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

Pathways SouthWest Recovery Groups (Bunbury, South West)

Pathways SouthWest is a specialist mental health organisation based in Bunbury that provides a range of mental health support and recovery services to people with severe mental health issues living in Bunbury, Collie and Busselton. Pathways offers a variety of recovery-oriented supports and groups for people with mental health conditions. These include informal social activities (e.g., art activities and cooking); facilitating links to services and people; housing and housing support; recreational activities (fitness, swimming, gym, bowling, pool and snooker, walking); assistance with daily living (shopping); gardening; social outings; and work skills/preparation for employment.

Pathways is also engaged in advocacy activities and mental health awareness/education, and aims to help facilitate access to holistic services to support the wellbeing of individuals presenting with mental health distress and their carers, families and community. Pathways is an NDIS service provider that partners with a range of individuals and organisations.

SUPPORTS THAT RAISE AWARENESS AND ADDRESS HELP-SEEKING

Poor mental health literacy, including lack of understanding about mental health, stigma and lack of knowledge around support options and help-seeking, is a significant issue in regional areas. In regional WA there are several locally-led awareness-raising initiatives that encourage individuals to seek help formally and informally. They are sometimes integrated into existing services/supports, and in other instances may be part of a standalone campaign or promoted within an organisational setting as in the example below.

Commercial Bulk Handling Regional Mental Wellness Initiative (Wheatbelt)

Commercial Bulk Handling (CBH) is a grain growers co-operative that handles, markets and processes grain from WA's grain growing regions. Within the regional grain growing communities of WA, mental health and wellness is a significant issue (including for young people). The Regional Mental Wellness Initiative aims to support the mental health of CBH's grain growers and the rural and remote communities in which they live. The initiative is a partnership between CBH and four WA and national mental health service providers, including Mental Illness Fellowship of WA (MIFWA), Lifeline, Youth Focus and Black Dog Foundation.

The Regional Mental Wellness Initiative involves several activities across the grain growing regions, including mental health awareness and suicide prevention education and training programs; customised workshops for teenagers and young people including Youth Mental Health First Aid, safeTALK and mental wellness sessions for teenagers; online support groups for parents, families, friends and carers; training and education for GPs and health professionals who work in grain growing regions; face-to-face counselling and video/telephone counselling and support; and resources to help individuals and communities respond to crises.

Regional Men's Health Initiative (Wheatbelt)

Based in Northam and servicing regional, rural and remote communities across WA, the Regional Men's Health Initiative (RMH) is operated by Wheatbelt Men's Health, a non-profit organisation. RMH involves building community awareness of mental health and wellbeing for men and empowering individuals to make positive decisions for their mental health and wellbeing, including building and tapping into existing support networks. Encouraging men to "Talk to a Mate" before mental health distress escalates is a foundational aspect of this philosophy. RMH delivers three activities: Warrior Education Sessions, which are community events to discuss men's holistic physical, mental and social/spiritual wellbeing; Fast Track Pit Stop, which is an interactive presentation themed around the servicing of a vehicle; and advocacy, which includes the provision of short-term resilience and referral pathways, links to professional services, and encouraging more conversation around men's mental health and wellbeing in regional communities.

RMH tries to prevent mental health issues from becoming serious by promoting awareness of mental health and good social links among men, helping to develop action plans to address the situational factors (such as financial stress) which are causing or compounding distress. RMH is funded by the WA Department of Primary Industries and Regional Development.

SUPPORTS THAT ADDRESS HOUSING AND FINANCIAL STRESS

Homelessness and housing stress are major causes of mental ill-health and people with mental health conditions are at heightened risk of severe housing distress. The provision of housing support and advocacy are important forms of mental health support, particularly in rural and remote areas, where limited formal mental health services exist. Financial counsellors have an important role to play in the lives of people with both mental health problems and financial difficulties. Financial difficulties are also a significant reason why people choose not to seek help from mental health supports and services, and thus addressing this can have positive knock-on effects (Butterworth et al., 2018).

Just Home Margaret River (Margaret River, South West)

Just Home Margaret River is a local collective and community-led organisation that helps community members experiencing (or at risk of experiencing) homelessness. At the time of this consultation, the Augusta Margaret River region was facing a severe housing crisis, and Just Home could provide support for individuals and families (particularly single mothers) unable to secure or afford local housing. Just Home provides a Housing Information and Referral Service for people experiencing homelessness and housing stress and, in their advocacy role, have called on the government for greater action on the housing crisis. Individuals who come to Just Home are supported to access or maintain public and private housing, apply for public housing and bond assistance, and connect with other services in the region. Just Home is funded by various sources including the Shire of Augusta Margaret River, Lotterywest, local community organisations, and community donations.

Rural Financial Counselling Services WA (throughout regional WA)

Financial counselling services can play a key role in addressing some of the social determinants of mental health issues, such as preventing or supporting people experiencing significant emotional and psychological distress due to difficult financial circumstances. Rural Financial Counselling Services WA (RFCS WA), run by Rural West, provides free, confidential, mobile and independent financial counselling services to primary production enterprises and small business in rural and remote areas of WA. RFCS WA services are available to individuals involved in: all types of farming including livestock, grain, fruit and vegetables; professional fishing; forestry; and small rural businesses that support these industries, such as fencing, harvesting, spraying or stock management contracting.

While financial counsellors do not provide emotional, social or personal counselling, or family counselling, they support people experiencing significant emotional and psychological distress due to difficult financial circumstances and provide referral to other types of mental health services and supports that are available locally. The RFCS WA fulfils this need in regional communities throughout WA. It is funded by the National Emergency Management Agency.

SUPPORTS TO ASSIST IN A CRISIS

Care for people in acute distress typically lands on emergency departments and informal supports such as family and friends in regional WA communities. However, emergency department access is not always an option nor is it always the preferred means of support, even in a mental health crisis. Reliance on informal supports alone is also not generally enough in the context of acute distress. Community supports which assist people in crisis are uncommon in regional WA but can play an important role in reducing distress and providing a safe, welcoming space for immediate and ongoing assistance.

Safe Haven Cafés (Perth and Kununurra)

Although not a case study from the three focus regions of this Project, Safe Haven Cafés are a good example of supports deemed appropriate for, and needed in, regional areas. Two Safe Haven Cafés opened as pilot projects in 2020 at Royal Perth Hospital in the Perth CBD and the Kununurra District Hospital (Kimberley region). They provide an alternative to emergency departments for people with mental health issues who are experiencing distress. The cafés offer peer-based support for people who may otherwise attend the emergency department but do not require immediate intensive clinical or medical support. Safe Haven Cafés operate after hours alongside emergency departments.

SUPPORTS FOR YOUNG PEOPLE

Throughout the consultation for this Project, young people were highlighted as a cohort that was highly vulnerable to experiencing serious mental health distress in regional WA. A number of youth-focused community supports for mental health operate throughout regional WA, sometimes with specific focusses – for example cultural connection for Indigenous youth, 'life coaching' and education, or employment and skills training.

Moorditj Youth Foundation Aboriginal Corporation (Wheatbelt)

The Moorditj Youth Foundation Aboriginal Corporation is a registered Aboriginal foundation that exists to provide culturally appropriate and culturally secure mentoring, advocacy, liaison and support services to Aboriginal families, children and youth in the Wheatbelt region. The Moorditj Youth Foundation receives both Commonwealth and State Government funding. The Foundation's priorities are youth mental health, youth suicide prevention and postvention, strengthening social and emotional wellbeing supports, and establishing disability support services for young people (particularly people with mental disabilities) earlier in life.

Initiatives of the Foundation include Aboriginal Early Childhood Programs and the Yidarra10 Project, a 10-week targeted program in Narrogin for Aboriginal young males at risk of offending or reoffending. Additionally, the Foundation provides youth mentoring to connect young people to Country and culture through day camps and intergenerational learning, as well as support around employment, housing and education. The Foundation also employs an Aboriginal Community Liaison Officer (ACLO) to work with Aboriginal communities across the Wheatbelt to support the implementation of region-specific Aboriginal suicide prevention plans. The ACLO plays an important role in ensuring the regional plans and associated initiatives remain responsive to community needs. The region-specific plans form part of the implementation of the Western Australian Suicide Prevention Framework 2021-2025 (2020) and include culturally informed social and emotional wellbeing initiatives designed by and for Aboriginal people.

Blackwood Youth Action (Bridgetown and surrounds, South West)

Blackwood Youth Action Inc (BYA) is a charitable organisation based in Bridgetown that supports at-risk and marginalised young people in the Shires of Boyup Brook, Bridgetown-Greenbushes, Nannup and Manjimup. The BYA supports young people to improve their wellbeing through operating a youth space; creating linkages between all youth-related organisations and activities; improving youth belonging and engagement in the community; and empowering young people to meet their fullest potential. They provide assistance with linking young people to mental health services, recreational activities, group work, family mediation, counselling, training and employment services, peer support groups and activities, youth events and community activities. They are currently developing a community service hub and youth drop-in and activity centre in Bridgetown. The BYA also undertakes research into youth mental health. The BYA is widely acknowledged as the lead service provider for youth mental health in the Blackwood region, providing approximately 3,000 sessions with young people each year. However, it receives only minimal funding, with the majority sourced locally.

SUMMARY

The number of community-led initiatives that address mental health need in regional communities, and the scale of what some of these initiatives are achieving outside of formalised mental health funding streams, was a surprising finding from this Project. Several people commented that many of these initiatives lack visibility beyond the communities around them. They are also not present across all regional populations – to flourish they rely too heavily on community champions, and the right mix of skills and supportive partnerships, as well as funding sources that are opportunistic rather than sustained. Therefore they have emerged in unexpected communities, and not necessarily all regions (most of the examples uncovered in this project were in the Wheatbelt or South West).

While many of these place-based initiatives are thriving with support from local partners such as local governments and businesses, the stability of funding is a persistent issue. As one survey respondent commented, “there is a high turnover of staff in all services and some programs are short-lived due to the funding cycles. People lose confidence and hope, [and] get confused and angry at the constant rate of change.”

With the widespread lack of mental health services and support options in regional WA, there are many who have come to rely on these community-led initiatives. In those communities fortunate enough to have them they are highly valued by local people, but people are also worried about the uncertainty of the future of locally-led community supports. Sustained funding and increased operational support were raised as important ways to help community-led initiatives to thrive in regional communities.

SECTION 6:

The way forward

6.1 Overview of findings

The findings presented in this report demonstrate that regional communities in WA, while resilient and thriving in their own ways and in some contexts, are facing disadvantage in terms of their experiences of mental health and access to support.

The consultation process sought to answer three key questions:

1. What are the lived experiences of individuals experiencing mental health issues at various levels of severity in regional areas?
2. What are the gaps in need versus access to mental health supports in regional areas?
3. What are the unique factors of living regionally that affect experiences of mental health, service access and funding, and what do communities say needs to change?

Evidence fell broadly across three key findings, which were that:

1. Regional communities experience significant life challenges and pressures, coupled with increased difficulties in accessing support
2. There are gaps in supports available that address a holistic range of needs, encompassing, for example, social connections, financial security and physical wellbeing. Treating mental health in isolation, or addressing symptoms only, is not seen as appropriate or effective
3. One-size-fits-all does not work for regional communities and there are no specific solutions that can be implemented across regional WA without detailed consultation and understanding of the characteristics, needs and dynamics of the local context

POOR MENTAL HEALTH OUTCOMES DUE TO LIVING PRESSURES AND DIFFICULTIES ACCESSING SUPPORT

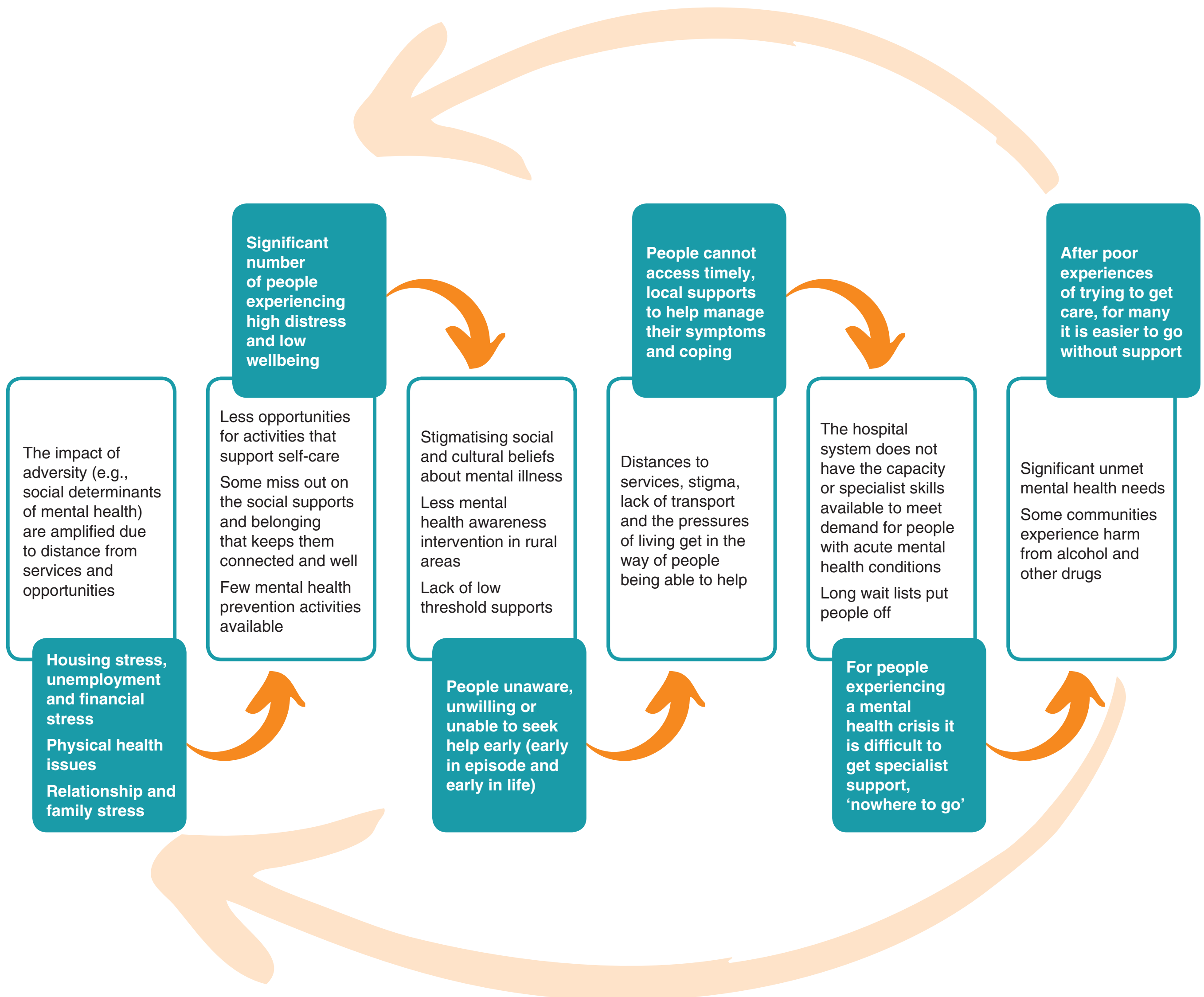
While we could not present data to make direct comparisons between regional and metropolitan experiences, our consultation did uncover and unpack the particular dynamics of living in regional areas that result in poorer mental health outcomes. People spoke of specific factors that promote poor mental health, such as social isolation, inadequate housing, and vulnerability to climate and market variations, which can cause financial stress. People who live in regional WA also experience significant barriers in accessing quality and timely mental health care. These barriers, and the flow-on effects on communities when people do not get the help they need, cannot be underestimated.

"Most people are on low income. The only transport they have is the train but it doesn't get there on time to see doctors. So they go it alone and put up with it"

(Consultation participant)

The following diagram (Figure 21) summarises the ways that living regionally can amplify the drivers of mental health need, as well as contribute to limiting access to support – creating vicious feedback loops that perpetuate poor mental health outcomes.

Figure 21: Indicators and drivers of unmet mental health needs, and compounding effects, for people living in regional settings



While this diagram highlights the compounding factors that contribute to mental health disadvantage, it also reveals the possible points of intervention. Crucially, it illustrates what communities have told us – that alongside community-level interventions, key system and structural changes could dramatically help disrupt the cycle of disadvantage.

HOLISTIC SUPPORTS ARE NEEDED TO ADDRESS A RANGE OF NEEDS

One finding that came through strongly was an understanding of mental health as holistic and, in a rural context, linked closely to social determinants. People consulted asked for more support that can address the contextual drivers of mental health problems, and if needed, to reach beyond clinical models of treatment.

"There are not enough places where people can go and be listened to, without people jumping to uninformed solutions to their needs. My experience of the psychiatry system is that it is too systemised to allow for normal dialogue to get to know the problem someone has. Too busy filling in forms, note taking and conforming to the Diagnostic and Statistical Manual. Problems are always a human reaction to a situation or environment that is being oppressive in some way" (Survey respondent)

Supports that address whole-of-person and whole-of-life issues, without necessarily a mental health focus, would be effective and relevant, especially for communities where there is widespread stigma about mental health.

THE CONTEXT OF EVERY COMMUNITY IS DIFFERENT

The hundreds of people consulted across three regions in WA – the Midwest, the South West and the Wheatbelt – shared similar grievances about accessing mental health support. Yet these experiences were context-specific, varied with the size and location of a community, and were influenced by demographic and socioeconomic factors.

While many people we listened to called for more mental health support for their communities, it was not always clear-cut in terms of what that might look like. The practicalities of initiating change in each local context, and with the needs and preferences of the community in mind, are typically the 'make or break' of any effort to improve experiences of mental health and mental health support in the regions. This could be why at times the DIDO model of visiting services is not effective, and why the informal, community-driven initiatives are well supported (although not often successful at attracting formal mental health funding).

What works for one regional community may not work for another, even if they are located close together or share similar characteristics. There is no one-size-fits-all solution for regional communities in terms of support for mental health. This was the case particularly for non-clinical support options, where the appropriateness of any specific intervention will depend on the unique dynamics, drivers and needs within the community.

6.2 Priorities for action

After conversations about community needs, people consulted also offered well-formed ideas for changes that they believed would help them and their communities. Four key action areas emerged from the consultation process, summarised as follows:

1. Address the high levels of distress and low wellbeing by understanding social determinants as a key driver of poor mental health
2. Resource regional communities to promote mental health literacy and help-seeking behaviour locally
3. Improve the accessibility of clinical supports and provide more options beyond clinical care
4. Engage local leadership in decision making to ensure that supports are relevant, effective and sustained.

Against each learning the Project Team has proposed actions that may be generally applicable to all community sizes and in all regions because of their universality. However, consideration must also be given to the unique contexts of each community.

ACTION AREA 1:

Address poor mental health outcomes through understanding the role of social determinants

Rates of mental health distress, and low wellbeing, are high in regional communities and often factors outside of a person or a community's control have a large impact on mental health and wellbeing, while options for helping people cope with these factors are limited

Survey data showed that a large number of people living in regional areas experienced significant self-reported levels of high psychological distress and low wellbeing. The impact of social determinants of mental health was highlighted by stakeholders as a driver of distress, and needs to be at the forefront of mental health support in the regions.

As an example to validate this perspective, analysis of the survey results revealed that experiences of greater social support were associated with lower distress. However, one third of survey respondents felt that they were not getting enough social support, through lack of opportunities for social connection. Other issues identified that may contribute to high distress and low wellbeing were physical health issues, not having a sense of belonging, and community-wide stigmatisation of mental health issues meaning that people tend to suffer in isolation until they reach crisis point.

In regional communities the social determinants seemed particularly intensified for some groups, for example the impact of housing shortages and unemployment on young people; social isolation among CALD families; cultural disconnection for Indigenous communities; and the effects of climate, global markets and debt for farmers. Different community sizes experienced these social determinants at varying degrees of intensity. Small agriculture-based communities experienced a greater impact from social determinants such as financial stress, while for large regional centres the impact of other things such as social disconnection (e.g., due to time or work pressure, or a FIFO lifestyle) was often greater.

> Communities reported that the impact of social determinants played a significant – and according to some people the most significant – determining role in mental health.

Communities reported that the impact of social determinants played a significant – and according to some people the most significant – determining role in mental health. According to one stakeholder, addressing mental health distress will not be effective without also addressing the social determinants of mental health, and to ignore these factors could be even damaging, especially in communities where there are high levels of shame and stigma around mental illness.

SUGGESTED PRIORITIES FOR ACTION

Greater emphasis on social support, belonging and wellbeing

- Ideally a greater amount of choice and access to social support would be offered in regional communities to keep people socially connected and feeling well, especially for groups typically excluded from existing supports. This will help decrease levels of distress, reduce feelings of isolation, and improve wellbeing
- Communities need more opportunities for people to improve their self-identified need for better physical health, such as improving eating, sleeping and exercise habits

Addressing the social determinants of mental health

- Particular social determinants that are more pronounced in regional and rural settings include social isolation, loneliness, cultural disconnection, financial stress (including debt and market uncertainty among farming communities), un/underemployment or insecure employment (especially for young people), and housing shortages
- It is recommended that all conversations about mental health, both in clinical and non-clinical settings, should consider the influence of the social determinants of mental health
- On-the-ground mental health supports in regional communities (including prevention initiatives) should look carefully at the social determinants to address the causes, not just the symptoms, of mental health distress. However, many of these factors will be outside of a community's control, and the role of the social determinants of mental health must also be considered at a systems and policy level

ACTION AREA 2:

Resource regional communities to promote mental health literacy and help-seeking behaviour locally

Enhancing mental health literacy is required to reduce stigma, normalise conversations about wellbeing and getting support for mental health, and to encourage people to seek and accept help, early in life and at the onset of experiencing challenges with mental health

The consultation process found that help-seeking for mental health in regional WA is compromised by poor mental health literacy among many individuals. Particular groups that this applied to were young people, middle-aged male farmers, Aboriginal people and people from CALD communities.

It was not simply that people in regional communities had a lack of knowledge about mental health (although this was sometimes the case), there was also a widespread lack of acceptance of the 'problem' and the need for help, mostly due to stigma. Communities repeatedly said that greater mental health literacy for the whole community – not just for those affected by mental illness – would help to reduce stigma in regional areas by helping people to understand more about mental health distress, and to collectively (or culturally) normalise getting help and alleviate the shame around it. Community-wide mental health literacy was raised as a critical way to help people to recognise early warning signs in themselves and in others they care about, encourage open and honest conversations in both formal and informal settings, and normalise help-seeking.

SUGGESTED PRIORITIES FOR ACTION

Strengthen prevention and early intervention activities

- Greater emphasis needs to be placed on preventing mental health from deteriorating in individuals living in regional and remote areas. A greater focus on the early intervention stage of mental distress will help prevent problems from becoming acute, and reduce pressure on clinical services in the regions
- Review the range of mental health supports available in regional areas in terms of ensuring an appropriate balance between investing in prevention activities verses services for more acute and severe mental ill-health

More psychoeducation/ stigma reduction/ mental health literacy – especially in schools

- Stigmatising beliefs about mental ill-health and the need for support need to be addressed in community-wide promotion activities and campaigns
- For mental health conversations to be normalised across the community, they should reach people where they are, rather than require people to attend mental health services. Practically, this might involve: recreational activities or gathering places for communities and specific groups within communities (e.g. youth) where facilitated conversations can be had about mental health; psychoeducation events about wellbeing, mental/physical health and AOD (including in settings such as schools); and locally-developed health promotion messaging that can help to reduce stigma around mental health

ACTION AREA 3:

Improve accessibility of clinical supports and provide more options beyond clinical care

Existing clinical services in the regions are necessary but not sufficient in terms of accessibility, quality and suitability. Communities would like more support options beyond clinical care in order to address holistic needs, and also to support people who are unlikely to seek clinical services for their mental health struggles

Individuals generally felt that clinical services were important, but many consultation participants also raised grievances with the clinical care system and suggested it was insufficient to meet their needs. The barriers to accessing clinical support can feel insurmountable. The pressures of living, stigma about mental health, limited opportunities to informally discuss mental health to identify when help is needed, unreasonable wait times when seeking appointments, and overcoming transport and distance barriers, as well as cost were discussed. Often there were also issues with the quality and continuity of staff and services. Particularly for smaller regional communities, it was not uncommon for staff to move away or for services to cease operating, and this meant that individuals and families struggled to build relationships with practitioners and continue accessing support. There were also issues with hospital access, most notably a shortage of mental health beds and sometimes a lack of empathetic and appropriately trained staff.

> The barriers to accessing clinical support can feel insurmountable.

We heard how overwhelming it can be for people to overcome the multiple barriers to access clinical services, and if their efforts are not rewarded with positive experiences, they may choose to manage their mental health condition by themselves – especially if choices are limited. The self-assessment measures in the survey indicating widespread high distress and low levels of wellbeing suggest that this approach is not working for individuals and communities.

People also articulated that clinical care cannot provide the holistic, personalised, wraparound support for mental health that people need in the regions. For other people it was not necessarily holistic or wraparound support that was needed, but that standard clinical care options were just not accessible enough nor appropriate for the diverse range of people in their community. Preferences were expressed for community groups, hubs, and recreation facilities and spaces such as Men's Sheds, however, interpretation of survey data indicated that other non-clinical support options not yet considered by communities may also be suitable and effective (such as recovery supports). A clear message was that more was needed to support individuals 'where they are at': that is, delivered in a range of settings (such as schools); in close proximity to where people live; and, available to all, no matter the level of symptom severity.

The urgent task is to improve access to high-quality and timely clinical care, while also bolstering non-clinical support options that can address the causes or early symptoms of mental health distress and provide support in other meaningful and sustainable ways beyond a clinical setting.

SUGGESTED PRIORITIES FOR ACTION

Improving access to funded clinical services

- For the many people who find it too difficult to access or sustain connection with clinical services, reducing the known access barriers is critical. This could include: provision of more clinical services, particularly in more remote settings; expansion of existing services with more skilled clinicians to reduce wait times; more funding for free psychological support/clinical care; assistance with transport; and if appropriate for the community's needs, more travelling services to small and remote communities
- In addition to logistical barriers faced by people living regionally, consideration should be given to other perceived barriers such as ensuring people working in mental health support roles are aware of the impact of stigma on regional communities, are warm and inclusive, and can accommodate different cultural needs. Actions to ameliorate this type of access barrier may include: ensuring clinical staff have mental health training and an appropriate 'bedside manner'; incorporating more peer and lived experience support in clinical and hospital settings; providing culturally safe and appropriate support/service options for Indigenous and CALD people, including Aboriginal-specific means of support ideally operated by Aboriginal people

Reducing reliance on clinical only

- Communities called for more non-clinical mental health support options, as a way to both reduce the reliance and demand for clinical services, as well as provide alternative options for people seeking support. This could include informal models of support such as community groups, hubs, and recreation facilities and spaces such as Men's Sheds, where staff are adequately skilled to support mental health
- More investment in a diverse range of community-level interventions will help promote individual and community resilience and wellbeing, address risk factors and social determinants of mental ill-health and allow those with early-stage mental health issues to get help early. This should reduce the need for more intensive specialist clinical, emergency and non-clinical services and support

ACTION AREA 4:

Engage local leaders in making decisions about what the community needs

Mental health support options need to be 'place-based'; i.e. context-specific, and community-driven. Not only is it critical to consult with communities, but involving key community stakeholders in decision-making about what gets funded and how models are implemented will help make mental health support in the regions more relevant and effective

One-size-fits-all solutions do not work in regional WA communities. Consultation participants said that where 'cookie cutter' approaches had been tried in the past, generally they had failed to address the true needs of the community. The kind of support options that may work well in metropolitan settings or large regional centres may be inappropriate for smaller communities, and similarly, what is appropriate in the context of farming towns in the Wheatbelt may not be effective in a regional centre such as Bunbury. Services and support options for mental health need to work with the unique dynamics of each community, taking into account demographics, socioeconomic make-up, culture, diverse histories and experiences of trauma, the prevailing social and cultural understandings of mental health and other context-specific factors, and it is local leaders who live in the community or have a history of service in the community who have this knowledge.

"I think the most important factor in providing adequate services for people in rural, regional and remote WA is to not underestimate the strength and the capacity of local community members, who are the first point of contact for people in distress (whether that be through direct disclosure or not). Regional, rural and remote services need to build and add to the strength of communities, and not 'parade' around as the answer to all their problems. I'm not knocking professional services, as they do play an important role, but unfortunately there are some rogue organisations that work in silos"
(Survey participant)

Consultation participants felt that locally-based and community-driven supports are beneficial in keeping people well (i.e. preventing mental health from deteriorating), particularly in the early help-seeking stage, the recovery and reintegration stage and, to an extent, the symptom reduction and coping stage.

SUGGESTED PRIORITIES FOR ACTION

Support for local place-based solutions

- Operational and funding support should be given for community-based grassroots support options which are designed and led by the community in response to local needs and experiences
- Support options should be considered on the assumption that the community already knows what it needs in a basic sense (sometimes with very well developed ideas and/or existing support options that are successfully run and may just need expansion, more training for staff or more sustained funding)

Mechanisms to involve local leaders in what gets funded

- Additionally, support options provided for communities which are rolled out by centralised agencies, organisations or governmental bodies should be designed/managed in collaboration with local community leaders, who understand the types of support options that would work in the unique context of their community to best support different groups of people
- Community leaders should be offered opportunities to make decisions about what they need to keep the local population well and thriving, and the opportunity to receive funding directly

6.3 Concluding thoughts

It is clear from the findings presented in this report that many things could change, and need to change. Suicide was not a specific focus for this Project, however self-harm and suicide were alluded to in many conversations and survey comments: for example, as the "devastating consequence" of a loved one not being adequately supported. These 'consequences' are not just examples of the system failing to support people experiencing a mental health crisis; they represent lives tragically lost, and community members who are dearly missed. Some of the community members' comments, therefore, should be read as a call to action to better support the mental health of people living regionally. (The consistently higher suicide and intentional self-harm rates in regional Australia compared to metropolitan populations, is another reminder of the urgency of the need to listen and act.)

The conversations with community members were rich and, when collated together, give a clear view on mental health experiences outside of Perth. Notably, there were some small towns where there were no funded mental health supports available, although there was certainly a local awareness of this lack, and also in some communities a commitment to fill the void with their own initiatives.

In their insight, community members also pointed to practical, and sometimes very simple, ways and opportunities to increase the wellbeing and mental health of people in their communities, so there are less acute problems and less reliance on clinical, emergency care. Of course, this is a good principle always, but especially in remote areas where specialist support is so difficult to access.

Community mental health supports are a viable solution where there are difficulties finding a qualified workforce to deliver clinical models of support. In fact, based on our understanding of need, community mental health support models, that is, non-clinical options for responding to mental distress, might represent some of the most appropriate supports for regional communities. Community supports have the flexibility to be more holistic and less stigmatising, they are typically low-barrier and low-threshold supports (less costly to implement and access), address social determinants and causes of distress, and can be delivered by peer workers in innovative settings. Community mental health supports might also be effective in addressing cultural barriers, for example potentially delivered as an on-Country option, or with translation of resources and appropriate models of support for different cultural groups who may feel especially isolated in regional areas.

Across all mental health supports, strengthening diversity and inclusion practices will enable supports to be more effective for more people. Trauma-informed practices could be also strengthened, and expanded to include working with diverse histories of trauma and intergenerational trauma.

Reviewing funding allocations, models and streams was out of scope for this Project, however it seemed impossible to have conversations with community members without the issue of funding coming up. This was in relation to a sense of hopelessness that larger towns seem to attract all the resources, or in relation to pride in the community-driven activities that are sustained only by small buckets of local money, and goodwill.

Funding is not only about resources, it is about sovereignty and all the decisions that are made in the commissioning process. Targeted investment may be needed to better support youth, Indigenous people, CALD communities, families and carers, first responders, or people with severe or complex needs. Funding should also flow to services that can address a growing crisis around housing and homelessness, financial stress, AOD, or a lack of recreational and social opportunities. All of these decisions depend on the community context. Local leaders and mental health advocates with local knowledge must be able to help make these critical resourcing decisions.

For any funding that aims to support mental health in regional WA, no matter how, it is recommended that the conditions of the funding be considered closely. The best support for regional communities is to ensure funding allocations are sustainable, long term and provide local communities some control and access to resources to make decisions based on their understanding of their community's needs. The evidence presented in this report suggests that this single, structural change alone could result in a significant improvement in mental health outcomes for people living in regional communities.

It is clear that mental health supports offered outside of Perth must be informed by community development principles, involving a commitment to include the people affected by the intervention in the decision making. This would ensure programs will be more equitable and be seen as trusted and legitimate by local community members (Nickels & Rivera, 2018), which is especially important for addressing an issue for which many still hold stigmatising beliefs. Engaging local leaders also allows for adaptive responses to the changing needs of communities, and targeting resources to where it is needed most (e.g., to support young people, provide cultural healing or address unemployment).

To enact these principles, Aboriginal elders would play a greater role in the design and provision of mental health supports for Aboriginal people and communities, and ensure there are Aboriginal-led mental health and other support services both in Aboriginal communities as well as regional centres. Local governments can also play a key role in building community responses from the ground up, and are already taking leadership in several communities, where the positive effects of their leadership can be seen.

> It is clear that mental health supports offered outside of Perth must be informed by community development principles, involving a commitment to include the people affected by the intervention in the decision making.

Importantly, locally-based solutions better utilise the strengths and assets of a community, and give services the opportunity to work flexibly and creatively. This can allow services to experiment, for example, with different innovative approaches and supports that they feel will work best, as well as make adjustments around the location of appointments, timing of service hours, mix of group and individual supports, types of outreach, brokerage and practical support – all issues that people told us must be considered to help people overcome the additional barriers to seeking help that people living in regional areas experience.

The realities of living out of Perth, living in a town that is a long drive from Perth, or even living a great distance from Perth, need to be experienced to be understood. Based on this small Project we cannot speak for all of regional WA. However, we can confidently say that those place-based characteristics that can make life satisfying or incredibly challenging, and the resources available that enable a person to find their way through the difficulties they will inevitably face, do vary greatly from town-to-town and region-to-region.

Despite this variation, it seems that the opportunities to do better at supporting mental health are abundant across all communities and regions we explored – in terms of making some impact, there seem to be many 'easy wins'. The hundreds of comments and anecdotes from community members who responded to the survey suggest there is a pressing need to do things differently, which was strongly validated through our in-depth conversations with stakeholders who work in rural, regional and remote mental health. Our community visits were most powerful however; even in very small towns people were keen to engage and it is clear that many want to talk more about mental health and how it is impacting their lives, communities and loved ones. During the visits it was also heartening to observe highly supportive community leaders who turned up to meet us, and either quietly listened or boldly put forward their view, but nonetheless were equally receptive to change both the 'on the ground' as well as system-level conditions, so we can better support the mental health of people in regional WA.

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Appendices

Appendix A:
Region and size of community of survey respondents

Table 5: Regions represented by survey respondents

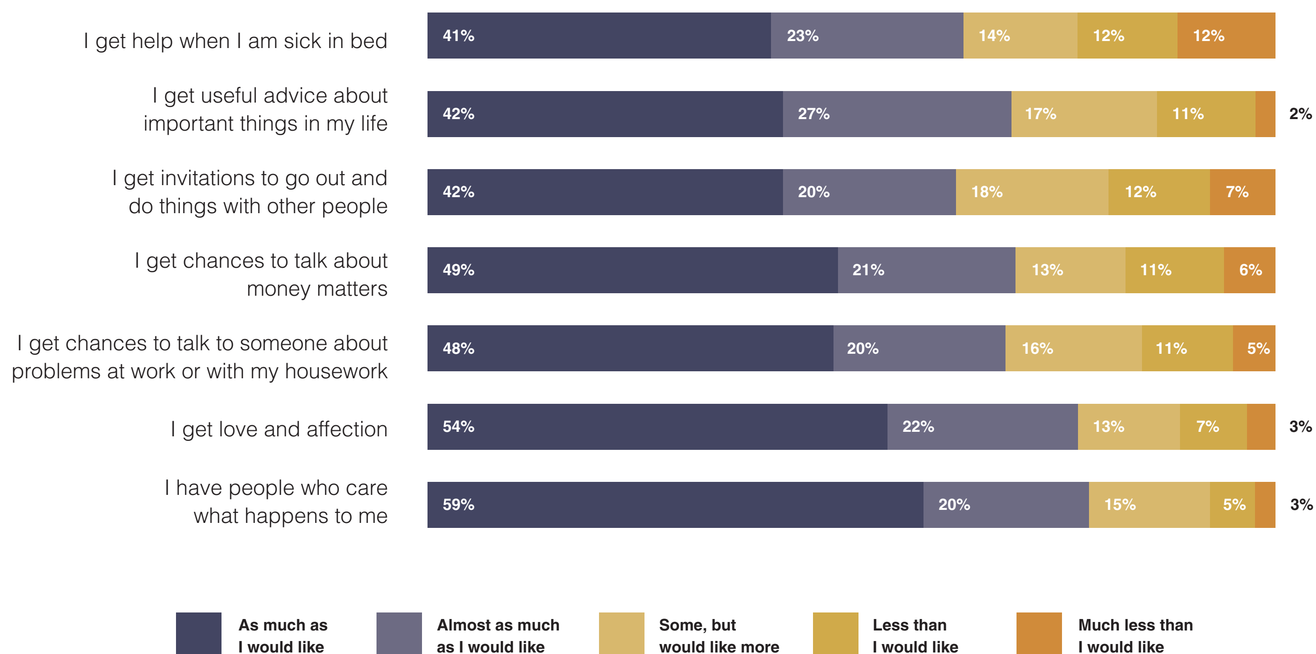
Region	Frequency	Per cent
Kimberley	8	2.0
Pilbara	19	4.6
Gascoyne	5	1.2
Midwest	57	13.9
Wheatbelt	31	7.6
Peel	12	2.9
South West	157	38.4
Great Southern	37	9.0
Goldfields-Esperance	13	3.2
Perth metropolitan area	69	16.9
Unsure	1	0.2

Table 6: Size of communities of survey respondents

Size of community	Frequency	Per cent
Capital city (Perth, including outer metropolitan areas)	83	21.1
Large rural centre (regional city with population of more than 25,000)	117	29.8
Small rural centre (town with a population between 10,000 and 24,999)	80	20.4
Remote centre (town with a population between 5,000 and 9,999)	37	9.4
Other remote area (all other places that are remote with a population under 5,000)	55	14.0
Unsure	21	5.3

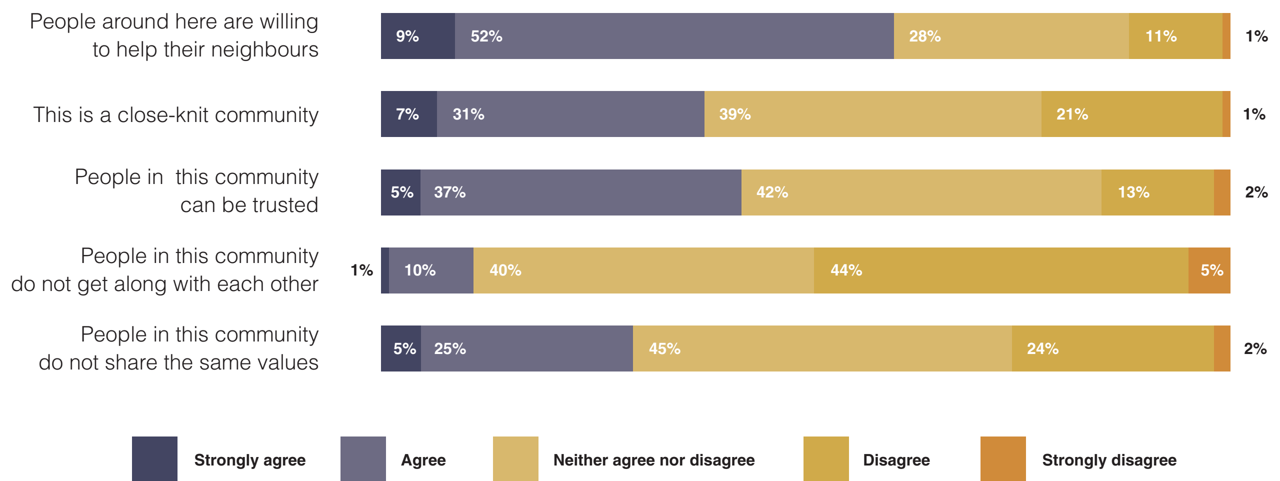
Appendix B: Perceived functional social support questions

Figure 22: Perceived functional social support of survey respondents



Appendix C: Social cohesion questions

Figure 23: Social cohesion of survey respondents



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