MENTAL HEALTH IN RURAL AND REMOTE AUSTRALIA

NATIONAL RURAL HEALTH ALLIANCE INC.

...good health and wellbeing in rural and remote Australia

The reported prevalence of mental illness in rural and remote Australia appears similar to that of major cities. Access to mental health services are substantially more limited than in major cities. Tragically, rates of self-harm and suicide increase with remoteness.

People in rural and remote areas face a range of stressors unique to living outside a major city. These include a greater prevalence of some chronic conditions and disability, and generally poorer health. Rates of smoking, risky drinking and illicit drug use are also higher. There are fewer employment opportunities leading to lower incomes and less financial security. There is greater exposure and vulnerability to natural disasters, while rates of overcrowding, housing stress, and homelessness are higher.

Despite this, the prevalence of people experiencing mental illness is similar across the nation: around 20 per cent[1]. 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.

People in rural areas regularly score better than their major city counterparts on indicators of happiness. This may be testament to the positive aspects of rural life, and the interconnectedness of people living there. In rural areas there are higher levels of civic participation, social cohesion, social capital, and volunteering and informal support networks between neighbours, friends and the community[2].

These positive dimensions to rural life do not negate the need for professional mental health services. In 2014-15 MBS funded GP mental health encounters per 1,000 people, were 739 in major cities, rising slightly to 758 in rural areas with a significant decline to 338 in remote areas[3].

However, there is less access to specialised mental health care in rural areas (Table 1). The numbers of psychiatrists, mental health nurses and psychologists in rural/regional areas in 2014 were, respectively, 34 per cent, 82 per cent and 55 per cent that in major cities, with even poorer comparisons in remote areas. (18%, 58% 32%)[4].

Table 1: Mental Health Professionals, Full time equivalent, by Remoteness, 2014

	Major Cities	Inner Regional	Outer Regional	Remote/Very Remote
FTE per 100 000 population				
	16.6	6.2	4.4	3.0
Mental Health Nurses	87.3	81.5	51.2	50.9
Psychologists	92.4	55.5	40.8	29.6

Source: https://mhsa.aihw.gov.au/resources/workforce/

This reduced access to care is reflected in Medicare data (Table 2). When compared with major cities, per capita Medicare expenditure on mental health services in rural and remote areas in 2013-14 was, respectively, 67 per cent and 17 per cent[5].

Table 2: Per capita MBS expenditure, Mental Health services, 2013-14

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
All pofessionals	$44.95	$34.67	$21.33	$10.16	$4.51

Source: https://mhsa.aihw.gov.au/resources/expenditure/

In rural areas there can often be apprehension around help-seeking and a fear of the stigma sometimes associated with mental illness - particularly in smaller communities where individuals are more visible and confidentiality may be less assured. 'Rural stoicism', resilient attitudes and lower educational levels can also influence help-seeking behaviour, readiness to engage with mental health services, and adherence to preventive advice [6, 7]. Lower incomes also make it more difficult to afford mental health care, and limited or non-existent public transport is also a barrier to accessing mental health services. These factors combine to increase the risk and sense of social isolation, especially for those who are physically unwell, unemployed or living with a disability[8].

Timely diagnosis, treatment and ongoing management of a mental health condition in rural and remote areas is likely to occur later or not at all, often resulting in an increased likelihood of hospitalisation and sometimes leading to the most tragic of outcomes - self-harm and suicide.

The rate of hospitalisation from mental health conditions (Table 3) as well as drug and alcohol use and intentional self-harm (i.e. which includes cases where persons have intentionally hurt themselves, but not necessarily with the intention of suicide) increases with remoteness. In 2013-14, the overall mental health overnight hospitalisation rates were 11 and 26 per cent higher in rural and remote areas respectively (960 and 1,100 hospitalisations per 100 000 population) as compared to metropolitan areas (870 per 100 000)[9]. While data indicates significant difference in the rates of hospitalisation in rural and remote Australia compared with major cities, it also reveals significant variation within regions – the rates of hospitalisation in some towns can be almost 8 times higher than for other towns of the same remoteness[10].

Table 3: Mental Health Hospitalisations (same day and overnight stays), age standardised rate (per 100 000 people), 2013-14

	Major Cities (High SES*)	Major Cities (Mid SES*)	Major Cities (Low SES*)	Inner Regional	Outer Regional	Remote
Rate per 100 000 population						
All mental health disorders	856	873	874	946	991	1096
Intentional Self Harm	125	132	147	174	191	231

Source: http://www.myhealthycommunities.gov.au/our-reports/mental-health-and-intentional-self-harm/september-2016 ***Notes: SES refers to Socio-Economic Status***

The rate of suicide in remote and very remote Australia (Table 4) is almost double the rate in major cities[11]. This rate is even higher for particular groups.

The rate of suicide in rural areas is about 40% higher than in major cities. This statistic is worth noting given it reflects rates in a population that is ten times greater than that in remote areas.

Table 4: Incidence of Suicide, age standardised, 2009-13

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Rate per 100 000 population					
Males	14.7	20.2	21.4	26.8	30.0
Females	n.p	n.p	n.p	8.7	10.7
Persons	9.7	12.6	13.7	18.1	21.5

Source: http:://www.aihw.gov.au/deaths/mort/

Young people in rural and remote areas often face pressure to conform to locally acceptable patterns of behaviour. A sense of pessimism about future prospects, unemployment, loneliness, and the loss of relationships can exacerbate the risk of mental health problems. A lack of understanding in some rural communities for same-sex preferences, and the high use of alcohol and other drugs, add to the problem[12].

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. Greater availability of lethal means of self-harm contributes to this[13].

Aboriginal and Torres Strait Islander communities in rural and remote Australia face a number of challenges associated with socio-economic disadvantage. Given the importance of the connection between the health of their 'country' and their cultural, mental and physical wellbeing, any changes to the physical environment (e.g. climate change, land clearing, deforestation) can have a major influence on the mental health of Aboriginal and Torres Strait people[14]. Some experts argue that there is a lack of 'fit' between Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing and mainstream concepts of mental health and illness which have informed mental health service provision[15].

The rate of suicide among Aboriginal and Torres Strait Islander people is 2.0 times higher than that of non-Indigenous people, rising to 3.7 times higher for Indigenous compared with non-Indigenous 15-24 year olds[16].

Farm incomes, which directly and indirectly underpin the livelihoods of many people in rural and remote areas, are influenced by weather conditions, commodity and fuel prices, and exchange rates, and many of them can vary unexpectedly. This variability is likely to be further exacerbated by climate change.

Older people in rural and remote areas are more likely to be living with a chronic condition, chronic pain or disability, either singularly or in combination. They are also more likely to experience challenges around mobility, social isolation – partly attributable to the lack of public transport – and access to pain management and palliative care.

The rate of suicide among men aged 85 years and over who live outside major cities is around double that of those living within them[17].

Help in rural areas

There are a number of phone and web-based support services enabling access to expertise without the costs of travel, and reducing concerns associated with stigma and confidentiality[18].

The Alliance has prepared a Rural Mental Health Help Sheet – a guide to information: www.ruralhealth.org.au/factsheets

CRANAplus' Bush Support Line provides telephone (24/7) counselling for rural and remote health service providers and their families. It is staffed by registered psychologists who have experience working in rural and remote areas. Call 1800 805 391.

Mindframe has guidelines and support for journalists who report on suicide and mental illness: www.mindframe-media.info

Given appropriate and timely intervention and treatment, mental illness can be successfully managed. Many people who experience mental illness are able to lead healthy and fulfilling lives. With strong national leadership, adequate resources flexibly used and local service planning, mental illness can be well managed in rural and remote areas as well as in major cities.

References

1. http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4326.02007?OpenDocument

2. Social capital and health in rural and urban communities in South Australia (2009), Australian NZ Journal of Public Health, http://www.ncbi.nlm.nih.gov/pubmed/19236353

3. Mental Health Services Australia, AIHW, https://mhsa.aihw.gov.au/home/, GP encounters are estimated from the BEACH survey. The rural and remote estimates are population-weighted averages for Inner Regional plus Outer Regional areas, and Remote plus Very Remote areas respectively.

4. https://mhsa.aihw.gov.au/resources/workforce/ The rural and remote estimates are population weighted averages for Inner Regional plus Outer Regional areas, and Remote plus Very Remote areas respectively.

5. https://mhsa.aihw.gov.au/resources/expenditure/

67% and 17% are based on population weighted averages of Inner Regional and Outer Regional areas and Remote and Very Remote areas respectively.

6. Hoolahan B (2002) 'The Tyranny of Distance'. Issues that impact on mental health care in rural NSW. NSW Centre for Rural and Remote Mental Health, Orange, NSW. http://health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-p-mono-toc~mental-pubs-p-mono-ref#r78

7. Beyond Blue, http://www.beyondblue.org.au/resources/research/research-projects/research-projects/depression-in-farmers-and-farming-families

8. APS, http://www.psychology.org.au/inpsych/impact_disasters/

9. The rural and remote estimates are population-weighted averages for Inner Regional plus Outer Regional areas, and Remote plus Very Remote areas respectively. Major cities estimate is based on the Mid SES Major Cities rate.

10. http://www.myhealthycommunities.gov.au/our-reports/mental-health-and-intentional-self-harm/september-2016

11. http://www.aihw.gov.au/deaths/mort/

The rural and remote estimates are population-weighted averages for Inner Regional plus Outer Regional areas, and Remote plus Very Remote areas respectively.

12. http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-r-recons-toc~mental-pubs-r-recons-2~mental-pubs-r-recons-24~mental-pubs-r-recons-243

13. http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features30Mar+2011

14. AIHW, http://www.aihw.gov.au/indigenous-observatory-homelessness/

15. http://www.indigenouspsychology.com.au/workshop/about-the-workshops/

16. ABS, http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3303.02015?OpenDocument

17. http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features30Mar+2011

18. http://www.abc.net.au/news/2014-06-18/young-people-with-mental-illness-do-not-seek-help/5530748