Section 2

SUICIDE PREVENTION IN RURAL AREAS

This Position Paper represents the agreed position of the twenty-two Member Bodies of the National Rural Health Alliance but not necessarily the entire view of all individual Member Bodies.
SUICIDE PREVENTION IN RURAL AREAS

As at December 2000

The National Rural Health Alliance, the peak non-government rural and remote health organisation, notes that:

1. According to the Australian Institute of Health and Welfare (2000), suicide was the seventh leading cause of premature death in Australia in 1998, following various cancers, heart disease and stroke. Suicide rates have remained relatively stable since the 1920s, however rates have fluctuated within age groups in the population.

2. Men are four times more likely than women to die from suicide, often adopting more violent means which result in a greater number of deaths. However, females have higher rates of hospital admissions for suicide and self harm attempts. Hospitalisation due to self-harm between 1996-1997 peaked in the 15-19 year old age group for women.

Australian Bureau of Statistics (1998) figures indicate that the suicide rates for men aged between 20-39 are significantly higher than for young men aged between 15 and 19 years. However, over the period 1979-1998, the suicide rates for 12-24 year olds rose 40%.

3. Rates of suicide are consistently higher in remote areas and rural towns than in metropolitan and regional areas. In communities with a population of less than 5000, the male suicide rate is one-and-a-half times the capital cities rate, and the suicide rate of males aged 15-24 is almost twice that of their city counterparts. Here the impact of structural adjustment in agriculture and the withdrawal of government and other services, such as banks, has been most dramatic.

33 of the 37 poorest electorates in Australia are rural electorates, with average weekly earnings in rural areas considerably lower than the national average. High youth unemployment is a feature of many of these communities despite out-migration for higher education and work.

4. Factors associated with a greater risk of suicide include mental illness, unemployment, socio-economic disadvantage, loss of parent through separation or divorce, family and inter-personal problems, physical and/or sexual abuse, issues of sexuality, homelessness and substance abuse. Access to means (eg firearms) and previous suicide attempts are other key factors.

Research indicates that the downward trend in firearm suicides nationally conceals the significant increases that have occurred in firearm suicides in small rural communities over the last 30 years, and particularly between 1989 and 1993.

5. Suicide rates for young indigenous males are up to 40% higher than the national average. Suicide rates for all young males have increased significantly over the past 30 years.

According to the report “Bringing Them Home”, cultural and family dislocation are factors to be considered in indigenous suicide.

Same Sex Attracted young males aged between 18-24 years are 3.7 times more likely to attempt suicide than males in the general population. Most of these attempts occurred after the person had self identified as being gay.

6. Shortages of GPs, mental health nurses, psychiatrists and psychologists in rural and remote communities undermine the development of intervention strategies for people at risk.

The current shortfall of GPs in rural and remote areas is estimated to be in the range 500-750 practitioners. Many rural GPs lack specific training in mental health or suicide prevention and/or lack the time that needs to be spent with a depressed or mentally ill person. Options for referral are all but non-existent in many rural and remote areas.

There is a critical shortage of psychiatrists, psychologists and outreach mental health teams in rural and remote areas. Only 7.5% of psychiatrists are located in rural or remote locations with more than 90% of those in non-metropolitan areas being in major regional centres.
Shortages of clinical psychologists are also evident in rural and remote areas. The situation has been exacerbated by the rationalisation of public services in rural areas that employed psychologists. Lack of access to training, professional isolation, heavy workloads and limited resources affect the recruitment and retention of psychologists to rural and remote areas.

Few local hospitals have the resources to deal with people in the acute phases of mental illness who often require hospitalisation.

7. The incidence of suicide is higher amongst health professionals than other professional groups. Stress and burnout are frequently cited problems for health professionals in rural and remote communities, particularly where there is a lack of professional support, combined with excessively long hours of work and social and cultural isolation.

The Bush Crisis Line (1800 805 391) established in 1997 provides a valuable 24 hour telephone counselling and debriefing service for remote area health professionals and their families.

8. Healthy Horizons (1999-2003), the strategic framework for rural, remote and regional health, identifies mental health as a key issue. Mental health is also one of the six National Health Priority Areas, along with cardiovascular disease, cancer control, injury prevention and control, asthma and diabetes mellitus.

In 1993, the National Mental Health Strategy (NMHS) was re-affirmed by Health Ministers with a five-year Second National Mental Health Plan in 1998. In the 1996-97 Budget, the Federal Government announced an additional $18m funding to support the National Youth Suicide Prevention Strategy to 1999-2000. $48 million dollars over five years has been allocated for the National Suicide Prevention Strategy (NSPS) Project called “LIFE-Living Is For Everyone”. Issues which impact on the risk of suicide in rural and indigenous communities are identified as two of the four priority areas under LIFE.

Funding has been provided under the National Youth Suicide Prevention Strategy, to the telecounselling, information and referral services with Kids Help Line (a 24 hr, centrally located free service for young people who need support with life skills and resiliency), Lifeline (a national, 24 hr telecounselling service for all ages) and Reachout! (an Internet-based information service providing a map-based search system for people to self refer).

Early intervention programs targeting school age children have been funded by a number of State governments. These programs aim at improving self-esteem, developing resilience and coping strategies, and reducing violent and anti-social behaviour such as bullying.

9. A lack of resources and commitment by both Federal and State Governments is evident in relation to the issue of suicide and adult Australians - particularly men.

Threatened or actual loss of the family farm, declining off-farm employment opportunities, the dominance of traditional male norms, community decline, family breakdown, alcohol abuse, lack of education and a lack of appropriate services are all factors implicated in the rising rate of suicides by rural men in the middle years.

10. Information technologies such as telepsychiatry and video-conferencing provide important adjuncts to the services provided by health professionals in rural and remote locations. It can also improve the support and training of local health professionals who provide service to this population.

Consultations using telepsychiatry or video-conferencing facilities can reduce the need for a person in a rural area to travel to the capital city for assessment and treatment.

The Royal Flying Doctor Service (RFDS) plays a vital role in the assessment and evacuation of people with a mental illness. The RFDS has released an educational and interactive CD-Rom for health professionals, aimed at improving the knowledge and awareness of the issues of mental health.

11. There are 6 priority mental health targets for rural and remote communities outlined in the National Action Plan for Mental Health Promotion, Prevention and Early Intervention 1998-2003. These priority targets are:

- promote family and community cohesion;
- promote protective factors that impact on the effects of unemployment, environmental hazards, geographical isolation, alienation and loss, building on particular strengths of people in rural and remote communities;
- reduce the prevalence of risk factors for depression, anxiety, stress and suicide;
- capacity building of infrastructure and communication technologies to assist improve mental health outcomes for rural and remote communities eg. telehealth/telemedicine;
- develop and support initiatives as determined by the local community; and
- increase access to mental health promotion and prevention services.
12. Member Bodies of the Alliance strongly support the Commonwealth Government’s stricter gun control laws introduced following the Port Arthur tragedy. Given the high incidence of suicide by firearms in rural communities, the Alliance considers the stricter ownership and storage control measures are important to reducing access to the means of suicide in rural areas.

The National Rural Health Alliance affirms that:

13. It is important to focus on early intervention and school programs aimed at providing positive role models and improving the self-esteem, resilience and coping strategies of young people. Member Bodies of the Alliance support the introduction of a national school based package which is specifically targeted to rural students and long term strategies for maintaining, valuing and enhancing the family.

14. Member Bodies of the Alliance strongly support the inclusion of mental health as a national population health priority.

15. Member Bodies support the service provided by the Bush Crisis Line (1800 805 391) designed to assist remote area health professionals through telephone counselling, debriefing and stress management after critical incidents or traumatic stress situations.

16. Member Bodies of the Alliance support the funding of the National Suicide Prevention Strategy by the Federal Government and the actions identified under LIFE- Living Is For Everyone.

17. Member Bodies of the Alliance support initiatives that support the provision of mental health information to consumers, including the Commonwealth’s telecounselling and internet information service.

The National Rural Health Alliance resolves to:

18. Lobby for funding from the Federal Government to undertake further research to assist with the development of effective suicide prevention programs for men in rural and remote areas and for Aboriginal Peoples and Torres Strait Islanders.

19. Form a working relationship with Suicide Prevention Australia to address the issues of suicide in rural and remote areas.

20. Maintain close links with Mental Health Branch of the Department of Health and Aged Care in order to provide support to the National Rural Health Alliance’s resolutions on mental health and suicide.

21. Support incentives to recruit, retain and support rural mental health workers and counsellors, including GPs to small rural communities, and to increase the skills of others, such as teachers, sports coaches and youth workers involved with young people at risk.

22. Support, as a priority, initiatives to improve mental health training for GPs, nurses, allied health professionals and Aboriginal Health Workers.

23. Support the expansion of funded telepsychiatry and video-conferencing services as an adjunct to, not a replacement for, face-to-face services in rural and remote communities.


References:


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