A Psychological Service: A collaborative way to address access to mental health services >

Final Research Report – Project 2017-06

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Executive summary

Far East Gippsland has some of the most isolated communities within Victoria, and access to mental health services is limited. During 2017, the Royal Flying Doctor Service Victoria (RFDS), with funding support from Gippsland Primary Health Network (Gippsland PHN), piloted an initiative designed to improve access to mental health support. This program is known as Flying Doctor Wellbeing (FDW). Operating within an integrated and stepped care service model, Flying Doctor Wellbeing uses a blended model of mental healthcare delivery.

Flying Doctor Wellbeing is delivered from the bush nursing services located in Far East Gippsland, namely Buchan, Cann River, Dargo, Ensay and Gelantipy. The service provides free and confidential mental health appointments for people aged over 18 years. Clients do not need a referral from a general practitioner (GP) or Mental Health Care Plan to access the service.

Using a mixed methods approach, the FDW initiative was evaluated to determine whether the blended approach, delivered within an integrated and stepped care service model, improved mental health service access for residents of Far East Gippsland. This research project 'A Psychological Service: A collaborative way to address access to mental health services' had ethics approved by Latrobe Regional Hospital Human Research Ethics Committee (Project 2017-06). The study sought to understand service impacts from the perspective of service users/clients of the service, local bush nurses, steering and advisory committee members and other service providers.

Overall, the evaluation findings indicate that the Flying Doctor Wellbeing mental health pilot program has improved access to mental health services for residents of Far East Gippsland. Key findings include:

- Improved access to mental health services was related to:
    - Local availability through integration with local bush nursing centres.
    - Lessening service user's concerns about confidentiality and anonymity through the use of a visiting mental health practitioner.
- Service users gained positive mental health outcomes.
- Barriers to service access included:
    - Connectivity and technology problems
    - Attitudes to the use of telehealth.
- Service users who engaged in telehealth sessions were comfortable the service.
- Bush nurses reported a reluctance to refer patients to practitioners from some allied disciplines.

Despite a small sample size, these findings add to evidence of the need to tailor mental health services to suit the local rural context. However, determining whether integrated and stepped care service models improves access to mental health care in remote communities requires further research.

Background

Access to mental health care in Far East Gippsland is limited due to a lack of mental health services in the area, scarcity of mental health practitioners across the region, and the natural geography of the region (Gippsland PHN, 2016). Gippsland PHN's health needs assessment identified that these service gaps were having detrimental mental health impacts on the communities of Far East Gippsland (Gippsland PHN, 2016). Consequently, Gippsland PHN identified mental health as a priority issue for Far East Gippsland and committed to increasing access to mental health services in the area.

Far East Gippsland is situated in far southeast Victoria, approximately 400kms (a 4.5 hour drive) from Melbourne. The shire has a population of over 45,000 (Australian Bureau of Statistics, 2019). The regional centre, Bairnsdale, is situated in the south-west corner of the shire; however, many of the local residents have to travel two or more hours reach Bairnsdale.

Almost one in ten (9.1%) of the adult population of East Gippsland reported experiencing high or very high psychological distress, (Department of Health Victoria, 2016) and between 2010-2014 rates of suicide and self-inflicted harm in East Gippsland were 1.7 and 1.3 times the state average respectively. (Torrens University Australia, 2019). Furthermore, prescribing rates of anti-depressant and anti-psychotic medication are higher than the state average (Australian Commision on Safety and Quality in Health Care, 2015). Mental health related hospitalisations for adults in East Gippsland are also significantly higher than the Victorian average (Australian Institute of Health and Welfare, 2016).

A range of barriers are known to affect mental health seeking behaviours, particularly in relation to that of farmers and others living in rural communities. A recent systematic qualitative review of 11 studies, most of which were from Australia, identified key attitudinal barriers including: stigma or the perception of being judged for having a mental health issue; stoicism, indicating that self-sufficiency, independence and silent coping were typical ways of dealing with mental distress; distrust, with participants questioning service quality and service provider relatability; and understanding, with participants having limited mental health literacy or thinking that professional help was only for those with extreme symptoms (Cheesmond, Davies, & Inder, 2019). Explicitly linked to rurality were attitudes of independence, strength, pride and self-reliance; fears around privacy and confidentiality; and reluctance to seek help from non-rural health professionals (Cheesmond et al., 2019). The broader literature supports the notion that rural people and farmers

have a preference for self-reliance and seeking help from friends and family over professionals (Brew, Inder, Allen, Thomas, & Kelly, 2016; Hull, Fennell, Vallury, Jones, & Dollman, 2017; Judd et al., 2006).

Limited service availability, cost and distance are cited in the literature as structural barriers to accessing mental health services for people in rural and agricultural communities (Brew et al., 2016; Judd et al., 2006; Perkins et al., 2013). The lack of GP's (who play an integral role in both treating and referring those with mental ill-health) can provide further challenges to rural people in accessing services (Brew et al., 2016; Kavalidou, Mcphedran, & De Leo, 2015; Perkins et al., 2013). Difficulty in accessing healthcare services, combined with limited or non-existent public transport can increase social isolation for people in rural Australia (in particular, older people, unemployed people and people living with disability or a chronic condition) (National Rural Health Alliance, 2017).

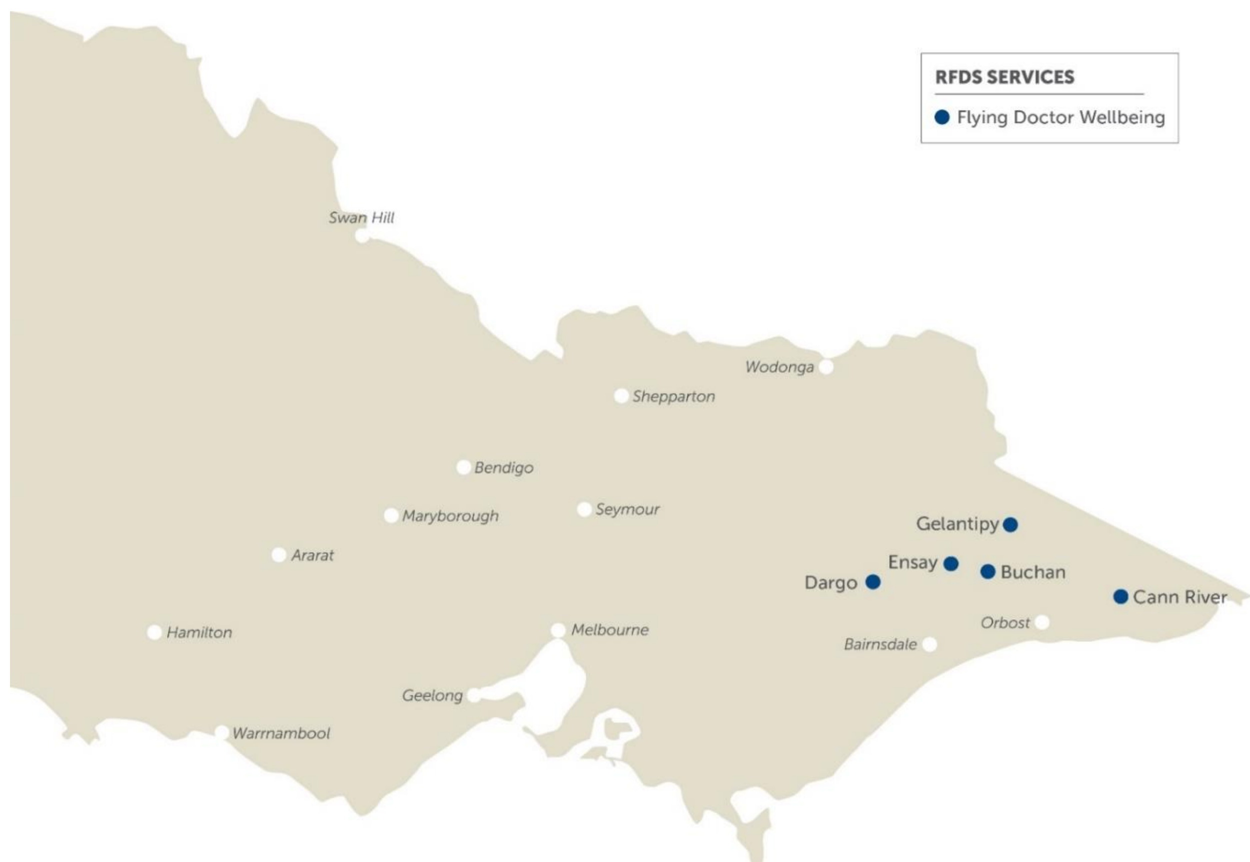
In recent years, a growing number of mental health care interventions that use a blended model of modalities including face-to-face, telephone, video and internet (Erbe, Psych, Eichert, Riper, & Ebert, 2017; Simpson & Reid, 2014) have emerged. Simpson & Reid (2014) conducted a review of rural telepsychology services and found that therapeutic alliance was at least as high in videoconferencing sessions compared to face-to-face therapy, even when connectivity affected the quality of image and sound. They noted the additional effort that therapists made to build rapport, seek clarification and prepare as factors that may have resulted in the high therapeutic alliance (Simpson & Reid, 2014). Another recent systematic review found that, when compared to face-to-face only interventions, blended models of care could save clinicians time and reduce drop-out rates without reducing therapeutic outcomes (Erbe et al., 2017). The review did however note a lack of evidence with regard to the optimal ratio of face-to-face compared to internet-based interventions and which clients or presentations specifically would most benefit from a blended model (Erbe et al., 2017).

In an effort to address an identified gap and improve access to mental health services in Far East Gippsland, RFDS (with funding support from Gippsland PHN) launched the pilot program, Flying Doctor Wellbeing. The service piloted a blended model of mental healthcare (face to face and telehealth services) delivered via an integrated approach with the Bush Nursing Centres in Buchan, Cann River, Dargo, Ensay and Gelantipy (see Figure 1). Operating within a stepped care model, the Flying Doctor Wellbeing service provides treatment for clients experiencing low to moderate mental health concerns, with more acute or severe presentations triaged to appropriate secondary or tertiary mental health services. Mental health appointments are free, confidential and available for those aged 18 years and over. Bush nurses in these communities were provided with mental health

assessment, triage and referral training and provided with referral tools to enable them to more confidently support the clients to receive mental healthcare. This not only eliminated the barrier of having to travel far distances for services but also the need for GP referrals.

The pilot program was developed, established and implemented with the support of an executive steering committee and an operational advisory group. These committees included representatives from Gippsland PHN, local health services, a bush nurse and a consumer representative.

Figure 1: Flying Doctor Wellbeing service locations



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Methodology

Study design

A mixed method evaluation was conducted to determine whether a blended approach, delivered within an integrated and stepped care service model, improved access to mental health services for residents of Far East Gippsland. The study aimed to understand the impact of the service from the perspective of key stakeholders including service users/clients of the service, local bush nurses, steering and advisory committee members and other service providers.

Interview participant recruitment strategy

There was a very poor response to the initial approach, instituted during November 2018, to recruit service users via local bush nurses providing individual clients with a participant information statement, consent form and reply-paid envelope to forward signed consent forms to the research team. Consequently, during May 2019, a revised recruitment strategy, approved by Latrobe Regional Hospital Human Research Ethics Committee (LRH HREC), was instituted. The process involved the research team mailing a letter of invitation that contained a participant information statement, consent form and a reply paid envelope to all discharged clients (N=27) of the service. Potential participants were invited to read the information and return a signed consent form via the reply paid envelope if they wished to be interviewed. Those mailed also received a follow-up phone call within two weeks of the postage date. The majority of service user participants were recruited as a result of the follow-up phone call.

Bush nurses, committee members, and other service providers were directly invited by the research team to participate in the research project through a variety of methods including email, mail and telephone. Potential participants were provided with a participant information statement, consent form and a reply paid letter to return signed consent forms.

Data collection

De-identified data for all episodes of care (N=52) provided by Flying Doctor Wellbeing service between July 2017 and August 2019 were extracted from the RFDS Wellbeing clinical database which is used by the service.

20 semi-structured interviews, conducted via phone or teleconference, were completed in November 2018 and August 2019. The interviews involved eight service users, five bush nurses, six advisory committee members and one service provider. Interviews consisted of both open-ended questions and 5-point Likert rating scales designed to measure attitudes and perceptions. Service user interviews sought to elicit personal experiences with the service and included issues such as

level of comfort with local bush nurses and the RFDS mental health clinician, service quality and appropriateness, service engagement and telehealth experience. Non-service user interviews sought to explore personal experience of and perceptions of the impact of the service. This included topics such as service integration, service engagement, referral pathways and understanding the stepped model of care.

Interviews were recorded and transcribed verbatim. Length of interviews ranged from 15 minutes to 1 hour.

Data analysis

The quantitative dataset was checked for missing data prior to analysis. Due to small sample size, in the main descriptive statistical analysis was employed; however, independent sample t-tests and paired sample t-tests were also conducted. Inferential statistical analysis was undertaken using STATA (StataCorp, 2019).

Thematic analysis, as described by Braun and Clarke (Braun & Clarke, 2006) was employed to identify, interpret and analyse the common themes that emerged from the qualitative interviews. This involved two researchers independently coding the data, identifying themes and constituent subsequent subthemes. Final agreement on emergent themes and constituent subthemes was reached through discussion and debate during meetings that involved all three members of the research team.

Ethics

This research project 'A Psychological Service: A collaborative way to address access to mental health services' had ethics approved by LRH HREC (Project 2017-06). (Project 2017-06) for the period of 1 July 2017 until 30 June 2019. However, four amendments were required including an extension of the project until 31 December 2019; changes to investigators involved; revision of the participant recruitment strategy; and amendments to interview schedules.

Results

The findings presented in this section are the results of all client data (N = 52) for all episodes of care between August 2017 and end of July 2019. The results will be presented in the following order: referral and service user data; client demographics; client risk; episode of care and psychological distress.

Referral and service user data

Figure 2 illustrates that the majority of clients were seen in four Bush Nursing Centres, with the least number of clients accessing the service from Buchan Bush Nursing Centre. Almost two thirds of referrals came via the Bush Nursing Centres (Figure 3).

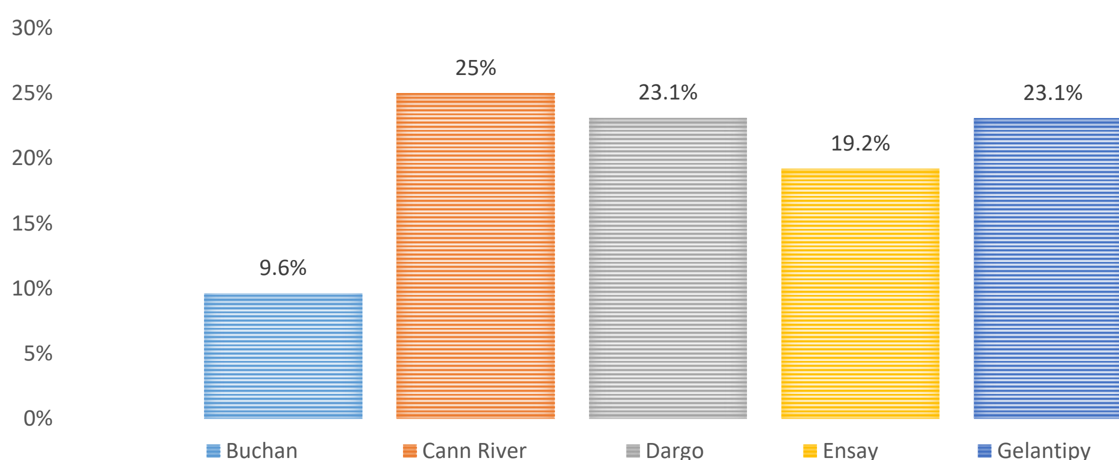

Figure 2: Proportion of clients by host Bush Nursing Centre (n=52)

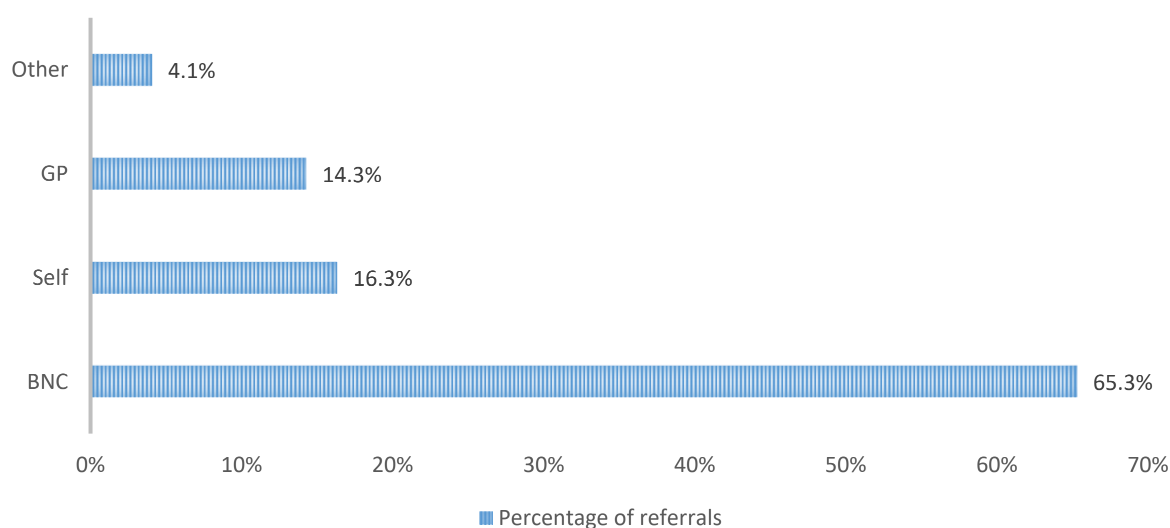

Figure 3: Referral source (N=49)

As illustrated in Table 1, the overwhelming majority of referrals (82.6%) were for sub-syndromal symptoms/problems rather than for clients with a mental disorder.

Table 1: Reason for referral (N=52)

Reason for referral	%
No formal mental disorder but subsyndromal problems	82.6%
Anxiety disorders	15.4%
Affective (mood) disorders	1.9%

The main secondary stressors reported by clients were partner or family relationship problems, health problems, social isolation, and grief and loss. Less commonly reported secondary stressors include history of trauma and abuse, financial stress, substance abuse, domestic violence, work-related stress, psychiatric condition and post-traumatic stress. Figure 4 indicates that about a third of those referred reported having one significant stressor in their life; however, 60% of clients reported dealing with two or more stressors.

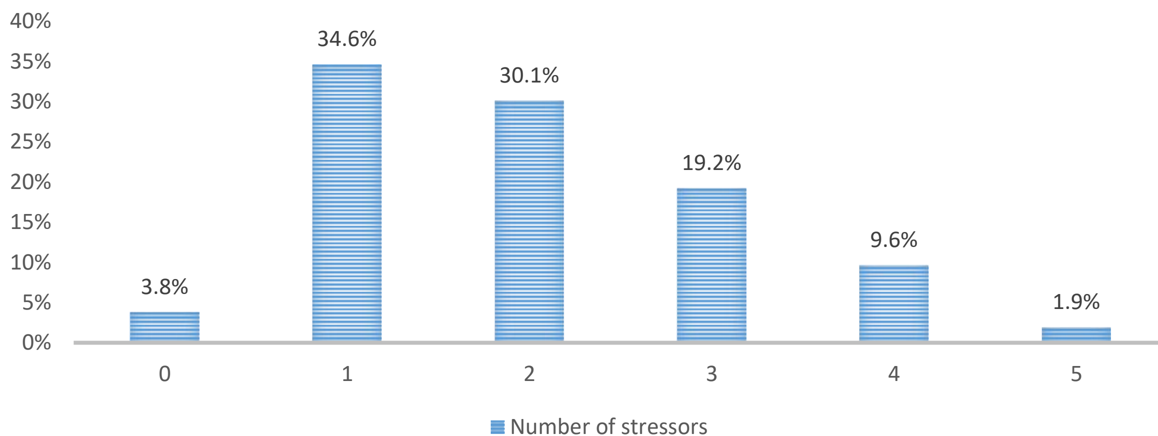

Figure 4: Number of secondary stressors reported by individual clients at referral (N=42)

Table 2 indicates that at referral, about 17% of clients had impaired levels of functioning. While most clients reported having a moderately to limited supportive network (69.9%), only 13.8% reported having a highly supportive network. All clients with a prior history of mental health problems reported a moderate response to treatment. The majority of clients (96.2%) were judged to be actively to moderately engaged (96.2%) with the referral for mental health treatment.

Table 2: Bush nurse assessment of client at referral stage

Assessment Factors		%
Client's level of functioning at referral stage (N=29)	None/mild	34.5%
	Moderate	48.3%
	Significant impairment in one area	13.8%
	Serious impairment in several areas	3.5%
Client's level of support at referral stage (N=29)	No problems/highly supportive network	13.8%
	Moderately supportive network	37.9%
	Limited supports	31.0%
	Minimal supports	17.3%
Client's treatment history (N=23)	No problems/minimal difficulties	87.0%
	Moderate response	13.0%
	Poor response	0.0%
	Minimal response	0.0%
Client's attitude to treatment at referral (N=29)	No problem/actively engaged	79.0%
	Moderately engaged	17.2%
	Poorly engaged	3.5%
	Minimal engagement	0.0%

Client demographics

Between the beginning of August 2017 and end July 2019, 52 episodes of care commenced that involved 46 individuals. Table 3 provides a profile.

Table 3: Demographics of engaged clients

Factor		Mean	Range
Age		56	19-82
		N	%
Gender (N=52)	Male	19	36.5%
	Female	33	63.5%
	Other	0	0.0%
Martial Status (N=33)	Single/never married	10	30.3%
	Married/defacto	15	45.5%
	Separated/ divorced	6	18.2%
	Widowed	2	6.1%
Living Status (N=28)	Alone	11	39.3%
	With partner	11	39.3%
	With family	5	17.9%
	Other	1	3.3%
Employment Status (N=24)	Unemployed	10	41.7%
	Employed	7	29.2%
	Not in labour force	7	29.2%

The Socio-Economic Indexes for Areas (SEIFA) was analysed and is detailed in Figure 5. SEIFA ranks areas from most disadvantaged (Decile 1) to least disadvantaged (Decile 10). The Australian ranking provides a national comparison and the Victorian ranking provides a state based comparison. Over 60% of the clients resided in locations ranked within the most disadvantaged areas at both a National and State level.

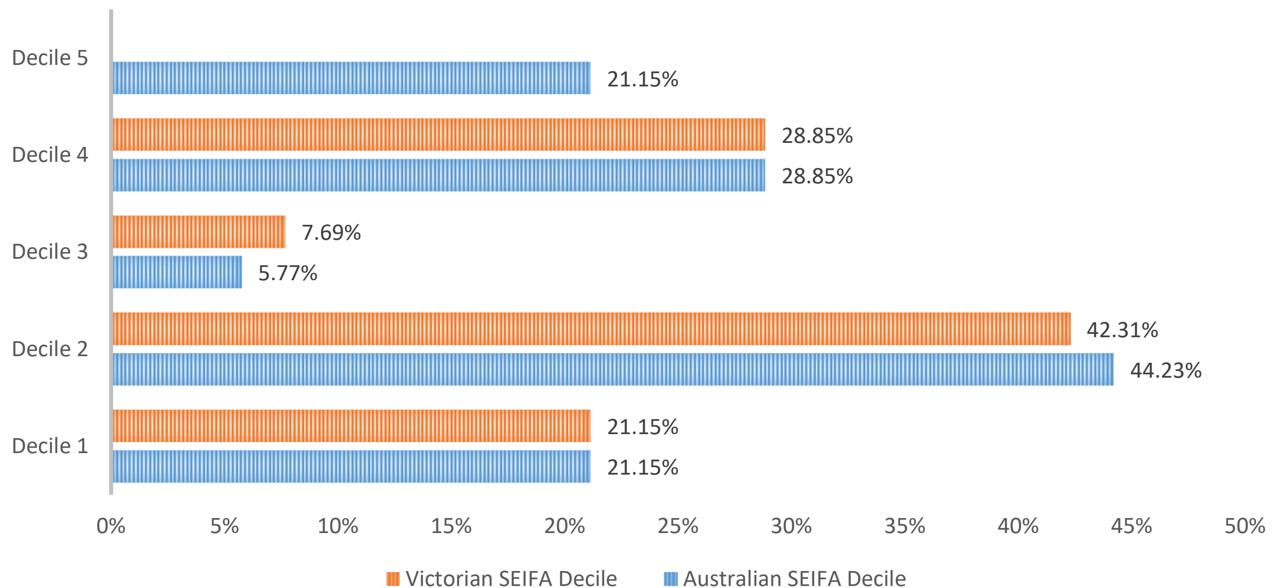

Figure 5: Proportion of clients by the Australian and Victorian Ranking of Socio-Economic Indexes for Areas (SEIFA) Decile scores.

The Modified Monash Model of remoteness was used to assess level of residential remoteness (See Appendix A). Within the Victorian context, service users reside in the most remote areas of the state, either in MM 5 - small rural towns (78.9%) or MM 6 - remote communities (21.1%).

Client risk

At referral, bush nurses are required to rate the client's level of risk to self, to others and their overall risk as either: none, low, moderate or high. The mental health clinician's also undertake a similar risk assessment as part of their initial consultation.

Figures 6 and 7 suggests some congruence between bush nurse's and the mental health clinician's assessments. However, bush nurses were more likely to report no risk than the mental health clinicians.

As illustrated in Figure 6, the overwhelming majority of people presenting to the service were assessed as being at low risk of harm to self.

No clients were assessed as being at medium or high risk of harming others. Minimal data from bush nurse's assessment in respect to this risk issue limited the scope of analysis.

Figure 7 illustrates that both bush nurses and mental health clinicians reported over 70% of clients to have an overall low level of risk.

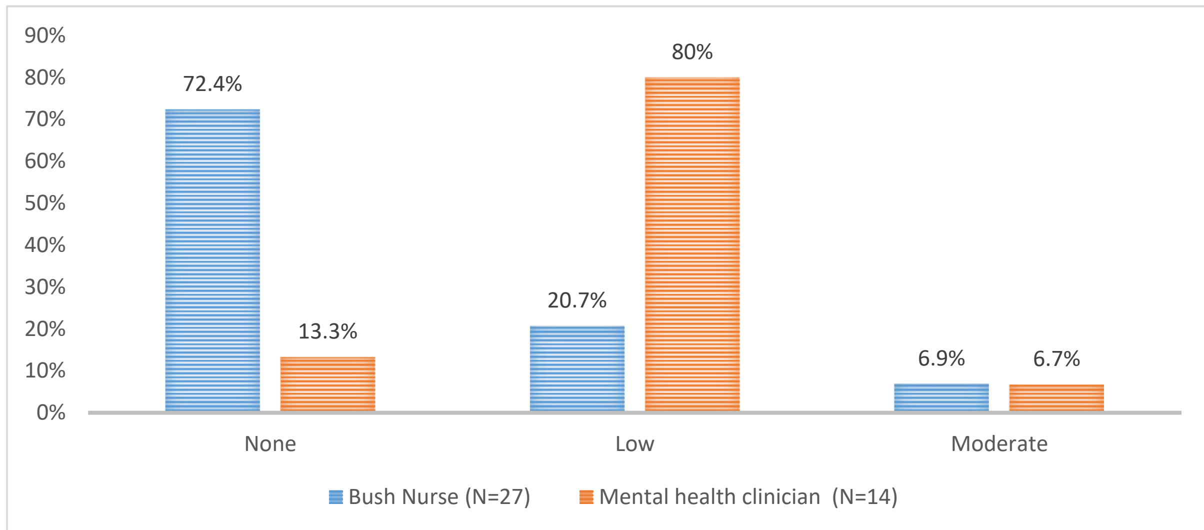

Figure 6: Assessment of client's level of risk to self

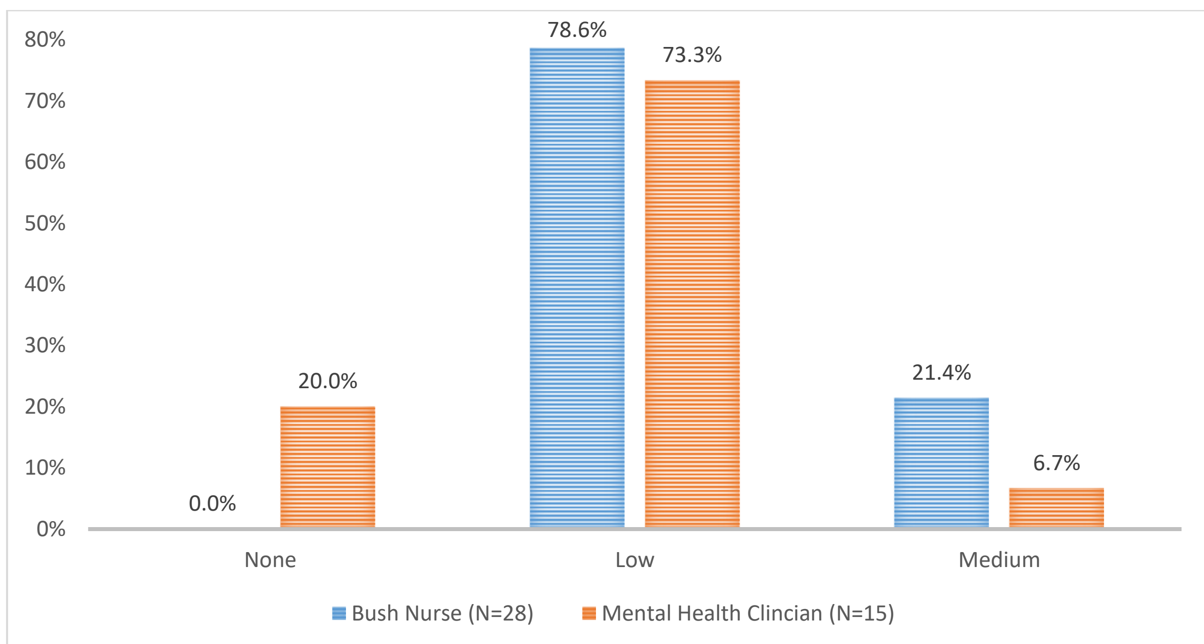

Figure 7: Assessment of client's overall level of risk

Episode of care

During the initial consultation, the mental health clinician assessed the person's history of mental health treatment and current substance use. Of the available data (N=31) just over half the clients (54.84%) reported they had no prior history of mental health treatment with the remainder (45.16%) reporting they had a history of treatment. Just under half (48.4%) of these 31 clients also reported substance use during their initial assessment with the mental health clinician.

The mental health clinician used information collected during the initial assessment to determine the suitability of clients for ongoing care from the Flying Doctor Wellbeing service. This data indicates that all referrals were suitable for service. Consequently, no referrals to other services resulted from an initial consultation.

Thirty-seven episodes of care were completed (i.e. treatment had been completed and the individual had been discharged or was referred to another service and discharged) in the period beginning August 2017 to end of July 2019. Interestingly six clients engaged in a second episode of care following discharge from a first episode of care. Fifteen clients were still engaged in an episode of care at the data extraction point.

Two thirds of clients who engaged with the service received three or less appointments with the mental health clinician. As shown in Figure 8, only a fifth attended between four and six sessions and a further 11% required more than six appointments. Figure 9 illustrates that the majority of clients (61.5%) only accessed face-to-face appointments.

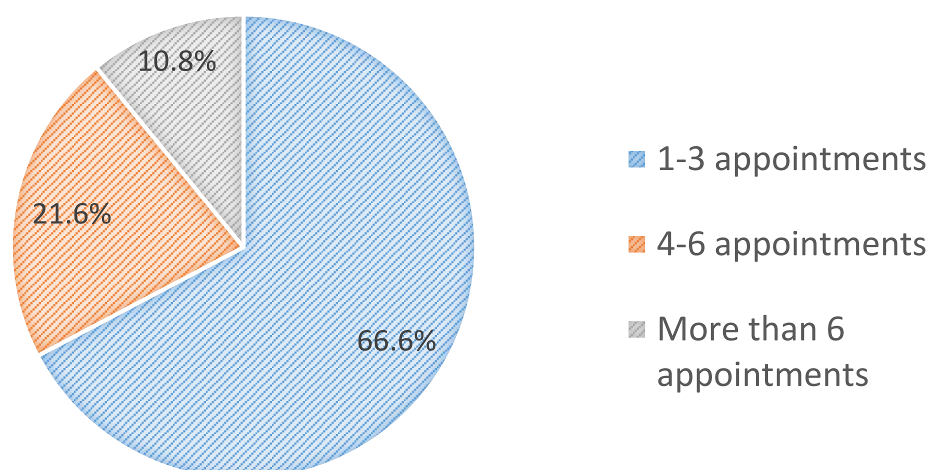

Figure 8: Number of appointments per individual client's episode of care (N=37)

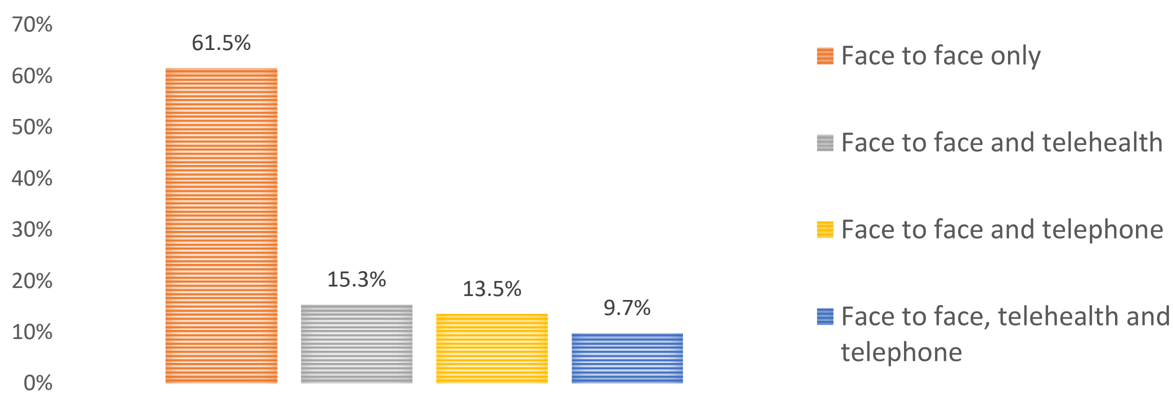

Figure 9: Type of appointments accessed by clients (N=52)

The majority of clients were discharged, as their course of care was complete. A small number of clients (6.5%) were discharged when the service was temporarily unavailable due to staff changes. Reasons for discharge are included at Table 4.

Table 4: Reason for client discharge (N=46)

Reason for client discharge	%
Course of care complete	69.6%
Patient failed to attend or make follow up appointment	10.9%
Patient requires lower level of care (eMental Health resources)	6.5%
Service temporarily unavailable	6.5%
Other	4.4%
Patient not suitable or comfortable with telehealth appointments	2.2%
Maximum number of apt reached	0.0%
Patient requires higher level of care	0.0%

Psychological distress

As a measure of psychological distress, the Kessler Psychological Distress Scale (K10) was collected from clients at service entry and again at discharge. A score out of 50 indicates the level of psychological distress at the time of survey completion, where a score of 10-15 indicates low distress; 16-21 indicates moderate distress; 22-29 indicates high distress; and 30-50 indicates very high distress. Table 5 reports the mean and median K10 scores at entry and discharge from the FDW service. While the range of individual K10 scores at both entry and discharge varied considerably, service users

tended to be experiencing high levels of psychological distress at entry and moderate levels of psychological distress at discharge.

Table 5: Pre and Post K10 score at entry and discharge

K10	Mean	SD	Median	Range
Pre-score (at entry) *(N= 34)*	26.75	6.86	26.5	12-42
Post score (at discharge) *(N = 20)*	19.8	7.13	16.5	12-40

A single sample paired t-test was conducted to determine whether there was a difference in K10 scores from service entry to discharge. Only 19 clients had data for comparison. At discharge, clients reported significantly lower distress levels (M = 20.05, SD = 7.24) than clients reported at entry (M = 26.76, SD = 6.68), $p < 0.001$. A large effect size was seen (Choen's d = 1.50).

An independent sample t-test was conducted to determine whether there was a difference between men and women's K10 scores at service entry and discharge. The average K10 score at service entry for men was 24.09 *(SD = 4.61)* and 28.02 *(SD = 7.46)* for women. The average K10 score at service discharge for men was 17.67 *(SD = 4.08)* and 20.01 *(SD = 8.06)* for women. There is no evidence of a difference between men's and women's K10 score at entry (p=0.12) or at discharge (p=0.40).

Participant interview results

Service satisfaction and confidence

The service had a high satisfaction level among clients, with the majority (75%) reporting they were extremely satisfied with both their engagement with the service (Figure 10) and the quality of mental health services provided by the RFDS mental health clinician (Figure 11). No clients reported that they were dissatisfied with their engagement or the quality of services provided.

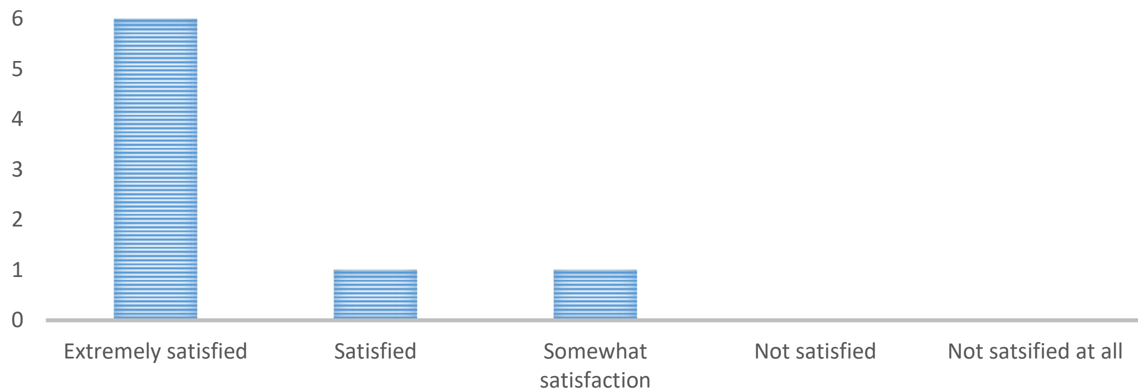

Figure 10: Client satisfaction with service engagement (N=8)

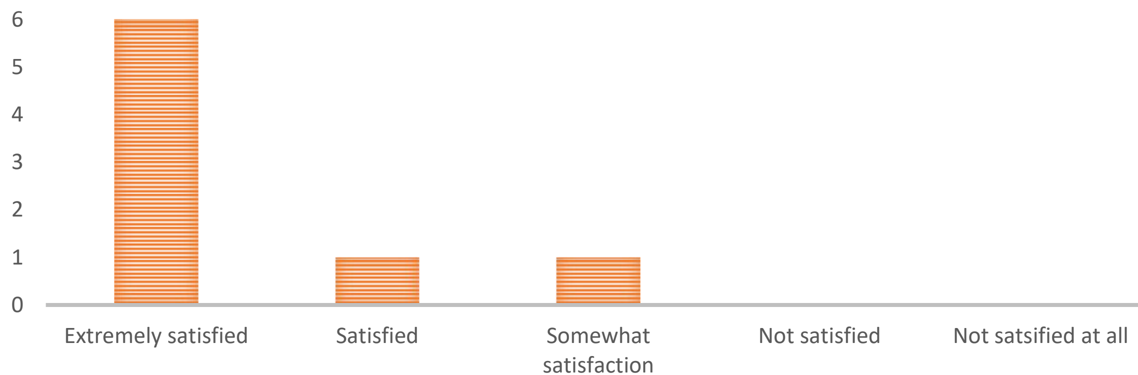

Figure 11: Client satisfaction with quality of service provided by RFDS clinician (N=8)

Most clients (87.5%) reported feeling confident or extremely confident discussing their mental health both with the bush nurse and the mental health clinician. (Figure 12).

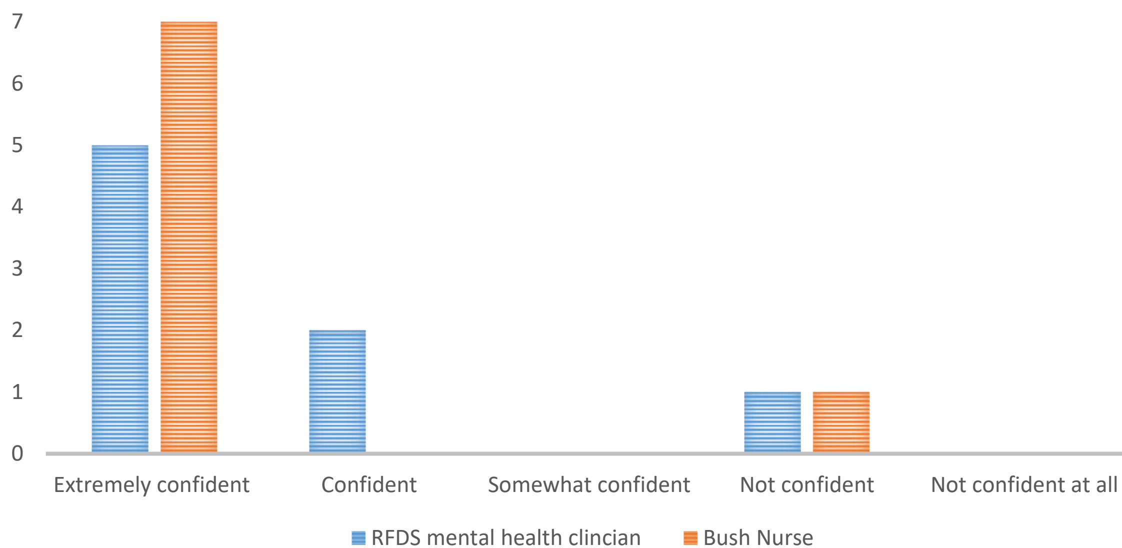

Figure 12: Client confidence speaking about their mental health with the RFDS clinician and bush nurse (N=8)

The majority of clients (87.5%) considered that the service was appropriate or extremely appropriate for them. No clients considered the service was not appropriate for them. Of the four clients that engaged in telehealth appointments, 75% felt comfortable or extremely comfortable engaging in this modality (Figure 13). Nearly all clients (87.5%) reported they were extremely likely to recommend the service to a friend.

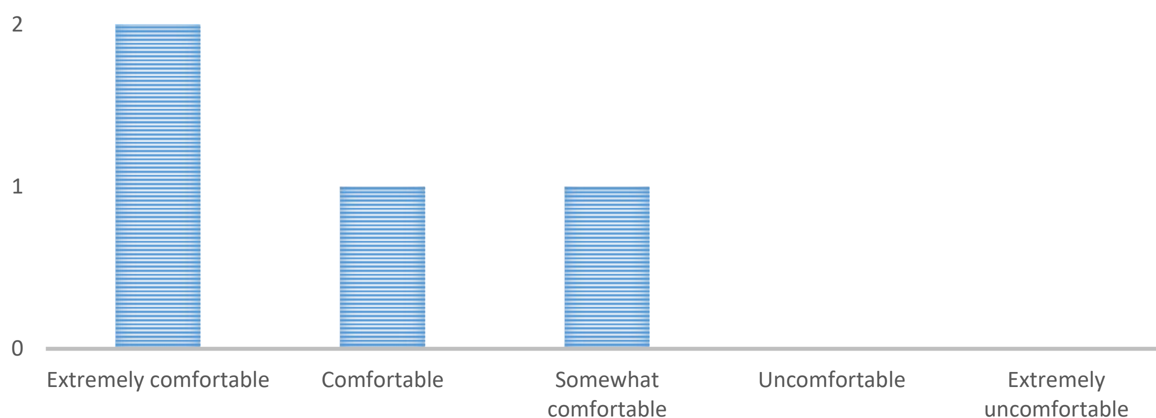

Figure 13: Client confidence using telehealth (N=4)

Most bush nurses, committee members and stakeholders (75%) reported that they were confident or extremely confident in their understanding of where the service sits within the stepped model of care and two thirds felt that the service was well integrated or extremely well integrated with existing mental health services.

Most bush nurses reported being confident in their understanding of service eligibility (Figure 14), confident or extremely confident referring clients to the service (Figure 15); and likely or extremely likely to refer clients to the service (Figure 16).

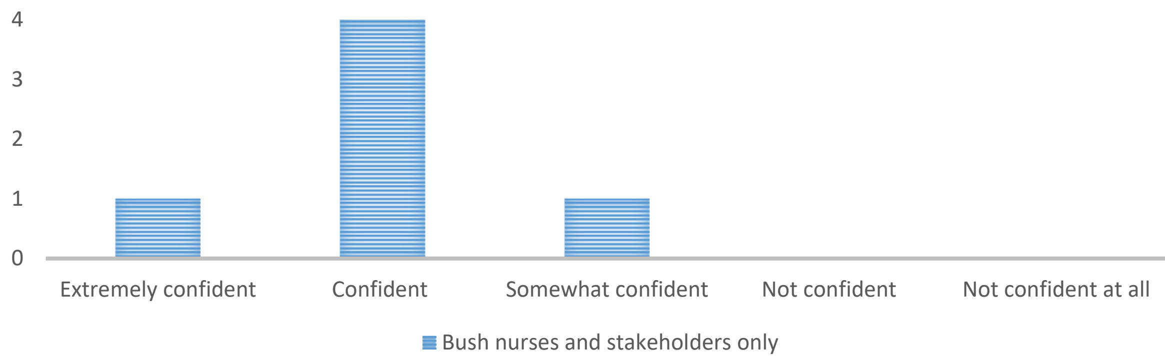

Figure 14: Bush nurse and stakeholder confidence in determining client eligibility (N=6)

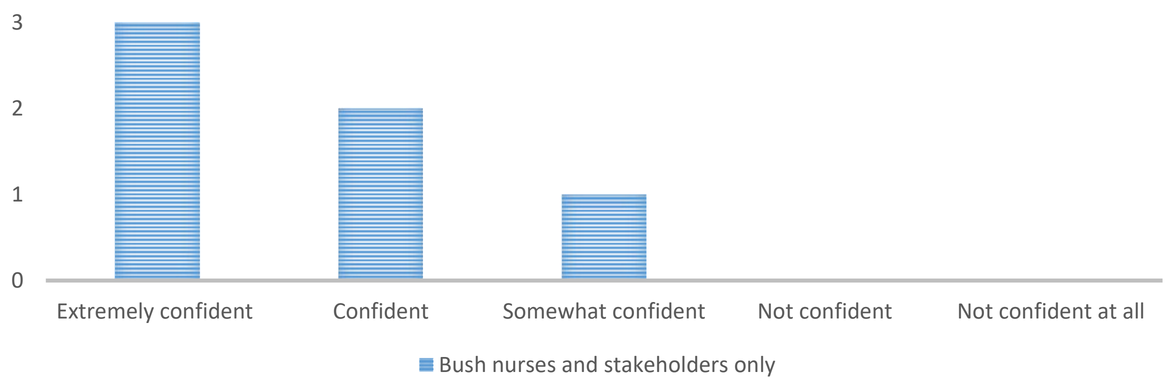

Figure 15: Bush nurse and stakeholder confidence in referring clients (N=6)

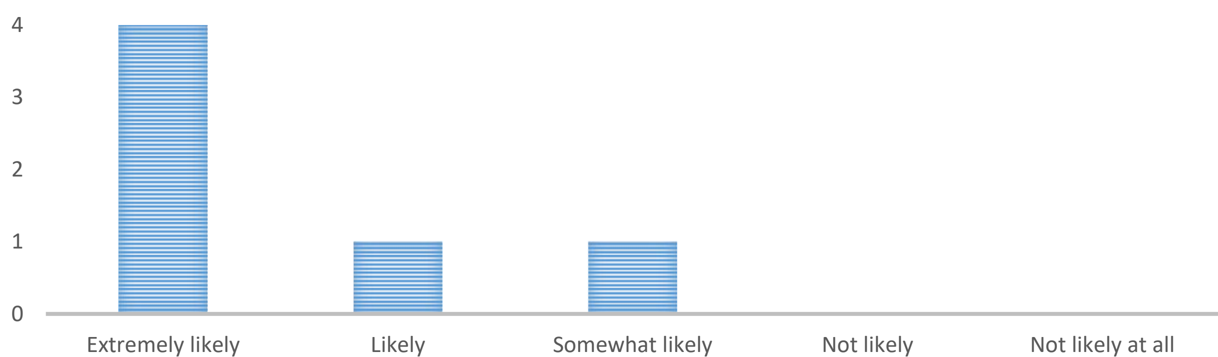

Figure 16: Bush nurse and stakeholder likeliness to refer (N=6)

Overall, two thirds of bush nurses and stakeholders reported that they were satisfied or extremely satisfied with the level of engagement they have had with the service. One bush nurse reported that they were not satisfied with the level of engagement (Figure 17).

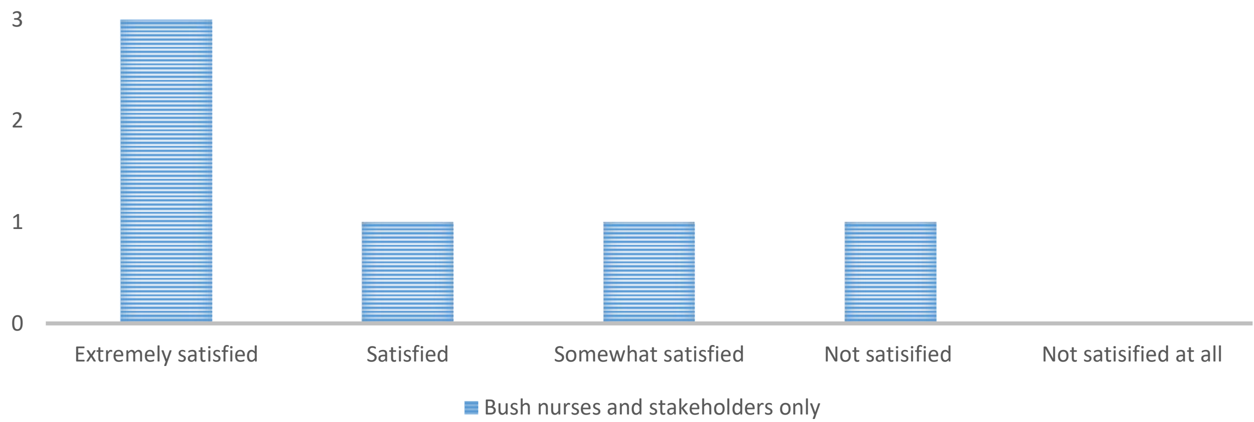

Figure 17: Bush nurse and stakeholder satisfaction with engagement with the service (N=6)

Interview themes

The overarching themes include access, choice and control, client outcomes, community attitudes and stigma, confidentiality and anonymity, enabling a therapeutic relationship, engagement, sustainability and consistency and operational challenges.

Access

Access, defined as the availability of appropriate health services within reasonable reach of those who need them, was a major theme discussed by all participant groups. The overarching theme consisted of three subthemes: locality of the service, service integration and no cost for appointments.

Locality of service

Comments from most participant groups suggests that improved access is facilitated by availability of a mental health service that is local, or within a close proximity to where people reside. In support of the service locality, clients referenced challenges of long travel distances to other services, the impact of age on driving ability, managing family responsibilities, and local bushfires. The impact of locality is illustrated by the following quote:

> *"It was local so I live in a remote area, um, so the sessions were 15km to where I had to go, as opposed to 100km"* – Client 495

Service integration

Committee members and stakeholders felt that integrating the program within the local bush nursing centres contributed to increased service access. In particular, the role of bush nurses in the initial referral and triage stage was considered an effective element of the program design. This is because the bush nurses were seen to be highly respected and trusted members of the community.

> *"I think getting the bush nurses trained and getting them as kind of conduit into that is great because they are the key kind of trust holders and people that are connected to the community and building on the strengths that are already there and increasing the access and I think that's been the best part.."* – Stakeholder 1

Clients also highlighted that they benefited from the integration, with their concerns about privacy and confidentiality allayed because when in the waiting area one was unable to identify the reason for another person's presence.

> *"it was very private, like you know it wasn't like anyone else would know that you were having a referral [for]"* - Client 571.

Cost

Two service users commented on cost as a factor that impacts upon service access. Cost includes the cost of the service plus the indirect and opportunity costs, such as travel costs to and from the service and loss of income.

> *"it was free which made a big difference"* – Client 571

One client suggested that those experiencing financial hardship were not likely to prioritise spending money on their mental health even if they needed it. Hence, the importance of providing access to a free mental health service:

> *"Women are going without eating so that they can keep feeding their animals and things like that on the farm, so you know that if they aren't even prepared to feed themselves so that they can keep their farm going, they're definitely not going to spend money on their mental health*" – Client 660.

Choice and control

Service user comments suggest that having autonomy, flexibility and involvement in the decisions concerning their own mental health treatment was important. This includes choice regarding the gender of the mental health clinician. As illustrated by the quote below, several clients reported that they found it beneficial working with the mental health clinician to develop their own wellbeing strategies:

> *"Rather than a lot of probing sort of stuff, actually letting you, or letting me as the client come up suggestions…that would work for you to do, you know, so it was very empowering I would say, rather than some sessions which could be disempowering.."* – Client 571

Many clients also mentioned that when it comes to finding the right person for counselling, it is not a 'one size fits all' approach. They spoke about the importance of developing rapport and a connection with the mental health clinician in order to feel comfortable continuing treatment. One client spoke about their wish to be able to access a female practitioner:

> *"it would have been good to have a male/female choice.."* – Client 571

Client outcomes

Client outcomes emerged as a common theme, particularly among the bush nurses. This refers to the perceived and anecdotal changes in a client's mental health that result from access to mental health treatment. The theme includes a range of perceptions. While most bush nurses reported that

clients had positive mental health outcomes, one considered that clients were not benefiting from the service. One committee member was unsure if clients would have a positive mental health outcome.

> *"the people that have actually used the service have definitely benefited from it, so um, so that's one good thing"* **–** Bush Nurse 4

> *"The feedback I'm getting from clients is, you know that, they are not what we referred in the past, they are not getting a huge amount of outcomes really"* **–** Bush Nurse 3

Community attitudes and stigma

Community attitudes and stigma emerged as a theme across all participant groups. This is defined as thoughts, feelings and/or beliefs held by members of the community (including local health professionals), in particular viewpoints that present a barrier to accessing mental health services. Both clients and a committee member mentioned that in general, stigma about mental illness still exists within the community, particularly among men and farmers. This results in a reluctance by community members to seek professional support for their mental health concerns, particularly due to the fear of others finding out.

> *"There is still a stigma attached to people. They don't like other people to know they're accessing mental health services"* - Committee Member 1

Other subthemes that emerged include; self-reliance, suicide and confidence to refer.

Self-reliance

Two clients spoke about attitudes of people they know, that indicate that people are more likely to rely on themselves and their own resources to manage their mental health problems rather than seeking professional support. This is reflected by the quote below:

> *"A lot of people don't go because they don't want their problems, you know they're old school, and they don't like laundering their problems in front of other people and just trying to manage people themselves."* - Client 502

Suicide

Two clients suggested that community attitudes and the reluctance to seek help are risks for suicide, as illustrated by the following quote:

> *"Men are the biggest people for not seeking help, and they're the biggest ones to say "I've had enough" and I've got put a shotgun to their head or hang themselves seem to be the two most popular ones around here."* - Client 500

Confidence to refer

It appears that the thoughts, feelings and/or beliefs held by the local bush nurses, influences their referral behaviour. The majority of bush nurses talked about the skill sets and capabilities of certain mental health professionals (e.g. social workers, counsellors and psychologists). Several bush nurses appeared to hold the belief that social workers were not qualified to provide the same quality of mental health care to clients as other mental health professionals such as counsellors or psychologists. This is illustrated in the comments below:

> *" I suppose you think of a social worker as different don't you, then a counsellor, like if saw a counsellor it would probably be better than a social worker"* - Bush Nurse 4.

> *"I guess if I'm referring someone for mental health support, I'm actually looking for a mental health clinician, not necessarily a social worker,* and *I don't mean that in a negative sense"* - Bush Nurse 1.

As illustrated in the comments below, these beliefs appear to have impacted upon individual bush nurse's confidence to refer clients to the FDW service:

> *"If you look at the pattern of referrals from myself, you will see as I've learnt, what the skill set is, the referrals have all but stopped"* - Bush Nurse 1.

> *"In last three months, we had four referrals and out of the four referrals only one referral was suitable for the RFDS person, whereas in the previous program you had, where you had psychological care or support or whatever you called it, we actually would have referred all of these four to the RFDS clinician.* - Bush Nurse 3

Confidentiality and anonymity

Both clients and bush nurses highlighted the importance of client privacy and anonymity when accessing mental health services, particularly in relation to attending appointments and handling of health information. Client comments indicated that they felt comfortable speaking to their local bush nurses about their mental health because they trusted that the local bush nurse would maintain their privacy and anonymity.

> *"I guess our local Bush Nursing Centre, I tend to know most of the people that tend to be there, and get along with them all well, so, it always feels welcoming and you know, they don't have any issues with confidentiality or anything like that."* - Client 495

Several service users also made comments around the benefits of receiving mental health treatment from someone who was not a member of the local community. This appears to provide reassurance of confidentiality.

> *"it was good to be able to talk to someone that wasn't, um, a local member in such a small area…especially in such a small town, yeah I didn't feel comfortable with speaking someone I knew on a personal level."* - Client 660

Engagement

Engagement, referred to as the actions, processes and activities of RFDS staff to actively promote or drive interactions with the service was a topic discussed throughout the interviews. The theme comprised of two subthemes, community engagement and integration.

Community engagement

All participant groups spoke about the communication, activities and interactions undertaken by RFDS staff promoting the service and/or establishing links with the local community. According to the feedback, the service would benefit from more advertising and promotion. Suggestions included a letterbox flyer drop and more self-promotion from the mental health clinician. However, a bush nurse and a committee member said that RFDS has made a good attempt at engaging the community. Other suggestions from both a committee member and a bush nurse indicate that using informal approaches is the most effective way to build trust and engage the community with services. As reflected in the comment below:

> *"You just can't bluster into a community. You have to actually engage with the community and not engage in an upfront way necessarily, just sit back and be there"* – Committee Member 3

A suggested approach to effectively understand and build rapport with the local community, is to attend existing community group meetings and have casual conversations with members.

> *"Even just dropping in, say there's a craft group or something happening, just drop in on the craft group, say that is what we are here about, just sit around and just have a general yarn.. maybe it might take 2 or 3 or 4 meetings or dropping in on this group and have a cuppa with them before someone comes forward and says 'hey look can I catch up with you'.. you know, bang you've made the link.."* - Bush Nurse 2

Integration

Service integration refers to the efforts by RFDS to develop effective relationships and partnerships with existing local health service stakeholders, in an effort to integrate the service within the existing

primary health landscape. Most feedback came from the committee members, indicating that RFDS could have done more to communicate information about the program to other local health services.

> *"Maybe our communication to other local services. That appears to be a problem and so clearly there must be more we can do around that"* – Committee member 3

The stakeholder went on to suggest other ways to improve service integration including; increasing the visibility of, and information about the program; embedding referral pathways in the Gippsland health pathways program; and maintaining a connection with the PHN to ensure that primary care providers are aware of the service and how to refer to it.

Enabling a therapeutic relationship

Service user feedback suggests that within their interactions with the mental health clinician there were specific enablers to the therapeutic relationship including: comfortability and connection; humour; relatability; and skills.

Comfortability and connection

Feedback from clients suggests that they had a level of comfort, connection and rapport with their treating mental health clinician. Many clients mentioned they felt comfortable with the mental health clinician because they were easy to talk to and provided non-judgmental support.

> *"He just made you feel at ease and they just made it into a situation that was accessible for myself to go to that I felt that I could comfortably be there, and not feel, I spose, judged."* – Client 660.

Some clients also mentioned that the level of comfort and connection they felt with the mental health clinician made it feel like a friendship.

> *"I was in a pretty fragile start when I first saw Clinician 2, um, yeah I think in the end it started to feel like, kind of a friendship in fact as we talked more and more, we connected with each other quite well"* – Client 495

One client mentioned that they did not 'click' with the RFDS clinician, therefore did not feel comfortable enough to continue.

Humour

Although not frequently mentioned, some clients highlighted that the use of humour during the therapeutic engagement facilitated emotional comfort and support.

“there was a bit of humor going on, humor is actually quite a good thing, to introduce it to those things” – Client 495

Relatability

Comments from clients indicated that the ability to relate, draw personal comparisons or share experiences with the mental health clinician, facilitated a better therapeutic relationship, as illustrated in the following quotes:

> *“I wouldn’t have liked to have done counselling with someone that was like, 30, 20 or 30 you know, I would have asked for someone different. Or probably have not really gone in, because I think they wouldn’t have really had much understanding of what I was talking about”* – Client 571

> *“Clinician 2 could talk about quite openly from his own point of view...he involved himself by saying ‘I’ve gotta work on these things as well’, so it wasn’t like you felt alone in your problems.. he placed himself in the situation so that he totally understood where you were coming from”* – Client 660.

Skills

Several clients mentioned their mental health clinician’s capabilities and skill set throughout the interviews. Comments suggest that clients felt the mental health clinician provided effective treatment that was suitable for their level of need. This is reflected in the client comments below:

> *“The counsellor had experience which I found very effective, very helpful and yeah, that couldn’t have been better really”* – Client 571

> *“I think Clinician 2’s really skilled and he’s appropriate for us”* – Client 10095

While one client did not think that the mental health clinician was an appropriate person to manage their particular situation, most clients felt that the mental health clinician had the capabilities and appropriate skill set to deliver effective mental health treatment.

Sustainability and consistency

The concept of sustainability and consistency was a theme which emerged from interviews with service users, bush nurses and committee members. The assurance that the service will be both sustainable into the future and that continuity of care will be provided, is addressed in the following subthemes: sustainability, consistency and reassurance.

Consistency

The desire and importance for continued care with the same mental health clinician was emphasised among most participant groups. Many participants highlighted that at the beginning of the program there was a change in staff, resulting in the need to recruit for a new mental health clinician. Many participants made comments (as illustrated by the quotes below) about the importance of consistency with clinicians, particularly when it comes to mental health and telling their story.

> *"We don't want to keep telling our story over and over again. We want to tell our story once."* – Committee Member 1

> *"That's probably the biggest one…is the continuity."* – Client 206

> "*You know when we are dealing with people's mental wellbeing we want consistency of the clinicians.."* – Bush Nurse 1

Sustainability

Bush nurses and committee members spoke about the importance of ongoing access to mental health services. The theme refers to the implementation of ongoing and accessible mental health services into the future. According to the bush nurses, the Flying Doctor Wellbeing program had provided a more sustainable service in comparison to other mental health services.

> *"I mean we have other services over the years that there are there for 5 minutes and funding is gone so it's pulled out.. the sustainability is important and that's where RFDS, I feel, have been good because it takes a long while to get the communities trust, and to then pull something out, they'll be like 'ooh, that always happens to us', kinda of thing, so that's why it's important to keep the continuation of it."* – Bush Nurse 5

This comment indicates that earlier service initiatives in these communities were not sustained. Consequently, local people lack trust in new services due to the risk that eventually the service will cease operating.

Reassurance

Comments from service users indicates that having the RFDS mental health service available in the community offered a sense of reassurance. This is illustrated by the quote below:

> *"Sometimes when you live remote, knowing something is there, is psychologically, even though you may not use it, knowing that it's there is a real support, you may not use it but knowing you can if you need to is psychologically, ah, a real asset.."* – Client 495

One client mentioned that she engaged with the mental health service in an attempt to ensure the service continued to be available for others, as per the quote below:

> *"..that's why I went along and chatted to the people so that we could keep it open for others to come in, so they would keep people coming here, not stop them from coming"* – Client 502

Operational challenges

There were a number of operational challenges identified throughout the interviews that have influenced the quality, efficiency and effectiveness of the service, including day-to-day actions, management, processes, systems or risks. The following subthemes emerged; telehealth technology, telehealth attitudes, training, booking system/process issues and youth-based services.

Telehealth technology

Issues related to telehealth technology were prominent challenges identified by bush nurses, committee members and clients throughout the interviews. According to these participants, issues such as reduced sound or visual clarity and/or connectivity issues impacted on the quality and experience of telehealth appointments. This negative impact is illustrated by the following quotes:

> *"A couple of sessions… haven't gone very smoothly like something else goes wrong like the audio or the visual and I just feel like something is lost"* – Bush Nurse 1.

> *"Quality of internet probably held that back a bit"* – Client 206.

Attitudes about telehealth

The feedback indicates that the majority of bush nurses and some clients prefer face-to-face appointments compared to telehealth consultations. Both clients and bush nurses spoke about the benefits of a tangible human interaction compared to an online interaction. These attitudes are illustrated in the quotes below:

> *"I think if you look at the nature of the people you're dealing with, um, they actually don't cope with that, um, the lack of being able to see the person and talk to the person, you know they actually want people in the room sorta thing.."* – Bush Nurse 1

> *"I just think for something like this you get so many nuances and your facial and bodily expressions that it doesn't work very well, I mean if you didn't have any other options. If you didn't have any other options than for sure, but I really don't like doing stuff like that"* – Client 571.

Two bush nurses also suggested that the age of a service user should be considered, and that telehealth was less appropriate for more aged clients.

However, in general, clients that had engaged in telehealth appointments said that after initial reservations they felt comfortable using it.

> *"The first session was just getting used to it I suppose, by the second time and the third time it almost felt like I was in the same room"* – Client 495

Training

Although less frequently mentioned, there were comments regarding the need for additional training to ensure that the service is implemented efficiently, effectively and to a high quality. A service user suggested that the mental health clinician could benefit from training about the transgender community.

> *"he um, could really really really do with some training regarding transgender or gender diverse people"… in particular things like pronouns and that sort of thing."* – Client 206

A bush nurse thought that it would be beneficial to have annual refresher training concerning the referral processes, the Wellbeing platform, and other changes that had occurred.

Booking system/process issues

Comments from the bush nurses indicate that the web-based booking system and associated processes resulted in some frustration when making referrals or booking appointments. Most of the bush nurses mentioned a preference for the mental health clinician to manage appointment bookings, as reflected in the comment below:

> *"Twice I've had trouble actually booking appointments and I contact Clinician 2 and he does it from his end'* – Bush Nurse 4

Youth service

One of the bush nurses highlighted the need for more accessible youth-based mental health services in the community, as indicated by the following quote:

> *"There are lots of other kid related, you know, youth related mental health programs and everything else, but in our areas some of them are difficult to access."* – Bush Nurse 5

Another bush nurse suggested that as the program does not provide services for young people, the RDFS mental health clinician should have a role in suggesting appropriate referral pathways for young people.

Results summary

The local availability of the service was considered one of the most significant benefits, as it eliminated the direct and indirect impacts associated with having to travel long distances for mental health treatment. Considering that the majority of clients reported being unemployed or not in the labour force, it was interesting that only a few clients (and no other participants) discussed the service cost as a factor. The data suggests that all participant groups thought that the integration with the local bush nursing centres was a key factor in improving service access in these communities. Comments suggest that service users felt safe accessing the service because of the trust they placed in their local bush nurses and the belief that privacy and anonymity was protected because the RFDS mental health clinician was not from the local community. However, it was evident that building trust within the local community and integrating a service is a process that takes time and persistence.

Service users appear to have a high level of satisfaction with the service. They appreciated and benefited from having the opportunity to have choice and control throughout their episode of care. Both qualitative and quantitative data indicates that most clients felt a level of comfort and connection with their mental health clinician.

Many bush nurses felt reluctant to refer to mental health professionals that weren't psychologists or mental health nurses which may have led to low referrals. Interestingly however, none of the bush nurses reported that they that they were unlikely to refer clients to the service. Some bush nurses thought that clients were not benefiting from the service. This perception was in contrast to the reductions in psychological distress measured by significant change in the pre- and post- K10 scores.

Comments suggest that most clients and bush nurses think that face-to-face appointments are more effective than telehealth appointments. However, there was a high level of satisfaction with telehealth appointments reported by clients who had used the telehealth service.

The importance of service sustainability, not only for ongoing service access but also so that clients are not deterred from engaging with mental health services in the future, was an important issue identified.

Discussion

This study aimed to determine whether a blended approach, delivered within an integrated and stepped care service model, improved residents of Far East Gippsland's access to primary mental health services. Previous research identified that factors such as cost and distance are barriers to accessing mental health services in a rural and remote setting (Brew et al. 2016; Judd et al. 2006). This study suggests that providing a cost-free primary mental health service integrated within the bush nursing centres has overcome these barriers for some Far East Gippsland residents.

Consistent with the literature, our research found that people in rural communities have concerns about confidentiality and anonymity when accessing mental health services (Brew et al. 2016; Hull et al. 2017; Kennedy AJ et al. 2014; Sutherland et al. 2017). However, this study suggests that integrating the mental health service within the local trusted bush nursing centres reduced such concerns. Service users reported trusting and feeling comfortable speaking to their local bush nurses, which suggests that bush nurses have a pivotal role in assisting community members access and engagement with mental health services. This study also provides more insight regarding community perceptions in relation to visiting or outreach mental health workers. Our findings support previous research that clients perceive a visiting mental health clinician as advantageous for reasons of increased confidentiality, as they are not a member of their local community. Consequently, people are more willing to access the service (Sutherland et al. 2017).

The finding that community attitudes and stigma related to mental health can present a barrier to seeking help and accessing services aligns with previous research (Brew et al., 2016; Hull et al., 2017; Rawolle, Sadauskas, van Kessel, & Dollman, 2016). Consistent with the findings from a systematic review by Cheese et al. (2019), this study suggests rural people tend to be self-reliant and not seek help from mental health professionals.

Interestingly, this study also provides a new insight into rural health professionals' perceptions regarding the appropriateness and capacity of some health professions to provide mental health care. The results indicate that bush nurses' attitudes about appropriateness of social workers providing mental health treatment was a barrier to referring community members to the FDW service. Importantly, services users did not hold these views and attitudes, most recounted positive experiences and some explicitly referred to the appropriateness of the clinician's professional experience, approach and skill set. The bush nurses' concerns were also contradicted by the comparison of K10 scores at intake and discharge, which indicated that service users derived positive mental health outcomes from the treatment and support provided. Further research into the views expressed by the bush nurses regarding the capacity of social workers to provide mental health care

is required. However, this barrier to referral needs to be addressed in the short-term through programs designed to increase the bush nurses understanding and confidence in relation to the service model, staff capabilities and service outcomes.

Attitudes towards telehealth appointments were a challenge encountered with the blended service model. While many bush nurses and clients favoured face-to-face appointments, the small number of clients who had experience with telehealth held positive attitudes towards the modality. Interestingly, Simpson & Reid (2014) found the therapeutic alliance developed during psychotherapy provided by teleconference to be as strong as that when provided in person. Reasons for the attitudinal differences and/or changes in attitude found in this study are unclear and this finding should be treated with caution due to the small sample size. Further research that investigates service user and health professional attitudes to the use of tele-mental health services, particularly in the context of a blended service model, is required. Such research should examine service user perspectives regarding the impact of telehealth and blended models of primary mental health care upon the development of therapeutic alliance.

Our findings are consistent with those of a systematic review that identified high quality therapeutic relationships, a safe and supportive environment and genuine experiences of person-centred care as key elements to client experience in mental healthcare (Staniszewska et al., 2019).

This study found that continuity of care, ideally with the same mental health clinician, to be an important factor in the client experience and their decisions regarding ongoing and/or future service access. This finding is consistent with a study by Biringer et al. (2017) which concluded that the provision of continued care through the same mental health clinician should be a priority for mental health service providers. This evaluation also suggests that continuity of care improves stakeholder confidence in service sustainability.

It is important to note that a range of operational factors resulted in an extension of the evaluation timeframe. Additionally, as operational challenges were encountered they were addressed through program management and governance systems. Consequently, modifications aimed at improving service quality, client experience and stakeholder satisfaction were instituted throughout the evaluation period and the period following data collection. While not directly captured through the data, this study indicates the importance of seeking regular feedback from service users and key stakeholders to continuous service improvement.

Conclusion

Overall, the evaluation findings indicate that the Flying Doctor Wellbeing mental health pilot program has been successful in improving access to mental health services for residents of Far East Gippsland.

There is clear evidence that the program has improved access to mental health treatment due to both the availability of a local service and integration with the local bush nursing centres. Principally, as a result of reduced concerns about privacy and the role of the bush nurses in the referral eliminated the need for a GP referral. The visiting nature of the mental health clinician further reduced concerns related to confidentiality and anonymity. The small portion of service users who engaged in telehealth appointments believed this method felt the same as face-to-face appointments. However, most clients chose to not use telehealth for their appointments. The bush nurses' confidence to refer to certain mental health professionals is one of the most significant themes to emerge in this research. Overall, the majority of the clients and service stakeholders were satisfied with the service, and client outcomes demonstrate a positive improvement in mental health.

These findings add to evidence for the need to tailor mental health services to suit the local rural context. However, further research is required to determine whether integrated and stepped care service models improves access to mental health care in remote communities.

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Appendices

Appendix 1: Key activities summary

When	Activity	Summary
May 16	Gippsland Collaborative Group established	Representatives from RFDS, Gippsland PHN and Gippsland Lakes Community Health agreed to work collaboratively (under an MOU) to plan and implement a psychological service in Far East Gippsland.
May 16 – Feb 17	Consultation and planning period	During this period, consultation was conducted with representatives from local health and community organisations as well as community members. Consultation guided the development of the service model and assisted with the potential challenges.
Feb-Apr 17	Bush nurse training	A 2-day workshop, followed by four webinars was provided to the bush nurses in collaboration with the Australian College of Mental Health Nurses to increase knowledge and confidence with regards to mental health assessment, triage and referral. RFDS telehealth system training was also provided.
May 17	Service agreement with Gippsland PHN executed (May 17 – Jun 18)	A 14-month service agreement was executed with Gippsland PHN to trial the model in approved communities.
Aug 17	Clinician 1 commenced Serviced delivery commenced	Clinician 1 (mental health nurse) commenced with the organisation.
Aug - Dec 17	Community engagement and service promotion	A variety of community engagement and service promotion strategies were employed including: • Service brochure letter box drop • Community presentations and informal attendance at community events • Media release • RFDS website, newsletters and electronic mail
Sept 17	Executive Steering Group MOU executed	Representatives from RFDS, Gippsland PHN and Gippsland Lakes Community Health agreed to support strategic decision making for the program
Nov 17	Bush nurse training evaluation	A post-training evaluation was conducted with bush nurses demonstrating a positive experience that improved awareness and confidence to manage mental health care.
Nov 17	Launch event	Launch event held at Ensay Bush Nursing Centre with RFDS staff, bush nurses, funders and local stakeholders
Mar 18	Clinician 1 resignation	All active clients were discharged and referred to other appropriate services.
Mar - Jun 18	Recruitment period	No services were delivered for a three-month period as the recruitment process took longer than anticipated.

When	Activity	Summary
	No services delivered	
Jun 18	Service agreement with Gippsland PHN executed	Service agreement extends Jul 18 – June 19
Jun 18	Service name change	Feedback from clients, local community members and stakeholders indicated that the service name 'Flying Doctor Psychological Service' presented a barrier to service access and it was not inclusive of those experiencing non-diagnosed mental health concerns. In collaboration with the operational and executive partnership groups, the service was renamed 'Flying Doctor Wellbeing'.
Jul 18	Clinician 2 commencement and service delivery re-commenced	Clinician 2 (social worker) commenced with the organisation. Engagement strategies were implemented to reengage communities and stakeholders with the service. Service promotion was also conducted including: • Social media advertisements • Community engagement activities • Newsletter articles
Jul - Aug 18	Clinical supervision for bush nurses provided	Bush nurses were offered regular clinical supervision with a psychiatrist, provided in-kind by Latrobe Regional Health. One session was provided. Feedback from the bush nurses indicated that they would prefer to access support in an ad-hoc manner rather than regular supervision. Therefore, ongoing sessions were not organised.
Aug 18	Procedural changes	Changes were made to minimise the input of the bush nurses, based on their feedback.
Nov 18	Qualitative data collection commenced	Qualitative data period extends from Nov 18 – Aug 19
Dec 18	Commencement of eUpdate	As a strategy to keep key stakeholders up to date with changes and activities of the Flying Doctor Wellbeing rollout, a monthly eUpdate was commenced.
Dec 18 – Mar 19	Flying Doctor Wellbeing roll out	With additional funding from the Commonwealth Government, Flying Doctor Wellbeing was rolled out to an additional nine communities across Victoria, including three new Gippsland sites. Six new staff members joined the service including one additional Gippsland clinician and a senior clinician to provide oversite.
Feb – Jun 19	Service promotion	With the commencement of new services across the state, an increased level of service promotion was conducted. This included: • Distribution of new program resources • Newspaper advertisements • Social media advertisements • Community engagement • Media release • Articles in community newsletters • Letters to GPs

When	Activity	Summary
Jun – Aug 19	Major upgrade to online system	Major upgrades were made to the online booking and client management system including the addition of streamlined processes for referrers, clinical and admin staff.
Aug 19	Quantitative data extraction	Quantitative data extraction includes data from Aug 17 – Aug 19
Aug – Oct 19	Data analysis period	
Nov – Dec 19	Research report development	

Appendix 2: Proportion of clients by Modified Monash Model of remoteness

Modified Monash Model	
Category	Definition
MMM1	**Metropolitan areas:** Major cities accounting for 70% of Australia's population.
MMM2	**Regional centres:** Inner and Outer Regional areas that are in, or within a 20km drive of a town with over 50,000 residents.
MMM3	**Large rural towns:** Inner and Outer Regional areas that are not MM 2 and are in, or within a 15km drive of a town between 15,000 to 50,000 residents.
MMM4	**Medium rural towns:** Inner and Outer Regional areas that are not MM 2 or MM 3, and are in, or within a 10km drive of a town with between 5,000 to 10,000 residents.
MMM5	**Small rural towns:** All remaining Inner and Outer Regional areas. Islands that have an MM 5 classification with a population of less than 1,000 without bridges to the mainland will now be classified as MM 6.
MMM6	**Remote communities:** Remote mainland areas AND remote islands less than 5kms offshore. Islands that have an MM 5 classification with a population of less than 1,000 without bridges to the mainland will now be classified as MM 6.
MMM7	**Very remote communities:** Very remote areas and all other remote island areas more than 5kms offshore.

Appendix 3: Glossary of terms

Term	Meaning
Access	The availability of appropriate health services, within reasonable reach of those who need them, when they need them.
Locality of Service	The availability of quality mental health services within the geographic area in which clients live or close by.
Service Integration	The ability to engage in a mental health service that is integrated within an existing trusted health service – in this instance the local bush nursing centres.
Cost	The ability to engage with a mental health services without financial burden. This takes into account the price of the service but also indirect and opportunity costs such as the costs of transport to and from the service and the cost of taking time away from work.
Choice and Control	A client's ability to have autonomy, flexibility and involvement in the decisions made around their own mental health treatment. This also includes the client's choices with regards to clinician's gender.
Client Outcomes	The perceived and anecdotal changes in a client's mental health as a result of receiving mental health treatment.
Community attitudes and stigma	The thoughts, feelings and/or beliefs held by members of the community (including local health professionals), in particular the viewpoints that present a barrier to accessing appropriate services.
Confidence to refer	The thoughts, feelings and/or beliefs held by the local bush nurses, that impact on their confidence to refer clients to the service.
Self-reliance	The preference for clients to rely on themselves and their own resources to manage their mental health over seeking professional support.
Suicide	The reluctance to seek help for mental health to avoid the perceived stigma and discrimination, contributing to individuals completing suicide.
Confidentiality and anonymity	The desire for privacy and anonymity for clients when they access mental health services. This includes both during appointments and also the handling of health information.
Engagement	The actions, processes and activities of RFDS staff to actively promote or drive interactions with the service.
Community engagement	The communication, activities and interactions of RFDS staff to promote or involve the local community with the service.

Integration	RFDS's efforts to develop effective relationships and partnerships with existing local health service stakeholders, in an effort to integrate the service within the existing primary health landscape.
Enabling a therapeutic relationship	The components of interactions that impact the relationship between the mental health clinician and the client.
Comfortability and connection	The level of comfort, connection and rapport that that client feels with the treating mental health clinician.
Humour	The use of humour within the therapeutic engagement that facilitated emotional comfort and support for the client.
Relatability	The client's ability to relate, draw personal comparisons or share experiences with the mental health clinician, which facilitated a better therapeutic relationship.
Skills	The belief that the mental health clinician had (has) the capability and appropriate skill set to deliver effective mental health treatment.
Sustainability and Consistency	The assurance that the service will be both sustainable into the future and that continuity of care will be provided for clients.
Consistency	The desire for continuity within the service delivery model, in particular the same mental health clinician delivering the service.
Sustainability	The implementation of ongoing and accessible mental health services into the future.
Reassurance	The feeling of security and relief of knowing that mental health services are available within the community, if needed.
Operational challenges	The day-to-day actions, management, processes, systems or risks that have impacted on the quality, efficiency and effectiveness of the service.
Telehealth technology	Technology and/or connectivity issues that have impacted on the quality and experience of telehealth appointments between the client and mental health clinician.
Attitudes about telehealth	Attitudes towards telehealth that have impacted the effective implementation of the service delivery model, in particular the preference for face-to-face appointments.
Training	Training required by RFDS staff or stakeholders to ensure that the service is implemented efficiently, effectively and to a high quality.
Booking system/process issues	The web-based booking system and associated processes that have impacted on the bush nurses' ability to refer and book appointments easily for clients.
Youth Service	Limitations within the adult only service scope that do not align with client, community or stakeholder needs for youth-based services
Stepped care service model	A staged framework that uses a hierarchy (or steps) of interventions, from the least to the most intensive, which are matched to the individual's needs.

Blended model of care	A service that uses a combination of modalities including face to face, videoconferencing, telephone and online to deliver mental health care.
Bush nurse	Bush nurses or remote area nurses are qualified nurses who have an extended scope in practice to provide clinical care in geographically remote locations.
Mental health clinician	RFDS mental health clinicians are trained as psychologists, social workers, mental health nurses or mental health occupational therapists and it’s within their scope of practice to provide psychological support to clients.