COTA
For older Australians

Submission to the Senate Community Affairs References Committee

Inquiry into the accessibility and quality of mental health services in rural and remote Australia

Prepared by
COTA Australia

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COTA Australia

COTA Australia is the national consumer peak body for older Australians. Its members are the State and Territory COTAs (Councils on the Ageing) in each of the eight States and Territories of Australia. The State and Territory COTAs have around 30,000 individual members and more than 1,000 seniors' organisation members, which jointly represent over 500,000 older Australians.

COTA Australia's focus is on national policy issues from the perspective of older people as citizens and consumers and we seek to promote, improve and protect the circumstances and wellbeing of older people in Australia. Information about, and the views of, our constituents and members are gathered through a wide variety of consultative and engagement mechanisms and processes.

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Introduction

COTA Australia welcomes the opportunity to provide brief comments to the Senate Inquiry into the accessibility and quality of mental health services in rural and remote Australia.

The mental health of older Australians is a significant public health concern. Older Australians experience higher rates of suicide, particularly among men over the age of 85[1]; reduced access to appropriate mental health treatment[2]; and ageist attitudes in general health and mental health care[3].

In rural and remote Australia, these concerns become magnified; with suicide rates nearly double that of the general population.[4] With a rapidly ageing Australian population, it is critical that suicide prevention and broader mental health prevention and early intervention measures are implemented; and the capacity of mental health services and systems improved, in order to support this group of older Australians.

This response provides brief comment on the following four terms of reference of the Senate Inquiry, in relation to older Australians:

a. Nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate
b. The higher rate of suicide in rural and remote Australia
e. Attitudes towards mental health services
f. Opportunities that technology presents for improved service delivery

Nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate

Across the general population, Australians over the age of 65 have the lowest rate of contact with community mental health care services*; and use of ATAPS (Access to Allied Psychological Services) also decreases with age. However, use of mental health related prescriptions increases with age, indicating that older people are more likely to receive pharmacological treatment for mental health issues, rather than other forms of therapeutic treatment.[5] Polypharmacy (use of multiple medications) has been identified as a significant concern for older people that can lead to adverse outcomes.[6]

*with the exception of children under the age of 15.

[1] Australian Bureau of Statistics. (2017). *3303.0 – Causes of Death, Australia, 2016*. Canberra: ABS.

[2] McKay, R. (2016). *Access and Affordability in Primary Health Care*. Presentation at the COTA Australian 2016 Policy Forum, Reframing Primary Health Care for Older Australians. Canberra.

[3] Draper, B. (2015, September 3). *Elderly men have the highest suicide rate – and ageism stops us from doing something about it*. The Conversation. Available at: https://theconversation.com/elderly-men-have-the-highest-suicide-rate-and-ageism-stops-us-from-doing-something-about-it-46923

[4] Australian Institute of Health and Welfare. (Updated 16 January 2018). *Rural and Remote Australians*. Web report.

[5] McKay, R. (2016). ibid.

[6] Elliot, R., & Booth, J. (2014). Problems with medicine use in older Australians: a review of recent literature. *Journal of*

This public health situation is exacerbated in rural and remote areas of Australia. Men and women are both less likely to receive professional help for a mental health disorder in non-metropolitan areas, than their metropolitan counterparts, including those over the age of 60.[7]

Although the Aboriginal and Torres Strait Islander population has a young age structure, the number of Aboriginal people aged 55 years and over is expected to double between 2011 and 2026.[8] Aboriginal and Torres Strait Islander people comprise 25% of the population living in remote areas of Australia. While we do not have access to specific data about older Indigenous Australians, research indicates that overall, Aboriginal Australians access mental health services at higher rates than non-Aboriginal people. However, there is also likely to be a large number across the age groups who need services but do not access them, which has been attributed to cultural inappropriateness of services.[9]

Rural and remote regions experience a reduced availability of medical practitioners, including specialists, in which the number of general practitioner (GP) services provided per person in very remote areas is about half that of major cities.[10] In 2015, almost 9 out of 10 FTE psychiatrists, 8 in 10 FTE psychologists, and three quarters of FTE mental health nurses were employed in major cities.[11]

In the context of these structural challenges, older people experience additional barriers, causing them to access services at a lower rate. In a recent Australian study of mental health services for older people in rural areas, health and social care providers identified availability of and access to services as barriers to service provision.[12] Access barriers include difficulties obtaining appointments with GPs and mental health services; specialist mental health services not being available locally; and services being at full capacity. People living in remote areas of Australia may need to travel long distances to access health services, and transport can be an issue for those older people who no longer drive and where public and community support transport is sparse.

In particular, the study highlighted the separation of physical and mental health in service delivery; where mental health services are not well set up to also provide support for physical health issues. Older people are more likely to experience comorbid mental and physical health conditions, and would benefit from an integrated and holistic response.[13]

Pharmacy Practice and Research, *44*: 258-271.

[7] Caldwell, T.M., Jorm, A.F., Dear, K.B. (2004). Suicide and mental health in rural, remote and metropolitan areas in Australia. *Medical Journal of Australia, 18*(7 Suppl): S10-4.

[8] Australian Bureau of Statistics. (2014). *3238.0 – Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*. Canberra: ABS.

[9] Isaacs, A., Maybery, D., & Gruis, H. (2012). Mental health services for Aboriginal men: Mismatches and solutions. *International Journal of Mental Health Nursing, 21*(5), 400-408, p 401.

[10] Australian Institute of Health and Welfare. (Updated 16 January 2018). *Rural and Remote Australians*. Web report.

[11] Australian Institute of Health and Welfare. (Updated 3 May 2018). *Mental health services in Australia*. Web report.

[12] Muir-Cochrane, E., O'Kane, D., Barkway, P., Oster, C., & Fuller, J. (2014). Service provision for older people with mental health problems in a rural area of Australia. Aging and Mental Health, 18(6), 759-766.

[13] Muir-Cochrane, E., O'Kane, D., Barkway, P., Oster, C., & Fuller, J. (2014). ibid.

Additional barriers highlighted in the study included a lack of knowledge about what services are available and where to access them; transport; and a lack of collaboration between health care organisations, such as residential and community aged care, general health and specialist mental health services, local government organisations and carer support services. With regard to collaboration between services, the study highlighted the competitive nature of funding as problematic. Where service funding is allocated on an outcomes basis (with physical conditions having more 'tangible' outcomes than mental health issues), the mental health care needs of older people can be neglected. Gatekeeping may also occur, if service providers with specific eligibility criteria do not accept referrals.

In relation to services for Aboriginal people, researchers have suggested that collaborations between mental health services and Aboriginal organisations may be a useful way to develop services that are more user-friendly. Limited cultural competency is compounded by a lack of Aboriginal staff in generalist mental health services, which presents an additional barrier to use of services.[14]

In COTA Australia member consultations, we also received feedback highlighting concerns about the exclusion of older people from community based mental health services funded only to work with people up to the age of 65; as well as some instances of difficulties in the transition from 'adult' to 'aged' mental health services, some of which are based in rural areas.

A Victorian Government technical paper discussed this issue, identifying that the access criteria for clinical mental health services was based on 'chronological age, rather than functional fit', precluding individuals younger or older than 65 from accessing the full range of services that might better suit their needs.[15]

Stigma is also a relevant factor in preventing older people in rural and remote areas accessing services. We outline this further in 'attitudes towards mental health services'.

The higher rate of suicide in rural and remote Australia

The National Rural Health Alliance (NRHA) identifies that the prevalence of mental illness is roughly the same in rural and regional areas of Australia as in urban centres, despite a range of stressors unique to living in rural and remote areas, such as a greater prevalence of chronic conditions and disability, generally poorer health, lower incomes and less financial security.[16] NRHA highlights that this may be due to a range of protective factors in rural and remote areas, such as higher levels of civic participation, social cohesion, social capital and informal support networks.

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[14] Isaacs, A., Maybery, D., & Gruis, H. (2012). Mental health services for Aboriginal men: Mismatches and solutions. *International Journal of Mental Health Nursing, 21*(5), 400-408, p 401.

[15] Department of Health and Human Services. (2015). *Mental health and wellbeing of older people: 10-year mental health plan technical paper.* Melbourne: State of Victoria, p 2.

[16] National Rural Health Alliance Inc. (2017). *Mental health in rural and remote Australia*. Factsheet, December 2017.

However, suicide rates are 1.7 times higher in rural and remote Australia, than in major cities.[17] In the general Australian population, the suicide rate is highest among men over the age of 85, and for females, highest in the 50-54 age group.[18]

Two-thirds of all farmer suicides occur in older age groups, particularly men over the age of 55.[19] Farming has an ageing workforce, with a median age of 53 years, compared to 40 years in all other occupations, due in part to farmers working beyond retirement age, with almost 25% of farmers aged 65 years and over, compared to just 3% in other occupations.[20]

Relevant factors leading to a higher rural suicide rate are thought to include economic change leading to financial insecurity; stress caused by drought, flood and bushfires; social stigma in small communities; 'living at work'; and masculine attitudes and rural ideologies.[21] Other studies support these factors, and also suggest that personality characteristics, long work hours, social isolation, an ageing population, pending retirement, availability of firearms, poor access to health services, and regulatory and industry factors may be additional stressors.[22] A recent Australian study highlighted the importance of contextualising individual pathways to suicide in relation to wider social and environmental contexts, and suggested that male farmers require targeted prevention, assessment and treatment strategies, within their communities and across the lifespan, including for retirement and succession planning.[23]

COTA Australia has heard anecdotally that the death of a wife may be a provoking factor in the decision of some older men in rural communities to commit suicide. The NHRA also highlights the gradual de-population of rural and remote communities and withdrawal of essential services, as contributing to a declining quality of life, resulting in loss of primary relationships and increased loneliness.[24] More research may be required to understand the context in which older men in rural communities decide to end their lives. A better understanding of common factors present in the lives of those who commit suicide is essential to create effective, targeted suicide prevention strategies.

Attitudes towards mental health services

A recent systematic review of literature examining the mental health impacts of drought, which included several Australian studies, found that rural and remote populations face unique challenges that increase their vulnerability; including that health "may sometimes be defined differently, often with an emphasis on one's ability to be productive and with distress seen

[17] Australian Institute of Health and Welfare. (Updated 16 January 2018). ibid.
[18] Australian Bureau of Statistics. (2017). ibid.
[19] National Rural Health Alliance. (2009). *Suicide in rural Australia*. Factsheet 14. National Rural Health Alliance.
[20] Australian Bureau of Statistics. (2012). *4102.0 – Australian Social Trends, Australian farming and farmers*. Canberra: ABS.
[21] National Rural Health Alliance. (2009). ibid.
[22] Kunde, L., Kolves, K., Kelly, B., Reddy, P., & De Leo, D. (2017). Pathways to Suicide in Australian Farmers: A Life Chart Analysis. *International Journal of Environmental Research and Public Health, 14*(4): 352.
[23] Kunde, L., Kolves, K., Kelly, B., Reddy, P., & De Leo, D. (2017). ibid.
[24] National Rural Health Alliance. (2009). ibid.

more as a problem of daily living rather than a mental health issue"[25].

The study described the phenomenon of 'rural stoicism', which can pose a barrier to help-seeking when combined with a culture of self-reliance, and identified that individuals who consider seeking help from mental health services may fear being marginalised if others in their community find out. It highlighted the importance of mental health literacy as a protective factor, and as a way to reduce stigma by increasing knowledge and help-seeking behaviours.

A separate study noted that stigma is a particularly important barrier in rural settings, especially in smaller towns. [26] It highlighted that while improving mental health literacy is important, mental health services may also need to be framed in such a way as to alleviate concerns about admitting or dealing with emotions and problems.

A recent Australian study exploring the views of health and social care providers, in relation to barriers to mental health care for older people in rural areas, identified several attitudinal barriers to service access.[27] Among older people, these included a reluctance to admit they might have a mental health problem; reluctance to access mental health services due to perceived stigma; stoicism; feeling that others were more in need of such services; and a lack of trust, including fear that they may be institutionalised or subjected to frightening procedures. The study emphasised this last point, highlighting that a lack of trust may have been connected to past relationships and experiences with health and mental health professionals. In a separate study, Aboriginal men and service staff also emphasised distrust as a deterrent to engagement, suggesting that relationship-building is important for help-seeking.[28]

In examining how attitudes can present barriers to service access, it is critically important to also examine how the attitudes of health professionals may affect older people's access to mental health services. Health and social care providers have identified a tendency for health professionals to focus on physical illnesses or concerns of older people, while ignoring or dismissing indications or concerns about mental health issues. Mental health concerns were often viewed as dementia-related, or less severe mental health problems interpreted as being a 'normal' part of ageing; resulting in older people not being referred to appropriate mental health services.[29] Ageism and discrimination by health professionals and within the Australian healthcare system is an ongoing and significant issue.[30] [31] [32] Within the broader policy context, an analysis of Commonwealth policy found that older people experiencing mental health issues are absent in policy solutions and priority actions.[33]

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[25] Vins, H., Bell, J., Saha, S., & Hess, J. (2015). The Mental Health Outcomes of Drought: A Systematic Review and Causal Process Diagram. *International Journal of Environmental Research and Public Health, 12*(10): 13251-13275, p 12359.
[26] Judd, F., Jackson, H., Komiti, A., Murray, G., Fraser, C., Grieve, A., & Gomez, R. (2006). Help-seeking by rural residents for mental health problems: The importance of Agrarian values. *Australian and New Zealand Journal of Psychiatry, 40*(9), 769-776.
[27] Muir-Cochrane, E., O'Kane, D., Barkway, P., Oster, C., & Fuller, J. (2014). ibid.
[28] Isaacs, A., Maybery, D., & Gruis, H. (2012). ibid.
[29] Muir-Cochrane, E., O'Kane, D., Barkway, P., Oster, C., & Fuller, J. (2014). ibid.
[30] Urbis. (2013). *Fact or fiction? Stereotypes of older Australians*. Research report. Australian Human Rights Commission: Sydney.
[31] Australian Ageing Agenda. (2017, July 27). *Push for better mental health care for seniors*. Available online at: https://www.australianageingagenda.com.au/2017/07/27/push-better-mental-health-care-seniors/
[32] Draper, B. (2015, September 3). ibid.
[33] Oster, C., Henderson, J., Lawn, S., Reed, R., Dawson, S., Muir-Cochrane, E., & Fuller, J. (2016). Fragmentation in Australian

Ageist attitudes in the healthcare system can be compounded for older Indigenous Australians, with one study reporting that racism within health care settings is an important concern which may have a more negative impact than racism in other settings, and which is associated with psychological distress, an indicator of increased mental illness.[34]

Opportunities that technology presents for improved service delivery

There is significant and valuable potential for technology to improve service delivery in rural and remote areas, particularly for those areas where there is limited or no availability of medical and mental health professionals. Additionally, given the impact of stigma in preventing help-seeking in smaller rural communities, digitally delivered services may support private access to services, potentially without requiring extensive travel. However, we also note that where digitally delivered services are provided with existing health services, older people may still experience challenges obtaining transport to services.

Where digitally delivered services are implemented, it is important that older Australians are not inadvertently excluded from accessing treatment and support. People over the age of 65 are the lowest proportion of internet users, and the Australian Digital Inclusion Index (ADII) ranks Australians aged 65 years and over as the most digitally excluded age group.[35] Further to this, data indicates that the digital divide exists between urban (ADII score of 58.6) and rural (ADII score of 50.7) areas, relating to access, affordability and digital ability. Indigenous Australians also have low digital inclusion (ADII score of 49.5), below the national average.[36]

A recent study about familiarity with and intentions to use Internet-delivered mental health treatments among older rural adults found that overall awareness of such treatments was low.[37] Ninety-five percent of participants, including those with current psychiatric symptoms, had either never heard of Internet-delivered treatments, or did not know any details about them. The most commonly endorsed negative belief was, 'I don't know whether to trust the accuracy of the information provided', followed by concerns about privacy on the Internet, and doubt about whether Internet treatment would work for mental health problems. However, higher familiarity with Internet treatment contributed to higher intentions to use such programs, particularly for those with higher distress and greater computer literacy.

When asked in the study which service they would go to first for help with a mental health

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Commonwealth and South Australian State policy on mental health and older people: A governmentality analysis. *Health, 20*(6): 541-558.

[34] Kelaher, M., Ferdinand, A., & Paradies, Y. (2014). Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities. *Medical Journal of Australia, 201*(1): 44-47.

[35] Australian Bureau of Statistics. (2014). *8146.0 – Household Use of Information Technology*. ABS: Canberra. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/8146.0Chapter32012-13

[36] Thomas, J., Barraket, J., Wilson, C., Ewing, S., MacDonald, T., Tucker, J. & Rennie, E. (2017). *Measuring Australia's Digital Divide: the Australian digital inclusion index 2017*. Melbourne: RMIT University, p 11.

[37] Handley, T., Perkins, D., Kay-Lambin, F., Lewin, T., & Kelly, B. (2015). Familiarity with and intentions to use Internet-delivered mental health treatments among older rural adults. *Ageing and Mental Health, 19*(11): 989-996.

problem, 1.2% indicated they would use an Internet service; while over 85% reported that they would consult a general practitioner. The study highlighted the need for social marketing campaigns to raise familiarity with these services in older age groups, although it also noted an absence of research examining the efficacy of Internet treatments for older populations. Researchers highlighted the potential opportunity for general practitioners in rural and remote areas to raise awareness about, facilitate access to, and alleviate concerns about credibility and confidentiality.[38]

Other comments

While much of the available literature focuses on the mental health needs of older rural men, or older people in general, COTA Australia highlights the need to ensure that the specific mental health needs of older women in rural and regional areas are not overlooked. While research reinforces the difficulties that older rural women may experience in accessing GPs and other health services[39], there appears to be limited research on their specific mental health needs.

Key recommendations

COTA Australia recommends the Committee consider the following recommendations:

- Ensuring that Primary Health Networks (PHNs) and associated programs, initiatives and funding use a life course approach to support both males and females across the life span, including at key transition points, to ensure a nuanced approach to mental health service delivery in rural and remote areas.
- Encouraging PHNs to take a leadership role in addressing ageist attitudes across health care professionals and systemic ageism within health services.
- Ensuring that PHNs identify and address the individual and structural barriers to service access for older people with mental health issues within their regions, including:
    - providing integrated and holistic service delivery, to support older people with the range of comorbid mental and physical health needs that they may experience;
    - providing support to older people to access transport to and from health services, where transport is a barrier;
    - improving the cultural competency of health professionals and services to support Aboriginal and Torres Strait Islander people.
- Ensuring that PHNs build GP and health professionals' capacity and knowledge to better understand the mental health needs of older people, including comorbid conditions and how they can facilitate access to appropriate services.
- Ensuring that PHNs improve collaboration between health and allied services that support older Australians, including general health, mental health, residential and

[38] Handley, T., Perkins, D., Kay-Lambin, F., Lewin, T., & Kelly, B. (2015). ibid.
[39] Women's Health Victoria. (2009). *Women and Ageing. Gender Impact Assessment*, No. 10. WHV: Victoria.

community aged care, local government organisations and carer support services. This includes:
    - a person-centred approach to collaboration which places the best interests of the individual at the centre of service planning and delivery, including transitions between services;
    - a focus on improving collaboration between mental health services and Aboriginal health services and community organisations, to develop cultural competency to support older Aboriginal and Torres Strait Islander people.
- Development and implementation of specific and targeted, evidence-based suicide prevention strategies, and mental illness prevention and early intervention strategies, within PHNs, to counter barriers such as stigma, masculine attitudes and rural ideologies.
- Ensuring that the needs of older Australians are specifically included in the design and implementation of digital delivery of mental health services in rural and remote areas. This includes:
    - building GPs' capacity to facilitate access to digitally delivered mental health services for older Australians, including raising awareness of appropriate programs and alleviating potential concerns;
    - providing practical support, where appropriate, to support older people with low digital inclusion, to use digitally delivered services. This may include spending time with older people to demonstrate how specific online programs work, or providing transport to access digital services where these are based in health services;
    - ensuring that adequate and appropriate services are available for older Australians who do not want to engage in digitally delivered services.
- Funding research to examine the efficacy of Internet mental health treatments for older populations.

Ends