Diversity in Rurality

An Exploration of Barriers to Accessing and Providing Mental Health Services in Rural Victoria

Kristen Van Bael
Victoria University
2017

Acknowledgments

I wish to thank my academic supervisor, Ed Lock, for providing me with guidance and support. Producing this report would not have been possible without the assistance of Emma Kealy, and her dedicated staff, Suzanne and Kim. I am thankful I could explore an issue from a different perspective. The insights of service providers significantly contributed to the final product, and I appreciate their assistance. Finally, thank you to my family and friends for supporting me—especially my father, who accompanied me to Horsham.

Kristen Van Bael

Victoria University

Ms. Emma Kealy

MP for Lowan

June 2017

Cover image source: Geraghty, D. (Photographer). (2017). Pink Lake in Dimboola Victoria [Online image]. *The Australian.* Retrieved from http://www.theaustralian.com.au/

Table of Contents

Glossary

A&E	Accident and Emergency Department
ABS	Australian Bureau of Statistics
ACIS	Acute Community Intervention Services
ACSO	Australian Community Support Organisation: Organisation tasked with assessment and referral of persons requiring mental health interventions
AIU	Acute Inpatient Unit
ATAPS	Access to Allied Psychological Services
BHS-MHS	Ballarat Health Services Mental Health Services
Consumer	A person that has used or uses a mental health service
CCU	Community Care Unit
LGA	Local Government Area(s)
MBS	Medicare Benefits Schedule
MHCSS	Mental Health Community Support Services
MHFA	Mental Health First Aid
NDIS	National Disability Insurance Scheme
PBS	Pharmaceutical Benefits Scheme
PCP	Primary Care Partnership
PHN	Primary Health Network: Organisations tasked with the objectives of increasing the efficiency and effectiveness of medical services for patients, and improving coordination of care.
Rural Victoria	Areas outside of metropolitan Victoria. Described in data sources as Country, Regional, or Rural Victoria. This report uses the term 'Rural Victoria'.
SECU	Secure Extended Care Unit
Service Provider	An organisation or person working in the mental health sector that provides (specialist) mental health services
SES	Socioeconomic Status
The Wimmera	The Wimmera Southern Mallee region. Report focuses on Hindmarsh, Horsham, West Wimmera, and Yarriambiack LGAs.
WUC	Wimmera UnitingCare

Executive Summary

This report seeks to identify barriers to accessing and providing mental health services in rural Victoria. Policymakers recognise that mental wellbeing contributes to overall health. This has become increasingly important in policymaking, as incidences of mental illness and suicides across the state have reached concerning levels.

Presently, a series of frameworks, plans, and strategies exist to increase and promote mental wellbeing, strengthen the mental health workforce, and reduce suicide rates. These underpin the Government's approach towards realising these objectives, and include: *Victoria's 10-Year Mental Health Plan*, *Victorian Suicide Prevention Framework*, and *Mental Health Workforce Strategy*.

The Government acknowledges that accessing mental health services in rural areas of the state is difficult. This report examines the barriers to accessing such services in rural Victoria through the lens of a case study on the Wimmera —a rural region in western Victoria. The Wimmera is characterised by small towns spread across large distances. It is a diverse region with strong community values, but factors associated with rural life contribute to poorer mental health outcomes. Rurality provides context for barriers in access. These include lower socioeconomic status, occupational and situational stress, the physical environment, and restricted access to Internet, transport, and health services.

Through interviews with Wimmera service providers, this report finds that barriers in policy impact on the capacity to provide services, which contributes to barriers experienced by rural Victorians accessing mental health services.

A 'one size fits all' approach to policy restricts rural service provision and accessibility. Although adhering to expectations is required, funding models are restrictive, and hinder mental health promotion among communities. Rurality is rarely considered in present Victorian policy. A reactive approach to implementing strategies and funding of rural mental health services is not sustainable. Increased funding is typically in response to drought, floods, or fires.

The workforce is skewed to densely populated areas of the state. Barriers experienced by service providers include the attracting, recruiting, and retaining of mental health professionals in rural Victoria. Factors contributing to this barrier include a lack of incentives

to stay or relocate, job security, and professional isolation. Training and the dissemination of knowledge to professionals are restricted in rural Victoria, and explain difficulties in sustaining the workforce. Changes to service provision also impact on providing services, due to poor communication regarding rollouts, and uncertainty regarding future implications.

For consumers, factors associated with rurality are the largest barriers to accessing quality mental health services in a timely manner. These include poorer mental health literacy, restricted access to quality Internet services, challenges navigating the current mental health system, and a lack of specialist services.

Although stigma associated with mental health problems has been tied to rural communities, the report finds that poorer mental health literacy exacerbates this. While rural consumers are encouraged to use telehealth or web-based services, this is difficult if disparities in Internet access between metropolitan and rural areas persist. Rural consumers face difficulties navigating a complex mental health system—either not understanding what services provide, or they experience burnout from cyclical referrals. Lengthy waiting times also deter consumers from accessing services. Wimmera consumers experiencing significant mental health problems do not have access to a wide range of services, and travel long distances to access them. This impedes on recovery, as consumers access treatment away from their community.

This report recommends the following:

1. Consider rurality when developing programs to improve mental health
2. Explore ways to attract mental health professionals to rural areas in Victoria
3. Increase training of the mental health workforce based in rural areas of the state
4. Develop initiatives towards increasing mental health literacy in rural areas
5. Consider funding for ‘flexible’ acute inpatient beds in local rural hospitals

Introduction

The mental health of all Australians is important. Mental health contributes to our everyday functioning. According to the World Health Organisation (2014), mental health is understood as a "state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community".

Factors in an individual's life can affect their ability to cope, and result in mental health problems—which interfere with behaviours, cognitions, and emotions (Judd et al., 2006b). If these are not managed, they can manifest in mental illness (Department of Health, 2007). Mental illness can significantly affect functioning (Department of Health, 2007; Wrigley et al., 2005, p. 515). There are several types of mental illnesses, including anxiety, depression, schizophrenia, and eating disorders (Department of Human Services [DHS], 2006, p. 4). Recognition of the importance of mental health and wellbeing has increased, and governments around the world have increased their efforts to deliver mental health services.

Like many other governments, the Victorian State Government has sought to address the challenge of promoting mental health. However, the accessibility of services differs markedly across Victoria. The purpose of this report is to identify barriers to accessing and providing mental health services in rural Victoria. To do so, this report explores how mental health is addressed through Victorian policy. It provides an overview of the Government's objectives towards increasing mental health and wellbeing, and reducing suicides. This is through development and implementation of plans, frameworks, and strategies.

This report utilises primary data from interviews with Wimmera service providers. Secondary data were sourced from existing research and statistics related to rural Victorians, and socioeconomic factors linked to mental health outcomes. This report surveys current Victorian policy relating to mental health; evaluates the provision of services under this policy in general, and the Wimmera in particular; then identifies the specific barriers that limit service accessibility. This report concentrates on policy-related barriers, barriers that limit service provision, and barriers that restrict users in their access to services.

Limits on the scope of this report and the available resources necessitated a focus on local service provider perspectives. Future research could engage with providers from clinical settings, such as Ballarat Health Services, and bush nursing centres.

Chapter 1. Context

Mental health contributes to our everyday functioning. According to the World Health Organisation (2014), mental health is understood as a "state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community".

Factors in an individual's life can affect their capacity to cope with stress, and result in mental health problems—which interfere with behaviours, cognitions, and emotions (Judd et al., 2006b, p. 769). If these are not managed, they could manifest into a mental illness (Department of Health, 2007). Mental illness can significantly affect an individual's functioning (Department of Health, 2007; Wrigley et al., 2005). There are several types of mental illnesses, and each can be experienced with varying degrees of severity (Department of Health, 2007). These include anxiety, depression, schizophrenia, and eating disorders.

An estimated one in five Australians experiences a mental illness each year (Department of Health and Human Services [DHHS], 2016c, p. 13). However, some populations are more at-risk than others, such as people living in rural areas of the state. This has necessitated prioritising mental health and wellbeing in Victorian policy. Chapter 1 provides an overview of mental health frameworks developed by the Victorian Government. This section also summarises current mental health policy frameworks and mental health legislation that inform mental health service provision in Victoria.

1.1. History of Mental Health in Victorian Policy

Past Frameworks, Plans, and Strategies

The Victorian Government has a storied history with mental health in practice and policy. Several policies have been developed over the past few decades to encourage mental health service reform (DHS, 2006a). Past publications aided in the structure, growth, and objectives of Victoria's mental health service system, which are expressed through frameworks, plans, and strategies. These described the delivery of mental health services in Victoria, and detailed strategic directions that were focuses of the Government (DHS, 2006a). Figure 1 provides an overview of past mental health frameworks, which have informed those that have followed (DHS, 2006a, 2006b, 2011).

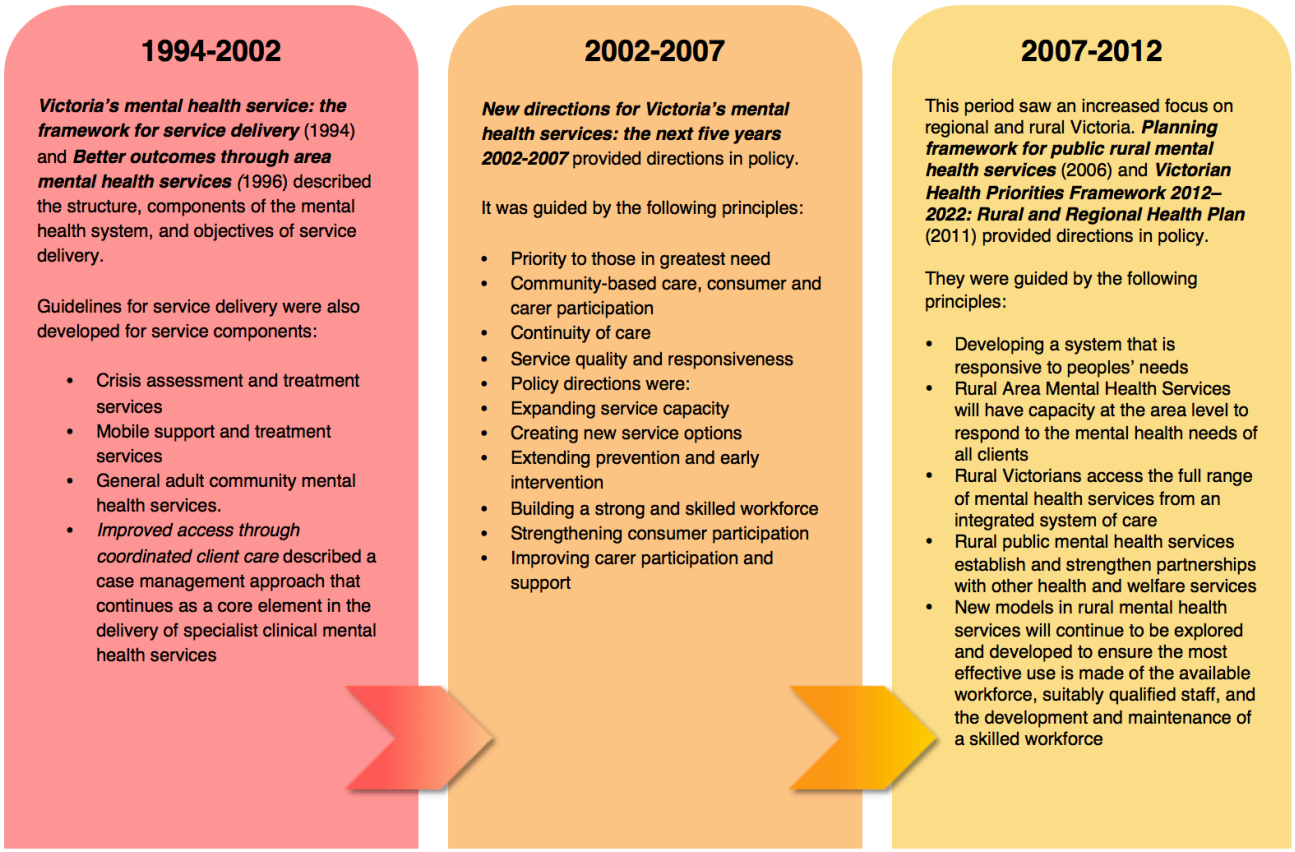


Figure 1.

Mental health frameworks, plans, and strategies from 1994-2012

Prior to 2006, the Victorian Government focussed on addressing this area in policy through Statewide frameworks. From 2007, successive Governments identified the needs of rural and regional Victorians. The frameworks were developed to bolster access and service provision.

1.2. Current Policies and Frameworks

Mental Health Act 2014

The *Mental Health Act 2014* (Vic) came into effect on July 1 2014 (DHHS, 2015). It repealed and replaced the *Mental Health Act 1986* (Vic), which legislated the assessment and treatment of persons with mental illness accessing state-governed mental health services. The Act informs mental health services provided at a clinical level in Victoria, especially for those experiencing the sudden onset of severe and distressing psychiatric symptoms. The Act guides policymakers in developing current frameworks for the governance and provision of mental health services in Victoria (DHHS, 2016a, 2016b, 2016c).

Mental Health in Policy

Awareness surrounding mental wellbeing as contributing to overall physical wellbeing has informed the Government's vision: Ensuring that all Victorians experience their best possible health, including mental health (DHHS, 2016d, p. 5). A single framework or plan does not exist to outline the directions of the Government. The Government has developed several plans, which pertain to overall health, and mental health. Frameworks are directly related to one another. Specific goals, directions, and proposed outcomes are expanded on in each document.

Figure 2 provides a summary of the current frameworks and plans, as developed by the Andrews Labor Government (DHHS, 2016a, 2016b, 2016c, 2016d).

Figure 2
Current Plans, Frameworks and Strategies of the Victorian Government

Victoria's Public Health and Wellbeing Plan

Victoria's Public Health and Wellbeing Plan (DHHS, 2016d) plan encompasses the Government's priorities to improve mental health among Victorians (DHHS, 2016d, p. 37):

- Enhance and develop strategies to promote mental health and wellbeing and reduce current high levels of psychological distress
- Increase the intensity of targeted action for those who experience greater social and economic disadvantage

- Specifically consider and support the social and emotional wellbeing of Aboriginal Victorians
- Invest in early identification and intervention with vulnerable children and families
- Focus on promoting wellbeing and preventing suicide in at-risk populations including Aboriginal Victorians, young Victorians and those living in low socioeconomic areas

Victorian policy builds on these objectives through *Victoria's 10-Year Mental Health Plan*, *Mental Health Workforce Strategy*, and *Suicide Prevention Framework*.

Victoria's 10-Year Mental Health Plan

Victoria's 10-Year Mental Health Plan (DHHS, 2016a) is a long-term plan that establishes the state's mental heath agenda for the next decade. The Government focuses on prevention, and providing seamlessly integrated services and support for vulnerable Victorians, including Aboriginal and Torres Strait Islander people, LGBTQI communities, and rural and remote residents.

The plan outlines the Government's aim to work with people experiencing mental illnesses, their families, and carers to co-develop and improve services. The plan entails targeted, specific outcomes contributing to mental wellbeing. Some key strategies include:

- Victorians have good mental health and wellbeing
- Victorians promote mental health for all ages and stages of life
- Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness
- The service system is accessible, flexible and responsive to people of all ages, their families and carers, and the workforce is supported to deliver this

Mental Health Workforce Strategy

The *Mental Health Workforce Strategy* (DHHS, 2016b) establishes the state's agenda for the next decade for the sector. Some of the Government's key aims to bolster the workforce are to:

- Provide new and more learning and development in priority areas of need, including responding to trauma, family-inclusive practice, dual diagnosis, cultural safety and gender sensitivity and safety
- Create better, and safer, working and learning environments

- Build workforce collaboration, prioritise learning and development in service and care coordination, and prepare the workforce for the National Disability Insurance Scheme (NDIS), which will affect service provision
- Implement models of co-production in workforce development with consumers, carers, and service providers
- Support workforce innovation through innovation grants

Suicide Prevention Framework 2016-2025

The Government aims to halve Victoria's suicide rate by 2025 (DHHS, 2016c). The 2016–17 Victorian Budget (2016) provided $27 million over four years for suicide prevention initiatives. There are five objectives, which are to:

- Build resilience
- Support vulnerable people
- Care for the suicidal person
- Learn what works best
- Help local communities prevent suicide

To realise this, assertive outreach and place-based trials are running throughout Victoria. Through assertive outreach, the Government provides resources for people that have attempted suicide after they leave hospital. This implements a 'chain of continuous care'—an evidence-based approach that improves outcomes (DHHS, 2016c, p. 22). Place-based trials are helping local communities prevent suicides through the delivery of universal, targeted interventions. Through trials, evidence-based practices are implemented simultaneously, and localised governance occurs, involving multiple government sectors, and health providers. Figure 3 depicts where trials are occurring in Victoria (DHHS, 2016c).

Figure 3

Locations of Assertive Outreach and Place Based Trials in Victoria

Measuring Mental Health and Wellbeing

The Government uses quantitative methods to measure mental health and wellbeing throughout the state. For example, an objective of the Government is to reduce the rate of at-risk persons experiencing high psychological distress (DHHS, 2016a). To determine this, the Kessler Psychological Distress Scale (K10) is used. The K10 measures depression, anxiety, and stress. It is self-reported; higher scores indicate higher psychological distress (CIV, 2017b). People with scores above 21 determine the percentage of the adult population that experience psychological distress.

Social Determinants of Health and Wellbeing

Understanding and measuring health and wellbeing requires more than just considering the burden of disease. Although figures are important, data do not account for social determinants of health, which contribute to mental health outcomes (DHHS, 2016d). The determinants of health include physical, social and economic environments, education, employment, and access to services (DHHS, 2016d; NRHA, 2011). Victorian policy has increasingly acknowledged these determinants. Several factors and conditions have been correlated to poorer outcomes (National Rural Health Alliance [NRHA], 2011; Services for Australian and Rural Allied Health [SARRAH], 2017). Lower socioeconomic status (SES) and a person's geographic location have been linked to restrictions in accessing services, education, and employment (SARRAH, 2017). This contributes to poorer mental health outcomes.

Chapter 2. The Wimmera: Rurality and Mental Health

To understand how location affects mental health, Chapter 2 explores 'rurality'. It provides context for how mental health services are delivered and accessed in rural Victoria. This is explored through a case study of the Wimmera –a rural western Victorian region. A community profile of the Wimmera provides an overview of socioeconomic status, occupations, and the physical environment. This chapter explores data related to the number of persons accessing mental health services and medication, and incidences of self-harm and suicide in the Wimmera. The chapter focuses on the provision of mental health services in Victoria's public and private sectors, explaining how the people in the Wimmera access them.

2.1. Defining Rurality

Rurality can be understood as a descriptor for rural life. Through interviews, service providers intimated that rurality is associated with disadvantages that arise from where individuals live, including reduced access to health services and transportation, population dispersion, and geographical distances. This is a view supported by the literature (Gregory, 2009, p. 51; SARRAH, 2017). The context of rurality is crucial to understanding mental health outcomes in rural Victoria (NRHA, 2011). Social determinants of health are closely linked to rurality (NRHA, 2011). To explore how rurality affects mental health, the Wimmera region will be utilised as a case study.

> *"Rurality is a thing—it's there, we know about it. It refers to people who are disadvantaged because of where they live. Some have no choice. People don't choose to live in an area that can't provide stable housing, can't provide public transport, can't provide service provision, can't provide medical services—they don't choose to live there…They can't choose to move anywhere else. Or, they live there because that's where their job is—they're farmers. They can't just pick their farm up and move to Melbourne; it doesn't work that way."*
>
> – Leigh Cooksley,
> Manager of Community Mental Health Services,
> Wimmera UnitingCare

2.2. Location of the Wimmera

The state of Victoria is vast. Rural Victoria is presently divided into nine regions, as displayed in Figure 4 (RDV, 2016).

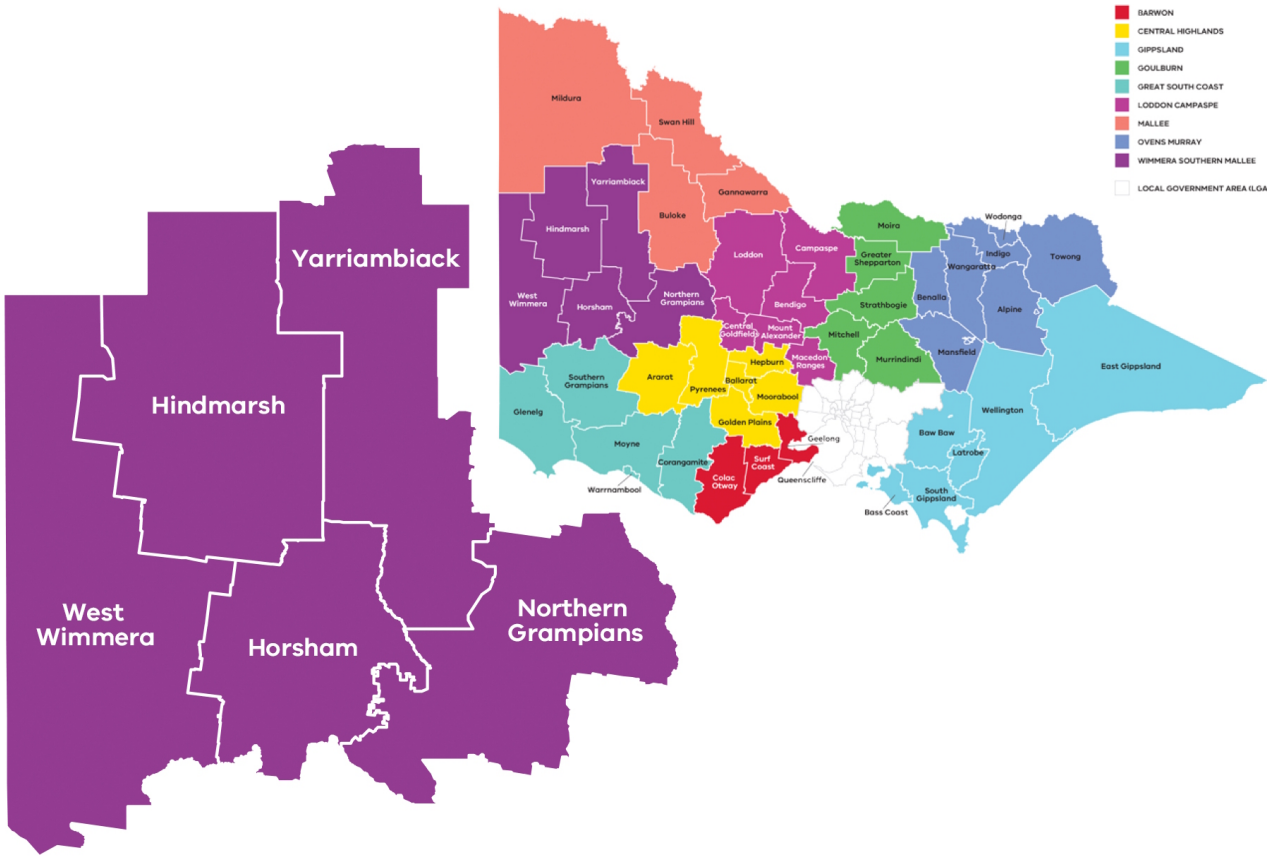


Figure 4

Victorian Regions: The Wimmera

This report focuses on the Wimmera Southern Mallee region (Wimmera) to illustrate how services are accessed and delivered in rural Victoria. The Wimmera is located in the Grampians region of western Victoria, comprising 5 local government areas (LGAs). It is a rural region, characterised by small towns spread over large distances. This report considered the distribution of Primary Care Partnership (PCP) catchments. PCPs combine local health providers with human services, who align to improve access to health services, and provide ongoing care in their communities (DHHS, 2017b).

The Wimmera PCP catchment covers the LGAs of Hindmarsh, Horsham, West Wimmera, and Yarriambiack (Wimmera PCP, 2016a). Persons residing in Northern Grampians LGA access local services in the Central Highlands region; it was omitted from analysis (Grampians Pyrenees PCP, 2015).

An estimated 36,416 persons live within the Wimmera; Horsham is the most populated LGA (ABS, 2011a). It is the access point for many mental health services in the Wimmera (Wimmera PCP, 2016a). These include the offices of key organisations, such as Ballarat Health Services Mental Health Services (BHS-MHS), and Wimmera UnitingCare (WUC).

2.3. Wimmera Community Profile

Social Determinants of Health and Wellbeing in the Wimmera

Several data related to social determinants of health and wellbeing among the Wimmera were obtained (ABS, 2011a; Community Indicators Victoria [CIV], 2017a; Public Health Information Development Unit [PHIDU], 2017). These aid in understanding the prevalence of mental health problems, the ability to access mental health services, and suicide in rural Victoria. The following section explores some social determinants of health for the Wimmera.

Socioeconomic Status: The Social Gradient

Socioeconomic Indexes for Areas (SEIFA) is based on social and economic data from the Census (NRHA, 2011). SEIFA provides a socioeconomic overview of a geographical region, taking into account factors that determine socioeconomic status. Data are provided as an index of relative socioeconomic disadvantage (IRSD). The index ranges from advantage to disadvantage. High index values are indicative of relatively high levels of socioeconomic advantage, and low values indicate high levels of disadvantage (Wimmera PCP, 2016b, p. 40). Table 1 provides the SEIFA 2011 index of relative socioeconomic disadvantage for Wimmera LGAs.

Table 1

Socioeconomic Disadvantage of Wimmera LGAs

LGA	IRSD	State Percentile
Hindmarsh	947	12
Horsham	987	45
West Wimmera	986	41
Yarriambiack	952	18

Hindmarsh and Yarriambiack LGAs had an index score in the bottom 25 per cent of all Victorian LGA scores; Horsham and West Wimmera LGAs were in the bottom 50 per cent. On average, the Wimmera has areas that experience relatively high levels of disadvantage, which can contribute to poorer mental health outcomes (NRHA, 2011).

Social Environment

Having strong friendships, good social relationships, and supportive networks are conducive to improved mental health at home, work, and in the community (NRHA, 2011). Table 2 provides an overview community-based wellness indictors for the Wimmera (CIV, 2017).

Table 2

Indicators of Wellness in the Wimmera, relative to the Grampians Region and Victorian state average

	Indicator	
Location	Community Connectedness [a]	Social and Support Networks [b]
Hindmarsh	78.8	90.4
Horsham	80.3	89.6
West Wimmera	78.2	92.1
Yarriambiack	79.8	91.0
Grampians	*75.5*	*92.2*
Victoria	**72.3**	**91.7**

[a] denotes Satisfaction with Feeling Part of the Community index score (2011, VicHealth Survey)

[b] denotes % of adult population: People Who Can Get Help from Friends or Family or Neighbours When Needed (2008, Dept of Planning & Community Development)

Despite the geographical spread of the region, Wimmera residents strongly value and engage with their communities, and have sufficient social support networks during challenging periods. The ratings among Wimmera LGAs are significantly higher than the Grampians and Victorian state averages.

Occupations

According to the 2011 Census (ABS, 2011b), the top industry of employment was 'Sheep, Beef, Cattle, and Grain Farming' throughout all Wimmera LGAs. The percentage of respondents working in these industries is displayed in Table 3.

Table 3

Top three industries of employment in the Wimmera, per the 2011 Census

LGA							
Hindmarsh		**Horsham**		**West Wimmera**		**Yarriambiack**	
Industry	**%**	**Industry**	**%**	**Industry**	**%**	**Industry**	**%**
Sheep, Beef Cattle and Grain Farming	20.8	Sheep, Beef Cattle and Grain Farming	7.8	Sheep, Beef Cattle and Grain Farming	39.1	Sheep, Beef Cattle and Grain Farming	25.5
Hospitals	10	Hospitals	6.8	Hospitals	8.0	Hospitals	6.9
School Education	5.8	School Education	4.7	School Education	5.0	School Education	6.2

Hindmarsh, West Wimmera, and Yarriambiack LGAs have a significant number of people employed in farming.

Physical Environment

The Wimmera is predominantly agricultural, producing wheat, oilseeds and legumes. Other agriculture includes olives, native flowers, poultry, and lamb and wool production (Wimmera PCP, 2017). These industries are reliant on environmental conditions. The farming industry has been associated with higher levels of stress, which may lead to psychological distress (Fraser et al., 2005; Judd et al., 2006b). The loss of a farm or livelihood due to crop or production fail, and seasonal conditions, such as drought, flooding, or fires can exacerbate distress (Fraser et al., 2005). Generally, rural populations may experience heightened mental health problems following a period of seasonal conditions (Tonna et al., 2009).

Access to Public Transport and the Internet

Rurality may affect the quality and accessibility of commonplace services, such as telephone and Internet reception, and transportation (SARRAH, 2017).

Figure 5 displays data related to Wimmera dwellings' home Internet access, and persons experiencing transport limitations (PHIDU, 2017; CIV, 2017).

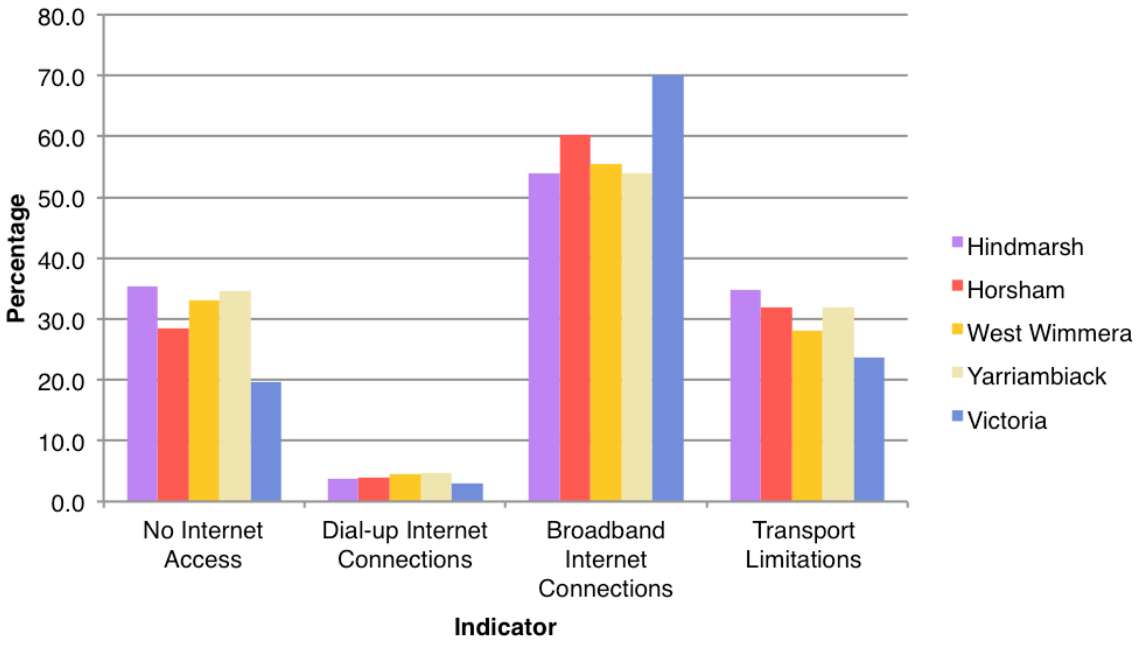


Figure 5

Percentage of Wimmera Residents with Access to Internet and Experiences of Transport Limitations compared to the Grampians Region and Victoria

A greater number of dwellings in the Wimmera had no Internet access in 2011, when compared to the Victorian average. Additionally, more dwellings in the Wimmera accessed the Internet using dial-up connection, and fewer accessed the Internet using broadband connections. Furthermore, the Wimmera experienced a greater number of transport limitations when compared to the average Victorian.

2.4. Mental Health and Wellbeing in the Wimmera

Mental, Behavioural, and Mood Problems

Data related to the mental health of persons living in the Wimmera were obtained. Figure 6 provides estimated rates of the population with mental and behavioural problems (PHIDU, 2017).

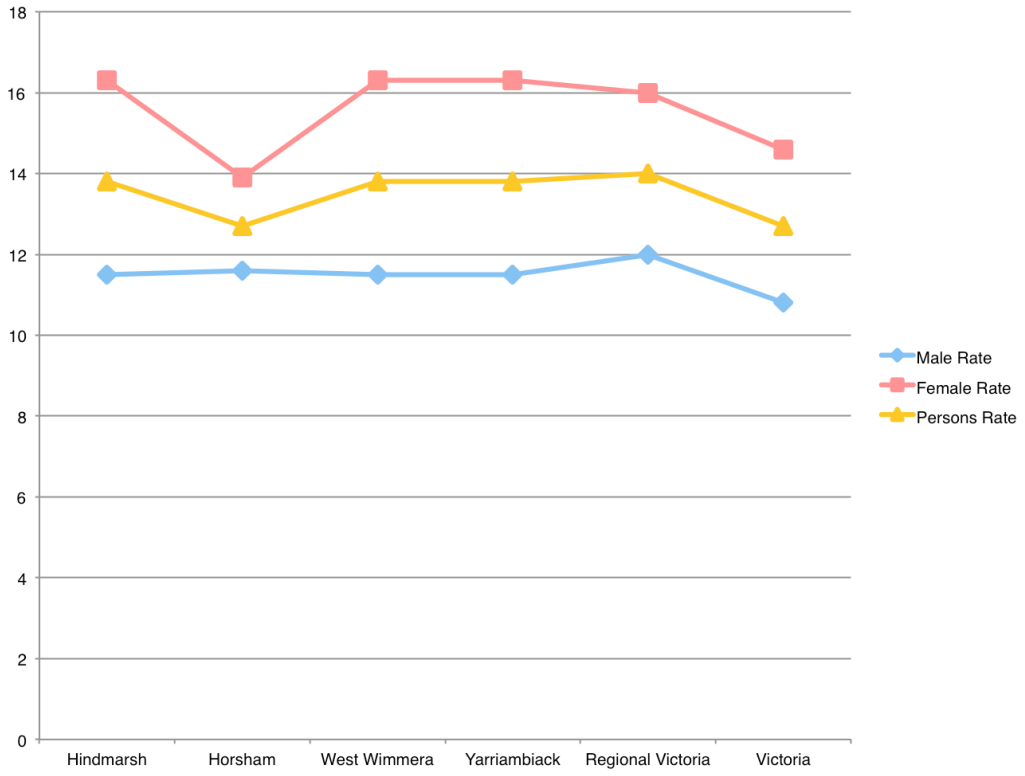


Figure 6

Estimated rates of population with mental and behavioural problems (2011-13)

Note. Indirectly age-standardised rate per 100 persons

The data indicate that women experience higher rates of mental and behavioural problems in Wimmera LGAs when compared to men, regional Victoria, and Victorian averages. Men in the Wimmera experience lower rates of mental and behavioural problems when compared to regional Victoria—but incidences are higher than the Victorian average.

Psychological Distress

The Government aims to reduce the rate of at-risk persons experiencing high psychological distress, which includes rural Victorians (DHHS, 2016a). Current data related to psychological distress in the Wimmera population are from 2014-15 (PHIDU, 2017). These are presented in Table 4.

Table 4

Estimated number of Wimmera people aged 18 years and over with high or very high psychological distress, based on the K10

Location	Number	Rate
Hindmarsh	373	9.4
Horsham	1,477	10.3
West Wimmera	273	9.3
Yarriambiack	456	9.4
Regional Victoria	*135,281*	*13.3*
Victoria	**564,408**	**12.5**

Note. Rate is age-standardised, per 100 people

Adults in the Wimmera were less likely to report psychological distress when compared to regional Victoria and Victoria.

Mental Health Service Users

Under Commonwealth regulated schemes, people in the Wimmera access mental health-related prescription medications and mental health services. These include the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Schedule (MBS), respectively. Many health professionals and services operate under these schemes through the Western Victoria PHN. PHNs facilitate efficient and effective medical services for consumers—particularly those at risk of poor health outcomes (Department of Health, 2016). They receive Commonwealth funding to operate. Figure 7 depicts the remoteness areas of this catchment (Department of Health, 2016).

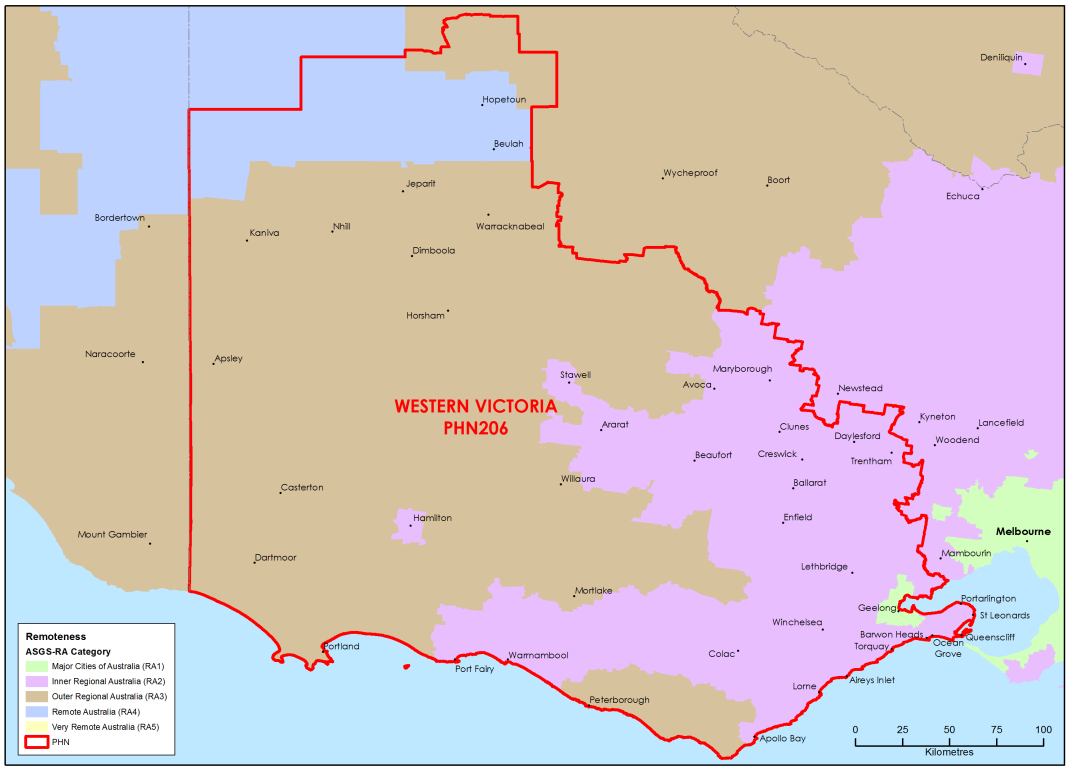


Figure 7

Remoteness areas of Western Victoria PHN

Small sections of the catchment are classified as a major city, or remote. A large portion of this catchment is classified as inner regional. A greater portion is classified as outer regional, or rural. The Wimmera is predominantly rural (Department of Health, 2016).

The number of people accessing PBS prescription medication and MBS services through the PHN are illustrated in Figure 8 (ABS, 2011a). For PBS medication, these are broken down into access by remoteness area. MBS services are for 'outer regional' populations only. Refer to Appendix A for descriptions of what each service and medication entails.

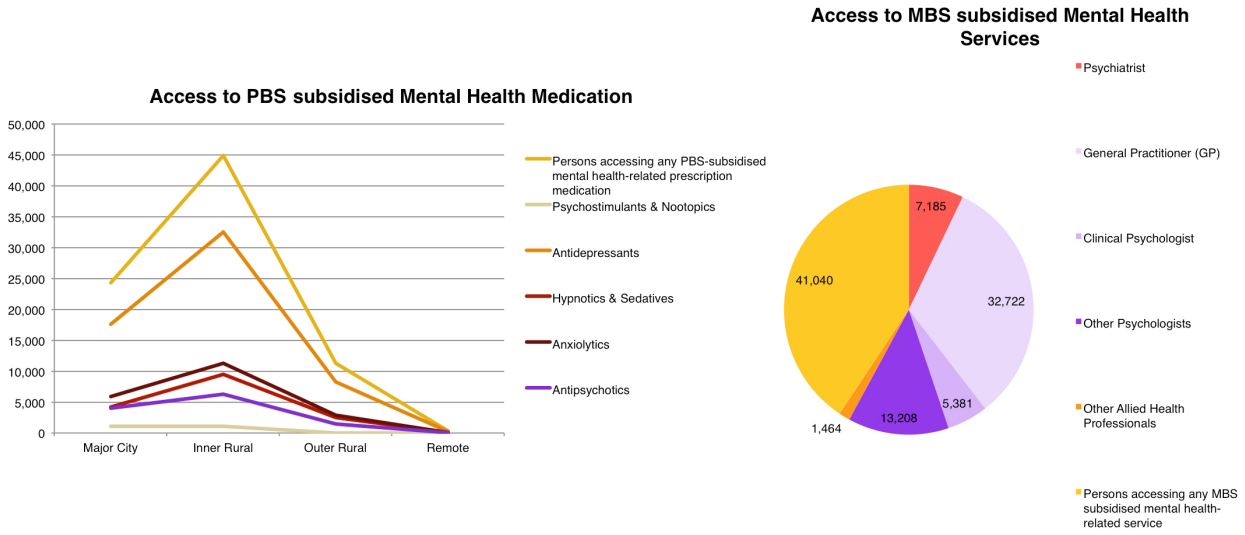


Figure 8

People accessing PBS subsidised medication and MBS subsidised mental health services in Western Victoria PHN

The skewed figures for accessing PBS subsidised mental health medications can be attributed to remoteness. There is a significant decrease in accessing psychotropic medications as remoteness increases. People living in the Western Victoria PHN catchment physically access mental health services via their General Practitioner (GP). Taken together, these figures could be due to difficulty accessing local specialist services in rural areas. To substantiate this, data were obtained for the rate of GPs per population, contained in Table 5 (Wimmera PCP, 2016b).

Table 5

GPs per population in 2013

Location	Rate*
Hindmarsh	1.4
Horsham	1.0
West Wimmera	0.3
Yarriambiack	0.7
Regional Victoria	1.2
Victoria	1.2

Note. * denotes age standardised rate per 1000 people

Compared to regional Victoria and Victoria, there was a lower rate of GPs per population in Horsham, West Wimmera, and Yarriambiack LGAs. These rates should be interpreted with caution, as the exit of 9 local GPs from Horsham since late 2016 has impacted accessibility to GPs (Martinich, 2017).

Self-Harm and Suicide

Self-harm is a behaviour that has been associated with suicides in the literature (Judd et al., 2006b). In statistical data, suicides are classified as avoidable mortality. Figure 9 provides the rates of hospital separations for self-harm (2011-14), and avoidable mortalities from self-inflicted injuries (2009-13) (PHIDU, 2017).

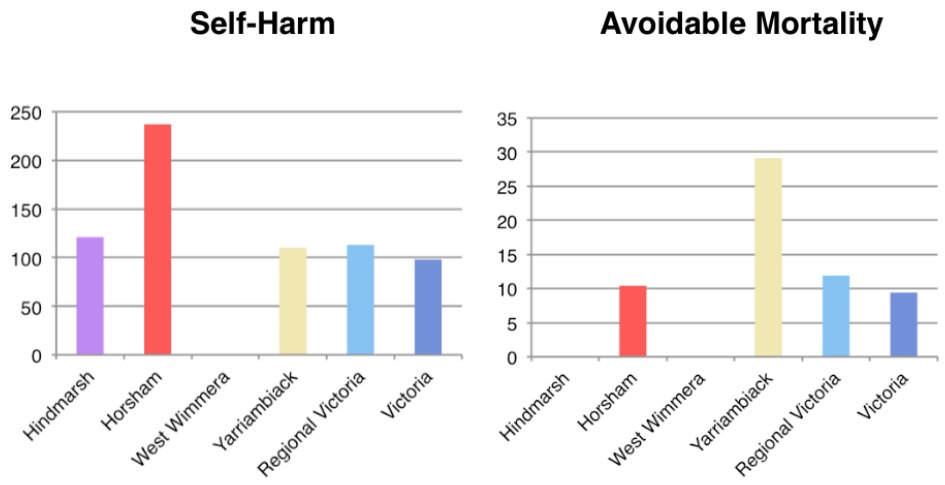


Figure 9

Rates of hospital separations for self-harm injuries, and avoidable deaths from suicide and self-inflicted injuries

Note. Age standardised average per 100,000 people. Self-harm and suicide data for West Wimmera, and suicide data for Hindmarsh were not published to preserve confidentiality.

Compared to regional Victorian and Victorian rates, the Wimmera generally experiences higher rates of self-harm, and avoidable deaths from suicide and self-inflicted injuries.

2.5. Accessing Mental Health Services in the Wimmera

Rural consumers have access to a range of mental health services, but services depend on the nature of the experienced mental health need. This is due to the structure of the system. It presently functions as a 'mixed model', with services overseen by Commonwealth and State Governments (DHHS, 2016a). Wimmera services generally operate within business hours—9AM to 5PM, Monday to Friday (Wimmera PCP, 2016c). This section summarises public and private mental health service provision, and how Wimmera consumers access them.

Public Mental Health Service Provision

The Victorian Government supports a range of clinical and non-clinical services in the public sector (DHHS, 2016c, 2017a). These exist to help people experiencing significant psychological distress. The State Government oversees service provision, and how consumers access these services. It funds services to operate, according to developed criteria (DHHS, 2017b; 2017d).

Clinical Services

Acute Mental Health Services

People experiencing acute psychiatric crises requiring immediate attention access these services. The provided service depends on the severity of experienced psychiatric symptoms, distress levels, and the risk of harm to self or others.

Ballarat Health Services Mental Health Services (BHS-MHS) delivers a range of community and bed-based mental health services for children and adolescents (0-18 years), adults (16-64 years), and older persons (65+ years) affected by serious complex mental illness across western Victoria. BHS-MHS cover a large section of western Victoria. Figure 10 depicts the catchment area of BHS (2010).

Figure 10

Coverage of Ballarat Health Services

Acute Intervention

Acute community intervention services (ACIS) are provided by specialist public mental health services in response to requests for urgent assistance from members of the public, police, ambulance, general practitioners, service providers and health professionals (DHHS, 2017a). ACIS responses are available for people of all ages, 24 hours a day, seven days a week, through applications of the following three approaches, depending on locale:

- Telephone triage: An initial telephone assessment to determine the urgency and nature of an ACIS response
- Emergency department care: A senior mental health practitioner is available for assessment, consultation and advice
- Acute assertive community outreach: An ACIS response delivers short to medium-term community treatment as an alternative to acute inpatient treatment or to support transition from inpatient services

BHS-MHS (2010) provides these services from several locations, including Ballarat and Horsham for the Wimmera. Where treatment of acute crises cannot occur in the community, inpatient care may be required. Acute Inpatient Units (AIUs) for adults and aged persons are located in Ballarat. Refer to Table 6 for further information regarding AIUs for the region.

Subacute Mental Health Services

Subacute services provide transitional treatment and rehabilitation to minimise hospitalisation. They promote independence for persons at a crucial point of recovery or relapse from mental illness (DHHS, 2017a). Subacute services available in Ballarat include: Community care units (CCUs) and secure extended care units (SECUs).

Community Care Units

CCUs provide clinical care and rehabilitation services in a home-like environment. They support the recovery of people seriously affected by mental health problems to (re)develop skills in self-care, communication and socialisation in a community-based residential setting.

Secure Extended Care Units

SECUs provide medium to long-term inpatient treatment and rehabilitation for people with recurring, severe symptoms of mental illness, or clinical disorder(s). These units are located in hospital settings. SECUs are for people experiencing difficulties living in their community—due to behavioural problems—or living independently. Admission criteria apply to SECUs. Priority is given to persons with the greatest need for care and supervision in this setting.

Table 6 provides a summary of this section, detailing AIU provided by BHS-MHS (2010).

Table 6

BHS MHS AIUs: Number of Beds, Eligibility, and Admission

AIU	Beds	Eligibility	Admission
Adult Acute Unit	23	Adults (18—65 years) experiencing an acute phase of mental illness	Post-assessment by Adult or Youth Community Mental Health teams
Aged Acute Unit	10	Older adults (65+ years) experiencing an acute phase of mental illness	Post-assessment by Aged Persons Community Mental Health team
Aged Residential Unit	20	Older adults (65+ years) with psychiatric illness that excludes them from being cared for in a non-psychiatric facility	Post-assessment by Aged Persons Community Mental Health and Aged Care Assessment Services teams
Residential Recovery Program (CCU)	20	Adult consumers with significant and prolonged history of mental illness and associated deterioration in psychosocial function.	Information not provided
SECU	12	Adults (18-65 years) with psychiatric illness that cannot be treated in less restrictive settings	Internal referral

Note. Per the Victorian Budget 2017/18, the Government is investing $8.3 million to establish a new 12-bedroom AIU for BHS

Non-Clinical Services

Mental Health Community Support Services

Mental Health Community Support Services (MHCSS) support people experiencing severe mental illness throughout their recovery in their communities. MHCSS help people manage self-care, improve social and relationship skills, and achieve a broader quality of life via physical health, social connectedness, housing, education, and employment (DHHS, 2017a).

Consumers access MHCSS programs through centralised catchment-based intake assessment. For regional and rural Victoria, the Australian Community Support Organisation (ACSO) conducts assessments. These can be completed in person, via telephone, or submitted online. Wimmera residents access physical assessments at ACSO's Ballarat headquarters. Individuals are categorised as Priority 1, Priority 2, or Priority 3, based on the acuity of the mental health problem (Wimmera PCP, 2016a).

Wimmera UnitingCare (WUC) is located in Horsham, and organises MHCSS for the Wimmera. After a referral has been received from ACSO, this is processed by WUC, who will allocate a caseworker to an individual eligible for services. Figure 11 depicts outreach sites for consumers accessing MHCSS across the Wimmera (Wimmera PCP, 2016a).

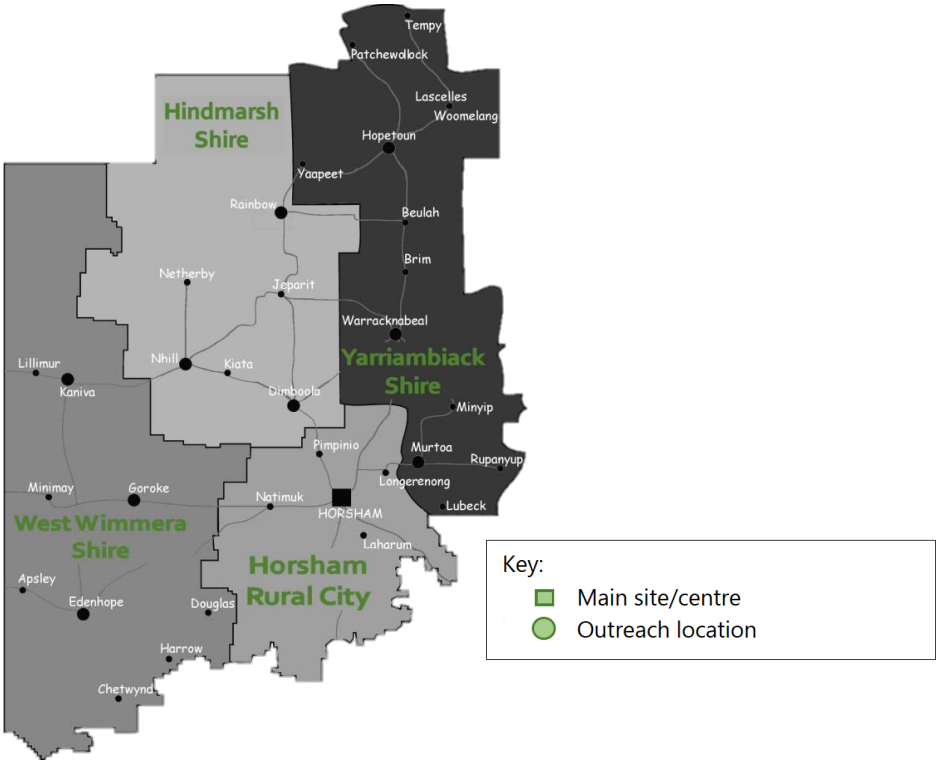


Figure 11

Wimmera UnitingCare Outreach Sites for Mental Health Community Support Services

Private Mental Health Service Provision

The Commonwealth Government generally oversees private mental health services. Privately practicing mental health providers, such as psychiatrists, psychologists, and mental health social workers, provide services for consumers within this sector, and can see clients with a referral under Commonwealth programs, or privately—where fees for consultations are paid in full.

Western Victoria Primary Health Network: Access to Allied Psychological Services

The Western Victoria PHN provides mental health services for a large portion of the state (see Figure 7 for catchment coverage). People can access mental health services through the Access to Allied Psychological Services (ATAPS) program (Department of Health, 2015). Through ATAPS, consumers can access a maximum of 12 therapeutic sessions per calendar year with psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers. ATAPS is designed to provide short-term intervention for people experiencing mental health problems. To access these services, a consumer receives a referral from a GP. Following 6 sessions, another referral for an additional 6 sessions can be obtained.

Chapter 3. Barriers to Accessing and Providing Services

Chapter 3 of this report covers barriers to accessing and providing mental health services in rural Victoria. Barriers were identified through a literature review, and interviews with service providers (participants) in the Wimmera. Policy and rurality affect service provision, which affects timely access to services Barriers created by policymaking are first addressed. Barriers experienced by service providers are then addressed, followed by consumer barriers.

3.1. Policymaking

The 'One Size Fits All' Approach

The Department of Health and Human Services (2017b) is tasked with ensuring that high quality services are delivered to communities. It develops policies, funds, and regulates health service providers and activities promoting and protecting the mental health of Victorians (DHHS, 2017b). Several organisations in the Wimmera are funded by the State Government to operate, and comply with expectations (Wimmera PCP, 2016a, 2016b), which are to:

- Deliver the volume of services for which funding is provided
- Deliver quality services consistent with prescribed standards and guidelines
- Deliver services that are accessible, inclusive, and responsive to the diverse Victorian community
- Provide agreed data and reporting to meet accountability and planning requirements
- Work with the department to develop new approaches to service delivery

Participants within some state-funded organisations acknowledged that expectations were understandable, but frustrating, as the focus on quantification does not consider rurality. Similar findings have been observed in other studies (Moore, Sutton, & Maybery, 2010; Silburn, 2015). Participants indicated that current models are better suited to densely populated or metropolitan areas. The Department's expectations and funding was regarded as restrictive, and not conducive to developing resilience and wellbeing.

The 'one size fits all' approach might be perpetuated by quantitative methodology, such as those determining the prevalence of mental illness in Australia (Fraser et al., 2002). These data provide much insight into the burden of disease. Although distinctions between metropolitan and rural residents are made explicit in reporting, variables such as socioeconomic status and rurality are not controlled for (Fraser et al., 2002). These factors can exacerbate mental health problems (SARRAH, 2017).

"We have really good relationships with the Department [of Health and Human Services], and they're sympathetic to where we are, and what we're trying to do. The reality is, there's no money in the system, and you really have to go to lobby, and show there's this great need [to build resilience]…To do that on top of everything else you need to everyday—we don't have grassroots community groups up here…because we just don't have the community to do that. It relies on people in my position—our CEO—to lobby [for funding]."

– Leigh Cooksley,
Manager of Community Mental Health Services,
Wimmera UnitingCare

Where Is 'Rurality'?

The Victorian Government has increasingly acknowledged the mental health needs of rural Victorians in policy (e.g., DHS, 2006b, 2011; DHHS, 2016a). On the surface, the Government acknowledges challenges faced by rural communities. Participants indicated that the Government's approach to rural populations was unrealised—particularly in the funding and provision of services.

All current mental health frameworks were examined to conceptualise how policymakers describe rurality. Search terms utilised were 'regional', 'rural', and 'remote', respectively. Overall, there were 15 mentions of these terms in the current frameworks (DHHS, 2016a, 2016b, 2016c). Refer to Appendix B for all mentions within these publications.

"Rurality is high on the agenda…it appears that it's happening, but out on the ground, the reality is that it's not. It's not being funded accordingly, because the purse is small…Ballarat has gotten a lot in the last budget, and its talking regionally, but it piles into there. It's the same as the suicide dollars that came across—$6 million dollars that went to PHNs from the Victorian State Government—a Commonwealth entity, but now being funded around suicide, and two forms of acute setting and prevention. In our region, which covers nearly a third of Victoria, there are two pileup programs: The acute setting is done in Geelong, and the preventative setting is in Ballarat, which doesn't really filter to [the Wimmera]."

– Geoff Witmitz,
Executive Officer,
Wimmera Primary Care Partnership

Analysis revealed that language describing rural Victorians is broad. Specific areas throughout regional and rural Victoria are not addressed. This is

concerning, given the Government's acknowledging that accessing mental health services in rural Victoria is difficult. Although the Government specifies it intends to ensure the needs and expectations of rural Victorians are met, it does not detail how it will develop targeted programs for at-risk constituencies (DHHS, 2016b, p. 3).

The Reactive Approach

Service providers expressed concerns regarding the funding and provision of rural services, indicating that current models are reactive. Rural communities are typified by their exposure to stressful seasonal conditions in policy (Fraser et al., 2002, p. 291). This appears evident in current Victorian publications (e.g., DHHS, 2016b, 2016c, 2016d). Mentions of regional, rural, or remote populations tend to be followed with flood, fire and drought (DHHS, 2016c, p. 17). Though this is objectively true, the physical environment is just one factor affecting rural people. Although the Government seeks to increase resilience and mental wellbeing in at-risk rural Victorians, additional funding to facilitate this occurs in the wake of flooding, fires or drought.

> *"There have been a number of things over the years that have been put in place around community response…It's been reactive, not proactive—reacting to the circumstance—whether that be fire, flood, or drought. And the problematic part of that is that services start through those one-off funding streams, and then they may disappear...What I would generally say is that the community has lost confidence in the ability to have good mental health through services that they have access to in a timely manner…What we've learned is that there's so many great initiatives that have been rolled out over the years [and] disappeared, because funding disappears."*
>
> – Geoff Witmitz,
> Executive Officer,
> Wimmera Primary Care Partnership

For example, grants for farm recovery have been provided to Victorian producers and communities affected by flooding (Agriculture Victoria, 2016). The presence of new mental health workers to the affected region increases, which helps people manage the immediate physical and psychological aftermath (Hart et al., 2011; Tonna et al., 2009). A downside of this is the flow-on effect: Local service providers' workloads and reporting figures decrease (Tonna et al., 2009). A participant advised that this scenario occurred following a period of drought in the Wimmera.

Though helpful, these approaches are immediate responses to significant crises. The implemented programs and associated monies are not long-term, and when funding ceases, this presence and structure diminishes (Hart et al., 2011). There is no rural model, and these approaches are not proactive. Sustainability cannot be achieved, as funding is inflexible, and reactive.

> *"I don't want us to be 'crisis responders'. I want us to be 'preventers', and that's what I've always wanted—as long as I've done this work. We should be preventative, not reactive…I've been a part of a flood recovery program with Wimmera UnitingCare, and there was a lot of money that came to that [which] funded bits and pieces. The thing about me is not about the crisis response; how do you build a place up so that when a crisis comes, people can deal with it?"*
>
> – Tim O'Donnell,
> Mental Health Social Worker

3.2. Service Providers

Attracting, Recruiting, and Retaining

Workforce distribution is disparate; it tends to be concentrated in larger populations (DHHS, 2016b). To understand how the mental health workforce is distributed in Western Victoria, service providers for ATAPS were reviewed. Figure 12 provides a glimpse at the number of ATAPS providers in several towns across Western Victoria, and the Wimmera (Western Victoria PHN, 2017).

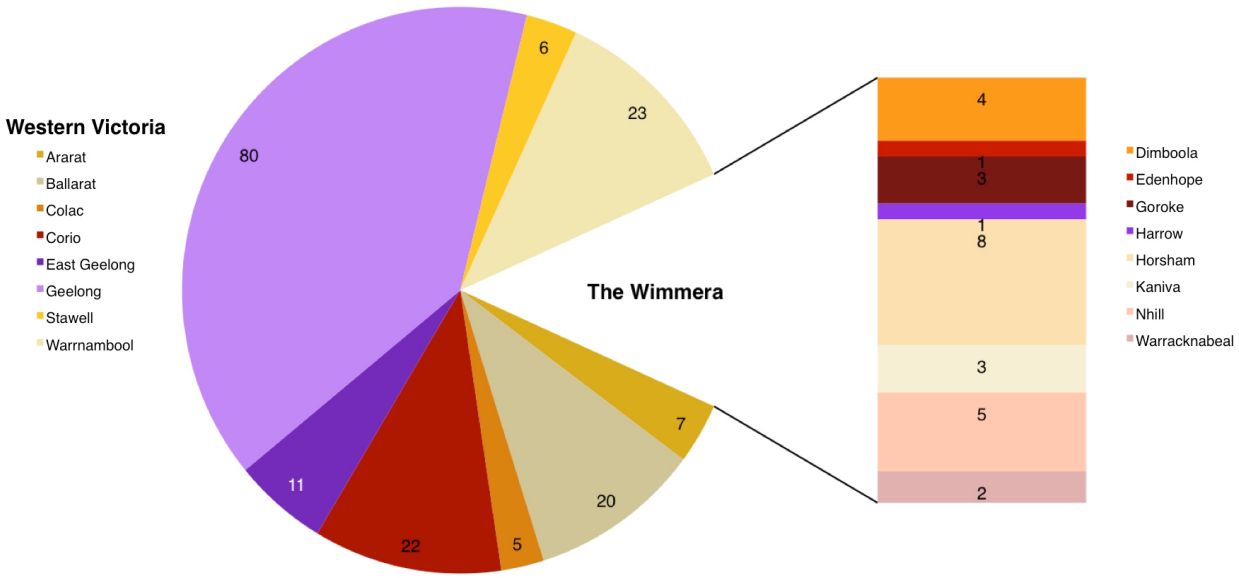


Figure 12

Frequencies of ATAPS providers per town in Western Victoria and the Wimmera

The workforce is skewed in more populated cities of Western Victoria, such as Geelong and Ballarat; the number of service providers decreases as rurality increases. This is commonly the case in Victoria (DHHS, 2016b; McGrail, et al., 2011; Perkins et al., 2007).

Difficulties attracting, recruiting, and retaining mental health professionals in rural areas are well documented (e.g., Fraser et al., 2005; Moore et al., 2010). The turnover rate of mental health professionals in rural areas is higher than in metropolitan areas (Wilks et al., 2008). Maintaining a stable workforce in rural Victoria is challenging, as rurality is related to lower population density, fewer specialist services, and unsustainable services (Moore et al., 2010).

Interviewees advised these factors affected service provision for the Wimmera, noting other contributing issues: A lack of incentives to stay or relocate to rural regions—particularly from metropolitan areas. Job security was another issue; an interviewee indicated that the ability to offer longer-term contracts was more appealing to prospective employees. Some implied they worked in isolation, and felt physically and professionally disconnected from fellow providers. Previous studies have revealed similar findings related to the rural Victorian workforce (e.g., Kenny & Allenby, 2013; Moore et al., 2010).

Training

The ability to maintain professional knowledge ensures that consumers access quality, evidence-based services (DHHS, 2016b). In a rural setting, service providers experience difficulties accessing adequate training (Kenny & Allenby, 2013; Moore et al., 2010). The Government is aware that skill development is imperative to increasing competencies, but access to this differs, depending on your physical location (DHHS, 2016b). To address this barrier, the Government will establish specialist training units to help service providers respond to trauma and comorbidities, focussing on priority areas. This should improve the coordination of mental health workforce development and learning across the state (DHHS, 2016b).

> *"The maintaining of education seems to be a huge factor…because training [is in] Ballarat, or Melbourne. Webinars are great obviously, but then you miss out on the networking that happens face-to-face, or just that extra conversation that happens, so if staff are missing out on that. I can understand why they would then want to be with their like colleagues in an area that they're going to access good training, networking, all of those things."*
>
> – Frankie Blake
> Chief Social Worker,
> Wimmera Health Care Group

High Workloads

Providing mental health services to rural consumers is often associated with higher workloads, due to workforce distribution (Cosgrave et al., 2014; Jackson et al., 2007). The demand for mental health services in the Wimmera is great, given the lengthy waiting times for services (Wimmera PCP, 2016c). Service providers across rural Victoria similarly experience high workloads (Sutton et al., 2011). This can be unattractive, deterring service providers from working in rural Victoria—which contributes to difficulties attracting, recruiting, and retaining staff (Kenny & Allenby, 2013; Jackson et al., 2007).

Burnout

Service providers for the Wimmera indicated that workloads lead to burnout. In rural mental health workforces, this appears to be a common experience (Cosgrave et al., 2014; Sutton et al., 2011). Some participants advised that their services evolve to meet organisational and consumer demands, particularly in areas with inadequate crisis support.

The 2014 recommission of MHCSS profoundly affected service providers (Silburn, 2015). Caseworkers for Wimmera UnitingCare (WUC) were primarily dealing with Priority 1 MHCSS referrals. These clients experience significant difficulties with psychosocial functioning, and require considerable support to recover. WUC provides outreach services for MHCSS across the Wimmera, which requires substantial travelling. Their caseloads increased, resulting in burnout.

> *"We're getting staff burnout, because they are taking on higher caseloads, they are travelling a hell of a lot, and trying to fit a heck of a lot into their day. As much as we try and balance that with extra training and support, there's not a great deal you can do, unfortunately. The work's still got to be done, and people can only work so many hours in the day. Even when you're getting people on board, they're flat out from the day they start, so they don't last overly long. We're quite lucky—we've been relatively stable over the past few years, but we've done a lot of work with our staff. It takes a lot."*
>
> – Leigh Cooksley,
> Manager of Community Mental Health Services
> Wimmera UnitingCare

Absence of Services

The absence of specialist services in rural areas contributes to burnout, increased responsibilities, and blurred professional boundaries (Endacott et al., 2006; Moore et al., 2010). Participants indicated that it was difficult to maintain professional boundaries in the Wimmera, because there were fewer services available to people. There were multiple mentions of consumers contacting service providers outside of business hours to discuss mental health problems, or how to access services.

Several interviewees also expressed concerns regarding the level of knowledge that local GPs and health professionals had about mental health, and appropriate treatment options. GPs are the first point of contact for many consumers, given shortages of specialist mental health services (Hodgins et al., 2007). In Horsham, one privately practicing psychiatrist visits a local practice each Wednesday (Wimmera PCP, 2016b). If a consumer is unable to access psychiatric services, they may consult their GP. Due to inconsistent knowledge about mental health among GPs and consumers, the provided services at this level may be inadequate (Hodgins et al., 2007).

The Changing Landscape of Service Provision

Interviewees indicated that funding and service provision was in a constant state of flux. Past reforms, such as the 2014 recommissioning of MHCSS, significantly affected the capacity to provide quality services in a timely manner (Silburn, 2015; Wimmera PCP, 2016c). This is expected to intensify following introduction of the NDIS.

2014 Recommission of MHCSS

The 2014 recommissioning of MHCSS considerably affected Wimmera service providers and consumers. Interviewees indicated that the rollout was poorly communicated, and left consumers unable to access services in a timely, efficient manner. The lacking incorporation of rurality in the recommission amplified effects in the Wimmera. Similar sentiments have been observed among rural Victorian service providers (Silburn, 2015). The recommission involved centralised intake—via ACSO—which conducted assessments, and referrals based on priority. This change deemphasised local intake and assessment, deterring consumers from accessing services (Silburn, 2015). Waiting times for MHCSS increased as caseloads increased. Consumers categorised as Priority 2 and 3 could be waiting up to 18 months to be allocated to a caseworker (Wimmera PCP, 2016a). Even so, Priority 1s were waiting between 3 to 6 months for caseworker allocation (Wimmera PCP, 2016a). Due to extensive waiting times, people on waiting lists were ‘un-contactable’, and have been removed from WUC’s database.

Rollout of the NDIS

The NDIS is an insurance scheme, targeted towards people with significant, permanent disabilities to improve health outcomes across the lifespan. The NDIS is rolling out across the Wimmera from October 2017. Funding for MHCSS is being rolled over into the NDIS, which introduces another major system change over a small timeframe (Silburn, 2015).

Interviewees expressed uncertainty surrounding its effects on providers and consumers of existing mental health services. Prior research conducted by Wimmera PCP (2016a, 2016c) indicates that other service providers across Wimmera-based organisations feel similarly.

3.3. Consumers

Mental Health Literacy

Mental health literacy is important. It refers to knowledge and beliefs about mental illness, which can aid in an individual's recognition, management, or prevention (Hoolahan et al., 2007). Studies show that mental health literacy decreases as rurality increases (Griffiths et al., 2009). Rural people are also less likely than metropolitan residents to rate evidence-based psychological interventions as effective treatments for mental illness (Griffiths et al., 2009). Participants advised that people in the Wimmera were generally not well informed about mental illness.

Stigma

The stigma of mental health problems and stoicism among rural communities is well documented (e.g., Boyd et al., 2007; Wrigley et al., 2005). Several factors contribute to this, and reduce help seeking. These include demographic factors—such as being male or an older adult, and person-based causal attributions for mental illnesses (Jackson et al., 2007; Wrigley et al., 2005).

> *"The culture around here is, "Oh well you've shown your weakness," when you're asking for help, rather than have some cement and toughen up. I think the reason why [is because] people have gone on for so long [without services], have got all these issues that built up and that's when they explode…"*
>
> – Felicity Johns,
> Project Officer
> Wimmera Primary Care Partnership

Participants attributed inadequate knowledge about mental health and illness in their communities to 'stigma' perpetuation. Participants suggested that poorer attitudes towards help seeking exist, because people have historically not had access to a wide range of mental health support, and are accustomed to "sucking it up".

There are ways to overcome this barrier, and increase mental health literacy. Participants from Wimmera PCP advised that in 2014, the Wimmera experienced a snap drought. In response to this, local governments and members of health organisations implemented 'Seasonal Conditions Meetings' to establish sustainable, proactive programs that helped the

community cope with present and future hardships (Werner, 2015). Part of the initiative included lobbying for funds to deliver mental health first aid (MHFA) training across the Wimmera and Southern Mallee region. Monies were acquired through the Victorian State Government's drought package. Interest in the course was high: 265 people have participated in 17 MHFA workshops across Wimmera LGAs in 2016.

Previous research into the efficacy of MHFA has revealed that it is highly effective in rural areas experiencing drought (Hart et al., 2011; Hoolahan et al., 2007; Jorm et al., 2004; Tonna et al., 2009). MHFA has been shown to increase mental health literacy, and promote mental health—which lessens the effects of stigma among communities (Jackson et al., 2007; Judd et al., 2006b).

> *"[Telehealth] is great if you've got the Internet at your house, isn't it? What a joke. Sure, lots of people have got smartphones, but if you haven't got any mobile phone coverage at your house, you're not going to bother with a fancy smartphone. Telehealth is all very well, but people have to have the hardware for a start…Lots of people out here get 400 megabytes of data a month on their phone. They can't have a one hour session with a [psychologist]."*
>
> – Del Widdowson,
> Provisional Psychologist,
> Wimmera Psychology

Internet Access

Rural residents, like all Australians, are encouraged to use telehealth, or e-resources. While these are notionally easily accessible and particularly bridge the gap in areas without specialist services, rurality affects Internet access. Reduced access to quality Internet contributes to social isolation, and poorer mental health (Park, 2015; Jackson et al., 2007). In Australia, there are digital inequalities between metropolitan and rural areas (Park, 2016). Rural Victorians experience poorer broadband connectivity (Park, 2016).

Although efficacies of telehealth and face-to-face therapy are generally equivalent, promoting technological interventions is problematic if disparities persist (Park, 2015; Richardson & Simpson, 2015). In 2011, a significantly greater number of Wimmera people did not have home Internet, and fewer had home broadband connections compared to the Victorian average (see Figure 5). If rural consumers are to utilise telehealth—i.e., psychotherapeutic videoconferencing—poorer connections could cause dropouts, and deter users (Hoolahan et al., 2007; Park, 2016).

Participants expressed mixed feelings towards web-based services. All conceded that they could increase mental health literacy. This is dependent on whether consumers have access to strong Internet connections, and questions surrounding the personalisation of these services were raised. Other concerns pertained to preferences of rural consumers: They value initial face-to-face contact on matters regarding mental health.

Navigating the System

The mental health sector is complex (Bateman & Smith, 2011). Due to this, participants advised that rural consumers experience difficulties navigating the system. This can be attributed to a lack of awareness regarding available mental health services, and their respective functions (Buckley et al., 2017; Wimmera PCP, 2016a).

> *"I think that for some people…they are accustomed to being part of the system that refers and refers and refers—to this agency, to this agency, over here for help, over here for assistance. They're used to that, and they don't necessarily value the opportunity. They might be burnt out from referral after referral across their lives...[Support is] not necessarily seen as an opportunity, rather as...part of the machinery of life…I think the absolute single largest barrier to people seeking help is just not knowing how to do it...It's a very complex system to navigate. People don't understand how to get help. That's the biggest problem."*
>
> – Del Widdowson,
> Provisional Psychologist,
> Wimmera Psychology

Although digital sources remain an integral source of information for rural people, consumers generally rely on word of mouth and print media (Buckley et al., 2017). Age differences among rural consumers have also been observed: Older adults are more likely to access information from their GP than the Internet (Buckley et al., 2017). If people are unable to easily access GP services, it is difficult to ascertain how they acquire information regarding mental health support.

The process of accessing services is streamlined—particularly specialist services for acute crises—but participants advised that consumers are exposed to extensive assessments and referrals, which causes frustration. This has been observed in other studies (Fitzpatrick et al., 2017; Happel, 2008).

> *"With psych services, they don't have anyone in the youth program on a Friday, so Monday to Thursday. I just get annoyed when I hear that there's these services, when that's [not true]. I mean, I'm lucky enough that I have worked in the system, and have some idea of the setup and the pathways, but those pathways mean [nothing] when you're in crisis, because you need it straight away."*
>
> – Felicity Johns
> Project Officer
> Wimmera Primary Care Partnership

Lack of Services

Rurality is associated fewer mental health

clinicians, and services—both general and specialist (Judd et al., 2006b; SARRAH, 2017). Barriers experienced by consumers include their geographical distance from specialist services, and their relationships with local service providers (Endacott et al., 2006; McGrail et al., 2015). Consumers also experience lengthy waiting times to access limited services.

Distance From Specialist Services

Participants advised that local services for crisis support were inadequate. If a person requires crisis support in the Wimmera, they can present to the Wimmera Base or by contact the Horsham-based BHS-MHS ACIS team for assessment.

> *"The Wimmera does not have adequate public transport and people with the most severe mental health issues are least likely to be able to transport themselves, and may well be living in the most isolated towns, due to the availability of low-cost housing in these towns. I have often provided services to people less frequently than is optimal due to the difficulty with them getting to Horsham for therapy sessions. Visiting services to small towns have never seemed to work optimally either."*
>
> – Dr. Kate Alessia
> Clinical Psychologist and Social Worker,
> Wimmera Psychology

If a person is assessed as experiencing an acute psychiatric crisis, they may be transferred to BHS-MHS in Ballarat, where specialist acute services and units are located (BHS, 2010). Although these services are available, physical distance from the services, transport limitations, and unfamiliarity with Ballarat affect the capacity to access them, and recover.

The Wimmera has areas of significant socioeconomic disadvtange, and residents experience greater transport limitations than the average Victorian (CIV, 2017; PHIDU, 2017). Although people residing in sparsely settled communities are willing to travel greater distances to access health services, it is challenging when consumers have limited access to a car, or adequate public transport (McGrail et al., 2015).

Figure 13 depicts the distance and estimated time of travel by car from a town in the Yarriambiack LGA, Patchewollock to Horsham to Ballarat Health Services.

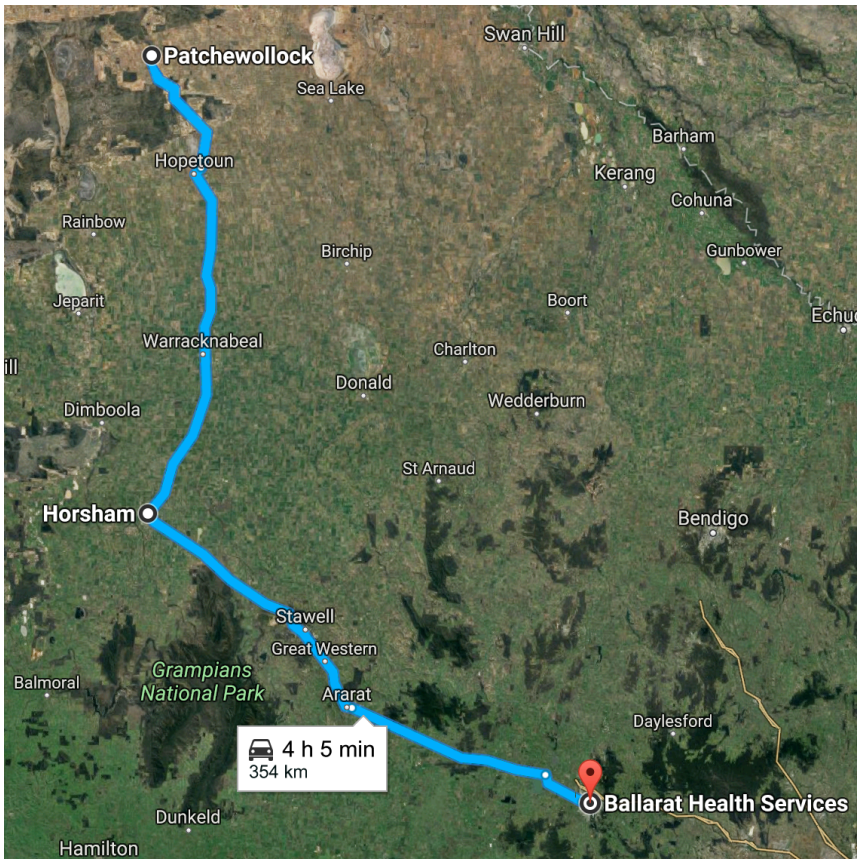


Figure 13

Distance from Patchewollock to Ballarat Health Services

Note. Image sourced from Google Maps

This is a lengthy journey to access mental health services, and it is understandable that distance and time could deter people. Participants advised that consumers may arrive at Ballarat for further assessment, deemed stable, and discharged with no follow-up.

Community-based recovery has been shown to improve mental health (DHHS, 2016a). If rural people are expected to travel great distances for specialist mental health services as depicted in Figure 13, this may result in poorer mental health

> *"People [don't] come to Kaniva and work at 6 o'clock at night, because it's mental health stuff…One Friday night, [a consumer] lost the plot…He rang me up, and he said [he was struggling]…His mother was on my doorstep…[saying] he wants to kill himself...I went and saw him, and sat with him for two hours…Calmed him down enough, but I'd already organised an ambulance to come and take him down to Horsham. By that time, he was reasonable, but he still had these issues. We went by ambulance to Horsham. He got home by 5:15 the next morning, because there was no actual mental health people in Horsham to see him. They did a phone linkup with Ballarat [Health Services]…and that was it."*
>
> – Mal Coutts,
> Former Rural and Remote Engagement (RARE) Officer

outcomes, and relapse. To overcome this, one service provider suggested the Government provide funding for additional mental health beds, which could be transferred between local rural hospitals, as required. This could facilitate quicker recovery, as individuals experiencing acute crises could remain in their communities.

Range of Local Services

Rurality presents a unique, complex relationship between local service providers and consumers. Due to social and physical environments, service providers may know consumers on levels beyond health matters (Endacott et al., 2006). This can dissuade rural consumers from accessing the services of a provider (Endacott et al., 2006).

> *"I have had it said to me that there's people [consumers] wont go and see, because of family connections, or they know someone who knows someone…There are a number of psychologists around, and during my assessment, if I'm feeling there's some sort of disorder, or something that's not quite gelling with the thought processes… then I will be suggesting psychology. And those are the comments: "I've been to them before," or "No, I know them through family.""*
>
> – Frankie Blake,
> Chief Social Worker,
> Wimmera Health Care Group

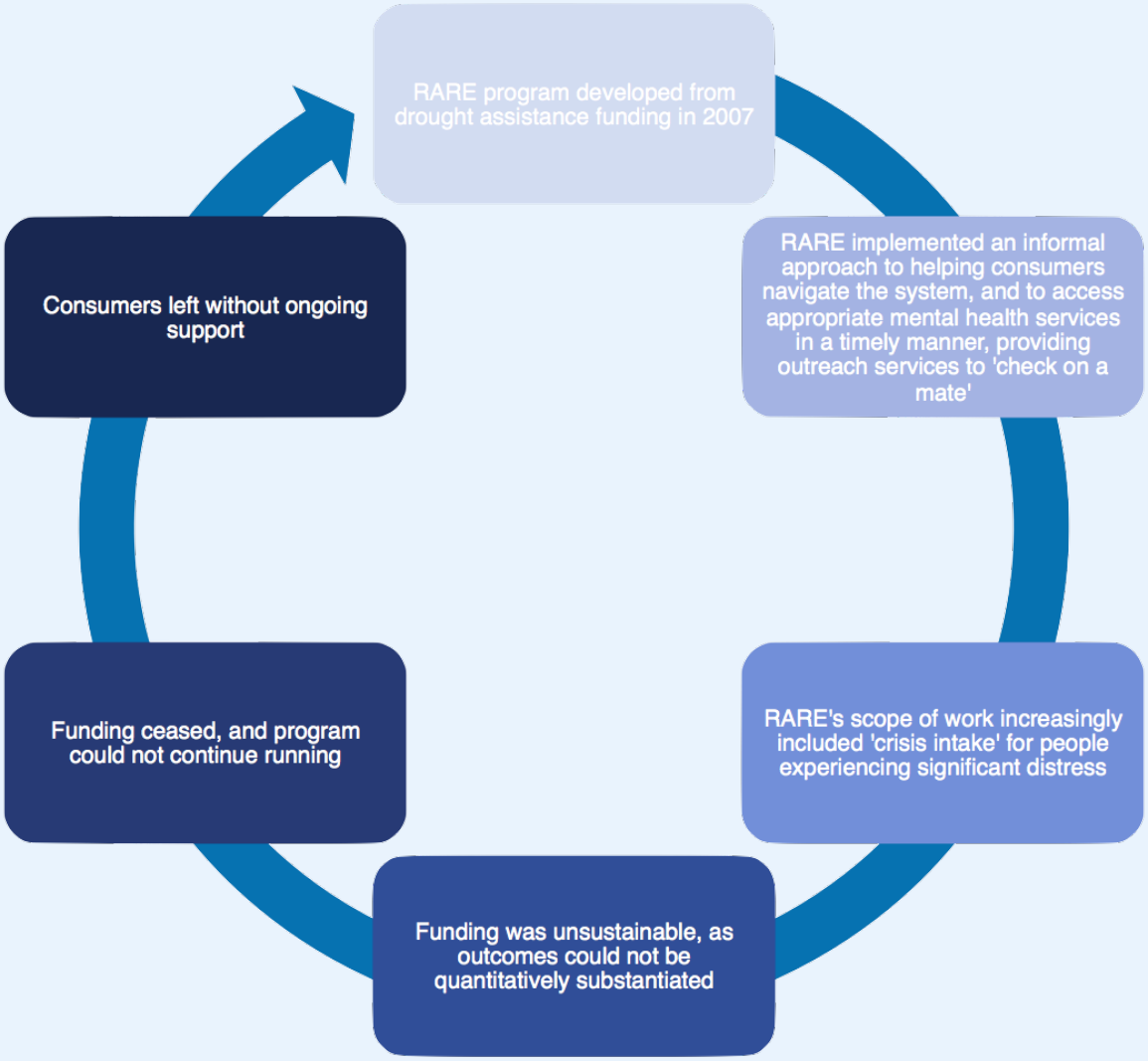
There are also fewer specialist services in rural Victoria, and the Wimmera, such as psychiatry (Judd et al., 2006b). As previously mentioned, one privately practicing psychiatrist visits Horsham on a Wednesday. Clients are required to pay the full fee for services. When considering the socioeconomic status of Wimmera residents, this could be difficult to access.

Waiting Times

People are more inclined to seek help during lower emotional periods, or following a crisis (Fraser et al., 2005). Waiting times for rural services are lengthy, and consumers have no choice but to wait to access these services (Wimmera PCP, 2016a). Consequently, consumers feel discouraged to use services. Participants advised that consumers lose confidence in a system they feel is difficult to access, but appreciate when they are seen quickly.

Case Study: The Rural and Remote Engagement (RARE) Program

The RARE program was an informal mental health service offered to people in the Wimmera until 2016. Its establishment, evolution to meet consumer needs, and cessation, encapsulate of the barriers in policymaking, service provision, and accessibility identified in this report.



Chapter 4. Recommendations

Based on the findings of this report, a series of recommendations for future approaches to the provision of mental health services in rural Victoria have been developed.

1. *Consider rurality when developing programs to improve mental health*

If the Government seeks to increase the intensity of targeted action for those experiencing greater socioeconomic disadvantage, it is suggested that rurality is considered. However, rural Victorians are not an homogenous population. Though this report focuses on the Wimmera, each rural area is unique. It is suggested that transparency regarding how the needs and expectations of specific regional, rural, and remote areas are quantified increases. If e-resources and telehealth are to remain a 'proxy' service provider for all consumers, then it is suggested that the Government continues to focus on improving the quality of Internet services in rural Victoria.

2. *Explore ways to attract mental health professionals to rural areas in Victoria*

Although attracting mental health workers to rural Victoria is difficult, it is recommended that the Government develop press releases about the advantages of rural living. Wimmera PCP has created a video campaign advertising the region, and social advantages of rural life. It appears that psychiatric services are lacking in rural areas of the state. Exploring how to best increase this presence would greatly benefit rural consumers. It is also recommended that the Government explore opportunities to incentivise the workforce through avenues such as tax rebates, housing provision, and support systems—including professional development, technological systems, and rebates for travel to outreach sites.

3. *Increase training of the mental health workforce based in rural areas of the state*

Restricted access to adequate training and professional development contributes to an unsustainable workforce and skewed distribution. It is understood that the Government aims to invest in developing high quality state-wide training for the mental health workforce. It is suggested that the Government continues to collaborate with rural members of the workforce to establish areas requiring further improvement. Furthermore, to increase transparency regarding priority areas: Whether it pertains to geographic priority, or profession type. It is recommended that the Government continue to develop strategies that will increase the frequency of training in rural areas. If possible, this would ideally extend to rural GPs.

4. *Develop initiatives towards increasing mental health literacy in rural areas*

Improving mental health literacy is conducive to health promotion. Improved mental health literacy helps to destigmatise mental illness, and increase awareness regarding available therapeutic options for mental health problems. It is recommended that the Government develop targeted initiatives towards increasing the mental health literacy of vulnerable populations, such as rural Victorians. This could be implemented through the facilitation of rolling out mental health first aid training, such as that provided through the Government's drought funding in 2014 for the Wimmera. Evidence suggests that mental health first aid is particularly effective in communities exposed to drought, flooding, and fires. It is further recommended that the Government explore additional evidence-based initiatives designed to increase mental health literacy beyond reactive approaches to seasonal conditions.

5. *Consider funding for 'flexible' acute inpatient beds in local rural hospitals*

People recover more quickly when they can access services in their communities. It is understandable that specialist services are located in more densely populated areas of regional Victoria. However, rural residents are required to travel long distances to access services for acute crises or serious mental illness. It is recommended that the Government explore options to provide funding for 'flexible' acute inpatient beds that can be transferred between local rural hospitals on a needs basis.

References

Primary Sources

Written Correspondence. (2017, May 24). Dr. Kate Alessia, Clinical Psychologist and Social Worker – Wimmera Psychology, Horsham, VIC.

Personal Interview. (2017, May 26). Frankie Blake, Chief Social Worker for Wimmera Health Care Group, Horsham, VIC.

Personal Interview. (2017, May 26). Leigh Cooksley, Manager of Community Mental Health Services – Wimmera UnitingCare, Horsham, VIC.

Personal Interview. (2017, May 05). Mal Coutts, Former Rural and Remote Engagement (RARE) worker, Horsham, VIC.

Personal Interview. (2017, May 05). Felicity Johns, Koolin Balit Project Officer and Facilitator of Mental Health First Aid Rollout – Wimmera Primary Care Partnership, Horsham, VIC.

Personal Interview. (2017, May 04). Tim O'Donnell, Mental Health Social Worker – Droylsden House, Horsham, VIC.

Personal Interview. (2017, May 26). Del Widdowson, Provisional Psychologist – Wimmera Psychology, Horsham, VIC.

Personal interview. (2017, May 05). Geoff Witmitz, Executive Officer – Wimmera Primary Care Partnership, Horsham, VIC.

Secondary Sources

External Statistics

Australian Bureau of Statistics. (2011a). *2011 Census QuickStats: Hindmarsh, Horsham, West Wimmera, Yarriambiack*. Retrieved from http://www.abs.gov.au/websitedbs/censushome.nsf/home/quickstats

Australian Bureau of Statistics. (2011b). *Characteristics of people using mental health services and prescription medication* (No. 4329.0). Canberra, ACT. Retrieved from http://www.abs.gov.au

Community Indicators Victoria. (2017a). *Wimmera Snapshot*. Retrieved from http://www.communityindicators.net.au/live_reports/wimmera_snapshot

Public Health Information Development Unit. (2017). *Social Health Atlases of Australia: LGAs*. Retrieved from http://phidu.torrens.edu.au/

Government Reports

Department of Health. (2007). *What is mental illness?*. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-w-whatmen

Department of Health and Human Services. (2016a). *Victoria's 10-year mental health plan*. Retrieved from https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan

Department of Health and Human Services. (2016b). *Victoria's 10-year mental health plan*: *Mental health workforce strategy*. Retrieved from https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan

Department of Health and Human Services. (2016c). *Victoria's 10-year mental health plan: Victorian suicide prevention framework 2016–25*. Retrieved from https://www2.health.vic.gov.au/mental-health/prevention-and-promotion/suicide-prevention-in-victoria

Department of Health and Human Services. (2016d). *Victorian public health and wellbeing plan*. Retrieved from https://www2.health.vic.gov.au/about/health-strategies/public-health-wellbeing-plan

Department of Human Services (2006a). *An introduction to Victoria's public clinical mental health services*. Retrieved from https://www2.health.vic.gov.au/mentalhealth

Department of Human Services (2006b). *Planning framework for public rural mental health services: A framework to guide the enhancement of public rural mental health services over the next five years*. Retrieved from https://www2.health.vic.gov.au/mentalhealth

Department of Human Services (2011). *Victorian Health Priorities Framework 2012-2022: Rural and Regional Health Plan*. Retrieved from https://www2.health.vic.gov.au/about/publications/policiesandguidelines/vic-health-priorities-framework-2012-22-rural-plan

Journal Articles

Bateman, J., & Smith, T. (2011). Taking our place: Community managed mental health services in Australia, *International Journal of Mental Health*, *40*(2), 55-71. doi: 10.2753/IMH0020-7411400203

Boyd, C., Francis, K., Aisbett, D., Newnham, K., Sewell, J., Dawes, G., & Nurse, S. (2007). Australian rural adolescents' experiences of accessing psychological help for a mental health problem, Australian Journal of Rural Health, 15, 196-200. doi:

Buckley, D., Brimson, S., & Reyment, J. (2017). Community awareness of the availability of health services and information-seeking practices across a large health service district in rural Australia, *International Journal of Healthcare Management*, *10*(1), 66-74. doi: 10.1080/20479700.2016.1266137

Cosgrave, C., Hussein, R., & Maple, M. (2014). Factors impacting on retention amongst community mental health clinicians working in rural Australia: A literature review, *Advances in Mental Health, 13*(1), 58-71. doi: 10.1080/18374905.2015.1023421

Endacott, R., Wood, A., Judd, F., Hulbert, C., Thomas, B., & Grigg, M. (2006). Impact and management of dual relationships in metropolitan, regional and rural mental health practice, *Australian and New Zealand Journal of Psychiatry*, *40*, 987-994.

Fitzpatrick, S. J., Perkins, D., Luland, T., Brown, D., & Corvan, E. (2017). The effect of context in rural mental health care: Understanding integrated services in a small town, *Health and Place*, *45*, 70-76. doi: 10.1016/j.healthplace.2017.03.004

Fuller, J., Edwards, J., Procter, N., & Moss, J. (2000). How definition of mental health problems can influence help seeking in rural and remote communities, *Australian Journal of Mental Health*, *8*, 148-153. doi:

Fraser, C., Judd, F., Jackson, H., Murray, G., Humphreys, J., & Hodgins, G. A. (2002). Does one size really fit all? Why the mental health of rural Australians requires further research, *Australian Journal of Rural Health*, *10*(6), 288-295. doi: j.1440-1584.2002.00463.x

Griffiths, K. M., Christensen, H., & Jorm, A. J. (2009). Mental health literacy as a function of remoteness of residence: an Australian national study, *BMC Public Health*, *9*(92), 1-21. Retrieved from http://www.biomedcentral.com/1471-2458/9/92

Happel, B. (2008). Determining the effectiveness of mental health services from a consumer perspective: Part 2: Barriers to recovery and principles for evaluation, International *Journal of Mental Health Nursing*, *17*, 123-130. doi: 10.1111/j.1447-0349.2008.00520.x

Hart, C. R., Berry, H. L., & Tonna, A. M. (2011). Improving the mental health of rural New South Wales communities facing drought and other adversities, *The Australian Journal of Rural Health*, *19,* 231-238. doi: doi: 10.1111/j.1440-1584.2011.01225.x

Hodgins, G., Judd, F., Davis, J., & Fahey, A. (2007). An integrated approach to general practice mental health training: The importance of context, *Australasian Psychiatry, 15*(1), 52-57. doi: 10.1080/10398560601083019

Hoolahan, B., Grosvenor, J., Kurtz, H., & Kelly, B. (2007). Utilizing technology to raise mental health literacy in small rural towns, *Learning in Health and Social Care, 6*(3), 145-155. doi: j.1473-6861.2007.00158.x

Jackson, H., Judd, F., Komiti, A., Fraser, C., Murray, G., Robins, G., Pattison, P., & Wearing, A. (2007). Mental health problems in rural contexts: What are the barriers to seeking help from professional providers?, *Australian Psychologist*, *42*(2), 147-160. doi: 10.1080/00050060701299532

Jorm, A. F., Kitchener, B. A., O'Kearney, R., & Dear, K. B. G. (2004). Mental health first aid training of the public in a rural area: A cluster randomized trial, *BMC Psychiatry*, *4*(33), 1-10. doi: 10.1186/1471-244X-4-33

Judd, F., Cooper, A., Fraser, C., & Davis, J. (2006a). Rural suicide—people or place effects?, *Australian and New Zealand Journal of Psychiatry*, *40*(3), 208-216. doi: j.1440-1614.2006.01776.x

Judd, F., Jackson, H., Komiti, A., Murray, G., Fraser, C., Grieve, A., & Gomez, R. (2006b). Help-seeking by rural residents for mental health problems: the importance of agrarian values, *Australian and New Zealand Journal of Psychiatry*, *40*, 769-776. doi:

Kenny, A., & Allenby, A. (2013). Barriers to nurses providing psychosocial care in the Australian rural context, *Nursing & Health Sciences*, *15*, 194-200. doi: 10.1111/nhs.12014

Lee, A. & Browne, M. O. (2008). Subjective well-being, sociodemographic factors, mental and physical health of rural residents, *Australian Journal of Rural Health*, *16*, 290-296. doi: 10.1111/j.1440-1584.2008.00986.x

McGrail, M. R., Humphreys, J. S., Joyce, C., Scott, A., & Kalb, G. (2011). Rural amenity and medical workforce shortage: Is there a relationship?, *Geographical Research*, *49*(2), 192-202. doi: 10.1111/j.1745-5871.2011.00690.x

McGrail, M. R., Humphreys, J. S., & Ward, B. (2015). Accessing doctors at times of need–measuring the distance tolerance of rural residents for health-related travel, *BMC Health Services Research*, *15*(212). doi: 10.1186/s12913-015-0880-6

Moore, T., Sutton, K., & Maybery, D. (2010). Rural mental health workforce difficulties: A management perspective, *Rural and Remote Health*, *10*(1519), 1-11. Retrieved from http://www.rrh.org.au

Murray, G., Judd, F., Jackson, H., Fraser, C., Komiti, A., Hodgins, G. … Robins, G. (2004). Rurality and mental health: the role of accessibility, *Australian and New Zealand Journal of Psychiatry*, *38*, 629-634. doi: 10.1111/j.1440-1614.2004.01426.x

Park, S. (2015). Digital inequalities in rural Australia: A double jeopardy of remoteness and social exclusion, *Journal of Rural Studies*, 1-9. doi: 10.1016/j.jrurstud.2015.12.018

Perkins, D., Larsen, K., Lyle, D., & Burns, P. (2007). Securing and retaining a mental health workforce in Far Western New South Wales, *The Australian Journal of Rural Health*, *15*, 94-98. doi: 10.1111/j.1440-1584.2007.00860.x

Richardson, L. K., & Simpson, S. (2015). The Future of Telemental Health and Psychology in Australia: Restoring the Psychologically "Clever Country"?, *Australian Psychologist*, *50*, 307-310. doi: 10.1111/ap.12134

Sartore, G., Kelly, B., Stain, H. J., Fuller, J., Fragar, L., & Tonna, A. (2008). Improving mental health capacity in rural communities: Mental health first aid delivery in drought-affected rural New South Wales, *Australian Journal of Rural Health*, *16*, 313-318. doi: 10.1111/j.1440-1584.2008.01005.x

Sutton, K., Isaacs, A. N., Dalzel, K., & Maybery, D. (2017). Roles and competencies of the Support Facilitator in Australia's recovery-oriented mental health initiative: A qualitative study from Gippsland, Victoria, *Australian Health Review*, *41*, 91-97. doi: 10.1071/AH15183

Tonna, A., Kelly, B., Crockett, J., Greig, J., Buss, R., Roberts, R., & Wright, M. (2009). Improving the mental health of drought-affected communities: An Australian model, *Rural Society*, *19*(4), 296-305. doi: 10.5172/rsj.351.19.4.296

Wrigley, S., Jackson, H., Judd, F., & Komiti, A. (2005). Role of stigma and attitudes toward help-seeking from a general practitioner for mental health problems in a rural town, *Australian and New Zealand Journal of Psychiatry*, *39*, 514-521.

Wilks, C. M., Browne, M. O., & Jenner, B. L. (2008). Attracting psychiatrists to a rural area - 10 years on, *Rural and Remote Health*, *8*(824), 1-9. Retrieved from http://www.rrh.org.au

Media Reports

Martinich, R. (2017, February 27). Horsham doctor shortage leads to busier Wimmera Base Hospital: Member for Lowan Emma Kealy, *The Wimmera Mail-Times*. Retrieved from http://www.mailtimes.com.au/story/4496022/horsham-doctor-shortage-floods-emergency-kealy/

Werner, C. (2015, October 20). Wimmera Season Conditions Committee to develop dry season mitigation strategies, *The Wimmera Mail-Times*. Retrieved from http://www.mailtimes.com.au/story/3434427/report-due-for-season-options/

Web Documents

Australian Bureau of Statistics (2008). *Information paper: Measures of socioeconomic status* (No. 1244.0.55.001). Retrieved from http://www.abs.gov.au/

National Rural Health Alliance. (2011). *The determinants of health in rural and remote Australia*. Retrieved from http://ruralhealth.org.au/advocacy/current-focus-areas/social-determinants-health?page=1

Silburn, K. (2015). *Recommissioning community mental health support services and alcohol and other drugs treatment services in Victoria: Report on findings from interviews with senior personnel from both sectors*. LaTrobe University, Bundoora: LaTrobe University. Retrieved from www.hwpcp.org.au

Wimmera Primary Care Partnership. (2016a). *Mental Health Service Directory: Covering the areas of Horsham Rural City, Yarriambiack Shire, West Wimmera Shire and Hindmarsh Shire*. Horsham, VIC: Wimmera Primary Care Partnership. Retrieved from http://wimmerapcp.org.au/wsmmhmp/

Wimmera Primary Care Partnership. (2016b). *Wimmera Primary Care Partnership Population Health and Wellbeing Profile 2016*. Horsham, VIC: Wimmera Primary Care Partnership. Retrieved from http://wimmerapcp.org.au/

Wimmera Primary Care Partnership. (2016c). *Wimmera & Southern Mallee Mental Health Service Mapping Project*. Horsham, VIC: Wimmera Primary Care Partnership. Retrieved from http://wimmerapcp.org.au/wsmmhmp/

Websites

Agriculture Victoria (2016). *Farm recovery after floods and storms*. Retrieved from http://agriculture.vic.gov.au/agriculture/emergencies/recovery/farm-and-land-recovery-after-floods

Ballarat Health Services (2010). *Mental health*. Retrieved from https://www.bhs.org.au/mental-health

Community Indicators Victoria. (2017b). *Metadata.* Retrieved from http://www.communityindicators.net.au/indicator_metadata

Department of Health. (2015). *Access to Allied Psychological Services (ATAPS)*. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-boimhc-ataps

Department of Health (2016). *Western Victoria PHN Profile*. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Western_Victoria

Department of Health and Human Services. (2015). *Mental Health Act 2014*. Retrieved from https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014

Department of Health and Human Services (2017a). *About Victoria's mental health services*. Retrieved from https://www2.health.vic.gov.au/mental-health/mental-health-services

Department of Health and Human Services (2017b). *Funding, performance and accountability*. Retrieved from https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability

Department of Health and Human Services. (2017c). *Primary Care Partnerships*. Retrieved from https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships

Department of Health and Human Services. (2017d). *Service quality*. Retrieved from https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/service-quality

Grampians Pyrenees Primary Care Partnership (2015). *About Grampians Pyrenees Primary Care Partnership*. Retrieved from http://www.grampianspyreneespcp.org.au/about-gppcp

Regional Development Victoria. (2016a). *Victorian Regions and Regional Cities*. Retrieved from http://www.rdv.vic.gov.au/victorian-regions

Services for Australian Rural and Remote Allied Health. (2017). *Remote and rural context*. Retrieved from https://sarrah.org.au/content/remote-and-rural-context

Wimmera PCP. (2017). Wimmera Primary Care Partnership. Retrieved from http://wimmerapcp.org.au/

Western Victoria Primary Health Network. (2017). *Psychological Therapy Services*. Retrieved from https://westvicphn.com.au/community/mental-health/psychological-therapy-services

World Health Organisation. (2014). *Mental health: A state of well-being*. Retrieved from http://www.who.int/features/factfiles/mental_health/en/

Appendices

Appendix A: MBS and PBS Subsidised Services

Providers Items for Medicare Benefits Schedule (MBS) Subsidised Mental Health-Related Services

Provider	Item group
Psychiatrists	Initial consultation new patient(a)
	Patient attendances—consulting room
	Patient attendances—hospital
	Patient attendances—other locations
	Group psychotherapy
	Interview with non-patient
	Telepsychiatry
	Case conferencing
	Electroconvulsive therapy(c)
	Referred consultation for assessment, diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder (PDD)(d)
General practitioners	GP Mental Health Treatment Plan—accreditted
	GP Mental Health Treatment Plan—non-accreditted(a)
	GP Mental Health Treatment Plan—other
	Focussed Psychological Strategies
	Family Group Therapy
	Electroconvulsive therapy(i)
	3 Step Mental Health Process—GP(j)
	3 Step Mental Health Process—other medical professional(j)
Clinical psychologists	Psychological Therapy Services(a)
Other psychologists	Enhanced Primary Care
	Focussed Psychological Strategies (Allied Mental Health)(a)
	Assessment and treatment of PDD(c)
	Follow-up allied health service for Indigenous Australians(k)
Other allied health providers	Enhanced Primary Care—mental health worker
	Focussed Psychological Strategies (Allied Mental Health)—occupational therapist(a)
	Focussed Psychological Strategies (Allied Mental Health)—social worker(a)
	Follow-up allied health services for Indigenous Australians—mental health worker(k)

Items for Pharmaceutical Benefits Schedule (PBS) Subsidised Mental Health-Related Medication

Antidepressants	Drugs used to treat the symptoms of clinical depression.
Antipsychotics	Drugs used to treat symptoms of psychosis (a severe mental disorder characterised by loss of contact with reality, delusions and hallucinations), common in conditions such as schizophrenia, mania, and delusional disorders.
Anxiolytics	Drugs prescribed to treat symptoms of anxiety.
Hypnotics and sedatives	Hypnotic drugs are used to induce sleep and treat severe insomnia. Sedative drugs are prescribed to reduce excitability or anxiety.
Psychostimulants and nootropics	Agents used for attention-deficit hyperactivity disorder and to improve impaired cognitive abilities (nootropics).

Appendix B: Mentions of 'Regional', 'Rural', and 'Remote' in Current Frameworks

Document	Reference
Victoria's 10-Year Mental Health Plan	"Some groups face greater challenges to their mental health. Aboriginal people, people from culturally and linguistically diverse backgrounds, people experiencing family violence, refugees, older and younger Victorians, people living in regional and rural communities and lesbian, gay, bisexual transgender and intersex people are all at greater risk of poor mental health and wellbeing." (p. 7) "There is a critical need to better address the needs of people with mental health problems who become involved with the justice system at all points of contact…The drivers of offending and reoffending are complex and interdependent. They can include issues such as family violence, mental illness, alcohol and drug misuse, the stress of living in regional, rural and drought-affected areas, unemployment, poor educational attainment and insecure housing." (p. 11) "[W]e developed this plan along with people with mental illness, their families and carers, service providers, clinicians, workers and other experts and community members. We conducted workshops in Melbourne and in rural and regional areas" (p. 14) People should be able to get the right services at the right time, local to where they live – be it metropolitan Melbourne, a regional centre or a rural area. (p. 20)
Victorian Suicide Prevention Framework 2016–25	Although suicide rates are lower among young people, suicides account for a larger proportion of deaths of young men and women. The suicide rate is higher in regional Victoria (14.9 per 100,000) than in metropolitan Melbourne (9.4 per 100,000). (p. 2) OBJECTIVE 2: SUPPORT VULNERABLE PEOPLE Uniting behind groups who are experiencing higher risks of distress and suicide, including early responses to concerns among dairy farmers, regional communities, Aboriginal communities, emergency services workers, paramedics, police, and lesbian, gay, bisexual, trans and gender diverse and intersex people (p. 6) Services will be encouraged to support LGBTI people to develop full and healthy identities, and provide culturally appropriate and accessible services across all ages and in both metropolitan and regional settings. (p. 16) Suicide rates are higher in regional and rural communities, and mental health services can be difficult to access. Rural communities are also more affected by fire, flood and drought. The government will support programs that promote mental health, recovery from disaster and strengthen resilience and community support across rural and regional Victoria. The Victorian

	Government will ensure that the National Centre for Farmer Health can continue to improve the health and wellbeing of Victorian farmers and their families. The government will work in partnership with the centre to identify further training and program opportunities, such as brief intervention programs to reduce emotional distress and the risk of suicide. (p. 17) Sporting clubs are an essential part of the community fabric. Victorians of all ages and backgrounds come together in grassroots clubs to be active, enjoy themselves in a positive environment and socialise. Many people with higher risk factors participate in club sport – for example Aboriginal, LGBTI, rural communities, young people affected by suicide and families and friends of suicidal people. This makes sporting clubs an important setting to reach out to those who need help. The government will continue to work with the sector to improve mental health and wellbeing outcomes for Victorians. (p. 18) All Victorian Government agencies will collaborate on developing a data and information sharing system that builds on existing data collections and improves the sharing of this information at local, regional and state levels (p. 25)
Mental Health Workforce Strategy	Consistent with the objectives of Victoria's 10-year mental health plan, actions identified in the Mental health workforce strategy are designed to…improve responsiveness and inclusion, and create ongoing connection to vulnerable communities – including Aboriginal and culturally and linguistically diverse communities, lesbian, gay, bisexual, transgender and intersex people, people with a disability, and people who live in rural and regional Victoria – to ensure their needs and expectations are met (p. 3) 'Opportunities should be provided for senior mental health discipline-specific positions, especially in rural/regional areas' Goulburn Valley Area Mental Health Service (p. 6) We know that in some areas such as in rural and regional areas and growth corridors it is difficult to access mental health services. This can be attributed to a skewed distribution of the workforce. (p. 7) One of the issues affecting the sustainability of the mental health workforce is that mental health work is not always seen as an attractive career option due to stigma and community perceptions about people with mental illness, the people who work with them, and the nature of that work. The ability to attract mental health workforce to rural and remote areas is further affected by negative perceptions of living in those areas held by people who have trained or studied predominately in metropolitan areas. (p. 16) Initiatives to support workplace innovation… placed-based workforce planning in rural and growth areas – to find solutions to workforce needs in targeted geographical areas (p. 24)