Farmers’ mental health: a survey of Australian rural financial counsellors—first points of contact in primary mental health care

Jeffrey Fuller, University Department of Rural Health (Northern Rivers), University of Sydney and Southern Cross University

Introduction

Australia is in the grip of the worst and most prolonged drought ever recorded. This is a profound and stressful challenge on family farms and also on the rural communities that directly depend on agriculture. Take the case of Robert Neale, reported in the Australian newspaper last October. He is a fourth generation farmer from Cobar facing “drier and dusty paddocks”, who stated that in relation to past times “… its not the same now because you can work your guts out and still not get anywhere”. Facing such prospects, and with antennae out for the psycho-social impacts, we might ask:

- What impact might this drought have on Robert Neale and his family?
- What barriers do such farming families face in seeking assistance?
- How could services be provided for these families that are accessible and acceptable?

What do we know about the extent to which such circumstances have as a mental health impact in rural and remote Australia? While recent studies suggest that there is very little difference in the prevalence of mental disorders of rural and urban Australians2,3 this is not the case for markers of general mental health and well-being, such as suicide. Male suicide rates are 1.2–1.5 times higher than expected outside of major cities4, and young non-metropolitan men are less likely to seek professional mental health help than metropolitan men (11.4% cf 25.2%).5

Mental health status is one thing and access to services is another. Work in Northern country South Australia has revealed a large gap in counselling services for people who have mental health problems that are more treatment ‘grey areas’ than acute and serious mental illness.6 Other services that are thin on the ground are those that deal with children’s mental health, relationship problems, drug and alcohol problems, domestic violence and gambling. For instance, in the Northern region of South Australia at the time of the 2001–2004 regional mental health planning project, there were only two mainstream drug and alcohol workers to service a population of 54 000 spread over an area of more than 750 000 square kilometres.7 This ratio of workers to population is even more of a problem when the ‘rugged’ nature of the region and its people are considered, where there is twice the state percentage of people in the high alcohol risk category.

As well as accessible, services also need to be available in a form that is acceptable to the cultural traditions of a particular community. For instance, in rural communities a culture of self-reliance works against help seeking for ‘emotional’ problems. This tradition of self-reliance can have two effects. First it fosters an environment in which one is not allowed emotional “weakness”, which is especially true for farming men, and second, a mistrust of outsiders, especially professionals from the city who may not be seen to understand the rural circumstance.8 When these barriers are added to the close-knit nature of many small towns, this can constrict the discussion of sensitive problems, particularly when there are concerns about anonymity.9
While small town farming communities do not have a range of professional mental health services, across country regions there are relevant resource people such as agricultural support workers and other non-mental health and informal helpers. These resource people can be the first port of call for emotional support and referral, such as for faming families like Robert Neale’s. The following two areas of mental health service reform are relevant to the inclusion of such helpers in the system:

1. **A cultural shift in how mental health is perceived within the community.** This means improving community understanding about and de-stigmatising mental health. So, mental health needs to be built into local community activity.

2. **Enhancing primary mental health care and so a focus on early intervention.** This move is to make mental health a part of the core business of mainstream primary health care providers. This will require an acceptance by mainstream and also specialist mental health providers to change work practices and collaborate more closely. It is in primary mental health care that we need to develop new roles, relationships and system supports with GPs and non-government providers based on the way that rural and remote communities function.

Given the need and with this policy emphasis it is timely to examine the role that various local human service providers can play alongside the formal mental health sector.

**Rural financial counsellors**

One group of local helpers in rural Australia are Rural Financial Counsellors (RFCs). The are employed by non-profit community groups, jointly funded through the Department of Agriculture Fisheries and Forestry (DAFF), state governments and local communities. RFCs provide rural financial counselling and information to primary producers experiencing hardship. DAFF state that while RFCs do not provide personal counselling they can provide referrals and information. The 2004 Drought Review Panel found that the Rural Financial Counselling Service was highly regarded by the community because it was local, counsellors had knowledge of community services and there was little embarrassment associated with its use.

The purpose of this study was to determine the extent to which mental health and well-being issues were a part of the work of RFCs.

**Method**

A questionnaire was administered in 2004 to all Australian Rural Financial Counsellors from contact details provided by the Commonwealth Department of Agriculture, Fisheries and Forestry. The questionnaire sought counsellors’ observed need for assistance by their clients over the past 3 months for mental health related (i.e. non-financial) issues and use of referral networks. We defined mental health broadly as covering social, emotional or stress related issues and we defined referral to include making a suggestion through to making the links for a client to another service, regardless of whether the client acted on this.

**Results**

Of the 103 counsellors identified, 77 replied. Approximately half reported that more than 20% of their clients required mental health related assistance. Just under a half referred at least 75% of these clients. The range of responses was from no assistance, because they stated their employment contract precluded emotional or personal counselling, to involvement that verged on being outside the boundaries of the role. Although the role does not cover personal counselling, some RFCs described the dilemma in keeping counselling about financial matters separate from personal matters and the difficultly in “unravelling the strands”.

### 9th National Rural Health Conference

Albury NSW

7-10 March 2007
As a known and trusted service, RFCs by default became a first point of contact for talking to someone about a range of matters as the following counsellor explained:

Often RFCs are the first contact that a rural family has, in their home, with someone they can talk to confidentially … usually a good rapport develops and other issues as well as financial ones can emerge.

The client’s comfort in disclosing issues did present counsellors with a role dilemma because, as the known and accessible service, “clients sometimes like us to take on a counselling role which we are not qualified for.” Almost all counsellors indicated that they usually refer clients for mental health matters, the main points of referral being to the GP. Just under half found referrals difficult and those who reported referrals as being easy described good working relationships with social counsellors and other agencies in their area.

As a referral some counsellors simply gave a recommendation to the client, while others took a more active and delicate approach to suggest a referral without getting the client off side, as one counsellor explained:

Giving people referrals can be a delicate task because … we need to be careful to ensure they don’t feel labelled … convincing them that a referral can offer real assistance … is our biggest challenge. The farming community (especially men) are particularly independent and will not look for outside assistance to help their situation.

Just under two thirds thought referrals could be improved and the three main suggestions to help this were:

- networking with mental health and other counsellors in the region
- training
- a referral guide.

**Discussion, further work and implication for service development**

RFC involvement beyond only financial matters was identified as controversial and clearly they should perform the financial assistance role for which they are employed. However, separating financial and other matters is not straightforward. While some counsellors were very clear that their role was only to do with financial matters, most expressed a need to communicate sufficiently with the client in order to effect a referral for mental health assistance, if needed, so that financial problems could then be dealt with by emotionally functioning individuals.

Given that in small rural and remote communities, front line people such as rural financial counsellors, and others such as police, teachers and clergy do provide some form of mental health help, these front line workers do need support. For quality service they should be included in a network that includes links to mental health services.

In a subsequent project we are evaluating a series of interventions to promote farmers mental health service networks in NSW. The intervention involves joint skills development of both the local mental health and also agricultural support workers under the aegis of the area mental health service. As a part of the evaluation we are developing the use of social network mapping as a means to describe how the local health service network operates before and after the intervention. The local network is bound by compiling a list of “agents” from those names given to us by 3–5 local key informants. Each agent is then contacted and asked to rate over the past 3 months the extent to which they have linked with the other agents on the list to exchange service information, make and receive referrals and plan programs together. Through the use of sociograms (see figure 1) and network measures we are able to show which agents are most influential and prominent in the local mental health network and also how highly connected the network is as a whole, giving some indication of the network strength. These data will then be used to identify where network improvements might be made and also as a post
intervention measure to illustrate the extent to which network improvements have been made. It can be seen in figure I (which is a the pre intervention network in Town C) that the network is dominated by the agricultural support and welfare agents centred largely on the Rural Financial Counsellor. Overall, the main agents in this network response to farmers' mental health and well-being (broadly defined) were the Rural Financial Counsellor, the Department of Primary Industry Drought Support Worker, the Department of Community Services and Centacare. While it cannot be easily seen in this busy sociogram, there was no link between the most dominant agent (RFC) and the mental health team and it is here that surely some service improvement is required.

References


Presenter

Jeffrey Fuller was trained as a mental health and community health nurse. He has worked for over 20 years in multi-disciplinary public health settings, including as a manager in community health services and over the last 10 years in university posts. His current post is at the Northern Rivers University Department of Rural Health, University of Sydney, with senior responsibilities for rural health curriculum development. He and Associate Professor Schofield share a University of Sydney grant funding CIRHTS and a study of ageing and retirement of health professions. He previously co-ordinated the Master of Public Health program at the Department of Public Health, University of Adelaide, and prior to that he was the foundation Director of Public Health at the Spencer Gulf Rural Health School in South Australia. His research interests are in rural mental health, Indigenous and cross-cultural health servicing and public health program planning. His teaching interests are in community health and interdisciplinary teamwork.
Figure 1  Town C worked together—pre intervention whole network