FACT SHEET - AUGUST 2014

MENTAL HEALTH & SUICIDE IN RURAL & REMOTE AUSTRALIA

NATIONAL RURAL HEALTH ALLIANCE INC.

...good health and wellbeing in rural and remote Australia

Country people encounter particular stressors which influence their mental health, yet many have limited access to mental health services and/or are less likely to seek help. Tragically, the rate of suicide outside Major Cities is 66 per cent higher than within them.

People in rural and remote areas encounter a range of stressors which influence their mental health, including:

- greater prevalence of chronic conditions, disability and generally poorer health;
- fewer employment opportunities, lower incomes and less financial security;
- greater exposure and vulnerability to natural disasters;
- higher rates of overcrowding, housing stress, and homelessness; and
- higher rates of smoking, risky drinking and illicit drug use.

They face a range of challenges in their ability to cope with these stressors, including:

- poorer access to specialised care (for example, almost 9 out of 10 psychiatrists are employed in Major cities);
- apprehension around help-seeking and fear of stigma (particularly in smaller communities where individuals are more visible and confidentiality is less assured);
- 'rural stoicism' and resilient attitudes;
- lower educational attainment - affecting one's ability to obtain information on prevention, and mental health services and programs;
- lower incomes - making it more difficult to afford mental health care; and
- limited or non-existent public transport - limiting one's access to mental health care, and increasing the risk of social isolation (particularly a problem for the less mobile, such as those who are frail or living with a disability).

Because of these factors, diagnosis, treatment and ongoing management of a mental health condition in rural and remote areas are likely to occur later in its progression, or not at all.

MENTAL HEALTH CARE IN RURAL AND REMOTE AUSTRALIA

In rural and remote areas, primary mental health care is provided mostly by GPs and community mental health services. While the rate of use of community health services is similar across geographic areas, access to GP services declines with increasing remoteness (Table 1).

Table 1: The relative role of community mental health services and GPs, by geographic area, 2011-12

	MC	IR	OR	R	VR
				R/VR	
Community mental health encounters – per 1000 population	322.1	333.2	295.4	285.7	307.2
GP encounters for mental illness – per 1000 population	668.2	651.1	595.3	241.3	

The number of mental health professionals also declines (though more sharply) with increasing remoteness (Table 2) and some communities must rely on visiting services or travelling to communities where services are available.

Table 2: FTE mental health professionals per 100,000 population by geographic area

	MC	IR	OR	R/VR
Psychiatrists	16.4	5.8	3.4	4.6
Mental health nurses	81.7	78.6	47.8	38.8
Psychologists	98.3	56.2	45.3	32.9

ABORIGINAL AND TORRES STRAIT ISLANDERS

Almost one-third of Aboriginal and Torres Strait Islander people aged 18–24 years experience high or very high levels of psychological distress - more than twice the rate for non-Indigenous young people. Indigenous communities face a number of challenges associated with socio-economic disadvantage, experiencing the stressors listed on the front of this page to a greater degree. In addition, given the importance of the connection they perceive between the health of their 'country' and their cultural, mental and physical wellbeing, changes to the physical environment (e.g. climate change, land clearing, deforestation) can also influence mental health.

The rate of suicide among Aboriginal and Torres Strait Islander people is 2.7 times higher than that of non-Indigenous people, rising to 5.1 times for Indigenous youths (15-24 year olds).

FARMERS

Farm incomes (which provide livelihoods for many people in rural and remote areas) are influenced by weather conditions, commodity and fuel prices, and exchange rates. The unpredictable nature of these factors can induce psychological distress and subsequent mental illness. For example, in 2008, a study found that among farmers who were in drought, 17 per cent had mental health issues, compared with 8 per cent who had not experienced drought in the three previous years.

The rate of suicide for male farmers is significantly higher than for non-farming rural males. In 2008, a study showed that 34 in every 100,000 male farmers die by suicide – significantly more than the 24 per 100,000 among rural men generally (a rate which in itself is significantly higher than the national average).

YOUNG MEN

Stressors faced particularly by young people in rural and remote areas include: pressure to conform to locally acceptable images or patterns of behaviour; having little privacy; having 'nothing to do'; pessimism about future prospects; unemployment; loneliness and the loss of relationships brought about by the drift of many younger rural people to coastal and urban areas; alienation due to a lack of understanding in some rural communities for same-sex preferences; and higher rates of use of alcohol and other drugs.

In 2008, men who resided outside Major Cities were 68 per cent more likely to have died by suicide than those who lived in Major Cities. For men aged 15-29 years, the death rate from suicide for those who lived outside Major Cities was twice as high as that in Major Cities.

OLDER PEOPLE

Older people in rural and remote areas are more likely to be living with a chronic condition, chronic pain and disability. They are also more likely to experience challenges around mobility (which result in the need for in-home visits), social isolation, and access to pain management and palliative care.

Nationally, the highest suicide rate is observed in the 85+ age group with a noticeable spike occurring from 75+ years of age (likely to be more prevalent in rural and remote areas where the ageing of Australia's population is more marked). The rate of suicide among men aged 85 years and over who live outside Major Cities is around double that of those living within them.

WHERE TO GET HELP

- Online mental health resources, including several funded by the Australian Government, such as mindhealthconnect.org.au operated by Healthdirect Australia, ANU's eHub online self help programs ehub.anu.edu.au, and MindMatters mindmatters.edu.au
- Support via telephone through Lifeline lifeline.org.au (13 11 14), the SANE Helpline sane.org (1800 18 7263), and the Kids Helpline kidshelp.org.au (1800 55 1800).
- Community organisations which provide age/gender-appropriate support such as Country Women's Association of Australia cwaa.org.au and Men's Sheds mensshed.org
- Providers of supported and temporary accommodation, such as Homelessness Australia homelessnessaustralia.org.au
- Respite and family support services, such as the Mental Health Respite: Carer Support (MHR: CS) program and the National Respite for Carers Program (NRCP)

SUPPORT FOR MENTAL HEALTH PROFESSIONALS AND PROVIDERS

- Initiatives to engage mental health professionals in rural areas such as Mental Health Services in Rural and Remote Areas, the Mental Health Nurse Incentive Program, Access to Allied Psychological Services (ATAPS), Partners in Recovery, the Personal Helpers and Mentors service (PHaMs), the visiting psychiatric services through the Medical Specialist Outreach Assistance Program (MSOAP), and MBS item numbers for telepsychiatry.
- Opportunities for continuing professional development in mental health for rural GPs, nurses and Aboriginal Health Workers such as Rural Health Continuing Education (Stream 2) (RHCE2) and mental health first aid programs.

Mindframe recently released guidelines providing practical advice and support to journalists when reporting on suicide and mental illness: www.mindframe-media.info