



MENTAL HEALTH IN RURAL AND REMOTE AUSTRALIA

...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. However, access to mental health services is 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 major cities. 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 cent¹. 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 cities counterparts on indicators of life satisfaction² and feelings of wellbeing³. 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 community⁴.

These positive dimensions to rural life do not negate the need for professional mental health services. In 2015-16 there were 482 MBS funded mental health encounters per 1,000 people in major cities, compared with 382 and 108 encounters per 1,000 people in rural and remote areas respectively⁵.

Other mental health services are funded by State and Territory governments, and in 2014-15 these were supplied at the rate of 328, 364 and 398 per 1,000 population in major cities, regional/rural and remote areas⁶.

This overall lower service provision rate may reflect the lesser 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 2015 were, respectively, 36 per cent, 78 per cent and 57 per cent of those in major cities, with even poorer comparisons in remote areas.⁷

Table 1: Prevalence of mental health professionals, by Remoteness, 2015

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Clinical FTE per 100,000 population					
Psychiatrists	13	5	4	5	2
Mental Health Nurses	83	74	46	53	29
Psychologists	73	46	33	25	18

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 2015-16 was, respectively, 74 per cent and 21 per cent⁸.

Table 2: Per capita MBS expenditure, mental health services, by Remoteness, 2015-16

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
All professionals	\$50.94	\$42.18	\$28.09	\$13.15	\$7.44

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

The rate of hospitalisation from mental health conditions (Table 3) as well as drug and alcohol use and intentional self-harm (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) when compared with metropolitan areas (870 per 100 000) . While data indicates significant differences 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 communities can be almost eight times higher than for other communities of the same level of remoteness¹⁰.

Table 3: Rate of same-day and overnight mental health hospitalisations, 2013-14

	Major Cities (High SES*)	Major Cities (Mid SES*)	Major Cities (Low SES*)	Inner Regional	Outer Regional	Remote
Age standardised 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

Aboriginal and Torres Strait Islander people (two thirds of whom live in rural, regional or remote areas) are almost three times as likely as non-Indigenous people to report high or very high levels of psychological distress¹¹, with the prevalence of this level of psychological distress decreasing from 34 per cent in major cities, to 32 per cent in regional areas and 31 per cent in remote areas (compared with around 12 per cent for non-Indigenous people across these areas)¹². Factors such as discrimination and racism, grief and loss, child removals and unresolved trauma, life stress, social exclusion, economic and social disadvantage, incarceration, child removal by care and protection orders, violence, family violence, substance use and physical health problems have been linked to social and emotional wellbeing concerns for Aboriginal and Torres Strait Islander people¹³. 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 provision¹⁴.

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^{15,16}. 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.

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.

Compared with major cities, the rate of suicide in rural and regional areas is about 40 per cent higher while the rate in remote areas (Table 4) is almost twice the major cities rate¹⁷.

Table 4: Incidence of suicide, by Remoteness, 2010-14

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Age standardised rate per 100,000 population					
Males	14.9	21.3	22.9	28.3	29.7
Females	n.p.	n.p.	n.p.	9.5	13.0
Persons	9.9	13.1	14.4	19.6	22.3

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

Note: n.p. not published

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 problem¹⁸.

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 this¹⁹.

The rate of suicide among Aboriginal and Torres Strait Islander people is 1.9 times that of non-Indigenous people, rising to 3.7 times higher for Indigenous compared with non-Indigenous 15-24 year olds²⁰.

The rate of suicide among men aged 85 years and over who live outside major cities is around double that of those living within them²¹.

Regional incomes can be heavily reliant on farming, mining, tourism, fishing or forestry. Income from these industries directly and indirectly underpins the livelihood of many people in rural and remote areas, which can be strongly influenced by external factors such as weather conditions, commodity and fuel prices, and currency exchange rates, all of which are subject to periodic fluctuation. Stress induced by unfavourable conditions and natural disasters such as drought, bushfires, floods and cyclones, the frequency of

which is projected to increase as climate change continues to roll out, can adversely affect mental health²².

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 combination²³. They are also more likely to experience challenges around mobility and social isolation – partly attributable to the lack of public transport – and access to pain management and palliative care. The greater prevalence of older people in rural and regional areas, along with the general ageing of the Australian population makes mental health of older rural people an important and growing issue over the coming decades.

In many respects, mental illness is like physical illness; given appropriate and timely intervention and treatment, mental illness can be successfully managed. Many people who have experienced 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.

Help in rural areas

Need to talk to someone? There are a large number of phone and web-based support services enabling access to mental health support.

If you need immediate assistance, call Lifeline on 13 11 14.

CRANApus' Bush Support Line provides telephone counselling (24/7) 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.

For more information about mental health services in rural and remote areas download our guide to Rural and Remote Mental Health Help (<http://rural-health.org.au/sites/default/files/publications/2017-rural-mental-health-help-sheet.pdf>)

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