



NATIONAL RURAL HEALTH ALLIANCE INC

Position Paper

Mental Health in Rural Areas

January 2003

This Position Paper represents the agreed views of the National Rural Health Alliance but not the full or particular views of all 24 Member Bodies

Mental Health in Rural Areas

The Alliance has a separate Position Paper on suicide prevention¹, adopted on 27 November 2000. This Position Paper on mental health complements that one and focuses on the broader issues related to the mental health of people living in rural and remote Australia. While there is some overlap between the two papers, each provides a different emphasis.

The National Rural Health Alliance, the peak non-government rural and remote health organisation, **notes the following.**

1. Mental health problems are experienced at significant levels by all groups in the Australian community.

According to the Mental Health and Well-Being Profile of Adults,² one in five Australians aged 18 years and over suffered from a mental disorder during the 12 months prior to the survey in 1997. Fourteen percent of children and adolescents in Australia were also found to be experiencing mental disorders. There is a higher prevalence of child and adolescent mental health problems among those living in low income, step/blended and sole parent families.³

The highest levels of mental disorder (27%) were experienced by young adults between the ages of 18-24 years. This declined steadily to 6.1% for those over 65 years.

The most common conditions are affective disorders, including depression and anxiety. In the younger adult age groups (particularly among males) substance abuse, which is deemed a mental health disorder, is also common.

Australians experiencing mental health problems also have a higher risk of experiencing co-morbid physical and mental disorder. The Mental Health and Well-Being Profile found that just under half (43%) of those experiencing a diagnosed mental disorder also had a chronic physical disorder. About one in four persons who had an anxiety, affective or substance abuse disorder also had at least one other mental disorder.⁴

2. The Australian Institute of Health and Welfare estimates that the burden of mental disorders nationally in the Australian community represents 30% of the non-fatal disease burden.⁵ Worldwide, the World Health Organisation considers mental illness to be the fourth leading cause of disability and this is predicted to rise to the second in developed nations by 2020. While not a major cause of death, accounting for only 1.4% of years of life lost, mental disorders are a major cause of chronic disability accounting for 27% of years lost due to disability.

The implications of these epidemiological surveys of mental health problems for Australians living in rural and remote areas are significant. This profile equates to over one million people living in rural and remote Australia experiencing a mental illness. This group is also likely to experience corresponding levels of substance abuse, disability and co-morbidity with other physical and mental illnesses.

3. There are huge economic implications for all Australians from this high prevalence of mental illness, as well as the direct burden on individuals and their families. Health care costs alone for mental disorders accounted for over \$2.6 billion dollars in 1993-94 or 8.3% of total health care costs. In addition there are numerous, but unquantified, indirect costs such as absenteeism, lost productivity, burden on families and carers, legal costs and lost quality of life.⁶
4. There is some evidence that in overall terms people in rural and remote areas have higher levels of mental illness than those living in urban areas. A number of small studies undertaken during the early 1990s in rural and remote locations in South Australia (the Riverland), Western Australia (the Kimberley) and NSW (Broken Hill) did find higher rates of some mental disorders.⁷ The 'relaxed, laid back lifestyle' of these regions appears to be a myth, arising primarily from data that actually represent an under-utilisation of resources (resources that may already be scarce).

The Mental Health and Well-Being Profile of Adults also found that women who live outside the capital cities experience a higher rate of mental illness than city women.⁸

People with a mental illness are at greater risk of committing suicide. The literature estimates that the majority of people who commit suicide have a previous psychiatric diagnosis and up to 80% are also linked with harmful drug or alcohol use. Young people who have previously attempted suicide are estimated to be thirty times more at risk of dying from suicide.⁹ Overall the suicide rates for young males have almost tripled over the past 30 years⁹ but have stabilised for teenage males since the 1980s.

There are indicators suggesting that the consequences of mental illness might be more severe in rural and remote areas. Rates of suicide are consistently higher in rural towns than in metropolitan areas. In communities with a population of less than 5000, the suicide rate of males aged 15-24 is almost twice that of their city counterparts.¹⁰ In the most remote regions of Australia the male suicide rate is 30% more than the city rate. The overall suicide rate in Aboriginal and Torres Strait Islander communities is estimated to be 40% higher than the national average.⁹

Socio-economic factors such as economic disadvantage, low educational achievement and unemployment are important factors that contribute in a cumulative way to increased suicide risk. In rural and remote regions the impact of structural adjustment in agriculture and the withdrawal of government and other services, such as banks, has been considerable. 33 of the 37 poorest electorates in Australia are rural, with average weekly earnings in rural areas considerably lower than the national average. High youth unemployment is a feature of many of these communities despite out-migration for higher education and work. The Mental Health and Well Being Profile of Adults found that the highest rates of mental disorder for both males and females were for the unemployed (35% for men and 32% for women).

5. There is a growing body of literature that is concerned with finding evidence to substantiate the connection between social factors (on the one hand) and psychological distress and mental illness (on the other). There are studies that demonstrate that levels of education, family income, unemployment, economic hardship, minority status and undesirable or unexpected events can have a direct effect on levels of distress experienced. Of all the things that explain social patterns of distress, a sense of control over one's life is central. People living in rural and remote areas face a number of social factors which may lessen their sense of control over their lives, thus exacerbating the problems of mental illness. People in rural and remote areas are poorer, face higher rates of unemployment, and face additional challenges such as isolation, stigma as a result of less anonymity, exposure to environmental hazards, lack of appropriate services and service providers, and the effects of economic restructuring.

Lowering or losing a sense of control can result in experiencing depression, anxiety and other mental disorders. Strategies for preventing distress and psychological ill health can be centred on improving education levels, having a fulfilling job, having supportive relationships and a decent living.

*These are to mental health what exercise, diet and not smoking are to physical health.*¹¹

Early diagnosis and intervention are keys to effective management of mental illnesses,¹² and the relative lack of services and mental health education is a major issue in rural and remote Australia. Research has indicated that a range of rural health workers identified mental health services as one of the most significant deficiencies in rural and remote Australia.¹³ There is a shortage of mental health nurses, psychiatrists, psychologists and other mental health professionals (including Aboriginal mental health workers) in rural and remote communities. Lack of access to training, professional isolation, heavy workloads and limited resources affect the recruitment and retention of mental health personnel in rural and remote areas. Access to after-hours mental health services is especially limited in many rural and remote areas.

There are very few specialist programs for children and adolescents in rural Australia. Mental health problems can have a significant adverse impact on children and adolescents and also on their parents and family members. It is critical that interventions for this younger age group provide a broad base of support for parents and families as well as for the young people themselves. Family doctors, school-based counsellors and paediatricians provide the services that are most frequently used by young people with mental health problems. To function effectively these professionals need to be supported by a greater number of child and adolescent mental health specialists.

Only 7.5% of psychiatrists are located in rural or remote locations, and more than 90% of those in non-metropolitan areas are in major regional centres like Toowoomba. There are also shortages of clinical psychologists and social workers in rural and remote areas. The situation has been exacerbated by the rationalisation of public services in rural areas that employed these health professionals.¹⁴ As with other professionals, lack of access to training,

professional isolation, heavy workloads and limited resources affect the recruitment and retention of psychologists and social workers to rural and remote areas.

Few local hospitals have the resources to deal with people in the acute phases of mental illness, who often require hospitalisation and intensive therapy.

6. These shortages of mental health professionals undermine the development of intervention and prevention strategies for people at risk. As a consequence of the shortages, non-mental health professionals in rural areas are more likely to be treating people with a mental illness.

The Mental Health and Well Being profile found that one third of the Australians who actually had a mental illness and had used a service in the past twelve months for this illness had consulted with a GP. Yet there is still a shortage of doctors and other primary health care professionals. The current shortfall of GPs in rural and remote areas was put in the range 500-750 practitioners¹⁵ and has been estimated (13 December 2002) by the RDAA to be around 1,000. Further, there are rural and remote GPs who lack specific training in mental health or suicide prevention, and lack the time that needs to be spent with a depressed or mentally ill person. There is also a serious and growing shortage of nurses in rural and remote areas. Options for referral are all but non-existent in many rural and remote areas.

7. Despite these limitations, there are some positive developments in rural and remote mental health services. Some of the best examples of mental health initiatives have occurred in regional centres and larger rural environments, though the same research also identified rural and remote communities as having some of the worst services.¹⁶

Information technologies such as telepsychiatry and video-conferencing provide important adjuncts to the services provided by health professionals in rural and remote locations. They obviously reduce the need for rural people to travel to a capital city for assessment and treatment, and they also improve the support and training of local health professionals who provide service to this population.

Specialised services such as the Bush Crisis Line (telephone counselling) provide much-needed support for the primary health care workforce in rural and remote Australia.

The Royal Flying Doctor Service (RFDS) plays a vital role in the assessment and evacuation of people with a mental illness. The RFDS has released an educational and interactive CD-Rom for health professionals, aimed at improving the knowledge and awareness of the issues of mental health.

8. Changes to mental health treatments and care arrangements have resulted in a higher proportion of people with mental illness living in the community. This has placed extra demands on the families and carers of people with mental illness. It is well established in Australia that support for families and carers is quite limited. In rural and remote areas special factors such as isolation, distance and the relative paucity of services exacerbate the situation of families and carers.

*“Despite recent trends in policy developments, the needs and activities of informal carers are hardly recognised”.*¹⁷

9. Australian Health Ministers are currently developing a proposed 3rd National Mental Health Plan. Amongst the areas identified as needing improvement are:
 - greater assistance to carers, for example through expanded and enhanced networks for carers and consumers;
 - further measures to reduce stigma associated with mental illness;
 - respite care; and
 - providing funds for training for consumers, carers and advocates.¹⁸

It is vital for the well-being of rural and remote communities that relevant and practical measures are developed to assist carers in rural and remote areas in policy and program responses to these needs.

A particularly vulnerable group of family members and carers is the children of parents with a mental illness. There is considerable concern about the impact of mental illness and the associated burden of caring on this group. A project is currently underway to develop guidelines and principles and complementary resource materials for services/workers parents and young people¹⁹. The NRHA has been involved in consultations on this project.

10. The NRHA is a strong supporter of involving consumers in all aspects of health service provision including assessing needs, determining priorities, planning and implementing services and evaluation. Evaluation of the National Mental Health Strategy stated that “the structural changes made to include consumers and carers introduced under the Strategy are amongst its most important achievements.”²⁰

Despite this positive conclusion there is considerable scope for improvements in the way consumers are involved in mental health services. For example in 1997, 37% of mental health services had no mechanism in place for participation by consumers and carers.²¹

11. There has been a range of national policies and associated activities supporting improved access to mental health care and better mental health outcomes in rural and remote areas. Healthy Horizons (1999-2003), the strategic framework for rural, remote and regional health, identifies mental health as a key issue. The Healthy Horizons update (2002) provides descriptions of some of the programs operating in Australia’s various health jurisdictions. Mental health is also one of the six National Health Priority Areas, along with cardiovascular disease, cancer control, injury prevention and control, asthma and diabetes mellitus.

The National Mental Health Strategy was adopted by Health Ministers in 1993 and reinforced in 1998 by their adoption of the 5-year Second National Mental Health Plan. Under this broad policy framework there have been several initiatives in rural and remote mental health including:

- National Demonstration Projects in Psychiatry;
- pilots of rooming-in services;
- a project to identify ways to enhance the role of general practitioners in mental health care; and

- increased numbers of mental health workers and improved services in some rural areas.

Consultations were undertaken in 2002 as part of developing a 3rd National Mental Health Plan.

In 2002, the Mental Health Council Australia and beyondblue: the national depression initiative, conducted a review of the 2nd National Mental Health Plan. The results clearly showed that while a great deal of progress has been made much more remains to be done. Those consulted felt that more of the same will not suffice. Resource issues need to be seriously addressed and national leadership and accountability are top priorities for the community and the sector. The neglect of the basic human rights of people with mental illness needs immediate review. The data clearly show that people with chronic disorders are living institutional lives in the community, consumers generally only receive care when they are in crisis and the majority of people with high prevalence disorders are not getting any care. Stigma is alive and well, consumer and carer participation is token and it seems that multiple levels of government systems are wasting the community's and the profession's goodwill.

At the Commonwealth level the Office of Aboriginal and Torres Strait Islander Health (OATSIH) has funded a Social and Emotional Well Being Program for Aboriginal organisations to provide a range of mental health support and training activities. Indigenous Australians have taken a broad holistic concept of mental health which is addressed through this specialist program. Most states and territory health departments have also developed specialist Aboriginal mental health policies and programs.

12. There are six priority mental health targets for rural and remote communities outlined in the National Action Plan for Mental Health Promotion, Prevention and Early Intervention 1998-2003.²² These priority targets are:
 - promote family and community cohesion;
 - promote protective factors that impact on the effects of unemployment, environmental hazards, geographical isolation, alienation and loss, building on particular strengths of people in rural and remote communities;
 - reduce the prevalence of risk factors for depression, anxiety, stress and suicide;
 - capacity building of infrastructure and communication technologies to assist in improving mental health outcomes for rural and remote communities eg: telehealth/telemedicine;
 - develop and support initiatives as determined by the local community; and
 - increase access to mental health promotion and prevention services.
13. The Mental Health Council of Australia, a peak body for mental health created through the National Mental Health Strategy, made a number of recommendations for rural and remote mental health in its 2001 Federal Election Submission²³ including:
 - additional funding to provide mental health services in rural Australia comparable with those in metropolitan areas;

- increased incentives and other initiatives to attract and retain multidisciplinary mental health professionals to rural and remote areas and to encourage urban mental health specialists to provide some services in rural and remote areas;
 - expanded recruitment of Indigenous mental health practitioners;
 - national accreditation of cultural awareness and sensitivity training for mental health professionals; and
 - the provision of professional development opportunities for mental health professionals in rural and remote areas.
14. The national depression initiative *Beyond Blue*, with its emphasis on a population health approach to mental illness, has a special task force specifically devoted to rural, remote and Indigenous communities. Its priorities include reducing the stigma of mental illness and increasing community awareness of, and knowledge about, mental illness.
15. The complexities of the factors affecting a community's mental health, exacerbated by the ongoing shortages of mental health professionals, suggest that the development of partnerships between consumers, schools, general practitioners, Aboriginal health services and communities, emergency services, police, private mental health sector, Rural Counsellors, non-government and government services and the broader community is an important route to improve mental health of people in rural and remote areas. Such partnerships will also provide a more supportive network for service providers within the sector and a targeted and preventative program for rural and remote clients.

The National Rural Health Alliance affirms the following principles.

16. "Total health cannot be achieved without mental health. It is essential therefore, that mental health initiatives be fundamental to the primary care approach."²⁴

Member Bodies of the Alliance strongly support the inclusion of mental health as a national population health priority.

It is important that there be increased inter-agency mental health co-operation in areas such as community education, improved skills of key groups, reducing stigma and providing professional and peer support.

17. Member Bodies of the Alliance support initiatives to provide mental health information to consumers, including the Commonwealth's tele-counselling and Internet information service.

Member Bodies of the Alliance support the extension of successful models of innovative mental health services to rural and remote areas which remain underserved by existing mental health services.

The National Rural Health Alliance believes the following action should be taken.

18. The Commonwealth, State and Territory Governments should continue to focus some of their mental health funding in rural and remote areas on building

partnerships between health and welfare providers and local communities. These partnerships would address locally identified mental health needs, in particular mental health promotion, illness prevention and suicide intervention.

19. There should be a greater number of incentives to recruit, retain and support mental health workers and counsellors, including GPs, to and in small rural communities, and to increase the skills of others, such as teachers, sports coaches and youth workers involved with young people at risk.
20. All parties and agencies should support the priority mental health targets outlined for rural and remote communities in the Mental Health Promotion, Prevention and Early Intervention National Action Plan 1998-2003.
21. Greater attention should be given nationally, and in rural and remote areas in particular, to the needs of the carers of those with a mental disorder.
22. The managers of mental health services should ensure they have mechanisms in place for participation by consumers and carers.

The National Rural Health Alliance resolves to take the following actions itself.

23. It will support and promote *Healthy Horizons Outlook 2003-2007* as a strategic framework for improved mental health in rural, regional and remote areas.
24. It will support initiatives to improve mental health training for GPs, nurses, allied health professionals and Aboriginal Health Workers.
25. It will continue to support the expansion of funded telepsychiatry and video-conferencing services as an adjunct to, not a replacement for, face-to-face services in rural and remote communities.
26. The Alliance will seek input to the work of *Beyond Blue's* special taskforce on rural, remote and Indigenous communities.
27. The Alliance will maintain close links with the Mental Health Branch of the Department of Health and Ageing and continue to promote its resolutions on mental health and on suicide.
28. As a Member of the Mental Health Council of Australia, the Alliance will support the MHCA in its work, particularly as it relates to mental health in rural, regional and remote Australia, and including in the context of the recommendations in the MHCA's 2001 Federal Election Submission.
29. The Alliance will support a new national inquiry focussing on the human rights aspects of mental health, including the lack of ready access to care in the community and the lack of appropriate accommodation.

References.

- 1 National Rural Health Alliance (2001), *2000~2001 Position Papers*, Canberra.
 - 2 Australian Bureau of Statistics (1998), *Mental Health and Wellbeing Profile of Adults, Australia, 1997*, Commonwealth of Australia.
 - 3 Sawyer M, Arney F, Baghurst P, Clark J, Graetz B, Kosky R, Nurcombe B, Patton G, Prior M, Raphael B, Rey J, Whaites L, Zubrick S (2000), *The Mental Health of Young People in Australia, Child and Adolescent Component of the National Survey of Mental Health and Wellbeing*, NMHS.
 - 4 Andrews G, Hall W, Teesson M, Henderson S (1999) *The Mental Health of Australians, National Survey of Mental Health and Well Being, Report 2*, NMHS.
 - 5 Australian Institute of Health and Welfare (2001), *The Burden of Disease and Injury in Australia*, AIHW.
 - 6 Australian Institute of Health and Welfare (2000), *Australia's Health 2000*, AIHW.
 - 7 There is no accurate data for the prevalence of mental illness for people residing in remote areas as they were not included in the 1997 study. For a discussion of these studies see O'Kane, A., and Tsey K (1999), *Shifting the balance*, Menzies School of Health Research.
 - 8 Andrews G, Hall W, Teesson M, Henderson S (1999), *The Mental health of Australians, National Survey of Mental Health and Wellbeing, Report 2*, NMHS.
 - 9 CDHAC (2000), *Life Framework, Learning's about Suicide*, AGPS.
 - 10 Australian Institute of Health and Welfare (2000), *Australia's Health 2000: the seventh biennial health report of the Australian Institute of Health and Welfare*, Canberra: AIHW.
 - 11 Mirowsky J, Ross C (1990), *Social Causes of Psychological Distress*, Aldien de Gruyler.
 - 12 Myhill K (1999), *Innovations in Mental Health Service Delivery for Rural Communities*. Paper presented at the 5th National Rural Health Conference, 14 – 17 March.
 - 13 Hodgson L, Jackson J (1997), *An interactional model for rural mental health services: the effects on the roles of allied health professionals*. Paper presented at the 4th National Rural Health Conference, Perth 9 -12 February.
 - 14 The rate of access to social workers drops significantly for residents in small rural centres and remote areas (51% below the national average). The rate of access to clinical psychologist drops significantly for residents in small rural centres (52% below the national average) and even further for those in remote areas (83% below the national average) (ABS, 1996).
 - 15 Mara P, (1999), *Paper presented in the health theme component of the Regional Australia Summit*, 27 - 29 October.
 - 16 Hickie I, (2001), *Beyond Blue: the national depression initiative*. Paper presented at the 6th National Rural Health Conference, Canberra 4 -7 March.
 - 17 Mitchell M, and Thompson M (2001), *Changing conceptions of informal care in Australia*, Paper presented at the National Social Policy Conference, 4-6 July.
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- 18 Australian Health Care Agreements Reference Group Report (2002), *Improving Mental Health*.
 - 19 Australian Infant, Child, Adolescent and Family Mental Health Association (2002), *Discussion Document, Principles and National Practice Guidelines, Children Of Parents With A Mental Illness*, prepared for the Commonwealth Department of Health and Ageing.
 - 20 AHMAC Evaluation Steering Committee (1997), *Evaluation of the National Mental Health Strategy: Final Report*, Australian Health Ministers' Advisory Council, December.
 - 21 Commonwealth Department of Health and Aged Care (1998), *National Mental Health Report, 1997*, Commonwealth of Australia.
 - 22 National Mental Health Strategy (1999), *Mental Health Promotion and Prevention National Action Plan*, Commonwealth Department of Health and Aged Care, Canberra.
 - 23 Mental Health Council of Australia (2001), *Promoting the mental health of all Australians: a 2001 Federal Election Submission*, MHCA, Canberra.
 - 24 Norris G, Beaver C (1992), *Aboriginal Health - a primary mental health care approach*. Paper presented to the Australian Rural Health Conference, Toowoomba, 12 –15 August.