

Key Issues in Rural Health: Perspectives of Health Service Providers in Rural Queensland

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SUMMARY

Funding was received by the Centre for Rural and Remote Area Health (CRRAH) to hold a series of workshops with health service providers across southern Queensland. The purpose of the workshops was fourfold: to determine key health issues that could inform future strategic planning of CRRAH; to increase networking among stakeholders; to identify potential research partners; and to identify potential sources of funding.

Workshops were held in Charleville, Dalby, Kingaroy, Hervey Bay, Toowoomba, Roma, St. George and Warwick. Participants invited to the research workshops were key stakeholders in health provision and other organisations with an interest in community health in target communities and surrounding regions. Attending the workshops were 85 participants from 41 organisations.

A nominal group technique was used to identify key areas of research need. Subsequent content and thematic analysis identified 17 themes. Prioritisation of the themes, frequency of themes across all workshops and number of comments generated per theme were used to provide a ranking of the themes.

The four key themes of: *Workforce*; *Mental Health*; *Access to Services*; and *Community Perceptions and Expectations of Health Services*; were raised at every workshop. *Interagency Cooperation*, *Aged Care* and *Transport Issues* were the next three highest ranked themes.

Within the theme of *Workforce* the main issues raised by participants were general lack of qualified and trained health providers in many rural areas, a fall in recruitment in some disciplines and an ageing workforce particularly in nursing.

Participants from all disciplines expressed concern over the rising incidence in mental health issues exacerbated by the drought and the changes in economic climate. Poor resources for early intervention and cultural issues in seeking assistance were perceived to compound the problem.

The themes and their contained issues raised many interesting research questions, some of which may be appropriate for CRRAH to become involved in. However before committing resources to research areas that were identified from the project, careful consideration should be made. Some topics (e.g., workforce) are already areas of study at CRRAH and for which the Centre has expertise. Other areas into which CRRAH may decide to commit resources (e.g., health education), will require input from a variety of sources.

Results were compared to the outcomes of a similar single workshop held in 2003 in Toowoomba. At that workshop, direct providers of health care and aged care accounted for 35 percent of the participants and 50 percent from university departments. In comparison, 75 percent of the participants in the 2006 workshops were involved in direct care and only 5 percent were from an academic base.

The theme of *Workforce* was highest in both years, with the issues of continuing professional education, training and orientation of new health workers and recruitment and retention featuring strongly in both years. *Mental Health* remained a major theme with assessment; drought, as a driver of mental illness; and access to professional services; principal issues in both years.

What was perhaps surprising in view of the different participants that made up the workshops in 2003 and 2006 was the similarity in health concerns. This may be considered to be indicative of the importance of those themes and issues. The major differences between the two years were: the increased focus on interagency cooperation; access; and health information in 2006. Whether these reflect changes with time or are merely a product of the different participants is not known.

Evaluation of the workshops was requested from participants. Response was low (15%); however without exception all of those that did respond said the workshops were useful or very useful offering opportunities to network and collaborate with other health providers, generate research ideas and acquire knowledge.

In conclusion the workshops were highly successful. Key issues in rural health were identified by the people at the forefront of health provision. The identification of those issues will allow the CRRAH to adopt a research strategy based on informed decision. Furthermore the workshops achieved their other stated objectives of networking, identifying future research partners and of raising the profile of both CRRAH and the University of Southern Queensland in community engagement.

1. INTRODUCTION

1.1. The Centre for Rural and Remote Area Health

The Centre for Rural and Remote Area Health (CRRAH) is based on the Toowoomba Campus of the University of Southern Queensland (USQ). It is a jointly badged research centre of USQ and The University of Queensland (UQ).

CRRAH has its foundations in nursing research. However since 2002 it has established itself as a truly multidisciplinary research centre, incorporating members from disciplines within USQ's Faculties of Sciences and Business, from UQ's Faculty of Medicine, Rural Clinical Division and from various departments within Queensland Health.

The mission of the Centre is to conduct and facilitate health-related research and training in rural and remote communities for the benefit of the community and the health workforce. This mission supports the vision of the Centre in improving the well-being of rural and remote communities.

1.2. Aim of the project

To conduct a series of interactive research workshops with key stakeholders from targeted communities and regions in Southern and Central Queensland.

1.3. Purpose

To increase the ability of the Centre for Rural and Remote Area Health (CRRAH) to:

- Network with stakeholders in rural and remote area health
- Identify and prioritise research needs in rural and remote health
- Identify potential researchers.

An additional purpose of the workshops is that of raising the profile of both CRRAH and the University of Southern Queensland in community engagement.

1.4. Rationale

Achievement of the targets of the Centre will only be met by undertaking work that is topical and applicable to the targeted communities. This is best achieved by engaging those communities in an appropriate forum.

The Centre has had past success with interactive research workshops. In 2003 an interactive research workshop was conducted by the CRRAH in Toowoomba. The aims of that workshop were to: provide an opportunity to identify and prioritise the research needs in the Toowoomba area; identify potential partners for grant applications in this area; and enable CRRAH members to establish networks with key stakeholders in the city and its surrounding areas (Baker, Hegney, Rogers-Clark, Fahey, Gorman, & Mitchell, 2004). A total of 75 participants from 45 organisations, including general practice, universities, Queensland Health, aged care providers, private hospitals, Indigenous health services, Queensland Police Service and Toowoomba City Council attended the workshop.

From this process 43 key research needs were identified and organised into 12 major themes:

- Health professional development and support
- Mechanisms for identifying regional/local needs
- Mental health
- Health and interaction with the environment
- Management of common conditions of which little is known
- Post acute/aged care
- Evidence-based practice
- Health workforce including volunteers
- Indigenous health
- Access to health service delivery
- Economic impact of new programs
- Outcomes impact of research partnerships.

The three year research strategy of CRRAH from 2004 to 2006 has been informed by these identified themes.

In addition, there were a number of research-related outcomes from the workshop, including:

- A successful ARC linkage grant application
- Sponsorship of a CRRAH publication by an industrial partner
- A peer-reviewed publication
- Invited symposia and conference presentations
- Enrolment of two students into research higher degrees
- Research consultancies and other funding provided by key stakeholders
- The overall strengthening of ties with key stakeholders attending the workshop.

Most importantly CRRAH became recognised as an approachable research leader in the district. There were many follow-up contacts from both workshop participants and people referred to us by workshop participants. This has helped make CRRAH the first port of call for people contemplating research in the district and has assisted in the growth of the Centre.

Almost three years have passed since this successful workshop was conducted. Additionally, one of the aims of the CRRAH is to expand its sphere beyond the local region and establish networks in other regions of rural and remote Queensland. CRRAH has already developed ties with some key stakeholders in many of the identified communities. The workshops were expected to enhance those already developed ties and establish new ties. Such ties will greatly enhance the likelihood that CRRAH will be able to effectively and efficiently conduct its core activities, enhance the USQ philosophy and commitment to regional development and increase the amount of research income to USQ through these activities.

An additional benefit to hosting workshops is to increase the effective size of the University research workforce by tapping into the existing pool of highly educated health providers in the rural and remote areas of Queensland. Potential researchers may be identified through the workshop program and support given to develop their research skills.

From previous experience, we have found the best way to engage potential health researchers is through going to them, making ourselves available, listening to their interests and priorities, providing the encouragement and expert advice they need in developing study designs and funding applications, and giving them the support and

confidence they need to pursue research. With appropriate support, many will choose to pursue their research interest as higher degree students.

The research team consulted widely in the preparation for this project. The proposed project received wide support from key stakeholders in targeted communities, providers of health services to these communities and key professional bodies.

I agree that this will be an invaluable resource in helping you gather further information about perceived areas of research needed across these areas – Agency head.

[our organisation] believes that this initiative will be of real benefit and value to the rural and remote communities of Southern and Central Queensland - Agency chair.

Sounds like a great project – Care organisation Director.

The process by which local communities are given the opportunity to assess and prioritise their needs pertaining to specific research is a great example of effective and open consultation and I congratulate [CRRAH] on this initiative – Town Mayor.

This concept has strong appeal for [our town] – Town CEO.

1.5. Expected outcomes

There are many expected outcomes from the workshop program including:

- Increase the profile of CRRAH and USQ in the targeted regions
- Provision of the opportunity for key stakeholders in targeted regions to have a voice about the direction of the research program conducted by the CRRAH
- Identification and prioritisation of research needs in targeted communities and surrounding regions
- Incorporation of project outcomes into future CRRAH research streams
- Strengthening of ties with key stakeholders in the targeted communities and increasing the pool of industry associate members of CRRAH
- Identification of potential partners to provide in-kind and cash contributions for competitive research grant applications
- Publication of a DEST-eligible research paper and presentation of findings at relevant state and national conferences
- Increase in the pool of researchers available for partnerships.

2. METHODOLOGY

2.1. Ethical clearance

Ethical clearance was obtained from the University of Southern Queensland's Human Research Ethics Committee.

2.2. Location of Workshops

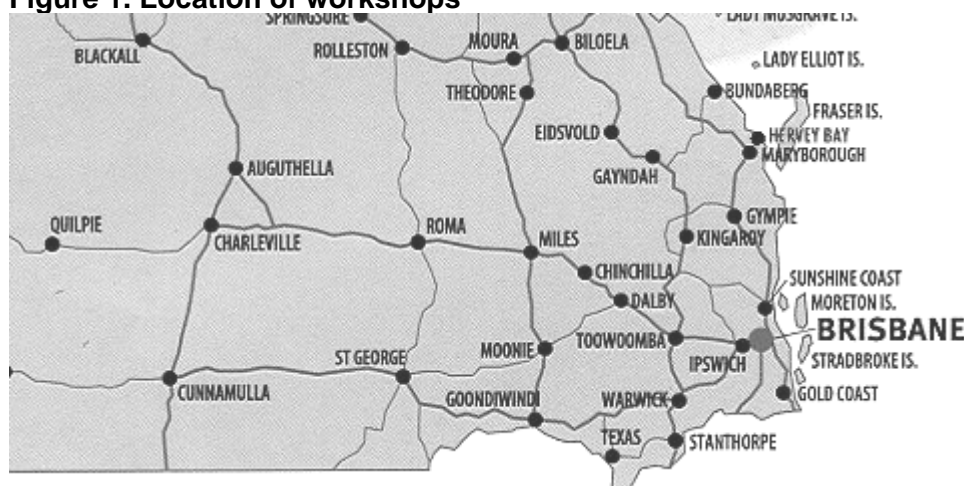
The town locations and their remoteness classification are listed in Table 1.

Table 1. Remoteness classification of workshop locations¹

	ARIA	Percentage of population by ASGC				RRMA	SLA
		Inner Regional	Outer Regional	Remote	Very Remote		
Charleville	10.38			60.9	39.1	7	5014
Dalby	1.45	100				5	10130
Kingaroy	2.08	83.3	16.7			5	11835
Hervey Bay	1.92	97.2	2.8			4	39697
Roma	5.15		100			6	6673
St George	7.54			88.8	11.2	7	5564
Toowoomba	0.29	100				3	116085
Warwick	1.29	100				4	11354

The towns were chosen as being a representative selection of population centres in the region (Figure 1).

Figure 1. Location of workshops



¹ **ARIA** - Accessibility/Remoteness Index of Australia - remoteness as accessibility from 11,338 inhabited towns across Australia to four levels of urban service centre categorised on the basis of population size.

ASGC - Australian Standard Geographical Classification - a hierarchical classification system consisting of six interrelated classification structures.

RRMA - Rural, Remote Metropolitan Areas - a seven-scale classification of remoteness, founded on the Statistical Local Area (SLA).

SLA - Statistical Local Area 2001 population.

Further information on these indices may be obtained from the Department of Health and Ageing or Australian Bureau of Statistics web sites.

Two additional locations, Goondiwindi and Cunnamulla were targeted for workshops, however these were cancelled as fewer than four organisations confirmed attendance. However other organisations that serviced these two locations attended workshops in Warwick, St. George or Charleville.

Toowoomba, the largest of all the towns, represented not only an inner regional town with many health facilities but is also the site of the regional headquarters of many of the targeted health organisations.

Warwick, Dalby and Kingaroy are also inner regional towns, although Kingaroy has almost one fifth of its population considered to be outer regional. Warwick is also classified as less remote by RRMA than Dalby and Kingaroy. All three towns have similar populations.

Roma which is a major rural hub is outer regional and Charleville and St. George represented remote/very remote locations. These three towns all have similar town populations.

As shown in Table 2 all the selected towns have large rural or remote catchment areas and have, with the exception of Toowoomba, populations within the health district double or even treble the town populations.

Table 2. Town and health service district population and percentage of population over 50 years of age

	Town Population	Health Services District	Population*	Population over 50*
Charleville	5014	Charleville	8765	26.8
Dalby	10130	Northern Downs	30857	31.8
Kingaroy	11835	South Burnett	33596	34.4
Hervey Bay	39697	Fraser Coast	83070	39.5
Roma	6673	Roma	18216	27.1
St George	5564	Roma	18216	27.1
Toowoomba	116085	Toowoomba	144835	29.1
Warwick	11354	Southern Downs	59080	32.3

* As of 30/06/03: Source Queensland Health

Demographics of the populations vary, with the percentages of the population over 50 years of age also presented in Table 2 against a Queensland average of 27.2%. In particular Hervey Bay, on the Fraser Coast, has almost 40% of its population over 50.

With the exception of Roma and St. George all the towns are each located in a different Queensland Health District. The district demographic data from the 2001 census indicate that four of the seven health districts in which the workshops were held have Indigenous populations higher than the State average of 3.1% (Northern Downs 3.5%; South Burnett 6.4%; Roma 8.3%; Charleville 12.4%).

Furthermore all the health service districts had lower percentages of their populations from a non-English speaking background (NESB classification) than the 7.1% State average. Figures ranged from a low of 0.9% for Roma to a high of 3.0% for Warwick.

2.3. Participants

Participants invited to the research workshops were key stakeholders in health provision and other organisations with an interest in community health in the target communities and surrounding regions. These included aged and community care providers, general practitioners and medical specialists, consumers, allied health workers, health promotion

officers, and representatives from relevant Queensland Health service districts, Indigenous health services, city and shire councils, charitable organisations, public and private hospitals, and the Queensland Police Service.

Participants were recruited through existing established networks of CRRAH and through media opportunities in targeted communities. In addition, snowball sampling (Morrison, 1988) was utilised, where prospective participants in targeted communities were asked about other stakeholders who might wish to attend the workshop. The workshops were advertised in the local newspapers and on the radio. In total 230 individuals representing 168 different organisations were contacted. Those contacted were also asked to pass on information to other people and organisations that they believed would be interested.

Contact was established in the main by phone call followed by email (or occasionally fax) of a letter of invitation that contained details of the project. Recipients of the letter were encouraged to contact CRRAH should they require further information. Prior to the start of the workshops, participants were given a Plain Language Statement and Informed Consent Form. (See Appendix 1).

2.4. Format of Workshops

Data for the project were collected through interactive research workshops attended by key stakeholders in the targeted regions.

The Research Liaison Officer and a member of the project team travelled to each community to conduct the research workshop.

The workshops used the nominal group technique to identify key areas of research need (O'Neil & Jackson, 1983). This technique involves a structured workshop which allows for both individual and group processes in decision making while overcoming a number of critical problems typical of interacting groups (Delbecq & Vande Ven, 1971). The workshops began with silent generation onto cards of key health issues. Ideas from the group were presented, discussed for clarification and pooled into themes. Participants were given the opportunity to identify the key issues and those with the highest priority were discussed further in small groups and key points presented on sheets of paper. Research needs within these key areas were also discussed and presented.

All discussions were audio-taped. Each workshop started at 1000 and finished between 1400 and 1430 with a half hour break for lunch.

2.5. Analysis

Recordings from the workshops were transcribed to aid in interpretation of the generated cards and paper.

All identifying information from the qualitative data was removed prior to analysis. Data were analysed by content analysis; thematic coding of interview texts; comparison through the process of indexing and re-analysis through text search. In addition the data were quantified within and among both workshop and thematic issue according to prioritisation by participants, frequency of theme appearing and number of comments generated. An assessment of the overall importance of the theme was made by the researcher who attended all eight workshops. Combining all these data generated a ranking of themes by importance.

3. RESULTS

A total of 85 participants representing 47 services and 41 different organisations attended the eight workshops. The names of the organisations are presented in Table 3.

Table 3. Organisations represented at the workshops

Type of organisation	Name of organisation
Agencies	
	Commonwealth Respite and Carelink
	CRS Australia
	MBF
	Medibank Private
	Medicare
Care delivery	
	Anglicare
	Blue Care
	Fraser Coast Multicultural Respite Centre
	Ozcare
	Queensland Health Aged Care Services
	RSL Care
	St. Luke's Nursing Service
	Tricare
Community Health Services	
	Lifeline Community Care
	Maranoa Health Enhancement Program
	Queensland Bush Nursing Association
	Queensland Health Community Health Services
	Queensland Health Public Health Services
	Queensland Health Mental Health Services
	Royal Flying Doctor Service
	South West Queensland Healthy Ageing Program
	Wide Bay Women's Health Centre
Local government	
	Kingaroy Shire Council
	Murweh Shire Council
Counselling	
	Centacare – Southwest Queensland Psychology Service
	Hervey Bay Neighbourhood Centre
	South West Financial Counselling Service Inc
Hospitals	
	Baillie Henderson Hospital
	Charleville Hospital
	Hervey Bay Hospital
	Killarney & District Memorial Hospital Ltd
	Maryborough Hospital
	South Burnett Community Private Hospital

Type of organisation	Name of organisation
Indigenous Health Services	
	Carbal Medical Centre
	Goondir Aboriginal & Torres Strait Islander Corporation for Health Services
Pastoral services	
	Bayside Christian Church
	Church of Christ Pastoral Care
	Queensland Health Pastoral Care Services
	St. John's Anglican Church
	Queensland Police Service
Medical support organisations	
	GP Connections
	National Rural Health Network
	Rural and Regional Queensland Consortium Ltd
	Southern Queensland Rural Division of General Practice
Medical and Health educational	
	TAFE
	University of Queensland Rural Clinical Division
	University of Southern Queensland Department of Nursing

The participants by sector and location at each of the workshops are presented in Table 4.

Table 4. Participants by location and sector

Sector	Location								Total
	Charleville	Dalby	Kingaroy	Hervey Bay	Roma	St George	Toowoomba	Warwick	
Agencies		2	1		2	1	3	1	10
Care	1	3	3	3	2		6	1	19
Community health	2	4	2	3	2	4	2	2	21
Council	1		3						4
Counselling	1		1		2		1		5
Hospital	1		1	2			1	1	6
Pastoral Services				2		2	2		6
Police	1	1					1		3
Other				1			6		7
Total	7	10	11	11	8	7	22	5	81

3.1. Prioritisation of themes

After the generation of issues participants were asked to nominate the issues or themes that they believed were the most important. The instruction was that they could not nominate an issue that they had generated. Each participant nominated one issue that

was 'most important' and one issue that was 'important'. These were scored 3 and 1 point, respectively. The points were tallied and are presented by theme in descending order of priority in Table 5.

Table 5. Prioritisation of themes

	Charleville	Dalby	Kingaroy	Hervey Bay	Roma	St George	Toowoomba	Warwick	Total
Workforce	11	4	21	1	13	10	14	8	82
Aged care			2	24			3	10	39
Mental health		8	5	7	5	1	4		30
Access		6	7	6	1	2	4	3	29
Substance abuse		3		2		1	20		26
Interagency cooperation	7	4				6	7		24
Perceptions/expectations		5	4		5		3		17
Carers		9					7		16
Indigenous health		9					7		16
Disability			3	1			10		14
Counselling	4	3		4	1				12
Health education			6					5	11
Youth				1	7	3			11
Chronic disease	7	3							10
Transport	1	1			6	1			9
Health providers				2		4			6
Health information					1				1

By combining priority rating and frequency of prioritisation, workforce, mental health and access may be considered the highest themes followed by aged care, perceptions/expectations and interagency participation.

Another way of ranking issues was by number of comments per theme (Table 6). Aged care generated the largest number of comments followed by workforce and access.

Table 6. Number of comments

	Number of comments
Aged care	462
Workforce	326
Access	318
Perceptions and expectations	198
Health information	191
Transport	159
Interagency cooperation	153
Health education	117
Mental health	111
Health providers	72
Carers	63
Substance abuse	38
Indigenous health	34
Chronic disease	27
Youth	24
Disability	18
Counselling	12

Finally the number of times (ignoring prioritisation) in which the themes were raised across workshops was determined (Table 7). Workforce, mental health, access and perceptions and expectations were raised at all workshops; transport, aged care and interagency cooperation at seven; carers, counselling, health education, health providers, health information, youth and substance abuse at six; disability at five and chronic disease and Indigenous health at four workshops.

Table 7. Number of workshops in which the theme was raised

	Charleville	Dalby	Kingaroy	Hervey Bay	Roma	St George	Toowoomba	Warwick	Total
Workforce	X	X	X	X	X	X	X	X	8
Mental health	X	X	X	X	X	X	X	X	8
Access	X	X	X	X	X	X	X	X	8
Perceptions/expectations	X	X	X	X	X	X	X	X	8
Interagency cooperation	X	X	X	X	X		X	X	7
Aged care	X		X	X	X	X	X	X	7
Transport	X	X	X	X	X	X		X	7
Substance abuse	X	X		X	X		X	X	6
Carers		X	X	X		X	X	X	6
Counselling	X	X		X	X	X		X	6
Health education	X	X	X	X	X			X	6
Health information	X		X	X	X		X	X	6
Youth	X		X	X	X	X		X	6
Health providers	X		X	X		X	X	X	6
Disability			X	X	X		X	X	5
Chronic disease	X	X	X			X			4
Indigenous health	X	X				X	X		4

Combining all the prioritisation, frequency and numbers of comments with overall perceptions of the research team regarding participants' interests, we conclude that the most important issues as identified by the participants to the eight workshops are workforce, followed by mental health, access to services, perceptions and expectations of the community of rural health services and interagency cooperation. These are noted in bold in each of the Tables.

Each of the issues is presented in the following pages. The first five issues are listed in the order of their importance. Comments are summarised and quotes are included to illustrate many of the comments.

It should be noted that the comments are used to demonstrate the perceptions of the participants. The authors of this report have not commented on the accuracy of those perceptions in the results section, however have done so in some instances in the discussion.

3.2. Workforce

Delegates identified workforce issues as being the largest threat to sustainability of health services in rural and remote Southern Queensland. Workforce issues, in particular recruitment and retention of staff, were raised and prioritised at all eight workshops. The theme was considered to be the highest priority at five workshops. The number of comments generated was 326; second only to aged care. However in the case of workforce, comments were distributed across all workshops whereas half of the aged care comments came from one workshop (Hervey Bay).

The comments raised mirrored those collected by CRRAH in its 2001 and 2004 studies of the Queensland Nurses Union members. Furthermore at a forum convened by GP Connections, and held in Toowoomba in July, that addressed Indigenous health issues, workforce again was a prominent feature. Specifically mentioned at that forum was the need for capacity building of the Indigenous health workforce.

3.2.1. Issues

Skilled workforce

Participants noted a general lack of qualified and trained health providers, a fall in recruitment in some disciplines and an ageing workforce.

Our mix of mature-aged students increases every year. That doesn't improve the overall age of the workforce. Overall there's a 12% reduction in Queensland of interest in studying nursing.

Attracting and keeping personnel is a major issue.

As we all know it's also more exciting a job and it's better down the coast.

Many of the rural and remote nurses were stated to be those who trained in the country and stayed while the newer nurses who go away to train are less likely to return.

Ninety percent of the people out here are nurses that were trained in the country and they're still here. They are now fairly aged. They trained here, they married here and they stayed here. However once you send them away to university they don't come back here. This is the last place in the world they want to be in.

Workforce issues were considered to be particularly problematic in the areas of mental health and aged care. It was stated that although on paper positions exist they are often not filled and this as a result leads to a reduction in services in remote areas.

The response is that we have, say five psychiatrists, I'm not sure if that's what the exact figure is, but when you actually look at what they're doing that probably equates to about two and a half full-time person weeks because of all their commitments. The manpower is such that – lack of manpower is such – that even the facilities [in Toowoomba] are not functioning properly; so what hope is there to provide the outreach services to us?

Problems associated with workforce in rural areas are not unique to health.

We've had at least three in the last two years who have had to resign rather than come to Charleville or Cunnamulla. Yet those who actually come in with the right attitude have an absolute ball and the best time they had in their police service.

Work practice

They also noted a change in work ethic.

We aren't encouraging loyalty because of shift to short term contracts.

Too much reporting was stated to be taking qualified staff away from clinical practice:

Well qualified people that are not actually doing hands-on work.

One participant suggested a new type of multi-skilled worker who can multi-task:

Currently we've got workers who are very specialisedand every rural area is not going to have an occupational therapist or a physio, or the numbers which they need, so it's developing these multi-skilled workers which can do a certain percentage of the job and just referring on to a physio when they need someone with those specialised skills or a doctor or a cardiologist or whatever.

Terms of service

Terms of service was considered an issue for recruitment and retention in relation to the salary inequities between the private and public sectors.

I just think it's appalling the wages and the attitudes toward workers in the private sector.

Conditions of service are considered to be a major issue in aged care.

Even our aged care workers, they're all paid under the Private Hospitals Award and our carers in the hostel only get basically \$11 something an hour.

Other examples of terms of service affecting recruitment were insufficient flexibility for meeting child care demands for shift workers, lack of housing and poor bereavement leave.

I think that's going to be a general incentive in future years – because we're going to be competing for employees – things like child care and all those sorts of things are going to become real incentives.

Specific barriers to living and working in rural and remote areas are social limitations, educational opportunities for workers and their children, the rural lifestyle, and self and partner's career prospects.

There's the question of the other spouse and lifestyle would be housing, job opportunity, schooling, a whole host of other lifestyle factors to enter into the equation. The packages have got to be out there to attract them.

The well being and health of the workforce was stated to be lacking, with assault on the increase. The increase in violence was however refuted with some participants suggesting that although reporting had increased actual violence had not.

Excuse me, can I say categorically it hasn't increased. I've been in the game for 30-odd years and it was much worse 30 years ago than it is now. It's only the reporting that's increased.

Training and education

Health workers get deskilled and yet access to retraining for rural workers was invariably poor and accompanied by travel issues and associated costs.

A lot of community health workers actually find themselves deskilled over time and there's not a lot of programs where they can actually go and up-skill with a minimum of cost or effort

There was stated a need for improving educational opportunities, handover for new staff and providing mentoring for new staff.

I was a new grad, no one on the ground with me, no mentor and I think that reflected on my case management as well. Dealing with farmers and people in a totally different world and I think it took me a while to build up their trust because I'm a young female.

There was a view that overseas health professionals require more cultural information about their work location.

From a personal perspective, it would have made such a difference for me if I had to go through cultural training almost before I entered the community because we don't know.

Recruitment and retention

Specific issues relating to recruitment and retention were raised.

Even if funds are available often there is no-one to fill the role and training is not part of the funding package.

There is competition for recruitment in rural areas.

Basically the rural areas are snitching (sic) from all the other rural areas.

Turnover was noted to be high and it was considered that it could be even higher

The only reasons some stay is maybe their long service leave or they've got x amount of years until they retire and they're not prepared to go through that starting again process.

More emphasis was needed to encourage school students to consider a career in health. The participants at the workshops were very passionate about their own jobs and recognised that current health personnel could make a contribution to recruitment.

But it's nice to put your own personal stamp on something and that's where you get the opportunity. I think a lot of our particular young people out here get opportunities to do roles in their different professions; if they were in the big smoke they would have to wait another 10 years and probably three rounds of promotion to do it.

They noted that the benefits and opportunities of working in rural and remote areas need to be stressed. Noted was the responsibility and independence offered by the jobs.

There's at least 200k between each of those towns. So there's also the variety that comes into it which adds to the challenge of managing and dealing with the job aspect.

In many ways, and our service specifically, we are talking of pretty much running your own show.

Stressed was the sense of community that may be missing in larger towns or cities.

A lot of our clients here, because we live in the same town and the same area, we actually keep in touch with them. Five or six years down the track, it's me saying, 'I remember that young fellow. I gave him a bloody kick up the butt and told him to bloody pull his head in, now he's joined the Army or something like this', then you can actually see that job satisfaction – you actually see a reward for what you do.

3.3. Mental health

After workforce, mental health was the most important theme raised at the workshops. Mental health was considered to be the greatest health condition affecting people in rural and remote areas. The theme was raised in all workshops, prioritised in six and received the third highest priority rating. The need for a proactive approach with early intervention, early and positive exposure was identified but lack of staff and services and client culture were seen as major obstacles.

3.3.1. General issues

Mental health issues are tied in with homelessness, substance abuse, violence and crime. The problem has been exacerbated by the prolonged drought and direct economic factors such as fuel costs and taxes.

There has been a fair increase for a number of reasons but the drought and economic situation in the district are the principal contributors to the anxiety and depression.

As a result people's livelihoods have been affected. Many small businesses have collapsed and depression and isolation of farmers is a huge problem.

People are going to go mad. Every small business is going broke. There's just not too many of us left. They're going to jump or they're going to start shooting themselves and all this sort of thing. They will.

3.3.2. Clients

Rural people are reluctant to access services largely because of 'the Australian identity' which prohibits men from seeking support:

Once they lose their wives and partners they haven't got a lot to do or they're just lonely. There's not a big support network, especially for men.

It was stated that health professionals must understand their clients; something that young inexperienced workers find it difficult to do.

When I came here and it was 98% female clients accessing the service and in the last three years it has changed absolutely. I'm now running at 70% males and 30% females. I think a lot of it has to do with the fact that I go and I work where the man is, whether it's under the bulldozer or whether it's cleaning out the dam.

As with general counselling there is stigma attached to support and issues of anonymity.

I know of one case where one person really needs to go and see someone but will not go because she knows the people that are there and she needs to sort out her problem and so does her husband but they know people there so they won't go.

Co-morbidity of other issues is a frequent problem for which the procedures fail.

For example, if it is alcohol dependent schizophrenia perhaps mental health can't deal with the schizophrenia side of things until the alcohol side of things has been organised, but then the alcohol-side of things workers can't work with that until the schizophrenia side of things is sorted.

Also of concern is the fact that access to youth is restricted by guidelines, confidentiality and the need for parental consent.

3.3.3. Services

Treatment of mental health is a major problem related to poor services in rural areas. Where services exist there are long waiting lists. Assistance to drought affected families is sparse and there is not much support for men. Many of the issues are related to workforce and a lack of trained and experienced personnel. A long list of resources and services were listed as being lacking in the communities. These included:

- Acute facilities
- Secure mental health units
- Lack of detoxification centres
- Psychological services for non-severe mental health
- Poor access for depression and other mental health issues that don't meet criteria
- Suicide prevention
- Accommodation/community housing
- Support services
- Lack of after hours support from social workers needed in emergency situations and
- Provision of out of hours medical assessment and care.

There is a lack of accommodation resources for people with mental health issues. You see more and more coming through that obviously require support and all our accommodation is off-site supervision and a lot them we just can't take because they need that person on site and they're either not medicated or need to be, some of them....then there's two month's wait to see a social worker at the hospital.

I've had a person that I've been associated with in the last two years that seems to fall through the cracks of every service I've tried to refer to. He has now just turned 18 but he has Asperger's Syndrome and does not qualify to be supported through Mental Health because it's not a Mental Health issue but he has no living skills and no family support and Disability Services Queensland say, yes, we'll support him but someone has to ask for a package for him and they will tailor make it.

There was an attempted suicide last week and that was referred – mental health said, 'It doesn't fit our service.' We tried to get a psychological assessment...from the Rural Allied Health Team and they said, 'No, too young; doesn't fit.'

3.3.4. Workforce

Health staffing is the major issue in the mental health area. There is a major lack of psychiatrists and psychologists. Psychiatric support largely comes from Toowoomba which too has suffered from low staff numbers.

My impression is that the mountain is the same for Toowoomba, lack of manpower is such that even their facilities are not functioning properly all the time. I understand that money is perhaps not the issue; the assailing problem is actually the lack of manpower.

Experience of many workers was considered to be low, leading to poor understanding of the issues. Limited facilities/space, worker burnout, lack of professional support, remuneration, incentives and training all compound the issue. These are addressed more thoroughly in the workforce section of the report.

3.4. Access to and provision of services

This theme was raised in all workshops and was prioritised in seven. Overall it was ranked fourth in priority and had the third highest number of comments. The general theme was about limited availability of services in rural and remote areas for diagnostics, basic and specialist health services, transport, accommodation, counselling, waiting times and respite.

It was recognised that rural towns were attractive to live in because of lifestyle and the lower cost of living; however their basic services had fallen behind. As a result the health of the populace was being compromised and those who are at risk range from the general public at large to particular groups such as the youth, those with disabilities, the aged or the mentally ill.

One general comment was that services were being taken out of rural communities without a real understanding by policy makers of what the demands are in those communities. The general feeling is that decisions based on finances or population can be misplaced.

Everything is being centralised to the city and they're all telling us what's best for us out here in the bush – just because they might need to do it in Brisbane doesn't necessarily mean that we need to follow suit.

The greatest concerns were expressed in the areas of services for the mentally ill and disabled, facilities such as respite for carers, general transport issues and support in the aged care sector. These five areas are addressed in detail in dedicated sections of this report whilst this section deals with other access and provision issues that were raised as indicated in the subheadings below.

3.4.1. Assessment

Assessment of clients for determination of support was considered to be slow and often difficult.

Firstly there are long delays to have the assessment done and secondly because of the demand on the resources, it's not very flexible.

Particularly problematic were people who did not clearly fit into the defined categories.

We tried to get a psychological assessment of that person and the only psychological person – person with that background that we could use was someone from the Rural Allied Health Team and they said, 'No, too young, he doesn't fit'.

3.4.2. Accommodation

Lack of accommodation was noted for single women, mental health patients, the youth and the intellectually disabled. There was also a lack of step-down or interim care facilities for the aged. Furthermore there is very little crisis accommodation available in the rural towns.

I had to send someone off to Toowoomba because he had nowhere else to go. So he took up a bed in the local hospital, ended up going to the Psych Unit at Toowoomba, whereas if we had crisis accommodation and I could look at some more local supports,

we could have stopped that. You know he was flown out on the plane. Can you imagine how much money that would have all cost?

A step down or even convalescent type of facility was advocated in several instances however it was recognised that drawing the boundaries is difficult.

It will either be used by people pushing patients who are really too sick into it because the hospital is overflowing, or if the hospital is not overflowing and there's a bit of a gap there, then people who aren't quite sick enough who probably could manage at home will stay there for an extra week or so just to make sure everything is alright.

There is a lack of hospice provision in most rural areas and the entire Fraser Coast has no hospice.

Well, persons that have been diagnosed with terminal cancer are often transferred into nursing homes because there's no hospice available in the district and the closest one would be Brisbane and they don't want to go outside their area.

3.4.3. After hours access to health services

Very little after hours access was available in many communities:

And that impinges on the hospital because our general out-patients is just going right through the roof in the last 12 months. It's gone crazy. Just general GP type stuff, there's just thousands, increasing all the time.

However it was recognised that changes to hours for some services may not work out.

We trialled Medicare office Saturday opening and tried it for four weeks but it didn't work out. The first day one person came in to say hello. We were very grateful that he did. The second time I think there was one or two.

3.4.4. Childcare

Lack of child care facilities for both health professionals and their clients was a stated concern. However some expectations would stretch facilities and appear to put an unrealistic responsibility of being a parent on someone else.

Child care access, if it's a lengthy enquiry like you would have at Centrelink or one of those agencies and you've got the children in tow, that can be very distressing.

3.4.5. Community

Poor community safety was noted in some towns (e.g. lighting, bike paths and seating for the elderly) and lack of community participation in health initiatives. There was concern that town expansion was permitted with little regard for the long term health consequence.

There's a new complex being built just down the road ...a retirement village. Where is the increase in health services? In five years time these 200 extra people will need even more health attention. Who is going to provide? Where is the nursing home?

3.4.6. Cultural diversity issues

The increase in specific demands on staff working with culturally diverse clients was recognised. The need for effective interpreters and staff training was highlighted. Concern was expressed as to whether in future there would be sufficient support in environments where a large influx of foreign nationals is expected (e.g. Vietnamese in the meat industry in Charleville).

That's going to be one big shock to the health service.

3.4.7. Diagnostic services

Diagnostic services were stated to be poor in some communities.

People don't get diagnosed out here until they're in such a state that they're really suffering from ill health because there's nothing here to do diagnosis of cancer.

3.4.8. Financial costs

Cost of accessing GP services and insufficient bulk-billing especially for the financially disadvantaged was noted, as was the fact that there are no Medicare services west of Dalby.

They've increased their bulk billing but they've closed their books now because they've got so many patients, they can't actually look after them properly.

Sporadic funding means that projects come and go and people lose confidence.

A lot [of programs] are only funded for six months and they get the community and the workers in hook, line and sinker; they reorganise their lives around it and then next thing the funding has gone.

3.4.9. Privacy

Although services may be available, lack of anonymity may prevent a person from accessing that service.

It could be someone wanting to get something from the chemist filled that might have implications, or someone visiting a counsellor. It could be an adolescent wanting a condom. There are no condom machines so they will have to go to the chemist; so they will do without and go and get an STD.

3.4.10. Palliative care

Restrictions to palliative care was raised and the focus on care for cancer rather than other diseases.

Chronic obstructive airways, heart failure, other motor neurone disease, none of those are considered as palliative care. It's all cancer and that's what the funding is for. Not enough funding for anything else.

3.4.11. Pastoral Care

A more professional approach to pastoral care was suggested.

I think traditionally a lot of pastoral care has been very ad hoc, not coming from any good research base. A lot of different faiths just do what's their thing and there's no common approach across faiths. There's a lot of spiritual abuse that happens where people just Bible bash people. [We need to look] at getting some good frameworks within which to do pastoral care that's client-centred and positive. Measuring the effectiveness of pastoral care and having planned pastoral care rather than just ad hoc stuff.

3.4.12. Professions

Examples of lack of specialist medical services included obstetric and anaesthetic support and access to allied health professionals such as podiatrists, dieticians and speech therapists. Also noted was the lack of female GPs and dental services.

There's a four year wait [for dentists]; it's not appropriate for aged care service because if you wait for four years...

3.4.13. Services

Accessible blood donation services have been removed from many rural areas.

Giving blood is more of a sort of impromptu type of thing isn't it? You just think, 'It's there, and I will go and give it.' You don't want to organise your whole day to just go and give a pint. And in many cases you can't afford the time unless it's convenient.

One concern expressed was the large catchment areas of the rural towns.

We are a regional centre, but we're only a considerably small town, we provide a whole raft of services here that aren't for 12,000, they're for 35,000 and it's hard to get the Government to recognise that.

3.4.14. Volunteers

The issue of volunteers and the legal requirements, red tape and expectations of reporting to government were a concern especially for services that are dependant upon volunteers for existence.

Community groups that don't receive any Government funding whatsoever and they still have to go through this enormous accountability and crap. It's getting to the point where even our local hospital auxiliary looks like it's going to fold. We can't get anybody willing to take on the role in the committee because the expectation is just too huge and they feel too open for being sued and all this sort of stuff.

This area is certainly one where there is a great deal of resentment in what is perceived to be unnecessary intervention and overkill.

The really sad part for me is a lot of the times these community groups are run by the elderly who are retired and they're looking for something to keep themselves stimulated and then they're faced with all this stuff that you nearly need a degree to be able to meet the requirements.

3.5. Interagency cooperation

Interagency cooperation was one of the top five health themes. It was raised in seven workshops, prioritised in four and generated 153 comments. The theme was tied very closely to health information.

Sadly a lot of us are in competition... I think that's a bit of a pity because I think we should share all of our information.

3.5.1. The problem

Providers are concerned that they communicate poorly among themselves. Common parlance is 'working in silos'.

I guess in some ways some of us might be a bit ignorant as to what other organisations or what other providers are doing and maybe they could come up with a way of communicating or developing a database or something ...

Cooperation between public and private health will maximise services and it was recognised that greater communication is required for greater understanding of service scope and avoidance of duplication of services.

I know Queensland Health started doing an audit of all the services and all the transport needs within the community. Now our program had already done that and I quite willingly handed it all over because, like I said, it's a waste of time and resources.

Resources are not being utilised efficiently. There is a lack of awareness of current and past programs offered.

Different projects are funded in areas that we don't hear about until the funding has been pulled... [I need] regular updates on what's happening.

Access is needed to all relevant services in local and surrounding areas to support clients. Unfortunately policy changes are not thought through and the bottom line is that quality care for consumers is not maximised.

They changed the privacy rules and we, as a community service with the hospital, are no longer involved in client services meetings. Supposed protection of clients actually harms them. This is just silly and must be addressed.

3.5.2. The causes

Various reasons for the lack of cooperation were suggested. These included ownership issues intensifying lack of coordination and collaboration, splintering ('divide and conquer'), problems associated with the sharing of intellectual property and over-regulation. Funding was however the key issue.

All of us are working in isolation because we're all competing for the same bucket of funding rather than saying who is actually in the community delivering that care. Why does another organisation need to come in and compete for the same funding if another body is already doing it well? And so we don't train, we don't educate with each other, we don't share resources.

Team work; everyone understands team work, but no one knows how to work with other service providers because funding is not about working together.

Some of these issues are actually taken up with funding. People want to hang on to their clients because they need the statistics for the fundingso they really are unwilling to give people information to other services. They are not told what services if they've gone beyond what Queensland Health can offer[it's] really irritating that people are missing out on services when they shouldn't be and it's all because of the money.

It was recognised that interagency meetings do occur, however time restraints, incompatibility in IT and culture ('it's not my job') were offered as reasons for poor attendance. Several participants stated that interagency meetings lack a clear structure or provided the wrong type of information resulting in loss of interest.

We thought this might be something that would go well in [name of town]. 'How can we all work on this together?' But it's very much, 'This is what we're doing' and that's it. That's where it gets left.

People are saying things like 'We're not going to these meetings because we don't find them productive' and people are questioning why people aren't going.

3.5.3. The solution

It is essential that health providers see that provision of information can be just as important as direct health care.

They don't prioritise [meetings] as being that important, and yet sometimes what they would get out of them would actually make their work a lot easier and they would be more productive because of it.

That's all really our responsibility, that side of it, isn't it, if we all let each other know and inter link and help where we can I guess.

To work properly networks require communication and the identification of target groups and key stakeholders.

Effective and practical networks must actually have some clear goals on why they're meeting together and what they want to achieve when they get there and it doesn't just become a 'Let's meet the new people talkfest'.

Community engagement was stressed.

The community has a responsibility to care for itself and to operate as a healthy community and so the community needs to take some ownership in coordination of services that are available to its members.

And the key people to be involved in that would be at least one shire councillor from each area, at least one key community member from each area and maybe at least one service provider from each area to perform – even for a short time, maybe not a permanent group even, but just to get together and work out how we can set up some structures and procedures to make sure that our community is cared for effectively, that sort of thing.

Training in communication techniques is required as are suitable information packages for providers.

A regional orientation package is probably what is needed. That's aimed at service providers, 'Where are the connections?' I would imagine that there would be some things that go with each other like hand in glove and there would be other things that are really totally – they're on different planets. Maybe they have different stakeholder groups, but which services are constantly hitting the same target group? What services should be connected intimately with one another? What services currently are and what aren't available that should be?

Providing information to fellow organisations can be accomplished by different mechanisms.

Their question to me was, 'How can we help you?' My answer to them was, 'Help me by keeping me updated of the changes.' What I'm aiming for is to get the organisations in the local areas to automatically feed the information into me in the form of an email stating changes.

Additional results and comments in this area may be found in the section on Health Information; For Health Providers. (See Page 43).

3.6. Perceptions and expectations of health and health care

Community perceptions and expectations was raised at all workshops and prioritised in four. It was the fourth highest of the 17 themes in terms of comments with 191. The overall theme was that community perceptions and expectations of the health services have changed.

You aren't expected just to look after the person's illness any more; you are supposed to look after the whole holistic well being. Family expectations on what you're supposed to do are unbelievable. You are supposed to sort out bank balances and access to this and that. 'Can you go and feed the dog? Can you put it somewhere?'

The local health service is expected to be very involved in the local community and still they expect you to be sitting there ready to do their dressings, sew their fingers back on and everything else, whereas you need to be down at the pre-school running the Under 8's Day doing health promotion, doing home visits and those sorts of things. You need to be out and about. And if you're not at the clinic, then that's a big problem. 'Why were you closed?'

3.6.1. General issues

There was a view among participants that community perceptions and expectations are not in alignment with the model of care that is provided. There is a constant lack of consultation between policy makers and consumers.

I think the community perception is more for the medical model than the primary health care model. That's where Queensland Health has fallen apart because their focus goes into community and not into people coming through the front door.

The opinions of consumers are often not sought and this is a concern in the light of changes in the mode of care. A specific example was given of practice nurses whereby policy was introduced way before any views were sought as to whether changes would be accepted.

Changes [are occurring] in the workforce and there will be a need to look at what changes in the health workforce would the community actually agree with? Because if we suddenly decide we're going to have a lot of nurse practitioners and not very many medical officers, will that be acceptable?

Also the criticism was levelled that even where there are consultations they result in either no outcome or an unsatisfactory outcomes. The suggestion was made that consultation was undertaken in order to be seen to be doing the right thing of community engagement.

I think rural communities are sick to death of being consulted and not actually having an outcome. It's not that we don't like to be asked but there has to be action as a result.

The general consensus at all the workshops was that consumers are less self reliant than they used to be.

Now it's so easy to pick up the phone to get assistance and to actually get from point A to point B in a vehicle; it's a lot quicker and so there is not that need of self-reliance.

In past generations there was no choice and no access. The pendulum has now swung the other way in that expectations are higher but services have been reduced.

I think a lot of people in the community expect too much of the health care providers in the community sometimes.

Participants believed that society is becoming less responsible for each other and greater responsibility is required by the community at large for decisions made in relation to health and well being.

We are losing some common facts in life, common issues in life where you in your street... you know, you watched the dear old lady three doors down and she's not around by nine o'clock of the morning you go looking for her, things like that. Those sorts of elementary things are I think starting to dwindle in the community.

I think there is also a perception out there that people want to live their own lives and don't want to be bothered with their elderly folk. Because the community is drawing back in caring for each other, then the expectation on health and welfare services is exponentially expanding.

Of course perceptions and expectations differ by age, gender, nationality and community.

You look at Europe for instance where they live with their families until they die literally, don't they?

I think the elderly person who is probably used to viewing the doctor in a certain light will say, 'Ok, doctor I will take your advice.' Whereas a younger person will say, 'I want a second opinion.'

Young mothers probably don't see past the child developmental stuff or a kid with sore ears. The older people just want to sit down and tie you up for an hour and have a chat because they're lonely.

Problems associated with attitudes to different cultures were noted.

A lot of older gentleman – we've got a little Philippine nurse and a lot of them won't even have her near them, they just call her Japanese or Asian or something and don't want her near them. She's really good and just caring but they just have this wall they put up.

Taking self responsibility for health is suggested not to be as present in younger generations. Lifestyle has changed and health responsibility hasn't e.g. obesity is now an issue but responsibility for obesity hasn't caught up.

I don't think anyone really takes enough responsibility for their own health - we need to go back and teach people how to look after themselves.

There was criticism of the role of the media and television in particular. Firstly, everything is a drama. As one participant noted 'a headache is a brain tumour!' Secondly there is the portrayal that everyone has the right to fully extend the services with all possible diagnostic tests and additional opinions. Thirdly the media have propagated an era of distrust in professional staff. This has not been helped by high profile malpractice cases such as 'Dr. Death' in Bundaberg. Finally, the world is being portrayed (and believed by many) to be an unsafe place – a murder in Perth affects behaviour in Charleville.

[People] expect other appropriate investigations although the bottom line is that it is not going to alter your management. The expectation is you will have all the tests. You will have a CAT scan, you will have an MRI, you will go and see a specialist, you will do this, do that.....

Yes. I think the elderly person who is probably used to viewing the doctor in a certain light will say, 'Ok, doctor I will take your advice.' Take your word for it. Whereas a younger person will say, 'I want a second opinion.' 'I'm going to get a second opinion.'

Health professionals admitted that they hadn't always done enough to support their cause.

We don't do enough in terms of – not necessarily promoting – but creating an awareness of the competence of the practitioners in town.

They also recognised that they need to recognise different expectations.

If you have one generation that is very stoic, does not want to engage with the health sector or with services, and then another generation that is not stoic and does want to engage and does expect things as a right, that's actually a problem for the workers because how do you decide what to do.

Not all participants believe that expectation had changed radically. Opinion was also expressed that it was the health service and not the expectations that had changed.

Health care has changed, it's changed really radically since I first started in the health profession which was years ago, but nothing has really changed with the general public or the community about what they think their right is or their access to health care or what should be provided to them.

3.7. Aged care

Concerns about aged care were raised in seven workshops. The theme was prioritised in the four of the eight towns with the highest aged populations (Kingaroy, Hervey Bay, Toowoomba and Warwick). This resulted in a second placed ranking by priority listing. Aged care also had the highest number of comments.

Participants from Hervey Bay, which has an aged population 50% higher than the state average, considered services to aged care the highest priority of all towns.

Over 22% of the people in this area are over 65. That's 10% above the national average, but the resources don't appear to match that population demographic.

The issues surrounding aged care and sustainability of aged care services in the region come about largely because of an ageing population in a changing economic environment.

Mum and Dad used to run their farm to the end of their working lives, and then they'd sell the farm and move to the coast. They can't any more because the coast prices have grown so quickly and real estate in rural areas has dropped so dramatically that they're caught between the devil and the deep blue sea. So there's a lot of pressure there from rural people alone, let alone when you start talking about the drought and the other things that are affecting their lives. That's enormous pressure that I don't think anybody even begins to realise.

It was thought that many aged people are unhealthy due to lack of support in the home and this situation is increasing because of changes in the retirement practices.

We've got the ageing living in the poor, remote communities such as Yarra [sic] and they're retiring to the remote areas, growing old and sick there with poor access to medical officers in these communities.

There was concern that deinstitutionalised care leads to increase in community demands.

Our current community model of care that we are moving towards is actually increasing isolation because it's keeping elderly and frail aged in their homes. We're taking services to them and I think that it's increasing isolation.

Of concern is that there is insufficient political will to change health care for the aged in a really meaningful way.

Aged care are not a very powerful lobby group as yet and money seems to come from the Government, not based on the quality of the delivery of care, but on the political aspects of it and we can only change that at the ballot box.

3.7.1. Carers

See separate section on carers.

3.7.2. Client care

Many issues were raised that were related to direct care of the aged.

Accommodation issues

There are insufficient hostel and nursing home beds and it is not uncommon for there to be long-stay elderly patients in acute care beds.

Aged people in acute beds in hospital is no good for them and it's certainly no good for the hospital and no good for the rest of the community that is trying to access acute beds.

Also noted were gaps between home, hospital and nursing homes with the requirement for step down or interim care facilities. Essentially the old convalescent home was required.

People are admitted to hospitals that need that an interim place to go while they wait for the nursing home bed. They're not good enough to be at home but there's very little care that they're having done and don't need to be in hospital.

Dementia

Dementia is a huge problem and increasing as people live longer.

Mental health issues in aged care, especially in dementia, very often it's in the too hard basket. No one wants to deal with it.

Little support was available for people with dementia.

There is always a chronic shortage of aged care facilities, particular dementia-specific units for dementia care. It's very rare in rural areas. We do not have one and we desperately require one and we're not going to get one.

Also identified is the need for innovative and flexible models of respite service e.g. mobile respite services, including dementia and age appropriate and dementia assessment services for linguistically diverse populations are required.

Governance issues

Over-regulation and excess documentation requirements were considered to be taking away from hands on care.

Bureaucracy has gone mad! I will give you an example; our Centre in January went through accreditation. Afterwards I sent my Clinical Manager off on holidays and I went to Brisbane to a meeting and we got the fax through to say we're having a spot audit. He stayed in my office and waited for me to drive back from Brisbane for a spot audit! Meanwhile we had done that two weeks before and got a clean bill of health. Three weeks ago we had a support visit, then we had the RCS Validation Team come through, two Registered Nurses for three days spot checking 15 charts to the point where we've got our i's and t's married up. Is any of this actually improving quality of care?

Isolation and depression

Depression may be caused by isolation, bereavement or cognitive decline. Although senior men were specifically identified as having difficulty in connecting with other people, youth isolation is also considered to be a problem. One of the issues with aged people that contributes to mental health problems is the difficulty in identifying and engaging elderly isolated people.

We've got women from the generation that didn't drive that are stuck out on farms and that's [the family farm] considered to be an asset so they therefore don't get the financial support.

Social isolation is often exacerbated by breakdown of the family unit and specifically with separation from long term partners.

I've seen a number of times a couple retires here, they set up everything and then one partner dies not too long after they get it all sort of set up and then because of the economic situation of increasing house prices back in the market they've come from they can't buy back into that but that's where all their family is. That means they're cut off.

Palliative care

The lack of palliative care within aged care was raised and the specific resources that it required.

The nursing is different and at the moment it's very ad hoc. We need additional funding for palliative care within aged care facilities because it's a totally different ball game.

Services

Of concern was the apparent lack of foresight for services.

They [the Council] are actually trying to attract more retirees here to town because of the quality of life for them. Small point though; we just need the medical to back it up.

As noted in the section on access to services, deficiencies were noted across all sectors. In the aged care sector specifically mentioned were the lack of doctors, specialists and allied health professionals in the areas of occupational therapy, physiotherapy, podiatry, speech therapy and oral health. There was also noted to be a lack of cognitive and functional ability assessments for long term care residents. After hours care is also lacking and leads to inappropriate admission. In general it was felt that there was little community support for people in home after hours.

3.7.3. Finance

The increased cost of housing has led to changes in retirement plans. Retirement to the coast or to regional centres has been affected and people are staying in rural towns or remote locations because of price increases.

They'd sell the farm and move to the coast and have money to do that. They can't any more because the coast prices have grown so quickly and real estate in rural areas has dropped so dramatically.

In fact it was reported that there is a large influx of people moving back to rural areas to retire thus increasing demands on health services.

There's been a trend in Roma even that when people retire off the property, they move to Toowoomba temporarily, but then in their later years come back to Roma.

Also of concern was that self-funded retirees find difficulty in funding places in nursing homes.

One of the things that actually inhibits people accessing a retirement village is the Federal fee structure when they go in, particularly because we've got a lot of self-funded retirees in town, so it has a real negative impact on it. This includes people who

are probably quite dangerously living in the community who should be in a retirement facility of some description.

3.7.4. Information

A frequent issue in all sectors but one that appeared to be particularly affecting aged care was that the community were unaware of services. The concern was expressed that this was in part because of the inability to access information – e.g. need user friendly access to phone companies.

It's people not knowing how to actually access aged care. It's quite complex for a lot of people, they just don't know where to start and they don't understand the ACAT and they might ring up and get fobbed off and there's a huge waiting list and they've got a six-week waiting list before we see people.

3.7.5. Workforce

Workforce in general is dealt with in another section of the report however specific workforce issues were raised in relation to aged care. These included recruitment, skill mix, lack of younger workers, training of staff, remuneration of staff and duty of care for registered nurses.

The skill mix ratio is a real problem in that with limited resources of registered nurses, and yet they are responsible for everything that happens in the facility, so it's a big responsibility to take on – the duty of care issue.

The lack of qualified staff actually results in additional expenses as aged people are moved into acute facilities.

We don't have registered nurses actually delivering care and our personal carers can't look after somebody with an intravenous infusion, so they have to go into an acute bed rather than being able to continue to be looked after in an aged care facility.

It was noted that the aged care sector often attracts staff with emotional baggage who demand senior staff time in resolving their own personal issue; time that is lost to caring for clients or residents.

Well I feel that a lot of people who come to work in the industry have a lot of issues with caring, they're caring people and so they get very emotionally attached and they often bring a lot of their own baggage into the work place. As aged care managers we spend a great deal of our day counselling staff on issues that are not related to work.

Barriers to recruitment and retention

In general when compared to other sectors: the job is more physical, the remuneration is poorer, the working environment is less well resourced with lower safety and there are more opportunities for abuse from patients and clients. Recruitment suffers because of the aforementioned issues and in addition the environment is not appealing to many perhaps in part due to poor marketing. Child care facilities are poor which particularly affects the single mums and grandparents who are caring.

Many of the aged care areas are rather right up to date with their buildings and what have you but it's still a place where people go to die. They're not going to walk out and be better so there's an environment of maybe sadness and that sort of thinking around it. Plus your buildings, your colours, landscaping, rabbit 'warren-ness' of rooms, of facilities – that's the sort of thing we're putting in the environment bucket and that would probably deter younger people from working in that setting.

3.8. Carers

The theme of carers and the lack of support, lack of respite, lack of counselling for carers and lack of recognition of those that don't meet certain criteria were raised in six of the eight workshops and prioritised in two.

All the funding seems to be going to frail aged and a very small percentage for the people under 50 especially where they need help and they're just not getting anywhere.

The question was raised as to when does someone become a carer from both their perspective and that of support services? Is it when they support someone with personal hygiene? It was noted that a lot of people are caring for both their children and for their parents at once without support and that there were no financial incentives for grandparents to look after grandchildren.

But sometimes it's also the 'sandwich' generational. Like the middle age person could be caring for both the older [parents] and the younger grandchildren; baby sitting them both, and a lot of people can get caught in that sort of situation.

3.8.1. Assessment and eligibility

Of concern was that some people fall through cracks e.g. a 57 year old with Parkinson's in hospital is too young for Aged Care Assessment Teams (ACAT) and can't go to respite as they are in hospital.

The families are so desperate, the carers, and when you talk to them they might have been in the last two years contacting so many different groups and they keep meeting these brick walls because they say, 'Sorry you don't meet our criteria' or 'We just have no vacancies.'

It was noted that Blue Care run a facility in Brisbane that is not ACAT assessment dependant and perhaps this is a model that can be used elsewhere.

Also among providers there was concern that there is a general lack of empathy for individual situations and too many carers are not meeting criteria for service provision.

There is a real lack of empathy for or understanding there's a big cut off point which I don't understand. I know someone with an autistic child. In 22 years they've had four days break and that was just last year and one of the parents is 70 and one is 60 and so that's really awful and because they don't meet the criteria with a lot of these groups they're just left so suffer and the emotional trauma that people go through is just as severe as a lot of physical abuse or whatever out there.

3.8.2. Information

However there was recognition that carers themselves are often unaware of services available to them.

There are a lot of carers in the senior population who – they're on a pension and they just think, 'Oh, well my partner is sick, that's my job.' And they don't realise that they can get that additional whopping \$90 a fortnight to assist, even if that goes towards paying taxi fares to go into doctors or something like that.

Again, there needs to be more information out there of the available services and they need to be coordinated so that aged parents or carers all know who to contact instead of having to do the rounds all the time.

Also noted was the fact that health workers themselves are not knowledgeable:

Maybe [what is needed] is not just resources that are available to the carers, but awareness of resources that are available to other service providers so that they know what other people can offer.

I'm interested that you're saying 60. I went to a meeting with ACAT in Toowoomba and they said 70. then someone else told us 65.

3.8.3. Interagency cooperation

Greater coordination of services and transfer of information to carers is desired. The role that GPs could play was considered to be very important.

Because often that is the one contact carers have when they take their caree (sic) to the GP.

However there was some concern as to how this was done in practice.

We train doctors to be absolute individuals and not team workers... they will say, 'I don't know what those Blue Nurses do. I don't know what that Ozcare person does'. You say, 'Well, maybe you could find out'. And they say, 'Oh, no it's up to them to come and educate me.'

3.8.4. Respite

Respite for carers was a major concern. It was recognised that many carers have lost their choice to lead a normal life and there was concern that there is little community support for carers. Although there are gaps in the available assistance it was recognised that there is often a gap in knowledge by carers of what assistance is available.

Having flyers on the wall [which say] 'Are you caring for someone? Yes. Then please speak to the Practice Nurse.' And that person can just have a checklist. 'Are you a carer, are you getting carer's allowance, what is the set up for your for respite?'

A major deficiency is the lack in accommodation for respite.

Where they're not bad enough to be given any funding or assistance through the Government disabilities but they still require 24 hour care by these parents and it eats away at them day by day.

The rural respite and dementia respite services have been cut substantially due to lack of funding. Although some respite services still exist there was strong belief that the old system of rural respite needed to be reintroduced.

We need innovative, flexible models of mobile respite that can respond to the farms and age appropriate respite.

3.8.5. Aged care

There are many aged carers of disabled adults who require information in an accessible format which is probably not the internet. If the aged carer falls ill a quick response is needed.

I've worked in aged care for a long time and it's usually after Christmas you've always got a heap of phone calls probably because a relative saw how hard it was and just because people got really stressed at that time.

Carers of those with dementia fall between the cracks and after the Rural and Remote Dementia Respite Program funding was withdrawn and there was no service introduced to replace it.

There's not enough access to the appropriate services or education or promotion of what's available ... he'd been caring for his wife for 10 years and didn't know. ...a lot of them, they're propping up the system in a lot of ways because they're not a burden on the system, but at the end of the day somebody's got to take care of these people.

3.8.6. Hidden or young carers

Young carers are carers of middle-aged parents with substance abuse and mental health substance abuse issues.

Anyone over 11 is actually entitled to a carer allowance/carers payment, but the payments can't be paid to the child, they get paid to the parent who then uses the money to continue the behaviours.

3.8.7. Indigenous health

Acknowledged was the low level of access to services by Indigenous people.

Most of the people that actually apply for carer allowance are young people, trying to look after the kids. I suppose something indicative of the level of awareness in the Indigenous community.

3.9. Chronic disease

Chronic disease and chronic health issues are on the increase and this was raised and discussed in four of the eight workshops and prioritised in two. The increase in chronic health issues like asthma, hay fever, diabetes and obesity in young children have been well publicised. There are limited resources in the community for the management of chronic disease e.g. adolescent diabetics. Also noted were inadequacies in activities, facilities, accommodation and carer support for the chronically unwell.

There was some resignation that addressing some of these issues was virtually impossible.

Some problems are meant to be and I don't see any immediate solution. Having children in school weighed, maybe that will create a problem rather than solve it.

People live so much longer with chronic conditions. It was postulated that rural people for whatever reason do not present regularly; especially those with chronic disease.

Conditions have improved a lot, but I mean people live for so much longer and when you're 90 and you are obese and you've got multiple chronic conditions it's just not a treat to look after you any more; I'm sorry!

The emphasis by many participants was that there was a need to devote more attention to prevention than management for which greater awareness in the community is required. The media can play an important role.

Five servings of veg and the three things [of fruit], it is being bombarded through the media and hopefully has a relatively sort of positive impact. Use of the media in a good way is something that still should be pursued.

A large part of chronic health particularly in children is the greater role that parents must play. For this parents require knowledge – responsibility at home as well.

There's a big expectation at the moment in society that everyone else is responsible and we felt that parents did have to play a major role.

Workplaces could be more proactive by providing gyms and showers.

Our staff satisfaction survey asked, 'If you were provided with a gym or something like that would they uptake?' Yeah, they would. They themselves would like to be fitter.

One concern was 'junk' food in hospital waiting areas.

I suppose too it's come from up the top. The Health Department talks about chronic disease prevention and obesity and all the other healthy lifestyle type things. So we're really being pushed to run programs to address those sorts of things but then you go to the waiting room and there it is.

A higher incidence of cancers has been reported in cotton growing areas and apparently some residents attribute this to a fall of acid rain in 1953.

Everyone in my age and here in '53 has either got cancer or dying of cancer or dying of leukaemia.

3.10. Counselling

Counselling issues were raised in six workshops and prioritised in four. Comments however on this theme were very few. For the purposes of this program counselling was confined to general services including counselling services for grief, relationships, family issues, financial issues, carers, youth and the aged. What participants referred to as 'real' mental health and services related to support of mental health are referred to in section 3.3 Mental Health.

Of the people that come to the mediation service, they're often couples with children who are separating and the wife may have come out to the rural community only because her husband lives here. They get divorced, the husband gets a mining job somewhere, she can't move the children because they have a support network at school, but she's got no family support, chances are because of the divorce she's got no friends.

Lack of funding, continuity of funding and staff shortages all contribute to the problem.

There are very few counselling services, especially for people with dementia. You can't get anyone out to see them or talk to them unless it's a real mental health issue.

Communities lose confidence in whatever services that do exist. However it was also recognised that in rural and remote areas there is a reluctance to see a locally based person because of anonymity. To reduce this some services have been based at the taxation office or at the doctor's surgery so that people will go and access them with less concern as to everyone knowing where they are going.

People won't go to see that person because they would know them. If I walk in there, fingers are pointed and 'we know what you're doing'.

The area of assessment leads to some concerns.

So you're denying it now to the people who needed it, but in the past you were providing it to everybody whether they needed it or not.

Counselling services were identified as being deficient in locations for:

- Trauma counselling at point of care which is often accident and emergency.
- Small business owner counselling especially those affected by drought.
- Relationship counselling for marriage, divorce, separation and family.
- Sexual abuse counselling.
- Youth counselling especially for depression, alcohol abuse, boredom, break down of families.
- School counselling in how to identify depression and anxiety.
- Bottle feeding mothers.

Breast feeding mothers get all the help and the bottle feeding ones they fall off the radar. I would just like to see more support and counselling for bottle feeding mothers. I know the World Health Organisation promotes breast feeding but once people fall off that there's nothing there to support them to prevent post-natal depression because it just didn't sort of go according to plan.

- Grief.
- Culturally and linguistically diverse persons.
- Veterans.

I've come across some who've said, 'When we went to war they promised that we would be looked after in our old age' and now they can't get home help and they are disgusted why I can only put someone in for two hours a week. They are disgusted.

- Carers counselling.
- Staff counselling for teachers and others who work with children with learning difficulties, for aged care workers and for nurses after assault or violence.

3.11. Disability

Disability was raised in five workshops, prioritised in three but only received 12 comments. The main issues are as follows.

3.11.1. Facilities

There is a general lack of resources and support for the disabled and their carers.

3.11.2. Service providers

Noted was a lack of services for specific groups such as the young.

Our funding is directed more at frail aged and not for the younger disabled.

3.11.3. Service co-ordination

Lack of coordination of services was identified. There was a need to ensure that there were links among services that can take over when a carer is not able to cope.

3.11.4. Respite

Respite services are insufficient and their value tended not be appreciated.

A couple of hours respite means nothing to someone who does not look after a child with disability.

Funding has been reduced without due consideration of alternatives.

There were three places on the coast that just got notification overnight to shut down; end of story, no more money and the service stops.

3.11.5. Accommodation

The lack of information for carers was identified as well as inappropriate placing of clients.

Inappropriate mix of clients so you get volatile clients with specific management problems, people who have mental health disorders or alcoholic disorders or whatever and they're put into a placement with somebody who just really needs the physical supports of a supported environment.

The project undertaken by CRRRAH for the Toowoomba Intellectual Disability Support Association (TIDSA), which looked at future accommodation needs for the intellectually disabled in Toowoomba and surrounding areas, was discussed informally and many of the participants took copies of the report.

3.11.6. Workforce

The lack of training for skilled health staff was stated to be inadequate in specific areas of client needs. Furthermore there was considered to be mismanagement of staff with regard to inappropriate staff mix and ratios.

And there needs to be more promotion and awareness of the different things that are available to them.

3.11.7. Miscellaneous

Other issues that were mentioned included the lack of access to maintenance for wheel chairs and scooters and that the taxi voucher scheme being too restrictive.

3.12. Health education

This theme was raised at six workshops, prioritised in two and received 117 comments. This area is linked very closely with consumer expectations of health and health services.

3.12.1. The problem

The problem was identified to be about educating people to be responsible for their own health and prevent ill health. There is a need for community education about what is practical and what is not within health services.

There hasn't been that education process to the general public of the reality of having and maintaining an operating theatre. That you need this, this, this, this and this and whether that is really a good use of resources.

The focus should be on wellness and the earlier the initiative is taken the better the outcome for all.

And we need some commitment as well and this would go hand in hand with finding out what they [the community] actually want and need is to engage them to actually want to learn and to actually use the facilities and the services that are available. It's all well and good to have all services out there but if no one comes through the door there's no point.

Unfortunately health education programs generate little interest. People do not attend and with diverse communities it is difficult to address all needs. It was pointed out that we really don't know why people don't engage and little work has been undertaken to determine this.

We also don't really know how people are motivated to be involved in health education or to even pursue or take on challenges through health education. We haven't actually asked people in a very meaningful way as to why they don't participate in or become involved in education.

The opinion was expressed that the rural community at large are less prepared than they used to be to address health issues.

Or that they've been in boarding school and haven't had that general education for want of a better word from mum if they're at home on the property or out in the outer lying areas fixing things. And not only is it education but they do have a lack of confidence in themselves, the young mothers probably. It could be too that they have this feeling of isolation. It's more about them going than the child.

3.12.2. Activities

The specific areas in which health education was considered to be required are:

- Prevention of preventable childhood injuries.
- Prevention of preventable injuries on properties.

There's so much done in industry – you go to these factories and they have so many days without an injury. There is so much focus on that. We really need to do that with our farming people because a lot of them get very, very badly injured.

- Road and pedestrian safety.
- Safe work practices for individuals and for businesses.
- Drug/alcohol education.
- For travellers to the outback, how to drive on roads and what services to expect:

I talk to grey nomads three nights a week up at the caravan park. One of the things I talk about is health issues because they come from Melbourne. They're expecting a chemist in every town.

- Education in school and for school leavers about good health and availability of services.
- Men's health.
- Education about teenage pregnancy:

There are a lot of factors with teenagers having babies. The teenage mothers are less compliant in their ante-natal care, they tend to smoke more, they breast feed less and their diets are poorer. Babies born of teenage mothers, because of those factors, tend to be lower birth weight and they tend to have more medical problems. There are a lot of associated factors with teenage pregnancy which impinges on the whole community and the health system.

- Short courses/workshops to improve health lifestyles for all people to counter obesity.

3.13. Health information

The need for health information came up at six workshops but was only prioritised at one. However it generated 191 comments. What was most striking was the lack of information people believed they had access to. Very often this was linked with interagency cooperation and/or with health education.

People aren't aware of services available and other services are unaware of services available.

What many people seemed to be saying was that the technology that we now depend on is not being used efficiently or effectively to either store or access information.

We need the old switch board and a service directory.

3.13.1. Information for the community

As far as the community are concerned the workshop participants noted that there is a perceived lack of service information. People are generally not being kept aware of support available. It is recognised that people only go looking for information when they need it, for example how to apply for an aged care placement.

It's like anything though, you can put information out for people but until they want it and then they start asking, 'Where do I go?'

Furthermore it must be kept up to date and it was noted that much data on providers is hopelessly out of date.

Our problem is that with the constant change in service providers in the agencies we end up with a generic number, a generic telephone number and a generic description of what services are provided because people change all the time.

There was criticism of GP's for not providing more information.

Patients don't seem to be told that there's a Cancer Support Group. We've had people come to us after they've been trying to find their own accommodation. We've given them the Cancer Hotline to give them advice on where to stay and do things like that. The information [about the Cancer Support Group or Carelink] should really be coming from their GP.

On the other hand there are obviously practices that do have that type of information but suffer because of constant changes in services.

I work as a Practice Manager for a medical practice. In our practice we have, and constantly update, the Allied Health Services Directory, mental health, and also because we deal with doctors, we also have written out in our orientation folders exactly what services are available in the town. I imagine that every General Practice in town would have exactly the same information available to them.

It was suggested that information may be more forthcoming from practice nurses.

We've actually found that Practice Nurses are the better people as they look at more than just the medical model.

It was generally believed that councils have the responsibility to provide information for new residents.

The local Council does offer it for every new resident that comes into town, but I don't know how they determine who is a new resident. They offer this whole pack but most new people don't know that it's there.

As with any source of information its value is determined by the accuracy of the data. It was suggested that if community information is provided by council then providers need the facility to change their own data.

It needs to have the facility that you can change your own data. And there's no reason you can't do that with a password protected area that is unique to your organisation.

Current directories are often incomplete. For example the Health section in the Toowoomba City Council Community Directory lists no public hospitals or allied health services. Not all web sites are very intuitive or logical to users. For example Kingaroy has no specific health information on its web site but provides detailed information through a search facility in their Business Database. Other council web sites list health services in different locations (such as business listings) and with varying amounts of information. These are summarised in Table 8.

Table 8. Location of Health Service information on council web sites.

Town or Shire Council	Location of information	Information offered
Charleville/Murweh Shire	Community/Community directory/Community and business directory pdf file	Name, telephone
Dalby Town Council	Community/Organisations/Community Directory	Name, address, telephone
Kingaroy	Business/Business database/search	Name, address, telephone, fax, email, web site, contact name, description of service
Hervey Bay	Hervey Bay/Health services Work and Business/Fraser Coast Business Listing/Doctors, dentists and hospitals	Page of description with link to Fraser Coast District Health Service Link to yellow pages
Roma	Tourist information/visitors guide pdf file	Name, telephone
St George/Balonne Shire	Community/Health Services/Health contacts	Name address, telephone, fax and email
Toowoomba	Community Directory/Community Information Directory/Browse/Health Services	Name, address, telephone, fax, email, web site, contact name, description of service
Warwick	Lifestyle and Community/Community Organisation/ Welfare Directory pdf file	Name, address, telephone

Too much information provided in a fragmented fashion can also be problematic. What is needed is for providers of information to determine what type of information people want and in what format rather than just flooding the market.

If you stood on a street corner and asked people, 'If you had a health problem who would you go to find out about information?' And then maybe have a list of things and say, 'Have you heard of any of these people?' And you could have a tick yes or no and then little other things, the things that we never think of, that they can add. I reckon it would be really interesting because I think that we don't really know how people access stuff.

There were strong opinions that a single co-ordinated health resource information system should be established. It was noted that consistency in format throughout the State would be advantageous.

What is needed is coordination of community resources in rural Queensland. One person sets it up, runs with it, puts the procedures in place and gets the common linkage. If you don't have a funded person to drive a project it will never get off the ground.

A project could create a template into which organisations can easily put their information. The look and access would be the same for all communities and could be sited or accessed through the council web sites.

One of the possibilities would be to push for it at the Heads of Local Governance level when they get together to get access. Because if you shared it across a large enough group of Local Governments, the cost would be minimal for each one to contribute.

3.13.2. Information for health providers

Most participants considered that information about other services was essential to improve their practice.

Awareness of resources that are available, and maybe just not resources that are available to the carers, but awareness of resources that are available to other providers and other services so that they know what other people can offer.

But they noted that such information if available was very fragmented.

I know it sounds minor but people come in to us and they want to know who to go to for funding for disabilities. Well if we had a register somewhere or if you could say, 'Look this is on a register, access that and find out who you go to'.

They saw the need for central lists for providers and a definite need to improve information transfer among providers.

I only came down from the Territory two years ago and just trying to find out what resources and providers there were available in this area I found very difficult and there seems to be heaps of them. However once you start researching there's heaps of them.

I've got a little book for Dalby, I've got a little book for Millmerran, I've got a little one for Pittsworth but you need something altogether.

Personnel change frequently within service providers and a form of regional orientation package was considered to be useful.

I'm not familiar with what sort of areas of service provision are here but I would imagine that there would be some things that go with each other like hand in glove and there

would be other things that are really totally on different planets. Maybe they have different stakeholder groups, but which services are constantly hitting the same target group? What services should be connected intimately with one another? What services currently are and what aren't? [We need] a resource map of all of this.

Although apparently a single resource has been tried.

We tried to sort of put this into one resource and it never eventuated because people didn't see it to be a priority, so we ended up again keeping our own individual ones. But since I've been doing the relief program everywhere I've gone I've always asked, 'Have you got a phone directory so I know the local contact numbers for GPs, hospitals and stuff? Do you have a resource directory?' So when I'm out there visiting a client, I can give them a number to contact or I can contact on their behalf. Not one district has been able to provide me with that.

As with a community health information resource it was considered that consistent information for providers would be beneficial.

What would be really good if you could have the sort of tool that is in a generic form right across South-East Queensland so that everywhere you went you would be able to pick up this document.

Sharing of information will never be the case until updating information is easy and not tied down by IT department red tape.

But you can't get that information updated because it's all in this IT Department and you can't touch it and you can send it up and it gets lost somewhere along the way.

3.13.3. Commonwealth Carelink

Time and time again Commonwealth Carelink was mentioned. They provide services to the aged, the disabled and to those who look after them. Carelink don't offer coordination, only what services are available. Unfortunately although this is the one service that should be known by everyone, it is not. There was reported to be general lack of knowledge by the community at large of what Carelink does or has to offer and it became clear that this lack of knowledge extends to a lot of providers.

What's Carelink?

Don't you have a Carelink Office? No idea, I've never heard of it.

There was also confusion as to the difference between Carelink and the Commonwealth Carer Respite Centres that coordinate access to respite services in local area.

The information I've got is Carelink has got nothing to do with looking after the carers; it's nothing to do with it at all.

The lack of information is despite the fact the organisation has advertised widely to the community.

I've seen its offices around but you've got to wonder where these institutions are put up but they don't relate back to human behaviour patterns or in a way to let people use services. So that's quite an interesting issue in itself.

Participants suggest that Carelink needs to target service providers more.

I've only been in this position 12 months and I have to say I'm blown away by the fact that the organisation has been running now for five or six years and that people still do not know what Carelink does.

More location-specific information would also be desirable.

It's not specific enough for your own community. If people take the time and effort to access the site like that or a health provider does, then they want information that's to the dot basically. You could make it as broad as that, so do it across health services.

Participants were informed that a new strategy has been adopted by Carelink to specifically target GPs, pharmacies and allied health staff and time will tell if this changes knowledge. However it was noted that Carelink does rely on service providers supplying information to them and the information they can provide is only as good as the information that they are given.

Unfortunately the organisation suffers from a very confusing name. Some consumers believe the offices to be Commonwealth Bank or Centrelink and confusing Carelink with Centrelink is a very common issue.

They say, 'I've come in to find out something about the Commonwealth Bank.' The next person in will say, 'Look my pension...'. 'Sorry, but we're not Centrelink.'

It was generally agreed that the name Carelink is not very descriptive of what the organisation does. This is not helped by the fact that two services are now combined to form Commonwealth Carelink and Respite although in some regions these are referred to the Commonwealth Respite and Carelink Centre. If ever an organisation needs a new name it is this one!

3.14. Health providers

This theme related to policy and funding which affect the service that may be offered by health providers. It was raised in four workshops, prioritised in two and received 72 comments.

3.14.1. Policy

Participants were critical of gross over-regulation which reduces spending at the point of care. They also noted top heavy management structures that resulted in over consultation and often lack of action. Requests by health workers for support or action often took so long that the services were compromised.

Over regulation costs us so much money in terms of complying with incredible amounts of red tape and paper work and we have to have very highly qualified people often do this which really takes away from the quality of care that we're actually able to deliver on the ground, whether that's in a respite centre or in the home, where ever it is.

More interaction between public and private health providers was needed and true recognition of the value of the services.

I hate to bag Queensland Health again – but Queensland Health strategic planning may be adequate for its public services, but the interface between public and private and the non-Government agencies is very poor. It doesn't appear to take into account services that can be offered in the community by community groups.

We try to talk to the Government about maximising the cooperation between the public and the private health. Locally we want to do it, but at the Government level is a blockage because you're talking to the politicians, that's public health, especially at the State level, and they say, 'Oh, the services that the private sector provide are too expensive' but when you sit down and analyse it it's not.

Political will often provides a quick fix that in the long run only exacerbates the problem because it's not sustainable and confidence of the communities is lost.

If you've got limited funding, what you do is live for a quick fix, a program that will fix things within a limited period of time. It's very naive and in the long run it doesn't fix anything. In fact it actually frustrates patients and clients.

3.14.2. Funding

It was noted that many NGOs upon which health provision is largely dependant, are competing from the same pot of funds. Delayed access to funding is detrimental to the sustainability of the workforce creating lack of continuity of services across regions, shires and states. Competitive funding means providers work in isolation as it does not encourage service providers to work together within communities.

Whether it's for the benefit of the community or not, we will still both be going for the same money.

There were ownership issues that affected integration of other services and retention of information within communities when moving workforce.

And I think we're just too scared often to share information because if we say, 'Oh, we do this and we do that'. Someone else might go away and go, 'Well, if they're doing that, we can do that and we'll get that funding' and seriously it comes down to the fact that you have to sack people. You have to take a job away from somebody because we're having to compete for funding and we don't get it. That's maddening.

Moreover there was criticism that funding sometimes goes to large organisations who then refer clients on after one consultation.

What we found is that the funding will come to those big organisations who will farm it out to their regions in very small amounts. Those people get the funding to do the work, they will see the client once and then refer to us and send the client on. Their funding is limited, so is ours, but it keeps their figures up.

The quality of service and funding was questioned.

And it's not about quality of care, it's about whether you meet your governance, whether your auditing is correct, whether you're properly accredited, whether your i's are dotted and your t's are crossed. Just because a particular body gets funding doesn't mean to say that they are the best person to be providing the quality of care because we never measure it really.

3.15. Indigenous health

The area of Indigenous health was only identified in workshops in Toowoomba, Dalby, Charleville and St. George. This was no doubt in part due to poor representation of Indigenous health providers in the other towns. Representatives of Indigenous medical services were only able to attend the workshops in Toowoomba and Dalby and it was at those workshops that the area was prioritised and where most of the 34 comments came from.

3.15.1. Workforce

Workforce issues that were specific to Indigenous health were the paucity of workers due to poor education in science and the general lack of support for Indigenous health workers.

We don't have any Indigenous workers that work with us so our knowledge level of what's needed in the Indigenous community is very low. We advertise for Indigenous care workers and I don't think in the last seven years we've actually had one applicant.

3.15.2. Services

Indigenous health services are not offered in all communities. Other services are not culturally appropriate.

[We need] a hospice, aged care facility, a respite centre that's actually culturally appropriate for them because they don't actually access any of those services at all because they're just not culturally appropriate.

Distance and transport was an issue in accessing providers but when it is available the transport service is often underused. Lack of education, lack of understanding, lack of awareness, fear of filling out forms and reluctance of Indigenous persons to access Government services all contribute to this.

I'm the Indigenous Liaison Officer here and it's very rare that we would have an Indigenous person come in. They fear Government agencies.

Opinions were expressed that suggested frustration at the lack of uptake of services offered to Indigenous communities, and that the community must assume some responsibility.

We take our docs out to rural areas and try and really embed them in the cultures and half the time Aboriginal people won't turn up – instead of educating the medical staff positively it accurately reinforces all the negative issues in Indigenous health. We try and try and try but we just can't get people to work with us.

3.15.3. Health education

To improve health education there is a need to adopt different strategies such as building knowledge through different methods of delivery. There is also a need to target generations and genders differently. What is essential is to engage Indigenous Elders in planning and to create links with Indigenous Health Workers. It is important to convince people that it is ok to learn and encourage commitment to educate their own families.

With the Indigenous people, there is a lack of self-esteem to attend to health, sport and recreation activities and education.

3.15.4. Substance abuse and mental health

Substance abuse and mental health issues play an important role in the lack of well-being of Indigenous people. These issues were also discussed in relation to other community sectors such as youth and are dealt with specifically in another section of the report.

3.15.5. Indigenous health forum

In mid July an Indigenous health forum was convened by GP Connections, (the Toowoomba and District Division of General Practice) and was attended by one member of the research team (rme). Nominal group technique was used to identify the principal issues in Indigenous health as perceived by the 30 participants representing health service providers and Elders. Diseases such as glaucoma, diabetes, obesity, cardiovascular disease, substance abuse, service access and use of services, lack of education, Indigenous health providers and equity were all raised as major issues. However the health issue that was considered to be of highest concern was that of mental health. This was consistent with the importance of this area in the health research workshops.

3.16. Substance abuse

Participants in six workshops identified this theme and it was prioritised in four. The greatest concern was expressed at the Toowoomba and Dalby workshops at which Queensland Police were represented. In Toowoomba substance abuse was considered by participants to be the greatest priority.

3.16.1. General issues

The issues revolved around services which do not exist or are limited e.g. not for under 18's and the reported increase in drug use.

It's an increasing thing with people coming up to the hospital collecting sharps kits and there is just more of it in town and that impinges on our patients and accident and emergency with people coming in.

Petrol sniffing, alcohol related violence, assaults on emergency personnel, under age drinking, abuse of prescription drugs and of parents taking their children's medication were all stated to be on the increase. Alcohol and drug abuse was considered to be higher in the marginalised people, particularly among Indigenous persons.

Alcohol was also noted to be a new factor causing concern within the Sudanese community in Toowoomba. Substance abuse was reported to be associated with the existence of young carers looking after their parents in Warwick.

We've got one as young as six.

Alcohol abuse was largely attributed to peer pressure, the Aussie culture, the ease of access and cost.

Parental alcohol misuse or abuse ... tends to be a pattern which is replicated in children. If young people see their parents exceeding the usual dose of alcohol it will tend to carry over to the next generation.

Some of it we can perhaps blame on sponsorship and marketing, some of the best ads on TV are related to alcohol sales.

The costs are high.

Binge drinking in youth.... impacts on their social skills and on their education.

Alcohol health care tends to be ad hoc with lack of local detox and rehab centres and long waiting lists.

The counselling service is reactive to the situation. There's no one there now.

In most communities people have to leave the location for adequate attention.

It's always been an issue and we haven't got in-house places for these to go to. There's a community service but for them to have rehab they have to leave the district and they're very hard to get into places there. There's a long waiting list.

The need for more interaction in the schools was noted.

You need someone in town to build those linkages and be in the high school every three months, be visible. Look at the promotion as well as being able to deal with the issue when it occurs.

But I don't think that there's enough done from those early years looking at trying to identify all the circumstances that would indicate the need for early intervention in a child's school. They don't ask a parent when they come in, 'Are you depressed? Have you got an alcohol problem? Do you use amphetamines?'

3.17. Transport

Transport was raised at seven workshops, prioritised at four and generated 159 comments.

3.17.1. General issues

It was noted that health outcomes are poorer because of inadequate transport and transport is particularly problematic for elderly, disabled and cancer patients.

Cancer Fund studies ..., the further away you are from a metropolitan area, the poorer the outcome and a lot of that is related to transport.

As a result of these problems people are unable to go for specialist appointments and because rural health services are lacking the cost and logistics of travelling to Toowoomba or even Brisbane are high. For many people time is a major issue e.g. especially for farmers or self employed.

3.17.2. Public transport

There is a general lack of transport in rural and remote areas and even within regions there is little or no public transport. This in part is due to closure of several services.

Toowoomba is seven hours away in a car or in a bus and Roma is three hours. You get to Toowoomba, nine times out of ten you can't get back if you're in the public system.

An alternative is taxis however they are often not fitted with appropriate access nor are drivers trained.

[Some] drivers aren't trained in how to deal with those sorts of clients, so there's a whole range of restrictions with taxis.

Furthermore the taxi voucher scheme is very rigid.

We've got people that we feel should qualify for it but it gets knocked on the head time and time again.

Where resources (e.g. volunteers) are available, licensing and other red tape issues have created problems. There are restrictions to transport (e.g. HACC, ACAT eligibility). Roma for example has transport, for only HACC eligible people, published through the Neighbourhood Centre web site. Even if transport is available many needy people don't meet the criteria. In addition the restrictions on whether they have someone travelling with them are quite tough.

A lot of the licensing with the school bus operators and things like that, if they were to offer their buses in the down time it does affect their licensing fees and permits, so that [there are] all different classifications of what their drivers have to have.

...developed a little informal transport assistance program around a church but it got tied up in relation to litigation and the cost of insurance.

Although some inter city bus services are available (e.g. Greyhound) this is often not appropriate for people with certain medical conditions.

If you've got chemo you've got a lot of problems. You've got depressions, anxiety and you just really shouldn't travel by yourself at any stage and you've got no immunity. You sit on a bus with people jumping in with stuff that could kill you in a couple of hours. We know people that have taken the bus and flown home from Brisbane, because the special flew them home, and died three days later with pneumonia sort of thing.

It was queried whether arrangements could be made with scheduled flights to have subsidised seats.

Some towns have no or a limited emergency service. Could QAS maintain a vehicle that could be driven by police or a volunteer? There is a great shortage of emergency vehicles in some rural locations

I had to wait four hours the other night to get an ambulance for a patient with chest pain.

Apparently they raised the funding for an ambulance once before but then couldn't find sufficient funds to maintain it.

There are community transport forums (e.g. Stanthorpe/Warwick) and one shire (Booringa) has successfully operated a council vehicle for health purposes.

3.17.3. Awareness

Concern was expressed at the lack of awareness of where to find information about transportation and whether there were fact information sheets on how to get around town. It was suggested that more coordination may be possible among agencies with perhaps a nominated representative in each town to compile options.

3.18. Youth

The area of health related specifically to youth was raised in six workshops, prioritised in three and received 24 comments. However youth were also mentioned in relation to substance abuse, counselling, carers, health education and chronic disease.

3.18.1. General issues

Many youth have low self esteem. This is associated with alcohol abuse, boredom, break down of families and limited role models. Noted was lack of support for young people about drugs and alcohol and little support for the young or children with behavioural problems outside of mental health. Hardly any child psychology programs exist and child safety officers are in short supply in rural areas.

I see this massive, massive hole. These kids are so curable if I can use that word, but there's nobody to step in, no one to step in and help these kids.

In locations where services exist they were considered to be fragmented.

We've got a lot of groups who work with youth and a lot of people who are interested in youth, but I think as [person's name] was saying, it's all very fragmented and we don't often seem to work together and we sort of do a program here and a program there for this or that reason, but we never look at whether that program does anything

Concern was expressed that some services are poorly considered or started for the wrong reasons.

The philosophy of 'we've got to do something.' So, 'Oh, look, there's that [project] and it's free and schools will enjoy that so let's go put that in a school' and it does nothing, the schools probably don't want it. It's not appropriate for those children.

Few opportunities are taken for early intervention and prevention of depression. Confidentiality is an issue.

A young person may present – for example, if they presented to me I could actually see them without parent consent, but I can't refer them to another service, to the Mental Health Service, for example, because they can't see them without parent consent, so there's that kind of issue there as well.

Also parental support to access services may be lacking.

So the service might be there but because they don't have that parental support they can't access it.

General support and support for parents, relations and friends is required.

3.19. General observations by participants.

3.19.1. Research

The problem with rural communities is that we don't gather the data and it's all anecdotal. Everyone talks about it but there is little data to say what is really going on.

I think rural communities are sick to death of consultation and no outcomes.

3.19.2. Sustainability of programs

Cut out pilot projects which set people up to fail. They become reliant on a six-month pilot project, but there's nothing to go on past that. They get people in hook, line and sinker, they reorganise their lives around it and then next thing the funding has gone.

All I know is that as I move around the South-West I'm observing communities grieving for a program they loved and I keep reporting that. I've got no hard data to support that when I prepare a submission.

3.19.3. Funding

[Competitive funding] creates a culture not conducive to actually delivering good care.

The Government is saying to us as, collaborate, be innovative, set up partnerships. The new buzz word is engagement. And then we're competing with each other. We are not going to get together if we are going to cut each other's throat with the funding.

...fund distribution and funding on mental health services and for health services in rural areas because at the moment all these different organisations are in competition for funding and we tend to lose track of the fact that the funding is actually for the community as a whole I'm just wondering whether the way that the funding is structured at the moment is contributing to the fragmentation that we do see here. And I also feel that there is a lot of over lapping in terms of funding.

Queensland Health strategic planning may be adequate for its public services, but the interface between public and private and the non-Government agencies is very poor and so Queensland Health strategic planning does not take into account, it doesn't appear, to take into account services that can be offered in the community by community groups. [This is exemplified in the funding where] Queensland Health will fund a program for three years and then not ring until the week before it's due and say, 'Oh you've got your money.'

In contrast:

We are funded until the end of September [2006]. I provided the Department of Health and Ageing with a report December [2005]. They came out early April and did actual site visits, consultations with other agencies that we had been working with; virtually gave us the verbal that, yes, they are going to be recommending that we are refunded back then in April, which is really great from my perspective for team stability.

There's two things related to this. The one is that you can't plan properly as you will lose all these people, but the other thing is I think it contributes to the quick fix solution culture. If you've got limited funding, what you do is live for a quick fix, a program that will fix things within a limited period of time.

3.20. Similarities and differences between the 2003 and 2006 workshops.

It must be stated at the outset that comparison of results from the 2006 workshops with those of the single workshop undertaken in 2003 was not a stated objective of the project. Nevertheless it is interesting to determine whether the same themes and issues identified as being of major importance in 2003 were so in 2006.

3.20.1. Participants

There were distinct differences in the representation between the two years which may be expected to contribute to differences in views of importance of health issues (see Table 9).

Table 9. Comparison of the type of organisations represented between the two years.

Organisation	Year			
	2006		2003	
	n	%	n	%
Direct care				
Queensland Health (all sectors)	18	22	11	15
Aged care facilities/providers	16	20	6	8
Psychologists and counsellors	4	5	1	1
GPs	0	0	3	4
Indigenous health services	3	4	1	1
Private hospitals	3	4	2	3
Hospices	0	0	2	3
Other health providers	16	20	0	0
Subtotal direct care	60	75	26	35
University departments	4	5	34	45
Local council	4	5	2	3
Police	3	4	2	3
Health profession membership organisations	4	5	2	3
Consumers	0	0	3	4
Government departments	0	0	4	5
Non-government service organisations	6	7	0	0
Total	81	101*	75	98*

* Figures do not add to 100% because of rounding

The 2003 meeting was heavily represented by academics (45%). Direct providers of health care and aged care accounted for only 35% of the participants. In 2006 75% of the participants were involved in direct care and only 5% were from an academic base.

In 2003 11 of the 26 (42%) direct care providers represented Queensland Health. In 2006 the percentage was 30% with a further 27% coming from non-governmental health providers. Consumers, represented in 2003, were not represented in 2006.

Another interesting difference was that the latest series of workshops had representation from service organisations such as Commonwealth Carelink and Medicare.

3.20.2. Themes and issues

Compared to the single workshop in 2003 there were five themes as indicated in bold in Table 10 that bore great similarity to those generated in 2006. Other 2003 themes within which there were issues that bore some similarity to the themes in 2006 are indicated in italics.

Several of the important 2006 themes generated little comment in 2003. Examples include carers and disability. The greatest differences were in health information and access which featured far more prominently in 2006.

One theme, that of outcome impact of research partnerships, was not raised by participants in 2006, however was introduced by the research team as developing research partnerships was a stated aim of the project.

Table 10. Comparison of themes emerging from the 2003 and 2006 workshops.

2006 themes	2003 themes
Access	Access to health service delivery
Aged care	Post acute/aged care
Carers	
Chronic disease	Management of common conditions of which little is known
Counselling	
Disability	
Health education	<i>Mechanisms for identifying regional/local needs</i>
Health information	
Health providers	Economic impact of new programs
Indigenous health	Indigenous health
Interagency cooperation	<i>Evidence-based practice</i>
Mental health	Mental health
Perceptions and expectations	<i>Health and interaction with the environment</i>
Substance abuse	
Transport	
Workforce	Health workforce including volunteers Health professional development and support
Youth	
	Outcomes impact of research partnerships

Comparison of the results between the years is given in the order of the ranking of theme in 2003.

3.20.3. Workforce

Workforce issues were highest in both years with continuing professional education, training and orientation of new health workers and recruitment and retention featuring strongly in both years. Carers and volunteers were also mentioned in 2003; carers in particular featured strongly in 2006.

In 2003 there was also great focus of use of technology to assist health professionals. This was absent in 2006.

3.20.4. Mechanisms for identifying regional/local needs

It should be noted that presentation of this theme was heavily influenced by the research focused participants to the workshop. In 2006 the only participants with a research focus were two at the Toowoomba workshop.

In 2003 three specific issues were raised under this theme. The first was related to safe communities and included the need for increased awareness of personal safety and injury prevention. It included data collection, central registry of injuries, risk assessment, and identification of trends and priorities. In 2006 injury prevention was mentioned as a part of health education but did not achieve the high importance that it reached in 2003.

The second issue raised in 2003 was that of using Geographic Information Systems (GIS) for planning health needs and delivery. The presence of USQ researchers who focused on GIS undoubtedly contributed to this issue being raised into such prominence. The issue was not raised at all in 2006.

The third issue was that of identifying then focussing research on the greatest burden/need in community. This issue is basically one of the principal aims of the entire 2006 workshop program.

3.20.5. Mental health

Mental health remained a major theme with assessment, drought as a driver of mental illness and access to professional services again principal issues. Indigenous mental health, youth and community support were raised in both years. The issue of effects of de-institutionalisation which featured in 2003 was not raised in 2006.

One issue that was raised in 2003 within the theme of mental health and that was raised in 2006 in most themes was that of the need for effective dissemination of community information.

3.20.6. Health and interaction with the environment

This was raised in 2003. The closest theme in 2006 was that of perceptions and expectations.

The theme was about recognising that rural communities needs differ from those in urban areas and although implied was not openly raised by the recent participants. The concept raised in 2003 was that there was a false assumption that rural and urban people wanted the same services. Moreover that it was wrong to use the same service delivery in both urban and rural areas. In 2006 it was mooted that policies were made to centralise services without regard for what was needed in the rural environments. Thus some similarities between the workshops were evident.

In 2003 it was recognised that there was a mix of demographics from rural community to rural community requiring flexible health systems that were responsive to local needs. In 2006 these thoughts did not materialise. There was recognition of different attitudes among communities however demographic mix was not stated to be the cause. Rather it was more to do with the 'culture' of the towns. Moreover flexibility of services to accommodate differences was not stated.

The recognition that health providers held considerable practical knowledge of rural health and the need for a bottom up model tapping into that local knowledge was not discussed at the 2006 workshops. Rather the need for determining from consumers what they wanted was stated.

The difficulty that health workers who were 'outsiders' have in being accepted into the local community was contained in this 2003 theme and that was also discussed with relation to workforce in 2006.

3.20.7. Management of common conditions

Identifying then focusing on research of common conditions of which little is known was the principal issue in the 2003 theme. Management of poorly researched common

conditions was not discussed in 2006 instead there was a greater focus on chronic diseases such as obesity and diabetes.

3.20.8. Post acute/aged care

Respite, step down facilities and accommodation generated attention in both years and aged care in general was an obvious area of concern.

3.20.9. Evidence-based practice

Most of the 2003 discussion centred around the use of what was referred to as 'best practice' in the introduction of change to health service delivery. One issue that was discussed was that intra- and inter-organisational rivalries caused obstruction to the introduction of change. Parallels may be drawn in that issue with the 2006 focus on Interagency Cooperation.

3.20.10. Indigenous health

The theme was raised in both years with focus on resources and factors preventing engagement of healthy lifestyles. In 2006 there was also a focus on factors preventing engagement with health services. In both workshops the presentation of this theme was undoubtedly affected by the representation from the Indigenous Health Services which was confined to Toowoomba and Dalby.

3.20.11. Access to health service delivery

In 2003 access as a whole received little attention. Most noticeably transport which was a major focus in 2006 although mentioned in 2003 received a low priority. Also mentioned in both 2003 and 2006 were limited access to specialists and red tape affecting health service delivery.

3.20.12. Economic impact of new programs

The only reference to this theme in 2006 was a concern that some programs are viewed only by cost and their direct economic impact, rather than the long term benefits.

3.20.13. Outcomes impact of research partnerships

This theme which was identified in 2003 referred to research on research processes and was not addressed in 2006. The theme certainly reflected the make up of the participants.

3.21. Participant input and evaluation

Participants were sent a draft version of the report with the following text.

Please find attached a draft version of the report that resulted from the health research workshops that were undertaken in May and June. If you have time to look at this report and wish to comment on it we would be very pleased to receive those comments. The final version of the report will be made by the end of the year and this will incorporate suggestions made by participants such as yourself.

They were also asked to evaluate the workshop. (See Appendix 2).

Evaluation forms were returned from 13 participants; a 15% response rate.

Results from the evaluation are as follows.

1. Did you find the workshop to be	
a. Very useful	XXXXXX
b. Useful	XXXXXXXXXX
c. Not very useful	
d. Not useful at all	
2. In what way(s) did you find the workshop useful?	
a. Networking	XXXXXXXXXXXXXX
b. Research ideas	XXXXXXXXXX
c. Collaborative opportunities	XXXXXXXXXX
d. Knowledge acquisition	XXXXXXXXXX
e. Other (please specify)	
3. Do you have any comments about the workshop you attended?	
<i>I didn't realise other service providers felt the same frustration at the lack of support by their peers.</i>	
<i>The size of the workshop was ideal because it gave us the opportunity to network and get to know the backgrounds of all participants. The cross section of people was good because we had a common bond being Health and/or education and so we gained from the experiences and comments of all.</i>	
<i>Interesting day. Good participation from all who attended. I still believe we need to evaluate what consumers expect from a health care system in a rural setting.</i>	
<i>Very interesting, good to have a mix of different groups for both information exchange and networking.</i>	
<i>There are a huge numbers of health-related issues out there and sometimes it can be daunting knowing where to start in order to address them all. This workshop was a good starting point.</i>	
<i>Well run.</i>	

<p>Thanks for the opportunity to discuss the respite services action research conducted across the Darling Downs /SWQ region over the past five years.</p> <p>The discussion provided me with an opportunity to reflect on the work carried out by the 2URR, RARDS and the two mobile respite services delivered from caravans and consider strategies to complete this action research.</p> <p>Any further work would make this data more useful when preparing future submissions. Discussions, letters and applications have been completed in an attempt to secure research funding to complete this work. Thank you for the support to recognise what direction I needed to take.</p>
<p>Well organised.</p>
<p>Very beneficial and interesting in what needs/issues identified by the local community.</p>
<p>It was a pleasure and congratulations on a great piece of work.</p>
<p>I thought it was very informative and understand the frustrations are across the board and not just in my work area.</p>
<p>It was well run, quite well attended and the content was good. It will be a pity if the work is not progressed and continued.</p>
<p>I found the workshop to be stimulating. Within the report there are many references to sharing or accessing information. This workshop helped to further the cause of sharing knowledge.</p>
<p>Great opportunity to network and revisit issues in health service delivery in rural Qld/ Australia. Well organised.</p>
<p>4. Do you have any comments about the report?</p>
<p>The report is very long and I only intend to read the bits that I feel I might gain from.</p>
<p>From the preliminary reading I have just done it appears to reflect what was discussed at the Kingaroy meeting. It is easy to read and understand. The issues highlighted are obviously not being adequately addressed as they continue to persist.</p>
<p>Also, the information is obviously very anecdotal and some of the gaps in knowledge may warrant investigation of education / resources for health providers in services available; e.g. Only Greyhound bus to Brisbane is incorrect, the QAS and QCF run several buses per day to Brisbane leaving from the Toowoomba Hospital Transit Lounge. ACAT also does assessments for younger people not just older people and has now merged with HACC to be ACHAT. These kinds of examples show a lack of knowledge by providers.</p>
<p>Well written.</p>
<p>Very thorough.</p>
<p>I feel from reading this document that there must be a lot of naive service providers out there in service delivery land and I wonder where the system is breaking down. I'm wondering if it is in the training of our health professionals. Are they trained only in their specific areas and do they believe that their single service is the answer to all problems. It is clear to me travelling across the region that those communities which utilise service provider networks are the happier communities/workplaces. It appears practice nurses do not join in the networking and therefore there is no feed back to GPs and I feel this is causing some of the issues.</p>
<p>The report highlights collaboration in action. Thank you for the opportunity to participate.</p>
<p>As a health professional working in a rural community, I think this report is a true and relevant reflection of the issues facing service providers in rural communities. Sadly however I also think that many of these issues are unchanged from 5-10years ago, which is why I think it is important for information such as this to be brought to the attention of relevant policy makers and government at all levels, local, state and federal.</p>

4. DISCUSSION

Nearly three quarters of the participants came from organisations that provided direct care to their clients. Most participants work with clients and patients on a day to day basis. That they made time to participate at the workshops demonstrated that they valued the opportunity. We can conclude that engagement of health professionals working in south west Queensland, which was a stated objective of the workshops, was realised by the approach that was taken. Taking the workshops out to the towns was highly productive in terms of community engagement and ensuring that there was input from a wide health service base. The status of CRRAH as a research centre with genuine community concerns was enhanced by this approach; participants recognising that long road journeys were required to meet with them.

Analysis of the data by four techniques of frequency of prioritisation, priority ranking, frequency of the theme arising and number of comments resulted in similar themes and issues within the themes to be highlighted. Small differences that existed could be attributed largely to over or under representation of different health sectors at one or more of the workshops. For example the aged care sector was heavily represented at the Hervey Bay workshop. This no doubt contributed to the fact that 41% of all comments in Hervey Bay were about aged care. Clearly aged care is of great concern in Hervey Bay which has over 10% more elderly persons than the state average. However the comments on aged care from that workshop contributed a third of all the aged care comments in the eight workshops. A pure quantitative approach to ranking of themes would suffer from this bias and could not be removed as comments could not be matched to individuals.

In order to reduce this bias the one researcher who attended all the workshops added his perceptions of the overall emphasis placed by participants in the themes and issues. These perceptions were qualified with the researcher's knowledge of the sectors represented by the participants and indeed their contributions to the workshops. Based on this information small modifications were made to the ranking of issues which resulted in aged care not being in the top five issues. A similar situation arose for substance abuse in Dalby and Toowoomba. The research team recognise that the element of subjectivity may be open to criticism however do stand by the use of this approach.

Almost half of the participants at the 2003 workshop came from university departments and not surprisingly there was a heavy research emphasis on the recommendations from the workshop. In 2006 virtually all of the participants were direct health providers who admitted to having no research background at all.

This had both positive and negative effects in workshop outcomes. The negative effect of the perceived lack of knowledge in research was recognised when the CRRAH research team asked participants if they could identify areas for which research was seen to be needed. Most participants could not respond to this question. They found it difficult to recognise that in most cases they were already undertaking 'research', in that they were collecting data and analysing it for reporting purposes. As a result most research areas generated from the workshops and identified in the report have been developed by the research team and not by the participants.

The positive effect of the lack of research background was a genuine interest generated in participants to undertake research in future. This response achieved another stated objective of the study, namely to identify and encourage future researchers. The following statement in the evaluation describes this success:

The discussion provided me with an opportunity to reflect on the work ... and consider strategies to complete this action research. Any further work would make these data more useful when preparing future submissions. Discussions, letters and applications have been completed in an attempt to secure research funding to complete this work.

What was perhaps surprising in view of the different participant make up of the workshops in 2003 and 2006 was the similarity in health concerns. This may be considered to be indicative of the importance of those themes and issues. The major differences between the two years were the increased focus on interagency cooperation, access and health information in 2006. Whether these reflect changes with time or are merely a product of the different participants is not known.

In 2006 the five most important themes and indeed most of the other themes are inter-related. For example workforce deficiencies impinge on access to services and provision for mental health; expectations of the community are related to both health information and health education. One of the principal objectives of the program was to inform future research activities and strategic planning of CRRAH and the themes/issues that we generated will certainly support that objective. However the inter-relationships will have to be considered very closely in that process.

Before committing resources to research areas that were identified from the project careful consideration should be made. Some topics e.g. workforce, are already areas of study at CRRAH and for which the Centre has expertise. Other areas into which CRRAH may decide to commit resources, e.g. health education, will require input from a variety of sources. The extent and outcomes of prior work in the area will have to be determined along with potential benefits of research outcomes. To assist in this process participants to these workshops have been asked if they would be interested in becoming members of expert panels or working groups to research questions. Already some success in this approach has been achieved resulting in a project on health information (see below).

Concern about the health workforce was identified as the most important theme. Particularly what came to the fore was an emphasis on personnel numbers and the recruitment and retention issues that play a role. A variety of causes and solutions to the problems were offered with the common denominator overwhelmingly being conditions of service. Whether there are any research questions in that area for CRRAH are unclear at this time.

However another area of workforce does appear to offer further work. Many opinions were expressed by participants as to the relative amount of loss of workforce among health professions. Specific questions were raised; do workers in mental health burn out faster than those in other professions; has retention of doctors in rural areas changed; are workers 'stolen' from one organisation by another to work in other rural areas? All these questions have a common root and there appears to be merit in mapping the flow of health professionals in specific locations or across the region. The information that is currently available from the Census and AIHW reports seems to be very coarse and it should be possible to build a richer picture. Detailed documentation of what is really happening to the rural health workforce could be of considerable interest to many stakeholders including government in their workforce planning.

Volunteers constitute a significant proportion of the health service workforce especially in the areas of counselling and social work. Several participants suggested that volunteering had been affected by changes to legislation and as a result services that were dependant upon volunteers were being compromised. Determining the validity of this statement could

support necessary changes to rectify this situation and is an area worth considering for future research.

Mental health was identified as the second ranked priority area by participants to the workshops. Substance abuse, Indigenous health and youth were issues that were most often linked to the mental health theme. The importance of this theme was confirmed in two other meetings. Firstly in July 2006 the Division of General Practice in Toowoomba held a forum to explore areas of need in Indigenous health; mental health was identified as the number one issue. Secondly at the Centre for Rural and Remote Area Health's conference Showcasing Toowoomba Area Health Research in August 2006, mental health was the number one issue identified by the participants.

The theme of mental health may be concluded to be one of great importance by a large variety of health professionals and clearly they consider current services to be inadequate. Of great concern is the lack of adequate interventions before individuals meet criteria for health service support, as was the lack of recognition or acceptance of depression among individuals. Since the completion of the workshops a research proposal has been submitted by CRRAH to partially address the second issue. This is yet another positive output from the research workshops.

Access to services, the third ranked theme, generated several research questions that CRRAH may want to explore. A potential area of study is how rural locations differ from other locations in respect to the issues that were raised in the workshops? Do rural communities provide special circumstances or barriers or do some of the issues occur irrespective of locations? Solutions to reduce access issues require such detail.

However perhaps the most pertinent issue relates to the amount of forward planning that has been done in the locations to match future needs with population changes and demands. CRRAH has experience in this area having undertaken several audits of existing services and needs analyses such as transport demands of cancer patients in Toowoomba and south west Queensland travelling to Brisbane for services and provision of psychological services in south west Queensland. Our expertise in this area is recognised and at the time of writing we have been consulted to evaluate allied health provision in southern Queensland. Clearly this theme is one that CRRAH may continue to research.

The type of services offered in any location is affected by resources such as personnel and finance or by policy. Resultant access to services influences consumer perceptions and expectations of the health services. What became very clear during the workshops was that health providers are concerned that they are not meeting both their own standards and their clients' requirements. What was surprising was that the theme of consumer expectation and perceptions was the fourth ranked of all the themes. There was the very strong opinion that there have been major changes in the expectations of the general public in what their health service should be.

In the past few decades the post war baby boomers have been succeeded by the X and then the Y generations. It is a generally accepted that societal values, attitudes, and expectations are very different in each generation. Participants suggested that this has resulted in a shift in attitudes about health that have not been reflected in changes in the provision within the health service. There is an increasing trend in the belief that health support is a right regardless of lifestyle and individuals are no longer responsible for their own health, society is. This was considered to be compounded by the fact that more fear is propagated by the media and the immediate reaction to an ailment is the worst – a headache may be a brain tumour, fever in a child could be meningitis. Furthermore the

general public are becoming sceptical of expert opinion and expecting a second or even third opinion.

Many interesting sociological questions raised within this theme are probably well outside of CRRAH remit. However equally there may be issues for research that will have implications in models of care, service delivery and access. Perceptions and expectations of the community of health provision and health education are two themes that are closely tied. The mapping of cultural change may be a starting point if this area of research was to be expanded. The topic is one that requires due consideration and it is an area where expert input will be required.

During the course of the workshop program many opinions about lack of services were offered. Assessment of these services may be required to determine if the perceived lack of services are actually real supply issues or are more related to information. This is exemplified by the recent view by many health providers and consumers in Toowoomba that support for bereaved persons was lacking. Subsequent research by CRRAH identified over 20 local providers of such service and concluded that information about service provision and not the supply itself was a limiting factor.

During the workshops a lack of information for the general public about service providers within communities was identified. However during the course of writing this report we discovered that resources are provided by councils largely through their web sites. Following discussions with several of the workshop participants, CRRAH has received funding from USQ for a small project to determine the knowledge of these resources and their use by the general public in four towns. Information resulting from the study will inform not only future work by CRRAH but will also be given back to the councils who have expressed great interest in the results. Knowledge about the access and use of their own resources has not been determined and results should assist them in maximising these.

Interagency cooperation, the fifth ranked theme, poses some interesting research questions; some of which are linked with health information. Participants recognised that cooperation was not as high as it could be and it became evident from discussion that there is a lack of knowledge of what other providers do. Health providers are client focussed and activities that are not seen to directly advantage clients are given a low priority. Cooperation among agencies should provide this direct advantage however current practices suggest that cooperation is not perceived to do so.

Possible research in this area could determine what are the benefits to increased cooperation especially in terms of patient/client care? Why, if there are benefits, is cooperation not greater? What models/format are used and have been used in various locations or among different organisations? Why are these successes and/or failures? Exactly what type of information needs to be exchanged and what are the best mechanisms to achieve this?

Aged care generated a lot of concern particularly in regard to workforce issues. One possible topic within the workforce theme that is particularly relevant to aged care, is determining not why people leave their jobs or indeed the profession, but rather what makes them stay. Another potential research theme is the study of the models of recruitment and retention for health professionals working in rural and remote areas. Determining the relative successes and failures of such models may be a valuable exercise.

Migration of the ageing population also offers some interesting questions. It has been a common practise for both rural people and those from inter state to retire to the coast. However changing economic conditions have made coastal properties expensive and

many retirees have been moving to rural towns. Participants reported that more and more people are remaining on their properties. Changes in migration patterns have huge implications for future health service demands. Gathering a clearer picture of what is happening in this regard would be a useful avenue to explore.

Much of the discussions about carers revolved around respite and this appeared to be very closely related to information of what services were on offer. The most obvious of these was the lack of knowledge of services of Commonwealth Carelink and Respite by the health service providers; the very people whose clients would most benefit from that knowledge. One participant stated in their evaluation that

I feel from reading this document that there must be a lot of naive service providers out there in service delivery land and I wonder where the system is breaking down.

What type of information and in what manner of presentation would be best assessed by carers is worthy of discussion.

Audits of demand and supply or evaluation of successes and failures with regard to community based transport services may require further research. However from comments that were made at the workshops it appears that several local transport surveys have been undertaken to determine the extent of the problem. Without further consultation we are not clear whether opportunities for research exist.

Research areas within the themes of chronic disease, counselling and disability were not identified in any detail from the workshops. However it should be noted that CRRRAH has undertaken recent projects in two of these areas. Firstly CRRRAH on behalf of the Southern Queensland Rural Division of General Practice undertook a needs analysis of psychological services in south west Queensland. This research may soon be expanded to all allied health services. Secondly CRRRAH prepared a report for the Toowoomba Intellectual Disability Support Association on the accommodation needs of intellectually disabled people in Toowoomba and surrounding areas and more funds have been sought to continue these studies in other locations.

Some comments must be made about Indigenous health. This area is recognised to be extremely important with many illnesses and diseases more prevalent within the Indigenous communities. Access to services is often reported to be poor and the socio-economic environment in which many Indigenous people reside affects their health status. Average age of death is below 60 for both males and females and this is over 20 years lower than in non Indigenous populations.

Some health service providers indicated frustration when working in the area of Indigenous health. Especially as a result of providing services which are not taken up. This can lead to victim blaming and lack of willingness to try again. There is a need in these circumstances to undertake Indigenous community driven research to find out how the service can be provided so that the community utilises it.

Of the seven health service districts represented in the workshops three had Indigenous populations double or more than the state average of 3.1%. Charleville in particular has an Indigenous population of 12.4% and this would be expected to play a significant impact on the health service provision.

Specific providers of support for the Indigenous communities were invited to all workshops with attendance in Toowoomba and Dalby from the Indigenous Medical Services in those locations. It is unfortunate that participation was not possible from the other invited organisations although it should be noted that Goondir, which is based in Dalby does

provide services to some of the other areas in this study so could be seen to represent them. We are unclear as to the reason for the lack of participation. Further investigation as to why this happened may reveal alternative formats that are more likely to achieve participation.

The overall conclusion about the workshops was that we believe the project was extremely successful and achieved its stated objectives. Community engagement was achieved, new research areas have been outlined and some potential researchers were identified. The outputs of the project will not only contribute to improved health in rural and remote areas of Southern and Central Queensland but will also raise the profile of the University of Southern Queensland among the community.

5. REFERENCES

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6. APPENDICES

6.1. Appendix 1 Plain Language Statement and Consent Form

The Centre for Rural and Remote Area Health, a jointly badged research centre of the universities of Queensland and Southern Queensland is undertaking a study to identify and prioritise the health research needs of Southern and Central Queensland communities. The study has been funded by the Strategic Development fund at the University of Southern Queensland.

The objectives of the study are to increase the ability of the Centre for Rural and Remote Area Health (CRRAH) to:

- Network with stakeholders in rural and remote area health
- Identify and prioritise research needs in rural and remote health
- Identify potential researchers

An additional purpose of the workshops is that of raising the profile of both CRRAH and the University of Southern Queensland in community engagement.

CRRAH sees a real potential to tap into the existing pool of large numbers of highly educated health providers in the rural and remote areas of Queensland, developing and supporting their research skills and aspirations, bringing them into associate membership of the Centre, and thereby dramatically increasing the pool and scope of researchers and research projects managed through the Centre.

From previous experience, we have found that the best way to engage potential health researchers is through going to them, making ourselves available, listening to their interests and priorities, providing the encouragement and expert advice they need in developing study designs and funding applications, and giving them the support and confidence they need to pursue research. With appropriate support, many will choose to pursue their research interest as higher degree students

The format of the study is that of workshops held in Cunnamulla, Charleville, Dalby, Goondiwindi, Hervey Bay, Kingaroy, Roma, St George, Toowoomba and Warwick. Stakeholders to the study and invited participants to the workshops include (but are not restricted to) representatives from education, Queensland Health, aged care providers, private hospitals, hospices and Indigenous Health Service, the police, city and shire councils plus self-employed general practitioners and psychologists and consumer representatives.

The CRRAH has had past success with interactive research workshops. In 2003, an interactive research workshop was conducted by the CRRAH in Toowoomba. From this process, key research needs were identified and put into the development of CRRAH research streams. In addition a number of research-related outcomes came from the workshop, including, among others:

- A successful ARC linkage grant application;
- Sponsorship of research reports by local stakeholders;
- A peer-reviewed publication;
- Conference presentations;
- The overall strengthening of ties with key stakeholders attending the workshop, including:
- Research consultancies and other funding provided by key stakeholders; and
- Incorporation of research needs identified in the workshop.

Each workshop will last half a day. Prior to lunch health issues and research area will be identified and discussed. After lunch priorities will be established. In addition to the collection of written documentation the workshops will be recorded and the tapes transcribed verbatim.

When we write up the study we will not use any place or person names that could identify you, your employer or where you live. You are free to withdraw from the study at any time. To do this you need to contact any one of the named personnel. If you do withdraw, we will not use the information given by you in the workshop.

Any questions regarding the study can be directed to either Dr. Rob Eley, 07 4631 5477, eleyr@usq.edu.au, or Dr. Tony Fallon, 07 4631 5455, fallon@usq.edu.au at the Centre for Rural and Remote Area Health (CRRAH), University of Southern Queensland, Toowoomba, Queensland:

Any concerns you may have about ethical issues in this study should be directed to the Human Research and Ethics Committee, University of Southern Queensland. Phone: 07 4631 2956.

CONSENT FORM

I [name] _____

of [address] _____

have had the study 'Identifying and prioritising research needs of Southern and Central Queensland communities' explained to me. I have read the Plain Language Statement and agree to participate in the study. I am aware that my participation is voluntary, and that I can withdraw from the study at any time by contacting Drs. Eley or Fallon. I agree that the information I contribute to the study can be published as long as I cannot be identified in any way.

Signed

Date

Witness Signed

Date

Please complete and return this form before the start of the workshop.

6.2. Appendix 2 Evaluation

As part of an evaluation process we would be very grateful if you would answer the following questions and return them to us either by email to eleyr@usq.edu.au or fax (4631 5452). If you wish your comments to be anonymous you may mail them to Centre for Rural and Remote Area Health, University of Southern Queensland, PO BOX DARLING HEIGHTS, 4350.

Even if you do not have chance to read the report we would appreciate if you could respond to the first three questions.

5. *Did you find the workshop to be*

- a. *Very useful*
- b. *Useful*
- c. *Not very useful*
- d. *Not useful at all*

6. *In what way(s) did you find the workshop useful?*

- a. *Networking*
- b. *Research ideas*
- c. *Collaborative opportunities*
- d. *Knowledge acquisition*
- e. *Other (please specify)*

7. *Do you have any comments about the workshop you attended?*

8. *Do you have any comments about the report?*