Winner of 2024 PIF Australian Essay Competition

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Essay topic - 'Addressing equity in psychiatric care' – including but not limited to improving mental health care of culturally and linguistically diverse individuals, and in rural and remote areas.
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'Addressing equity in psychiatric care – *A tipped scale*'

Introduction

The Titanic had only 20 lifeboats capable of carrying half of the 2200 crew and passengers onboard its maiden voyage leading to a tragic demise of mostly third class passengers (Wheeler, 2025). In Australia, there are less than 4300 psychiatrists (AIHW, 2024b) currently practicing to help treat the estimated 1 in 5 or 4.3 million Australians that have experienced a mental disorder in the last 12 months (AIHW, 2024c). In a system that is grossly overburdened and under resourced, it may come as no surprise that access to potentially lifesaving psychiatric treatment is not without bias. In a utopian society, access to psychiatric care and treatment would be fairly distributed amongst its citizens regardless of their wealth, background, or location. However, in our current buckling system, society's most vulnerable and disadvantaged patients are being left behind as there are so few lifeboats available to those seeking psychiatric care.

Money can't buy happiness, but you can afford your own private psychiatrist

Since the early roots of psychiatry there has been a great divide in the treatment of patients based on class and status. Historically, members of the general public displaying symptoms would often be involuntarily placed in lunatic asylums where living conditions were inhumane, long-term restraints were common, and members of the public could pay entry to torture and torment the inhabitants (ScienceMuseum, 2018). Conversely, if you had money or status your family could pay for private treatments and hide you away in luxury spas, estates, or Windsor Castle as was the case for the infamous 'The Mad King' George III (HistoricRoyalPalaces, 2025). Today, there is still a strong divide between the private and public systems as accessing a psychiatrist in the Australian public system can be comparable to winning the lottery. In 2022, executive director of Orygen Professor Patrick McGorry AO quoted that waiting times for youth in crisis to access mental health care was as long as six to twelve months (Cunningham, 2022). Patients in crisis seeking help at emergency departments will wait on average several hours to a day before a mental health bed can be secured (AMA, 2024), and this is only if they are deemed unwell enough to be admitted for acute treatment. The waitlist for addiction rehab facilities can often be 12 months long leaving patients at prolonged threat of risk taking and self-destructive behaviours (Storie, 2022). Waiting times for psychiatric services and inpatient facilities can be drastically reduced if you can afford private health and the exuberant out of pocket costs for each appointment often exceeding hundreds of dollars (Unity, 2023). The accumulative cost of regular appointments and reviews makes psychiatric advice and treatment a financial impossibility for everyday Australians battling the rising costs of living. One of the biggest findings of the Victorian Royal Commission into Mental Health was that 'a disproportionate number of people living with mental illness have low incomes and no private health insurance (Armytage et al., 2021)'. Living in poverty will not only reduce your access to mental health care but also increase your likelihood of needing it as housing instability, job insecurity, and financial stress all increase the probability of suffering from a mental health illness (Armytage et al., 2021). In Norway, waiting times to see a psychiatrist are less than 40 days for all patients due to a robust and adequately funded public system and relatively small private sector (Yang et al., 2022). In comparison, approximately 50% of Australian psychiatrists are employed by the private sector (DOH, 2017) and access to their services are limited by a patient's means. With public waiting times exceeding months and private fees exceeding what is affordable, many Australians are forced to go without mental health care or wait until it is possibly too late.

Lost in translation

On my first psychiatry rotation, there was a non-English speaking patient who would often rant and rave at staff at length outside translated interviews. Eventually, a covering psychiatry registrar fluent in the patient's native language translated these outbursts to the equivalent of 'you're all idiots and no one can tell me otherwise.' Clearly, the limited capacity of staff to communicate with the patient had led to a suboptimal therapeutic relationship and this in turn adversely affects the patient's likelihood of a positive health outcome (Stubble, 2018). Communicating effectively with patients of diverse backgrounds takes time and energy. While language barriers can be broken down with access to translating services and technology, doctors under pressure may be tempted to cut corners using family or friends to translate (Rimmer, 2020) or limit the depth of interviews as translation time blows out the allotted appointment schedule (Torresdey et al., 2024). Furthermore, approaching patients from diverse cultural backgrounds including our indigenous population also requires effort from clinical staff in the form of respect and empathy. In 2018-29, 32% of Aboriginal and Torres Strait Islander peoples did not access needed health services due to a past experience of cultural discrimination and inappropriateness, and 20% of those accessing care in 2022 reported experiences of racism by medical staff during their encounter (AIHW, 2023a). If patients do not feel culturally safe, they will not continue engage with mental health services and given the suicide rate of Aboriginal and Torres Strait Islander peoples is more than double that of the non-indigenous population (AIHW, 2023b), this is a risk we cannot afford to take. Additionally, patients from diverse backgrounds are more likely to have limited health literacy and be unfamiliar with the complicated health and welfare systems putting them at greater risk of poorer quality health care, service delivery and poorer health outcomes (AIHW, 2024a). Luckily, we have specialised indigenous healthcare workers and liaisons to bridge this gap to care but this service is also dependent on our own initiative and early recognition. In a similar vein, there are a host of multicultural groups and resources to assist breaking down barriers to care for patients from various backgrounds such as 'Embrace Mental Health', a project focusing on helping patients from culturally and linguistically (CALD) backgrounds, and the 'Forum of Australian Services for Survivors of Torture and Trauma' (FASSTT), a specialist rehabilitation agency working to help war torn refugees find healing from their horrific personal traumas that many clinicians will be unable to relate (SBS, 2020). Providing safe and accessible mental health care to culturally and linguistically diverse patients is not an impossible task but requires delicacy and time to understand the language of the patient and their cultural barriers. In an ideal world, psychiatrists would have the time and means to achieve this, but in our burnt-out system, how many of us are truly able to take that extra step?

A Farmer wants a Psychiatrist

As previously established waiting lists and access to psychiatry services are already extensive for the average Australian, however, this difficulty is only further exacerbated for those living in rural or remote locations. Access to psychiatry services is more than halved in remote locations compared to major cities per capita and similarly, access to mental health nursing and psychology also dramatically decreases (NRHA, 2021). Rates of drug and alcohol abuse more than doubled in remote regions at a rate of 1294 per 100 000 population except the ability to access an alcohol and drug (AOD) clinical service is greatly reduced as the average drive to a centre is 91.6 minutes (AIHW, 2019). As a potential consequence the rates of suicide incidence are doubled in remote regions compared to major cities (AIHW, 2023c). The severity of mental illness and addiction may furthermore be increased in rural and remote settings as the primary sources of income in agriculture, tourism, forestry and fishing are under constant crisis from climate change and the increasing severity of natural disasters including fires and flooding (Gardiner et al., 2020). A strength of rural communities is their closeness and familiarity with each other, but this also leads to feelings of shame when discussing mental illness due to perceived stigma and an increased burden of conformity especially from individuals with LGBTQI+ backgrounds (NRHA, 2021). A dear friend of mine suffered from crippling anxiety and depression for many years growing up in a rural community that stigmatised members of the transgender community and lacked specialised mental health services to allow them to live as there most authentic self. Living in Australia's treasured outback and golden plains is a tough life, and yet there is lacking mental services where we should be focusing our attention most.

A Conclusion and an Unhappy Ending

The first step to solving inequity in psychiatry is a much-needed boost to the workforce and mental health resources. More funding and clinicians would increase availability of services through the public system, give practitioners more time to develop an understanding relationship with patients from diverse language and cultural backgrounds, and allocate more resources to rural and remote regions. However, recent attempts to increase psychiatry funding was denied by the NSW government and we are about to bear witness to 220 psychiatrists resigning from the NSW public health system on January 21st 2025 as a consequence (Carr, 2025). The inequities listed in this essay are likely to further amplify as access to public psychiatric care is reduced and many will be forced to pay enormous out of pocket costs or go without. Time poor psychiatry trainees and consultants will not have the energy to explore the cultural context of their patients and interviews requiring translation will likely be compromised. The already limited rural public workforce in NSW will not be bolstered and will most likely be further reduced. Historically, Australia has prided itself on the right for everyone to have a 'fair go', only this is not currently the case for those seeking psychiatric care, and given the current development in NSW, we may be heading further backwards.

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