Improving the mental health of rural Australians: a review

Report Phase One
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Improving the mental health of rural Australians: a review

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**Acknowledgements**

We pay respects to the traditional custodians of all the lands on which we work, and acknowledge their Elders, past, present and emerging.
About the Report

This report summarises insights from research undertaken to understand how to improve help for rural Australians, in addressing their mental health and wellbeing needs.

Research insights were garnered from analysing existing data, published research findings and policy-related documents, as well as from interviews with nine expert stakeholders.

The review was funded by a philanthropic organisation that wishes to remain anonymous under the conditions of funding.

Based on analysis, we summarise ‘the problem’ with rural mental health and explore potential causes of the problem. We conclude by suggesting options for investment to address the problem that could be stimulated by philanthropy in partnership with communities, based on the evidence at hand. The report does not tackle changes that could be made by other stakeholders - such as government. Several other documents deal with this - including the 2018 Senate Inquiry into accessibility and quality of mental health services in rural and remote Australia.

Suggestions for investment are guided by philanthropic investment filters as ways to proceed that will: make significant impact; ensure a distinctive role for philanthropy with measurable outcomes; and that have collaboration potential.

The report content is structured into six main parts:

• Problem Statement, Background and Objectives
• Approach
• Context
• Problem Disaggregation
• Qualitative Evidence
• Findings Synthesis and Direction

This report is presented by ‘The Orange Partnership’, a group formed by researchers from Swinburne University of Technology Social Innovation Research Institute, University of Newcastle Centre for Rural and Remote Mental Health and the Australian National University Centre for Mental Health Research (see Appendix 1). The group has a stated commitment to improve Australian rural mental health outcomes (Perkins et al, 2019). The Orange Partnership has a large and growing partnership among rural mental health stakeholders across Australia.
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Key messages

• This review is to inform about suggested activities to improve the help that rural Australians receive for their mental health and wellbeing needs.

• Data shows that mental illness prevalence is similar across Australia, yet there is incidence of higher rural emergency health service admissions and suicides in rural/remote areas. There also is less uptake of Medicare-subsidised benefits for mental illness in rural/remote areas.

• Review methodology included: data review, literature review of existing reviews and their recommendations, identifying the current approach to address needs (e.g. through Primary Health Networks) and exploration of innovations in Australia and comparable jurisdictions; exploration with key stakeholders/experts; synthesising evidence and producing recommendations.

• Through this process we raise two overarching problems:
  . Social disadvantage: rural areas tend to have higher socio-economic disadvantage, higher costs, longer distance to specialist services, higher Indigenous population who experience historical cultural trauma. Internationally, rural economies are in long-term decline.
  . Services do not meet existing needs: services are fragmented – provided by different providers and systems; timely local access to expertise is inaccessible; knowledge is not widespread, encouraging stigma; it is unclear if social supports are widely available.

• There are major gaps in philanthropy, advocacy and policy leadership for rural mental health.

• Community-level mental health services are currently primarily determined through PHN commissioning using standard national tools.

• Evidence about interventions to close the current gap between demand (driven by social disadvantage) and supply (fragmented and inconsistently available where and when needed) is provided by consistent types of emergent initiatives addressing: community wellbeing, early intervention locally, skilling-up of local staff to address immediate need and integrated care. These initiatives are currently confined to localised implementation and small-scale.

• Given that actions for government and other stakeholders are signposted in other reports, here we were tasked to highlight what can be done by philanthropy in partnership with communities.

• Key suggested investments are:
  . Advocacy: to highlight that ‘a problem exists’, catalyse a movement to improve rural mental health nationally, lead on data and research needs (detailed in the full report), liaise with policy and practice to implement evidence-informed innovations.
  . A clearing space: collecting, disseminating and providing training in evidence-informed innovations.

• Philanthropy should work in partnership with: community-level stakeholders (PHNs, local government, emergency services, Royal Flying Doctor Service); policy and government (National Mental Health Commission, Rural Workforce Commission, Indigenous bodies); foundations and non-profits (Foundation for Rural & Regional Renewal, Gandel Philanthropy, Rotary), research groups (Orange Partnership, Menzies School, Lowitja Institute); and community groups and individuals.
Executive summary

- This review is to inform about activities to improve the proportion of rural Australians receiving appropriate help for their mental health and wellbeing needs.

- The review methodology included: data review; literature review of existing reviews and their recommendations, contemporary Federal and State policy and published journal articles; identifying the current approach to address needs (e.g. through PHN) and exploration of innovations in Australia and comparable jurisdictions; exploration with key stakeholders/experts; synthesising evidence and producing recommendations.

- Rural is generally understood as ABS Remoteness Categories 3-5, including Outer regional, Remote and Very remote.

- Data review shows that:
  - Almost a third of Australians live outside capital cities and populations in more remote areas are relatively young.
  - More of the population in rural and remote areas is made up of Indigenous Australians.
  - Much of rural Australia has high socio-economic disadvantage, low capacity to adapt to changing economic conditions, and is heavily impacted by climate change.
  - The prevalence of mental illness is similar across Australia – around 20%.
  - But rates of suicide and emergency health service admissions worsen with rurality.
  - Alcohol, cannabis and meth/amphetamine misuse rises with rurality.
  - There is less uptake of Medicare-subsidised mental health services, with rurality.
  - Indicative evidence suggests a lack of services appropriate to need, and that are accessible locally.

- Literature review shows that rural mental health challenges are commonly attributed to:
  - Stigma and stoicism: due to small communities with traditional norms, coupled with difficulties of leaving jobs and properties to reach help.
  - Environmental challenges: rural incomes are lower than cities and declining with time, employment in traditional industries is declining, drought plus bushfires are associated with stress.
  - Risk profile: younger age, social disadvantage and exposure to social adversity are predictors of mental illness and suicide.
  - Cultural incompetence: larger proportions of Aboriginal Australians in rural areas can struggle to find health services that acknowledge, and are empathetic to, alternative belief systems and cultural trauma.
  - Inaccessible services: there are fewer specialists, but more GPs, with rurality; timely access through flexible staffing, costs and transport are other barriers to help.
  - Service fragmentation: ‘systemic fragmentation’ is attributed to lack of rural management approaches, distant PHNs, competitive contracting, clinical vs social and physical vs mental health emphasis, State/Federal divides, and the new National Disability Insurance Scheme (NDIS).

- Through the evidence review process we raise two overarching problems:
  - Social disadvantage: rural areas tend to have higher socio-economic disadvantage; rural people incur higher costs and experience longer distance to specialist services; there is a higher Indigenous population of people who experience historical cultural trauma. Rural economies are in long-term decline driven by technological and climate change.
Services do not meet existing needs: services are fragmented – provided by different providers and systems; timely local access to expertise can be inaccessible; mental health knowledge is not widespread, encouraging stigma; and there is some evidence that social supports are not widely available.

• Community-level mental health services are currently primarily determined through commissioning by 15 non-metropolitan PHNs commissioning using standard national tools and approaches.

• Evidence about interventions to close the current gap between demand (driven by complex social disadvantage) and supply (which is currently characterised by lack of joined-up, easily and timely accessible services where needed) was found during this review. These interventions are emergent in rural Australia and can be characterised broadly as of four types:

  1. Community wellbeing initiatives: these are prevention-focused and often driven by community-based collaborations (e.g. Our Healthy Clarence). They provide awareness, conversations, mental health first aid, suicide prevention and social connection.

  2. Early intervention initiatives: these are initiatives often at area level and driven by local health services/council collaborations (e.g. West Wimmera Rural Outreach Workers). They provide early intervention on self- or neighbour referral in the form of ‘a chat’ and service navigation or referral.

  3. Skills escalators and ‘grow your own’: these initiatives are often at region level and driven by States/Workforce Agencies (e.g. ‘A Strategy for Queensland 2017-20’). They provide skills to enable local and primary care workers to provide first line local help and referral.

  4. Service integration initiatives: these initiatives were found at general practice or PHN levels (e.g. Western Australian Primary Health Alliance). They drive joint governance and case management, collaborations for targeting need, timely access via joined up services such as GP and online/telephone services.

• Expert stakeholder interviewees suggested investments to ‘make a difference’ would be:

  1. In the short-term: operationalise the Orange Partnership declaration; develop integrated health precincts; enable counsellors to access Medicare Benefits Scheme; run parenting interventions; extend access to internet; extend mental health literacy; help communities to co-design wellbeing initiatives; better mental health data.

  2. In the longer-term: develop rural-specific services, workforce, management and funding approaches; data linkage; place-based programs for community resilience and mental health training; capacity-building for PHNs and local government; make mental and physical health have the same priority for government, data agencies and research bodies.

• We identified major gaps in advocacy, policy leadership and philanthropy - specifically for rural mental health.

• Given that actions for government and other stakeholders are signposted in other reports, here we were tasked to highlight what can be done by philanthropy in partnership with communites.

• Success in providing help would result in changes measured as reduced rural suicides and emergency admissions and increased Medicare-subsidised benefits for rural people with mental illness.

• Key suggested investments are:

  1. Advocacy: to highlight a distinctive problem, catalyse a movement specifically focused on improving national rural mental health, liaise with policy and practice to scale-up implementation of evidence-informed innovations, work with agencies to address:

     a. Gaps in data, including:

        i. Routine demographic analysis by ABS remoteness categories

        ii. A wider range of consumer experience data e.g. about service accessibility.

        iii. Mental Health Atlas data about services that can be benchmarked.

        iv. Long-term tracking of mental health effects of climate events/change.
. Activity of mental health NGOs, online and telehealth providers.

Gaps in research evidence, including:

. Impacts of emergent mental health initiatives and of scaling-up these initiatives.
. Long-term tracking of multiple social disadvantage and mental health.
. Qualitative mental health/illness and service experiences across Australia.
. Service collaboration incentives and measures.
. Online and telehealth use and impacts.
. Accessibility of appropriate social supports.

II. A clearing space: to collect and share evidence about impactful initiatives for wider implementation, providing toolkits and specialised consultancy and training in implementation.

III. Capacity building: PHNs and local government would be the main targets, with PHNs because they are service commissioning agencies and local government as it is located in rural communities with a remit across business and community organisations. Capacity-building would target: resilience-building in/for communities to enable people to deal with change; collaboration methods to drive local co-design and partnership; and in implementing evidence-based innovations, using co-design to achieve place-based solutions.

• Philanthropy should work in partnerships with organisations including: community-level stakeholders (PHNs, local government, emergency services, Royal Flying Doctor Service); policy and government (National Mental Health Commission, Rural Workforce Commission, Indigenous bodies); foundations and non-profits (Foundation for Rural & Regional Renewal, Gandel Philanthropy, Rotary), research groups (Orange Partnership, Menzies School, Lowitja Institute); and community groups and individuals.
Research question, background and objectives
Overall research question

In 10 years, how can we make a substantial improvement in rural Australians receiving appropriate help for their mental health and wellbeing needs?

Context

Challenges plus actions for governments and other stakeholders have already been flagged in reports such as the Federal Government Senate Inquiry into ‘Accessibility and quality of mental health services in remote and rural Australia’ (Parliament of Australia, 2018) and the Royal Flying Doctors Service ‘Mental health in remote and rural communities’ (Bishop et al, 2017). This report particularly fills a gap in highlighting what philanthropy could fund that would make impactful difference.

The prevalence of mental illness is reported to be around 20% across all of Australia (ABS, 2015); however, rates of suicide and emergency health service admissions for mental illness increase with rurality and remoteness. Some groups are highlighted as particularly affected; for example, the rate of suicide among men aged 15-29 years who live outside major cities is almost twice as high as it is in major cities (ABS, 2016a). In an analysis of their aeromedical emergency evacuations, the Royal Flying Doctors Service (RFDS) showed that Indigenous Australians were 20 times more likely to be retrieved for a mental disorder than non-Indigenous Australians, between 2013-16 (Bishop et al, 2017). Issues commonly linked with socio-economic disadvantage, including rates of cannabis, meth/amphetamine, prescription drug and alcohol misuse, all show a gradient rising with rurality and remoteness (ABS, 2019a). Simultaneously, there is less uptake of Medicare-subsidised mental health-specific services that also follows a remoteness gradient (AIHW, 2018c), with under-utilisation partly attributed to inaccessibility of appropriate services. Not reaching the right services occurs for various reasons which are explored later in this review (Bishop et al, 2017; Parliament of Australia, 2018).

As summarised by the National Rural Health Alliance (2017):

“the prevalence of people experiencing mental illness is similar across the nation: around 20%. However, rates of self-harm and suicide increase with remoteness suggesting that there are very significant mental health issues to be addressed in rural and remote areas”.

Recent reports specifically focused on rural, as opposed to general, mental health issues have sought to explore the mismatch between mental illness prevalence and the manifest rural mental health crisis. Reports are of a Federal Government Senate Inquiry into ‘Accessibility and quality of mental health services in remote and rural Australia’ (Parliament of Australia, 2018) and of a RFDS research study ‘Mental health in remote and rural communities’ (Bishop et al, 2017). In addition, the Australian Government National Mental Health Commission’s ‘Contributing lives, thriving communities: report of the National Review of Mental Health Programmes and Services’ (Australian Government, 2014) had a section exploring remote and rural issues.

There are other reports, plans and guidance on mental health, but they tend to consider mental health across all of Australia. Rural and remote conditions are quite distinct on many issues and require specific attention.

We present analyses of available evidence, suggest clear opportunities for investment and highlight gaps in research evidence and data.

Work for this Phase 1 Report was conducted over eight weeks through Sept-Oct 2019.
Research objectives

The objectives of this review were to:

- Explore, analyse and synthesise existing published data and research evidence that helps to understand rural mental health in Australia;

- Source expert stakeholder views to validate evidence synthesis and provide new insights;

- Reveal gaps in data and research evidence;

- Suggest initial evidence-based options for philanthropic investment.
Approach
**Partnership group**

A partnership group was assembled, consisting of three researchers from University of Newcastle Centre for Rural and Remote Mental Health (CRRMH), three researchers from Swinburne University of Technology Social Innovation Research Institute (SIRI) and four researchers from the Centre for Mental Health Research (CMHR), Australian National University. Members of this group held regular discussions and workshops.

**Desktop research and analysis**

The following data and evidence sources were identified and analysed:

- Published data reports e.g. from the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS).
- Recent reports and reviews specifically about rural and remote mental health.
- National and State policy documents and guidance.
- A scoping search of journal articles about rural mental health initiatives in Australia and similar jurisdictions.

**Field analysis workshop**

A workshop of the researchers was conducted to generate the field analysis.

**Expert stakeholder interviews**

Interviews were held by phone with nine expert stakeholders.

**Segmentation**

A qualitative segmentation was built using existing reports and data summaries.

**Notes**

Note that there are no Indigenous researchers on the research team and thus the Indigenous aspects of this research are only explored at a high level. This should be addressed in future work and a review like this purely from an Indigenous perspective would be a useful addition.

Fuller details of the Research Approach are in Appendix 2.
Context
Remote and rural Australia

Generally, throughout this review, the Australian Statistical Geography Standard (ASGS) Remoteness Structure (for short the ABS Remoteness Categories) is applied (ABS, 2019a). It measures “relative access to services”.

Rural is mostly applied here to include Outer regional, Remote and Very remote areas, except where highlighted.

Australia is distinctive from other countries with significant rurality in that a very large extent is very sparsely inhabited areas (see Fig. 1). Seven million people live outside Major cities (29% of the population), with Outer Regional: 9% (2.14m); and Remote or Very remote: 2% (476,000).

Figure 1 Remoteness Areas

Compared with Major Cities; Remote areas have proportionally more children, fewer young adults, slightly more people of working age, similar numbers of people in late working age approaching retirement, and substantially fewer elderly people (ABS, 2011).
Indigenous Australians

The proportion of the Australian population identifying as Aboriginal or Torres Strait Islander is 3.3%. Figure 2 shows that the highest proportion of Indigenous people lives in Major cities (35%).

Figure 2 Indigenous vs non-Indigenous population by remoteness

<table>
<thead>
<tr>
<th></th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote</th>
<th>Very remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>35%</td>
<td>22%</td>
<td>22%</td>
<td>7.7%</td>
<td>14%</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>71%</td>
<td>18%</td>
<td>8.7%</td>
<td>1.2%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

The Indigenous population is substantially younger than the non-Indigenous population. The birth rate of Aboriginal and Torres Strait Islander people is 25% higher than that of all of Australians (NRHA, 2019).

Socio-economic disadvantage

The Socio-Economic Indexes for Areas (SEIFA) ranks areas in Australia according to relative socio-economic advantage and disadvantage. Figure 3 shows SEIFA by local government areas (LGAs). While there is considerable variation in SEIFA score within rural LGAs, looking at the 10 most disadvantaged LGAs (2016) – these are all rural and characterised by having higher proportions of younger people, higher levels of housing rentals in lower value housing; and low incomes, compared with more advantaged LGAs (ABS, 2019b).

Figure 3 SEIFA disadvantage by local government areas
Economic resilience

The Productivity Commission created an Index of Relative Adaptive Capacity to compare regions’ economic resilience (Australian Government, 2017) (see Fig 4). This is a measure of an area’s capacity to thrive despite changing economic conditions. It combines indicators of: skills and education, infrastructure and services, financial resources for investment, and industry diversity. Figure 4 shows this mapped for Australia. Three per cent of the population (659,000 people) live in the lowest capacity regions which are often agricultural and marginal mining regions. A considerable proportion of these areas include small rural towns where a shrinking population experiences reduced amenity and access to services, local leadership and social and cultural life.

![Figure 4 Economic resilience by regions](image)

The Senate Inquiry (Parliament of Australia, 2018) proposed that economic disadvantage and consequent social exclusion, is likely linked to higher levels of rural/remote area suicide – highlighting that groups that seem likely more sensitive to economic decline, social disruption and loss of hope - i.e. they suggest, males, young people, Indigenous people and farmers – are the most at risk groups as shown by statistical data.

Climate-related disruption

Rural areas are disproportionately affected by climate change. Traditional rural industries are dependent on favourable weather. Australia has warmed by one degree Celsius in the last century (Bureau of Meteorology, 2019). Climate-related disaster combined with technological changes can combine to push traditional rural industries to fail. By some estimates, loss of wealth due to reduced agricultural and labour productivity as a result of climate change is projected to exceed $19 billion by 2030 (Climate Council, 2019).
Prevalence of mental illness

The last National Survey of Mental Health and Wellbeing was in 2007 (a new survey is in preparation) (Australian Government Dept. of Health, 2019) so data (shown in Figure 5) are potentially out-of-date.

Figure 5 Prevalence of mental health problems

<table>
<thead>
<tr>
<th>Mental health problems</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional/remote</th>
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<tr>
<td></td>
<td>17%</td>
<td>19%</td>
<td>19%</td>
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Figure 6 shows burden of disease in DALYs (Disability Adjusted Life Years) for selected diseases (AIHW, 2019b). DALYs are a measure of healthy years of life lost to disability or dying prematurely. While years lost to suicide show a negative gradient for Major city to Remote areas, for some mental illnesses, there appear to be fewer years of life lost for those living in rural areas. These data could be unreliable; for example, national prevalence estimates were obtained from the 2007 National Survey of Mental Health and Wellbeing and the 2013–14 Young Minds Matter Survey, which used diagnostic criteria to assess for mental health conditions. Severity was not directly available, and was based on those used by Global Burden of Disease Study 2013. Data transformations were used to overcome gaps in age distribution, and to adjust prevalence figures (AIHW, 2019b).

Figure 6 Age-standardised DALY rate of selected diseases, by remoteness area, 2015

Irrespective, the RFDS conclude that – despite various academic studies - there remains no evidence of higher rural and remote mental illness prevalence (Bishop et al, 2017).
Suicide rates show a negative gradient relationship from Major cities through to Remote areas (Figure 7). Per 100,000 people, those living in Very remote areas have a death rate over 2.5 times as high as people in Major cities (256 vs 96 per 100,000 population) (ABS, 2016a).

Figure 7 Age-standardised potentially avoidable death rate by remoteness area, 2015

In 2015, Indigenous Australians were twice as likely as non-Indigenous Australians (25.5 vs 12.5 deaths per 100,000 population) to die from suicide (Bishop et al, 2017). In one study of the Northern Territory (NT), Cheung et al. (2012) concluded that higher rates of suicide in the NT and in some Remote areas could be explained by the large numbers of Indigenous Australians living there. However, no figures of Indigenous versus non-Indigenous suicide rates, also analysed by the ABS 5 categories of remoteness, could be located within the time available for researching this report.

Male farmers also have high levels of suicide, with risk attributed to younger age, single or divorced/separated status, living alone, and using alcohol and drugs (younger farmers), as well as experiencing factors that may affect social isolation, such as job insecurity (Bishop et al, 2017). Young males aged 15–29 years in remote and rural areas are almost twice as likely as males in Major cities to complete suicide. Risk factors include high use of drugs and alcohol; pressure to conform to specific patterns of behaviour; pessimism about future prospects; unemployment; relationship issues; a sense of having ‘nothing to do’; greater availability of lethal means; social isolation; and a lack of available services. In 2015, males aged 85 or over had the highest suicide rate of an Australian population grouping, at 39.3 deaths per 100,000 males.
Alcohol and illicit drugs

Alcohol misuse shows a gradient from Major cities through to Remote and Very remote areas (Figure 8) and there is a higher likelihood for all age groups (other than 70+ years), in Remote and Very remote areas, to have used illicit drugs recently (figures from 2016) (AIHW, 2019a). Cannabis and meth/amphetamine have higher use in Remote areas, while cocaine and ecstasy use is higher in Major cities (Figure 9).

Figure 8 Drinking status, people aged 14 and over, by remoteness area, 2016 (%)

Figure 9 Recent illicit drug use, people aged 14 and over, by remoteness area, 2016 (%)
Using services

Despite similar prevalence of mental illness across Australia, Figure 10 shows rates of Medicare-subsidised mental health-specific services has remained fairly static, over time, in Outer regional, Remote and Very remote areas while rising in Major cities, between 2008-2017 (AIHW, 2018c). In 2015-16 the per capita Medicare Benefits Schedule (MBS) expenditure in Major cities was 6.84 times greater than in Very remote areas.

Figure 10 Number (‘000) of people receiving Medicare-subsidised mental health specific services, by remoteness, 2008-9 to 2016-17

Figure 11 Rate of same day overnight medical hospitalisations, 2013-14

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<th>Age standardised rate per 100 000 population</th>
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Regarding mental health hospitalisations (Figure 11), there is a Major city through to Remote areas, rising gradient (NRHA, 2017). Over all areas, Indigenous Australians had more than double the rate of emergency hospitalisations compared with other Australians (147.5 per 100,000 people versus 64.4 for other Australians).

The RFDS analysed their own data about aeromedical evacuations. They found that 25% of aeromedical evacuations were for depression/stress (Bishop et al, 2017).

The RFDS (2017) report concluded:

“prevention, early intervention and ongoing treatment services for people with mental disorders...may be helpful in reducing incidence and mediating impact of mental disorders” (Bishop et al, 2017).
Accessibility of appropriate services

A balance of types of services is advised by the World Health Organisation (WHO) and the World Organisation of Family Doctors (WONCA), which is an international organisation of rural GPs that cater for different needs (WHO & Wonca, 2008).

A Mental Health Atlas methodology using the international DESDE (Description and Evaluation of Services and Directories in Europe) classification was applied at two rural PHNs (van Spijker et al, 2019). For both rural PHNS, there was a higher number of services per 100,000 inhabitants than in urban areas (Western Sydney).

However most services located were clinical in nature, they were provided by a mix of public, private and NGO providers and many services were mobile and specialised rather than flexible and local. Most residential care was for acute situations, with little available locally. Few structured ‘day’ services were found so there are gaps in work and social connection opportunities. No specific information, guidance, advice or advocacy services were found.
Problem disaggregation
Initial problem disaggregation

A scoping of reviews and literature raised several reasons (see Fig 12) that could account for the rural situation where there is similar mental illness prevalence across Australia, but higher rates of suicide and mental health emergencies, and lower rates of Medicare-subsidised mental illness services used, with rurality/remote area.

Figure 12 Problem Disaggregation

In 10 years, make a substantial improvement in rural Australians receiving appropriate help for their mental health and wellbeing needs

1. Stigma & stoicism

There is considerable literature, internationally, recognising the idea of rural stoicism (Brett, 2011; Farmer et al, 2012). This is held to manifest as reticence to come forward with problems and is associated with rural areas because these are tightly governed by conservative social norms maintained due to long-term and highly visible relationships between small numbers of people.

Turning to stigma, despite wider and increasing societal discussion of mental health, mental illness is still discussed as particularly stigmatising in rural places (Lyons et al, 2015). Again, this is related to the ‘visibility’ of people in rural places; being seen to have a mental illness could affect peoples’ employability and social inclusion. The Senate Inquiry (Parliament of Australia, 2018) notes that ‘everyone knowing everyone’s business’ and pressure to ‘be normal’ are still prevalent in rural places and lack of confidentiality/anonymity and fear of being judged were issues raised in submissions. Local health practitioners could also be friends and neighbours. It could also just be hard to get away from farming/property responsibilities for long enough to visit services.

A number of grassroots initiatives to raise awareness about mental health and combat stigma have emerged in communities showing that community members themselves see overcoming stigma as an important issue. These community wellbeing initiatives are discussed later in the section on National Innovations.

2. Rural specific challenges

Rural areas experience challenges related to economic and social decline and climate change. Internationally, there is a movement of population from rural areas, to cities. The Productivity Commission in its ‘Transitioning Rural Regions’ (Australian Government, 2017) report highlighted that these changes lead to a loss of local leadership and capacity which, in turn, compounds social and economic decline. It highlights a general decline in rural incomes such that, in 2015-2016, there was an 18% gap in rural versus city disposable household income and a 29% gap in net household worth.

Agricultural employment is declining (see Figure 13). Thus, while some farmers have higher incomes, social isolation is increasing as there are fewer farm workers. One NSW study showed that climate change compounds financial hardship and drought-related stress, particularly affecting farmers aged under 35 years in the study (Austin et al, 2018).
A literature review of mental health effects associated with flooding (Fernandez et al, 2015) showed ‘a potentially negative impact on mental health, with increasing levels of Post Traumatic Stress Disorder, anxiety, depression and use of psychotropic medication’ (p.11). However, there is inconsistent evidence of associations between floods and suicide, alcohol or substance misuse.

3. Risk profile

Higher rural socio-economic disadvantage and the relative youth of remote area populations, in particular, implies a higher risk profile due to mental illness impacting younger people (the majority of mental illness has first onset before the age of 24 years) and exacerbated by inherited vulnerability interacting with social vulnerability (Arango et al, 2018).

Similarly, rural and remote places may be more prone to suicide because evidence shows that suicide is associated with rapid changes in social structure, economic turmoil and social isolation and these factors can combine with predisposing genetic and social/family history, environmental effects such as exposure to substance misuse, access to means and poor access to help (Turecki & Brent, 2016). Particular factors associated with higher suicides have been suggested for Australian rural and remote areas including economic decline, financial hardship, climate events, lack of access to employment, pessimism about the future and a sense of having nothing to do, high levels of problem gambling and inaccessible supports (Bishop et al, 2017).

4. Cultural competence

This is a challenging topic to comment upon here as we do not have Aboriginal or Torres Strait Islander researchers on our team. Also, in the short time available, we were forced to produce only a general review. At this stage, we provide some evidence from the Senate Inquiry (Parliament of Australia, 2018) and note that other reports, government document and reviews are available.

Coverage of mental health needs and service accessibility for Aboriginal and Torres Strait Islander people living in rural and remote areas suggests lack of cultural competence of many mainstream health services and that the health system is a significant problem. The Senate Inquiry (Parliament of Australia, 2018) notes that:
“A culturally safe health system is as important as a clinically safe health system...when people experience culturally unsafe health care encounters they will not use health services...even when this maybe life threatening” (2018).

“Current mental health service models are based on models of care which are culturally inappropriate and do not target underlying systemic issues. This impacts on the health and wellbeing of all community members…” Northern Qld PHN spokesperson (p.99).

Indigenous people have ‘disproportionately low outcomes on almost every scale of social, health and wellbeing (Parliament of Australia, 2018, p.99). All evidence points to intergenerational trauma, racism, social exclusion, lack of housing and loss of land and culture affecting mental and physical health of Australian Indigenous peoples.

5. Access to services

Problems in accessing services can sometimes seem to be almost wholly about lack of specialist workforce. However, it is unrealistic to think that a range of specialist workforce can be locally accessible across remote and rural areas. Internationally, there is growing acknowledgement that health services should aim for the same outcomes but not the same methods of service provision (e.g. NHS Scotland, 2007). Consequently, in Australia, there is discussion in some State workforce plans about new ways to design and skill local teams. New models are intended to be suitable for needs in different place contexts, and to develop local practitioners, peers and lay workers through ‘skills escalator’ and ‘grow your own’ strategies. These are discussed later in the section on National Innovations.

Below we consider Access to Services in terms of workforce, service models, transport and costs.

a. Workforce

There is a gradient in availability of all specialist mental health workforce from Major cities through to Remote areas. For example, in 2018, the Full-time Equivalent (FTE) rate of psychiatrists per 100,000 for Major cities was 13.2FTE vs 3.3 FTE for Very remote areas; for mental health nurses was 90.8 FTE vs 31.1 FTE; and for psychologists was 80 FTE vs 23.2 FTE (AIHW, 2018c). A study by Wakerman et al (2006) showed that, even to support a sustainable range of general primary health services, a population of at least 5000 is required.

In contrast with specialists, there is a higher proportion of GPs per 100,000 in Remote and Very remote areas, compared with Major cities (Figure 14).
The National Mental Health Commission (Australian Government, 2014) report concluded that, in lieu of specialist mental health professionals, other rural workforce is forced to fill gaps, including police and emergency workers.

b. Services

The World Health Organisation and World Organisation of Family Doctors (the international association of rural GPs) (2008) guidance notes that a range and balance of care types is needed for mental health and much need relates to social supports such as occupation/work, social isolation and community-level wellbeing. In rural areas, emerging evidence suggests, there may be low diversity of types of care and services (van Spijker et al, 2019).

From 2013-14, with the advent of the National Disability Insurance Scheme (NDIS), psychiatric disability support services are now provided under the National Disability Agreement (NDA). In short, social support services for people with mental health is provided through a separate system to health. NDIS services are meant to include residential facilities such as hostels, and group homes; accommodation, community support and respite services; and employment services.

As well as a requirement for a range of types of supports and services for mental health and wellbeing, it is also important that services work together and are integrated so that a continuous experience can be provided for individual clients and so that the service system as a whole is most effective and efficient:

“[The] importance of integrated service delivery, collocated, multi-sector care and increased availability of sub-acute care and other alternatives to hospitalisation...[is] especially true in regional, rural and remote locations, given the lack of access to services, particularly specialist mental health services...” (Australian Government, 2014).
From review of literature, pilot projects and examples of new integrated and collaborative services are occurring in rural Australia e.g. examples found in our non-systematic search included: the Mid North Coast Model, New South Wales (Mid North Coast Local Health District, 2015) which aims for rapid client assessment and treatment in the community; shared planning, case management and governance; and the Orange, New South Wales model (Fitzpatrick et al, 2018) – where one GP practice drives joint case management in primary care. More examples are discussed later in the sections on National Innovations and International Innovations.

c. Transport

Travel issues include time to travel, safety and readiness of services at the final destination (i.e. delays or waiting times). As noted in the Senate Inquiry (Parliament of Australia, 2018):

“Transport was raised as a significant barrier to accessing mental health services in rural and remote Australia by witnesses at every hearing and in over half of the submissions received by the committee...for consumers whose only mental health service option ‘is to travel to another location, it may mean a whole day or two off work rather than a lunch hour appointment, as would be possible for a city dweller” (Parliament of Australia, 2018, p.70).

Surveys conducted by mental health peak bodies show many mental health consumers consider that transport is a major barrier to accessing services and is itself a cause of mental health issues (Bishop et al, 2017). Difficulties are compounded for socio-economically disadvantaged people due to: less likelihood to own a vehicle; costs of fuel over long distances; unsealed roads in more remote areas. It has been estimated that, in rural areas, half the population has no access to public transport or air transport.

d. Costs

We could find no systematic published evidence about out-of-pocket direct costs of mental health care, for consumers in different areas of Australia. Some general evidence sheds light on this topic. In general, people living in disadvantaged areas are twice as likely to delay or not fill a prescription compared with people living in advantaged areas (by SEIFA indicators); and people on lower incomes are more likely to forego health services due to cost (Duckett et al, 2017). People living outside Major cities are more likely to delay or avoid using health services due to cost and there is less bulk-billing by GPs outside Major cities. Out-of-pocket charges for allied mental health services are high compared to physical health conditions and over 40% of people with depression, anxiety and other mental health conditions skip treatment due to cost. Medicare rebates for mental health are low relative to fees charged by practitioners. People with mental health problems are more likely to use GPs as they are cheaper than specialist practitioners (Callander et al, 2017). The Better Access Program which allows access to subsidised therapy if the patient has a mental health plan, agreed by a GP, is used more in richer urban areas than in poorer non-urban areas (Rosenberg, 2019).

Combined, this evidence suggests high relative cost burdens for rural people with mental health challenges.

6. Service fragmentation

The Senate Inquiry (Parliament of Australia, 2018), RFDS report (Bishop et al, 2017) and the National Mental Health Commission (Australian Government, 2014) all highlight fragmented rural mental health service provision – due to multiple providers and inputs to mental health care from multiple systems (e.g. NDIS, mental health system, physical health system):
“Throughout the Inquiry, the committee heard that the way mental health services in Australia are funded and commissioned can be complicated, confusing and frustrating for many service providers and consumers in remote and rural Australia” (Parliament of Australia, 2018, p.17).

Research by Henderson and colleagues (Henderson et al, 2018a; 2018b; 2019a; 2019b) confirm that “there is evidence of systemic fragmentation” and list the multiple sources of fragmentation, including:

• Competitive, short-term contracts, for individual service provider organisations;

• Primary Health Networks (PHNs) are distantly located and lack local connections and relationships to enable service collaboration at community level;

• Clinical/health focus versus social/community needs – PHNs commission health services using the Mental Health Services Planning Framework (designed for ‘ideal’ metropolitan situations); and are separate to the National Disability Insurance Agency (NDIA) which is responsible for social aspects of care/support.

• State versus Federal funding – the States and Territories are responsible for funding secondary/tertiary mental health services while the Federal Government commissions primary mental healthcare through PHNs.

• Mix of (competing) NGO, public and private providers – moves to contracting have multiplied the numbers of providers and set them up to compete with each other for contracts.

There are no incentives structures for collaboration – although policy documents state that collaboration is necessary. The Senate Inquiry (Parliament of Australia, 2018) provided some examples of experiences on the ground, e.g.:

“The Aboriginal Medical Services Alliance Northern Territory (AMSANT) described how FIFO [fly in, fly out] workers do not build relationships with the community and the impact this has on service delivery: sometimes there is no cultural safety awareness. There’s also the flying in and flying out and not having access to actual community members on the ground. They might not be there for appointments or they might not show up. What we find is that, when people are within the community and have those relationships, they’re able to drive around and find the people that they’re meant to be meeting with and meeting in a safer environment. The people who fly in and fly out may not necessarily have that sort of relationship with community members to be able to have an understanding of where to meet and that sort of thing. Senate Inquiry (2018, p.40).”

**Problem summation**

While the evidence portrays a complex array of causes of the rural mental health and health service situation, overall analysis suggests there are actually two fundamental problems:

1) Social Disadvantage: Firstly, there is significant rural and remote socio-economic disadvantage, which is exacerbated by poor access to a range of amenities. Long-term economic decline has led to many (but not all) rural and remote places facing a long-term decrease in economic activity which, in turn, results in loss of local infrastructure and leaders and associated, hard to measure, feelings of hopelessness. Simultaneously, effects of climate change brings pressures that are both financial and tangible, but also effects that are less tangible in terms of eroding mental wellbeing and emotional resilience. Chronic social disadvantage and historical and cultural trauma experienced by many Indigenous people living in remote and rural areas compounds the rural/remote disadvantage scenario.
2) Service and Support Systems: Secondly, the service and support system has been unable to match the needs of people living in rural and remote areas. Service system structures and tools have not addressed the issue that rural and remote places need to have different ways of providing services compared with urban places. While urban-devised systems are intended to provide efficiency, these systems are actually inefficient for rural areas – they appear costly (by available data – see Appendix 4) and people are falling through the gaps resulting in suicides and emergency admissions. Systemically, changes in recent years have resulted in service fragmentation – with effects such as competition rather than collaboration between service providers on the ground. The result is challenges for people in immediate need on the ground in remote and rural locations who require timely, joined-up services to avert crisis and preserve best quality of life.

This situation can be changed. Some communities, health services, States and Territories and Primary Health Networks and Councils appear to be already taking steps as outlined in further sections.
Qualitative evidence
Introduction

This section summarises features of Primary Health Networks, which are a key part of the current service system, presents evidence about emerging national and international innovations, summarises interviews with expert stakeholders, and provides an overview of philanthropy targeted at rural mental health.

Primary Health Networks

Figure 15 provides an overview of Australia's mental health care system (AIHW, 2018c). Appendix 5 provides information about all aspects of the system.

Fig 15 The mental health system as depicted by Australian Institute of Health & Welfare

There are 31 PHNs in Australia and 15 of these cover non-metropolitan areas. PHNs are responsible for planning and commissioning: low intensity mental health services; early intervention for children and young people with, or at risk of mental illness; psychological therapies for people in under serviced and/or hard to reach populations; clinical care coordination for people with severe and complex mental illness; suicide prevention; and Aboriginal and Torres Strait Islander mental health services (Australian Government Dept. of Health, 2017). PHNs must:

• Implement guidance from Federal government; and
• Provide services that match population health level needs.

a. Guidance from Federal Government

PHNs use the National Mental Health Service Planning Framework to assess services and workforce needed (National MHSPF, 2019). This tool enables PHNs to input data about need and prevalence and helps to identify optimum service models. An adapted tool for rural and remote areas planning is under development.

The ‘stepped care’ approach is used by PHNs to categorise mental health need. The principle is that a ‘person presenting to the health system is matched to the least intensive level of care that most suits their current treatment need’ (Australian Government Department of Health, 2017, p.9). Figure 16 shows the stepped care approach. There has been some discussion that the stepped care model is not appropriate for use with remote and rural populations and others have suggested that it needs to be adapted for rural settings.
b. Services that match population health needs

PHNs use a range of data to assess mental health need including performance and outcomes data about commissioned services, GP data, consumer survey data. The Commonwealth government is working with PHNs to improve these data, including developing a minimum basic data set. PHNs also gather qualitative data about consumer and provider experiences and have a role in driving collaboration between services. According to one PHN mental health commissioning manager interviewed: “there is an expectation that we develop a community of practice and collaborative governance; there are clauses about being integrated and collaborative in contracts”. Service providers (contracted by PHNs to provide health services) are encouraged to attend regional forums. With the NDIS developments, this is a new set of relationships that have to be developed.

The PHN mental health commissioning manager that we interviewed noted that, to date, there has been a gap in data sharing between Federal and State government levels, but we were told that platforms for data sharing are under development. This will enable preparation of regional mental health and suicide prevention plans. At present, the NDIS is not part of this process, but will be in the future.
Innovations in rural mental health care

1. National innovations

Consistent types of innovations in rural mental health care were found in the literature and through expert interviews. These are summarised below.

a. Community wellbeing initiatives

A number of initiatives have emerged as a response to suicide rates and concerns about social isolation and wellbeing. Examples are:

Our Healthy Clarence: this initiative has been evaluated by Powell et al (2019). It came about in 2015–2016, in the Clarence Valley, Northern New South Wales as a response to a high number of deaths by suicide. It is a community-wide positive mental health and wellbeing initiative established following community consultation, surveys and workshops. It uses a strengths-based approach to suicide prevention, health promotion, prevention activities, advocacy, and cross-sectoral collaboration. Powell et al (2019) suggest the initiative could be a model for other communities to address suicide, self-harm and improve wellbeing on a whole-of-community scale.

As part of a project funded by the Helen McPherson Smith Trust, Farmer and colleagues identified 27 individual community wellbeing initiatives that had been established in Victoria alone (paper in preparation). These variously targeted mental health, well-being and suicide prevention initiatives included: Every Life Matters (Castlemaine, Vic) started by members of the community who were affected by a suicide in their family; Live4Life (Macedon Ranges), a community response to reports from health and emergency services of increase in depression, anxiety, cyber-bullying and self-harm; HALT (across Victoria), an initiative started by and targeting ‘tradies’ following suicide by a rural Victorian tradesman; the Tree Project (Strathewen), a response to trauma of Black Saturday bush fires; Ride4Life (Bendigo), a mental health awareness raising initiative by motorcycle riders; This Farm Needs a Farmer (Kyneton) to address social isolation of retired farm workers.

The RFDS (Bishop et al, 2017) report on remote and rural mental health lists a number of Social and Emotional Wellbeing (SEWB) Programs that RFDS runs or contributes to (Bishop et al, 2017, p.11).

Some of the expert stakeholders interviewed for this review, as well as the Senate Inquiry (Parliament of Australia, 2018; pp.119-122), discussed the work of Indigenous Social and Economic Wellbeing programs, highlighting their value for Indigenous people and that they should receive more emphasis and funding.

b. Early intervention initiatives

Some health services, sometimes in partnership with local councils and other community organisations have developed mental health community outreach worker roles. For example, a current scheme in West Wimmera, Victoria is the ‘Rural Outreach Worker Scheme’. The workers are funded by a partnership between health services and councils to: respond to individuals who are in psychological distress and may be showing early signs of mental ill-health; provide community awareness sessions; liaise with local police and emergency services for early intervention and prevention. The outreach worker role is designed to respond to a community member’s need for immediate support and to assist them to navigate and access services. The Rural Outreach Workers do not provide therapeutic or clinical interventions, rather, their responsibility is to respond to the person’s immediate needs and connect them with the service or supports that meets their needs.

Similar roles have been found in other parts of Australia, including the: Rural Adversity Mental Health Program (RAMHP) workers in NSW [www.crrmh.com.au/programs-and-projects/ramhp/]; and the Rural Alive and Well Scheme in Tasmania [www.rawtas.com.au/].
c. Skills escalator and ‘grow your own’ workforce initiatives

These initiatives are targeted at enabling greater flexibility to deal with problems in communities, engaging a range of workforce. Plans and reports provide examples:

Advancing rural and remote service delivery: strategy for Queensland 2017-2020 (Queensland Government, 2017): features ways to further develop existing workers in rural communities, growing rural generalists and training staff in leadership, telehealth and digital literacy, improving housing and Wi-Fi access; and looking at ways to grow connections between health workers.

Building a sustainable health workforce for rural NSW (NSW Health, 2015): features effective use of workforce where they are located, building collaboration and leadership, supporting local decision-making.

A sustainable rural and remote workforce for disability (Centre for Applied Disability Research, 2018): based on a review of the evidence, provides guidance about how to develop a rural and remote disability workforce including using local and outreach workers collaboratively, technology, local community based ‘quasi or non professional workers’ and community-centred principles.

Mental Health Peer Workforce – Health Workforce Australia recently evaluated peer workers in mental health. The document highlights that ‘peer workers have been identified as able to contribute to better health outcomes... there is evidence to suggest that peer workers offer a number of benefits and can reduce the rate of hospital admissions for the service users with whom they work’ (Health Workforce Australia, 2014, p.9).

d. Service integration initiatives

These initiatives are about encouraging agencies to work together so that local timely access to services can be provided and services work collaboratively around a person. Examples found are:

Murray PHN Integrated Health Networks (Murray PHN, 2019): this initiative came about to address service fragmentation, and to design the best care for patients with the most complex care needs. The Integrated Health Networks involve establishing networks of providers across communities in a region, joint planning (covering populations of 30-50,000), co-designed referral pathways and clinical governance, shared business costs and pooled funding. This initiative is not specifically targeted at mental health care, but applies across primary care.

Western Australia Primary Health Alliance (WAPHA, 2019) - the WAPHA Framework for Integrated Primary Mental Healthcare - the WAPHA model is designed to provide quick access to mental health services for people in need. It is aimed at community-based early intervention, enhanced support for those with limited access to services and better services for those with high unmet need. Care is provided by GPs, with psychologist supports by phone, community supports and an integrated care management model. WAPHA has adopted the ‘European Alliance Against Depression Model’ which has four pillars: education for primary care providers, a public marketing campaign about mental health, trained community facilitators and interventions with targeted groups.
Mid North Coast Model (Mid North Coast Local Health District, 2015): this initiative aims for rapid assessment and treatment of mental illness, in the community. The model involves shared clinical governance and quality assessment, joint care planning and conferencing, clear roles and responsive acute treatment in the community.

Orange Shared Case Management model: this was developed at the Orange, NSW GP practice and involves shared case management and planning for people with mental illness, in primary care (Fitzpatrick, 2018).

2. International innovations

A limited amount of evidence about international innovations in rural mental health was found. Below, a brief summary of some initiatives is provided:

Nuka System (South Central Foundation (SCF), Alaska) is an Alaska Native customer-owned system that has a range of community mental health services including crisis intervention, medication management and psychotherapy through village providers, telemedicine and scheduled on-site clinical services. The Nuka approach has 3 main elements: integration of mental health into primary care; learning circles – a form of therapy group based on storytelling and listening and run by therapists or clinicians; a client co-designed intake process for mental health which enables same day access to services (South Central Foundation, 2016).

Canada – a summary of ‘mental health approaches for rural communities’ was found and included: telepsychiatry; integrated care; treating mental health as a public health issue including running programs on mental health resilience, illness prevention and mental wellness. Caxaj concludes that “community-based approaches are the most appropriate strategy to help enhance local capacity.” (Caxaj, 2016, p.40).

European Alliance Against Depression Model – this approach is operational in 100 European regions and has a demonstrated 24% reduction in suicidal acts over two years. It has four levels of intervention: co-operation between primary and mental healthcare, focusing on training GPs; public awareness campaigns; co-operation with communities; support for people at high risk and their relatives.

World Health Organisation Mental Health Gap Action Programme – provides a set of operating processes, training materials and apps so that communities in low resource settings can skill up local communities and local practitioners in ten priority mental health conditions.

3. Summary of innovation findings

The findings about innovations suggest a consistent set of ways that communities, services and commissioners are evolving in order to address rural mental health system problems. However, at present – certainly in Australia – the initiatives developed appear to be ‘one-off’ with individual communities, services and commissioners developing their own initiatives. Some community wellbeing and local health service early intervention initiatives can be hard to sustain financially, over time.
Interviews and field analysis

Interviews were held by phone with nine expert stakeholders*. A summary of topics raised is given below – for full summary see Appendix 6.

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<th>Topics</th>
<th>Expert Interviews</th>
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<td>Who are key advocates, policymakers &amp; philanthropy?</td>
<td>Summed up by the conclusion of one interviewee - “a vacant space”</td>
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<tr>
<td>Would make change in short-term?</td>
<td>Operationalise the Orange Partnership declaration; develop integrated health precincts; enable counsellors to access Medicare Benefits Scheme; run parenting interventions; extend access to internet; extend mental health literacy; help communities to co-design wellbeing initiatives; better mental health data</td>
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<tr>
<td>Would make change in longer-term?</td>
<td>Develop rural-specific service, workforce, management and funding approaches, data linkage, place-based programs for community resilience and mental health training, capacity-building for PHNs and local government; make mental and physical health have the same priority for government, data agencies and research bodies</td>
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*Expert stakeholders interviewees include: senior health services, policy and research stakeholders. In addition, we conducted a field analysis within the research team which includes a number of experts in rural mental health – for full field analysis, see Appendix 7. The main conclusions of the field analysis were: there is a lack of rural-specific planning and management tools; a fragmented evidence based with considerable gaps (see later for a summary of research and data gaps); a lack of national advocacy and little targeted philanthropy.

Philanthropic funding review

A review of funding was conducted by examining Grants Hub, Philanthropy of Australia’s Directory of Funders, Grant Guru and the Fundraising Research and Consulting Gift Search database. Full findings are at Appendix 8. We found little specific philanthropic directed to rural mental health; examples found were:

- Foundation for Rural & Regional Renewal (FRRR) ($10-$40k grants annually) (community wellbeing type initiatives)
- Helen McPherson Smith Trust (mental health services) ($200k annually)

Some funds targeted at mental health, specifically mentioned rural mental health as included:

- Wilson Foundation (‘non-pharmacological approaches to improve brain and mental health outcomes’) by invitation – amount unspecified
- Gandel Philanthropy (‘longer-term positive social impact’) by invitation ($40k-$250k)
- BreakThrough Mental Health Research Foundation (‘precision research, early interventions, new technologies, next generation therapies’)
- Ian Potter Foundation (‘mental health, Indigenous health and health in rural and remote areas’) – amount unspecified
- Australian Men’s Shed Association (‘males with a mental illness... males living in rural and remote areas’) up to $500,000
• Channel 7 Childrens Research Foundation of SA – children’s mental health $100,000
• Geelong Community Foundation – depression related to violence $40k

Some funds mention inclusion of rural communities, but many offer only very small or unspecified amounts. We found some large amounts for general mental health e.g.:

• Ian Potter Foundation - $3m for Orygen, National Centre for Excellence in Youth Health (2016)
• Gandel Philanthropy - $1.25m for Orygen
• Colonial Foundation - $46.2m for Orygen
• Paul Ramsay Foundation - $14.7m for Black Dog Institute
• Bendigo Bank - $1.2m to Menslink (mental health and wellbeing of men)
• Future Generation Global Investment Co. - $2.25m for BlackDog Youth Centre
• Wilson Foundation - $1m to Deakin University ‘microbiome and mental and brain health’
• Harold Mitchell Foundation - $5m to Florey Institute – dementias, depression, etc

Many donations are recorded with amount ‘unspecified’ but to general mental health and not rural.
Findings synthesis and directions
Introduction

In this section, evidence is synthesised to provide summaries of: data and research gaps; suggested areas for philanthropic activation; and potential partners.

Data gaps

The review raised a number of gaps in available data that should be addressed:

1. Routine demographic analyses by ABS remoteness categories: official statistical publications and reports do not routinely include spatial location (e.g. by the five ABS rural-urban categories) as a demographic factor. Thus, while reports routinely show data by age, male/female, socio-economic disadvantage, by State or by Indigenous/non-Indigenous population, routine analyses by rural-urban are often unavailable. It might be possible to obtain data-sets by spatial categories, by contacting the ABS/AIHW, but the limited timescale and resources of this project precluded this. However, since Australia has such significant rural and remote landmass, it is a gap that data are not routinely analysed by the five ABS spatial categories; or by: major cities; inner regional; outer regional and remote (noting that numbers can small for very remote areas and reports could be sensitive).

2. More data about mental illness and services are needed: reports specifically about rural and remote health such as the recent (Oct 2019) release from AIHW contain little evidence about mental illness or mental health service accessibility. Rather, their focus is on physical health conditions and numbers of health professional workforce.

3. Costs of mental health services for consumers: no systematically collected data, by ABS remoteness categories, could be found on out-of-pocket costs for patients/clients.

4. More informative evidence about suicide (if possible): fine grained analyses of suicides, by ABS remoteness categories and Indigenous vs non-Indigenous people could not be found, perhaps due to the sensitivity of such granular data. It is therefore difficult to definitively assess the extent to which higher suicide rates in remote areas is associated with higher Indigenous population.

5. Consumer experiences of mental health services: we note that the ‘Yes! Survey’ is increasingly being used. It is encouraging that this has been taken up and is available to NGOs. We have not systematically examined the Yes! Survey or its current geographical uptake across Australia, but note that it measures clients’ experiences once they have accessed and used a service. The survey does not capture experiences of navigating, finding out about eligibility, waiting, delays and the process of seeking services to address multiple or complex need.

6. Data about mental health service availability that can be benchmarked internationally: The Centre for Mental Health Research at the Australian National University (ANU) have developed a Mental Health Atlas methodology, using the international DESDE classification. To date, data have been gathered for two rural Australian PHNs. It would be useful to have this data for all Australia. This would enable analyses of associations between service availability, utilisation and health outcomes; and international comparisons.

7. Data enabling tracking of climate related events and mental health impacts: it would be useful to have data over a long timespan, examining associations between mental health and climate change. Current data are limited to cross-sectional smaller studies.
8. Activity of mental health NGOs: activity data about/of mental health services provided by NGOs is noted as a gap by the AIHW.

9. Activity of telehealth and online providers: there is a gap in data about use and costs of these services, to consumers.

Research gaps

The main research gaps identified were as follows:

1. Climate and social stress and mental health: there is a gap in longer-term research at scale that tracks associations between place-based social and climate stresses, and mental health and wellbeing indicators and outcomes. There would be value in tracking factors associated with the economic and social decline of smaller rural towns and settlements such as those highlighted by the Productivity Commission’s (2017) Transitioning Rural Regions report: including social isolation, loss of community leadership, declining amenity and infrastructure; and climate stresses; against mental health outcomes.

2. Mental health consumer experiences across Australia: there is a gap in qualitative evidence about experiences of consumers in finding the help they need. Qualitative research would track patient journeys, costs, choices, assessments of quality, safety and cultural safety and other issues deemed significant by mental health consumers themselves.

3. Collaboration incentives and measures: systems and services are repeatedly highlighted as fragmented. Yet integrated services are significant for mental health improvement. Given this gap, research to explore how to incentivise organisations to collaborate would be valuable. A collaboration outcome measure could be developed from this work.

4. Online and telehealth services utilisation: there is a significant gap in knowledge about service providers, service utilisation, by whom, costs, efficiency and effectiveness, and the relationship between these types of services and traditional face-to-face services.

5. Evaluation and scaling of emergent initiatives: a range of national and international innovations (see sections above) were surfaced through this review. It currently appears that each initiative builds from its own scarce resources and many are unevaluated. It would be beneficial to evaluate these emergent initiatives with a view to developing evidence of what works, examining how to scale-up initiatives and to provide evidence-informed toolkits so that other communities and services can build impactful initiatives and learn from each other.

6. Social support services and their accessibility: we found no evidence of research to find and ‘map’ the range of social support services that would be valuable to support people with a range of mental health conditions.
Areas with potential for philanthropic activation

Interviews and research have uncovered some areas of focus that philanthropic organisations, working with communities, could usefully address to:

In 10 years, make a substantial improvement in rural Australians receiving appropriate help for their mental health and wellbeing needs.

The suggested areas are distinct from, but complement, recommendations of recent reviews such as those of the Senate Inquiry (Parliament of Australia, 2018) and the RFDS (Bishop et al, 2017). These interventions are intended essentially to activate rural mental health as an area of action, research and policy movement - targeted at improving outcomes. Rural mental illness and suicide are likely to be related to social disadvantage so interventions to address social disadvantage in rural areas are significant here, but we did not focus on finding these in this review. Rather, we focused on rural and remote mental health, supports and services. As has been seen, this is a specific field with little systematic research evidence about what works and what data gaps exist so it is difficult to advise on scaling up existing interventions or initiatives. The types of initiatives found during the review require research and evaluation to assess whether they work. A range of investment foci were suggested by expert stakeholders at interview so there was no consensus about where to invest.

Because of these issues, we focus on investments intended to activate the field.

1. Advocacy: “it’s a vacant space” (expert stakeholder interviewee)

We define advocacy as activities aiming to influence decisions within political, economic, and social systems and institutions.

The review found a glaring gap in advocacy in rural and remote mental health.

Rural and remote mental health falls between the areas of rural health and mental health which each individually has a field of work, but the cross-over between rural health and mental health receives relatively little attention (other than to highlight alarming suicide rates). Another subtlety is that it may appear that remote and rural mental health is ‘taken care of’ in Aboriginal health. However, as has been shown in this review this issue is by no means clear and non-Indigenous people are also implicated in emergency hospitalisations, aeromedical evacuations and suicides.

Expert interviewees noted that there is less emphasis on mental health in the overall health system (one indicator is that there is much less routinely collected national data about mental health issues, in comparison with physical health issues).

It is significant that no organisations or policy leaders could be identified as associated with rural mental health in interviews or literature review; nor could significant philanthropy be found that focused on rural mental health.

The only significant figures that were consistently associated with advocacy for rural mental health are Russell Roberts (editor, Australian Journal of Rural Health), David Perkins (Director of University of Newcastle Centre for Rural & Remote Mental Health) and, regarding Aboriginal and Torres Strait Islander mental health - Pat Dudgeon (University of Western Australia) and Ngiare Brown (National Mental Health Commissioner). The Orange Partnership was noted by some as a novel addition to the field that had produced a declaration about rural mental health, but as one expert interviewee noted – this now needs operationalised into a plan for change.
Investment in advocacy would:

• raise awareness of the problem of rural mental health;
• catalyse a movement and a ‘brand’ for existing stakeholders to follow;
• provide a neutral gathering ground bringing together the various stakeholders;
• drive for implementation of findings of reviews;
• drive for appropriate research and data;
• drive for evidence-informed practices.

It is important that this advocacy space is not hijacked by professional bodies or groups that tend to be territorial. Indeed, the advocacy space might be much more driven by a community development ethos, a key direction implied as important across policy recommendations and research reviews.

2. A clearing space: This idea for investment lies somewhere between advocacy and capacity-building and would, ideally, be linked with both.

A clearing space is some form of organised group that drives collection and distribution of evidence-informed information.

During the review, several emergent initiatives were found that were targeted at improving aspects of mental health and wellbeing. This includes Community Wellbeing initiatives, Early Intervention initiatives, ‘skills escalator’ and ‘grow your own’ initiatives to develop flexible workers that can provide timely intervention and referral for those in immediate need in communities, and Service Integration initiatives to drive services to collaborate.

Some of these emergent initiatives have been evaluated. A clearing space would collect the initiatives, drive for evaluation and disseminate evidence-informed practices using guidance, toolkits and training. A message from reviews is that individual communities need their own place-based and co-designed initiatives, but a clearing space would provide examples, evidence, capacity-building and support.

Investment in a clearing space would:

• raise the profile of rural and remote mental health initiatives as evidence-informed;
• enable each community, health service or PHN to save time/resources as they would not all be ‘re-inventing the wheel’;
• empower communities to help themselves;
• enable under-resourced/less innovative communities, health services or PHNs to activate;
• catalyse improvement by providing toolkits for change to underpin local collaborative co-design.

Such an initiative could be built as a project with a 5-10 year lifetime. Thus emphasising action, rather than supporting an ongoing institution.
3. Capacity building: From the review, evidence from expert interviews and literature supports the idea of building capacity among key stakeholders to drive improvement in rural and remote mental health.

Capacity building is the process of developing and strengthening the skills, abilities, processes and resources that organisations and communities need to adapt and thrive.

Entities suggested as benefitting from capacity-building were identified primarily as local government (present locally with a wide community wellbeing remit) and Primary Health Networks (tasked with commissioning mental health services to meet needs).

Considering areas that are not already activated by other entities (e.g. mental health first aid is a movement that is potentially already activated), capacity-building would target:

1. Capacity to generate community-level resilience-building;
2. Capacity to build collaborations, partnerships and integration at system and individual client care levels;
3. Capacity to use and implement learnings from existing initiatives (via the ‘clearing space’ idea indicated above).

Investing in capacity-building would:

- recognise the role of local organisations in driving change and collaboration;
- support communities to help themselves;
- enable communities and local stakeholders to co-design place-appropriate solutions;
- address key gap issues emerging from the review – resilience, collaboration and integration, scaling evidence-based initiatives.

Some expert interviewees noted that, in lieu of local mental health services, some councils were moving to address community wellbeing. Others noted that initiatives that had previously been successful in supporting collaboration at community level are now missing – e.g. Partners for Recovery, meaning a lack of impetus supporting collaboration.

Another area for building capacity raised by one expert interviewee was running community programs in parenting, although he also noted a lack of evaluation evidence for the specific program that he named, in a rural Australian context.
Potential partners

Any potential work in this field should be pursued with partners. The following potential partners* were identified:

<table>
<thead>
<tr>
<th>Community-level stakeholders</th>
<th>Universities/ research</th>
<th>Organisations including philanthropy</th>
<th>Policy &amp; government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Networks</td>
<td>Orange Partnership</td>
<td>Foundation for Rural &amp; Regional Renewal</td>
<td>National Mental Health Commission</td>
</tr>
<tr>
<td>Local Government</td>
<td>Australian Journal of Rural Health/ Russell Roberts</td>
<td>Helen McPherson Smith Trust</td>
<td>Rural Workforce Commissioner</td>
</tr>
<tr>
<td>Country Womens Association</td>
<td>Flinders University (Julie Henderson team)</td>
<td>Gandel Philanthropy</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>Police &amp; emergency services</td>
<td>Black Dog Institute</td>
<td>Ian Potter Foundation</td>
<td>State consumer health peak bodies</td>
</tr>
<tr>
<td>RFDS</td>
<td>National Centre for Farmer Health</td>
<td>Bendigo Bank</td>
<td>Health professional bodies</td>
</tr>
<tr>
<td>Men's Shed Association</td>
<td>Pat Dudgeon, UWA</td>
<td>Online services providers</td>
<td>Indigenous health professional bodies</td>
</tr>
<tr>
<td>National Rural Health Alliance</td>
<td>Lowitja Institute</td>
<td>NGOs (e.g. Beyond Blue, SANE, Headspace)</td>
<td></td>
</tr>
<tr>
<td>Australian Rotary</td>
<td>Menzies School of Health Research</td>
<td>Rural &amp; Remote Mental Health SA (training organisation)</td>
<td></td>
</tr>
<tr>
<td>Online service providers</td>
<td></td>
<td>Global Foundation</td>
<td>Paul Ramsay Foundation</td>
</tr>
</tbody>
</table>

*we did not specifically focus on Indigenous peoples’ mental health because we do not have Indigenous researchers on our team and we recommend that separate work would need to be conducted to fully explore this aspect.
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Appendices
Appendix 1: The Orange Partnership

This project is conducted by The Orange Partnership for Rural Mental Health – principal members are:

- Professor Jane Farmer, Director, Social Innovation Research Institute & Social Data Analytics Lab, Swinburne University of Technology, Melbourne, Vic. [lead on this project]
- Professor David Perkins, Director, Centre for Rural & Remote Mental Health (CRRMH), University of Newcastle, Orange, NSW
- Professor Luis Salvador-Carulla, Director, Centre for Mental Health Research, Australian National University, Canberra, ACT.

The mission of the Orange Partnership is to support rural communities to radically improve Australian rural mental health. The Partnership came together in Nov. 2018 in response to ongoing troubling reports about rural mental health experiences coupled with growing knowledge of community frustration and consequent community action. The three Directors have world-leading track records in rural health, mental health epidemiology, rural mental health and community co-design.

The Orange Partnership also has a wide range of other stakeholders, including health, medical, economics and social sciences researchers from multiple universities (e.g. UNSW and the University of Sydney); rural health services of diverse sizes in different States; and PHN managers. The partnership declared their action to improve rural mental health in The Orange Declaration on rural and remote mental health, which was published in the Australian Journal of Rural Health in 2019.

Due to its composition, the Orange Partnership is unique in its open-mindedness to diverse perspectives in mental health, its interdisciplinarity and access to a wide range of stakeholders all activated to change rural mental health; all underpinned by capacity to produce the best evidence using the most innovative methods, including through data analytics (Swinburne Social Data Analytics Lab), Mental Health Atlas methodology (ANU) & community co-designed mental health & wellbeing initiatives (U. Newcastle CRRMH).
Appendix 2: Research approach

Partnership group

A partnership group was assembled, consisting of three researchers from University of Newcastle Centre for Rural & Remote Mental Health (CRRMH), four researchers from Swinburne University of Technology Social Innovation Research Institute (SIRI) and two researchers from the Centre for Mental Health Research (CMHR), Australian National University. Members of this group held regular discussions and workshops.

Desktop research and analysis

The following data and evidence sources were identified and analysed:

• Published reports containing analysed/presented data e.g. from AIHW and ABS.

• Recent reports and reviews specifically about rural and remote mental health. Key sources are the Senate Inquiry (2018) and submissions; and the RFDS (2017) research report on rural and remote mental health.

• Summary data and information sheets from the National Rural Health Alliance.

• Recent national mental health policy documents including from/of, National Mental Health Commission, Australian Government Department of Health and documentation specifically regarding Primary Health Network (PHN) planning and commissioning.

• Current State and Territory mental health plans and strategies.

• Findings from a Scopus search for journal articles using the search string: “rural” AND “mental health” AND “Australia” AND DOCTYPE (article OR review) AND PUBYEAR > 2014 [This is a limited search, but was constrained by time and resources available].

• Findings from a Google Scholar search for “rural” AND “mental health” in relation to key identified countries/regions (specifically targeted at identifying government/region policy and initiatives reported in English language): Alaska, Canada, England, Finland, Iceland, Norway, New Zealand, Scotland, Sweden.

• Various papers and presentations found as a result of the expert stakeholder interviews.

• Field Analysis Workshop

• A workshop of the researcher partnership group was conducted to generate the field analysis.
Expert stakeholder interviews

Interviews were held by phone with nine expert stakeholders. These were identified as experts by the researcher partnership group and include: senior stakeholders from government, research plus health services (see later in this document).

Analysis of Senate Inquiry submissions

As there is a lack of data about consumer views on rural mental health, the 132 submissions to the Senate Inquiry (2018) that are available on the Inquiry website, were analysed applying a high level thematic analysis. This allowed identification of key themes about the challenges perceived by stakeholders about rural mental health.

Notes about this approach

Note that there are no Indigenous researchers on the research team and thus the Indigenous aspects of this research are only explored at a high level.
Appendix 3: Rural mental health costs of the systems

National cost of rural mental health: data are poor or non-existent as there is no specific initiative to calculate all the different costs pertaining to different system inputs at Federal, States, etc levels.

“Current reporting of mental health expenditure is limited due to data gaps and different methods for calculating expenditure” (National Mental Health Commission (2019) Monitoring Mental Health & Suicide Prevention Reform p.12)

Such evidence as does exist says:

$9.1bn was spent on mental health related health services in 2016-17 (crude extrapolation to rural @29% of population = $2.6bn)

Though a report by Nous Group and MediBank estimated all mental health expenditure annually at $28.6bn (crude extrapolation to rural @29% of population = $8.3bn)

Higher figures than the above are stated by the Federal Government.

Proportionately, monies are spent as follows: State and Territory governments: 62%; Federal Government: 33%; Private Health insurance companies: 6%.

Additionally, consumers pay out-of-pocket costs.

The above information is from [National Mental Health Commission (2019) Monitoring Mental Health & Suicide Prevention Reform].
Appendix 4: The service system

Federal Government

Medicare-subsidised mental health services are provided by general practitioners (GPs), psychiatrists, psychologists and allied health professionals (for example, through the Better Access initiative).

Subsidised mental health prescription medications are provided under the PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS).

Veterans health services are provided through the Department of Veterans’ Affairs.

Primary care commissioning and quality and access monitoring, is through Primary Health Networks (PHNs).

PHNs receive and distribute both quarantined funding for specific mental health services and a flexible funding pool for planning, integrating and commissioning other mental health services in each PHN’s local community. In 2018–19, the flexible funding pool represents around 59% of mental health funding to PHNs, while 32% is quarantined for youth psychosis and Headspace and 9% is for Aboriginal and Torres Strait Islander mental health.

Mental health and suicide prevention funding to non-metro regions is weighted by the Commonwealth Government to account for rurality, Indigenous status and socioeconomic status; this means that the funding per capita in these non-metropolitan PHN regions is around double that of metropolitan regions.

Grants-based mental health programs through five program areas: national leadership; primary mental health care; promotion, prevention and early intervention in mental health; psychosocial support; and suicide prevention. Funding is provided either directly to service providers for specific programs (for example, to Beyond Blue for the Way Back Support Service and to Lifeline Australia for telephone crisis services) or to Primary Health Networks (PHNs).

Aboriginal Community Controlled Health Services (ACCHS) are primary health care services initiated and operated by local Aboriginal and Torres Strait Islander communities to deliver comprehensive and culturally-appropriate health care to communities, and are controlled through a locally-elected board of management. ACCHSs receive grants for the operation of the service, targeted programs (such as child and maternal health), Medicare rebates, and other program funding through PHNs. Some ACCHSs also receive some grant funding through state and territory programs.

Social security payments also pertain; for example, through the Disability Support Pension.

The National Mental Health Commission.

Mental health research through the National Health and Medical Research Council.

State and Territory Governments

Management and administration of public hospitals and community mental health services. This includes: public psychiatric hospitals; psychiatric units or wards in public hospitals; community mental health services; residential mental health services; and commissioning of non-government organisations to deliver services.

State and territory governments also provide school psychologists, counsellors, guidance officers and nurses through their departments of education. These professionals can have a significant role in identifying young people with psychosocial, mental health or substance use
issues and providing follow-up care, particularly in remote communities.

In addition, several states have an independent mental health commission, each with different operating and reporting structures and responsibilities, but with a common goal of mental health reform.

**Shared Federal and State/Territory responsibility**

Funding of public hospital services based on an agreed national activity-based funding (ABF) formula as outlined in the National Health Reform Agreement.

Registration and accreditation of mental health professionals through the Australian Health Practitioner Regulation Agency (AHPRA). The National Disability Insurance Scheme is intended to facilitate access to mental health services for some people with mental health and psychosocial disability.

Homelessness services as outlined in the National Housing and Homelessness Agreement and suicide prevention (a National Partnership Agreement is in development).

The information in this section is from The Senate Inquiry (2018) into Accessibility and quality of mental health services in rural and remote Australia.
Appendix 5 Summary of interviews with 9 key informants identified as significant to rural mental health

1. Key leaders and advocates identified

Russell Roberts; Centre for Rural & Remote Mental Health (University of Newcastle)

The Orange Declaration Partnership [these were the only ones that came up consistently]
All agreed there is a big gap in advocacy specifically for rural mental health: “it’s a vacant space” (National Mental Health Commissioner)

Western Australia PHN Alliance seems to be the leading PHN/group mentioned at a community level: Country Womens Association, Local councils, local initiatives

Regarding Indigenous mental health: Ngiare Brown (Founding Director of Ngaoara, a not-for-profit dedicated to Aboriginal child and adolescent wellbeing which supports communities to develop strength based approaches to breaking intergenerational cycles of trauma and disparity.); Pat Dudgeon (Professor and Poche Research Fellow at the School of Indigenous Studies at the University of Western Australia) Sue Brumby, Centre for Farmer Health - training; Jennifer Bowers – prevention and early intervention training.

SUMMARY: Few leaders and no real advocacy

2. Key policymakers

Everyone said there are no policymakers and that, in the absence of policymakers – Russell Roberts & David Perkins of CRRMH are regarded as the key policy informants. Ngiare Brown is on the National Mental Health Commission

SUMMARY: No policy champions

3. Perspectives on causes of the problem

In order of most mentioned:

1. Rural decline/drought/financial problems and consequent loss of hope has led to ‘doom and gloom’ leading to higher rates of suicide and other aligned problems such as domestic violence, gambling and erosion of traditional male roles

2. Rise of competition/contracts and PHNs as commissioning organisations has led to a focus on episodic clinical inputs & a lack of focus/resources or incentives for collaboration. It has also led to ‘loss of a trust trail’ between clients, local providers and specialist networks.

3. There continues to be stigma around mental health

4. Entrenched social disadvantage is linked with poor parenting and impacted youth lives which cycles generationally

5. Payments systems for health professionals are not aligned with rural exigencies

6. Physical and mental health are dealt with by different systems and paradigms in rural areas, which is particularly inefficient because there is considerable co-morbidity and GPs/primary care deals with a lot of mental ill-health. Some Indigenous communities programs would be well-oriented to non-Indigenous communities as well.
7. PHNs are too big and their role is clinical/transactional so they cannot be local, relational or collaborative.

8. Loss of organisations, programs and incentives around local collaboration & joined-up working.

9. A medical/acute model is applied when much of the issue is prevention & early intervention and could be dealt with outside a biomedical/clinical model.

SUMMARY: perspectives vary somewhat in relation to informant's background, but most emphasise rural loss of hope, lack of service collaboration, inappropriate workforce and overly clinical approach as key problems.

4. Nature of the evidence base

It was generally agreed that there is some good evidence, but not systematised/systematic and not widely read. There are considerable gaps in data ('we are good at measuring dead people and physical health epidemiology'); and a particular gap is that no-one seems to know much about online offerings - what they are, who uses them and effects negative or positive?

SUMMARY: lack of relevant data & non-systematic evidence base.

5. Services provided – who/how

PHNs – considered to be commissioners that find it hard to get at local or joined-up due to their operating model from government.

NGOs – regarded as sometimes more concerned with their own survival and competing.

Local councils – regarded as taking up a lot of the slack (with variable competence & capacity) e.g. for population level wellbeing, community-generated initiatives and with the potential for a holistic view.

Councils were regarded as a particular opportunity by several informants.

Police and ambulance due to being the default position where there are no services or ‘when the mental health system has gone to sleep’

General practice – picks up a lot of community mental health and wellbeing; one informant said “85% of my work is mental health – this has changed in the last 5 years”

A range of other practitioners were mentioned including counsellors who are viewed as a valuable resource that cannot access medicare benefits. Online services, but no-one knew much about these.

SUMMARY: PHNs are distant – GPs/primary care and local government try to make things happen on the ground with varying capacity.

6. Key philanthropy

Rotary Generally agreed there isn’t significant philanthropic funding.

SUMMARY: little specific, at scale, to rural mental health & wellbeing

7. Immediate things that would make a difference

1. Take the next step with the Orange Declaration of the Orange Partnership - making an operational plan. Align this with taking the National Mental Health Plan and operationalising it for rural.

2. Develop health precincts with pooled funding and salaried workers; get these workers also to do community development beyond obvious health service provision; have good business management in this model.

3. Enable medicare access for trauma-informed counsellors

4. Run parenting and grandparenting (prevention/early intervention) programs using ‘Circle of Security’ course

5. Extend access to internet, telehealth, mental health literacy & awareness

6. Extend co-design approaches for communities to design their own initiatives

7. Data collection about and relevant to mental health and wellbeing

8. Place-based mental health literacy campaign

SUMMARY: Range of immediate solutions suggested.

8. Longer term things that would make a difference

1. Develop new service, workforce and management models (4)

2. Explore data linkage -> data-driven planning and management

3. New funding models

4. Place-based mental health literacy/mental health training/community development for wellbeing/develop community resilience (4)

5. Help relevant organisations to build capacity – local government & PHNs (2)

6. Make mental and physical health have the same priority

9. What should a philanthropy organisation fund that would make a difference and that shouldn’t be funded by government?

1. Focus on local government capacity building – mental health should be looked at as a community rather than an individual issue.

2. Fund development of health precincts

3. Fund locally-based ‘skills escalators’ so that local place-based workforce can be developed and capacity-built

4. Transport initiatives

5. Ensure there are accessible youth detox facilities for rural youth
6. Implement the ‘circles of security’ early intervention/prevention parenting program

7. Ways to use workforce differently

8. Community-wide initiatives to address social determinants and involving councils, schools, employment, health etc. and that acknowledges the interconnectedness of social determinants of health

**Appendix 6 Field analysis**

**Problem statement**
Change help seeking and help getting for rural Australians over the next ten years.

**Shared identity**
Communities, varying with capacity, take action; some examples of productive relationships with PHNs. High fragmentation operationally (actors, ‘world-views’, policy). Growing consensus on elements of ‘the problem’, but the field is overall characterised by competition rather than collaboration and lack of trust.

**Key players**
Health Minister, local councils/ mayors, Local health districts/PCPs, PHNs, Local Alliances, GPs, AOD services, Royal Flying Doctors, Headspace, NGO providers, ACOSS, schools & education, employers, Consumer and carer bodies, emergent community/lay/peer initiatives, peak bodies, research, Beyond Blue, Sane, Lifeline, Royal Far West, Justice system, Domestic Violence, distant online & telehealth providers.


**Standards of practice**
No rural approach – metro-centric perspective, needs different approaches. Workforce system is ‘rural light’. Specialist workers on higher pay scales – grade inflation. Broad/flexible scope of practice needed. Inexperienced workers – lack of supervision, high churn.

PHNs – regional planning -stepped care handed down from Federal govt. is overcomplicated. Medical & psychiatry-based model; deficit-focused and clinical rather than prevention/ promotion.

**Knowledge base**
National data are out of date. Widespread lack of data about everything in rural mental health. Evidence base is diffuse, no research of emergent novel approaches at scale. Traditional ‘clinical’ researchers vs disruptive new approaches e.g. community/ data-driven. Assumptions are made based on outdated myths e.g. re stigma - people are ready to talk over longer-term (though currently unresearched/ unevaluated). Key researchers – ORANGE Partnership – U. Newcastle Centre for Rural & Remote Health/ ANU Mental Health Atlas / Swinburne University rural health innovative data approaches and collective impact. Indigenous researchers & communities in research are key actors.
**Leadership and grassroots support**

Big gap in specific rural mental health leaders & advocates. Caught between mental health & rural health. Most leadership – CRRMH/RFDS currently.


Community: CWA, Farmers, Education Richmond Fellowship, PCYC, Men’s shed Clubhouse, Grow – peer support, Safe spaces, HALT. Some communities demonstrate strong leadership and collaborate together. Shortage of local leaders due to rural loss of amenity.

**Funding and policy**

Majority of funding is through government: Fed govt via PHNs - primary care – GP, MBS/ PBS; Headspace; Beyond Blue NGOs. States – specialist/acute; public/private. System set up for competition not collaboration on many levels. Research agenda - mainly via government - ARC, NMHRC, MRFF (but more clinical). Short term funding cycles.

Limited funding through philanthropy e.g. Global Foundation, Foundation for Regional and Rural Renewal, Rotary – clinical focus. Funding priorities across system – mental health is second/third in line. Parity of funding and esteem in mental health services with physical health services is needed. Little consideration of impacts of funding at social & correction systems on population mental health and wellbeing.
# Appendix 7 Review of philanthropic funding

This table lists grants that have a focus on mental health research across Australia. Eligible applicants include rural and regional communities.

<table>
<thead>
<tr>
<th>Name</th>
<th>Grants</th>
<th>Frequency of grant rounds</th>
<th>Next funding round</th>
<th>Funding Amount</th>
<th>Eligible Applicants</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Foundation for Rural &amp; Regional Renewal (FRRR)</td>
<td><strong>Caring for Ageing Rural Australians</strong>&lt;br&gt;One of the priorities of this grant is to improve community health and social wellbeing by supporting projects that address physical health, improved nutrition and access to fresh food and sustainable local food systems, projects that enhance mental health, and those which assist vulnerable, older members in communities to improve their health and wellbeing.&lt;br&gt;Small Grants Tier: $10,000&lt;br&gt;Larger Grants Tier: $40,000</td>
<td>Annual</td>
<td>Current round closes 24 Sep 2019</td>
<td>$10,000 - $40,000</td>
<td>Rural specific</td>
</tr>
<tr>
<td>The Foundation for Rural &amp; Regional Renewal (FRRR)</td>
<td><strong>In A Good Place Grant</strong>&lt;br&gt;The three objectives of this program is to:&lt;br&gt;1. Reduce social isolation&lt;br&gt;2. Increase social participation and connectedness&lt;br&gt;3. Increase help-seeking&lt;br&gt;4. Assist vulnerable members in communities to improve their mental health and wellbeing.&lt;br&gt;PRIORITY will be given to initiatives that:&lt;br&gt;1. Are delivered via non-clinical first providers of mental health care&lt;br&gt;2. Improve accessibility and availability of mental health services, tools or support&lt;br&gt;3. Provide innovative responses&lt;br&gt;4. Confront stigma surrounding help-seeking behaviour</td>
<td>Bi-annual</td>
<td>Feb 2020</td>
<td>$20,000</td>
<td>Rural-focused community assistance</td>
</tr>
<tr>
<td>Helen Macpherson Smith Trust</td>
<td><strong>Impact Grants for Health:</strong>&lt;br&gt;Goal is: to improve affordable access to quality health services in rural and regional Victoria. By supporting projects that provide affordable access to a full range of reliable, quality mental health services for Victorians living in rural and regional Victoria.&lt;br&gt;This grants program is ONLY available at the Impact Grants level and has one specific focus area.</td>
<td>Annually</td>
<td>28 July 2020</td>
<td>$200,000</td>
<td>Includes rural and regional communities</td>
</tr>
<tr>
<td>The Wilson Foundation</td>
<td>The Wilson Foundation partners with experts and communities to deliver impactful and lasting improvements to mental health. A key focus area of the Wilson Foundation is to progress cutting edge research and evidence based non-pharmacological approaches to improve brain and mental health outcomes.</td>
<td>Unspecified</td>
<td>Invitation Only</td>
<td>Unspecified</td>
<td>Includes rural and regional communities</td>
</tr>
<tr>
<td>Funding is by invitation only</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Gandel Philanthropy</strong></td>
<td><strong>Major Grants</strong></td>
<td>To provide more substantial and meaningful support to not for profit organisations to achieve stronger and longer-term positive social impact within the specified area of interest which includes health &amp; medical research. Selected organisations may be invited to apply throughout the year, while decisions will generally be made twice a year.</td>
<td>Unspecified</td>
<td>TBA</td>
<td>$40,000 - $250,000</td>
</tr>
<tr>
<td></td>
<td><strong>Flagship Grants</strong></td>
<td>Same as above</td>
<td></td>
<td></td>
<td>$2mill max</td>
</tr>
<tr>
<td><strong>Break Through Mental Health Research Foundation</strong></td>
<td><strong>Breakthrough research grants</strong></td>
<td>will support a broad range of mental health research ideas, with a focus on the four Breakthrough research themes:</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA</td>
</tr>
<tr>
<td></td>
<td>- Precision Research</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Early Interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- New Technologies</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>- Next Generation Therapies</td>
<td></td>
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<tr>
<td></td>
<td>The first Breakthrough Mental Health Research Foundation grant round will be announced in the near future.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>The Australian Men’s Shed Association</strong></td>
<td><strong>National Shed Development Programme (NSDP) Shed Grants</strong></td>
<td>Australian Government will allocate $1,000,000 (GST excl.) in the 2019/2020 financial year. There will be two funding rounds each allocated $500,000. Funding priority will be given to Health and Wellbeing and Events and Equipment to reflect Government policy, priority is also given to those Sheds in areas of greatest need and meet the needs of members from the designated Priority Groups which includes - Males with a mental illness (e.g. Depression) and Males living in rural and remote areas.</td>
<td>Bi-annual</td>
<td>TBA</td>
<td>$500,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The Ian Potter Foundation</strong></td>
<td><strong>Health and Disability Grants:</strong></td>
<td>Most recently, the Foundation has supported projects that seek to improve health outcomes for the Australian community through public health initiatives with a particular emphasis on mental health, Indigenous heath and health in rural and remote areas. Encourage innovative approaches to increasing employment opportunities for individuals with disability.</td>
<td>Annually</td>
<td>30 March 2020</td>
<td>TBC September 2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Illness Fellowship, Western Australia - Tecwyn Jones Grant</strong></td>
<td>In order to be eligible to apply for a grant, you need to become a MIFWA member by 31 December 2019. Next round of grants is January 2020.</td>
<td></td>
<td></td>
<td></td>
<td>$1,000.00</td>
</tr>
</tbody>
</table>
### Channel 7 Children's Research Foundation of S.A. Inc.

**Research Grants**

The CRF has announced the following research priority areas:
- improving child protection and its effects
- improving children’s mental health and the impact of developmental disorders
- reducing childhood obesity and its impact
- understanding the social determinants of childhood health and development

**Research projects funded**

<table>
<thead>
<tr>
<th>Annuality</th>
<th>Dates</th>
<th>Amount</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annually</td>
<td>Feb 2020 (EOI)</td>
<td>$100,000</td>
<td>Includes rural and regional communities</td>
</tr>
</tbody>
</table>

### Channel 7 Children's Research Foundation of S.A. Inc.

**Early Career Grants**

The CRF has announced the following research priority areas:
- improving child protection and its effects
- improving children’s mental health and the impact of developmental disorders
- reducing childhood obesity and its impact
- understanding the social determinants of childhood health and development

**Annually**

<table>
<thead>
<tr>
<th>Dates</th>
<th>Amount</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb 2020 (EOI)</td>
<td>$40,000</td>
<td>Includes rural and regional communities</td>
</tr>
</tbody>
</table>

### Geelong Community Foundation

**The Foundation’s key priority is to support programs which address the following issues:**
- Lower levels of education, professional skills and training
- Higher levels of poor physical health, such as obesity, poor diet and risk of harm from alcohol
- Higher levels of chronic disease, particularly in areas of identified disadvantage
- Higher levels of depression and crime associated with violence

**Annually**

<table>
<thead>
<tr>
<th>Dates</th>
<th>Amount</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb 2020</td>
<td>$40,000</td>
<td>Regional</td>
</tr>
</tbody>
</table>

### Black Puppy Foundation

**The BPF Travel Award**

The Black Puppy Foundation funds research in to mental health issues affecting Australia’s youth. This travel grant is an annual prize that is awarded to an enrolled PhD student. The award recipient uses the prize to fund a research trip to an international mental health conference of their choice.

**Annually**

<table>
<thead>
<tr>
<th>Dates</th>
<th>Amount</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBA</td>
<td>Unspecified</td>
<td>Includes rural and regional communities</td>
</tr>
</tbody>
</table>

### Black Puppy Foundation

**The Black Puppy Fellowship**

The Black Puppy Fellowship (‘the Fellowship’) is a full time position for a candidate in early career research in to youth mental health. This is the largest funding project undertaken by The Black Puppy Foundation and is run in conjunction with our partners at the Black Dog Institute.

**Every two years**

<table>
<thead>
<tr>
<th>Dates</th>
<th>Amount</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBA</td>
<td>Unspecified</td>
<td>Includes rural and regional communities</td>
</tr>
</tbody>
</table>

### The Gay and Lesbian Foundation of Australia

**Small Grants Program**

This small grant funds projects that directly or indirectly assist, involve and benefit LGBTQIA+ people and promote positive social outcomes and mental health in the community.

**Quarterly**

<table>
<thead>
<tr>
<th>Dates</th>
<th>Amount</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Dec 2019</td>
<td>$500</td>
<td>Includes rural and regional communities</td>
</tr>
</tbody>
</table>

### Healthway

**Health Promotion Research Grants**

The Grant will accept applications for research projects that deliver on Healthway’s strategic priorities; increasing healthy eating, increasing physical activity, improving mental health, preventing harm from alcohol, creating a smoke-free WA and Aboriginal health.

**Bi Annual**

<table>
<thead>
<tr>
<th>Dates</th>
<th>Amount</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 Octo 2019</td>
<td>Unspecified</td>
<td>Includes rural and regional communities</td>
</tr>
</tbody>
</table>
Research Projects Funded by Donors

This table lists research projects on mental health across Australia, which have been funded by Trusts and Foundations and other philanthropic bodies.

<table>
<thead>
<tr>
<th>Name</th>
<th>Links</th>
<th>Grants</th>
<th>Funded Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jellis Craig Foundation</td>
<td>Jellis Craig Headspace partnership</td>
<td>Official partner of <em>headspace</em>. the Jellis Craig Foundation committed funds to support the Food for Thought program, which aims to increase the confidence, skills and knowledge of key staff in secondary schools to enable them to identify early, intervene appropriately and support young people who may be experiencing disordered eating and other early warning signs of an emerging eating disorder.</td>
<td>unspecified</td>
</tr>
<tr>
<td>Ian Potter Foundation</td>
<td>Orygen mental health centre</td>
<td>Orygen, <em>National Centre for Excellence in Youth Health</em> (2016) Orygen, The National Centre of Excellence in Youth Mental Health, have been awarded $3 million (over 5 years) towards the establishment of modern health care and research facilities that will provide the base for the Orygen’s national and international leadership of innovative clinical care, cutting edge research, and education and training. It will house up to 500 staff and help treat thousands of young people each year. The $78 million project will rebuild dilapidated premises currently housing Orygen’s mental health researchers and clinical services in substandard facilities in Parkville, VIC.</td>
<td>$ 3 million</td>
</tr>
<tr>
<td>Helen Macpherson Smith Trust</td>
<td>Swinburne University of Technology</td>
<td>2019 Community Collective Impact: A best-practice, community-based approach to accessing rural mental health services.</td>
<td>$199,269</td>
</tr>
<tr>
<td>Helen Macpherson Smith Trust</td>
<td>First Step Program</td>
<td>First Step is unique in Australia, possibly the world, as a wrap-around addiction and mental health outpatient clinic with a fully integrated legal service. HMST funded this (multi-year grant) project for the purpose of (a) coherently explain First Step’s social impact in order to attract sustainable funding partners AND (b) test the efficacy of the business model in order to scale it.</td>
<td>$89,978</td>
</tr>
<tr>
<td>Helen Macpherson Smith Trust</td>
<td>The Royal Childrens Hospital Foundation</td>
<td>Building capacity of primary schools as a universal platform to address children’s mental health issues (multi-year grant). Scope and develop an innovative program to address rising child mental health issues using primary schools as a universal platform, co-designed with the Victorian Government (DET and DHHS).</td>
<td>$49,104</td>
</tr>
<tr>
<td>Gandel Philanthropy</td>
<td>Orygen</td>
<td>Orygen Youth Mental Health Gandel Philanthropy supports <em>Orygen Youth Mental Health’s Substance Use Prevention</em> for Youth Mental Health (VIC).</td>
<td>$1.25 million</td>
</tr>
<tr>
<td>Gandel Philanthropy</td>
<td>SANE Australia</td>
<td>Support for SANE In 2015, SANE built a new website service following extensive consultation with people living with a mental illness, their families and friends, integrating SANE’s Forums seamlessly along their chat facility. This allows people to visit SANE’s website for information on a specific illness can find out the latest conversations taking place on the topic around Australia. Gandel Philanthropy also supported the development of an innovative online application to help people living with bipolar, and those who care for them, to be alerted to the early onset of a potentially elevated period. SANE works with the University of NSW Department of Psychiatry and Isobar to develop this initiative.</td>
<td>$40,000 - $250,000</td>
</tr>
<tr>
<td>Gandel Philanthropy</td>
<td>Starlight Children’s Foundation Australia</td>
<td>Gandel Philanthropy funded research project, Livewire – Transforming the Hospital Experience for Adolescents in Mental Health Units through a major grant of 1-3 years.</td>
<td>$40,000 - $250,000</td>
</tr>
<tr>
<td>Foundation</td>
<td>Partnership</td>
<td>Description</td>
<td>Amount/Details</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
<td>-------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Abercromby’s Charitable Fund</td>
<td>Australian Communities Foundation</td>
<td>Official partner of BeyondBlue but is by invitation only. It is a sub-fund of Australian Communities Foundation. They do not have any funding rounds but they definitely have a big focus on mental health.</td>
<td>Unspecified</td>
</tr>
<tr>
<td>The Balnaves Foundation (Black Dog Institute)</td>
<td>Black Dog Institute partnership</td>
<td>The Balnaves Foundation Staff Grant (2019). This grant will support the Black Dog Institute to deliver a three-year roll-out of a large-scale evaluation of the “Building Educator’s skills in Adolescent Mental health” (BEAM) training program.</td>
<td>$100,000</td>
</tr>
<tr>
<td>Colonial Foundation</td>
<td>Colonial Foundation - SANE Grant Partner</td>
<td>Colonial has supported SANE by providing funding over a six-year period. Colonial’s funding is applied to scale up the capabilities and national reach of a key community service – the SANE Forums. The Forums are a national initiative that enables Australians affected by mental illness to connect online and to support each other through the provision of two online moderated forums: one for those with Lived Experience and the other for Carers.</td>
<td>Unspecified</td>
</tr>
<tr>
<td>Colonial Foundation</td>
<td>Orygen, The National Centre of Excellence in Youth Mental Health</td>
<td>The National Centre of Excellence in Youth Mental Health Colonially contributed $46.2million towards Orygen’s development of a comprehensive research base and service platform in youth mental health, including headspace centres and early psychosis centres throughout Australia. Orygen leveraged this $46.2million in philanthropic funding to generate nearly a billion dollars of Australian Government support for the youth mental health sector.</td>
<td>$46.2million (over 17 years)</td>
</tr>
<tr>
<td>Colonial Foundation</td>
<td>Orygen’s Capital Project</td>
<td>Orygen’s Capital Project The Foundation funded $5 million towards the redevelopment of a new purpose-built building at Orygen’s Parkville campus, which houses their clinical, research, policy and education and training services on youth mental health all under one roof.</td>
<td>$5 million</td>
</tr>
<tr>
<td>Paul Ramsay Foundation</td>
<td>Paul Ramsay official partner of Black Dog Institute</td>
<td>Is supporting the Black Dog Institute to implement LifeSpan, a world-first systems-based approach to suicide prevention. Over the next six years, LifeSpan will be implemented and evaluated in four regions across New South Wales. The foundation’s $14.7 million donation represents the single largest philanthropic donation to suicide prevention received in Australia. If successful, it is hoped that this program will provide the national framework for suicide prevention.</td>
<td>$14.7 million</td>
</tr>
<tr>
<td>Paul Ramsay Foundation</td>
<td>Paul Ramsay funds SANE Research</td>
<td>SANE Australia</td>
<td>Unspecified</td>
</tr>
<tr>
<td>Collier Charitable Fund</td>
<td>Melbourne City Mission</td>
<td>Frontyard Youth Services is the cornerstone of the Victorian homelessness service system and an important interface with mainstream and specialist services including out of home care, mental health, alcohol and other drugs, disability, family violence and youth justice. The Collier Charitable Fund has supported Melbourne City Mission for over 35 years and most recently supported the growth of our holistic therapeutic programs at Frontyard.</td>
<td>Unspecified</td>
</tr>
<tr>
<td>Minderoo Foundation</td>
<td>Riding for a reason</td>
<td>The Hawaiian Ride for Youth is held annually over 4.5 days, with riders travelling from Albany or Jurien Bay to Perth over a total of more than 3000kms to raise funds and awareness for Youth Focus. It is a unique independent for-purpose organisation that supports vulnerable young people in Western Australia by offering a range of mental health services. It operates with a team of highly trained and skilled psychologists, social workers and occupational therapists to provide a range of early intervention and prevention services free of charge, aimed at supporting young people and their families to overcome the issues associated with suicide, depression, anxiety and self-harm.</td>
<td>Goal of $1.8 million</td>
</tr>
</tbody>
</table>
David Jones  **Official Black Dog Institute Partner**

David Jones partnership with the Black Dog Institute (2016) will encourage Australians to maintain good mental health, in particular through **Black Dog’s Exercise Your Mood program**. David Jones donated 10% of activewear sales from August 28 till 11 September 2016, to support mental health research and programs.

<table>
<thead>
<tr>
<th>Bendigo Bank</th>
<th>Menslink</th>
</tr>
</thead>
<tbody>
<tr>
<td>Menslink provides mentoring to young men through tough times, which provides much needed support and the benefits are felt through the entire community. Menslink aims to improve <strong>mental health and overall wellbeing</strong> of men and their loved ones in Canberra. To date, the Canberra Community Bank Group has contributed over $1.2 million in profits to local organisations working towards a vibrant, thriving Canberra community.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HSBC</th>
<th>HSBC Community Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSBC is supporting delivery of two vital programs: 1. Development of an innovative adolescent online mental health clinic, delivered through Australian high schools 2. The national roll-out of <strong>mental health education programs</strong> to young people, health professionals and communities in rural and regional Australia.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HSBC</th>
<th>Twenty10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twenty10 is a Sydney-based service that works across NSW that provide a broad range of specialised services for young people aged 12-25 including housing, <strong>mental health</strong>, counselling and social support. HSBC supports the delivery of a series of skills-based workshops designed to keep young people engaged in education and to develop the soft skills required to secure gainful employment, while also connecting them with professional mentoring.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Ross Trust</th>
<th>The Mental Health Legal Centre (MHLC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Mental Health Legal Centre (MHLC) provides a free and confidential legal service to anyone who has experienced <strong>mental illness in Victoria</strong> where their <strong>legal problem relates to their mental illness</strong>. The Ross Trust funded their 2015 project Towards Effective Advanced Statement for Improved Recovery Journeys.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Ross Trust</th>
<th>HerSpace Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>HerSpace is a <strong>mental health provider</strong> and works with women and young girls (16 years and over) who self-identify as being impacted by experiences of sexual exploitation, regardless of race, culture, ethnicity or residency status.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Ross Trust</th>
<th>Macpherson Smith Rural Foundation Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Ross Trust funded Macpherson Smith Rural Foundation’s (now known as YouThrive) Building Leadership Capacity and <strong>Mental Health</strong> Awareness in Young Rural Victorians project over a span of three years.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Future Generation Global Investment Company</th>
<th>Designated Charity Snapshot:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Study – <strong>A stepped care online adolescent clinic to prevent mental illness:</strong> From 2016-2021, FGG will support Black Dog's Youth Centre for Research Excellence in <strong>Suicide Prevention</strong> and its mission to reduce suicide attempts and deaths in young people. This specific youth-focused research centre will develop solutions that lower suicide risk by implementing evidence-based therapies and programs leveraging technologies popular with young people, such as smartphones and social media.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Virgin Australia</th>
<th>Exercise Your Mood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virgin Australia have participated in Black Dog Institute’s annual campaign, Exercise Your Mood, to raise awareness on mental health and protection against depression.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CBH Group</th>
<th>CBH Group invests $300,000 into WA regional mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBH Mental Wellness Program The CBH Black Dog Mental Wellness Program has been designed to <strong>improve mental health</strong> understanding, enhance wellbeing and reduce the incidence and impact of mental health issues in grain growing regions of Western Australia.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EISS Super</th>
<th>Official funding partner of the Black Dog Institute</th>
</tr>
</thead>
<tbody>
<tr>
<td>EISS Super fund 10 training workshops that support mental health professional across metro and regional NSW.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Goodman</th>
<th>Goodman Grant Youth Education Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through the generous financial support from the Goodman Foundation, the Black Dog Institute is delivering INSIGHT, its youth mental health education program to high schools across Sydney and surrounding areas.</td>
<td></td>
</tr>
<tr>
<td>Foundation</td>
<td>Project</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Myer Foundation</td>
<td>Myer Institute funding partner of the Black Dog Institute</td>
</tr>
<tr>
<td>Australian Foundation for Mental Health Research</td>
<td>The RAFT Project</td>
</tr>
<tr>
<td>Myer Institute</td>
<td>The RAFT Project</td>
</tr>
<tr>
<td>The Ottomin Foundation</td>
<td>Supporting the Raise Foundation</td>
</tr>
<tr>
<td>Freemasons Foundation of Victoria</td>
<td>Let’s Talk</td>
</tr>
<tr>
<td>Supre Foundation</td>
<td>Headspace partnership</td>
</tr>
<tr>
<td>Wilson Foundation</td>
<td>Deakin University</td>
</tr>
<tr>
<td>Harold Mitchell Foundation</td>
<td>The Florey</td>
</tr>
<tr>
<td>Pratt Foundation</td>
<td>Centre for Women’s Mental Health</td>
</tr>
<tr>
<td>Freemasons Foundation of Victoria</td>
<td>Lodge Support Grants</td>
</tr>
</tbody>
</table>
## Government Grants

<table>
<thead>
<tr>
<th>Name</th>
<th>Grants</th>
<th>Frequency of grant rounds</th>
<th>Funding Amount</th>
<th>Rural/ Regional</th>
</tr>
</thead>
</table>
| **National Health and Medical Research Council** | 1. Investigator Grants, will consolidate separate fellowship and research support into one grant scheme that will provide the highest-performing researchers at all career stages with funding for their salary (if required) and a significant research support package.  
2. Synergy Grants, will provide $5 million per grant for outstanding multi-disciplinary research teams to work together to answer complex questions.  
3. Ideas Grants, will support innovative and creative research projects, and be available to researchers with bright ideas at all career stages, including early and mid-career researchers.  
4. Strategic and Leveraging Grants, will support research that addresses identified national needs. | Unspecified | Aboriginal community living in Murray |
| **Shire of Murray** | **Completing the Circle Grant**  
Funds projects that address mental health concerns for young Aboriginal people living in Murray.  
Investment into the Mental category includes projects that:  
- Provides mental health training and coping mechanisms;  
- Involves advocates sharing their mental health journey and providing advice;  
- Increases awareness and accessibility to services;  
- Provides participants with self-management skills and resources; or  
- Drug and Alcohol education. | Monthly | $5,000 |
| **Healthway** | **Health Promotion Project Grants**  
Priority Health Areas:  
- Reducing smoking and working towards a smoke-free WA  
- Preventing harm from alcohol  
- Preventing overweight and obesity  
- Promoting good community and individual mental health  
- Preventing skin cancer  
- Reducing harm from illicit drug use. | Always Open | Both |
Contact:

Professor Jane Farmer  
Social Innovation Research Institute  
Swinburne University of Technology, John Street, Hawthorn  
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