Does rurality effect mental health? A primary care study.

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ABSTRACT

The aim of this study was to investigate whether rurality has an impact on psychological wellbeing by assessing the role that location, socio-demographic factors and physical health have on psychological wellbeing. A selection of nine general practitioners, located in North Queensland, voluntarily participated in the survey. 304 respondents, consisting of 89 urban/regional and 215 rural, were screened before their GP appointments. Respondents completed the GHQ-12 and general demographic questionnaires. General practitioners completed an assessment form on the respondent's physical and psychological wellbeing at the time of the appointment. The study found that rurality impacted psychological wellbeing. In particular, living in a rural location combined with factors of relationship status and caring for a disabled family member predicted greater psychological distress. This study adds further weight to the growing research in this area and emphasises the unique and often challenging nature of residing in rural and isolated areas where adequate mental health care can be difficult to provide.

INTRODUCTION

The effective treatment of mental health disorders in rural and remote locations involves particular challenges for mental health service providers. Mental health surveys have established how common psychiatric disorders are. The 1996 WHO Global Burden of Disease study found mental health disorders to be the fourth leading cause of disability, with depression ranked as one of the leading problems (Sanderson and Andrews, 2001). In addition the 1997 Australian National Survey of Mental Health and Well-Being (NSMHWB) found almost one in 5 Australian adults had an anxiety, affective or substance use disorder in the previous year (Judd et al., 2004).

Contrary to popular belief, urban living is not necessarily a risk factor for developing a psychiatric disorder (Fraser et al., 2002, Wainer and Chesters, 2000, Humphreys, 1999). A growing body of research is now concentrating on the impact that living in a rural and/or remote area has on psychological wellbeing. To date however, no large scale epidemiological studies have been conducted in Australia to clearly delineate the impact location has on mental health status. Some studies on urban versus rural differences in mental illness prevalence have suggested other factors combined with rural location can have a considerable impact on mental health status (Humphreys, 1999, Wainer and Chesters, 2000).

These factors include poverty, unemployment, being female, not being married (in particular being a women who is separated or never married), being of a lower socio-economic status, alcohol abuse problems, a history of childhood sexual abuse, poor social

networks, a stressful life event in the previous 12 months, the size of the individual's primary support group, low perceived social support, and employment status (Judd et al., 2002a).

While there is still a lack of general consensus on what constitutes rurality, rural and remote location can be easily defined by using geographical, demographic or economic measures. The most commonly utilised standardised geographical measures are the ARIA (Accessibility/Remoteness Index) and RRMA (Rural Remote Metropolitan Areas). The latter classification is used by governments for planning and funding allocation programs (Humphreys et al., 2003). Again, neither of these measures captures the range of potentially important aspects of rurality such as population size and growth, community relationships and economic and aesthetic variables but they do have face validity and play an important role in mental health care planning and funding (Murray et al., 2004).

Mental Health Care Management in Primary Care

General practitioners have a pivotal role in the detection and treatment of mental health problems particularly in rural and remote communities. Eighty percent of Australians see a GP each year, and three-quarters of those who do seek mental healthcare do so by consulting a GP (Fuller et al., 2004). Most respondents with a mental health problem present with mixed symptoms; a combination of somatic (tiredness, headaches and pain) and psychological symptoms (sleep disturbance, depression and anxiety). These symptoms are often at levels that do not meet the symptom criteria for any specific psychiatric disorder (Hickie et al., 2001a).

A primary strategy of the Australian government in mental health initiatives has been for mental health to be seen as "health" [12]. This has been conceived of as a bottom-up approach starting in the primary care setting. As general practitioners have been identified as the first point of contact for the majority of people with mental illness, it has been thought essential that patients be managed well in the primary care setting to ensure a better overall health outcome. In addition, it has been argued that the more GPs promote and validate their central role in managing mental health problems, the more the community position towards help-seeking for mental health problems can be improved (Hickie and Groom, 2002).

Much of the research concerning psychiatric disorders in primary care maintains there are still low detection and treatment rates of mental health problems (Hickie et al., 2001b). Recognition rates of mental health problems have been shown to be low, and subsequent treatment rates have been identified as being commensurately extremely low. Treatment for depression in primary care has been estimated at 4%, but its known prevalence is 10-25% (Hickie et al., 2001b). The demands on general practitioners particularly in more isolated practices, combined with the reluctance of their patients to discuss their mental health, can adversely affect recognition rates.

A number of factors have been identified that contribute to the low recognition and treatment rate in general practice. It has been suggested that patients were reluctant to report their mental health problems; that the disorders that were missed were transient and minor, not disabling or requiring intervention; time pressures on appointments; lack of mental health training and appropriate diagnostic tools suited to general practice; and the reluctance of general practitioners to use time-efficient self-report screening questionnaires or tools with their patients (Hickie et al., 2001a).

METHODS

Data were collected as part of two stage cross-sectional survey design. The results of the first stage are reported here.

The area of study was Townsville and outlying rural areas in the Far North region of Queensland. General practitioners were recruited from a list provided by the Townsville Division of General Practice and the North-West Primary Care Division in a geographical area encompassing a regional centre (Townsville) and rural areas of Cardwell, Charters Towers, Ingham and Ayr. These centres were also selected according to their Rural, Remote and Metropolitan Area (RRMA) classification. Townsville was a 2 and the remaining rural areas were rated as 5, 6 and 7 by the RRMA classification.

A faxed letter was sent to every general practice surgery in the selected areas outlining the nature of the proposed study. This was followed by a meeting with those GPs who had expressed an interest to discuss the study and the data collection procedure.

Nine of twelve general practitioners who were approached, agreed to provide respondent questionnaires to their patients prior to the patient's appointment. The questionnaires were collected over the period of one week or 100 completed respondent questionnaires (whichever came first).

Patients were asked by practice staff if they would be willing to participate in a research study conducted by James Cook University on rurality and psychological wellbeing. Respondents were given the questionnaires which comprised the General Health Questionnaire (GHQ-12) and basic demographic information. Respondents were also asked to report any pre-existing physical or psychological conditions from a checklist. They then provided a self rating (3-point scale) on their current physical and psychological wellbeing. Finally, the respondents provided information about their current living circumstances, including length of residence, satisfaction with location, quality of life, and whether they were caring for an aged or disabled relative. On completion of the questionnaires, the respondents placed the forms inside an envelope and handed this to the GP during their consultation.

The GP then completed a patient assessment section indicating if the patient had been previously diagnosed with a physical or psychological condition or complaint, rating the patient's physical wellbeing on a scale of 1 (very poor) to 8 (very good), their psychological wellbeing on a scale of 1(very poor) to 8 (very good), and whether they

had conducted any psychological interventions, prescribed medication or referred the patient to a mental health specialist during the consultation.

The respondent questionnaires were completed by a total of 309 eligible adult patients. Patients were eligible to participate if they were 18-years-old or over, read English well enough to understand and complete the GHQ-12 screening instrument and were about to consult the participating GP for their own health concerns.

Outcome Measures

GHQ-12 “caseness” was identified as respondents with a cutoff of 2/3 using the standard binary scoring method. The GHQ-12 was chosen because of its suitability for surveying in the primary care settings and its acceptable levels of specificity and sensitivity for case detection of depression, anxiety, social impairment and hypochondrias (McDowell and Newell, 1996). The GHQ has been used in international studies (Sartorius et al., 1993), national household surveys (Henderson et al., 2000, Korten and Henderson, 2000) and primary care studies (Olfson et al., 1996, Cleary et al., 1982).

RESULTS

Statistical analyses were carried out using SPSS version 11.0. In addition to basic descriptive analysis, a linear regression was carried out to examine the relationship between age, sex, marital status, and perceived physical and psychological health status, and GP reported health status with regard to GHQ-12 scores.

The demographic characteristics of the participants are provided in Table 1. The sample was predominately female, the average age was 52 years and most of the participants were currently in a relationship and had a high school level of education. A relatively large number (36.1%) of the participants did not want to report their total annual income, and 22.8% earned between $21,000 and $40,000 per annum.

Table 1: Sociodemographics of Primary Sample (N= 304*)

Characteristics of sample		N(%)
Location		
	Urban /regional	89 (29.3%)
	Rural	215 (70.3%)
Gender	Male	106 (35.1%)
	Female	196 (64.9%)
Relationship status		
	In a relationship	203 (71.2%)
	Separated	37 (13.0%)
	Single	45 (15.8%)
Employment status		
	Employed	141 (49.5%)
	Unemployed/disabled	22 (7.7%)
	At home	122 (42.8%)
Education level		
	Didn't finish school	50 (17.6%)
	High school level	197 (69%)
	Higher education	38 (13.4%)
Income		
	Didn't say	103 (36.1%)
	Less than $20,000	58 (20.4%)
	$21-$40000	65 (22.8%)
	$41-$60000	29 (10.2%)
	Greater than $61,000	30 (10.5%)

*2 participants with missing data

The data in Table 2 reports the responses provided by participants as to whether they had a physical condition, a psychological condition or family problems. The GPs were also asked to indicate whether the respondents had physical, psychological, or family problems, and the corresponding GP reports are presented for comparison. A much larger number of respondents reported having a psychological problem (26.6%) than were reported by the GP (6.3%) to have a psychological problem. The number of respondents reporting having a physical condition (52%) was greater than was reported by the GP (30%) but the difference was less extreme. There were no major differences between respondent and GP reports of family problems (4% vs. 5%).

Table 2: Reporting of Physical, Psychological and Family Problems Within Primary Care Sample. (N=304*)

Characteristics		N(%)
Patient reports physical condition		
	No	146 (48%)
	Yes	158 (52%)
GP reports patient has physical condition	No	214 (70.4%)
	Yes	90 (29.6%)
Patient report psychological condition	No	223 (73.4%)
	Yes	81 (26.6%)
GP reports patient has psychological condition	No	285 (93.8%)
	Yes	19 (6.3%)
Patient reports family problems	No	292 (96.1%)
	Yes	12 (3.9%)
GP reports patient has family problems	No	288 (94.7%)
	Yes	16 (5.3%)

Using the 2/3 cut-off acore, 25% (n=69)of the total sample with complete data (n=273) were predicted to be cases according to the GHQ-12. A comparison of probable "caseness" between the urban/regional sample (n=81) and the rural sample (n=192) found that significantly more participants in the rural sample were predicted to be cases (n=55, 29%) than in the urban regional sample (n=14, 17%) ($X^2 = 3.89$, df=1, $p < 0.05$: See Table 3).

Table 3: Probable "Caseness" by the Reality

			Probably not a case	Probably a case	Total
Location	Regional/urban	Count	67	14	81
		%within Location	82.7%	17.3%	
		% of Total	24.5%	5.1%	29.7%
	Rural	Count	137	55	192
		%within Location	71.4%	28.6%	
		% of Total	50.2%	20.1%	70.3%
Total		Count	204	69	273
		%within Location	74.7%	25.3%	

The measures of wellbeing, quality of life, and socio-demographics were included in regression to examine their contribution to variance on the total GHQ12 scores. The variables were entered in four blocks: demographics (including age, rural status, income, etc); respondent reported quality of life (including whether they were caring for an aged or disabled relative); respondent's self reported physical and mental wellbeing; and GP report of physical and/or psychological wellbeing. The final model was found to be meaningful (Model 4 F=4.75, df=27/272, p<0.001) accounting for 27% (adjusted $R^{2)}$ of the variance. The final model is presented in Table 4 and it can be seen that several variables contributed significantly to the variance of the GHQ-12 scores. These were living in a rural area, being in a relationship, caring for an aged/disabled relative, being resident in a location for less time, self rating of psychological wellbeing, respondent report of a physical condition, respondent report of family problems, and the GP report of a physical or psychological condition.

Table 4: GHQ-12 Model Summary (Coefficients).

	B	**Std. Err**	**Beta**	**t**	**Sig**
(Constant)	7.656	1.251		6.122	0.000
Rurality	0.734	0.271	0.159	2.707	0.007
In relationship	1.007	0.343	0.209	2.939	0.004
Caring for someone	-0.745	0.373	-0.110	-1.995	0.047
Time resident	-0.014	0.007	-0.111	-1.955	0.052
Self rated psychological problems	-0.646	0.215	-0.183	-2.998	0.003
Patient reports physical condition	0.659	0.236	0.165	2.794	0.006
Patient reports family problems	1.382	0.640	0.123	2.159	0.032
GP Rating physical problems	0.163	0.085	0.117	1.917	0.056
GP Rating psychological problems	-0.319	0.085	-0.255	-3.760	0.000

Dependent Variable = GHQ-12

Post-hoc comparisons were made between rural and regional/urban participants on a range of variables. Table 5 shows the results of the t-tests performed. Rural participants were found to score significantly higher on the GHQ than the urban/regional participants and, as a corroboration of this, that GPs rated rural respondents as having lower levels of psychological wellbeing. Taken together these results provided support for the regression findings that rural participants were more likely to have psychological problems.

Table 5: Independent samples test

	Rurality	N	Mean(SD)	t(df)	Sig(2-tailed)
Self rated physical well-being	Regional/urban	83	2.46 (5.70)		
	Rural	209	2.36 (0.64)	1.23 (290)	n.s.
Self rated psychological well-being	Regional/urban	74	2.62 (0.54)		
	Rural	194	2.53 (0.63)	1.16 (266)	n.s.
GP rated physical well-being	Regional/urban	80	6.18 (1.61)		
	Rural	192	5.90 (1.60)	1.28 (270)	n.s.
GP rated psychological well-being	Regional/urban	78	6.55 (1.74)		
	Rural	194	5.96 (1.78)	2.50 (270)	$p<0.05$
Time resident in current location	Regional/urban	83	13.23 (13.17)		
	Rural	193	17.26 (17.82)	-1.85 (274)	n.s.
Satisfaction with current location	Regional/urban	83	2.78 (0.470)		
	Rural	193	2.71 (0.488)	1.16 (274)	n.s.
Quality of life in current location	Regional/urban	80	2.66 (0.615)		
	Rural	189	2.63 (0.575)	0.420 (267)	n.s.
GHQ -- original score	Regional/urban	81	5.32 (2.08)		
	Rural	192	6.25 (2.07)	-3.36 (271)	$p<0.01$

Additional post-hoc comparisons were carried out for categorical variables in relation to rurality using chi-square analyses. Table 6 reports these results. It was found GPs from the urban/regional area reported the pre-existence of more physical conditions (47.2%) compared to rural GPs (22.3%) and GPs in rural areas reported the pre-existence of fewer psychological problems (4.2%) compared to GPs from the urban/regional area (11.2%). There were more participants in rural areas who cared for a disabled person or relative (13.7%) compared to the urban/regional participants (4.9%).

Table 6: Chi-Square Findings Summary.

Variable	Rurality	N	% - Yes	Chi-Square
GP reports a physical condition	Regional/urban	89	47.2%	
	Rural	215	22.3%	Chi-square=18.67, $p<0.005$
GP rated psychological well-being	Regional/urban	89	11.2%	
	Rural	215	13.4%	Chi-square =5.339, $p<0.21$
Caring for aged/disabled relative	Regional/urban	82	4.9%	
	Rural	197	13.7%	Chi-square =4.568, $p<0.033$

DISCUSSION

The mental health status of individuals living in a rural and remote areas compared with an urban/regional area was assessed using a questionnaire survey conducted in a primary care setting. This survey of general practice patients achieved an adequate response rate. As was anticipated with this methodology, the mean age of the sample was older and the proportion of women in the sample was higher.

A significant association was found between rurality and psychological distress measured on the GHQ-12. Other risk factors for experiencing psychological distress included being in a relationship, caring for an elderly or disabled relative, and self reported family problems.

The finding of 25% prevalence of psychological problems in the total sample is similar to the established prevalence rates of mental health problems in the community found in other primary care studies (Barrett et al., 1988, Von Korff et al., 1987, Kessler et al., 2002). The urban/regional sample in this study had a 17% prevalence of psychological problems while the rural sample had a 29% prevalence. The higher prevalence of probable cases in the rural areas surveyed, supports the growing research on the adverse impact rurality can have on mental health status.

Various socio-demographic variables were examined to identify what risk factors could contribute to psychological problems in rural and remote areas. It appeared that age, but not gender, in combination with living in a rural area was a risk factor. As discussed earlier, being in a relationship and living in a rural area created a greater risk for experiencing psychological problems. This finding appears counterintuitive, as being in a relationship should be a protective factor not a risk, and it certainly contrasts with Korten & Henderson's (Korten and Henderson, 2000) review of the NSMHWB's findings on relationship status and mental health impairment. The findings of this current study in regard to relationships, rurality and mental health are intriguing and warrant further investigation.

Low detection rates of psychological problems in general practice has been documented in a number of primary care studies in rural and urban areas (Henderson et al., 2000, Aoun et al., 1997, Hickie et al., 2001b, Brody et al., 1997), and is referred to as "unmet need" (Hickie et al., 2001d). To address the difficulty of diagnosing mental health disorders in primary care, the 34-item SPHERE questionnaire (Somatic and Psychological Health Report) was developed and launched in 1998 (Hickie et al., 2001b, Hickie et al., 2001d, Hickie et al., 2001c). Subsequent studies by SPHERE researchers have identified continuing low detection rates of mental health problems in primary care (Hickie et al., 2001b). Continuing educational programs in mental health for GPs and appropriate screening tools for use in the primary care setting are essential to further reduce this unmet need.

An explanation for the low detection rate recorded in this study may be the general reluctance of patients to discuss their psychological wellbeing with their doctor. This has

been attributed to a variety of reasons, such as lack of mental health literacy in rural populations (Judd et al., 2002b); the stigma associated with being labelled (Hickie et al., 2001a); the nature of small rural communities and the lack of anonymity (Judd et al., 2002b); and the cost of a referral to mental health specialists and the time and distance required to travel to see any specialists (Hickie et al., 2001a). In effect, reluctance to seek help among the rural and remote populations may be detrimental to receiving adequate mental health care.

The findings of this study support the body of research that has identified rurality as an important factor in mental health planning and service provision. Significant resources are allocated to attracting and maintaining mental health workers in rural and remote areas. It is suggested that increased emphasis be placed during training at university level for nurses, psychologists, social workers and doctors to aid a deeper understanding of the unique challenges faced by rural practitioners.

Considering the diversity and distance that comprises Australia's rural and remote communities, generalisation from these findings to the very remote regions in Australia should be avoided. Again, case studies of primary care samples in such communities would help build a more accurate representation of the risk and protective factors that effect psychological wellbeing and further explore the heterogeneity of rural and remote mental health.

Future Directions

Educational programs for general practitioners and mental health care providers have been prioritised in government initiatives. Likewise, attracting more mental health care workers to rural and remote centres has been identified and promoted as key to improving mental health care provision. Considering the increased likelihood of mental health problems in the future, it is important that the health care service providers who service rural and remote areas have all the support and expertise possible available to them. But, the pressures on country GPs and the reluctance of patients to discuss their mental health make the detection and successful treatment of mental illness difficult. The prevalence of subthreshold symptoms in mental illness further complicates this issue. From the practitioners' perspective, mental health status needs to be integrated into every day general health matters and become part of the routine check-up procedure a GP performs every day.

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