Unfenced road ahead: a review of rural and remote mental health service delivery and policy

A report for the Mental Health Unit,
Queensland Health
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2 EXECUTIVE SUMMARY AND RECOMMENDATIONS

This consultancy has reviewed the literature and undertaken strategic consultations on rural and remote mental health services and needs, and contains recommendations relevant to Queensland.

The literature review reveals that fragmentation, poor coordination and resource barriers are common in mental health service delivery in most rural and remote areas both nationally and internationally. Despite the rural and remote population being consistently identified as a special needs group in mental health policy documents in Australia at national and State levels, available evidence suggests that the omission of specific strategies for policy implementation in rural and remote areas inhibits attention to the unmet needs, resource limitations and organisational deficits identified. Investigation of the effectiveness of approaches to mental health service delivery is inhibited by the paucity of service and project evaluation available. Most literature describes discrete projects and presents limited, if any, evidence about effectiveness, generalisability or sustainability. There are significant gaps in the rural and remote service delivery literature and policy documents both in terms of the broad spectrum of interventions, and particular populations and groups with special needs.

Despite the limitations of this work, from the literature review and consultations it is clear that the information base on which determination of needs for mental health services and activities, and of the outcomes of existing initiatives in rural and remote settings, is inadequate. While this compromises policy and planning at a ‘macro’ level, the consequences are amplified at a local level by the diversity of rural and remote communities and populations. Resource allocation is consistently identified as a problem and appears, generally, to be *ad hoc* rather than strategic and is not informed by an understanding of that diversity. Regardless, existing data demonstrates higher levels of need, particularly for certain subpopulations such as those of Indigenous and culturally and linguistically diverse backgrounds. Others include children and youth, the aged, forensic populations, and those with dual diagnoses.

The evidence suggests that most rural and remote health services are struggling with providing basic crisis care and treatment in the community. In this context, with many barriers to service delivery, efforts to improve access, continuity, comprehensiveness and standards of care are often thwarted. There is limited evidence of population approaches, and support for consumers, carers, human services workers and generalist health practitioners commensurate with contemporary perspectives about roles, partnerships, coordination and linkages. The available literature focuses on clinical activities and, to a lesser extent, activities through primary care. There is very little relating to the non-formal community sector or self and family care. Services are often characterised by a restricted range of activities (particularly in terms of mental health promotion and prevention), reduced options for those requiring clinical services (such as subacute care and specialist areas), problems with workforce development and retention, and limited uptake and support of information and communication technology applications. While broad competencies are expected there appears to be little systematic training or preparation to address the specific workplace and social demands of practitioners residing in rural and remote communities. Levels of consumer and carer involvement in service planning in these populations are low and

appear to be largely ineffectual in the absence of dedicated support. Consumers with serious mental disorders and their carers living in these settings are not only disadvantaged in terms of access to acute and longer-term psychiatric inpatient facilities, but (in Queensland) by a Mental Health Act and review processes that do not reflect the social realities of treatment constraints in rural and remote communities.

Achievements in rural and remote health service delivery and resource allocation following the National Rural Health Strategy and the Tasmanian Rural Mental Health Strategy indicate that targeted rural health policies are a key driver in health service development in rural and remote areas. Flexible community development approaches that focus on existing local networks and services through resourcing and government support offer promise to the consumers, families and communities currently struggling with unmet mental health needs.

While a priority in terms of policy statements, promotion and prevention is not prioritised in terms of activities in rural and remote settings and there is a need for support at the policy implementation level. There is also a need for data relevant to the rural and remote social and service context to support this which can demonstrate both need and outcomes from mental health promotion and prevention activities, and for this data to be made available in appropriate form to providers and consumers. Promotion and prevention activities should be informed by adequate consultation, be owned by local communities with meaningful involvement of consumers, and should draw on the existing capacity in communities. Mental health service providers should be involved in these initiatives which demand that there is an appreciation of population level activities by such organisations, that the conflicts between clinical and non-clinical demands are addressed, and that formal agreements support cooperation with other organisations. Addressing stigma in these settings is a necessary component of such activities.

Effective linkages with general practice are a priority in rural and remote settings. Continuity of care was clearly identified as an issue reflecting problems in terms of recruitment, retention and range of services with the strengths of existing services and activities often reflective of the personalities of the incumbents rather than sustainable structures and processes. Linkages across districts, services and sectors are compromised by differences in understandings, language and priorities, and impacts, particularly with certain special-needs populations. This is compounded by the difficulties of coordination between what are often very small programs in rural and remote settings where there are limited resources for activities that are not directly service-related. This extends to engaging consumers and carers in reciprocal learning and mutual growth, objectives that require dedicated time and resources. Addressing the broad demands of this work requires flexibility for staff in terms of roles and time, which should be articulated in role descriptions and supported by the necessary resources including IT-based options which, in turn, require access and infrastructure support across the range of services involved.

The obvious differentials in the resources available in rural and remote communities by comparison to metropolitan Australia should not be accepted lest differentials in mental health outcomes be similarly understood as unchangeable. The rural and remote mental health workforce needs to be more aware of equity and quality issues generally and, in particular, in relation to the requirements of special needs

populations. Visiting specialist staff should flexibly accommodate local circumstances and limitations. In these settings stigma and isolation can be particularly difficult for consumers who have difficulties with access to basic social services. Providers need to be aware of and utilise local capacity and IT options to improve outcomes. Ensuring best practice in rural and remote settings requires appropriate protocols, improved collaboration with general practice and between mental health and ATODS services, and confrontation of rigid constructions of mental health which may, in turn, require supported, systematic reform within local mainstream mental health service settings. These issues may best be addressed through a whole-of-government approach to rural and remote social and mental health needs generally.

The rights of people with mental disorder are supported when clinical services are provided by professionals with expertise and experience, and who are intimately familiar with the mechanisms and limitations of the Mental Health Act. In this regard, the workforce difficulties noted above are clearly consequential. However the circumstances of rural and remote settings are such that not only are consumers and carers disadvantaged by comparison to those in metropolitan Australia in terms of access to a range of social supports and resource, these are further compromised in times of economic hardship in the bush. Support for the rights of consumers and carers demands identifying local resources and champions, providing settings for interagency coordination that is inclusive of consumers and carers, and providing training as necessary to a wide range of formal and non-formal workers. The experience in Tasmania suggests that effectively empowering consumers and carers demands adopting a community development and recovery framework, rather than solely a clinical orientation. Furthermore, that framework is supported and operationalised through funded consumer and carer positions with a designated coordinator able to give close attention to their needs as representatives and advocates.

The quality of service provision is informed by the experience and expertise of service providers and the degree to which they are supported professionally and socially in settings where options in this regard may be limited. There is a need for effective approaches to providing such support including innovative linkages across rural metropolitan services. Improving quality of service delivery requires ensuring that the culture of quality improvement is embraced in rural and remote settings and ensuring that resources and guidelines are available to support this both for mental health staff and for generalist staff taking on mental health roles. Reluctance or resistance to greater use of IT resources by rural and remote workers may be an issue that will require systematic attention and training. Building effective and sustainable linkages between rural services and academic centres can promote appropriate research, evaluation and service enhancement and would be supported through establishment of a centre for rural and remote mental health.

Acknowledging the challenges of providing a full range of mental health services outside of metropolitan Queensland, the following recommendations are made with view to ensuring (as stated by a Tasmanian informant) "*best possible access to comprehensive specialist services*". In our view, comprehensive specialist services should cover the mental health spectrum of activities (from mental health promotion to provisions for longer-term care needs), and are best understood as part of a broader optimal mix of mental health services (per WHO: Diagram 1 – see section 5. p 13).

Following the overarching issues, recommendations are consistent with these WHO service levels. In order to ensure the primacy of consumers and carers in policy and planning, the areas of greatest need (and opportunity given activity costs) are presented first.

RECOMMENDATIONS

Overarching issues

1. Resourcing rural and remote mental health activities will require realistic weighting in terms of funding allocation and must be informed by accurate information regarding the additional burden of need. To this end Queensland Health should support the ongoing collection and collation of mental health-relevant social indicators and service data for rural and remote communities.
2. Queensland Health should consider approaching the Australian Bureau of Statistics to over-sample rural and remote Queensland in the planned repeat National Mental Health Survey. This will provide invaluable data specific to Queensland's rural and remote mental health needs.
3. Resource allocation for rural and remote mental health should take into account requirements across the mental health spectrum of interventions. Specifically, particular attention needs to be given to prevention and mental health promotion in rural and remote settings and linkages with other sectors.
4. Queensland Health should allocate funds for infrastructure and support, to enable optimal use of existing information and telecommunication resources in rural and remote communities, and expansion in terms of geographic range, clinical and educational applications, and local capacity. These initiatives should include systematic evaluation (for instance through collaboration with the Centre for Online Health, University of Queensland).
5. Competency and effectiveness of the specialist mental health workforce will only be ensured through mechanisms that provide appropriate education, orientation and training, and support retention in rural and remote settings. This demands attention to professional and career development (including supervision), skills to address the social requirements of working in small communities (given dual relationship issues and related demands on clinicians), and the broader social needs of the rural and remote workforce.
6. The roles and responsibilities of Indigenous mental health practitioners must be defined and formalised (to include a clinical role), including certification, accreditation, training and support.
7. Role definitions and expectations of rural and isolated practitioners should be defined, developed and supported. In addition to general mental health skills, this will necessarily include competencies within a community development framework, ability to consult and liaise with community based organisations, skills across the mental health spectrum of interventions (particularly mental health promotion and prevention activities) and local administrative capacities.
8. The specific needs of special-needs populations (Indigenous, culturally and linguistically diverse…) must be incorporated across all levels of service delivery.
9. While the Mental Health Review Tribunal – ATSI Issues Reference Group is considering the Mental Health Review Tribunal's protocols in relation to

Indigenous consumers and carers, there are problems more generally with the Mental Health Act and its implementation in remote settings (for both Indigenous and non-Indigenous consumers). This should be reviewed with view to possible amendments to the Act.

10. The rural and remote mental health policy implementation will require (as in Tasmania) a Statewide rural and remote mental health coordinator. This position should relate to regionally-based rural and remote mental health network coordinators (which may or may not be within Queensland Health, for instance, these positions could be funded through *beyondblue* or other NGOs operating within public, private and NGO organisations, and across health and other sectors), and to regionally-based rural and remote consumer and carer consultants.

Self and family care

11. Queensland Health should enable consumer and carer participation through regionally-based rural and remote consumer/carer consultants relating to and supported by the Statewide rural and remote mental health coordinator.
12. Support to local NGOs and community organisations to encourage community-level consumer and carer participation and support.

Informal community care

13. Increase emphasis on programs to facilitate consumer and carer inclusion within communities and access to community-based services and resources.
14. Consistent with the mental health spectrum of interventions, increased attention to prevention and mental health promotion activities through community-based organisations.
15. Development of a rural and remote mental health literacy strategy for implementation through community-based and non-health sector organisations.
16. Linkage and coordination across self and family care, and informal community care activities through regionally based rural and remote mental health network coordinators.

Mental health services through primary health care

17. Primary care services are and will remain a major vehicle for the provision of mental health services in rural and remote settings. Continuing emphasis should be given to expanding and supporting the competencies of generalist primary care practitioners (in Queensland Health and other organisations).
18. Where possible, existing service networks with track records in rural and remote health should be utilised for service delivery. These include the Divisions of General Practice, the Royal Flying Doctor Service (Queensland Branch) and Indigenous community-controlled services.
19. To ensure viability, coordination and effectiveness, these relationships should be formalised and supported through Queensland Health (in line with the linkage coordination role in Tasmania).
20. Support should be provided to ensure the competency and effectiveness of relevant primary care providers to address and/or cooperate in the management of comorbidity.

Community mental health and general hospital inpatient services (non-specialist)

21. Funding should be provided for a carefully evaluated trial of rooming-in models of care associated with rural/regional general hospital services.
22. Funding should be provided to support sub-acute, step-through facilities in regional centres with careful evaluation. Contingent on this evaluation this may be appropriately extended to district centres.
23. Clear protocols are needed to ensure 24 hour mental health assessment and triage support to generalist practitioners in emergency departments.
24. General health and mental health providers need training to support the broader mental health skills-base required in rural and remote practice.
25. While development of local mental health capacity should be encouraged, outreach specialist services will remain essential for many rural and remote communities. This demands dedicated positions and flexibility in relation to delivery mode and may best be undertaken in collaboration with or through non-government services (for instance RFDS, the Divisions of General Practice or Indigenous community-controlled agencies). These activities must be adequately resourced, taking the higher burden of disorder and disability, the time and costs of travel, requirements for providing and supporting information technology and telecommunications approaches, and the demands of non-clinical activities (such as mental health promotion, community capacity building, and generalist health staff development and support.
26. Coordination with activities in the informal community care and primary care sectors should be ensured through the rural and remote network coordinator.

Specialist services and long stay care

27. Responsibility must be allocated for ensuring reasonable access (either through outreach or in regional centres) to subspecialist mental health services, including child and youth, aged care, forensic.
28. Access should be ensured to child and youth inpatient facilities across each Zone. The needs of Indigenous children and youth need to be carefully considered and ‘out-of-home community’ options should be explored and evaluated.
29. Longer stay options for adults (longer term institutional dependency, forensic, psychiatric rehabilitation and psychogeriatric) need to be more clearly defined and coordinated to ensure sufficiency and equity of access with least possible disadvantage to residents of rural and remote communities. This may include additional funds for supported visits and use of videoconferencing to ensure continuing engagement with natural supports in community of origin.

Implementation

30. The findings of this review and the recommendations should inform the development of a specific policy on mental health in rural and remote Queensland.
31. Queensland Health should provide resources for the implementation of this policy and its subsequent evaluation. On the basis of the experience in Tasmania, this should include a position for at least three years.

3 INTRODUCTION

The North Queensland Health Equalities Promotion Unit of the University of Queensland was contracted by the Service Development Team of the Queensland Health Mental Health Unit to undertake a 10-week project. The project brief required a literature review and key informant consultation about mental health policy and models of service delivery in relation to people living in rural and remote areas. The purpose of the project was to identify effective strategies and models employed nationally and internationally with potential application for Queensland. The scope of the project was to include rural and remote mental health, models/policies across the continuum of care, including: acute in-patient; acute community; extended in-patient; extended community; consultation liaison; and sub acute/rehabilitation.

4 METHODOLOGY

4.1 Project methods

The project methods included:

- a search of key databases including PsychINFO, Medline and CINAHL;
- a Google web-based search to identify unpublished literature and government reports, strategies and policies pertaining to rural mental health policy and models of mental health service delivery in rural and remote areas. Searches were conducted of websites for health departments, mental health branches or units and Centres for Rural Mental Health in Australia, and a selection of related sites in Canada, the United States of America, Great Britain and New Zealand;
- circulation of 22 electronic surveys (see Appendix 1: Electronic Survey proforma) to a purposive sample of Queensland mental health professionals across the mental health intervention spectrum who were located in regional, rural and remote locations. Informants were sought from government, non-government and private practice sectors and the special needs areas of forensic, child and youth, Aboriginal and Torres Strait Islander, aged care, comorbidity/dual diagnosis, and culturally and linguistically diverse groups. Representatives from mental health zonal management, workforce development, quality and legislation and information systems and outcomes were also approached (see Table 1: Key informant Consultation Framework). A total of 16 completed survey responses were analysed (see Appendix 2: Survey Respondents);
- a telephone interview with three key informants to explore Tasmanian policy and program developments (see Appendix 3: Interview Questions);
- inclusion in the report of relevant material about context and service delivery from a previous Queensland Health funded project report "The Queensland Centre for Rural and Remote Mental Health Discussion paper" (Kreger & Hunter, 2004).

Table 1: Key informant Consultation Framework*

	Health Promotion & Prevention	Clinical	Longterm
Regional	(South- QH)	(South)	(State-wide)
Rural	(North- QH)	North	No Response
Remote	No Response	(North-west:– Aboriginal Community Control & Private Practice)	(North: Non-Health government)
Child and Youth		QH: State-wide	
Child and Youth		QH: Rural mental health team leader	
Dual Diagnosis		UQ	
ATSI – Community controlled		Aboriginal community controlled	
ATSI – QH		No Response	
Culturally & Linguistically Diverse		QTCMHN	
Forensic		Dept of Corrective Services	
Aged Care		No Response	
Workforce		No Response	
Quality and Legislation		Q&L team	
Information Systems and Outcomes		IS&O team	
Zonal Mental Health		South	
Zonal Mental Health (Central)		No Response	

* shaded areas indicate responses received

4.2 Limitations of the project

Limitations were presented by:

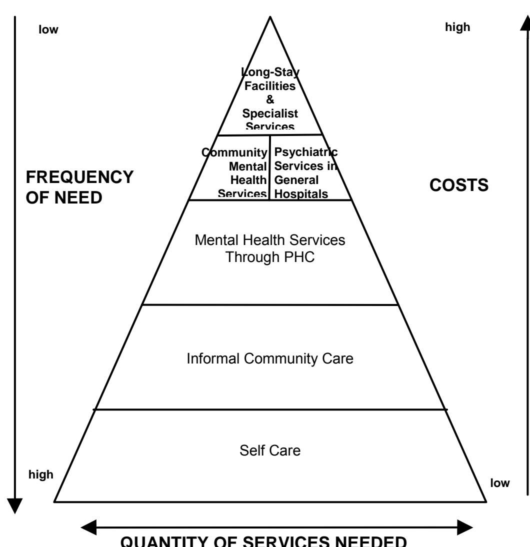
- the complex mix and range of issues in relation to the policy and service delivery areas required for review;
- the coding of key words 'rural' and 'remote' was not included in all journals and electronic databases which means that some relevant literature may not have been identified;
- accessibility problems with unpublished project data in Australia;
- many websites are not updated regularly so information gathered may not be the most current;
- limited availability of epidemiological evidence about mental health in rural and remote populations of Queensland; and
- ambiguities in terminology about service delivery resulting from both the range and interchangeable use of terms in the literature reviewed.

5 REPORT FRAMEWORK

The framework for this report was informed by a set of overarching constructs or contexts, in which rural and remote mental health must, necessarily, be located.

- First, rural and remote mental health needs to be considered within the broader context of rural and remote health which, itself, is poorly anchored in terms of defined service models and policy in Australia.
- Second, it needs to be understood within the national mental health context which identifies rural and remote needs as a priority but provides limited detail in terms of specific approaches.
- Third, as adopted by the Mental Health Strategy, this review recognises that a population health model must be comprehensive, that is, it must take account of the spectrum of mental health interventions, levels of service, and special populations within a whole of life framework (Raphael, 2000).
- Fourth, as outlined in the World Health Organization (2003) publication "Organization of services for mental health", this review acknowledges that there is, ideally, an optimal mix of different mental health services, (see Diagram 1: Optimal mix of different mental health services). While the greatest burden of care (and need) resides in the arena of self-care and informal community care, service related activities are predictably the focus of institutional attention, despite providing significantly higher cost services to a much smaller proportion of the population. Within this service context, while the area of greatest need and activity in rural and remote settings is at the level of primary care, the preponderance of reports relates to specialist mental health services – that is, at the levels of community mental health and specialist services.
- Fifth, policy in relation to rural and remote mental health is poorly defined but is central within a quality improvement framework.

Diagram 1: Optimal mix of different mental health services



Source: WHO (2003, p 34).

6 RURAL AND REMOTE CONTEXT

6.1.1 Rural and remote Australia

While Australia is predominantly an urban population, 30% of the national population live in non-metropolitan areas. Those living in rural and remote areas have a reduced life expectancy and higher fertility rates compared to their urban counterparts. Social indicators such as economic resources, other indices of disadvantage, education and occupation demonstrate increasing disadvantage with distance from major urban centres. The Australian Bureau of Statistics (2005) reports that for 2000-2001 15.1% of total gross personal income was derived from government cash benefits for non-metropolitan residents compared to those in cities with mean income from wages and salaries for those employed being $27,900 compared to $34,400 (indeed the levels of government cash benefits were also lower being $9,900 vs $8,200).

Health status indicators reveal elevated rates of alcohol and tobacco consumption, and a greater contribution by injury to premature mortality and elevated hospitalisation rates. The situation is compounded by health resource inequities with reduced supply of general practitioners, medical specialists, and allied health professionals resulting in a higher proportion of care provided by nurses in the rural and remote areas (Australian Institute of Health and Welfare, 2004).

In a summary of rural, regional and remote mortality, the Australian Institute of Health and Welfare notes:

> *While all of the causes of death described in this report are significant, two broad causes stand out as being of particular importance: circulatory disease and injury. Circulatory disease is important because of the large number of deaths involved, while injury is important because of the large number of 'excess' deaths outside Major Cities, the young age of many of the people affected and the trends for rates to remain unchanged or to increase over time. These two broad causes are responsible for 66% of all the 'excess' deaths that occur outside Major cities…*
>
> *While access to health services, the higher risks associated with some occupations and with country driving likely to contribute to higher death rates outside Major Cities, other issues are also likely to be relevant. Strong influences on health outcomes are also likely to result from higher rates of smoking, physical inactivity, risky alcohol consumption and poor nutrition, and lower rates of employment, income and education. At least for Indigenous people, disadvantages with regard to these issues, and issues around the social environment, lack of control over aspects of one's life, potentially leading to a sense of hopelessness, have been cited as major possible reasons for poorer health outcomes.* (Australian Institute of Health and Welfare, 2003)

6.1.2 Rural and Remote Queensland

Queensland is the most decentralised State in Australia. Whereas two thirds of the national population live in capital cities, the proportion for Queensland in 2004 was 46.9%, the lowest for any state save Tasmania (45.5) (Australian Bureau of Statistics, 2005). In 2001 the population distribution across the State was 53% in metropolitan areas, 44% in regional areas and 3% in remote areas. Rural and remote populations

include 55% of Queensland's Aboriginal and Torres Strait Islander peoples (De Leo & Heller, 2004).

The projected rate of population growth for Queensland over the next fifteen years is significant in that it will exceed the rate of population growth for the "world as a whole" (Brown, Kinfu, Taylor, & Bell, 2004). There will be moderate growth in coastal regions and Queensland will become less decentralised with most population growth to occur in the south east.

Projections at State and health service district levels can mask sub-population enclaves in rural and remote areas where health status, determinants and trends are not well understood or consistent with the State, Zone or District data which include urban populations. For instance, a 25% growth in national populations in savanna regions of Australia by 2021 (i.e. North & West Queensland) and a 27.1 % increase in arid region Indigenous populations are predicted (Bell, 2004). Arid, semi-arid and tropical savanna areas have: "u*nique socio-economic characteristics"* that are poorly understood and have *"very different population dynamics for indigenous and non-Indigenous populations"* (Brown, Kinfu, Taylor, & Bell, 2004).

In terms of health determinants:

- *People living in remote areas of Queensland reported higher satisfaction with life , particularly with safety and feeling part of the community, and were more willing to help each other, compared with urban and rural areas;*
- *People in remote areas are more likely to die from lung cancer, CHD, stroke, suicide, injury, poisoning, road traffic injury, diabetes, asthma and COPD;*
- *In remote areas, there were higher death and hospitalisation rates due to hazardous and harmful consumption of alcohol and tobacco smoking as well as a higher proportion of harmful and hazardous alcohol consumption;*
- *People in remote areas were more likely to be over-weight or obese and physically inactive;*
- *Healthy food costs more in remote areas of Queensland;*
- *In accessible areas, people were more likely to die or be hospitalised due to illicit drugs. (Queensland Health, 2004a)*

Data for 1996 showed an "*association at SLA level between high proportions of single parent families and socioeconomic disadvantage*" with the most remote areas having the highest proportion of single parent families, that is, 13.1 % compared to 10.1% for all non-metropolitan areas of Queensland (Glover & Tennant, 1999). In general the proportion of low income families increases with increasing remoteness with 23 % in 'Very Remote' areas and 20.3% in 'Very Accessible ' areas (Glover & Tennant, 1999). Although relevant, unemployment figures were unreliable because underemployment and hidden unemployment was not reported (Glover & Tennant, 1999).

Although planning for health services is limited by inadequate information regarding health status, determinants of health and health system performance outside of metropolitan areas (Australian Institute of Health and Welfare, 2003), it is evident that there is a disproportionate burden of unmet mental health needs within these locations. In Queensland:

> *Indigenous status, the level of socioeconomic disadvantage and to a lesser extent rural or remote location all have a major effect on health. However with*

> *current data the effect of each of these factors is unable to be separated from the effect of the other factors. This is because , Indigenous peoples most often live in areas of most socioeconomic disadvantage, and 55% live in rural and remote areas of Queensland. The result is that each of these factors combines and interacts to influence the health of a particular population. Thus it is important to be aware that the key health issues for the socioeconomically disadvantaged groups and rural and remote population groups … and indigenous peoples are not independent." (Queensland Health, 2004a)*

The recently published 'Suicide in Queensland 1999-2001' provided an indicator of the extent of variance in mental health status between in metropolitan, rural and remote areas:

- *Mortality rates for males in remote areas (42.3 per 100 000) were significantly higher than the male rates for metropolitan areas and Queensland as a whole. Regional rates for males and all persons were significantly higher than those from counterparts in metropolitan areas.*
- *The male suicide rate in remote areas was about two times the rates seen in other areas of Queensland.*
- *The rate of suicide among young males in remote areas (80.1 per 100 000) was more than four times the rate seen in metropolitan counterparts.*
- *For females of all ages in remote areas, mortality rates were twice those of females in metropolitan areas.*
- *In remote areas, more than half of all suicides were persons aged under 35 years old, with only 13% by persons older than 55 years.*
- *Hanging was the most common method of suicide in all areas of Queensland and accounted for two-thirds of all suicides in remote areas.*
- *The rate of suicide for males in the Western region was of particular concern, with a suicide mortality rate 75% higher that the Queensland rate (peaking in the 15-24 year age group, at 60.5 per 100 000).*
- *Indigenous people in Queensland had a rate of suicide that was 56% higher that the whole Queensland population 20.1 per 100 000 vs 12.9 per 100 000). This discrepancy is greatest in young Indigenous males (15 -24 years); with a rate of suicide almost 3.5 times that of all young males in Queensland. Indigenous males aged 25-34 years completed suicide two times greater than the State average. The majority of Indigenous suicides were under the ages of 35 at the time of death (83%) which was approximately two-times the proportion seen in Queensland as a whole (42%). Hanging accounted for almost all suicides by Indigenous people. (90% vs QLD 41 %).*
- *Twelve suicides occurred among young people under 15 years of age. The majority of these deaths occurred in rural areas with the majority being of Caucasian ethnicity.* (De Leo & Heller, 2004)

6.1.3 North Queensland Health Zone

In 2004 with the assistance of the Cairns Tropical Public Health Unit the following information on mental health in the North Queensland Health Zone was reported by Kreger and Hunter (2004, p 9-12). It provides an indication of the health differentials that may occur within a zone, and between the zone and State as a whole.

The Northern Queensland Health Zone occupies approximately 750,000 square kilometres from Mackay District on the East Coast and Mt Isa District adjacent to the

Northern Territory border, to the Torres District bordering Papua New Guinea. It encompasses diverse ecosystems from the coastal ‘wet tropics’ to savanna and ‘dry tropics’ in the west and south. The economy is similarly diverse with significant activity in the mining, agriculture, tourism and fisheries sectors, as well as government services. According to the 2001 census the Zonal population was 596, 725. Within the region the age distribution varies by location, with a smaller proportion of young adults in rural compared to urban settings (see Appendix 4: Population pyramid - Rural urban comparison by age, Northern Zone 2004). Of the Zonal population, some 53,794 identified as being of Aboriginal and/or Torres Strait Islander descent, this being 9.0% of the total (compared to 3.1% for Queensland). Across the four statistical divisions within the Zone the Indigenous proportion of the population varies from: 3.2% in the Mackay Statistical Division to 25% in the North West Statistical Division – Mt Isa and the Gulf country (see Table 2: Offences against property and person). The age structure of the Indigenous population is significantly different from that of the wider Queensland population with a substantially smaller proportion of surviving elderly and an elevated youth dependency ratio which has been associated with higher risk of certain adverse youth outcomes (Hunter, 1993).

Offending behaviour provides an index of social disadvantage and also varies across the zone. While offences against property are broadly similar to levels for the State as a whole (indeed marginally lower), offences against the person are substantially higher reflecting differences in the proportion of Indigenous residents in each division and the broad social disadvantage of that population and their particular vulnerability in the criminal justice system (see Table 2: Offences against property and person).

Table 2: Offences against property and person: Statistical Division: Queensland rate ratios, 2002-2003 (Mackay, Northern, Far North and North West Statistical Divisions)

	Mackay	Northern	Far North	North West
Property offences	0.77	0.97	0.94	1.1
Offences against person	1.18	1.32	1.7	4.06
% Indigenous	3.2%	6.2%	13.6%	25.0%

Within both the Indigenous and non-Indigenous populations of the zone social disadvantage is not evenly distributed. This is demonstrated in the Socio-Economic Indexes for Areas review of Indigenous SEIFA for Queensland (Rawnsley & Baker, no date). As shown in Appendix 5: (Indigenous and non-Indigenous SEIFA quintiles), the distribution of SEIFA quintiles for both populations varies substantially across the State and within the Northern Zone, with remote areas being particularly disadvantaged for Indigenous populations by comparison to the non-Indigenous populations living in the same area.

This, in turn, is reflected in health statistics. Appendices 6 and 7: (Male & Female Age Specific Death Rates by ASGR Remoteness area) show age specific mortality for non-Indigenous males and females by residence (metropolitan, inner regional, outer regional, remote, very remote) and Indigenous, demonstrating that the excess mortality experienced by Indigenous residents is not explicable simply on the basis of remoteness. This is also consistent with national Australian Bureau of Statistics data on Indigenous deaths and hospitalisation for accidents and injuries, with injury being the second most common cause of deaths for males and the fourth most common cause for females across Queensland, WA, SA and the NT in 1999-2001 with rates three times higher than for the population as a whole. Hospital separation rates for 2001-02 for injury were twice as high for Indigenous people as for other Australians with assault being the leading cause of hospitalisation for both males and females (www.healthinfonet.ecu.edu.au).

There is limited data on mental health for north Queensland. What is available for the total population of the Zone for the period 1998 to 2002 indicates that the mortality rates for 'all mental disorders' were broadly similar to Queensland as a whole (see Appendix 8: Urban, rural, Northern Zone mortality rates). This data is unreliable. Some 70% of deaths in this category were those attributed to 'unspecified dementia' with the remainder being from a broad range of other causes. These contributed only in small numbers to the indicator and were generally of questionable aetiological significance. This points to significant data deficiencies which are also present in relation to identification of socioeconomic disadvantage through conventional approaches (Burgess et al., 2002).

Data for suicide rates is more reliable. The standardised mortality rates for suicide showed significantly elevated rates for both men and women in 2001 and for men in 2002 (see Appendix 8: Urban, rural, Northern Zone mortality rates). This is reflected in aggregate data for this period (Table 3: Mortality rate ratios).

Table 3: Mortality rate ratios (all mental disorders and suicide): Urban, rural and Northern Zone residents - Queensland, 1998-2002 (by sex)

All Mental Disorders - mortality rate ratios, males and females			
Female	Urban	Rural	Zone
1998-2002	122 (98-150)	129 (100-164)	125 (106-146)*
Male			
1998-2002	116 (91-147)	128 (99-162)	122 (102-144)*
Suicide - mortality rate ratios, males and females			
Female	Urban	Rural	Zone
1998-2002	102 (75-135)	118 (84-162)	108 (87-134)
Male			
1998-2002	102 (88-117)	131 (113-151)*	114 (103-126)*
* Significantly higher than Queensland			

Bearing in mind the limitations of this data, it does suggest elevated levels of need. Thus it is notable that the age standardised hospital separation rates for all mental disorders, schizophrenia, depression and self-harm (with one exception) were lower for both men and women in the northern Zone compared to Queensland across all four years 1998/99 to 2001/02 (see Table 4: All mental disorders hospital separation rate ratios Northern Zone).

Table 4: All mental disorders hospital separation rate ratios, Northern Zone.

All mental disorders hospital separation rate ratios,
Males and Females Northern Zone 1998-2001

Female	Urban	Rural	Zone
1998/99	53 (50-56)**	74 (70-78)**	61 (59-64)**
1999/00	54 (51-57)**	54 (51-58)**	54 (52-56)**
2000/01	57 (54-60)**	59 (55-63)**	58 (55-60)**
2001/02	52 (49-55)**	60 (56-64)**	55 (53-58)**
Male			
1998/99	70 (67-74)**	88 (83-93)**	78 (75-81)**
1999/00	78 (74-82)**	91 (87-96)**	84 (81-87)**
2000/01	88 (84-92)**	78 (74-82)**	84 (81-86)**
2001/02	83 (79-86)**	72 (68-76)**	78 (75-81)**

* Significantly higher than Queensland **Significantly lower than Queensland

At the request of the acute inpatient unit at Cairns Base Hospital the North Queensland Health Equalities Promotion Unit examined the overall patterns of occupancy, admissions and length of stay for the period 1999- 2004. While further investigation of Indigenous LOS and residence is in progress, findings to date include:

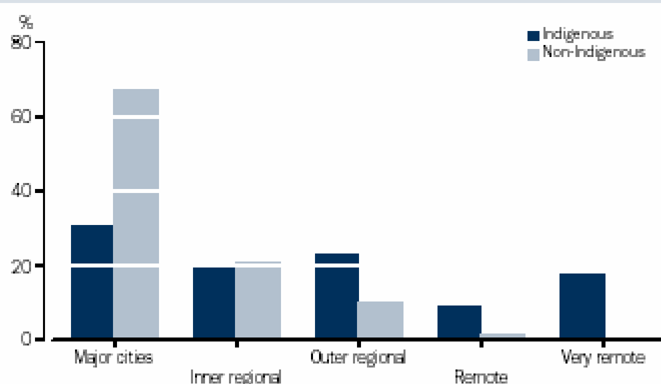
- Definite upward trend in occupied bed days since 1999;
- Occupancy rates for 2004 have exceeded all other years;
- Increase in admissions from ‘community services’ (definition of which is unclear);
- Increase in admissions of 50+ age group;
- Sharp increase in occupied bed days and per cent of admissions for the 18-29 year group in 2004;
- A drop in long and short stays but mid length duration (11-35 days) have increased;
- Per cent of admissions recorded as Indigenous clients increased steadily (16.6 % to 21.3%);
- No trends in respect of diagnostic category were identified except that admissions for personality disorder decreased.

6.1.4 Indigenous mental health

A greater proportion of Australia’s Indigenous population live in rural and remote settings (Diagram 2). While Indigenous Australians are disadvantaged by comparison to non-Indigenous citizens, those living in non-metropolitan settings are less likely to own a house, more likely to live in Indigenous housing, more likely to be dependent on government cash benefits. As a measure of “income and financial stress” the proportion of respondents indicating inability to raise $2000 within a week for something important was 72.7% of remote Indigenous respondents compared to 47.3% of non-remote Indigenous only 13.6% of non-Indigenous respondents (Australian Bureau of Statistics, 2005).

Diagram 2 Population remoteness (ABS, 2005)

Population by Remoteness Areas(a) — 2001



(a) Estimated resident population, all persons.

Source: *Experimental estimates of the Aboriginal and Torres Strait Islander population* (ABS cat. no. 3238.0).

According to the 2001 Census the Indigenous population of Australia was 458,520 (2.4% of the national total) with 125,910 or 27.4% resident in Queensland, constituting 3.5% of the State total. Of those, 28,453 identified Torres Strait Islander status, being 58.4% of all Torres Strait Islanders in Australia, the majority living in the Northern Zone. As noted earlier the total Aboriginal and Torres Strait Islander population of the zone in 2001 was estimated at 53,794 being 9.0% of the total Zonal population.

Unfortunately, while there are numerous reviews of Indigenous mental health (Hunter, 2003; Reser, 1991; Reser & Morrissey, 1991) population level data is poor. However, national data from the Australian Institute of Health and Welfare (Table 5) on hospital separation as an index of morbidity shows that both Indigenous males and females are more likely to be hospitalised than their non-Indigenous peers for organic mental disorders, disorders due to psychoactive substances, psychotic and mood disorders.

Table 5: Standardised Morbidity Ratios* for mental and behavioural disorders: Indigenous: non-Indigenous, 1998-1999

	Indigenous males	Indigenous females
Organic mental disorders	3.1	2.6
Mental disorders due to psychoactive substances	4.1	3.5
Schizophrenia, schizotypal and delusional disorders	1.8	2.0
Mood and neurotic disorders	1.3	1.2
Other mental disorders	0.8	0.6
All mental and behavioural disorders	2.0	1.5

* Based on all Australian age-, sex-, and cause-specific rates. Categories are based on ICD 10, Australian modification. AIHW National Hospital Morbidity Database.

There is even less information regarding Indigenous children and youth, most being gross measures of behavioural disturbance such as deaths from injuries for which Indigenous males and females aged 15-24 years are 2.3 and 1.6 times more likely respectively to die than their non-Indigenous peers in the years 1995-1997 (AIHW

Mortality Database). Hospitalisation rates for this population (Table 6) show that while Indigenous people in this age-group are more likely to be admitted to hospital for injuries and violence (with young women being some fifteen times more likely), they are no more likely to be hospitalised for mental disorders, suggesting problems of functional access. This is despite a wealth of other information suggesting increased exposure to emotional and psychological traumatisation, such as child sexual abuse.

Recent information from the Western Australian Aboriginal Child Health Survey found that while Aboriginal children were clearly at elevated risk for serious emotional and behavioural disorders compared to non-Indigenous children, that risk was relatively less in areas of extreme isolation (Zubrick et al., 2005). A similar trend was seen in adult self-report in the Indigenous household sampling survey within the 2001 National Health Survey (Booth and Carroll, 2005). What this means in Queensland, with its particular history of onerous controls with isolation and concentration in remote settings, is unclear.

Table 6: Reasons for Hospitalisation, young people 15-24 years, Indigenous: non-Indigenous, 1997-1998

Selected Diagnoses	Indigenous males	Indigenous females
Mental	1.1	0.9
Violence	2.7	15.0
All injuries	1.1	1.7
All causes	0.9	1.3

AIHW National Hospital Morbidity Database

Among many mental health issues for the Indigenous population for which there is concern but inadequate data, intentional self-harm has at least received more consistent attention. The number of Indigenous suicides recorded in Queensland increased four-fold between 1992 and 1996, with the rise entirely accounted for by increased deaths by hanging, primarily of young males, with rates for those aged 15–24 and 25–34 being some 3.6 and 2.2 times, respectively, the rates of men in those age groups for the State as a whole (Baume, Cantor, & McTaggart, 1997). Data for Queensland as a whole for 1999-2001 shows that 80% of Indigenous suicides are in the 15-34 age group and 82.5 % of all Indigenous suicides are male (Appendix 7: Indigenous Suicides in Queensland 1999-2001). For the period 1996 to 1998, these rate ratios were four and three times greater than the State rates (De Leo & Evans, 2002). Indigenous suicide is unevenly distributed by age (being concentrated among young adult males) and it is also unevenly distributed geographically. In reviewing the data for 1999 to 2001 these authors found:

> *In the Mackay-Fitzroy region indigenous people had suicide rates more than four times that of the general population, while rates in the Western Region for indigenous people were almost two times those of the general population. For indigenous males in North and Far North, the mortality rate was 80% greater that for the general male population.* (De Leo & Heller, 2004)

Even within the north of the State suicide is further concentrated: for the period 1990 to 1996 three communities constituting less than 20% of the region's Indigenous population account for 40% of the deaths by suicide. These communities contribute to the excess at different times, there appearing to be overlapping 'waves' of suicides,

suggesting a condition of community risk that varies by location and time (Hunter, Reser, Baird, & Reser, 2001).

Other issues of national and regional concern at present include alcohol and cannabis misuse, alcohol-related birth defects, the consequences of child abuse and neglect, and premature cognitive decline. Associated with all is alcohol abuse which has received considerably more attention including a review of services and needs in relation to alcohol across five sites in north Queensland (city, rural town, remote community, Torres Strait community and a mining support centre) (Hunter, Brady, & Hall, 1998). Consistent across both substance use and mental health fields is unmet need.

7 LITERATURE REVIEW

7.1 POLICY CONTEXT

Development of policy for rural and remote mental health in Queensland occurs in a broader policy context. While not the focus of this review, the following documents define that context.

7.1.1 Rural Health - National

- National Rural Health Strategy (Australian Health Ministers' Conference, 1994);
- Healthy Horizons: A Framework for Improving the Health of Rural and Remote Australians (National Rural Health Alliance and National Rural Health Policy Forum, 1999).

7.1.2 Mental Health - National

- Mental Health Statement of Rights and Responsibilities (Australian Health Ministers, 1992a);
- National Mental Health Policy (Australian Health Ministers, 1992c);
- National Mental Health Plan (Australian Health Ministers, 1992b);
- National Mental Health Strategy (Australian Health Ministers, 1996);
- National Standards for Mental Health Services (Australian Health Ministers' Advisory Council's National Mental Health Working Group, 1996);
- Second National Mental Health Plan (Australian Health Ministers, 1998);
- National Practice Standards for the Mental Health Workforce (National Mental Health Education and Training Advisory Group, 2002);
- National Mental Health Plan 2003-2008 (Australian Health Ministers, 2003);
- Social and Emotional Well Being: A National Strategy Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Well Being (Social Health Reference Group, 2004);
- Comorbid mental disorders and substance use disorders (Teeson & Proudfoot, 2003).
- Framework for the implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia (Commonwealth of Australia, 2004).

7.1.3 Mental Health - Queensland

- Queensland Mental Health Policy (1993);
- Queensland Mental Health Plan (Queensland Health, 1994);
- Ten Year Mental Health Strategy for Queensland (Queensland Health, 1996b);
- Queensland Mental Health Policy Statement, Aboriginal and Torres Strait Islander People (Queensland Health, 1996a);
- Mental Health Services for Older People (Queensland Health, 1997);
- Framework for the development of the future mental health workforce in Queensland (Queensland Health, 2000a);
- Queensland Health Mental Health Information Development Plan 2000-2003 (Horner, MacMillan, & Mantle, 2000);
- Queensland Forensic Mental Health Policy (Queensland Health, 2002);
- Queensland Health Mental Health Education and Training Model Project Draft Summary Report (Queensland University of Technology, 2003);

- Towards Consumer Centred Services, Queensland Health Action Plan for Consumer and Carer Participation in Queensland Mental health Services (Queensland Health, 2003e);
- Mid-Term Review of the Implementation of the Ten Year Mental Health Strategy for Queensland: Findings and Recommendations (Queensland Health, 2003a);
- Review of the Mental Health Community Organisation Funding Program (Queensland Health, 2003c);
- Reducing Suicide: Action Plan 2003 - The Queensland Government Suicide Prevention Strategy 2003-2008 (Queensland Government, 2003).

7.1.4 Queensland Mental Health Service Delivery Models

- A Model of Service Delivery for Mental Health Acquired Brain Injury Extended Inpatient Services for Queensland (Queensland Health, 2004b);
- A Model of Service Delivery for 'Extended Treatment and Rehabilitation' and 'Dual Diagnosis' Clinical Programs in Queensland (Extended Treatment and Rehabilitation and Dual Diagnosis Service Development Reference Group, 2003);
- A Model of Service Delivery for Extended Inpatient Mental Health Services for Older People in Queensland (Queensland Psychogeriatric Services Development Reference Group, 2001).

7.1.5 Other Government Policy - Queensland

- Position Statement : Health Service Integration in Queensland (Queensland Health, 2000b);
- Smart State Health 2020 : Directions Statement (Queensland Health, 2003d);
- Continuity of Care Planning Framework for Queensland (Randall & Buckland, 2003).

7.1.6 Rural Mental Health Policy Development Internationally

While the review identified a limited range of rural-focused mental health activities internationally no national rural mental health policies were identified.
Apart from Australia, only literature from the United States (US) identified a need for national or State rural mental health policy development. The President’s New Freedom Commission on Mental Health Subcommittee on Rural Issues (New Freedom Commission on Mental Health, 2004) identified a range of issues for attention in rural mental health policy development and recommended the establishment of national mental health benchmarks through the creation of a national rural mental health plan.

A selected sample of US health departments’ websites in States with large rural areas indicated that the need to improve access to mental health care was not widely acknowledged. Available information from those States (California, Nevada and Arizona) with strategic goals for rural mental health details efforts towards identification of issues in mental health service sufficiency but no specific policies.

7.1.7 Rural Mental Health Policy Development in Australia

7.1.7.1 National

Following the achievements guided by the 1994 National Rural Health Strategy, the later "Health Horizons – A Framework for Improving the Health of Rural and Regional and Remote Australians" (National Rural Health Alliance and National Rural Health Policy Forum, 1999) refocused reforms to improve health services, health workforce and health status in rural and remote areas. Citing the success of these policy initiatives a number of Australian rural and mental health commentators have called for the development of a national rural mental health strategy (Fraser et al., 2002; Judd & Humphreys, 2001; National Rural Health Alliance, 2003).

However, with the exception of the Tasmanian Rural Mental Health Plan (Mental Health Plan Steering Committee, 2001) no specific rural mental health policies were located, although reports specific to rural and remote mental health services in Western Australia and Northern Territory are particularly relevant. In general, other State policies specific to mental health (such as, emergency psychiatric services, regional operations, and supported accommodation or rehabilitation) were narrow in the level of attention given to implementation of those policies in rural and remote areas (Health Department of Western Australia, 1998a, 1998c; Mental Health Implementation Group, 2002; NSW Health Department, 2002; Office of Mental Health, 2004b). Rarely were details about the infrastructure, community and workforce context of rural and remote areas or related strategies delineated.

7.1.7.2 Tasmania

The Tasmanian Rural Mental Health Plan provided a framework for implementation by local communities to accommodate local circumstances within key policy goals and principles of the National Mental Health Strategy (Mental Health Plan Steering Committee, 2001). The plan was based on partnerships and flexibility, and aimed to build on existing rural networks, multipurpose services and local management. Key features included:

- establishment of a local mental health network within each rural health management area;
- dedicated, local mental health worker positions to support local services, outreach and urban based providers;
- more allied health and mental health outreach;
- formalisation of partnerships and linkages with general practitioners and alcohol and drug services;
- Medical Specialist Outreach Assistance Program (MSOAP);
- suicide prevention, mental health promotion;
- training/education of primary health care professionals, and;
- travel assistance.

The Plan is underpinned by a commitment to:

- care in home community;
- organising around people and their needs;
- timely access to specialist and acute care;
- building capacity of people and communities;
- using technology;

- establishing effective alliances and networks;
- maintenance of rights;
- supporting carers and families;
- providing opportunities for development of local resources, and;
- adoption of a primary health care approach (Mental Health Plan Steering Committee, 2001).

The framework for implementation defined a staged process: stage 1) appointment of coordinator and implementation committee; stage 2) establishment of working groups for specific strategies, consultation with stakeholders to scope a work plan, and to develop guiding principles and an evaluation process.

The Tasmanian Rural Mental Health Plan's implementation process was evaluated in 2004 (Boote & Cook, 2004). Sufficiency of time for collaboration and agreement across diverse sectors and agencies was the most significant barrier reported. Complex partnerships were involved and in addition to endorsement within those partnerships, broader endorsement was required. A large proportion of coordination involved gaining commitment to the plan and facilitating communication. While resources were sufficient for the eight pilot areas, funding for implementation of the plan did not extend for the total duration of the plan 2001-2004. Regardless, achievements included:

- a community development approach through regular visits to sites and staff;
- a 90% increase in funding for primary rural mental health and mental health worker positions sourced from Commonwealth regional health service funds;
- finalisation of service agreements with five out of eight pilot positions, and;
- confirmation that unique community solutions are possible when they are resourced and supported by government.

Key 'learnings' from the evaluation were that reduction of stigma demands long-term strategies and that resolution of problems requires a multilevel approach involving decision makers and service delivery staff. Other findings of note were that:

- adoption of consumer and carer participation policy, and awareness of national practice standards for the mental health workforce were not widely achieved;
- no services complied fully with National Standards for Mental Health Services, and;
- further funding is required to implement the plan across all rural areas.

The evaluation recommended that the life of the plan be extended to enable a mainstreaming approach with inclusion of the principles and policy directions into all government agencies.

Interestingly, the Review of Mental Health Services in Tasmania (Department of Health & Human Services, 2004) failed to make any reference to the Tasmanian Rural Mental Health Plan itself or the evaluation completed in 2004.

7.1.7.3 Western Australia

The Rural and Remote Mental Health Services Working Party report for Western Australia's State Mental Health Strategic Plan 2003-2008 priority recommendations included:

- continuation of the Rural and Remote Mental Health Services Working Party to develop an implementation plan for their recommendations;
- development of a rural and remote mental health services portfolio to facilitate liaison between regions, mental health, and NGOs to maximise opportunities and resources across departments and sectors;
- establishment of a 24 hour 7 day a week access throughout the State to specialist emergency psychiatric consultation utilising video and telephone;
- increased access to mental health awareness training for generalist primary care and allied health staff;
- flexible and innovative approaches to recruitment and retention of the mental health workforce in rural and remote areas;
- clarity in procedures for access to metropolitan inpatient beds for rural and remote patients;
- development of admission and discharge protocols for inpatients from rural and remote areas;
- increased consumer and carer participation including funding for one fulltime equivalent consumer consultant per health region and establishment of a CAG in all regions;
- continuation of the State-wide clinical services enhancement program;
- formal linkages, MOUs and pathways between government and non-government organisations to coordinate services for dual diagnosis clients;
- formalisation of shared care arrangements between mental health services and primary care practitioners;
- increased numbers of Aboriginal mental health workers, and ;
- establishment of an academic post in rural and remote mental health (Rural and Remote Mental Health Services Working Party, 2003).

7.1.7.4 Northern Territory

The Mental Health Service System Development Strategy Project Final Report (Healthcare Management Advisors Pty Ltd, 2003) included a range of recommendations relevant to Queensland. These were for:

- funding 1.5 times per capita for non-metropolitan services and weighting of resource allocation between urban and regional centres;
- additional positions especially for child and youth mental health;
- enhancing the mental health capacity of primary health care staff;
- placement of mental health professionals in general practices as trialled and evaluated by Harmon, Carr and Lewin (2000);
- development of both mental health promotion and prevention strategies across government departments;
- workforce development for Aboriginal mental health workers;
- collaborative collocated mental health and alcohol and drug service models;
- increased community accommodation and non acute beds;
- community resources to support recovery and rehabilitation;
- more resources for the non government sector;
- minimum staffing standards for regional hubs, and;
- partnerships with the tertiary education sector.

7.1.7.5 Relevance to Queensland of initiatives from other States

Despite the limited range of rural mental health policy documents, a range of core factors were identified. These are reflected in the Smart State: Health 2020 Directions Statement (Queensland Health, 2003d) that emphasised:

- integration;
- patient focus;
- community involvement and enhancement;
- workforce development especially for Indigenous people;
- targeting health improvement (depression, suicide, child and youth mental health) through a whole of government approach;
- a focus on prevention and continuous improvement;
- collocation and multipurpose service centres;
- optimisation of information and communication technology;
- progressing new practitioner models;
- stronger partnership arrangements between rural, regional and metropolitan services;
- increasing access for Indigenous people;
- strengthening primary health care;
- investing in community capacity;
- intersectoral coordination and effective partnerships;
- linkages with universities;
- a service culture supporting evidence-based approaches, and;
- research and development.

7.2 HEALTH SERVICE DELIVERY MODELS[1]

In general, the reviewed literature revealed a preoccupation with individual treatment approaches at discrete locations in rural and remote areas rather than a comprehensive population approach encompassing the continuum of interventions (Kreger & Hunter 2004). In respect to the optimal mix of services as identified by the World Health Organisation (see Diagram 1: Optimal mix of different mental health services in section 5) the reviewed literature indicated that current approaches to service delivery tend to favour components in the lower frequency of need and higher cost areas of an optimal service mix. This was exemplified by the paucity of evaluation, literature and policies about self-care, informal community care and to a lesser extent provision of mental health services through primary health care.

In relation to service delivery per se in rural areas, Judd et al. (2002a) identified a range of special issues which were rarely discussed in the literature reviewed, including: the rural community and location, the changing focus and role of mental health services, and the availability of and demands on mental health practitioners.

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[1] It should be noted that the term 'model' presents conceptual and definitional problems. Diverse terminology is used in the literature and difficulties were encountered identifying the discrete characteristics of such 'models'. Furthermore, in the review for this project there is overlap in activities between different models, some models have components of two or more other models, some with the same name have different components. Models often occupy a parlous space of theory or trial and may be viewed with optimism or suspicion without proof of effectiveness or sustainability. In effect, there is more ambiguity than clarity in the way in which the term 'model' is used in relation to service delivery.

This includes that consumers in non-metropolitan settings have expectations of more flexible social boundaries with their mental health service providers than is the case in metropolitan settings[2], an issue raised by Scopelliti, Judd, Hodgins, Fraser, Hulbert, and Wood, (2004) as a significant training concern. Although the capacity of any service delivery model is linked to provision of appropriate infrastructure and a skilled workforce (Humphreys, Hegney, Lipscombe, Gregory, & Chater, 2002), those resources were rarely delineated in the context of mental health care in rural and remote areas.

The limited documentation of evaluation in rural and remote mental health service delivery further constrained identification of effective models. This deficit was evident in the recommendation for urgent attention to evaluation of outcomes and impact of the existing models, particularly in respect to the reliance on primary care practitioners and the amount of specialist service input that is required for effective treatment in rural areas (Judd et al., 2002a). This recommendation in itself illustrates the disproportionate attention given to treatment in the spectrum of interventions but also presents questions about how, to date, mental health service developments in rural and remote areas have been identified. It must be noted that these authors emphasised the need to link service delivery with research, evaluation, education, training, support, policy formulation and implementation. Despite the identified problems, these authors note that development of mental health service delivery in rural and remote areas offers opportunities which include:

- the potential to work outside traditional roles;
- acknowledgement and promotion of the place of informal care and community support systems;
- improved collaboration between local health and human service providers, and;
- the potential for development of innovative services (Judd et al., 2002a).

7.2.1 Mainstream

In mainstream models mental health services are structured as a specialist area within the general health system in contrast to historical approaches where mental health care was delivered through an "*organisationally separate system*" (Queensland Health, 1996b). Mainstreaming involves the integration of inpatient and community mental health services for a defined catchment.

In regional areas of Queensland, components of "mainstream" integrated mental health services (for example, acute inpatient units) are service providers for satellite community mental health services in health districts beyond the one which was organisationally responsible for the inpatient unit itself. In addition, this central service also provides other specialised mental health activities (such as, child and youth, psychogeriatric, extended care/rehabilitation and health promotion) to satellite services.

Satellite services (also categorised in the literature as 'hub and spoke' and outreach) involve networking arrangements between larger mental health services and smaller,

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[2] This point was articulated clearly to the authors of this report at a consumers' and carers' forum held in Mt Isa in July 2005 where it was noted that for consumers in small communities social networks are depleted and social options limited. Consequently, the relationship with a mental health provider takes on additional importance a fact which is reinforced by the increased social interactions that occur in small town settings.

distant health services to provided fixed on-site services (Judd et al., 2002a). Satellite services are usually individual practitioners or small teams collocated with district health services that do not have a comprehensive integrated mental health program. Satellite services may be supported by visiting psychiatrists, child and youth mental health teams and principal service centres in relation to acute inpatient care, sub-acute care and non-clinical services such as, mental health promotion, professional development, Mental Health Act administration, service development and electronic data collection systems. This approach can lead to conflicts between operational and professional responsibility across the local District health service and the distant mental health program principle service centre as was identified in a review report on services in Cape York (Hunter, Brownlie, Haswell-Elkins, Wargent, & Hall, 2004).

7.2.2 Outreach

Outreach models usually involve mobile, visiting mental health services to smaller communities with no fixed service (Judd et al., 2002a). This may be from regional centres or from satellite services to even more remote communities which have no fixed services. In addition to direct care, outreach visits may involve skills development through education to mental health and other human service personnel in the rural areas and community capacity building (Cord -Udy, 2003; Owen, Tennant, Jessie, Jones, & Rutherford, 1999; Santhanam, 2005). One national example is the Commonwealth-funded Medical Specialist Outreach Assistance Program (MSOAP), through which urban or regional-centre based psychiatrists provide support on an intermittent basis to generalist and mental health professionals.

The Royal Flying Doctor Service (RFDS) was acknowledged for innovation and delivery of flexible, coordinated outreach services in rural and remote areas (National Rural Health Alliance and National Rural Health Policy Forum, 1999). Their mental health outreach feasibility study recommended the formation of linkages with other service providers to improve access to specialist mental health care in remote areas (Williams, 1996). This and other recommendations in the areas of service delivery, health promotion, research, education and personal support have attracted funding and key partner support (personal communication, R. Williams 11 April, 2005). Progress with RFDS linkage initiatives to support outreach is evidenced by the increased accessibility to Remote Child and Youth Services facilitated by RFDS for Cape York communities (Santhanam, 2005).

Following community-wide consultations the Northern Queensland Rural Division of General Practice developed a model for outreach allied health service delivery (including mental health) within a primary health care framework to remote communities of northwest Queensland. This model gave particular attention to service sustainability, delivery preferences and options in remote settings, and a range of strategies to support recruitment and retention of allied health professionals. The service was described as a “hub and spoke” outreach model with allied health professionals providing mental health services, training, and input into community development (Battye & McTaggart, 2003). Of note was the continuity of care resulting from the recruitment and retention strategy (personal communication, K. Mc Taggart, 8 August 2004).

A study of mental health services for older people in rural and remote areas of New South Wales found they experienced poor access to psychogeriatric staff, resource limitations for psychogeriatric services, and inadequate liaison and support. Bi-

disciplinary and consultative models had resulted in gaps and poor access (Draper et al., 2003). While collocation with aged care was recommended in this report a US study found that outreach and in-home services in rural areas increased access from 4% to 21% for the over 60 years age group (Maiden, 2003).

Other authors have identified specific issues with some forms of rural outreach, for example, the unproductive travel time involved in assertive outreach mental health services in rural areas of England reduced by half the staff patient ratios in guidelines from 1:10 to 1:5 (Asthana, Gibson, Moon, & Brigham, 2003). In Australia, limitations were reported when clinical service was provided by a visiting psychiatrist alone. This approach was reported to have little influence on the standards of practice by local health staff and did not match emergency psychiatric presentations (Owen et al., 1999). Consequently intermittent visits with an expanded team of urban based practitioners piloted a broader range of outreach service delivery in remote locations which included direct care, peer support and skills development for general health and other human services staff, such as, police and ambulance. Evaluation of this pilot found improved accessibility and availability, client acceptability, skills development of local health workers and positive evaluation of education packages (Owen et al., 1999). The shift to a team approach presented challenges as did staff turnover, local communication, organisational management and support problems.

In the United States a review of 25 mental health outreach programs in rural areas identified successful programs as those that address the needs as identified and perceived by consumers in the context of the communities in which they live (Lambert, Donahue, Mitchell, & Strauss, 2002). The review found that:

- outreach should be a core service in rural areas;
- provision of service by, and repayment programs for certified nurse specialists helped both recruitment and retention;
- community partnerships were essential;
- additional funding was required for outreach to cover the higher costs of travel and work with dispersed populations.

The reviewers recommended further research, funding to support telehealth, training for outreach workers and the tailoring of outreach to specific populations.

Telepsychiatry was another form of outreach which provides services on a regular, as required or emergency basis (Judd et al., 2002a). A national review found that the component of mental health telemedicine programmes directed to clinical services was “low” in Australia but that telehealth can increase access to populations in rural and remote locations (Lessing & Blignault, 2001). Usage of telepsychiatry with video conferencing varies considerably in relation to the availability of psychiatrists, distance to psychiatric services and the extent of integration between health services (Lessing & Blignault, 2001; Simpson, Doze, Urness, Hailey, & Jacobs, 2001a). Sustainability was demonstrated with a seven year program in South Australia servicing 48 centres (Kavanagh & Hawker, 2001). Telehealth projects in rural and remote areas have found acceptance with rural clients, carers and clinicians (Dossetor, Nunn, Fairley, & Eggleton, 1999; Gelber, 2001; Kopel, Nunn, & Dossetor, 2001). In Victoria, this mode was most effective when complementary to face-to-face services (Gelber, 2001) and there was no evidence that telehealth was used as an ongoing alternative approach to care with one Canadian study finding that 75% of clients participated only once (Simpson et al., 2001a). Evidence also suggests that telehealth has a minimal effect

on referral patterns, that it may have reduced the frequency of admissions, and that visits to rural mental health centres increased in association with a telehealth project (Simpson et al., 2001a). Major benefits for patients and cost saving for those who would otherwise need to travel for the service were identified. Reductions in typical waiting times from 2 to 12 weeks to less than 10 days were achieved (Simpson, Doze, Urness, Hailey, & Jacobs, 2001b; Starling, Rosina, Nunn, & Dossetor, 2003). A reduction in the social and financial disadvantage associated with travel away from home was anticipated.

While videoconferencing has been used with people from culturally and linguistically diverse and Indigenous backgrounds there was no specific evidence of evaluation in those populations. Conflicting evidence about the cost effectiveness of various trials and programs in Canada indicates that videoconferencing was not necessarily cost effective in comparison to on-site service (Simpson et al., 2001a).

The evaluation of a Child and Youth mental health telehealth initiative in Victoria confirmed the utility of the approach (although felt to be less satisfactory than face to face meetings) but noted a lack of enthusiasm for the approach on the part of urban clinicians (Starling et al., 2003).

Non-commercial tele- and web-based counselling services involve information, referral, empathic listening and support, and one-to-one counselling (Owen et al., 1999; Urbis Keyes Young, 2003). However, tele-counselling service demand outweighs service capacity with up to 62-90% of calls to three core providers unanswered. Evaluation of these models in terms of behaviour and well being was found to be limited and problematic. While questions about effectiveness and quality remain unanswered, these services were both complementary and supplementary to other services and provided an access pathway (Urbis Keyes Young, 2003).

7.2.3 Integration

In Australia, recent developments with rural and remote health services have focused on integration and coordination. Initiatives for integration included multipurpose services, regional health services programs, and coordinated care trials based on alternative, pooled funding arrangements and focused on reorientation of services to consumer needs (Humphreys, 2002).

Models for integration also dominated the literature on the organisation of mental health services. Internationally, the World Health Organisation explored full and partial integration of mental health services. Clinical integration can occur at primary, secondary and tertiary levels of health care. Full integration involving managerial and administrative integration has disadvantages whereas separation at lower levels of management has preserved professional identity of mental health staff and protected budgets for mental health care. Strategic planning for integration was found to be crucial. Integration at a basic level incorporating other health and social programs may assist with resource problems. Prerequisites for successful integration in general primary care settings included adequate coordination, human resources and infrastructure, training of primary care staff, and clear referral and linkages systems (World Health Organisation, 2003).

In the US, integration was recommended by policy experts, researchers and providers as a means to increase access to mental health care in rural locations and it is noted that integration involves structural factors which are potentially responsive to policy intervention (Bird, Lambert, & Hartley, 1995). These authors recommended further research into the "effects of integration on access, quality and cost of care" (p. 305) to elucidate how models of service integration can be enhanced by policy.

Primary care practitioners in the United States were found to have primary responsibility for diagnosing and treating common mental illness within a fragmented, under resourced, uncoordinated rural and mental health system (National Advisory Committee on Rural Health and Human Services, 2004). After successful trials of collaborative models between rural psychologists and family physicians, the collocation of mental health and primary care services was implemented for "Federally Qualified Health Centers". The initiative aimed to address identified barriers around administrative and regulatory provisions, funding, professional licensing, public/private contracts to enable improved access to telehealth, and interdisciplinary approaches in psychiatric and rehabilitative care in home communities (National Advisory Committee on Rural Health and Human Services, 2004).

Studies of effective integration between primary care, substance abuse and/or mental health services in rural areas of the US were found to have utilised (either combined or singly): diversification; linkage; referral or enhancement (Bird et al., 1995). Other issues identified in the studies were that:

- fiscal constraints, paucity of clients and absence of peer backup militate against speciality care, and;
- higher levels of discretion are needed on the part of planners and providers to meet local needs.

This report recommended the development of primary care networks, training primary health staff in detection and treatment of mental health disorders, population approaches for high risk groups and decentralised training around local needs.

The New South Wales Far West Mental Health Integration Project evaluation report described a population health approach in planning and primary health care which accommodated a 'generic model' with metropolitan psychiatrists, through visits and videoconferencing conducting primary and secondary consultations, clinical supervision, health promotion, liaison activities and education (Perkins & Lyle, 2003). Resources were accessed through "cashing up" of Commonwealth Medicare benefits and State funds. Greater integration and increased access to psychiatrist services, reduced evacuation to a psychiatric hospital and increased access to local treatment for clients were demonstrated (Perkins & Lyle, 2003). In a project response to this evaluation it was described as a 'hub' model which also promoted integration of on-site mental health staff with other services including those addressing alcohol and drugs, sexual assault, domestic violence, child and adolescent mental health, and physical abuse and neglect of children (Sanders & Roberts, 2003). The services were collocated with primary health care teams, incorporated a specialist psychiatry consultancy service, and facilitated access for aged care assessment teams, palliative care and oncology staff. The authors recommended expansion to include videoconferencing for specialist areas and professional development.

Another example from New South Wales of an integrated model involved mental health nurses in the public sector collaborating closely with general practitioners (GPs) in expert consultation, liaison, counselling and psychotherapy, and a shared care approach to case management in difficult cases (Harmon, Carr, & Lewin, 2000). Advanced skills training was required for most mental health nurses to ensure effective integration with general practice. The improved accessibility and responsiveness enabled by this model compared positively to a shared care model. This model has potential but problems with high turnover, recruitment and retention and access to professional development and supervision in rural and remote areas presents challenges to development of the advanced level of nursing practice and collaboration required. The different training and ideologies of the various professional groups has also presented problems with integration in other initiatives (Judd et al., 2002a).

Generalist and primary mental health care models are integrated approaches staffed by generalist medical, and other health practitioners as the access pathway to specialist mental health care (Aoun & Johnson, 2002; Aoun, Underwood, & Rouse, 1997; Judd et al., 2002a; Malcolm, 2000). Generalist models present challenges, particularly in remote areas where practitioners are expected to be multiskilled. Some commentators viewed the capacity to achieve and maintain generalist practice in the diverse range of specialty areas required in rural and remote areas including the diagnosis and management of mental illness as limited (Humphreys et al., 2002). This perspective is questioned by an evaluation in South Africa of the integration of mental health care into the practice of primary health care (PHC) nurses which included training in the diagnosis and treatment of the common psychiatric disorders and referral of those that they couldn't manage (Sokhela, 1999). The evaluation found a significant improvement in the mental health assessment, diagnosis and treatment provided to patients at PHC services, a significant attitude change in the nurses, and expansion of nursing practice to include counselling and rehabilitation.

An evaluation of a 'linkage' model investigated the placement of mental health centre staff within the general health care setting (Van Hook & Ford, 1998). This was undertaken in recognition of the need for service delivery models which integrate physical, social and psychological well-being holistically. The approach involved interorganisational and interdisciplinary arrangements. The evaluation investigated only staff perspectives. Perceived benefits included increased access to services, increased cooperation with medical services, reduced stigma, more holistic care and improved continuity of care. The main problems identified were lack of space, discipline differences and administrative problems, isolation of mental health staff and need for clear guidelines for referral.

Another US survey of 53 successfully 'linked' services which ranged from small local initiatives to complex multicounty networks were unable to identify any core factors for success (Lambert & Hartley, 1998). The report concluded that primary care was the defacto mental health system in rural areas of the US and that cooperation with linkages cannot be mandated and therefore organisations needed to perceive that participation would meet their own interests.

7.2.4 Shared Care

Canadian initiatives in underserved rural areas focused on shared care and outreach to family physicians. Services included clinical, educational, telephone back up, video consultations and case conferencing (Collaborative Working Group on Shared Mental Health Care, 2000). No information on evaluation was reported.

In Victoria, a stepped, collaborative, four level-of-care program aimed at increasing the proportion of people with mental health problems who receive treatment (Judd et al., 2004). The program involved promotion of shared care arrangements and agreements between specialist and primary practitioners about who receives care at which level, and ready access to specialist services when required for those in primary care. Support and development for primary care providers included cognitive behaviour training, and secondary consultation and clinics were also provided. Participants included community health, GPs, and psychiatric disability support services.

Another example described as a shared care/attachment model employed psychiatric/mental health nurses to work with GPs in a rural area to provide education to individuals and community groups, home and hospital visits, counselling, liaison with other counselling services, and to research mental health in the local area (Malcolm, 2000). Shared care and liaison models with GPs and mental health professionals in rural areas were described as effective in enabling increased access to treatment and prevention at a local level (Malcolm, 2000; McCann & Baker, 2003) although the evidence provided was limited.

7.2.5 Consultation –Liaison

A modified liaison- attachment model from rural Victoria involved bi-annual general practice visits, primary and secondary consultations, education, supervision and case discussion (Judd et al., 2003). Changes in patient outcomes were not assessed but GPs reported changes in their assessment and treatment practices. These authors noted that other studies have found that both education and consultation liaison have limited effects in producing changes in practice (Bower & Sibbald, cited in Judd et al., 2003).

One component of the South Australian Rural and Remote Mental Health Service was the consultation liaison model with visiting psychiatrists that was later integrated into the MSOAP program (Hawker, 2003). Limitations reported for this model were the poor understanding and support from the broader health system, in particular with CEOs and managers.

7.2.6 Role Enhancement

A report of mental health nurses' sole practice in rural New South Wales found that service demands were compounded by responsibilities placed on rural practitioners beyond those which are formally authorised, often in the absence of adequate support, mentoring or professional development (Gibb, Livesey, & Zyla, 2003). In addition to the recent review of mental health services in Tasmania which recommended advanced practice education for mental health nurses (Department of Health & Human Services, 2004) a number of other commentators have suggested the development of nurse practitioner models for mental health nurses in particular (Gibb et al., 2003; Grigg, 2001). Nurse practitioner roles, educational requirements and regulation have been progressed in New South Wales, Victoria and Queensland.

A US study found that the practice, training and philosophy of courses for advanced practice psychiatric nurses, although not specifically targeting rural practice, was congruent with the requirements for rural mental health practice (Hartley, Hart, Hanrahan, & Loux, 2004). This was evidenced, as noted earlier, by another US study which found that provision of service by, and repayment programs for certified nurse specialists helped both recruitment and retention in rural areas (Lambert et al., 2002) .

Another approach to role enhancement involved adapting professional development and support for rural clinicians to the needs of the service so that evidenced based interventions, such as CBT, could be provided without the immediate presence of a psychiatrist or psychologist (Griffiths, 2003; Hodgins, Murray, Donoghue, Judd, & Petts, 2004).

7.2.7 Capacity Building & Partnerships

The majority of the preceding literature focuses on health services and mental health professionals. Some efforts have been directed to other human services and workers but few publications detail efforts to optimise the capacity and resources for self care and informal mental health care within rural communities.

Partnership models recognise previously unskilled and unsupported human service and non-government organisation (NGO) workers at the point of first contact. This approach arose from identified problems with teamwork, service access and acceptability in rural South Australia. Recommendations included the appointment of a regional mental health coordinator to facilitate collaboration, peer support and other networking approaches, and the operationalisation of partnerships. A focus on boundaries was suggested in order to minimise inflexibility and gaps in service delivery (Fuller, Edwards, Martinez, Edwards, & Reid, 2004).

In New South Wales a rural-urban partnership enabled local intersectoral partnerships, clinical placements, telepsychiatry workforce development, consultative support, and community awareness in local media to achieve, in rural and remote areas, reorientation of services for children and young people towards early intervention (Kowalenko, Bartik, Whitefield, & Wignall, 2003).

Lessons from projects involving rural partnerships in the promotion of mental health and wellbeing identified:

- commonalities between mental health promotion activities and community capacity building;
- linkages between capacity building and sustainability;
- workforce development requirements for workers to implement mental health promotion;
- requirement for longer term projects in development of organisational capacity in addition to short term projects;
- emphasis on partnership development, with clear definition of purpose and planned and fostered projects;
- economic participation required knowledge of good practice in economic development, workforce development and cross sector partnerships, and;

- building on individual and community strengths from the outset strengthens mental health promotion projects (Victorian Health Promotion Foundation, 1999).

Partnerships with other agencies and the community are one predictor of sustainability in the reorientation of services to early intervention. Other predictors included workforce development, organisational development for management and policy support and targeted resource allocation. The barriers encountered were heavy workloads, high staff turnover and inadequate funding (O'Hanlon, Ratnaike, Parnham, Kosky, & Martin, 2002).

In rural Victoria, the Carers Education Exchange Programme provides education and facilitates development of support networks in a flexible manner to rural consumers and has been found to increase carer wellbeing and positive outlook (Hayman, 2005).

7.2.8 Indigenous approaches

The national mental health policy framework includes a strategic focus on the social and emotional wellbeing of Aboriginal and Torres Strait Islander Australians (Social Health Reference Group, 2004). Improved coordination and a focus on service delivery through partnerships, framework agreement forums and comprehensive primary health care are emphasised. Problems of under-resourcing and disproportionate reliance for achievements on the Indigenous community controlled health sector was identified with the earlier social and emotional wellbeing action plan (Roxbee & Wallace, 2003).

In Central Australia acknowledgment of the capacity of the traditional healers ‘ngangkari’ to “eradicate emotional problems and heal the spirit” led the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) to employ two ‘ngangkari’ who specialise in emotional problems and mental health. Mainstream services and non-Indigenous health professionals are encouraged to understand and collaborate with ‘ngangkari’ and involve them in mental health care by promoting, supporting and funding their participation (Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation 2003).

An evaluation of a ‘dual model’ approach with traditional Aboriginal healers and psychiatric care at a rural Aboriginal community controlled health service in Western Australia found:

- increased accessibility and acceptability for the Aboriginal population;
- the importance of training of human service providers;
- decline in Aboriginal hospital admissions and reduction in demand on local mental health services, and;
- that ensuring accessibility required flexibility and responsive service approaches such as establishment of a “drop-in” approach (Laugharne, Glennen, & Austin, 2002).

In trying to meet the fundamental service delivery needs in Cape York and the Torres Strait, the process of critical evaluation within action research has been crucial to developing and transforming mental health service structures for Indigenous children and families (Santhanam, 2005). In this setting, the importance of integrating Indigenous mental health care within the broader primary care and chronic disease

management agenda has been emphasised (Haswell-Elkins et al., in press). Innovative action research approaches have also been used as an intervention with youth in rural settings in New South Wales (Selby & Bradley, 2003).

In Canada, the Health Transition Fund research projects demonstrated a reduction in transfers to regional services resulted from the remote Inukjuak community-based ‘achievement centre’ for clients with mental illness and addiction problems (Goldner, 2002).

7.3 INTERVENTIONS, SPECIAL NEEDS AND POPULATION GROUPS

7.3.1 Crisis, emergency and transportation services

The Mental Health Commission of New Zealand identified principles for crisis services (Mental Health Commission, 2004). Such services should be or provide:

- 24 hour, seven days a week access to assessment;
- approaches that promote and sustain recovery;
- part of system wide approach enabling care coordination ;
- culturally capable;
- design determined by local population and needs, and;
- evidence based interventions designed to resolve crisis.

In Scotland, the risks to patients, staff and communities associated with psychiatric emergencies and transportation from rural and remote areas to a receiving hospital were acknowledged (Remote and Rural Areas Resource Initiative, 2003). Proposals for the safe management of acutely disturbed psychiatric patients included: prevention and proactive care of patients, staff governance, transport and escort issues, estates and facilities, clinical governance and interagency cooperation. The report further recommended that each locality develop a psychiatric emergency plan and establish a Rural Mental Health Network to support the professionals involved in emergency care.

Less comprehensive approaches were identified in Australia. Emergency care for consumers through a single State-wide phone contact, triage and service access facilitation was proposed in New South Wales, South Australia and Western Australia (Centre for Mental Health, 2003; Hawker, 2003; Health Department of Western Australia, 1998a). New South Wales aimed to improve access to mental health emergency services through emergency departments in part by increasing the number of mental health nurses and on duty psychiatric registrars (Office of Mental Health, 2004a). Limitations on the provision of mental health staff 24 hours a day, seven days per week were acknowledged and rural emergency department access to 24 hour specialist mental health consultation (at a minimum by telephone) was recommended (Centre for Mental Health, 2003). The New South Wales strategy for accident and emergency departments included education for health personnel and the community, improved coordination between emergency departments and mental health; implementation of triage guidelines for psychiatric illnesses, and; regular liaison with police and ambulance services and area health services. Memoranda of understanding and collaborative review processes were also to be established (Centre for Mental Health, 2003). The WA policy proposed telephone advice services, video linkups with general practitioners, police and other agencies (Health Department of Western Australia, 1998a).

7.3.2 Community mental health

Many rural and regional services offer standard rather than assertive community treatment. The evaluation of an extended hours community mental health service in Tasmania found that crisis work restricted the capacity of the service to do consistent rehabilitation with consumers and that the service did not provide an alternative to hospital care; rather, it enabled "fewer, more coordinated admissions and earlier discharge" (Habibis, Hazelton, Schneider, Davidson, & Bowling, 2003). The authors concluded that this service could not provide the continuity of care and security required for seriously ill clients.

These findings were supported by a report exploring pathways to recovery and prevention of relapse, which concluded that the general rural health system relied on general practitioners with a focus on crisis rather than relapse prevention and continuing care (Rickwood, 2004). The report identified the need to target community mental health services in rural areas in terms of what is realistically achievable within the social and health resourcing context, suggested a focus on rehabilitation or crisis intervention, and the development of partnerships and telehealth to fill gaps.

7.3.3 Mothers and babies

In Queensland, a project funded through the *beyondblue* national depression initiative is providing education regarding post-natal depression for midwives, maternal and child health nurses and rural nurses, and undertaking focus groups for Indigenous women. Little else was identified in the review. In Western Australia State-wide post natal depression services are planned through expansion of NGO community services (Office of Mental Health, 2004a) and, in Tasmania, access to mother and baby services through private hospital services was recommended (Department of Health & Human Services, 2004).

7.3.4 Rooming-in / special care

The rooming-in model of acute inpatient service delivery, trialled at three sites in regional Western Australia, involved on-site family support in single rooms in general hospitals. The sample was too small for trends or effectiveness to be determined (Aoun, Pennebaker, & Janca, 2002).

7.3.5 Aged care

In New South Wales, policy and strategic directions for mental health services for older people have favoured expansion of adult inpatient services and the formalisation of supportive links with metropolitan services, including telepsychiatry, rather than purpose-built services (Draper et al., 2003). In Western Australia, mental health consultation-liaison, integration with aged care and primary care services, rooming in approaches and special care in general hospitals were proposed. Involvement of the local Aboriginal community and formal links with Aboriginal aged care and primary care services were also recommended (Health Department of Western Australia, 1998b).

7.3.6 Extended community

No literature about service delivery for extended care within rural and remote communities was identified.

7.3.7 Extended in-patient

No literature about service delivery for extended in-patient care within rural and remote communities was identified.

7.3.8 Sub acute care & rehabilitation.

Western Australian policy proposed the development of a psychiatric rehabilitation consortium which would address a range of needs, including:

- flexible accommodation service funding for temporary relocation to centres where intensive case management was available;
- purchase of community support services adapted to regional rural and remote consumer needs, and;
- disability support workers and case management coordination.

Commitment to flexibility was emphasised to address problems with response to tenders for services in rural and remote areas (Office of Mental Health, 2004b).

In a report of the Mental Health Implementation Group, access for rural and remote populations to sub-acute and rehabilitation services in New South Wales has been identified as a priority. While the means to achieve this were not specified, a conceptual framework for rehabilitation in mental health was defined, including:

- a recovery orientation and wellness focus;
- a distinction between clinical rehabilitation and disability support, and;
- functional links with housing and accommodation support (Mental Health Implementation Group, 2002).

7.3.9 Housing and supported accommodation

Expansion of community supported accommodation and housing was recognised as crucial to maintenance of family and community networks and the reduction of itinerancy of rural and remote mental health consumers in New South Wales, Western Australia and Tasmania (Department of Health & Human Services, 2004; NSW Health Department, 2002; Office of Mental Health, 2004a). Outcome targets in New South Wales included accommodation provision, and collaboration between mental health services and NGOs to develop innovative models of outreach for home based support in all geographic areas (NSW Health Department, 2002). The Joint Guarantee of Service for People with Mental Health Problems and Disorders (NSW Department of Health, 2003) delineated the roles and responsibilities of service agencies. Strategies were directed to coordination in delivery of mental health, support and housing services with particular emphasis on preventing or addressing homelessness with Aboriginal and Torres Strait Islanders communities.

7.3.10 Forensic

No literature or policies about delivery of forensic mental health care in rural and remote areas were identified.

7.3.11 Dual diagnosis / comorbidity

Given that the national report on comorbid mental disorders and substance use disorders (Teeson & Proudfoot, 2003, p 150) reported that *“not enough research has preceded this to allow definitive answers as to how to set up the services to take full account of comorbidity”* it is predicable that no approaches to service delivery were identified apart from one in Canada (see previous section 7.2.8 Indigenous approaches). Formal agreements with intellectual disability, drug and alcohol and

mental health services were proposed in Tasmania (Department of Health & Human Services, 2004).

There is now considerable evidence that mental disorders can constitute major risk factors for physical illness. However, as noted by the HealthRight Advisory Group in Western Australia, there are significant gaps in access to physical care experienced by people with mental illness (HealthRight Advisory Group, 2003). The Advisory Group was responding to the 2001 report - "Duty to Care: Preventable physical illness in people with mental illness" - which identified the excess morbidity and mortality experienced by people with mental illness in Western Australia, including those who had regular and at times lengthy contact with mental health services.

There is little published information on integrated approaches to the management of comorbid mental and physical disorders in rural or remote settings. One integration approach (a 'linkage model') from the US included management of physical comorbidity, however no relevant outcomes were reported (Van Hook & Ford, 1998).

7.3.12 Cultural and linguistic diversity

While there are significant culturally and linguistically diverse populations living in rural and remote settings, no reports or evaluations of specific approaches were identified.

7.3.13 Consumers, families and carers

The role of rural and remote practitioners in supporting consumer participation has been raised in the Queensland Health Action Plan for Consumer and Carer Participation in Queensland Mental Health Services. With some practitioners servicing large areas with high demand and significant travel requirements, the Action Plan questions their ability to engage in consumer participation, quality assurance and service development activities without supportive resources, such as a dedicated consumer and carer project officer (Queensland Health, 2003b). The recent review of mental health services in Tasmania recommended e-health support service for carers and families in rural areas (De Leo & Evans, 2002; Department of Health & Human Services, 2004), and other initiatives in that State to support consumer participation are reported in the interview section of this report.

While consumer self help models are well established in urban areas of the US, the benefits generally have not been realised in Australia or non-metropolitan areas of the US. Bjorklund and Pippard have noted the paucity of research into the rural consumer movement and drew attention to the opportunities, barriers and challenges presented to advocates, practitioners and policy makers for consumer-oriented program development in rural areas of the US (Bjorklund & Pippard, 1999. p 348). Indeed, these authors asserted that:

> *The preponderance of research addressing urban aspects of mental health issues contributes to the vacuum in rural mental health theory building.*

7.4 RESOURCING

While there is a relative dearth of information about strategies to address the increasing dimensions and societal burden of mental illness and disability in rural and

remote areas of Australia, the broader rural health context offers lessons for effective mental health policy and service development. However, while over the past ten years there have been many community and service provider initiatives to improve the effectiveness, accessibility and acceptability of rural and remote health services:

> *Many of these initiatives have, however, foundered for want of appropriate resources allocation to underpin their implementation.* (Humphreys, 2002, p 288)

Resource allocation is a powerful policy tool (World Health Organisation, 2004). Rural and remote health services are disadvantaged in the absence of flexible and equitable resource allocation (Humphreys et al., 2002). In rural and remote mental health care, funding arrangements are often not consistent with the need for sustainable resources and services, or integration across and within the primary, secondary and tertiary levels of care (Humphreys et al., 2002; O'Hanlon et al., 2002).

An extensive range of resource-related barriers were reported in research into mental health service delivery in rural and remote areas of Australia. Examples included heavy workloads; inadequate funding; significant workforce shortages; recruitment and retention problems; scarcity of education, training and supervision for human service personnel, and generalist and specialist health clinicians; insufficient Indigenous practitioners; unresourced protocols and guidelines; a paucity of best practice guidelines for generalist health practitioners; the non-availability of mental health professionals after-hours and during situational crises, and; inadequacies with a wide range of community infrastructure (Fuller et al., 2004; O'Hanlon et al., 2002; O'Kane & Tsey, 1999; Roxbee & Wallace, 2003; Slaven & Kisely, 2002; Sweeney & Kisely, 2003). In this context, the capacity to reorient and sustain services is significantly impeded (O'Hanlon et al., 2002). Evidence from the discussion paper about a Queensland Centre for Rural and Remote Mental Health mirrors the findings about resource related issues from other States (Kreger & Hunter, 2004).

In an exploration of rurality in respect to resource allocation in England, Asthana, Gibson, Moon and Brigham (2003, p 486) found that the National Health Service formula: "introduces systematic biases in favour of urban areas in the way it expresses the 'need' for health care", and that it "takes insufficient account of the additional cost of rural service provision". The authors noted the relationship between achievement of national quality standards and the culture of tolerance of "lower levels of service". The study found cost variations in the provision of health services in rural areas, with a range of factors contributing to the increased costs. These included:

- greater distances combined with smaller and dispersed populations;
- increased travel for clients [including families] often with no public transport;
- additional transport, clinical governance and training costs for health services;
- the need for multi-skilling which is linked to;
- the need for a higher proportion of more senior staff where supervision is an issue;
- greater proportion of nurses on high level pay scales where medical capacity is limited;
- increase cost of interagency activities;
- low institutional capacity;
- problems of economy of scale;

- high levels of unproductive time and the resulting lower efficiency factor;
- under-resourcing of the voluntary sector;
- additional communication costs;
- poor access to training, relief staff; consultancy and other support services;
- difficulties in building and sustaining networks, particularly where there has been a previous lack of community development investment, and;
- the slow pace of development work (Asthana et al., 2003).

Both research and anecdotal reports indicate that these issues are experienced in rural and remote mental health services throughout Australia.

A number of Australian researchers have recommended attention to resource allocation to reduce the inefficiencies and inequities identified in mental health care. In Central Australia a framework for planning and resource allocation for mental health services in remote areas aimed at more equity in distribution of resources was developed (O'Kane & Tsey, 1999). It is unclear whether the framework was adopted as a more recent report from Northern Territory found that although the allocation of resources for mental health care was weighted to take account of the higher costs in rural and remote areas, the weighting was *'relatively low'* when the extra costs of providing services in rural and remote areas were considered. The reduced resource security identified in the Alice Springs region was attributed to inequities in the proportion of recurrent to non-recurrent funding between regions (Healthcare Management Advisors Pty Ltd, 2003). The report recommended 1.5 per capita funding for non-metropolitan services and in addition the weighting of resource allocation between urban and regional centres.

Further research has been recommended, for example with respect to the range of non-mental health specialists involved in the delivery of mental health care. Agreement about the role and contribution of all providers requires clarification before the need for specialist mental health services and adequately informed population based allocation of public sector resources by States can be determined (Burgess et al., 2002). Another issue involves recognition that socio-economic features of an area affect the chance of major mental illness morbidity in various ways (for instance through levels of unemployment). At present in Australia the effect is more readily understood for urban than non-urban areas but further specifically designed epidemiological survey would be required as basis for equity orientated mental health resource decisions (Meadows, Burgess, & Bobevski, 2002).

Neil, Lewin and Carr (2003, p 21) specifically called for a "*more rational basis for resource allocation in mental health care, and a move away from advocacy and historic allocation*". Recommendations from that study of particular relevance to rural and remote mental health care include the need to:

- re-orientate interventions and services;
- improve monitoring and evaluation;
- focus on clinical and service delivery outcome evaluations;
- identify societal and opportunity costs, and;
- undertake economic modelling to inform service development priorities (Neil, Lewin, & Carr, 2003).

7.5 COMMENTARY

The literature review reveals that fragmentation, poor coordination and resource barriers are common in mental health service delivery in most rural and remote areas both nationally and internationally. Despite the rural and remote population being consistently identified as a special needs group in mental health policy documents in Australia at national and State levels, available evidence suggests that the omission of specific strategies for policy implementation in rural and remote areas inhibits attention to the unmet needs, resource limitations and organisational deficits identified.

Investigation of the effectiveness of approaches to mental health service delivery is inhibited by the paucity of service and project evaluation available. Most literature describes discrete projects and presents limited, if any, evidence about effectiveness, generalisability or sustainability. There are significant gaps in the rural and remote service delivery literature and policy documents both in terms of the broad spectrum of interventions, and particular populations and groups with special needs.

The evidence suggests that most rural and remote health services are struggling with providing basic crisis care and treatment in the community. In this context, with many barriers to service delivery, efforts to improve access, continuity, comprehensiveness and standards of care are often thwarted. There is limited evidence of population approaches, and support for consumers, carers, human services workers and generalist health practitioners commensurate with contemporary perspectives about roles, partnerships, coordination and linkages. Obvious deficits are evident in mental health promotion and prevention, early intervention, assertive treatment which includes relapse prevention and a recovery focus, rehabilitation and extended care in the community. The special needs of carers, Indigenous people, culturally and linguistically diverse populations, mothers, babies, children and youth, older people and the people with comorbidity have not had systematic attention.

Given sufficient resources, policies involving the strengthening of population approaches in primary health care, local community and human service capacity building through linkages, integration and enhancement offer the potential for sustainability through an expansion of informal community care and self help. Through partnerships, specialist mental health services and practitioners will be crucial to effective local level development and sustainability.

Achievements in rural and remote health service delivery and resource allocation following the National Rural Health Strategy and the Tasmania Rural Mental Health Strategy indicate that targeted rural health policies are a key driver in health service development in rural and remote areas. Flexible community development approaches that focus on existing local networks and services through resourcing and government support offer promise to the consumers, families and communities currently struggling with unmet mental health needs.

8 QUESTIONNAIRE AND INTERVIEW FINDINGS

As described in the methodology, additional information was obtained from questionnaires returned by Queensland informants selected to represent the diversity of settings and activities across the State, and from a group interview with Tasmanian key informants familiar with the development and operation of the Rural Mental Health Plan. The analysis of data from the questionnaires informed issues raised in the group context.

8.1 QUESTIONNAIRE

Analysis of the 16 responses to the questionnaire revealed a wide range of issues which clustered in five thematic areas, these being:

1. Workforce and resourcing
2. Community capacity
3. Processes (policy, protocols and programs)
4. Linkages (within and between agencies and sectors)
5. Data and information management

In the sections that follow the responses to each of the five questions (Appendix 1) will be summarised in turn according to these five themes followed by a broad synthesis.

8.1.1 Promotion and Prevention

Workforce and resourcing

Failure to take account of the circumstances of non-metropolitan centres in resource allocation was identified as compromising the realisation of this strategic direction.

> *Failure to acknowledge that resource allocation to rural communities may need to be substantially higher to deliver the same level of services to rural communities as in metropolitan (i.e. limitations of population based models) recognising the contribution of relative isolation and socio-economic disadvantage prevalent in such communities.*

Compromising factors were also widely noted in terms of the range and sufficiency of services in rural and remote settings, including the range of professional disciplines, availability of services out of hours, recruitment and retention and, consequently, sustainability of clinical and program activities. These issues are particularly evident in relation to subspecialty areas such as child mental health. Many of these considerations are captured in one comment:

> *Access to services is also an issue. If people are living in a rural/remote location it may be difficult to access services. There is little capacity for extended hours services.*
>
> *Choice of treatment is also limited. This extends from private psychiatry (usually non existent or extremely limited in range) to the local mental health service (again often extremely limited in choice of case manager i.e. may not be a choice of gender/ discipline or range of skills of the case manager). Many rural mental health workers are newly graduated and do not possess the complex array of skills necessary to manage the diversity of work.*

Suggested directions to provide solutions included increasing the resources available to mental health practice and other rural incentive supports, one informant noting that increased resources must be sustainable and provide broadly for practitioner needs:

> *Reviewing funding formulae for mental health staff per population taking into account geographical location and providing incentives for recruitment and retainment of appropriately trained staff with support provided to ensure adequate clinical supervision and ongoing professional development is made available.*

Community capacity

Community capacity is compromised generally by the relative paucity of resources and opportunities (work, leisure, services…) in non-metropolitan settings, but also by issues relating to health literacy and persistent stigma:

> *Stigma in rural areas is problematic. This impacts on being able to confidentially access a mental health service (without the whole town knowing – given that half of the staff also are known to locals in other capacities i.e. neighbours, children at the same sporting group, school etc.). No-one wishes to identify as a mental health consumer therefore promotional activities or consumer driven community development is difficult to initiate. Mental health is also not something that is well accepted by rural men particularly. It is seen as a sign of weakness to these traditionally stoic males.*

This informant has noted the particular issues of rural men. Stigma was also raised in relation to CALD populations for whom it was noted that before mental health promotion activities can occur: *"a respectful environment that acknowledges cultural and linguistic beliefs and perspectives needs to be created whereby people feel safe to discuss such issues"* is needed. In these populations developing community capacity: *"is very difficult to do with groups who have traditionally not received much support and have been excluded from other initiatives".* With limited resources for a dispersed CALD population in Queensland, value-adding to existing initiatives (rather than creating new programs) is compromised by difficulties identifying ongoing programs with which to collaborate. Existing capacity in Indigenous settings was also noted with an informant commenting that: *"Community Councils are struggling to provide basic services and do not have the infrastructure or expertise to establish, develop and supervise small programs".*

Solutions to these issues were perceived as flowing primarily from recognising and capitalising on existing strengths through processes that provide the means (such as inclusive community activities) to promote community participation and identify local leadership. As noted by one informant:

> *Greater recognition of the roles played by other groups for example indigenous councils, elder groups, cattleman's union, mining companies etc. in promotion of healthy lifestyles and attention to mental health problems and opportunities for mental health prevention and promotion as well as far more traditional prevention and promotion routes. Development of community capacity in individual communities especially at the level of things defined by community consultation.*

Similar ideas were presented in relation to the specific needs of CALD populations and, as noted above, the importance of building on existing activities:

> *Culturally and linguistically appropriate community development initiatives that acknowledge where the communities are currently at in regard to mental health literacy can be initiated. Capacity building is the starting point for a lot*

> *of this work, an approach that incorporates mental health promotion into existing networks, services, programs rather than a stand alone approach is more effective and sustainable.*

Processes (policy, protocols and programs)

Predictably, impeding the development of activities in areas of mental health promotion and prevention is the lack of existing services across the spectrum of interventions. However, one informant suggested that this area was compromised by lack of understanding of the benefits of population level approaches on the part of governments and a continuing focus, as identified by another respondent: *"on the treatment of illness as a priority, rather than the identification of what constitutes mental wellness and how that can be optimised"*. In this regard (and related to issues of 'linkages') it was noted that these matters should be *"everyone's business".* Expanding on earlier comments regarding existing capacity it was further noted that:

> *Individual and community resilience in rural areas needs to be respected and supported. An understanding of support systems in various rural areas needs to occur so that individual and community resilience is not eroded by the imposition of inappropriate programs/projects, but rather existing networks are enhanced and resourced to be able to focus on promoting mental health in a way that is relevant to their setting and context.*

In terms of solutions, clarity was emphasised – clarity in terms of prioritising promotion and prevention in these settings at a policy level, clarity in relation to the roles of agencies and programs, and clarity in terms of developing the evidence base for such programs in rural and remote populations. These, in turn, demand improvements in communication and education:

> *Communication and education strategies for the community and service delivery agencies to ensure shared goals and visions with regard to optimising mental health and wellbeing. This would also include a strategy and process to encourage research and/or the dissemination of evidence-based knowledge.*

Another informant touched on these issues but noted that: *"it is not enough to have the technology available, but resources need to be invested in the workforce knowing how to use them and promote its availability to consumers"***.**

Linkages (within and between agencies and sectors)

It has been noted that promotion and prevention *("everyone's business")* should be a goal and that, according to this informant: *"the promotion/prevention end of the spectrum is primarily dealt with by non-mental health services, leaving the specialist mental health interventions to the specialist mental health services".* Problems developing the necessary functional linkages across sectors and agencies were noted, one informant commenting on the:

> *Lack of co-operation/shared understanding at all levels, between mental health and public health. Excellent joint initiatives are possible to undertake mental health promotion activities in rural areas, including activities which help identify indicated populations where early intervention would be helpful (eg. some current projects in Roma), however these opportunities are not always capitalised on. Difficulties [are] inherent in getting disparate agencies working*

> *together in a seamless way (eg. GPs, schools, TAFE, private healthcare providers, police, NGOs, primary production industries, etc.).*

Suggestions for improving linkages largely focused on development of formal agreements between mental health and public health, for integration of mental health and general health activities, and between mental health and community based services, with one commentator suggesting that this should include resources and support for joint training around community-based activities.

Data and information management

The importance of developing an evidence base for this work has been noted and, consequently, this requires reliable data relevant to rural and remote populations. One informant commented on the current:

> *Lack of consistency in mental health information collected by service providers; Lack of availability of population level mental health information; Lack of feedback of mental health information to support decision making for mental health service planning and provision.*

Addressing these systematically and ensuring: *"that information is available in a form which is easily understood for clinicians, team leaders, managers, policy makers and the public to support decision making"* is critical in this area as it is in clinical care. However, the diversity and particular issues of rural and remote populations requires mechanisms and capacities that will allow:

> *An analysis of the existing range of services in specific rural areas and matching this with demographics and known prevalence of mental health disorders and other relevant risk factors in the area. This would allow the ability to plan what types of services are required in specific areas so that that a coherent argument can be advocated for the development of a range of services to support and enhance the delivery of mental health service delivery in the specific rural area.*

8.1.2 Continuity of Care, Strategic Linkages and Partnerships

Workforce and resourcing

Numerous problems were identified in terms of workforce sufficiency, expertise, range, support, IT proficiency and resourcing in rural and remote Queensland. Persistent stigma and negative attitudes within general health and other services was also noted. Recruitment and retention problems, resulting in frequent staff turnover:

> *Compromises the effectiveness of many processes including education, regular inter-agency meetings, etc., when the history and knowledge of initiatives is lost, and/or these initiatives are driven by individuals who do not remain in their positions for the duration of the initiative.*

Several other comments reflected this issue of initiatives reliant on: *"specific people being incumbents of a specific position",* which are thus vulnerable in the face of low staff retention which, in turn, compromises continuity of care. Contributing to these realities is the greater reliance on program-based (and often, 'start-up') funding to support rural and remote activities, which has particular relevance in terms of Indigenous communities:

> *The limited availability of recurring funding opportunities tends to encourage a competitive attitude to the acquisition of funding to resource programs. Limited*

> *resources and services in remote rural settings make it difficult to be able to provide sustainable & effective solutions to service delivery. Often restrictive time frames and reporting mechanisms do not take into account the timely process of rapport building with remote rural communities where the object is to establish sustainable and observable outcomes for communities.*

Suggested solutions clustered around enhanced resources (including addressing the intermittency of program-based funding on which many community controlled services are reliant) and training, both in terms of the general workforce, but also through elements of the workforce that are particularly critical in rural and remote settings such as general practitioners and Indigenous health workers. The need for clear identification of responsibilities within the mental health workforce were emphasised in one comment:

> *Promote MOU's between key stakeholders clearly outlining a collaborative approach to service provision and early intervention strategies. Explicit MOU's between principal service providers and satellite services, clearly outlining the responsibilities of the principal service provider in the areas of service provision, backfill capacity, rotation of staff between sites to gain experience and mentoring and supervision for more junior practitioners.*

Community capacity

The issue of personality-dependent programs (reliant on a particular incumbent) was raise in relation to factors compromising the development of community capacity. Similarly, the lack of a shared language across services and community members, failure to develop policy adequately reflecting the important role of families, and persistent stigma were mentioned. As an informant noted with particular reference to CALD populations: *"Stigma is high in small communities where everyone knows each other (including the various service providers). Linking consumers and carers with other services means more people knowing about their problems. This is a particular issue for people from CALD backgrounds."*

Informant-suggested solutions included policy informed by principles of capacity enhancement, more emphasis on mental health literacy and strategies to specifically recruit sub-populations (for instance CALD) in community participation activities. However this is approached, it will demand accountability locally and:

> *Flexible and appropriate timeframes for [addressing the] goals and objectives as determined by the local community through a lengthy process of consultation, where accountability to funding bodies does not dictate the urgency and appropriateness of timely responses (rather the community determines the appropriate time frame).*

Processes (policy, protocols and programs)

Process problems in ensuring continuity of care mentioned by respondents included a wide range of issues, most of which were captured by one informant's comments:

> *Health services have a lack of recognition of the role played by families and other supporters. Often there is a failure to involve these people on a level of giving information particularly about progress of the person being treated or cultural and family issues which affect practice. There is often a failure about feedback or information about treatment being given or relatives not being invited as partners in treatment. A change of policy that would reflect the role*

of families and other supporters would be helpful. The system of care with specialist mental health services tends to break down in small communities, there's often a lack of mental health training for general health workers and other service providers outside of the mental health system.
A large number of people temporarily acting in positions constitute a failure of continuity. Often there are no overarching senior mental health personnel to ensure continuity of care from early detection of problems to treatment especially when that treatment requires the person to leave their home place. The division of Districts and the provision of individual services through Districts can often impede people whose family ties lie across Districts or who need to transfer between Districts to receive specialist services.

Other informants also commented on coordination and collaboration difficulties, including across District and District/Branch boundaries. This is even more complicated across sectors where, as a result of a lack of real local partnership there is:

duplication of services and gaps in service delivery due to the poor communication and knowledge of various services re: what the other service is funded to do and what early intervention projects they are undertaking.

The particular problems resulting from the lack of *"culturally competent, sensitive and appropriate"* services in rural and remote settings was noted in relation to continuity of care, the informant explaining that *"one weak link in the chain can result in clients dropping out".*

Developing culturally appropriate processes was raised in relation to both CALD and Indigenous populations with one response noting that this is more than simply providing 'information' but should be:

a reciprocal learning model whereby consumers, carers, the community, and service providers learn from each others' explanatory models in regard to causation and treatment of mental illness – very important in a cross cultural context. Negotiate innovative service responses in partnership with stakeholders that fit with others' explanatory models and local issues to maximise service utilisation, treatment compliance and recovery.

In relation to addressing continuity of care issues across District boundaries one respondent suggested*: "Perhaps the identification of specific rural services, defining services with the proper management structure particularly the nomination of an overarching clinical director who would look at the care of patients across the spectrum"*.

Linkages (within and between agencies and sectors)

Perceived obstacles to effective partnerships to support continuity of care included lack of coordination and dialogue between Commonwealth and State funded programs and services (this has particular relevance in relation to Indigenous mental health), difficulties arising from the resource capacities of other agencies in small communities which results in pressure for direct service rather than participating in collaborative activities. The lack of formal agreements between mental health services and these agencies, and with General Practitioners was also commented on. As noted earlier (in relation to CALD and community capacity), in small communities linkages

across groups can be more difficult as a result of personality and confidentiality issues.

By far the most common direction identified to overcome these barriers was through development of formal mechanisms and agreements to support collaborative activities. One respondent recommended greater accountability in relation to these activities and identified the importance of key agents:

> *Identification and encouragement of key agents who will promote linkages locally and will maintain involvement over a significant period. Minimum standards for service agreements, while promoting local variations. Promotion of liaison meetings. Provide increased involvement of consumers and carers in decision making re services. Make funding contingent on liaison.*

Data and information management

Failure to take advantage of existing IT capacities (telemedicine, internet-based education etc) was noted in a number of contexts as were the possibilities of better utilising these opportunities. In addition, the lack of integration of the mental health information system, issues in relation to access and infrastructure support were raised as compromising factors in relation to effective partnerships supporting continuity of care. In addition to suggested solutions which directly related to these specific problems, one informant noted the importance of securing bandwidth access in small communities, suggesting: *"support District business cases to request improved bandwidth for areas with limited capacity".*

8.1.3 Equity

Workforce and resourcing

Problems in adequately resourcing as noted in earlier sections and particularly in regard to specific needs groups such as CALD populations were reported. In relation to this group, ensuring that rural practitioners have greater awareness both of cultural issues but also of the IT-based resources available was suggested. One informant, calling for a broader and systematic approach, recommended:

> *Creative thinking and use of resources by rural mental health services, and support to do this by QH. Workforce team in MHU, in consultation with the Workforce Directorate and those working at the National level on recruitment and retention in health services, to formulate a comprehensive plan for rural and remote recruitment and retention, with innovative strategies, and implement this across the State in collaboration with Zones and Districts*

Community capacity

Stigma and the isolation of consumers in rural and remote settings, compounded by the lack of infrastructure, such as transport, were noted to compromise the delivery of quality care in non-metropolitan settings. In addition, the belief that services are not accountable to Indigenous communities was raised. Bringing benefits of improved services across individuals, communities and families demands: "*a holistic approach to health care that focuses on the role of the individual as a constituent part of the family to which they belong, the community where they live and the homeland from where they are descended*". While particularly relevant in the Indigenous context, this applies more broadly and touches on the earlier raised recommendations regarding recognising and utilising the expertise and capacity within communities.

Processes (policy, protocols and programs)

Problems in this area are informed by many factors including: "*a passive acceptance of health differentials between urban and rural areas*", rigid constructions and understandings of mental health and mental illness, lack of awareness or resources that are available, and resistance to reform on the part of service providers, particularly where there are Commonwealth / State tensions. In terms of Indigenous populations (but relevant more broadly) is inflexibility in terms of what constitutes appropriate practice:

> *The belief that Indigenous health workers are advocates in the process of changing the attitude of the community with respect to services and their appropriateness to assisting Indigenous people. This relates to the arrogance of some service providers who offer only one type of intervention and treatment that is not appropriate to the needs of the community, where that service is not flexible in its model of service provision, where the belief is that the service is a definitive statement of what is best practice. In this instance the attitude is that the service proposed is the authority, where the attitude change is seen as needing to occur within the community, hence promoting health workers as advocates for a shift in community thinking rather than as advocates for changing and developing service delivery appropriateness.*

Suggestions for priority actions to facilitate service reform included defined and implemented protocols and procedures for the population as a whole and for identified subgroups, improved collaboration with general practitioners, and: "*increased acceptance of people with mental health problems by community services, and strategies to increase their integration and involvement in leisure, housing and employment programs*". Acknowledging that reliance on project-based funding can lead to problems of continuity and sustainability, it was noted by one informant that given the demands on rural service providers, such reform activities demand funding for dedicated project positions. The service demands are such that not only must there be, as mentioned earlier, reconsideration of funding and staffing levels, but also of roles, a respondent suggesting:

> *Re-align policy for indigenous mental health workers and other mental health workers in rural areas to reflect the true need so that the staff ratios are reformed. This will lead to a higher level of service provision. Repositioning some of the service provision towards community development and less clinical care may reap rewards in the future.*

Linkages (within and between agencies and sectors)

Coordination of activities across boundaries has already been commented on and in this section note was made, on: "*the split between MH, ATODS and general medicine [which] has produced gaps that add to the problem*". The failure to develop working relationships with external agencies has notable consequences for impeding community capacity building, an informant suggesting in relation to child and youth services:

> *Poor linkages with other agencies to provide capacity building programs. For CYMHS, programs could include linkages with schools to provide early intervention programs. Linkages with community agencies such as Lifeline to provide Family Therapy/ Intensive family interventions to promote resilience within the family unit.*

Suggestions to improve cooperation included a: "*whole of government approach*" and more micro-level issues such as development of integrated care pathways and guidelines for treatment, and improved use of general practice:

> *establish remote delivery of mental health services through correspondence, internet and telephone. Improve awareness of/access to telephone based consultation and support for GPs re mental health. Improve knowledge and skills re management of mental disorders in primary care, and earlier detection of and intervention for relapse by GPs and mental health staff.*

Data and information management

Predictably, such IT-facilitated activities were raised across the range of issues impacting rural and remote services. However, as one informant noted in relation to CALD populations (but relevant more broadly), this is also confronting the:

> *The mentality that everything has to be provided locally and lack of interest in using available technology to facilitate access to services that may be complementary, eg: the clinical consultation service of the QTCMHN is available State-wide through video conferencing and accessing a bilingual mental health consultant should be of benefit to any cross cultural interaction in mental health for culturally appropriate input, but often there is a reluctance to go out of the service to do that.*

8.1.4 The Rights of People with Mental Disorder.

Workforce and resourcing

Predictably, compromising factors in terms of ensuring rights focused on the lack and turnover of staff, the service demands on them and, consequently, the difficulty of getting staff off-line to provide relevant education. In this regard one informant recommended improved incentives to attract experienced clinicians to work in rural areas and attention to social as well as work needs in these settings.

Community capacity

Stigma, limited community infrastructure, and lack of accommodation and employment options for people with mental disorders all contribute to compromising the protection of patients' rights. This is compounded by "*a greater acceptance of mental illness*" and lack of awareness of rights at a community level. Responses to this included identifying natural leaders within the community "*change champions who are supported and nurtured to continue to effect change as a continual process*", and continuing emphasis on mental health literacy for the community as a whole, including supporting positive media representations at a local level. One informant also recommended: "*funding specifically targeted outreach services from community advocacy services*" and "*increased focus on the development of smaller occupancy public housing in rural communities*".

Processes (policy, protocols and programs)

Particularly in relation to CALD and Indigenous populations, lack of experience and expertise was identified as compromising this goal, as was confidentiality in these settings and: "*continued stigmatisation and discrimination by services and agents*". These factors were summarised by one informant:

> *Lack of awareness or widespread use of mechanisms to promote patient rights eg Allied Persons provisions under the Mental Health Act; Insufficient information widely available on consumer rights; Lack of information available in other languages re consumer rights under the Mental Health Act; Lack of standardised training and education on the Mental Health Act across the State.*

This question also stimulated comments regarding the implementation of the Mental Health Act in remote and rural areas that are also touched on in Question 5:

> *The problems operating the Mental Health Act in rural and remote areas is that patients seem to wait longer before they are seen but there are less appropriate uses of the Act for people in isolated areas. Often the Act is only used for short term measures i.e. to contain somebody that might be suicidal when they are drunk but then does not go on to offer appropriate treatment for those people who are identified as having a mental illness. This is because of the requirements of psychiatrists to authorise ongoing treatments in person and a lack of resources to either get the person to the psychiatrist or the psychiatrist to the person means they always often discharge prematurely thus denying the person access that compulsory treatment would bring. Sooner or later some of the definitions of mental illness per se with the exclusion of alcohol problems, anti-social behaviour and cultural problems can lead to the situation where rural people, particularly indigenous people, are excluded from the Act and then denied treatment. There is a very low rate of conversion of Emergency Examination Orders into Treatment Orders which may equate as a lack of education about how the orders were used, but is more likely to reflect a lack of resources in defining treatment for people who initially present with potentially identifiable mental health problems.*

In relation to this the informant suggested: "*review of the function of the Mental Health Act in rural and remote areas would be helpful*". Another informant commenting on Mental Health Act issues pointed out:

- *Recent publication and dissemination of posters and brochures for consumers, carers, providers and allied persons on allied persons provisions;*
- *Finalisation of additional mental health consumer rights publications in 2005;*
- *Planned translation of information currently available re consumer rights under the Mental Health Act;*
- *Current development of State-wide Training and Education Framework for the Mental Health Act and Learning Management System (interactive computerised training program on provisions in the Act).*

Other responses to these issues stressed adherence to existing standards and strategies, and increased attention to staffing needs in relation to training. Staffing was also noted in relation to child and youth services in order to enable providing for consumer needs outside of the clinic:

> *Increase potential for rural mental health practitioners to provide an outreach service including home visitation and extended hours services. To do this effectively there would need to be an increase in resources (staff) allocated to the rural areas. If we continue to base our staffing on population, and not take*

> *into consideration contextual factors such as access to other resources, geographical isolation and travel, then this will be unlikely to occur. This is particularly pertinent to CYMHS staffing ratios. There are very few ancillary services in rural areas that will focus on the needs of a young person. CYMHS are often the only service providing counselling to young people and are not resourced appropriately. Indigenous communities for example will never meet the population criteria to secure a CYMHS worker on site, yet there is clear evidence that these communities are in dire need of CYMHS staff and do not tend to access the mainstream CYMHS services outside of the indigenous community. This situation needs immediate review.*

Linkages (within and between agencies and sectors)
Few direct comments related to the problems and opportunities available to facilitate services supporting the rights of people with mental disorder. However, development of local communication strategies, including: "*local liaison/interagency meetings for community groups and agents*", and: "*fora for community members to join in community-based interventio*ns" were identified.

Data and information management
Similarly, there were few comments in this area save for better utilisation of IT resources to enhance communication and support for rural practitioners and services.

8.1.5 Quality and Effectiveness of Service Delivery.

Workforce and resourcing
Impediments to achieving the highest standards of mental health care were identified as the demands of working and living in these settings, including problems in terms of IT support, continuing education, supervision and relief. In relation to support, one informant also commented on the: "*poor mental health and wellbeing of those that deliver the services*".

Suggestions to address these difficulties included increased awareness and use of IT resources, specific educational and professional development opportunities and incentives, and a more systematic and strategic approach that might involve linking rural and metropolitan services, and services and training institutions:

> *For instance a more organised mental health service could address some of these issues, particularly looking at other methods of ensuring continuity of care and higher standards, such as support of holiday cover from activities of larger services; promotion of "reverse bonding" and people setting up a large part of their training bonds at the end of their career when they are more experienced; and attractive schemes to employ more senior people would help this.*

Community capacity
Stigma, funding restrictions and community infrastructure were noted as problems, the interaction of service capacity with community resources, for instance schooling, being such that there are additional social demands on providers in rural and remote settings: "*by the time they get relief they are completely burnt out*".

Processes (policy, protocols and programs)
Problems in the processes informing quality improvement were identified at a number

of levels from professional and attitudinal biases ("*the resistance of people generally to change patterns of behaviour when there is no perceived threat or risk associated with the use of current practice*") to lack of resources to support quality control and enhancement, and the lack of: "*practice guidelines relevant to rural and remote areas*". This area becomes particularly complicated for specific sub-groups, for instance:

> *In the area of transcultural mental health, a lack of understanding of what constitutes "highest standards of mental health care", and how to continuously improve the quality of mental health services available to CALD people living in rural communities. For staff who do acquire this understanding a lack of organisational support and resources (including policies and procedures) quickly extinguishes the knowledge, skills and attitudes they have gained through education.*

Suggestions for addressing these matters focused primarily on developing clear guidelines for practice and quality review, and adherence to the National Standards for Mental Health Services. However, some informants noted the particular needs in these settings, such as the greater reliance on general health staff and, consequently, their need for education and support.

Linkages (within and between agencies and sectors)

There were few comments directly addressing linkages relating to service improvement, however one respondent noted the: "*Lack of partnership agreements/protocols to promote integrated practice approaches, particularly for high risk population groups eg consumers subject to the Mental Health Act, consumers who are acutely unwell"*. Another comment related to linkages supporting service enhancement through linkages with the community: "*Greater engagement with service clubs and community groups to support access to workplaces to raise mental health awareness*". Finally, one informant documented three initiatives with relevance to this general area:

- *Proposed development of Mental Health Clinical Collaborative in 2005 to develop State-wide clinical practice guidelines in priority areas;*
- *Development of Statewide Clinical Review program in 2005;*
- *Project to develop partnership agreement with RFDS, QAS, QPS etc re transport of consumers over long distances.*

Data and information management

The *"lower level of clinician engagement in mental health information development strategies in some areas … lower level of support for mental health information development strategies … [and] lack of access of rural and remote staff to professional development opportunities and training"* were all noted by one informant as compromising factors in relation to improving service quality and effectiveness. This respondent presented a range of suggested solutions:

- *Ongoing support for mental health information development which is tailored to local requirements via zonal outcomes coordinators;*
- *Linkage of information development strategies with other statewide training initiatives and partnerships with the tertiary mental health education sector;*
- *Communication and marketing strategies to support change management processes;*
- *Standardised measurement of mental health outcomes to derive information to support quality improvements;*

- *Use of mental health information to drive quality activities such as benchmarking projects;*
- *Dissemination of guidelines to support appropriate use of mental health information;*
- *Reporting of mental health information according to National Key Performance Indicator Framework.*

8.1.6 Other comments

A number of additional comments were provided, many of which echoed issues raised elsewhere. However, the need for a broad *"macro view"* of rural and remote mental health on the part of Queensland Health was noted by a respondent. This is consistent with the recommendation by another for a more integrated approach:

> *Discussions with rural mental health service team leaders, Directors of Primary Health, District Managers, and Managers/Directors of mental health services in the principal service centres for rural networks, would yield highly valuable information.*

The need for coordination and collaboration with the academic sector was also underlined with the one commentator noting that*: "the establishment of a rural remote centre for mental health would be essential as a way to focus some of these activities".*

8.2 GROUP KEY INFORMANT INTERVIEW

Responses to the questionnaire informed the lead questions (see Appendix 3: Interview Questions) which were used in a telephone interview with three informants with experience in rural mental health practice and policy in Tasmania. One member of this group had earlier been the Implementation Officer for the Tasmanian Rural Mental Health Plan and the other two were rural mental health practitioners auspiced through local government.

8.2.1 Context of the Tasmanian Rural Mental Health Plan

The literature regarding the Tasmanian Rural Mental Health Plan has been discussed in the literature review. These informants explained at the outset that the Rural Mental Health Plan only provided funding to support the Implementation Officer for three years. Development of the Plan had been driven at the outset by rural consumers and their advocates. In parallel, funding for services on the ground through rural-based workers located in local government and non-government agencies had been accessed through the Commonwealth Regional Health Services Funding. Thus the Plan served to build on a groundswell of consumer advocacy and existing service development. These critical partnerships had been significantly facilitated by the national mental health priorities. Agreements between Mental Health Services and participating auspicing organisations provided leverage in negotiating local implementation arrangements and, consequently, supporting coordination of the Plan as a whole. Funding from Mental Health Services provided resources to support implementation of the Rural Mental Health Network, as well as designated support for each of the rural mental health positions. The Rural Mental Health Network provides for face to face meetings four times a year including professional development and team building activities, as well as IT-based supervision, practice and personal support, and continuing education.

It was the opinion of this group that sustainability of the Plan in the Tasmanian context (with positions based through local government) demanded a permanent coordinator position within Mental Health Services to broadly support activities. Experience had demonstrated that for locally-auspiced positions to be effective close attention was required, not only to developing clear agreements with the auspicing bodies, but also to identifying protocols defining roles and responsibilities.

In this regard it was also noted that the funding provided for these activities was not consistent with State remuneration for equivalent positions and did not take into account the additional costs associated with service provision in a non-metropolitan settings, or the difficulties resulting from non-recurrent funding. These workforce issues were identified by all three informants as being critical to sustainability, compounding the already well-recognised problems of recruitment and retention in rural settings.

In the following sections informants' responses are presented following each lead question.

8.2.2 Mental health promotion and prevention

In addition to emphasising the importance of the Rural Mental Health Plan in ensuring broad attention to rural mental health needs, it was the strongly stated that the success of the Plan had been informed by a sense of ownership and commitment on the part of rural communities, consumers and other groups from the outset, and that this had been recognised and actively enhanced. It was emphasised that the role of rural mental health consumers was critical as drivers in this process.

All of the informants noted that mental health promotion demanded time and planning in the face of unrelenting clinical demands. Indeed, the demand for services increased from the time of the needs assessment and continued to do so as the local workers developed their working relationships with community groups and other service providers. As is the case everywhere, crises demand responses and ensuring time and energy for promotion and prevention requires commitment and flexibility. Capacity building with consumers and community groups was energy intensive, particularly at the outset, but critical to enabling real community participation.

Identifying mental health promotion and prevention needs demanded effectively engaging communities. This had been undertaken through broad community needs assessments that had preceded the Plan and had included but not fore grounded mental health (being part of broad rural community needs assessments). The locally based mental health workers were thus able to progress these agendas with existing community groups. Recognition of the importance of this work by respective auspicing bodies demanded being able to demonstrate outcomes, specifically the cost benefits.

It was noted that, as elsewhere, stigma regarding mental health is significant in rural communities, thus the manner in which rural consumers were engaged was important, both in terms of acknowledging and responding to consumer sensitivities, but also in terms of being able to harness consumer capacities constructively.

8.2.3 Continuity of care, linkages and partnerships

There was consensus that, in general, there remained very significant gaps in the understandings of the needs of mental health consumers and the range of interventions (beyond medications and counselling) necessary to address these. For practitioners in the field probably the most important issue in terms of being able to address both clinical and non-clinical mental health needs is time. To do so, given the burden of clinical demands, requires flexibility in work practices, and capacity to build on existing resources within the community. This may require "creating the role" in an environment in which there is no precedent or incumbent. However, also noted was the importance of careful consideration of the role expectations of practitioners when appointed through generic position descriptions that do not encompass specific professional skills (for example psychotherapeutic techniques versus counselling) and practice demands.

In order to ensure strong relationships with the key organisations, attention to formal agreements and to providing appropriate and timely feedback is essential. The relationship with General Practitioners in these rural settings was emphasised as being essential to the success of the mental health worker role.

8.2.4 Equity (Access to comprehensive services)

In relation to the scope of services it was noted at the outset that rural settings, even in a State the size of Tasmania, would never support the full range of specialist services available in metropolitan settings. Telemedicine provides some options but should not be viewed as an alternative to services on the ground (for these services videoconferencing was provided at no cost and thus practitioners felt free to take advantage of this option). Thus it is likely that there will be gaps (for instance in rural Tasmania in relation to forensic mental health) and, consequently, the realisable goal is to provide the "best possible" access to comprehensive specialist services. There thus remain a number of areas that require ongoing development to address needs.

In order to do this local service providers need breadth in their skills-base, and should be able to access other approaches to addressing consumer needs (for instance, non-clinical activities through local non-government agencies). They also need to know how to inform local consumers and services about services available at a distance (such as internet based resources). This means being up to date in terms of IT skills and resources.

While visiting specialists address important issues, they also make demands of local service providers, demands which at times are beyond the role and responsibility of those on the ground. Consequently it is important that visiting providers not only have expertise in their area of work, but they are informed about what is available and possible locally, and are themselves flexible in terms of practice. It was noted by one informant that at times visiting psychiatric services are restricted in their focus and do not appear to appreciate the "big picture" of rural practice. Consequently their potential impact is reduced in terms of facilitating broader interventions relevant to the local context.

8.2.5 The rights of people with mental disorder

It was noted that mental health consumers and carers participated across a range of support groups and advisory bodies in rural communities. However, these consumers

did not necessarily identify as mental health consumers and carers per se. This, at least in part, reflects issues of stigma in small communities.

The Consumer Advisory Group, a Ministerially-appointed body funded by Mental Health Services has been critical in terms of consumer issues State-wide. At present there is a process in train to employ three consumers and three carers, one of each of whom will be based in the three Districts (North-west Coast, North, and South). This has been the culmination of long planning and the development of a consumer and carer framework which must necessarily precede appointment to these positions (which will be in place in late 2005). The lessons from this process (which in its entirety has been ongoing for several years) include the realisation that ensuring meaningful consumer participation is difficult; that such participation requires resources; and that having a framework to guide such participation is critical. Issues for consideration in this regard include attention to the mental health needs of consumer representatives (who may at times be unwell, thus requiring criteria to guide participation and demands made of them), ensuring that representation addresses the needs of consumers as a group (rather than as individuals), that real responsibilities attach to the consumer representative role (such as participating in auditing processes) and that consumers are themselves representative of and capable of representing local consumers (rather than being convenience appointments on the part of services).

It was noted that being a consumer representative means public acknowledgement of that status, raising (again) issues of stigma. Empowering those consumers who do take on these tasks is an active process and demands ensuring opportunities to develop particular skills. It also requires adopting appropriate models that allow their existing capacities to be utilised appropriately – for instance working through a community development model while being attentive to clinical realities. An overarching recovery focus supported these initiatives in Tasmania, however it was noted that despite this focus there were a number of obvious deficiencies, for instance in terms of ensuring the information needs of carers are adequately addressed. Although there were numerous issues raised in terms of the difficulties of ensuring appropriate consumer and carer participation, it was also stated clearly that when consumers and carers were empowered and participating, the work of the rural mental health workers were supported (in terms of clearer direction, support and reduced stress).

8.2.6 Quality and effectiveness

In terms of quality and effectiveness, input through the MSOAP and MAHS projects (both Commonwealth funded) were noted as key contributors to professional development. However, it was pointed out that these are not recurrently funded. Telehealth and the Rural Mental Health Network were also raised, the latter both in terms of continuing education and practitioner support. Each of these rural services coordinated through the Plan will be audited, and informants noted that consumer and carer participation will be part of the auditing process.

8.3 SUMMARY OF FINDINGS FROM INTERVIEWS

8.3.1 Mental health promotion and prevention

While a priority in terms of policy statements, promotion and prevention is not prioritised in terms of activities in rural and remote settings and there is a need for support at the policy implementation level. There is also a need for data relevant to the rural and remote social and service context to support this which can demonstrate both need and outcomes from mental health promotion and prevention activities, and for this data to be made available in appropriate form to providers and consumers. Promotion and prevention activities should be informed by adequate consultation, be owned by local communities with meaningful involvement of consumers, and should draw on the existing capacity in communities. Mental health service providers should be involved in these initiatives which demand that there is an appreciation of population level activities by such organisations, that the conflicts between clinical and non-clinical demands are addressed, and that formal agreements support cooperation with other organisations. Addressing stigma in these settings is a necessary component of such activities.

8.3.2 Continuity of care, strategic linkages and partnerships

Effective linkages with General Practice are a priority in rural and remote settings. Continuity of care was clearly identified as an issue reflecting problems in terms of recruitment, retention and range of services with the strengths of existing services and activities often reflective of the personalities of the incumbents rather than sustainable structures and processes. Linkages across Districts, services and sectors are compromised by differences in understandings, language and priorities, and impacts, particularly with certain special-needs populations. This is compounded by the difficulties of coordination between what are often very small programs in rural and remote settings where there are limited resources for activities that are not directly service-related. This extends to engaging consumers and carers in reciprocal learning and mutual growth, objectives that require dedicated time and resources. Addressing the broad demands of this work requires flexibility for staff in terms of roles and time, which should be articulated in role descriptions and supported by the necessary resources including IT-based options which, in turn, require access and infrastructure support across the range of services involved.

8.3.3 Equity

The obvious differentials in the resources available in rural and remote communities by comparison to metropolitan Australia should not be accepted lest differentials in mental health outcomes be similarly understood as unchangeable. The rural and remote mental health workforce needs to be more aware of equity and quality issues generally and, in particular, in relation to the requirements of special needs populations. Visiting specialist staff should flexibly accommodate local circumstances and limitations. In these settings stigma and isolation can be particularly difficult for consumers who have difficulties with access to basic social services. Providers need to be aware of and utilise local capacity and IT options to improve outcomes. Ensuring best practice in rural and remote settings requires appropriate protocols, improved collaboration with General Practice and between mental health and ATODS services, and confrontation of rigid constructions of mental health which may, in turn, require supported, systematic reform within local mainstream mental health service settings. These issues may best be addressed through a whole-of-government approach to rural and remote social and mental health needs generally.

8.3.4 The rights of people with mental disorder

The rights of people with mental disorder are supported when clinical services are provided by professionals with expertise and experience, and who are intimately familiar with the mechanisms and limitations of the Mental Health Act. In this regard, the workforce difficulties noted above are clearly consequential. However the circumstances of rural and remote settings are such that not only are consumers and carers disadvantaged by comparison to those in metropolitan Australia in terms of access to a range of social supports and resource, these are further compromised in times of economic hardship in the bush. Supporting the rights of consumers and carers demands identifying local resources and champions, providing settings for interagency coordination that is inclusive of consumers and carers, and providing training as necessary to a wide range of formal and non-formal workers. The experience in Tasmania suggests that effectively empowering consumers and carers demands adopting an appropriate framework, which may be a community development or recovery, rather than clinical orientation. Furthermore, that framework is supported and operationalised through funded consumer and carer positions with a designated coordinator able to give close attention to their needs as representatives and advocates.

8.3.5 Quality and effectiveness of service delivery

The quality of service provision is informed by the experience and expertise of service providers and the degree to which they are supported professionally and socially in settings where options in this regard may be limited. There is a need for effective approaches to providing such support including innovative linkages across rural metropolitan services. Improving quality of service delivery requires ensuring that the culture of quality improvement is embraced in rural and remote settings and ensuring that resources and guidelines are available to support this both for mental health staff and for generalist staff taking on mental health roles. Reluctance or resistance to greater use of IT resources by rural and remote workers may be an issue that will require systematic attention and training. Building effective and sustainable linkages between rural services and academic centres can promote appropriate research, evaluation and service enhancement and would be supported establishment of a centre for rural and remote mental health.

9 SYNTHESIS AND SUMMARY

Despite the limitations of this work, from the literature review and consultations it is clear that the information base on which determinations of needs for mental health services and activities, and of the outcomes of existing initiatives in rural and remote settings, is inadequate. While this compromises policy and planning at a 'macro' level, the consequences are amplified at a local level by the diversity of rural and remote communities and populations. Resource allocation is consistently identified as a problem and appears, generally, to be *ad hoc* rather than strategic and is not informed by an understanding of that diversity. Regardless, existing data demonstrates higher levels of need, particularly for certain subpopulations such as those of Indigenous and culturally and linguistically diverse backgrounds. Others include children and youth, the aged, forensic populations, and those with dual diagnoses.

The available literature focuses on clinical activities and, to a lesser extent, activities through primary care. There is very little relating to the non-formal community sector or self and family care. Services are often characterised by a restricted range of activities (particularly in terms of mental health promotion and prevention), reduced options for those requiring clinical services (such as subacute care and specialist areas), problems with workforce development and retention, and limited uptake and support of information and communication technology applications. While broad competencies are expected there appears to be little systematic training or preparation to address the specific workplace and social demands of practitioners residing in rural and remote communities. Levels of consumer and carer involvement in service planning in these populations are low and appear to be largely ineffectual in the absence of dedicated support. Consumers with serious mental disorders and their carers living in these settings are not only disadvantaged in terms of access to acute and longer-term psychiatric inpatient facilities, but (in Queensland) by a Mental Health Act and review processes that do not reflect the social realities of treatment constraints in rural and remote communities.

10 RECOMMENDATIONS

Acknowledging the challenges of providing a full range of mental health services outside of metropolitan Queensland, the following recommendations are made with view to ensuring (as stated by a Tasmanian informant) "*best possible access to comprehensive specialist services*". In our view, comprehensive specialist services should cover the mental health spectrum of activities (from mental health promotion to provisions for longer-term care needs), and are best understood as part of a broader optimal mix of mental health services (per WHO: Diagram 1 – see section 5). Following the overarching issues, recommendations are consistent with these WHO service levels. In order to ensure the primacy of consumers and carers in policy and planning, the areas of greatest need (and opportunity given activity costs) are presented first.

Overarching issues

1. Resourcing rural and remote mental health activities will require realistic weighting in terms of funding allocation and must be informed by accurate information regarding the additional burden of need. To this end Queensland

Health should support the ongoing collection and collation of mental health-relevant social indicators and service data for rural and remote communities.

2. Queensland Health should consider approaching the Australian Bureau of Statistics to over-sample rural and remote Queensland in the planned repeat National Mental Health Survey. This will provide invaluable data specific to Queensland's rural and remote mental health needs.
3. Resource allocation for rural and remote mental health should take into account requirements across the mental health spectrum of interventions. Specifically, particular attention needs to be given to prevention and mental health promotion in rural and remote settings and linkages with other sectors.
4. Queensland Health should allocate funds for infrastructure and support, to enable optimal use of existing information and telecommunication resources in rural and remote communities, and expansion in terms of geographic range, clinical and educational applications, and local capacity. These initiatives should include systematic evaluation (for instance through collaboration with the Centre for Online Health, University of Queensland).
5. Competency and effectiveness of the specialist mental health workforce will only be ensured through mechanisms that provide appropriate education, orientation and training, and support retention in rural and remote settings. This demands attention to professional and career development (including supervision), skills to address the social requirements of working in small communities (given dual relationship issues and related demands on clinicians), and the broader social needs of the rural and remote workforce.
6. The roles and responsibilities of Indigenous mental health practitioners must be defined and formalised (to include a clinical role), including certification, accreditation, training and support.
7. Role definitions and expectations of rural and isolated practitioners should be defined, developed and supported. In addition to general mental health skills, this will necessarily include competencies within a community development framework, ability to consult and liaise with community based organisations, skills across the mental health spectrum of interventions (particularly mental health promotion and prevention activities) and local administrative capacities.
8. The specific needs of special-needs populations (Indigenous, culturally and linguistically diverse…) must be incorporated across all levels of service delivery.
9. While the Mental Health Review Tribunal – ATSI Issues Reference Group is considering the Mental Health Review Tribunal's protocols in relation to Indigenous consumers and carers, there are problems more generally with the Mental Health Act and its implementation in remote settings (for both Indigenous and non-Indigenous consumers). This should be reviewed with view to possible amendments to the Act.
10. The rural and remote mental health policy implementation will require (as in Tasmania) a Statewide rural and remote mental health coordinator. This position should relate to regionally-based rural and remote mental health network coordinators (which may or may not be within Queensland Health, for instance, these positions could be funded through *beyondblue* or other NGOs operating within public, private and NGO organisations, and across health and other sectors), and to regionally-based rural and remote consumer and carer consultants.

Self and family care

11. Queensland Health should enable consumer and carer participation through regionally-based rural and remote consumer/carer consultants relating to and supported by the Statewide rural and remote mental health coordinator.
12. Support to local NGOs and community organisations to encourage community-level consumer and carer participation and support.

Informal community care

13. Increase emphasis on programs to facilitate consumer and carer inclusion within communities and access to community-based services and resources.
14. Consistent with the mental health spectrum of interventions, increased attention to prevention and mental health promotion activities through community-based organisations.
15. Development of a rural and remote mental health literacy strategy for implementation through community-based and non-health sector organisations.
16. Linkage and coordination across self and family care, and informal community care activities through regionally based rural and remote mental health network coordinators.

Mental health services through primary health care

17. Primary care services are and will remain a major vehicle for the provision of mental health services in rural and remote settings. Continuing emphasis should be given to expanding and supporting the competencies of generalist primary care practitioners (in Queensland Health and other organisations).
18. Where possible, existing service networks with track records in rural and remote health should be utilised for service delivery. These include the Divisions of General Practice, the Royal Flying Doctor Service (Queensland Branch) and Indigenous community-controlled services.
19. To ensure viability, coordination and effectiveness, these relationships should be formalised and supported through Queensland Health (in line with the linkage coordination role in Tasmania).
20. Support should be provided to ensure the competency and effectiveness of relevant primary care providers to address and/or cooperate in the management of comorbidity.

Community mental health and general hospital inpatient services (non-specialist)

21. Funding should be provided for a carefully evaluated trial of rooming-in models of care associated with general hospital services.
22. Funding should be provided to support sub-acute, step-through facilities in regional centres with careful evaluation. Contingent on this evaluation this may be appropriately extended to district centres.
23. Clear protocols are needed to ensure 24 hour mental health assessment and triage support to generalist practitioners in emergency departments.
24. General health and mental health providers need training to support the broader mental health skills-base required in rural and remote practice.
25. While development of local mental health capacity should be encouraged, outreach specialist services will remain essential for many rural and remote communities. This demands dedicated positions and flexibility in relation to delivery mode and may best be undertaken in collaboration with or through

non-government services (for instance RFDS, the Divisions of General Practice or Indigenous community-controlled agencies). These activities must be adequately resourced, taking the higher burden of disorder and disability, the time and costs of travel, requirements for providing and supporting information technology and telecommunications approaches, and the demands of non-clinical activities (such as mental health promotion, community capacity building, and generalist health staff development and support.

26. Coordination with activities in the informal community care and primary care sectors should be ensured through the rural and remote network coordinator.

Specialist services and long stay care

27. Responsibility must be allocated for ensuring reasonable access (either through outreach or in regional centres) to subspecialist mental health services, including child and youth, aged care, forensic.
28. Access should be ensured to child and youth inpatient facilities across each Zone. The needs of Indigenous children and youth need to be carefully considered and out-of-home community options should be explored and evaluated.
29. Longer stay options for adults (longer term institutional dependency, forensic, psychiatric rehabilitation and psychogeriatric) need to be more clearly defined and coordinated to ensure sufficiency and equity of access with least possible disadvantage to residents of rural and remote communities. This may include additional funds for supported visits and use of videoconferencing to ensure continuing engagement with natural supports in community of origin.

Implementation

30. The findings of this review and the recommendations should inform the development of a specific policy on mental health in rural and remote Queensland.
31. Queensland Health should provide resources for the implementation of this policy and its subsequent evaluation. On the basis of the experience in Tasmania, this should include a position for at least three years.

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12 APPENDICES

Appendix 1: Electronic survey proforma

Rural and remote mental health policy and service delivery in Queensland

The North Queensland Health Equalities Promotion Unit is undertaking a brief review of the international and national literature relating to rural and remote mental health policy and models of service delivery. This will be used by Queensland Health to inform service development for rural and remote Queensland. It is understood at the outset that the resulting recommendations must be consistent with key national policy, specifically, the Aims of the National Mental Health Strategy:

- To promote the mental health of the Australian community
- To, where possible, prevent the development of mental disorder
- To reduce the impact of mental disorder on individuals, families and the community
- To assure the rights or people with mental disorder

Certain other States have undertaken substantial work in this area resulting in key policy documents that have taken these aims as guiding principles. This is the case for Tasmania, with the Tasmanian Rural Mental Health Plan identifying five "Strategic Directions" and six associated "Key Policy Goals":

1 Optimise the mental health and wellbeing of individuals and communities and support environmental change to improve rural mental health
  - Promote mental health issues within rural areas
  - Prevent, where possible, the development of mental disorders in people living in rural areas

2 Ensure continuity of care for people in rural communities through improved strategic linkages between service providers, consumers and carers
  - Develop partnerships in service reform and delivery

3 Implement service reform to achieve equity and quality care to rural communities
  - Reduce the impact of mental disorder on the individual, family and rural communities

4 Ensure that rural mental health services are consistent with accepted international and national principles for the protection of people with mental health problems and their carers
  - Ensure the rights of people with mental disorder

5 Promote the highest standards of mental health care, and continuously improve the quality of mental health services available to people living in rural communities
  - Improve the quality and effectiveness of service delivery

While these principles will be similarly applicable in Queensland, specific policy and service delivery models must respond to the circumstances and needs of rural and remote populations throughout this large, diverse and decentralised State. Given the time and resource constraints of this project (two months part time) we have chosen to accept but 'problematise' these principles in order to clarify how the particular features of Queensland should be addressed. In the table which follows you are asked to consider each of these principles and to: 1) identify and describe what compromises the realisation of this strategic direction in Queensland; and, 2) identify potential policy

and service solutions. Please keep in mind that to be comprehensive, mental health policy and service models must be relevant to:

- the range of activities across the mental health spectrum of interventions from mental health promotion to long term care;
- all age-groups;
- the range of service settings including acute in-patient, acute community, extended in-patient, extended community, consultation-liaison, and sub acute/rehabilitation; and,
- the specific needs of particular populations within rural and remote Queensland including Indigenous, culturally and linguistically diverse, forensic, child and youth, the aged, and people with dual diagnosis.

Please provide comments in the table that follows below each identified 'principle'. Do not be constrained by space and feel free to comment in relation to your own particular area of work, interest and expertise (informants have been selected in an attempt to capture diverse issues). Please also provide any further thoughts that are you feel are relevant but which are not captured within your earlier answers. Your contributions are greatly appreciated.

PLEASE USE AS MUCH SPACE AS NEEDED FOR EACH ANSWER

1 *Optimise the mental health and wellbeing of individuals and communities and support environmental change to improve rural mental health:* • *Promote mental health issues within rural areas* • *Prevent, where possible, the development of mental disorders in people living in rural areas*
What compromises the realisation of this strategic direction in Queensland • •
Identify potential policy/service solutions • •
2 Ensure continuity of care for people in rural communities through improved strategic linkages between service providers, consumers and carers • *Develop partnerships in service reform and delivery*
What compromises the realisation of this strategic direction in Queensland • •
Identify potential policy/service solutions •
3 Implement service reform to achieve equity and quality care to rural communities • *Reduce the impact of mental disorder on the individual, family and rural communities*
What compromises the realisation of this strategic direction in Queensland • •
Identify potential policy/service solutions • •
4 Ensure that rural mental health services are consistent with accepted international and national principles for the protection of people with mental health problems and their carers • *Ensure the rights of people with mental disorder*
What compromises the realisation of this strategic direction in Queensland • •
Identify potential policy/service solutions • •
5 Promote the highest standards of mental health care, and continuously improve the quality of mental health services available to people living in rural communities • *Improve the quality and effectiveness of service delivery*

What compromises the realisation of this strategic direction in Queensland • •
Identify potential policy/service solutions • •
6 Please provide any further comments that you feel are relevant to the development of mental health policy and service delivery models for rural and remote Queensland • •

I do / do not wish to have my comments specifically attributed to me
I do / do not wish to be listed among informants / contributors

Appendix 2: Survey Respondents

NAME	INTERVENTION	LOCALITY	SECTOR
Bruce Kelly	Health promotion prevention	Regional (South)	Public
Carmelita Almain	Health promotion prevention	Rural (North)	Public
No response	Health promotion prevention	Rural/Remote (West)	NGO
David Crompton	Clinical	Regional	Public
John Allen	Clinical	Rural	Public
Andy Paras	Clinical	Remote (North West)	Private
Judith Krause	Child & Youth/ Clinical	Rural (South)	Public
Barbara Lees	Longterm	North	Public (Non Health)
Name with held by request	Longterm	State-wide	Public
No response	Longterm	North	Public
Judith Piccone	Child & Youth	State-wide	Public
Greg Pratt	Aboriginal and Torres Strait Islander	North	NGO Indigenous community controlled
No response	Aboriginal and Torres Strait Islander	North	Public
Rita Prasad- Ildes	CALD	State-wide	Public
Tony Falconer	Forensic	State-wide	Public (Non Health)
David Kavanagh	Dual Diagnosis (Drug and alcohol)	State-wide	Education Tertiary sector
Awaiting response	Aged Care	Central	Public
Quality & Legislation Team	Quality & legislation	State-wide	Public
No Response	Workforce	State-wide	Public
Information Systems Team	Information Systems	State-wide	Public
No Response	Zonal MH	Central	Public
Andrea Baldwin	Zonal MH	South	Public

Appendix 3: Interview Questions

TASMANIAN RURAL AND REMOTE MENTAL HEALTH PLAN

Mental health promotion and prevention
Mental health promotion and prevention is a recognised priority nationally. In terms of rural mental health this requires informing and shifting attitudes at the policy level and at the level of services. What is the information that is needed in order to influence policy and programs, and how can one effectively communicate these needs in such as way as to influence policy and resource allocation, and service delivery? That is, how does one justify and access the resources necessary for these activities and how does one enable these activities at the coalface?

Continuity of care, linkages and partnerships
It is clear that a balance of activities across the spectrum of interventions is desirable in rural settings as elsewhere. How does one go about identifying an appropriate balance of activities in rural settings, for instance between community development versus clinical activities, and what strategic approaches and linkages are necessary to enable this?

Rights
In rural and remote settings engaging and involving mental health consumers and carers is difficult for many reasons, particularly as much of the mental health effort is through the primary care sector. What are the lessons from Tasmania in terms of promoting consumer / carer participation in mental health service delivery, either through mental health services per se or the primary care sector?

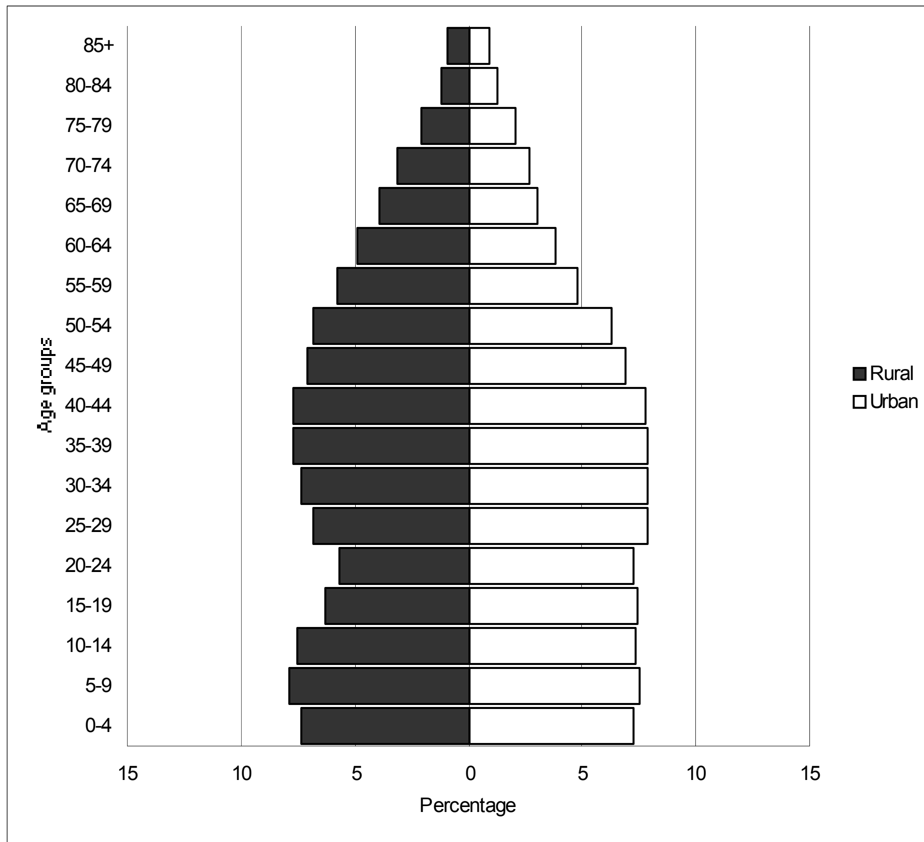
Equity
Rural and remote mental health consumers should have access to the same scope of mental health services as consumers elsewhere. What approaches are effective in increasing and sustaining the scope of service provision? For example access to special needs services such as comorbidity, forensic ….

Quality and effectiveness
In rural settings, what are the approaches to ensuring quality in terms of evidence-based service delivery – across the spectrum of intentions and across mental health disciplines? What approaches are effective in increasing and sustaining the levels of expertise and excellence in service provision?

Would you like to say anything more, for instance in relation to:

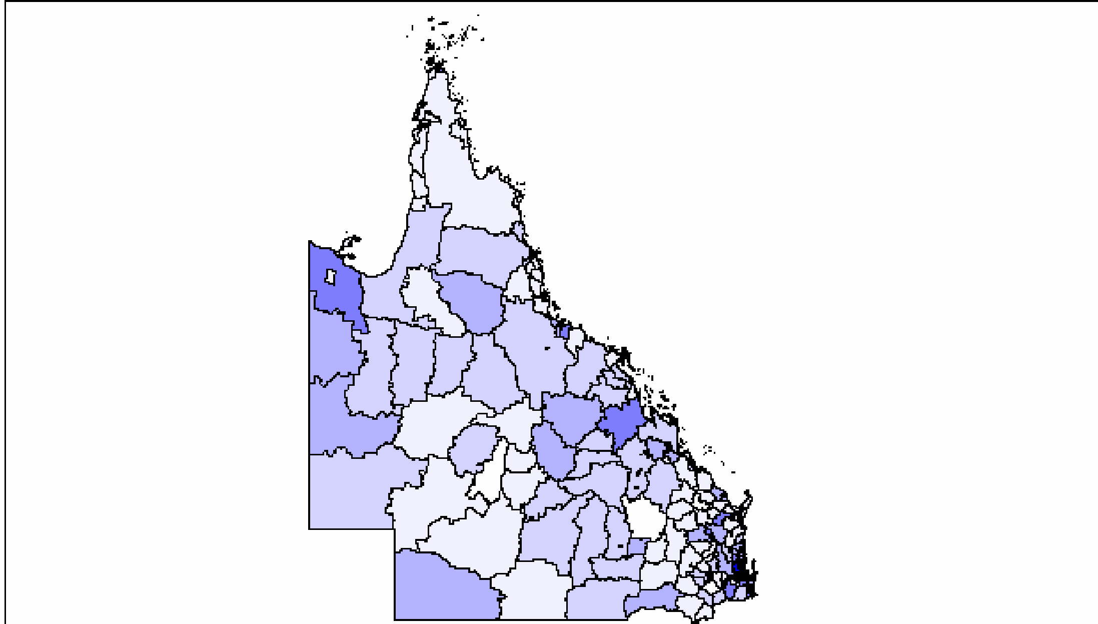
- The Mental Health Act and its application in rural and remote settings;
- Appropriate funding formulas;
- Any other issues.

Appendix 4: Population Pyramid: Rural urban comparison by age Northern Zone 2004

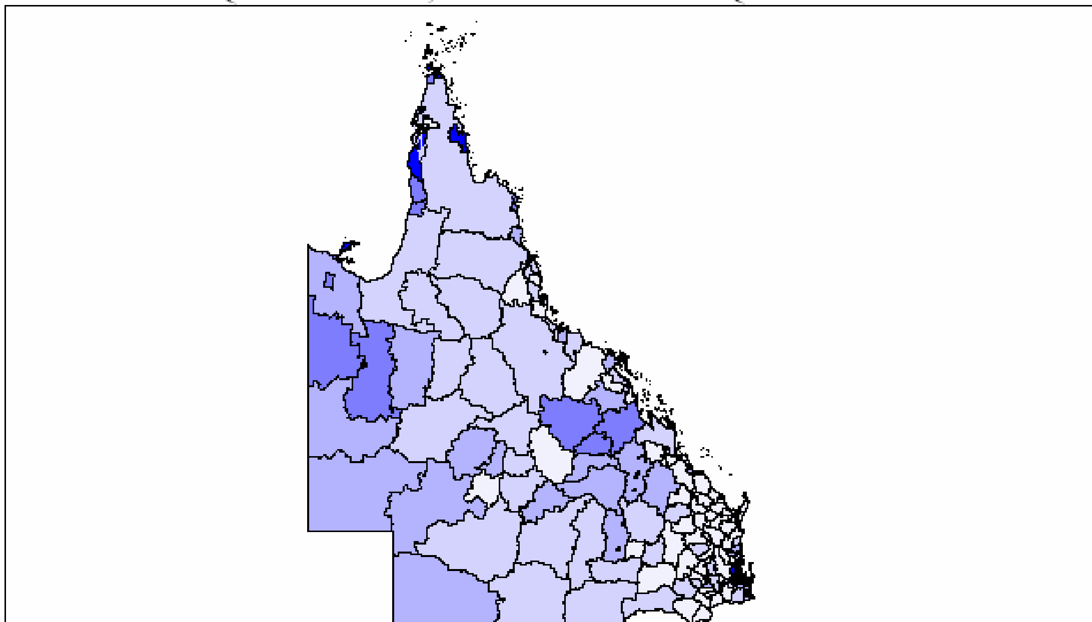


Appendix 5: Map of Queensland SEIFA Quintiles -
Source: 2001 Census data
Rawnsley, T. and J. Baker (no date). Indigenous SEIFA for Queensland Report prepared for Office of Economic and Statistical Research, Analysis Branch, Methodology Division Australian Bureau of Statistics.(In the following schematic representations, the darkest colour relates to the highest levels of advantage; the palest shades relates to the highest disadvantage).

Indigenous Quintiles



Non Indigenous Quintiles



Appendix 6: Age specific death rates by ASGR Remoteness area – females

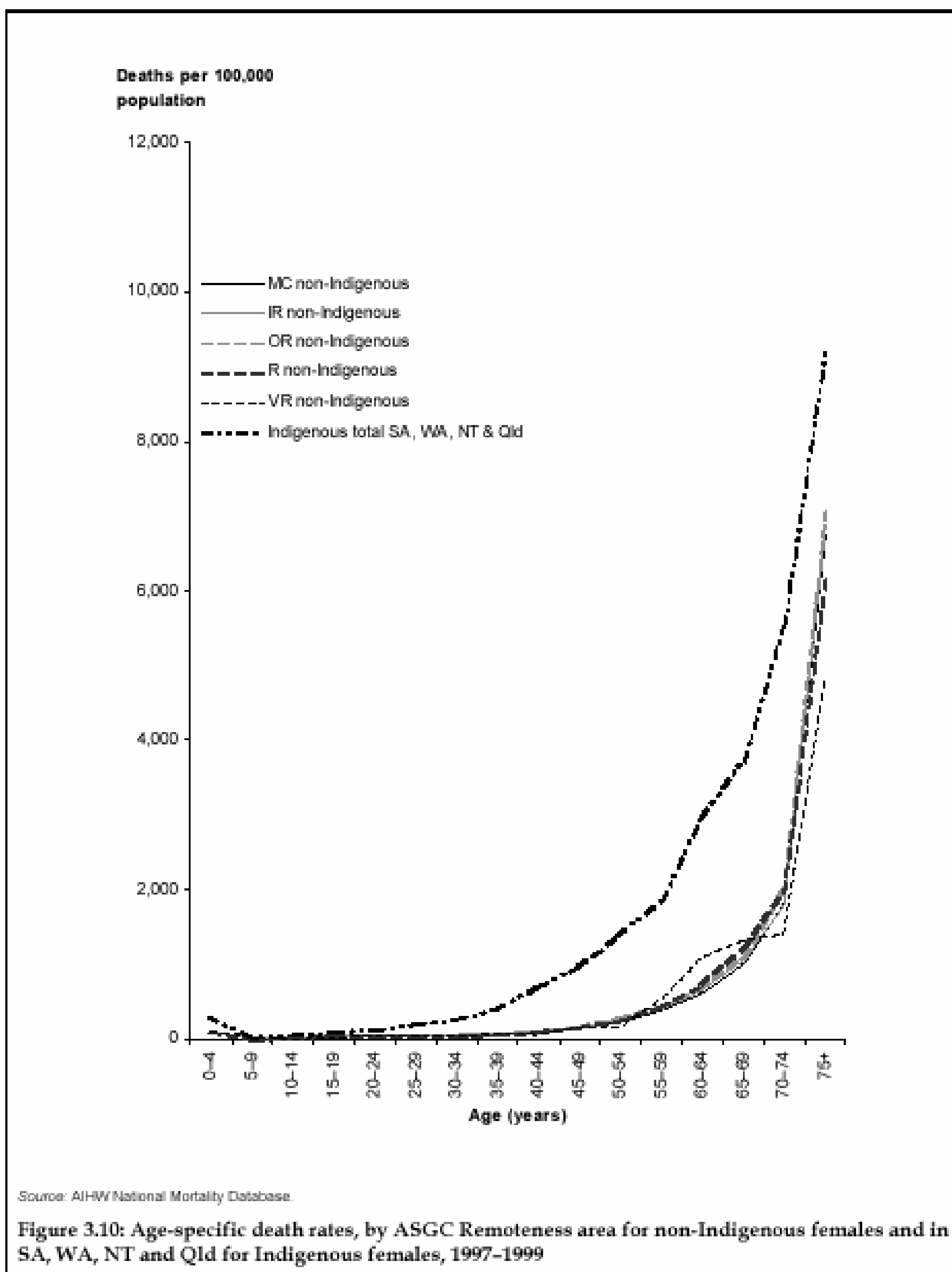


Figure 3.10: Age-specific death rates, by ASGC Remoteness area for non-Indigenous females and in SA, WA, NT and Qld for Indigenous females, 1997–1999

Appendix 7: Age specific death rates by ASGR Remoteness area -males

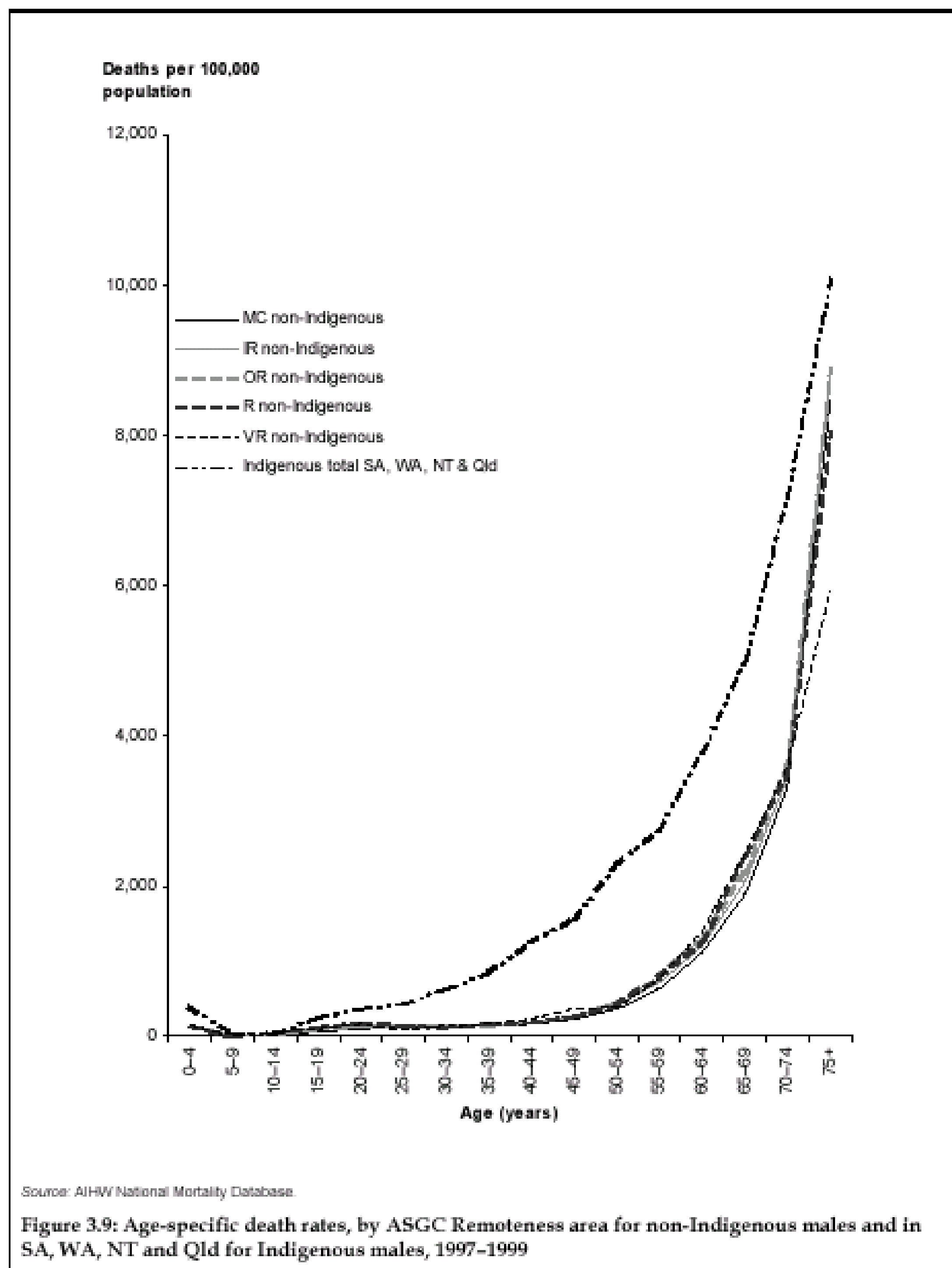
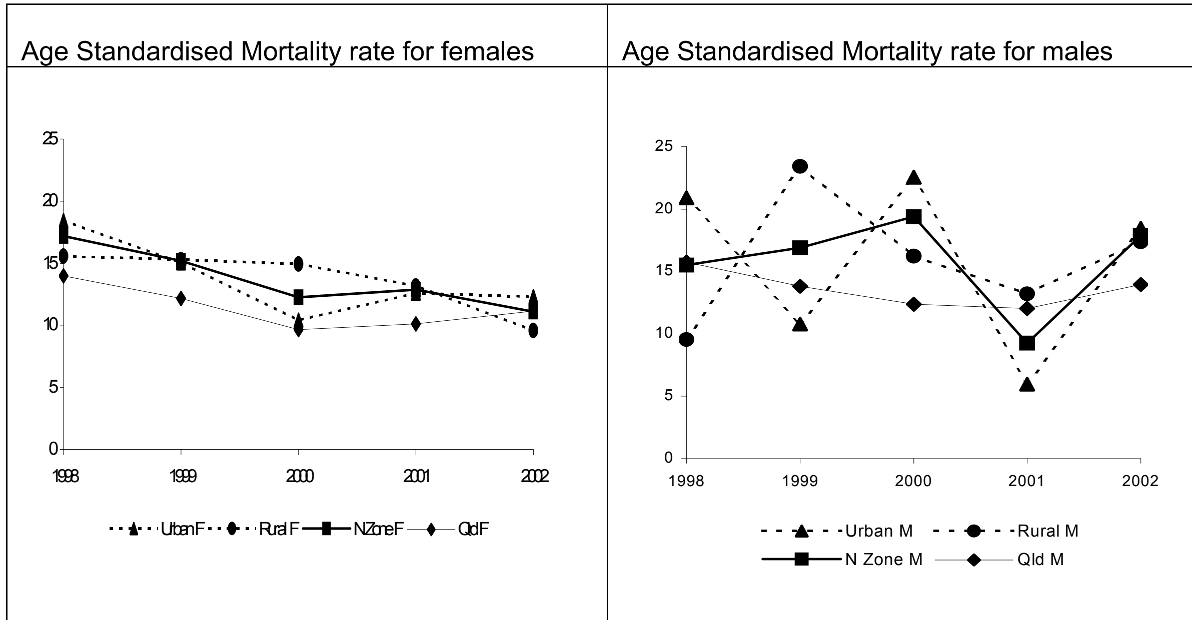


Figure 3.9: Age-specific death rates, by ASGC Remoteness area for non-Indigenous males and in SA, WA, NT and Qld for Indigenous males, 1997–1999

Appendix 8: Urban, Rural, Northern Zone Mortality rates

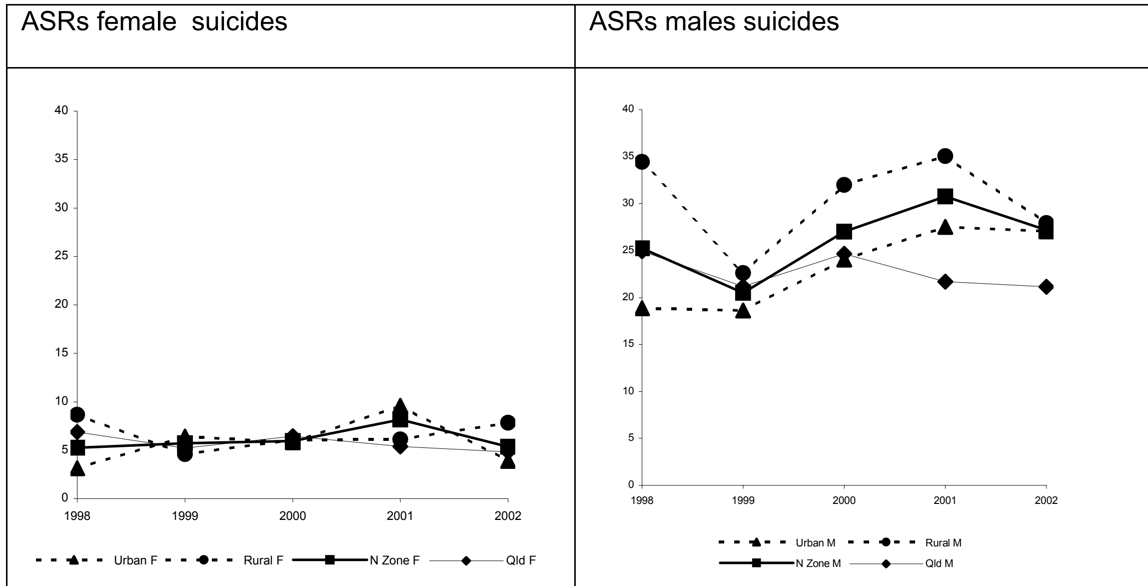
Deaths

All mental disorders age standardised mortality rates for Northern Zone for the periods 1998-2002 were broadly similar to Qld as a whole. ASRs generally were high for males overall.



Analysis of mortality rate ratios for all mental disorders recorded for the zone for the periods 1998 – 2002 where data was aggregated for the period showed significantly higher rate ratios than Queensland for both males and females see Table 3.

Suicide



Suicide ASRs for males are generally 2-3 times higher than females for all areas.

Analysis of mortality rate ratios for suicide for the periods 1998 –2002 where data was aggregated for the period showed significantly higher rate ratios than Queensland for both rural and zone area for males only see Table 1.

Appendix 9: Indigenous Suicides in Queensland 1999-2001

Indigenous suicide rates for Males by age groups, 1999-2001.

Age group	Deaths	Population*	Rate#
<15 years	1	23001	-
15-24 years	31	10277	100.5
25-34 years	23	8424	91.0
35-44 years	8	6497	-
45-54 years	1	4119	-
55-64 years	1	1869	-
≥65 years	1	1361	-
All Ages	66	55548	39.6

Indigenous suicide rates for Females by age groups, 1999-2001.

Age group	Deaths	Population	Rate
<15 years	1	22208	-
15-24 years	7	10239	-
25-34 years	3	9189	-
35-44 years	1	7070	-
45-54 years	2	4497	-
55-64 years	-	2341	-
≥65 years	-	1680	-
All Ages	14	57224	8.2

Indigenous suicide rates for Persons by age groups, 1999-2001.

Age group	Deaths	Population	Rate
<15 years	2	45209	-
15-24 years	38	20516	61.7
25-34 years	26	17613	49.2
35-44 years	9	13567	-
45-54 years	3	8616	-
55-64 years	1	4210	-
≥65 years	1	3041	-
All Ages	80	112772	23.6

Data sources:
Australian Bureau of Statistics (2002). 2001 Census of Population and Housing. Canberra: ABS.
Queensland Suicide Register, Australian Institute for Suicide Research and Prevention.

* Population figures are based on 2001 Census data, and presumed constant over the preceding years. Therefore, the suicide rates obtained are probably slightly conservative, allowing for estimated indigenous population growth in Queensland of 2%.

Where there is an absence of the suicide rate (-), this means that the rate was not calculated because the number of suicides was less than ten. © Australian Institute for Suicide Research and Prevention, 2004