

WHERE DO I START?

MENTAL HEALTH SERVICE ACCESS IN SMALL RURAL COMMUNITIES IN THE SOUTHERN MALLEE CATCHMENT

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SHORT SUMMARY ABSTRACT

In this action research study, service providers, consumers and carers came together to explore mental health service access in small rural communities. Within the literature there are few examples of these groups working together on service planning. An extensive scoping review was completed to map the evidence base. Interviews with 20 consumers and carers ensured local issues were contextualised. Seven themes emerged: *Try standing in my shoes, Creating a drama, Capability aligned with need, Seeking stability and connection, Unseen and unimportant, Pick your team, and People like me.* Entrenched stigmatizing attitudes evident in small rural communities impacted on the emotional wellbeing of consumers, carers and family members. Barriers to service access included a lack of understanding of mental illness amongst community members, health professionals and emergency service staff. Participants stated that the only way they could get help was in a crisis situation, and they described contacting multiple services for support. A lack of discharge planning and inadequate service coordination was described. Stories were consistently told about how family members were excluded from care. Stigma reduction strategies, service coordination, early intervention to avoid crises, skill and knowledge development of health professionals and other support workers, improved discharge planning, recognition of the role of families and carers, different methods of engaging with people, and a central coordination model were identified as recommendations. The key recommendation is for a multi-sectoral, strategic, whole of system, coordinated, and longitudinal body of work, to implement a planned and coordinated approach in addressing the multiple system failures.

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EXECUTIVE SUMMARY

Using a participatory action research design, the aim of this study was to bring together people who design and deliver mental health services, and people who use mental health services, to explore service access in the Southern Mallee catchment. The need to involve mental health consumers and carers in all stages of healthcare design, delivery and evaluation is identified in health policy, but there are few examples of health professionals, service staff, consumers and carers working together to directly address local mental health service planning. This study addresses this gap.

Following ethics approval from La Trobe University Human Ethics Committee, a group of three consumers/carers, four health professionals/service providers, two health service planners and researchers met five times, over a six-month period, with meetings lasting approximately two to three hours. The Chief Executive Officer of the Southern Mallee Primary Care Partnership chaired meetings. The group engaged in extensive dialogue, planning, action, observation and reflection about issues related to mental health service access. All meetings were audio-recorded, with recordings transcribed verbatim and circulated to the group for discussion and confirmation that they were an accurate account of group meetings.

In-depth interviews with 20 consumers/carers who had lived experience of serious and enduring mental illness were undertaken to inform the work of the group. Participants were recruited via media advertisements, and following informed consent processes, were engaged in interviews, with the average length of interview one and a half hours. With the permission of participants, interviews were audio recorded and thematically analysed.

The participatory action research group worked through a three-phase process. In the first phase, an extensive scoping review was conducted to map the evidence base on mental health service access in rural communities. The group discussed a multitude of

consumer, community and health professional factors that impact on service access, with entrenched stigma identified as a major barrier.

In the second phase, the group considered data from 20 interviews and had input into analysis. Seven themes emerged from the data: *Try standing in my shoes*, *Creating a drama*, *Capability aligned with need*, *Seeking stability and connection*, *Unseen and unimportant*, *Pick your team*, and *People like me*. The entrenched stigmatizing attitudes evident in small rural communities impacted on the emotional wellbeing of consumers, carers and family members. Participants discussed a lack of understanding of mental illness amongst community members, health professionals and emergency service staff. Consistently across all interviews, carers described the enormity of the ongoing, persistent pressure and stress that they encountered. Participants stated that the only way they could get help was in a crisis situation, and they described contacting multiple services for support. Enormous frustration was expressed about the knowledge and skill level of professionals that were encountered, including those working in health and emergency services. Whilst, a few examples were given of quality care given by individuals, these experiences were not widespread.

Consistently, a lack of discharge plan and coordination between regional centres and local providers was identified. When services were accessed, the lack of coordinated care was seen as a major barrier to good outcomes. Stories were consistently told of family members being excluded from care and their expertise being ignored. In many cases, carers and consumers suggested they were judged harshly by the professionals they encountered.

One of the most important points made throughout the interviews was that people valued (or would value if it was available) the opportunity to connect with others with lived experience. Consumers were uncertain of any mechanism for them to connect with other people 'like them'. Carers groups were not viewed as able to meet the needs of all people who have family members with mental illness. Carer groups while consistently offered, are voluntary in nature, and are considered self-help options.

The participatory action research group reflected on the interviews, with the lack of service access, coordinated care and need to create crises familiar to group members. The lack of coordinated and integrated care and effective discharge planning was highlighted as a major failing, with discussion occurring around the personal and financial cost to consumers seeking care outside the region.

The major comments from all group discussion were summarised by a person with enduring mental illness who posed a single profound question: *Is it valuing rural and not seeing it as a back-water?*

In attempting to formulate recommendations, the group discussed stigma reduction strategies, service coordination, early intervention to avoid crises, professional development of health professionals, and other support workers, improved discharge planning, recognition of the role of families and carers, different methods of engaging with people, and a centralised point for service co-ordination. However, whilst strategies associated with these issues were identified as crucial, the key recommendation was to stop, piecemeal, band-aid solutions to what is a human rights crisis, and invest proper funding in a multi-sectoral, strategic, whole of system, coordinated, and longitudinal body of work, to implement a planned and coordinated approach to addressing the multiple system failures. The strongest recommendation was the need for this process to include people who live with this system failure every day. In spite of the enormity of the burdens that they carry, consumers and carers expressed a passion for longer-term involvement in a process to address what they described as: *'A nightmare that no-one should have to live with'*.

Whilst this small study was conducted in one rural region in Australia, the opportunities for dialogue and exploration of deeply entrenched issues indicated an urgent need to move beyond tokenistic attempts to engage consumers in health planning, to a system where they are central to all planning processes. Failure to recognise the centrality of consumer participation in all aspects of health service planning, delivery and evaluation will ensure that mental health will remain as a siloed, human rights issue, with a system

that responds, (often badly), to acute episodic crises, but does little to support the notion of psychological wellbeing as a fundamental right of all people, irrespective of geographic location.

On behalf of all project members I am pleased to present our final report

A handwritten signature in black ink that reads "Amanda Kenny". The signature is written in a cursive style with a large, looping 'A' and a trailing flourish.

Professor Amanda Kenny

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ACKNOWLEDGEMENTS

We wish to warmly thank the fantastic consumers and carers that gave up their time for this valuable study. Clearly, their stories were incredibly hard to hear, but their resilience and tenacity was inspirational.

To the members of the participatory action research group who worked so productively on this project, you have demonstrated how Government policy, of engaging stakeholders in health service planning is supposed to work. The respectful way that you came together, and managed the sometimes challenging, difficult conversations, demonstrated the fantastic expertise that you shared. Your work illustrated how given time, and a space for dialogue, so much can be achieved in a short time.

As a team, we would like to thank the fantastic support that we have received from Ms Bronwyn Hogan and Ms Sallie Amy and their team from the Southern Mallee Primary Care Partnership. We look forward to being involved in any plans to continue/expand this work.

We would like to acknowledge and thank the Southern Mallee Primary Care Partnership and Murray Primary Health Network for funding this project.

On a personal level, I would like to thank the fantastic team that have worked with me on this project. Thanks to Christine Cummins for her early work, and to Kerryann Meredith for her (as always) great administrative support. To Virginia, Carol, Sue, Jo, Nat, and Ange and Rahila, I know I have asked the impossible with this project but you have delivered. Well done to all – fantastic effort!



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STRUCTURE OF THIS REPORT

This report is presented in three parts. Part one, is a manuscript that draws together the major findings from this study. The manuscript is being submitted to the international, high impact journal *Social Science and Medicine*.

Part two of the report is a scoping review undertaken to map the literature on rural mental health service access.

In part three (appendix 2), the summary documents used to guide this action research project are included as PDF files.

All aspects of this study were approved by the La Trobe University Human Research Ethics Committee.

Enacting mental health policy at the local level: mental health service access in rural communities, an Australian study

INTRODUCTION

In this article we outline a participatory action research study designed to bring together people who design and deliver mental health services, and people who use mental health services, to explore service access for people with serious and enduring mental illness in a large rural area of Australia. The study is a direct response to World Health Organization (WHO) (2013a) demands for local action and leadership, to address inadequate global responses to mental health access. As rural researchers, we are interested in local, community driven responses to health service design, with the direct involvement of people who use services, central to our work.

Our interest aligns with current mental health policy, which identifies the need to involve mental health consumers and carers in all stages of healthcare design, delivery and evaluation (World Health Organisation, 2013a, 2013b). However, enacting this policy at a service level is often inadequate, and success is commonly measured in terms of a tokenistic consumer on a service advisory group (Kidd, Kenny, & Endacott, 2007). Within the literature, there are few examples of health professionals, service staff, consumers and carers working together to directly address local mental health service planning (Kidd, Kenny, & McKinstry, 2014, 2015; Kidd, Kenny, A., & McKinstry, C. , 2015). This study directly addresses this gap.

LITERATURE REVIEW

It is estimated that 25% of the world's population will be affected by a mental illness at some point in their lives, with mental, neurological and substance abuse accounting for 10% of the global burden of disease (World Health Organisation, 2013a). In the Australian context, the location for this study, recent estimates indicate that 2-3% of Australians (approximately 600,000 people) have a severe and enduring mental illness (Department

of Health and Ageing, 2013). In Australia, mental health conditions account for 14% of the health burden, however, less than 7% of health expenditure is allocated to this area (Australian Institute of Health and Welfare, 2014b).

Global estimates indicate that the cumulative impact of mental illness, expressed as lost economic outputs, will total US\$16.3 trillion between 2011 and 2030 (Bloom et al., 2011). Statistical data, however, conceals the full impact of mental health problems on individuals, families and communities, with key reports noting that people with serious mental illness face major stigma and discrimination, and are denied access to basic, essential care (World Health Organisation, 2013a). In countries such as Australia, there are significantly higher rates of disability and mortality for people with mental illness, when compared to the general population (Institute for Health Metrics and Evaluation, 2013), and outcomes for some groups, such as rural and indigenous people are well below what should be expected in a high income country (Australian Institute of Health and Welfare, 2014a).

Recognition by the WHO of the global crisis in mental health (World Health Organisation, 2013b) resulted in an historic global Mental Health Action Plan (2013-2020) that established critical policy direction for mental health service planning. The action plan and resolutions reflected acknowledgement by world leaders of the need to improve outcomes in mental health, with community-based supports central to the proposed actions (Ivbijaro, 2012). It was acknowledged that mental healthcare has, over the last decades, suffered benign neglect, with financial and resource investment inadequate to reverse poor global mental health outcomes (World Health Organisation, 2013a). One of the most important, adopted resolutions, highlighted the need for 'grassroots', local leadership to 'provide comprehensive, integrated and responsive mental health and social care services in community based settings'(World Health Organisation, 2013b).

Whilst the WHO (2013b) highlighted major inadequacies in the management of mental illness in low and middle income countries, a major point was made that poor outcomes for people with mental illness in Western, high income countries reflects failure of these countries to address the issue at a local community level. In countries such as Australia,

critics state that there is lack of political will to address the current 'crisis' in the mental health system (Hall, 2015; Hickie & McGorry, 2007).

In Australia, action to address mental health issues in rural areas is viewed as critical, with people living outside metropolitan areas more likely to experience mental illness, with suicide rates 1.3 times higher outside major cities (Standing Council on Health, 2012). The rate of suicide in Aboriginal and Torres Strait Islander people is 2.7 times higher, than non indigenous. In the age group 15-24 years, suicide rates are 5.1 times higher for indigenous young people (National Rural Health Alliance, 2015). This is a critical issue for Australia, with 67% of indigenous people located outside major cities (Australian Bureau of Statistics, 2011).

For well over a decade, major issues surrounding mental health service access in rural areas have been documented. These include stigma, distance from services, lack of coordinated care, limited consumer involvement in healthcare design, lack of anonymity, lack of skilled health professionals and lack of family and community supports (Judd & Humphreys, 2001; Nicholson, 2008). Given the complexity of the issues identified within key reports, and the broader literature, we were committed to designing a study that would facilitate conversations between people with lived experience of mental health, and service provision, to directly inform healthcare service planning (Abelson, 2001; Anderson, Shepherd, & Salisbury, 2006; Quick & Feldman, 2011).

METHOD

The objective of this study was to engage people who design and deliver mental health services, and people who use those services, to explore mental health service access in small Australian rural communities with populations less than 1500 people. Drawing on participatory, relational epistemology (Heron & Reason, 2006), the use of action research aimed to support dialogue around mental health service access, through consideration of the context, and social world of those who participated (Reason & Torbet, 2001). In participatory research, the researcher and the researched become co-investigators and

work together to help develop the project, collect the data, analyze the data and assist in interpretation and dissemination (Brydon-Miller, Kral, Maguire, Noffke, & Sabhlok, 2010).

In using this methodology, our purpose was to create a democratic process, where power differentials were named and acknowledged, and where the lived experience of all participants could be harnessed to explore how mental health policy initiatives were enacted on a day to day basis (Bergold & Thomas, 2012; Janes, 2015; Liangputtong, 2012). Built into participatory studies is an understanding that the process of participating, and the findings, will be of some benefit to the people within the study, and to the wider community (Kidd & Kral, 2005). The study was outcome focused, with a commitment to developing key strategies to improve integrated, community based mental healthcare across a large geographic region.

THE ACTION RESEARCH GROUP

Following ethics approval from a university ethics committee, letters of invitation to participate in the group were sent to key health and social care agencies across a large rural region. The invitation sought a representative from their agency, and also asked them to identify consumers or carers who might be interested in participating, to contact the research team. A consistent group of nine members, comprised of three consumers/carers, four health professionals/service providers and two health service planners met five times, over a five-month period, with meetings lasting approximately two to three hours. There was acknowledgement that the consumer/carers members were entering a 'power laden space' but the group engaged in extensive dialogue about this, to create an environment for respectful communication where all members were seen as experts.

Consistent with an action research methodology (Brydon-Miller et al., 2010; Reason & Torbet, 2001), the group engaged in extensive dialogue, planning, action, observation and reflection about issues related to mental health access. All meetings were audio-

recorded, with recordings transcribed verbatim and circulated to the group for discussion and confirmation that they were an accurate account of group meetings.

IN-DEPTH INTERVIEWS

Consistent with the focus of this study, in-depth interviews were used to inform the work of the group, by capturing the lived experience of serious enduring mental illness in small rural communities (Kroch & Kahlik, 2006; Minichiello, Hays, & Aroni, 2008). A semi-structured interview schedule was developed based on key themes identified in the literature and included; access to mental health services, barriers and enablers to services, and solutions or alternative approaches that might support better service access.

Participants were recruited via media advertisements, and following informed consent processes, engaged in interviews, with the average length of interview one and a half hours. The interviews were carried out by experienced research team members (AK,SK,VDS,CM) in person (at participants place of residence or another venue chosen by them) or via the telephone. With the permission of participants all interviews were audio recorded and then transcribed verbatim for analysis (Grbich, 2012).

DATA ANALYSIS

Data analysis followed an iterative process (Ezzy, 2002; Grbich, 2012) and was undertaken by experienced qualitative researchers (AK & VDS). The transcripts of action research group meetings, and the individual interviews, were read, and a thematic analytic approach applied. This included line-by-line reading, and extraction of key quotes and text segments related to the questions posed within the group and the interviews (Ezzy, 2002). An initial coding framework from the interview data were developed, and presented back to the action research group for their input and refinement. Following group discussion, final thematic concepts were developed.

FINDINGS

In presenting the findings, we describe each phase of the action research process, the activities undertaken and the resultant group planning, action, observation and reflections.

PHASE ONE OF THE ACTION RESEARCH PROCESS – CONSIDERATION OF THE LITERATURE

In the first phase, an extensive scoping review was conducted to map the evidence base on mental health service access in rural communities. Scoping reviews are useful to map and collate a broad range of literature in a summary format (Arksey & O'Malley, 2005).

The major issues drawn from the scoping review were clustered into key categories and are described in table 1.

Table 1 barriers described in the literature.

Consumer focused barriers	Community focused barriers	Professional barriers
<ul style="list-style-type: none"> • Stoicism • Limited mental health knowledge and understanding • Geographic location • Distance to services • Perceptions of being seen at a 'mental health service' • Ability to maintain long term employment • Lack of knowledge of services provided and how and when to gain access • Limited consumer involvement in health care design, delivery, evaluation • Lack of transportation • Limitations on access to child care • Lack of family and community support • Lack of anonymity – concerns about 	<ul style="list-style-type: none"> • Community attitudes to mental illness • Personal and perceived stigma • Self stigma • Structural stigma 	<ul style="list-style-type: none"> • Recruiting and retaining clinicians in rural and remote areas is always challenging and has an enormous impact on service delivery and confidence in the standard of care • Lack of well connected inter-professional care • Regular delays in assessment, diagnosis and treatment • Lack of interest in mental health/GPs not always interested/skilled • Hesitance of health professionals to refer • Bypassing local care serves to further deskill. • Lack of easy access to second opinions • Dual relationships • Focus on high prevalence or low prevalence – often associated with GP

<p>confidentiality, dual relationships</p> <ul style="list-style-type: none"> Financial constraints 		<p>interest</p>
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Group discussion, planning, observation and reflections

The group had long and passionate discussions about stigma within their small communities. The issue of entrenched stigma created ardent banter between health professionals, service planners and consumers alike. A consumer explained the need to have open and frank discussions that normalize mental illness in the same way as other conditions:

With men they feel ashamed within themselves to say I'm not well. It's extremely hard to say I can't do this anymore ... it's taken me two wives and three kids I still every day talk to someone about it, because I don't want it to bottle up inside me until it bursts. That's what happens which ends up driving some people to suicide – they go so far, they've got nobody to talk to.

A health professional agreed, but reinforced other views within the group that these kind of discussions were extremely difficult to have:

People don't know what to say, I have found in a social situation, when people ask what I do, almost immediately the conversation comes to a complete halt.

There was a great deal of discussion about the risk of community members being open about mental illness. There was a perception that within communities mental illness may

be seen as an opportunity to gain a neighbour's property for economic gain, and that within the broader community there is little understanding of support needed for a person experiencing mental illness:

To admit weakness in that context is not economically sound, it's a competitive society. See that more in the farming community. They don't want to talk to their neighbours about themselves.

If a member of the community has an acute medical condition the community will rally around them, however, the same doesn't apply if somebody has a mental illness

The impact on newcomers to the community who had mental illnesses was described as incredibly difficult:

The small communities have expectations, that you like football, and will work on community activities for the town. You have to meet that criteria and if you do then wow you are accepted.

Broader discussion on other barriers occurred within the group, but discussion consistently came back to a lack of community acceptance. Collectively, there was a great deal of enthusiasm for the dialogue that had commenced as a result of this project. The group actions were aimed at having a broader conversation within their own communities, and learning from others with lived experience.

PHASE TWO OF THE ACTION RESEARCH PROCESS – CAPTURING WIDER EXPERIENCES

In the second phase, the group considered data from 20 interviews and had input into analysis. Seven themes emerged from the data: *Try standing in my shoes, Creating a drama, Capability aligned with need, Seeking stability and connection, Unseen and unimportant, Pick your team, and People like me*, with the interviews creating lengthy, conversations within the group. To provide context to the group discussion the following section outlines key interview data considered by the group.

Try standing in my shoes

The entrenched stigmatizing attitudes evident in small rural communities impacted on the emotional wellbeing of consumers, carers and family members. A couple that were interviewed described what it was like living in a small community:

We moved up here a few years ago cause we couldn't afford the cost of the city. We came seeking a new life. What did we get? Being called feral and having people stone our roof.

Parents described the difficulties of living in a small rural community with children with mental illnesses:

Well people still to this day, I have been here nine years, still think my son's a monster because he wanders up and down the street talking to himself.

Local, small town gossip was seen to perpetuate feelings of isolation for people with mental illness and their carers/family members:

So everybody knows what's going on and the fact that the police were there. I said I am ringing to let you know. I wanted you to hear the facts rather than gossip from everybody else who's hanging out their windows thinking my gosh what's going on at that house.

A man who had lived with mental illness for many years described the lack of understanding within communities:

And I mean people, most people that don't, do not understand what it's like. It's the most, most hideous bloody disease I've ever come across. I mean it affects you in different ways

Many people talked about how neighbours treated them differently, and how mental illness was considered in a very different way to any other chronic or serious condition:

This is going to sound really selfish but if my daughter have cancer she would have been treated differently. I would have had someone holding my hand and all my neighbours around here would be making casseroles ...We have the Royal Children's hospital appeal that raises millions and millions of dollars, and doesn't it come back to a judgment thing? Mental health is not as sweet and cuddly as kids with cancer

Participants discussed the lack of understanding expressed by others, including health professionals and emergency service staff, and the culture of blame within the community. Carers explained how they were perceived as bad parents:

And then this Doctor rang me and said “She’s just a very naughty girl who’s seeking attention.”

A lack of societal and government understanding was described:

And, and I mean what frustrates me the most is the Government say “We’re going to do this for cancer and we’re going to do that for breast cancer and we’re going to do that” and then they’ll talk about that, but “Oh people with mental health, oh you ring up Beyond Blue”.

Consistently across all interviews, carers described the enormity of pressure and stress that they encountered:

I didn’t even know where I was going. At one stage there, this is not bullshit, I was driving ... I come around this corner and I’m just driving along and it was really, really, really getting to me and I saw this big truck coming, coming around the corner and it was a big long straight, I thought I might just line this bastard up and just run straight into it

Despite a lack of support, carers remained committed to their family members

And I’ve been there fifteen bloody years now, so I don’t know what’s wrong with me.

Creating a drama

Across all interviews, participants stated that the only way they could get help was in a crisis situation:

It’s got to be in a crisis situation ... to really get an appointment, you’ve basically got to get carted into the ED in the back of a paddy-wagon.

Participants consistently described contacting multiple services to get help:

So I spent like lots of days with her, trying to get her in. She was actually suicidal and she, herself had been ringing around, I don’t really know everywhere she rang. But I tried community health, I tried [larger centre], I tried [regional city]. No one I rang could tell me where to get help and in the end I was ringing [regional city]. In the end they said to me “You will have to do what I’ve done before ... Having her arrested basically...so then I called the police.

Carers described the feeling of living on the edge, not knowing when an incident might happen

You know and I mean you know it's frightening I just can't take anymore, I get stressed I can't handle it

I worry about whom I call. I worry about - oh my god do I need to lock up the knives every night.

When carers are in desperate need of help they perceive that there is nowhere for them to turn:

We will make an appointment for you to go to see them in [larger town] in two weeks time. Not now, two weeks time

There is a real sense of frustration of not knowing who to call for help:

The phone book is the most complex piece of paper you could ever come across when you are in a stressful situation and you are trying to find some sort of assistance and you open up the phone book, and you're thinking it's not sexual, it's not domestic, it's not, and you're going through all these things and you think I just want!

She was suicidal she had a noose in her bag, she was going to kill herself. It was awful but the worst bit was, you don't know who to ring

Capability aligned with need

Enormous frustration was expressed about the knowledge and skill level of professionals that are encountered:

I'm not highly educated or anything like that, but if you rock into ED in [larger town] with your suicidal daughter and you have got no education at all you're f...

There was discussion that it was not only health service staff that struggled to know how to manage people with mental illness. It was often the police who arrived in times of crisis, but they did not always have the skills and knowledge to know how to manage someone. Examples were given of people being in desperate need but paramedics joking that mental illness is not an emergency. A consumer who had taken an overdose explained:

Yeh and the attitude of the paramedic was just atrocious. He said "Oh it's not an emergency, she's just mental health" that what his reaction was. I had taken an overdose for God's sake. He was like frustrated, frustrated to have to come out to a mental health patient well you know and he just kind of was joking about it and he said "Oh well, yeh mental health, it's not classed as emergency."

Carers expressed frustration that they were aware of services but when they tried to reach out they did not feel their needs were supported:

Beyond Blue, when you ring up, and you are a carer, and you're finding it hard to cope because you're not mentally ill yourself, piss off.

Enormous frustration was expressed about lack of discharge plan and coordination between regional centres and local providers:

Then from [regional city] to [larger regional city], then after my son had endeavoured to commit suicide we were sent home. I was pleased that he was well enough to come home but shocked. Knowing what services people receive for physical illnesses, I was quite amazed that this person who tried to die was sent home

Seeking stability and connection

When services were accessed, the lack of coordinated and consistent care was seen as a major barrier. Participants suggested that the lack of access to a regular local service had an impact on the severity of the next episode:

It could be John Smith this six weeks, in another six weeks it could be Tom Jones

She spent thirty eight weeks at the [major metropolitan service] Yeh I'd spend most weekends down there and at that stage [my son] wasn't home so there was still like we had to like keep the farm going.

But that's another thing you know I've got these other appointments I have got to go to in [regional centre], like to access that service I have to go to [regional centre], to see a psychologist I waited four months to get into see her, so that's just what it's like living around here I guess.

Even when participants had resources to seek care outside their community it was difficult to know how to get help:

There was two guys in [regional centre], one guy just wouldn't return my call and the other guy said that he wouldn't treat anyone under the age of sixteen and at that stage [daughter] was only just fifteen.

Participants were very positive about metropolitan services but frustrated about the lack of services locally. They highlighted the lack of local case management:

On paper [region] looks like it's very well serviced because we have, you know, a lot of organisations that say they provide services for residents, but we don't have any services that actually come into the place. It's all outreach

When things became exceptionally difficult participants indicated the only option for respite care was a nursing home:

Yeh and then he says to me "No worries" he says "We'll give you some respite" he says "We'll whack her up there in [nursing home] with all of the oldies." I said "No, you bloody won't."

Concern was expressed about the lack of follow up in the region:

But there was no follow up and there was no counselling while they were in there, there was nothing. There was, they were just a number, but getting her in there was the hardest and then when we got out... Well that was harder. Well she literally got in the back of the car and she said "Mum I'm really scared" because, she said "I don't know what to do because I will use again, because I will be around you know come back and I will be around..." no support ... but she'd had no counselling and no rehab and no, she was scared, she was crying you know it was awful.

And I said you know she really needs help with rehabilitation and all of that sort of stuff, but they had no real suggestions, so we walked out of there and I did a lot of ringing around and I finally found somewhere.

People were concerned about the trajectory for those who did not get care:

There are kids in there that they're going to roll on from the adolescent system into the adult system into the justice system.

Unseen and unimportant

Stories were consistently told about how family members were excluded from any care or their expertise was ignored:

Actually one of the, it was horrific, I actually I threw a hissy fit and I thought "Oh my God if I don't pull this together, they're going to lock me up."

They just shut the door on, on the family. Like [son] would get discharged they will ring me up. He's coming home and that's it.

And I'm sitting there with a bruised face and all blown up and they didn't even come out and say "This is what's happening."

Pick your team

The importance of who was there to support you and provide care was highlighted:

He [policeman] said to me "Look you can lay charges, but don't go down that path." He could see that we had problems.

So she rings me up and we have a chat. I have met her for coffee when I have been in [larger town].

Examples were given of the small acknowledgements that made a difference:

"How are you going, is there anything?" When [family member] had an admission to [larger town] about twelve months ago the doctor wanted to see me and I went in there and she said "What do we need to do to help you?" I burst into tears.

People like me

One of the most important points made throughout the interviews was the opportunity to connect with others with lived experience:

But if it was a person that's feeling suicidal for the first time they, they need somewhere to go that someone can talk to them

Carers groups for many people were not seen as able to cater to the diversity of people's needs:

And I really admire them but me, me to be sitting around the only bloke there to be sitting around with a group of bloody sheila's having cups of tea and eating scones and things like that, it ain't going to work.

And the thing is you're dealing with this stress you know all the time, all you want to do is go and have a bit of a laugh and a talk...But you don't want to be sitting there listening to whinging all the time.

There was acknowledgment that often carers groups and other local organisations were left to “pick up the pieces” and to offer the only local services to people with mental health issues without training or support

It was like you know great we've got this service in but it's not a service, it's a volunteer group!!

There was agreement that being able to sit and talk to someone who understood on a one to one basis was crucial:

I'm only a lonely old, bloody little old Carer.

Group discussion, planning, observation and reflections

There was much sadness amongst group members when reflecting on the interview data, but little surprise. The lack of service access, coordinated care and need to create crises was familiar to group members who provided their thoughts:

I had to take a whole bottle of sleeping pills, wait for a little bit, and then ring the ambulance. I stayed in hospital for a couple of days, then a mental health nurse came to see me “you didn’t really want to commit suicide did you”? “No, I didn’t” “Well you’re ok to go home then.” Wrong answer.

If they threw a brick through a policeman’s window they would get some help. If you go through the normal channels it can be 10 days before you see anyone and by then you could have slit your throat.

The lack of coordinated and integrated care was highlighted as a major failing, with discussion occurring around the cost to consumers of seeking care outside the region.

The cost if you’re a private patient is \$200 - \$120 comes back from Medicare and then the cost of how fuel for the round trip, there is very little left out of a fortnightly pension.

Cancer care is different, if you have to travel to Melbourne for oncology there is accommodation and different things like that.

A clinician expressed her frustration:

I triaged him and he has also triaged himself on several occasions. They wanted this client to drive to see their clinician and he was extremely unwell, heavily medicated on extremely high levels of anti-psychotics. I am actually going to ask him to write a complaint, because the treatment and judgement he received from the clinician was absolutely disgusting.

Long discussions were held on the lack of education amongst health professionals, and other support workers. There was resounding agreement that coordinated, recovery focused care for mental illness is rare:

The lack of education coming through from the GPs is one of the major stumbling blocks. If you’re diagnosed with diabetes you are immediately sent off to the diabetes clinic to see a nurse

There was group discussion on telehealth solutions, with everyone agreeing that it cannot replace face-to-face support. It is often used badly, by placing an isolated consumer in front of a screen:

Even if it was a local clinician, albeit a psych or social worker, or nurse even. If they were supported by a psychiatrist by videoconference the continuity being the local clinician. Once the local clinician is gone, you’re stuffed.

The major comments from all group discussion was summarised with a single profound question:

Is it valuing rural and not seeing it as a back-water?

PHASE THREE OF THE ACTION RESEARCH PROCESS — CONSIDERATION OF POSSIBLE STRATEGIES AND DEVELOPMENT OF RECOMMENDATIONS AND FUTURE ACTION.

In attempting to formulate recommendations, the group discussed stigma reduction strategies, service coordination, early intervention to avoid crises, professional development of health professionals and other support workers, improved discharge planning, recognition of the role of families and carers and support for them, different methods of engaging with people, and a central point for interconnection. However, whilst strategies associated with these issues were identified as crucial, the major recommendation was to stop, piecemeal, band-aid solutions to what is a human rights crisis, and invest in funding a multi-sectoral, strategic, whole of system, coordinated, and longitudinal body of work, to support a planned and systematic approach to addressing multiple system failures. The strongest recommendation was the need for this process to include people who live with this system failure every day. In spite of the enormity of the burdens that they carry, consumers and carers expressed a passion for longer-term involvement in a process to address what they described as:

A nightmare that no-one should have to live with.

DISCUSSION

In a policy environment that highlights the centrality of consumer participation in all stages of healthcare design, planning and evaluation (Commonwealth of Australia, 2012; Department of Health and Ageing, 2011; Green, Price, Lipp, & Priestley, 2009; Kulig & Williams, 2012; National Health Hospitals Reform Commission, 2009; World Health Organisation, 2010), there is acknowledgement by government of a lack of clarity on how participation policy agendas can realistically be achieved (Francis, 2013; Mitton, Smith, Peacock, Evoy, & Abelson, 2009; Victorian Auditor General, 2012). A recent review of

community participation in rural health (Kenny et al., 2013) indicated few studies that report participation beyond the levels of tokenism, described in the seminal work of Arnstein (1969).

At first glance, the dearth of research in the area of consumer participation in rural regions of high-income countries would seem surprising. Prominence is given to consumer participation in global health policy reform (Committee on the Future of Rural Health Care, 2005) (Commonwealth of Australia, 2012; Kulig & Williams, 2012; Wagstaff, Lindelow, Wang, & Zhang, 2009; World Health Organisation, 2010), based on contentions that rural communities are fertile grounds for participatory processes (Organisation for Economic Co-operation and Development, 2010). However, at a practical level, there is acknowledgement that meaningful participation is not easy (Kenny, Farmer, Dickson-Swift, & Hyett, 2014), and that creating participatory spaces for consumers and organisations to work together is a challenging undertaking (Eversole, 2011).

The action research process described in this article is unique, in that participatory processes generally involve ‘usual suspects’, who are confident in power compromised social settings (Kenny et al., 2014; Taylor, Wilkinson, & Cheers, 2006). Whilst the action research process we used, was built around an ‘invited space ... structured and owned by those who provide[d] them’ (Cornwall, 2008), we drew on the work of Kilpatrick (2009) to develop a strong governance mechanism and actively recruited and supported a small group of consumers who were strongly engaged in the process. It has been argued that mechanisms to engage people who are marginalized continue to be elusive (Taylor, Wilkinson, & Cheers, 2005) and most fail to achieve inclusive participatory processes (S Kidd, A Kenny, & R Endacott, 2007; Kilpatrick, Cheers, Gilles, & Taylor, 2009; Taylor et al., 2006). Whilst authors have suggested that rural people are ‘increasingly wary of being involved’ in participatory activities (Beresford, 2002), this was not our experience.

An important part of the initial establishment of our group was explicit acknowledgment that all members were ‘experts’ and lived experience was valued as highly (or more highly) than ‘professional knowledge’. We were explicit about unequal power relationships (Turner, 1987), being cognizant of harsh criticisms that have been directed

at psychiatry for perpetuating biomedical dominance (Bracken & Thomas, 2001; Cutcliffe & Happell, 2009; Foucault, 2002; Turner, 1987; Willis, 1994).

Whilst the group worked hard to create a participatory space (Eversole, 2011), where people were respected, and open dialogue was encouraged (McArdle, 2008), the findings from our study indicate that mental illness, more broadly, continues to be conceptualized through a biomedical lens, with only cursory consideration given to the psychological, environmental and social realities associated with its enduring nature.

Well over a decade ago, Judd and Humphreys (2001) stated, that a major priority of Australia's then National Mental Health Strategy (Australian Health Ministers Advisory Council Evaluation Steering Committee, 1997), was service access to rural mental health care. In Australia's Fourth National Mental Health Plan (2009-2014) service access, coordination and continuity of care continued to be key priority areas (Australian Health Ministers, 2009). The actions in this fourth plan included the development of strong partnerships between 'service providers, consumers and carers and other relevant stakeholders to develop local solutions to better meet the mental health needs of communities' (Australian Health Ministers, 2009).

It is clear, that formal documented processes, such as the action research work described in this article, are rare (Kidd et al., 2007; Kidd et al., 2014, 2015; Kidd, Kenny & McKinstry, 2015). However, authors reinforce the major gains that can be made by increasing public input into the design of healthcare (Quick & Feldman, 2011), particularly when addressing complex service issues (Abelson, 2001; Anderson et al., 2006). Despite decades of government policy, focused on consumer participation in rural mental health (Australian Health Ministers, 1992, 1998, 2003, 2009; Australian Health Ministers Advisory Council, 2013), at this point, there appears to be a failure to capitalize on this potential.

Whilst communication and information flow between all sectors of the healthcare system, continuity of care and co-operative service models are highlighted as central to

achieving equitable, universal access, irrespective of age, gender, position or geographic location (World Health Organisation, 2012), there is a consistent message in the data from this study that effective service co-ordination remains an elusive goal.

Within the findings of this study there is data to support a strong critique of key notions of rurality. In Scotland, it was indicated that people with enduring mental illness often move toward urban centres, due to declining social status or to access services (Nicholson, 2008). In our study, the opposite was true. Many of the participants in this study, had moved to the area in search of cheaper housing and reduced living costs. Authors (Farmer, Currie, Kenny, & Munoz, 2015) have identified a major shift in rural demography, with in-migration from people facing disadvantage. The resultant impact of this is that people with the greatest need, are at the greatest distance from needed services, and face some of the highest barriers to service access.

‘Rural’, conceptualised in bucolic and idyllic terms, does not reflect the reality of the region in which this study was conducted. Descriptions of homogenous, welcoming rural communities (Cohen, 1985), classically represented in the notion of *gemeinschaft* (Tonnies, 2001), were not evident within this study. People told gut-wrenching stories of stigma, prejudice and discrimination. The issue of stigma, associated with mental health, is consistently featured in the literature and key policy reports. From this study, the findings would indicate that despite decades of campaigning for the human rights of people with mental illness (World Health Organisation, 2013b), little gains are being achieved in changing entrenched community perceptions, with mental health consumers and carers devastated by systemic discrimination and societal prejudice (Pescosolido, 2013; Ridgeway, 2001).

It would be naïve to propose a simple solution to address sustained discriminatory practices and attitudes surrounding mental illness, but the data presented in this article suggests a need to conceptualize mental illness in a different way. Key reports focus on mental disorders (World Health Organisation, 2013b), and this reinforces biomedical approaches to mental illness. There is little doubt of the importance of medical management of acute and enduring mental illness, however, participants in this study indicated that mental illness was perceived differently to other chronic conditions. By

conceptualizing mental illness as a chronic condition, there are opportunities to improve discharge planning, self-management and recovery focused programs, to ensure that rural people are not left languishing when acute episodes subside. Conceptualisations of mental illness in this way may go some way to improving pathways into and out of the mental health system and may enable a greater focus on rehabilitation (Jablensky et al., 2000). It is intriguing that rehabilitation, associated with other chronic conditions such as myocardial infarction are well established, yet participants in this study indicated a total absence of programs following discharge from acute mental health facilities.

The findings from our study would suggest that considerable work is needed to achieve the WHO (2013b) vision of a multi-sectoral approach where:

services support individuals, at different stages of the life course and, as appropriate, facilitate their access to human rights such as employment [including return-to-work programmes], housing and educational opportunities, and participation in community activities, programmes and meaningful activities.

In our study, there were isolated examples of service excellence, reflected in the theme 'pick your team', but it is not unreasonable to expect that people, irrespective of geographic location, are not reliant on the 'luck' of encountering a supportive provider. Whilst calls for ongoing education of health professionals (Jelinek, Weiland, Mackinlay, Hill, & Gerdtz, 2011) and initiatives such as telehealth (Hazelton, Habibis, Schneider, Davidson, & Bowling, 2004) have merit, current piecemeal approaches to addressing the social inequalities associated with mental illness, will do little to address the rapidly rising health, social and economic burden (World Health Organisation, 2013a) associated with inaction. In the Australian context, harsh criticisms are directed at Government for their apathy and failures to demonstrate major leadership in addressing the disparities associated with mental health (Hall, 2015; Hickie & McGorry, 2007). The same criticisms are directed at all major Western countries (World Health Organisation, 2013a). Whilst the current level of issues associated with mental illness should be viewed as a human rights crisis, waiting for government action will see the crisis deepen.

Conclusion

Whilst global policy highlights the need for urgent action to reverse decades of benign neglect of mental health services and care, this study reinforces the need for localised, systematic and multi-sectoral approaches to addressing the crisis situation that was consistently described by participants. In a system dominated by biomedical thinking, the need to involve people with lived experience of the system in planning and decision-making is critically important. However, prioritising professional knowledge over the expert knowledge of people who struggle for service access will do little to address structural, systemic and entrenched apathy, stigma, and prejudice. Whilst this small study was conducted in one rural region in Australia, over a relatively short period of time, the opportunities for dialogue and exploration of deeply entrenched issues indicated an urgent need to move beyond tokenistic attempts to engage consumers in health planning, to a system where they are central to all planning processes. Failure to recognise the centrality of consumer participation in all aspects of health service planning, delivery and evaluation will ensure that mental health will remain as a siloed, human rights issue, with a system that responds (often badly) to acute episodic crises, but does little to support the notion of mental wellbeing as a fundamental right of all people, irrespective of geographic location.

- Abelson, J. (2001). Understanding the role of contextual influences on local health-care decision making: case study results from Ontario, Canada. *Social Science & Medicine*, 53(6), 777-793.
- Anderson, E., Shepherd, M., & Salisbury, C. . (2006). 'Taking off the suit': engaging the community in primary health care decision-making. *Health Expectations*, 9(1), 70-80.
- Arksey, H, & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, 8(1), 19-32.
- Arnstein, S. (1969). A ladder of citizen participation. *Journal of the American Institute of Planners*, 35(4), 216-224.
- Australian Bureau of Statistics. (2011). *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Canberra: Australian Bureau of Statistics.
- Australian Health Ministers. (1992). *National Mental Health Plan*. . Canberra.
- Australian Health Ministers. (1998). *Second National Health Plan*. Canberra.
- Australian Health Ministers. (2003). *National Mental Health Plan 2003 - 2008*. . Canberra.
- Australian Health Ministers. (2009). *Fourth National Mental Health Plan*. Canberra: Commonwealth of Australia.
- Australian Health Ministers Advisory Council. (2013). *A national framework for recovery oriented health services: Policy and theory*. Canberra.
- Australian Health Ministers Advisory Council Evaluation Steering Committee. (1997). *Evaluation of the National Mental Health Strategy: Final report*. Canberra.
- Australian Institute of Health and Welfare. (2014a). *Australia's Health 2014*. Canberra.
- Australian Institute of Health and Welfare. (2014b). *Health expenditure Australia 2012–13. Health and welfare expenditure series*. Canberra: Australian Institute of Health and Welfare.
- Beresford, P. (2002). Participation and social policy: transformation, liberation or regulation? In R. Sykes, C. Bochel & N. Ellison (Eds.), *Social Policy Review* (pp. 265-287). Bristol: Policy Press.
- Bergold, J. , & Thomas, S. (2012). Participatory research methods: A methodological approach in motion *Forum: Qualitative Social Research*, 13(1).

- Bloom, D.E., Cafiero, E.T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L.R., Fathima, S., Weinstein, C. (2011). The Global Economic Burden of Noncommunicable Diseases. Geneva: World Economic Forum.
- Bracken, P, & Thomas, P. (2001). Post psychiatry: A new direction for mental health. *British Medical Journal*, 322, 724 - 727.
- Brydon-Miller, M., Kral, M. J. , Maguire, P. , Noffke, S. , & Sabhlok, A. (2010). Jazz and the Banyan tree: Roots and riffs in participatory action research. In N. Denzin & Y. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (4th ed., pp. 387-400). Thousand Oaks, CA: Sage Publications.
- Cohen, A.P. (1985). *The symbolic construction of community*. London: Routledge.
- Committee on the Future of Rural Health Care. (2005). *Quality Through Collaboration: The Future of Rural Health*. Washington DC: The National Academies Press.
- Commonwealth of Australia. (2012). *National Strategic Framework for Rural and Remote Health*. Canberra.
- Cornwall, A. (2008). Unpacking 'Participation': models, meanings and practices. *Community Development Journal*, 43(3), 269-283.
- Cutcliffe, J. , & Happell, B. (2009). Psychiatry, mental health nurses and invisible power: Exploring a perturbed relationship within contemporary mental health care. . *International Journal of Mental Health Nursing*, 18(2), 116-125.
- Department of Health and Ageing. (2011). *Improving Primary Health Care for All Australians*. Canberra: Commonwealth of Australia.
- Department of Health and Ageing. (2013). *National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993-2011*. Canberra: Commonwealth of Australia.
- Eversole, R. (2011). Community Agency and Community Engagement: Re-theorising Participation in Governance. *Journal of Public Policy*, 31(1), 51-71.
- Ezzy, D. (2002). *Qualitative Data Analysis: Practice and Innovation*. . French's Forest: Allen & Unwin.
- Farmer, J., Currie, M., Kenny, A., & Munoz, S. (2015). An exploration of the longer-term impacts of community participation in rural health services design. *Social Science & Medicine*, 8, 141:164.
- Foucault, M. (2002). *The archeology of knowledge*. London Routledge
- Francis, R. . (2013). *The Mid Staffordshire NHS Foundation Trust Public Inquiry* London.

- Grbich, C. (2012). *Qualitative Data Analysis: An Introduction*. . Thousand Oaks, CA: Sage Publications.
- Green, G, Price, C, Lipp, A, & Priestley, R. (2009). Partnership structures in the WHO European Healthy Cities project. *Health Promotion International*, 24(S1), i37-i44.
- Hall, B. (2015, September 16). Australia in the middle of "mental health crisis" with unnecessary deaths escalating, *The Age*. Retrieved from <http://www.theage.com.au/victoria/australia-in-the-middle-of-mental-health-crisis-with-unnecessary-deaths-escalating-20150916-gjnqpd.html>
- Hazelton, M., Habibis, D., Schneider, R., Davidson, J., & Bowling, A. (2004). Effect of an extended-hours community mental health team on family caregiving in a semi-rural region of Australia. *Australian Journal of Rural Health*, 12(5), 220-222. doi: <http://dx.doi.org/10.1111/j.1440-1854.2004.00608.x>
- Heron, J, & Reason, P. (2006). *The Practice of Cooperative Inquiry: research with rather than on people*. . In P. Reason & H. Bradbury (Eds.), *Handbook of Action Research: The concise paperback edition* (pp. 144-154). London: Sage
- Hickie, I. , & McGorry, P. . (2007). Increased access to evidenced based primary mental health care: will the implementation match the the rhetoric? *Medical Journal of Australia*, 187(2), 100-103.
- Institute for Health Metrics and Evaluation. (2013). *The global burden of disease: Generating Evidence, Guiding Policy* (pp. 27-29). Seattle: Institute for Health Metrics and Evaluation,.
- Ivbijaro, G. (2012). The case for change: The Global Mental Health Action Plan 2013–2020. *Mental Health in Family Medicine*, 9, 135.
- Jablensky, A., McGrath, J. , Herrman, H. , Castle, D., Guryere, O., Evans, M., & Harvey, C. (2000). Psychotic disorders in urban areas: an overview of the study of low prevalence disorders *Australian and New Zealand Journal of Psychiatry*, 34(2), 221-236.
- Janes, J. (2015). *Democratic encounters? Epistemic privilege, power, and community based participatory action research* *Action Research*.
- Jelinek, G. A., Weiland, T. J., Mackinlay, C., Hill, N., & Gerditz, M. F. (2011). Perceived differences in the management of mental health patients in remote and rural australia and strategies for improvement: findings from a national qualitative study of emergency clinicians. *Emergency Medicine International Print*, 2011, 965027. doi: <http://dx.doi.org/10.1155/2011/965027>

- Judd, F, & Humphreys, J. (2001). Mental Health Issues for Rural and Remote Australia. *Australian Journal of Rural Health*, 9, 254-258.
- Kenny, A, Farmer, J, Dickson-Swift, V, & Hyett, N. (2014). Community participation for rural health : a review of challenges. *Health Expectations*. doi: 10.1111/hex.12314
- Kenny, A, Hyett, N, Sawtell, J, Dickson-Swift, V, Farmer, J, & O'Meara, P. (2013). Community participation in rural health: a scoping review. *BMC Health Services Research*, 13(64).
- Kidd, S, Kenny, A, & Endacott, R. (2007). Consumer advocate and clinician perceptions of consumer participation in two rural mental health services. *International Journal of Mental Health Nursing*, 16(3), 214-222.
- Kidd, S. A., & Kral, M. J. (2005). Practicing participatory research. . *Journal of Counseling Psychology*, 52, 187-195.
- Kidd, S., Kenny, A., & Endacott, R. . (2007). Consumer advocate and clinician perceptions of consumer participation in two rural mental health services *International Journal of Mental Health Nursing*,, 16, 214-222.
- Kidd, S., Kenny, A., & McKinstry, C. . (2014). From experience to action in recovery oriented mental health practice; A first person inquiry *Action Research*, 12(4), 357-373.
- Kidd, S., Kenny, A., & McKinstry, C. . (2015). Exploring the meaning of recovery oriented care: An action research study. *International Journal of Mental Health Nursing*,, 24(1), 38-48.
- Kidd, S., Kenny, A., & McKinstry, C. . (2015). The meaning of recovery in a regional mental health service: an action research study. *Journal of Advanced Nursing*., 77(1), 181-192.
- Kilpatrick, Sue. (2009). Multi-level rural community engagement in health. *Australian Journal of Rural Health*, 17(1), 39-44.
- Kilpatrick, Sue, Cheers, Brian, Gilles, Marisa, & Taylor, Judy. (2009). Boundary crossers, communities, and health: Exploring the role of rural health professionals. *Health & Place*, 15(1), 284-290. doi: 10.1016/j.healthplace.2008.05.008
- Kroch, T. , & Kahlik, D. . (2006). *Participatory Action Research in Healthcare*. . Oxford: Blackwell.
- Kulig, J, & Williams, A (Eds.). (2012). *Health in Rural Canada*. Vancouver: UBC Press.
- Liamputtong, P. (2012). *Qualitative Research Methods* South Melbourne: Oxford University Press.

- McArdle, K.L. . (2008). Getting in, getting on, getting out: On working with second person inquiry groups In P. Reason & H. Bradbury (Eds.), *The Sage Handbook of Action Research* (pp. 602 - 614). Los Angeles: Sage Publications
- Minichiello, V. , Hays, T. , & Aroni, R. . (2008). *In Depth Interviewing* Melbourne: Pearson.
- Mitton, C, Smith, N, Peacock, S, Evoy, B, & Abelson, J. (2009). Public participation in health care priority setting: A scoping review *Health Policy*, 91, 219-228.
- National Health Hospitals Reform Commission. (2009). *A healthier future for all Australians - Final Report*. Canberra.
- National Rural Health Alliance. (2015). *Mental Health in Rural and Remote Australia*. Deakin West: National Rural Health Alliance, .
- Nicholson, L. (2008). Rural mental health. *Advances in Psychiatric Treatment*, 14, 302-311.
- Organisation for Economic Co-operation and Development. (2010). *Strategies to improve rural service delivery*. Paris: OECD Publishing.
- Pescosolido, B. . (2013). The public stigma of mental illness. What do we think? What do we know? What can we prove? . *Journal of Health and Social Behaviour*, 54(1), 1-21.
- Quick, K., & Feldman, M. (2011). Distinguishing participation and inclusion. *Journal of Planning Education and Research*, 31(3), 272-290.
- Reason, P., & Torbet, W. . (2001). The action turn towards a transformational social science. *Concepts and Transformation*, 6(1), 1-37.
- Ridgeway, P. . (2001). Re - storying psychiatric disability: learning from first person accounts of recovery. *Psychosocial Rehabilitation Journal*, 18(4), 5-10.
- Standing Council on Health. (2012). *National Strategic Framework for Rural and Remote Health*. Barton: Commonwealth of Australia.
- Taylor, J, Wilkinson, D, & Cheers, B. (2005). Rural places and community participation in health services development. Paper presented at the International Conference on Engaging Communities (2005: Brisbane, Qld). <http://www.engagingcommunities2005.org/abstracts/Taylor-Judy-final.pdf>

- Taylor, J, Wilkinson, D, & Cheers, B. (2006). Is it consumer or community participation? Examining the links between 'community' and 'participation'. *Health Sociology Review*, 15(1), 38-47.
- Tonnies, F. (2001). *Community and Civil Society*, . Cambridge: Cambridge University Press.
- Turner, B. (1987). *Medical Power and Social Knowledge*. Newbury Park: Sage Publications.
- Victorian Auditor General. (2012). *Consumer participation in the health system*. Melbourne: Victorian Auditor-General's Office.
- Wagstaff, A., Lindelow, M., Wang, S, & Zhang, S. (2009). *Reforming China's Rural Health System*. Washington DC: The World Bank.
- Willis, E. (1994). *Illness and Social Relations*. St Leonards: Allen and Unwin.
- World Health Organisation. (2010). *Rural poverty and health systems in the WHO European Region*. Copenhagen: WHO Regional Office for Europe.
- World Health Organisation. (2012). *Zero Draft. Global Mental Health Action Plan 2013-2020*. Geneva: World Health Organisation.
- World Health Organisation. (2013a). *Investing In Mental Health: Evidence for Action*. Geneva: World Health Organisation,.
- World Health Organisation. (2013b). *Mental health action plan 2013-2020*. Geneva: World Health Organisation.

LITERATURE REVIEW

STRUCTURE OF THE REVIEW

This review is structured in six parts. A short introduction is provided to set the context for the review. In the second part of the review, an initial narrative review is provided that included a small number of studies of direct relevance to the Southern Mallee region. What was clear from this review was that a more systematic approach to identifying relevant literature in the international context was required. This provided the impetus for conducting a systematic search using a scoping review methodology. The methodology and method is provided in the third part. Part four contains the results of the review presented in tabulated format. In part five, we provide a summary of the major key references that relate to service access barriers. In part six, we include a summary of strategies that have been utilised or recommended to address service access.

INTRODUCTION

For well over a decade, major issues surrounding mental health service access in rural areas have been documented. These issues include stigma, distance from services, lack of coordinated care, limited consumer involvement in healthcare design, lack of anonymity, lack of skilled health professionals and lack of family and community supports (F Judd & Humphreys, 2001; Nicholson, 2008). In recent critiques of the Australian mental health system, it would appear that little has changed (Hall, 2015; Hickie & McGorry, 2007). The purpose of this literature review was to provide background for a study that aimed to capture consumer and carer perspectives related to mental health service access in small townships and areas with a population of under 1500 people in the Southern Mallee region of Victoria. This area comprises three Local Government Areas: Buloke Shire,

Gannawarra Shire and Swan Hill Rural City (not including Robinvale). Figure one provides detail of the catchment.



Source:<http://www.smpcp.com.au/AboutSMPCP.aspx>

Defining terms

In 2011, mental health services in rural areas were described as the most complex of all health services (Price Waterhouse Coopers, 2011). Within the Australian context mental health services are delivered by State and Territory Governments and range from specialised, acute psychiatric inpatient services through to social and community support (Australian Institute of Health and Welfare, 2015). A multitude of service agencies and providers are involved in the provision of mental health services including State managed public mental health services, private sector services, and primary health care services [including strong reliance on community based general practitioners].

Definitions of 'rural' are contested, with much debate about the difficulties in reaching consensus on rural definitions (Kenny & Duckett, 2004). For the purposes of this review,

we utilise a pragmatic definition of rural as non-metropolitan (Kenny, Farmer, Dickson-Swift, & Hyett, 2014).

AN INITIAL SEARCH OF THE LITERATURE

We commenced this review with an initial search of the literature. The narrative review that was completed provided guidance as to the likely scope of current literature in the field. In a key study by Robinson et al. (2012), financial constraint, a shortage of health care providers, a lack of transportation, limitations on access to childcare, and family and community support were identified as key barriers to service access. The distance from regional services was reported to create travel and financial concerns, with a negative impact on outcomes. In recent studies, authors (Henderson, Crotty, Fuller, & Martinez, 2014) have reported on delays in assessment, diagnosis and treatment for mental illness due to the distance from specialist clinicians and a shortage of health care providers.

The recruitment and retention of clinicians in rural areas was identified as problematic, with an impact on service delivery and confidence in the standard of care (Crotty, Henderson, & Fuller, 2012). It was argued that when services appear to be limited, the community will lose confidence in professional treatment (Perkins et al., 2013). Concerns regarding the skill level of health professionals was identified in the initial articles with mental health specialists often located in regional centres. Concerns were raised that GPs were not always experienced and interested in the management of mental health problems and as a result acted as a barrier to service access (Robinson et al., 2012).

Crotty, Henderson and Fuller (2012) identified privacy and trust as a problem with accessing mental health care within a small rural or remote community. A lack of anonymity can become a barrier to access when the consumer or family lacks trust in the health provider's ability to maintain confidentiality and discretion in social settings (Handley et al., 2014). When studying the preferences and intentions of rural adolescents toward seeking help for mental health problems, Boyd et al. (2007) described fear of stigmatization as a significant factor. The study suggested that anti stigma campaigns in

rural areas were needed; the sense that there was no anonymity impacted on decision making.

People aged 65 years were seen to have logistical access issues and limited mental health knowledge and understanding. In a study where older people and mental health was considered (Muir-Cochrane, O’Kane, Barkway, Oster, & Fuller, 2014) limited transportation in rural areas and a general lack of knowledge of services provided, and how and when to gain access was identified. In many rural areas support groups have been unsuccessful, not because they are not warranted but because the stigma of being seen attending a group in a small community stands in the way of success (Robinson et al., 2012).

Attitudinal impacts

It has been recognised that stoicism and attitude play a crucial part in a person's response to help seeking, particularly in relation to accessing mental health care. Attitude can be identified as cultural among rural and remote population groups, with little regard to gender, age, marital status or level of education (Judd et al., 2006). This acts as a barrier, with older people less likely to identify a need to access service with low levels of mental health literacy recognised as a contributing factor (Muir-Cochrane et al., 2014).

It is evident that stigma plays a key role within rural and remote communities and acts as a barrier to help seeking and pursuing ongoing treatment and support (Handley et al., 2014). The negative impact of stigma associated with mental illness has been identified as having a profound impact on help seeking (Henderson et al., 2014). Robinson et al. (2012) states fear of gossip and social exclusion play a major role on help seeking, with people convincing themselves to deal with problems on their own to avoid social stigmatisation.

Judd et al., (2006) revealed a preference to rely on the support of community, family and friends over the concept of formal help seeking. The attitudinal response to “carrying on” and refusal to adopt a sick role was seen as a contributing to the image of stoicism in “the bush”. Whilst attitudinal factors were viewed as problematic, there was some

evidence that location may have an effect on wellbeing. Kelly et al. (2011) described a strong sense of community as a positive factor in rural and remote communities.

KEY PAPERS

In the course of the initial review, four key papers were identified that were of particular relevance to our study. Well over a decade ago, Fraser, Judd, Jackson, Murray, Humphreys and Hodgins (2002) identified the need for further research examining the specific issues relating to mental health access in addition to “how place and community impact on mental health”. In their article they discussed barriers to service access and the need to recognise the diverse conditions of rural Australians when addressing mental health policy and the delivery of services.

In the second article, the impact of stigmatising attitudes on seeking help for mental health conditions in small communities was identified (Wrigley, Jackson, Judd, & Komiti, 2005). In a later review by some of the same authors (Jackson et al., 2007), a study was conducted on the barriers that rural people face when seeking professional help. In the fourth article, written again by some of the same authors, the relationship between rural lifestyle and mental health was identified with the role of stoicism in consumers accessing mental health treatment and support explored. The study was conducted within some parts of the Southern Mallee region (Judd et al., 2006).

SCOPING REVIEW METHOD

Our initial work indicated that a much more systematic approach was needed to capture the international literature in the field. A scoping review was designed to gain an international understanding of barriers and enablers for people accessing rural mental health services. A scoping review is a useful method to locate and map current evidence, identify evidence gaps and determine future research priorities (Grant & Booth, 2009). This method supports an assessment of the scope and size of existing research literature, outlining the nature or type of research designs used. While authors of scoping reviews

do not critically appraise the quality or rigor of the research, they can characterise or summarise the quantity and quality of the literature (Grant & Booth, 2009). Issues of access to rural mental health services have been highlighted in past literature although the extent and nature of barriers and enablers were not fully known.

Study Design

The scoping review followed the methodological framework outlined by Arksey and O'Malley (2005). This framework comprises five stages: (1) Identifying the research question; (2) Identifying relevant studies; (3) Study selection; (4) Charting the data; and (5) Collating, summarizing and reporting the results.

Stage 1: Identifying the Research Question

The research question was: What is known about the enablers and barriers to access rural mental health services?

Stage 2: Identifying Relevant Studies

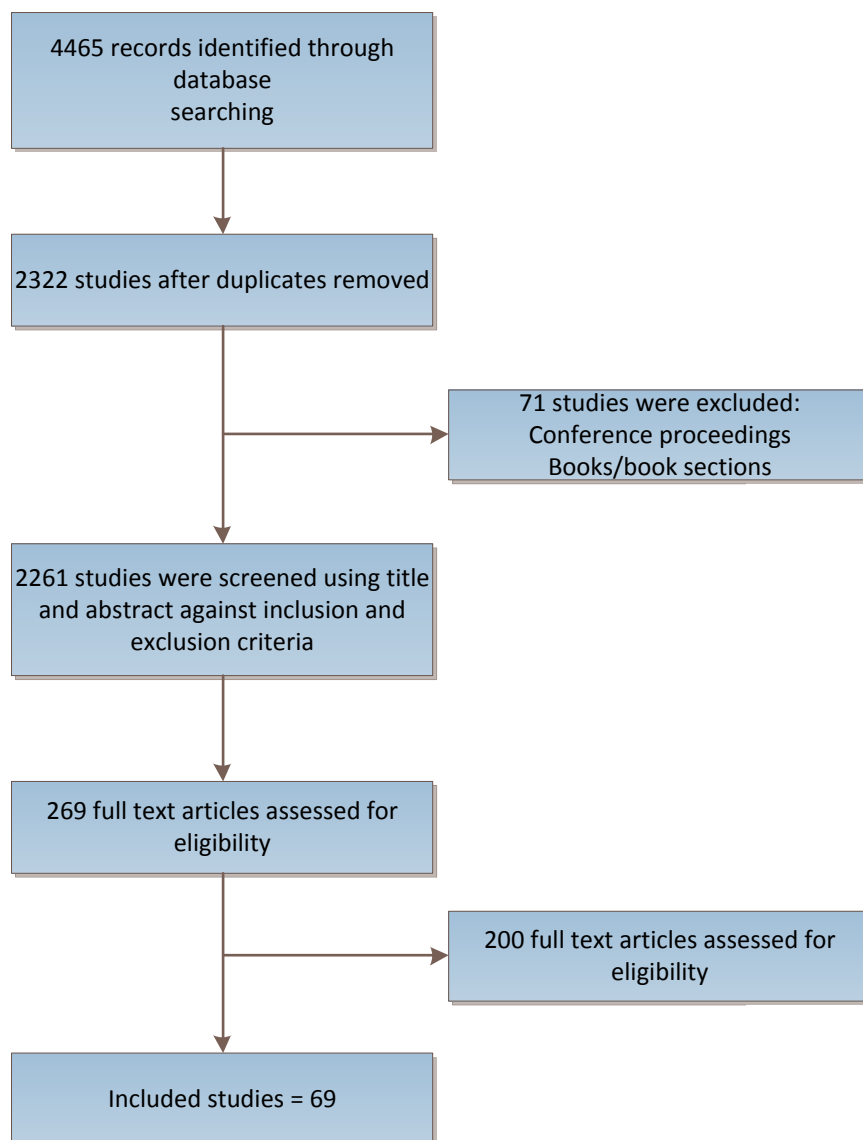
A search of evidence databases: MEDLINE (1948 – Ovid), EMBASE (Ovid), CINAHL (EBSCO), PsycINFO (1806 – Ovid), AMED (Ovid) and SCOPUS (Elsevier) was conducted using the following search terms: “access”, “use”, “service provision”, or “equity” were combined with the terms “mental health service”, “mental health care”, “mental health”, “mental illness” or “Psychiatr*” and combined with “rural”, “regional” or “remote”. All primary research, both quantitative and qualitative, that addressed the research questions was included. Abstracts, letters, literature reviews, editorials, correspondence and non-English literature were excluded. Studies published after the year 2000 and up until August 2015 were included for review. Primary outcomes of interest included studies that focused on accessing mental health care, support, information or services.

Stage 3: Study Selection

After removing all duplicates from the search a total of 2,332 articles were identified a review of title against the inclusion and exclusion criteria was conducted. Abstracts were

then reviewed against the inclusion and exclusion criteria for the remaining studies. A review of full text copies of the 269 articles was conducted. Figure one outlines the search and selection results.

Figure 1. *Figure 1.* PRISMA flow diagram illustrating the process of article selection



RESULTS OF THE REVIEW PRESENTED IN TABULATED FORMAT

(SEE APPENDIX 1)

Stage 4: Data Charting and Collation

This stage of scoping review framework involves charting the characteristics and major findings of the evidence. Data were extracted from the articles and entered in a spreadsheet database. Information from included studies was obtained according to the study location, aim, research participants, research design, major findings, barriers and strategies/interventions.

A SUMMARY OF THE KEY REFERENCES RELATED TO SERVICE ACCESS

BARRIERS

Stage 5: Summarising and Reporting Findings

We reviewed the findings of included studies and identified three major themes:

1. Community focused barriers
2. Consumer focused barriers
3. Health professional/service barriers

Community focused barriers

Community focused barriers were a major theme in the literature reviewed. There is strong negative stigma relating to mental health issues or illness. Rural people are expected to be stoic through difficult times and this impacts on mental health. Rural communities and individuals have perceptions that rural people are resilient, where gender stereotypes and traditions dictate what services or assistance are considered acceptable. This results in structural stigma characterised by the community's own perceptions of mental health. Self-stigma is frequently present, where accessing mental health services is perceived to be a sign of individual weakness or failure (Alang, 2015; Allan, 2010; M. M. Barry, Doherty, Hope, Sixsmith, & Kelleher, 2000; Boyd et al., 2007;

Colon-Gonzalez et al., 2013; Happell, Scott, Platania-Phung, & Nankivell, 2012; Jack-Ide & Uys, 2013; Jayaram, Goud, & Srinivasan, 2011; Kermode, Bowen, Arole, Joag, & Jorm, 2009; McColl, 2007; Rathbone-McCuan, 2001; Saldivia, Vicente, Kohn, Rioseco, & Torres, 2004; Sweeney & Kisely, 2003).

Limited awareness of what services are available can be a barrier for rural communities accessing services. Often there are low levels of mental health literacy and rural people struggle to know when, and how to access appropriate services. A major community barrier is a fear of being seen entering or using a mental health service and having others within the community knowing that there is an issue. A real concern for those with a mental health issue is that people in the community, such as employers, may lose confidence in someone with a mental illness and their ability to maintain long-term employment or continue in their community role. In addition, social exclusion may be experienced due to fear that other community members may discover an individual's mental health issues and react negatively. The responsibility of being a community leader and having others relying on them can also prevent, or inhibit, timely and appropriate service access. The lack of engagement in services limits opportunities for consumers to identify how mental health services that may benefit them. This also inhibits their involvement in having a 'voice' regarding improved health care design, delivery and evaluation. (M. M. Barry et al., 2000; Boydell et al., 2006; Isaacs, Maybery, & Gruis, 2013)

For many communities, a lack of local mental health services or access to local mental health professionals is a major barrier. Geographical distance from mental health services, and particularly specialised services is problematic. Community confidence in services and mental health professionals is essential, otherwise a preference to self-manage or delay accessing services will frequently occur. Overall, rural communities themselves pose their own inherent barriers to accessing mental health services (Anderson & Gittler, 2005; Bee, Lovell, Lidbetter, Easton, & Gask, 2010; Draper et al.,

2003; Fuller & Broadbent, 2006; Jelinek, Weiland, Mackinlay, Hill, & Gerdtz, 2011; Kermode et al., 2009; McColl, 2007).

Consumer focused barriers

At an individual level, there can be barriers that prevent someone with a mental health issue or illness seeking assistance or services. Practicalities such as a lack of transport to travel to see a mental health professional are frequently reported, particularly where public transport is limited or does not exist. The cost of travel and loss of earnings, or disruption to work, are other factors associated with having to travel for service access. Having regular appointments that result in large amounts of time away from work can have negative impacts on relationships with employees or employers and can be a deterrent in timely access to services in rural areas with high unemployment. The financial constraints associated with both the expense of services, as well as the time off work for consultations places an additional burden of financial restraint on those with mental health issues.

(Alang, 2015; Boydell et al., 2006; Brooks, Dailey, Bair, & Shore, 2014; Chemali, Borba, Henderson, & Tesfaye, 2013; Forchuk, Jensen, Martin, Csiernik, & Atyeo, 2010; Brenda Happell et al., 2012; Hunter, 2006; Iezzoni, Killeen, & O'Day, 2006; Jack-Ide & Uys, 2013; Jayaram et al., 2011; Kermode et al., 2009; Simpson, Doze, Urness, Hailey, & Jacobs, 2001)

Rural women who have responsibilities for caring for children may face difficulties obtaining childcare to enable them to access and attend mental health services. Lack of family support or from others in the community to provide care can prevent attendance at appointments (Simpson et al., 2001).

In small communities, there is concern regarding one's anonymity if seeking mental health services. It is highly probable that the service provider and rural client share involvement in social environments and community clubs. Given the stigma relating to mental illness in rural areas, and the dual relationship for mental health professionals living and working in rural communities, people with mental health issues may avoid

seeking timely help (Boyd et al., 2007; Boydell et al., 2006; Cheek et al., 2014; Isaacs et al., 2013).

Health professional/service barriers

If a person with mental health issues living in a rural area manages to overcome the community and consumer focused barriers to seek help, they may then be confronted with health professional/service barriers. A consistent barrier to accessing mental health services reported in the literature is the challenge associated with recruiting and retaining clinicians in rural areas. The high turnover of rural clinicians directly impacts service delivery and the confidence consumers have in the standard of care they are receiving (Anderson & Gittler, 2005; Draper et al., 2003; B. Happell, 2008a; Lee, Lohmeier, Niileksela, & Oeth, 2009).

General practitioners are often the first point of contact for members of the community when seeking help regarding mental health. Given the medical workforce shortages in rural areas, there are often lengthy patient wait lists and high doctor to population ratios. General practice mental health expertise may be inconsistent across rural areas and referral to local or speciality mental health services may be problematic or delayed. Rural general practitioners may be hesitant to refer patients to more specialised services, or accessing second opinions may be difficult, often being located some distance away. Specialists from metropolitan areas may visit rural areas to assist those requiring more specialised care however, these visits may only occur every few months resulting in delayed assessment, diagnosis and treatment. It may be difficult for the consumers to establish a relationship with the service provider, with the consumer often having to repeat their mental health history to a new specialist at each visit. The lack of consistency in service provision can result in a lack of confidence and trust in the care being received. There may be a preference to travel to receive consistent specialised care with the same clinician. Unfortunately, the bypassing of local care results in these local service centres being further deskilled, subsequently adding to the barriers discussed (Bambling et al.,

2007; Bathgate, Bermingham, Curtis, & Romans, 2001; Caldwell et al., 2004; Hunter, 2006; Isaacs et al., 2013; Wright, Harmon, Bowman, Lewin, & Carr, 2005).

Conclusion

Many factors or barriers have been identified as inhibiting or preventing rural people with mental health issues accessing appropriate services in a timely manner. These barriers are wide ranging and have been categorised as community, consumer or health professional/service related barriers. Very few strategies have been identified to overcome or minimise these barriers and further research is needed to evaluate them. Given the complexity of the issues relating to mental health service access for rural people, the perspectives of all stakeholders including consumers, carers and service providers are needed to identify or generate sustainable action to address this significant health problem.

SUMMARY OF STRATEGIES THAT HAVE BEEN UTILISED OR RECOMMENDED TO ADDRESS SERVICE ACCESS.

In the final part of our review, we identified strategies that have been utilised or recommended to address rural mental health service access.

Strategies for countering access barriers to rural mental health services

A range of strategies have been proposed to address issues relating to accessing rural mental health services. These range from improved service delivery models, including the use of technology, improved collaboration and coordination between services, upskilling health professionals or enabling access to mental health specialists, to a population or community based approach to increase mental health literacy.

Capacity building of health professionals to broaden and increase role

- Increasing the capacity of primary care workers to undertake a greater range of tasks including those related to mental health assessments and drug and alcohol management (Allan, 2010).
- Upskilling local workers such as Rural Financial Counsellors to ensure facilitation and referral to appropriate services (Fuller & Broadbent, 2006).
- Community mental health consultation-liaison service to provide support to primary care practitioners and family carers (Hazelton, Habibis, Schneider, Davidson, & Bowling, 2004).
- Localisation of services and attachment of specialist clinicians to rural mental health teams (Henderson et al., 2014).
- Having 'expert generalists' in mental health enabling a specialist in addiction, a youth specialist and a geriatric specialist in a team approach using a mobile crises service model involving police crisis teams that are supported by mental health teams (Forchuk et al., 2010)
- Promoting generalist education in mental healthcare (Colon-Gonzalez et al., 2013).

Guidelines and clinical pathways to increase teamwork and cross agency collaboration

- Increase evidence-based practice and improve communication between general practitioners and community nurses (Annells et al., 2011).
- Establish pathways to meet the broad needs of Indigenous clients and those with high needs, particularly strengthening families and community involvement, enhancing mental health literacy and health promotion and contribution to workforce development (Cooper, 2009)
- Guidelines for ED health professionals (Jelinek et al., 2011)

Early intervention services

- Provision of early intervention centres for adolescent mental health in regional areas will improve access, particularly if including youth friendly facilities and web-based services (Rickwood, Telford, Parker, Tanti, & McGorry, 2014).
- School based counselling services can improve rural adolescents' access to mental health care before needing GP or allied health services. May keep them at school (Boyd et al., 2007)
- Local services that enable early intervention and education /health promotion in schools and child care settings that empower parents and reduce stigma (Boydell et al., 2006)
- Increased screening of groups at high risk of depression (Cole, McCusker, Sewitch, Ciampi, & Dyachenko, 2008). School based health care centres to improve access particularly to disadvantaged rural students (Grossman et al., 2007; Wade et al., 2008)

Education

- Improved education particularly training in mental health assessment and management, including medication management for health professionals in rural emergency departments (Jelinek et al., 2011).
- Increased education for general practitioners for psychiatric conditions (Bathgate et al., 2001).
- Specific education for emergency personnel (e.g. police, paramedics and nurses) on mental health matters in all communities (Forchuk et al., 2010)

Improved mental health staffing

- Improved levels of mental health staffing and access to allied health staff would assist general practitioners to manage the needs of less complex people with mental health issues and better manage current service demands (Bambling et al., 2007).
- Increased referral to allied health by general practitioners (Morley, 2010).
- Additional human resources to decrease caseloads (Ryan-Nicholls, Racher, & Robinson, 2003)

Improved communication and collaboration between services

- Greater communication between services, particularly general practitioners and non-government sector services would assist manage demand and particularly those with complex needs (Bambling et al., 2007).
- Greater integration between mental health and other community-based services using MOUs (Sweeney & Kisely, 2003). Map services to identify service gaps and ensure people get the right service in a timely manner (Turpin, Bartlett, Kavanagh, & Gallois, 2007).
- Situate mental health services within an integrated health system to improve access and ensure holistic approach to rural health care (Brinkman, Hunks, Bruggencate, & Clelland, 2009; Rathbone-McCuan, 2001).
- Improved coordination of care for youth particularly leaving intensive inpatient services to distributed interdisciplinary outpatient services that are located in local areas (Carlisle, Mamdani, Schachar, & To, 2012).
- Improve communication and teamwork between team members (Ryan-Nicholls et al., 2003).
- Involve community health workers in discharge planning (Ryan-Nicholls et al., 2003)
- Integrate behavioural health in primary care to decrease stigma (Alang, 2015).
- Providing mental health services in primary care physician offices rather than in speciality mental health sites to decrease stigma (Colon-Gonzalez et al., 2013).
- Collaborations between education sector and youth mental health services (Farmer, Burns, Phillips, Angold, & Costello, 2003).

Group based services

- Outpatient AOD intervention groups having longer follow-up may prevent relapse (Bradley, Baker, & Lewin, 2007).

Telepsychiatry

- Use of telepsychiatry or videoconferencing has the potential to enable more timely access to MH services (Buckley & Weisser, 2012).
- Telephone based support and advice or telehealth (Hazelton et al., 2004; Pomerantz, Cole, Watts, & Weeks, 2008).
- Use of web-based tools to provide information for young people seeking services (Nicholas, Oliver, & O'Brien, 2004).

- Increase access to specialist services through use of telemental health services as an alternative to rural physicians (Cloutier, Cappelli, Glennie, & Keresztes, 2008).
- Telepsychiatry could reduce the issues rural patients have with dual relationships with local treatment providers (Brooks et al., 2014).
- Electronic screening tools to enable primary screening and triage (Farrell et al., 2009).
- Provide a phone-based child mental health consult service for primary care providers to enable access to specialist advice (Hilt et al., 2013).

Utilisation of consumers in designing MH services

- Need to increase the focus on the views and experiences of consumers to develop more responsive MH services (Happell, 2008b).
- Involve mental health consumers in training health professionals (McColl, 2007)
- Recognition that the 'lived experience' of consumers and carers is a form of expertise (Barry, 2007).

Improve mental health literacy

- Programs that improve the mental health literacy and health promotion programs for indigenous men developed collaboratively between mental health services and indigenous stakeholders (Isaacs et al., 2013)
- Consumer education (Ryan-Nicholls et al., 2003), and more information for families about mental health services particularly parents and children (Starr, Campbell, & Herrick, 2002).

- Alang, S. M. (2015). Sociodemographic Disparities Associated With Perceived Causes of Unmet Need for Mental Health Care. *Psychiatric Rehabilitation Journal*. doi: 10.1037/prj0000113
- Allan, J. (2010). Engaging primary health care workers in drug and alcohol and mental health interventions: challenges for service delivery in rural and remote Australia. *Australian Journal of Primary Health*, 16(4), 311-318. doi: <http://dx.doi.org/10.1071/PY10015>
- Anderson, R. L., & Gittler, J. (2005). Child and adolescent mental health. Unmet need for community-based mental health and substance use treatment among rural adolescents. *Community Mental Health Journal*, 41(1), 35-49.
- Anells, M., Allen, J., Nunn, R., Lang, L., Petrie, E., Clark, E., & Robins, A. (2011). An evaluation of a mental health screening and referral pathway for community nursing care: nurses' and general practitioners' perspectives. *Journal of Clinical Nursing*, 20(1/2), 214-226. doi: 10.1111/j.1365-2702.2010.03275.x
- Arksey, H, & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International journal of social research methodology*, 8(1), 19-32.
- Australian Institute of Health and Welfare. (2015). Mental Health Services in Australia. Canberra.
- Bambling, M, Kavanagh, D, Lewis, G, King, R, King, D, Sturk, H, Bartlett, H. (2007). Challenges faced by general practitioners and allied mental health services in providing mental health services in rural Queensland. *The Australian Journal of Rural Health*, 15(2), 126-130. doi: <http://dx.doi.org/10.1111/j.1440-1584.2007.00866.x>
- Barry, K. J. (2007). Collective inquiry: Understanding the essence of best practice construction in mental health. *Journal of Psychiatric and Mental Health Nursing*, 14(6), 558-565. doi: 10.1111/j.1365-2850.2007.01128.x
- Barry, M. M., Doherty, A., Hope, A., Sixsmith, H., & Kelleher, C. C. (2000). A community needs assessment for rural mental health promotion. *Health Education Research*, 15(3), 293-304.
- Bathgate, D., Bermingham, B., Curtis, D., & Romans, S. (2001). The views of Otago urban and rural general practitioners on mental health services. *New Zealand Medical Journal*, 114(1134), 289-291.

- Bee, P, Lovell, K, Lidbetter, N, Easton, K, & Gask, L. (2010). You can't get anything perfect: "User perspectives on the delivery of cognitive behavioural therapy by telephone". *Social Science & Medicine*, 71(7), 1308-1315. doi: <http://dx.doi.org/10.1016/j.socscimed.2010.06.031>
- Boyd, Candice, Francis, Kristy, Aisbett, Damon, Newnham, Krystal, Sewell, Jessica, Dawes, Graham, & Nurse, Sarah. (2007). Australian rural adolescents' experiences of accessing psychological help for a mental health problem. *The Australian Journal of Rural Health*, 15(3), 196-200. doi: <http://dx.doi.org/10.1111/j.1440-1584.2007.00884.x>
- Boydell, K. M., Pong, R., Volpe, T., Tilleczeck, K., Wilson, E., & Lemieux, S. (2006). Family perspectives on pathways to mental health care for children and youth in rural communities. *Journal of Rural Health*, 22(2), 182-188.
- Bradley, A. C., Baker, A., & Lewin, T. J. (2007). Group intervention for coexisting psychosis and substance use disorders in rural Australia: outcomes over 3 years. *Australian & New Zealand Journal of Psychiatry*, 41(6), 501-508.
- Brinkman, K., Hunks, D., Bruggencate, G., & Clelland, S. (2009). Evaluation of a new mental health liaison role in a rural health centre in Rocky Mountain House, Alberta: a Canadian story. *International Journal of Mental Health Nursing*, 18(1), 42-52. doi: [10.1111/j.1447-0349.2008.00582.x](http://dx.doi.org/10.1111/j.1447-0349.2008.00582.x)
- Brooks, Elizabeth, Dailey, Nancy, Bair, Byron, & Shore, Jay. (2014). Rural Women Veterans Demographic Report: Defining VA Users' Health and Health Care Access in Rural Areas. *Journal of Rural Health*, 30(2), 146-152. doi: [10.1111/jrh.12037](http://dx.doi.org/10.1111/jrh.12037)
- Buckley, D., & Weisser, S. (2012). Videoconferencing could reduce the number of mental health patients transferred from outlying facilities to a regional mental health unit. *Australian & New Zealand Journal of Public Health*, 36(5), 478-482. doi: <http://dx.doi.org/10.1111/j.1753-6405.2012.00915.x>
- Caldwell, T. M., Jorm, A. F., Knox, S., Braddock, D., Dear, K. B., & Britt, H. (2004). General practice encounters for psychological problems in rural, remote and metropolitan areas in Australia. *Australian & New Zealand Journal of Psychiatry*, 38(10), 774-780.
- Carlisle, C. E., Mamdani, M., Schachar, R., & To, T. (2012). Predictors of psychiatric aftercare among formerly hospitalized adolescents. *Canadian Journal of Psychiatry*, 57(11), 666-676.
- Cheek, C., Bridgman, H., Fleming, T., Cummings, E., Ellis, L., Lucassen, M. F., . . . Skinner, T. (2014). Views of Young People in Rural Australia on SPARX, a Fantasy World Developed for New Zealand Youth With Depression. *JMIR Serious Games*, 2(1), e3. doi: <http://dx.doi.org/10.2196/games.3183>

- Chemali, Z. N., Borba, C. P., Henderson, T. E., & Tesfaye, M. (2013). Making strides in women's mental health care delivery in rural Ethiopia: demographics of a female outpatient psychiatric cohort at Jimma University Specialized Hospital (2006-2008). *International Journal of Women's Health*, 5, 413-419. doi: <http://dx.doi.org/10.2147/IJWH.S43617>
- Cloutier, P., Cappelli, M., Glennie, J., & Keresztes, C. (2008). Mental health services for children and youth: A survey of physicians' knowledge, attitudes and use of telehealth services. *Journal of Telemedicine and Telecare*, 14(2), 98-101. doi: <http://dx.doi.org/10.1258/jtt.2007.070815>
- Cole, M. G., McCusker, J., Sewitch, M., Ciampi, A., & Dyachenko, A. (2008). Health services use for mental health problems by community-living seniors with depression. *International Psychogeriatrics*, 20(3), 554-570.
- Colon-Gonzalez, C., McCall-Hosenfeld, J., Weisman, C., Hillemeier, M M., Perry, A N., & Chuang, C H. (2013). 'Someone's got to do it' - Primary care providers (PCPs) describe caring for rural women with mental health problems. *Mental Health in Family Medicine*, 10(4), 191-202.
- Cooper, S. (2009). Interorganizational relationships among providers of public social services for emotionally disturbed children in rural East Texas. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, 69(7-A), 2875.
- Crotty, M M, Henderson, J, & Fuller, J. (2012). Helping and hindering: Perceptions of enablers and barriers to collaboration within a rural South Australian mental health network. *Australian Journal of Rural Health*, 20(4), 213-218.
- Draper, B., Jochelson, T., Kitching, D., Snowdon, J., Brodaty, H., & Russell, B. (2003). Mental health service delivery to older people in New South Wales: perceptions of aged care, adult mental health and mental health services for older people. *Australian & New Zealand Journal of Psychiatry*, 37(6), 735-740.
- Farmer, E. M. Z., Burns, B. J., Phillips, S. D., Angold, A., & Costello, E. J. (2003). Pathways into and through mental health services for children and adolescents. *Psychiatric Services*, 54(1), 60-66.
- Farrell, S. P., Zerull, L. M., Mahone, I. H., Guerlain, S., Akan, D., Hauenstein, E., & Schorling, J. (2009). Electronic screening for mental health in rural health care: feasibility and user testing. *CIN: Computers, Informatics, Nursing*, 27(2), 93-98.
- Forchuk, C., Jensen, E., Martin, M., Csiernik, R., & Atyeo, H. (2010). Psychiatric Crisis Services in Three Communities. *Canadian Journal of Community Mental Health*, 29, 73-86.

- Fraser, Caitlin, Judd, Fiona, Jackson, Henry, Murray, Greg, Humphreys, John, & Hodgins, Gene 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.
- Fuller, J., & Broadbent, J. (2006). Mental health referral role of rural financial counsellors. *Australian Journal of Rural Health*, 14(2), 79-85.
- Grant, M, & Booth, A. (2009). A typology of reviews: an analysis of 14 review types and associated methodologies. . *Health Informatics and Libraries Journal*, 26, 91-108.
- Grossman, J., Laken, M., Stevens, J., Hughes-Joyner, F., Sholar, M., & Gormley, K. (2007). Use of psychiatric nurse practitioner students to provide services in rural school-based health clinics. *Journal of Child & Adolescent Psychiatric Nursing*, 20(4), 234-242.
- Hall, B. (2015, September 16). Australia in the middle of "mental health crisis" with unnecessary deaths escalating, *The Age*. Retrieved from <http://www.theage.com.au/victoria/australia-in-the-middle-of-mental-health-crisis-with-unnecessary-deaths-escalating-20150916-gjnqpd.html>
- Handley, Tonelle E, Kay-Lambkin, Frances J, Inder, Kerry J, Lewin, Terry J, Attia, John R, Fuller, Jeffrey, . . . Kelly, Brian J. (2014). Self-reported contacts for mental health problems by rural residents: predicted service needs, facilitators and barriers. *BMC psychiatry*, 14(1), 249.
- Happell, B. (2008a). Determining the effectiveness of mental health services from a consumer perspective: part 1: enhancing recovery. *International Journal of Mental Health Nursing*, 17(2), 116-122.
- Happell, B. (2008b). 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(2), 123-130.
- Happell, Brenda, Scott, David, Platania-Phung, Chris, & Nankivell, Janette. (2012). Rural physical health care services for people with serious mental illness: A nursing perspective. *The Australian Journal of Rural Health*, 20(5), 248-253. doi: <http://dx.doi.org/10.1111/j.1440-1584.2012.01303.x>
- Hazelton, M., Habibis, D., Schneider, R., Davidson, J., & Bowling, A. (2004). Effect of an extended-hours community mental health team on family caregiving in a semi-rural region of Australia. *Australian Journal of Rural Health*, 12(5), 220-222. doi: <http://dx.doi.org/10.1111/j.1440-1854.2004.00608.x>
- Henderson, J, Crotty, M M, Fuller, J, & Martinez, L. (2014). Meeting unmet needs? The role of a rural mental health service for older people. *Advances in Mental Health*, 12(3), 182-191.

- Hickie, I. , & McGorry, P. (2007). Increased access to evidenced based primary mental health care: will the implementation match the the rhetoric? *Medical Journal of Australia*, 187(2), 100-103.
- Hilt, Robert J., Romaine, Melissa A., McDonell, Michael G., Sears, Jeanne M., Krupski, Antoinette, Thompson, Jeffery N., Trupin, Eric W. (2013). The partnership access line: evaluating a child psychiatry consult program in washington state. *JAMA Pediatrics*, 167(2), 162-168. doi: 10.1001/2013.jamapediatrics.47
- Hunter, M. E. (2006). Mental health care in rural and isolated areas: Lessons from northern British Columbia. *British Columbia Medical Journal*, 48(4), 174-177.
- Iezzoni, Lisa I., Killeen, Mary B., & O'Day, Bonnie L. (2006). Rural Residents with Disabilities Confront Substantial Barriers to Obtaining Primary Care. *Health Services Research*, 41(4, part1), 1258-1275.
- Isaacs, Anton N., Maybery, Darryl, & Gruis, Hilton. (2013). Help seeking by Aboriginal men who are mentally unwell: A pilot study. *Early Intervention in Psychiatry*, 7(4), 407-413. doi: <http://dx.doi.org/10.1111/eip.12015>
- Jack-Ide, I. O., & Uys, L. (2013). Barriers to mental health services utilization in the Niger Delta region of Nigeria: service users' perspectives. *The Pan African medical journal*, 14, 159. doi: <http://dx.doi.org/10.11604/pamj.2013.14.159.1970>
- Jackson, Henry, Judd, Fiona, Komiti, Angela, Fraser, Caitlin, Murray, Greg, Robins, Garry, . Wearing, Alex. (2007). Mental health problems in rural contexts: What are the barriers to seeking help from professional providers? *Australian Psychologist*, 42(2), 147-160.
- Jayaram, Geetha, Goud, Ramakrishna, & Srinivasan, Krishnamachari. (2011). Overcoming cultural barriers to deliver comprehensive rural community mental health care in Southern India. *Asian Journal of Psychiatry*, 4(4), 261-265. doi: <http://dx.doi.org/10.1016/j.ajp.2011.08.005>
- Jelinek, G. A., Weiland, T. J., Mackinlay, C., Hill, N., & Gerdtz, M. F. (2011). Perceived differences in the management of mental health patients in remote and rural australia and strategies for improvement: findings from a national qualitative study of emergency clinicians. *Emergency Medicine International Print*, 2011, 965027. doi: <http://dx.doi.org/10.1155/2011/965027>
- Judd, F, & Humphreys, J. (2001). Mental Health Issues for Rural and Remote Australia. *Australian Journal of Rural Health*, 9, 254-258.

- Judd, Fiona, Jackson, Henry, Komiti, Angela, Murray, Greg, Fraser, Caitlin, Grieve, Aaron, & Gomez, Rapson. (2006). Help-seeking by rural residents for mental health problems: the importance of agrarian values. *Australian and New Zealand Journal of Psychiatry*, 40(9), 769-776.
- Kelly, Brian J, Lewin, Terry J, Stain, Helen J, Coleman, Clare, Fitzgerald, Michael, Perkins, David, Lyle, David. (2011). Determinants of mental health and well-being within rural and remote communities. *Social psychiatry and psychiatric epidemiology*, 46(12), 1331-1342.
- Kenny, A, & Duckett, S. (2004). A question of place: medical power in rural Australia. *Social Science & Medicine*, 58(6), 1059-1073.
- Kenny, A, Farmer, J, Dickson-Swift, V, & Hyett, N. (2014). Community participation for rural health : a review of challenges. *Health Expectations*. doi: 10.1111/hex.12314
- Kermode, M., Bowen, K., Arole, S., Joag, K., & Jorm, A. (2009). Community beliefs about treatments and outcomes of mental disorders: A mental health literacy survey in a rural area of Maharashtra, India. *Public Health*, 123(7), 476-483. doi: <http://dx.doi.org/10.1016/j.puhe.2009.06.004>
- Lee, Steven W., Lohmeier, Jill H., Niileksela, Chris, & Oeth, Jessica. (2009). Rural schools' mental health needs: Educators' perceptions of mental health needs and services in rural schools. *Journal of Rural Mental Health*, 33(1), 26-31. doi: <http://dx.doi.org/10.1037/h0095970>
- McColl, L. (2007). 'They just don't care': the experiences of mental health consumers in a Queensland bush community. *Australian e-Journal for the Advancement of Mental Health*, 6(2), 1-9.
- Morley, Christopher P. (2010). Disparities in ADHD assessment, diagnosis, and treatment. *International Journal of Psychiatry in Medicine*, 40(4), 383-389. doi: 10.2190/PM.40.4.b
- Muir-Cochrane, Eimear, O'Kane, Deb, Barkway, Pat, Oster, Candice, & Fuller, Jeffrey. (2014). Service provision for older people with mental health problems in a rural area of Australia. *Aging & Mental Health*, 18(6), 759-766. doi: 10.1080/13607863.2013.878307
- Nicholas, J., Oliver, K., & O'Brien, M. (2004). Help-seeking behaviour and the Internet: an investigation among Australian adolescents. *Australian e-Journal for the Advancement of Mental Health*, 3(1), 1-8.
- Nicholson, L. (2008). Rural mental health. *Advances in Psychiatric Treatment*, 14, 302-311.
- Perkins, David, Fuller, Jeffrey, Kelly, Brian J, Lewin, Terry J, Fitzgerald, Michael, Coleman, Clare, Roberts, Russell. (2013). Factors associated with reported service use for

- mental health problems by residents of rural and remote communities: cross-sectional findings from a baseline survey. *BMC Health Services Research*, 13(1), 157.
- Pomerantz, A., Cole, B. H., Watts, B. V., & Weeks, W. B. (2008). Improving efficiency and access to mental health care: combining integrated care and advanced access. *General Hospital Psychiatry*, 30(6), 546-551.
- Price Waterhouse Coopers. (2011). The Australian Government Department of Health and Ageing
- Mental Health Service in Rural and Remote Areas Program Evaluation. Canberra: Australian Government Department of Health and Ageing.
- Rathbone-McCuan, E. (2001). Mental health care provision for rural elders. *Journal of Applied Gerontology*, 20(2), 170-183.
- Rickwood, D. J., Telford, N. R., Parker, A. G., Tanti, C. J., & McGorry, P. D. (2014). headspace - Australia's innovation in youth mental health: who are the clients and why are they presenting? *Medical Journal of Australia*, 200(2), 108-111.
- Robinson, W. D., Springer, P. R., Bischoff, R., Geske, J., Backer, E., Olson, M., . . . Swinton, J. (2012). Rural experiences with mental illness: Through the eyes of patients and their families. *Families, Systems & Health: The Journal of Collaborative Family HealthCare*, 30(4), 308-321. doi: 10.1037/a0030171
- Ryan-Nicholls, K. D., Racher, F. E., & Robinson, J. R. (2003). Providers' perceptions of how rural consumers access and use mental health services. *Journal of Psychosocial Nursing & Mental Health Services*, 41(6), 34.
- Saldivia, Sandra, Vicente, Benjamin, Kohn, Robert, Rioseco, Pedro, & Torres, Silverio. (2004). Use of mental health services in Chile. *Psychiatric Services*, 55(1), 71-76. doi: <http://dx.doi.org/10.1176/appi.ps.55.1.71>
- Simpson, J., Doze, S., Urness, D., Hailey, D., & Jacobs, P. (2001). Telepsychiatry as a routine service--the perspective of the patient. *Journal of Telemedicine & Telecare*, 7(3), 155-160.
- Starr, S., Campbell, L. R., & Herrick, C. A. (2002). Factors affecting use of the mental health system by rural children. *Issues in Mental Health Nursing*, 23(3), 291-304.
- Sweeney, P., & Kisely, S. (2003). Barriers to managing mental health in Western Australia. *Australian Journal of Rural Health*, 11(4), 205-210.

- Turpin, M., Bartlett, H., Kavanagh, D., & Gallois, C. (2007). Mental health issues and resources in rural and regional communities: An exploration of perceptions of service providers. *Australian Journal of Rural Health, 15*(2), 131-136. doi: <http://dx.doi.org/10.1111/j.1440-1584.2007.00870.x>
- Wade, T. J., Mansour, M. E., Guo, J. J., Huentelman, T., Line, K., & Keller, K. N. (2008). Access and utilization patterns of school-based health centers at urban and rural elementary and middle schools. *Public Health Reports, 123*(6), 739-750.
- Wright, M. J., Harmon, K. D., Bowman, J. A., Lewin, T. J., & Carr, V. J. (2005). Caring for depressed patients in rural communities: General practitioners' attitudes, needs and relationships with mental health services. *Australian Journal of Rural Health, 13*(1), 21-27. doi: 10.1111/j.1440-1854.2004.00641.x
- Wrigley, Sarah, Jackson, Henry, Judd, Fiona, & Komiti, Angela. (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*(6), 514-521.

APPENDIX A

AUSTRALIA

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
Australia	Allan, Julliane 2010	To gain an in-depth understanding of service delivery within the practice settings to ensure that the diversity of practice challenges, constraints and interactions could inform the agency's approach to developing drug and alcohol services in the primary care setting.	Participants working for either Lyndon Community (a rural non-government drug and alcohol service provider working with several ACCHS providing specialist drug and alcohol treatment at their request), as PHCWs or visiting workers in the ACCHS where Lyndon Community provided services; or with agencies that referred clients to Lyndon Community or the ACCHS for drug and alcohol intervention.	A sociological action research approach – a qualitative study	Thematic analysis of interview data identified divergent perspectives according to a participant's work role about drug and alcohol treatment, client needs and problems and service delivery approaches. The interview findings presented were mostly from two perspectives – insider (drug and alcohol workers) and local (PHCWs in the ACCHS). Drug and alcohol workers were conceptualised as insiders. Most did not have knowledge or experience of the primary health care setting. Therefore they could not assist primary health care workers to integrate drug and alcohol	Professional and organisational barriers constrain the primary health care worker role and limit the application of specialist interventions. Drug and alcohol work is only one of many competing demands in the primary health setting. The lack of understanding of the primary health care worker role and responsibilities is the most significant barrier to implementing specialist interventions in this role. Primary health care workers' perceptions of substance misuse are	Building the capacity of primary health care workers to do more varied tasks requires a good understanding of the pragmatic and practical realities of their day to day practice and the philosophies that underpin these. The interview data were able to inform an action plan for the drug and alcohol agency and the ACCHS involved in the project. There were two strategies planned. The first was an education and support plan for PHCWs to be delivered by visiting drug and alcohol workers. The plan was supported by ACCHS managers and time was allocated for planned and structured education sessions supported by practice supervision and case

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					<p>interventions into their interactions with clients. Primary health care workers were conceptualised as locals. They tended to perceive that drug and alcohol interventions should quickly prevent individuals from on-going problematic use.</p>	<p>more consistent with the individual moral or personal deficit philosophy of drug and alcohol treatment than harm minimisation approaches. This is a challenge for a specialist agency that is promoting harm minimisation and an adaptive approach to treatment within the primary care setting.</p>	<p>review. The education sessions include harm minimisation philosophy and strategies and motivational interviewing techniques that could be used to discuss any health problem that clients or patients wanted to address. One or more PHCWs within each ACCHS were identified to participate and time for training and practice was scheduled during Lyndon Community outreach visits. The second action strategy was to promote PHCW expertise and knowledge in their area of speciality – primary health care. The aim was to give specialist workers some experience in primary health care practice by providing opportunities to observe PHCW practice including community consultation and interaction. The aim was for the drug and alcohol specialists in particular to learn how and when substance use discussions and interventions could fit into the rhythms and demands of primary health care practice. The acceptability of the strategies requires evaluation.</p>

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Australia	Allan, Julliane 2011	Describes the establishment and operations of an advanced rural skills training program at the Lyndon Community – a rural drug and alcohol treatment organisation in New South Wales.	Five general practice registrars, three female and two male, who had completed a 6 month Lyndon Community GP training post placement	Interviews as a part of a 3 year multimethod action research project investigating drug and alcohol service provision in rural New South Wales.	Feedback from registrars participating in the placement indicated that their experience at the Lyndon Community influenced and enhanced their practice. An addiction medicine rotation offers general practice registrars the opportunity to develop skills and experience in psychosocial interventions as well as physical and mental health issues common in the treatment population.		In response to feedback from participants, some changes have been made to the placement over time. In particular, more structure has been incorporated into the training period to ensure best use of time so that opportunities are not missed. Barriers to inclusion on remote visits were addressed ensuring that all registrars had the opportunity to practise their skills in remote communities. Assigning a treatment role to the registrar ensured their inclusion. The treatment role included responsibility for alcohol use assessment and identifying the impact on general health including chronic disease. Supervisors were then able to discuss with registrars how to adapt proposed treatment plans to the context of the remote location and available healthcare. Other changes over time have

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							<p>included better integration of the medical side of addiction medicine training with the psychosocial aspects of the treatments provided at the Lyndon Community. Following clear role clarification, registrars were able to provide primary healthcare to therapeutic community residents. This also reduced the demands on local GPs.</p> <p>A thorough orientation to the organisation and its programs and establishing a learning plan within the first month of the training period has also been noted to increase the quality of the experience for registrars.</p>
Australia	Anells, M 2011	To evaluate a feasible, best practice mental health screening and referral clinical pathway for generalist community nursing care of war veterans and war widow(er)s in Australia	Community Nurses and GPs	Mixed Methods	Most nurses found the pathway clear and easy to understand but not always easy to use. They emphasised the need to establish trust and rapport with clients prior to implementing the pathway. It was sometimes difficult to ensure effective referral to general practitioners for clients who screened positive for a mental health problem. When referral was		<p>The trialled pathway, which was modified and refined following the study, is an evidence-based resource for community nurses in Australia and similar contexts to guide practise and maximise holistic care for war veterans and war widow(er)s and possibly other client groups. Findings from the trial and evaluation of the mental health screening and referral clinical pathway indicate that nurses and some GPs found the</p>

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					<p>accomplished, general practitioners reported adequate and useful information was provided. Some general practitioners also commented on the difficulty of achieving effective communication between general practitioners and nurses.</p>		<p>pathway useful for their practice, with several suggestions offered regarding improvement by simplifying the trialled versions of the pathway and accompanying guidelines and improving communication between nurses and GPs.</p> <p><u>Findings support the following recommendations:</u></p> <p>The pathway and guidelines, as modified, are added to the existing suite of pathways for DVA-funded community nursing care.</p> <p>Where possible, the pathway is applied by a community nurse at a time later than the admission of the client into community nursing care when rapport and trust have been developed with the client.</p> <p>Research is conducted to identify and explore the constraints and possible solutions for optimal referral and communication processes between community nurses and GPs concerning potential</p>

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							<p>mental health care needs of veterans and war widow(er)s. Research is conducted to identify and explore interventions for generalist nurses with a mental health focus.</p> <p>Evaluation findings were discussed with the panel of key stakeholders and content experts. Modifications were completed and the modified pathway is available as a web-based document from DVA (2009). Although the clinical pathway was designed initially for veterans and war widow(er)s, transferability to other client groups is possible, as is its use in other contexts internationally.</p>
Australia	Aoun, S 2012	To collect information, compare and evaluate the functioning of novel types of psychiatric services, including rooming-in facilities, using outcome measurement	All rural sites throughout the state, whether rooming-in or other inpatient related psychiatric services, were invited to participate in the training in the use of one of the outcome measures, Health of the Nation Outcome Scales (HoNOS), via	Cohort	The assessment of staff attitudes towards routine outcome measurement revealed a need to provide staff with reasons and incentives for incorporating outcome measurement into routine practice, in addition to provision of a thorough and on-going training and support in time and resources from	Technical difficulties, lack of adequate local IT support and shortage of staff prevented some of the sites from participating.	When asked what would facilitate mental health professionals completing assessments routinely, these suggestions were put forward: the need for a smaller case load; having the assessments entry time counted as an occasion of service when looking at staffing requirements; the need for fewer assessment tools and rather one appropriate tool;

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		tools, and to assess the attitude of mental health professionals towards routine outcome measurement	telepsychiatry link-ups.		management.		for assessments to be incorporated in team clinical reviews and; training in the usefulness of these assessments and demonstrating the positives for the organisation.
Australia	Bambling, M 2007	To examine the views of rural practitioners concerning issues and challenges in mental health service delivery and possible solutions.	GPs, Queensland health mental health staff and participants from community organisations.	Qualitative study	There is considerable misunderstanding between GPs, community mental health and the non-government sector regarding each other's capacity to deal with growing mental health service demand. Significant challenges remain in creating effective shared care arrangements. There was substantial consensus that there are significant problems with inter-service communication and liaison, and that improved collaboration and shared care will form a critical part of any effective solution. Differences	GP: The current system excessively emphasised crisis management, and was not adequately focused on a continuum of care. Treating patients with co-occurring mental health and substance use issues was challenging, because of effects on the doctor-patient relationship produced by personality disorder and drug use. Specialist services for these patients were inadequate. 3. GPs reported	Improvements to mental health staffing and to access to allied health might increase the ability of GPs to meet the needs of less complex patients, but specific strategies to promote better integrated services are required to address the needs of rural and regional with complex mental health problems. Increased mental health staffing as a result of recent State and Federal Government initiatives might enhance mental health services' capacity to manage service demand challenges. Greater communication and improved intersectoral collaboration between GPs, the community and non-

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					between groups reflected differing organisational contexts and priorities, and limitations to the understanding each had of the challenges that other groups were facing.	difficulties finding time to follow up patients and coordinate care with other services. Furthermore, follow-up care for patients with mental health problems was often unpaid. There was consensus that resources were lacking for people who did not meet standard criteria for psychiatric disorders, but were functioning suboptimally and required intervention. Community Mental Health: Insufficient service focus on early intervention and relapse prevention (including medication compliance) was a considerable barrier to improvement. Limited cooperation by GPs in shared care was reported, and communication with	government sector will be critical to an effective solution of current problems. Effective service responses to complex mental health needs demand integrated service responses and not simply goodwill or referral capacity.

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						<p>them about patient care and referral was problematic.</p> <p>Community Sector: Implementing an effective intersectoral model of care would require a cultural change by services towards early intervention and providing assistance based on individual needs. A barrier to the sector having a leadership role in rural mental health was a perception that they only provided 'soft end services'.</p>	
Australia	Bei, B 2015	To examine the impact of floods on the mental and physical health of older adults and explored risk and protective factors.	Two hundred and seventy four older adults (age ≥ 60) completed surveys before and after a flood event. Both the surveys included measures of anxiety,	Longitudinal prospective design	Compared to those not personally affected (78.8%), personally affected individuals (21.2%) reported significantly higher PTSD symptoms, with about one in six reporting PTSD symptoms that might		Findings in the study suggest that even though the impact of floods on the mental and physical health of older adults was mild overall, a small proportion of affected individuals might present with symptoms that require clinical

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			depression, self-reported health, and satisfaction with life; the post-flood survey also included questionnaires on flood experience, symptoms of post-traumatic stress disorder (PTSD), stoicism, and psychological coping with floods		require clinical attention. Personally affected individuals also reported a greater increase in anxiety post-flood, but changes in their depressive symptoms and self-reported health were not significantly different from those not personally affected. Greater flood exposure and the lack of social support were the risk factors for poorer mental and physical health. Higher stoicism was associated with higher post-flood depression and poorer self-reported mental health. The use of maladaptive coping, such as venting and distraction, was associated with greater deterioration in mental health after floods, whilst emotion-focused coping such as acceptance, positive reframing, and humour, was protective against such deterioration.		<u>attention. Effective tools are much needed to identify these individuals for timely intervention and support.</u> The findings on stoicism and coping suggested that in working with this population, <u>a proactive approach might be particularly helpful as older adults might not initiate help-seeking themselves.</u> Encouraging the use of coping strategies such as acceptance, positive reframing, and humour, whilst being cautious about the use of maladaptive ones such as venting and avoidance might be protective against disaster-related increase in psychopathology <u>Psychological interventions that focus on the reframing of a stressful situation and work towards acceptance of the uncontrollable and unchangeable</u> could be particularly helpful amongst individuals affected by disasters.
Australia	Boyd, C 2007	Aims to explore Australian rural adolescents' experiences of accessing help for	Six first-year psychology undergraduate students from the University of Ballarat	A qualitative phenomenological research design. Semi structured Interviews were	Participants highlighted various barriers to seeking help for mental health problems in the context of a rural community, including:	Participants highlighted various barriers to seeking help for mental health problems in the context of a rural	School-based counselling has an integral role in improving rural adolescents' access to mental health care. A model of stepped care for

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		a mental health problem in the context of their rural communities.	(one male and five female) between the ages of 17 and 21 years who sought help for a mental health issue during their adolescence and who at that time resided in a rural area.	conducted face-to-face at the university.	social visibility, lack of anonymity, a culture of self-reliance, and social stigma of mental illness. Participants' access to help was primarily school-based, and participants expressed a preference for supportive counselling over structured interventions. Characteristics of school-based helpers that made them approachable included: 'caring', 'non-judgemental', 'genuine', 'young', and able to maintain confidentiality. School-based counselling has an integral role in improving rural adolescents' access to mental health care.	community, including: social visibility, lack of anonymity, a culture of self-reliance, and social stigma of mental illness	rural adolescents with mental health problems that includes supportive general counselling as a first step – before access to a GP and/or allied health services at the next step – might have utility for adolescents with emerging mental health problems while still at school
Australia	Bradley, 2007	Effectiveness of outpatient group interventions in a rural area for AOD clinicians over a 3 year period	N= 39	Service evaluation project Clinician administered ratings made for retrospectively four times - 3 month intervals and 12 times	Significant change in functioning – (including substance abuse and symptomatology) with short outpatient group intervention complementing usual treatment	Lack of this kind of service	Longer involvement may be further associated with prevention of relapse and less unscheduled service use

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				post recruitment observations	Participants willing and able to commit for long periods of time		
Australia	Bridges, JFP 2001	Before an education program was attempted, NSW Health inquired into the specific needs for casemix education in rural NSW	The research was targeted at two rural Area Health Services: Macquarie (MAHS) and Mid West (MWAHS). This included open-ended interviews with rural managers and a survey of staff.	Mixed Methods Open-ended qualitative interviews : aimed at understanding the needs of the rural areas, and a survey that was designed to determine the existing level of understanding of casemix in rural areas. The interviews used a semi-structured form that focused the content of the interview on the need for casemix education and the design of an optimal education program. Participants were also allowed to discuss other matters of concern. Respondents were asked about their level of knowledge of the four key casemix classifications used in NSW. These are: (i)	Results of the quantitative analysis indicate that the understanding of case mix classifications is highest among managers. Of concern were the relatively low proportion of Allied Health staff who had more than a vague understanding of the Sub- and Non-Acute Patient (SNAP) classification; <u>the lack of any knowledge of the Mental Health Costing And Service Classification (MH-CASC) by nursing staff;</u> and the lack of any knowledge of the emergency department classification: Urgency, Disposition and Age-related Groups (UDAG), either by clinical or nursing staff. The results of the qualitative analysis show that casemix education for rural areas needs to differ from metropolitan education programs. The analysis also highlights the perception of casemix in rural areas and		Time for future educational activity should be carefully scheduled to suit staff; for example, during normal meeting times. The provision of refreshments was recommended as a way of attracting staff to the education sessions. Casemix education has to be presented clearly and be both practical and clinically based. Where possible, examples from rural experience or practice should be used rather than examples from city-based teaching hospitals. Have a strong clinical presence at the education sessions. Presenters would be most effective if they were rural-based 'number crunchers' and could back up their presentations with appropriate statistics. Follow up and other forms of reinforcement, such as up-to-date benchmarks, were considered to be an important component of a successful education strategy

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
				Diagnosis-Related Groups (DRG), which cover acute inpatient care; (ii) the Sub- and Non-Acute Patient (SNAP) classification, which covers care such as rehabilitation and palliative care; (iii) Mental Health Costing and Service Classification (MH-CASC), which classifies mental health; and (iv) Urgency, Disposition and Age-related Groups (UDAGs), which cover emergency and ambulatory care patients treated in emergency departments.	the special circumstances in rural hospitals that place limits on the ability to use casemix more fully.		Further education should focus on these aspects; for example, how casemix can effect a hospital's/ clinical department's funding in a casemix-based funding environment or how casemix can be used to improve patient care. While fairness and equity have been drivers of the NSW funding system, it needs to be made more transparent, especially in rural areas. Casemix would not be implemented successfully in rural hospitals unless there was someone in particular to drive it.
Australia	Buckley, D 2012	To determine if the addition of a video link to the existing phone connection, enabling patients	Patients admitted (n=1,943) to a health services regional hospital with a primary diagnosis of mental and	<ul style="list-style-type: none"> Retrospective pre-post intervention analysis The introduction of videoconferencing in January 2008 was 	After the introduction of videoconferencing the percentage of patients transferred fell from 66.8% (95%CI 64.0 to 69.5) to 59.6% (95%CI 56.1 to 63.1)		Videoconferencing has the potential to enable more timely access to rural and regional Australians requiring mental health services. There appears to be much to

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		admitted for mental and behavioural disorders to be seen by a centrally located psychiatrist or mental health clinician, would change the probability of these patients being transferred to the central mental health unit.	behavioural disorders (ICD10-AM code F00-F99) between January 2002 and December 2010.	examined by testing if the inclusion of a binary intervention variable was significant when added to the best fitting risk adjustment model.	($\chi^2 = 10.42$, $p = 0.001$). After adjusting for age, sex, clustering in hospitals and repeat visits the odds of transfer were 0.69 (95%CI 0.49 to 0.97) of previous. Aboriginality, being non-Australian, long-term linear trend, admitted on the weekends or after hours were not significant predictors of the probability of transfer.		commend the use of videoconferencing to enable improved examination of remotely located patients with mental and behavioural disorders.
Australia	Caldwell, 2004	Rates of GP services for psychological problems across rural, remote and metropolitan areas		Bettering Evaluation and care of Health program, Medicare and Pharmaceutical Benefits Scheme	Rural and remote patients visited GP's less frequently than their metropolitan counterparts Lower rates of GP encounters for psychological problems for most non-metropolitan areas GP's prescribed mental health medications at half the rate for residents of remote areas than city areas	Limited access to services for psychological problems Sparse provision of GP practice care for mental health problems Study did not measure prevalence across metropolitan and rural areas	GP reported higher rates of depression in rural areas Fewer anxiety problems Rate of prescribing different ? greater reliance on medication in rural areas
Australia	Cheek, C	This study sought to explore the acceptability of SPARX (a computerized	Local youth on the SPARX program from two community-based organizations in the town offering	Qualitative study	Participants reported that young people want help for mental health issues but they have an even stronger need for controlling how		Computerized therapy offered in ways that support privacy and choice can improve access to treatment for rural youth. Foreign accents and style may

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		cognitive behavioural therapy (CBT) program (Smart, Positive, Active, Realistic, X-factor thoughts -SPARX) by youth in rural Australia and to explore whether and how young people would wish to access such a program.	a variety of community programs aimed at improving the towns' health and well-being		they access services. In particular, they considered protecting their privacy in their small community to be paramount. Participants thought computerized therapy was a promising way to increase access to treatment for youth in rural and remote areas if offered with or without therapist support and via settings other than school. The design features of SPARX that were perceived to be useful, included the narrative structure of the program, the use of different characters, the personalization of an avatar, "socialization" with the Guide character, optional journaling, and the use of encouraging feedback. Participants did not consider (New Zealand) accents off-putting. Young people believed the		not be off-putting to teenage users when the program uses a playful fantasy genre, as it is consistent with their expectation of fantasy worlds, and it is in a medium with which they already have a level of competence. Rather, issues of engaging design and confidential access appeared to be more important. The findings suggest a proven tool once formally assessed at a local level can be adopted cross-nationally.

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					SPARX program would appeal to those who play computer games generally, but may be less appealing for those who do not.		
Australia	Cheung, Yee Tak Derek 2012	To visualize the sex-specific suicide pattern over the country from 2004 to 2008, and studying the metropolitan-rural-remote differentials of suicide across all states/territories.	The 5-year populations-at-risk by postal areas for the whole study period	Poisson hierarchical model to yield smoothed sex specific, age standardized mortality ratios of suicide in all postal areas, and compiled the age standardized suicide rates across different levels of remoteness and different jurisdictions	Study identified the area variation of suicide risk across states/territories, and metropolitan-rural-remote differential with rates higher in rural and remote areas for males. Spatial clusters of some high risk postal areas were also identified. Socio-economic deprivation, compositional factors, high risks for Indigenous people and low access to mental health service are the underlying explanations of the elevation of suicide risk in some areas.		Important to consider geographical variations in suicide risk into account in national policy making. Particular suicide prevention interventions might be targeted at males living in remote areas, and some localized areas in metropolitan zones.
Australia	Collins, JE 2009	To investigate barriers to help seeking for mental health concerns and to explore the role of psychological mindedness in a South Australian	Residents from one rural centre (11 women, five men) aged between 36 and 75 years	Qualitative study	Prior research-driven thematic analysis identified themes of stigma, self-reliance and lack of services. Additional emergent themes were awareness of mental illness and mental health services, the role of general practitioners and the need for change. Lack of	Many rural people are unwilling to talk about problems or feelings. Participants suggested that men in their community were particularly lacking in openness.	Campaigns, interventions and services promoting mental health in rural communities need to be compatible with rural cultural context, and presented in a way that is congruent with rural values. Psychological mindedness may provide a tool to assist in the process of men

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		rural centre.			psychological mindedness was related to reluctance to seek help		sharing their problems or feelings
Australia	Draper, 2003	Compare the perceptions of aged care services, adult mental health services and mental health services for older people	Aged care services N= 58 Adult mental health services n= 62 Mental health services for older people n= 20	Postal survey Canvassed service profiles, regional variations, availability of resources, processes of care, views of working relationships across services, difficulties and gaps	59% of aged care services and adult mental health services considered that their local mental health services provided an adequate service wide variety in service access variable staffing levels problematic	Resources and budget Many services offer a consultation service only private sector cannot fill the gap	Lack of access to psychogeriatric staff Resource limitations of service for older people Cross referrals and joint working possible way to address system issues ACHS, AMHS and MHSOP need to establish good working relationships
Australia	Fuller 2006	To quantify the proportion of rural financial counsellors' (RFC) clients requiring social, emotional and stress-related (SESR) assistance and the referral of these clients to other services.	Australian RFCs employed over the months of November and December 2004.	Cross sectional The survey comprised questions of a demographic and observational nature with invitation for anecdotal responses	Counsellors reported that on average 20% of their clients' required SESR assistance and half of the counsellors referred more than 75% of these clients. Referrals were mainly to GPs, mental health teams, personal counselling and health and welfare organisations. Almost half (49%) reported that referrals were difficult because of rural clients' reluctance to acknowledge such problems and use		The mental health system needs to include locally available helpers in the mental health service network. In so doing, these local helpers can be linked into a more informed and quality system of referrals thereby optimising the 'window of intervention opportunity'. Workers in a network are more likely to learn from other members of the network, thereby building local mental health service capacity. Rural Financial Counsellors need to maintain a high standard of

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					mental health services, as well as the lack of these services. Counsellors were placed in a practical role dilemma when clients raised personal issues that were beyond the counsellors' role but were linked to the financial reason for presentation. Strategies identified to improve referrals were to network with mental health and personal counsellors in the region, training and a referral guide.		professional service by facilitating referral of clients to appropriate services.
Australia (VIC)	Happell (2008)	To explore the views of consumers regarding factors that impede recovery and to explore the principles that ideally should underpin the evaluation of MH services.	16 consumers of mental health services from one rural (n=7) and one metro (n=9) mental health service	Qualitative exploratory: Focus group interviews	Main themes emerging regarding aspects of mental health services that pose barriers to recovery: Staffing issues Hearing the person not the illness Lack of safety and security Isolation Main themes emerging regarding the evaluation of mental health services were: Consumer involvement in rigorous evaluation Meaningful activity and peer support (particularly when discharged)	See main findings	The effective evaluation of mental health services requires an increased focus on the views and opinions of consumers in order to develop more responsive mental health services.

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					More responsive care and treatment		
Australia (QLD)	Happell et al. (2012)	To understand nurse perspectives on the physical health needs of mental health clients and how well rural services are meeting their overall care needs	38 nurses in public mental health care	Exploratory qualitative study. Focus groups with semi-structured format	Themes emerging were: Stigma of mental illness Barriers to accessing physical health care services Nurse adaptations under demands Community and integration towards better overall health	Nurses perceived reluctance of specialist staff and GPs in treating even physical health probs in the mentally unwell due to stigma. This also perceived to be reason why clients not accessing primary care services due to staff negative reactions. Shortage of services for physical health as well as geographical and economic barriers. System fragmentation Gaps in cross-cultural communication Stretching nurses role without the corresponding supports.	Nurses adapted to constraints and demands through forethought and assisting clients with daily activities. Integration of services (“one-stop-shop” – physical and mental) and community development Mobile general health services (outreach)
Australia (NTH QLD, NT)	Haswell-Elkins et al. (2005)	To reflect on the current organisation of mental and		Review	Mental health services in region have operated in parallel to other specialist services which have been	Barriers to the joining of primary and mental health care have been due to patterns of	The Aust. Integrated Mental Health Initiative (AIMhi) has been established to focus on people in rural areas, people

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		physical health services in remote Indigenous settings of Far Nth QLD and NT identifying some of the major disadvantages being experienced.			based in regional centres There has been limited impact on increased mental health capacity at the local level especially in terms of Indigenous providers. NT mental health specialist services remain separate to primary care	thinking about mental and physical health. Historical care methods have assisted in these running parallel to each other rather than being integrated: For example by having isolated psychiatric institutions. Despite de-institutionalisation a lot of work is still having to be put into merging physical and mental health care systems together.	with high support needs and Indigenous communities. Aim of indigenous stream was to establish pathways to meet the broad needs of Indigenous people with serious mental illness in remote communities and assess their impact on mental health outcomes. The AIMhi identified 6 key focus areas where substantial improvement is needed if improved mental and physical health outcomes are to be achieved: Strengthening families and communities Improving clinical service delivery Assisting in the implementation of reliable and valid mental health outcome measures Facilitating better information management for decision-making and monitoring Enhancing mental health literacy and health promotion Contributing to effective workforce development.
Australia (TAS)	Hazelton et al. (2004)	To examine the effect of an extended-hours community	2 groups of family carers: Group 1 recruited before access to a	Follow-up study (4 time points: baseline, 1 mth, 6mths, 12mths) assessed on measures	Group 1 had significant improvements with use of CMHT, with degree of worry, burden, disruption of daily	Under resourced and under developed mental health programs in rural areas	A community mental health consultation-liaison service could provide support to primary care practitioners and

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		mental health team on family caregiving in a semi-rural region of Australia	community mental health team (CMHT), Group 2 recruited after establishment of a CMHT	of objective and subjective burden of care and satisfaction with treatment	routine, whether the patient looked after themselves. Group 2 who was already accessing CMHT had significant improvement over time in sociability. Group 2 more satisfied with treatment		assist family carers Telephone based support and advice or telehealth may provide cost-effective solutions of remoteness
Australia (SA)	Henderson et al. (2014)	To explore the extent to which service providers, carers and consumers view the "Older Persons' Mental Health Service" (OPMHS) as meeting the needs of rural older people with mental health problems. OPMHS integrates services for older people into existing mental health services to establish an integrated and	3 case study sites where OPMHS clinicians were located. 22 key informants from mental health teams and organisations providing care to older people 4 consumers 5 carers	Semi-structured interviews	Establishment of OPMHS led to: increased access to specialist services for older people and earlier assessment/treatment of consumers. Greater service integration and knowledge sharing about older persons' mental health	OPMHS set up to help combat barriers to access and unmet consumer needs due to: Poor geographical access to services Extended waiting periods for GP appointment Limited access to and choice of GPs and specialists Stigma and its likelihood to reduce help-seeking	Localisation of services and attachment of specialist clinicians to rural mental health teams Expand and enlarge OPMHS (more staff, more locations, out of hours contact)

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		multidisciplinary system of care for the aged.					
Australia (VIC)	Issacs et al. (2013)	To explore help-seeking behaviour of Aboriginal men who are mentally unwell in a rural Victorian community.	17 Aboriginal people interviewed (15 men). Sample comprised clients and non-clients of mental health services, carers and service providers.	Qualitative description; semi-structured interviews	Themes emerging were: Difficulty in recognizing mental health problems Barriers to disclosing one's problems Reluctance to contact services Alternate coping strategies	Mental health symptoms viewed by community as a characteristic of the person. Lack of knowledge of what a mental health problem is. Language used by services not used by this community. Discomfort amongst Aboriginal culture to talk about mental health problems Male role in community is to be strong and they want to preserve their masculinity by not help-seeking To preserve masculinity they opt for a coping strategy which protects that image even if harmful to health (i.e. alcohol). Lack of trust and fear of services and government	Need for programs which improve mental health literacy Need promotion of help seeking among Aboriginal men who are mentally unwell Such programs need to be co-developed between mental health services and Aboriginal stakeholders and implemented in a culturally acceptable way (inc. the type of language and words used)
Australia	Jelinek et al.	To describe	20 ED doctors and 16	Descriptive exploratory	Themes emerging of	Lack of access in rural	Improvements to resources for

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	(2011)	perceptions of Aus emergency clinicians of differences in management of mental health patients in rural and remote Aus compared with metro hospitals and what could be improved.	ED nurses across states/territories rural and metro interviewed	study; semi-structured telephone interviews	differences between rural and metro: Resources/environment Staff and patient issues	areas to psych support services, alcohol and drug services Limited referral options in rural Lack of knowledge, understanding and acceptance of mental health issues in rural. Rural ED medical staff having generalist skills and lack of confidence and skills in managing mental health emergencies. Lack of understanding by medics in rural about dual diagnosis	drs: access to experts for consultation, access to mental health services in rural, assistance in managing aggressive patients, enhance psych coverage Improve education: training to improve mental health knowledge, about patient assessment and management, about medication, upskill Guidelines: utilise best practice and resources
Australia (VIC)	Judd et al. (2001)	To describe a collaboration between Uni Melb Dept of Psych and Psychiatry and a rural area mental health service to provide a specialist anxiety and depression	Child and adolescent and adult with a focus for clinical work including individuals age 15-65yrs				

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		treatment service in rural Vic. "The depression and anxiety research and treatment group (DART) – Bendigo health care group initiative"					
Australia (VIC)	Judd et al. (2007)	To examine the level and type of service utilization by rural residents for MH probs and explore the influence of level of need, sociodemographic factors and town size on such service use.	3 locales in rural north west Vic: a large regional centre, towns of 5K-20K population and towns of <5K population. 391 participants. Sample drawn from a larger sample of adults (n=7615) recruited randomly from electoral roll who participated in an earlier survey. The participants indicated on the original study their willingness to be contacted for future research so were invited to participate in a face-to-face interview for this study.	Cross-sectional, community-based study. Interviews asking about mental health, help-seeking. Demographics taken from original study survey	46% of sample had sought help for probs with emotions or MH from at least one formal health provider at some point in their lifetime. One in three had suffered from a mood, anxiety or substance use disorder in their lives. One in six met criteria for a mental disorder in the month preceding the interview. Individuals who had more than 1 diagnosis were 3x more likely to seek help. Those with a mental disorder were more likely to have sought help from a combination of health professionals. Factors arising from a logistic regression analysis that predicted having ever	A possible reason why those living in medium sized towns may be more likely to seek help is because health service providers are more visible and accessible It may also be that in towns 5-20K population there is more emphasis on community development and social inclusion results in social networks which enable help-seeking.	Need to acknowledge the heterogeneity of rural Aus and work on service delivery and service utilisation in rural areas.

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					sought help from a formal health provider for emotional or MH probs were: a lifetime and/or current psychiatric disorder being female (5x more likely than males) being separated, divorced or widowed living in medium sized towns (5-20K pop)		
Australia	McColl, 2007	To examine the experiences of mental health consumers in a rural community	Eight community members that were mental health consumers and part of a CAG	Mixed methods (although not stated) using questionnaires and interviews	Mental health consumers face a number of issues including discrimination, alienation, and disempowerment and often feel unsupported and alone. They also reported negative perceptions of mental health issues, barriers and stigma and problems with service provision and lack of support from the community	There is a need for increased consumer involvement in mental health awareness, promotion and educational activities.	Involve mental health consumers in the training and develop skills to break down barriers
Australia	Morley, 2007	To explore whether 51 rural Access to Allied Psychological services projects	Evaluation of 49 rural projects and 53 urban projects	Utilised a range of evaluation methods data sets. Service models survey Minimum datasets	The results referred to uptake of services (1587 GPs had referred 14137 consumers to 359 AHPs via the rural projects. Those in	Proportionately uptake of the projects has been higher in urban than rural however there are issues	Rural projects have the potential to improve access to mental health care for rural residents by enabling GPs to refer to allied health

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		that were funded under the Better Outcomes in Mental Health Care program are improving services access and if they are translating into positive consumer outcomes		(extracted numbers of clients) Use of case studies	rural were less likely to be female and older than the metro ones. Rural consumers were less likely to be tertiary educated with more rural consumers taking medications (antidepressants most common).	associated with recruiting and retaining service providers	professionals
Australia	Nicholas, 2004	Evaluate the effect of a brief school-based intervention on help-seeking behaviour among Australian adolescents using Reachout (web-based). Secondary aim to examine gender differences	243 male and female students from eighteen government and non-government schools	Quantitative evaluation using a presentation and post presentation questionnaire	The students reported learning about help seeking and the presentation helped them to increase their knowledge about where to go to get help, who to talk to and what a tough time is. Participants reported that they were more likely to use the Reach-out website for information and help seeking after the presentation	The likelihood of seeking help depends on the nature of the problem Need to explore the nature of help seeking for different issues	Using web-based tools to provide information for young people seeking help for a range of personal and interpersonal issues is useful
Australia (QLD)	Turpin, 2007	To identify service providers and community organisations perspectives of the resources available to support people with mental	Key informants from 5 towns 10-14 members for each of 5 focus groups (no mention of final numbers). Providers of mental health services and community	Qualitative with 5 focus groups	There were gaps in services in relation to health, employment, education, housing and social inclusion recognised. There are also issues with limited funding	There was a lack of understanding within the service providers of what others did. Despite intersectoral collaboration being part of the current mental health plan there was little	Unless there is mapping of the different purposes of organisations there will be service gaps and people will report getting the run around.

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		illness and the unmet need of this group in rural QLD	organisations			collaboration. There are also a range of communication challenges	
Australia	Wahlin, 2012	To examine the relative influence of parents and others on the decision of young people to seek formal help	119 parent-child dyads between the ages of 14-18 attending a clinical assessment interview with CAMHS in Sydney or Illawarra (NSW)	Questionnaire and standard assessment measure routinely used by CAMHS	Reported on influences on adolescent help seeking which included parents, school counsellors, doctors, friends, relatives, teachers, youth workers and other health professionals	Sample was limited to those that were already in the system. Difficulty in accessing people for advice	Help seeking is a social process that often involves a high degree of influence from parents or others. Referral sources and clinicians need to be aware of the effects of the different views between parent and child
Australia	Williams, 2009	Measure the distribution of "access" as measured by utilisation to private FFS psychiatric services at a regional level and to determine the temporal trend in equality in regional access to these services		Conventional measures of statistical dispersion and economic inequality – applied to quarterly timeseries data on quantities of private psychiatric services for Australia's regions since 1984	Inequality at a regional level has hardly improved in regards to the distribution of psychiatric services Due to the spatial distribution of psychiatrists The forces of industrial agglomeration for service industries, The effect of service utilisation of the "time price" of service use varying spatially The availability and price of substitutes	Non uniform distribution of psychiatrists Broad economic forces are as significant in the psychiatric industry as others Time and travel costs Intractable spatial inequality in psychiatric services	Inequality of access hasn't changed between 1984 and 2001
Australia (NSW)	Wright, 2005	To examine the needs and	99 GPs (from Hunter Valley region NSW)	Mail survey for GPs self reported contact rates	Depression was most commonly seen with an	Most common barrier for GPs in diagnosing	Most patients referred for CBTs (group) therapy and GPs were

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Hunter Valley)		practices of rural GPs and their relationship with local acute mental health services		with people with depression, confidence in dealing with them, needs and beliefs	average of 1.44 patients per GP per month being referred to local acute services and most commonly for suicidality.	mental health issues was time constraints.	most confident in recognising depression and anxiety
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Australia	Allan, Julliane 2010	To gain an in-depth understanding of service delivery within the practice settings to ensure that the diversity of practice challenges, constraints and interactions could inform the agency's approach to developing drug and alcohol services in the primary care setting.	Participants working for either Lyndon Community (a rural non-government drug and alcohol service provider working with several ACCHS providing specialist drug and alcohol treatment at their request), as PHCWs or visiting workers in the ACCHS where Lyndon Community provided services; or with agencies that referred clients to Lyndon Community or the ACCHS for drug and alcohol intervention.	A sociological action research approach – a qualitative study	Thematic analysis of interview data identified divergent perspectives according to a participant's work role about drug and alcohol treatment, client needs and problems and service delivery approaches. The interview findings presented were mostly from two perspectives – insider (drug and alcohol workers) and local (PHCWs in the ACCHS). Drug and alcohol workers were conceptualised as insiders. Most did not have knowledge or experience of the primary health care setting. Therefore they could not assist primary health care workers to integrate drug and alcohol	Professional and organisational barriers constrain the primary health care worker role and limit the application of specialist interventions. Drug and alcohol work is only one of many competing demands in the primary health setting. The lack of understanding of the primary health care worker role and responsibilities is the most significant barrier to implementing specialist interventions in this role. Primary health care workers' perceptions of substance misuse are	Building the capacity of primary health care workers to do more varied tasks requires a good understanding of the pragmatic and practical realities of their day to day practice and the philosophies that underpin these. The interview data were able to inform an action plan for the drug and alcohol agency and the ACCHS involved in the project. There were two strategies planned. The first was an education and support plan for PHCWs to be delivered by visiting drug and alcohol workers. The plan was supported by ACCHS managers and time was allocated for planned and structured education sessions supported by practice supervision and case

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					<p>interventions into their interactions with clients. Primary health care workers were conceptualised as locals. They tended to perceive that drug and alcohol interventions should quickly prevent individuals from on-going problematic use.</p>	<p>more consistent with the individual moral or personal deficit philosophy of drug and alcohol treatment than harm minimisation approaches. This is a challenge for a specialist agency that is promoting harm minimisation and an adaptive approach to treatment within the primary care setting.</p>	<p>review. The education sessions include harm minimisation philosophy and strategies and motivational interviewing techniques that could be used to discuss any health problem that clients or patients wanted to address. One or more PHCWs within each ACCHS were identified to participate and time for training and practice was scheduled during Lyndon Community outreach visits. The second action strategy was to promote PHCW expertise and knowledge in their area of speciality – primary health care. The aim was to give specialist workers some experience in primary health care practice by providing opportunities to observe PHCW practice including community consultation and interaction. The aim was for the drug and alcohol specialists in particular to learn how and when substance use discussions and interventions could fit into the</p>

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							rhythms and demands of primary health care practice. The acceptability of the strategies requires evaluation.
Australia	Allan, Julliane 2011	Describes the establishment and operations of an advanced rural skills training program at the Lyndon Community – a rural drug and alcohol treatment organisation in New South Wales.	Five general practice registrars, three female and two male, who had completed a 6 month Lyndon Community GP training post placement	Interviews as a part of a 3 year multimethod action research project investigating drug and alcohol service provision in rural New South Wales.	Feedback from registrars participating in the placement indicated that their experience at the Lyndon Community influenced and enhanced their practice. An addiction medicine rotation offers general practice registrars the opportunity to develop skills and experience in psychosocial interventions as well as physical and mental health issues common in the treatment population.		In response to feedback from participants, some changes have been made to the placement over time. In particular, more structure has been incorporated into the training period to ensure best use of time so that opportunities are not missed. Barriers to inclusion on remote visits were addressed ensuring that all registrars had the opportunity to practise their skills in remote communities. Assigning a treatment role to the registrar ensured their inclusion. The treatment role included responsibility for alcohol use assessment and identifying the impact on general health including chronic disease. Supervisors were then able to discuss with registrars how to adapt proposed treatment plans to the context of the remote location and available healthcare. Other changes over time have

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							included better integration of the medical side of addiction medicine training with the psychosocial aspects of the treatments provided at the Lyndon Community. Following clear role clarification, registrars were able to provide primary healthcare to therapeutic community residents. This also reduced the demands on local GPs. A thorough orientation to the organisation and its programs and establishing a learning plan within the first month of the training period has also been noted to increase the quality of the experience for registrars.
Australia	Annels, M 2011	To evaluate a feasible, best practice mental health screening and referral clinical pathway for generalist community nursing care of war veterans and	Community Nurses and GPs	Mixed Methods	Most nurses found the pathway clear and easy to understand but not always easy to use. They emphasised the need to establish trust and rapport with clients prior to implementing the pathway. It was sometimes difficult to ensure effective referral to		The trialled pathway, which was modified and refined following the study, is an evidence-based resource for community nurses in Australia and similar contexts to guide practise and maximise holistic care for war veterans and war widow(er)s and possibly other client groups. Findings from the trial and

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		war widow(er)s in Australia			general practitioners for clients who screened positive for a mental health problem. When referral was accomplished, general practitioners reported adequate and useful information was provided. Some general practitioners also commented on the difficulty of achieving effective communication between general practitioners and nurses.		<p>evaluation of the mental health screening and referral clinical pathway indicate that nurses and some GPs found the pathway useful for their practice, with several suggestions offered regarding improvement by simplifying the trialled versions of the pathway and accompanying guidelines and improving communication between nurses and GPs.</p> <p><u>Findings support the following recommendations:</u></p> <p>The pathway and guidelines, as modified, are added to the existing suite of pathways for DVA-funded community nursing care.</p> <p>Where possible, the pathway is applied by a community nurse at a time later than the admission of the client into community nursing care when rapport and trust have been developed with the client.</p> <p>Research is conducted to identify and explore the constraints and possible solutions for optimal referral and communication processes between community nurses and GPs concerning potential</p>

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							<p>mental health care needs of veterans and war widow(er)s. Research is conducted to identify and explore interventions for generalist nurses with a mental health focus.</p> <p>Evaluation findings were discussed with the panel of key stakeholders and content experts. Modifications were completed and the modified pathway is available as a web-based document from DVA (2009). Although the clinical pathway was designed initially for veterans and war widow(er)s, transferability to other client groups is possible, as is its use in other contexts internationally.</p>
Australia	Aoun, S 2012	To collect information, compare and evaluate the functioning of novel types of psychiatric services, including	All rural sites throughout the state, whether rooming-in or other inpatient related psychiatric services, were invited to participate in the training in the use of	Cohort	The assessment of staff attitudes towards routine outcome measurement revealed a need to provide staff with reasons and incentives for incorporating outcome measurement into routine practice, in addition	Technical difficulties, lack of adequate local IT support and shortage of staff prevented some of the sites from participating.	When asked what would facilitate mental health professionals completing assessments routinely, these suggestions were put forward: the need for a smaller case load; having the assessments entry time counted as an occasion of

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		rooming-in facilities, using outcome measurement tools, and to assess the attitude of mental health professionals towards routine outcome measurement	one of the outcome measures, Health of the Nation Outcome Scales (HoNOS), via telepsychiatry link-ups.		to provision of a thorough and on-going training and support in time and resources from management.		service when looking at staffing requirements; the need for fewer assessment tools and rather one appropriate tool; for assessments to be incorporated in team clinical reviews and; training in the usefulness of these assessments and demonstrating the positives for the organisation.
Australia	Bambling, M 2007	To examine the views of rural practitioners concerning issues and challenges in mental health service delivery and possible solutions.	GPs, Queensland health mental health staff and participants from community organisations.	Qualitative study	There is considerable misunderstanding between GPs, community mental health and the non-government sector regarding each other's capacity to deal with growing mental health service demand. Significant challenges remain in creating effective shared care arrangements. There was substantial consensus that there are significant problems with inter-service communication and liaison, and that improved collaboration and shared care will form a critical part of any effective solution. Differences	GP: The current system excessively emphasised crisis management, and was not adequately focused on a continuum of care. Treating patients with co-occurring mental health and substance use issues was challenging, because of effects on the doctor-patient relationship produced by personality disorder and drug use. Specialist services for these patients were inadequate. 3. GPs reported	Improvements to mental health staffing and to access to allied health might increase the ability of GPs to meet the needs of less complex patients, but specific strategies to promote better integrated services are required to address the needs of rural and regional with complex mental health problems. Increased mental health staffing as a result of recent State and Federal Government initiatives might enhance mental health services' capacity to manage service demand challenges. Greater communication and improved intersectoral collaboration between GPs, the community and non-

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					between groups reflected differing organisational contexts and priorities, and limitations to the understanding each had of the challenges that other groups were facing.	difficulties finding time to follow up patients and coordinate care with other services. Furthermore, follow-up care for patients with mental health problems was often unpaid. There was consensus that resources were lacking for people who did not meet standard criteria for psychiatric disorders, but were functioning suboptimally and required intervention. Community Mental Health: Insufficient service focus on early intervention and relapse prevention (including medication compliance) was a considerable barrier to improvement. Limited	government sector will be critical to an effective solution of current problems. Effective service responses to complex mental health needs demand integrated service responses and not simply goodwill or referral capacity.

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						<p>cooperation by GPs in shared care was reported, and communication with them about patient care and referral was problematic.</p> <p>Community Sector: Implementing an effective intersectoral model of care would require a cultural change by services towards early intervention and providing assistance based on individual needs. A barrier to the sector having a leadership role in rural mental health was a perception that they only provided 'soft end services'.</p>	
Australia	Bei, B 2015	To examine the impact of floods on the mental and physical health of older adults and explored risk and protective factors.	Two hundred and seventy four older adults (age ≥ 60) completed surveys before and after a flood event. Both the surveys included measures of anxiety,	Longitudinal prospective design	Compared to those not personally affected (78.8%), personally affected individuals (21.2%) reported significantly higher PTSD symptoms, with about one in six reporting PTSD symptoms that might		Findings in the study suggest that even though the impact of floods on the mental and physical health of older adults was mild overall, a small proportion of affected individuals might present with symptoms that require clinical

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			depression, self-reported health, and satisfaction with life; the post-flood survey also included questionnaires on flood experience, symptoms of post-traumatic stress disorder (PTSD), stoicism, and psychological coping with floods		require clinical attention. Personally affected individuals also reported a greater increase in anxiety post-flood, but changes in their depressive symptoms and self-reported health were not significantly different from those not personally affected. Greater flood exposure and the lack of social support were the risk factors for poorer mental and physical health. Higher stoicism was associated with higher post-flood depression and poorer self-reported mental health. The use of maladaptive coping, such as venting and distraction, was associated with greater deterioration in mental health after floods, whilst emotion-focused coping such as acceptance, positive reframing, and humour, was protective against such deterioration.		attention. <u>Effective tools are much needed to identify these individuals for timely intervention and support.</u> The findings on stoicism and coping suggested that in working with this population, <u>a proactive approach might be particularly helpful as older adults might not initiate help-seeking themselves.</u> Encouraging the use of coping strategies such as acceptance, positive reframing, and humour, whilst being cautious about the use of maladaptive ones such as venting and avoidance might be protective against disaster-related increase in psychopathology <u>Psychological interventions that focus on the reframing of a stressful situation and work towards acceptance of the uncontrollable and unchangeable</u> could be particularly helpful amongst individuals affected by disasters.
Australia	Boyd, C 2007	Aims to explore	Six first-year	A qualitative	Participants highlighted	Participants highlighted	School-based counselling has an

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		Australian rural adolescents' experiences of accessing help for a mental health problem in the context of their rural communities.	psychology undergraduate students from the University of Ballarat (one male and five female) between the ages of 17 and 21 years who sought help for a mental health issue during their adolescence and who at that time resided in a rural area.	phenomenological research design. Semi structured Interviews were conducted face-to-face at the university.	various barriers to seeking help for mental health problems in the context of a rural community, including: social visibility, lack of anonymity, a culture of self-reliance, and social stigma of mental illness. Participants' access to help was primarily school-based, and participants expressed a preference for supportive counselling over structured interventions. Characteristics of school-based helpers that made them approachable included: 'caring', 'non-judgemental', 'genuine', 'young', and able to maintain confidentiality. School-based counselling has an integral role in improving rural adolescents' access to mental health care.	various barriers to seeking help for mental health problems in the context of a rural community, including: social visibility, lack of anonymity, a culture of self-reliance, and social stigma of mental illness	integral role in improving rural adolescents' access to mental health care. A model of stepped care for rural adolescents with mental health problems that includes supportive general counselling as a first step – before access to a GP and/or allied health services at the next step – might have utility for adolescents with emerging mental health problems while still at school
Australia	Bradley, 2007	Effectiveness of outpatient group interventions in a rural area for AOD clinicians over a 3 year period	N= 39	Service evaluation project Clinician administered ratings made for retrospectively four times - 3 month intervals and 12 times	Significant change in functioning – (including substance abuse and symptomatology) with short outpatient group intervention complementing usual treatment	Lack of this kind of service	Longer involvement may be further associated with prevention of relapse and less unscheduled service use

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				post recruitment observations	Participants willing and able to commit for long periods of time		
Australia	Bridges, JFP 2001	Before an education program was attempted, NSW Health inquired into the specific needs for casemix education in rural NSW	The research was targeted at two rural Area Health Services: Macquarie (MAHS) and Mid West (MWAHS). This included open-ended interviews with rural managers and a survey of staff.	Mixed Methods Open-ended qualitative interviews : aimed at understanding the needs of the rural areas, and a survey that was designed to determine the existing level of understanding of casemix in rural areas. The interviews used a semi-structured form that focused the content of the interview on the need for casemix education and the design of an optimal education program. Participants were also allowed to discuss other matters of concern. Respondents were asked about their level	Results of the quantitative analysis indicate that the understanding of case mix classifications is highest among managers. Of concern were the relatively low proportion of Allied Health staff who had more than a vague understanding of the Sub- and Non-Acute Patient (SNAP) classification; <u>the lack of any knowledge of the Mental Health Costing And Service Classification (MH-CASC) by nursing staff;</u> and the lack of any knowledge of the emergency department classification: Urgency, Disposition and Age-related Groups (UDAG), either by clinical or nursing staff. The results of the qualitative analysis show that casemix education for rural areas needs to differ from		Time for future educational activity should be carefully scheduled to suit staff; for example, during normal meeting times. The provision of refreshments was recommended as a way of attracting staff to the education sessions. Casemix education has to be presented clearly and be both practical and clinically based. Where possible, examples from rural experience or practice should be used rather than examples from city-based teaching hospitals. Have a strong clinical presence at the education sessions. Presenters would be most effective if they were rural-based 'number crunchers' and could back up their presentations with appropriate statistics. Follow up and other forms of reinforcement,

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				of knowledge of the four key casemix classifications used in NSW. These are: (i) Diagnosis-Related Groups (DRG), which cover acute inpatient care; (ii) the Sub- and Non-Acute Patient (SNAP) classification, which covers care such as rehabilitation and palliative care; (iii) Mental Health Costing and Service Classification (MH-CASC), which classifies mental health; and (iv) Urgency, Disposition and Age-related Groups (UDAGs), which cover emergency and ambulatory care patients treated in emergency departments.	metropolitan education programs. The analysis also highlights the perception of casemix in rural areas and the special circumstances in rural hospitals that place limits on the ability to use casemix more fully.		such as up-to-date benchmarks, were considered to be an important component of a successful education strategy. Further education should focus on these aspects; for example, how casemix can effect a hospital's/ clinical department's funding in a casemix-based funding environment or how casemix can be used to improve patient care. While fairness and equity have been drivers of the NSW funding system, it needs to be made more transparent, especially in rural areas. Casemix would not be implemented successfully in rural hospitals unless there was someone in particular to drive it.
Australia	Buckley, D 2012	To determine if the addition of a video link to the existing phone connection, enabling patients	Patients admitted (n=1,943) to a health services regional hospital with a primary diagnosis of mental and	<ul style="list-style-type: none"> •Retrospective pre-post intervention analysis •The introduction of videoconferencing in January 2008 was 	After the introduction of videoconferencing the percentage of patients transferred fell from 66.8% (95%CI 64.0 to 69.5) to 59.6% (95%CI 56.1 to 63.1)		Videoconferencing has the potential to enable more timely access to rural and regional Australians requiring mental health services. There appears to be much to

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		admitted for mental and behavioural disorders to be seen by a centrally located psychiatrist or mental health clinician, would change the probability of these patients being transferred to the central mental health unit.	behavioural disorders (ICD10-AM code F00-F99) between January 2002 and December 2010.	examined by testing if the inclusion of a binary intervention variable was significant when added to the best fitting risk adjustment model.	($\chi^2 = 10.42$, $p=0.001$). After adjusting for age, sex, clustering in hospitals and repeat visits the odds of transfer were 0.69 (95%CI 0.49 to 0.97) of previous. Aboriginality, being non-Australian, long-term linear trend, admitted on the weekends or after hours were not significant predictors of the probability of transfer.		commend the use of videoconferencing to enable improved examination of remotely located patients with mental and behavioural disorders.
Australia	Caldwell, 2004	Rates of GP services for psychological problems across rural, remote and metropolitan areas		Bettering Evaluation and care of Health program, Medicare and Pharmaceutical Benefits Scheme	Rural and remote patients visited GP's less frequently than their metropolitan counterparts Lower rates of GP encounters for psychological problems for most non-metropolitan areas GP's prescribed mental health medications at half the rate for residents of remote areas than city areas	Limited access to services for psychological problems Sparse provision of GP practice care for mental health problems Study did not measure prevalence across metropolitan and rural areas	GP reported higher rates of depression in rural areas Fewer anxiety problems Rate of prescribing different ? greater reliance on medication in rural areas
Australia	Cheek, C	This study sought	Local youth on the	Qualitative study	Participants reported that		Computerized therapy offered

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		to explore the acceptability of SPARX (a computerized cognitive behavioural therapy (CBT) program (Smart, Positive, Active, Realistic, X-factor thoughts -SPARX) by youth in rural Australia and to explore whether and how young people would wish to access such a program.	SPARX program from two community-based organizations in the town offering a variety of community programs aimed at improving the towns' health and well-being		<p>young people want help for mental health issues but they have an even stronger need for controlling how they access services. In particular, they considered protecting their privacy in their small community to be paramount. Participants thought computerized therapy was a promising way to increase access to treatment for youth in rural and remote areas if offered with or without therapist support and via settings other than school. The design features of SPARX that were perceived to be useful, included the narrative structure of the program, the use of different characters, the personalization of an avatar, "socialization" with the Guide character, optional journaling, and the use of encouraging feedback. Participants did not consider (New Zealand) accents off-putting. Young people believed the</p>		<p>in ways that support privacy and choice can improve access to treatment for rural youth. Foreign accents and style may not be off-putting to teenage users when the program uses a playful fantasy genre, as it is consistent with their expectation of fantasy worlds, and it is in a medium with which they already have a level of competence. Rather, issues of engaging design and confidential access appeared to be more important. The findings suggest a proven tool once formally assessed at a local level can be adopted cross-nationally.</p>

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					SPARX program would appeal to those who play computer games generally, but may be less appealing for those who do not.		
Australia	Cheung, Yee Tak Derek 2012	To visualize the sex-specific suicide pattern over the country from 2004 to 2008, and studying the metropolitan-rural-remote differentials of suicide across all states/territories.	The 5-year populations-at-risk by postal areas for the whole study period	Poisson hierarchical model to yield smoothed sex specific, age standardized mortality ratios of suicide in all postal areas, and compiled the age standardized suicide rates across different levels of remoteness and different jurisdictions	Study identified the area variation of suicide risk across states/territories, and metropolitan-rural-remote differential with rates higher in rural and remote areas for males. Spatial clusters of some high risk postal areas were also identified. Socio-economic deprivation, compositional factors, high risks for Indigenous people and low access to mental health service are the underlying explanations of the elevation of suicide risk in some areas.		Important to consider geographical variations in suicide risk into account in national policy making. Particular suicide prevention interventions might be targeted at males living in remote areas, and some localized areas in metropolitan zones.
Australia	Collins, JE 2009	To investigate barriers to help seeking for mental health concerns and to explore the role	Residents from one rural centre (11 women, five men) aged between 36 and 75 years	Qualitative study	Prior research-driven thematic analysis identified themes of stigma, self-reliance and lack of services. Additional emergent themes were awareness of mental	Many rural people are unwilling to talk about problems or feelings. Participants suggested that men in their community were	Campaigns, interventions and services promoting mental health in rural communities need to be compatible with rural cultural context, and presented in a way that is

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		of psychological mindedness in a South Australian rural centre.			illness and mental health services, the role of general practitioners and the need for change. Lack of psychological mindedness was related to reluctance to seek help	particularly lacking in openness.	congruent with rural values. Psychological mindedness may provide a tool to assist in the process of men sharing their problems or feelings
Australia	Draper, 2003	Compare the perceptions of aged care services, adult mental health services and mental health services for older people	Aged care services N= 58 Adult mental health services n= 62 Mental health services for older people n= 20	Postal survey Canvassed service profiles, regional variations, availability of resources, processes of care, views of working relationships across services, difficulties and gaps	59% of aged care services and adult mental health services considered that their local mental health services provided an adequate service wide variety in service access variable staffing levels problematic	Resources and budget Many services offer a consultation service only private sector cannot fill the gap	Lack of access to psychogeriatric staff Resource limitations of service for older people Cross referrals and joint working possible way to address system issues ACHS, AMHS and MHSOP need to establish good working relationships
Australia	Fuller 2006	To quantify the proportion of rural financial counsellors' (RFC) clients requiring social, emotional and stress-related (SESR) assistance and the referral of these clients to other services.	Australian RFCs employed over the months of November and December 2004.	Cross sectional The survey comprised questions of a demographic and observational nature with invitation for anecdotal responses	Counsellors reported that on average 20% of their clients' required SESR assistance and half of the counsellors referred more than 75% of these clients. Referrals were mainly to GPs, mental health teams, personal counselling and health and welfare organisations. Almost half (49%) reported that referrals were difficult because of rural clients' reluctance to acknowledge such problems and use		The mental health system needs to include locally available helpers in the mental health service network. In so doing, these local helpers can be linked into a more informed and quality system of referrals thereby optimising the 'window of intervention opportunity'. Workers in a network are more likely to learn from other members of the network, thereby building local mental health service capacity. Rural Financial Counsellors need to maintain a high standard of

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					mental health services, as well as the lack of these services. Counsellors were placed in a practical role dilemma when clients raised personal issues that were beyond the counsellors' role but were linked to the financial reason for presentation. Strategies identified to improve referrals were to network with mental health and personal counsellors in the region, training and a referral guide.		professional service by facilitating referral of clients to appropriate services.
Australia (VIC)	Happell (2008)	To explore the views of consumers regarding factors that impede recovery and to explore the principles that ideally should underpin the evaluation of MH services.	16 consumers of mental health services from one rural (n=7) and one metro (n=9) mental health service	Qualitative exploratory: Focus group interviews	Main themes emerging regarding aspects of mental health services that pose barriers to recovery: Staffing issues Hearing the person not the illness Lack of safety and security Isolation Main themes emerging regarding the evaluation of mental health services were: Consumer involvement in	See main findings	The effective evaluation of mental health services requires an increased focus on the views and opinions of consumers in order to develop more responsive mental health services.

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					rigorous evaluation Meaningful activity and peer support (particularly when discharged) More responsive care and treatment		
Australia (QLD)	Happell et al. (2012)	To understand nurse perspectives on the physical health needs of mental health clients and how well rural services are meeting their overall care needs	38 nurses in public mental health care	Exploratory qualitative study. Focus groups with semi-structured format	Themes emerging were: Stigma of mental illness Barriers to accessing physical health care services Nurse adaptations under demands Community and integration towards better overall health	Nurses perceived reluctance of specialist staff and GPs in treating even physical health probs in the mentally unwell due to stigma. This also perceived to be reason why clients not accessing primary care services due to staff negative reactions. Shortage of services for physical health as well as geographical and economic barriers. System fragmentation Gaps in cross-cultural communication Stretching nurses role without the corresponding supports.	Nurses adapted to constraints and demands through forethought and assisting clients with daily activities. Integration of services (“one-stop-shop” – physical and mental) and community development Mobile general health services (outreach)
Australia (NTH QLD, NT)	Haswell-Elkins et al. (2005)	To reflect on the current organisation of mental and		Review	Mental health services in region have operated in parallel to other specialist services which have been	Barriers to the joining of primary and mental health care have been due to patterns of	The Aust. Integrated Mental Health Initiative (AIMhi) has been established to focus on people in rural areas, people

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		physical health services in remote Indigenous settings of Far Nth QLD and NT identifying some of the major disadvantages being experienced.			based in regional centres There has been limited impact on increased mental health capacity at the local level especially in terms of Indigenous providers. NT mental health specialist services remain separate to primary care	thinking about mental and physical health. Historical care methods have assisted in these running parallel to each other rather than being integrated: For example by having isolated psychiatric institutions. Despite de-institutionalisation a lot of work is still having to be put into merging physical and mental health care systems together.	with high support needs and Indigenous communities. Aim of indigenous stream was to establish pathways to meet the broad needs of Indigenous people with serious mental illness in remote communities and assess their impact on mental health outcomes. The AIMhi identified 6 key focus areas where substantial improvement is needed if improved mental and physical health outcomes are to be achieved: Strengthening families and communities Improving clinical service delivery Assisting in the implementation of reliable and valid mental health outcome measures Facilitating better information management for decision-making and monitoring Enhancing mental health literacy and health promotion Contributing to effective workforce development.

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Australia (TAS)	Hazelton et al. (2004)	To examine the effect of an extended-hours community mental health team on family caregiving in a semi-rural region of Australia	2 groups of family carers: Group 1 recruited before access to a community mental health team (CMHT), Group 2 recruited after establishment of a CMHT	Follow-up study (4 time points: baseline, 1 mth, 6mths, 12mths) assessed on measures of objective and subjective burden of care and satisfaction with treatment	Group 1 had significant improvements with use of CMHT, with degree of worry, burden, disruption of daily routine, whether the patient looked after themselves. Group 2 who was already accessing CMHT had significant improvement over time in sociability. Group 2 more satisfied with treatment	Under resourced and under developed mental health programs in rural areas	A community mental health consultation-liaison service could provide support to primary care practitioners and assist family carers Telephone based support and advice or telehealth may provide cost-effective solutions of remoteness
Australia (SA)	Henderson et al. (2014)	To explore the extent to which service providers, carers and consumers view the "Older Persons' Mental Health Service" (OPMHS) as meeting the needs of rural older people with mental health problems. OPMHS integrates services for older people into existing mental health services to establish an integrated and	3 case study sites where OPMHS clinicians were located. 22 key informants from mental health teams and organisations providing care to older people 4 consumers 5 carers	Semi-structured interviews	Establishment of OPMHS clinicians led to: increased access to specialist services for older people and earlier assessment/treatment of consumers. Greater service integration and knowledge sharing about older persons' mental health	OPMHS set up to help combat barriers to access and unmet consumer needs due to: Poor geographical access to services Extended waiting periods for GP appointment Limited access to and choice of GPs and specialists Stigma and its likelihood to reduce help-seeking	Localisation of services and attachment of specialist clinicians to rural mental health teams Expand and enlarge OPMHS (more staff, more locations, out of hours contact)

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		multidisciplinary system of care for the aged.					
Australia (VIC)	Issacs et al. (2013)	To explore help-seeking behaviour of Aboriginal men who are mentally unwell in a rural Victorian community.	17 Aboriginal people interviewed (15 men). Sample comprised clients and non-clients of mental health services, carers and service providers.	Qualitative description; semi-structured interviews	Themes emerging were: Difficulty in recognizing mental health problems Barriers to disclosing one's problems Reluctance to contact services Alternate coping strategies	Mental health symptoms viewed by community as a characteristic of the person. Lack of knowledge of what a mental health problem is. Language used by services not used by this community. Discomfort amongst Aboriginal culture to talk about mental health problems Male role in community is to be strong and they want to preserve their masculinity by not help-seeking To preserve masculinity they opt for a coping strategy which protects that image even if harmful to health (i.e. alcohol).	Need for programs which improve mental health literacy Need promotion of help seeking among Aboriginal men who are mentally unwell Such programs need to be co-developed between mental health services and Aboriginal stakeholders and implemented in a culturally acceptable way (inc. the type of language and words used)

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						Lack of trust and fear of services and government	
Australia	Jelinek et al. (2011)	To describe perceptions of Aus emergency clinicians of differences in management of mental health patients in rural and remote Aus compared with metro hospitals and what could be improved.	20 ED doctors and 16 ED nurses across states/territories rural and metro interviewed	Descriptive exploratory study; semi-structured telephone interviews	Themes emerging of differences between rural and metro: Resources/environment Staff and patient issues	Lack of access in rural areas to psych support services, alcohol and drug services Limited referral options in rural Lack of knowledge, understanding and acceptance of mental health issues in rural. Rural ED medical staff having generalist skills and lack of confidence and skills in managing mental health emergencies. Lack of understanding by medics in rural about dual diagnosis	Improvements to resources for drs: access to experts for consultation, access to mental health services in rural, assistance in managing aggressive patients, enhance psych coverage Improve education: training to improve mental health knowledge, about patient assessment and management, about medication, upskill Guidelines: utilise best practice and resources
Australia (VIC)	Judd et al. (2001)	To describe a collaboration between Uni Melb Dept of Psych and Psychiatry and a rural area mental health service to provide a specialist anxiety and depression	Child and adolescent and adult with a focus for clinical work including individuals age 15-65yrs				

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		treatment service in rural Vic. "The depression and anxiety research and treatment group (DART) – Bendigo health care group initiative"					
Australia (VIC)	Judd et al. (2007)	To examine the level and type of service utilization by rural residents for MH probs and explore the influence of level of need, sociodemographic factors and town size on such service use.	3 locales in rural north west Vic: a large regional centre, towns of 5K-20K population and towns of <5K population. 391 participants. Sample drawn from a larger sample of adults (n=7615) recruited randomly from electoral roll who participated in an earlier survey. The participants indicated on the original study their willingness to be contacted for future research so were invited to participate	Cross-sectional, community-based study. Interviews asking about mental health, help-seeking. Demographics taken from original study survey	46% of sample had sought help for probs with emotions or MH from at least one formal health provider at some point in their lifetime. One in three had suffered from a mood, anxiety or substance use disorder in their lives. One in six met criteria for a mental disorder in the month preceding the interview. Individuals who had more than 1 diagnosis were 3x more likely to seek help. Those with a mental disorder were more likely to have sought help from a combination of health professionals.	A possible reason why those living in medium sized towns may be more likely to seek help is because health service providers are more visible and accessible It may also be that in towns 5-20K population there is more emphasis on community development and social inclusion results in social networks which enable help-seeking.	Need to acknowledge the heterogeneity of rural Aus and work on service delivery and service utilisation in rural areas.

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			in a face-to-face interview for this study.		Factors arising from a logistic regression analysis that predicted having ever sought help from a formal health provider for emotional or MH probs were: a lifetime and/or current psychiatric disorder being female (5x more likely than males) being separated, divorced or widowed living in medium sized towns (5-20K pop)		
Australia	McColl, 2007	To examine the experiences of mental health consumers in a rural community	Eight community members that were mental health consumers and part of a CAG	Mixed methods (although not stated) using questionnaires and interviews	Mental health consumers face a number of issues including discrimination, alienation, and disempowerment and often feel unsupported and alone. They also reported negative perceptions of mental health issues, barriers and stigma and problems with service provision and lack of support from the community	There is a need for increased consumer involvement in mental health awareness, promotion and educational activities.	Involve mental health consumers in the training and develop skills to break down barriers
Australia	Morley, 2007	To explore whether 51 rural Access to Allied Psychological services projects	Evaluation of 49 rural projects and 53 urban projects	Utilised a range of evaluation methods data sets. Service models survey Minimum datasets	The results referred to uptake of services (1587 GPs had referred 14137 consumers to 359 AHPs via the rural projects. Those in	Proportionately uptake of the projects has been higher in urban than rural however there are issues	Rural projects have the potential to improve access to mental health care for rural residents by enabling GPs to refer to allied health

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		that were funded under the Better Outcomes in Mental Health Care program are improving services access and if they are translating into positive consumer outcomes		(extracted numbers of clients) Use of case studies	rural were less likely to be female and older than the metro ones. Rural consumers were less likely to be tertiary educated with more rural consumers taking medications (antidepressants most common).	associated with recruiting and retaining service providers	professionals
Australia	Nicholas, 2004	Evaluate the effect of a brief school-based intervention on help-seeking behaviour among Australian adolescents using Reachout (web-based). Secondary aim to examine gender differences	243 male and female students from eighteen government and non-government schools	Quantitative evaluation using a presentation and post presentation questionnaire	The students reported learning about help seeking and the presentation helped them to increase their knowledge about where to go to get help, who to talk to and what a tough time is. Participants reported that they were more likely to use the Reach-out website for information and help seeking after the presentation	The likelihood of seeking help depends on the nature of the problem Need to explore the nature of help seeking for different issues	Using web-based tools to provide information for young people seeking help for a range of personal and interpersonal issues is useful
Australia (QLD)	Turpin, 2007	To identify service providers and community organisations perspectives of	Key informants from 5 towns 10-14 members for each of 5 focus groups (no mention of final	Qualitative with 5 focus groups	There were gaps in services in relation to health, employment, education, housing and social inclusion recognised. There are also	There was a lack of understanding within the service providers of what others did. Despite intersectoral	Unless there is mapping of the different purposes of organisations there will be service gaps and people will report getting the run around.

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		the resources available to support people with mental illness and the unmet need of this group in rural QLD	numbers). Providers of mental health services and community organisations		issues with limited funding	collaboration being part of the current mental health plan there was little collaboration. There are also a range of communication challenges	
Australia	Wahlin, 2012	To examine the relative influence of parents and others on the decision of young people to seek formal help	119 parent-child dyads between the ages of 14-18 attending a clinical assessment interview with CAMHS in Sydney or Illawarra (NSW)	Questionnaire and standard assessment measure routinely used by CAMHS	Reported on influences on adolescent help seeking which included parents, school counsellors, doctors, friends, relatives, teachers, youth workers and other health professionals	Sample was limited to those that were already in the system. Difficulty in accessing people for advice	Help seeking is a social process that often involves a high degree of influence from parents or others. Referral sources and clinicians need to be aware of the effects of the different views between parent and child
Australia	Williams, 2009	Measure the distribution of "access" as measured by utilisation to private FFS psychiatric services at a regional level and to determine the temporal trend in equality in regional access to these services		Conventional measures of statistical dispersion and economic inequality – applied to quarterly timeseries data on quantities of private psychiatric services for Australia's regions since 1984	Inequality at a regional level has hardly improved in regards to the distribution of psychiatric services Due to the spatial distribution of psychiatrists The forces of industrial agglomeration for service industries, The effect of service utilisation of the "time price" of service use varying spatially The availability and price of substitutes	Non uniform distribution of psychiatrists Broad economic forces are as significant in the psychiatric industry as others Time and travel costs Intractable spatial inequality in psychiatric services	Inequality of access hasn't changed between 1984 and 2001
Australia	Wright, 2005	To examine the	99 GPs (from Hunter	Mail survey for GPs self	Depression was most	Most common barrier	Most patients referred for CBTs

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(NSW Hunter Valley)		needs and practices of rural GPs and their relationship with local acute mental health services	Valley region NSW)	reported contact rates with people with depression, confidence in dealing with them, needs and beliefs	commonly seen with an average of 1.44 patients per GP per month being referred to local acute services and most commonly for suicidality.	for GPs in diagnosing mental health issues was time constraints.	(group) therapy and GPs were most confident in recognising depression and anxiety

CANADA

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
Canada	Bathgate, D 2001	To examine the views of Otago general practitioners (GPs) about local mental health services and their role in providing such health care.	46 from Dunedin city GPs (urban) and 54 from GPs practising out of Dunedin (rural).	Cross sectional A simple four-page questionnaire was distributed to GPs practising in Otago. 100 completed questionnaires were received,	There were large differences between GPs in the estimated numbers of patients with psychiatric conditions they were seeing. 85% were keen on sharing management of patients with mental health services. Average confidence levels for diagnosis and management of depression and anxiety were good. GPs felt less confident about psychosis, somatisation, eating and personality disorders.	Obstacles to GPs doing more mental health work included time, cost, access to specialist services and training. The overwhelming recognition by these GPs that they experienced real difficulty undertaking mental health work because of the remuneration system.	Funding for mental health and a review of the payment for GPs mental health work. Improved liaison with mental health services. More psychiatrists' time and counselling/social work. GPs said they would welcome further education on treatment of psychiatric disorders. Rural GPs said they would like additional education for given psychiatric conditions: schizophrenia (65% of respondents), depression (48%), anxiety disorders (61%), alcohol and drugs (57%), eating disorders (59%), somatisation disorders (72%) and personality disorders (61%). A more cost-effective

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							arrangement would ensure that patients with major mental disorders living in the community have free and adequate access to general practice staff, who in turn have easy access to secondary specialist support and advice
Canada	Blais, 2003	To determine whether publically funded mental health services and resources available in 4 large regions in the province of Quebec were distributed according to needs of children aged 6 – 14 to assess whether variations in mental health services and resources across 4 regions had changed over a 5 yr period	N=2400 non institutionalised children 1992 – 3 1997 - 8	Indicators of need according to the child's parent Was compared with both in school and community professional resources – and physician and hospital services	Mental health resources were not distributed according to need	Lack of access did not change over time	Need to have health policy that stresses equity in access Access should be monitored
Canada	Boydell, KM 2006	To examine issues of access to mental health care for children and	30 parents of children aged 3-17 who had been	Qualitative study In depth interviews	Interview data indicated 3 overall thematic areas that describe the main barriers	Lack of awareness of the availability of mental health	1. The need for local accessibility to services and supports,

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		youth in rural communities from the family perspective.	diagnosed with emotional and behavioural disorders. Participants were recruited from rural areas of 2 regions in Ontario. <u>The first was the catchment area around the city of Owen Sound</u> in south western Ontario, which is one of the most rural districts in southern Ontario. <u>The second region was the catchment area of Sudbury,</u>		and facilitators to care. These include personal, systemic, and environmental factors. Family members are constantly negotiating ongoing tension, struggle, and contradiction vis-à-vis their attempts to access and provide mental health care. Most factors identified as barriers are also, under different circumstances, facilitators	services was frequently mentioned as a service barrier. Accessing mental health care for children was clearly affected by monetary issues on a number of different levels. Unique to rural communities is the need to travel great distances to access care, which often entails having to take time off work as well as the costs of gas, wear and tear on the car, parking, meals, and sometimes hotel accommodation. The small size of the community contributes to the lack of anonymity and concerns about stigma associated with mental illness. Particular challenges have	integration, early intervention, education and promotion, school and child care, parental support, and a rural approach to service delivery 2. The World Psychiatric Association's global antistigma program has shown positive outcomes resulting from their process for setting up antistigma projects in local communities. This process includes establishing a local action committee, conducting a survey of sources of stigma, selection of target groups, messages and media, and evaluation of the impact of interventions

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						been identified in maintaining anonymity and boundaries between service providers, family caregivers, and clients that may be significantly different from those found in an urban setting The fear of being seen is frequently an important issue related to the decision to avoid seeking mental health services. In fact, stigma has been cited as one of the greatest obstacles to the treatment of mental illness.	
Canada	Breton, JJ 2005	To aim to identify hospital resources by region, determine human resources by type	The target population included all psychiatry	Cross sectional Semi structured questionnaires to all child psychiatry service heads	Response rate was 100%. Study identified 35 child psychiatry services: 13 in central regions, 9 in	Due to heavy workloads of treating adult patients, most	CMQ has suggested evaluation of youths in child psychiatry be conducting in a clear

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		of service or region, and describe how services generally operate in child psychiatry within Quebec	departments, programs, services, and teams in Quebec's general and specialised hospitals.		adjoining regions and 13 in peripheral regions. Overall study identified 177 short stay beds, 476 places in day or evening hospitals and 113 places in day or evening centres and 113 places in day or evening centres. Most of these resources were located in the central regions. Quebec had 138.2 full time equivalent child psychiatrists (69.8% in the central regions) and 706 FTE professionals. At March 2001, <u>4285 youths were waiting for services.</u> The study observed <u>a shortage of child psychiatrists and professionals,</u> regardless of the norms used. Adjoining and peripheral regions have access to minimal range of human and hospital resources in child psychiatry.	psychiatrists refuse to treat youth. Budget planning by Quebec Ministry of Health and Social Services (MSSS) limits itself to the all-compassing category of 'psychiatry'. As a result child psychiatry must compete with adult psychiatry. The health and social functions as though child psychiatry is a medical speciality with organisation and service delivery independent of adult psychiatry. No norms on number of beds should be assigned to child psychiatry	ranking system. The Practice Research Network has proposed the following the waiting period for evaluation - emergency, priority, routine and elective. Western Canada Waiting list project have proposed a checklist for assessing the priority of child psychiatry referrals. <u>Analysing these two systems will offer better grasp of factors underlying the waiting period for evaluation of child psychiatry.</u> To contribute to the integration of mental health services. Child psychiatrists and professionals must focus their interventions on youths presenting with complex psycho pathologies characterized by impairment, comorbidity, and

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							resistance to earlier interventions. First line clientele should not have direct access to child psychiatry services, provided of course that primary level services are sufficiently operational.
Canada	Brinkman, K 2009	The overall purpose of the evaluation was to capture feedback on the Mental Health Liasion role focusing on access, continuity of care, quality of care, and provision of education in a rural community in Alberta	116 questionnaires were distributed to physicians, hospital staff, and community mental health	A questionnaire was developed to assess stakeholder perception relating to various functions of the MHL.	A 50% (n = 58) response rate was achieved with broad representation from different partners, including 75% of local physicians. The majority of respondents positively perceived the roles, functions, and impact of the MHL, including relationship development across the hospital community, improved access to services, and perceived improved client outcomes. The results reinforced that the MHL service meets a previously		The overarching goal is to situate MHL services in an integrated health system, where effort is placed on improved access to effective MHS, innovative clinical practice and improved health outcomes across the continuum of a holistic approach in rural health care.

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					unmet need in this rural setting. Findings are being used to refine roles, provide local learning and resource development, understand issues relating to programme development in other areas, and develop client level outcomes relating to the services delivered		
Canada	Carlisle C E 2012	To investigate time to aftercare for adolescents following psychiatric hospitalization.	Adolescents aged 15 to 19 years with psychiatric discharge between April 1, 2002, and March 1, 2004, in Ontario, using encrypted identifiers across health administrative databases to determine time to first psychiatric aftercare with a primary care physician (PCP) or a psychiatrist within 395 days of discharge.	Retrospective Cohort study	Among the 7111 adolescents discharged in the study period, 24% had aftercare with a PCP or a psychiatrist within 7 days and 49% within 30 days. High socioeconomic status (adjusted hazard ratio [AHR] 1.31; 95% CI 1.21 to 1.43, $P < 0.001$) and psychotic disorders (AHR 1.24; 95% CI 1.12 to 1.36, $P < 0.001$) were associated with greater likelihood of aftercare. Youth in the northern part of the province (AHR 0.48; 95% CI 0.32 to 0.71, $P < 0.001$), rural areas (AHR 0.82; 95% CI 0.76 to 0.89, $P < 0.001$), and with self-harm or suicide attempts		Must develop regionalised services that promote efficient movement of youth within the continuum of care from intensive inpatient services to distributed, interdisciplinary outpatient services located geographically close and synchronously with need Child and adolescent psychiatry is in urgent need of systematic, comprehensive, inter-professional data collection, including clinical data outcomes, so that we may better

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					(AHR 0.58; 95% CI 0.53 to 0.64, $P < 0.001$) and substance use disorders (AHR 0.50; 95% CI 0.44 to 0.56, $P < 0.001$) were less likely to receive aftercare.		understand the current state of mental health service delivery to youth and plan appropriately for much needed care
Canada	Cheung, A H 2006	To examines the rates of depression and suicidality in adolescents aged 15-18.	Study population was composed of Canadian Community Health Survey Cycle (CCHS) 1.2 respondents aged 15–18.	Cross sectional Data from the CCHS Cycle 1.2 on Mental Health and Well-being, a population-based survey conducted by Statistics Canada, were used to examine the rates of depression and suicidality in adolescents aged 15-18. Lifetime prevalence rates were calculated for depression and suicidality by region for males and females. Multivariate analyses were conducted to test the robustness of these results.	The lifetime prevalence rates were 7.6% for depression and 13.5% for suicidality. There were significant gender differences for both: 4.3% of males and 11.1% of females had depression, and 8.8% of males and 18.4% of females had suicidality. After adjustment for age, sex and household income, the Maritimes had a lower rate of depression and British Columbia had a higher rate of suicidality relative to Ontario. Youth from low-income households had a higher risk of suicidality.		Giving priority to regular surveillance of the mental health of young Canadians to help regional and local governments develop strategies to identify and assist these youth. In addition, ensuring the effectiveness of these strategies will require understanding the role of such factors as gender and income in order to target programs and decrease the barriers to accessing needed mental health services by the most at-risk Canadian youth.
	Choi, S 2014	To describe barriers and gaps in accessing mental	A retrospective cohort study was	A retrospective cohort study	950(27%) were identified with co-morbid depression		Careful considerations with the impacts of

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		health services among this high-need population in Ontario.	conducted from 2008-2012 by linking the Ontario HIV Treatment Network(OHTN) Cohort Study (N= 3,545) with administrative health databases <u>(did not have access to full text)</u>		<p>at the baseline. 523(55%) and 444(47%) had used the primary care and specialist care respectively during a year after they identified with co-morbid depression. Mean number of visits to primary and specialist mental health services were:6(SD= 16) and 8(SD= 18).</p> <p>•For those who were depressed, we found that non-English speakers were two times less likely to use primary (aOR:0.5;95%CI:0.3-0.8) and mental health specialist(aOR:0.6;95%CI:0.4-0.9) services when compared to their English speaking counterparts. In addition, those who were identified as homo-sexual/gay, having annual income< \$20,000 or residing in rural area were two times less likely to use mental health specialist care. For accessing primary and specialist care, we found that ethnic minorities or being</p>		language barriers, geographic restrictions, and cultural differences would be important to address in delivering successful mental health care for this high-need population in Ontario.

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					homosexual/gay were likely to have 40-50% fewer encounters to care.		
Canada	Cloutier, P 2008	To assess the knowledge, attitudes and practices of health-care providers about referring children and youths for mental health services through a regional centralized intake	All physicians in the Specialized Psychiatric and Mental Health Service (SPMHS) catchment area were potential participants. The population for the survey database was generated from a Canadian database (mdselect.com) that permitted selection of physicians based on location and medical specialty	Cross sectional	Only 27% of responders were aware of the available videoconferencing services. The proportion of physicians who reported having referred patients for the various mental health services through videoconferencing was 0–24%. The proportion of physicians who reported that they would refer patients through videoconferencing was 55–92%. Reduced travel time and care provided closer to home were seen as the primary benefits of referring patients to mental health services through videoconferencing. Unclear referral patterns and technology compromises were seen as	<ul style="list-style-type: none"> • Incentive and remuneration is a possible barrier to implementation • Organizational patterns and technological challenges are also considered to be obstacles to successful implementation Unclear referral patterns technological compromises as a limitation. 	<ul style="list-style-type: none"> • A34:134 The health-care system in Ontario is a large, publicly funded, centralized system with clearly defined referral systems (structured and regulated). Therefore, providing increased access to specialists via telemental health may be a welcome alternative for rural physicians. In other health-care delivery systems which are decentralized and private, there may be different incentives and deterrents to the use of telemental health by physicians

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					limitations of referring patients to videoconferencing. Access to rural populations and improved access to patients were seen as benefits to practice, and undeveloped remuneration procedures as the primary limitation. Promotion may be important to successful implementation of telemental health services for children and young people.		
Canada	Cole, MG 2008	To characterize patterns of Health Service (HS) use for mental health problems by seniors with depressive disorders and symptoms during the previous 12 months.	Study used data from the Canadian Community Health Survey (CCHS) Cycle 1.2: Mental Health and Well-Being. Cross-sectional survey of a nationally representative sample of individuals aged 15 and older conducted by Statistics Canada	Retrospective Cohort study	Rates of any HS use for mental health problems ranged from 1.8% for those with no depressive symptoms to 31.1% for those with major depression. •Variables predicting increased HS use were: depressive disorder or symptoms, clinically significant distress or impairment, age 65–84, single, post-secondary education, religiousness, disability, co-morbid mental disorder and fewer		Identifying groups at high risk of depression (or low HS use for depression), screening of these groups to detect cases and development of disease management models for depression care in primary or other professional care settings. Such models have already been described (Unutzer et al., 2002; Bruce et al., 2004; Ciechanowski et

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
			between May and December 2002 (N=36,984).		friends and positive social interactions. Variables predicting HS use among depressed seniors were physical health, psychiatric co-morbidity and activity limitation.		al.,2004). These models might be enhanced by incorporating additional elements of chronic disease management
Canada	Forchuk, 2010	To compare communities with three models of crisis service: (a) police as part of a specialized mental health team, (b) mental health worker as part of a specialized police team, and (c) informal relationship between police and mental health crisis service.	•Police, emergency/ crisis staff, community and hospital service providers, consumers of the crisis service, and family members. Individuals who had experienced mental health issues and had accessed crisis services (mental health service provider and/or police) were eligible to participate as consumer participants.	Qualitative (ethnographic approach) Focus groups and participant observations	Consistent themes that emerged- Perceptions of strengths and limitations of the crisis service from the perspectives of consumers, families, and service providers: all communities value their crisis services problems arise due to a lack of public transportation, need for immediate assistance when an individual is in crisis, all crisis programs have peak periods when they cannot handle volume, improved access to psychiatric inpatient beds is essential, consumers want peer		Mobility of Crisis Programs The organization and delivery of services must take into account the context of the community in which the services are offered. The crisis model for rural settings must include a mobile component if universal access is a goal. There is no integrated policy on transportation and access to mental health services in Ontario. Consumers need to be able to get safely to services and then safely back home,

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
			<ul style="list-style-type: none"> Family members must have had a family member access a crisis service. <p>Service providers and police had to have direct experience with people experiencing mental health crises in the community</p>		<p>support as part of their crisis care, crisis services require interagency collaboration, and specific gaps are unique to each community.</p> <p>What are the differences and similarities in service delivery between each model:</p> <p>Participant observation revealed how each crisis service addressed and managed crisis situations, and how teams responded to gaps and deficits within the mental health system in their community. The amount of time that teams spent in outreach versus intake varied between programs. Systems that provided quick access to psychiatric beds saved prolonged waiting by staff and consumers alike.</p>		<p>particularly when they come to the emergency room but are not admitted to hospital. Thus, the Ontario Public Hospitals Act should be revised so that, following a psychiatric assessment that does not lead to hospitalization, people can be offered a safe means of transportation home, especially when they live in another community.</p> <p>Access to Beds</p> <p>The development of a centralized registry of available psychiatric beds, similar to that which exists for other specialties such as labour and delivery, and emergency rooms.</p> <p>Staffing</p> <p>The worker must become an “expert generalist” in mental health. In these settings, a team</p>

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							<p>approach with increased specialization of team members can occur; there may be an addiction specialist, a youth team, and/or a geriatric team to respond to different crisis situations.</p> <p>The salaries of crisis team staff members should be comparable to the wages of hospital staff who do similar work. Crisis staff members who are highly trained and experienced should be paid according to their expertise; this would ensure recruitment and retention of appropriate staff.</p> <p>Development of a coordinated telephone service between crisis services, so that neighbouring areas can serve as back-up for</p>

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							<p>each other.</p> <p>Models</p> <p>The need for mobile crisis services and generalists in rural communities suggests that police crisis teams supported by mental health staff may be a more appropriate approach for this setting. A mental health team supplemented by police officers would be more appropriate. The specific education of police officers on mental health matters is critical in all communities. Information on mental health issues should be included in the basic curriculum at the Ontario Police College. This information should also be included as part of ongoing professional development programs once officers are assigned to a detachment, as their</p>

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
							<p>role will vary depending upon the community which they serve.</p> <p>Assessment of Gaps A good strategy for assessing the gaps in a given community is to examine the nature of the crisis calls that are received. However, crisis programs run the risk of “mandate drift” as they struggle to respond to gaps in the service system.</p> <p>Peer Support Peers are a cost-effective alternative to providing support, and peer support should continue to be an integral part of the mental health crisis system.</p>
Canada	Hardy et al. (2011)	To examine the role of rural residence in relation to service	Canadian data (n=35140 rural and urban)	Data analysis	Among rural residents with probably anxiety or mood disorder:		Rural residence was not an important factor in predicting any

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
		utilization	<p>collected in 2002 from Statistics Canada's Canadian mental Health survey cycle 1.2 analysed.</p> <p><i>Note: rural residents in this analysis did not live in Aboriginal reserve communities, remote communities.</i></p> <p>Rural = population <1000, density of <400/km², discontinuous areas >2km</p>		<p>38.3% sought help from a professional in last year (compared to 42.5% urban).</p> <p>16.1% consulted mental health specialists (compared 22.2% urban)</p> <p>Rural and urban people with probably anxiety/ mood disorder equally likely to use mental health services</p> <p>Rural versus urban residence was not a significant predictor for any type of professional mental health service when other demographic, social, and health status characteristic taken into account.</p>		<p>service use or use of specialised mental health services.</p> <p>Rural and urban receive professional and specialized mental health care at similar rates</p> <p>Limitations recognised by researchers for this study (see italic in design column)</p>

Canada British Columbia (northern, rural and isolated areas)	Hunter (2006)		Short review (narrative)		<p>Common problems: Various forms of PTSD rank high on list. Causes include: residential school syndrome (being removed from home to go away and live at school with long periods of not seeing family, also experiencing cultural disconnect) and cross-generational family violence (assoc with alcohol abuse and sexual assault). Levels of depression and anxiety disorders high. Causes can be associated with missing family or friends for those who were used to living and working in populated areas once. Substance abuse – leads to crime which contributes to weakened society Dissociative disorders Violence and isolation (which is also experienced by police, other gov workers – who subsequently may need their own psychological help)</p>	<p>Cultural issues Lack of expertise Travel Residential school syndrome Alcoholism Family violence Poor collaboration between mental health professionals and family physicians Lack of continuity of care due to psychiatrists only visiting every so often and large periods of time between each visit. Often support is offered by people (i.e. family and friends) who are already on a short emotional tether themselves.</p>	<p>Productive collaboration in form of teleconferencing and workshops. Need knowledgeable people who can help by providing education and therapeutic interventions then perhaps social change will begin to occur which will promote further change. Patients may need to be transferred to a larger community to obtain continued care. Good collaboration between GPs and specialists</p>
Canada	Wade, 2008	Addresses issues of	Students aged 5	Quantitative	Utilisation patterns	American health	School based health

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
		access and utilization related to newly implemented school based health centres	to 15 N= 7,460 (57.2% of all eligible students) Attending four rural schools and four urban schools Over a three year period 2000 - 2002	Demographic and encounter data entered into an online database Welligent – including referral data, presenting health problem using ICD -9 coding and whether the student was sent home following the health encounter Descriptive analyses	suggest improved access to health care for disadvantaged and rural students Rural students had lower enrolments but if enrolled their utilisation was higher than urban students Improved access to students with chronic conditions Support parents with the burden of care – time and cost Rural students had a lower rate of return to classroom after health encounter Over the three years of the study teachers reduced their referrals over time and parents increased their referrals over time Mental health visits accounted for 1% of visits in the first year and 22% of visits in the final year	care system - Not having school based health centres, lack of health insurance and lack of access to primary health care	care centres improve access and health care provision to disadvantaged groups and rural students

ETHIOPIA

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
Ethiopia	Chemali, Z. N.2013	To present the delivery of mental health care to a sample of women living in Jimma, rural Ethiopia, and their access to mental health services.	Women seen at Jimma University Specialized Hospital (JUSH)	Cohort Psychiatric charts were reviewed for all women seen at JUSH from 2006 to 2008. In total, 246 psychiatric charts were retrieved for review. Of these, 20 charts lacked notations. As a result, a total of 226 psychiatric records were reviewed in depth. Authors extracted relevant data from charts onto a data sheet before analysis. For the same time period, authors documented a total number of 42,000 medical visits to the hospital under general medicine. Medical visits were defined as medical consults such as headaches, HIV, pneumonia, fever, and malaria.	The mental health charts included documentation ranging from one paragraph to a full note. No psychiatric chart recorded medication status, detailed substance abuse history, or a history of violence.	Women's limited time and access to money, and their restricted mobility, or lack of autonomy over health care decisions, often delays their seeking health care. Further, women's self-perceived low status may hinder female patients from effectively communicating their health needs, or their ability to make decisions regarding appropriate care.	Given the strong cultural implications of traditional Ethiopian society, particularly pertaining to women, culturally sensitive and women-friendly care is necessary to provide better care for women, increase compliance in female patient populations, and raise the health status of women, including mental health. Women-friendly treatment requires gender-responsive action, where providers strive to empower female patients in determining their health care outcomes. Gender issues that impact health-seeking

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							<p>behaviour should inform the location or timing of services.</p> <p>Creation of exclusive spaces for women's treatment may make services more culturally "acceptable" for women, their husbands and/or other family members, particularly in highly traditional or religious families.</p> <p>The range and content of health services provided must also address biological differences between women and men, in terms of health conditions that occur exclusively or more commonly in women, manifest differently, or have different risk factors.</p> <p>Similarly, the list of essential medicines should reflect and meet women's different health needs, including issues related to childbearing.</p>

HAITI

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
Haiti Rural	Wagenaar, 2013	Examining patterns, determinants and costs of care for mild to moderate psychiatric distress	Household survey n = 408 adults 2011	Quantitative Cross sectional zone stratified household survey Multivariable logistic modelling	32% endorsed god 29% endorsed clinics and hospitals 47% chose providers on anticipated efficacy Suicidal individuals were 7.6 times as likely to prefer community based providers over hospitals or clinics If a family member had had a mental health problem they were more likely to access community based providers	Cost for vodou priest 100 x higher than hospitals or clinics – the poorest residents chose the most expensive form of care Religious and community options outranked hospitals and clinics in terms of efficacy Vodou practice is stigmatised	Biomedical providers need to gain more training and education in providing interventions for mild to moderate psychiatric distress – and cultural sensitivity Affordable existing community resources should be supported and biomedical staff should form partnerships

INDIA

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
India	Cowan, J 2012	To examine the facets of service provision amongst doctors providing primary health care in a rural area of Karnataka is Southern India.	Government and private MBBS-trained doctors operating in Doddaballapur Taluk. Ayurvedic and homeopathic-trained doctors operating in the government sector were also included	Cross sectional	The majority of participants (69.6%) felt competent in providing mental health services to their patients. However, there was a substantial level of endorsement for several statements that reflected negative attitudes. Almost one third of participants (28.0%) had not received any training in providing mental health care. Whilst three-quarters of participants correctly identified depression (76.1%) and psychosis (76.1%) in a vignette, fewer were able to name three common signs and symptoms of depression (50.0%) and psychosis (28.3%).	PHC doctors had not received any training at all in mental health. The duration of mental health training that had been received was typically one week or less, and very few had received any training in mental health during their graduate study. •Negative attitudes were more commonly endorsed by doctors practicing in private clinics, doctors who had not received any mental health training, and doctors who did not feel competent in providing mental	Integrating mental health into primary health care requires evidence-based up-skilling programs. Doctors desired such training and would benefit from it, with a focus on both depth of knowledge and uncovering stigmatising attitudes towards people with mental health problems. It is important that any mental health training and support initiatives are extended to doctors operating in private clinics in addition to their government counterparts.

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						health services.	
India	Kermode et al. (2009)	To undertake a mental health literacy assessment in a rural area of India in order to inform the development of a mental health training programme for local community health workers in a primary healthcare setting.	240 systematically sampled community members 60 purposively sampled village health workers	Cross-sectional: Mental health literacy (MHL) survey: interviewer-administered. Participants provided with vignettes describing people experiencing mental health probs and asked to name the prob, identify treatments and people who would be helpful and likely outcome for person	Mental health problem recognised (terms “depression” or “brain/mind problem” commonly used. Frequent labelling as “stressed” Socio-economic interventions provided by family, friends, neighbours considered most helpful (most considered issue to be related to financial stress or social issues). Local village health workers considered helpful, but psychiatrists less so. Half sample considered dealing with the problem alone would be helpful. Endorsement of special diets, tonics, appetite stimulants and sleeping pills Awareness of psychiatric medications was negligible.	Limited knowledge and understanding of effective responses and treatments are limited. Most considered those in vignettes as not a “real illness” Stigma and distance for consultation attached to psychiatrists – viewed as not helpful. “distant and unfamiliar” service providers	Need to enhance mental health literacy in this community, including with village health workers. Build capacity of primary healthcare staff so they are equipped to provide effective local response to those with mental health probs. Promotion of knowledge about the effectiveness and affordability of evidence-based psychotropic medications Dispel myths (i.e. marriage is a useful form of treatment – when believing mental health issue is social based) Discouraging special diets etc.
India	Jayaram et al.	To describe obstacles	1490 registered	Clinic established to assimilate	Cultural related obstacles	Female gender	Implementation of an

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	(2011)	overcome in establishing/implementing a community psychiatry program in rural India	patients from 187 villages in Southern India 4 trained, well known and respected (culturally important) female case workers	psychiatric care into primary care: regular clinic setting and hours, 24hr emergency care, female case workers, free or nominal fee, supervision/outreach offered. Program funded and overseen by US and used a model from Johns Hopkins Hosp community psychiatry program	had to be carefully managed in program (see barriers) for any form of success. Respect for the countries methods and working with that rather than trying to enforce a Western approach. Vast and broad communication amongst community required (to educate and raise awareness of mental health and program particularly to the women to develop them as case workers). Follow up through outreach important Transportation for outreach must be provided to case workers as often no road access (i.e. provide motorbikes) Due to mental health stigma, a promotion of "total health" helped people come forward Funding support (external – Rotary international) necessary Program been running at Maanasi clinic since 2002	(gynaecological complaints, and also cultural issues regarding women case workers required to work with women patients or married women for male patients) Low education Poverty Lack of access to running water in home Hunger Stigma – willingness of case workers to work with mentally ill who have poor standing amongst community Lack of resources for mental health care (inc. lack of transport methods to obtain it) Non-compliance to medications due to myth (i.e. antidepressants cause blindness)	affordable and accessible program of care delivery which targets women, integrated mental health into primary care, and sustain it for long term

IRELAND

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
Ireland	Barry, MM 2000	To describe the needs assessment phase of a mental health promotion programme for rural communities in Ireland.	The District Electoral Divisions (DED) list was used as a sample frame to randomly select a rural community with less than 1500 population within each of the four geographical regions. A total sample of 1014 people were surveyed across the four communities	Cross sectional - combination of interviewer administered questionnaire and the vignette method	Lower levels of awareness, less confidence in dealing with mental health issues, negative attitudes to help-seeking and social stigma emerge as particular issues for men and the under 40 age group. Women were found to have more positive attitudes generally, were more likely to use informal social support networks and were more open about discussing mental health matters. Social relationships, negative thinking patterns and social stresses were perceived as being particularly important in explaining the origins of depression.	Concerning barriers to seeking professional help 12% referenced the social stigma surrounding mental health services, e.g. feeling ashamed that people would be talking about you and also a sense of embarrassment and fear about the social and employment consequences for oneself and one's family. The remaining responses referred to: distrust of the	Given the reluctance of both younger respondents and men to contact the services, enhancing the possibilities for informal or peer support would appear to be critically important. While examining mental health attitudes and beliefs at the wider community level, the findings point to significant differences between socio-demographic groups which will need to be addressed in the planning of the intervention

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						services (4%), not recognizing the need for help and spontaneous remission (4%) such as believing that 'things would cure naturally'. Respondents of higher levels of education and those under 40 years of age were found to be more likely to report barriers to service take up, in particular the barrier of social stigma.	programmes. The more positive attitudes among women could also be reinforced in supporting the development of local programmes.
Ireland	Barry, KJ 2007	To explore what best practice in community mental health means to those engaged in its everyday experience.	The sample consisted of a consultant psychiatrist, a community psychiatric nurse, a therapist, a member of housekeeping staff and three service users.	Qualitative phenomenological study	A number of themes emerged as important and include the inherent value placed on consistent familial style relationships between service user and provider. This was deemed pivotal to the provision of expertise, good clinical decisionmaking, choice and collaboration. The study also highlighted stakeholder preference for		In deconstructing the meaning of best practice, the study prompts a closer consideration of how best practice is created and suggests a view of best practice as a fluid dialogic process that is co-constructed by its participants in ongoing dialogic communication and

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					<p>autonomy and openness to inquiry into developing practice.</p> <p>Three categories encompass the findings on the meaning of best practice in mental health:</p> <ul style="list-style-type: none"> relationship and expertise; information and choice; •co-constructed practice and responsibility. 		<p>reflection.</p> <p>The meaning of best practice for people living through its everyday routines, structures and codes of governance, etc. should receive ongoing and reflective attention if real user and stakeholder opinion is to become part of the co-construction of quality mental health systems and responses.</p> <p>The lived experience of stakeholders should gain recognition as 'expertise' moving away from the notion of the 'all knowing' professional. This will require a more inquisitive approach on the workings of everyday practice</p>

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							<p>and reflection on what is working well and what might be improved in local settings.</p> <p>Best practice should be considered a pattern rather than an entity, and formed through the actions and meanings of all stakeholders.</p> <p>Best practice in mental health must never be exclusive of evidence-based practice as we are unlikely to wish to regress to unexamined effectiveness of interventions but we must broaden the frame of its discourse so that practices can be considered and developed through regular inquiry at practice sites and with anyone involved in its construction.</p>

NEPAL

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
Nepal	Clarke, K 2014	To explore how distressed mothers interact with their families and the wider community.	Mothers - Participants were identified during a cluster-randomised controlled trial in which mothers were screened for psychological distress using the 12-item General Health Questionnaire (GHQ-12).	Qualitative study	Distress was termed tension by participants and mainly described in terms of physical symptoms. Key perceived causes of distress were poor health, lack of sons, and fertility problems. Tension developed in a context of limited autonomy for women and perceived duty towards the family. Distressed mothers discussed several strategies to alleviate tension, including seeking treatment for perceived physical health problems and tension from doctors or dhimmis, having repeated pregnancies until a son was delivered, manipulating social circumstances in the household, and deciding to accept their fate. Their		Cultural sensitive screening tools incorporating physical symptoms of tension should be envisaged, along with interventions to address gender inequity, support marital relationships, and improve access to perinatal healthcare.

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					ability to implement these strategies depended on whether they were able to negotiate with their in-laws or husbands for resources.		

NIGERIA

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
Nigeria (Niger Delta region)	Jack-Ide et al (2013)	Explore barriers that prevent people from utilizing mental health services. Identify key factors to increase access and improve service delivery	20 service users (10 caregivers, 10 clients) attending outpatient clinic of neuropsychiatric hospital. Been accessing service for at least one year.	Qualitative study	Themes emerging for barriers to mental health services were: Physical Financial Cultural	Physical: Poor knowledge of mental health service, centralised mental health service, waiting time. Financial: Travel distance/transportation probs, cost of service, loss of productive income Cultural: Stigma and discrimination, feelings of shame	Extensive efforts required to overcome ignorance and discrimination to reduce stigma. Provide mental health services throughout health care system so can be accessed locally and affordably.
Nigeria	Omigbodun, 2001	To review the existing model and training for PHC workers in 2 local government areas	Two local government areas in Nigeria and an review and analysis of the provision of Mental Health	Not mentioned specifically but utilised interviews and forms of content analysis of the syllabus of the programs and direct observation	Provision of training in mental health heavily subsidised by the government and each person has around 80 hours instruction	Needs continuous supervision from mental health professionals are there are large numbers of patients Does not require	Important to equip every health worker to provide holistic care for mental health and that will require ongoing supervision

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			services within PHC was carried out			technology but training of all PHC staff	

UK

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UK	Bee, PE 2010	To explores users' acceptance of T-CBT	<u>Study 1</u> : Demographically representative sample of 15 interviewees reporting severe and long standing mental health difficulties greater than 2 hr duration. Self defined mental health difficulties included anxiety, depression, agoraphobia and panic. 76% females, 86% white British, aged 22- 66 years <u>Study 2</u> : 15 employees absent from work for mental health	Two qualitative evaluations of T-CBT: <u>Study 1</u> was a qualitative service evaluation commissioned by a voluntary UK-based organisation (AnxietyUK). <u>Study 2</u> was a nested qualitative process evaluation undertaken as part of a larger RCT	User satisfaction with T-CBT was mixed. However, the relative ease with which most participants adapted to telephone-based care was suggestive of a shared construct of mental health service provision that prioritised the accessibility and availability of services over the social, professional and medico-legal perspectives that conventionally promote the co-location of practitioner and client.	Some participants found a lack of visual information to be a barrier to establishing a therapeutic relationship. Participants from both samples described an initial lack of knowledge surrounding the nature of the telephone-based intervention, and in doing so intimated a level of discord between their expectations and more deeply engrained constructs of conventional therapeutic exchange. The medical, social and institutional norms that governed the way in which they conceptualised the practitioner-patient encounter meant that they perceived the remoteness of telephone care as being	

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			problems and on a 8-10 days sick leave as authorised by GP certificate. Self defined mental health difficulties included mild-moderate depression and anxiety. 52% female, 97% white British, aged 22- 60 years			capable of delivering little more than a supportive educational intervention. Yet, with the exception of the group noted earlier, this misapprehension was soon resolved.	
UK	Wane, 2007	Establishing whether an assertive outreach team model is effective in reducing hospital bed usage and improving engagement with services and social functioning	Mixed urban and rural area in the UK n= 42 Between February 2004 – July 2005	Prospective within subject control design, comparing data from a cohort of 42 for 2 years prior to implementation and 1 year after implementation Occupied bed days Engagement measure (Hall 2001) Functional assessment of care environments (Clifford 2000)	Possible to implement assertive outreach service with high fidelity to a model Reduction in hospital admissions and occupied bed days Improvements in engagement and some health and social functioning AOT model may promote greater engagement and more collaborative relationships Ability to manage higher level of risk in the community – leading to	Proposed that the quality of relationships between workers and more opportunities for openness are highly valued by patients wasn't tested here Functioning not tested in detail – however an statistically significant improvement in social circumstances	Feasibility of implementing an AOT in rural UK setting for people with serious psychotic disorders is possible

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					better knowledge of patient and family Shorter stays in hospital may be about ongoing engagement with team even when the person is in hospital		

USA

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USA	Adler, Geri 2014	To improve access to telepsychotherapy at community clinics and identify facilitators and barriers to its implementation.	Three medical centers participated to provide services to six clinics. 12 therapist participated	Pre and post test cohort The project used a FOCUS-PDSA model, a quality-improvement framework used by many healthcare organizations, to plan and evaluate interventions. Pre and post training questionnaires were used	Therapists were asked about their knowledge, confidence, and motivation regarding TMH (TeleMental Health). Adopters were more motivated than nonadopters to begin TMH. Training increased knowledge for both adopters and nonadopters. At project completion, adopters reported “excellent” knowledge of TMH, whereas nonadopters reported “good” knowledge. Similarly, those with hands-on experience conducting telepsychotherapy reported “excellent” confidence; nonadopters reported “good” confidence. Overall, adopters had	Clinical leaders had not acknowledged telepsychotherapy as a priority. It appeared some had not considered therapist characteristics that might best fit with telepsychotherapy, despite investigators stressing this. Some therapists reported little interest in conducting telepsychotherapy, and many were unprepared for the effort necessary. Slow credentialing processes whereby licensed therapists were unable to provide direct care independently until their training had been verified and delays in equipment installation. At one site, work orders were lost and had to be resubmitted several times before installation could occur. At another, telehealth equipment was mislabeled and lost for months. At some	The paper recommends formalized decision making with clinical leaders regarding project goals, better matching of therapists with this modality, and assessing medical center and clinic readiness. Paper also suggests identifying more therapists per site to account for attrition and increasing frequency of communication with clinical leaders. Identifying and using TMH champions, as recommended by Gagnon et al., ⁹ could also facilitate adoption.

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					more positive views of the modality from the beginning and did not worry about staffing, a concern of nonadopters, Adopters noted that "[TMH] is not as difficult or as disruptive as I thought it was going to be" and "...have been surprised how well Veterans have seemed to accept the telehealth approach."	clinics, placement of equipment limited its usability or accessibility: one had the system in a room that was not soundproof.	
USA	Alang, Sirri M 2015	To assess associations between sociodemographic characteristics and perceived causes of unmet needs for mental health care. The five dependent variables are: cost, stigma, minimization, low perceived treatment effectiveness, and structural barriers.	A sample of 2,564 adults (18 years and older) with unmet mental health need was obtained from the National Survey on Drug Use and Health.	Cross sectional study	More females than males, and a greater proportion of persons in small or large metropolitan areas compared with rural areas reported perceived unmet need. Almost one-quarter of persons with unmet need rated their physical health as fair or poor, and another quarter met criteria for alcohol or drug abuse or		In the current study, insured persons were significantly more likely to report higher rates of stigma, minimization, and structural barriers to treatment. Therefore, access through insurance coverage alone is unlikely to resolve the problem of unmet mental health need. The ACAs provision of

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					<p>dependence. About half of the sample received at least some professional mental health within the past year, and 30% received alternative forms of mental health care such as care from an herbalist, a spiritual leader, or participating in peer support groups. About 26% of persons with unmet need were uninsured.</p> <p>Cost/Affordability: The “all others” race/ethnic category consisting of Asians, AIANs, and persons who reported multiple or other races were less likely than Whites to report cost-related barriers to mental health care</p> <p>Stigma: Compared with non-Hispanic Whites, both Blacks and Hispanics had significantly greater odds of reporting stigma as a reason for perceived unmet need for mental</p>		<p>creating health homes to coordinate and integrate patient-centered care for people with chronic conditions including disability—persons with increased risk for mental health problems, will also reduce information and other structural barriers to mental health services. Several models are being tested to integrate behavioural health in primary care (Bao, Casalino, & Pincus, 2013). For example, because most patients interact with the health care system in the context of primary care, some primary care practices may operate as patient-centered medical homes for persons with mild to moderate behavioral health problems (Casalino et al., 2010).</p>

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					<p>health care.</p> <p>Minimization: Persons 35 and older had significantly lower odds of thinking that they can handle mental health problems by themselves, compared with their younger counterparts between 18 and 25 years old.</p> <p>Low Perceived Effectiveness: Higher education was surprisingly associated with low perceived effectiveness of mental health services. Persons with a college degree or higher had greater odds of reporting low perceived treatment effectiveness than respondents with no high school education. The odds of low perceived treatment effectiveness were much lower among</p>		<p>This model has the potential of linking persons who already receive services for other medical conditions to behavioural health care, and therefore, reduce stigma and information barriers to mental health care common among race and ethnic minority populations. More long-term integrative models of health homes will provide a continuum of care for persons with the most debilitating disorders (Casalino et al., 2010; Mechanic, 2014). If these models are adopted across the country, outcomes might include increased and sustained utilization of mental health services,</p>

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					<p>respondents with substance use problems but slightly higher with increasing distress scores.</p> <p>Structural Barriers: Blacks were significantly more likely than Whites to indicate lack of time, transportation problems, and lack of information about where to seek mental health services as reasons for unmet need</p>		<p>mental health literacy within certain populations, and ultimately lower rates of unmet need.</p> <p>Psychiatric rehabilitation practitioners can develop stronger partnerships with primary care providers to form clinician cartels that will coordinate and facilitate the delivery of both medical and mental health services among populations that experience structural barriers to mental health care.</p> <p>More needs to be done health homes will provide a continuum of care for persons with the most debilitating disorders (Casalino et al., 2010; Mechanic, 2014). If these models are adopted across the country, outcomes might include increased and</p>

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
							sustained utilization of mental health services, mental health literacy within certain populations, and ultimately lower rates of unmet need. Psychiatric rehabilitation practitioners can develop stronger partnerships with primary care providers to form clinician cartels that will coordinate and facilitate the delivery of both medical and mental health services among populations that experience structural barriers to mental health care. More needs to be done effectiveness, and benefits of psychiatric care at the clinical encounter. Educating patients and their

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							families can reduce stigma and increase mental health literacy among patients, their care-givers, and the general population.
USA	Anderson, Chad 2013	To investigate the potential value of iPad tablets for enhancing health services delivery by primary care physicians in rural Nevada.	Five physicians from rural Nevada were selected to receive iPads and funding for apps that would enhance their medical practices.	Case study	Use and perceived usefulness of the iPad was mixed but generally positive with some physicians utilizing it much more than others. The iPads were primarily used by the physicians to access medical information through online resources (e.g. Epocrates and UpToDate) for reference and diagnostic purposes, although they were also used for some interaction with patients. All felt that resources available through the iPad were limited and that better applications would improve the usefulness of the iPad, particularly in regard to graphical and video content suitable to sharing with	Security concerns. Another issue evidenced in the data is the need for dedicated applications on a tablet computer like the iPad. Tablets have internet browsers but the physicians in this study often perceived them as less responsive and harder to use than a desktop browser with a mouse. Therefore, when accessing traditional websites most of the physicians reported they would opt to use their desktop rather than the iPad because of that ease of access issue. Using the iPad for interactions with patients was another key issue. The physicians in this study	iPad could fill a need between smartphones and desktops, which were the physicians' primary technology tools prior to receiving the iPad, but that useful medical applications and resources are currently limited for the iPad. In particular, better graphical and video content would improve the usefulness of the iPad as a tool for patient interactions. Apps that store content locally would serve to mitigate inconsistent internet access that is still common in rural settings, increasing the usefulness of the iPad in that context. Tablets like the iPad also have potential for

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					patients.	generally felt that using graphics and video to enhance patient education would improve the education process. But, while they liked the idea of using the iPad to share information with patients, in most cases the information they wanted to share was not available through the iPad in a format they wanted to use. Also notable is that the main difference between physicians reporting high scores for the TAM scales and those reporting low scores is the degree of organizational support for the device reported by physicians.	use in accessing the electronic medical record systems that are increasingly being implemented in rural hospitals and healthcare facilities.
USA	Anderson, RL 2005	To assess the extent of unmet service need for rural youth with mental health (MH) and/or substance use (SU) problems.	Adolescents (12–18 years) who had been discharged from community-based MH and/or SU treatment and who lived in a	Cohort	Two-thirds (64%) of adolescents with co-occurring disorders did not receive treatment consistent with widely supported guidelines	Barriers to coordinating treatment for individuals with co-occurring MH and SU disorders are a particular problem in rural areas. The data suggest that the provision of and access to	Efforts to improve care must focus on adolescent, familial, program, funding and policy factors that act as barriers to unifying

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			three-county region in southeast Iowa		recommending that individuals with co-occurring disorders receive treatment for both their MH and SU problems. Higher severity of depression, more supports, prior MH service utilization and lower prevalence of prior abuse predicted the receipt of dual services. Finally, adolescents with co-occurring problems who received only MH treatment showed improvement on MH needs at discharge but no improvement on SU needs. Similarly, adolescents with co-occurring problems who received only SU treatment showed improvement on SU needs but not on MH needs.	necessary services for adolescents with co-occurring MH and SU disorders and their families may be complicated by a number of factors. Generally, these findings may reflect the barriers experienced all too often in seeking MH and SU treatment. Many MH and SU services have historically been adult focused, and so the capacity to provide services for adolescents, the availability of specialized services for adolescents, and the resources committed to their treatment have been insufficient. These treatment barriers for adolescents with co-occurring disorders in rural areas are further complicated by the fact that rural programs have insufficient professional staff, especially child psychiatrists and certified alcohol and drug abuse counselors	philosophies and practices needed to advance appropriate care. Service use must be understood in the context of an adolescents' and their families' prior experiences and with consideration of other contingencies tapping the unique characteristics of a rural health delivery system. In a rural area, behavior may be influenced by many factors aside from treatment effects including information sources from which to understand illness and treatment, the acceptability of formal treatment modalities and the stigma of mental illness and substance use. Future research efforts with attention to understanding rural

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							adolescents' strengths and support networks may assist service providers in developing treatment options that are more acceptable by rural adolescent's and their families
USA	Bischoff, RJ 2014	To determine how to address the acceptability problem by learning from medical and mental health care providers what mental health therapists need to know to be successful in providing care in rural communities.	Medical and mental health care providers practicing in 3 rural Nebraska communities. The focus groups had a total of 17 participants which included four males and 13 females. All participants were Caucasian who ranged in age from 24 to 55.	Qualitative design with focus groups conducted in three rural communities	In addition to sound clinical skill, mental health therapists should (A) be sensitive to the culture of the rural community in which they are working and (B) practice in a way that accommodates to the care culture of the community. The latter includes spending time with patients commensurate with what is expected by other providers, engaging in generalist practice, and collaborating with local providers in patient care. three prominent themes		Mental health care must be acceptable to both the residents of the community and the gatekeepers to health care. Participants cautioned that the traditional models of care provision that students, interns, and residents are trained in are based on urban practices and do not always work in rural communities. Participants agreed on three standard-of-care practices that reflect the care culture in rural communities: spending

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					emerged, each fitting within the attitudinal domain of cultural sensitivity. The discussion of culture, in one form or another, dominated the discussion in each focus group suggesting that participants see cultural sensitivity as the most important ingredient to successful rural practice.		time with patients, being a generalist in practice, and a willingness to collaborate with other providers within and across disciplinary lines. Mental health providers should be specially trained for work in rural communities so that appropriate accommodations can be made to any model of care to meet the unique needs of the community. Mental health providers practicing in rural communities would be wise to recognize that they have at least two clients with every case—the patient-client and the medical provider-client—and that both need to be considered in addressing the accessibility of care.

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USA	Brooks, E 2014	To describe the population demographics and health care utilization of rural female veteran patients enrolled in the Department of Veterans Affairs (VA).	(1) urban and rural and (2) urban and highly rural women veterans.	Using the National Patient Care Datasets (n = 327,785), the study ran adjusted regression analyses to examine service utilization between (1) urban and rural and (2) urban and highly rural women veterans.	Rural and highly rural women veterans were older and more likely to be married than their urban counterparts. Diagnostic rates were generally similar between groups for several mental health disorders, hypertension, and diabetes, with the exception of nonpost-traumatic stress anxiety that was significantly lower for highly rural women veterans. Rural and highly rural women veterans were less likely to present to the VA for women's specific care than urban women veterans; highly rural women veterans were less likely to present for mental health care compared to urban women veterans. Among the users of primary care, mental health,	Health generally worsens with age, we can expect that service needs might already be greater for rural women veterans. Transportation to and from distant medical appointments is likely to increase among older veterans, creating further health care barriers.	Improved service options for women's specific care and mental health visits may help rural women veterans' access care. Telehealth technologies and increased outreach, perhaps peer-based, should be considered. Other recommendations for VA policy and planning include increasing caregiver support options, providing consistency for mental health services, and revising medical encounter coding procedures. 3. Rural patients are likely to have dual relationships with local treatment providers, it is important to consider the negative impact that privacy and

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					women's specific, and all outpatient services, patients' annual utilization rates were similar.		confidentiality concerns may have on mental health visits. The implementation of telemental health programs with a distant provider can reduce these concerns.
USA	Burnam, M. 2001	To report the use of mental health and substance abuse treatment services in the first national probability survey of adults receiving ongoing medical care for HIV infection.	<ul style="list-style-type: none"> The study used a multistage design in which geographic areas, medical providers, and patients were sampled. The study enrolled 57 of 58 urban known providers and replaced the 1 nonparticipating institution with a similar institution in the same city. The study also enrolled 61 (70%) of 87 urban other providers, 22 (79%) of 28 rural known providers, and 19 (83%) of 23 rural other providers. Among 	<ul style="list-style-type: none"> Multistage study design Data are from the HIV Cost and Services Utilization Study, a longitudinal study of a nationally representative sample of HIV-infected adults receiving medical care in the contiguous United States in 1996. At the first stage, 28 metropolitan statistical areas and 24 clusters of rural counties were sampled, with probabilities based on the number of reported acquired immunodeficiency syndrome cases during 1995. In the second stage, 58 urban and 28 rural "known providers" were sampled from lists of all 	61.4% of 231400 adults under care for HIV used mental health or substance abuse services: 1.8% had hospitalizations, 3.4% received residential substance abuse treatment, 26.0% made individual mental health specialty visits, 15.2% had group mental health treatment, 40.3% discussed emotional problems with medical providers, 29.6% took psychotherapeutic medications, 5.6% received outpatient substance abuse treatment, and 12.4% participated in substance abuse self-help groups. Socioeconomic factors commonly associated	The article suggests that those with HIV account for a little less than 1% of inpatient and residential admissions and around 2% of ambulatory admissions, which are non trivial percentages. This raises important questions about <ul style="list-style-type: none"> how well specialty providers are prepared for and are appropriately treating these patients with complex medical and mental health needs. It is not clear, for example, the extent to which specialty Alcohol, Drug and Mental Health providers (ADM) providers are aware of their patients' HIV status and consider the special issues facing persons with HIV. Nor do authors know whether ADM care is 	As a whole, our findings suggest important variations in access to specific types of care as a function of socioeconomic, HIV clinical severity, and regional factors. Inequalities in access to mental health services urge increased attention to improving outreach and services for lower socioeconomic status and minority HIV-infected populations and for those in regions that are relatively underserved, such as the South. Inequalities in access to substance abuse care can be understood in the context of a distinctive

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			selected patients, 2864 (71%) completed the full interview at baseline. This baseline sample provides a 68% coverage rate of the population that would have been directly represented if there were no refusals at any stage.	providers known by local informants to provide HIV care. An additional 87 urban and 23 rural “other providers” were selected from among providers who reported caring for patients with HIV in a screening survey of approximately 4000 physicians randomly selected from the Physician Masterfile of the American Medical Association, Chicago, Ill. At the third stage, 4042 patients were sampled from anonymous lists of all eligible patients who visited participating providers during the population definition period (January 5, 1996, to February 29, 1996, in all but 1 metropolitan statistical area, where it occurred about 2 months later). Third-stage	with poorer access to health services predicted lower likelihood of using mental health outpatient care, but greater likelihood of receiving substance abuse treatment services. Those with less severe HIV illness were less likely to access services. Persons living in the Northeast were more likely to receive services.	routinely coordinated with general medical care for this population, or whether counselling to help these patients deal with barriers to and difficulties in complying with complicated HIV medication regimens is commonly provided by ADM specialists. Although substantially more ADM care is provided by specialty providers, our findings suggest that general medical providers also provide extensive ADM-related care to this population: about 40% of the population discussed emotional or personal problems with their general medical providers and generally did so just a little less than once a month. Previous research has suggested that general medical providers are less likely to deliver appropriate levels of care to patients	public substance abuse treatment system that is more responsive to disadvantaged populations, that provides better access to HIV populations in the Northeast relative to other parts of the country, but that may not attract or easily accommodate higher socioeconomic status populations or those whose HIV infection is more advanced.

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				sampling rates were set to be as uniform as possible within subgroups ▪This overall sampling rate was then doubled for women and increased again for those in staff model health maintenance organizations (in which clinical providers are employed directly by the health maintenance organization)		with depression than are mental health specialists, but some patients may find it more comfortable to talk with their physicians about such issues. Physicians treating many patients with HIV may have a particularly high burden of responsibility for providing ADM care, and thus it is important to evaluate needs that these providers may have for improving the quality of this care (eg, through training or better linkages with specialty providers).	
USA	Colon-Gonzalez, MC. 2013	To explore the attitudes and practices of Primary Care Providers (PCPs) regarding the care of mood and anxiety disorders in rural women.	Family physicians, internists, and obstetrician-gynaecologists (OBGYNs) in office-based practices in rural central Pennsylvania	Qualitative study	PCP responses reflected these themes: PCPs identify mental illnesses through several mechanisms including routine screening, indicator-based assessment, and self-identification by the patient Rural culture and social ecology are significant barriers to women in need of mental healthcare Mental healthcare	Social stigma is a significant obstacle to seeking mental healthcare in rural communities.	Providing mental healthcare in PCPs' offices, rather than in mental health specialty sites, as suggested by some of the PCPs in the study, offers a partial solution to social stigma issue. Community programs to reduce the stigma of mental illnesses in rural communities may promote healthcare seeking and receptiveness to

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					resource limitations in rural communities lead PCPs to seek creative solutions to care for rural women with mental illnesses To improve mental healthcare in rural communities, both social norms and resource limitations must be addressed		treatment. Promoting generalist education in mental healthcare, and expanding access to consultative networks. PCPs serving rural populations should be encouraged to increase identification of mental health disorders among their female patients. Better guidelines for screening of anxiety disorders and assessment of trauma history are needed
USA	Farmer, 2003	To examine points of entry into the mental health service system for children and adolescents as well as patterns of movement through five service sectors: specialty mental health services, education, general medicine, juvenile justice, and child welfare	1,420 youths who were nine, 11, or 13 years old at study entry.	A longitudinal epidemiologic study of mental health problems and service use among youths. Each youth and a parent were interviewed at baseline and every year thereafter about the use of services for mental health problems over the three-year study period (The data were	Population estimates indicated that 54 percent of youths have used mental health services at some time during their lives. The education sector was the most common point of entry and provider of services across all age groups. The specialty mental		These results also suggest that the current emphasis of systems of care for youths with serious emotional disturbance may be too narrowly focused. Although youths with serious emotional disturbance tend to show more

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				from the Great Smoky Mountains Study)	health sector was the second most common point of entry for youths up to age 13 years, and juvenile justice was the second most common point of entry for youths between the ages of 14 and 16. Youths who entered the mental health system through the specialty mental health sector were the most likely to subsequently receive services from other sectors, and those who entered through the education sector were the least likely to do so		complicated and extended patterns of service use and to use services in more sectors, it is clear that these are not the only youths with such patterns of service use. It seems to be crucial to facilitate linkages between service sectors. In particular because the education sector serves as the initial point of entry for a majority of youths with problems, it is crucial that appropriate linkages be made between the education system and other sectors.
USA	Farrell, 2009a	To develop a computer-based electronic screening tool (eScreening) and determine the feasibility of implementing eScreening for rural users of primary care. Specific aims were to (1) explore the perceptions of consumers and	Patients served by University Medical Associates (UMA), a general internal medicine clinic at the University of Virginia (UVA) Primary Care Clinic, residing in	Mixed method Face to face interviews and online questionnaire: The two major instruments used in this study were the Patient Health Questionnaire-9 and the alcohol-use screening instrument (CAGE)	PHQ-9 The PHQ-9 total scores revealed that seven participants (35%) had no depressive symptoms; 25% had mild depression, 20% moderate depression, 10% moderately-severe depression,	Phase III revealed some problems with the physical implementation. The mobile cart with the eScreening system was feasible, but cumbersome to move among the examination rooms. The ideal eScreening system in a primary care clinic would not	Electronic screening instrument holds potential to be an efficient, accurate means of mental health case finding for nurses working in rural primary care clinics. eScreening in primary care can be completed

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		providers concerning the intervention of eScreening (Phase I), (2) test a newly-developed eScreen tool (Phase II), and (3) explore consumers' responses to implementation of the eScreening (Phase III). <u>This paper reports on Phase III: results of consumer responses to eScreening for mental health in rural primary care.</u>	rural area		and 0% severe depression (Figure 1). Out of 20 patients in this pilot study, four patients (20%) were identified as requiring more in-depth assessment and medical follow-up. • <u>CAGE</u> Of the five participants between the ages of 45 to 49 years, 60% of them reported using alcohol. Drinking patterns for the sample are as follows: 50% reported no alcohol use, 35% reported drinking one day a week, 10% two to three days a week, and one participant reported drinking alcohol six or seven days a week. Twenty-five percent of the sample reported drinking 1 drink a day on days they drank, 15% consumed two to three	have its own printer but instead be connected to a remote printer or interface with an existing automated patient documentation system.	while waiting to be seen by the provider, the anticipated costs would be minimal, requiring only the time to bring up the eScreen on a computer and the time to review the eScreen results on the computer screen or printed page.

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					<p>drinks a day, and one participant reported four to five drinks a day. The one participant who reported eight or more drinks a day was in the 25-44 age group.</p> <p>•PHQ9 plus CAGE Those who did not use alcohol reported less depression symptoms than those who did use alcohol, although the difference in mean scores was not statistically significant ($p = 0.100$). Those reporting use of alcohol had higher scores on functional status indicating more self-reported functioning problems on a daily basis due to the depressive symptoms reported in the PHQ-9.</p> <p>•Functioning Those who scored higher on the depression scale also reported greater difficulty with functional status on a daily basis. Of the four</p>		

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					<p>participants who required more in-depth assessment, two (50%) also reported “extremely-difficult” problems related to functioning and the other two (50%) reported “somewhat-difficult” problems. Seventy-five percent of those scoring in the moderate depression range reported “somewhat-difficult” problems. Less difficulty was reported with mild and moderate depression.</p> <p>•eSEIF Responses to the questions on the eSEIF indicated 80% of the participants agreed or strongly agreed that the information was accurate, 90% found the eScreening easy to use. Eighty-five percent</p>		

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
					agreed or strongly agreed that the eScreening was useful, and no one reported concerns regarding privacy. Qualitative data collected in the eSEIF indicated that the audio component of the eScreen was acceptable to some users and not to others.		
USA	Fortney 2000	To compare alternative measures of geographic access to health care providers using different levels of spatial aggregation (county, zipcode and street) and different methods of calculating the cost of space (Euclidean distance, road distance and travel time).	Community-based sample of rural (74%) and urban (26%) Arkansans ($n^{\wedge} = 435$) and all medical providers ($n^{\wedge} = 3,419$) and mental health specialists ($n^{\wedge} = 1,034$) practicing in the state of Arkansas in 1993	Cross sectional	Regression results demonstrated that the most commonly used county-based measures of geographic access (e.g., MSA designation and providers per capita) explained $3\% \pm 10\%$ of the variation in accessibility and $34\% \pm 70\%$ of the variation in availability. Results indicate that Geographic Information Systems can be used to accurately measure geographic access to health services in a cost effective manner.		The research presented here focused on the measurement accuracy of geographic dimensions of access. These methods can be applied directly in both fee-for-service and managed care environments. In managed care environments, it will be necessary to obtain a list of contracted providers in order to identify the appropriate subset of licensed providers to which enrollees have access. Lists of

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
							contracting providers can be easily obtained from managed care organizations.
USA (South Carolina)	Grossman et al. (2007)	To describe the clinical experience for graduate students who shaped the role of advanced psychiatric mental health nurses in rural settings Placement of psych nurse graduates into rural school based clinics to provide mental health service to youth within schools (due to lack of mh services, understaffed community mh centres and inability of current services to adequately address troubled school age children)	Three rural school based clinics - approx. 35 miles from urban area, townships below poverty level, shortage area for primary care and mental health 4 supervised Psych mental health nurse practitioners (PMHNP) and 3 undergrad nursing students	Weekly seminar with faculty and other PMHNP students to discuss evidence based practices and facilitate critical thinking and application of seminar Supervisors respond to specific mental health needs that arise with schools Faculty collaborated with school and students to plan and deliver an evening family skills building. The PMHNP students diagnosed and managed the mental health symptoms and disorders within the school based clinics PMHNP and nurse practitioners provided psychoeducation and	School based mental health services include a range of services and interventions that demonstrate strong evidence of impact for many emotional and behavioural problems, however, not all school-based mental health services have reached the level of evidence-based practice. The PMHNP provided clinical and functional outcomes in youth participating in these groups Access was enhanced by collaborative efforts between school based clinics and psychiatric mental health nursing		Experts in youth evidence-based mental health services recommend that they practices be deployed in schools as one strategy to address barriers in access and utilisation Psych mental health grad nursing students are often trained in evidence based mental health practices and can be part of addressing the shortage of rural youth mental health clinicians. School-based health clinics provide an opportunity to build capacity to deliver mental health services to youth in schools. Develo a Psychiatric

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
				consultation to school staff, participated in multidisciplinary staffings, referred youth to outside services			Mental Health Nurse Practitioner (PMHNP) in school based clinics.
USA	Grubaugh et al. (2008)	To examine attitudes towards medical and mental health care delivered via telehealth applications To examine attitudes among a sub-sample of patients with PTSD	194 Adult rural and urban primary care patients (58.8% or n=112 rural, 41.25% or n=78 urban)	Cross sectional – survey and questionnaires: demographic survey, Stressful Life Events Screening Questionnaire-Modified, Posttraumatic Stress Disorder Symptom Scale-Self report questionnaire, Telehealth Attitudes Questionnaire	Both rural and urban patients were receptive to receiving medical and psychiatric services via telehealth Few meaningful differences across variables between urban and rural patients No group diffs in concerns about telepsychiatry Rural group were significantly more likely to have a home computer than urban group but not gp diffs in availability to internet access Within both groups, younger patients were more likely to be more positive towards telepsychiatry than older patients (only sig diff in urban group). Higher education was positively correlated with	A small % of sample believed that the info tech would be too sophisticated, that telehealth would not help their problems and/or were concerned about what others would think. More than half the rural and half of the urban patients expected that telepsychiatry would not be as helpful as face to face intervention	Majority of rural patients had a home computer making it potentially possible for them to access telehealth. Almost half of the participants indicated that they would be likely to use telepsychiatry if it would save them a 2-hr drive While some predicted that telehealth may not be useful for them, they indicated that they would be willing to try it if it would improve their access to needed mental health services they might otherwise not receive.

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
					telepsychiatry attitudes. No meaningful difference by PTSD status.		
USA (eastern and southwest Washington)	Hilt et al (2013)	To evaluate a phone-based child mental health consult service (Partnership Access Line (PAL) program) for primary care providers PAL allows the primary care provider to call a number to connect with available child and adolescent psychiatrist who provide an immediate psychiatric consultation regarding the primary care provider's patient(s). Televideo was used if a more detailed consultation was required. This was designed as some primary care providers are not comfortable with their knowledge in mental health etc. (often	2285 PAL consultations by 592 (362 from 22 targeted rural counties) primary care providers.	Record review, provider surveys, Medicaid database analysis.	69% calls were about children with serious emotional disturbances and 66% about children taking psychiatric medications Primary care providers nearly always received new psychosocial treatment advice (87% of calls) and more likely to receive advice to start rather than stop a medication Primary care providers feedback was uniformly positive about the PAL program Children with a history of foster care experienced a 132% increase in outpatient mental health visits after the PAL call. Thus an increase in use of outpatient mental health care was observed	This study is in attempt to help address the barrier of primary care provider knowledge (or lack of knowledge) of mental health – thus referrals/prescribed medication etc.	This program has real-world implementation potential for mental health consult services for primary care.

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
		mentioned as a barrier – GP knowledge)					
USA Rural areas in Massachusetts and Virginia	Iezzoni et al. (2006)	To learn about the health care experiences of rural residents with disabilities	35 adults with sensory, physical or psychiatric disabilities	Focus groups	Key issues being raised by participant groups: Finding Caring and Competent Physicians Continuing need for specialists and sophisticated services. Poverty and Heavy reliance on Medicaid (insurance) Physical access to health care settings Barriers to local and long distance travel Need for advocacy and information resources	Difficulty finding physicians who understand their disabilities. Feeling that they must teach local drs about their underlying conditions. Would rather continuity with their dr to avoid this. Limited choices in drs in rural and often rotate as they are foreign / graduate / rotating drs. Most need ongoing specialty care thus need to travel periodically to large medical centres to get this as rural drs reach limit with their care. This is made more difficult for some by their inability to drive due to disability or public transport being inaccessible and unreliable. Many are poor or uninsured or limited to drs available to them on Medicaid coverage which complicates searches for willing primary care physicians Physician offices sometimes located in old buildings not equip with accessible	Meeting health care needs of rural residents with disabilities will require interventions beyond health care, involving transportation and access issues more broadly.

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
						<p>entrances or equipment Lack of reliable accessible transportation, both for reaching local and long distance health care facilities.</p> <p>Rural areas generally less sensitive to disability access issues than urban areas.</p> <p>Must find own health information as local providers have limited knowledge of disability.</p> <p>Other impediments for this is: can't afford computer to look up on internet, low education makes it difficult to understand information they do get. Some accessed local independent living centre which helped find services required, however many were unaware that such a centre existed in their town</p>	
USA	Menke, 2009	Examining the relationship between depression, mental health treatment in	3 primary care settings n=1103	Surveys measuring depression, stigma and treatment use Link stigma scale	African americans (AA) patients reported greater mental health stigma AA women greater	Both measures of stigma were self reports No control for socioeconomic status except	Significant relationships were found around gender, race and stigma

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
		African American and white primary care patients		secrecy subscale and devaluation and discrimination subscale CeS- D Hamilton rating scale	stigma than W women W patients more likely to use depression services than AA patients Greater depression severity higher stigma scores	educational attainment Did not includes uninsured patients	White patients more likely to use depression services than African American patients Greater depression symptoms may override stigma Greater stigma, especially devaluation and discrimination may lead to greater depression
USA	Neufeld, 2012	Evaluated a telemedicine	N = 138	Four component model that included access, quality, outcomes and costs Retrospective data collection from electronic medical record	Rapid initial acces Shorter wait times – half as long Younger patient profile – 5 years younger than other patients Service efficiency greater – 33 36% greater productivity	No ethics? Not a research study?	Combination of telemedicine and open scheduling produced greater service efficiency Nurse practitioners and psychiatrist
USA	Pomerantz 2008	To provide an example of implementation of a new program that enhances access to mental health care in primary care	New primary mental health care clinic	Evaluation methods	Paper reports evaluation of the model but the following principles of the clinic are useful Mental health providers should be part of the primary care team to assure easy access to assessment and treatment Care should be flexible to meet the needs of	The clinic was able to rearrange resources and move mental health care into the primary care setting and cut the waiting times for help from weeks to minutes.	Using a model of primary care to integrate mental health care. Patients can be seen by a range of specialists at the first port of call. Telephone and other methods are also used

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
					<p>providers and patients</p> <p>Access to care should be immediate with no scheduled appointments</p> <p>Most patients should be able to receive all of the mental health care they need without referral to more comprehensive care.</p> <p>Patients that used the clinic were satisfied with the services provided</p>		
USA (Texas)	Turlow, 2014	To better understand the physical and mental health status of rural residents receiving tele psychology services and compare them to the standard population on the HRQOL measures (SF-12).	Two samples 94 larger one completed the SF-12 and the PHQ-9 during their first tele psychology session and then compared to normal population. Smaller group (n=40) then were reassessed after 4 sessions to evaluate the effectiveness of	Evaluation study of patients utilising a tele psychology clinic. This included intake interview, assessments and video conferencing	Rural telepsychology patients had a lower physical health status than a representative sample of US citizens however their physical health status was similar to that of a national sample of depressed people. The health related quality of life for those attending for telepsychology was poor and their mental health status was 2 standard deviations below the	Need to have in place technology and expertise and there were limitations due to the brief nature of the intervention (4 sessions).	Telepsychology was effective in improving mental health status of clients who attended 4 sessions of therapy and this adds to the evidence that these types of services may overcome barriers of distance

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
			tele psychology		national average		
USA	Willging, C. 2006	How ethnically diverse lesbian, gay, bisexual and transgender(LTGB) people in rural areas of New Mexico access secular and sacred mental health care resources	N = 38	Part of a larger ethnographic study of help seeking behaviour among secular and gender minority groups in New Mexico. In depth semistructured interviews used to document help seeking processes Network episode model (NEM)	Referrals to to LGBT affirmative care relied on word of mouth social networks Distrust of professional options available – fear of negative response to LGBT people Inappropriate care and discontinuation of services Resolution of mental health and substance abuse problems was a matter of personal responsibility Families managed care of person – people sought support in family networks Use of non biomedical belief systems for healing Pragmatic help seeking using religion, family and community Schism between community support systems and advocacy of LGBT – affirmative care	Utilisation of available community resources Lack of affirmative LGBT social networks and services, fear of anti LGBT bias, lay understandings of mental illness Lack of social networks which could protect participants against facing the effects of discrimination, stigma and violence Distance and economic insecurity	Cost Lack of appropriate LGBT affirming services Participants made pragmatic choices about silence around sexuality to access services
USA	Willging, C. 2006	Assessing the effects of Medicaid managed care	N = 160 interviews,	Ethnographic research methods 2 years	Privatising Medicaid and contracting for for profit	Service fragmentation – few alternatives, no case	Assessing the effects of Medicaid managed

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
		and the implications for future reform	participant observation at safety net institutions Clinicians, staff members, administrators, 40 = adult users of mental health services at sni's 2002 - 2004	Qualitative inquiry	organisations place additional responsibilities on disciplined providers and clients Managed care models might seriously compromise the rural mental health safety net unless serious gaps and limitations addressed. Themes Non participation Partnering Caring for the uninsured population Adjusting to managed care Ineffective solutions to communities long term needs Lack of establishment of high quality, community based continuum of care	management, no social work services- reliance on non mental health providers, transportation, lack of cultural and linguistic competency, Medicaid enrolment, stigma and immigration status	care and the implications for future reform
USA Montana	Wagnild, 2006	To learn more about psychiatrist satisfaction with tele p psychiatry.	11 psychiatrists using tele psychiatry	Qualitative approach utilising semi structured interviews with psychiatrists who were using it for frontier patients	The most common issue was that psychiatrists found it less personal and difficult to establish rapport which can be particularly problematic	A range of interpersonal, technical and barriers for those needing treatment	This model is useful as for many patients to access in person treatment can require 1-3 days travel. It however does improve

Country	First Author Year	Aim	Participants	Research Design	Major Findings	Major Barriers	Strategies Intervention Proposed
					when patient needs crisis intervention (eg: suicidal). There were also a range of technical barriers that related to quality of service (picture, audio and support)		accessibility and is acceptable and effective from the psychiatrists perspective

MENTAL HEALTH SERVICE
ACCESS IN RURAL AREAS
PROFESSOR AMANDA
KENNY
DR VIRGINIA DICKSON
SWIFT
DR CAROL MCKINSTRY
SUSAN KIDD
NATALIE PEARCE
CHRISTINE CUMMINS
DR JO SPONG
ANGELA MCGLASHAN
RAHILA CHRISTIAN

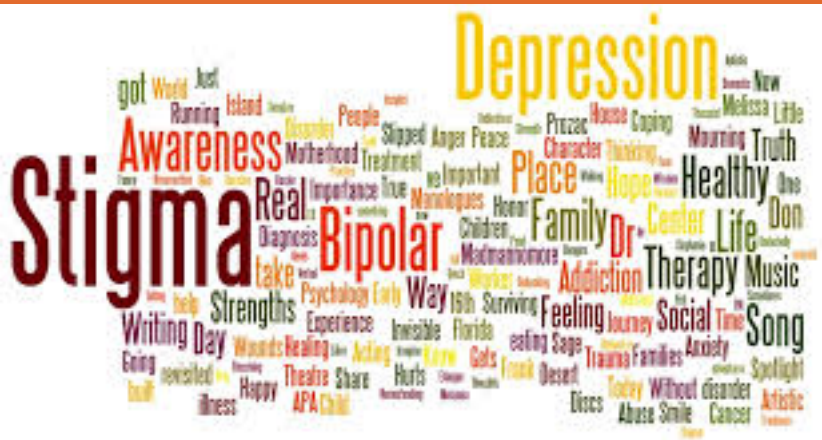


Image source:

<http://www.abc.net.au/radionational/programs/rnafternoons/rural-mental-health/6274578>

Research question : What is known about service access for mental health issues in rural and remote areas

Key terms

Access	Mental Health service	Rural
Use	Mental health care	Regional
Service provision	Mental health	Remote
Equity	Mental illness	
	Psychiatr*	

Inclusion criteria	Exclusion criteria
2000 – Current Original Research English Language	Letters, editorials, conference proceedings

CINAHL, PsychInfo, Embase, SCOPUS, AMED, MEDLINE

Three major areas of focus in the literature

Community focused barriers

Consumer focused barriers

Health professional/service barriers

Few strategies proposed to address barriers



Community focused barriers - Stigma

- gossip and social exclusion

- Community attitude to mental illness
huge impact (stoicism and attitude)
 - Personal and perceived stigma
(Mental illness only affects certain groups/people)
 - Self stigma (People depend on me and I am a failure/not successful if I stop to acknowledge there is a problem)
 - Structural stigma – culturally defined characteristics of certain groups (perceptions of masculinity, rural women etc)



Community focused barriers

- Limited mental health knowledge and understanding – mental health literacy
- Geographic location – distance from services
- Perceptions of being seen at a 'mental health service'
- Impact on employee/ employer relationships - ability to maintain long term employment
- Lack of knowledge of services provided and how and when to gain access
- Limited consumer involvement in health care design, delivery, evaluation



- Where services appear to be limited -community will look to self management and lose confidence in professional treatment

Barriers to service access – consumer focused

‘It is hard’

- Lack of transportation
- Limitations on access to child care
- Distance to services – taking time away from work/responsibilities even for short consultations
- Negative impacts on employee/ employer relationships - ability to maintain long term employment
- Lack of family and community support
- Lack of anonymity – concerns about confidentiality, dual relationships



Financial constraints

Health professional/service barriers

- Recruiting and retaining clinicians in rural and remote areas is always challenging and has an enormous impact on service delivery and confidence in the standard of care
- Lack of well connected inter-professional care (different to multidisciplinary)
- Regular delays in assessment, diagnosis and treatment
- Lack of interest in mental health/GPs not always interested/skilled



- [illegible]

Beyondblue.com.au

Try standing in my shoes - The issue of having a mental illness in a small rural community was highlighted and the stigma associated with it was an issue for mental health consumers, their carer's and families

So everybody knows what's going on and the fact that the police were there. I said I am ringing to let you know that [family member] is not well and this is what happened and she said ok; being SES she understood. I wanted you to hear the facts rather than gossip from everybody else who's hanging out their windows thinking my gosh, what's going on at that house

Well people still to this day, I have been here nine years still think my son's a monster, because he wanders up and down the street talking to himself.

Most people that don't, do not understand what it's like. It's the most, most, hideous bloody disease I've ever come across. I mean it, it affects you in different ways

But it's like if you can't see it, the community don't want to understand it. Right, you look like a normal person, so why are you acting so weird or, or just get over it.

This is going to sound really selfish, but if my daughter have of had cancer she would have been treated differently. I would have had someone holding my hand and all my neighbors around here would be making casseroles...We have the Royal Children's hospital appeal that raises millions and millions of dollars and doesn't it come back to a judgment thing? Mental health is not as sweet and cuddly as kids with cancer.

Yeh that's it you're, you're not really sick as such you know because there's that thought of, of mental health being sick is different to physical sick I suppose.

We got her into netball last year because with her medication. She's just got really big. And then of course the netball coach wasn't the most understanding, you don't want them to have special treatment but... She has just been put on Lithium at the start of last netball season. And of course she was just thirsty all of the time. And I said to the coach "You know she's just going to have to drink a lot" and she was going off the court drinking and the coach going "You're only getting out of doing exercise."

Well I think too you're isolating a whole group of the population. I think attitudes need to change as far as mental health

Yeh and like there she went off one day, she had run away and I eventually found her the next day in [a larger town] and when I found her she was that psychotic she belted me up.

And, and I mean what frustrates me the most is the Government say "We're going to do this for cancer and we're going to do that for breast cancer and we're going do that" and then they'll talk about that, but "Oh people with mental health, oh you ring up Beyond Blue"

Draft recommendations

- Stigma within rural communities must be directly addressed. This includes education of communities and addressing self stigma among people with mental illness
- Improving health literacy regarding mental health should be prioritised
- Whole of school/employer programs are needed to ensure mental health issues are understood
- What other recommendations should be included?



Creating a drama – Participants stated that the only way they could get help was in a crisis situation

No, it's not and it's got to be in a crisis situation ... to really get an appointment with CAMs or anything, you've basically got to get carted into the ED in the back of a paddy-wagon.

Well the next time that he was unwell, and he was very unwell, we rang the GP and the GP said no he couldn't see him, and eventually I had to ring for an ambulance which I did do, and of course the local police came.

It did mean that pretty much for most of her life she just sort of lived from crisis to crisis without you know being able to get help. Whereas, if perhaps if there had of been more, a more even distribution of help in that time, you might not get such bad like the crises.

The only time you're going to get any help is when there's a crisis and when the police have to be called or an ambulance, or something else?

So I spent like lots of days with her, trying to get her in somewhere and that, but this one particular day she was really, she was actually suicidal, and she herself had been ringing around, I don't really know everywhere she rang. But I tried Community Health. I think it was over in [place name removed], I tried [another town], I tried [another town], but we just didn't seem to be under any of those places services

Having her arrested basically ... so then I called the police.

And that's what makes me so angry because if there was better services at the start there wouldn't be such a backlog of people at the end, you know?

It would have taken a long time because the phone book is the most complex piece of paper you could ever come across when you are in a stressful situation and you are trying to find some sort of assistance and you open up the phone book and you thinking it's not sexual, it's not domestic, it's not, and you're going through all these things and you think I just want! So where do you go? You go to your local hospital to start with, so I think I would have pursued it but that's because of the person that I am. I have now set up this group and the support and I've got phone numbers and things on tap now that I have collected, she said where were you two years ago when I was in this situation?

Well yeh it is, it's really difficult that my GP here referred me to a Psychologist in Swan Hill, he wanted me to see a certain Psychologist in Swan Hill, she had a three, four month waiting list.

Draft recommendations

- A co-ordinated approach to mental health services is needed across the region with clear directions on how to access services
- Planning must occur to ensure early intervention to circumvent crisis situations
- What recommendation should be included?



Capability aligned with need -Enormous frustration was expressed about the knowledge and skill level of professionals that are encountered

Degree in this and a degree in that shit, you know what did you get it off the back of f... coco-pops? Like I said, some of these people, they wouldn't know the difference between goat shit and coco-pops if you put warm milk on them?

I don't I believe honestly that GPs should ever be allowed to prescribe psych medications. I reckon it's the biggest balls up ever.

We need nurses to understand more definitely. For younger people and you know, just the Adult Mental Health Service, there's a few services that are available, but they're pretty you know light on.

And then this Doctor rang me and said "She's just a very naughty girl's who's seeking attention."

I'm not highly educated or anything like that, but if you rock into ED in [larger town] with your suicidal daughter and you have got no education at all you're f.....

Yeh and the attitude of the paramedic was just atrocious. He said "Oh it's not an emergency, she's just mental health" that what his reaction was. I had taken an overdose for God's sake. He was like frustrated, frustrated to have to come out to a mental health patient well you know and he just kind of was joking about it and he said "Oh well, yeh mental health, it's not classed as emergency."

She walked in seen [daughter] for five minutes, changed all her medication ... And then sent her home but then had all of this drama, she was carted, she was sent home on the Wednesday she was in the back of the paddy-wagon by the Saturday. Doctor rang me up and said "I have to go to Parenting Classes. [daughter] needs discipline."

I guess that really showed how isolated we are when you know a welfare visit from the policeman is the only help that we can get

Beyond Blue, when you ring up and you're a, you're not, you are a carer and you're finding it hard to cope because you're not mentally ill yourself, piss off.

So when, when she was first diagnosed she was discharged from (regional centre), as an inpatient there and then the psychiatrist just said "Well take her home, there's no cure" you know? "Nothing that we can do" and so that was sort of basically what, what happened.

And without been unkind to the GP he, none of the GPs up here are trained to handle this.

...after my son had endeavoured to commit suicide we were sent home. And I was quite shocked, I was pleased that he was well enough to come home but shocked at the fact that because I had worked for [employer and role removed] knowing what services people receive for physical illness I was quite amazed that this person who tried to die was sent home.

Yeah she was sedated and whatever else and, and she was moved then straight to [psych service] the next day. Then I couldn't see her for, however long. You know about five hours or something. But I just found it really hard getting answers, like I went and saw her, nobody was willing to tell me anything.

No one could tell me sort of when a doctor was going to see her and one doctor was supposed to and never did. But there was no follow up and there was no counselling while they were in there, there was nothing. There was, they were just a number, but getting her in there was the hardest and then when we got out... Well that was harder. Well she literally got in the back of the car and she said "Mum I'm really scared" because, she said "I don't know what to do because I will use again, because I will be around you know come back and I will be around..." no support ... but she'd had no counselling and no rehab and no, she was scared, she was crying you know it was awful.

Even though I don't agree with it but I, I will do whatever you say just so I don't have to be here. Mum said "I do not want her here any longer" and dad said too and they said "We'll do everything we can from home and we'll take off work and we'll look after her and we will be her Carer and we will make sure she eats what you tell her to eat, but please don't keep her in here?"

Draft recommendations

- Professional development of all health professionals must be prioritised across the region
- Professional development should be extended to other professionals who encounter people with mental health disorders eg. police
- What recommendation should be included?



Seeking stability and connection - When services were accessed the lack of co-ordinated and consistent care was seen as a major issue

It could be John Smith this six weeks, in another six weeks it could be Tom Jones, who you know?

And then he was resigning from CAMs. They didn't know who was going to replace him, if there would be a regular service or would just catch what you can and it was just we needed more. And we needed to see someone weekly yeh.

She spent thirty eight weeks at the [major metropolitan service] Yeh I'd spend most weekends down there and at that stage [my son] wasn't home so there was still like we had to like keep the farm going.

Yeh, they need much better sort of case management and, and that sort of thing. Which I think you know the packages are, are really quite limited too, like the aged care packages are very limited and, and it's really, really quite difficult to, to get you know assistance, even you know some of the home care packages.

I said was there is no case workers there, there are case workers in Bendigo but there is none out in the regional areas and we have got to drive so far.

Like but that's another thing you know I've got these other appointments I have got to go to in Bendigo, like to access that service I have to go to Bendigo, to see a psychologist I waited four months to get into see her, so that's just what it's like living around here I guess?

So you know there was never even, even when she accessed services in later years there was never a continuity of care, so it might be just for a particular problem at the time.

On paper [shire] looks like it's very well serviced because we have, you know, a lot of organisations that say they provide services for residents, but we don't have any services that actually come into the place. Its all outreach

Well they told us as we were walking out, that basically there was no counselling while she was there, there was nothing. Nobody sort of told me what I was supposed to do with her once we walked out.

I mean like we are crying out for a Psychologist here

I couldn't get any answers, couldn't get anything, I couldn't even, half the time, find out what she was on and I'd be saying "Do they have counselling, like is she going to start seeing someone?" "No, no, no" and then she was just discharged.

There are kids in there that they're going to roll on from the adolescent system into the adult system into the justice system.

I think that historically that either the services haven't been available at all, or because of our distance and because we're on the edge of, of you know a lot of the regions and, and everything we just don't get the services here.

He, he's booked a month in advance at the moment, a GP is booked a month in advance and yeh I would say probably seventy percent of those are mental health. So they're not actually, they're mental health issues that he's dealing with, because obviously there's not the services around. I mean that that to me shows you?

Draft recommendations

- A planned approach to service delivery across the region should be prioritized including continuity of care
- The development of case management models for rural areas are needed
- The lack of discharge planning must be a priority for action
- What recommendation should be included?



Unseen and unimportant – Stories were consistently told about how family members were excluded from any care or their expertise was ignored:

That was at ten thirty in the morning, no-one come near me until quarter past seven that night I sat in the waiting room.

Actually one of the, it was horrific, I actually I threw a hissy fit and I thought “Oh my God if I don’t pull this together, I’m they’re going to lock me up.”

He said get an ambulance and that was the time we went down to [larger centre] and the ambulance was going to be 3 hours and we could drive her down in 2. So we gave her some Panadol, which was more a less just a bluff. She had had a bit of a headache, and that settled her down enough, so we could get them down there. We arrived in 2 and we arrived at 2.30 in the morning and did not see anybody till 8.30 in the morning and I know the times because they change shifts and they did not bring any breakfast or anything in to either of them.

I’ve had a lot of trouble with [regional city] with [son]. [regional city] they’re not family friendly at all. They just shut the door on, on the family. Like [son] would get discharged they will ring me up. He’s coming home and that’s it.

So I could ring up every day and say "How's he going?" and I don't get told a thing. And I'm sitting there with a bruised face and all blown up and they didn't even come out and say "This is what's happening."

It's lucky I had been in the system for a while so I, I knew what was going to happen, but it would have been nice just for someone to come and say "Hey she's okay."

Yeh you do you have to be tough, and yeh they'll tell you to sit down and shut up, you just get back up and look it pays off.

And they admitted her there and I wasn't allowed to see her for two days.

And that's taken away, it's involuntary again and he said to me "And we are going to do ECT and there's nothing you can do about it."

They were supposed, they were supposed to check on you every so often well they didn't I was awake most of the night I didn't think that they checked on me all that often.

Well he was just like well I don't know what to do with you, so I'm just going to take some blood tests and that, so we sat in that room a whole day, we got there at ten o'clock in the morning and I was still there at six o'clock, seven o'clock.

Draft recommendations

- Protocols and practical guidelines be developed regarding family involvement in care
- Family centred education be provided to all health professionals across the region
- What recommendation should be included?



Pick your team - The importance of who was there to support you and provide care was highlighted

There was one, there's always one person that stands out that you think "Gee you're a nice person."

Policeman. A most amazing man, but he had insight. He had family members and then you would get other police that would just treat you like shit.

So she rings me up and we have a chat. I have met her for coffee when I have been in [larger town].

Case manager from down there [Melbourne], because you build up a rapport with the nurses and the case managers.

So it's stuff like they put their jobs probably on the line but they knew, so after you know a few years of rapport with these people they care.

He said to me, he said "Look" he says "You can pick up on it straight away, you know" he says "Christ, you know as much about your wife as what I bloody do."

Yeh, every step of the way. You know “How are you going, is there anything?” When [family member] had an admission to [larger town] about twelve months ago the doctor wanted to see me and I went in there and she said “What do we need to do to help you?” I burst into tears.

Learning curve for them they’d never done anything, or dealt with anything like this before and they were prepared to, you know it took a while but yeh eventually the school come around and the school they have really now embraced (daughter) and yeh it’s going really well.

Are they prepared to do that?” and she goes “I don’t want to tell them” and I said “Well you have to, because if they say we can’t give you a job because of this well we will go and find a place that will give you a job.”

Draft recommendations

- A scheme/ process that recognizes and celebrates excellent care should be implemented
- What recommendation should be included?



People like me - One of the most important points made throughout the interviews was the opportunity to connect with others with lived experience:

So there's like twenty, I reckon there should be a twenty-four hour facility, where like there's just like ...Drop in and like they can just talk and they can sit on the couch and like there should just be a massive area.

But if it was a person that's feeling suicidal for the first time they, they need somewhere to go that someone can talk to them, and like even, just make them a cup of herbal tea and you know?

They've had some pretty serious drug and alcohol issues, even if they done like a partnering system like big brother, sister like.

And I really admire them but me, me to be sitting around the only bloke there to be sitting around with a group of bloody sheila's having cups of tea and eating scones and things like that, it ain't going to work.

And I went to one of their meetings and they're saying "Oh well you know I've been off and on and I've done this course on this and I know this." Like I said to you, I can go and do a course on bloody mechanics but it don't make me fix a car.

I mean there's things you don't want to tell them because nattering sound old ladies and I mean yeh then they will all know about my life.

I went to a carers group once and all you get there is seniors, the elderly. Right, and so the carer's group got over-run by the elderly, mainly wives of dementia patients and that, who just wanted to sit there and I felt like a fish out of water- my son is 24

And the thing is you're dealing with this stress you know all the time, all you want to do is go and have a bit of a laugh and a talk...But you don't want to be sitting there listening to whinging all the time.

But I need just somewhere for one day a week, for a couple of hours you drop in, you have a cup of coffee or something like that and you have a chat and a good laugh

Now, he I've never seen a man so bloody distraught and, and he wants people to talk to but then it was like, it was yesterday he come around and the wife was trying to talk to him and I thought "Well shit there" but then again I mean I let her because she's been there.

He did, I did ring him, I rang him yesterday he wouldn't answer, I went past his house last night there was no lights on, I rang him this morning and he had gone to his nephew.

They'll be able to sit down and use each other as a sounding board.

Draft recommendations

- Whilst carers groups are appropriate for some people, consideration must be given to other mechanisms to engage and support people
- What recommendation should be included?



Thank you

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