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Report - December 2012
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i) Participant consent (Activity 2)
j) Interview questions proforma (Part 1 & Part 2)

NB: Appendices presented as a separate document
## 2 ABBREVIATIONS

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<th>Description</th>
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<tr>
<td>A&amp;D</td>
<td>Alcohol and Drug</td>
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<td>ARHEN</td>
<td>Australian Rural Health Network – links and supports the 11 University Departments of Rural Health (UDRH) across Australia.</td>
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<tr>
<td>ASGC</td>
<td>Australian Standard Geographical Classification</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
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<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
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<tr>
<td>EI</td>
<td>Educational Institution</td>
</tr>
<tr>
<td>HWA</td>
<td>Health Workforce Australia – set up by Council of Australian Governments (COAG) to provide a coordinated, national approach to health workforce planning.</td>
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<td>MH</td>
<td>Mental Health</td>
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<tr>
<td>MHA</td>
<td>Mental Health Academics</td>
</tr>
<tr>
<td>MHS</td>
<td>Mental Health Service</td>
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<tr>
<td>MHNET</td>
<td>Mental Health Nurse Education Taskforce</td>
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<tr>
<td>MHTC</td>
<td>Mental Health Tertiary Curriculum</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government organisation</td>
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<tr>
<td>NT</td>
<td>Northern Territory</td>
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<tr>
<td>OT</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>QLD</td>
<td>Queensland</td>
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<td>RMHSP</td>
<td>Rural Mental Health Service Providers</td>
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<tr>
<td>SA</td>
<td>South Australia</td>
</tr>
<tr>
<td>SP</td>
<td>Service Provider</td>
</tr>
<tr>
<td>TAS</td>
<td>Tasmania</td>
</tr>
<tr>
<td>UDRH</td>
<td>University Department of Rural Health</td>
</tr>
<tr>
<td>VIC</td>
<td>Victoria</td>
</tr>
<tr>
<td>VICSERV</td>
<td>Psychiatric Disability Services of Victoria – peak body representing community mental health services in Victoria</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia</td>
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3 CONTRIBUTING AUTHORS

Contributing Authors

Management
Steering Committee (MSC)
Members

Assoc Prof David Pierce
Director, University Dept of Rural Health,
Rural Health Academic Centre,
Melbourne Medical School,
The University of Melbourne

Dr Michael Coates
Senior Research Fellow and Deputy Director, Greater
Green Triangle University Department of Rural Health,
Flinders University and Deakin University Partnership

Members of MSC and Project Team
Chris Healey
Project Officer,
Greater Green Triangle University Department of Rural Health,
Flinders University and Deakin University Partnership

Fiona Little
Academic Team Leader Mental Health, University
Department of Rural Health,
University of Newcastle

Dr Jem Mills
Mental Health Academic
University Center for Rural Health, North Coast
NSW

Project Team
Veronica Barlow
Broken Hill University Department of Rural Health
Broken Hill, NSW

Ms Kerri Boase-Jelinek
Project Officer
Combined Universities Centre for Rural Health Western
Australia

Dr Stacey Cotton
Clinical Psychologist,
Department of Rural Health,
University of Tasmania
Dr Anne Croker
Postdoctoral Research Fellow,
Department of Rural Health
University of Newcastle

Dr Maddalena Cross
Senior Research Fellow,
Rural Health Academic,
Melbourne Medical School,
The University of Melbourne

Kathryn Cronin
Network Senior Mental Health Clinician
Country Health SA
Port Augusta office (UDRH - Centre for Regional Engagement)

Dr Martin Harris
Lecturer, Mental Health Academic
Department of Rural Health,
University of Tasmania

Theresa Jokisch
Project Officer
Australian Rural Health Education Network (ARHEN)

Fiona McCook
Department of Rural and Indigenous Health, Monash
University Department of Rural Health

Genevieve McDonald
Mental Health Project Officer,
Mount Isa Centre for Rural and Remote Health (MICRRH)

Assoc Prof Louise Roufeil
Head of Research & Mental Health Academic, Mount Isa Centre for Rural & Remote Health
James Cook University

Jodie Riley
Project Officer, Mental Health Tertiary Curriculum Project, University Department of Rural Health,
Tamworth

Kellie Schouten
Project Officer
Centre for Remote Health, Alice Springs

Samantha Splatt
Rural Mental Health Academic
University of Tasmania & GP North
Frances Stewart  
Project Officer,  
Department of Rural Health, University of Tasmania  

Mr Keith Sutton  
Lecturer in Rural Mental Health  
Monash University Department of Rural and Indigenous Health

Acknowledgements

Department of Health and Ageing (as funding body for the project)

Project Stakeholders and Participants

The development of this report including the position statement and recommendations was facilitated by financial support from the Australian Government Department of Health and Ageing. The opinions expressed in this document are those of the authors and do not necessarily reflect the opinions of the funding body.
4 EXECUTIVE SUMMARY

The value of rural health placements is well established in the literature. However, there is limited information about rural mental health placements and their impact on the development of rural mental health services. This project sought to develop this field by surveying the current provision of mental health training placements in rural Australia and use the findings to improve and shape the future direction of mental health clinical placements and to inform future tertiary curriculum development.

The project was conducted by the Australian Rural Health Education Network (ARHEN) and the 11 constituent University Departments of Rural Health.

Key Findings

- Student mental health placements are hosted in a broad range of program areas in a number of rural health service provider sectors, although the majority are hosted in the adult service program areas of public mental health services.

- Clinical placements of between 1 to 6 months are most frequent although a significant number are for durations of 30 days or less.

- For students, rural mental health placements may be challenging but in many cases rewarding. Students are often surprised by the quality of their learning in terms of exposure to the full spectrum of care, more time with health professionals, extensive hands-on experience, exposure to the social determinants of health, and enhanced skills in managing confidentiality and boundary issues.

- The approach to monitoring and reviewing student mental health placements in rural and remote settings is inconsistent and ad hoc.

- The value of good interpersonal relationships between education providers and health service (placement) providers in promoting effective mental health placements for students in rural regions was identified, as were concerns that such links may be diminished in the future as centralised placement structures are implemented.

- Competition rather than cooperation between institutions and disciplines for student mental health placements in rural and remote settings is having a detrimental impact upon organising and arranging placements.

- The majority of educational institutions and service organisations remain interested in increasing student mental health placements in rural and remote settings.

- Opportunities exist for the expansion of university-led partnerships to providers outside of existing public mental health stream.

- Funding to support the costs of placements, including transport, accommodation and support for mental health professionals providing supervision for such placements, is limited.

Currently rural mental health placements occur in a range of settings. Demand for placements is increasing resulting in competition for placement opportunities. Appropriate responses may
include increasing available placements especially in new settings, effectively coordinating placement allocation and providing additional support to placements and supervisors. In addition the cost of rural placements needs to be adequately considered. Finally, the recognition of learning objectives that are particularly relevant to rural mental health care should be addressed. Informed by the findings of the project five key recommendations have been developed.

Recommendations

1. The recently established regional training networks in rural areas should be responsible for establishing cooperative approaches for the allocation of clinical placements in mental health.

2. Sustainable approaches to providing academic support for clinical placements and supervisors in mental health should be developed, including the use of UDRHs amongst others.

3. Specific learning objectives should be established for rural placements in addition to promoting those common to all mental health placements. The rural learning objectives should consider issues that are specifically relevant to rural placements, including the rural context of the mental health experience and increased potential for confidentiality compromise and overlapping relationship conflict.

4. The funding for rural mental health placements needs to adequately account for the costs of placements, including transport, accommodation and support for mental health professionals providing supervision for such placements.

5. The number of clinical placements in rural regions for mental health students should be expanded. This will require support from education providers and health services for the development of alternative placement options. There are good examples of how these could be developed based on the diversity of rural mental health placements already on offer.
5 POSITION STATEMENT INCLUDING RECOMMENDATIONS

5.1 PREAMBLE

The undersupply of health professionals, including mental health clinicians, in regional and rural Australia is well documented (Department of Health & Ageing, 2008; Productivity Commission, 2005). This workforce shortage is occurring at a time when one in five Australians will experience mental illness in any one year, and 45% of Australians will experience some form of mental illness at some stage during their life (ABS, 2008). It is the largest cause of non-fatal disability of any disease in the country (Begg et al, 2007).

There is growing evidence that student clinical placements in rural regions can assist in the recruitment of health professionals to non-urban locations (e.g., Dunbabin, McEwin & Cameron, 2006; Playford, Larson & Wheatland, 2006; Schoo, McNamara & Stagnitt, 2008). This strategy is based on the assumption that this is a way of building familiarity with rural values and beliefs and a chance for those not from a rural background to see what opportunities rural life and rural practice can offer. Providing mental health placements in rural regions is important, not just because they appear to have value in growing the rural workforce, but also because they offer a positive learning experience for students of the health professions.

As mental health care becomes an issue for all health professionals, there is increased demand for placements in the mental health sector that places additional pressure on the existing rural mental health workforce that is currently working at or at times beyond capacity. If rural communities and students are to benefit from such placements, urgent attention is required to address the currently fragile nature of rural mental health placements to ensure their sustainability and growth into the future.

The statement is based on the findings of the Mental Health Tertiary Curriculum Project, undertaken during 2012 by the Australian Rural Health Education Network (ARHEN) with support from the Australian Government through the Department of Health and Ageing (DoHA). Project officers, located in each of the eleven University Departments of Rural Health (UDRH) including each state and the Northern Territory and members of the Mental Health Academic network (MHA) in each UDRH have been key contributors to this statement.

5.2 PURPOSE

This position statement has been developed to inform all concerned with the mental health and wellbeing of people at risk of or living with mental illness in rural Australia. This includes rural families and communities but also health professionals, educators, policy makers, health professional associations and regulators. It provides a strong basis for action for governments, professional associations, education and health service provider organisations to address the currently fragile state of mental health placements in rural settings.
5.3 WHAT DO WE MEAN BY A MENTAL HEALTH PLACEMENT IN A RURAL SETTING?

A mental health placement in a rural location can be broadly conceptualised as:

1. Providing opportunities in a relevant professional setting for the education and training of health sector students for the purposes of:
   - Integrating theory into practice with regard to mental health knowledge and competencies
   - Familiarising the student with the rural practice environment including understanding the potential difficulties of maintaining confidentiality, addressing stigma and maintaining professional boundaries in that environment.
   - Building the knowledge, skills and attributes essential for professional practice, as identified by the education institution and/or external accrediting body¹

2. Occurring anywhere across the full spectrum of mental health services from prevention, early detection and intervention, to relapse prevention and recovery and involving exposure to the full spectrum of people at risk of or living with mental health problems, their carers and families

3. Taking place in a rural setting that can vary along a continuum from larger, more closely settled communities to small populations dispersed over large areas.

Mental health placements in rural settings are frequently characterised by:
- Diversity of setting, profession, provider size and locality, and
- Connectedness in terms of the inter-relationships between educational facility, service provider, student, supervisor, client and community.

5.4 WHAT SHOULD WE EXPECT STUDENTS TO LEARN ON A MENTAL HEALTH PLACEMENT IN A RURAL SETTING?

The primary focus for learning in a mental health placement is ‘mental health’ though there is increasing evidence that there is an inter-play between the determinants of mental health problems and geographic diversity (Kelly et al, 2010). While diversity seems to be important, no research has as yet compared the learning outcomes of mental health placements according to location. It is likely however, that there is a common core of learning irrespective of placement location. Importantly, the positive experience reported by many students who have undertaken a rural placement challenges the belief held by some that mental health placements in rural regions are somehow second-rate learning experiences.

When students are asked to describe what they learn in a mental health placement in a rural region they tend to focus on the facilitated opportunities for learning. (In other words, many of the impediments that they have experienced during urban placements, including just being one of many students, are minimised). The learning that takes place during a mental health placement in a rural region appears to be facilitated by the generally favourable staff-student ratios and a perception among students that staff have more time for them. Students report that in such an environment they feel more able to ask questions. The reduced size of rural

¹ Derived from the definition of a clinical placement offered by Health Workforce Australia (2011).
communities also enables students to better understand the role of social determinants in the development of mental health problems and how a full spectrum of services is needed to work collaboratively to support people with mental illness. Students appreciate exposure to a generalist interprofessional model of care as opposed to a specialist approach to service delivery and welcome the opportunity to be involved in client care, rather than only being an observer.

The specific learning objectives for a mental health placement will depend on the type of health profession and the stage of education of the student. However, mental health placements in rural regions seem to offer unique opportunities for students to translate their text-book learning about mental health to real world practice. This is particularly true for the following areas:

- Risk assessment
- Transportation of unwell clients
- Managing confidentiality and boundary issues, and
- Engaging effectively with people from different cultural backgrounds.

For more senior students, mental health placements in rural regions can provide high level learning experiences that are likely to significantly contribute to their work-readiness. Rural placements can assist these students to shift from possessing a set of core skills to which they rigidly adhere, to a state where the student can be more flexible with how these skills are applied. In rural communities where services are limited and distances vast, students are challenged to develop effective problem solving skills.

5.5 WHAT FACTORS ARE ASSOCIATED WITH A QUALITY MENTAL HEALTH PLACEMENT IN A RURAL SETTING?

There are actions that can be taken by educational facilities, service providers and students that can significantly enhance the quality of a mental health placement in a rural setting. Ensuring a quality placement is valuable not just in terms of the learning of individual students, but also because quality is important with regard to the ability of the placement to influence a student's future career plans. Students are not going to consider rural practice if their experience during placement is a negative one. Findings of the MHTC project (2012) including interviews with over fifty students who had completed a rural placement suggested that the following factors are associated with a quality learning experience:

- Agreement between education institutions and service providers on what constitutes a rural mental health placement and how this is defined to ensure students can have placements tailored to their learning needs
- Some coverage of mental health in the curriculum, including mental health legislation, basic mental health assessment and self-harm risk assessment be undertaken prior to placement for all students undertaking mental health placements.
- Some coverage of mental health in the curriculum be undertaken prior to placement for all health professionals undertaking rural placements, to ensure that health professionals can adequately identify mental health issues and refer to mental health services as required.
- Some coverage of rural practice issues and Aboriginal and Torres Strait Islander history and culture be undertaken prior to placement.
• The provision of sufficient notice to the student that they will be doing a rural placement to enable them to adequately prepare both privately and professionally; ideally, students would like to talk to their supervisor prior to the placement about professional issues and need information on things like access to mobile phone and internet in the community
• The provision of information to the student about the host organisation (e.g., mission statement, service description) and the community prior to placement
• Access to affordable and safe accommodation and transport to get to the community and during the placement
• The service provider agency needs to know when the student is arriving and have received information on learning objectives and assessment criteria for the placement written in accessible language
• Prompt and comprehensive orientation to organisation and community with sufficient time permitted for the student to get to know both before undertaking client-work. Students need to know about local issues, local health and community services, local events, and community facilities such as transport, gyms, churches and shops
• The provision of opportunities for social inclusion in the community; this will often need to be provided by the staff in the agency hosting the student, fellow students, and/or by a UDRH. In many cases, this role may fall to the supervisor.
• Incentives to encourage health professionals who currently provide supervision are important to encourage continuation of this role and additional processes to provide ongoing professional support for these supervisors should be seen as important
• Processes should be in place to ensure that supervisors are suitably qualified to manage the clinical and process issues associated with student placement. Supervisors need to ensure their own professional development is maintained and that supervision training is undertaken
• Provision of high quality, locally-oriented cultural competence training, as it relates to mental health care
• Good supervision that addresses not only clinical and professional issues but also 'how rural practice works' and strategies to address isolation be provided. Supervisors need to be familiar with the requirements of the placement and supervision needs to be regular and structured
• Provision of appropriate learning space including access to a desk, email and internet during the placement
• A culture of learning within the host agency for the placement such that staff and managers value students and supervisors and see both as contributing to best practice for the organisation as a whole, as well as a contribution to the future workforce. Organisations with a strong learning culture will have policies and procedures in place that support both students and supervisors.
• Embed the notion of interprofessional practice into the student placement to ensure students are able to work collaboratively with their colleagues in the context of mental health placement in rural areas
5.6 WHAT ARE THE OBSTACLES TO MENTAL HEALTH PLACEMENTS IN RURAL SETTINGS?

Setting up a mental health placement in a rural region is not always a smooth process and there are obstacles to be overcome for students, educational facilities and service providers. For students, barriers include:

- Difficulties leaving friends, family and job for an extended period
- High cost of travel to rural communities
- Limited amounts of affordable accommodation in rural communities.

For education facilities, barriers include:

- The shift to centralised placement systems that has removed the role of relationships between educational facilities and placement providers upon which many rural placements were based.

The barriers for rural service providers include:

- Reluctance to take students (lack of learning culture, workforce shortages, limited infrastructure, lack of funding to enable student to take part in outreach, concerns about client and organisational safety)
- Shortage of appropriate supervisors that meet professional requirements.

Mental health placements in rural areas have the potential to offer rich and diverse learning experiences. There are also windows of opportunities to address most of these barriers as specified in our recommendations.

5.7 RECOMMENDATIONS

This position statement was developed as a call to action for all with an interest in the development of the rural mental health workforce. The provision of high quality clinical placements in rural mental health settings provides at least part of the solution to building the capacity of this workforce. In order to improve the quality and quantity of mental health placements in rural regions, we make the following five recommendations.

The importance of cooperation and support

Cooperation between education facilities and health services in providing placements and ensuring those placements are adequately supported have been identified as valuable in promoting mental health placements in rural regions.

It is recommended that:

The recently established regional training networks in rural areas should be responsible for establishing cooperative approaches for the allocation of clinical placements in mental health.

It is also recommended that:

Sustainable approaches to providing academic support for clinical placements and supervisors in mental health should be developed, including the use of UDRHs amongst others.
Training health professionals: Rural mental health learning objectives

Clinical placements are an essential component of the training of health professionals and contribute to the development of the health workforce. Learning objectives relevant to rural mental health placements are important.

It is recommended that:

Specific learning objectives should be established for rural placements in addition to promoting those common to all mental health placements. The rural learning objectives should consider issues that are specifically relevant to rural placements, including the rural context of the mental health experience and increased potential for confidentiality compromise and overlapping relationship conflict.

Funding

The current level of mental health placements in rural regions is dependent on the maintenance of existing levels of funding to support the accommodation and transport needs of students.

It is recommended that:

The funding for rural mental health placements needs to adequately account for the costs of placements, including transport, accommodation and support for mental health professionals providing supervision for such placements.

Expanding mental health placements

Mental health is a concern for the whole community. Pressure on the limited number of mental health agencies in rural regions able to provide placements has been identified, with an increasingly diverse range of health professions seeking rural mental health placements.

It is recommended that:

The number of clinical placements in rural regions for mental health students should be expanded. This will require support from education providers and health services for the development of alternative placement options. There are good examples of how these could be developed based on the diversity of rural mental health placements already on offer.

5.8 REFERENCES


6 INTRODUCTION

Mental health placements are a crucial component to assist in capacity building of the rural mental health workforce. Increasing demand for mental health placements in general has directed the focus toward rural areas as an alternative option for student clinical learning. Increasing interest has been generated in examining the benefits of clinical learning, yet to date very little investigation has been conducted into mental health placements in rural areas. The Mental Health Tertiary Curriculum (MHTC) Project was developed as an initiative to investigate what is currently happening in mental health placements across health disciplines in regional, rural and remote Australia.

The concept for the MHTC project first originated in August 2011 with preliminary discussions occurring between the Department of Health and Ageing (DoHA), the Australian Rural Health Education Network (ARHEN) and the ARHEN Mental Health Academics Network. The MHTC project intended to build upon the findings from the original MHTC program introduced in 2006, a program which aimed to increase the mental health content of tertiary curriculum through the development of mental health training modules for undergraduate health professionals. This original program also included providing students with access to interprofessional clinical training placements to enhance the mental health skills of the newly graduating health workforce. Funding from this program was used to expand the current MHTC program conducted in 2012.

Increasing investigation into the development of mental health curriculum and clinical training has occurred over the past 5 years. The Mental Health Nurse Education Taskforce (MHNET) report examined the current and future mental health content in undergraduate nursing courses across Australia. Of particular interest to the current MHTC project was the reference made in the MHNET report to the importance of clinical placements in promoting students to consider specialising in the area of mental health. Barriers to the implementation of MHNET report included the need for improved liaison and collaborative relationships between universities and health service providers. In addition, it was identified that improvements were also required for clinical training placements addressing levels of coordination and preparation of placement with the need to clarify expected learning outcomes.

Following the completion of the MHNET report in 2008, two further reports outlined clinical placements in more detail. The first of these conducted by the National Health Workforce Taskforce, Health Education and Training- Clinical training governance and organisation (2009) explored the challenges and opportunities to develop clinical education and placement. The second report conducted by Health Workforce Australia, Mapping Clinical Placements (2010) advised on the development of a more systematic and comprehensive approach to the management of clinical placement demand and supply. The MHTC project intends to build upon the findings from these previous reports.

The project commenced in February 2012 following agreement between the Australian Government through DoHA and ARHEN. The project is to be completed by December 2012 with final report submission to DoHA by 21st December 2012. The project was structured such that ARHEN would be the fund-holding agency and coordinator of the project with individual UDRHs implementing the project in their region by employing a 0.4EFT project officer. This
model was based on the collegial nature of ARHEN as a body linking all 11 UDRHs in Australia. The project commenced on time with all UDRHs engaging enthusiastically with its aims.

For formal purposes, including reporting, the original project name, the 'Mental Health Tertiary Curriculum Project', continued to be used. However, following approval by DoHA, the alternative name 'Shaping the Future of Rural and Remote Mental Health Placements in Australia' was used on project documents to more clearly identify the activities of the project. Acknowledgement of the support of the Australian Government, through the Department of Health and Ageing, was included in all public project documents.

6.1 DEFINITION AND SCOPE OF THE PROJECT

Due to the short project timeframe and the significant collaborative nature of the project it was identified as imperative that the planning phase be completed prior to the project commencing. To this end the 11 UDRH Mental Health Academics (UDRH MHA) met with key members of the ARHEN Board on a regular basis between September 2011 and January 2012 to define the key aims and scope for the project. Key project aims, as agreed with DoHA were:

To conduct an analysis of the profile of mental health clinical placements across regional, rural and remote areas of Australia. Examination of the professional disciplines receiving placements will be conducted including location, duration of the placement, the process to access clinical placements and the current supervision capacity and utilisation. The findings from the 11 individual UDRH scoping studies will be used to complete a national summary document which will add to what is happening across regional, rural and remote mental health clinical placements in Australia.

The second aim focuses on the investigation of determinants and values that are specific to mental health placements in regional, rural and remote Australia. The purpose of this part of the project is to develop greater understanding of (1) the student learning experience in rural and remote placements (2) how the findings may be utilised to improve and shape the future direction of mental health clinical placements. The development of a position statement outlining the findings will be a key objective of the project. Recommendations from the position statement will be available to inform future tertiary level curriculum development.

The project was divided into two key activities. The first activity examined which health disciplines participate in mental health clinical placements, where these placements occurred and for how long, and what assisted or deterred the placement from being an effective learning experience. The second activity examined the student, educational institution and service providers’ perception of what they felt influenced the mental health placement experience. The first activity would use predominantly quantitative methods and the second would use qualitative methods.

The UDRH MHA’s role was significant in the development and support to the project. Recruitment of the project officers occurred through the MHA network with most UDRH sites having project officers ready to employ at the commencement of the project. In addition, all MHAs provided onsite support to the project officers. Project governance, coordination and academic leadership occurred through the establishment of a Management Steering Committee as a sub-committee of the ARHEN board. This committee’s role was to oversee the project,
ensuring adherence to the project timeline and to provide an additional level of advice to project officers.

The project was undertaken in regions of Australia served by the 11 UDRHs (see Figure 1). This included all states and the Northern Territory. Care was taken to ensure survey and interview data were collected in an orderly manner at locations on the borders of individual UDRH regions. Data collection locations were cross referenced with the ASGC-RA classification (see Figure 2).

**FIGURE 1: UDRH GEOGRAPHIC BOUNDARIES SCOPED IN THE PROJECT**
6.2 COLLABORATION

Effective collaboration was essential for the project to be successful. This collaboration occurred and was facilitated by:

Project Officers meetings (teleconference and similar) were held weekly throughout the project

Use of Adobe Connect as an effective electronic communication tool

Utilising the diversity of project officers’ backgrounds to match relevant aspects of the project

A face to face meeting in Adelaide, held at end of the project (November 2012) and coinciding with a rural health conference to draw together project findings and recommendations

6.3 DISSEMINATION OF THE FINDINGS

Ensuring that the work of the project and its key findings and recommendations are made available to key stakeholders has been included in project planning. Proposed activities to promote dissemination to and engagement with key stakeholders include:

- Abstract presentation at the 4th Rural and Remote Mental Health Symposium; Adelaide, November 2012
- Abstract accepted for presentation at the 12th National Rural Health Conference, Adelaide, April 2013
- Workshop to discuss findings and recommendations with key stakeholders in Adelaide, April 2013. (This activity has been linked to the National Rural Health Conference)
7 LITERATURE REVIEW

7.1 INTRODUCTION

Despite interest in the field of Rural Health growing steadily for the last 15 years in Australia it would be inaccurate to say that the literature base is extensive. Smaller still is the amount of credible, high quality evidence available from mental health research to inform major policy decisions relating to rural mental health. The field of rural mental health is in the process of emerging from a position characterised by broad categorical discussions around urban / rural inequalities to more nuanced, multifaceted models of the determinants of mental health across rural and remote Australia. This in turn brings the hope of better targeted and configured resources to meet the needs of rural communities. With such a small and emerging evidence base, the research specifically concerning rural mental health training placements and their impact on the development of rural mental health services is understandably sparse. Given this, factors identified from other health disciplines in relation to the experience and impact of rural training placements have been included in the review as they may also be relevant to mental health specific placements.

7.2 OBJECTIVES

To examine the current evidence base associated with:

1. The relationship between rural and remote mental health training placements and the recruitment and retention of staff;

2. The factors that act as barriers to the establishment and smooth running of rural and remote mental health training placements and which of these are specific to rural placements;

3. Facilitating factors that contribute to the successful set up and running of rural and remote mental health placements and which of these are specific to rural placements.
An initial search strategy was developed utilising broad terms with the aim of maximising the number of academic articles and in particular research studies relevant to the objectives of the literature review.

A search of English language papers published from 2000 to the present date using the terms:

- Rural Health
- Practice based Learning
- Inter-professional collaboration
- Mental Health (MH)

**TABLE 1: INITIAL SEARCH STRATEGY RESULTS UTILISING THE DATABASE ‘PSYCH INFO’**

<table>
<thead>
<tr>
<th>Search Term</th>
<th>Initial Results</th>
<th>Filtered using term 'Mental Health'</th>
<th>Combined with 'Practice based Learning'</th>
<th>Combined with 'Rural Health'</th>
<th>All terms combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Health</td>
<td>318</td>
<td>15</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Practice Based Learning</td>
<td>10,893</td>
<td>182</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Inter-professional</td>
<td>17,855</td>
<td>592</td>
<td>9</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

A second set of more detailed search terms were developed to validate this result.

Three databases were searched

- Psych info
- Medline
- CINAHL

**Category** | **Search Terms**
---|---
Population | student/undergraduate student*/postgraduate student*  
Intervention | placement/clinical placement/training/clinical training  
Comparison | urban/metropolitan/rural/regional/remote  
Outcome | mental health/recruitment/retention  
Fields Searched | title, abstract, heading word, table of contents, key concepts, original title, tests & measures
The combined results of this search yielded no directly relevant research.

Following the principle that related research would logically have varying degrees of relevance to the objectives of the literature review, 4 related strategies were adopted.

1. Specific searches were undertaken of the *Australian Journal of Rural Health* and the *International Journal of Rural and Remote Research, Education and Policy Health*. Any papers from the year 2000 to date judged relevant were included.

2. Drawing on expertise within the project group, most notably the supervising members of the Mental Health Academic Network, a Delphi style review was undertaken whereby selected papers were recommended and the content evaluated against the literature review objectives.

3. Results of the previous two database searches were reviewed for literature judged to be partially relevant to the literature review aims. E.g. a survey of medical students’ experience undertaking a clinical placement in a rural area that may have included some mental health experience.

4. A ‘snowballing’ technique was then employed whereby the reference lists of all of the resulting articles were reviewed for any papers not previously identified.

Grey literature was searched from relevant Government and professional bodies including:
- Health Workforce Australia
- Department of Human Services
- Australian Institute of Health and Welfare
- National Health Workforce Taskforce
- Department of Health WA
- Victorian DHS
- Victorian Healthcare Association
- Queensland NGO Mental Health sector
- Mental Health Nurse Education Taskforce
- Psychiatric Disability Services of Victoria

<table>
<thead>
<tr>
<th>TABLE 2: ADAPTED SEARCH STRATEGY RESULTS</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selected Journal Search</td>
<td>9</td>
</tr>
<tr>
<td>Delphi Style Review</td>
<td>5</td>
</tr>
<tr>
<td>Review of original database search results</td>
<td>16</td>
</tr>
<tr>
<td>Grey Literature search</td>
<td>4</td>
</tr>
<tr>
<td>Snowballing</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
</tr>
</tbody>
</table>
The resultant literature was reviewed and findings summarised under the themes

- Context
- Rural mental health placements and recruitment
- Factors influencing the success of placements
- Benefits associated with rural mental health placements

7.4 CONTEXT

7.4.1 RURAL MENTAL HEALTH CONTEXT

The inequality between rural and urban health outcomes has long been recognised but the research on the influence of rurality on mental health is inconsistent (Judd et al 2002). Factors influencing the prevalence of mental health issues in regional and rural Australia are thought to be more complex and multi-faceted than health research has historically portrayed. Recent research focuses on the socio-demographic determinants of mental health issues in rural areas and it is likely that there is an inter-play between known determinants of mental health problems and geographic diversity (Kelly et al 2010). For instance, Campbell et al (2006) found that whilst the prevalence of diagnosable mental health disorders was higher in a rural sample compared to a regional sample, other socio-demographic factors associated with rural residence such as gender and length of residence were associated with having a diagnosis.

In summary, rurality influences provision of access to and quality of services but this alone does not explain rural mental health inequalities. Rather, rurality may exacerbate other determinants of poor health such as socioeconomic and cultural/attitudinal factors.

7.4.2 RURAL MENTAL HEALTH SERVICE CONTEXT

Reduced access to mental health services in rural and remote areas is one significant contributing factor to the mental health inequalities experienced in those communities (Smith et al 2008). Allan (2010, p. 4) points further to the negative cycles of ‘maldistribution of resources, access to appropriate and timely services, burnout and training of health workers and the financial cost of dealing with crisis over prevention’. Arguably then, rural and remote mental health inequalities are at least partly associated with reduced access to appropriate services which is in turn linked to reduced availability of mental health professionals.

7.4.3 STIGMA OF MENTAL HEALTH IN RURAL AND REMOTE AREAS

Society in general has long experienced the stigma associated with mental ill-health. Stigma towards mental health issues can have a debilitating affect on people in all areas of their lives including high unemployment, education and housing issues and relationship breakdowns (Cleary et al 2012; Larson and Corrigan 2010). Barney et al (2006) state that general perceptions and self-stigmatisation people have towards mental health will often prevent them from seeking professional help.

Rural areas are particularly vulnerable to stigmatisation and confidentiality issues around mental health (Parr and Philo 2004). Boyd et al (2006) contrast urban and rural perspectives on stigmatisation and confidentiality surrounding mental health. They found rural residence was ‘physically distant but socially proximate’, thus impacting on the ‘silencing of mental health
difficulties and the exclusion of people with mental illness in a manner more acute than in urban areas’ (p. 3).

7.5 RURAL MENTAL HEALTH PLACEMENTS AND RECRUITMENT

Workforce shortages relating to the health professions around Australia are well documented in the literature. Health workforce shortages, particularly in rural and remote areas, add to the difficulties already faced in these communities. The fundamental undersupply of mental health professionals particularly in regional and rural areas illustrates the depth of the problem (Department of Health 2009). A strategy undertaken by state and federal governments toward workforce recruitment and retention in rural and remote areas is to provide learning opportunities and exposure for undergraduate health science students to experience a rural and remote clinical placement (National Health Workforce Taskforce 2008; Courtney et al 2002).

Despite limited literature on the impact of rural mental health placements on future recruitment, there is ample evidence to suggest that a positive experience on a clinical placement can have a major influence on the decision to choose a career in mental health generally (Mullen & Murray 2002; Stuhlmiller 2006; Mental Health Nurse Education Taskforce 2008). The following outlines literature on rural health placements generally, not necessarily mental health placements specifically.

7.5.1 IMPACT OF POSITIVE RURAL PLACEMENTS

There is some research indicating that students who experience a positive rural clinical placement are more likely to return to a rural or remote area post graduation seeking employment (Killam & Carter 2010; Courtney et al 2002; Dalton et al 2008). Playford, Larson and Wheatland (2006, p.14) point out that the ‘quality of placement is a highly significant factor associated with workforce choice’. Data from these studies identified what students perceive as a quality rural and remote clinical placement. The main factors identified were that students felt well supported and part of a team; were provided with good supervision; friendly staff; autonomy and the scope of practicing skills (Courtney et al 2002; Playford et al 2006; Webster et al 2010).

7.5.2 LOCALS undertAKING training more likely to stay in rural or remote area

Students with rural backgrounds are more likely to return to a rural or remote area post graduation (Murray & Wronski 2006; Lee & McKenzie 2003) however, Playford et al (2006) strongly suggest not to exclude metropolitan students as ‘any prior rural background is a significant predictor’ in attracting new health professionals to the bush.

7.5.3 FACTORS influencing THE success OF PLACEMENTS

The review identified a range of practical, personal and relational factors reported by students and placement providers as influencing rural mental health placement success. Some of these factors are applicable to rural health placements generally, though not necessarily specific to mental health. Unsurprisingly, transport and accommodation featured highly in areas where distance is a major factor influencing health service delivery. Other factors discussed influencing placement success include workforce
shortages, student preparation, length and timing of placements, quality of the relationships between the student, University and Service Provider and the personal attributes of the student. Finally, the potential for previous good experiences with rural placements to contribute to subsequent placements is also considered.

7.5.4 ACCOMMODATION AND TRANSPORT

A common barrier identified by students in Australia and also internationally, relates to issues of accommodation and transport to get to their placement location (Chief Health Professions Office 2009; Killam & Carter 2010; Maley et al 2009; Webster et al 2010; Van Diepen et al 2007). Accommodation in rural areas is limited and may exclude some students from accepting a rural placement. An additional difficulty arises if the student has family who also need to be accommodated (Maley et al 2009). To assist with housing, some Universities either fully provide or contribute to the cost of accommodation for students. This has a considerable impact on not only the overall enjoyment of a placement, but more importantly their ability to fully participate in the placement (Webster et al 2010; Van Diepen et al 2007).

Transport is equally challenging, affecting students directly due to the financial burden and tiring effect of travelling distances (Van Diepen et al 2007). Possibly equally frustrating for students are the indirect effects of limited rural transport on clients’ capacity to access services and make decisions about their health care (Armitage & McMaster 2000).

7.5.5 RESOURCE ISSUES

Lack of resources, including human resources, are significant barriers for both students and services. When students lack sufficient resources such as access to phones, computer, work spaces and the internet, this has an impact on the placement experience (Chief Health Professions Office 2009; Maley et al 2009). Not only does it impede the work that can be done while on placement, but it also may serve to increase the isolation felt by students if phone and internet access is poor (Webster et al 2010).

Health workforce recruitment and retention issues in rural areas can also be a source of considerable stress for students and supervising staff (Murray & Wronski 2006; Department Human Services 2007). The effect of spreading staff too thinly impacts on the student learning experience due to reduced motivation and service delivery that is more focussed on crisis management in preference to early intervention models (Armitage & McMaster 2000). Some of the positive and negative experiences are highlighted as students on a rural placement experience a broad range of practice (Lloyd et al 2002; Webster et al 2010), however may be more prone to burnout through lack of support (Denz-Pehey et al 2004).

Interestingly, despite the lack of staff in rural areas, students on these placements often enjoy a higher staff to student ratio than their urban counterparts (Maley et al 2009), thus enhancing the placement experience and possibly somewhat mitigating the negative effects of staff shortages.

7.5.6 STUDENT PREPARATION

Preparation, including knowledge of mental health issues and orientation to not only the placement agency but also to a rural area more generally, is also a significant contributor to success of a placement. Lack of mental health content in undergraduate courses is a frustration for students and preceptors alike, and has been reported across disciplines (McCann et al 2009;
Orpin & Gabriel 2005; Mental Health Nurse Education Taskforce 2008). In fact, one study looking at first and final year medical, nursing and pharmacy students found overwhelmingly that the rural course content actively discouraged students from pursuing rural practice (Orpin & Gabriel 2005). The Victorian Shaping the Future report on mental health placements (2009) recommends the inclusion of positive and rewarding curricula content as a crucial component to recruiting new employees to the rural workforce, including the speciality of mental health.

Aside from preparation in relation to mental health content of undergraduate courses, orientation to a rural area more generally is also an important factor to the success of a rural placement and to subsequent practice in a rural area. Students who have lived rurally at some point have been found to be more likely to undertake rural placements and work in rural areas post graduation (Wronski & Murray 2006; Lee & MacKenzie 2003). For those students new to rural life, placement in these areas can result in a steep learning curve in relation to cultural matters, which may be challenging at the time, but ultimately a valuable learning opportunity (Armitage & McMaster 2000).

7.5.7 PLACEMENT LENGTH AND TIMING

Longer placements are more effective in sparking interest in working rurally (Maley et al 2009; Happell 2008), and are also more beneficial to student learning (Denz-Pehey et al 2004). However, the timing of placements is an issue for both students and healthcare providers. Inflexibility on behalf of the University and student to undertake a placement outside of semester or normal working hours is a source of frustration for healthcare providers and a barrier to increasing placement capacity (Magnusson et al 2007; Mental Health Nurse Education Taskforce 2008).

7.5.8 TRAINING AND RECOGNITION OF PRECEPTORS / SUPERVISORS

A significant factor for staff, and ultimately students, is a lack of adequate training and recognition for taking on the preceptor role (Mental Health Nurse Education Taskforce 2008; Department of Human Services 2007; Killam & Carter 2010). This is a problem not unique to rural placements, but may be more exaggerated in these areas. The value of a good preceptor on students’ placement experience and ultimately their desire to work in a rural area is significant (Charlston & Goodwin 2004). In response to the issue of training, programs for preceptors have been trialled in Australia. Charlston and Goodwin (2004) evaluated a workshop for nursing preceptors which resulted in increased camaraderie, information exchange and a raised profile for preceptors which in turn helped the mental health service to influence students’ attitudes towards a career in the area. Another education program originally designed for pharmacy clinical educators was also developed in Australia and trialled with Allied Health educators. Results from the review indicate that clinical educators felt more confident and positive about taking students following an on-line training course for supervisors (Leversha et al 2009).

Successful placements also rely heavily on support from all levels of the health service, and an expectation that staff will supervise students as part of their everyday role (Department of Human Services 2007).
7.5.9 PERSONAL FACTORS

Personal factors can have a significant impact on a student’s experience of a rural placement. One such factor, student anxiety, is a major barrier for recruiting students to a rural medical placement (Denz-Pehy et al 2004; Maley et al 2009). Anxiety may include feelings of isolation, boredom, issues of privacy and confidentiality and concerns about the quality of teaching in a rural area (Maley et al 2009; Killam & Carter 2010). However, other personal attributes of the student have been reported as enablers of a positive rural placement experience. Attributes identified in the literature include maturity, confidence, an ability to work autonomously and with enthusiasm. The need therefore to carefully select students for such a placement is important to its success (Maley et al 2009; Killam & Carter 2010; Murray & Wronski 2006).

Isolation is an important factor in influencing the success of a placement and refers not just to separation from friends and family, but also a sense of distance from the educational institution (Denz-Pehy et al 2004; Magnusson et al 2007). Providing support, through access to a local preceptor and other staff and encouraging socialising between students, can mediate the impact of this (Webster et al 2010; Courtney et al 2002).

Finally, and unique to a rural placement, issues relating to privacy and confidentiality are a recurrent concern reported by students in the literature (Armitage & McMaster 2000; Killam & Carter 2010). Difficulties in finding solutions to problems of maintaining privacy and confidentiality have been reported (Armitage & McMaster 2000).

7.5.10 RELATIONSHIP FACTORS

The success of a placement rests largely on the relationships developed between the student, preceptor, staff, other students and the community.

The importance of a supportive preceptor is widely acknowledged and has a significant effect on a student’s overall enjoyment of a placement. However, perhaps equally important are the relationships developed between the student and other staff and students (Courtney et al 2002). Staff in rural areas have been found to be more supportive, friendly, relaxed and collegial than their urban counterparts (Armitage & McMaster 2000). Additionally, students have reported feeling more respected by colleagues and the community in a rural area (Courtney et al 2002). However, despite the commonly reported more relaxed atmosphere in rural areas, Armitage & McMaster (2000) found that students reported on the hierarchy that existed among staff and the traditional split between nursing and medical staff.

The opportunity to socialise and develop relationships with other students while on a rural placement also contributes to its success. Importantly such relationships also serve to decrease the isolation felt by many students while on a rural placement (Denz-Pehy et al 2004; Webster et al 2010).

However, relationships refer not just to those of the student, but those between the university and the healthcare provider. Successful placements require good communication between the two (McCann et al 2009; National Health Workforce Taskforce 2008).

7.5.11 PREVIOUS EXPERIENCES

While previous positive experiences in a rural health placement are not necessarily predictors of subsequent successful placements they may play a part in influencing students’ attitudes to similar future undertakings. In one Australian study, previous good experiences on rural placements, which included supportive and friendly staff and a range of clinical encounters,
prompted half of the participants to undertake another rural placement (Lea et al 2008). By doing this students felt that they would extend their nursing knowledge and skills. It is interesting to speculate whether such a positive pre-placement outlook would impact on learning opportunities and professional interactions in a beneficial way.

7.6 BENEFITS ASSOCIATED WITH RURAL MENTAL HEALTH PLACEMENTS

7.6.1 MORE OPPORTUNITIES FOR LEARNING

Positive attitudes to rural placement learning experiences may exist even before students are placed in a rural environment. Among both first year and final year students in medicine, nursing and pharmacy at the University of Tasmania, placement in a rural practice was perceived as a better opportunity to develop patient relations than was offered in a metropolitan setting. For other learning experiences, the positive expectations did not diminish either. The number of students who saw rural placements as providing diversity of practice increased from the first year to the final year (Orpin & Gabriel, 2005).

However, benefits are not confined only to student perceptions. Good learning opportunities, living in the community and taking part in social activities have resulted in positive experiences for students in a range of contexts (Denz-Penhey et al 2004; Webster et al 2010). However, these beneficial occurrences have been qualified, in some situations, by the acknowledgment that the students themselves needed to work hard at making such things happen and that with the benefits, came the worries and anxieties associated with working in a less structured environment than metropolitan health settings and being away from home (Denz-Penhey et al 2004). These findings suggest that individual characteristics like maturity, a self-starting personality and the ability to cope with uncertainty may play a large role in whether a student benefits from a long-term rural placement.

The opportunity to develop a wide range of clinical skills in a multidisciplinary healthcare environment, while observing the place of healthcare and service delivery within a community setting, is also a recognised benefit of rural placements (Worley et al 2000; Webster et al 2010; Johnson & Blinkhorn 2011). Students have opportunities to practice clinical decision-making in situations where factors such as family and community can influence outcomes. These opportunities are not afforded to their urban counterparts who may only experience a cross-section of caseloads (Worley et al 2000, Birden & Wilson 2012). One little discussed consequence of being exposed to such optimal clinical learning experiences is that not only are students immersed in a real context developing skills and knowledge but that they are also being assisted, through their participation, in developing their own professional identity (Dalton 2004). Additionally, students in remote sites have reported a much greater awareness of cultural issues when working in Aboriginal communities and felt they were more effective cross-cultural communicators as a result (Webster et al 2010). Thus working and living in a rural community not only enables skills, knowledge and personal development but also gives students a unique insight into rural life and an appreciation of the differences between rural and metropolitan healthcare.

However, as acknowledged in the introduction to this section, the majority of these experiences are not specific to mental health placements, although exposure to mental health cases may have occurred incidentally.

In fact, positive experiences specifically from rural mental health placements have proved difficult to locate. One Australian study reporting on the attractions of a mental health placement for nursing students identified staff support and participation in patient care as the
two main benefits. (Henderson et al 2006). However, although respondents were from both metropolitan and rural areas, the analysis compared the positive experiences by mental health setting: in-patient mental health settings and community health settings, features that the current undertaking has not investigated.

Where the research focus has been specifically on the rural mental health experience, the findings have often replicated those obtained in other rural health contexts. Students have the opportunity to both observe and participate in patient care within a community (Armitage & McMaster 2000; Webster et al 2010) which provides a much more holistic learning experience than what would be experienced in a metropolitan area. Often in these situations, where resources are stretched and health professionals scarce, the students may become a part of the health team (Armitage & McMaster 2000). This provides an invaluable opportunity to participate in an interprofessional learning experience.

7.6.2 IMPROVED EXAM SCORES

The perception that undertaking a rural placement will disadvantage a student because they will fall behind in class work, or that they will be operating in a less academic environment than students on metropolitan rotations or placements, is common (Maley et al 2009). These fears appear somewhat unfounded as there is evidence to show that students who have competed rural placements have both better exam scores and clinical skills in comparison to their metropolitan counterparts (Barrett et al 2011). A recent study found that medical students did better in their practical exams following a rural placement in mental health than did their urban counterparts and it is suggested that this may be because they had more opportunities to practice and more supervision / mentorship time offered (Birden & Wilson 2012).

7.6.3 FRIENDLY WELCOMING STAFF

The benefits of a rural placement are not necessarily measured only in terms of mental health skills and knowledge gained. Affective factors may also play a major role in determining whether or not a student has a positive experience. The relationship between mental health clinicians and their student charges is viewed as a key component of successful learning (Arnold et al 2004). Such a finding is perhaps unsurprising as students may be in a rural environment for the first time and far from their homes and support systems. Maintaining good interpersonal working relationships would seem essential particularly where placements may be lengthy. The importance of the human factor is not confined to just mental health: in other rural health settings friendly supportive staff and collegiality have been shown to influence students to take up careers in rural health after graduation (Maley et al 2009; Courtney et al 2002).

7.7 CONCLUSION

Given the inequalities in health care, particularly in mental health care, experienced by rural communities, further research focusing on ways to increase the workforce and therefore service provision is vital.

The value of rural health placements is well established in the literature and has been outlined here. However, obviously lacking from this review is research concerning rural mental health placements specifically, and their impact on the development of rural mental health services. The current project sought to develop this field by surveying the current provision of mental health training placements in rural Australia and identifying opportunities for their development.
8 METHODOLOGY

The Mental Health Tertiary Curriculum Project aimed to investigate mental health placements in rural Australia including factors that may promote such placements, barriers that might limit such placements and features that differentiate a mental health placement in a rural area from a mental health placement in a metropolitan area. The project was also called the Shaping the Future of Regional, Rural and Remote Mental Health Placements project in many of the documents used with project participants to enhance understanding of its purpose and activities. The project aims were:

To conduct an analysis of the profile of mental health clinical placements across regional, rural and remote areas of Australia. Examination of the professional disciplines receiving placements will be conducted including location, duration of the placement, the process to access clinical placements and the current supervision capacity and utilisation. The findings from the 11 individual UDRH scoping studies will be used to complete a national summary document which will add to what is happening across regional, rural and remote mental health clinical placements in Australia.

The second aim focuses on the investigation of determinants and values that are specific to mental health placements in regional, rural and remote Australia. The purpose of this part of the project is to develop greater understanding of (1) the student learning experience in rural and remote placements (2) how the findings may be utilised to improve and shape the future direction of mental health clinical placements. The development of a position statement outlining the findings will be a key objective of the project. Recommendations from the position statement will be available to inform future tertiary level curriculum development.

The project was undertaken in two separate activities, (Activity 1 and Activity 2). The project included guidelines for Activity 1 and Activity 2. These were as follows:

8.1 ACTIVITY 1 GUIDELINES:

1. Determine what health disciplines including (but not exclusive to) medicine, nursing and allied health are currently receiving mental health clinical placements as part of their learning curriculum. The scoping study will not be limited to the undergraduate stage of learning. It may also include postgraduate students who have already obtained health qualifications and wish to expand on their qualifications or specialise in mental health, for example.

2. Examine the settings and duration in which the clinical placement occurs will be scoped including placements that occur in the public, private and non-traditional health settings. Attention will be given to the processes followed to coordinate and create access for student clinical placement.

3. Investigate the current barriers or enablers that influence access to clinical placement, including the identification of current supervision capacity and utilisation, for organisations and private placements. Identify where there might be opportunity to expand upon existing clinical placements.
ACTIVITY 2 GUIDELINES

1. Develop a position statement providing a written framework to define what constitutes a rural mental health clinical training placement. This position statement may form the basis of draft placement guidelines as they refer to mental health placements focusing on what is specific to rural in these placements.

2. Utilise scoping activities to understand what the differences are in regard to what is learned by students in a rural and remote placement. This may include consultation with previous students who may have experienced a mental health clinical placement with the rural and remote setting.

3. Develop learning objectives and recommendations based on the finding from the scoping study which will be incorporated into the position statement.

The project structure included the involvement of ARHEN and all 11 UDRHs. ARHEN was the fund-holding agency and coordinator of the project. Individual UDRHs agreed to implement the project in their region by employing a 0.4-EFT project officer. Project officers’ roles involved both developing the project and implementing it in their UDRH, including obtaining ethics approval, identifying and recruiting participants, collecting data from their local area, contributing to data analysis and final report production.

Quantitative and qualitative methodologies were used in the project. Activity 1 predominantly used quantitative approaches using two survey instruments that were developed specifically for the project, one to collect data from education providers and the other to collect data from rural mental health service providers. These instruments are included as Appendix D and Appendix E. In most areas data were collected using these surveys in online format. In some locations this was not possible due to local factors including IT infrastructure. In these settings identical hard copies of the surveys were used.

In Activity 2, data were collected using qualitative methods, predominantly using individual interviews. Staff from rural health service providers that host student placements and from educational institutions that place mental health students in a rural area were interviewed. In addition, students were interviewed to investigate their experience of participating in a mental health rural placement. Qualitative methods were selected for Activity 2 to allow exploration in some depth of the views and experience of participants.

ACTIVITY 1

8.3.1 RECRUITMENT

Recruitment was undertaken by the project officers within the area of activity of their individual UDRH. This ensured that participants from all states and the Northern Territory were recruited. Two groups of organisations were targeted, Educational Institutions (EI) and Rural Mental Health Service Providers (RMHSP).

Educational institutions were identified that provide entry level health qualifications for practitioners to further identify those that potentially may provide mental health placements within the area of activity of the UDRH. This included universities, Further Education Organisations (TAFEs) and other accredited training providers. It was anticipated that universities would be the largest providers but others were recruited to ensure as complete a picture as possible was obtained.
Within these educational institutions the individual or individuals responsible for the coordination of student placements or with specific knowledge of student placements became the participant in the project. This process was followed for each health course at each institution.

Organisations within the area of activity of the UDRH that provide mental health services and potentially may have health students on mental health placement were identified by the project officers. RMHSP would be located in regional, rural, and remote areas and would provide consumers/patients with inpatient and/or community health services (including generalist and specialist mental health services and drug and alcohol services). RMHSPs may be from either government or non-government sectors. The specific participant(s) from each RMHSP was likely to have a role as a coordinator/mentor/supervisor/teacher and be involved with the supervision of students undertaking placements. Although in the questionnaire this cohort of respondents was referred to as Mental Health Service Providers, in the results section of this report the group are referred to simply as Service Providers. This approach was adopted to reduce any confusion that might arise in regard to the broad spectrum of service sectors surveyed.

Each project officer identified potential key participants from EIs and RMHSPs in their respective UDRH catchment area and formal contact made by either telephone or e-mail. The project officer briefed the potential participant on the project, providing further information and answering questions. The potential participant was then invited to join the project. Once potential participants agreed to participate, the project officers confirmed verbally whether the participant would be undertaking the survey online or request the information to be provided by a paper based questionnaire. In some locations, ethics approval did not allow informal contact of potential participants; in these locations formal contact became the initial point of contact.

Following verbal information about the project, participants received a copy of the Plain Language Statement (PLS). Participants completing the survey online received the web-link, and instructions for accessing and completing the survey. Participants choosing to complete a hard copy of the survey were posted a hard copy of the survey along with completion instructions and a reply-paid envelope for survey return. They were informed that they may receive three reminders to complete the survey, one within two weeks of receiving the project survey and others after four and six weeks of initial contact, if needed. All participants were informed that they may be contacted in the future to participate in activity 2 of the project. Each participant was able to decline a possible future approach.

8.3.2 SURVEY DATA

The survey structure and survey questions were developed by considering the clinical placement scoping tool developed by Health Workforce Australia and the survey questions used to inform the VICSERV Student Placement Survey Report. It was thought important to also capture other placement data relating to internships and/or graduate positions and placement activity offered by clinical mental health services that provide opportunities for capacity building for staff from the non-clinical mental health sector and/or non-mental health service staff.

Separate interview schedules were developed for placement sites and educational institutions and are included as Appendices D and E, respectively. Questions were structured and grouped into the sub-headings. For the educational institutions, these were (a) organisational information, (b) student placement information for 2010 & 2011, (c) placement organisation,
support and supervision, (d) barriers and enablers and (e) future mental health placements. For service providers, these were (a) organisational information, (b) TAFE or undergraduate mental health placements, (c) Post graduate student mental health placements, (d) Coordination of placements and (e) internships and graduate programs in mental health settings (f) placements for non-clinical service &/or non-mental health service staff, (g) barriers and enablers, (h) future mental health placements, and (i) capacity of future mental health placements.

Participants filled in an on-line survey, structured in Survey Monkey. The survey took approximately 30 minutes to complete. Where participants were unable to complete the survey on-line, hard copy versions of the relevant questionnaire were provided to the respondent.

A spread sheet was developed to track identified respondents across each UDRH and a master spread sheet was collated by the data collection subgroup to ensure that identified recipients were not receiving multiple requests in relation to Survey monkey. This was particularly relevant for those states that have multiple UDRHs, often with adjacent and/or overlapping regions of activity and with educational institution potentially sourcing rural mental health placements from a number of universities. Once the project team were confident there was no potential for duplication, the survey monkey link was distributed to each project officer to distribute to potential participants. Each project worker was then required to monitor responses and send the reminders to participants who had not yet completed the survey.

The initial timeline for collection of responses was three weeks but this had to be extended on a state by state basis as a result of delays in obtaining ethics approval. At the closure of the data collections period, the activity-1 subgroup cleaned the data and screened for any duplications. Duplicate entries were referred back to the appropriate UDRH project officer for clarification. Additional data variables were added, as required, such as ASGC Remoteness Area Classification.

Analysis was undertaken using SPSS Version 20.Analyses undertaken included descriptive statistics and Mann-Whitney U Test and independent sample t-tests to explore differences between the cohorts and sub-groups within a cohort. In some cases, however, where there were small numbers of respondents, inferential analysis was only possible at the between-cohort level.

8.4 ACTIVITY 2

8.4.1 RECRUITMENT

Recruitment was undertaken with the same two groups of organisations, Educational Institutions (El) and Rural Mental Health Service Providers (RMHSP), as used in activity one. In order to obtain a student’s perspective, current students from the disciplines of nursing, medicine, psychology, occupational therapy, and social work were also invited to participate in the project. Each of the eleven UDRH sites aimed to interview a minimum of seven students from the five relevant disciplines, with at least one TAFE student, if possible. The other two students were recruited from the educational institutions and the mental health placement sites.

All participants who completed the survey in Activity 1 were invited to participate in Activity 2 by contacting their local UDRH after completing the initial survey. Where interest was demonstrated, the key contact person (participant) for that service or educational institution was contacted by their local project officer and invited to participate in an interview. In
addition, project officers also used a cold call approach and invited professional contacts within their local setting to participate in the interview process.

Course coordinators of each of the relevant disciplines from the educational institutions were contacted and asked to assist in the recruitment of student participants. The course coordinators were asked to provide a plain language statement to students who had completed a rural mental health placement in the past 2 years, and to ask students to contact their local UDRH project officer if they wished to participate in the interviews. In addition, the project officer associated with each of the UDRHs contacted the course coordinator of an educational institution or a member of staff at a rural mental health service provider by phone or e-mail to invite them to participate in a one-on-one interview.

When project officers were contacted by potential participants, the project officer reiterated the information found in the PLS including the background and aims of the project, confidentiality and benefits of participating. They also described the method of activity 2 including that it included an interview which would normally take 45-60 minutes of the participant's time. Participants were also informed that they would be asked to provide written consent prior to participating in the interview, and that the interview would be recorded for the purposes of analysis. If the potential participant gave verbal consent to participate, a meeting time was arranged suitable to both the participant and the project officer.

Interviews were conducted either face to face or via phone, depending on availability and location. If the interview was to take place face to face, a mutually agreed meeting place was negotiated, typically at either the participant's work place or the local UDRH office. Interviews were not conducted in a participant's residence or a public location.

The consent form was e-mailed to the participant prior to the interview. The participant was asked to either bring the signed consent form with them to the interview, or e-mail or fax the signed consent form back to the project officer prior to the interview if they had opted for a phone interview. If the participant did not bring the signed consent form with them to the interview, another was provided for signing at the time of the interview. No interviews took place without a signed consent form.

**8.4.2 SURVEY DATA**

Separate interview schedules were developed for students, placement sites and educational institutions. Interview questions were structured and categorized into the sub-headings of expectations, preparation, living the rural/remote life, learning activities, supervision arrangements and reflection. Some questions contained 5-point Likert scales to support expression of the strength of participant responses.

All interviews were audio recorded. In addition project officers, where appropriate, supplemented the data with handwritten notes at the time of the interview. Immediately after conducting an interview, the project officer jotted down any key issues or impressions they had about the interview in a journal. This journal was used in the analysis phase of the project and was kept as included in the data set. Given the volume of data to analyse, funding restrictions and the short time frames for this project, the decision was made not to fully transcribe all of the interview data.

A systematic approach was used to analyse the data by developing a rigorous procedure to transfer the interview data to manageable chunks of key statements. This process included the manual transfer of interview data to a written template by the project officer that conducted the interview. As soon as possible after completing the interview, each project officer again listened
to each audiotape (question by question) and systematically jotted down the key points raised by the interviewee for each question. The project officer then re-listened to the specific question to determine whether all key points had been captured. This process was repeated until the template reflected an accurate account of the verbal interview. The process was repeated for each of the research questions:

- Identify unique features of rural and remote MH placements
- Describe barriers/enablers for EIs in coordinating placements
- Describe barriers/enablers for service providers in accepting and supporting students
- Describe barriers/enablers for students undertaking rural & remote MH placements.

Key quotes were also included and coded according to the interview of origin. In addition to an individualised interpretation of each question, the data were considered from an overarching interview as a whole perspective, where project officers considered the interviews as a whole and the group of interviews as a whole and documented the key findings.

A small working group with experience in analysing qualitative data was selected from amongst the project officers to undertake the analysis. The group met face to face to carry out the analysis. The raw data for the analysis were the material recorded in the templates produced by each project officer across Australia and derived from the interviews. The analysis of the data was made with the goal of adequately reflecting the rich data obtained. The aim was not to interpret the data, but rather to operate at a semantic level. Additionally, rather than seek to describe the entire dataset, the approach was to detail specific aspects of the data that fell within the boundaries of our key project questions. Therefore, the end point of the analysis was a set of themes within each project question that best described what the informants had described.

The steps undertaken to conduct the analysis were based on the recommendations for conducting simple thematic analysis proposed by Braun and Clarke (2006).

- Prior to the face to face meeting, each member of the working group familiarised themselves with the data by repeatedly reading through each template in an active way, noting key patterns and meanings with respect to the project questions. This preliminary coding was recorded and brought to the face to face meeting.

- At the face to face meeting, each member of the group read out their initial coding and similarities and differences between the findings were discussed with reference to the data – for each of the set project questions. This resulted in some preliminary codes being discarded as they could not be agreed upon by the group, some retained due to achieving consensus and some new codes developed as a result of the discussions and further reading of the data.

- As a group each project question was sorted from the initial codes into potential themes, again with constant reference to the data. Tables were used to assist the group to best organise the codes into themes. Some codes did not fit within any of the project questions and were discarded.

- The tabulated themes falling under each project question were distributed to all project officers across Australia as a check for trustworthiness of the emergent themes. All project officers indicated that the resultant themes adequately reflected the data.
• The final set of themes were named and defined by one of the project officers and a report of the findings was written up with accompanying evidence from the data. This was again reviewed by all project officers and felt to be a good representation of the interview data.

8.5 CONSENT AND ETHICS

For activity 1, consent was implied by completing and submitting an anonymous questionnaire. A separate consent form was not required. For activity 2 a paper based consent form was completed and returned to each project officer conducting the interview before the interview began.

Ethics approval was also obtained for the project. A master ethics application was submitted to The University of Melbourne ethics committee to represent the project as a whole. This was a minimal risk ethics application. The collaborative nature of the project across all UDRHs was outlined. After a three week independent review process, the minimal risk application was approved. This overarching approved application was then used as the basis for registration of the research project with the ethics committees associated with the other 10 UDRHs, other tertiary institutions and health services across the project.

In most cases ethics was approved based on the original application through the process of project registration. The project was not altered in any way. However, at a small number of sites the overarching ethics application from the University of Melbourne was not considered enough for project approval and the registration process was not applied. These sites asked for independent applications to be submitted by ethics committees within each UDRH jurisdiction before data collection could proceed. The submitted applications were based on the University of Melbourne original application and after a period of between four and eight weeks, ethics approval was granted with minor adjustment to the original application. The adjustments that were required did not alter the research protocols in any material way. Some UDRHs were required to submit ethics applications to more than one ethics committee, predominantly ethics processes that covered health service providers. More than 20 ethics applications were required for the whole project. Some delays were experienced in the process of data collection as a result because gaining ethics approval was more extensive than was originally anticipated.

Ethics approval for activity 2 of the project was submitted as an amendment to the original application. Again the amendment was first approved by the University of Melbourne and approval was granted. This amendment was then able to be used by each UDRH to register with their respective ethics committees. Generally this process was straightforward although for some sites, UDRH’s had to again register their application twice, (once with their host university ethics committees and once with their local health service). There was one exception to this process involving a state rural health service Human Research Ethics Committee which required a separate full application for activity 2 of this project. Given the time frames involved in obtaining ethics approval and the tight timeframe of the project, it was decided that ethics approval for activity 2 for rural health services in that state not be sought and as a consequence no state funded mental health services from that state participated in activity 2 of the project.

8.6 STORAGE OF DATA

All paper based information and interview audio files will be kept in locked facilities at each individual UDRH. All electronic data will be accessed by password and named researchers only. Information was shared by project officers by a secure, password protected, drop-box system.
Data will be retained for up to seven years after the completion of the project. This encompasses the five year minimum. After seven years the project information will be destroyed by deleting electronic files on all systems and shredding all paper-based information.

8.7 CONFIDENTIALITY

The surveys were returned anonymously. Although the identity of the participants was known to the interviewer, the reporting and publication of any information gathered through the interviews will be confidential. Any identifying information regarding persons the interviewee may mention will be removed from any subsequent analyses. The participants were advised of this in the plain language statement, and again when they were provided with the information on the project.

8.8 REFERENCE

Activity one involved the collection of data from educational institutions and health service providers, using on-line surveys. Most survey questions sought a response to pre-set alternatives. Some survey questions allowed a free response The results are organised into sections that include where student mental health placements are located, how placements are coordinated, a profile of mental health placements reported in rural and remote settings, supervision arrangements, placement support, monitoring the quality of placements, enablers and barriers to mental health placements in rural and remote areas, interest in expanding placements into the future, other comments about mental health placements in rural and remote areas and other types of placement supported by service providers. The detailed results of some sections of this chapter are organised into sub-sections that highlight specific aspects section topic. A brief summary of the key results precedes each shorter section or each sub-section section of the results outlined in this chapter.

This chapter of the report uses the abbreviation EI to refer to participants from educational institutions and SP to refer to service provider participants.

The summary below provides a brief overview of the key results described in this section of the report.

**KEYPOINTS**

- The majority of service provider EI and SP respondents reported that their organisations would like to increase student mental health placements in rural and remote settings into the future
- The majority of respondents reported student mental health placements in rural and remote locations are with public mental health services. Most (75%) of EI participants reported that no more than 60 students from their institution participated in mental health placements in both 2010 and 2011 and that no more than 30 students from their institution participated in mental health placements in rural and remote settings during the same period.
- Although slightly more than 50% of service providers reported hosting multiple student placements, the overwhelming majority reported that organisations hosted no more than 30 student placements in both 2010 and 2011
- Although the majority of educational institutions reported having formal student placement agreements with service providers, there appears to be no consistency in the range and level of support provided to service providers hosting students placements associated with these agreements
- EI respondents reported that competition between institutions and disciplines for student mental health placements in rural and remote settings is having a detrimental impact upon organising and arranging placements
- Despite the identified lack of access to supervisors in rural and remote settings, there appears no evidence that and educational institutions and service providers are working collaboratively to address the issue
- EI respondents reported that due to the competition for mental health placements, institutions are organising mental health placements with aged care services (a setting which potentially provides students with exposure to a limited range of mental health disorders).
• Approaches reported by both EI and SP participants indicate that the approach to monitoring and reviewing student mental health placements in rural and remote settings is inconsistent and ad hoc
• SP respondents tended to not agree that access to placements has been enhanced by using existing resources for more shifts throughout the day, night and into weekends, as this may not be applicable to service providers in rural and remote settings that generally operate during core business hours from Monday to Friday
Respondents were asked to indicate by postcode or place name the locations in which students had undertaken rural mental health placements during 2010 and/or 2011. Each reported location was re-coded by project workers based upon the ASGC rural and remote categories.

**Summary:**
- Majority of student mental health placements for 2010 and 2011 reported as located in ASGC Inner and Outer Regional category areas

As illustrated in Figure 3 below, nearly 70% of the reported student mental health placements were in rural/remote service settings located in ASGC Inner and Outer Regional category areas with a further 24-26% located in the remote area categories. A small number of respondents included Post Codes and placenames that corresponded to locations classified as Major Cities; these centres may be considered by some to be provincial centres as distinct from Capital Cities and therefore were included in the data as part of the ‘the regional/rural landscape’.

The location of reported student placements by ASGC categories of remoteness is very similar for both SP (n=82) and EI (n=77) respondents apart from the very remote category.

As indicated in Figure 4, both university and TAFE students undertake mental health placements in all areas defined as ASGC categories of remoteness. Due to the small number of responses, no similar conclusions can be drawn from the data in relation to the placement of students from educational institutions included in the ‘Other EI’ category. Further exploration of this issue in respect to this latter sector of educational providers is warranted, particularly in view of changes currently taking place in the educational/training provider sector.

**FIGURE 3: REPORTED LOCATION OF RURAL MH PLACEMENTS AS A PROPORTION OF REPORTED STUDENT PLACEMENTS BY ASGC REMOTENESS CATEGORY**

<table>
<thead>
<tr>
<th>ASGC Category</th>
<th>Educational Institution (n=77)</th>
<th>Service Provider (n=82)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASGC Very Remote</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td>ASGC Remote</td>
<td>18%</td>
<td>16%</td>
</tr>
<tr>
<td>ASGC Outer Regional</td>
<td>34%</td>
<td>33%</td>
</tr>
<tr>
<td>ASGC Inner Regional</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>ASGC Major City</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Reported location of rural MH placements as a proportion of reported student placements by ASGC remoteness category.
FIGURE 4: REPORTED LOCATION OF RURAL MENTAL HEALTH PLACEMENTS BY EI TYPE (N=77)

FIGURE 5: EI RESPONDENT REPORTED LOCATION OF RURAL MENTAL HEALTH PLACEMENTS BY STATE OR TERRITORY (N=77)

FIGURE 6: SP RESPONDENT REPORTED LOCATION OF UNDERGRADUATE RURAL MENTAL HEALTH PLACEMENTS BY STATE OR TERRITORY (N=82)
The location of rural mental health placements by State or Territory reported by EI & SP respondents is detailed in Figure 5 and Figure 6 above. Both cohorts of participants reported similar proportions of placements in Remote, Outer Regional and Inner Regional category areas in most jurisdictions. Placements in the Very Remote category catchment were reported by a slightly smaller proportion of EI respondents from two jurisdictions compared to a larger proportion of SP participants from four States and Territories. A similar proportion of EI & SP respondents reported placements in Major Cities. While only EI participants from New South Wales and South Australia accounted for this data, SP respondents from Victoria and Western Australia also recorded Post Codes or township names within ASGC defined Major City catchment areas.

9.2 PLACEMENT COORDINATION

9.2.1 FORMAL STUDENT PLACEMENT AGREEMENTS

EI participants were asked whether formal placement agreements existed between their institution and service provider organisations hosting student mental health placements in rural settings during 2010 and/or 2011.

Section Results Summary:
- Majority of EI respondents reported that formal written agreements for student mental health placements exist with service providers in rural and remote areas
- Student mental health placements are predominately initiated, organised and arranged by educational institution course placement coordinators

Formal student placement agreements between the educational institution and service provider were reported to exist by the majority of EI respondents (see Figure 7 below). As indicated in Figures 8 and 9, commonly these arrangements are the subject of written agreements between the entities and are the responsibility of an identified staff member from the educational institution.

FIGURE 7: EI REPORTED FORMAL AGREEMENT WITH RURAL SERVICE PROVIDERS BY EDUCATIONAL INSTITUTION TYPE (N=41)
9.3 PLACEMENT INITIATION

EI and SP participants were asked to detail who initiated and organised student mental health placements in rural and remote locations during 2010 and/or 2011.

Sub-section Results Summary:

- Majority of EI respondents reported that formal written agreements for student mental health placements exist with service providers in rural and remote areas.
- Student mental health placements are predominately initiated, organised and arranged by educational institution course placement coordinators.
As illustrated in Figures 10 and 11 below, the majority student placements in rural mental health settings are initiated and organised by educational institution course coordinators. As SP respondents were provided with separate options for university & TAFE initiated placements, the combined total of 68% indicates a similar trend to the 72% of placements reported by EI participants as being initiated by course coordinators.

**FIGURE 10: EI RESPONDENT REPORTED INITIATOR OF RURAL MENTAL HEALTH PLACEMENTS (N=47)**

EI respondent reported initiator of rural mental health placements (n=47)

Course Coordinator, 72.3%
Other, 12.8%
Student, 6.4%
Mental Health Service, 8.5%

**FIGURE 11: SP RESPONDENT REPORTED INITIATOR OF UNDERGRADUATE RURAL MENTAL HEALTH PLACEMENTS (N=99)**

SP respondent reported initiator of undergraduate rural mental health placements (n=99)

Student Initiated, 24.2%
TAFE Initiated, 21.2%
MHS Initiated, 8.1%
University Initiated, 46.5%

EI and SP participants reported service providers initiated 8% and 9% of placements respectively. However SP respondents reported that student initiated placements account for 24% of placements compared to the EI reported figure of only 4%. The lower figure reported by EI participants may have been influenced by the 'Other' initiator category option included in the educational institution version of the survey.
Both surveys sought to explore courses that lead to entry level qualifications, which, depending upon discipline/profession and specialisation, involves VET/TAFE, undergraduate and postgraduate courses, and postgraduate course qualifications required for advanced practitioner or specialist clinician status. Only one SP respondent provided detailed data relating to postgraduate student placements and, therefore, the results reported from SP participants relate to TAFE and university undergraduate course placements only.

This section of the survey results includes information relating to course requirements for mental health placements, student mental health placements in rural and remote setting during 2010 and 2011, the disciplines of students undertaking mental health placements in rural and remote settings, the profile of rural and remote service providers and program areas that hosted students, the scheduling of mental health placements, the hosting of single or multiple student placements and the duration of mental health placements.

### 9.4.1 COURSE MENTAL HEALTH PLACEMENT REQUIREMENT

EI participants were asked whether mental health placements are a compulsory requirement of the courses they were associated with, EI participants were invited to indicate whether during 2010 and 2011 students from their institutions had undertaken mental health placements in rural and remote settings, and both EI and SP participants were asked about the rural and remote service settings in which student mental health placements during 2010 and 2011 had occurred.

**Sub-section Results Summary:**

- Majority of EI respondents reported that mental health placements are a compulsory course requirement
- Majority of EI respondents reported that in 2010 & 2011 students from their institution undertook mental health placements in rural and remote locations
- Majority of SP respondents reported that in 2010 & 2011 their organisation hosted student mental health placements

The majority of EI respondents (72%) reported that mental health placements are a compulsory element of courses, with a little under a third of respondents reporting that mental health placements were either optional or a mix of both compulsory and elective requirements.
76% of EI respondents reported that during 2010 and/or 2011 students from their institution/course had undertaken mental health placements in a rural setting. The breakdown of this by type of educational institution is illustrated in Figure 13.

FIGURE 12: EI RESPONDENT REPORTED MENTAL HEALTH PLACEMENT COURSE REQUIREMENT (N=54)

FIGURE 13: EI RESPONDENT REPORT OF STUDENTS UNDERTAKING RURAL MENTAL HEALTH PLACEMENTS DURING 2010 AND/OR 2011 BY EDUCATIONAL INSTITUTION TYPE (N=71)
A higher proportion of Service Provider respondents (96%) reported that their organisation hosted student mental health placements. As shown in Figure 14, a range of service provider sectors reported hosting student mental health placements, but the majority work in a Public Mental Health Service, Counselling Service or Other Mental Health Service (which includes non-clinical/non-government mental health services).

FIGURE 14: SP RESPONDENT REPORT OF STUDENTS UNDERTAKING RURAL MENTAL HEALTH PLACEMENTS DURING 2010 AND/OR 2011 BY SERVICE PROVIDER TYPE (N=93).

Both EI and SP participants were asked to report on the number of student mental health placements that their organisations initiated or hosted during 2010 and/or 2011.

Sub-section Results Summary:

- Rural and remote service providers host student mental health placements for TAFE and university courses
- Data indicates that the majority of student mental health placements in rural and remote locations are hosted by public mental health services
- Most EI & SP respondents reported that for 2010 & 2011 rural and remote services in the main hosted 30 or less students per year

As mentioned earlier, due to the paucity of data collected regarding rural mental health placements of postgraduate courses, the SP participant data reported focuses upon TAFE and university undergraduate course placements.

Figures 15 and 16 illustrate the proportion of EI respondents who reported the total number of students from their institution who undertook mental health placements during 2010 and 2011.
and the number of students from their institution who undertook mental health placements in a rural setting in both years. The results indicate an increase in the number of respondents reporting that students from their institution undertook rural mental health placements in 2011 in comparison to 2010. Three-quarters of EI respondents reported that overall no more than 60 students from their institution participated in mental health placements in both 2010 and 2011, while no more than 30 students from their institution participated in mental health placements in rural and remote settings during the same period. These data suggests that rural and remote service providers host fewer student mental health placements than service providers located in major/capital cities.

FIGURE 15: PROPORTION OF EI RESPONDENTS REPORTING STUDENT MENTAL HEALTH PLACEMENT NUMBERS FOR 2010 (N=54)
Figure 17 illustrates the total number of students SP participant reported were hosted by their organisation during 2010 and 2011. The majority of participants reported that their service hosted 10 or less students in both years (82% in 2010 and 69% in 2011). A total of 16% and 27% of respondents reported that their services hosted between 11 to 100 students in 2010 and 2011 respectively. Only 2% of respondents in 2010 and 4% in 2011 reported that their agency hosted more than 100 students.
Due to the lack of data collected in respect to questions regarding the size of service provider organisations and relative size of the mental health program areas that hosted student placements, analysis of the data in respect to organisational size and capacity to host student placements was not possible. However, it would be reasonable to conclude that the high proportion of total student placements reported to be 10 or less students in a year hosted by rural and remote service providers relates to the limited capacity of rural and remote service providers to host mental health placements for students. The issue of rural and remote service provider capacity to host student placements warrants further investigation.

FIGURE 17: SP RESPONDENT REPORTED TOTAL NUMBER OF STUDENT MENTAL HEALTH PLACEMENTS FOR 2010 AND 2011

SP respondent reported total number of student placements hosted by their organisation during 2010 and 2011

- 200+ Students: 16.1%, 2.0%
- 101-200 Students: 6.5%, 2.0%
- 61-100 Students: 19.6%, 14.5%
- 41-60 Students: 11.8%, 14.5%
- 21-40 Students: 5.9%, 12.9%
- 11-20 Students: 7.8%, 12.9%
- 6-10 Students: 5.9%, 12.9%
- 5 Students: 1.6%, 11.8%
- 4 Students: 3.9%, 14.5%
- 3 Students: 2.0%, 11.8%
- 2 Students: 2.0%, 11.8%
- 1 Student: 2.0%, 16.1%
Figure 18 indicates that over half TAFE and University undergraduate student rural mental health placements for both 2010 and 2011 reported by SP respondents were hosted by public mental health services. Participants from ‘Other’ mental health services reported the next highest proportion of undergraduate placements of TAFE and university students, and alcohol and drug service respondents reported the third highest proportion of service providers hosting undergraduate student placements. Overall SP respondents from a broader range of service providers reported hosting university student placements than those who reported hosting student placements from TAFEs.

FIGURE 18: PROPORTION OF SP RESPONDENTS REPORTING UNDERGRADUATE STUDENT MENTAL HEALTH PLACEMENTS IN 2010 AND 2012 BY EDUCATIONAL INSTITUTION AND SERVICE TYPE (N=89)
9.6 DISCIPLINES UNDERTAKING MENTAL HEALTH PLACEMENTS

Participants were invited to indicate the disciplines of students who undertook mental health placements with rural and remote service providers during 2010 and/or 2011.

Sub-section Results Summary:

- A broad range of TAFE and university courses and associated disciplines require students to undertake a mental health placement

EI respondents who reported that students had undertaken mental health placements in a rural or remote setting indicated that they were linked to the following discipline courses in order of frequency: Nursing, Psychology, Medicine, Social Work, Physiotherapy, Speech Pathology, Counselling, Alcohol and Drug Work, Disability Work, Health Promotion, Youth Work, Community Development Work, Occupational Therapy, Non-clinical Mental Health Work, Paramedicine, Dietetics, Exercise Physiology, Pharmacy, Radiography, Art or Music Therapy, Radiation Science and Podiatry. See Appendix i for further details.

The data identified a number of disciplines requiring mental health placements that may not be seen as professions that require a high degree of experience within the mental health field.

9.7 RURAL AND REMOTE SERVICE PROVIDERS HOSTING MENTAL HEALTH PLACEMENTS DURING 2010 & 2011

Participants were asked to report on the type of rural and remote services and program areas that hosted student mental health placements during 2010 and/or 2011.

Sub-section Results Summary:

- During 2010 & 2011 student mental health placements were reported to have been hosted in a broad range of program areas by all service provider sectors surveyed
- Data indicates that the majority of student mental health placements in rural and remote locations are hosted in the adult service program areas of public mental health services
As illustrated in Figure 19 below, EI respondents reported that over 80% of student mental health placements in rural are located with Public Mental Health Services (52%) or Other Mental Health Services (31%). SP respondents reported a slightly broader spectrum of service sectors hosting TAFE and/or undergraduate student mental health placements. The graph indicates the diverse range of rural/remote service providers that reported hosting rural mental health placements.

**FIGURE 19: EI & SP REPORTED RURAL MENTAL HEALTH PLACEMENTS DURING 2010 AND/OR 2011**

EI & SP respondents reported that rural mental health placements during 2010 and/or 2011 had involved a broad range of service program areas. The diversity of service program areas that hosted student placements is detailed in Appendix ii (included at the end of this chapter of the report). Student placements were hosted in inpatient and community program areas of public and private clinical mental health services, non-clinical mental health services, Medicare and Commonwealth Government funded mental health programs, Aboriginal mental health/social and emotional wellbeing programs, generalist and specialist counselling services, mainstream and Aboriginal alcohol and drug program areas, primary health care services and school student support services. Respondents from New South Wales and Victoria reported the broadest range of services settings and associated program areas hosting student placements.

Figure 20, provides an overview of the program areas within Public Mental Health Services that hosted student placements during 2010 and/or 2011. Students were more commonly reported as having a placement within the adult program and community program areas of these clinical mental health services.
9.8 SCHEDULING OF STUDENT MENTAL HEALTH PLACEMENTS

Survey participants were invited to indicate the year and semester that mental health placements were scheduled for courses that required student mental health placements during 2010 and/or 2011.

**Sub-section Results Summary:**
- Majority of EI respondents reported that courses do not specify when mental health placements are to occur during a course
- 2nd, 3rd and 4th years were the most commonly reported times when mental health placements were scheduled and hosted
- Majority of EI respondents reported that courses do not specify when mental health placements are to occur during an the academic year
- The data indicates that mental health placements are more commonly scheduled during second semester
Almost a third of EI respondent reported courses that have a mental health placement requirement do not specify the year level in which the mental health placement is to occur (see Figure 21). The most commonly reported course year levels in which students are required to undertake a mental health placement are in the 2nd or 3rd year of study, particularly for undergraduate university courses.
As illustrated in Figure 22 below, the majority of SP respondents indicated that commonly placements occur in the 2nd to 4th year of undergraduate programs, with a little over 60% of reported placements occurring in these year levels in both 2010 and 2011.

**FIGURE 22: PROPORTION OF SP RESPONDENT REPORTED UNDERGRADUATE STUDENT PLACEMENTS FOR 2010 AND 2011 BY COURSE YEAR LEVEL.**

Almost 60% of EI respondent-reported courses that have a mental health placement requirement do not specify in which semester the placement is to occur (see Figure 23). A greater proportion of mental health placements were reported as being scheduled in second semester than first semester. Second semester scheduled placements also involved a broader range of course types than those reported for first semester.
FIGURE 23: EI RESPONDENT REPORTED SEMESTER IN WHICH MENTAL HEALTH PLACEMENTS OCCUR BY COURSE TYPE (N=58)

9.9 SINGLE/MULTIPLE STUDENT PLACEMENTS

SP participants were asked whether during 2010 and/or 2011 their organisation hosted ‘single’ or ‘multiple’ student placements. ‘Single student placements’ related to situations where an organisation only hosted a single student at a time, but might have hosted more than one student over the course of a year. ‘Multiple’ student placements related to situations where organisations hosted more than one student at a time whether or not they hosted one or more groups of students during the course of a year.

Sub-section Results Summary:
- Broader range of rural and remote services provider respondents reported hosting single student placements
- Public mental health service sector respondents reported hosting both single and multiple student placements

The total number of possible student rural mental health placements is limited by the number of organisations willing or able to host placements and the capacity of individual service providers to host one or more students for the duration of a placement. As indicated in Figures 24 and 25 below, slightly more than 50% of SP respondents reported that their organisation hosted multiple placements in both 2010 and 2011, but over half of these respondents are from Public Mental Health Services. By comparison, only 40% of respondents who reported that their organisation had hosted single student placements were from Public Mental Health Services. A higher proportion of respondents from service provider types other than Public Mental Health Services reported hosting single student placements. The number of SP participants reporting that their agency hosted single and/or multiple student placements for increased from 53 for 2010 to 63 for 2011.
Student placements are more likely to occur in public mental health services, a service setting that respondents indicated can cater for both single student and multiple student placements.

FIGURE 24: SINGLE STUDENT PLACEMENTS AS A PROPORTION OF SP REPORTED PLACEMENTS BY SERVICE PROVIDER TYPE FOR 2010 & 2011

FIGURE 25: MULTIPLE STUDENT PLACEMENTS AS A PROPORTION OF SP REPORTED PLACEMENTS BY SERVICE PROVIDER TYPE FOR 2010 AND 2011

9.10 DURATION OF MENTAL HEALTH PLACEMENTS

All participants were asked to indicate the duration of student mental health placements that they reported had occurred during 2010 and/or 2011.

Sub-section Report Summary:
- 1-3 month placements were the most frequently reported placement duration by both EI and SP respondents
Slightly more than 50% of EI respondents reported placement durations of 30 days or less. Over half SP respondents reported placement durations of between 1 to 6 months, and about a third reported placement durations of 30 days or less.

The EI participants reported duration of mental health placements varied as outlined in Figure 26 below. The most frequently reported placement duration was 1-3 months; this placement period was reported for diploma, undergraduate and postgraduate courses. Respondents indicated that postgraduate courses tend to have placements over longer periods of time than other courses.

FIGURE 26: EI RESPONDENT REPORTED DURATION OF MENTAL HEALTH PLACEMENTS (N=61)

In contrast, the most commonly reported undergraduate placement durations from SP respondents are 1-3 months and 3-6 months. The data varied significantly by profession. Medicine, nursing and social work were the most frequently reported disciplines and the placement duration for these professions ranged from 1-5 days up to 12 months. Physiotherapy, dietetics, health promotion, drug and alcohol, counselling, radiology and youth work placements were reported on less frequently and the placement duration for these disciplines was mostly reported as being 1-3 months.
9.11 SUPERVISION

Both EI and SP participants were invited to provide information regarding the requirements support and delivery of supervision to students on mental health placements in rural and remote settings. Information regarding training and support of supervisors was also sought.

Sub-section Results Summary:
- Commonly supervision and support of students is provided by staff of the organisation hosting the student placement

9.11.1 SUPERVISION ARRANGEMENTS FOR STUDENTS ON PLACEMENT

EI participants were asked to indicate how supervision of students on mental health placements with rural and remote service providers during 2010 and/or 2011 was organised.
The responses from EI informants indicate that the supervision of students on a rural mental health placement is predominately provided by service provider staff, either by a designated individual staff member or by staff in general including managers. Other arrangements for student supervision include the involvement of staff from both the educational institution and service provider or solely by the educational institution.

### 9.12 FORMATION REQUIREMENTS OF STUDENT SUPERVISORS

EI participants were asked to detail the qualification requirements associated with approving service provider staff to act as supervisors for students on mental health placements.

**Sub-section Results Summary:**

- To supervise students on placement clinicians are commonly required to have: a defined level of clinical experience; a discipline specific postgraduate qualification; or formal supervision qualification.

A small number of TAFE and university based respondents reported that their organisation/course had no formal requirements associated with whom could provide supervision to students on a mental health placement. Predominately though, respondents indicated that years of practice experience and a discipline specific postgraduate qualification were the most common requirements of a supervisor. Respondents from both TAFEs and universities reported that a qualification in ‘supervision’ is also a requirement for some courses and that other requirements may also exist.
EI and SP participants were also invited to comment upon what eligibility requirements had to be met for someone to be approved to provide supervision to a student on placement. The EI (n=10) and SP (n=9) respondents who provided comments reinforced the results reported above, their feedback indicates that the qualification requirements to supervise students ranged from 1-5 years of clinical experience, discipline specific qualifications and registration as a supervisor.

9.13 MENTAL HEALTH PLACEMENT SUPERVISION REQUIREMENT

Both EI and SP participants were asked to report on the level of supervision required by courses for students on mental health placements in terms of hours per placement day or hours per placement week and detail the associated tasks undertaken by service provider staff supervising students.

Sub-section Results Summary:
- Both EI and SP respondents indicated the most common supervision requirement was 0-2 hours per placement day.
- TAFE & undergraduate supervision requirement was commonly defined in terms of hours per placement day, while the postgraduate supervision requirement was generally referred to in terms of hours per placement week.
- The supervision requirement of some courses appears to involve most of the time the student is in the service setting.
- SP respondents reported that the focus of the tasks undertaken by supervisors centred upon supporting the learning and practice skills development of students.
The student supervision requirement associated with mental health placements set by educational institutions is illustrated in Figure 29. A third of EI respondents reported an expectation of up to 2 hours of supervision per student placement day. Over 20% reported an expectation of 4-6 hours of supervision per student placement day, which in practice would mean that a student is shadowing or working with a clinician for most of the shift or work day. Most responses indicated students to varying degrees are expected to be practicing and/or undertaking tasks independently and have access to support through supervision. Generally the requirement associated with TAFE and undergraduate courses were reported as hours per student day and postgraduate courses as hours per student week. Two respondents from the TAFE sector reported that there was no requirement for supervision of a student with particular courses. In this report we are unable to comment upon the rationale for the levels of intensity of student supervision as the questionnaire did not seek any qualifying comments regarding the rationale for a particular reported level of student supervision.

**FIGURE 30: EI RESPONDENT REPORTED STUDENT PLACEMENT SUPERVISION REQUIREMENT (N=42)**

It should be noted that one third of SP respondents reported that student supervision commitment required of staff was 0-2 hours per student placement day. More than half (61%) of the respondents reported that the time required by supervision of students was ranged from 0 hours per placement day to 6 hours per placement day. Almost 30% of respondents reported that student supervision required 4-8 hours of staff time per student placement day, suggesting that students were with the supervisor for the entire work period (shadowing the clinician) or that the supervision role significantly impacted upon clinicians’ capacity to undertake direct client work. The majority of SP respondents reported student supervision requirement in terms of hours per placement day.
FIGURE 31: SP RESPONDENT REPORTED STUDENT SUPERVISION TIME COMMITMENT (N=33)

SP respondent reported student supervision time commitment (n=33)

- No Supervision: 33.3%
- 0-2 hrs per placement day: 3.0%
- 2-4 hrs per placement day: 6.1%
- 4-6 hrs per placement day: 6.1%
- 6-8 hrs per placement day: 9.1%
- 0-2 hrs per placement week: 3.0%
- 2-4 hrs per placement week: 6.1%
- 4-6 hrs per placement week: 6.1%
- 6-8 hrs per placement week: 6.1%
Figure 32 illustrates that the service provider staff involved in supervising students are focused upon tasks and activities that actively support students achieve their placements learning outcomes. Respondents reported that activities principally focused on assessing student competencies, direct observation of student performance, teaching clinical skills, supervision and undertaking administrative tasks associated with these activities. Participants reported a lesser focus upon organising student placements and organisational administrative duties such as coordination of rosters.

FIGURE 32: SP RESPONDENT REPORTED STUDENT SUPERVISOR TASKS (N=89)

9.14 TRAINING AND SUPPORT FOR SERVICE PROVIDER STAFF SUPERVISING STUDENTS

SP and EI participants were asked to detail the kinds of support that their organisations provided to rural and remote service provider staff who supervised student on mental health placements during 2010 and/or 2011.

Sub-section Results Summary:
- SP respondents reported that their organisations are inconsistent in their approach to supporting staff who supervise students on placement
- EI & SP respondents reported an inconsistent and sometimes ad hoc approach by educational institutions approach to providing training and support to service provider staff who supervise students during their placement
SP Respondents reported an inconsistent approach within service providers to supporting staff that provide student supervision. The majority of SP respondents indicated that their organisations provide support to staff supervising students. While only a quarter of mental health service participant respondents reported that their organisation did not support staff supervising student placements, 46% of participants from the other service provider sectors surveyed reported that agency staff supervising students were not supported in the role by their organisation. Only university based EI respondents reported that their institution provided supervision training to host agency staff (see Figure 34). Over half SP participants reported that staff from their organisation received supervision training (see Figure 35 below). As illustrated in Figure 36, respondents from both TAFEs and universities indicated that their organisation offered host organisation staff involved in supervising students mentoring and/or supervision support. Figure 37 indicates that almost 30% of EI respondents reported that their organisation offered other forms of support to agencies hosting host mental health placements.

FIGURE 33: SP RESPONDENT REPORTED SERVICE PROVIDER STAFF SUPERVISING STUDENTS PROVIDED WITH SUPERVISION/MENTORING SUPPORT BY SERVICE TYPE (N=35)

FIGURE 34: EI RESPONDENT REPORTING THAT THEIR INSTITUTION OFFERS RURAL SERVICE STAFF SUPERVISION TRAINING (N=40)
Both SPs and EIs identify the importance of having or accessing qualified supervisors to support student placements. Only 45% of EI respondents indicated that supervision training was provided to the service provider staff.

FIGURE 36: EI REPORTED OFFERING RURAL SERVICE STAFF MENTORING/SUPERVISION SUPPORT (N=40)
SP participants who reported that staff from their organisation undertook formal supervision training were invited to provide details regarding the training provided to staff. The nine SP respondents who provided further information all reported that organisation of formal training for supervision was inconsistent and the uptake of training sporadic. The respondents indicated that they would like formal training and identified that all supervisors should have this training to be a student supervisor.

“Yes, some (not all) attend preceptorship/supervisor training. Training is not generally readily available.” NSA - UDRH

The twelve EI respondent (N=12) comments received in regard to the type of training that their institution provide to service provider staff who supervise students on placement suggest that the approach to offering training was too varied. Some indicated that training was offered once per year and others only responded to requests for supervision training. There appears to be no consistent approach to supervision training.

“Training is offered but in practice is not compulsory.” QLD UDRH

SP participants who reported that their organisation provided supervision/mentoring to staff who supervise student placements were invited to comment on the support provided. The eight responses to this question varied. One response stated that all staff supervising students are provided with supervision and/or mentoring, while other participants reported that no supervision or mentoring was provided by their organisation.

“Some ad hoc arrangements occur from time to time.” NSW UDRH

Similarly EI participants were invited to comment on the supervision/mentoring their institution provided to service provider staff supervising students on placement. The fourteen responses varied from “regular contact is maintained with all placement venues” to contact is organised on an “ad hoc basis” and “when requested”.

EI participants were also invited to comment the type of support provided to service providers when they indicated that their institution provided other forms of support to service provider staff supervising student placements. One of the twelve responses identified that administrative support was provided to the service provider hosting student placements. The other responses
indicated that educational institutions would consider and attempt, where possible, to respond to service provider requests for assistance.

9.14.1 EDUCATIONAL INSTITUTION SUPPORT TO SERVICE PROVIDERS HOSTING STUDENT PLACEMENTS

All participants were invited to detail the range of student placement support activities that their organisations and staff supporting placements undertook in relation to mental health placements in rural and remote settings during 2010 and/or 2011.

**Sub-section Results Summary:**
- EI & SP respondents indicated the support provided by educational institutions to service providers principally focuses upon organising and administering student placements
- Responses from both EI & SP respondents less frequently reported in-kind support or financial support being provided by educational institutions

As illustrated in Figure 38 below, the supports that educational institutions provide to organisations hosting rural student mental health placements are principally focussed upon planning and organising placements, clarifying expectations in regard to student learning needs and scope of practice, ensuring a student learning contract is in place and providing supervision to students. There were proportionally fewer reports providing routine support and/or training to the host organisation and significantly fewer reports of educational institutions providing in-kind or financial support to host agencies.

**FIGURE 38: PROPORTION OF EI REPORTED TYPES OF STUDENT PLACEMENT SUPPORT PROVIDED TO RURAL SERVICE PROVIDERS BY EDUCATIONAL INSTITUTION TYPE (N=54)**
Figure 39 illustrates that the range of placement support activities SP respondents reported that educational institutions provided to their organisations was of a similar nature to that reported by EI participants. The reported support activity predominately focuses on establishing student learning contracts, clarifying student learning needs and planning, coordinating student placements, providing supervision to students and supporting service provider staff through training and/or supervision. The least frequently reported support activities were the provision of in-kind incentives and financial incentives.

9.15 SERVICE PROVIDER STUDENT PLACEMENT ORGANISATION AND SUPPORT

SP participants were asked detail how their organisation arranged, coordinated and supported student placements during 2010 and/or 2011.

Sub-section Results Summary:
- Public mental health services participants more frequently reported that their organisation had a someone in a dedicated student placement coordinator.
- 50% of SP respondents indicated that the role takes up to 1-2 hours per placement week or 1-2 hours per placement day to supervise students.

FIGURE 39: PLACEMENT SUPPORT ACTIVITY PROVIDED BY EDUCATIONAL INSTITUTIONS TO SERVICE PROVIDERS REPORTED BY SP RESPONDENTS (N=89)
Figure 40 illustrates that almost 60% of SP respondents reported that responsibility for student placements was the responsibility of an identified individual staff member in their organisation, over half of whom were from public mental health services.

FIGURE 40: SP RESPONDENT REPORTED SERVICE PROVIDER STUDENT PLACEMENT COORDINATOR BY SERVICE TYPE (N=35)

Figure 41 illustrates the time commitment required of service provider student placement coordinators as reported by SP respondents. The most frequently reported time commitments were 0-2 hours per student placement day and 4-6 hours per placement day, the latter commitment would indicate that the placement coordinator spends almost their entire time organising and supporting student placements. A greater proportion of respondents reported the requirement as hours per placement week.

FIGURE 41: SP RESPONDENT REPORTED PLACEMENT COORDINATOR TIME COMMITMENT PER STUDENT PLACEMENT DAY (N=20)
9.16 SERVICE PROVIDER PLACEMENT COORDINATORS TASKS

EI and SP participants were asked to report about the role and function of placement coordinators from their respective organisations.

Sub-section Results Summary:
- EI & SP respondents reported that the service provider student placement coordinators tasks are principally focussed upon the organisational and administrative duties associated with hosting student placements.

As illustrated in Figure 42, EI respondents indicated that their institutions’ expectations regarding and role and responsibilities of host organisations’ placement coordinators and/or student supervisors focus upon supporting, teaching and assessing student performance and managing the local administrative duties associated with a placement (e.g. rosters & orientation to the service).

FIGURE 42: PROPORTION OF EI REPORTED RESPONSIBILITIES OF SERVICE PROVIDER STUDENT PLACEMENT COORDINATOR AND/OR SUPERVISORS BY EDUCATIONAL INSTITUTION TYPE (N=54)
SP Respondents reported that service provider placement coordinators tasks focussed upon orientating students to the organisation and administrative tasks associated with student placements such as record keeping and liaison with staff from educational institutions (see Figure 43 below).

**FIGURE 43: SP RESPONDENT REPORTED PLACEMENT COORDINATOR TASKS (N=89)**

<table>
<thead>
<tr>
<th>Task</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of initial contract</td>
<td>7.5%</td>
</tr>
<tr>
<td>Meeting with EI</td>
<td>9.8%</td>
</tr>
<tr>
<td>Completion of formal evaluation of student</td>
<td>8.3%</td>
</tr>
<tr>
<td>Organisational orientation</td>
<td>12.8%</td>
</tr>
<tr>
<td>Certification of documents</td>
<td>8.3%</td>
</tr>
<tr>
<td>Record keeping</td>
<td>10.5%</td>
</tr>
<tr>
<td>Formal student debriefing meeting/s</td>
<td>8.3%</td>
</tr>
<tr>
<td>Direct observation of student undertaking clinical work</td>
<td>6.0%</td>
</tr>
<tr>
<td>Teaching clinical skills</td>
<td>7.5%</td>
</tr>
<tr>
<td>Coordination of student clinical workload</td>
<td>6.8%</td>
</tr>
<tr>
<td>Assessing student competency</td>
<td>6.0%</td>
</tr>
<tr>
<td>Coordination of rosters</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

9.17 **MONITORING THE QUALITY OF STUDENT MENTAL HEALTH PLACEMENTS IN RURAL AND REMOTE SETTINGS**

All participants were invited to detail how the quality of student mental health placements in rural and remote settings was monitored during 2010 and/or 2011.

**Section Results Summary:**
- EI & SP respondents indicated that the approach to evaluating and monitoring the quality of student mental health placements in rural and remote settings varies considerably
- The data indicates a lack of communication and interaction between educational institutions and services providers in regard to the quality of student mental health placements
As indicated in Figure 44, a small number of TAFE and university based respondents reported that their organisation/course had no formal requirements for those who could provide supervision to students on a mental health placement. Predominately though, respondents indicated that years of practice experience and a discipline specific postgraduate qualification were the most common requirements of a supervisor. Respondents from both TAFEs and universities reported that a qualification in 'supervision' is also a requirement for some courses and that other requirements may also exist.

Figure 45 highlights that less than a third (30%) of SP respondents (n=89) reported that students on placement at their organisation had the opportunity to provide confidential feedback regarding the placement experience.
Both SP and EI participants were invited to describe how student placement feedback processes are organised and whether the feedback received informs the organisation and implementation of future student placements. The ten responses from SP respondents reported that feedback forms were commonly used to collect student placement feedback at the end of placements. One respondent detailed a very formal approach to the evaluation of student placements.

“Our organisation asks students to complete an evaluation the day before their placement is completed. This evaluation is then shared with the supervisor, Manager and Executive Director. We seek feedback from education providers, especially if this is a new program or new institution regarding satisfaction with our placement program and activities”. Vic UDRH

The five responses received from EI participants ranged from the process being dependent upon the ‘working relationship with the service provider manager’, the use of standardised evaluation forms and the review/assessment of individual student learning plans.

9.18 STUDENT PLACEMENT ENABLERS AND BARRIERS

Survey participants were invited to provide feedback in regard to factors that enable or are barriers to organising and hosting student mental health placements in rural and remote locations.

Section Results Summary:
- SP respondents tended to not agree that access to placements has been enhanced by using existing resources for more shifts throughout the day, night and into weekends, as this may not be applicable to service providers in rural and remote settings that generally operate during core business hours Monday to Friday
SP respondents tended to not agree that existing arrangements between educational institutions and service providers prevent other institutions gaining access to placements for students, as the majority of respondents were from public mental health services the response may also indicate that these participants did not consider that their organisations arrangements with educational institutions impacted upon the capacity of other local service providers to host student placements.

SP respondents generally did not agree that service provider staff attitudes did not hinder student placements from occurring.

EI respondents reported the distance of rural and remote placement sites from where a student studies and lives is a barrier to placements in rural and remote locations.

Respondents also reported that lack of access to resources including space to host students and suitably qualifies supervisors are barriers to placements in rural and remote services.

Respondents were asked to rate how strongly they agreed with the enabler domains identified by Health Workforce Australia (Mapping Clinical Placements; Capturing Opportunities for Growth - Supply Study June 2011) outlined in Table I below, on a scale where 1 = strongly agree and 5 = strongly disagree.

**TABLE 3: STUDENT PLACEMENT ENABLER DOMAINS**

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>expansion of university-led partnerships to providers outside of existing public mental health stream</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 2</td>
<td>enhancement of mental health clinical training placements by using existing resources for more shifts throughout the day, night and into weekends</td>
</tr>
<tr>
<td>Domain 3</td>
<td>provision of more support to providers, including administrative support, improving student ‘readiness’ and developing employment opportunities to improve work readiness</td>
</tr>
<tr>
<td>Domain 4</td>
<td>streamlined processes to improve the experience of providers in offering clinical placements</td>
</tr>
<tr>
<td>Domain 5</td>
<td>involvement of practicing mental health professionals in clinical placement design</td>
</tr>
</tbody>
</table>
FIGURE 46: EI & SP RESPONDENT MEAN RATING OF STUDENT PLACEMENT ENABLER DOMAINS

Figure 46 illustrates that respondents tended to agree with the domain statements apart from SP respondents rating of Domain 2. A Mann-Whitney U Test revealed a significant difference in the Enabler Domain 2 rating of SP informants (Md = 3.00, n = 81) and EI respondents (Md = 2.50, n = 54), U = 1488, z = -3.309, p = 0.001, r = 0.28.

This result indicates that SP respondents are unsure if mental health clinical training placements have been enhanced by using existing resources for more shifts throughout the day, night and into weekends. This enabler domain may not so readily apply to the rural/remote mental health service sector. A significant proportion of placements occur in the community team settings which predominately operate Monday to Friday from 9.00am – 5.00pm, which reduces the flexibility of when student placements can be rostered on. Additionally all elements of the service system tend to be structured as small teams dispersed over a catchment. This also limits the capacity of services to support student placements and also reduces the flexibility that services have to spread or expand the student placement load.

Both EI band SP participants were invited to list other factors that they considered would enable student mental health placements in rural and remote locations. The fifteen responses from SP respondents regarding enablers of student placements aggregated into the following themes: more flexibility and cooperation between educational institutions and service providers to improve pre placement introduction and orientation for students; support for administrative requirements associated with student placements; improved access to training for supervisors and financial incentives; and improved infrastructure in relation to access to space and computers. A key feature is that often small rural services do not have a dedicated position to oversee students and therefore supporting a student placement has to be managed in addition to the clinical work load. One SP participant highlighted the main issues as being related to capacity, infrastructure and GP teachers:

"We teach medical students in a variety of disciplines, including general practice and mental health. We do not take mental health placements as such. Major issues are capacity - infrastructure, GP teachers. Greater integration with the parent medical school and local area mental health services would assist in providing a more positive educational experience in mental health. Vic UDRH"
Another specific issue highlighted is a lack of education in relation to understanding and working with Aboriginal communities.

The themes identified from the thirteen EI participant responses include: affordable accommodation; access to training for supervisors; having clinicians involved in course development activities; a move away from depersonalised student allocation; consistent negotiation; and liaison with service providers through transparent processes.

"Being more flexible in defining the requirements of placements. Making rural/remote practicum’s compulsory so that systems are developed to accommodate these practicums. Have more than one student on placement at a time to maximise return for effort for the service and to reduce the burden." WA UDRH

Respondents were also asked to rate how strongly they agreed with the barrier domains identified by Health Workforce Australia (add ref here) outlined in Table II below, using a Likert Scale where 1 = strongly agree through to 5 = strongly disagree.

FIGURE 47: STUDENT PLACEMENT BARRIER DOMAINS.

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>limited infrastructure, in particular limited space for students, inadequate equipment and tools, or a lack of student accommodation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 2</td>
<td>insufficient supervisory resources (both in terms of time and quality)</td>
</tr>
<tr>
<td>Domain 3</td>
<td>existing arrangements between providers and tertiary education institutions, which can be a barrier to other tertiary education institutions gaining access to larger providers who are well established in providing clinical placements</td>
</tr>
<tr>
<td>Domain 4</td>
<td>variability in the suitability of practice settings to accept or increase placements, often as a result of clinical workload for the existing mental health workforce or differences in organisational culture regarding training the future mental health workforce</td>
</tr>
<tr>
<td>Domain 5</td>
<td>a culture among many providers that offering clinical training placements can be burdensome, and is not their responsibility</td>
</tr>
<tr>
<td>Domain 6</td>
<td>a perceived lack of adequate funding to rectify the above barriers</td>
</tr>
</tbody>
</table>
As illustrated in Figure 48 respondents tended to agree with the domain statements apart from SP respondents rating of Domain 3 and Domain 5. A Mann-Whitney U Test revealed a significant difference in the following domains:

- Barrier Domain 3 rating of SP informants (Md = 3.00, n = 80) and EI respondents (Md = 2.00, n = 54), U = 1370, z = -3.726, p = 0.000, r = 0.32;
- Barrier Domain 4 rating of SP informants (Md = 2.00, n = 79) and EI respondents (Md = 2.00, n = 55), U = 1761, z = -2.000, p = 0.046, r = 0.17;
- Barrier Domain 5 rating of SP informants (Md = 3.00, n = 80) and EI respondents (Md = 2.00, n = 55), U = 1143, z = -4.858, p = 0.000, r = 0.42;
- Barrier Domain 6 rating of SP informants (Md = 2.00, n = 80) and EI respondents (Md = 2.00, n = 55), U = 1783, z = -1.967, p = 0.049, r = 0.17;

As the Mann-Whitney U Test for Barrier Domains 4 and 6 both have p values close to 0.05, the same Median score for both cohorts and small effect sizes, the results are considered to have limited interpretive significance. However, the results for Barrier Domains 3 and 5 are considered to indicate difference in the perspectives in regard to these barriers between EI and SP respondents exists.

In respect to Barrier Domain 3, SP respondents are unsure if existing relationships between educational institutions and large service providers impact upon the opportunity to increase student placements with other smaller service providers. In respect of mental health placements in rural settings, this may also be interpreted as public mental health service respondents disagreeing that their existing student placements agreements with educational institutions impact upon the opportunity for student placements with other service providers within their catchment area.

In regard to Barrier Domain 5, SP respondents may be tending to disagree with the notion that attitudes within their service sector have a negative impact upon student placements. It is possible that these views indicate that the SP respondents perceive that in their services attitudes toward student placements are supportive and therefore disagree with the domain statement. Equally SP respondents may be expressing their personal views, particularly as they
are a group who organise and actively support student placements and disagree that attitudes in the service provider sector are impinging upon student placements.

EI and SP respondents were also to list any other factors which they thought were barriers to organising and hosting student mental health placements in rural and remote settings. The fifteen SP participant responses detailed a range of known rural placement barriers. The reported barriers include: lack of supervisors with adequate training and quality; a lack of ongoing relationships with educational institutions; service provider workforce issues and staffing levels; access to infrastructure and other internal resource issues including physical space for students; access to computers; lack of financial support for accommodation and student travel expenses; poor support from managers; and no recognition of workload implication for staff managing caseloads as well as supervising students. One SP identified the duration of placements as a barrier and suggested that longer placements are seen by service providers as more beneficial to the organisation.

“Student educational institutional barriers - lack of an ongoing relationship with the field education / placement units in the universities”. NSW UDRH

“The quality of clinical staff currently is a direct reflection of Government policy which branded the previous system as inadequate because of its cost rather than its merit. You get what you put in and/or are prepared to accept. When you have the principles of clinical service provision taught by people who have never worked in the field and agencies unable to provide hands on practical experience you have a problem. Hence government after government comes up with strategies to minimise the harm of a previous governments strategies. We would love to be able to help train and support future clinicians in the field but we have a lack of resources to do so”. VIC UDRH

“Poor communication between Educational Institutions and local Health units - the time commitment to having students’ needs to be recognised by Health Managers & staff” SA UDRH

Comments from the twelve EI participants who responded predominantly centred around the issues of the cost of travel and accommodation, a lack of discipline specific supervisors in rural areas (particularly for occupational therapy and psychology), competition for placements between educational institutions and that frequently placements are scheduled and/or sought within the same academic semester.

“Barriers we have come across for rural placements include the cost of travel and accommodation to go to a rural location. We do not have access to funds to support travel and accommodation. Also about 50% of our students are mature age and cannot easily move to a rural site. It is also extremely difficult to find a rural mental health placement. Mental health placements across the state seem to have declined in number since Queensland Health moved to a centralised placement system QLD UDRH

“The lack of qualified supervisors in rural regions. This is our major barrier. Students cannot afford to leave jobs to go to a rural block placement plus the travel costs”. QLD UDRH

“Uncertainty about the competencies of trainees. There is no routine completion of preliminary training such as that provided on the Northern Territory Rural Area Health
Corp website. There is a lack of accommodation and transport and tele-support technology. Lack of induction of university co-ordinators into the needs of rural placement settings - a visiting program would help”. **WA UDRH**

“Clashes between the courses offered by universities. (I.e. it seems that everyone wants mental health placements in 2nd Semester but none in 1st semester)”. **NSW UDRH**
All participants were invited to provide details regarding whether their organisation was interested in arranging or hosting increased student mental health placements in the future.

Section Results Summary:

- SP respondents from all service provider sector surveyed indicated that their organisations were interested in expanding the number of student placements in the future.
- EI respondents indicated an interest from their organisations in expanding student mental health placements in rural and remote locations.
- EI respondents tended to comment about the challenges of organising student placements in rural and remote settings, and did not detail how their institution planned to increase student mental health placements with rural and remote service providers.
- SP participant responses tend to highlight that increasing student placements was contingent upon access to both financial support and qualified supervisors.

Although 70.4% of EI Respondents (n=71) indicated that their institution would be seeking mental health placements in 2013, only 60% reported that their institution was interested in expanding the number of student mental health placements with rural service providers in the future. 70% of SP Respondents (n=93) reported that their agency was willing to expand the number of student mental health placements in the future. As indicated in Figure 49, respondents from all service provider sectors that currently host student placements indicated an interest in expanding student placements in the future.

FIGURE 49: SP RESPONDENTS REPORTING AGENCY INTEREST IN EXPANDING STUDENT PLACEMENTS IN THE FUTURE BY SERVICE TYPE (N=66)
From the data provided by SP respondents it is difficult to gauge what the expressed interest in expanding student placements equates to in terms of the increased number of student placements. However respondents reported that their organisations were interested in expanding student placements for the following disciplines: Social Work, Psychology, Occupational Therapy, Nursing, Medicine, Speech Pathology, Art & Music Therapy, Alcohol & Drug Work, Disability Work, Counselling, Physiotherapy, Health Promotion, Pharmacy, Paramedicine and Radiology.

Respondents reported interest in expanding placements for students undertaking VET/TAFE, university undergraduate and university postgraduate courses, a higher proportion of respondents expressed interest focused upon placements for 2nd, 3rd and 4th year university undergraduate students.

The responses indicate that, while the Public Mental Health Service, Alcohol and Drug Service, Counselling Service, Commonwealth Funded Mental Health Service and Other Mental Health Service sector respondents reported the capacity to support both single and multiple student placements in the future, respondents from Private Mental Health Services and headspace Services only reported the capacity to support single student placements while participants from Aboriginal Mental Health/Social Emotional Wellbeing Services only indicated an interest in multiple student placements.

FIGURE 50: SP RESPONDENTS REPORTING AGENCY INTEREST IN EXPANDING STUDENT PLACEMENTS BY COURSE TYPE AND YEAR LEVEL (N=93)
EI and SP participants were invited to comment upon the key factors that they think restrict the expansion of student mental health placements in rural and remote settings. The key themes identified from the 43 SP participant responses regarding this issue include management support, lack of recognition that supervising students is additional to the normal work load and competition for placements as educational institutions schedule placements at the same time during the academic year. Issues related to infrastructure include access to desks and computers, limited space, distance from place of study and need for accommodation, lack of qualified supervisors and the impact on clinician workloads.

“Management support and recognition of supervisors taking on students. Co-ordination across teams/stream/units. Training for supervisors. Ongoing peer supervision/consultation available to supervisors. More physical resources needed (rooms, desks, computer terminals).” NSW UDRH

“Lack of student coordinator No funding for an intern program for allied health. The restrictions placed on who can supervise clinical psychology students - we do not have many staff with this high level of expertise in the region thus cannot offer places easily. This is a serious inequity between professions and limits our ability to grow our own psychology workforce”. QLD UDRH

“Supervisory ability at higher level graduate study is not possible if the leadership team does not have a member with comparable qualifications. Need partnered supervision process formulated to provide placement to clinical and other university graduates with education provider” VIC UDRH

“Clashes of terms between University need organisation”. NSW UDRH
EI and SP participants who had indicated that their institution or organisation was interested in expanding student mental health placements in rural and remote setting were invited to detail their organisations expansion plan. The eleven responses from SP participants identified that expansion was contingent upon the provision of additional resources, specifically access to supervisors and a dedicated placement coordinator.

“I cannot give numbers as we could not take extra students without financial assistance and having a local coordinator and less restrictive requirements on supervisors (e.g. for psychologists). We would like to take more allied health e.g. OTs, SWs, psychologists”. **QLD UDRH**

The 37 EI respondent comments principally focus on maintaining or building on the current relationships that exist with service providers. Other strategies identified are to improve supervision training opportunities for service providers, look to increase placements within the private sector of mental health and seek alternative new service providers as they develop.

“Look to create more partners in the mental health fields from the private sector. As it’s such a critical area of nursing practice and will continue to be as they community seeks more mental health services. Someone needs to organise a town swap program so that nurses can travel to near towns in the rural setting to gain experience and not meet their neighbours in the process”. **VIC UDRH**

“Working with students to take these placements and maintaining good existing relationships with service providers”. **NSW UDRH**
Section Results Summary:

- Although SP respondents reported that their organisations did not readily acknowledge the burden supporting students placed upon the workforce, EI respondents commented upon the impost that supporting student placements places on clinicians.
- SP respondents suggested that it was important that service provider staff are not continuously hosting and supporting student placements.
- Some SP respondents reported that some students were ill-prepared for their mental health placement.
- Access to supervisor training was identified by both EI and SP respondents as important.
- Some EI respondents identified that the competition between educational institutions and disciplines for student mental health placements in rural and remote locations is negatively impacting upon organising and increasing student placements.
- Due to the difficulties educational institutions encounter accessing student mental health placements institutions often organise mental health placements in aged care services, a setting that only provides students with exposure to a very limited range of mental health disorders.

The 19 responses received from SP participants indicate that student placements are valued and seen as an important strategy for recruiting the future mental health workforce. Numerous comments indicate that supervising students is both rewarding and challenging. A significant issue is the additional burden supervising students' places on clinicians, attending to and maintaining their usual work load while also ensuring that students attain their learning goals and objectives is a challenge. SP respondents also reported that a significant amount of time and energy is invested in supporting student placements, which can result in increased stress and pressure on staff. A number of respondents suggested that student placements should not be offered continuously throughout the year and indicated that clinical staff required student free periods of time.

"Supervising students is challenging but also rewarding especially if we manage to "sell" a career in mental health. The most challenging aspect is keeping up with our work loads. Generally there is a lot of catching up to do after a student placement so they can't be continuous". **NSW UDRH**

"Generally staff are really pleased to be involved with student placements and enjoy the stimulation and challenge, however, as previously mentioned, sometimes in rural areas due to the numbers of people to support students, staff become "student fatigued". **NSW UDRH**

Several respondents identified training and support for supervisors as a critical issue. Three issues highlighted by respondents were: key access to training that is both relevant to the workplace and evidenced informed; lack of recognition of the contribution made by student
supervisors and other staff to successful placements; and service provider management quarantining a component of clinician time for student support.

“Training and support for supervisors and nursing staff is lacking. Supporting students takes time away from patient care with no recompense from the training organisation or extra staff/time allocation from management. It is however a vital recruitment tool and training opportunity for future staff”. TAS UDRH

Several SP respondents indicated that in their experience many students are unprepared for what can be a challenging placement which is often a departure from and different to other health care settings.

"We need these mental health places. Maybe we should consider simulation to enhance this placement as some of the issues are very confrontational for the students. Clinical placement preparation is paramount to prepare students for these placements”. VIC URH

“I would like to see far more student placements in psychology. I would like to see a closer working relationship with the placement universities, including training in supervision, access to the course work the students are undertaking, opportunities to feed back to universities regarding content of components of the masters programs. Opportunity to regular feedback to APAC”. NSW UDRH

All 22 EI respondents reported that there are significant challenges related to securing appropriate mental health placements for students and consequently educational institutions often resort to organising mental health placements in aged care services. Participants also suggested that the competition from various educational institutions and disciplines significantly reduces the capacity to locate placements within local UDRH areas particularly in Victoria.

“It has always been extremely difficult to secure mental health placement in appropriate settings, having been forced to utilise aged care facilities in the past which does not provide the students with adequate or relevant exposure to mental health issues in our region. The VET sector is also disadvantaged due to the costs now and the lack of available funding for placement”. VIC UDRH

“These are difficult to coordinate and arrange due to the competition of many allied health and nursing students for the Cert IV students to compete for placements - this is largely overcome mainly due to personal relationships that I have formed with the agencies but this should not be the case”. WA UDRH

Access to supervision was also raised as an area of concern by EI participants, who acknowledged that some placements that the institutions currently access are dependent on the availability of trained supervisors. EI respondents also commented on the importance of preparing students for a placement.

“I think it is important to understand that student placements can be useful if the clinicians demand continuity of clinical supervision for long enough that the students become useful. Reference: Walters L, Prideaux D, et al. (2011) demonstrating the value of longitudinal integrated placements for general practice preceptors. Medical Education; 45: 455-63”. VIC UDRH
EI respondents recognised the burden that hosting student placements have on service provider staff.

"Staff at the agencies who supervise our students do a wonderful job in trying conditions - there is a real shortage of Mental Health nurses in the rural areas, which means that the staff who take on students add to their workload considerably. NSW UDRH

9.21 OTHER TYPES OF SUPPORTED PLACEMENTS

SP participants were invited to detail whether their organisation had hosted placements for staff from non-clinical mental health services and/or staff from non-mental health services during 2010 and/or 2011.

Section Results Summary:

- A very low response rate in was received from SP participants in respect to both placements for non-clinical mental health service staff and non-mental health sector staff
- Further investigation of placements for staff from non-clinical mental health services and staff with non-mental health services with clinical mental health services or other mental health services is warranted.

9.21.1 INTERNSHIPS/GRADUATE PROGRAM PLACEMENTS

Only 7.5% of SP Respondents (n=93) reported that their organisation had offered internship and/or graduate positions during 2010 and/or 2011. Six of the seven positive responses were from respondents working in Public Mental Health Services. The reported number of internship/graduate positions offered varied from 1 through to 6 positions for 2010 and 1 through to 12 positions for 2011, with the highest proportion of respondents reporting 1 – 5 positions for both years. Respondents reported that the internship/graduate positions offered by their organisation were offered to the following disciplines: nursing, psychology, medicine, social work and occupational therapy. The responses indicate that internships and/or graduate positions are offered most frequently offered to nursing, psychology and medical graduates. All of the respondents from Public Mental Health Services reported that the internship/graduate positions offered by their organisations were linked to Graduate Diploma or Postgraduate Diploma courses. The majority of respondents indicated that their agency organised and arranged internship/graduate placements, with a smaller number reporting that individuals also initiate the process.

No conclusions can be drawn from the data relating to internship/graduate placements due to the low response rate, however the area warrants further examination. Internships and/or graduate positions are offered to new graduates for career/professional development purposes and provide the opportunity for clinicians to consolidate their knowledge and skills within a supportive environment; the approach is also a staff recruitment strategy.

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9.21.2 PLACEMENTS FOR WORKERS FROM NON-CLINICAL MENTAL HEALTH SERVICES OR NON-MENTAL HEALTH SERVICE SECTOR

8.6% of SP Respondents reported that their organisation offered placements to qualified staff from non-clinical mental health services or non-mental health services. Half of the respondents were from the ‘Other Mental Health Service’ sector, while the remainder were from Public Mental Health Services, Commonwealth Government Funded Mental Health Services or Aboriginal Mental Health/Social Emotional Wellbeing Services. The number of placements offered generally ranged between 1 through to 5 places in both 2010 and 2011. One respondent reported that their agency hosted forty placements in 2011. Participants for these placements were reported to be from a range of services including non-clinical mental health services, Aboriginal mental health/social emotional wellbeing services, alcohol and drug services, aged care services, child protection services and correctional services. Three of the eight respondents indicated that the placement their organisation hosted was linked to a formal qualification.

The low response rate in regard to this kind of placement limits the capacity for conclusions and generalisations to be drawn from the data. Of interest was the low level of reported placements by staff from Alcohol and Drug services considering the policy initiatives related to Dual Diagnosis over the last ten years. The topic warrants further investigation as these placements appear to be designed as informal capacity building opportunities for staff from the non-clinical mental health service sector which also promote a better understanding of the client experience and clinical mental health service system while fostering inter-sectoral worker relationships.
Appendix 1: EI respondent report course type by discipline and by state

EI Respondent Reported Course Type by Discipline by State

[Bar chart showing the distribution of EI respondents across various disciplines and states. Details on the chart are not transcribed.]
Appendix 2: SP respondent response to what number of students could your organisation support in the future?

SP Response - What number of students could your organisation support in the future?
### KEYPOINTS

- It was difficult to untangle the issues specifically related to *rural mental health* placements from those associated with a rural placement per se, and to placements more generally irrespective of location. However, in many instances the issue was magnified when that placement was in a rural mental health setting.
- For students, rural mental health placements are challenging but in many cases rewarding. Students appeared somewhat surprised by the quality of their learning in terms of exposure to the full spectrum of care, more time with health professionals, extensive hands-on experience, exposure to the social determinants of health, and enhanced skills in managing confidentiality and boundary issues.
- Educational provider were overwhelmed by the task of acquiring sufficient placements for students and found it particularly difficult to get places in rural mental health settings. Barriers included: workforce shortages, high staff turnover, work overload, insufficient suitable supervisors, and the shift towards centralised placements within public health that had devalued personal relationships between education and rural service providers.
- Service providers confirmed they were constrained by workforce issues but also nominated the following barriers: lack of a learning culture and exposure to students, limited infrastructure, concerns about client safety particularly when working with Indigenous clients, perceived limited understanding of services by teaching facilities combined with the perception that students were poorly prepared for a rural mental health placement.
- The facilitators for a positive rural mental health placement included: good communication between educational facility and service provider starting prior to the placement, access to affordable accommodation and transport for the student, including students in the community, provision of adequate locally-based cultural awareness training, quality supervision, and emotional support for the student.
A series of interviews were conducted with students who had undertaken a rural placement, rural mental health service providers, and key informants from university departments seeking placements for students in a mental health setting. The interviews sought to address several key questions:

- What is the learning experience like for students who undertake a rural mental health placement? What, if any, are the unique features of a rural mental health placement?
- What are the barriers and enablers for educational institutions when trying to coordinate rural mental health placements?
- What are the barriers and enablers for rural mental health service providers in terms of accepting and supporting students on placement?
- What are the barriers and enablers for students in terms of undertaking a rural mental health placement?

10.1 OVERVIEW OF DATA

In undertaking the analysis, a number of issues became apparent in addition to the themes pertaining to each project question. One of the most noticeable features of the data was the number of issues raised that were pertinent to rural student placements per se and not specific to the rural mental health setting. This was particularly evident in terms of the barriers and enablers to rural mental health placements raised by the informants. For example, many of the barriers to rural mental health placements identified by students have been identified in previous research on rural placements per se. These barriers include student concerns about isolation including leaving family, friends, work and rent commitments (Denz-Pehey et al, 2004; Magnusson et al, 2007), inflexibility in terms of the timing of placements (Magnusson et al, 2007); travel costs (Van Diepen et al, 2007); internet access and lack of affordable accommodation (Chief Health Professions Office, 2009). The pressures arising from isolation and costs associated with doing a rural placement (irrespective of domain of practice), may also account for the finding in the current project of a high level of positivity associated with a UDRH-supported placement. That is, our student informants who were supported by a UDRH may have been more likely to receive emotional support and practical advice to enable them to cope with a challenging placement in a rural setting.

While the issues raised by participants were sometimes relevant to all rural placements, it is interesting to note that one student did comment that the strong social immersion into a community that accompanies a rural mental health placement renders these type of placements somewhat different to a rural placement in another clinical area or a different discipline (e.g., physiotherapy).

Many of the factors identified as being associated with a less than ideal student learning experience in a rural mental health setting may also be better conceptualised as related to placements, in general, rather than being exclusively linked to location of workplace. For example, presumably the existence of a learning culture in the host organisation, clear learning objectives, and quality supervision are concerns for students wherever their placement is located. Equally, lack of communication and support from the university and variability between universities in assessment requirements would appear to be of concern to service providers regardless of location and type of workplace. In summary, in analysing the data it was often difficult to determine the extent to which an issue was uniquely relevant to a rural mental health placement. In many cases it appeared that the issue was pertinent to all rural placements and sometimes to placements regardless of location, but the issue was magnified when that
placement was in a rural mental health setting. Throughout the reporting of the findings, we indicate where this is the case.

A second noticeable feature of the data was the degree of variability between and within disciplines in terms of the length of placements. Overall, the length of placements varied between six days and 52 weeks (average length 10.5 weeks). As well as variability in length of placement, there was variability in the amount of mental health coursework undertaken prior to the placement. Many medicine, nursing and occupational therapy students reported that they had done little formal coursework related to mental health prior to their placement. On the other hand, psychology students and some social work students reported receiving adequate mental health coursework to support their placement. This wide variability and fact that some students are undertaking mental health placements with no formal preparation may simply reflect the differences between professions in terms of the dominant pedagogical approach as well as individual differences in learning styles. However, it may also raise questions about the wisdom of allowing students in broad-based entry level health professional training to undertake mental health placements, particularly in poorly resourced rural mental health services.

It was noticeable that about half of the students who were interviewed reported having a rural background. Rural students' interest in undertaking rural placements is to be expected given the consistent findings in the literature that this cohort has a higher likelihood of undertaking rural practice (Lee & MacKenzie 2003; Wronski & Murray 2006). It is possible that the preponderance of students with rural background combined with the self-selected nature of the sample is responsible for the generally high level of motivation to undertake a rural mental health placement that was evident in the cohort. It must be acknowledged, therefore, that the sample may not be representative of all students who undertake a rural mental health placement. It is also important to note the need for research on students who choose not to undertake a rural mental health placement and those who had a particularly unsatisfactory rural mental health placement in order to understand what barriers and potential enablers exist for them. Such work was outside the scope of the current project but would add significantly to our understanding of rural mental health placements.

In the following sections, we address the project questions and describe the respective emergent themes. The chapter concludes with the identification of key principles derived from the findings of the analysis of the interviews.
10.2 THE LEARNING EXPERIENCE FOR STUDENTS WHO UNDERTAKE A RURAL MENTAL HEALTH PLACEMENT: WHAT, IF ANY, ARE THE UNIQUE FEATURES OF A RURAL MENTAL HEALTH PLACEMENT?

10.2.1 VARIED VIEWS

There were varied views amongst students in relation to the uniqueness of the learning experience in rural mental health placements. Some students found the experience “superior to what you get in the city” (VB-01), and reported the experience to be particularly rewarding:

I think it is challenging! It took me out of my comfort zone! It increased my self-esteem; it increased my durability; my awareness... I went out there and I did it! [After this placement] I knew I would be okay in the workplace (AC-SW)

It’s definitely one of the experiences that stay with you and you can reflect back when you are the nurse (VB-RC03)

And I recommend it to everybody. I have got friends just starting off in first year now, and people in different professions, and I say go rural next year, it is the best experience you have (KB-J Student 1).

Others reported that a rural mental health placement is not critical to learning about mental health, but that the learning offered by such a placement enhances students understanding of rural health issues per se. For example:

I think that you don’t need to do a rural placement to understand mental health, but having done it, it would certainly help you understand rural areas and the key issues for people in rural areas... I think what we gained was a better understanding of health issues in general in rural areas (AC-MS).

In contrast, other students acknowledged that place had a substantial impact on them in terms of helping them to better understand how to work effectively in mental health. For instance, the need to learn about rural or local Indigenous culture in order to engage successfully with clients was recognised as important skill development. Another student recognised that the smaller size of rural communities enabled them to better understand both the role of social determinants in the development of mental health problems and the service system:

It’s like putting a community under a microscope because it’s smaller and you can get a handle on it; that’s what stands out in doing a mental health placement in a small remote area (VB-04).

Some students may perceive their rural placement as an easy option. As one service provider stated:

Some students see a rural placement as a bit of a holiday... Some of the perceptions are that the country is a poor cousin of the city and that there won’t be highly qualified and experienced staff around (JM-SP).

However, at least amongst the cohort of students interviewed for this study the actual experience of a rural mental health placement turned out to be a positive rather than negative
learning experience. Interestingly, few students talked about accepting a rural mental health placement because it offered a high quality mental health learning experience. Students seemed to be unaware of the quality of the learning experience prior to their rural mental health placement.

10.2.2 MORE TIME WITH A RANGE OF HEALTH PROFESSIONALS

Despite the varied views about the value of rural mental health placements, there appeared to be some features of these placements that students perceived as unique and of high value to their learning experience. Some students reported receiving a high degree of one-to-one teaching from supervisors that the students in turn attributed to less competition for supervisor time in the rural placement and having smaller facilities that facilitated more flexible learning opportunities. While it was reported that there can also be more quiet times in rural practice due to less patient throughput, the enhanced teaching opportunities were highly valued and encouraged students to relax and feel more able to ask questions. Medical students, in particular, valued their closer relationship to senior clinicians as a result of the low staff-student ratios and the involvement of a wide range of health professionals in their learning experience. Some students commented on the significant opportunities for interprofessional learning during their placement, with medical students often supervised by registered nurses and attending tutorials run by registered nurses.

10.2.3 EXPOSURE TO FULL SPECTRUM OF CARE

In addition to opportunities for interprofessional learning, students often commented on the enhanced exposure to multidisciplinary/multiservice environments in rural mental health settings. Students appreciated being invited to team and community network meetings and felt that the exposure to a broad range of health professionals and different service providers enhanced their understanding of the importance of networking and collaborating with a range of colleagues. Some students commented that this helped them to understand how the whole mental health system worked. Others described the experience as the first time they had seen all components of the continuum of care in operation as opposed to an urban mental health placement that tended to give students an in-depth look at only one aspect of the continuum of care. Many reported seeing clients in a range of settings from acute presentation through community mental health to the home setting. This is how one psychology student experienced her placement activities:

I start all my days going into review interviews with the consultant psychiatrist here, in the inpatient ward. That is a bit of an eye-opener. The consultant psychiatrist treats me pretty much the same as his own intern doctor. We both get quizzed about case formulation and things like that. That is certainly a bit of an anxiety provoking time. But it is a great experience that really consolidates the learning. I see clients in the outpatient area. They actually refer patients to me, psychotherapy, whether it is weekly or twice a week, depending on the needs of the patient. I also facilitate groups. So, that is a very wide variety of jobs. I work with the triage team once a week, so you walk and see patients. Basically, I spread myself right across the floor, purely because I am trying to get as much experience as I can. Everyone has been really supportive (KB-J Student 4).
10.2.4 WIDE SCOPE OF PRACTICE

Students also reported a lot of hands-on experience with clients rather than being allocated to an observer role, the latter being something that was reported as frequently experienced in urban placements. One student said that on a rural mental health placement you get:

"More flexibility around what you can do with your clients... getting in and giving things a go, running my own group, doing individual interventions and completing mental health assessment and getting all the basic (AC-OT)."

Many reported seeing a particularly broad range of presentations and on-going cases and were expected to participate in the care of complex cases rather than being told to wait outside. Students, in general, valued having supervisors who were generalists rather than specialists and could provide them with breadth of knowledge and experience as opposed to what was perceived to be a narrow experience offered by specialist urban-based mental health settings. Students often reported having greater scope to practice skills and as a result, developed a stronger sense of autonomy and responsibility; some reported that for the first time they felt they could contribute and were needed.

10.2.5 SPECIFIC SKILLS ACQUIRED

Some students and service providers felt that the rural mental health placement provided students with a greater chance to see and understand the impact of isolation, poverty and the other social determinants of health on psychological wellbeing, especially for Indigenous Australians. Many commented that the placement challenged them to implement strategies to better manage confidentiality and boundary issues to a far greater extent than urban placements given the small population base in rural communities:

"One of the biggest questions I had was, when working in a rural town, how do you not get bailed up down the street in the shopping centre by clients? That was one of my main concerns about living and working rural, how do I handle that? My supervisor who lives in the town said, “You just have to set the standards straight up and say, look that’s really important, make an appointment and come and see me one day next week” (KB-J Student 3)."

Other specific skills mentioned included transporting acutely unwell clients, risk assessment, setting up and running groups, types of psychological interventions and some pharmacology.

While there were clearly some uniquely positive learning opportunities related specifically to mental health mentioned by students, it was also noticeable how much was not said with regard to the learning of specific competencies during rural placements. It was evident in the data that students struggled to identify what they had learned during the placement in terms of clinical skills. This finding needs to be interpreted with caution as there would appear to be multiple explanations. For example, for many student informants, the interview was held sometime after completion of their placement and the requirement to reflect retrospectively on their learning may have been challenging. Additionally, the significant degree of structure within the interview schedule might not have elicited the depth of information we were seeking from students. The finding does, however, point to a need to examine the supposed links between curriculum-based teaching, practice-based learning and student outcomes.

It is also possible that rural mental health placements provide at least some students with a higher order type of learning experience. For example, several students described the
placement as being about shifting them from possessing a set of core skills that were rigidly applied to a state where they could be more flexible in how they applied these skills. As a result of the lack of resources and services in many rural communities, students said they were forced to think about how they could become more flexible in applying their skills. For example, a psychology student said that it helped her place her discipline into a much broader context so that she was able to see that she could be effective in multiple ways (e.g., health promotion, multidisciplinary care) other than the traditional one-on-one interventions undertaken by psychologists. Another student reported that a rural mental health placement:

... makes you be a bit of a jack of all trades. It makes you make the best of what you've got and consider how you can work around it. It definitely helped my problem solving skills (AC-OT).

10.2.6 NEGATIVE FEATURES

There were very few negative unique features of rural mental health placements mentioned by students. Of those negative features that were mentioned most pertained to the challenges facing the rural health workforce particularly in mental health. For example, some students noted that the high proportion of locums in rural services can make the learning experience less than ideal as some locums were reportedly less interested in supporting students. Service providers and students noted that the paucity of staff in rural mental health services can mean that if a key staff member (e.g., supervisor) resigns or takes leave, it can be hard to get a replacement.

10.3 WHAT ARE THE BARRIERS AND ENABLERS FOR EDUCATIONAL INSTITUTIONS WHEN TRYING TO COORDINATE RURAL MENTAL HEALTH PLACEMENTS?

10.3.1 OVERLOAD

The overall theme emerging from the interviews with educational institutions was a sense of total overload. Nearly all education providers conveyed to us a sense of desperation in terms of trying to find places for all their students, a task that was so challenging that it resulted in a tendency for the institutions to take a placement anytime and anywhere.

We have moved outside of the academic calendar, so I have placements in January [and] the week before Christmas. ..... I’m telling students before they have enrolled not to book a holiday at all throughout the whole course because I may have to use any time I can put you in a placement and it is particularly the mental health placement (CH- LM EI).

Situations such as those above were distressing for education providers. They were aware that the overwhelming need to obtain multiple places had the potential to reduce their ability to match student need to placement type and monitor the quality of placements.

Some informants from the education sector indicated that with so many institutions looking for placements, rural sites tend to be seen as an option when urban places fill up. While there is sometimes less competition for places in rural services, placements in small rural mental health units that are willing to take students also fill up quickly. It was noted that the extreme competition for places sometimes ends up with an educational institution offering financial
incentives to an agency to take students. It was apparent in the data that the option to 'buy' places was not available to all institutions and this inequity created discontent.

10.3.2 PLACES ARE HARD TO GET

In most cases, educational institutions indicated considerable difficulty in obtaining rural mental health placements, often due to the geographical isolation and workforce shortages in such regions. Within any one rural region there were often only a small number of options available for placements due to the limited number of agencies providing services. It was also reported that service providers were constantly facing workforce challenges including excessive workloads and high staff turnover that made it difficult for them to be confident how many students they could accommodate at any one time. From the educational institution's perspective,

The most consistent barrier [to obtaining placements] is the volatility of the organizations themselves. Changes of staff through funding impacts on supervisory resources. Having to forge new relationships with key staff- in any one year we would expect a third of the staff to change (JM EI).

Education institutions indicated that it was not uncommon to have service providers initially agree to take students then change their mind at the last minute. Sometimes it would only take the supervisor to require leave and the placement would have to be called off because there was no alternative supervisor. Due to staffing and rostering issues, rural service providers often had limited timeslots when they could take students but these did not always match with university schedules. Staff shortages and the challenging nature of rural practice often led service providers to prefer more advanced students with some skills and maturity in order to both assist the student to cope and ensure client safety. For many non-government service providers in rural regions it was also not uncommon for variations in their funding to impact on staffing and hence capacity to provide student supervision.

The difficulty in securing mental health placements was of real concern to some education providers who saw it as critical that students experience practice-based learning in mental health, an area which continues to increase in incidence and prevalence:

I think it is such an important placement because one in five have a mental health issue.... More of us are going to have mental health issues and its part of personal preparation as a professional, but also our students are just a slice of our community as well and this so often informs them for a lot that can apply to their own families and for themselves as well (CH-LM EI).

10.3.3 DIFFICULTY IN OBTAINING SUPERVISORS

The educational institutions also reported that a major barrier to rural placements was the difficulty in obtaining supervision for students. This problem manifested in a number of ways. Firstly, there was often difficulty in finding qualified supervisors as required by each profession. Many rural agencies have a preponderance of junior staff who are insufficiently experienced to supervise students. One social work fieldwork coordinator simply said there are very few social workers employed in rural mental health agencies. In some regions, there is just insufficient staff including nurse preceptors/nurse assessors with mental health experience to sign off when competencies have been met. Finding supervisors was particularly hard for psychology, which has extensive criteria that must be met in order for a psychologist to be able to act as a supervisor. However, particularly for the allied health professions, it was also the case that
finding suitably experienced clinicians willing to supervise was challenging. There was a range of reasons given for the difficulty. Some felt it was related to a lack of tradition of taking students in many rural mental health services that translates into a lack confidence to act as a supervisor, limited understanding of what the role entails, and a lack of internal policies and procedures to support both student and supervisor. Others commented on the predominance of multidisciplinary teams in rural mental health that made it challenging for the education institution to obtain profession-specific supervisors. Some disciplines utilised supervision from other health professions although it was evident in the interviews that there is variability both within and between disciplines in terms of acceptance of this broad-based supervision model. Some departments seemed concerned that supervision within a multidisciplinary team might be less than ideal because of variations in pedagogical approaches between professions and a perception that there is poor understanding of the role of their specific profession in such teams. Disciplines such as social work, psychology and occupational therapy will not permit supervision from another profession.

10.3.4 IT’S ALSO HARD TO GET STUDENTS TO DO A RURAL MENTAL HEALTH PLACEMENT

Getting rural placements was difficult but so was getting students who wanted to do a rural mental health placement. As previously mentioned, many of the students interviewed considered rural mental health placements to pose similar challenges to any rural placement; the barriers for many students being the associated cost of travel and accommodation to enable a rural placement; difficulty in leaving work, housing commitments, family and friends for a significant period of time; and perceptions about safety in some rural and remote regions. Access to affordable or free accommodation and funds to subsidise travel were often mentioned by universities as smoothing the way for rural placements to occur. Educational institutions also reported that students were more willing to go to what were perceived as exciting rural destinations (e.g., Alice Springs) as opposed to communities perceived as more mundane locations. Students interested in rural health per se, and positive feedback from students who had completed successful rural mental health placements seemed to increase the likelihood of agreeing to do a rural mental health placement.

10.3.5 THE IMPORTANCE OF RELATIONSHIPS

From the educational institutions point of view, the factor that appeared most related to establishing successful rural placement sites was the quality of relationships:

The whole placement process is about relationships. You want a good solid placement, good learning opportunities, and you want to give something back to the agencies….. I talk about reciprocity (KBJ-SP1).

These relationships were usually between a particular institution and the service provider (e.g., regular direct personal contact between fieldwork coordinator and service provider), but could also be between students and a service provider (e.g., a student may have grown up in the town where the service provider is located). While it is likely that the existence of similar relationships facilitates rural placements per se, it is possible that the small, team-based environment of many rural mental health services makes the development of key relationship particularly important. Many informants from the education sector emphasised that what success they had in obtaining rural mental health placements was largely due to continually fostering relationships with a key contact in the service that had good local knowledge:
We maintain as functional networks as we can to make sure we’re in touch with changes of staff, attend inter-agency meetings [and] monitor the email flow about projects (JM EI).

It was evident in both the interviews with the educational institutions and service providers (and students) that all groups of participants value effective communication so that they can better understand the perspective of the other. Service providers particularly value regular visits from staff from educational institutions:

*Visiting is about sustainability. They can put a face to a name; they have spoken to me and feel that I know what I am doing and am not likely to send someone that is going to be a nightmare* (KBJ-SP1)

*...visits to the site help placement coordinators to get to...... know the core business and what the place physically looks like* (FS-Service Providers).

Some placement coordinators provide annual in-service training to agencies, often using a variety of modalities to deliver the training. The majority of training was provided at a face-to-face workshop. As the search for placements has extended beyond the educational institution’s region, placement coordinators are developing in-service training that can be accessed online. In-service training assists service providers to understand what is required of them as well as facilitating two-way exchange of information.

Some informants noted that the placement system had long relied on personal relationships and networking by educational institutions but that this had been undermined by the centralised placements systems now operating in some state/territory health departments. Universities noted that under the centralised system it had become much harder to connect a student to a known good placement site, particularly in rural regions, and that overall, numbers of placements available to universities had declined as a result of the model. Fieldwork coordinators stated that having a third party involved in the identification of places also sometimes resulted in students being placed with a team that was not involved in the decision to accept the student and was inadequately committed to the process. Universities were also concerned that without personal relationships between education and service providers, under the centralised system they are left wondering whether or not their requests for placements ever make it to the on the ground service provider. Moreover, the ability of the education provider to match the student to the service is lost.

10.4 WHAT ARE THE BARRIERS AND ENABLERS FOR SERVICE PROVIDERS TAKING A STUDENT FOR A RURAL MENTAL HEALTH PLACEMENT?

Given the apparent difficulty experienced by educational institutions in obtaining rural placements, it was important to understand the barriers and enablers to accepting students reported by mental health service providers in these regions. In general, service providers considered they had a duty to be honest in judging their capacity to support placements for the sake of the student, staff and clients. Some of the reported barriers did appear to be relevant to all placements regardless of location (e.g., lack of information from the university regarding objectives and expectations, workload associated with lack of streamlined requirements and assessment criteria between universities, confusion created by having to deal with a fieldwork coordinator who is not a clinician, lack of learning culture within the organisation) and to all rural placements not just those in mental health organisations (e.g., lack of affordable
accommodation). However, many of these barriers are likely to be magnified in rural mental health services, particularly small units, where there are issues with recruitment and retention.

10.4.1 WORKPLACE CULTURE

The existence of a learning culture in the workplace is probably important to the success of any placement. However, in small teams the effect of culture and of individuals upon that culture can be magnified. It was clear that some agencies that took part in the interviews had developed a strong positive culture that enabled staff to view placements as beneficial to both the organisation and the student. For these service providers, having students was seen as fostering reflective practice and enabling them to examine their practice and policies more closely. They looked for suitable projects that could be completed by students and saw this as a way of building organisational capacity.

One benefit [of having students] is that you get an outside perspective and you get to ask questions that you would not normally get to ask yourself; the questions might expose some of the things you have been concerned about. A staff member might be asked, “Do you have a policy on X?”, and the staff member goes, “I don’t think so”. Then the question will be, shouldn’t we? .... and then everyone starts to be more vigilant about their business.” (KBJ-SP1)

Some informants commented on the importance of the team manager whose view of students sometimes heavily influenced how staff accepted students. Some service providers also indicated that the culture of the unit can determine which students are valued or whether some students are prioritised over others, particularly medical students over allied health professionals.

Service providers appreciated students who arrived at the placement with at least some knowledge of mental health practice and who were professional in their behaviour and dress. Service providers liked to have students who were interested in the community and interested in mental health; in other words, students who wanted to be on placement at that specific location.

10.4.2 INSUFFICIENT WORKFORCE

Workforce issues clearly permeated the interviews with rural mental health service providers. Confirming the issues raised by the educational institutions, providers often said that they do not have sufficient experienced and qualified supervisors in order to offer placements to all disciplines. With limited staff, it was reported to be particularly challenging to take on the additional work perceived to be associated with students even if the workplace is committed to a learning culture (e.g., rostering, booking transport and accommodation, orientating the student to the organisation and the community, paperwork).

10.4.3 INFRASTRUCTURE AND OTHER INTERNAL RESOURCE BARRIERS

Lack of infrastructure may be an issue for many rural services and it certainly presented challenges for some of the staff in mental health services interviewed for this project. Limited space to physically locate a student was raised as a real barrier as was difficulty booking student travel and accommodation to deliver outreach clinics. It was reported that cars used for outreach are often already full with a range of staff and that plane bookings have to be made one year in advance, with most flights quickly filling up. Particularly in services were the bulk of
work is undertaken by outreach, the lack of available funds to facilitate student travel and accommodation were raised as major barriers.

Some agencies that had not previously accepted students took the view that to shift their agency to a state of readiness for placements would be too onerous a task. They described a need to develop relevant policies and procedures and for training of staff in supervision practices. Others stated that the nature of the funding requirements for their programs specifically excluded students taking any real role in the day to day work of the organisation and thus they could not offer adequate learning experiences.

### 10.4.4 CLIENT AND STUDENT SAFETY

Some service providers mentioned the need to prioritise the safety of their clients and the welfare of the student when considering accepting placements. Considerable concern was raised by some agencies with regard to not being given enough information about the strengths and weaknesses of a student when they were faced with a decision as to whether or not to accept a particular student. Agencies worried about the level of maturity of the proposed student, their ability to cope with isolation and the clinical and cultural challenges they might face. Of particular concern was the extent of exposure that students might have to complex cases and aggressive clients and their ability to manage these situations. Uppermost in the mind of some agencies was concern for the cultural wellbeing of clients, particularly Indigenous clients. One provider delivering mental health services to remote Indigenous communities commented on the hard work they had invested in establishing trusting relationships with communities that they could not put at risk by exposing them to potentially culturally inappropriate behaviour from a student. Some agencies talked about having had a bad experience with a student and the legacy of that experience continued to influence their decision-making.

### 10.4.5 EDUCATIONAL INSTITUTION

In general, the service providers perceived the educational institutions as having very little understanding of their circumstances or of how their service operated. As well as many providers having concerns about the level of preparation of many students for a mental health placement or a rural placement, there were some who also raised concerns about the currency of knowledge to which students had been exposed. As mentioned, service providers found it difficult to connect effectively with universities and to understand learning objectives and requirements when communication was via an administrative person as opposed to a clinician. Similarly, providers were uncomfortable with centralised placement systems that isolated the provider from one-on-one discussions with the university about the strengths and weaknesses of particular students that they felt was needed to help inform their decision-making. Service providers sometimes felt that placements were of insufficient length to enable a student to obtain an adequate learning experience and were reluctant to take them for short period of time. Lack of flexibility with the timing of placements and previous history of poor communication with educational providers also acted as barriers to the acceptance of a student on placement.

In terms of the role of the educational provider, the service providers appreciated a consistent and reliable system for establishing and running of placements. It was considered important to have effective communication of learning objectives and receipt of practicum documentation prior to the placement starting, and a nominated contact person at the university. As stated by the educational institutions, service providers also saw value in the development of long-standing relationships between the university and the service providers. This was facilitated by
the educational facility being located near to the placement site so that at least some face-to-face communication could occur on a regular basis. Long standing relationships with universities was mentioned as a strategy for enhancing the community profile of rural service providers, particularly non-profit organizations:

Taking students is good business. We have become more well known, therefore our clients are more likely to come to us because they’re mindful that we have linkages with the university…. Being aligned with one helps cement you into the community. Being a non profit organization we need to have a very community face, so we need to give as well as get. Part of the giving is to provide placements for students (KBJ-SP1).

Perhaps most noteworthy was the stated need for more recognition and gratitude to be shown to the service provider by the various educational institutions, as well as understanding when a service provider was unable to take on students.

[Placements] are important. They can’t always be- it’s not like putting sausages through a sausage machine, and that’s why we haven’t had a placement this year (KS-MHSP).

Many of the service providers that we spoke to in rural regions reported instances of supervisors putting considerable effort into supporting students that included not just clinical support but also substantive assistance outside the work environment (e.g., providing accommodation, access to a motor vehicle, invitations to social engagements). Services often felt this work went unrecognised by the educational facilities.

10.5 WHAT FACTORS CONTRIBUTE TO A SUCCESSFUL/UNSUCCESSFUL RURAL MENTAL HEALTH PLACEMENT?

In this section, we draw together findings from the interviews with all three cohorts to identify the factors that contribute to a rural mental health placement being a successful learning experience for the student. It is important to point out that this included activities even before the placement started, as well as what actually happened during the placement.

10.5.1 PRE-PLACEMENT PROCESSES

Whilst unlikely to be specific to rural mental health placements, all three cohorts reflected on the importance of effective administrative processes prior to and during the placement. The data in the current study showed considerable diversity in terms of the ways in which rural mental health placements are set up, and the amount of information the student received. Informants from all three cohorts indicated some concern about the confusing and bureaucratic processes for setting up placements that at its worst, sometimes resulted in students arriving for a placement when staff were not expecting them. Good communication between the university, the student and the service provider prior to the placement and clear learning objectives assisted greatly in ensuring the supervisor and student were on the same page from the first day of the placement. Students reported that they benefitted from enough notice about where they would be going and what they would be doing when they got there so they could undertake their own research on the location and organisation before they arrived. Some students said they would have valued talking to their supervisor before they arrived to facilitate pre-reading related to the placement. It was identified as critical that this good communication
between all three parties continue across the duration of the placement given the physical isolation of the student and the challenging nature of rural practice.

It was noticeable in the data that there may be occasions when there is a mismatch between the service provider, student and the university in terms of clarity of the learning objectives. That is, in general, those interviewed within tertiary institutions considered learning objectives to be sufficiently clear although this was not always reported by students and service providers. Lack of clarity in learning objectives appeared to present real challenges to rural mental health services who were physically isolated from the teaching institution and operated within limited staffing while caring for high need populations. The lack of clarity in learning objectives and lack of perceived support from educational institutions may account for some of the reported reluctance for rural mental health service providers to take students when they are already overloaded.

In terms of process, some students commented that the length of their placement was important. The length of placements ranged from six days to five months. Irrespective of the placement length, it was thought that a balance needed to be reached between sufficient time to feel confident clinically, understand a community and being too long away from family. This may be the case for all rural placements, but it was interesting to note that many of the students in the current study talked about knowing community in the sense of understanding the client's needs rather than just exploring a new place (though this was perceived positively as well).

10.5.2 ACCOMMODATION AND TRANSPORT

As would be expected in most rural placements, many students mentioned the importance of having secure accommodation and transport during their placement experience. However, the importance of this infrastructure seemed to be magnified for a mental health placement as students struggled to make sense of the challenging nature of what they were seeing and experiencing on placement. It appeared that affordable and suitable accommodation and transport as well as an adequate amount of perceived support, enabled a stable platform to enable students to cope with their experience and facilitated a positive learning experience. Sharing student accommodation and connecting with others in similar situations, regardless of discipline, also seemed an important factor for success as long as the students got along with one another. Shared accommodation may be helpful for many students on a rural placement, but seemed to offer these particular students an important opportunity to debrief the challenging situations they were often facing at work.

10.5.3 SOCIAL INCLUSION

The need to feel part of the community in which they do their placement is probably common to many students undertaking a rural placement as is enjoyment of the often warm welcome to students from rural towns that are critically aware of the need to attract new health professionals to town. However, the need for social inclusion may be amplified when the student is required to engage with such a wide range of community members.

Being a smaller town you can get more involved in the community. People would say:

\emph{I've seen your car, you’re working in mental health when I go to the shops- there’s more inclusiveness- you should come along to this, we’re having a morning tea.... You see people in their daily lives (KB-J Student 3).}
Despite the efforts of many to involve students in the community, some still reported feeling isolated and disconnected from the community. A few students commented on how challenging it was for them to connect with a community and tears were not uncommon during their placement. The type of supports that seemed to be of assistance to students were practical things like provision of a bike; orientation to town including guidance on local services like gyms, shops and key services, and transport; access to the internet from their accommodation so students could contact family and friends and do assignments; good orientation to local health and community services; and inclusion in social and community events. Some of these supports were provided by service providers but also by the various UDRHs.

10.5.4 CULTURAL AWARENESS

Many students commented on the critical need to receive high quality cultural competence training with regard to local Indigenous groups in the community in which they were working. Other mentioned that it was even a challenge for them to connect with mainstream populations in some rural and remote communities where they had to understand different customs and beliefs in order to engage effectively with clients. There would appear to be a significant opportunity for rural mental health placements to assist students to develop skills in engaging with people from other cultures.

10.5.5 SUPERVISION

Whilst unlikely to be specific to rural mental health placements, all three cohorts noted the importance of quality supervision to a successful placement. It seems that good supervision is critical not just in terms of the development of clinical skills but also with regard to the ability of the student to feel included in the community and able to manage the challenge of rural practice. Many students commented on feeling out of their depth in terms of their knowledge of both mental health and rural issues and relied heavily on their supervisor for clinical learning and emotional and personal support. Supervisors also recognized this component of their role:

*It’s not so much about what the student can learn about the work…. it can actually mean that big component of the placement… where they were looking after the student and helping them integrate quite new experiences* (KS- MHSP).

Students valued having a supervisor who was very familiar with the requirements of the placement and who provided supervision that was structured and regular. They appreciated having a supervisor who provided much more than just formal supervision, that is, the supervisor also provided informal support in the way of assistance with social integration and day to day life.

Many students also appreciated being buddied up with another staff member until they developed the confidence to operate in a foreign environment. Students also valued having access to a desk, phone, email address and intranet during their placement.

10.5.6 EFFECTIVE COPING

Students were coping with the isolation from family and friends whilst confronted with the challenging work environment that can be found in many rural mental health services:

*It was a personal challenge... you are in an unfamiliar environment with all these demands. I found my rural placement the most demanding placements that I had. Everything is going on and it is finding that balance for yourself* (KB-J Student 1)
For young students a rural placement could be their first time living away from home and an opportunity to gain life skills:

"..... it is also the independence factor... being responsible for things that I am not necessarily responsible for myself, so that was an experience in itself. I could move out of home and I would be fine because I have done it for 14 weeks this year, which a lot of people in my course would not have experienced (KB-J Student 1)."

As mentioned, most of the students in our sample had a positive experience and were able to effectively cope with the situation by using a range of strategies. These included: bringing key objects from home; scheduling life in the same way they do at home (for example, going to gym, church, or other activities); planning how to communicate with friends and family before leaving for the placement; and socialising with other students and work colleagues even when it felt like an effort. It was noticeable that students in more remote locations were unable to go home on weekends and while this intensified their sense of isolation, students were generally aware that this enhanced their immersion into the community.
In February 2012, the Australian Rural Health Education Network (AHREN) comprising the Mental Health Academic (MHA) Network across the 11 University Departments of Rural Health was funded by the Australian Government Department of Health and Ageing to develop a profile of mental health clinical placements across regional, rural and remote Australia and investigate the determinants and values specific to mental health placements in these geographical locations. The purpose of the project was to describe the current situation with regard to mental health placements in non-metropolitan regions with a particular focus on the student learning experience, as well as identifying ways to improve and shape the future direction of mental health clinical placements.

Data analysed from activity one demonstrates the concept of diversity from a number of perspectives. This includes the range of health professions who participate in mental health placements, the duration of those placements and the type of locations in which mental health placements occur. Data analysed from activity two of the project explored the determinants and possible values that relate to a mental health placement in a rural area.

Findings from activity two specifically examined the student’s perceptions of their learning experience while on clinical placement in their chosen or nominated rural location. In addition, the perspective of education institutions and service providers were obtained. Findings highlighted that whilst the content of what students need to learn to build mental health skills may not differ greatly between metropolitan to rural areas, there are some key contextual differences that exist within the rural location. This is highlighted through the way in which students report they engaged with other health professionals (sometimes not from their health discipline) and the close association that health professionals have to each other and community members within the rural setting. The notion of connectedness that exists within smaller communities means that students have the opportunity to integrate within the communities in which they work. This may pose problems however if the student is not adequately prepared to understand how this might challenge professional boundaries. As rural clinicians often live within the communities in which they work maintaining confidentiality can be particularly challenging for students undertaking a rural mental health placement as can be approaches to address the impact of stigma.

Enthusiasm for rural mental health placements was noted in activity one with most education and health service providers indicating they would like to increase student mental health placements in rural and remote settings into the future. Most placements currently occur in public mental health services. The development of placements in other service providers needs to be considered. Many providers reported relatively small numbers of students undertaking rural mental health placements. This presents the challenge of balancing the benefits of small group learning in rural settings with the associated relative costs of small groups compared to larger groups. A concerning issue identified in activity 1 is that of competition for places in rural mental health settings, with the potential for less than ideal placements in settings of limited experience resulting. This is an issue that requires monitoring as does ongoing review of placements which was identified as often being inconsistent and ad hoc.

A total of 50 students who have undertaken a mental health placement in a rural setting were interviewed as part of activity two. There was remarkable consistency across the interviews in terms of the student’s perception of these placements as challenging but highly rewarding.
learning experiences. This finding is encouraging given that a positive rural clinical placement seems to be associated with a greater likelihood of a student going on to work in a non-urban setting (Courtney et al, 2002; Dalton et al, 2008; Killam & Carter, 2010). Many students were surprised by the high quality of learning on such placements citing the following as highlights: more time with health professionals, greater exposure to the full spectrum of care and social determinants of health, extensive opportunities for hands-on experience and a broader scope of practice including enhancement of their skills in managing confidentiality and boundary issues. Feeling supported and part of a team, good supervision, high staff-student ratios, friendly staff and autonomy and broad scope of practice have all been identified in previous research as components of a quality rural placement (Courtney et al, 2002; Denz-Pehey et al, 2004; Playford et al, 2006; Webster et al, 2010). The current project extends this understanding to suggest that the perceived quality of mental health placements in rural settings may also be related to the extent to which the placement enhances the student’s specific knowledge about mental health.

While the students who were interviewed for the project seemed to gain a lot from the experience, setting up and providing placements in rural mental health locations was a challenge from both the point of view of the education and service providers. The former were overwhelmed by trying to find placements for all their students. The extent of placement activity in Australia is well recognised with Health Workforce Australia (HWA, 2011a) noting that over 295,000 days of placement time occurred in mental health settings in 2009. Under immense pressure to get sufficient placements, some educational providers in the current project viewed rural placements as simply a way to boost the number of placements rather than as an opportunity to provide students with a unique learning experience. Overwhelmingly, the response from educational facilities was that rural placements were hard to find, often did not proceed, and accessing appropriate supervisors was a major challenge.

Rural service providers struggled to be able to reliably accept students due to workforce issues including shortages, high turnover, high reliance on locums, and a predominantly junior workforce. For some agencies, there was little history of accepting students and hence a limited culture of learning and a lack of supporting policies and procedures. Many agencies simply had insufficient infrastructure to take students and were worried about client safety and the reputation of the organisation in Indigenous communities. While there was some evidence that students might be considered by some service providers as a convenient way to address immediate workforce shortages, there was also a feeling that educational providers lacked understanding of the rural mental health service provider context and that students were poorly prepared for a mental health placement in a non-metropolitan setting.

In general, the challenges that confronted mental health providers in rural regions with regard to accepting students dovetailed with those identified in the 2011 HWA Mapping Clinical Placements Report. These include limited infrastructure, insufficient supervisory resources, excessive workloads, limited staffing and lack of flexibility to accommodate students, and organisational culture. Previous research has also noted the limited coverage of mental health and rural issues in a range of health professional course curriculum impacts negatively on students and supervisors (Mental Health Nurse Education Taskforce, 2008; McCann et al, 2009; Orpin & Gabriel, 2005). While the methodology employed in the current project did not allow any comparisons between rural and metropolitan mental health placements, it may be that in many ways, they are similar. The findings of the current study, however, would suggest that rurality magnifies some of these barriers, particularly with regard to the fragility of placements, confidentiality and boundary issues, and the importance of relationships. In the next section, we explore these dimensions in more detail in an attempt to define what is meant by the term ‘rural mental health placement’ as they currently occur in Australia.
11.1 DEFINING WHAT IS MEANT BY THE TERM ‘RURAL MENTAL HEALTH PLACEMENT’

A clinical placement is an example of a practice-based education strategy in which students learn about real situations practice. Of course, the concept of practice-based education is not unique to mental health or to rural placements. Practice-based education is thought to prepare students to deal with the complexities and unpredictable nature of professional practice. Practice-based learning (as a part of practice-based education) is:

...that learning which is explicitly designed to relate to professional practice standards. It includes learning which is work-based, undertaken in placements and which aims to enhance learners' employability (The Quality Assurance Agency for Higher Education, 2007).

HWA utilise a similar definition from The Australian Clinical Educator Preparation Program and state that clinical placements:

...provide opportunities in a relevant professional setting for the education and training of health sector students for the purposes of:
- integrating theory into practice
- familiarising the student with the practice environment
- building the knowledge, skills and attributes essential for professional practice, as identified by the education institution and/or external accrediting/licensing body (HWA, 2011b, p.4).

This definition enables one to conceptualise mental health placements in rural areas as having the potential to offer rich and diverse learning experiences and create the conditions for innovation and collaboration. The potential for mental health placements in rural regions to offer both quality learning experiences and opportunities for innovation and collaboration was evidenced throughout the findings of the current project. This is reflected in the three high level themes, or meta-dimensions, that were developed by the project team through iterative engagement with the data. These themes are: diversity, connectedness, and fragility and sustainability. Before proceeding to the discussion of these themes, it is important to note that the findings of the current project suggest that the ‘mental health’ component of the placement is generally, though not always, conceptualised by students, educational facilities and service providers as central to the learning of the student. The rural location of the placement is also paramount but it is probably more accurate to use the term ‘mental health placement in a rural region’ rather than placing the primary focus on location.

Diversity

The study undertaken by HWA (2011a) on the supply of clinical placements highlighted the huge number of clinical placements happening across the nation and the diversity of these placements in terms of profession, provider size and type, and locality. The findings of the current project also indicate that diversity is a major characteristic of mental health placements in rural regions. Activity one showed that a diverse range of professions undertake placements in rural mental health settings for varying periods of time, and in a range of different types of service provider organisations. What was also found was that across the professions undertaking placements are a multiplicity of different pedagogies and preferred learning styles. This diversity appears to put some pressure on supervisors and workplace colleagues, many of whom are likely to have limited educational background, to operate affectively across disciplines. The diversity of pedagogies may also be contributing to the perception among some service providers that students arrive poorly prepared for mental health placements. Despite
this, what was evident in the findings was the higher scope for learning to occur incorporating interprofessional practice across health disciplines.

The findings of the current study also highlight the diversity of settings in which issues of mental health are addressed and in which students can access rewarding learning experiences, especially in rural areas. In urban placements, students noted they would be likely to see one particular component of the full spectrum of mental health care, often limited to acute in-patient settings. In contrast, students in this project were usually based in one agency but the nature of rural mental health service delivery in rural communities is such that students often remained connected to clients from the acute setting throughout their transition of care through community services and the home environment. The diversity of experiences of a rural mental health placement thus may present students with opportunities for developing a range of skills associated with various stages of the patient journey.

The diversity of settings in which rural mental health placements occur is in keeping with the population health approach adopted in the Fourth Mental Health Plan 2009-2014. The Fourth Plan describes a holistic approach to care that covers:

- The full spectrum of services from prevention, early detection and intervention, to relapse prevention and recovery (including community support and accommodation)
- The full spectrum of 'health' from wellbeing to mental health problems, and mental health illness
- The full spectrum of people living with mental health problems, their carers and families.

The diversity of settings and services accepting students reflects the increasingly broad way in which mental health issues and appropriate service delivery models are conceptualised in Australia. Shared understandings of what constitutes a 'mental health' clinical placement for health professional students cannot be assumed. For example, a 'mental health' placement in a rural region could be:

- Undertaking community development activities with a social and emotional wellbeing team at a non-government organisation in a remote Indigenous community
- Doing home visits with the public community mental health team
- Joining the child and family team in a non-government organisation
- Attachment to a public in-patient psychiatric facility in a large regional centre working primarily with high prevalence disorders
- Accompanying a homelessness team.

Over the last decade, evidence has amassed to show that mental illness is common and exerts a significant burden on society. Mental health has become a focus of all governments and there has been a flurry of reform in the sector. As noted in the first report of the National Mental Health Commission (NMHC) (2012), Australia is increasingly recognising that mental health is a human rights issue, a community issue and a life and death issue (NMHC, 2012, p.14). As Allan Fels argues:

_Mental health is everyone's business. It is not about 'us' and 'them', it's about everyone_ (NMHC, 2012, p.4).

With this paradigm shift, we have seen mental health knowledge and skills no longer only being located within a speciality within the health sector. Addressing mental health issues now includes involvement of the broader health and community sector. In other words, there is
increasingly a need for a small number of health professionals to have a lot of knowledge and competencies in mental health coupled with a large number of health and other professionals with at least some capacity to work effectively with people at risk of or living with mental illness. This is illustrated in the following figure associating the wide range of mental health skills with health professionals and community members.

FIGURE 52 HEALTH PROFESSIONALS AND THE COMMUNITY LINKED TO A RELEVANT COMPONENT OF THE RANGE OF MENTAL HEALTH SERVICES

This newly emerging view of the optimal mix and quantity of services required for mental health is likely to be contributing to the diversity of professions seeking mental health placements and contributing to the sense of desperation currently being experienced by educational facilities. In terms of mental health placements in rural regions, the current study suggests the potential for high quality learning and while there is some capacity to enable innovative approaches to expanding the number of placements, the opportunities are still finite. In this environment, is it feasible to continue to offer practice-based educational opportunities in rural mental health services to all health professionals? Can the mental health learning needs of the general health professional be met in other ways such as through Mental Health First Aid Training and simulated learning? Developing and implementing innovative approaches to building the capacity of all health professionals to better manage mental health and illness might assist in freeing up much-needed placements in mental health services for those professionals operating at the more complex end of mental health service delivery.

Within non-metropolitan centres, the nature of health service delivery also varies widely from adequately resourced and staffed regional cities to smaller centres that provide limited services. To service remote areas, health professionals often travel significant distances between communities to see clients and access to acute services is difficult. Thus, any definition of mental health placement in a rural location needs to incorporate both variations in
geography and resultant health service model, as well as the potential for placements to sit anywhere on the full spectrum of care.

**Connectedness**
The findings from activity two highlighted the importance of connectedness to successful mental health placements in rural settings. Connections, particularly social connections, were identified as important in terms of:

- Setting up placements (relationship between service provider and educational facility)
- On-going communication between student, service supervisor and educational facility before and during the placement
- The relationship between the student and the supervisor
- The relationships between the student and other work colleagues
- The relationships between the student and other students on placement in the community
- The connectedness of the student to the client and to the community.

Falling within the concept of connectedness, is the broad range of disciplines involved in providing mental health care services in rural regions and hence the propensity for students to interact and collaborate with a diverse range of health professionals. There is a multiplicity of terms used to describe this phenomenon including interprofessional and multidisciplinary practice. While the data collected for the current project indicates that the interprofessional nature of rural mental health practice can create potential challenges for student placements, there is increasingly a view among health planners of the need to foster collaborative learning opportunities and interprofessional supervision in order to reduce the fragmentation and poor communication often seen in the Australian health care system (HWA, 2011a).

In summary, there is clearly a substantial human element to a quality mental health placement in a rural location. Lack of connection or a poor fit between people can be a major barrier to a quality learning experience for both the student and the service provider agency.

**Fragility and sustainability**
This project has highlighted the fragility of rural mental health placements on a number of levels. These placements are intensely dependent on access to affordable accommodation and transport, access to appropriate supervision, and the fluctuations in the capacity of the local workforce. These barriers have been noted in previous research on rural placements (e.g., Chief Health Professions Office, 2009; HWA, 2011a; Maley et al, 2009), though supervision and workforce capacity appears to be particularly salient in the rural mental health sector due to the small and multidisciplinary nature of many rural mental health service providers. Thus not only are the placements hard to get, but even when a placement is locked in, the agreement can be easily broken.

Many placements in rural mental health agencies also seem to rely on a number of ‘taken for granted’ factors that are rarely or explicitly valued. These include the personal relationships that underpin the existence of many placements and the high incidence of supervisors and students going ‘above and beyond’ for the benefit of placement experience. The reliance on the informal and often hidden components of placements further contributes to a sense of fragility in that in shaping the future direction of mental health clinical placements, great care must be taken to ensure these ‘taken for granted’ benefits are not lost.
In using the term fragility to describe the nature of mental health placements in rural locations, we hope to capture the current state of vulnerability that surrounds these type of placements. The lesson to be learned here is that if we value mental health placements in rural locations, in terms of both the clinical learning experience and the potential impact on the rural workforce, then attention is urgently needed to ensure the sustainability of clinical placements within the rural mental health sector.

### Mental health placements in a rural location can be broadly conceptualised as:

1. Providing opportunities in a relevant professional setting for the education and training of health sector students for the purposes of:
   - integrating theory into practice with regard to mental health knowledge and competencies
   - familiarising the student with the rural practice environment
   - building the knowledge, skills and attributes essential for professional practice, as identified by the education institution and/or external accrediting/licensing body^ 

2. Occurring anywhere across the full spectrum of mental health services from prevention, early detection and intervention, to relapse prevention and recovery and involving exposure to the full spectrum of people at risk of or living with mental health problems, their carers and families

3. Taking place in a rural setting that can vary along a continuum from larger, more closely settled communities to small populations dispersed over large areas.

^ Derived from the definition of a clinical placement offered by Health Workforce Australia (2011b)

### Mental health placements in rural settings are frequently characterised by:

- Diversity of setting, profession, provider size and locality, and
- Connectedness in terms of the inter-relationships between educational facility, service provider, student, supervisor, client and community.

Efforts are urgently required to address the current fragility of mental health placements in rural settings in order to ensure the sustainability of clinical placements within the sector and contribute to the much needed growth in the rural mental health workforce.

#### 11.2 LIMITATIONS OF PROJECT

By using the Mental Health Academics Network within the University Departments of Rural Health, the project team were able to capture data from students, educational facilities and service providers across Australia. While the resultant sample sizes were large and the findings consistent across States and cohorts, it was noticeable amongst the student cohort that students who had undertaken a placement supported by a UDRH were over-represented in the sample. It
is thus possible that the generally positive experience of a mental health placement found in the current project may be associated with the high level of tangible (e.g., accommodation) and emotional support these students received from the UDRHs. Such high level support is not available to all students undertaking a mental health placement in rural Australia. For example, there is only one UDRH in each of Western Australia and Queensland yet both states have vast rural landscapes. The existence of multiple UDRHs in Victoria and New South Wales also meant participants from these States were over-represented in the final sample.

A key constraint on the project was the short timeline for undertaking a nation-wide project. The requirement to complete the project in less than twelve months impacted on the project in several ways. One of the greatest challenges that confronted the project team was negotiating the variations between jurisdictions in terms of what was required to obtain ethics approval for the two project activities. The requirement in some jurisdictions to obtain separate ethics approval for both activities from both the respective university and health service providers caused delays in the project activities commencing. The short timeline also limited the time available for piloting the survey tool. This was highlighted when minor technical issues were identified with the activity 1 survey tool after it went live. Despite these problems, the ability to triangulate the findings of activities 1 and 2 and identify a high degree of consistency is suggestive of robust findings.

11.3 CONCLUSIONS: “SLEEPWALKING INTO DISASTER!”
The undersupply of health professionals in regional and rural Australia is well documented (for example, see Productivity Commission Report, 2005). One of the strategies to improve recruitment has been to expand the availability of rural clinical placements on the assumption that this is a way of building familiarity with rural values and beliefs and an opportunity for those not from a rural background to see what opportunities rural life and rural practice can offer. Much of the research that has examined the impact of such strategies has focused on specific professions as opposed to health professionals in the mental health sector. While the research that has been done certainly suggests there has been some positive impact on recruitment (e.g., Chan, Degani & Crichton, 2005; Dunbabin, McEwin & Cameron, 2006; Playford, Larson & Wheatland, 2006; Schoo, McNamara & Stagnitt, 2008; Wilkinson, Laven, Pratt & Beilby, et al, 2003), the findings are not consistent (Xu, Hedley, 2002; Veloski, Hojat, Politzer, Rabinowitz & Rattner, 2000). It has been suggested that these inconclusive results reflect methodological weaknesses in many of the studies in that they fail to control for potential confounding variables that are themselves correlated with uptake of rural practice, such as rural background (Ranmuthugala, Humphreys, Solarsh, Waters, Worley, Wakerman, Dunbar & Solarach, 2007). Providing mental health placements in rural regions is important, not just because they offer a positive learning experience for students, but also because they appear to have value in growing the rural workforce.

As mental health care becomes an issue for all health professionals, we are seeing intense demand for placements in the mental health sector that is placing pressure on the already struggling rural mental health workforce. To the extent that rural placements offer at least some solutions to the workforce crisis, the findings from the current study present a considerable degree of concern. There are clearly numerous obstacles for students, educational facilities and service providers in rural regions to overcome in order to develop placement capacity in the sector. We are still a long way off seeing education providers, rural mental health agencies and students taking shared responsibility for clinical placements. On the other hand, the findings from the current project clearly point to the educational value of mental health placements in rural locations. If rural communities and students are to benefit from such placements, urgent attention is required to address the currently fragile nature of rural mental health placements to ensure their sustainability and growth into the future.
REFERENCES


12 RECOMMENDATIONS

In order to improve the quality and quantity of mental health placements in rural regions, we make the following recommendations which have been noted earlier in the report under Position Statement:

1  The importance of cooperation and support

Cooperation between education facilities and health services in providing placements and ensuring those placements are adequately supported have been identified as valuable in promoting mental health placements in rural regions.

It is recommended that:

The recently established regional training networks in rural areas should be responsible for establishing cooperative approaches for the allocation of clinical placements in mental health.

Sustainable approaches to providing academic support for clinical placements and supervisors in mental health should be developed, including the use of UDRHs amongst others.

2  Training health professionals: Rural mental health learning objectives

Clinical placements are an essential component of the training of health professionals and contribute to the development of the health workforce. Learning objectives relevant to rural mental health placements are important. It is recommended that:

Specific learning objectives should be established for rural placements in addition to promoting those common to all mental health placements. The rural learning objectives should consider issues that are specifically relevant to rural placements, including the rural context of the mental health experience and increased potential for confidentiality compromise and overlapping relationship conflict.

3  Funding

The current level of mental health placements in rural regions is dependent on the maintenance of existing levels of funding to support the accommodation and transport needs of students. It is recommended that:

The funding for rural mental health placements needs to adequately account for the costs of placements, including transport, accommodation and support for mental health professionals providing supervision for such placements.

4  Expanding mental health placements

Mental health is a concern for the whole community. Pressure on the limited number of mental health agencies in rural regions able to provide placements has been identified, with an increasingly diverse range of health professions seeking rural mental health placements. It is recommended that:

The number of clinical placements in rural regions for mental health students should be expanded. This will require support from education providers and health services for the
development of alternative placement options. There are good examples of how these could be developed based on the diversity of rural mental health placements already on offer.

**Additional comments**

The following comments are not presented as formal recommendations but as reflections of the project team in the form of suggested approaches that may benefit rural mental health placements.

- Students from rural areas should be given priority to enable a placement within their rural locality.
- Educational facilities provide students with adequate notice of a rural placement, including information on the health service and community they are going to.
- In order to recognise the importance of the context in which mental health care is delivered, students undertaking a placement in a non-urban location need to be aware of specific issues of high relevance in rural area, including potential risks to confidentiality and overlapping relationships, and working with Aboriginal and Torres Strait Islander people.
- Service providers ensure all students receive a prompt and adequate orientation to the health service and to the local community.
- Educational providers facilitate the work of service providers in supporting students by providing those providers with learning objectives and assessment criteria that are written in plain language minimising educational jargon.
- Processes be developed to enhance the quality of feedback from students to service providers and educational facilities regarding the nature of the learning experience.
- Supervisors in rural service provider agencies be recognised and valued for the substantial role they play in developing the future workforce and that further work be undertaken to identify approaches that would ensure rural supervisors feel more valued, other than by additional financial remuneration.
- Develop, pilot and implement flexible models of supervision that can span different rural mental health settings and disciplines. This work will need to be undertaken with the support of the various health professional regulatory bodies in order to overcome the existing regulatory barriers for supervision.
- Supervision requirements for psychologists and professionals in other mental health disciplines be reviewed by the relevant credentialing agencies as a matter of priority to ensure maximum opportunities are available for students to gain fruitful rural experience and potentially develop the rural mental health workforce.
- When allocating placements in rural mental health agencies, priority should be given to the health professions requiring the highest level skills and competencies in working with clients experiencing mental health problems. This should include nursing, psychology, social work, occupational therapy and medicine.

- Alternative pathways to develop knowledge and skills in mental health be developed for other health professions not requiring the highest levels of mental health skill; this could include training programs such as Mental Health First Aid Training.