

Inequity amplified: climate change, the Australian farmer, and mental health

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We need to train our rural medical workforce in deeper mental health care skills



The “droughts and flooding rains” of our “sunburnt country” have been part of the national consciousness for generations of Australians. So it is understandable that many of us may not recognise the impact of increasing drought and climate change in rural Australia. However, rural and remote Australians depend on the land, not only for their own livelihood, but also for the sustainability of their communities. We also know that rural and remote Australians have higher rates of mental health disorders and risk of suicide,¹ but much less access to mental health services.² In this issue of the *MJA*, Austin and colleagues³ report that drought compounds this disadvantage, placing farmers and their communities at greater risk of mental illness and disability.



The Yolngu Aboriginal People of North East Arnhem believe that a disturbance to their environment disturbs relationships and connections, and this in turn

causes illness, particularly mental illness. It seems that Austin and her co-authors agree; drought increases distress in rural communities, and younger farmers are most affected by disturbed relationships and connections. Extreme weather events such as drought are increasing in number⁴ and have a disproportionate impact on rural communities. Climate change acts as a threat amplifier, compounding social injustices.⁵

The authors of the *Lancet* report on sustainable development and global mental health described mental health as the “most neglected of all human health conditions”⁶ and our inability to make real impact as a “failure of humanity”.⁷ Suicide rates continue to rise around the world, despite government programs and other attempts to stem the tide. During 2016–17, the Royal Flying Doctor Service (RFDS) held 24 396 mental health consultations around Australia. RFDS chief executive Martin Laverty has warned that mental health services in rural and remote areas are already in crisis.⁸ Remote communities have access to less than a third of the community health service support available in urban settings, despite greater rates of mental health problems and of more severe illness.²



General practitioners are an important source of support and referral, and are often the first point of contact for people worried about their mental health.^{9–11} People in rural and remote regions, where the availability of specialist services is limited, are more likely than people in cities to seek help for mental distress from their GPs,¹² and are even more likely to do so if they trust their GP to provide appropriate assistance.¹³ Unfortunately, there is also a shortage of GPs in rural and remote communities, compounding poor access to other primary care and to specialised services.¹⁴ It is critical that GPs, particularly in medically underserved communities, have access to the training they need to deliver effective care for vulnerable patients with mental health problems in these areas.

We must also recognise that rural doctors occupy an essential place in the community. The sanctuary of the rural doctor’s office does not bear the stigma of a mental health-specific service, and this allows them to incorporate screening and early intervention into a standard “medical” consultation without causing shame to anyone who needs help. In addition, rural doctors live, breathe and experience the environment in which mental illness arises, so they understand the context of the land and the community. While telehealth and e-mental health services have enriched the care available to patients, they can only supplement this core therapeutic relationship that sustains rural communities.

We now have an opportunity to train this workforce in deeper mental health care skills. Similar gains in procedural medicine were achieved by subsidising placements in appropriate secondary and tertiary care contexts and by providing an appropriate curriculum and training pathway for rural obstetricians, surgeons, and anaesthetists. For improving mental health, the training pathway should be based upon a partnership between the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Australian Psychological Society (APS) and the two general practice colleges, the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General

Practitioners (RACGP), and supported by appropriate rural consumer and carer input. And we need to remunerate the new specialists in rural and remote mental health appropriately, so that the best medical graduates are attracted to this type of practice, can afford to undertake it, and are encouraged to withstand its pressures.¹⁵

Rural generalism is a new medical speciality, and in February 2018 the National Rural Health Commissioner, Professor Paul Worley, met with representatives from the RACGP and ACRRM to discuss how best to secure a strong, sustainable and skilled national medical workforce that meets the needs of our rural and remote communities.

Rural doctors are already providing extended care for their communities, often in very challenging circumstances. It is time we helped them deliver the mental health care our communities deserve, so that we can reduce the levels of suicide and mental illness in rural Australia.

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