

**NATIONAL RURAL HEALTH ALLIANCE INC**

**PUBLIC SEMINAR**

**'KEY ISSUES IN RURAL AND REMOTE HEALTH'**

**CANBERRA**

**FRIDAY, 20 OCTOBER 2006**

---

***MENTAL HEALTH IN RURAL AND REMOTE AREAS:***

***Anne Tonna, Executive Officer (Development), NSW Centre for Rural and Remote Mental Health, Orange***

**ANNE TONNA:** This morning I'd like to talk about mental health in rural and remote areas. I'm from the Centre for Rural and Remote Mental Health, so just to tell you a little bit about us, we're a major initiative of the University of Newcastle and the Centre for Mental Health which is part of the New South Wales Department of Health, and we're also supported by the Greater Western Area Health Service, but our remit is to look at area health services across rural New South Wales. We see our aim as improving the mental health of people living in rural and remote New South Wales through a couple of strategies around research and education and service planning, service development, policy development, and by collaborating with the local area health services, with the rural communities and with research and educational institutions. So if that helps position us in your mind's eye, that's a bit about us.

This is a slide from a report commissioned by the Victorian government showing the days lost due to disability across the age ranges, and I'm sorry for its blurriness, but basically what it's showing is that mental health is the largest single cause of disability, and the dark green area represents the days lost across the age ranges. I'm a bit disappointed that it is fuzzy. I'm also disappointed that in the categorisation of ages I'm no longer in the prime working age, which is 25 to 44. But I think it does quite illustrate just how big an issue it is for particularly our young people.

When we look at mental illness and service use of the total community population, we know that roughly a quarter in any 12 month period will

experience a mental illness, but of those people only about a third will go on to seek help for that condition and of those most will go to a GP and very few make it through to specialist mental health services.

This is some information about the workforce across Australia in terms of the categories of major cities - inner regional, outer regional. In nursing, the number of nurses per hundred thousand of population, if you can follow that line across - it's the second row there - seems to hold fairly steady across all the sectors. But when you take a look at the specialist workforce - and this is more towards the bottom third of the graph - the number per hundred thousand diminishes quite steadily as you move towards the outer remote areas.

So what I'm doing now is just sort of laying a bit of a foundation for mental health in rural and remote New South Wales and Australia. In terms of rural service utilisation, we know that we've got less frequent attendance at general practice and that GPs provide fewer per capita mental health services. They are also less likely to attend a mental health service and, if they do go to a GP, the GPs are less confident in the non-pharmacological treatments for depression in particular. There's greater rates of presentation for depression at the larger regional centres and less contact overall with health professionals, and that's even before you factor in the sorts of distances that we're dealing with in getting to help, and I think that slide is quite illustrative.

So what are the key issues in rural mental health? These are the key issues that the Centre has identified. We need to understand a lot more through research about just what it is about mental health and the geography of mental health. I think that's a fairly clumsy term, but it sort of maybe hints at the sort of thing that we're thinking about exploring. What makes for pockets of resilience in rural communities? What can we understand about what's going on across and between rural communities?

What are the needs of particular high priority target groups? I've just listed two there, but there are many others - so Aboriginal social and emotional wellbeing and, importantly at the moment with the continuing drought, farmers' mental health. But there could be other groups, and we're certainly working on projects to do with trans-cultural mental health needs - innovative service delivery models and service collaborations that we can show to be effective, as well as the sort of support through education that people who provide mental health support services could use in rural New South Wales and rural Australia.

One of the challenges with mental health and rural - and would be familiar to those of you who work in rural - is rural is not rural is not rural. And so to say "rural mental health is like this" doesn't really paint a good picture of what rural mental health is like, just as saying "Well, rural communities are like this" doesn't really paint a good picture of what rural is like. And we tend to gloss over sometimes the diversity that sits there in terms of population size and income distribution and land use and population change and employment patterns, to name a few factors.

The other thing about rural is that things are changing fairly quickly. Interestingly, in the last 15 years between 1986 and 2001 the number of farming families decreased by a significant amount. So even when we think we've got a picture of what's going on, it changes before our very eyes. You would know that young people are very mobile and leave rural areas far more than come back into rural areas during that phase of their life, and that school completion rates and attendance at secondary school declines as you become more remote.

The Australian National Survey of Mental Health and Wellbeing didn't find any significant rural/urban differences. They did find socioeconomic disadvantage was linked with mental health and that there was poorer access to mental health care, so there was reason for concern. But one of the things that maybe needs to be looked at is that point that I was making earlier about the need to get more into what the nature of rural is and to particularly take a look at what's important in remote areas.

How common are mental health problems? Well, most of you would know these statistics, one in five suffer a mental disorder in any 12 month period. Most commonly it would be depression and anxiety and substance use, especially alcohol. Men tend to be more represented in the substance use group and women in depression/anxiety, and it's the second most common condition seen by general practitioners.

Suicide is thankfully a rarer condition, but they could find no differences between metropolitan and rural areas. When you start to dig down on some of the specifics – and here's a good example – we can find higher risk groups across Australia. So, in terms of males being more at risk than females across all the age ranges, that's true, but when you start to come down into rural centres and remote centres and Aboriginal youth, you see the rates starting to be much higher than you would expect from those averages. And we know that men in farming also have a higher than average rate.

Here is another graph looking at the age standardised mortality rates and rate ratios across the categories, the ARIA categories, and you can see a steady rise as the remoteness increases, both in the rate and the rate ratios. Interestingly, across Australia there's a lot of discussion about whether or not the suicide rate is increasing or decreasing. When we look at the average annual change in ratios of observed to expected deaths due to suicide, in the metropolitan and regional and outer regional areas they are in fact decreasing, but we can see a steady increase in the rates for remote and very remote areas.

So again, there's more to be learnt by looking at - in more fine-grained ways - at what's going on with mental health in rural and remote areas. So part of it is researching exactly that, and the Centre has been lucky to be funded by the NHMRC over the next three years to take a look at the nature of mental health in rural and remote areas. The study will take in over three and a half thousand households across about 70 per cent of New South Wales. We are spanning the

spectrum of rural communities, both coastal and rural and remote, and it's a fairly major collaboration between some significant research units out there: the University Departments of Rural Health at Broken Hill and at Lismore; the Australian Centre for Agricultural Health and Safety at Moree; and our Centre; alongside of the rural area Directors of Mental Health Services, so trying to really identify what's happening.

The study will take a look at mental health at three levels. It will be looking at the individual level and the factors that are at play there, including people's views about mental health and their perceptions of the community. We'll be looking at the household level and at issues such as family and household stress, and we'll be also looking at the community level and what's going on for that particular community. So - are they growing; are they shrinking; what's been the particular stresses for them in the last period of time?

So from that we're hoping that we'll find out a bit more about: are there differences between rural and urban and, importantly, are there differences between rural communities, between rural and remote communities, and what makes for better mental health at those levels: the individual level; the household level; and at the community level. So an important key issue is I think to understand more about mental health in rural and remote areas.

The next is to really understand some important mental health needs of high priority target groups, and I just wanted to pick out two today to highlight. One is the needs of Aboriginal peoples and their social and emotional wellbeing, and in this regard the Centre is really working very closely with the Aboriginal Health and Medical Research Council on key research priorities and developing some projects around evaluating particular mental health programs for Aboriginal health, including the men's groups, and supporting the Aboriginal mental health workforce. So what are the models for workforce support that would be helpful? And also we've been involved in some analysis of mental health needs in particular areas, and in this case the Central West.

Another important group is for us at the moment the farmers' mental health, and I wanted to spend a bit of time talking through this particular project, because I think it highlights the ways in which research and education and service planning and development can be brought to bear to address a particular issue. Some of you will have seen this slide which talks about farmers' suicide which tracks the age standardised mortality rates. In green at the bottom of the slide is for Australian men, the red represents agricultural labourers, and the blue at the top, farm managers, and a steady and increasing rate in the latter groups, and roughly double for the farm managers at the right-hand side of that particular graphic; so an important target group for mental health services.

There's a very interesting slide on drought in New South Wales showing that drought is in fact a regular feature of the Australian landscape. It is what we expect to see in rural New South Wales. That's from 1972 to 2002. But if you added to that 2003, 2004, 2005, 2006, I suspect you would see black right across

the band across the months, because the drought has really bitten hard in that period of time. The picture on the right-side I think speaks a little to the frustration that sometimes people have getting the message across about the impact of drought to our metropolitan cousins.

A study looking at drought impacts beyond the farm gate looked at the fall in real income for people. There had been a 1 per cent drop in GDP for 2002-03. That's been steadily increasing since that time. In any drought, a drought is not the same as a drought is not the same as a drought. Some of you who could cast your mind back to the eighties when interest rates were high, it was difficult to sell animals off farm and there was lots of distress around the drought, quite a different reaction to drought at that time. I think the farmers have probably planned better and gone into this particular drought in a more considered way and have management strategies in place, as well as the economic conditions being quite different for them this time.

But if you look at the impact of drought on the community, their need for resilience is happening at a time when their resources are perhaps at their lowest. So, having gone through four or five years of drought, communities are feeling fairly well exhausted by that sort of effort. The estimate back in that period was that 100,000 jobs had been lost in the agricultural sector alone, and I think that when you think about the businesses that support the farming sector, if you were selling tractors you may not have sold much in the last little while, and so your workforce may not be as substantial and it once was. And people were talking of five to seven years of consistently reasonable seasons, and when you go into the next season, as we have now, and see the crops fail yet again, it becomes fairly disheartening.

We know in the rural situation that people when they're feeling a level of distress will turn to local helpers. Sometimes in the absence of the mental health service, and sometimes despite knowing that the mental health help is there, they would still seek out local helpers. And these local helpers I guess present a window of intervention opportunity.

Some of you would know about the role of rural financial counsellors, and this is an article taken from the *Weekend Australian* in 2004. Rural financial counsellors provide services to farms and will at the invitation of a farm family or farmer provide information about their financial status and their cash flow options for them to be able to make decisions about the future of their farm. When the Drought Review Panel was looking at the role of the rural financial counsellors, they said here are some people who are local, they're accessible, they're knowledgeable of the available assistance, and there's little embarrassment for people in approaching a rural financial counsellor and asking for their help. The Drought Review Panel in 2004 said that:

*Rural financial counsellors provide a unique blend of general counselling in addition to financial counselling and, while that can fill a social and emotional void, many counsellors are not trained in that field.*

So here they are, they're talking with people about their finance, in the course of that discussion often some emotional distress will surface and Jeff Fuller and his colleagues surveyed the Rural Financial Counsellors and asked them just that, "What percentage of the people that you saw in the last three months probably needed some referral for emotional distress?", and over half of them said, "About 20 per cent of the people that we saw needed to see someone". They were then asked, "Well, what do you do about that?", and 75 per cent of those people tried to make the referrals. They were asked, "How easy was that?" More than half of them said it was really hard.

And then they were asked, "Well, what might help?", and they were allowed to choose three strategies, and you can see that while they said, "More services in my region would really help", in fact the ways that they thought that referrals or strategies could be improved was, "Networking with the mental health and the other counsellors in my area", "referral guide and training", and "I need some training about when this comes up what do I do, how do I make it safe for this person and how do I get them across to the mental health services".

Jeff Fuller and his team were doing this work in 2004 and they said the lessons from this were that mental health help is really wider than mental health services, that local helpers will be used as first points of contact and that local helpers are best included in the local system, and you include them by networks and by training and by having protocols and guides for how they might link in with the services. His results and conclusions mirror some work that we were doing in late 2003 and through to 2004. In late 2003 the funding for the drought support workers at DPI and the funding for the mental health drought support workers – we weren't quite sure how far forward that would be continuing, and the prediction was that everyone was going home at 30 December.

So we gathered together all the people who had been working in mental health services in a Wisdom from the Drought consultative conference and we asked them a few key focus questions because when they went back to their real jobs, their main jobs, we were going to lose all their wisdom, and so we asked them "what works well?". And they said, "When it works well we have local interagency partnerships between agriculture and between health. We build the capacity of the community to know about those things, to respond to mental health".

What could we be doing better? They said, "Well, you really need to be treating drought and have a plan for it as if it's a disaster. Sure, it's not an acute condition. It's chronic and it steps its way in, but we need some plans around that. We need mental health workers to know a bit about farming. Mental health services might be provided in rural areas, but often you can live in a rural area and not know much about what's going on in the farm sector. We need increased mental health literacy in our community".

So then we asked them, “Well, what can we be doing between droughts to be better prepared next time?”, thinking that there would be a between drought between when we did this and now, and they said, “Build and sustain that local community capacity. Keep those networks alive. Let that work for you. And help us understand the long-term psychosocial impact of drought on people”. So you can see both of those things coming together in terms of reaching fairly similar conclusions in the way that services for a particularly difficult to reach group like the farmer community can be looked at.

So what have we been doing? We’ve been doing some research on the impact of drought, so trying to understand people’s experiences of drought, what their perception is of what’s needed, and listening to their stories, and we’re doing that in a couple of ways.

We’ve also been thinking about and working towards building the community capacity and services networks, and we’ve been doing that in a couple of ways. Really we’ve been doing it through mental health first aid training for the services that are in the frontline working with farmers, so we’re talking agricultural support services here: drought support workers; Rural Lands Protection Board; rural financial counsellors; in some cases transport workers, local stock and station agents. And as we do that we’re making sure that they understand who is available in the mental health service in their local town. Sometimes services are available and people just don’t know they’re there.

We’ve also been running a program of orientation to farmers’ mental health and wellbeing for our health workers, having them understand what’s going on in the farming sector, what’s driving the pressures for farmers, and we’ve been assisted very much in that work by Lyn Fragar in the Agricultural Health and Safety Unit in Moree. Also New South Wales Health in 2004 instituted the Rural Mental Health Support Line and we’ve been promoting that to rural communities. So a person can ring the Rural Mental Health Support Line and ask about themselves or ask about a neighbour that they might be concerned for or about a client that they might have been seeing.

So in very many ways that line is set up for anybody to use, and also we’ve provided training to those trained mental health professionals about the sorts of services that are available in rural areas. So not only can the referrals come back to mental health services locally but people can also be referred and put in contact with the rural financial counselling, the drought support workers and the other agencies that might help them navigate their way through the maze of support that they might need.

We’ve been lucky to be supported by a grant in aid from the Australian Rotary Health Research Foundation to look at evaluating that as a strategy. We think it’s going to work and we’re setting about trying to establish that it does work and is effective. And the next thing for us is their support for the introduction of that as a new service delivery model. So, having done some of the pilot work around the place, how the heck do we then work with rural communities to roll this out

across New South Wales? We were very pleased last week to hear the announcement from the National Suicide Prevention Strategy for funding coming to the Centre to enable us to do that, to drive that service delivery change across rural New South Wales for the next two years.

So we'll be working very hard with the rural area health services, with our collaborators in the research and educational organisations, with state health and with others to really work through the establishment of this model as a way of doing business. I think in health we're very used to working with service partners like police and ambulance and DOCS and the welfare agencies and the counselling agencies. We may be not quite so accustomed to thinking about our services collaborators as people in other industries, and I think that this is a very interesting way for mental health services to move forward.

The collaborating agencies on this particular project are many, as you can see, not least of which is the New South Wales Farmers' Association who after the drought summit in 2005 and concern for farmers' mental health pulled together a farmers' mental health network and has been working with those agencies around a strategy of understanding who's out there providing services, what are the ways in which we might work together collaboratively, where are we each putting our efforts, where are the gaps, where are the duplications, how can we work better together. So this group of people and their agencies both at a state level and at a local level will be important service partners as we work on that project.

So the farmers' mental health and wellbeing is just one example of the sort of service development work that I think is needed in rural and remote mental health. Among key issues also are: mental health emergency and critical care; early psychosis and pathways to care; local clinical services evaluation. We have a lot of services in place. How do we establish that they're working and how do we plan for better services?

Finally, in all of that, it's really important to support the people who are delivering mental health services, both the mental health services themselves and the other people who work in the front line. We've been doing that in a couple of ways. We've developed a pilot program at the moment, an Introduction to Rural Mental Health Practice, so that new practitioners in rural areas can find their feet more quickly and identify where they might be safe to practice, what they might need to learn more about, and so their supervisors and mentors can use this as a bit of a guide to get them oriented to mental health practice and rural areas quickly.

We're also piloting at the moment the Rural Mental Health Emergency Care package that goes alongside of our emergency mental health critical care response policy and planning. And we've also in the past, and continue to, run a program that we've called TeleWest, originally funded through the Regional Health Services Program and designed to reach the very remote towns of less than 5000 people. In 2004 we – or 2005; I've lost track now – ran six workshops around the particular topics that you see on the screen there. We managed to reach over 250 participants and across the six workshops reached into 89 towns, which I

think shows the value of that sort of tele-education methodology, and we're continuing that.

This final slide really just shows the nature of the collaborations that we see as important to being able to address some of the key issues in rural and remote mental health. I'm sure I've left some agencies off, so apologies if I have. But really the importance of collaborating with research units, with other health organisations and training organisations and key rural agencies for us has been vital in addressing those key issues. So thank you.

---