Abstract In rural Australia mental health needs occur in a unique context. Social isolation, low mental health literacy, poor access and pathways to care, heightened visibility, relative lack of privacy, increased carer burden, reduced access to transport, and a lack of mental health services can place rural people with psychological issues at greater risk of stigma, untreated illness, social disconnection and chronic health problems. In south-western NSW some innovative practical strategies and services are being delivered that take into account these special challenges. Two of these will be outlined in this article: primary care-based clinical services, and university education and training. The former initiative aims to address pathways and access to care, isolation and transport, cost, and availability of mental health services to decrease the duration of untreated illness in the local community. The latter initiative concentrates on improving rural workforce (training locals to work local), professional support, and access issues.
Responding to local context:

Psychology services in south-western NSW

By Dr Aine McGovern MAPS
Mental Health Program Manager and clinical psychologist, Riverina Division of General Practice & Primary Health

and

Dr Gene Hodgins MAPS
Lecturer and clinical psychologist, School of Humanities & Social Sciences, Charles Sturt University

In rural Australia mental health needs occur in a unique context. Social isolation, low mental health literacy, poor access and pathways to care, heightened visibility, relative lack of privacy, increased carer burden, reduced access to transport, and a lack of mental health services can place rural people with psychological issues at greater risk of stigma, untreated illness, social disconnection and chronic health problems.

In south-western NSW some innovative practical strategies and services are being delivered that take into account these special challenges. Two of these will be outlined in this article: primary care based clinical services, and university education and training. The former aims to address pathways and access to care, isolation and transport, plus cost and availability of mental health services to decrease the duration of untreated illness in the local community. The latter initiative concentrates on improving rural workforce issues (training locals to work local), professional support, and access issues.

Primary care-based clinical services

The Riverina Division of General Practice & Primary Health (RDGP&PH) operates in south central NSW in the area referred to as the Riverina, an area located west of Canberra at the junction between three capital cities, Melbourne, Adelaide and Sydney. There are 105,790 people living within the Division boundaries (1.7% of the NSW population), spread across the geographic area of 35,575.3 square kilometres, with just 2.9 persons per square kilometre. The majority of the population within the Division (66%) resides in the inner regional centre of Wagga Wagga, with over 31 per cent residing in outer regional centres
and the remainder in remote rural centres (as defined by the Australian Bureau of Statistics). The NSW Department of Primary Industries has classified the entire area covered by the RDGP&PH as drought affected and the classification has stood consistently each month since March 2006 (DPI, 2007).

Like most Divisions of General Practice, RDGP&PH had little experience of mental health service delivery when it first received funding for the Access to Applied Psychological Services (ATAPS) Program under the Better Outcomes in Mental Health Care (BOMHC) initiative in January 2003. The next three and a half years of service delivery, however, highlighted a number of factors that, whilst not unexpected, presented significant challenges in the delivery of high quality and accessible services to our communities and members. These have included: workforce issues (retention and development), stigma, and strong demand for services. All of these issues have been found to be common among rural ATAPS projects (Morley, Kohn, Naccarella, Pirkis, Blashki & Burgess, 2006), but there have been variations in the way in which Divisions have sought to address these challenges.

**Workforce**

A review of the local Yellow Pages, or a search on the APS ‘Find a Psychologist’ site, will provide evidence that, as in many other rural areas, the supply of psychologists in Wagga and its surrounding areas is poor. In addition there is strong evidence of local public health services struggling to maintain services due to workforce issues. As a result of this, when establishing its mental health team the management of the Division was conscious of the need for adding to, rather than re-shuffling, the pool of local clinicians. In addition to attracting a number of psychologists to the region, the Division has achieved this goal through a commitment to providing internships for local psychology graduates (all from the Charles Sturt University Psychology Honours Program). This has resulted in the addition of three new psychologists to the local area. Ongoing issues, common to other rural services, are associated with providing opportunities for staff to maintain professional development. The considerable expense of having to travel to metropolitan centres is certainly one obvious barrier. Perhaps more difficult to address is the fact that the limited pool of local psychologists in rural centres can result in poor support and career mentoring for new graduates and those psychologists seeking a career path.

**Stigma**

A critical element of the model of mental health service delivery for our rural communities has been that the psychology sessions are held in the patient’s GP practice. In our internal ongoing evaluations of the program this has been consistently rated by patients as a very strong consideration in the decision to access the Division’s mental health services. One obvious explanation for this would be that the general practice environment offers a level of anonymity that private practice rooms and designated public mental health clinics do not.

**Demand management**
Whether it is the drought or the lack of alternative services, the demand for ATAPS services in the communities covered by RDGP&PH has been consistently high since the program was first established. Indeed, Morley and her colleagues (2006) in their review of ATAPS projects last year indicated that the proportion of people accessing ATAPS services was far higher in rural compared to urban areas. Demand management under the BOMHC arrangements was effected somewhat successfully through restrictions on the referral base of GPs who needed to have completed certain education requirements to register for the program. The advent of the Medicare Better Access to Mental Health Care initiative in November last year prompted all Divisions to reconsider the issue of demand management as this restriction on GP training was removed.

A brave new world!

After much consideration of the issues of demand as well as the other factors highlighted above, RDGP&PH has implemented a number of changes to its mental health services. As outlined in the boxed information, the ATAPS model remained unchanged except that it is now offering services only to our rural towns. To replace services previously provided in Wagga under ATAPS, a new Medicare-funded service has been established based on some variations to the ATAPS model. The main rationale for this change was to increase the funding for the provision of services. Under this plan, funds now available in ATAPS that were previously spent on services in Wagga will be invested in expanding services in our rural communities.

The Wagga Applied Psychology Service was only launched on 1st July 2007 and so is in its pilot stage at this point. It is hoped, however, that it will address some of the issues discussed above. Our clinicians all work in both models, offering them greater variety in their work, and, within the centralised model of the Wagga Applied Psychology Service, more opportunity for collegial support. In addition, it is hoped that for patients this will be a positive move offering greater flexibility with appointments, a low or no cost service, and one provided in a general practice environment.
A model of rural primary mental health care service delivery
The RDGP&PH currently operates two separate though co-ordinated models of service delivery to better meet the needs of its members and community. Funding for these services is drawn from two streams: Medicare (under the Better Access to Mental Health Care initiative) and ATAPS project funding (under the Better Outcomes in Mental Health Care initiative).

ATAPS model
- RDGP&PH directly employs clinicians
- Services are delivered in rural communities only (i.e. not regional centre of Wagga)
- Services are delivered in the practice of the referring GP
- Clinical records are integrated with the patient's medical file
- Travel time to communities is included in working hours
- The service is provided free of charge

Wagga Applied Psychology Services model
- RDGP&PH employs clinicians who each have Medicare Provider Numbers
- Services are delivered in a centralised clinic (the GP After Hours Clinic)
University education and training

Charles Sturt University (CSU) is a major regional university with campuses in Albury-Wodonga, Bathurst, Canberra, Dubbo, Goulburn, Orange and Wagga Wagga. The psychology discipline at CSU offers accredited undergraduate (BA, BSocSci(Psych), BPsych & GradDipPsych), fourth year (BA(Hons), BSocSci(Psych)(Hons) & PostGradDipPsych) and postgraduate (clinical, forensic, PhD) psychology programs. The courses are taught through Bathurst and Wagga campuses, and are available internally or by distance. Service teaching to allied health and human service disciplines is also prominent in the discipline.

CSU offers rural students locally taught undergraduate psychology degrees, as well as clinical and forensic postgraduate training through a unique mix of local teaching and clinical work, and flexible distance education. This allows students who live in Wagga and Bathurst to study locally and students who live in more isolated rural areas to study by distance education, in both instances without having to leave their local rural area. This is important as students who are trained in rural areas have an increased chance of staying and working in rural areas. As an example of this capacity to ‘train and retain’, 73 per cent of CSU graduates who were originally from rural areas, and 20 per cent of students from metropolitan areas, took up their first job in a rural or regional area (Western Research Institute, 2006).

CSU also links with its local communities to offer staff expertise through supervision, research, education and program evaluation opportunities. A number of staff supervise local psychology interns for their registration requirements. Research collaborations with hospitals, health services, Divisions of General Practice, the education sector and others aim to increase community capacity. Both clinical and research training workshops run by staff endeavour to build the capacity of local mental health service providers. In addition, academics are involved in a number of evaluations of local programs in mental health.

Conclusion

Initiatives such as those outlined above, as well as other programs being implemented around Australia, aim to improve the psychological wellbeing of individuals in rural and remote communities within the unique context of where they live. Some future possibilities to expand on the initiatives above include stronger ties between the RDGP&PH and CSU, and expanding CSU’s psychology services for rural students. There is also the establishment of the Centre for Inland Health at CSU, which aims to extend existing partnerships with health service providers across inland NSW and act as a leader and coordinator in exploring approaches that will improve health outcomes for inland communities. Mental health is one of the priority areas for the Centre.
The authors can be contacted on a.mcgovern@rdgp.com.au or ghodgins@csu.edu.au.

References

