

## EDITORIAL

# Progressing the agenda for rural mental health research

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It has been assumed that anxiety and depression are more common among urban than rural residents<sup>1</sup>. Such an assumption was based on idealised depictions of rural areas as aesthetically superior to cities, and characterised by social stability, integration and supportive social networks. These images are far from reality, with the 1980s and 1990s being one of the most difficult periods for Australian farmers<sup>2</sup>. This time was also characterised by a trend towards the centralisation of public and private sector services, taking jobs, capital and people out of rural areas to large regional and metropolitan cities<sup>3</sup>. The 1997 Australian National Survey of Mental Health and Wellbeing found the prevalence affective or anxiety disorders was no less in rural than urban areas<sup>4</sup>. This important milestone in rural mental health research was followed by two studies examining the prevalence of self-reported mental health problems in Australian rural residents. Both found no association between rurality and reported levels of psychological distress<sup>5,6</sup>. Recent issues of the Journal contain two articles

further addressing the important issue of the prevalence of mental disorder among rural residents.

One article sought to determine if remoteness *per se* (as distinct from other aspects of area) was associated with mental illness<sup>7</sup>. Remoteness was defined using the ARIA index<sup>8</sup>, a face-valid parameter of rurality. The authors found psychosocial factors were more important determinants of mental illness than remoteness *per se*. This is concordant with previous research which has consistently shown that individual level psychosocial variables affect risk of affective and anxiety disorders<sup>9,10</sup>, and thus previous studies have typically controlled for these compositional features of locales<sup>6,11</sup>.

The authors of this article acknowledge two important points. First, aggregated data may not be sensitive enough to separate out specific dimensions of locations. This has been highlighted previously as a major limitation of



epidemiological studies, including the Australian National Survey<sup>10</sup>. Relying on units of analysis such as 'rural' or 'urban' or ARIA categories can have the effect of averaging out differences between communities which are likely to be highly variable, and so obscure the localisation of community level variables possibly contributing to mental ill health<sup>12</sup>. Second, remoteness *per se* is only one aspect of an area; the authors note other important variables include services and amenities, and aspects of the physical and social environment that are important for mental health and wellbeing.

These two observations support proposals that further advances in research in rural mental health will require more sophisticated conceptualisation of 'rural'. One area of research which may provide some insight is the study of health and place. For example, in a recent review, Pickett and Pearl<sup>13</sup> found a modest but consistent effect of place on health, after controlling for compositional differences across a diverse range of studies. Various approaches have been applied in conceptualising the effects of place on health. One, which appears relevant to this area of endeavour, suggests three types of explanation for geographical variations in health: compositional, contextual and collective<sup>14</sup>. Compositional variables include the often studied individual level variables, such as age, sex, marital and employment status of individuals resident in particular places. Contextual variables include the availability and accessibility of services, as well as physical features of the environment and availability of healthy environments at home and work. Collective variables include sociocultural and historical features of communities, including attitudes towards mental illness and help-seeking.

Using this approach, Fraser and colleagues<sup>15</sup> found a relationship between mental health and living in a community with declining population. This result was not an effect of composition of the areas studied (as measured by the demographic variables of age, sex, education, nationality, duration of residence in the area, and living alone or not). The authors note population growth and decline did not lead to uniform demographic changes and that the drivers of these

changes were different in different locales. The importance of this study is that it clearly demonstrates that there are different patterns of mental health among rural communities, and a simple conceptualisation of rural, such as the bipolar dimension of accessibility/remoteness, is not sufficient. This has implications both for future research designed to better understand the mental health problems of rural residents, and for mental health policy.

The findings of the second study reported in the Journal can also be explored using the more complex notion of place to examine the relationship between geographical location and the mental wellbeing of rural residents<sup>16</sup>. The finding that mental disorders were more common among GP attendees in rural settings than the regional centre can be interpreted in several ways. One is that mental disorder is more common among rural residents, and that rurality is a factor in the development of psychological disorders. However, in the face of contrary results, including those also reported in this issue of the Journal, this is unlikely. The authors' finding that less time in an area was associated with a psychological problem, and their suggestion that this may be linked to stability of social networks, resonates with the findings of Fraser and colleagues regarding possible contextual variables which may differentiate communities.

An alternative and important interpretation of the findings relates to another key contextual variable - availability and accessibility of treatment for mental health problems. The greater rate of mental illness in GP attendees in rural areas could reflect service availability and accessibility. In regional centres there are more GPs per head of population<sup>17</sup> and more specialist services available<sup>18</sup>. By contrast, in many rural areas the only access to care many people with mental health problems have is through the local GP. The significantly fewer GPs/100 000 population in small rural centres compared with regional and urban centres is well documented<sup>17</sup> but, like other contextual variables, the between-community variation in this number, and the effects of this is less well understood.



A further factor may be the attitudes of rural residents to help-seeking for mental health problems (at least in part influenced by collective variables). Stigma has been shown to be a barrier to help-seeking for mental health problems, and it is assumed stigma is worse in rural areas where communities are smaller, social networks are closely enmeshed and privacy is lacking<sup>19</sup>. However, Australian studies have found that although perceived stigma is associated with negative attitudes towards help-seeking, rural residents are willing to discuss mental health issues with a GP<sup>20,21</sup>. This may relate to the different role played by GPs in rural areas and be consistent with the finding that GPs who are known to individuals in small communities are more acceptable service providers<sup>22</sup>. Planned changes to Medicare which will provide funding for clinical psychologists will provide an opportunity and the necessity to determine whether rural residents are also willing to discuss such issues with specialist providers.

Studies of the prevalence of mental disorder, such as those described in this issue of the Journal, are important but research in rural mental health needs to move beyond this. To do so, the heterogeneity of rural areas needs to be acknowledged and addressed. This is essential if we are to identify particular groups whose risk of illness is increased and/or whose willingness or opportunity to access care is reduced. Failure to do so will be a missed opportunity in efforts to reduce the substantial disability and distress experienced by rural residents with mental health problems, and will limit efforts directed towards prevention and early intervention.

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## References

1. Webb SD. Rural-urban differences in mental health. In: H Freeman (Ed.). *Mental health and the environment*. London: Churchill Livingstone, 1984; 226-249.
2. Budge T. Population decline in Victoria and Tasmania. In: P Newton, M Bell (Eds). *Population decline in Victoria and Tasmania*. Canberra: Australian Government Publishing, 1996; 192-204.
3. Smailes P. The diverging geographies of social and business interaction patterns: a case study of rural South Australia. *Australian Geographical Studies* 2000; **38**: 158-181.
4. Andrews G, Hall W, Teeson M, Henderson S. *The National Survey of Mental Health and Wellbeing: the mental health of Australians*. Canberra: Mental Health Branch, Commonwealth Department of health and Aged Care, 1999.
5. Murray G, Judd F, Jackson H, Fraser C, Komiti A, Hodgins G et al. Rurality and mental health: the role of accessibility. *Australian and New Zealand Journal of Psychiatry* 2004; **38**: 629-634.
6. Eckert KA, Taylor AH, Wilkinson D, Tucker GR. How does rural mental health status refer to accessibility and remoteness? *Medical Journal of Australia* 2004; **191**: 540-543.
7. Eckert KA, Wilkinson D, Taylor AW, Stewart S, Tucker GR. A population view of mental illness in South Australia: broader issues than location. *Rural and Remote Health* 6: 541. (Online), 2006. Available: <http://rrh.deakin.edu.au> (Accessed 30 June 2006).
8. Commonwealth department of Health and Aged Care. *Measuring remoteness*. Accessibility/Remoteness Index of Australia (ARIA). (Revised edn). Canberra: Commonwealth Department of Health and Aged Care, 2001.
9. Goldberg D, Huxley P. *Common mental disorders, a bio-social model*. London: Routledge, 1992.



10. Judd FK, Jackson HJ, Komiti A, Murray G, Hodgins G, Fraser C. High prevalence disorders in urban and rural communities. *Australian and New Zealand Journal of Psychiatry* 2002; **36**: 104-113.
11. Crowell BA, George LK, Blazer D, Landerman R. Psychosocial risk factors and urban/rural differences in the prevalence of major depression. *British Journal of Psychiatry* 1986; **159**: 307-314.
12. Haynes R, Gale S. Deprivation and poor health in rural areas: inequalities hidden by averages. *Health and Place* 2000; **6**: 275-285.
13. Pickett K, Pearl M. Multilevel analyses of neighbourhood socioeconomic context and health outcomes: a critical view. *Journal of Epidemiology and Community Health* 2001; **55**: 111-125.
14. MacIntyre S, Ellaway A, Cummins S. Place effects on health: how can we conceptualise, operationalise and measure them? *Social Science and Medicine* 2002; **55**: 125-129.
15. Fraser C, Jackson H, Judd F, Komiti A, Robins G, Murray G et al. Changing places: the impact of rural restructuring on mental health in Australia. *Health and Place* 2005; **11**: 157-171.
16. Campbell A, Manoff T, Caffery J. Rurality and mental health: An Australian primary care study. *Rural and Remote Health* **6**: 595. (Online), 2006. Available: <http://rrh.deakin.edu.au> (accessed 30 August 2006).
17. Australian Medical Workforce Advisory Committee. *The general practice workforce in Australia. Supply and requirements 1999-2010*. AMWAC Report 2000.2. Sydney, NSW: AMWAC, 2000.
18. Australian Medical Workforce Advisory Committee. *The specialist psychiatry workforce in Australia. Supply and requirements 1999-2010*. AMWAC Report 1999.7, Sydney, NSW: AMWAC, 1999.
19. Barney LJ, Griffiths KM, Jorm AF, Christensen H. Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry* 2006; **40**: 51-54.
20. Wrigley S, Jackson H, Judd F, Komiti A. The role of stigma and attitudes towards help-seeking from a GP for mental health problems in a rural town. *Australian and New Zealand Journal of Psychiatry* 2005; **39**: 514-521.
21. Komiti A, Judd F, Jackson H. The influence of stigma and attitudes on helpseeking from a GP for mental health problems: a rural context. *Social Science Psychology and Epidemiology* 2006; (in press).
22. Bayer JK, Peay MY. Predicting intentions to seek help from professional mental health services. *Australian and New Zealand Journal of Psychiatry* 1997; **31**: 504-513.