NATIONAL RURAL HEALTH ALLIANCE INC.

Submission to the

Senate Select Committee on Mental Health

May 2005

National Rural Health Alliance
PO Box 280
DEAKIN WEST ACT 2600

Contents

EXECUTIVE SUMMARY **3**

RECOMMENDATIONS **4**

1. BACKGROUND **7**

THE SITUATION FOR AUSTRALIANS LIVING IN RURAL AND REMOTE AUSTRALIA 9
Service limitations *9*
Risk factors for mental health and well being in country Australia *9*
Impact of poor mental health in country Australia *10*
APPROACHES TO MENTAL HEALTH IN RURAL AND REMOTE AREAS 11
The national framework *11*
Key documents *12*
A comprehensive population-based approach to mental health *13*
The importance of prevention *13*
World Health Organisation's 'Pyramid of services' *14*

2. ENHANCING MENTAL HEALTH IN RURAL COMMUNITIES **16**

FUNDING 16
ENHANCING PRIMARY HEALTH CARE 17
Workforce support *17*
Role of general hospitals *19*
Community mental health *20*
Special primary care needs of Indigenous people suffering mental illness *23*
Needs of people from linguistically and culturally different backgrounds *24*
SUPPORTING CARERS AND LOCAL PEOPLE TO CONTRIBUTE TO MENTAL HEALTH INTERVENTIONS 24
Support for direct carers *24*
Support for informal mental health workforce *25*
PREVENTION 26
Community knowledge of mental health and illness *26*
RESEARCH AND POLICY DEVELOPMENT 27
Research *27*
Policy development *28*

APPENDICES **29**

REFERENCES **32**

This Submission is based on the views of the National Rural Health Alliance, but may not reflect the full or particular views of all of its Member Bodies.

Visit 'Publications and News' at ***www.ruralhealth.org.au*** for all of the Alliance's policy documents.

EXECUTIVE SUMMARY

It is well known that rural and remote areas have some more extreme mental health problems than the major cities. Much of the evidence is anecdotal, however, and hinges on widespread understanding (and experience) of the devastating rates of suicide in country areas – much of which is attributed to depression and other mental health states.

It would be valuable to have clearer evidence of comparative rates of mental conditions in different areas and among different population groups.

Even in the absence of the certainty provided by quantitative evidence, some things are clear. People in rural and remote areas who do have a mental illness have fewer options for professional support; costs associated with diagnosis, intervention and management are likely to be higher; informal support networks (family, friends) are likely to be less confident and competent, due to their greater difficulties in accessing information, training and support for themselves and their caring activity; and those with a mental illness face the extra burden of greater visibility, stigma and confusion.

These disadvantages may be offset by a closer community which has the capacity (if not resources) to care for one of its number. However there are enough examples of 'characters' ostracised by their local community and not referred for professional help, to suggest that the notion of a close, caring rural community is sometimes a myth.

As with some other illnesses, the rate of mental illness may not be higher in country than city areas, but its effects are very often more severe.

Mental health has been a priority for the NRHA since its establishment. The Alliance has had a sequence of policy positions on mental health and suicide prevention. Our Member Bodies are involved in many aspects of the challenge on a daily basis. But in this submission we focus on just four issues:

- increased overall expenditure on mental health to 12% of national health expenditure;
- recruitment and support for the development of a stronger professional mental health workforce in rural and remote areas;
- formalised support for the carers of people with mental health illness, and those in the community who undertake the role of informal mental health workers; and
- a strong emphasis on prevention, particularly by supporting programs that recognize the importance of early intervention.

These four will be briefly dealt with here in turn.

The Alliance calls for a greater proportion of the health dollar to be spent on mental health. Currently only 7% of the national health expenditure is spent on mental health interventions. This should be increased by 1% annually until it reaches 12%. Of this overall expenditure, a fair proportion must be directed at the 30 per cent who live in rural, regional and remote areas.

The Alliance strongly supports the recruitment and development of a multi-disciplined mental health workforce in rural and remote areas. Specific strategies need to be put in place to ensure that a range of workers - mental health nurses, Indigenous mental health workers, psychiatrists, counsellors, social workers, occupational therapists and psychologists – are encouraged to move to work in country Australia.

The Alliance recommends that formalised support be put in place for the carers of people with mental health illness and those in the community who undertake the role of informal mental health workers – families, friends, teachers, people who work in Shire offices, libraries, shops and garages. This support should include training and the provision of necessary resources so that these people can continue their vital work in the absence of specialist workers in rural and remote areas.

The Alliance supports a strong emphasis on prevention of mental illness, particularly by supporting programs that recognize the importance of early intervention in identifying symptoms and limiting the onset of chronic illness. Prevention also encompasses information and educational programs that encourage attitudinal change. The building of a positive, inclusive and mutually supportive community is very important in contributing to its general mental health and well-being.

With mental health disorders accounting for 30% of the non-fatal disease burden in Australia[i], such new and additional expenditures are likely to result in substantial national returns. As with other aspects of health reform, however, there needs to be further clarification of the responsibilities of the various jurisdictions and sectors for mental health programs.

RECOMMENDATIONS

Principle for action

All health authorities should adopt a population-based approach to mental health in rural and remote Australia, drawing on the directions in the National Mental Health Strategy and *National Action Plan for Promotion and Prevention and Early Intervention for Mental Health,* while ensuring the approach adopts local solutions to local problems.

Recommendation 1

The Australian Government should be urged to demonstrate a genuine commitment to achieving improved mental health care and outcomes by committing to increase overall expenditure on mental health interventions to 12% of national health expenditure through 1 percentage point annual increases, starting immediately.

Recommendation 2

All governments should commit to ensuring that a substantial proportion of health expenditure is allocated to appropriate activities in country Australia, where 30% of the population lives, and establish monitoring systems to measure this distribution and publish the results.

Recommendation 3

The Australian Government should fund research to establish what resources are needed to implement a population health approach to mental health in rural and remote communities of various types.

Recommendation 4

Community-based mental health services in rural and remote areas should give priority to identifying and implementing ways to support general practitioners and other primary healthcare professionals in their role to provide mental health treatment and care.

Recommendation 5

The Australian Government should commit to maintain funding in the long-term for the Better Outcomes in Mental Health and More Allied Health Services Programs in country areas.

Recommendation 6

The Australian, State and NT Governments should give a higher priority to working together to ensure a comprehensive suite of initiatives is in place to attract and retain the primary health care workforce in rural and remote areas.

Recommendation 7

Regional health authorities should examine the barriers to local hospitals being effective providers of in-patient mental health services and put in train measures to ensure the hospitals can provide such care when needed to local people with low to medium needs, so avoiding the need to admit them to distant specialist services

Recommendation 8

The Australian Government and the Royal Australasian College of Psychiatrists should work together to examine the reasons for the very skewed distribution of psychiatrists in Australia and to identify and implement measures to involve psychiatrists more effectively in providing services in country areas, both directly and indirectly.

Recommendation 9

The Australian Government should give a higher priority to working with Indigenous Australians to improve the mental health and emotional wellbeing of Aboriginal Peoples and Torres Strait Islander communities through increased funding and the development and implementation of culturally appropriate, sustainable approaches.

Recommendation 10

Governments must be aware of the impact of their programs on the mental well-being of refugees and migrants; and consider the special and urgent needs of such people for mental health support and services. Special programs to recruit and retain mental health specialists will be needed in areas with concentrations of new migrants.

Recommendation 11

All Governments should give priority to increasing the number of activities to support carers in rural and remote areas, including long-term service planning to ensure that their loved ones can continue to receive appropriate care into the future.

Recommendation 12

The Australian Government should fund long-term programs in rural and remote areas to identify, develop and sustain an informal mental health workforce drawn from the local community. Such projects would be developed in consultation with communities, local service providers, representatives of mental health professions and education and training providers,

Recommendation 13

The Australian Government should provide funds to ensure that all Australians, wherever they live, have access to ongoing programs to improve their mental health literacy and capacity for self-care where appropriate. The materials and approaches should be appropriate in both content and delivery modes to the target communities.

Recommendation 14

The Australian Government should earmark ongoing funding to support practical mental health research to inform the future development of mental health interventions based on a population health approach in country Australia and to enable results to be disseminated widely, including to local communities to assist them in their population-based approaches to improving mental health.

1. BACKGROUND

The National Rural Health Alliance is the peak non-government body working to improve the health of people living and working in rural and remote Australia. It has twenty-four Member Bodies, each of which is a national organisation in its own right. They represent the consumers of rural and remote health services and a majority of the professions involved with health services in country areas.

The goal of the NRHA is to improve the health and productivity of rural Australians by co-ordinating its Member Bodies' knowledge and skills to help governments, health professionals and rural communities achieve health goals.

The NRHA works with its Member Bodies to collect and organise information, and then to disseminate and apply it, in ways that will help governments, professions and communities to improve the health and productivity of people who live and work in rural, regional and remote Australia, including through supporting policies and programs that promote good health and a sustainable health workforce.

One of the aims of the Alliance's work is to increase the profile of issues that matter in rural and remote health, and the level of discussion and understanding about them. One such issue is the mental health of people in rural and remote areas and how services are provided for those with a mental illness.

At the recent 8th National Rural Health Conference there were 13 concurrent session papers and six posters on mental health, and a special plenary session on the subject led by *beyondblue*, the national depression initiative. Mental health has been a priority issue for the Alliance since its establishment over a decade ago. Country people have long been aware of the special importance of services for mental health and the challenge they pose for service providers.

The submission does not address all the Terms of Reference of the Senate Committee, which are extremely broad and complex. Rather we have focussed on issues of particular relevance to people living in rural, regional and remote areas, the group for whom we advocate. Access to mental health services for country people is generally poor. This submission outlines the reasons for this, its consequences and what might be done to improve the mental health and well-being of country Australians and their communities.

Case Study 1

Sue's story: a tragedy of a mental health system failure[ii]

"My story … involves complex family and personal relationships. My story concerns my late husband Peter, my three children, our granddaughter and myself. Living in remote Australia has lots of advantages for those of us who like the life. There are some distinct disadvantages. We have floods, we have bushfires, we have drought. We also have mental illness in our community. Peter experienced a mental illness – and as a result of the system's failure to help him, he died.

Peter also had significant physical problems. He had diabetes, which was uncontrolled on occasions, and lead to a foot ulcer and amputation of toes. He also had cardiac problems – he had had a heart attack in the past. There is no

doubt that Peter's physical problems wore him down, but in the end it was his depression, and the inability of our system to help him, which led to his death.

In dying we lost not only a proud man, we lost a home and everything in it. Every physical possession that had meaning to us – lost in the fire. The fire was deliberately lit by Peter. He was found several hours after the fire started. Peter had died by his own hand. He gassed himself while sitting in the family car and never regained consciousness.

In June 2000 Peter had attempted suicide. He took an overdose of insulin, cut his wrist and was found in an isolated area, unconscious, with a loaded rifle by his side. He was assessed by the local community health services who found that – under the terms of the Mental Health Act – he wasn't depressed. Five weeks later Peter completed suicide.

In Australia we talk about having 'the fair go'. I believe that Peter didn't receive a 'fair go'. He deserved to have a proper psychiatric assessment, and to be started on antidepressant medication. Peter's life was cut short by depression.

Case Study 2

A teenager in a rural town in regional Victoria[iii]

This is a true story about a 16 year old who was anxious and depressed, and who was self mutilating. She lived in a town of 10,000 people about two hours from a big city, that most of rural Australia would consider being big enough to have a good range of health services.

She was a young person from a reasonably supportive family that was struggling to generate enough income to give their three children any more than the basics of life. She told her doctor that her parents wanted to help her, but they could not talk with her, and she "hated them, and they infuriated her".

She began to cut herself with a knife when she was 14 years old. She went to a local doctor when she was 16 years old because she realized that she needed help. She told the doctor that she often became extremely anxious and distressed, and she then felt compelled to cut herself. She said the pain made her feel better.

She had a boyfriend who told her she had to stop doing it. This was probably the precipitating reason for her to seek help.

The doctor saw her every week for months, providing counselling, advice and support. The pattern of her self-mutilation changed but overall did not diminish. She claimed that she had no intention of killing herself.

This town had no private psychiatrists working there or anywhere within 2 hours drive. A nearby tertiary hospital had no mental health outpatient services. There were private psychologists in town, but they all charged a high hourly rate – no concessions. The young woman's doctor rang the public mental health service and was told that they do not treat patients with these types of conditions – they would however make a diagnosis if the doctor felt that would be useful. The doctor asked them who they would recommend for the patient to be referred to for specialist care and was told that they would consider the question and ring back.

Two weeks later, they rang the doctor and advised that they had considered the question at one of their case meetings, and the recommendation from the team was that the doctor "should check the Yellow Pages".

The situation for Australians living in rural and remote Australia

As is well known, country Australians have poorer access to many health and related services than their urban counterparts.[iv] This is the case despite country people having, on average, poorer health and higher levels of exposure to health risk factors.[v]

There is no comprehensive information about comparative levels of mental illness in urban versus rural/remote areas. Some evidence suggests higher levels of some mental disorders outside urban areas. For example the Mental Health and Well-Being Profile of Adults found that women who live outside the capital cities experience a higher rate of mental illness than city women.[vi] A number of small studies undertaken during the early 1990s in rural and remote locations in South Australia (the Riverland), Western Australia (the Kimberley) and NSW (Broken Hill) found higher rates of some mental disorders.[vii]

Overall, however, it appears that levels of mental health are similar in country and city areas, with pockets of high levels of mental health problems in some country areas,[viii] perhaps reflecting communities under particular stress. Recent research suggests lower use of services rather than higher rates of mental disorders are a factor contributing to high suicide rates in rural and regional areas.[ix] Similar rates of disease occurrence, however, do not equate to similar impacts, and mental health is one of those where the demonstrated effects are more severe in country areas.

Service limitations

Metropolitan residents believe that there are major mental health service shortages in cities. Given the competition for scarce resources and the unwillingness of many professionals to work in country areas, it is therefore not surprising that it is so difficult for country Australians to obtain effective mental health care.

There are limited mental health services both in the public and private sector.

There is extra demand on the public sector in country areas because the private sector is not widely represented there, especially away from major regional centres. In urban areas the private hospital sector is a major provider of mental health services, through both in-patient and day programs, providing about 18% of in-patient days.[xviii] Furthermore, people in country areas are generally less likely to have private health insurance than their urban counterparts, so that these types of private sector services are not affordable, even if available, for many rural residents.

Risk factors for mental health and well being in country Australia

While the biological and psychological factors contributing to an individual's mental illnesses are by no means clearly understood, it is apparent that the level of mental illness and the overall mental health and well-being of any community is a complex product of many interacting factors. Socioeconomic factors such as levels of education, family income, unemployment, economic hardship, minority status, stigma, isolation, cultural differences and a sense of lack of control over one's own life are all risk factors for poor mental health. As well, stressful life events, especially when experienced by those with low self-esteem, little resilience and poorly developed coping skills can all lead to deteriorating mental health.

In many rural, regional and remote areas of Australia these risk factors are present to a high degree: the majority of Australia's poorest electorates are in country areas. Many such areas have been hard hit by structural adjustment in agriculture and the withdrawal of government and private sector services.

Indigenous people comprise a higher proportion of residents in country areas than elsewhere. Indigenous communities face all of these problems, exacerbated by their sense of alienation deriving from historical events and their ongoing impact in 21st Century Australia and the shortage of culturally appropriate mental health services.

Impact of poor mental health in country Australia

Poor access to services leads to people living in the community with unresolved mental health problems. For many this can lead to worsening social circumstances, for example unemployment and homelessness, domestic violence, family breakdown, drug and alcohol problems and contact with the criminal justice system. In country areas, support for people in declining social and economic circumstances is limited. Such life stresses are likely to exacerbate mental health illness and problems, contributing further to the downward spiral of the lives of those affected.

Many rural communities are in crisis due to the impact of structural adjustment, deterioration of infrastructure, long periods of drought, ageing and declining populations, and declining access to services. Communities can take on a sense of despair and hopelessness, making it difficult for them to find the energy and strength to deal with community issues. This in itself can lead to a negative spiral so that the risk factors in the community for mental illness increase.

There is now widespread use of the term 'social capital'. This brings an increased recognition that there are interactions between the social fabric and the networks in a community (its 'social capital') and mental health. Mental health is more difficult to deal with in poor social environments with, for example, high levels of unemployment, low income, limited education and unhealthy lifestyles.[x]

> "*In general, mental, social and behavioural health problems represent overlapping clusters of problems that, connected to the recent wave of global changes and new morbidities, interact so as to intensify each other's effects on behaviour and well-being.*"[xi]

The consequences for rural communities of high levels of unresolved mental health problems are huge. Not only do the individuals and carers directly affected carry a huge burden, but also there is a wider debilitating impact on the whole community.

Suicide is too often one of the tragic outcomes of mental illness. Suicide rates for some groups are highest away from urban areas and are particularly high for Indigenous youth, for example, although rates vary considerably from one area to another:

- the rate of death from intentional self harm for Indigenous young people aged 12-24 years is 31.1 per 100 000 compared with 6.4 for other Australian youth;[xii] and

- suicide rates for men aged 25-64 years increase with increasing remoteness from 27.6 per 100 000 in highly accessible areas to 38.2 in remote/very remote areas[xiii]
- suicide rates for men aged 15-24 years are 76 per 100 000 in remote and very remote areas compared with less than 30 in other ARIA categories.[xiii]

Anecdotally, there appears to be a high level of family tragedies such as murder/suicides, in country Australia, often flowing from unresolved matters in family breakdown. A lack of locally-available mental health services and support may be a contributing factor.

Approaches to mental health in rural and remote areas

The national framework

The broad national framework is provided by the National Mental Health Strategy. Its current manifestation is the *National Mental Health Plan 2003-2008*[xiv]. The Alliance is concerned that the Plan does not give sufficient special regard to the particular rural, regional and remote dimensions of the issues.

The Plan's four priorities are:

- promoting mental health and preventing mental health problems and illness;
- increasing service responsiveness;
- strengthening quality; and
- fostering research, innovation and sustainability.

Of these four, the most urgent and sensible priority for non-metropolitan areas is the first: as with everything else, prevention is better than cure; and the prospects of "increasing service responsiveness" and "strengthening (service) quality" are distant in the absence of sufficient staff and services in place. Access to appropriate services remains very limited for many people living in the bush.

The *National Action Plan for Promotion and Prevention and Early Intervention for Mental Health*[xv] provides a blueprint to advance the promotion and prevention agenda.

Its companion volume, *Promotion, Prevention and Early Intervention for Mental Health – A Monograph*[xvi] provides a detailed exposition of the theoretical and conceptual framework underpinning the National Action Plan, including approaches to many specific disorders. It contains a comprehensive list of risk and protective factors (Appendix 1) influencing the development of mental health problems and mental health disorders in five categories: individual factors; family factors; school context; life events and situations; and community and cultural factors.

Taken together, these documents and other publications from the National Mental Health Strategy provide an apparently solid base for developing world-class mental health treatment and care services and promoting good mental health, preventing mental illnesses and limiting their impact.

However, there are still major concerns with the Strategy:

- spending on mental health in Australia, at approximately 7% of overall health expenditure, remains low by international standards, with figures for comparable countries being 10 – 13%;[xvii]
- spending on mental health has not changed relative to overall health expenditure over the life of the National Mental Health Strategy[xviii] despite ongoing evidence of substantial unmet need;
- a high proportion of people with mental illnesses do not utilise mental health services;[xix]
- recent independent reports, for example by a non-government organisation, a NSW parliamentary committee and the Victorian Auditor General, have been very critical of many aspects of the mental health treatment and care system in Australia;[xvii]
- an international review of the Second National Mental Health Plan highlighted a range of problems including:
  - slow and unresponsive emergency and crisis care;
  - shortages of supported accommodation;
  - limited psychosocial rehabilitation; and
  - poor services for children and adolescents and for older people.[xviii]

These problems are especially acute in rural and remote areas. There therefore needs to be careful consideration of the ways the Mental Health Stategy's plans can be operationalised in country areas.

Key documents

Healthy Horizons[xx] and its more recent update, *Healthy Horizons Outlook 2003-2007*[xxi] set the framework for improved health in rural and remote Australia. Both documents have a strong focus on a population health approach through primary health care.

The NRHA developed a Position Paper on Mental Health in Rural Areas [xxii] in January 2003, and it is submitted to the Select Committee as a separate document. This submission draws on that Paper and advocates a holistic, comprehensive approach to achieving better mental health in country Australia. The Alliance has a separate Position Paper on Suicide Prevention in Rural Areas.[xxiii]

Since the NRHA developed its position papers, two other projects have contributed substantially to knowledge and understanding about mental health issues facing Australian rural communities. Firstly, based on a literature review and a structured survey of key people involved in all aspects of mental health in rural and remote areas, a 2004 paper by Ann Kreger and Ernest Hunter contains information about mental health issues in rural and remote areas.[viii] While their paper focuses mainly on Queensland, it provides useful insights of relevance to other parts of Australia. It identifies four key areas for future action: service provision; education and training; policy and program development; and research

In O*ut of Hospital, Out of Mind*, the Mental Health Council of Australia documents the results of a nationwide consultation with users and providers of mental health services.[xvii] It calls for a more comprehensive rural and remote mental health strategy with particular emphasis on

defining the essential elements of rural mental health service delivery, developing a range of models of services, and adopting an integrated and collaborative approach to workforce issues.

A comprehensive population-based approach to mental health

Mental illness and mental disorders cover a wide range of conditions. These range from those which, with appropriate treatment and care, can be relatively short-term to others which, for some people, can result in chronic disability. Mental health problems can also exist at the sub-clinical level.

Further, co-morbidities are common. Dual diagnosis (eg mental illness co-existing with substance use disorders) and dual disability (eg mental illness combined with intellectual disability) present special challenges. People with mental illnesses also have higher mortality and morbidity rates for some other illnesses than the general population. It has recently been suggested that there should be further investigation of co-morbid states involving obesity and depression.

There are predictions of an epidemic of mental illnesses. Mental illness is already the major contributor to disability and activity restriction, accounting for 29.3% of profound core activity restriction and 14.7% of all persons with a disability.[v] Depression alone costs the Australian community over $3 billion annually in direct and indirect costs.[ix]

This has major implications for society as a whole, with all sectors of society having the potential to make a contribution to reducing the burden of mental illness. Already over-stretched specialist mental health services will not be able to provide treatment to all affected. This means a greater role for non-specialists, including primary health care providers and the informal sector.

An effective system to minimise mental illness and reduce the impact of mental illness would adopt a population-based approach and provide a comprehensive range of services extending beyond treatment services for those with identified mental health problems to prevention, promotion, employment, education, training, social inclusion and supported accommodation. Professor Raphael has described a population model for mental health.[xxiv] The *National Action Plan for Promotion and Prevention and Early Intervention for Mental Health*[xv] provides guidance on implementing the promotion, prevention and early intervention components of such an approach.

The importance of prevention

The National Action Plan for Promotion and Prevention and Early Intervention for Mental Health identifies the importance of actively engaging the whole community in finding ways to reduce the burden of mental illness and assist individuals and communities to attain good mental health. It also lists a large range of sectors and settings where mental health interventions are appropriate (for example childcare centres, education facilities, housing agencies, workplaces, correctional services, sporting settings and community activities), emphasising the intersectoral nature of effective mental health strategies and the importance of partnerships. Hence a holistic approach to mental health requires both sufficient appropriate treatment and continuing care services, and a comprehensive approach to prevention.

It also incorporates notions of life stages. It emphasises the importance of recognising that there is a development trajectory of mental illnesses which can be ameliorated by effective strategies to minimise risk and build resilience starting in early childhood and continuing through life.

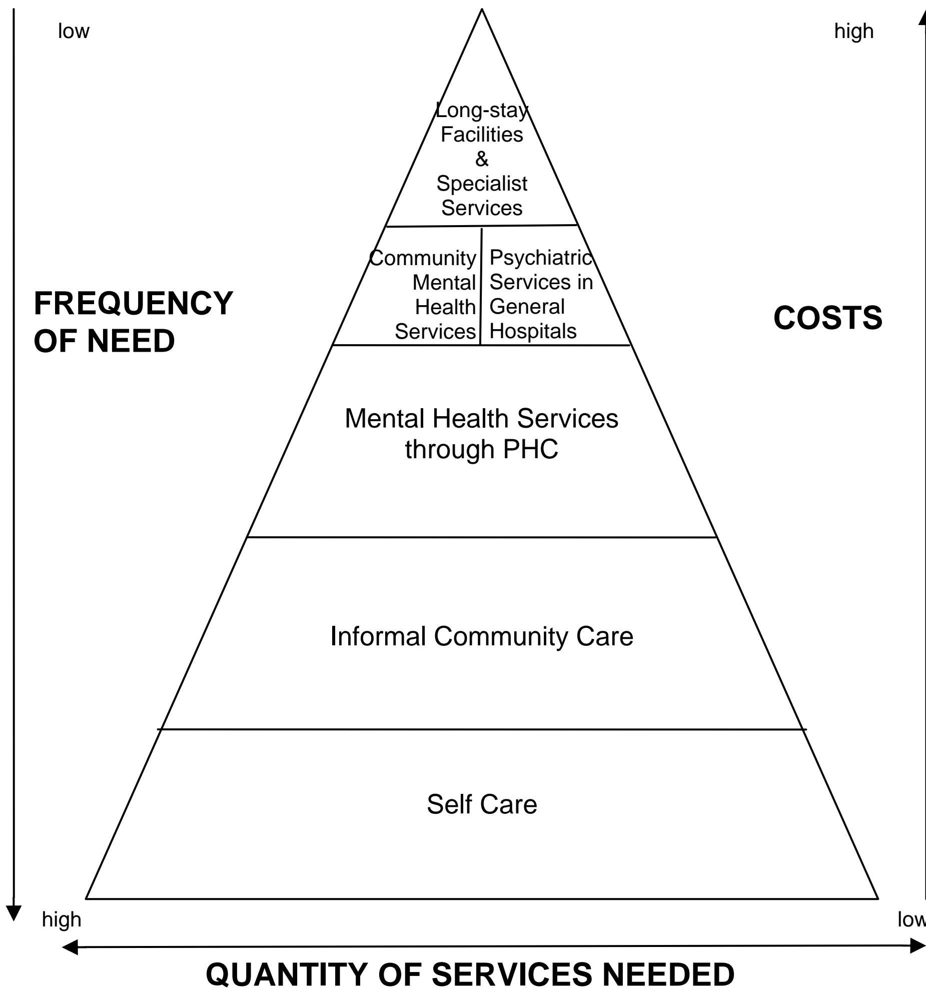
The Action Plan also identifies four priority populations: rural and remote communities; individuals, families and communities experiencing adverse life events; Aboriginal Peoples and Torres Strait Islanders; and people from culturally and linguistically diverse backgrounds.

Achieving good mental health requires different approaches and interventions at different life stages. The National Action Plan identifies seven priority age groups across the lifespan within the general population. As an example, Appendix 2 shows the complex array of interventions, partnerships and other factors which require attention for an effective approach to promotion, prevention and early intervention in middle-childhood.[xv]

World Health Organisation's 'Pyramid of services'

The service mix required to provide the mental health treatment and care needs of a community are illustrated in the pyramid in the diagram below, developed by the World Health Organisation.[xxv] The pyramid illustrates that frequency of need decreases, but costs increase, with the degree of specialist care required (see Figure 1).

Figure 1: Optimal mix of different mental health services



Organization of Services for Mental Health (Policy). World Health Organisation, Geneva, Switzerland: 2003; p 34

.

Improving mental health in country Australia demands attention to each element of this pyramid, interpreted broadly to encompass all aspects of a population health approach.

Principle for action

> All health authorities should adopt a population-based approach to mental health in rural and remote Australia, drawing on the directions in the National Mental Health Strategy and *National Action Plan for Promotion and Prevention and Early Intervention for Mental Health,* while ensuring the approach adopts local solutions to local problems.

Ideally such an approach would be fully integrated into a broader system that adopts a population health approach to overall health and wellbeing. Country Health in South Australia is currently attempting to introduce such an approach.[xxvi]

2. ENHANCING MENTAL HEALTH IN RURAL COMMUNITIES

Research has identified a wide range of barriers to achieving good mental health in rural and remote areas and an impeded capacity to reorient and sustain mental health services, including:

- significant workforce shortages and recruitment and retention problems;
- scarcity of education, training and supervision for human service personnel, and generalist and specialist health clinicians;
- insufficient Indigenous practitioners;
- heavy workloads;
- inadequate funding;
- differing cultural and work practices between services and professional groups;
- communication difficulties between services;
- unresourced protocols and guidelines;
- few best practice guidelines for generalist health practitioners;
- the non-availability of mental health professionals after hours and during situational crisis;
- lack of time for complex collaboration and agreements involved in partnership approaches; and
- inadequacies in a wide range of community infrastructure.[xxvii]

Improving mental health in rural and remote communities thus demands concerted action on a range of fronts. These include:

- increasing overall expenditure on mental health;
- recruiting and supporting the development of a stronger mental health workforce in rural and remote areas;
- recognising the importance of support for the carers of people with mental health illness, and those in the community who undertake the role of informal mental health workers;
- encouraging a strong emphasis on prevention, particularly by supporting programs that recognize the importance of early intervention; and
- research, including better information on a local area basis of the incidence and prevalence of mental disorders and mental health problems, and policy and program development to translate national directions for mental health reform into realistic approaches for rural and remote areas.

More details of these action areas, and recommendations on each, are given in the sections below.

Funding

There are insufficient resources devoted to mental health in Australia. While resources continue to be inadequate, mental health services will continue to be reactive and crisis-based, with little or no capacity to achieve good mental health outcomes for the population as a whole. Nowhere is this more apparent than in country areas.

Recently there has been a proposal to increase funding for mental health in Australia to achieve specific 10-year targets for mental health. The targets relate to increasing access to mental health services, reducing disability costs and suicide rates and increasing workforce participation for

people with psychiatric disabilities.[xxviii] There would be a particular emphasis on, *inter alia*, broad population measures and youth health and primary care.

Provision of funding through small, vulnerable programs and one-off pilot projects is not conducive to building sustainable models of population-based mental health interventions in the longer term. Such funding mechanisms also add considerably to the administrative burden of already stretched service providers in rural and remote areas.

Government and other funders should examine and introduce more appropriate funding mechanisms which deliver funds linked to identified needs, provide more control to local areas over their priorities and enable them to develop local, sustainable solutions to local problems. There is currently a groundswell of interest in reform of health care structures and financing in Australia. Helping to solve issues in rural and remote health should be a priority focus of any such reform and there needs to be widespread consultation with country Australians about proposals for change.

Recommendation 1

The Australian Government should be urged to demonstrate a genuine commitment to achieving improved mental health care and outcomes by committing to increase overall expenditure on mental health interventions to 12% of national health expenditure through 1 percentage point annual increases, starting immediately.

Recommendation 2

All governments should commit to ensuring that a substantial proportion of health expenditure is allocated to appropriate activities in country Australia, where 30% of the population lives, and establish monitoring systems to measure this distribution and publish the results.

Recommendation 3

The Australian Government should fund research to establish what resources are needed to implement a population health approach to mental health in rural and remote communities of various types.

Enhancing Primary Health Care

Workforce support

In rural and remote areas, the workforce providing primary health care encompasses general practice, remote area nurses, Aboriginal Health Workers, including Aboriginal Mental Health Workers and pharmacists, as well as providers in private practice who are accessible through self-referral such as psychologists and counsellors.

The World Health Organisation states that for most common and acute mental health disorders primary care can provide outcomes as good as those in more specialised settings. However achieving this requires significant investment in training and assumes that primary care providers have the time to deal with mental health problems.[xxix] The following case study is an example of a nursing organisation helping rural nurses and Aboriginal Health Workers to improve their capabilities in an important area of mental health care.

Case Study 3

The Association for Australian Rural Nurses program for mental health emergencies[xxx]

The association conducted a pilot project to develop and implement a workshop to improve the effectiveness of Rural Nurses' and Aboriginal Health Workers' responses to mental health emergencies. Evaluation was very positive. The Association now regards providing mental health emergency training as a priority and proposes several steps to further improve rural nurses and Aboriginal Health Workers' effectiveness in responding to mental health emergencies.

Aboriginal Mental Health Workers work in primary care settings. They also need support and training if they are to be effective. The following case studies provide examples of other health professionals working to support their Aboriginal mental health worker colleagues.

Case Study 4

Partnerships and collaboration in Aboriginal Mental Health[xxxi]

The Top End Division of General Practitioners is working in partnership with education providers and NT Mental Health Services to support and develop Aboriginal Mental Health Workers (AMHWs) working with remote Aboriginal communities. A Coordinator plays a key role in developing the AMHWs' role, supporting them and encouraging projects in mental health promotion and prevention.

Case Study 5

Aboriginal and Torres Strait Islander Child and Adolescent Mental Health Internship Program[xxxii]

New England Area Heath Service and the Children's Hospital Westmead working in close collaboration with Aboriginal Mental Health Service have established a joint program to improve the mental health and well-being of Indigenous children and young people. They have developed a model of mental health services delivery for Aboriginal and Torres Strait Islander children, young people and their families. Involves an internship program to provide supported, integrated training and professional development for individuals from Aboriginal and Torres Strait Islander communities to develop their expertise in child and adolescent mental health.

The shortages of mental health professionals place extra pressures on generalist health care providers such as general practitioners as they try to care for people with mental illness with little or no support from specialists. Yet these providers are themselves in relatively short supply, making it very difficult for them to find the time to meet the needs of people with mental illness and to improve their own skills and knowledge in managing mental illness.

Research has demonstrated that provision of mental health care through general practice can be cost-effective[ix]. Recent Australian research demonstrates that rural general practitioners identify 'time constraints' as the most common barrier to providing care for patient with depression. The research concluded that it was important for mental health services to find ways for more effective collaboration with general practitioners in relation to depression.[xxxiii]

Recommendation 4
Community-based mental health services in rural and remote areas should give priority to identifying and implementing ways to support general practitioners and other primary healthcare professionals in their role to provide mental health treatment and care.

Two recent initiatives to improve mental health care through general practice have been beneficial: Better Outcomes in Mental Health and More Allied Health Services. The former has improved the skills and capacity of general practitioners to treat mental illness and increased access to skilled mental health practitioners such as psychologists. The More Allied Health Services programme depends on being able to access allied health providers who wish to work in rural areas.

Recommendation 5

The Australian Government should commit to maintain funding in the long-term for the Better Outcomes in Mental Health and More Allied Health Services Programs in country areas

There have been many initiatives in recent years to attract and retain more health professionals in rural and remote areas. There has been some unevenness in these programs with a major emphasis on General Practitioners, and less on nurses, allied health staff and Indigenous Health Workers. It is as yet too early to evaluate the long-term success of such programs. Expanding the primary care workforce is essential if they are to expand their role in mental health care. The NRHA believes that workforce programs to do this should be maintained and expanded for those groups where the effort so far has been patchy.

Recommendation 6

The Australian, State and NT Governments should give a higher priority to working together to ensure a comprehensive suite of initiatives is in place to attract and retain the primary health care workforce in rural and remote areas.

Role of general hospitals

With the exception of Queensland, there are no public sector psychiatric hospitals outside major cities and inner regional centres.[xxxvi]

Hence all mental health in-patient care in rural and remote areas is provided in general hospitals. These hospitals have few or no psychiatrists – less than 3% of psychiatrists and psychiatrists in training work outside major cities and inner regional centres.[xxxvi] Therefore almost all mental health in-patient care outside major centres is provided either by primary care professionals or

visiting psychiatrists from regional or urban centres. For many rural residents, in-patient care is not available locally so they have to travel long distances to cities or regional centres with all the attendant costs, disruption and separation from friends and family.

It is therefore important that staff of general hospitals are assisted to be competent to provide as much mental health treatment requiring hospitalisation as possible. The following case study is one example of community mental health teams working to do this.

Case Study 6

Local solutions for local issues in rural Victoria

Mount Alexander tackles its high rate of suicide[xxxiv]

This rural area in Victoria has established a collaborative practice model for rural mental health.

It was developed out of gaps in service provision in rural Victoria and concerns about high suicide rates, but broadened into a more general mental health program.

Mental health staff from the local mental health team provide education and clinical supervision support to hospital staff, including local general practitioners, to enable short term admission in the local hospital for low to medium risk clients. This provides a safe place while follow-up plans were established. Has flourished into a sustainable model of collaborative mental health care.

Recommendation 7

Regional health authorities should examine the barriers to local hospitals being effective providers of in-patient mental health services and put in train measures to ensure the hospitals can provide such care when needed to local people with low to medium needs, so avoiding the need to admit them to distant specialist services

Community mental health

Community mental health services in rural and remote areas are traditionally beset with issues such as understaffing and poor after-hours and crisis services. This can result in many groups going without adequate services, especially those with special needs and those without the better-known acute mental illnesses.

The case study below provides an example of one rural community working effectively to form partnerships to fill gaps and make best use of limited resources.

Case Study 7

Comprehensive local services through partnerships in regional SA

Eyre Peninsula drives the dollar further to meet local needs better[xxxv]

The Eyre Region of SA has adopted a range of innovative approaches to develop a comprehensive mental health service. Key strategies have been use of locums to fill vacancies pending long-term recruitment of permanent staff and extensive use of partnerships to fill gaps in service provision within existing financial constraints.

Partnerships have focused on:
- improved services and expertise for a range of special needs groups often underprovided for in rural areas eg Indigenous people, people with dual diagnosis, older people, children and adolescents, adult survivors of child sexual abuse;
- psychosocial rehabilitation;
- collaboration with General Practitioners; and
- sharing infrastructure to reduce costs (eg office accommodation, IT and administrative support)

Specialist services

A major barrier to improving mental health service provision in rural and remote areas is the shortage of skilled mental health professionals. The maldistribution of Australia's health workforce between urban and rural areas is well documented. For the mental health workforce the picture is even bleaker. In rural and remote areas, services at the tip of the pyramid are virtually absent. For example for in-patients for mental health conditions, the likelihood that they will receive specialist psychiatric care decreases with increasing remoteness.[xxxvi]

The key professional groups providing mental health care to the population as a whole are psychiatrists, mental health nurses, psychologists, social workers and occupational therapists. These are all in limited supply away from metropolitan and urban areas. Aboriginal mental health workers play a key role in proving services to Indigenous communities, and are also in short supply.
- 2.4% of psychiatrists and psychiatrists in training work outside major cities and inner regional areas; [xxxvi]
- there is 0.1 full time equivalent private psychiatrist per 100 000 people in outer regional, remote and very remote areas compared with 8.9 in major cities and inner regional areas;[xxxvi]
- in South Australia, which has the highest ratio of psychiatrists to population in Australia, there should be 42 psychiatrists outside Adelaide by WHO standards, but there are no resident private psychiatrists there;[xxxvii]
- there has been no resident psychiatrist in Wagga Wagga, a major regional centre, for 12 years;
- 95% of private psychiatrists in NSW are said to practise in the CBD in Sydney;
- in 1999-00 the average Medicare Benefits per capita for psychiatric services was 4.7 times higher in capital cities than 'Rest of State' areas; [xviii]

- the nursing workforce is generally quite evenly distributed across geographic regions[xxxviii], but there are around 20 mental health nurses per 100 000 population in remote and very remote areas, compared with over 60 in major cities and inner regional areas.[xxxvi]

The barriers to attracting and retaining the mental health workforce in rural and remote areas are likely to be similar to those for other health professionals. It might be, though, that the support needs of the mental health workforce are even greater than those of other health professionals. An evaluation of strategies to support the rural specialist workforce identified a range of incentives and disincentives for rural specialist practice.[xxxix] Among the disincentives, specialists themselves highlighted the need for a critical mass of specialists in their specialty as being the top unmet need. The report also found that there were some differences between specialties, with requirements for supervision and disruption to practice from use of locums as being problematic for psychiatrists.

Governments and professional bodies representing the health workforce have recognised that action is necessary to improve the distribution of the health workforce. The NRHA has welcomed the many initiatives in recent years such as incentives and support for rural practice, a range of scholarship programs, greater use of country placements in education programs and support for innovative service models (see case study below) to enable greater access to specialist medical services. However the Alliance remains concerned that these initiatives remain fragmented and there is still no effective overall strategic approach to achieving a sufficient health workforce, including the specialist mental health workforce, in rural and remote areas.

Case Study 8

City adopts its rural and remote hinterland

Rural and Remote Mental Health Services of South Australia[xxxvii]

This is a consultation-liaison model in primary care that is delivering an integrated mental health service to rural and remote areas of SA.

Service provides:

- continuous access to expert psychiatric advice
- continuity of care with Adelaide based in-patient services seen as an extension of community care
- visiting psychiatrist services
- video teleconferencing
- validation of and support for GPs and regional health workers' roles
- facilitation of multidisciplinary approach
- community resource development
- specialised teaching in rural mental health at undergraduate and post graduate level
- research opportunities

A 1998 evaluation found a high level of user satisfaction with all aspects of the service with criticisms mainly focused on the limited resources of all aspects of the service.

Despite these and other initiatives, such as an expansion of telehealth in mental health, access to specialist mental health services remains limited for many country people. Face-to-face services are crucial for many aspects of mental health care, so that telehealth or other distance modes have

distinct limitations. Approaches remain piecemeal with little evidence of a national structured and strategic approach to ensuring that access to the specialist mental health workforce is linked to severity of need and does more to reduce the burden of mental illness and poor mental health in country Australia.

Recommendation 8

The Australian Government and the Royal Australasian College of Psychiatrists should work together to examine the reasons for the very skewed distribution of psychiatrists in Australia and to identify and implement measures to involve psychiatrists more effectively in providing services in country areas, both directly and indirectly.

Special primary care needs of Indigenous people suffering mental illness

The appalling health of Aboriginal Peoples and Torres Strait Islanders is a major contributor to the overall poorer health of people living in rural and remote communities.

This group must be given priority in improving mental heath outcomes.

The National Aboriginal Mental Health Policy and Plan, published in 1995, canvassed extensively issues relating to mental health for this vulnerable group and included strategies and goals. Despite this the mental health of Australia's Indigenous Peoples remains poor.

At the recent National Rural Health Conference a paper by an Indigenous Mental Health Worker underlined the fact that mental health remains neglected within Indigenous health care.[xl] The paper suggested that the focus needs to be on a "holistic health perspective underpinned by a sense of community that forms a sense of identity" and it suggested some guiding principles and proposals for improvement:

Guiding principles:

- needs-based services
- self-determination
- culturally appropriate services
- community-based services
- history and the underlying causes of mental illness
- appropriate diagnosis
- targeted and accessible services

Proposals:

- greater recognition of meaning of Aboriginal mental health
- national awareness of culturally appropriate strategies and methodologies
- greater funding
- a mental health training and learning culture with Aboriginal services
- leadership in developing and promoting high quality services delivery and continuous improvement.

Recommendation 9

The Australian Government should give a higher priority to working with Indigenous Australians to improve the mental health and emotional well-being of Aboriginal Peoples and Torres Strait Islander communities through increased funding and the development and implementation of culturally appropriate, sustainable approaches.

Needs of people from linguistically and culturally different backgrounds

Rural and remote communities are very diverse. Many cultural and linguistic groups are represented there, from different periods of migration. Their needs are as diverse as their backgrounds.

The ongoing mental health impact of torture and other traumas experienced by many refugees and other migrants to Australia compound the risk factors associated with leaving one's homelend and forging a new life in a vastly different country.

The paucity of mental health services and mental health professionals in rural and remote areas means that there is very little capacity to provide specialised services which are culturally appropriate to all the different groups in these areas.

Recommendation 10

Governments must be aware of the impact of their programs on the mental well-being of refugees and migrants; and consider the special and urgent needs of such people for mental health support and services. Special programs to recruit and retain mental health specialists will be needed in areas with concentrations of new migrants.

Supporting carers and local people to contribute to mental health interventions

The WHO pyramid demonstrates that the majority of mental health care is self-care and informal community care. In rural and remote areas this is even more the case because of the scarcity of health services in general and specialist mental health services in particular. Research is demonstrating the importance of self-care for illnesses such as depression and anxiety.[ix]

Informal community care includes a range of funded services such as telephone help lines, people in a range of occupations who might be well-positioned to detect emerging mental health problems such as school teachers, sports coaches, pharmacists and police, as well as individuals looking out for each other. The community can make a huge contribution, but to achieve this there must be some ongoing investment to prepare it for this role and to support it.

Support for direct carers

A key group providing informal community care is direct carers. They are especially vulnerable in rural and remote areas as they face the added burden of isolation and very limited support, including poor access to respite care, when compared with their urban counterparts. In many country areas, especially in the inland, populations are declining and ageing, other factors which suggest that carers are under great stress.

Programs which provide education and support for carers, including increased access to respite care, are essential if carers are to continue with their key role. Part of this support must include some long-term planning about how their loved ones will be cared for when their family carers are no longer able to provide such care. This is an issue which causes great concern for older parents who retain a major caring role for their adult children with serious mental illness and disability.

Recommendation 11

All Governments should give priority to increasing the number of activities to support carers in rural and remote areas, including long term service planning to ensure that their loved ones can continue to receive appropriate care into the future.

Support for informal mental health workforce

Further, effective population health approaches place major demands on all sectors of the community. Effectively engaging individuals and communities in self-care, informal care, and mental health promotion and illness prevention initiatives requires a high level of mental health literacy (that is, "knowledge and beliefs about mental disorders which aid their recognition, management or prevention"[xli]).

Other projects are seeking to improve communities' awareness and knowledge of mental illness and mental health problems, and to enlist members of the community to act as informal 'workers'. These include major initiatives by *beyondblue*[ix] and Rotary.[xlii] One regional area is working with hairdressers to improve their capacity to listen and respond appropriately to their customers' concerns about personal matters which might be affecting their mental health.

These outcomes are promising in terms of improving community response to people suffering mental health illness, and should be an integral part of a population health approach. However it must not be expected that Mental Health First Aid and other mental health literacy programs can substitute for having effective mental health assessment and treatment programs in place on the ground in country areas.

In order to engage the community in population-based approaches to mental health and in providing informal care, community members need to be effectively supported by ongoing education and professional help where needed. Budgets for mental health services therefore need to include provision for mental health professionals to devote time to these important activities.

One outcome of increased mental health literacy might be the creation of a pool of local people interested in becoming more involved in mental health care. This offers the potential to identify local people who might be interested in undertaking formal education and training leading to higher-level skills and knowledge in mental health care. This local pool of expertise could then meet some of the gaps in the formal mental health workforce.

Much more can be done locally to identify people in the area with a capacity to provide mental health services across the spectrum of interventions from prevention through to rehabilitation; to

provide education, training and support to them; and to identify innovative ways to use mental health professionals in different ways to enable their expertise to be spread more broadly. This might involve substantial changes in the established workforce practices of both the professionals and the volunteers.

> **Recommendation 12**
>
> The Australian Government should fund long-term programs in rural and remote areas to identify, develop and sustain an informal mental health workforce drawn from the local community. Such projects would be developed in consultation with communities, local service providers, representatives of mental health professions and education and training providers.

Prevention

Community knowledge of mental health and illness

There is a long history of shame and stigma being associated with mental illness, partly due to people not understanding its nature, causes and effects. There are lower general levels of education in rural and remote areas,[v] suggesting that these problems might be worse there than in major cities. Shame, stigma and associated ignorance may contribute to the relatively low level of resources devoted to mental health in Australia, and to the low level of priority that mental health care seems to attract, including in rural and remote areas.

These attitudinal factors contribute to a reluctance to seek help. Consequently it is important to implement innovative ways to reach out to people under stress or facing early stages of mental illness. Barriers to seeking help are complex and may include issues of confidentiality and trust in a small community. Also there may be little expectation of help, leading to a tendency not to seek it.

One approach to improving community awareness and assisting people to recognise signs of mental illness and to take action is to improve mental health literacy. Mental Health First Aid (MHFA) education is being used in Australia to do this.

An evaluation of the impact on 416 participants in MHFA training in a large rural area concluded that MHFA training produces positive changes in knowledge, attitudes and behaviour.[xliii] Another report of the impact of this type of education in fire- and drought-affected rural communities in North East Victoria indicated decreased stigma, increased knowledge, some intervention with family members, implementation of self-help strategies and utilisation of appropriate pathways to care.[xliv]

A project to enhance community awareness in mental health with an emphasis on Indigenous communities in Midwest and Macquarie Area Health Services was very successful with 96 graduates compared with a target of 40.[xlv] Participants were Indigenous health workers, community service providers and interested community members from communities with populations of less than 5000. Success was attributed to the program acknowledging and embracing the socio-politico-cultural contexts of Indigenous mental health and well-being.

Recommendation 13

The Australian Government should provide funds to ensure that all Australians, wherever they live, have access to ongoing programs to improve their mental health literacy and capacity for self-care where appropriate. The materials and approaches should be appropriate in both content and delivery modes to the target communities.

Research and Policy development

Research

Research on mental health issues in country Australia is quite limited. For example:

- there is little detailed epidemiological data which can inform local priorities for mental health interventions in rural and remote areas;
- there are no benchmarks about what constitutes a minimal and optimal mix of mental health interventions for different types of rural and remote areas;
- there are major issues relating to Indigenous mental health which require in-depth study; and
- insufficient is known about the service models and mental health interventions that are most appropriate (for example, there may well be a role for consumer operated services, that are playing an increasing role in other countries, for example the USA,[xlvi] but which are very limited as yet in Australia).

Another key issue is the poor dissemination of the results of research and pilot projects.

A report commissioned through the National Mental Health Strategy identified research priorities for mental health including:

- affective disorders, including depression;
- suicide and self-inflicted injury;
- care in the community and in primary care;
- prevention and promotion; and
- children and adolescents, Aboriginal and Torres Strait Islander Peoples and the socially and economically disadvantaged.[xlvii]

These priorities are all very relevant to improving mental health in country Australia.

Recommendation 14

The Australian Government should earmark ongoing funding to support practical mental health research to inform the future development of mental health interventions based on a population health approach in country Australia and to enable results to be disseminated widely, including to local communities to assist them in their population-based approaches to improving mental health.

Policy development

The previous sections describe some of the concerns that remain for mental health in rural and remote areas despite the actions taken to improve the situation. Sustained improvements will only be brought about by all relevant parties working effectively together to develop and implement a holistic, comprehensive population-based approach to improving mental health in rural and remote areas. This requires a whole of government approach, acting in concert with all sectors in the community, because so many factors influencing mental health derive from wider social, economic and cultural factors.

There is increasing evidence from innovative workforce and service models of what approaches can be effective. What is now needed is political commitment, effective national and local structures and sufficient resources to implement a broad-based intersectoral approach of long-term, sustainable, locally-relevant programs to achieve good mental health and to minimise the adverse effects of mental illness in rural and remote areas.

APPENDICES

Appendix 1

Protective and risk factors in mental health; from *Promotion, Prevention and early Intervention for Mental Health - A Monograph,* Commonwealth Department of Health and Aged Care, Canberra, 2000.

Table 1: Protective factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)

Individual factors	Family factors	School context	Life events and situations	Community and cultural factors
• easy temperament • adequate nutrition • attachment to family • above-average intelligence • school achievement • problem-solving skills • internal locus of control • social competence • social skills • good coping style • optimism • moral beliefs • values • positive self-related cognitions	• supportive caring parents • family harmony • secure and stable family • small family size • more than two years between siblings • responsibility within the family (for child or adult) • supportive relationship with other adult (for a child or adult) • strong family norms and morality	• sense of belonging • positive school climate • prosocial peer group • required responsibility and helpfulness • opportunities for some success and recognition of achievement • school norms against violence	• involvement with significant other person (partner/ mentor) • availability of opportunities at critical turning points or major life transitions • economic security • good physical health	• sense of connectednes s • attachment to and networks within the community • participation in church or other community group • strong cultural identity and ethnic pride • access to support services • community/ cultural norms against violence

Table 2: *Risk factors potentially influencing the development* of *mental health problems and mental disorders in individuals (particularly children)*

Individual factors	**Family/social factors**	**School context**	**Life events and situations**	**Community and cultural factors**
• prenatal brain damage • prematurity • birth injury • low birth weight, birth complications • physical and intellectual disability • poor health in infancy • insecure attachment in infant/child • low intelligence • difficult temperament • chronic illness • poor social skills • low self-esteem • alienation • impulsivity	• having a teenage mother • having a single parent • absence of father in childhood • large family size • antisocial role models (in childhood) • family violence and disharmony • marital discord in parents • poor supervision and monitoring of child • low parental involvement in child's activities • neglect in childhood • long-term parental unemployment • criminality in parent • parental substance misuse • parental mental disorder • harsh or inconsistent discipline style • social isolation • experiencing rejection • lack of warmth and affection	• bullying • peer rejection • poor attachment to school • inadequate behaviour management • deviant peer group • school failure	• physical, sexual and emotional abuse • school transitions • divorce and family breakup • death of family member • physical illness/ impairment • unemployment, home-lessness • incarceration • poverty / economic insecurity • job insecurity • unsatisfactory workplace relationships • workplace accident/injury • caring for someone with an illness/ disability • living in nursing home or aged care hostel • war or natural disasters	• socioeconomic disadvantage • social or cultural discrimination • isolation • neighbourhood violence and crime • population density and housing conditions • lack of support services including transport, shopping, recreational facilities

Appendix 2

Case study on principles for middle childhood; from *Promotion, Prevention and early Intervention for Mental Health - A Monograph,* Commonwealth Department of Health and Aged Care, Canberra, 2000.

Figure 2: Promotion, prevention and early intervention during middle childhood

Protective factors to enhance	Risk factors to reduce	Possible early signs and symptoms to recognise	Possible interventions	Settings for interventions	Workforce to engage and train	Ongoing partnerships to form
Family harmony Positive school environment School achievement Self-worth Self-efficacy Coping skills Social skills Personal confidante Positive peer group Active lifestyle	Family discord and violence Low family income Parental unemployme nt Parental substance misuse and mental health problems Coercive parenting style Poor monitoring and supervision at home and school Inconsistent behaviour management Poor peer relations School alienation	Disruptive behaviour Pronounced fears Behavioural inhibition Social withdrawal Sadness School failure Truancy	Programs to reduce social and economic disadvantage for families Programs to promote acceptance of cultural diversity Programs to support family functioning Parent skills training Screening and assessment of children and families Extra school resources where need identified Anti-bullying programs in schools Active lifestyle programs for children Psychosocial skills training for children Ongoing monitoring and care coordination for children identified as at risk	Family Schools Childcare Family services Parent support services General practice Child health clinics Sport and recreation Local community Aboriginal Community Controlled Health Services	Teachers General practitioners Childcare workers Child health clinic workers Welfare workers Juvenile justice workers Sport and recreation workers and volunteers Aboriginal health workers Family School	General practice Specialist health and mental health services Family services Sport and recreation services Workplaces Aboriginal Community Controlled Health Services

REFERENCES

[i] Australian Institute of Health and Welfare, 2000, *Australia's Health 2000*, Canberra, AIHW.

[ii] Extracted from a longer story published in Groom G, Hickie I &Davenport T, 2003, O*ut of Hospital, Out of Mind! A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-,*. Canberra, Mental Health Council of Australia.

[iii] Personal communication to the NRHA from a doctor practising in regional Australia, 18 April 2005.

[iv] Commonwealth Department of Health and Aged Care, 2000, *Rural & Remote Health Financing Project Paper 2 - Analysis of current health issues for rural and remote Australia.*

[v] Australian Institute of Health and Welfare, 2004, *Australia's Health 2004*, Canberra, AIHW.

[vi] Andrews G, Hall W, Teesson M, Henderson S, 1999, The Mental health of Australians, National Survey of Mental Health and Wellbeing, Report 2, NMHS.

[vii] There is no accurate data for the prevalence of mental illness for people residing in remote areas as they were not included in the 1997 study. For a discussion of these studies see O'Kane A & Tsey K ,1999, *Shifting the balance*, Menzies School of Health Research.

[viii] Kreger A & Hunter E, 2004, *The Queensland Centre for Rural and Remote Mental Health: Discussion Paper*.

[ix] Hickie I B, 2004, *Reducing the burden of depression: are we making progress in Australia?*, Medical Journal of Australia, 181 (7), 4 October, pp S4, 5.

[x] Cullen M & Whiteford H, 2002, *The Interrelations of Social Capital with Health and Mental Health Discussion Paper,* Canberra, Commonwealth of Australia.

[xi] Quoted in Cullen M & Whiteford H, 2002, *The Interrelations of Social Capital with Health and Mental Health Discussion Paper,* Canberra,Commonwealth of Australia, p27.

[xii] AIHW, 2003, *Australia's young people: Their Health and Wellbeing 2003*, Canberra, Australian Institute of Health and Welfare.

[xiii] Australian Bureau of Statistics Mortality Data

[xiv] *National Mental Health Plan 2003-2008*

[xv] Commonwealth Department of Health and Aged Care, 2000, *National Action Plan for Promotion and Prevention and Early Intervention for Mental Health,* Commonwealth Department of Health and Aged Care, Canberra.

[xvi] Commonwealth Department of Health and Aged Care, 2000, *Promotion, Prevention and early Intervention for Mental Health - A Monograph,* Commonwealth Department of Health and Aged Care, Canberra.

[xvii] Groom G, Hickie I, and Davenport T, 2003, O*ut of Hospital, Out of Mind! A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008,* Canberra, Mental Health Council of Australia.

[xviii] Commonwealth Department of Health and Ageing , 2002, *National Mental Health Report 2002: Seventh Report. Changes in Australia's Mental Health Services under the First Two Years of the Second National Mental Health Plan 1998-2000,* Commonwealth of Australia, Canberra.

[xix] Andrews G, Hall W, Teesson M, Henderson S, 1999, The Mental health of Australians, National Survey of Mental Health and Wellbeing, Report 2, NMHS

[xx] National Rural Health Alliance & National Rural Health Policy Forum, 1999, *Healthy Horizons,* National Rural Health Policy Forum.

[xxi] National Rural Health Alliance & National Rural Health Policy Sub-committee, 2002, *Healthy Horizons Outlook 2003-2007.*

[xxii] National Rural Health Alliance, 2003, *Mental Health in Rural Areas*, Position Paper. Canberra NRHA.

[xxiii] National Rural Health Alliance, 2001, *Suicide Prevention in Rural Areas,* Position Paper. Canberra: NRHA

[xxiv] Raphael B, 2000, A *population health model for the provision of mental health care*, Canberra: Commonwealth of Australia.

[xxv] World Health Organisation, 2003, *Organisation of Services for Mental Health (Policy).* Geneva: WHO.

[xxvi] Poole L, Ramsey R & Shepherd H, 2005, *South Australia country health reform – a change worth the wait*, paper for the 8th National Rural Health Conference, March 10 – 13.

[xxvii] Kreger,A,(2005) personal communication to NRHA, April 22.

[xxviii] Hickie IB, Groom GL, McGgorry PD, Davenport TA & Luscombe GM, 2005, *Australian mental health reform: time for real outcomes*, Medical Journal of Australia 182 (8), 18 April.

[xxix] World Health Organisation, 2003, *Organization of Services for Mental Health (Policy).* Geneva: WHO.

[xxx] Menere R, 2005, *Mental Health Emergencies Training for Rural and Remote Nurses*, paper for the 8th National Rural Health Conference, March 10 – 13.

[xxxi] Muholland D, Timothy W, &Broom R, *Aboriginal Mental HealthProgram 'Working both ways',* paper for the 8th National Rural Health Conference, March 10 – 13.

[xxxii] Bartik W & Dixon A, 2005, *Aboriginal and Torres Strait Islander mental heath training opportunities in the bush*, paper for the 8th National Rural Health Conference, March 10 – 13.

[xxxiii] Wright MJ, Harmon KD, Bowman JA, Terry J, & Carr VJ, 2005, *Caring for Depressed patients in rural communities: general practitioners' attitudes, needs and relationships with mental health services*, Australian Journal of Rural Health 13 (1), 21-27.

[xxxiv] Allenby A, Gregory B & Meegan E, 2005, *A collaborative practice model for rural mental health*, *paper* for the 8th National Rural Health Conference, Alice Springs, March 10 – 13.

[xxxv] Patterson S, 2005, *Multiple partners for mental health*, paper for the 8th National Rural Health Conference, Alice Springs, March 10 – 13.

[xxxvi] Australian Institute of Health and Welfare, 2005, *Mental Health Services in Australia 2002-3*. Canberra: AIHW (Mental Health Series no 6).

[xxxvii] Fielke K, 2005*, Mental Health Services in Rural and Remote South Australia: from "awful neglect" to gaining respect*, paper for the 8th National Rural Health Conference, March 10 – 13.

[xxxviii] Australian Institute of Health and Welfare, 2000, *Australia's Health 2000*, Canberra, AIHW.

[xxxix] Commonwealth Department of Health and Ageing, 2003, *Evaluation of Strategies to Support the Rural Specialist Workforce: summary of consultancy commissioned by the Commonwealth*, unpublished.

[xl] Bailey J, 2005, Yo*u're not listening to me!! Aboriginal Mental health is different – Don't you understand*, paper for the 8th National Rural Health Conference, March 7 – 10.

[xli] Francis C, Pirkis J, Dunt D, Blood RW, & Davis D, 2003, *Improving Mental Health Literacy: A Review of the Literature*, Canberra, Commonwealth Department of Health and Ageing, pv.

[xlii] Australian Rotary Health Foundation, http://www.arhff.org.au/mental illness/mental frameset.htm, www.arhrf.org.au-safari

[xliii] Kitchener B, 2005. *Mental Health First Aid Training in a rural area: a cluster randomized trial*, poster presentation, 8th National Rural Health Conference, March 10 –13.

[xliv] Malone G, 2005, *Stone in a pond – the ripple effect of Mental Health First Aid Education on fire and drought affected rural communities*, paper for the 8th National Rural Health Conference, March 10 – 13.

[xlv] Lawler L, 2005, *Indigenous community health program*, poster presentation, 8th National Rural Health Conference, March 10 –13.

[xlvi] Connor H, 2005, *Consumer Operated Services Discussion Paper*, developed for the National Mental Health Working Group.

[xlvii] Jorm A, Griffiths K, Christensen H, &Medway J, 2002, *Research priorities in mental health,* Commonwealth of Australia.