Mental health needs of rural communities

Brian Kelly, Director, NSW Centre for Rural and Remote Mental Health

Thank you, Julie. What I’m going to talk about now for the next few minutes is perhaps applying some of what Kris Battye has already been discussing, and some other issues, to the problem of mental health. I think we are all very gratified in mental health to see the level of increasing recognition and subsequent funding for this neglected area of health and to see that in the last 12 months or so. But it presents us with some very important challenges in the way we think about mental health services, how we staff those services, the models that we use, and how we apply them to rural areas.

So what I’m going to do is very quickly put some of that in context about what we know about mental health problems in Australia and in rural areas, the rural background that is pertinent to thinking about the sort of pressures and risk factors and determinants of mental health and mental health outcomes, look at some of the new directions for mental health that certainly form a big part of the Council of Australian Governments’ response and finally some service models and innovation that we can think about.

This is just a snapshot of what we understand about mental illness in Australia and I’d add to this that our understanding of mental health in Australia is very limited. These are the results from the first Australian National Survey of Mental Health and Wellbeing that tell and support the oft-quoted figure of one in five Australians in a 12 month period is suffering from a mental disorder. Now, I think the most concerning thing for all of us in health, not just in mental health services, is that it is only 35 per cent of those people that receive any treatment. We know we have very effective treatments in mental health. We’ve got a very strong scientific basis for those treatments but perhaps the greatest concern is that if people don’t have access to those treatments and access to those treatments at an early stage, it has a tremendous effect on outcome and subsequent disability. When people do seek treatment it’s a minority: only 2.4 per cent are ever seen by a specialist mental health service. It’s also a minority that are seen by general practitioners in primary care.

So this sets the scene: when we are thinking about mental health in any location, whether that be urban or rural, but particularly in rural areas, we need to think much more broadly about who we consider to be the mental health workforce as we try to get people to the most appropriate level of care. This might be a little hard for you to see, but it outlines the impact of mental illness. Mental illness accounts for the largest single cause of disability in our country. Of greatest concern is that the impact is highest in the young to middle-aged adult years, the 15 to 44 years, where it accounts as the greatest cause of illness related disability. Now, this is estimated to cost the country about $20 billion a year.

Now, let’s look at the rural context. In order to put this in context for rural areas we need first up to deal with the issue that while we talk about rural health and rural mental health, as you would all know, rural is a very blunt divide. What’s captured in rural areas is a great deal of diversity, not only in distance and geography, the sorts of populations, the employment patterns, whether that be tourism, mining, agriculture or a mixture of all of those, areas are undergoing population decline, some areas are undergoing population growth. There’s a great deal of cultural diversity across rural areas and a great deal of difference in income distribution and wellbeing. So behind this sits the problem when we talk about rural health and rural mental health.

We do know though that there are some important indicators of greater risk to health problems in some of these important determinants of mental illness and mental health and wellbeing. Rural areas overall have a lower socio-economic ranking than urban centres and socio-economic status is a very important factor associated with mental illness. It is not that socio-economic status causes mental illness, but it is associated with either raising the likelihood of having a mental illness or, when people suffer a mental illness, experiencing a decline in their socio-economic wellbeing.
Rural areas have lower employment, lower education rates, lower retention at school, and generally lower income levels. There’s a greater reliance on local industry, particularly primary industry, and that leaves rural communities to the sorts of forces that can alter primary industry, and we’ll talk about drought in a moment. When socio-economic change occurs it is felt more acutely given the sometimes quite fragile infrastructure base in rural areas and environmental issues are felt very acutely through the drought.

Other environmental challenges, of course, as many people in this room would have experienced, can have a devastating impact, whether they be drought, flood or fire. So these in themselves can have a substantial mental health impact but also an impact on the capacity of those communities and their infrastructure. We’ve talked a lot about drought at different times during this conference, but I guess amongst these figures that indicate the very real impact and the modifying factors that influence that impact, I draw your attention to the last point here, which is of particular concern in terms of mental health. What we are witnessing with this drought and into the future is the capacity of many communities to support themselves is at its weakest when the need is greatest.

The other feature of rural or non-urban communities in Australia is that these represent, as we move from metropolitan centres to very remote regions, a great percentage of people who are Indigenous. We have heard a number of times at this conference the greater risk that Indigenous people suffer to their health, greater mortality and morbidity from a range of conditions, and of course someone said in the session yesterday rural health could also be considered Indigenous health.

Access to health services, as we have heard already this afternoon, is a major problem. I will not go over the details of this. We acknowledge there is a shortage of health care providers. There is also greater restriction an access to care. There is discontinuity of care in terms of access to specialist services, an issue that we heard about earlier in this conference regarding cancer services. There is a dislocation from core service centres and there is a lack of services which are particularly tailored to the rural setting. We often think of the adaptation of urban models to rural settings.

One of the things I want to come back to later is what rural health can instruct urban areas on; the way in which urban services can work with communities to shape services that are appropriate to the people they’re serving. Urban areas don’t do that at all well yet. It is still needed there as much as it is in rural areas. Even where we have services such as general practitioners, the number of visits to a general practitioner per capita is less as you go into more remote areas of the country. So it’s not just the number of practitioners that we have, but how they are being used.

In terms of mental health, whilst we acknowledge there is less frequent attendance of GPs in rural areas, we also know that from the BEACH data that rural GPs provide fewer per capita mental health services than they do in urban areas. There is less confidence by GPs in non-pharmacologic treatments for illnesses like depression. There is less attendance at mental health services by people in rural areas where the mental health services do exist. There is an interesting trend towards perhaps some greater presentation with depression or rates of presentation with depression in larger regional centres, but in general less contact with other health services or the broader range of a health professional team.

So let’s look more at the determinants and outcomes of mental health with this background in mind. As I said at the outset, our knowledge of mental health in rural areas is very limited. The studies that have been conducted here in Australia and overseas are inconclusive. They tend to suggest that despite the heavy weighting towards major risk factors to ill health in rural areas, that there isn’t a demonstrative difference between rural and urban areas in mental health. Now this, I would hypothesise and speculate and put to you, is because of the crudeness of our research methods where we clump rural areas together rather than look at an issue I want to take up in a moment, at the geography of health and the distribution of factors across rural communities that might influence health that we’re just not capturing in our current methods.

We know, as I have said already, that there is a link between socio-economic disadvantage and mental health and there is poor access to mental health care in rural areas. Paradoxically, despite this evidence regarding mental health, we find that there are greater rates of injury, very serious injury in rural areas, chronic physical illness, cardiovascular disease, cerebrovascular disease, diabetes, cancer outcomes are
poorer in rural areas and that has been presented here in this conference again, and greater rates of substance use. Now, all of these carry with them significant mental health risks and we are increasingly recognising the mental health consequences of serious physical illness. So we are in a bit of a quandary when it comes to mental health.

Let’s talk about suicide then, as perhaps the most—the focal point or the very sharp end of the consequences of mental illness. As we know, almost all suicide is due to mental illness of one form or another. The highest risk groups across rural Australia are males, and when you compare the rural rates of suicide with urban rates, you can see that in general males have a higher level in rural areas than in urban areas. In remote areas that is substantially higher, particularly in young men. In aboriginal youth it reaches more than three times of that of their urban counterparts and of course men in farming have a substantially elevated rate of suicide. So we’ve got some curious research to think about.

Even of more concern is while much of Australia can feel reassured that in some areas suicide rates seem to be plateauing or even decreasing, in remote and very remote parts of the country these rates are increasing. Given the complexity of suicide there is a lot of work to do to understand why. What we do know from some of the national and international research is that suicide is not a very simple matter. Mental illness is the critical ingredient, but there are also powerful influences of socio-economic deprivation, social isolation and social integration linking to factors such as hopelessness. And particular subgroups are at greater risk.

While we’ve talked about aboriginal, young men and men in farming, in some rural areas older migrant men are found to have higher rates and some of the research that is trying to disentangle the suicide dilemma for us all strongly indicates that socio-economic indicators remain the most powerful across any geographic setting. Now these all indicate things that we need to be mindful of, if we are going to think about a considered mental health service model that tackles the critical factors upstream, of such a serious and tragic outcome of mental illness.

So the geography of mental health is important for us to consider when we start talking about any mental health service model. How do we address the sometimes quite complex environmental and social determinants of mental health and their outcomes? How do we understand the elements of location or place that influence health, relevant across the board in rural and urban settings, and the impact of community-wide risk factors and modifiers that influence vulnerability? And while there’s been very important recognition of community resilience, we also need to look at community risk factors and how they are addressed alongside the diversity of rural areas. So as has been said many times before, one size does not fit all. I don’t think we even understand what garment it is we’re trying to cut at the moment.

So let’s look at the new directions for mental health. As you’ll all know I’m sure with the level of interest in this issue, in July the Council of Australian Governments announced the very exciting initiative, The National Action Plan for Mental Health. This comes at the end of at least three national mental health plans and it is the first time that we’ve had such unified recognition of the challenge of mental health in Australia from State and national governments. It’s backed up by substantial funding and of course the challenge for us to make best use of this because it’s maybe a unique opportunity we’ll never have again to do something effective about mental health in Australia.

The National Action Plan has the following broad aims:

The National Action Plan is directed at achieving four outcomes:

(1) addressing the prevalence and severity of mental illness in Australia;

(2) reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery;

(3) addressing issues of access to the right health care and other relevant community services at the right time, with a particular focus on early intervention;
Now, I want you to just keep (3) in mind because I think it has particular relevance to us in rural areas when we think about the sort of services we need to be working with to mount an effective mental health response and improve the wellbeing of the people we’re serving. And finally:

(4) to increase the ability of people with a mental illness to participate in the community, employment, education and training.

Of course the concern about mental illness on young people is the effect that it has on those very important aspects of their life. In New South Wales, as some of you would be aware, we have also seen a great level of interest in mental health. Part of the platform of Premier Iemma when he took up his position was to focus on a number of issues, including mental health. We have what is called a new direction for mental health in New South Wales which looks at a range of enhancements particularly to community level services, and a document that I think is very, very pertinent to how we think about mental health care in rural areas, an Interagency Action Plan for Better Mental Health.

Now, many of us, I am sure, in the audience suffer from policy fatigue, but I think we need to look at how we can draw upon the work that sits behind such policies to inform that sort of services we will develop. This statement in the Better Mental Health Plan for New South Wales draws on the National Mental Health Plan as very important. Underpinning this approach is that improving the mental health of Australians cannot be achieved within the health sector alone. I would add within that the mental health sector alone.

A whole of government approach is required that brings together a range of services that impact on the mental health of individuals, such as housing, welfare and justice. In rural areas I would add many other services that need to be considered, but the important message there and part of this Interagency Action Plan is that it is a whole of community, a whole of service and whole of public service responsibility to improve the mental health of our community.

So how do we put all this in to some sort of meaningful service model and innovation? For those of us working in research it is quite a challenge to give policymakers and people designing services the information that they need. Ron Kessler who led up the World Mental Health Survey, and has been one of the leading psychiatric epidemiologists in the world, put this quite nicely in 2000 when he said:

The challenge for psychiatric epidemiologic research is to increase its relevance to preventative interventions and social policy

— he’s making reference to the fact that very often epidemiological research has been counting the numbers: how many people are experiencing mental health problems? We really need to move beyond that. I think the limitations of that approach are well demonstrated in the kind of logjam we now have about rural mental health. If you count the numbers it doesn’t tell us the sort of information we need to shape our services. He says that:

We require research that can more readily translate to community programs of secondary prevention —

in other words identifying early people who are experiencing difficulties —

identifying level of service need according to the problems and conditions people are suffering and identify the consequences of the limited access to care that we know exists.

This is one model which I think I have tried to capture here: the link between the various arms of health and how we can inform service change. This link between mental health research and health policy is a fraught one, any health research and health policy. It’s one that everyone struggles with to try to get a useful dialogue between the interests, cultures and direction of those working in both areas. But this capacity for health research translation is increasingly recognised at research funding levels. It is up to many of us working in mental health research to look at the capacity for our findings to translate into meaningful health policy which then becomes the vehicle through implementation to service change and to apply our research methods to evaluating not only the outcomes but the process of service
change and of course then further influencing policy. None of this is terribly easy but I think we can start to identify some progress that has been made in this pathway.

Responding to this sort of challenge are some innovations that I wanted to briefly refer to. They are not inclusive of all the organisational and service responses that are being made, but some that I think illustrate the benefits of particularly collaboration and community linkage. In New South Wales we have the New South Wales Centre for Rural and Remote Mental Health which is a state-wide centre funded by the New South Wales Government to improve research, education and to be informing service development in rural mental health policy.

We’ve also seen in the last twelve months the establishment and launch of a Queensland Centre for Rural and Remote Mental Health that has a similar state-wide role and both organisations through different arrangements have brought in community, health service and other organisational involvement to this challenge of rural mental health. So it’s not a health service agenda alone, but attempts to link research to the challenge of policy development. In New South Wales we’ve also had the exciting and I think very productive development of an Institute for Rural Clinical Services and Teaching which again brings clinicians, service providers and policymakers together and they’ve got a booth here which will tell you more about its activity.

Finally, I think that research infrastructure and capacity building are very important. The Australian Rural Health Research Collaboration, which is currently directed by Professor David Lyle from Broken Hill, has a major focus on capacity building. It’s supported by research structure capacity building grant from New South Wales Government and brings together health researchers from mental health, public health, basic sciences and particularly health services research in which mental health is one of the major streams.

An example of the sort of innovative service models that can be developed when we attempt to translate policy into action, I think, is illustrated by a project that some of you would have heard described in detail this morning, the New South Wales Farmers Mental Health Network. It’s built upon the evidence that is encompassed in the Promotion, Prevention and Early Intervention for Mental Health monograph which is a major national exercise to pull together the evidence that exists.

One of the things that I think is a great risk is that with the funding and interest in mental health we may see a blossoming of programs well-intentioned but perhaps duplicating work, putting effort into areas where the evidence is not as strong as it could be, and here we have a guide for us that tells us where we can productively intervene for the prevention of mental health problems.

The New South Wales Farmers Mental Health Network brings together a range of government, non-government agencies, health researchers and social researchers to define some key action areas that can be targeted to improve the mental health and wellbeing of farmers. Now, some of those actions are those that can be undertaken by health services but many of them are important mental health targeted activities to be undertaken by organisations like New South Wales Farmers Association themselves.

This initiative is led by them, is driven by farmers as an organisation concerned about their own welfare and wellbeing, and has brought together the sorts of health services and researchers to get a sense of co-ordination, common purpose, direction and some evaluation. It’s been very helpful body to lobby government for particular evidence based programs that can be undertaken. So I think it’s an example of the way in which mental health service models need to embrace a whole range of service organisations and involving mental health as a critical component of that but alongside general health services, community organisation, non-government organisations, at all levels.

Now what are the challenges in achieving these sorts of programs or even the challenges in being able to maximise the potential benefits of something like the National Action Plan for Mental Health or the Council of Australian Governments? First of all, it’s easy to say that mental health is a whole of community or whole of service responsibility. One of the biggest challenges we have in mental health is dealing with stigma and that stigma is not just experienced at a community level. It’s experienced and expressed often by health service providers. there’s some valuable evidence that has been put together
around this by people like Tony Jorm and his colleagues looking at mental health literacy in the community.

It’s identified that we have a challenge among ourselves as health professionals and how we think about mental health problems and the needs of people who suffer disability and mental illness. So there’s a major challenge there. How do we engage with and work for rural communities and shape the sorts of services that would flow on from these initiatives to be relevant and appropriate? And how do we evaluate that? One of the major emphases in terms of dealing with stigma has been addressing building mental health literacy. One of the things we also have to address as we build mental health literacy is ensuring mental health services and health services and primary care programs are responsive to mental needs of the community.

As we build awareness we’ve got to match that with a more effective response at all levels, otherwise we are putting people in a very difficult position. We need a research framework that translates to service innovation and that applies in all areas of health but I think particularly when we are looking at the opportunity for innovation in mental health that is particularly pressing. Finally, we need a workforce that can adapt to new service needs and models and acknowledge the very broad based nature of mental health care that includes prevention and promotion of mental health as well as delivering good acute and emergency mental health care and high quality recovery and rehabilitation services. Often our clinicians find it very difficult to walk across all of those components and we need workforce development and support of our clinicians to give equal value to those components of their work.

Finally, of course, we’ve all mentioned it and Kris talked about this as well, Kris Battye, addressing organisational barriers. If the issue between State and national governments is not addressed there is a great risk that some of the major programs and innovations won’t bring the benefits that we all hope for. There are major organisational barriers. There’s great potential for duplication and in rural areas that can be most acutely felt. To have service providers delivering services in parallel to small communities is obviously not good use of the resources that we have.

So the challenge for all of us will be how do we negotiate around those and set up structures that recognise the uniqueness of particularly services like NGOs and State funded health services, but also enable them to work towards a common purpose. Thank you.

**Presenter**

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