Growing the Business of Farming | NSW Farmers ASSOCIATION

Submission to
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INTRODUCTION

The NSW Farmers' Association (the Association) is an apolitical voluntary industry body representative of the whole farming community in NSW. Through its commercial, policy and lobbying activities it provides a powerful and positive link between farmers and the public. Currently the Association has some 11,000 members across NSW.

The Association respects that this inquiry seeks input into mental health services in Australia, however in this instance much of the Association's knowledge of, and concern for, mental health conditions and services in rural and remote NSW have arisen due to the current severe and ongoing drought.

Currently more than 96% of the landmass of NSW is drought-affected, with 87% of the state facing extreme drought conditions. Almost 50% of Australia's agricultural areas have been EC-declared (Exceptional Circumstances drought assistance), meaning that they are experiencing a 1 in 25 year drought – or worse. Some areas have now been in drought for over four years, which are well beyond normal drought circumstances and which are unrealistic to plan for. This means that a significant number of farmers are struggling to continue their farming enterprises, are facing severe financial hardship and have unstable futures.

The emotional stress from such adverse circumstances is impacting not only farmers, but also their families, communities and even the drought support services themselves. Through the Associations' extensive member and communication networks and our regionally based staff, the Association is hearing a growing number of reports of families breaking down, suicides, whole communities in depressive states, and drought support workers resigning due to burnout. In a May 2005 Australian Medical Association (NSW) newsletter, Canberra psychologist Anne McDonald has said more needs to be done to help reduce a potential depression epidemic in rural areas as a result of the long-standing drought. "The sheer duration of the event, the unremitting nature of this slow quiet disaster that we're experiencing has the potential to psychologically damage a number of people," Ms McDonald said (AMA NSW, 2005).

Even in times of non-drought, farmers' stress levels are rising. Research suggests that the changing nature of farming – globalisation, restructuring and downsizing, are all contributing to elevated stress (Pahl 1993; Brown 1996; Hooper 1998; Worrall and Cooper 1998;

Bosch1999; Burchell, Day et al. 1999; Smithson and Lewis 2000; Sparks, Faragher et al 2001). Deaths from suicide of male farmers and farm workers are approximately double that of the Australian male population (Fragar, 2001). There are also a significantly higher number of 'accidents' occurring, particularly in remote areas, including death by gun-fire (10 x more likely) and car accidents (3 x more likely), than in metropolitan areas (NSW Chief Health Officer, 2003). Whilst there are no accurate figures on levels of depression in rural NSW, the above research suggests a disproportionate level of depression in rural and particularly remote communities compared to their metropolitan counterparts.

There is also poorer access to mental health support in rural and remote areas. It remains difficult to attract and retain health workers in rural / remote areas, and mental health workers are no exception. Doctor and psychiatrist to population ratios are low, and there are fewer charity services to offer support. Members of the Association have suggested that rural mental health support, from prevention through to crises care, is "virtually non-existent".

Generally rural people are found to provide extensive support to one another in a time of crisis (Crockett 2002, 2003), however this is often not true in the area of mental health. Within the rural culture, mental illness can be perceived as a sign of weakness (Crockett, Taylor et al. 2005), thus preventing people from seeking assistance. The following example typifies the avoidance and feelings of helplessess currently occurring throughout rural areas. It was provided to the Association by a member:

> "… wife on farm with depressed and angry husband, combination of alcohol and isolation fuels deteriorating capacity for communication or appropriate decision making – husband will not ring anyone, husband will not go to visit anyone, 'they are all useless anyway and what would they know" – wife doesn't go out because she's scared to leave him alone, and she's embarrassed by his drinking when out."

Because of the isolation that farm families can experience socially, and in the course of their work, they can mask their condition to others successfully. If help is sought, the rural culture and fear of discrimination often steers clients and their families towards 'indirect' assistance, such as a Rural Financial Counsellor or a General Practitioner (GP), both of which can be seen under a different guise. The provision of mental health services therefore needs to be mindful of this rural culture in order to reach those in need.

The GP is usually the first to diagnose depression in a rural setting. They are usually the most accessible health worker in an area and the patient may visit the GP under a number of health guises. Often however, the GP may prescribe an antidepressant medication. They may also refer the patient to a mental health worker (Crockett, Taylor et al. 2005). There are some problems with this scenario. Medication may not be the best treatment, and mental health workers are often few and far between, have long waiting lists and have a stigma attached to their titles, thus deterring the patients from seeing them. That said, mental health workers, community nurses and psychologists remain a very important part of the rural / remote mental health team, something which their often overly long waiting lists reflect.

NSW Farmers' Association believes that the requirements for addressing the mental health illnesses currently occurring in rural / remote areas are twofold: to help rural / remote people to acknowledge and understand depression with a view to them seeking help; and to increase access to mental health support in all its forms including through the local GP.

SUGGESTED SOLUTIONS

Community education and destigmatisation of depression

The Association recognises the need and ongoing attempts to destigmatise mental illnesses, across Australia. However given that depressive disorder is the second most common chronic health problem managed by GPs, and that there appears to be a high prevalence in rural/ remote areas at present, the Association suggests it may be more beneficial and successful to focus on destigmatising depression first, rather tackling all mental illnesses in one go. Given that the current mode of service delivery for rural /remote families is dependent on them making contact for referral – thus presuming they're aware of their need and urgency – a destigmatisation / education campaign seems essential.

Rural and remote people of Australia have their own unique culture and perception of self. They see themselves as different from city dwellers and have different perceptions of health. It is suggested that their stoic 'she'll be right mate' attitudes have derived from the strong, rugged and predominately male rural history (Smith, J., 2004). These attitudes, which often hinder preventative medical treatment, may contribute to the fact that rural and remote Australians have poorer health than their metropolitan counterparts (Aust. Institute of Health and Welfare, 2005). Their mental health is no exception. It is therefore vitally important that

any campaign directed at rural Australians, to destigmatise depression (or promote preventative heath care), considers how best to communicate with the rural subculture. The Association is of the belief that BeyondBlue is currently looking into exactly that. Moreover, Hunter / New England Area Health Service has suggested that when preparing community awareness programs, it is imperative to consider the specific communities being addressed, as each respond differently to different communication methods. The AHS suggests consulting the local council community workers as they have a very good feel for how best to 'talk to' their communities.

Increase access to mental health support

Particularly within rural/remote areas the GP is usually the first contact for the diagnosis of depression (Crockett, Taylor et al. 2005), and may end up being the patient's only access to mental health support. Although rural doctors work closely with the local mental health support team, this team often does not exist, or have a waitlist which is worryingly long. Given this situation it seems logical to increase the GPs' awareness of depression and its management. Also, through the use of screening instruments and having psycho educational materials available for patients, they can help confront and destigmatise depression (Crockett, Taylor et al. 2005, RACGPOnline). The Association recognises however that such a solution would significantly burden the already overworked rural GPs, if that GP wasn't provided with sufficient support. Training practice nurses in basic counselling skills would help share this strain on resources. The patient would still be 'visiting the doctor' thus reducing fear of discrimination, and if they show they're experiencing a high level of distress they can be referred straight back to the doctor. The practice nurse might also be able to do a telephone follow-up of the patient 'just to see how you're going…' which was used in a recent study by Crockett, Taylor et al. (2005) and was found to provide excellent outcomes. As a farmer at the Drought Summit (Parkes, May 2005) said,

> "There are people that have effectively given up on their own health and the services are not there even if you could encourage them to take action. What all this points to is a typical long term level of depression and it actually takes a third party to pick these people up through local contact and support them till they have regained some level of confidence in themselves."

Skilling practice nurses in basic counselling skills should not be at the expense of the mental health team. Counselling can be a very important part of the depression treatment and it is

imperative that GPs can refer patients on to mental health specialists. Charles Sturt University is currently conducting a trial into a collaboration between GPs and psychologists whereby psychologists work from within the rural general practice, thus providing a more thorough service than the practice nurse solution suggested above. Early reports suggest the trial a success. Perhaps the application can be applied more broadly.

In rural areas general supportive counselling is usually done with a nurse or a social worker at the community health centre whilst mental health nurses, clinical psychologists and visiting psychiatrists are accessed for more severe mental illnesses. GPs refer to these health professionals but patients can also self refer to some of these staff. This circumvention of the local GP can encourage a rural depressed person's decision to seek help, especially where their local doctor is also a mate or member of their small local community, as is often the case in rural/remote areas. It allows them to 'save face' even with the GP.

The Hunter / New England Area Health Service states that over the past 18 months they have seen elevated levels of depression and mental illnesses within their area, and that GP referrals to mental health staff have doubled. Waitlists have grown accordingly. To be sure, this area is reflective of the rest of rural NSW, who are also experiencing the same, if not worse, levels of drought. More mental health nurses, clinical psychologists, community nurses and the rest of the rural mental health team including outreach workers, are required. As Dr Haikerwal of the AMA said "GPs clearly play an essential role in diagnosing and treating mental illness, but additional support services are in short supply, particularly in the public system" (Australian Medical Association, 2003). Attracting and retaining these staff is an issue. Consideration should be given to applying some of the incentives used to attract doctors to rural areas, more rural health worker training, and greater use of outreach workers, to tackle this.

As our farmer quoted above alluded to, the mental health of a rural community would likely benefit from a network of health workers trained in identification of warning signs of depression, appropriate referral strategies and skills development in communicating with patients with mental health problems. This training could be provided to health workers such as pharmacists, nurses, physiotherapists etc and included within their undergraduate studies. This would then help with detection and support of mental illnesses as well as reducing discrimination. A recent study into the role of the community pharmacist in the management of depression concurs (Crockett, Taylor et al. 2005).

Often other non-health trained staff within rural/remote communities play a very important

role in the support network. The Rural Financial Counsellors for example are often the first to receive a farmer in despair. Whilst these counsellors provide financial assistance, they are skilled in identifying farmers with emotional need and referring them on. The services these counsellors provide are absolutely essential for the wellbeing of farmers, particularly during times of hardship such as drought, something their long waitlists attest to. Unfortunately the Rural Financial Counsellors continue to face uncertainty in their positions as they must regularly reapply for funding through an arduous administration process. Particularly during times of drought, when they are already overworked and facing the stresses of drought themselves, this process makes many counsellors consider whether or not they've got the energy to go on. An alternative administration process, even if only applicable during times of drought and high demand, would assist in alleviating some of their pressures.

NSW Farmers' Association has been informed of a pilot program run by a nun in the Hunter / New England area and supported by the Sisters of St Joseph. The nun travelled up every road being sure to visit every farm family, establishing contact and checking on their health. In this way, the nun circumvented the many obstacles restricting rural/remote people from seeking help:

- As all clients received her services there was no (fear of) discrimination
- The families weren't required to recognise their own mental health needs and any urgencies (often hard to do when experiencing mental health problems)
- The families weren't encumbered by the expense of seeking support including time, fuel and the cost of appointments.

The program was considered successful, however the nun has since retired and not been replaced. The Association strongly recommends the Government consider supporting models of service delivery such as this, and those organisations that supply them.

CONCLUSION

Whilst the drought may have a limited life span, its ramifications such as depression, financial hardship, and loss (friends, stock, property etc) will continue for many years thereafter. The provision of extra mental health services for the rural / remote people should therefore not be considered a short term requirement, but rather a necessary adjustment to the rural mental health teams in place. Moreover, even without drought, rural/remote people

exhibit higher levels of mental illnesses than city dwellers, further suggesting their need for improved mental health teams.

Destigmatisation / education campaigns, respectful of the rural subculture, are required to assist rural/remote people with assisting themselves, particularly given the current system requires them to self refer. Expansion of the mental health care teams, and alternative models of service provision are also required.

RECOMMENDATIONS

- That in rural/remote areas an attempt be made to destigmatise depression first, rather than tackling the destigmatisation of all mental illnesses in one go.

- That the provision of mental health services in rural/remote areas be mindful of the rural subculture, in order to reach those in need.

- That any campaign directed at rural Australians, to destigmatise depression (or promote preventative heath care), considers how best to communicate with the rural subculture, and that the local council community workers be consulted with regard to the most appropriate way to 'talk to' their communities.

- That rural/remote GPs undergo more extensive training in depression and other mental illnesses, and their management.

- That consideration be given to training practice nurses in basic counselling skills.

- That consideration be given to broadly applying the concept of the current trial being conducted by Charles Sturt University in which psychologists are working in collaboration with GPs within the general practice.

- That more positions be made available within the rural mental health team including mental health nurses, clinical psychologists, community nurses and outreach workers.

- That consideration be given as to how to attract and retain mental health workers to rural areas, such as applying some of the incentives used to attract doctors, and more training of mental health workers in rural areas.

- That models of service provision which provide blanket, preventative home care, such as the nun supported by Sisters of St Joesph, be encouraged and supported.

- That non-mental rural health workers such as pharmacists, nurses and physiotherapists be trained in identification of warning signs of depression, appropriate referral strategies and skills development in communicating with patients with mental health problems.

- That Rural Financial Counsellors be given a less arduous funding administration process, even if only applicable during times of drought or high-demand.

REFERENCES

Australian Institute of Health and Welfare (2005). Media release "Poorer health, higher risks outside major cities" 13 May 2005.

Australian Medical Association (2003). Media release "Money needed for mental health support – AMA", April 2003.

Australian Medical Association NSW (2005). Newsletter "AMA Action - Health news in the spotlight 19/5/05", May 2005.

Bosch, G. (1999). "Working time: tendencies and emerging issues." International Labour Review 138: 131-150

Brown, K. (1996). Workplace health and safety: implications for diversity. Managing diversity. S. Lobel. Cambridge, Blackwells.

Burchell, B., D. Day, et al. (1999). Job insecurity and work intensification: flexibility and the changing boundaries of work. York, York Publishing Services.

Crockett, J. (2003). Rural Australia in transition - trouble on the farm. Orange, Centre for Rural and Remote Mental Health.

Crockett, J. (2003). Rural Australia in transition: trouble on the farm. Orange, CRRMH.

Crockett, J., Taylor, S., et al. (2005). The Role of the Community Pharmacist in the Management of Depression.

Dept of Health and Ageing (1999). Healthy Horizons – A Framework for Rural, Regional and Remote Australians 1999 – 2003.

Fragar, L. (2001). "The health of people in agriculture and its interdependence with the health of rural communities." NSW Public Health Bulletin 12(6): 155-159.

Hooper, N. (1998). Coping with the modern madness. Readings in human resource management. R. Stone. Brisbane, John Wiley and Sons: 230-235.

NSW Chief Health Officer (2003). Report of the NSW Chief Health Officer, Rural and Remote Populations Injury. http://www.health.nsw.gov.au/public-health/chorep/rur/rur_inj.htm

Pahl, R. (1993). "Rigid flexibilities? Work between men and women." Work , Employment and Society 7: 636-642.

RACGPOnline (2005). Royal Australian College of General Practitioners website: http://www.racgp.org.au/

Smith, Janie Dade (2004). Australia's Rural and Remote Health. A social justice perspective. Tertiary Press, Croydon.

Smithson, J. and S. Lewis (2000). "Is job insecurity changing the psychological contract?" Personnel Review 29: 680-698

Sparks, K., B. Faragher, et al. (2001). "Well-being and occupational health in the 21st century workplace." Journal of Occupational and Organisational Psychology 74(4): 489-509.

Worrall, L. and C. Cooper (1998). Quality of working life 1998 survey of managers' changing experiences. London, Institute of Management