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**Mental Health Programs in Remote
Divisions of General Practice:
PARC Knowledge Harvesting Program Issues Report**

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Executive Summary

Introduction

This discussion paper describes the mental health activities of Divisions of General Practice (DGPs) operating in remote areas of Australia , and documents the knowledge of the people who work in these programs. It is the first part of the Primary Mental Health Care Australian Resource Centre (PARC) Knowledge Harvesting project.

Method

Semi-structured telephone interviews were conducted with 12 of the most remote DGPs, (selected on the basis of their RRMA score), using a questionnaire that was developed after stakeholder consultation. Most of the interviewees were project officers. Interviews were conducted over December 2003 and January 2004, and reflect the programs at that time. Data was analyzed qualitatively using transcripts of the interviews, and the findings were then checked by the informants, and validated by interviews with the Development and Liaison Officers (DLOs) of the National Primary Mental Health Care Network (NPMHCN) from SA, NSW, Qld, WA and NT, and with assistance from the Principal Advisor in Mental Health of ADGP.

Mental Health programs in the remote divisions – interview results

Workforce

Mental health workforce was the most critical factor for a successful Divisional mental health program. Issues noted for GPs were high turnover, working in a time poor environment making it hard to access professional support and training in mental health, and the increasing percentage of doctors with overseas training.

The psychiatry workforce is even more of a problem in remote areas than the GP workforce, with access to psychiatrists often not adequate, and the relationship with visiting psychiatrists, where this existed, varying from excellent to problematic. Direct personal networking with psychiatrists was highly valued.

Divisions of General Practice have been able to source funding for allied mental health workers from a number of sources, and this has been very well received. As well as being able to provide more services to the community, this is seen as contributing to GP retention. Some innovations in these remote areas are Divisions moving to a primary health care model with even greater use of allied health services, and the incorporation of traditional indigenous healers in the allied health delivery model.

The non-clinical workforce of Divisional mental health program coordinators also have high turnover, as the Divisions respond to changed funding environments, so the mental health programs often have continuity gaps, and relationships with their member GPs and other services in the region need to be rebuilt.

Geography and Population

The population in rural and remote areas have lower life expectancy, and higher rates of injury mortality, homicide, alcohol and smoking. At the same time they have less access to health care; the proportion of adults with an unmet need for mental health care increased with remoteness. The increased transience of the remote population makes disseminating information about, and access to services more difficult.

Travel costs for Divisions are very high, and attending state or national meetings requires days of travel time.

Division of General Practice Programs

Divisional programs are responsive to the needs of their local population, and as well as programs directly labeled as mental health, they include mental health content in areas such as men's health, youth health and suicide prevention. To date, drug and alcohol co-morbidity with mental health problems has not been dealt with well by existing services, and Divisions see this as a major focus for improvement. Programs combining physical and mental health issues, and focusing on well being are common.

Implementation issues of the Divisional programs included working with State Mental Health Services, shared care and peer support, education and training, and resource development, funding issues, sustainability, program evaluation and issues around the Better Outcomes in Mental Health Care Initiative. It was sometimes hard for Divisions to make programs with a broad wellness orientation "speak the language" of mental health for funding and reporting purposes.

Indigenous Issues

All the remote Divisions have significant Indigenous populations, and have taken specific steps to address Indigenous issues. These include setting up new services to very remote communities, cultural awareness and competency training, referral pathways to mainstream programs, and Memoranda of Understanding with Indigenous Health Services.

Policy and program implications

Workforce issues

For all categories of workers: GPs, Allied Health Workers, Psychiatrists and Divisional staff comprehensive attention needs to be paid to recruitment, professional support and supervision, career pathways and other retention strategies.

Geography and population

Mental health services, to be equitable, should be available to people in their communities, as well as financially accessible.
Higher prevalence of mental health problems means additional services are needed
Distance requires increased travel funding and appropriate activity goals
Transience of the population means repeated effort to disseminate information
Consumer issues of affordability and choice need to be considered

Indigenous issues

Indigenous health services often put mental health in the context of overall emotional health and well being. Divisions running mental health programs should consider the same approach, in both Indigenous and non-Indigenous programs.

Training is needed for mainstream workers in cultural competency, and for indigenous workers in mental health.

Program implementation issues

Sustainability, continuing funding, ongoing evaluation, linkages with other services, and some possible operational changes to the Better outcomes in Mental Health Care Initiative are described.

Preface

This is the first of a series of discussion papers about the mental health activities of Divisions of General Practice. It is based on the knowledge harvesting program conducted by the Primary Mental Health Care Australian Resource Centre (PARC), in conjunction with the National Primary Mental Health Care Network (NPMHCN). We have chosen the remote Divisions as our first topic area because they face particular difficulties in setting up and maintaining a mental health program. Staffing, funding and implementing a mental health program over vast areas with low population density and few services requires a different approach than in the more populated regions. We wish to recognize and thank the staff from Divisions of General Practice, Leanne Wells, the Principal Advisor for Mental Health at Australian Divisions of General Practice (ADGP) and the Development and Liaison Officers from the NPMHCN for their generosity in sharing their time and expertise. Also we thank the Australian Government Department of Health and Ageing for their support for, and funding of, PARC.

Section 1 - Introduction

Aim

This discussion paper describes the mental health activities of Divisions of General Practice operating in remote areas of Australia. It aims to document the knowledge accumulated by the people who work on or are closely connected with these programs. It should be useful to those initiating or maintaining Divisional mental health programs, to those working in remote mental health care, and to those interested in primary mental health care policy development.

The material presented is part of the Primary Mental Health Care Australian Resource Centre (PARC) knowledge harvesting program, which has covered Divisions of General Practice throughout Australia. The remote Divisions have been selected for a more in-depth look because of their need for effective mental health programs and the particular challenges in setting up and maintaining mental health activities in this setting.

Method

Qualitative research, using in depth telephone interviews was chosen as the method of data collection because this information was not being captured in other publicly available material, such as surveys, Divisional business plans and websites.

The topics for the interviews were selected following initial consultation with the National Primary Mental Health Care Network, mental health program coordinators from six Divisions that were attending a South Australian network meeting, and with the relevant Branch of the Australian Government Department of Health and Ageing, then known as the Mental Health and Suicide Prevention Branch. From this a semi structured interview schedule was developed (Appendix 2), which included information about mental health program objectives, structure, outcomes, strengths, lessons learned and resources developed. Questions were also included about several areas of current relevance to national program and policy planning.

A letter (Appendix 3) was sent to each Division outlining the project and inviting them to participate. This was followed by a telephone call to arrange a time for an interview. The Division was invited to nominate who would participate. In most cases this was a Project Officer but in some cases the CEO was interviewed or joint interviews took place. The interviews took place during December 2003 and January 2004.   The interviews were audiotaped, transcribed and analyzed for themes. Information about the content of each Division's mental health program is available in Appendices 4, 5 and 6, however the comments and opinions that form the basis of the themes have been de-identified.

In order to ensure that the themes extracted were comprehensive and valid, triangulation and checking of findings was carried out by interviewing the Development and Liaison Officers (DLOs) of the National Primary Mental Health Care Network from the States of Queensland, New South Wales, South Australia, Western Australia and the Northern Territory, through several teleconferences, as well as the Principal Advisor for Mental Health of ADGP, and their comments were incorporated into the final paper. The themes from both sets of interviews together with reference to relevant literature provide the basis of this paper.

Selection of Divisions

The remote Divisions of General Practice were selected from a larger group of rural Divisions by their RRMA (Rural, Remote and Metropolitan Areas) classification, an index of geographical isolation combined with population density. RRMA scores range from 1-7, with 3-5 being defined as rural and 6-7 as remote.

There are 66 Divisions with a rural classification, according to ADGP. These have 5% or more of their total population within the RRMA 4-7 band. From this group we selected 14 of the most remote. They are large, sparsely populated, and comparatively lacking in services, covering most of the outback areas of W.A., Qld, N.T., S.A. and N.S.W.   In two cases, namely Cairns and Top End, large urban centres are part of the Division, but much of their total geographic area is remote.

Fourteen Divisions were identified and twelve agreed to participate. These were:

> Barrier DGP
>
> Central Qld Rural DGP
>
> Cairns DGP
>
> Southern Qld Rural DGP Assoc Inc
>
> North & West Qld Primary Health Care
>
> Far North Qld Rural DGP
>
> Flinders & Far North DGP
>
> Kimberley DGP
>
> Eastern Goldfields Medical DGP
>
> Mid West DGP
>
> Pilbara DGP
>
> Top End DGP

Of the two that did not participate, one was of very limited capacity, and the other has a policy that all communication must be cleared by the Board. One of the participating Divisions was very small and did not have a Mental Health officer, so provided only a short interview. In the end therefore, one brief and eleven full telephone interviews were conducted.

Limitations of this study

Interviews with representatives from twelve remote Divisions of General Practice took place during December 2003 and January 2004. They provide a snapshot of Divisions at one moment in time, in a landscape that is rapidly changing. The persons chosen by the Division to participate in the interview were, in most cases, Program Officers, who were responsible for implementation of the mental health programs, and their views may not be representative of the CEO or Board of the Division. Some Program Officers were relatively new to the Division and/or the position so did not always have complete knowledge of previous mental health activities– this reflects some of the constraints of mental health program provision in remote Divisions, and is one reason this study was conducted. Only one of the interviewees was a GP, so perceptions of the remote GP working environment are observations rather than direct experience. The end-users of services or programs were not interviewed.

Section 2 Mental health programs run by remote Divisions of General Practice

Finding a Common Language

It was not always easy for Divisions to apply the topics in the interview schedule to their own programs, as many of these mental health programs were multi functional. Peer support groups are also used for CPD points, the breakfast case conference meetings with psychiatrists allow opportunities for networking, but also provide peer support and continuing education. Child and youth mental health programs are often provided through schools programs, mainly the various versions of MindMatters. Shared care mostly involves allied health workers and networks and linkages with other service organisations, including State Based Organisations and area Mental Health Services.

Some programs were based on models of wellness, or of primary health care, rather than on the traditional categories of mental or physical illness. However, to attract new or continued funding these programs must be described in ways which can fit onto a template. This is necessary but it is sometimes hard to translate a complex system to a formal program description with a language that meets the needs of administrators, Divisions, and the community.

To Begin: Divisions Speak for Themselves

Firstly, what is it actually like to be developing and running a mental health programs in a remote Division of General Practice? In many case we have allowed respondents to speak for themselves. What emerges is a picture of enthusiastic individuals working in sometimes difficult conditions with great spirit. They have found ways of working around their difficulties, and have much to give so that others coming into the field can learn from their experience:

> "One of the things is to not spend a lot of time trying to force the state health services to provide the allied health services that are needed, but to look at getting funding for them yourselves. I think the other thing is certainly to work closely with the community, to work through the health service needs in that community, and to show that general practice has a broader interest than just the GPs sitting in their rooms."

> "If they want to do it, they really have to be creative, really have to be a team player, and not be tribalistic. It doesn't matter what they're doing at the upper echelons, politically, or whether the doctors or the CEOs or the directors are talking or there's a relationship, you've just got to get down with the people doing the work and make it happen. You've just got to say '*no boundaries, I don't care if you're private physio or a public physio, you're going to work along side me, and it's not about who you work for, it's about taking it to the community*.'"

> "You've got to have people who want to work on the weekends, that want to do travelling to some possibly forsaken place, to see smelly people, find it fun. I think (the project) certainly has been for us above and beyond, actually to do it without funding, a lot of it is on a volunteer basis, you can't pay people to go. Most of us do it on our weekends because we believe in it. That sounds absolutely pathetic. You can't, if you're going to make anything like this fun you've got to have ulterior motives."

This section now summarizes each of the themes that arose from the interviews. For detailed information about individual Divisional programs, see Appendices 4,5 & 6.

1 Workforce issues

"One of the most striking disparities between the city and country is in the access to, or availability of, health services, and many factors influence this. Great distances and low population densities characterize Australia's interior. There is persistent difficulty in attracting professionals to work outside the capital cities and to retain them when they do venture out. There are often significant cultural differences between the service providers and Indigenous people; between doctors who have migrated from other countries and the farming communities they serve. There are also the financing arrangements, developed to meet the needs of the urban majority, that do not always meet the needs of rural and remote general practitioners, hospitals, nursing and allied health services, public health activities, and, most of all, the people who live there". (Larson, 2002, p.58).

GP s

Background

Medicare data from Healthwiz 1999 (quoted in Larson, 2002, p59) gives data for the head of population per full time equivalent general practitioner across RRMA classifications in Australia:

Capital city (RRMA 1)	985
Other large metropolitan areas (RRMA 2)	1085
Large rural centre (RRMA 3)	1206
Small rural centre (RRMA 4)	1309
Other rural areas (RRMA 5)	1602
Remote areas (RRMA 6)	2026
Other remote areas ((RRMA 7)	2524

The same pattern exists is all States, with the discrepancy between metropolitan and remote areas greatest in the NT, Queensland and Western Australia, sites of ten of our surveyed Divisions.

The Rural Doctors' Association of Australia (2003) looked at viable economic and organisational models of rural and remote general practice, where a viable rural general practice is defined as "*one that meets the particular medical needs of the community by providing appropriate services in a way that takes account of the financial and personal costs to both the practitioner and the community at large".* Viability dimensions were identified as professional, economic, pra ctice organisation and structure, geographical and social factors (of the specific location and the geographic region), and family issues. Practice viability was found to be mostly dependent on professional issues (difficulty of recruiting appropriately s killed doctors, excessive workloads, high intensity and responsibility and the lack of systemic provision of adequate relief), on economic issues (drop of actual income due the discrepancy between the structure of the Medicare Benefits Schedule and changes to general practice and cost structures) and practice organisation and infrastructure issues (including infrastructure and management provision). This report found that one in five rural practices do not meet the requirements for viability.

Interview Results

In the surveyed Divisions, many remote areas, including remote Indigenous communities, are without GPs, or have only a single GP.

"Obviously it can be a bit tricky when you have a GP coming up from down south who has all the intentions of working in remote communities but doesn't realise all the complexities of it, that can be a problem where GPs do leave earlier. However we've reasonably lucky with that , in as much as most of our GPs will stay around for a while, we've had some GPs who, especially when the children are younger or they don't have any children, and partner has work somewhere close or they are a lone GP. They will tend to stay longer. "

Lack of support for GPs in remote Indigenous communities also contributes to high turnover – the Aboriginal Mental Health Worker program is attempting to address this issue by providing cultural education and support for clinic staff

One of the reasons that GPs do leave, according to several interviews, is the need for secondary schooling for their children.

> "The majority of our remote[communities] do not have high schools, so any children that want to do secondary education, will have to go into boarding schools, some GPs are not all that keen about that, anyway, so there's a financial factor as to whether or not they stay once the children get to high school age. "

One division described remote GPs as being "time poor", and the pressures of working as a solo GP were mentioned in several interviews – very long working days, the lack of any allied health workers to share care with, the paradox of needing peer support but having to choose between a videoconference the end of a twelve hour day and spending time with the family. These are all factors contributing to GP turnover.

Overseas trained doctors have become one way of dealing with present and projected shortages. According to the Australian Rural and Remote Workforce Agencies Group minimum data set (Pope, Jeanette & Deeble, John, 2003) 40% of doctors practising in RRMA 4-7 locations in Queensland have obtained their basic medical qualifications overseas. Figures have not been collected systematically for the other states.

Three of the Divisions mentioned having high rates of overseas trained doctors, who may be comparatively transient, are usually working in the remotest areas with little support and have a great deal to learn in a short time about all aspects of the Australian health system. Taking on additional training in mental health may be very low on the list of their survival priorities. One Division worker expressed her admiration at the work these doctors are doing, under very hard conditions.

Cultural attitudes towards mental illness may also be different, with mental illness being more stigmatized, and more feared, or just differently understood. (see Seah et al 2001).

Psychiatrists.

Background

The Australian Workforce Advisory Committee on the specialist psychiatry workforce in Australia (AMWAC) emphasized in its 1999 report that *"access to psychiatrists is inadequate and that three issues have impacted on this situation, namely, an inadequate supply of psychiatrists, maldistribution of the workforce and the work practices of some psychiatrists"* (AMWAC, 1999, p 7). At the time of the report AIHW data indicated that there were 10.6 psychiatrists per 100,000 population in Australia. Above average ratios were found in Victoria (13.4) and South Australia (12.1) while ACT (7.4), Western Australia (7.2), Queensland (8.8) and the Northern Territory (5.3) were below average.

The AMWAC committee, in a survey of Divisions of General Practice found that " 41.9% of Divisions of General Practice considered access to psychiatry 'specialist treatment' services to be totally inadequate, a further 47.7% considered treatment services to be in short supply, and 5.8% indicated that supply was about right. A greater proportion of rural Divisions considered access to specialist psychiatric treatment services to be totally inadequate than did metropolitan Divisions, while no differences were observed based on State/Territory in which the Division was located" (AMWAC, 1999, P58).

The AMWAC report quoted AIHW data which indicated that while there were just under 2,000 psychiatrists practicing in Australia most of these practice in capital cities, with 86.1% of the workforce located in a capital city, 5.4% in a major urban area, 4.9% in a large rural centre and 3.5% in an 'other' rural or remote location. However rural outreach services have been expanding with 14% of metropolitan based psychiatrists providing regular visiting services and/or telepsychiatry services. (Ibid, P52)

Interview Results

Several Divisions indicated that many positions in Mental Health Services and hospitals were unfilled or intermittently filled, and that psychiatrists come in on a fly-in fly-out basis, but that there is a high turnover. Several Divisions said that psychiatrists would need to be constantly traveling to meet all the regional needs. It was suggested that this may be more suited to a psychiatrist at the beginning of his/her career, and may not be sustainable in the long term, with more desirable employment choices available for psychiatrists elsewhere. One Division did specify how it has lost psychiatrists in a large regional centre – one has retired and moved out of the area, one has ceased to practice as a result of some legal matters, one has moved over into specialised Workcover work, two young women alternate while raising children, and the Hospital has decided not to fill another position.

Divisions complained about the twin issues of no psychiatry services or constantly changing psychiatrists. Also, a culture of distrust between psychiatrists and individual GPs seems to have been established in some areas.

> "They've got a psychiatrist from xxx, who changes about every three months, of limited capabilities. They have a lot of enmity to GPs, they don't respect GPs, they don't respect their patients, and then they change."

A difference between the cultures of primary mental health care and psychiatry, according to one Division, is the way that GPs see their patients. He described GPs as essentially generalists, "lumpers" rather than "splitters", with less desire or need to classify patients in detail, and concerned more with their general problems than with their diagnoses. He talked about the SPHERE statistics about missed diagnoses of mental health issues in GP patients as being related to this, rather than to their inability to diagnose – as more an irrelevancy that a cause for concern, with the primary GP role being to treat the basics and coordinate care.

Others Divisions have developed share care arrangements or projects with Mental Health Services, and one Division commented that this had led to a change of culture – the GPs still complain about the visiting psychiatrists, but not about the Mental Health Service, which now has strong links with the Division, and a culture where shared care is valued.

Four of the Divisions run mental health case conferencing groups with GPs and a visiting psychiatrist, usually over a meal, and in another Division it has lapsed. This provides peer support for isolated GPs and also advice from the psychiatrist, as well as opportunities to network, but is not usually available to solo GPs in very small centres.

Despite the lack of local services, only one of the Divisions is running a telepsychiatry trial, one is talking to the State Health department about possible implementation and two are waiting for broadband technology to be introduced. Another had tried videoconferencing psychiatry consultations previously, but was frustrated by technological limitations and the inhibiting presence of technicians.

Allied Health Workers.

Larson (2002, p.69) points out that a multiplicity of definitions and regulatory bodies makes it hard to describe the rural and remote allied health workforce – even what disciplines it consists of, although they are mostly people with professional training.

Interview Results

Allied Health Workers in mental health are mainly employed under both the Better Outcomes in Mental Health Care Initiative (BOiMHC) and the More Allied Health Services (MAHS) program. The Divisions employ or contract out psychologists, mental health nurses, social workers, drug & alcohol workers, and Indigenous health workers, with the range of allowable allied health workers being broader under MAHS. Four Divisions employ allied mental health workers through MAHS,

mostly psychologists, but also social workers and triage nurses in one Division, and several Divisions have formerly done so, but are looking to replacements using BOiMHC money. Three are employing under BOiMHC, with four others applying in the next funding round – one of these mentioned the competitive nature of the funding applications. Another Division which employs allied health workers did not say how they were funded.

One Division is making the recruitment and employment of allied health workers of all kinds a priority, and moving towards a model of primary health care (including primary mental health care) which uses teams of allied health workers as well as GPs, who have come from a situation of having no allied health workers to share care with. While this is intended to improve care in a very large and remote Division, it appears to have the potential to improve GP retention as well.

In regard to Indigenous workers, one Division is incorporating traditional Indigenous healers in its expanded allied health provision, which would not be possible under BOiMHC. Indigenous mental health workers and drug and alcohol workers are being selected by their communities and then trained in a Division, rather than the Division doing the selection. It was pointed out by one of the DLOs that in indigenous communities, the traditional healer can be the first port of call, with healers who work very closely with the rest of the health system, but who receive no remuneration and little recognition for this work.

As well as BOiMHC, and MAHS, a couple of Divisions also fund allied health workers from other sources. One Division has funding under MAHS for psychologists and Aboriginal health workers, as well as money from the Home and Community Care (HACC) program and from a regional organization. Another Division that is a large user of allied health workers has outsourced its psychology services under BOiMHC, and employs Aboriginal Mental Health Workers under MAHS and other funding. It plans to extend its program to include Indigenous Drug and Alcohol workers using funding from the Alcohol Education and Rehabilitation Foundation (AERF).

Most of the allied health workers operate out of GP practices, where these exist, and several Divisions spoke of the benefits to both GPs and patients of this arrangement, in terms of integration of services and record keeping, reducing patient waiting lists, and support for all workers. It was also suggested that operating out of GP surgeries was popular with patients, because of the stigma of mental health issues, and the comparative neutrality of going to the GP surgery rather that the Mental Health Service.

In general, the employment of allied health workers by the Division seems to have been well received, even when the funding is only sufficient only a few hours a week or month , and several Divisions said that the demand for services has increased, rather than any competition developing between subsidized services and private practice – the subsidized services in fact increase the demand by making it possible for more people to access allied health workers.

Divisional staff

Interview results

Divisional staffing was not covered in the interviews, but several interviewees mentioned it spontaneously.

Of the 11 remote Divisions interviewed, one staff member has been in the job since September 2003, one since April 2003 (and in the Division since October 2002), one since May 2002, one Division was in the middle of a transfer of responsibility for Mental Health programs to another staff member from January 2004, one has been there for 3 1/2 years, and describes herself as "the grandmother." One Division is without a mental health staff member, due to financial cuts, but the work is being carried on by a GP. Of the three Divisions that were not interviewed, one was waiting for a Mental Health program staff member to be appointed, one was new in the position, and one has only one staff member for the entire Division.

Three of the staff apologised for their lack of knowledge about programs that had been developed before they were working in the Division. This certainly reinforces the need for program information to be held somewhere, and probably reflects the temporary and funding cycle based nature of Divisional activities.

Three interviewees talked about previous positions in the same Division, so staff turnover can occur through internal movement, either between jobs (in at least two cases) or as a result of Divisional restructuring (at least one Division has restructured quite radically as part of a move towards regionally based services, and several others appear to have changed their staffing structure according to program funding and priorities).

One staff member (who has been there 3 1/2 years) suggested that *"the program staff, you either stay and work yourself to the bone, or you just stay for a little while and you go nuts."* This is certainly reflected in the turnover, and the workload – the job, particularly in the remote Divisions, may not be sustainable over a long period. She also talked about Divisional staffing being according to funding, so that a staff member may be employed only for the duration of a particular funding or program cycle, and have no job security. Neither is there any kind of career structure for Divisional staff - this also contributes to a culture of impermanence reflected by the occupancy times.

Paradoxically, the development of relationships with individuals in other organisations was mentioned by several Divisional staff as an important part of their work, which could be set back by staff changes. This would also apply when Divisional staff changes occur, so has implications for the ongoing effectiveness of Divisional work, which includes a large component of community capacity building. The GP interviewee talked about the frustration of working with about five Divisional staff over five years, and having to start from scratch in relationship building each time.

2 Geography and population issues

Characteristics of remote areas – Background

> "The main communities in remote areas include Indigenous settlements and industry based communities such as pastoral properties, fishing, farming, mining, and tourism. While these communities represent less that 5 per cent of the national population, they are spread across approximately 78 percent of Australia's land mass". (Wakerman & Lenthall, 2002, p.126).

The proportion of Indigenous people is about 2% of the total Australian population, with 30% of these living in capital cities, but with increasing remoteness the proportion of Aboriginal and Torres Strait Islander population increases, so they make up 13% of the population in remote centres (RRMA 6) and 26% in other remote areas (RRMA 7). (AIHW 1998). From a service delivery point of view, cross cultural knowledge and competence becomes important.

The remote population may be highly mobile (and often also transitory), although public (and sometimes private) transport becomes less available with increasing remoteness, as does access to health and other services, particularly in a government policy environment of rationalising services into larger population centres. (Wakerman & Lenthall, 2002).

At present Commonwealth government departments, including AGDHA, define remoteness in terms of the RRMA (Rural, Remote and Metropolitan Areas) classification, which classifies Statistical Local Areas (SLAs) from 1-7 as metropolitan, rural or remote according to population and their straight line distance from the nearest centre in four categories of urban hierarchy. This does not take into account road distances, road conditions or island communities. Remote areas have a RRMA classification of 6 or 7.

AGDHA is moving to using the Accessibility/Remoteness Index of Australia (ARIA), on a continuous scale from 0 (high accessibility) to 12 (high remoteness), which uses geographical information system technology and a number of variables involving road distances between service centres and populated areas. Remote areas have a score between 5.8 and 9.08, very remote areas score between 9.08 and 12. (AIHW, 2004)

Mental health in remote areas - Background

The Australian Institute of Health and Welfare (AIHW) 1998 report *Health in rural and remote Australia* found that people in rural and remote areas have higher mortality rates, and a lower life expectancy. There are higher rates of injury mortality, homicide, alcohol and smoking, and at the same time less access to health care, including the critical shortage of doctors that has already bee mentioned. The health of Indigenous people is the worst, with life expectancy 16-20 years less than white Australians, and rates of alcoholism, and also of homicide and violence 11 times higher than the national average (Baxendell, N (1997), *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*).

It seems unclear whether the rates of mental health problems and disorders are different between urban, rural and remote Australia. Andrews et al (1999), in a AGDHA report *The Mental Health of Australians,* found negligible differences between metropolitan and non-metropolitan areas, although they cautioned that broad categories can average out variation within an area. Fraser et al (2002) explore the need for further research into mental health of rural Australians, suggesting that existing studies have not adequately investigated the relationship between the diversity of rural lifestyles and mental health, and caution that most rural mental health policy in documents such as *Second National Health Plan, Mental Health Promotion and Prevention National Action Plan* and *Mental Health Promotion Plan* assumes a homogeneity of disadvantage, needs and response, with communities all characterised as '*isolated' and 'impoverished', exposed to stressful environmental hazards and [having] 'a culture of violence'* and that only a single set of strategies is provided to deal with these problems

Meadows (2000) found that the proportion of adults with an unmet need for mental health care increased with remoteness, and that barriers to care were firstly self reliance, then pessimism, ignorance, stigma and finance. An additional complexity is the definition of mental health problems and disorders. Fuller et al's (2000) rural and remote respondents, in a South Australian study, equated mental health problems with severe psychiatric disorders or 'insanity', requiring hospitalisation – mental distress was not defined as a mental health problem, and the stigma of any mental health problems prevented people from accessing Mental Health Services. The culture of self reliance means that people are used to meeting their own needs, and expected to by the community, so help seeking options were limited and people are expected to solve their own problems – often informal helpers are sought out rather than professionals, who may also be outsiders and distrusted. External stressors are provided by factors such as loss of industry and population in rural areas, high unemployment, and drought and economic downturn in farming areas, which can lead to loss of income and farming futures, overwork due to lack of rural workers, or ability to pay them. Fuller et al (2002, p.172) also point out seasonal differences in the prevalence of mental health problems– *depression has been noted to fluctuate according to cyclical or seasonal phenomena, such as harvests or droughts.* (Auon et al, 1997, Roberts et al, 1999).

Fraser et al (2002) document research links between mental illness, particularly depression, and suicide, and also between depression and chronic physical illness such as cardiovascular disease, and between anxiety and substance misuse

Suicide

Background

According to the ABS *2002 Mortality Atlas*, death as a result of intentional self harm was 13.6 per 100,000 people in Australia, with suicide, at 2% of deaths, the highest contributor to external causes of death in Australia for 1997-2000. Male rates of suicide were nearly 4 times that of female suicide during that period. In general, rural and remote Statistical Divisions throughout Australia had higher suicide death rates. The Kimberley in WA and North West Queensland had the highest rates, at 39.8 and 32.9 deaths per 100,000. The Pilbara recorded the lowest rate of 9.7 deaths per 100,000. The suicide rate for Darwin was 18.6 per 100,000– other capital cities had much lower rates.

These figures are measured at the level of Statistical Divisions, so high rates in particular areas may be evened out and not appear – e.g. the Pilbara Division is part of a multi-agency working party addressing high suicide rates among mine workers in part of their region, but at a broad level these statistics do not suggest major problems in the region, (unless there has been a sudden increase since 2000).

Suicide prevention programs – Interview results

Suicide prevention in the Divisions is often tackled in conjunction with State Health Services, or as a combined community service provider response to specific problems - one program is targeting men of 24-45, and particularly the fly in fly out mining workforce, another one is aimed at Youth at risk. Where there is access to psychology or other allied health services, patients can be referred. Several Divisions mentioned the lack of services or waiting lists for services as a problem in meeting these needs. For the mine workers, counselling services are actually being provided by the companies, but in a way that may prevent men from using them because of stigma.

Most of the Divisions do not have their own programs, although they do provide information to the GPs. Some initiatives occur at a local level with input by GPs.

Several groups of people are seen to be at higher risk, and do have targeted programs. Men in remote areas, particularly farmers, were identified by several divisions as high and targeted suicide risks in areas where rural industries are being restructured, or where the returns can fluctuate widely - the sugar and tobacco industries, dairying, uncertain crops. Suicide rates may be may be cyclic and vary according to the season.

The men's Pitstop programs, run by a number of W.A. Divisions, (but only one included in our sample), have a mental health component, and the ability to be referred to a psychologist. These programs have the potential to monitor community mental health and suicide risk, so that specific programs can be put into place if depression or suicide rates rise.

Youth suicide is another identified area of need, which is being addressed mostly through the Mind Matters programs. One other youth suicide program was mentioned, the Youth at risk card, which gives information about youth friendly support services. Cards can be accessed through schools, GPs and the Mental Health Service. Another Division includes suicide contacts on its Youth Mental Health Resource Guide, accessible on-line.

Indigenous suicide in remote communities was mentioned by one Division as a big problem that they were not addressing. The Aboriginal Mental Health Worker Program of another Division deals with suicide in the wider context of community mental health care, and the Mental Health workers can provide community education as well as community support for suicide issues.

Drug and alcohol comorbidity – Interview results

Drug and alcohol comorbidity with mental health is not well dealt with in the remote Divisions, and it was suggested that this may be a cultural issue across the specialist state based services.. One Division said that

> "Comorbidity is very badly dealt with through the Mental Health Service – if someone comes in there with any suggestion of a drug problem they're really turfed out of the Mental Health Service, you'll be aware, which goes around the country, basically because of their lack of understanding of the problem, and I think if they have an out then they have an out. So and also these people are incredibly much harder to deal with. "

This Division has fairly close links with the Drug and Alcohol Service, but the GPs that are involved with this tend to be different ones from those who are concerned with mental health issues.

Some Divisions include education on comorbidity in their Level 1 training, indicating a widening awareness of the issues. Divisions which are providing share care programs with their State Mental Health Service may be dealing with comorbidities within the wider program context. These programs are operating in at least two of the Divisions in the survey.

In addition, alcohol and drug workers are specifically employed as allied health workers in at least two Divisions. One Division is starting a dedicated Aboriginal Drug and Alcohol Health Worker program in some of its remote indigenous communities, as an extension to its existing Aboriginal Mental Health Worker program. Two other Divisions mentioned the issue of alcohol abuse in some Indigenous communities, but do not have specific programs.

Two Divisions have access to quite limited programs on aspects of drug comorbidities: one a program for benzodiazepine withdrawal, the other a prescriber program for drug addiction medication.

Alcohol and smoking are dealt with as part of the physical and mental health issues covered in one Division's Men's health program, and were also raised in connection with other programs targetting remote mine workers.

Mental health /physical health comorbidities – Interview results

Mental health and physical comorbidities are being included in the BOiMHC Level 1 training provided by some Divisions, indicating a widening awareness of the issues.

One Division is running a pilot share care program with their Mental Health Service, which is specifically addressing the issue of the physical health of Mental Health Service patients, by providing them with GP access. Less formally, this may occur wherever allied health workers are working out of GP practices, or shared care programs are operating.

Two Divisions mentioned their wellness programs, which are promoting both mental and physical wellbeing – one for women, one community wide.

The Men's Pitstop program is also looking at both physical and mental health, and its checks include a "shock absorbers" section on emotional health, with immediate counselling or referral to psychology services if necessary.

One Division is explicitly working with physical and mental health comorbidities, generally in its move towards multidisciplinary primary health care and particularly in relation to diabetes and depression, with the diabetes educators working with psychologists to test for depression, as part of facilitating permanent lifestyle changes to manage the chronic disease of diabetes.

Transient populations and mental health – interview results

Two Divisions talked about having comparatively high rates of transient populations, and of the effects of transience on community mental health, particularly in the tropics.

> "The actual population turns over between 25 & 50% every year. Some people come up here just for work or for the experience of living in the tropics, and there's many people who can't cope with the heat. Or they come up and they've left all family and friends support behind them, and they also includes people associated with the military bases up here, which we've got army, navy and air force. But there's lots of spouses and people who come up, who might be working in the mining industry up here or whatever, and they find themselves quite isolated within xxx, and then of course the wet season sets in and it's pretty difficult for those who are not acclimatised to it."

This Division has high rates of presentations for depression and anxiety, both by young people and adults

The other one has a high level of fly-in fly-out mining workforce, and a burgeoning suicide rate, due partly to the working and living conditions.

> "As you can imagine that has its own problems, like they're away from home and its six week on, one week off. The working conditions here are quite harsh, it's hot, it's dry, you're going back to single men's quarters, there's no one there to talk to, and our suicide rate went through the roof, really, and we had other youth as well."

An implication of this transience is that health promotion and community capacity building must be continuous, and easy to access, to reach people who are just moving in and may not have much knowledge of community grapevines or services. The posters and cards that have been developed in this Division are an accessible and non threatening way of making information and contacts available.

Mental Health programs for specific population groups – interview results

Target populations for mental health programs

Because of Divisional and service capacity issues, programs targetting specific population groups within the remote areas may be less possible or less appropriate than in regions with more services and larger populations. One group described the target group of its share care program as: *"All ages, whole of community, elderly, psycho geriatrics, child abuse, neonatal, postnatal, adult mental ill, ATSI, everyone in rural is always together, because there's nobody anywhere else, it's still rural."*

Child & youth mental health programs

Current child and youth programs are mainly associated with schools programs, mostly Mind Matters Plus, although there have been several quite big Divisional youth programs which have finished – e.g. one Division had an extensive ADHD program.

A Kids at Risk suicide prevention card project is being run in one Division in conjunction with other community service providers; this is an offshoot of their adult suicide prevention program. The card is distributed through schools and other youth gathering places.

Another Division has youth as a focus for 2004, and is expecting to develop youth mental health partnerships with other service p roviders.

Schools programs

The Mind Matters Plus program is the most common child and youth health program – this is currently running in schools in two Divisions, another said that it had a schools program but did not specify which, and two other Divisions are currently applying for Mind Matters programs. One other Division had a very successful "Mind Yourself" program from 1998-2000, involving a number of partners, but the funding was not extended.

Several Divisions have GP links with schools, some in relation to the Mind Matters program, others informally. One is running a Mind Matters Plus GP program, trying to develop effective referral pathways for students at risk, and to provide GP services at no cost, using bulk billing and other mechanisms.

Men's health programs

Men's Health programs in at least one State have had funding cuts, so several Divisions (only one of which was interviewed) are partnering Men's Health in running programs for men, the Pitstop programs, which are looking at both physical and mental health issues, including suicide.

High rates of rural male suicide among 25 -45 year olds, particularly fly-in fly-out mine workers, are being addressed in another program, which involves the Division as one of the participants in a working party looking at suicide prevention.

Women's health programs

Women's mental health was not among the hot topics named in the consultation. Specific programs for women were mentioned by two Divisions. One is a wellbeing program that takes a very holistic approach to health, including mental health. This was targeting Indigenous women.

The other involves Indigenous women who have been diagnosed with diabetes, and is addressing physical/mental health comorbidity issues by also looking at depression in these women. This program again is using a rather more holistic approach, so that ongoing lifestyle change can take place to manage a chronic medical condition.

Aged care issues

Mental health of the Ageing was not named as an issue in the consultation, and dementia is specifically excluded under BOiMHC. One Division is negotiating to receive money from HACC for an aged care program, looking at mental health issues of carers and families as well as the people who are directly receiving care. These people may have dementia, but are also likely to have other mental health issues associated with Ageing, such as depression.

Distance and travel issues – interview results

Lack of reliable air services were mentioned as a problem in at least two States, with airlines under threat of closure, and very infrequent services, or no services between smaller centres. One Division said that a GP going to Perth for a three day course might be away from the surgery for ten days because of flight schedules - a great disincentive to doing training. Infrequent flights make it very hard to run or access any training that is spread out over weeks rather than being taught in a block, which severely limits options, particularly for those GPs who do not have any access to direct airline services. Locum services are not necessarily available, so the community suffers as well as the GPs.

When psychiatrists fly in and fly out, their access also depends on flight arrivals and departures - scheduling becomes very hard.

Another Division talked about plane services to remote communities, which have limited seats as well as limited flights. If either is unavailable the choices are to charter a plane, at the cost of thousands of dollars a trip, be stranded for three days in the community or drive, which is very time consuming and may not be possible in the wet season.

> "You're often stuck in a community for 2 or 3 days because the airlines do not have a flight that goes out the day you want it to go out. You have to manage your movements around what flights are available. We actually had to charter a plane off the strip because we were late listed on the plane, the plane was going out but it was full - there's only 12 seats on a plane that comes out of XXX, so if you can't get on a plane because it's full then you're stuck there for 3 days. So there's all those sorts of things that need to be taken into consideration. The biggest part of the budget of indigenous programs is the travel, it costs an enormous amount of money just to whiz around the communities, travel small distances, some communities don't have any flight set to go down on a regular basis, such as XXX you're going to need to charter a plane – that costs thousands of dollars to charter a plane down there and back. Other than that it's a ten hour drive, 10 hours there and 10 hours back. And that's if the roads aren't closed. You're looking at, depending on where the river is and how and where it is located. If it's a tidal river it's going in and out with the tides, what the tides are you may have a two or three hour wait for the tide to really go down and then you can cross – you've got a window of so many hours before you can get back across the river, wherever you are. The other side of it is that if you're on a flood plain in the wet season then the roads will be closed for most of the time."

A large travel budget seems vital for all remote Divisions, although one person said she did not go to all the mental health network meetings because of the cost. The cost of meaningful consultation was also raised by one Division - again involving large amounts of travel.

Access to telecommunications technology – interview results

Technological limitations to videoconferencing or teleconferencing were implied in passing by several Divisions. Two Divisions are waiting for broadband trials to be completed before trying telepsychiatry.

PriMeD on-line training modules were mentioned by three Divisions as a possible educational solution for large decentralized regions, but it was not clear how much of the technology to access them is available to the remotest GPs.

Classification of Divisions and effects on funding – interview results

This issue came up in relation to only one of the Divisions we interviewed, but apparently is more widespread in Qld. The Division, which consists of a regional city and its surrounds, shares boundaries with its local city council, and has an international airport, so under RRMA it is classified as less remote than its geographical position would suggest. This means that it is actually disadvantaged in terms of funding, and this has severely compromised the Division's ability to afford staff and run programs. This leads to reduced Divisional capacity to apply for future funding as well.

3 Indigenous issues

Indigenous mental health – Background

> "Dispossession, destruction of traditional lifestyles, rapid cultural change, disruption of families and communities, discrimination, cultural exclusion, poverty, lack of educational opportunity, and poor health are the legacies of colonisation (Dodson 1990). These legacies, in turn, place Indigenous Australians at high risk of developing health and mental health problems, in particular depression, anxiety, self-harm, and excessive alcohol and other psychoactive substance use (McKendrick (1993), Swan & Raphael (1995)." (McKendrick, 2001)

These researchers, show that Aboriginal populations have higher rates of psychiatric morbidity than the general population, with very high rates of depression and post traumatic disorders making up the excess morbidity. Rates of schizophrenia and bipolar disorder appear to be similar to those in the general population.

According to McKendrick (2001), the nature and patterns of mental health problems of Indigenous people anywhere in the world has been little studied, nor their needs for services, and most of the research has been conducted using Western diagnostic categories, and Western meanings which may not be appropriate. McKendrick (1993), McKendrick & Thorpe (1994) and Swan & Raphael (1995) have questioned the accessibility and cultural appropriateness of mainstream Australian mental health services for Indigenous people – they suggest that programs which look at depression, post traumatic disorders and substance abuse in their social and cultural context are more effective. New frameworks for mental health are being developed in Swan & Raphael (1995) *Ways forward: National consultancy Report on Aboriginal and Torres Strait Islander Mental Health Care,* and the current *Consultation Paper for Development of the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing* (Social Health Reference Group, Office for Aboriginal & Torres Strait Islander Health of AGDHA, 2003), and are being implemented in Aboriginal contexts, such as the Aboriginal Health Council of South Australia (1995), Reclaiming our stories, Reclaiming our lives project for the families of South Australian Aborigines who had died in custody. These frameworks are looking at mental health not as an individual problem, but in the context of social, family and community wellbeing, of connection to land and culture, of wellbeing that links physical, emotional, spiritual, cultural and social factors.

Indigenous programs – interview results

Most of the remote Divisions have high Indigenous populations, some living in towns, some are in remote Indigenous communities. Indigenous mental health care services are provided in various ways, depending partly where people are living, and are not necessarily run by Divisions.

Several Divisions said that Indigenous people are included in all their programs, because of their high Indigenous populations, but are not specifically targeted. There may however be specific referral pathways from programs such as Pitstop to allied health services, through Indigenous Medical Services.

One Division stated that many Indigenous people in towns also use the mainstream GP services, and access MAHS workers through mainstream pathways– they cautioned that it was too simplistic to lump all Indigenous people together, and to have only one pathway into services for them.

Several Divisions have MoUs with their local Indigenous Health Services, and of course there are GPs within most Divisions who have specific Indigenous focus and expertise through working in these services. These GPs may also provide training for others through mental health small group learning programs. Several Divisions also mentioned working with the Royal Flying Doctor Service (RFDS), particularly if someone needs to be flown out of a remote community.

Several Divisions also have partnerships with groups based in remote Indigenous communities. One Division is planning to extend its pilot town-based GP access program to other towns in the region, and then eventually into the remote Indigenous communities. This will involve close partnerships with local Aboriginal Health Services.

The Divisions may not provide services into very remote communities– two specifically mentioned that they did not, but that mental health services were provided by the Indigenous Health Services. One of these Divisions is certainly very aware of the mental health, substance abuse and physical health problems in its remote Indigenous communities. It was unclear from the interview how much it is currently involved in multi agency service planning or service provision.

Two Divisions have specific programs that go into remote communities. One of these consists of multidisciplinary teams of workers going out to communities. They employ an Aboriginal Health Worker who mostly does liaison work with the communities, and mentioned how much more effective this has made their entry into communities– they also mentioned this as a finding that is supported by the literature. This Division is moving towards providing multidisciplinary primary health teams. Because most of the indigenous population lives in communities that do not have GP practices, they are trying to work with other service providers, in hospitals etc.

The other program is a major project which provides local Aboriginal Mental Health Workers in remote communities, as a resource for both the community and the GPs in community clinics. This project is now being extended to include Aboriginal Alcohol and Drug workers.

> "The aim of the program is to improve the health care of indigenous people in remote communities, and do that in the most cost effective manner, culturally sensitive manner, as well as providing GPs with the cultural link to knowledge and understanding, and the language of those indigenous people. And the other side of that is to evaluate the government's initiative in retaining GPs in the bush, so they feel supported in their role and can do their work far easier. So at the moment the program supports about 17 staff across eight communities and the main objective is to build capacity, thereby educating both the GP and the Aboriginal health worker in both western and indigenous ways, and to provide local solutions to local problems, seeing that each community is a different cultural place."

The Mental Health Workers can clarify mental health issues and cultural matters for the clinic staff, as well as acting as community educators and working closely with Mental Health Services. Inappropriate mental health referrals have dropped enormously, and care of people in the community has improved. Because of rigorous initial and ongoing consultation with Indigenous people and the individual communities, the programs are reported to have been very well accepted in the communities.

Indigenous issues – Interview results

Ongoing consultation, liaison and communication with communities

Two Divisions are specifically working with remote Indigenous communities, and both talk about the necessity for ongoing consultation and liaison with the communities, and for cultural sensitivity. Aboriginal Mental Health Workers are employed in the Division to do this.

> "I find nearly the best thing I can say out of that is you must consult with Indigenous people and you must listen to what they say and go with what they want. There's an awful lot of extremely intelligent Indigenous people out there who know exactly what it is that they need for their community. And every one of our Indigenous Aboriginal health workers will say 'I do this job because I care about my community and I want my community to tell.' They're just absolutely passionate about making life succeed in their community.

> And obviously you need to have that input from senior Aboriginal people, primarily Aboriginal males, I've seen their ability, from communities and are well known across the communities. The indigenous grapevine is better than any mobile phone that I know, and we can, all we need to do is tell one person one thing, and before we know it is spread across half the Territory. And it's very important in wanting information or wanting advice or looking for direction that you consult with senior Indigenous people so that they understand what it is that you can do, and have, take direction from them."

Cultural awareness and cultural competence

Awareness of cultural processes and cultural issues is vital for Divisions and GPs who are trying to work across cultures – and these may be quite specific to communities.

> "The main issue is the cultural appropriateness of the process, and if you don't do it you can find yourself in trouble, or not so much trouble, but the information that you want is not forthcoming. My Indigenous staff can get far more information out of the Community Council than I will ever get.

> Each step of the program everything that's done needs to be checked culturally. We have senior Indigenous advisors that are attached to the program, that when we're not sure, if either my Indigenous staff are not sure about a particular cultural issue or cultural process, then our Indigenous advisors find that information out before we go in, to ensure that we've met with the appropriate people in the community about a particular issue.

> There's many male/female issues that need to be addressed, there could be some, we need to check to make sure there's no ceremonial things going on, at the time when we come in, if there's a particular ceremonial celebration or event that's happening in a community it could be that there's no female white people are allowed in the community on the streets at that time. It could last for 2 or 3 days. There, it could be an issue that arises with one of our Indigenous staff that we've not sure about, that we need to go to the community elders to discuss, there could be a death in the community that, which means that we can or cannot go into the community at that particular time. It could be that our Indigenous staff may be involved with ceremony to the extent where they are taken away from the clinic for a period, we need to inquire and make sure that is explained to the GP, so why our staff are not available at that particular time. So there's various little bits and pieces that we need to check on to make sure that we are being extremely culturally sensitive in each respect, in each thing that we do.

> Myself being non-Indigenous I need to be very careful about who I speak to, what language they use, making sure that I discuss a particular issue with an appropriate person, it might need to be one of the elders, it might need to be one of the Council members, the Council president, a health worker, before I go and talk to somebody else, before I go and talk to the GP.

> So it's just a matter of being particularly culturally sensitive. Seeing that we have eight different communities, they all have different ways of doing things, and our Indigenous

advisors, if they have no cultural links, family or cultural or understanding link to that community they can therefore find out from somebody that has, and provide us with that information.

Just another example of that is one of my coordinators has no family ties with a particular community, then it would be necessary to look around to find someone who could introduce him to the elders of that community. Once he's been introduced to those members of the community by a recognised elder or family connection, then he is able to go into that community, and therefore get the information that we require."

She also talks about the impact on the health services of another issue

"Something might happen in the clinic and someone, curses the clinic. That happens many times, where either the Indigenous staff cannot enter the clinic, being on the level of the of the curse, so the Indigenous staff can't enter the clinic or the clinic itself has to be actually closed. This is normal everyday, it doesn't happen everyday, but a normal occurrence that will happen any number of times just within those boundaries. "

The GP needs to be aware of these cultural issues and respond appropriately. Aboriginal Mental Health Workers are able to distinguish between personal behaviour which has a cultural component (eg mourning behaviour, prohibitions on speaking at certain times or to certain people) and mental illness, and to prevent inappropriate removals by the Mental Health Services– which are very expensive and probably counter productive.

4 Divisional program implementation issues

Priority of mental health in Divisions – Interview results

Mental health, and primary mental health care obviously are given very different priorities across Divisions, and the priorities change over time. This may be attributable to Divisional capacity, where funding is generally impermanent, and to the cyclic nature of different funding programs.

One Division talked about Mental Health as something that the GPs thought had already been "done", making it harder to engage them in training activities or in some programs. Another, who has been involved in cross-Divisional training with them, confirmed this. This interviewee said that his Division had not included mental health in their strategic planning. He sees that mental health care is less spectacular and easy to quantify than other aspects of a Division's work such as immunisation, so tends to be given a lower priority by hard worked GPs. He said that mental health issues are also ongoing and require ongoing commitment, which not all GPs are willing to make, and not all Divisions are financially able to make.

Another Division, which experiences problems in its relationship with its Mental Health Service, believes that many of its GPs resent having to provide mental health care rather than being able to refer their patients to a good service. Uptake of BOiMHC training and registration has not been very great in this Division, which the worker attributes to this resentment, and to GP fear of being left with the responsibility once the funding for allied health workers runs out.

Another Division talked about not having a budget line for mental health, despite having a mental health program coordinator, but it is unclear whether it has previously had one. This Division works closely with the State Health Services, which actually provide mental health services, and with Aboriginal Health Services, so mental health is covered, but not by the Division.

Staffing structures of mental health programs – Interview results.

Divisional structures vary considerably, as does Divisional capacity and ability to specialize – one remote Division has only one staff member, others have six or less.

Of the Divisions interviewed, only four had dedicated Mental Health Program Officers (one of these a GP), four have Programs Officers or Programs Managers with responsibility for mental health as well as a variety of other programs, and three have Executive Officers or Executive Assistants with an interest in mental health. One programs manager said she was responsible for eight programs, so does not have much time for mental health as she would like.

Divisional structures also change over time, with two interviewees saying that dedicated mental health officers no longer exist in the Division – does this reflect changing priorities or changes to funding?

The MAHS program, in at least one case, is administered by a different person from the one that was interviewed, so there was less knowledge about whether mental health related Allied health workers such as psychologists would be reemployed if their contracts had expired.

State Based Organisations – interview results

Three Division staff mentioned getting support and information from their respective State Divisions – one acts as a mental health advisor for the State Division as well. This person said that "*we try to keep up our links there because it is only by discussing things with them that we know what is going on".*

The SBO was mentioned by another Division as providing training when they need it.

Another Division talked about the benefits of the state network of mental health officers, and of the role of the Development and Liaison Officer of the Primary Metal Health Care Initiative (DLO):

"We've got a fantastic network of mental health officers in xx" and of the DLO *"she really keeps us together and keeps us turning over."* This is particularly necessary given the time limited nature of mental health programs – so the role of the DLO of keeping all the Divisions in the loop is particularly important.

This Division mentioned the frustration when funding for resources, or external resource development does not occur until after the program has finished, by which time the mental health officers have perforce developed their own.

Working with Mental Health Services and other State based services
Background

Services for Mental Health in remote areas are provided by a mixture of Australian Government and State government funding and organisations – there may be very few private providers of allied health services, and Wakerman & Lenthall (2002) point out that remote services tend to be supply driven, rather than demand driven – access is limited by the availability of staff and services, not by population needs. The Australian government provides funding for some aspects of primary care, e.g. GPs through Medicare rebates, some Indigenous health services and AGDHA programs such as Better Outcomes in Mental Health Care. It also funds the Divisions movement. Mental Health Services, Drug and Alcohol Services, some Aboriginal Health Services, Community Health Services, hospitals, are State responsibilities, with different histories, work cultures, service and employment criteria and health regions. Psychiatrists, allied health workers and of course GPs may work in either the public or private sectors, or in both. This creates a complex cultural and working environment, particularly in small centres where there are not many services or individual practitioners for consumers to choose from. Likewise, the government policy environment is complicated, with some overlap, some gaps between Commonwealth and States in policy and funding.

Cooperation is logical, but there may be entrenched distrust and cultural differences between different sectors, or individuals within them – which may or may not be resolved by shared care or communications programs or joint working parties.

Interview results

Relations between Divisional GPs and the local Mental Health Services seem to vary, with some having close working relationships, but in at least one case there are long standing problems, and GPs feel resentful at being unable to refer. Divisions have made formal links with Mental Health Services, which are expressed as MoUs, and also links at an informal level. In at least two Divisions shared care programs are being run with the Mental Health services, with the aim of increasing the efficiency of both services and reducing waiting lists. One of these involves co-employment of project officers, who are then in a position to bring about lasting change to organisational culture – change that will last beyond their employment.

> "But if you can make the policy, procedural, cultural, systems changes before they leave, then it's not vulnerable, and that's what we started implementing, it's actually part of the policy of both to continue to provide shared care, it's the only way that Mental Health Services can touch with the GPs. It's like a codependency, they can't do without each other. "

MoUs exist in several of the Divisions not only with Mental Health Services, but also with Aboriginal Health Services and other organisations. Some Divisions do not have these and one talked of historical distrust between the Division and State based service providers at a management level, although there is informal cooperation between workers.

Several Divisions are involved in working parties with other local services, to provide a whole of community approach to problems, particularly in suicide prevention – they mentioned that this has also improved knowledge of other services, and has enabled better working protocols to be developed, e.g. between the police and the hospital Emergency Department staff over suicide attempts.

Networks and linkages – interview results

Networks and service linkages occur at various levels. The most formal are the MoUs at organizational level between a number of Divisions and their Mental Health Services. In at least two cases these formal relationships have also been used to apply for joint funding for projects in shared care. One of these has also involved co-employing project officers to work across both services and bring about organizational and policy changes to embed shared care into the culture of the Mental Health Service.

Less formal are the relationships that develop between individual workers at an operational level, so that they can cooperate on patient care even when official organizational relationships are quite bad, as they are in one Division. Several Divisions mentioned that in small communities it is easier to develop these relationships, because individuals are constantly going to the same meetings.

In some Divisions, also, Divisional representatives (staff or GPs) sit on boards or advisory groups for other organizations. One Division mentioned its connections with employment groups for people with mental illness, consumer and carer organizations, Youthline, with an organization that provides home care support for people who have been discharged from institutions, with a hospital advisory group on mental health issues. In this situation the Divisional representative may have an advocacy and educational function about the services provided by GPs, as well as being an expert provider of services. GP involvement in schools is another example of this type of linkage, and nearly half of the Divisions report this kind of project.

One Division mentioned a specific difficulty in trying to develop mental health care plans with the Mental Health Teams - the teams usually work with individual GPs, and found it hard to become involved in organizationally based group activities - the organizations were willing, but the individuals found it hard to change their culture and way of working.

Several Divisions talked about working parties, where Divisional representatives and other service providers come together to work jointly on specific problems or projects - suicide prevention and youth projects in particular. One Division mentioned the benefits for all the participants of finding out what the other services could provide, as well as being able to heal old disputes and develop

procedures so they could work together effectively - her example was a protocol developed between the police and the hospital emergency department in relation to attempted suicides.

Shared care – interview results

Shared care also occurs at several levels. Two Divisions are running major share care programs with GPs and Mental Health Services, which also involve some fund sharing between services. One of them is co-employing project officers across both organisations, ensuring long term changes to integrate GPs with the mental health services. The other is working with the Mental Health Service to link some of their long term patients into the GP practices, so that their physical health needs are also met, and both services are better able to meet patient needs.

One Division had a shared care committee with the local hospital, which has now evolved into an advisory group to mental health services. Despite extensive formal and informal shared care in this Division, there is apparently only one GP who is doing comprehensive share care plans (which are more extensive than the ones required by BOiMHC).

Shared care occurs between GPs and allied health workers in a number of Divisions, through direct employment by Divisions under MAHS or BOiMHC, by collocating allied health workers in GP practices, or through financial arrangements that facilitate access to private practices. One Division started off with no allied health workers to share care with, and has therefore made the provision of allied health services a central part of its work. Others have employed allied health workers as funding permits, and in at least one case a psychologist who was employed by the Division then went on to be employed by another local organisation, so is still available in the Division.

Peer support – interview results

Peer support needs and provision vary widely within Divisions, with GPs in regional centres better catered for than the solo, really remote GPs.

Mental health peer support programs are of several kinds – discussion groups, small group learning for CPD/CME points, case conferencing with additional input from a psychiatrist, or supervision groups. They may be facilitated by the Division or by a GP facilitator, and are run in face to face mode with the GPs coming in to a central point, or using teleconference or videoconference technology for scattered participants. All these models, or a combination, are used in the remote Divisions, or in different parts of the same Division. Small group learning is also one of the ways that BOiMHC Level 1 & 2 training is provided.

Nine of the Divisions mentioned that there are, or have been peer support activities running, although several of these have no more funding, or will run out of funding in June 2004. One of these groups has decided to continue in the absence of funding. It is located in a major rural centre, where communications and physical access are probably not major problems for the participants – the form of organisation was not stated in the interview, but presumably no longer involves the Division.

Face to face communication seems to be most sustainable, despite the stated logistical problems of finding times when GPs can attend at a central location, and of fitting small group training around other Divisional activities and airline s chedules. Several Divisions are running small groups for about ten GPs, in cycles of about 5 meetings, using the format for small group learning recommended by the RACGP. Topics have included Indigenous mental health, suicide prevention, specific disorders, or aspects of CBT. Three of the Divisions talked about the tricky logistics of providing facilitation training for the GP leaders of these groups, and about the keenness of the GPs involved, one of them talked of the importance of GP facilitators for motivating other participants.

One of these groups also involves a fly-in psychiatrist, and has a series of meetings over the day, starting with a breakfast meeting. The GPs nominate a difficult case who will be seen by the psychiatrist that day, and more advice and peer discussion occur in the evening.

One Division has regionalised its peer group activities, with small group planning for GPs in two centres, and mental health case conferences in three centres. For large Divisions which subdivide logically into regions, this may be easier than trying to gather all the interested GPs into one place.

Another Division summed up the problems of providing peer support for remote GPs as:

> "Overall, it's the rural and remote GPs that we find it hardest to look after. And they come in, or they don't participate, because teleconferencing, videoconferencing aren't reliable, so even if they could get it they are single GPs.

> Int: So they're likely to have five patients come in the middle?

> Or if they've had a normal twelve hour day, the last thing they want to do is plonk themselves in front of a videoconference when really they need peer support but they'd rather be with their families. So it's very much of a challenge."

Teleconferencing or videoconferencing seem hard to sustain, with another Division talking about setting up a teleconference that began with ten people and got down to three, explaining it as *"it's a real time issue, because they're so time poor – getting them to give up time, you have to support them."*

Education and training – interview results

One Division said that BOiMHC is useful because it provides a backbone to organise training This Division has been doing SPHERE training, including CBT training, and running small group learning. They have also been providing some SPHERE training to adjacent Divisions.

Five of the Divisions interviewed specifically mentioned they are running BOiMHC Level 1 & 2 training - one still has considerable waiting lists for the Level 1 training.

Training is provided in various ways. SPHERE, Signals 1 & 2 and PriMeD were all mentioned as courses or providers, with PriMeD courses having the possibility of on-line delivery for remote GPs. One Division said that some of its training needs were met by the State Division.

Funding is usually provided to the Division through BOiMHC, although one Division has also used chronic diseases funding. Another Division talked about running training workshops paid for by pharmaceutical companies, but provided by their local psychiatrist.

Extensive training is also being provided as part of the shared care programs, and the Aboriginal Mental Health Worker project has an arrangement with Batchelor Institute of Indigenous Education to provide comprehensive .education for mental health workers and drug and alcohol workers.

Education & training/resource development – interview results

Very few remote Divisions are developing education and training resources. Much of the training seems to be through existing programs by external training organisations, so it is not necessary for Divisions to produce their own training resources, nor perhaps do they have the capacity to do so.

Several Divisions have developed resources for community or GP purposes. One has a folder of information on Community Treatment Orders and detentions procedures, another has developed a Get Fit Kit, and two have mental health resources kits which are displayed on their websites. One talked about resource provision in the context of training for their prototype shared care program, and it was unclear whether the resources provided had also been developed through the Division

Funding – interview results

Two of the Divisions have developed funding partnerships with their Mental Health Service, and have then gone on to develop joint programs, using their joint funding.

A general concern was expressed about sustainability of programs once funding comes to an end. Several Divisions have had programs that were running well, but were not refunded at the end of one cycle, even though the needs were still there. These programs then ceased to run.

The Divisional priority, in an environment of cyclical funding and impermanence, must always be to build programs and relationships that will last beyond the life of the funding. Community capacity building becomes a popular program model in these circumstances, as does GP capacity building through education. However communities are still susceptible to changes in population and conditions, GPs may leave the area and collective knowledge is lost with changes to organisations and staff, so it is not a complete answer. Programs with a limited funding life may create expectations of increased services, e.g. by allied health workers, which then have to be met by the GPs once the funding cycle has ended. One Division attributed the low level of uptake of BOiMHC training and registration in that Division to a fear that training would eventually lead to GPs being left with no support, but with even more work and responsibilities.

At least one Division has no budget line for mental health, despite covering an enormous physical area, and needing to do extensive travel and consultation. Another Division talked about running programs without specific funding.

One Division has had its funding cut, so there is no longer a mental health program officer to provide support for programs that were already running well, and no capacity to seek further funding for specific programs.

Several Divisions talked of wanting to find funding elsewhere to continue programs after the initial funding cycle –a time consuming practice, especially for a small Division, with no guarantee that funding applications will be successful. Funding is available from a number of sources however, although the sources change. Several programs have run in conjunction with University departments, for instance.

Some Divisions have moved from MAHS to BOiMHC funding for allied health workers, with at least one Division expressing uncertainty about whether MAHS funding would continue..

One Division has quite diverse funding for its allied health program, and is being invited by external organizations to apply for funding to run regional programs, e.g. for HACC. They said they were well placed because of being a local organization and therefore prepared to run services into small centres, and of having only a small bureaucracy. They are working to attract other funding sources like this.

Sustainability – interview results

Mental health is not something that can be "done" and then it is over. One Division pointed out that about 1/3 of any practice is mental health work, another that about 60% of patients coming through a general practice have mental health issues that are not definable (in addition to the ones that are). Primary mental health care is really a perpetual part of a GP's work, so program sustainability becomes a major issue, even if mental health is not always a designated and funded priority for the Division.

Sustainability occurs in various ways: in sustainability of effort, or resources, or capacity building, in setting up relationships and partnerships that will continue, in making cultural changes that ensure long term survival, in providing support to workers.

Most peer support and case conference programs are largely run by participants, the GPs or the psychiatrist. Divisions provide some administrative support, pay for a meal, or perhaps provide training for the GPs who are run the programs. The GP facilitator notifies others when the psychiatrist will be in town and the meeting is on, and the GPs bring their cases for discussion. Some of these programs have been running for up to twenty years, although they may have changed form during that time - from a journal club to a case conference group in one case. Division staff mentioned that the program sustainability came from having one keen GP to organize and also to keep others motivated and enthusiastic. Other indicators for survival were that the program could be taken over by another GP if necessary. Threats to these groups have come from the organizer becoming sick and not being able to continue, and the program then losing momentum.

Sustainability, in GP access or share care programs may involve financial input by the Division, so that GPs can bulk bill and be reimbursed, or patients on low incomes can have subsidized access

to services. This kind of sustainability requires that funding is available, but also aims to increase organisational capacity by encouraging more efficient use of services, so that patients are not using Mental Health Services for all their physical health needs or for repeat prescriptions. An element of capacity building may also be providing training to individual GPs or divisional staff, who then become resources for others - this is recognised in the small group learning programs.

Partnerships across organizations are an important aspect of building sustainable services-relationship and trust building between individuals, and between organizations, enable joint programs to be run, the resources of other organizations to be known and used, a culture of interdependence to be developed.

Sustainability may mean starting small, with a well designed and rigorous pilot program, and then moving out, into other schools, or communities, or towns, using the experience (and credibility) gained from the pilot, and developing a series of working partnerships. Several Divisions are using this strategy, one in relation to setting up shared care right through the region, the other to providing multidisciplinary regional services.

Good communication with other community service providers is an element of sustainability, and enables joint projects to be developed, or working parties to form and continue. One Divisional officer said she spent most of her time in meetings, another talked about having a program launch to which all the local health workers were invited, thus providing support for the program as well as ownership by all potential partners when the program expands. Continuing consultation may be part of this, particularly when working with Indigenous communities.

Another aspect of sustainability for the Divisions, is keeping their doctors and other health workers by providing support for GPs, particularly those in the most remote parts of Divisions– whether it is peer support, education or access to psychiatry and allied health services. The Aboriginal Mental Health Worker program is aware of potential stresses on their workers (who are on call in the communities at all times), and has built in regular group meetings and a mechanism for time away from home communities - this program has a very high retention rate of workers.

The motivation and passion of the Division workers is another important element. Talking about her men's health program, the coordinator said that probably all the participants were motivated by having "blokey blokes" in their lives - giving value to the client group, and a personal motivation to go out to work voluntarily at the weekends. Particularly in the remote Divisions, the commitment of the staff is enormously important to program success and ultimately to program sustainability.

GP involvement in Divisional programs – interview results

For remote Divisional staff, relations with GPs may be easier to develop than in urban centres simply because the numbers are smaller. Several Division staff talked about knowing all the GPs, knowing their families, knowing the practice nurse, knowing what their concerns are, and having a very high rate of membership. One said that he engaged GPs simply by walking in the door of the practice and talking to them.

The way to engage GPs in Divisional mental health activities is just to ask them what they want and then try to give it to them, according to another Division. In mental health this will usually be access to psychiatrists or psychologists to refer their patients to. Continuing consultation is recommended by several Divisions, and the result is a high level of GP involvement, if they can see that the Divisional work is directly benefiting them and their patients.

Several Divisions talked about specific GPs who are very enthusiastic about mental health or specific projects, and have become Divisional resources, running groups and keeping others motivated to come, acting as peer educators and working with the Division and other community organisations. The Divisions try to support these GPs by providing them with training, and use them as a way of disseminating information.

Despite the presence of these very involved GPs, they may be a minority – one Division talked about 10 out of a total of 110 who were actively involved in mental health CPD.

One specific involvement comes from allied health workers sharing space in GP clinics– this facilitates a three way involvement of the Division, the GPs and the allied health workers.

> "The allied health staff, that's a common comment they make. They don't necessarily get formal/organised time with the GPs, but running across them in the corridors and seeing them at lunch time is invaluable. So depending on the systems that are in the practice they have access to the patient notes and can write directly into the patient notes, and they have, it's not just working with the GPs, its working with the whole practice, so the practice nurse and the practice manager and the receptionist and so on. They can set up systems, they can integrate themselves into the systems that operate in the practice as well. It also provides the Division with the opportunity to assist with upgrading systems and so on. We have our information management officer of the organisation works in the practices, setting up information management systems in the practices, we've had quite a history of practice support, training practice staff and putting in place systems for things like enhanced primary care, to try to facilitate those changes in the practice. We try to embed the services into systems that facilitate shared care, a whole of practice approach to these things."

Program evaluation – interview results

Evaluation has been embedded into some programs from the planning stages, particularly programs that have received substantial funding and require evidence of effectiveness. In this case all stages of a program will be evaluated. The process for one of these projects was *"we did baseline data collection at the start of it, we did regular evaluations during the implementation phase and then the data collection process was evaluated as well.* The CESA data base from Queensland Health is being used in their analysis of data.

Another major project is being formally and very comprehensively evaluated by the University, which has done extensive interviews with participants, as well as attempting to analyse data from clinic records - although there could be problems of data consistency with this because of the number of different clinic structures, and therefore computer systems used.. This evaluation has been going on for two years, and will be released later this year.

Another shared care pilot project is collecting baseline and ongoing data, but has not yet evaluated their project.

Efforts have been made in most Divisions to put computer systems in place for consistent record keeping and to allow the recording of baseline data. This effort has not been related to any one program, but should allow better data recording for all. Baseline data collection was mentioned as the first stage of evaluation for several programs.

One Division made the distinction between service delivery evaluation and health outcomes evaluation, with health outcomes evaluation obviously being more long term and broader in its implications, but requiring more data collection.

Smaller projects may still be evaluated - one of the case conferencing programs has been, using pre and post tests over a year, with participants choosing ways of case management before and after the case conferences.

One participant talked about the need for evaluation of her project because it was now applying for funding - so evaluation is one of the indicators of accountability for funding.

The BOiMHC evaluation is proceeding through an external evaluator, but several Divisions asked questions about the form of the evaluation, which not looking at health outcomes at the moment, but at operational aspects only.

Better Outcomes in Mental Health Care

The Better Outcomes in Mental Health Care Initiative is a systematic, multi dimensional Australia wide pilot program to provide access to short term treatments for mental health problems. A

number of structural and access issues were mentioned in the interviews, as well as the evaluation issues in the previous paragraph.

Medicare rebate issues for GPs

The issue of time(and skill) for a mental health consultation and the remuneration provided for it were raised by one Division, as an equity issue, and as a disincentive for GPs to take up the new Medicare numbers for extended consultations.

> "$85 for 45 minutes comes out to $28 for 15 minutes, and you get $28, or you'll get more than that with the new package for seeing someone with a cough or a cold who is a five [minute appointment]."

The new package includes increased remuneration for bulk billing patients, but according to this Division there are still major issues of economic viability for GPs bulk billing patients with mental health issues, because of the time involved. The comment made by the GP respondent was *"how can any aspect of mental health be approached within between six or seven minutes, it's absolutely intolerable, the concept."* .

This issue was raised in another way by another Division, attributing the slow uptake of level 1& 2 training to the fear that funding will cut out, leaving them with the problem of mental health patients they cannot afford to treat.

Another Division mentioned that not all patients complete six sessions, and that GPs find it difficult to keep track of patients in rural areas if they do not get to all sessions – under current structuring they also lose remuneration.

Medicare MH classification, confidentiality and stigma

This was mentioned by only one Division, in the context also of the confidentially of patient records due to Workcover having legal powers to subpoena doctor's records Stigma is a real issue in rural areas, perhaps providing a disincentive for patients to bring their mental health issues to the GP.

Administrative issues

Two Divisions talked about the collection of baseline data about income and socio economic status. One described it as "*an absolute nightmare*" because of its intrusiveness, putting the GP in the position of having to explain to the patient why this information is required. The other talked about the administrative aspects of maintaining the minimum data set, referring to it as "*very labour intensive.*" .

 The same Division also questioned the b asis of the evaluation process, with its concentration on operational aspects rather than the impact of BOiMHC on patients and GPs.

Several divisions mentioned that they did not know how many GPs had registered after doing Level 1 or 2 training. Because the Registration goes to HIC, they have no way to know who is registered, which can have implications also for referrals to allied health workers.

One Division compared the administration of BOiMHC with MAHS, which it considers far easier to administer, and a very successful program. The block contracts were praised as a very efficient way to deliver service, with the ability to be rolled out in a hurry and target areas of need. They also mentioned insurance problems associated with BOiMHC, but did not elaborate. BOiMHC was generally regarded as very labour intensive, and less flexible, perhaps over targeted.

Allowable therapies under Better Outcomes in Mental Health Care

The range of evidence based therapies allowable under BOiMHC, was questioned by one Division, which cited GPs with a strong interest in mental health who were skilled in Family Therapy and hypnotherapy respectively, but were unable to get registration at Level 2 because these therapies

are not considered evidence based under the BOiMHC Initiative. This Division has provided extensive training in CBT, but questioned whether this approach was necessarily the only way to engage patients in a GP setting.

Better Outcomes as pilot program

Most seriously, as an issue, was an expressed distrust by GPs in several Divisions that the pilot program might cut out, and they would be left with further responsibilities and nobody to share the load with. One of these Divisions attributed the slow uptake of level 1& 2 training to the fear that funding will finish, leaving them with the problem of mental health patients they cannot afford to treat.

AGDHA coordination

One Division complained of inconsistency of approach and lack of internal coordination between programs coming out of different sections of the Australian Government Department of Health and Ageing (AGDHA). They are also concerned about over information and overkill actually turning GPs off mental health care, although they admit the need for good rigorous programs – they mentioned MindMatters and an improved BOiMHC as examples of useful programs.

Section 3: Policy and Program Implications

Workforce

Four strategies were identified as being relevant to the mental health workforce issues identified in rural and remote areas:

Recruitment

Professional support and supervision

Career pathways

Other retention strategies (in addition to those provided by professional and career support)

Each of these four strategies need to be applied across the following categories of workforce:

GPs

A great deal of work has already been done on recruitment and retention of remote GPs, which will not be recapitulated here, however some specific points about mental health can be made. In regard to recruitment, many new GPs are overseas trained, and it is important to ensure that this group has an understanding of the importance of mental health work in Australian general practice, as this area may not have received the same emphasis in their previous practice. Both existing and new GPs need to be able to access mental health training. A distance education option for Level 1 training in the BOiMHC Initiative has greatly increased accessibility of training, and a similar option for Level 2 training is needed. To support ongoing practice, the Divisions have done their best to ensure that continuing education and peer support is available through a range of methods. Adequate and accessible referral pathways for both emergency and less urgent mental health problems also support continuing mental health work by GPs. Without this, the GP can find it very difficult to balance mental health work with all the other demands of a remote practice. Locum availability is very important both to allow attendance at training and to balance work and family life. A family support program existed which has just finished in some areas, such as the Northern Territory, and this is likely to have an impact on retention, particularly in these remote areas

Allied health

Recruitment has proven to be difficult, both in the mental health services funded by the States and Territories, and in the programs funded by Divisions of General Practice. Because there are almost always no existing private providers (the areas concerned lack the population or the setting for a viable private practice), the Allied Mental Health Programs under BOiMHC have not been able to utilize a voucher system as has often been done in the urban areas. Instead, the Divisions have needed to either employ allied health workers directly, or contract from the State or Territory mental health services. These staff need both clinical supervision and access to a network of peers in order to prevent isolation. This network can be arranged on a state-wide basis, as has occurred in South Australia, although one model would not suit all States and Territories. The same issues regarding family support and ability to access training exist as for GPs, and the Divisions have played an important role here. There are increasing opportunities for joint training in conjunction with GPs. Career pathways are a problem as career development usually requires moving, and contributes to high turnover.

Psychiatrists

In the remote areas, the various models of visiting psychiatrists, telepsychiatry, and the urgent advice component of the BOIMHC Initiative, are likely to remain the mainstays of providing psychiatry services. Consumer feedback stresses the importance of continuity of care by the same psychiatrists wherever possible, with lack of continuity being a disincentive for consumers to return. Continuity is also a professional issue, as both GPs and psychiatrists value an ongoing working relationship with each other. The types of models that would promote continuity include increased

recruitment of regular visiting psychiatrists, as has occurred utilising the More Specialists Outreach Assistance Program, and the further development of telepsychiatry.

Divisional staff

As with the clinical staff, there are issues of recruitment and retention for mental health program staff within the Divisions of General Practice. The smaller remote Divisions cannot employ a program coordinator full time on their mental health program so most staff have a portfolio of roles. This multi-skilling has been useful for continuity of employment by Divisions, as it offers the potential for staff retention by changing roles as programs change. However, more attention could be paid to career development by being able to take one's skills and experience between Divisions. It would be useful to have consistent methods of providing information to new Divisional staff – induction/orientation procedures, policy and procedures manuals, and knowledge management across the Divisional network.

Geography and population

Distance and travel

There are clearly increased time and costs needed for travel in remote areas. Both the increased resources required on the local level, and what is required in linking with state and national bodies needs to be taken into account. This also impacts on the increased cost of training in rural and remote areas.

The activity requirements for program staff and clinical staff need to take account of the time that travel requires, for example in considering the number of practices a Divisional coordinator can visit, or the number of clients an allied health service can see.

Transience of the population

Help seeking and mental health literacy information needs to be accessible and regularly renewed in the community, so that it is easily obtainable by new arrivals and also visitors to the area.

In regard to the three step process of the Better Outcomes in Mental Health Initiative, transience leads to difficulty in triggering the incentive payment because patients are less likely to attend for the review consultation. The rules for this payment could be reviewed under these conditions.

Prevalence of mental health problems.

Remote areas have increased rates of suicide, depression and alcohol consumption. National campaigns aimed at reducing the stigma of mental illness could be assessed to see if it was also possible to directly target remote areas.

To attempt a response that is going to have an effect at the population level, it is necessary to move beyond ad hoc programs for local "hot spots". Depression and anxiety is already a focus for the Better Outcomes Initiative, however initiatives are underway to link suicide prevention and co-morbid substance misuse more closely. Also a nationally consistent, integrated primary mental health care policy to act as an overarching framework would be very valuable.

Consumer Issues

One of the main issues from the consumer point of view is a lack of choice about who to see – with allied health services there are limited opportunities to find, say, a psychologist or other provider of a particular gender or utilizing a particular approach to treatment. Consumers may be reluctant to approach services which are labeled as mental health because their attendance is visible to the community, despite reassurances of confidentiality. In remote areas there is also less likely to be a choice of doctors, so consumers cannot change GPs until they find someone with whom they feel compatible, as is possible in larger centres. Private general practices are less likely to bulk bill,

although alternatives to fee for services models exist, particularly for the very remote areas and Aboriginal Medical Services. For people who have been hospitalised, there is a lack of transitional accommodation and services.

Indigenous Issues

Holistic Health

Indigenous health services often put mental health in the context of overall emotional health and well being. Divisions running mental health programs should consider the same approach, in both Indigenous and non-Indigenous programs.

Cultural appropriateness

The mainstream workforce needs to develop cultural competency, so that they can:

Assess when a problem is due to a mental health issue as compared to a social or cultural issue.

Be sensitive and respectful communicators in working with indigenous clients to develop mutually agreed solution

Know about the range of treatment resources and be able to either implement or make an appropriate referral.

The indigenous workforce needs opportunities to develop more mental health skills. Increased access to training, or joint training with mainstream services are possibilities.

Access and equity

Mental health services need to be accessible to indigenous people, and this may involve taking the service out to the community. Services involving up front fees or gap payments are unlikely to be accessed, so Divisional allied health programs, for example, need to consider this factor.

Program Implementation Issues

Sustainability

To achieve more sustainable remote mental health programs, these issues need to be considered:

Sustainability of employment and funding

Begin by investing in relationships with local partners, so that trust is built, and the will to change systems is created.

Some program goals can centre on changing culture and strengthening formal partnerships. This may create changes in practice that outlast the individuals.

Avoiding short term "pilots" that don't have any mechanism for ongoing implementation. In addition to these being unsustainable by themselves, they create cynicism, make it more difficult to achieve long term change, and may actually be damaging to the community in the longer term.

Funding mechanisms

Funding cycles are inevitable, however one can try not to leave gaps when moving from one program or source of funding to another, by planned transition.

Starting small and then growing the program will allow methods that work to be developed and then extended out. This is opposed to the approach where a bigger amount of funding is given in the first year and then this gradually reduces.

Developing the ability of Divisional staff to apply for grants and source funding can be very valuable: consider delegating this to a small number of staff who are practiced at this. New staff can find this very time consuming, with no guarantees of success

Evaluation

Evaluation capacity is very variable: the allied health program has a minimum data set, but there is no systemic evaluation in other areas of Divisional mental health programs. A quality and/or evaluation framework would help in evaluation of this and other Divisional programs, but would need to be supported at a state or national level, for example with a consistent database and evaluation support. This type of support would most naturally fall to the State Based Organisations in each jurisdiction.

Better Outcomes in Mental Health Initiative

Specific barriers have been discussed previously that make it harder to implement this Initiative in remote areas. Some of these are resolvable via minor changes or small program additions that would not affect the integrity or intent of the entire initiative. Examples include:

Small amounts of funding to support access and affordability of Level 2 Focused Psychological Strategies training in remote areas. Alternatively, a distance education module could be developed.

Assistance and encouragement for Indigenous health services, also remote practices, youth services, domestic violence organisations etc to become accredited practices. This may involve some flexibility. Alternatively, the registration of GPs for the Initiative could allow them to provide services in remote locations that are not accredited.

Allowing some flexibility for implementation of the allied mental health programs in remote areas, for example by broadening the types of providers that can be uti lized, or the types of interventions able to be carried out. At present, the interventions must be based on evidence that is already available, but there is the potential to use this program to collect new evidence through gathering patient outcome data. If this was done in a methodologically rigorous manner then additional types of interventions could be added over time.

Linkages with other services

Linkages with mental health services are variable: a minority of remote Divisions have an explicit, systematic shared care program with their local mental health services. Many rely on informal arrangements.

Linkages can be developed if they are supported by commitments to GP/mental health services integration, through the Divisional State Based Organisations and nationally through the AHMAC National Mental Health Working Group. This would encourage a greater system wide engagement with primary mental health care reform.

References

Aboriginal Health Council of South Australia (1995). "Reclaiming our stories, reclaiming our lives" in Dulwich Centre Newsletter 1: 1-40, Adelaide, Dulwich Centre.

Al Yaman, F.,. Bryant M, et al. (2002). Australia's children: their health and wellbeing 2002. Canberra, ACT: Australian Institute of Health and Welfare

Andrews, G., Hall, W, Teeson, M & Henderson,S (1999). The mental health of Australians. Canberra, Mental Health & Special Programs Branch, Dept of Health and Ageing.

Aoun, S. and. Johnson L (2002). "Capacity building in rural mental health in Western Australia." Australian Journal of Rural Health 10: 39-44

Auon, S., Underwood, R and Rouse, I (1997). "Primary mental health care in a rural community : patient and illness profiles, treatment and referral." Australian Journal of Rural Health 5: 32-47

Australian Bureau of Statistics (1999) Cause of death Australia (series), cat no 3303.0, Canberra, Australian Bureau of Statistics.

Australian Bureau of Statistics (2002). Mortality Atlas, Australia. Canberra, Australian Bureau of Statistics

Australian Institute of Health and Welfare (1998). Health in Rural and Remote Australia, Canberra, Australian Government Publications

Australian Institute of Health and Welfare (2004). Rural, regional and remote health; a guide to remoteness classifications. Canberra, AIHW

Australian Medical Workforce Advisory Committee (1999). The specialist psychiatry workforce in Australia. AMWAC report. Sydney, Australian Medical Workforce Advisory Committee.

Bartik, W.,. Kowalenko N, et al. (2001). "Anxiety and depression in young people: a collaborative rural and remote model." In: Good Health good country: from conception to completion: proceedings of the 6th National Rural Health Conference, Canberra, March 2001

Bartik, W.,. Kowalenko N, et al. (2001). "Anxiety and depression in young people: a collaborative rural and remote service model." Youth Studies Australia 20: 38-42

Bartik, W.,. Kowalenko N, et al. (2001). "Anxiety, depression and early intervention in children and young people: a collaborative rural and remote model." Stepney, SA: Australian Infant, Child, Adolescent and Family Mental Health Association, 4th National Conference

Baxendell, N. (1997). The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples, ATSIC and ABS.

Best, J. (2000). Rural health stocktake: advisory paper to the Commonwealth Department of Health and Aged Care. Canberra, ACT: Department of Health and Aged Care

Bramston, P.,. Rogers Clark C, et al. (2000). "Gender roles and geographic location as predictors of emotional distress in Australia women." Australian Journal of Rural Health 8: 154-160

Bramston, P.,. Varela S. M, et al. (1991). "Gender role socialisation and emotional health in Queensland men." In: Rural and remote health papers 1991-1998. Deakin West, ACT: National Rural Health Alliance, 1998

Brideson, T. (1998). "Mental health information goes bush." Aboriginal and Islander Health Worker Journal 22: 8-10

Brown, F. W. (1998). "Rural telepsychiatry." Psychiatric Services 49 (7) :963-4

Buist, A.,. Coman G, et al. (2000). "An evaluation of the telepsychiatry programme in Victoria, Australia." Journal of Telemedicine & Telecare : 6 (4) : 216-21

Cowain, T. (2001). "Cognitive-behavioural therapy via videoconferencing to a rural area." Australian & New Zealand Journal of Psychiatry 35(1): 62-4

Davies, L. (2001). "A shared concern: improving the mental health of young people in rural and remote communities." Health Education Australia 1: 23-26

D'Espaignet, E., Measey, M. et al. (2002). Northern Territory Health and Wellbeing Survey: non-Indigenous population: December 2000. Darwin, NT: Department of Health and Community Services

Dodson, P. (1990). "The Regional Report of the Inquiry into underlying issues in Western Australia" Royal Commission into Aboriginal Deaths in Custody Report, AGPS, Canberra.

D'Souza, R. (2002). "Do patients expect psychiatrists to be interested in spiritual issues?" Australasian Psychiatry 10(1): 44-7

Dudgeon, P., Garvey, D. and Pickett, H. (eds) (2000). Working with Indigenous Australians: a handbook for psychologists. Perth, WA: Gunada Press, Curtin Indigenous Research Centre, Curtin University of Technology,

Dudley, M. (2001). "Responding to rural youth suicide in Australia." Australian Health Consumer 1: 30-2

Ermer, D. J. (1999). "Experience with a rural telepsychiatry clinic for children and adolescents." Psychiatric Services 50 (2) :260-1

Fragar, L. (1997). "A picture of health?" In: Gregory, G. and Murray, D. eds. Rural public health in Australia 1997: proceedings of the National Rural Public Health Forum, October 1997. Deakin West, ACT: National Rural Health Alliance, 1998, p13-28,

Fraser, C., et al (2002). "Does one size really fit all? Why the mental health of rural Australians requires further research." Australian Journal of Rural Health 10: 288-295

Fuller, J.,. Edwards J, et al. (2001). "Regional mental health planning: juggling the rational and contingent agenda." In: Good Health good country: from conception to completion: proceedings of the 6th National Rural Health Conference, Canberra, March 2001

Fuller, J.,. Edwards J, et al. (2000). "How definition of mental health problems can influence help seeking in rural and remote communities." Australian Journal of Rural Health 8: 148-153

Fuller, J,. Edwards J, et al. (2002). "Mental health in rural and remote Australia." in Wilkinson, D & Blue, (eds) (2002) The new Rural Health. Melbourne, Oxford University Press, p.171-185.

Gelber, H. (2001). "The experience in Victoria with telepsychiatry for the child and adolescent mental health service." Journal of Telemedicine & Telecare 7 Supplement 2 : 32-4

Gelber, H. and Alexander M. (1999). "An evaluation of an Australian videoconferencing project for child and adolescent telepsychiatry." Journal of Telemedicine & Telecare : 5 Supplement 1 : S21-3

GISSA University of Adelaide (National Key Centre for Social Applications of Geographical Information Systems) and Dept. of Health & Aged Care (1999). Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA). Adelaide, Commonwealth of Australia

Hawker, F.,. Kavanagh S, et al. (1998). "Telepsychiatry in South Australia." Journal of Telemedicine & Telecare 4 (4):187-94.

Hunter, E. (1995). "Is there a role for prevention in Aboriginal mental health?" Australian Journal of Public Health 19(6): 573-9

Judd, F. K. and. Humphreys J. S (2001). "Mental health issues for rural and remote Australia." Australian Journal of Rural Health 9: 254-258

Kavanagh, S. and. Hawker F (2001). "The fall and rise of the South Australian telepsychiatry network." Journal of Telemedicine & Telecare 7 Supplement 2 : 41-3

Kavanagh, S. J. and. Yellowlees P. M (1995). "Telemedicine--clinical applications in mental health." Australian Family Physician 24(7): 1242-7

Kennedy, C. and. Yellowlees P (2000). "A community-based approach to evaluation of health outcomes and costs for telepsychiatry in a rural population: preliminary results." Journal of Telemedicine & Telecare 6 (Supplement 1) : S155-7

Larson, A. (2002). Health Services and the workforce. in The new rural health .ed D. B. Wilkinson, Ian. Melbourne, Oxford University Press: 58-76

Lessing, K. and Blignault I. (2001). "Mental health telemedicine programmes in Australia." Journal of Telemedicine and Telecare 7 (6) :317-323.

Lowcay, B. and Kalucy, E (2003). Sharing the Know-how: knowledge sharing between the Divisions of General Practice. Adelaide, Primary Health Care Research & Information Service.

McConachy, Sandy (2003) "Working both Ways": the Top End Division of General Practice, Northern Territory Aboriginal Mental health worker program, Indigenous Health Matters, November 2003.

McCormack, P.,. Mohammed F, et al. (2001). "Learning to work with the community: the development of the Wujal Wujal guidelines for supporting people who are at risk." Aboriginal and Islander Health Worker Journal 25: 19-25

McKendrick, Jane (2001) "The mental health of Australia's Indigenous populations." in Meadows & Singh (2001) Mental Health in Australia: Collaborative Community Practice, Melbourne, Oxford university Press, pp.63-66

McKendrick, J.H. (1993). Patterns of psychological distress and implications for mental health service delivery in an urban Aboriginal general practice population, Doctor of Medicine thesis, Melbourne, University of Melbourne.

McKendrick, J.H. & Thorpe, M. (1994). "The Victorian Aboriginal Mental Health Network: Developing a model of mental health care for Aboriginal communities," Australasian Psychiatry, 2(5) pp.219-21

McLennan, A. (1998). Mental health and wellbeing: profile of adults, Australia, 1997. Canberra, Australian Bureau of Statistics.

Meadows, G.,. Singh, B et al. (2002). "Psychiatry and the need for mental health care in Australia: findings from the National Survey of Mental Health and Wellbeing." Australian and New Zealand Journal of Psychiatry 36: 210-216

Mental Health Council of Australia and Carers Australia (2000). Carers of people with mental illness project: final report. Canberra, ACT: Mental Health Council of Australia, and Carers Australia

Mitchell, J.,. Robinson, P. et al. (2000). "An evaluation of a network for professional development in child and adolescent mental health in rural and remote communities." Journal of Telemedicine & Telecare

Mitchell, J. G. and. Robinson P. J (2000). "A multi-purpose telehealth network for mental health professionals in rural and remote areas." Telemedicine Today

Moon, L.,. Meyer P, et al. (1999). Australia's young people: their health and wellbeing 1999: the first report on the health of young people aged 12-24 years by the Australian Institute of Health and Welfare. Canberra, ACT: Australian Institute of Health and Welfare

Muenstermann, I.,. Hawker F, et al. (2000). "Psychiatric service delivery in rural and remote South Australia: the mental health consumers' views." In: Kellehear, K. et al, (eds). Creativity and Development: Services for the Future. 10th Annual TheMHS Conference 243

Neil, C.. Brealey B, et al. (1983). "Delegitimization of mental health myths of new remote mining communities in Australia." Community Health Studies 7(1): 42-53

O'Kane, A. and Cruikshank R. (1999). "Becoming informed: the first step towards planning." In: Miller, V. et al, eds. Whose dreams? Whose realities? 9th Annual TheMHS Conference 1999: proceedings. Balmain, NSW: The Mental Health Services Conference of Australia and New Zealand, 2000, p200-203

Perkins, D. A. (1999). "Towards integrated mental health services in rural and remote Australia." In: Leaping the boundary fence: using evidence and collaboration to build healthier rural communities: proceedings of the 5th National Rural Health Conference, Adelaide, March

Peterson, C. L. (2000). "Rural health and families: e-health solutions to health inequities." Journal of Family Studies 6: 296-301

Pollard, S. E. and LePage, J. P. (2001). "Telepsychiatry in a rural inpatient setting." Psychiatric Services 52 (12):1659

Pope, Jeanette and Deeble, John (2003). Reality bites: rural and remote GP workforce information. A preliminary analysis of the Australian Rural and Remote Workforce Agencies Group minimum data set. Canberra, Australian Rural and Remote Agency Workforce Agencies Group.

Roberts, L., Battaglia, J & Epstein, R (1999). "Frontier ethics: mental health care needs and ethical dilemmas in rural communities." Psychiatric Services 51(1): 497-503

Robinson, P.,. Koszegi B, et al. (1999). "Bringing child and adolescent mental health services to rural and remote communities." In: Leaping the boundary fence: using evidence and collaboration to build healthier rural communities: proceedings of the 5th National Rural Health Conference, Adelaide, March 599: 10767-19991208

Rogers Clark, C.,. Bramston, P. et al. (1991). "Women's emotional health and well-being: a rural/ urban comparison." In: Rural and remote health papers 1991-1998. Deakin West, ACT: National Rural Health Alliance, 1998

Rohland, B. M.,. Saleh, S. S et al. (2000). "Acceptability of telepsychiatry to a rural population." Psychiatric Services 51 (5) :672-4

Royal Commission into Aboriginal Deaths in Custody (1991) Final Report of the Royal Commission into Aboriginal Deaths in Custody, 5 vols, (Elliot Johnston, Commissioner), AGPS, Canberra.

Samuels, A. H. and. Owen, C (1998). "A day in the country: a perspective on rural psychiatry." Australasian Psychiatry 6(6): 283-6

Sarantakos, S. E. (1998). Quality of life in rural Australia. Wagga Wagga, NSW: Centre for Rural Social Research, Charles Sturt University

Seah, E et al (2001) Cultural Awareness tool : understanding cultural diversity in mental health. Transcultural Psychiatry Unit, Curtin University and The Royal College of General Practitioners SA Research Unit, Perth.

Sheahan, B. (2001). "Does this remote community really need a child and adolescent mental health service or could it even do damage?" Australian Infant, Child, Adolescent and Family Mental Health Association, 4th National Conference, Stepney S.A.

Sheahan, B. (2001). "Rural CAMHS: for better or worse?" Youth Studies Australia 20: 44-48

Sheahan, B. (2002). "Remote communities, child telepsychiatry and primary health care." Youth Studies Australia 21: 52-55

Sheehan, M., Ridge, D. et al. (2002). "'This was a great project!': reflections on a 'successful' mental health promotion project in a remote Indigenous school." Health Promotion Journal of Australia '13 (3):201-204

Sheldon, M "Psychiatric assessment in remote Aboriginal communities". In: Dudgeon, P., Garvey, D. and Pickett, H. eds. Working with Indigenous Australians: a handbook for psychologists. Perth, WA: Gunada Press, Curtin Indigenous Research Centre, Curtin University of Technology, 2000

Sheldon, M. (2001). "Psychiatric assessment in remote Aboriginal communities " Australian and New Zealand Journal of Psychiatry 35 (4): 435-442

Simpson, J., Doze, S. et al. (2001). "Evaluation of a routine telepsychiatry service." <u>Journal of Telemedicine & Telecare</u>

Simpson, J., Doze, S. et al. (2001). "Telepsychiatry as a routine service--the perspective of the patient." <u>Journal of Telemedicine & Telecare</u>

Smith, H. A. (1998). "Telepsychiatry." <u>Psychiatric Services</u> 49 (11): 1494-1495

Social Health Reference Group (2003) <u>Consultation paper for Development of the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004-2009.</u> Social Health Reference Group, Office for Aboriginal & Torres Strait Islander Health, Dept. of Health and Ageing, Canberra.

Stone, L. (2002). "The use of internet resources to support mental health care in rural and remote areas." <u>The Australian College of Rural and Remote Medicine: "Integration Working Together for Rural Medicine"</u> pp 86-89

Swan, P & Raphael, B (1995). <u>Ways forward: National consultancy report on Aboriginal and Torres Strait Islander Mental Health Care</u>, Canberra, AGPS.

Thurley, Dr Jim & Goodluck, Kim (2003). "Developing a sustainable workforce in the remote areas of the Northern Territory, Australia". in <u>6th Wonca World Rural Health Conference: Rural health in a changing world. 24-27 September 2003. Santiago de Compostela, Spain. Book of Abstracts</u>: 83. Santiago de Compostela, Spain.

Vicary, D. and Andrews, H. (2001). "A model of therapeutic intervention with Indigenous Australians." <u>Australian and New Zealand Journal of Public Health</u> 25: 349-351

Wakerman, J. L., Sue (2002). "Remote health". in <u>The new rural health</u>. ed Wilkinson, D & Blue, Ian (2002), Melbourne, Oxford University Press: pp.126-148

Walker, J. (2001). "University departments of rural health - how do they benefit rural and remote health consumers?" <u>Australian Health Consumer</u> 1: 17-8

Walpole, S. (2000). "Human rights for rural and remote communities." In: Rural and remote Australia: health for all by the year 2000: proceedings of the 4th National Rural Health Conference, February 1997. Deakin, ACT: National Rural Health Alliance, 1998, p41-49

Werner, A. (2001). "Unanswered questions about telepsychiatry." <u>Psychiatric Services</u> 52 (5): 689-90

Wiese, R. (1998). "Health care access for rural young people." <u>Up2date</u> 6 (4) Apr 1998: 1,6

Wilkinson, David & Blue, Ian eds, (2002). <u>The new Rural Health.</u> Melbourne, Oxford University Press.

Williams, R. I. (1998). "Assessing the feasibility of providing mental health services to remote communities with the Royal Flying Doctor Service." <u>Mental Health in Australia</u> 8: 69-75

Wooldridge, M. (1997). "Perspectives on public health in rural Australia." In: Gregory, G. and Murray, D. eds. <u>Rural public health in Australia 1997: proceedings of the National Rural Public Health Forum, October 1997.</u> Deakin West, ACT: National Rural Health Alliance, 1998, p63-6

Appendix 1 Methodology

Background to the Knowledge Harvesting Program

In 2001 PARC conducted a telephone survey of Mental Health Program Officers from the Divisions of General Practice. We were interested in how they gathered information to support their mental health programs. The results showed that, while a plethora of mail came over their desks, access to information to support their program development was patchy. The Divisions did not have access to and often did not seek out journal articles or formal knowledge sources but were super networkers and knew who to ask and who the local experts were. A study by The Primary Health Care Research and Information Service (PHCRIS) on knowledge sharing between Divisions (Lowcay and Kalucy, 2003) had similar findings. They found that knowledge is shared by networking, but that it is haphazard and based on relationships between Divisions who perceive themselves to be philosophically similar.

The problem is that the network is too large and too geographically dispersed for this to be effective and that there is a fast staff turnover leading to the loss of much valuable know how. Lowcay and Kalucy found that nearly all information sharing is within States. There is no way to easily find out what is happening in other areas, what the common problems are with similar projects, or to gain an overview of how successful national initiatives are. Neither are there processes in place for systematically learning from successes and failures and applying those learnings.

Interestingly the PHCRIS study found that Divisions would value having a central body collate and interpret the learnings from program activities by Divisions. PARC took up this challenge in the field of mental health and in 2003 developed a Knowledge Management Strategy for the National Primary Mental Health Care Initiative.

Prior to the commencement of this project we consulted with the Development and Liaison Offers of the Primary Mental Health Care Initiative, Program Officers from a number of South Australian Divisions, and the Commonwealth.

Knowledge Harvesting involves the following stages:

- Identify and prioritise knowledge to be harvested.
- Identify the experts who have the knowledge.
- Choose elicitors to do the sessions.
- Review the needs of target learners.
- Elicit the knowledge through sessions.
- Make sense of the session results.
- Conduct post sessions review and follow up. (Knowledge Harvesting Inc, 2001)

with the interviewer drawing out the information by "*asking the right questions and shepherding the dialogue*".

Examples of the type of knowledge that needed to be gathered to promote organizational learning and support mental health program development are:

- knowledge of what has been done elsewhere;
- knowledge of what works and what doesn't;

- and knowledge of the issues which have arisen elsewhere.

At the same time the information needs of the Primary Mental Health Care Initiative and policy makers needed to be taken into account. Each round of research needed to be proceeded by a period of consultation to assess:

- current sources of knowledge about Divisions projects, i.e. recent and current research by other organisations (so as to avoid duplication);
- current hot topics and policy developments for which information is needed.

Objectives of the project

To gather knowledge from Divisions about their mental health programs to develop an insight into who is doing what.

To document the different models of program design and the advantages and disadvantages of each.

To develop an understanding of key issues associated with mental health program implementation in remote areas, highlighting successes and providing an insight into lessons learned.

Funding was granted by the Commonwealth Department of Health and Ageing in July 2003 to begin the PARC Knowledge Harvesting Program. In order to pilot our methods and to find the balance between breadth and depth of harvesting we decided, in the first round, to focus on twelve remote Divisions. Interviews took place during December 2003 and January 2004.

Appendix 2 Interview Questions

Tell me about the mental health programs/activities in your Division. Refer to checklist below for possible areas. Any new ones coming up?

Are there one or more of these which have been particularly successful? Can you tell me about them.

How was that set up?

What approach does it utilize? E.g. GP education, community awareness etc

Details of the setting in which run, population group targeted

The process used to plan, implement and evaluate the program

How was the program evaluated?

Sustainability – steps taken to ensure this?

Can you describe the time and effort required for this program? What staffing resources were necessary?

What issues have arisen during this program?

What lessons have been learned from the experience?

What advice would you give to other Divisions thinking about setting up a similar program?

What was the level of GP involvement in to the program? How did you gain their involvement? Any tips of how to engage GPs in Division mental health activities?

Mental Health Programs/Activities in the Divisions of General Practice

Allied health services projects

Peer support

Drug and alcohol, comorbidity

Child and youth mental health

Mental health and physical activity

Advice from psychiatrists – includes telepsychiatry

Education and training resource development

Shared care

Suicide prevention

Indigenous mental health

Networks/linkages

Schools programs

Others (please specify)

Appendix 3 Letter to Divisions

Department of General Practice

Flinders University of South Australia

PO Box 2100

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SA 5001

Telephone: +61 (08) 8204 5917

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Dear

As promised in our recent phone conversation, this letter provides a brief outline of the knowledge harvesting project which PARC is about to undertake with the remote Divisions of General Practice across Australia. This project will provide Divisions with an ideal opportunity to showcase their mental health programs and share their experiences with other Divisions. In addition, the project allows Divisions to contribute to the growing body of knowledge about primary mental health care and raise awareness of the significance of this aspect of their work not only within the Division network but also among the wider community.

Aim

To promote organisational learning and the management of mental health program knowledge within the Divisions of General Practice.

Objectives

To gather knowledge from the remote Divisions about their mental health programs to develop an insight into who is doing what.

To document the different models of program design and the advantages and disadvantages of each.

To develop an understanding of key issues associated with mental health program implementation in remote areas, highlighting successes and providing an insight into lessons learned.

Methodology

Semi-structured telephone interviews will be conducted with Mental Health Program Officers in remote Divisions of General Practice. Each interview will last between 30 - 45 minutes and be recorded on audiotape, with the permission of interviewees.

Intended Outcome

Information gathered will be compiled into a report which will be available on the PARC website (http://som.flinders.edu.au/FUSA/PARC/). The report will consist of:

Part 1: A Division by Division description of their mental health programs and activities.

Drafts will be sent to the interviewee before being put on the website, so that any necessary changes can be made.

Part 2: A discussion paper which provides an overview of mental health programs in remote areas and examines the key themes and issues which emerged from the project. Divisions will not be identified in this section.

It is possible that some of the material will be used for conference presentation. Again, the Divisions will not be identified if this happens, unless prior permission is sought.

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We also invite you to write up any programs that you would like to share in more detail, for inclusion in the PARC journal.

As we agreed, I have scheduled your interview for [date. time]. I am also including a copy of the interview questions for your information and prior consideration.

If you have any queries, please feel free to contact me on 08 8204 5297 or via email, elizabeth.osman@flinders.edu.au. I look forward to speaking with you, and thank you for your participation.

Yours sincerely

Liz Osman

Research Officer, PARC

Appendix 4 Overview of mental health programs run by the remote Divisions

Mental health programs run by Divisions of General Practice (at December 2003)

Division	Allied health services	Peer support	Drug & alcohol comorbidity	Mental health/ physical health	Child & youth mental health	Schools programs	Suicide prevention
Central Qld Rural DGP	MAHS - 2 social workers, 1 psychologist BOiMH - 3 psychologists	Y	Have done			Y	Participated in suicide prevention interventions through Qld Health
Cairns DGP	Applying for BOiMHC funding 3rd round	Corporate learning program 10 GPs	ATODS program for benzodiazepine withdrawal. MH Service doesn't deal with patients with drug problems	In education program	In education program MindMatters Plus program	Trinity Bay State High School Mind Matters Plus program	Through linkage with Youthline and MindMatters Plus
Southern Qld Rural DGP	MAHS psychologist has left. Applying for BOIMH funding 3rd round	Peer group teleconference started with 10, now 3			MindMatters Plus GP applied for	GPs in schools has been scaled back	
North & West Primary Health Care	Large increase in allied health workers of all kinds, moving into multi-disciplinary primary care teams. 6 psychologists	Small group planning for GPs at two centres Mental health case conferences in 3 centres		Multi-disciplinary teams of health workers going out to communities – including psychology services.		Nothing at present – allied health workers and division staff have worked with school counsellors.	Nothing specific at a Division level. Information provided to GPs, psychology referrals available.

	provide psychology services for entire region. Division as main provider of allied health services – diverse funding sources, including BOiMHC, HACC Extensive moves to accreditation of allied health program at Mt Isa – pilot for other centres			Moving towards providing holistic primary health care. Health worker in Townsville studying diabetes and related depression in Aboriginal women – diabetes educators working with psychologists, being trained to do depression test – recognition of difficulty of making behaviour changes in chronic disease.			Activities mostly locally based as needed – work with Qld Health on Integrated Suicide Service.
Far North Qld Rural DGP	MAHS funding for 7 psychologists – under block funding. BOiMHC funding		Drug and alcohol person two days a week.	Division involved in initiatives around healthy food in Indigenous communities			
Flinders & Far North DGP	One psychologist in Pt Augusta through MAHS. BOiMHC - Allied health worker funding for triage nurse, social worker, 4	Teleconference group has lapsed.	Included in Level 1 training, PriMeD workshops.				Funding not approved

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	hrs of CBT.						
Kimberley DGP			Dept of Justice prescriber training in 2002 for 5 GPS & 2 pharmacists – able to prescribe drug addiction medication	GP access program, working with Mental Health Services and GPs in Broome.		Reviewing Mind Matters program, will use lessons leaned from the very successful Canning Stock Route Challenge program	GP access program (indirectly)
Eastern Goldfields Medical DGP	2004 Application for BOiMHC funding to subsidise access to psychiatrist in Esperance and other allied health services – community health nurse, psychology services at GP practices..	.Peer support discussion and learning group based in Esperance, meetings with fly-in psychiatrist for case conferencing and discussion, psychiatrist interviews patients whose cases are being discussed			Kambalda High school program included ability to refer to psychologist – applying for funding for psychology services. Youth health a focus for 2004 – will include youth mental health program partnerships with other service providers	Very successful Mind Yourself program linked with Kambalda High School and other service providers, including University 1998-2002, but funding not renewed.	Included in schools project, all health and wellbeing programs include suicide.
Mid West DGP	Applying for BOiMHC third round funding. MAHS - a Social worker has been employed	Peer support program had started, using tele-conferencing but due to the funding ceasing program was unsupportable. .	No funding but liaising with Drug and Alcohol services to enhance referral pathways and linkages. Pitstop program includes alcohol, smoking and	Pit stop men's health program, Move Motivate Midwest committee projects are dealing with health through physical activity – includes walking trails, get fit kit.	Large program has finished due to lack of continuing funding – included ADHD program		Pitstop men's health program includes health promotion/ brief intervention, and is also expected to have a monitoring function, so specific suicide program may be

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			coping skills component.				put in place if funding was obtained.
Pilbara DGP		One successful group running, another starting.			Youth at risk cards – an offshoot of Suicide prevention Program in Roeburne Shire. Information about youth friendly resources and local artwork. Available in schools, surgeries etc.		Suicide prevention working party in Roeburne Shire – targeting men from 24-45, fly-in fly-out mine workers etc - have developed posters and protocols for working between organisations.
Top End DGP	BOiMHC allied health services outsourced to NT Rehab services – CBT services etc MAHS funding for Aboriginal Mental Health Workers in 8 remote communities, now being expanded to include community alcohol and drug workers	Small group learning developed from Allied health services – CBT, case discussions. has developed into supervision group which is continuing, although funding has finished. High element of peer support in Aboriginal Health Worker program, for all workers.	New program to address drug and alcohol issues in Indigenous communities, extension of Aboriginal health worker program to include local workers in 4 communities, with training provided by Batchelor Institute.			Mind Matters Plus GP program with Taminmin High School.	Nothing specific. Element in Aboriginal health Worker program, and Programs are run by other organisations and Division uses these for staff training.

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Mental health programs run by Divisions of General Practice (cont)

Division	Education & training resource development	Advice from psychiatrists including telepsychiatry	Shared care	Indigenous mental health	Networks & linkages	Others
Central Qld Rural DGP	Large amount of resources for GPs participating in National Health Development Fund shared care model	Telepsychiatry trial	Developed model of shared care for rural communities – National health Dev't fund shared care program	Through allied health	Y	
Cairns DGP	Mostly through small group learning	Not enough psychiatrists to provide much advice	Shared care committee with local hospital has now turned into advisory group on mental health services	Contacts with indigenous groups and doctors fro ATSIMS involved in peer support group – no specific programs	Extensive: - Indigenous groups - Youthlink - Worklink employment group - CAG - St John's Community Care - Advisory group to mental health services at hospital	
Southern Qld Rural DGP	Local psychiatrist provides training. Some funded through pharmaceutical companies	Case conferencing at Beaudesert once a month with hospital psychiatrist			MoU with Southern Downs District, MoU with Health Service	Drought campaign general wellbeing campaign running out of Toowong?
North & West Primary Health Care	Case conferencing accredited for CPE points	Visiting Psychiatry services from Townsville	Objective of case conferencing Dev't of allied	Aboriginal Health worker Townsville working on	.	

		spasmodic due to lack of psychiatrists.	health services to enable shared care with GPs to happen. Allied heath workers work our of surgery when they can.	diabetes and related depression in Aboriginal women. Indigenous health worker Mt Isa doing community liaison work. Moving towards multidisciplinary teams, sometimes incorporating traditional healers		
Far North Qld Rural DGP	73 GPs have done BO level 1 & registered, more waiting to do. 1 level 2 Resistance to registering.	Psychiatrist flies in from Weipa 4 times a year under MSOAP.	MAHS project, EPC care plans Case conferences BOiMHC program	Some specialist programs – Drug & alcohol to Karamba clinic, Innisfail, Cooktown. Division involved in meetings about suicide in Indigenous communities.		
Flinders & Far North DGP	12 out of 35 GPs have done Level 1 training. Some resource development – small file on DTOs and detention procedures.	Visiting psychs to Roxby Downs, Coober Pedy, Leigh Creek Lunchtime case conferencing with visiting psychiatrist has lapsed.		Services provided to several remote communities. Indigenous mental health services provided by Pika Wiya.	Good relationships with regional Mental health Service, Pika Wiya. Port Augusta is hospital base for RFDS. Work from Regional mental health	

					plan (not Divisional).	
Kimberley DGP	GP access program education and training development	Telepsychiatry not viable at present – will be revisiting	GP access program, run in conjunction with North West Mental Health and GPs in Broome for Pilot project. Will move out to other centres	GP access program includes indigenous mental health.	GP Access program run in conjunction with North West Mental Health. Will become more networked as it moves out of Broome.	Health lifestyle program in Broome and Derby – women's wellbeing, using holistic approach to physical, mental health, general wellbeing.
Eastern Goldfields Medical DGP	Education through BOiMHC & chronic disease funding used to run Signals 1& 2 courses	Videoconferencing trialled – not well taken up – technicians needed to be present. Broadband IT/ telecommunications options being trialled in Kalgoorlie – will enable more adequate telemedicine trial		MoUs with indigenous health services, and some GPs work with an indigenous emphasis.	MoU with Esperance Community Mental Health Service, and Kalgoorlie Mental Health, and with Aboriginal Medical Service and Bega Garnbittingu	
Mid West DGP	BOiMHC - 12 have done level 1 training, 2 Level 2 problems with remoteness and access.	One psychiatrist in Geralton	Child psychologist was previously employed by Division, now in Aboriginal Medical Service.	Pitstop program includes indigenous men – can be referred to psychologist from Aboriginal Health Service.	No MoU with Mental Health Service, but informal cooperation between workers from a number of disciplines over the Pitstop program, and other programs	
Pilbara DGP	Will be trialling PriMeD	Small breakfast meetings with		Included in all mental health.	Work with North West Mental	

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	modules	GPs from each town, and psychiatrist flying in from Broome, North West Mental Health Service. Case conferencing.		Partnerships with communities.	Health Service. Suicide Prevention Working Party involves a large number of service providers and community groups in Roeburne Shire	
Top End DGP	Dedicated training arm of Division. BOiMHC training. PriMeD training about to begin for remote GPs.	Telepsychiatry has not worked because of lack of psychiatrists. NT Health trying to employ extra psychiatrists to provide services for remote GPs.	Occurs through programs – Mind Matters and Aboriginal Health Worker program.	Large Aboriginal Health Worker program employs local Aboriginal Mental Health Workers in 8 remote communities who work closely with GPs and community around mental health and cultural issues. Extensive consultation and training provided. Program is expanding to include Drug and Alcohol Workers	Linkages with other mental health agencies, and other	

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Appendix 5 Programs described by the remote Divisions in detailed interview

The following programs were identified by the Divisions as those they wished to talk about in detail.

Allied health projects (including MAHs and Better Outcomes funding)

North & West Qld Primary Health Care – move towards multi disciplinary services across whole Division, and towards multidisciplinary Primary Care. Accreditation of AHWs at Mt Isa. Division as major supplier of AHS.

Far North Qld RDGP MAHS program.

Peer support

Cairns DGP Corporate Learning Program (also education and training) (also includes breakfast meetings under Advice from psychiatrists)

Advice from psychiatrists (including telepsychiatry)

Southern Qld Rural DGP – Monthly case conferencing with psychiatrist at Beaudesert.

Pilbara DGP – Mental Health Breakfast meetings

Shared care

Central Qld Rural DGP National Health Development Fund Shared Care project – development of a model of rural shared care.

N&W Qld PHC allied health provision.

Networks and linkages

Cairns DGP - extensive networks and linkages (also shared care – MoUs)

Suicide prevention

Pilbara DGP – Joint Working Party on Suicide Prevention – Roebourne Shire.

Pilbara DGP - Youth Suicide card

Drug and alcohol comorbidity

Top End Division of General Practice Aboriginal Alcohol and Drug Worker Program (starting 2004)

Mental health /physical health

North & West Qld PHC – teams of allied health workers travelling out to communities. Townsville study of diabetes and related depression in Indigenous women – diabetes educators working with psychologists to test for depression. HACC project starting

Kimberley DGP GP access program (also shared care, networks and linkages)

Child & youth mental health/Schools programs

Eastern Goldfields Medical DGP - Kambalda High School Mind Yourself project, 1998-2000.

Indigenous mental health

Top End Division Aboriginal Mental Health Worker Program

Men's health

Mid West DGP – Men's Pitstop program

Others

N&W Qld PHC allied health provision – regional organisation

Appendix 6 Program Descriptions from Interviews with Remote Divisions of General Practice

DIVISION: 410 Central Qld Rural DGP

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SETTING: Central Qld Rural Division covers 163,912 sq km of the rural sector inland from the coastal cities of Gladstone, Rockhampton and Mackay. It stretches from Moranbah in the north to Theodore in the south, and west to the Gemfields. There are about 66,000 people, 46 member GPs and 22 practices. The Division has 10 staff members. RRMA 4-7

MENTAL HEALTH PROGRAMS/ACTIVITIES

Allied Health services projects

The majority of allied health services in the region are provided by Division and Q Health in some districts. Two social workers and a psychologist are already employed under MAHS funding, and BOiMHC Access to Allied Health Worker funding has been applied for to employ 3 psychologists, who will then be able to provide counselling services in every community in the Division. The BOiMHC funding will also allow for group work and integration with GPs, psychologists and the Mental Health Services.

Peer support

Under funding through the New Primary Mental Health Care grants an ongoing process of mental health education and peer support has been set up within the Division. This allows the GPs to meet in small groups 3-4 times a year and participate in an interactive session with a psychiatrist facilitator who will present information and then work with the group as GPs present relevant case histories and management scenarios to the group.

Drug and alcohol comorbidity

The Drug and Alcohol unit in Brisbane has done a CPD across the Division which focused on Mental Health and Drug and Alcohol related co-morbidities, early diagnosis and management of these patients.

Advice from psychiatrists, including telepsychiatry

A telepsychiatry trial is running in conjunction with the Health share organization which is based in Brisbane and has developed GP friendly systems which allow for a streamlined booking system and consultations to be available for GPs in their own practices. Two GPs are participating in the initiative but it has the potential to be used throughout the Division. A team of three psychiatrist participate in this project and also visit the Division every two months to undertake face to face consultations and provide education for the GPs.

Education & training resource development

Large amounts of education and training resources have been provided to GPs involved in shared care program – funded through the National Health Development fund and now completed. Level one training has been provided as part of the BOiMHC project and the Division has made a commitment to offer opportunities for level 1 and 2 training on an annual basis.

Indigenous mental health

Services are provided through Allied Health providers as required. Qld Health employs indigenous health workers in the majority of communities covered by the Division. The Division included these workers in local programs and includes them in local liaison and community networking forums.

Suicide Prevention

The Division has participated with Qld Health in suicide prevention interventions. Activities under these initiatives have included participation in the development of a green card system and community and service provider education programs.

Schools programs

Mental health education programs are held through the schools as part of a high school education program developed by the Division and often delivered in conjunction with programs run through the schools.

Others

The Division is a participant with Qld University in Aim High research project looking at broader spectrum short interventions across the spectrum of the community in rural, regional and urban centres.

Shared care

A model of shared care for rural areas has been developed, funded by the National Health Development Fund.

MENTAL HEALTH PROGRAM

National Health Development Fund project - developing a model of rural shared care.

This program was initially set up in 2001 to cover the Central Highlands (1/3 – ½ of total Division). The Division partnered Central Highlands Mental Health Service in an application to Qld Health to apply for a National Health Development Fund grant. A model of rural shared care was developed, involving Mental Health Services and GPs.

A part time project officer was employed for 2 years, co-employed by the two organisations, to set up and develop the project. Education and training is provided to GPs – funded by the Division, and policy and cultural changes made to Mental Health Services to build a share care culture.

The approach used is multidimensional – GP education, community education, community awareness, service provider awareness, NGO education, mental health education, development of policies and procedures, changes to paperwork documentation.

The setting and target population group incorporates all ages and the whole community – elderly, psychogeriatrics, child abuse, neonatal, postnatal, adult, indigenous – "everyone in rural is always together , because there's nobody anywhere else, it's still rural."

The Project developed in the Central Highlands and is then to be implemented in three other districts – ultimately covering the whole .Division. It has been set up to be self sustaining once the project officer has finished, in part because relationships have been built, the benefits are clearly visible to all, and changes to the culture, procedures and systems of the Mental Health Service to encompass shared care have been enshrined in policy.

The whole project has been carefully planned. Evaluation has been built in from the beginning, with initial collection of baseline data collection, regular evaluations during implementation phase, evaluation of data collection process. As part of the data collection process, surveys of community allied health services are provided to the GPs, statistical data is collected about waiting times, referral times, where referrals coming to, Data analysis pre and post program by using the CESA database for analysis.

GPs have been involved from the beginning of the project and in all aspects: initial program design, participation in steering committee, model design and implementation, education program, evaluation.

One benefit of the project has been to improve relationships between the GPs and the Mental Health Service.

GPs have been engaged by targeting issues of major concern and providing resources to enable them to participate. It is easier to engage GPs in rural Divisions, due to direct contacts and knowledge of their concerns.

Issues arising from program

It would have been better for development of trust relationships to employ 3 project officers in Mental Health Services to implement project – trust relationships need to be established and organisational culture changes made first. Local ownership is important - the project was very effective where the project officer was locally based, but not as effective once the project extended across the whole Division.

Lessons learned from program

Time is needed to develop trust relationships across organisations, prior to changes bring made.

Linkages of co employment were needed to change culture of Mental Health Service – working from inside, not outside. Changes then need to be built into organisation while project officer is working there – policy, procedural, systems, so that they will continue once project officer has left

Advice to other Divisions

Linkages and co employment – project officers employed to work both with Division and organisation that is being changed. Creates a "codependency" between organisations about continuing to work together.

References and useful resources

Report available March 2004

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MENTAL HEALTH PROGRAMS/ACTIVITIES

Allied Health Services projects

Most of the Division is not eligible for MAHS funding. A first round application for Better Outcomes Allied Health Worker funding was not successful, reapplying in February 2004 round.

Peer Support/education and training

A Corporate Learning Program is running, with small group learning cycle beginning in June 2003 and 5 meetings held in 2003. About 10 GPs are involved. Topics have included Indigenous mental health, ADD, youth suicide, mental health/physical health comorbidity.

This group has also served to raise interest in Better Outcomes level 1 & 2 training. Some Level 1 training has occurred.   Several SPHERE 1& 2 courses have been run, both for Cairns and rural divisions.

Drug& alcohol/mental health comorbidity

ATODS (Alcohol, Tobacco and Other Drug Service) is running a program for benzodiazepine withdrawal – this is providing backup support for GPS. There is close liaison between Division and ATODS, but different doctors are involved than those involved with mental health.

There is little Service understanding of alcohol and drug comorbidities - Mental Health Service refers patients with drug issues to Drug Services.

Mental health/physical health comorbidity

Some CME training has been provided by the Division during 2003, but limited by available funding.

Child and youth mental health/Suicide prevention

Some training has been provided through CME, including ADTD and youth suicide.

Division has been involved for last two years in Trinity Bay State High School Mind Matters project – GP takes 4 or 5 sessions with groups of Yr 11 students.

This program is also moving into Mind Matters Plus Project, and is developing flier/handout to encourage more student involvement with GPs, and also more GP involvement in Trinity Bay High School activities.

There is some GP involvement in Youthlink, which is looking also at youth suicide prevention.

Indigenous mental health

The Division has contacts with indigenous groups at Yarrabah, and doctors at Wu -Tropperen Aboriginal & Torres Strait Islander Medical Service are involved in small group learning, but no specific projects exist.

Networks & linkages

Links with Aboriginal & Torres Strait Islander Health Service, Wu-Tropperen.

Ongoing Youthlink involvement - this also used to include counselling session.

Worklink has involvement with local organisation providing employment services to people with mental illness – Divisional involvement with both.

There is Division representation at meetings of the Mental Health Help group – Cairns consumer and carer group, connected with CAGs. This group was formed from an amalgamation of Mental Health Help (part of Schizophrenia Fellowship) and the Mental Health Association.

Division has a MoU with St John's Community Care, which provides home care and support services to people who were originally chronically institutionalised and at that stage also had close access to GPs and Mental Health Services.

Division is a member of the advisory group to mental health services at the hospital – this follows from shared care committee with hospital, which has lapsed.

Meetings have been held with two of the community Mental Health teams about shared care and developing mental health care plans – this has been difficult to organise due to different ways of working – Mental Health Teams accustomed to working with GPs more at an individual than a Divisional level.

Advice from psychiatrists, including telepsychiatry

"Advice from psychiatrists is running pretty thin up here because we don't have enough of them"- several have recently left. Division has a lot of association with local psychiatrists, but more at a networking level than for specific or professional advice.

No telepsychiatry at local level.

Shared care

Division was a member of shared care committee with hospital, which has now transformed into advisory group.

Only one GP is doing detailed shared care plans – more detailed than the Better Outcomes structure.

Sustainability

All programs are under threat due to under funding – admin costs and admin support lacking

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MENTAL HEALTH PROGRAMS/ACTIVITIES

Allied health services projects

A psychologist was employed under MAHS funding, but left at end of 2003.

Better Outcomes funding has been applied for to replace psychologist. Application funded from July 2004- June 2005. 4 Psychologists will be contracted for 5 towns.

Peer support

A small group peer support teleconference was running until June 2003 when state funding ran out. This began with 10 GPs, but numbers dropped due to GP time constraints. This has not been refunded in 2004.

Child and youth mental health/ Schools programs

Funding has been applied for to run Mind Matters Plus GP in 2004, in one school.

Currently running and an application for continued funding being submitted end of June.

GPs in Schools program is still going, although scaled down from last year *2003.*

Advice from psychiatrists – includes telepsychiatry

Beaudesert chapter of the Division (about 10 GPs), has monthly case conferencing with the hospital psychiatrist, held over morning tea or lunch. The psychiatrist facilitates the group and the GPs bring their own cases to discuss. This has been running for many years, requires very little effort or funding to run, and is largely self sustaining.

Evaluation was done over a year in 2001using pre and post tests on the same cases before and after case conferencing, and comparing outcomes.

This program was initially set up by GPs, who then approached the Division for support *who assist with the venue and catering and admin support.*

Education and training resource development

A local psychiatrist provides some training, and has been funded by pharmaceutical companies to run early psychosis workshops, and others. GP interest in Better Outcomes training. Level 1 training has been held in 5 towns. No level two training has been conducted.

Suicide prevention

A general wellbeing drought campaign was been run in all of the areas of the Division.

Networks/linkages

MoUs with various health services, including Mental Health Services.

DIVISION: 416 North & West Qld Primary Health Care

Have restructured in last 12 months. Division now incorporates Northern Qld Rural DGP and Central West Rural DGP

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MENTAL HEALTH PROGRAMS/ACTIVITIES

Allied health Services Projects

There has been a large increase in Allied health workers of all kinds in last 3 years, moving towards provision of multi disciplinary services across Division, and eventually to multidisciplinary primary health care teams– slower development due to previous lack of allied health services in whole region, and backlogs in referrals.

Mental health psychology services are now being provided across the five geographical areas which make up the entire division. Outreach from 3 centres, Townsville, Mt Isa and Longreach, employing 6 psychologists, working out of GP practices when possible. After 18 months, they are able to start broadening approach to include physical health issues as well as mental health.

Allied health practitioners working out of GP practices have extensive involvement, much of it informal, with whole practice - GPS, practice nurses, receptionists etc– including ability to set up systems, access and add to patient files and generally integrate themselves into practice systems. Division is involved in practices systems upgrade, which facilitates whole of practice enhanced primary care and shared care.

Division has become the major provider of Allied Health services, due to lack of other providers, and low priority given by statewide organisations to small centres– now major Divisional strategic focus. Effectiveness is due to position as a small regional organisation with small bureaucracy, knowledge of local needs and ability to respond quickly to opportunities.

Multiple sources of funding, including MAHS, Better Outcomes and others– now attracting funding from a variety of sources on the basis of work being done.

Sustainability is provided by variety of funding sources, and by development of Divisional credibility as effective and accredited service provider, but still vulnerable to program funding changes and time limits.

Division has been restructured around place planning, with 5 regional area managers– job is to work with their communities to build up appropriate services for those regions. Services to be as rigorous and evidence based as possible, but taking into account local needs.

Trying to build in rigour and evaluation.

Mount Isa is the first and prototype, with funded manager/director position, and has received funding specifically for business systems, data collection systems. Working on accreditation of organisation, allied health services.

Regional outreach service being developed from Mt Isa down western border of Qld to Birdsville, including indigenous communities there. Mental health services and psychology services a significant part of service. No other allied health services in this area.

Division seeking HACC funding to provide services throughout its area of operation to assist early dementia sufferers and their families/carers– including dementia counselling and also care planning for sufferers, families and carers.

Peer support

Small group planning for GPs at two centres providing peer support for GPs in upskilling for mental health.

Mental health case conferences are held every 4-6 weeks at 3 centres, Ayr, Ingham and Charters Towers (those with more than one practice).These include participation by psychiatrists and psychologists. CPD points are available for participation.

These were developed by previous mental health program officer after consultation with GPs about needs. The Division takes a low key role in administering them.

Case conferences informally lead to shared care.

Mental health and physical health

Newly formed multidisciplinary teams of allied health workers travel out to communities, looking at health in the broad sense – group of 3 different specialties will go at the same time – not necessarily the same ones each time. Specialties include occupational therapy, physiotherapy, speech pathology, podiatry. dietetics as well as psychology. Moving towards holistically based primary health care – e.g. Aboriginal health worker in Townsville is studying diabetes and related depression in Indigenous women – diabetes educators starting to train and work with psychologists to administer depression test for newly diagnosed patients - recognition that behaviour change is very difficult to achieve, particularly in people with chronic disease. GPs as advocates to this approach.

More developed in indigenous health.

Indigenous mental health

Most indigenous people are living in communities without GPs, e.g. Palm Island, Mornington Island, Doomadjeree, so running allied health services out of GP practices is not possible there. Trying to coordinate services with other service providers, Qld Health, RFDS, remote area nurses etc, as well as moving towards a multidisciplinary, primary health oriented team approach.

In some communities, traditional healers are being incorporated.

Indigenous Health Worker in Mt Isa is doing community liaison, leading to increased effectiveness in getting into communities.

Shared care

Objective of case conferencing – not necessarily formalized, and of allied health program – initially there were no allied health workers for GPs to share care with, so strong emphasis has been put on development of allied health worker program, and developing more holistic approach to health care.

Now allied health workers in GP practices .

Advice from psychiatrists, including telepsychiatry.

Visiting psychiatry services from Townsville to larger centres have been spasmodic, and there are unfilled psychiatry positions in Mt Isa and elsewhere – difficult to fill positions and keep people. Services provided for a few months via Medical Specialists Outreach Assistance Program.

Psychiatrist is now visiting Mt Isa from Townsville one day a month, but sees private patients only.

Not aware of any GPs using MBS item numbers for psychiatry, so assume that no telepsychiatry taking place at present.

Queensland Health is considering a joint telepsychiatry project with Division – not yet established.

Suicide prevention.

No specific Divisional programs in suicide prevention, but information is p rovided to GPs, and psychologists available for referrals. Activities are more locally based initiatives, organised by service delivery people, in regions of higher risk, particularly in sugar growing areas.

Schools programs

Allied health workers and Division staff have worked in conjunction with school counsellors, but no specific programs at present**.** Awareness of Mind Matters.

Advice to other Divisions

Look at getting funding to provide needed allied health services, rather than trying to force provision through state health services.

Work closely with community to provide health service needs, and to show that general practice has a broader interest than GPs surgeries.

References and useful resources

Not much written, but conference presentations by Lorrraine Ashworth, Kelly McTaggart, Kris Battye.

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MENTAL HEALTH PROGRAMS/ACTIVITIES

The Division works closely with the SBO in mental health – they provide training workshops if necessary.

Allied health services projects

MAHS program is in fourth year of funding and working very well, although there are still unmet needs in mental health and elsewhere.

7 psychologists are employed under MAHS funding. Areas serviced are Mossman, Innisfail, Kuranda Port Douglas, Mission Beach, Tully, Atherton, Mareeba, Ravenshoe and Cooktown. These range from weekly to fortnightly visits, and operate out of GP practices. This model is very well appreciated by all stakeholders and enhances EPC (Enhanced primary care items).

A Drug and Alcohol worker is also employed.

MAHs funding has enhanced private allied health practices, despite initial fears about impacts on private practitioners. Has increased access for people not in private health care, who are able to access Allied Health Services through private GPs.

Drug and alcohol comorbidity

Drug and alcohol service has been contracted out under Better Outcomes A Drug and Alcohol counsellor is employed 2 days per week, one day to Kuranda and the other to Ravenshoe

Advice from psychiatrists

Psychiatrist flies to Weipa on a quarterly schedule under the Medical Specialist Outreach Assistance Program (MSOAP). This is all arranged by QDGP, with the Division only supporting it by linking this service in with local GPs.

Education and training resource development

13 GPs have done Better Outcomes Level 1 training and registered– 15-18 are ready to go for next training, which is scheduled late April 2004. There is 1 Level 2 GP based in Ravenhope. Resistance to registration.

Shared care

MAHS project, EPC care plans, case conferences, BOiMHC program are all operating.

Indigenous mental health

20 % of the Division's population is indigenous.

Drug and Alcohol services to Kuranda Clinic.

Primary Mental Health Care Australian Resource Centre   November 2004

In Cape York the Division is involved in Primary Health Care Access program (PHCAP) in implementation and is not directly involved in any services, including services to the Torres Strait Islands.

The steering committee of PHCAP addresses all complex issues like suicide and alcohol use.

Some indigenous people prefer to use mainstream GP services in the towns, and mainstream into MAHS services, which include Aboriginal Health Workers

Mental health and physical health

The Division has been involved with local Indigenous initiatives through PHCAP implementation

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MENTAL HEALTH PROGRAMS/ACTIVITIES

Allied Health services projects

One psychologist in Port Augusta, employed under MAHS funding, 10 hours a week.

The Division is seeking funds under Better Outcomes in Mental Health Care Initiative for an Allied Health Worker funding to employ an Allied Health Worker to triage for an additional Psychology Service. This would be limited to Depression and Anxiety, and utilizing CBT.

Peer support

Has been a teleconference group in the past, which GPs found useful. Not continuing. This was disbanded when SADI ceased to fund it.

Drug and alcohol comorbidity

Included in Level 1 training.

Advice from psychiatrists

Lunchtime case conferencing with visiting psychiatrist has lapsed

Psychiatrists employed through MSOAP visit Roxby Downs, Coober Pedy.

Education and training resource development

Folder was developed on Community Treatment Orders and detention procedures. This was developed by the division, and distributed to our GP members. This couldn't be distributed interstate as legislation varies. 17 GPs are currently Level One Trained under BOiMHC.

Indigenous mental health

Large transient indigenous population travel around region, between Pt Augusta, Alice Springs, Ceduna.

Services provided to Nepabunna, Hawker, Quorn, by Pika Wiya and Coober Pedy through Ummona (Aboriginal health services).

Networks and linkages

Good relationships with regional Mental Health Service, Pika Wiya (Aboriginal health service), RFDS

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MENTAL HEALTH PROGRAMS/ACTIVITIES

Drug and alcohol comorbidity

The Department of Justice ran a brief prescriber training program with 5 GPs & 2 pharmacists, who are now accredited in prescribing drug addiction medication, e.g. Naltrexone & Methadone. This occurred in 2002, and prescribing is ongoing. This program was Broome based, however Doctors from throughout the Kimberley were invited.

Indigenous mental health

All programs include indigenous health. The Aboriginal population makes up 47% of the Kimberley population and 70% of the population in the towns of Halls Creek and Fitzroy Crossing.   This places a significant importance in providing suitable models and sources of support for indigenous populations within the Kimberley.

Schools programs

Currently, no school based programs dealing with mental health are being investigated. The Division has previously participated in the Canning Stock Route Challenge, a successful school based program targeting type II Diabetes among pre and primary school children. As a result, the Division has identified a successful model as a foundation for any future school based mental health programs.

Advice from psychiatrists – including telepsychiatry

Telepsychiatry is currently not a viable option for GP members due to a lack of resources and available psychiatrists in the region.

Suicide prevention

GP access program prevention has indirect suicide prevention function

Others

A Women's Healthy lifestyle and wellbeing program, targeting Type II diabetes, has been run in Broome and planning for a similar program has commenced in Derby and Kununurra. A holistic approach to health is used - physical health, mental health, diet and exercise, and general wellbeing.

Kimberley Division has applied for funding under the Better Outcomes in Mental Health (BOIMHC) initiative. If the funding request is accepted, an innovative model for mental health care will be implemented throughout the Kimberley.

Mental health and physical health comorbidity/Education and training resource development/ Shared care/Networks/linkages/suicide prevention

GP access program (pilot program –timescale Nov 2003-May 2004)

MENTAL HEALTH PROGRAM

GP access program (pilot program –timescale Nov 2003-May 2004)

The GP Access pilot program is currently being run in Broome by the Kimberley Division in conjunction with North West Mental Health Service (NWMHS) and the 2 Broome private general practices. It aims to provide team management of mental health, to provide improved and coordinated primary health care to people with mental health conditions, to improve total health system efficiency by referral of patient care to an appropriate setting, and to improve the capacity of each service. NWMHS Referral of patients to the GP setting reduces overload on specialist mental health services.

Throughout the pilot phase, NWMHS is identifying 10-16 patients who have chronic but stable mental illnesses. Patients are then introduced to GPs by Mental Health case workers, who also provide case history and patient notes for the doctors. The referred patient is invited to sign a form stating patient understanding of confidentiality processes and participation in the pilot project.

The role of NWMHS is to identify suitable patients, facilitate access by providing transport and organisation of appointments, and to introduce patients to GPs through a qualified mental health case manager. The GP's primary role is to provide non-urgent and routine in-hours general care of the patient and fulfill any primary and secondary health care needs for the patient. In a situation where specialist mental health care is indicated, this care will be managed by NWMHS until the patient is stable enough to be managed by the GP. If after-hours urgent care is needed the patient is to present to Broome Hospital Emergency Department.

The Division will fund 5 'level B' consultations and encourages the use of two consultations during the first appointment to allow communication and assessment. Reimbursement will be paid by the Division of General Practice to the full amount even if the patient does not attend the booked appointment.

The program is only running in Broome at present, and covers a diverse population. It was developed from an existing strategic liaison between GPs & NWMHS through previous agreements and fund sharing between Kimberley DGP, Pilbara DGP, and North West Mental Health Services. After consultation with GPs, the program was revived in 2003 as a pilot program. A draft program was developed by the Division in conjunction with the other participants, and the pilot program then commenced on 3rd November 2003.

As of April 2004, approximately 10 patients have received 3-5 consultations from Broome GPs. Feedback has been positive from all participants and administration has been kept to a minimum.

Evaluation is built into the program. This includes patient feedback, GP feedback, clinic records of consultations and non attendances, clinic spreadsheet data etc. Formal evaluation will occur at the end of the Pilot project – May 2004, before the program is extended.

When the program is sustainable in Broome, it will be set up in other towns, initially Derby in the East Kimberley, then Kununurra in the West Kimberley. This will involve developing partnership with town based health services and establishment of local sustainability

In Broome there exists a high level of involvement and interest from town health services and agencies, and an effective model was developed for the three participating services to work together. GP involvement has been high and enthusiastic in the small community of Broome – at the beginning the Division organised a GP lunch, provided opportunity for feedback, and discussed particulars of the program and subsequent approach. Ongoing communication by email, telephone and fax assists continuing involvement.

Communication has occurred with all health workers in the region, to help extend the program.

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MENTAL HEALTH PROGRAMS/ACTIVITIES

Allied health services projects.

Application for one-year funding under *Better Outcomes in Mental Health Care Initiative* - Access to Allied Health has been successful. This program will be based in Esperance commencing 1st July 2004 with an Allied Mental Health Professional working one session a week in each of the four practices to provide FPS to clients referred by GPs. A Project Officer will also be employed to assist to coordinate services and improve communication between health service providers

Peer support

GP peer group discussions and learning in Esperance utilized the services of a visiting psychiatrist for three visits in quick succession, January and February 2004. GPs nominated topics and cases for discussion to GP facilitator. Psychiatrist flew in for each day of activity, starting with breakfast meeting with psychiatrist providing education. He then interviewed nominated patients, before meeting with GPs again that night, where the local GP presented case for peer review, with psychiatrist offering for case advice and facilitating discussion. A planning meeting preceded three meetings over a two month period, followed by GP evaluation meeting. Attendance at the three rapid-fire psychological discussion meetings was awarded with CPD points for small group learning.

Advice from psychiatrists, including telepsychiatry

Videoconferencing has been trialed, but has not been taken up very well - required technicians to be physically present along with GP and patient when accessing psychiatrist on other line – this was inhibiting.

EGMDGP is a national test site for the Broadband technology strategy, which will enable development of greater telecommunications options for the Divisional region. This may enable telemedicine to be more adequately trialed. Our involvement in this project is in the initial information gathering stage, with announcements to be made by the Health Minister in the next month following delivery of next budget.

Education and training resource development

Funds allocated though Chronic Disease funding allowed for Signals 1 & 2 mental health training courses in Kalgoorlie and Esperance as well as familiarization training. This provided the necessary requirements for registration with level one on the BOIMHC initiative. Not many GPs in our division were able to participate in each of the three training events to enable the sign up to occur. Uptake of Initiative has also been compounded by associated paperwork, and limited ability to refer to other Mental Health professionals. Better Outcomes training and its uptake has been affected by logistical problems of running courses for GPs in remote areas – they need to be presented in a block, not fly in fly out over several weeks, or GPs need to be funded to go to Perth. Conflicts have occurred with other weekend education events.

Indigenous mental health

No specific Indigenous programs, but EGMDGP has a memorandum of understanding with Bega Garnbirringu (Aboriginal Health Service) in Kalgoorlie and Ngangganawili (Aboriginal Medical Service) in Wiluna. Some individual GPs work with Indigenous emphasis.

Networks and linkages

MoUs were developed between EGMDGP, Kalgoorlie and Esperance Community Mental Health Services in 2000. These were developed utilising one-off Commonwealth funding available for brief psychological interventions and GP liaison facilities in WA – Intervention services were provided in Esperance for a six month period.

Child and adolescent Mental Health

Youth health is a focus for 2004 – 2007; this will include youth mental health partnerships between Division and other service providers.

Mind Yourself project was run in conjunction with Kambalda High School between 1998 and 2000, but funding was not renewed to allow continuation or extension, and then staff changes led to reduced capacity to run it. Several partners were involved - Division, school, social health providers such as School Arts Program linked in through Curtin University, Kalgoorlie/Esperance based psychologist. Good program, involving extensive communication and partnerships.

Project was extensively evaluated, and report is available on Division website.

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MENTAL HEALTH ACTIVITIES

Allied health projects

Applying for 3rd round BOiMHC funding

Peer support

A peer support program has started after considerable difficulties, but there are problems in remote areas due to reliability of teleconferencing and videoconference technology, and solo GP overload in small communities. This program is taking a two tiered approach, with peer support upskilling being provided to 5 health provider champions, and then 5 groups are running, 4 regionally based groups and a videoconference group, (which has fallen into abeyance).

Drug and alcohol, comorbidity

There is no specific funding for Drug and Alcohol program. The Division is always looking for primary care partnerships and other collaboratives.

Men's health Pitstop program includes alcohol and drug (smoking) components– fuel additives and exhaust sections, including Shock Absorbers , which is coping skills, as part of total health.

Youth mental health

A large youth program finished about 2 years ago, due to end of funding. Included ADHD education for GPs and others, and shared employment of a mental health nurse under Youth Mental Health with Central West Mental Health. Information about this is still available on the Divisional website.

A Youth Mental Health Directory was compiled as part of the same project, and is available on the Division website.

Mental health and physical health

The Division is a participant in the Move, Motivate Midwest Committee, a broad based working party of government and non government organisations. This group applies for funding for a variety of physical activity and beautification projects, e.g. for publicity of walking tracks and other projects to improve physical and mental health and build on community capacity.

Another of their projects has been the development of a Get Fit Kit, listing every available physical activity and activity. This is available through the Division, and has been distributed to GPs, pharmacists and the Population Health Unit, as well as to all town councils and other health related organisations.

Advice from psychiatrists, including telepsychiatry

Telepsychiatry is not happening.

There is one psychiatrist in Geralton to cover the whole area of the Division. A problem of psychiatrist retention exists, in a job involving enormous amounts of travel and remoteness from services, including lack of high schools.

Ruralink Mental Health line is promoted on the Division website, but the Division is not involved in its operation.

Education and training

Some GPs have completed Better Outcomes level 1 & 2 training, but statistics are not available for registration. The Division has a good relationship with Primary Mental Health Research Unit at University of W.A, which provides some training.

It is hard for GPs to attend mental health training, due to isolation, and particularly problems with airline timetabling or absence of direct flights and consequent time away from surgery.

Shared care

A child psychologist was originally employed by Division with MAHS funding to work at Aboriginal Medical Service – now employed by the Medical Service, so services are still available. There is a social worker at Onslow.

Suicide prevention

The Pitstop program includes an emotional health component, directed towards men in remote areas.

There are high rates of suicide in farming areas in bad seasons, and the program may be a way to monitor problems in remote communities, if resources are available for evaluation.

Indigenous mental health

Pitstop covers all men – part of the follow up may be encouragement to see the psychologist at Aboriginal Health Service.

Networks and linkages

Many linkages are still occurring at worker level rather than organisational, but Divisional aim is to set up relationships and programs that will outlast funding and outlast staff members. No formal MoUs are in place, but the Pitstop program provides a venue for workers from different organisations to work together at an informal level.

MENTAL HEALTH PROJECTS

Pitstop program for men's health

The intention of this program is to get men to use GPs and other health services, and to make healthy lifestyle changes. It is run in collaboration with the Men's Health Program, which has now been refunded till June 2005, but with no funding from the Division.

Workers from a variety of professional specialties go out (mostly on a volunteer basis) to remote communities, to country shows etc, mostly on weekends. These workers will include local health professionals where possible. The program uses the theme of Body as Car, with men going through a series of checks/tests covering areas of physical and mental health – Chassis (waistline), Shock Absorbers (mental health), Fuel Additives (alcohol), Exhaust (smoking), Spark Plugs (testicles and cancer), Torsion (flexibility), Oil Pressure (blood pressure). Men may be referred to GPs to follow up on particular health issues, or given a yellow sticker if overall health status is not good (and the incentive to make changes so they will pass next time).

It is necessary to have professional staff working in the Pit, to provide immediate advice if it is needed, in the probably absence of other local services in remote areas (e.g. registered mental health nurse or social worker who is able to provide immediate counselling in the shock absorber section, if it is required.)

The collaboration between Men's Health and the Division started in the middle of 2003, , so has not yet done repeat visits to a number of centres. It still has no funding from the Division, so staff are working voluntarily on it.

There is potential for the program to monitor community mental health and provide evidence of community support needs (e.g. if rates of suicide or depression go up). This happened in Meekatharra, flagging alcohol and youth suicide problems associated with the mine workers.

Formal evaluation of the program has not yet been done, due to its newness. An evaluation tool needs to be developed to move from the basic statistical data to an ability to analyze it in detail and report back on needs. Funding has been applied for in conjunction with the Combined University Centre for Remote Health for a person to do the evaluation in 2004. Other funding has already been obtained from PHC RED's research program. The study needs to be longitudinal, to allow for changes in conditions from year to year (e.g. drought and crop cycles).

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MENTAL HEALTH PROGRAMS/ACTIVITIES

Peer support

The Division ran one successful peer group in 2003, with 2 groups starting in 2004, one in Port Hedland, one in Karratha.

Mental health breakfasts also provide peer support for GPs.

Advice from psychiatrists (including telepsychiatry)

Mental Health breakfast meetings between GPs and psychiatrist from North West Mental Health Service.

Mental Health Direct telephone line is publicized through the Division website and newsletter, but the Division is not directly involved.

Indigenous Mental Health

Indigenous mental health is included in all mental health, but the Division doesn't specifically target the Indigenous population. Divisional partners include Indigenous health services and communities.

Child and youth mental health/suicide prevention

Youth Support cards.

Suicide prevention

Joint Suicide Prevention Working Party in Roebourne Shire

Networks and linkages

Joint Suicide Working Party in Roebourne Shire

MENTAL HEALTH PROGRAM DESCRIPTIONS

Mental Health breakfast meetings

These meetings were jointly developed by North West Mental Health Service and Divisional GPs, several years ago, and have been run in the towns for last 3 years. A psychiatrist from North West Mental Health Service in Broome joins GPs from practices in small outlying areas for a breakfast, usually at the hospital. GPs bring case conference notes with them, or issues that have developed within their practices.

If there are no cases from GPs, the psychiatrist will bring a subject for discussion. The Division is also looking at trialling PriMeD modules involving cases.

The meetings earn CPD points for small group learning, allow networking between the GPs and the psychiatrist, and provide peer support for GPs. They also rely on peer motivation to continue

There is very high involvement and enthusiasm by GPs in smaller towns (1,2,3 GPs per town). Problems with closures of air services have interrupted continuity, and the meetings have lapsed in some larger towns, but they are about to restart in Karratha with a new GP facilitator and new psychiatrist,. depending on GP interest and time allowing.

These meetings are sustainable in terms of resources (cost of breakfast only) and coordination required –some Divisional time to communicate to GPs when psychiatrist is coming and when meeting will be on. GPs now know what to expect and what to bring, so not much organisation is required prior to the meeting.

Meetings are held irregularly, when the Psychiatrist visits.

Joint Working Party on Suicide Prevention, Roebourne Shire

This working party has been going since March 2003, operating in Roeburne Shire, in the towns of Karratha, Roebourne, Wickham, Pannawonica.

A broad based group of service providers has come together – Pilbara Division, GP rep, police, hospital Emergency Department, Mental Health Services, phone care, school chaplain, youth groups, mining company reps etc to work on ways to reduce rapidly increasing rate of suicide among the fly-in fly-out workforce and other youth.

The group initially targetted is men from 24-45, the aim is suicide prevention and intervention. But the group is there to support any need in Suicide Prevention so if that is younger people or females they will not be excluded.

The first project is a series of posters with simple messages and phone numbers, including Lifeline and GPs, and removable cards with the same phone numbers. They include a "distressed" poster and a "suicidal" poster. These are displayed in areas where men are, mine sites, men's toilets– with awareness of issues of stigma and privacy.

The Group has had other benefits in terms of improved communication and cooperation between assorted service providers, and joint initiatives, e.g. new procedures for Emergency Department/police cooperation.

The Division has supported training and participation of the GP rep, who has developed skills which are also being used for the Youth at Risk project.

The group started with no funding, and is now starting to apply for funding from a variety of sources. The work load is shared among members, so no extra staffing resources are needed to run it.

This project is not yet evaluated – the Christmas period is expected to be busy and to provide more data.. It may be evaluated after a year, although it may be hard to directly attribute increased use by men of GPs and hospital to the success of the project. One measure of effectiveness may be a change in suicide stats

Lessons learned

need for strong focus, to know where you want to go

benefits of community networking and cooperation, greater knowledge of people and services

Youth Support card – Let's reach out in the Pilbara.

This has mostly been developed by the Division, with some input by other members of the Suicide Prevention Task Force. The card has been distributed around all high schools in the Pilbara and to GPs

The front side of the card is artwork from local youth, in several designs including indigenous art, drawing by young person at risk, and Pilbara pictures (variety allows choice and draws on regional

pride). The other side lists free, up to date and youth focused emergency telephone numbers and websites

This project began in early 2003, and will be repeated each school year.

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MENTAL HEALTH PROGRAMS/ACTIVITIES

Allied Health Services projects

Allied Health Services under Better Outcomes in Mental Health have been outsourced to N.T. Rehabilitation Services, which provides clinical psychologist services in CBT for individuals and groups. Referrals by registered doctors. A wider range of services will be provided in 2004, including total referral service and skilling up of GPs.

There are high rates of anxiety and depression in Darwin due to transient populations without support or families – youth, military personnel and families, short term workers.

Aboriginal Mental Health Workers are employed in eight remote indigenous communities under MAHS funding, and the project is now expanding to include drug and alcohol workers as well.

Peer support

A small group learning group has developed from allied health services, learning about CBT and assessment, discussion of cases, and has developed into supervision group. The funding has now finished, but the group is continuing.

Drug and alcohol comorbidity

A new program to address drug and alcohol issues within Indigenous communities is starting in 2004, funded by Alcohol Education Rehabilitation Promotion, and employing local drug and alcohol workers in four Aboriginal communities. This is linked to the Indigenous Community Mental Health program. Training will be provided through Batchelor Institute of Indigenous Tertiary Education.

Child and youth mental health/schools programs

A Mind Matters Plus program in conjunction with Taminmin High School aims to bring primary care sector together to develop better referral pathways for care of secondary students, including pathways to GPs. This incorporates bulk billing and subsidized fees.

A capacity building approach is for schools to support students at risk, extending to both the students and their parents

Many networks have developed, within school and in the community, and a number of service providers are involved, including Division, ADGP and GPs, youth agencies, school staff etc.

Advice from psychiatrists, including telepsychiatry

Telepsychiatry has been available for NT GPs in the form of consultation phone calls to the hospital up until now. Territory Health is now about to employ a psychiatrist specific to this service.

Education and training resource development

The Division has a dedicated Education and Training arm, and Better Outcomes Level 1 & 2 training has been taken up by many GPs. Some GPs are now doing CBT within their own practice

rather than referring. PriMeD training is about to start via the internet – a flexible alternative to block training in Darwin for remote GPs.

Shared care

A component of Mind Matters Plus and Aboriginal Health Worker programs.

Suicide prevention

A component of Aboriginal Health worker and Mind Matters Plus programs.

Networks and linkages

Extensive links with government and non government mental health care agencies.

Indigenous mental health

The Aboriginal Health Worker program aims to improve mental health care of Indigenous people in remote communities in the most culturally sensitive, cost effective possible manner as well as providing cultural links and support for GPs in Indigenous communities– a community capacity building approach is used.

The program developed as a response to many needs - from remote GPs requiring allied health services, particularly mental health services, Aboriginal people wanting to address Indigenous health disadvantage, government concerns about GP retention in remote areas, needs for Aboriginal community self determination, among others.

The program currently supports about 17 staff across 8 communities– educating Aboriginal Health workers and GPs in Indigenous and Western ways, and in providing local solutions to local problems – each community is different. Aboriginal Health Workers undergo 2 years of block learning at Batchelor Institute and additional training as needed.

Extensive and continuing consultation with indigenous communities by the Division occurs at all stages - initial needs study, whether community wants Aboriginal Mental Health Worker working with the GP, who is to be employed and under what conditions, needs for them to address, cultural issues, ongoing community concerns and happenings, etc. This leads to a high degree of community ownership and support of Mental Health Workers. The program employs two Indigenous coordinators (male and female) and has senior cultural advisors attached to program to refer to in case of complex cultural issues

Health workers have initial credibility by virtue of their positions as respected community members, and are able to talk with, monitor patients, ensure medication is taken, liaise with visiting Territory Mental Health Services staff about ongoing treatment and access to patients, provide education for the community and community outreach activities, deal with emergencies etc. They are also able to distinguish between mental health issues and culturally based behaviour that might be interpreted by GPs as mental illness (e.g. mourning or self harm). They work closely with GPs and practice nurses within the clinic and in an outreach capacity on patient care.

The Division acts as a broker between Aboriginal Mental Health Workers, GPs, Nursing staff and Community Council, as well as providing ongoing training and support for all participants. A forum held each year, bringing together Indigenous staff and GPs from across the top end associated with the program, providing an additional opportunity for discussion, debriefing and support for workers who are often under stress– leading to a very high worker retention rate.

Extensive evaluation has been carried out by Charles Darwin University over a two year period, with the final report due in June 2004. One aspect has been an attempt to standardize record keeping across communities– but problems of consistency across a variety of clinic types – privately owned/run, government, community run may prevent this, despite efforts of the health workers. When this evaluation report becomes available it will be provided for the PARC library.

This program is very resource intensive, but has vastly improved health service sustainability and effectiveness of the GPs working in remote communities, as well as cutting down the number of inappropriate patient air evacuations. Funding runs out in June 2004, but negotiations are under way to continue. Major cost is travel to remote communities, which may involve chartering a plane if no regular services are available – road travel is very time consuming and roads may be closed during the wet season.

Two full time Indigenous coordinators are employed, one based at Nhulunbuy, in East Arnhem Land. The program relies on them for cultural and community information - this cultural sensitivity and ongoing community consultation is vital for its success. Program success is also related to the trust that has built up between participants over its three years of operations, and to the support that is provided to all program workers.

The program has achieved:

Finalist category at the THEMHS Sept. conference in Canberra, 2003.

Winner at the ADGP Nov. conference in Brisbane , 2003.

References and useful resources

McConachy, Sandy (2003) "Working both Ways": the Top End Division of General Practice, Northern Territory Aboriginal Mental health worker program, <u>Indigenous Health Matters</u>, November 2003**.**

Proceedings of THEMHS conference Canberra, 2003

Proceedings of the ADGP conference, Brisbane, 2003

Appendix 7 Glossary

ADGP	Australian Division of General Practice
AERF	Alcohol Education and Rehabilitation Foundation
AGDHA	Australian Government Department of Health and Ageing (formerly DoHA
AHWAC	Australian Health Workforce Advisory Committee
AIHW	Australian Institute of Health & Welfare
AMWAC	Australian Medical Workforce Advisory Committee.
ARIA	Accessibility/Remoteness Index of Australia
ATSI	Aboriginal & Torres Strait Islander
BOiMHC	Better Outcomes in Mental Health Care Initiative
CBT	Cognitive Behavioural Therapy
CESA	The Client Event Services Application (CESA) provides IT Data collection and analysis for Health Service Providers in Mental Health Services in Qld.. CESA also allows closer integration of Health Services and provides mechanisms for estimating staff workloads and district funding requirements.
CME	Continuing Medical Education
CPD	Continuing Professional Development
DGP	Division of General Practice
DLO	Divisional Liaison Officer (of the Primary Mental Health Care Initiative)
DoHA	Department of Health & Ageing. Now AGDHA
HACC	Home and Community Care
ICD-10	International Classification of Diseases (10th edition)
MAHS	More Allied Health Services
MHS	Mental Health Service
MSOAP	Medical Specialist Outreach Assistance Program
NPMHCN	National Primary Mental Health Care Network
PARC	Primary Mental Health Care Australian Resource Centre
PHC RED	Primary Health Care Research Evaluation & Development Program
PHCRIS	Primary Health Care Research & Information Service
RACGP	Royal Australian College of General Practice
RDWA	Rural Doctors' Workforce Agency
RFDS	Royal Flying Doctor Service
RRMA	Rural, Remote, Metropolitan Areas classification
SBO	State Based Organisation
SGL	Small group learning
SLA	Statistical Local Area