

MENTAL HEALTH IN RURAL AND REMOTE AUSTRALIA



... healthy and sustainable rural, regional and remote communities

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 also greater exposure and vulnerability to natural disasters, while rates of overcrowding, housing stress and homelessness are higher as well.

Aboriginal and Torres Strait Islander peoples make up a higher proportion of the population with increasing remoteness from major cities.¹

The prevalence of people experiencing mental illness is similar across the nation: around 20 per cent.^{2,3} However, it has been suggested that the comparable rates of mental illness in rural areas and major cities mask a high prevalence of psychological distress and untreated (or undiagnosed) mental illness.⁴ Rates of self-harm⁵ and suicide⁶ increase with remoteness and people who experience suicidality are more likely than the general population to have a mental health disorder or condition.⁷ Comorbidity of substance use and mental illness is also widely accepted.⁸ Rates of lifetime risky drinking (more than two standard drinks per day on average) show strong regional dependence⁹, while illicit drug use is higher in remote and very remote areas compared to all other regions.⁹

People in rural areas regularly score better than their major city counterparts on indicators of life satisfaction¹⁰ and feelings of wellbeing.¹¹ 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, as well as informal support networks between neighbours, friends and the community.¹²

These positive dimensions to rural life do not negate the need for mental health services, yet patterns of service utilisation are altered in rural Australia when compared to major cities.

The mental health care service system

The mental health care service landscape is complex. Mental health care services are provided in the private sector via the Medicare Benefits Schedule (MBS)-subsidised system, utilising private health insurance rebates and patient contributions, among other funding streams. Non-government organisations (sometimes with state or federal government funding, for example through Primary Health Networks and other departmental programs) also deliver ambulatory and residential mental-health-specific services. State and territory health and hospital services and private hospitals deliver both community and hospital-based services. Outside of major cities, organisations such as the Royal Flying Doctor Service (RFDS) provide mental-health-related retrieval services and primary mental health care, with much of their funding derived from federal government sources.

State and territory governments contribute the largest slice of expenditure on mental-health-related services – \$6.4 billion in 2018–19. This was followed by the Australian Government who contributed \$3.6 billion (not including their contribution to public hospital costs), then private health and other third-party insurers (who altogether contributed \$584 million).¹³

The five leading types of mental-health-related expenditure of the Australian Government in 2018–19 (\$ per capita) were: national programs and initiatives (\$59.59), combined MBS expenditure (\$51.45), the Pharmaceutical Benefits Schedule (\$20.58), private health insurance rebates (\$6.63) and research (\$3.42).¹⁴ It is important to note that, while national programs

and initiatives are the largest benefactor of federal funding, publicly available data doesn't allow the analysis of service provision by remoteness. This is a limitation of this publication.

Mental-health-specific service provision in rural Australia

Table 1 below summarises the provision of MBS-subsidised mental health care services in primary health care¹⁵, by remoteness category¹. Overall service provision by all providers is 2.7 times less in Remote areas and 5.6 times less in Very Remote areas. The rate of service reduces with increasing remoteness in each professional category except 'other allied health'. The highest rate of service in each remoteness category is provided by GPs, yet GP mental-health-specific services reduce significantly in Remote and Very Remote areas. Services provided by a psychiatrist reduce dramatically once outside of Major Cities, as do those provided by clinical psychologists. More services are provided by 'other psychologists' than clinical psychologists in all remoteness categories.

Table 1. MBS-subsidised primary mental health services 2019–20 (rate per 1,000 population)

	GP	Psychiatrist	Clinical psychologist	Other psychologist	Other allied health	All providers
Major Cities	154.7	112.0	111.9	129.2	17.4	525.2
Inner Regional	151.5	78.9	88.5	114.4	25.9	459.1
Outer Regional	119.5	48.7	51.4	75.1	18.5	313.1
Remote	78.0	34.8	29.6	42.7	7.9	193.0
Very Remote	38.1	19.6	14.1	19.8	2.1	93.7

Source: www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/medicare-subsidised-mental-health-specific-services/interactive-data

Primary mental health services are also provided by community mental health care services delivered by state or territory governments, although eligibility criteria for these services are usually limited to those with acute or severe and complex illness. Table 2 below illustrates that the rate of utilisation of community mental health care services generally increases with remoteness. It also shows the much higher rates for Indigenous people.¹⁶ Increased utilisation of this system in rural areas might indicate presentation later in the course of an illness or disorder.

Table 2. Community mental health care service utilisation 2018–19 (service contacts per 1,000 population)

Major Cities	Inner Regional	Outer Regional	Remote	Very Remote	Indigenous	Non-Indigenous
351.0	389.1	411.7	463.0	412.0	53.8	16.1

Source: www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia

Table 3 below shows¹⁷ mental health emergency department presentations increase with remoteness such that the rate in Remote and Very Remote areas is 2.1 times that in Major Cities. The rate of emergency department presentations for mental health issues in Indigenous people is 4.5 times higher than in non-Indigenous people. This regional disparity in utilisation of emergency departments for mental-health-related conditions might be used as an argument for the inadequacy of access to primary mental health care services in rural Australia relative to population need.

Table 3. Mental-health-related emergency department services 2019–20 (presentations per 10,000 population)

Major Cities	Inner Regional	Outer Regional	Remote	Very Remote	Indigenous	Non-Indigenous
105.6	139.4	141.1	225.4		480.9	107.9

Source: www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services/patient-characteristics

State and territory governments deliver hospital-based mental health care services. Table 4 presents several hospital services by remoteness category, including hospital admissions data both with and without specialised psychiatric care.^{18,19} This data, which includes admissions for 'alcohol and other substance use disorders', illustrates similar total rates of admission for same day mental health services in Major Cities and Inner Regional areas, alongside higher rates in Outer Regional and Remote and Very Remote areas combined. Total overnight admissions (including 'alcohol and other substance use disorders') are similar in Major Cities, Inner and Outer Regional areas but higher in Remote and Very Remote areas combined.

A trend is evident, for same-day admissions in public hospitals, towards reducing specialised and increasing non-specialised mental health care with increasing remoteness. The same trend is apparent for overnight-admitted separations: specialised mental health care services reduce with remoteness and non-specialised mental health care services increase with remoteness. It is worth noting that the relationship between harmful alcohol use and remoteness might be a confounder here and contribute to the increasing rate of admissions without specialist services with remoteness. 'Mental and behavioural disorders due to the use of alcohol' was the most prevalent principal diagnosis for both same-day-admitted public and overnight-admitted public and private hospital separations without specialist services.^{20,21}

Utilisation of hospital-based mental health care services is much higher for Indigenous people than non-Indigenous people in all categories presented. The rate of separation for same-day-admitted public hospital services in Indigenous people is almost 3.5 times greater than in non-Indigenous people, while the rate of separation for overnight-admitted public and private hospitals is 2.7 times greater in Indigenous people.

¹ Refers to the Australian Statistical Geography Standard Remoteness Areas (ASGS - RA): Major Cities, Inner Regional, Outer Regional, Remote and Very Remote Australia (see www.abs.gov.au/ausstats/abs@nsf/mf/1270.0.55.005).

Table 4. State or territory mental health care services 2018–19 (separations per 10,000 population)

	Same-day-admitted public hospitals			Overnight-admitted public and private hospitals		
	With specialist services	Without specialist services	Total	With specialist services	Without specialist services	Total
Major Cities	8.6	14.3	22.9	68.0	37.0	105.0
Inner Regional	4.4	16.2	20.6	67.5	38.3	105.8
Outer Regional	3.7	23.7	27.4	55.8	48.5	104.3
Remote	1.4	40.0	41.4	37.2	73.5	110.7
Very Remote						
Indigenous	11.7	58.4	70.1	153.6	105.2	258.8
Non-Indigenous	6.1	14.0	20.1	63.4	31.4	94.8

Source: www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia

Rural Australians are less likely to access MBS-funded primary mental health care services than their city counterparts, yet more likely to utilise state and territory community mental health services. They are also more likely to present to an emergency department with a mental health concern and more likely to be admitted to hospital for a mental health problem in Remote and Very Remote areas. When rural Australians access hospital-based mental health care, they are less likely to receive specialised psychiatric services.

The Alliance believes this data illustrates the lack of alignment between population need and access to primary mental health care outside of major cities. This results in a shift of care to more acute parts of the health system, where people are likely to present later in the trajectory of their illness or condition with more severe symptoms. A lack of access to, and utilisation of, primary mental health care in rural areas not only costs the health system more in the long term but is likely to contribute to poorer outcomes for rural communities. A lack of access to specialised psychiatric services when admitted to hospital also has the potential to result in poorer outcomes for rural Australians.

Reduced access to primary mental health care is also reflected in MBS expenditure data, illustrated in Table 5.²² When compared with Major Cities, per capita MBS expenditure on mental health services in 2019–20 reduced with remoteness. Expenditure in Remote areas was 2.8 times less than Major Cities and in Very Remote areas it was 5.7 times less.

Table 5. Mental-health-specific services via MBS by remoteness 2019–20 (\$ per capita expenditure)

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
All professions	56.87	48.25	32.97	20.38	9.92

Source: www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services/interactive-data

It is important to note that MBS expenditure does not characterise the entirety of primary mental health care service provision, particularly outside of major cities. Block-funded services (provided, for example, by the RFDS) are an important part of the rural mental health care landscape and might contribute to increased differential expenditure in rural areas. But data on primary mental health care service provision outside of the MBS is difficult to obtain via publicly available sources and is therefore not discussed further in this publication.

Workforce

The altered pattern of mental health service utilisation in rural Australia is related, in part, to the lack of an appropriate health workforce. In general, the health workforce reduces with increasing remoteness and is disproportionate to increasing need. Table 6 below shows the prevalence of selected mental health professions by remoteness.²³ The distribution of psychiatrists is skewed heavily towards Major Cities. There are 2.2 times as many psychiatrists (per 100,000 population) employed in Major Cities as there are in Remote areas and 5.3 times more than in Very Remote areas. The prevalence of psychologists decreases progressively with remoteness, as does the prevalence of mental health nurses. There are 4.1 times as many psychologists (per 100,000 population) and 2.6 times more mental health nurses employed in Major Cities than in Very Remote areas.

Table 6. Prevalence of mental health professionals by remoteness 2018 (clinical FTE per 100,000 population)

	Psychiatrists	Psychologists	Mental health nurses
Major Cities	13.3	77.5	86.2
Inner Regional	6.0	48.9	79.0
Outer Regional	4.9	34.5	49.5
Remote	5.7	27.6	51.2
Very Remote	2.5	18.8	32.9

Source: www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce

Barriers to access and needs of specific population groups

Various additional issues influence access to mental health and wellbeing services and support in rural Australia. These include:

- attitudinal factors – such as beliefs about usefulness and privacy concerns
- cost – including the services, any travel and the cost of other work foregone
- digital factors – including access to technology, useability and speed of connectivity.

Some sections of the rural population face unique challenges. Within rural communities, farmers have been found to be less likely to access health care generally and mental health care specifically.²⁴ Barriers to help-seeking in farmers include: a 'need for control and self-reliance'²⁴, a preference for self-management²⁵, lack of confidence that anything will help²⁵, difficulty communicating with health professionals²⁴ and concerns about privacy²⁶

Stigma related to mental health perpetuates privacy concerns for rural people, where health professionals are embedded within local communities and might be known to individuals. '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.^{26,27}

Aboriginal and Torres Strait Islander peoples (two thirds of whom live in rural, regional or remote areas) also have specific social and emotional wellbeing needs. Factors such as discrimination and racism, grief and loss, intergenerational 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 people.²⁸ Some experts argue that there is a lack of 'fit' between Aboriginal concepts of social and emotional wellbeing and mainstream concepts of mental health and illness which have informed mental health service provision.²⁹ Indigenous people were 2.4 times more likely than non-Indigenous people to experience high levels of psychological distress in 2018–19, after adjusting for age differences in the populations: 31 per cent of Aboriginal people experienced high levels of distress compared with 13 per cent of non-Indigenous Australians.³⁰ The proportion of the Indigenous population experiencing high or very high levels of psychological distress was greatest in Inner and Outer Regional areas combined in 2018–19 (34.5 per cent).³¹

Structural barriers such as the need to travel vast distances to access care, and costs related to travel, accommodation and time away from work are also a significant concern. Lower incomes and limited or non-existent public transport compound this. While access to digital health care and support services may ameliorate some of these barriers, reduced digital literacy in consumers and health

professionals, and lack of access to digital infrastructure (including reliable and affordable internet and mobile phone connectivity, hardware and interoperable software) presents challenges to equitable access outside of major cities, where the potential for benefit is large.

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.³²

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, and 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 the effects of climate change increase – can adversely affect mental health.³³

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.³⁴ 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.

Drug and alcohol misuse

Access to drug and alcohol services is also of concern in rural Australia, given higher rates of substance misuse and the link between substance misuse and mental illness. The rate of clients accessing a drug and alcohol service in 2016–17 increased from 585.8 per 100,000 population in Major Cities, to 724.5 in Outer Regional and 1294 in Remote and Very Remote areas combined.³⁵ People in Remote and Very Remote Australia, who are accessing these services at the highest rate, have to drive the furthest to get the care they need. The median driving time to a drug and alcohol service for those who had sought treatment for their own drug use was 91.6 minutes in 2016–17 in Remote and Very Remote areas, compared with 18.2 in Major Cities, 19.5 in Inner Regional areas and 13.9 in Outer Regional areas.³⁶

The geographical spread of drug and alcohol treatment agencies also demonstrates the variability in access to services for substance misuse. For example, in 2019–20 there were only five drug and alcohol treatment agencies in Remote and Very Remote New South Wales (5.7 agencies per 100,000 population), whereas in Remote and Very Remote Western Australia there were 21 agencies (13.9 agencies per 100,000 population).³⁷

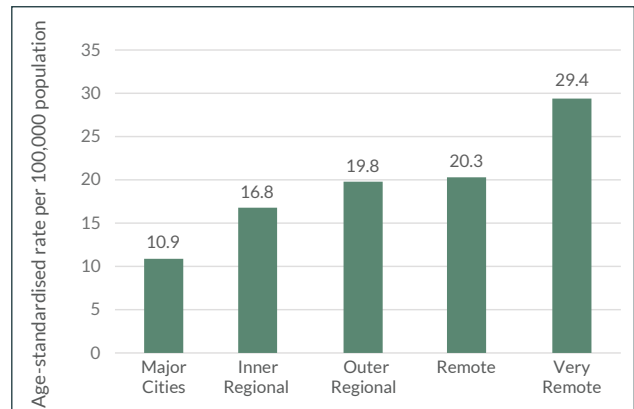
Self-harm and suicide

There is significant unmet population need for services and supports, challenges to the provision of a suitable and sustainable workforce, and multiple barriers to access in the area of mental health and wellbeing in rural Australia. Due to lack of timely access to services, diagnosis, treatment and ongoing management of a mental health condition in rural and remote areas is likely to occur later or not at all, resulting in increased utilisation of the acute care sector and sometimes leading to the most tragic of outcomes – self-harm and suicide.

There is a strong relationship between self-harm hospitalisation and remoteness: in 2019–20, hospitalisations increased from 102.6 per 100,000 population in Major Cities, to 197.7 in Very Remote areas⁵; the rate of hospitalisation for self-harm in Indigenous Australians in 2019–20 was 3.4 times greater than for non-Indigenous Australians (347.9 compared with 103.6 per 100,000 population).⁵

Figure 1 illustrates the relationship between suicide and remoteness in all persons in 2019⁶ and shows the incidence of suicide in Very Remote areas was over twice that in Major Cities. The incidence of suicide in Indigenous Australians in 2019 was over twice that of non-Indigenous Australians (27.1 compared with 12.7 deaths per 100,000 population, age-standardised).⁶

Figure 1. Incidence of suicide by remoteness area 2019



Source: www.aihw.gov.au/suicide-self-harm-monitoring/data/data-downloads

A more detailed exploration of the factors contributing to rural suicide can be found in the following fact sheet: *Suicide in rural and remote Australia* (www.ruralhealth.org.au/sites/default/files/publications/nrha-rural-suicide-factsheet-july2021.pdf)

Conclusion

Mental illness, like physical illness, can be successfully managed given appropriate and timely intervention and treatment. Many people who have experienced mental illness are able to lead healthy and fulfilling lives. There is a clear commitment from government to prioritise mental health and wellbeing for all Australians and recognition of the specific challenges and outcome gaps for rural Australians. If strong national leadership and an agenda of action and measurable change is coupled with adequate resources, workforce innovations, local service planning and collaborative partnerships building on existing capacity, there is potential for mental illness to be well managed and social and emotional wellbeing to be maximised in rural Australia, in line with 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.

CRANaplus' 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 *Rural and remote mental health help sheet*. (www.ruralhealth.org.au/sites/default/files/publications/2019-rural-mental-health-help-sheet.pdf)

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Note: Density of drug and alcohol agencies by remoteness category were calculated by NRHA using ABS population data.