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Regional responses to the challenge of delivering integrated care to older people with mental health problems in rural Australia

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Abstract

Objective: Integrated care has been identified as means of managing the demands on the healthcare budget while improving access to and quality of services. It is particularly pertinent to rural health services, which face limited access to specialist and support services. This paper explores the capacity of three rural communities in South Australia to deliver integrated mental health support for older people.

Methods: Thirty-one interviews were conducted with local health and social service providers from mental health, community health, general practice, residential aged care, private practice, NGOs and local government as part of a larger action research project on service integration.

Results: Participants highlighted differences in service delivery between the communities related to size of the community and access to services. Three structural barriers to delivery of integrated care were identified. These are as follows: fragmentation of governmental responsibility, the current funding climate, and centralisation and standardisation of service delivery.

Conclusion: We conclude that despite a focus upon integrated care in mental health policy, many features of current service delivery undermine the flexibility and informal relationships that typically underpin integration in rural communities.

Keywords

older person; mental health; policy; rural; integrated care; Australia

Introduction

The aging of the baby boomer generation is leading to concern in developed countries about management of resources to meet the needs of this population. One response has been increasing use of private and non-government (NGO) service providers (Henderson, 2005) leading to fragmentation of service delivery (Petrich, Ramamurthy, Hendrie, & Robinson, 2013). Governments have sought means to integrate care between service providers. Integrated care is viewed as a means of managing demands on healthcare budgets while improving access to and quality of services. It is also viewed as a way to address gaps in service delivery (Petrich et al., 2013).

The premise of this paper is that policy solutions that apply in metropolitan contexts may not be appropriate in rural contexts. Farmer et al. (2012b) identify a lack of theoretical framework for understanding the impact of rural context upon health practice. In attempting to remedy this, Bourke, Humphreys, Wakerman, and Taylor (2012) draw upon Giddens' structuration theory to explore the impact of the interconnection of structure (social institutions) and agency (individual capacity for action) on health practice in rural communities. In short, Giddens (1984) argues that while people make conscious choices about their actions these actions occur within a social context and social norms that people position themselves in relation to. Most day-to-day activity is of a repetitive and routine nature that is affected by a tacit knowledge of how to operate within given social contexts (Giddens, 1984). Bourke et al. (2012) identify six factors that allow the researcher to contextualise the practice of rural health practitioners. These factors are geographical isolation, rural locale, health responses to rural locale, broader health systems, broader social systems and power.

Background

Background In Australia, one in seven people were aged over 65 in 2011, with 35% living outside of major cities (defined as population above 100,000) (ABS, 2014). Rural residents generally experience poorer health outcomes associated with ageing of the rural population (Farmer, Prior, & Taylor, 2012b) and adoption of unhealthier lifestyles (Bourke et al., 2004). Extended waiting times for General Practitioner (GP) appointments and limited access to specialist health services and support services also affect health status (Polain, Berry, & Hoskin, 2011; Vaganes, McLaughlin & Dobson, 2009). There is evidence that rural people are less likely to seek help for mental health issues with stigma, lack of knowledge of mental illness, lack of services, self-reliance and concerns with the capacity of GPs to manage mental health all barriers to help seeking (Collins, Winefield, Ward, & Turnbull, 2009; Pierce & Brewer, 2012). Bourke et al. (2012) associate these factors with geographical isolation.

Rural locale is defined as the social relationships and normative values that provide the context for health care (Bourke et al., 2012). Rural locale may influence which behaviours are accepted, either promoting or undermining health, and may impact the manner in which health services are delivered. Rural communities are often viewed as having a culture of social cohesion and collective problem solving alongside self-sufficiency (Farmer et al., 2012a). As a consequence, rural service providers have been identified as being more likely to work collaboratively and to adopt generalist and extended roles to maximise available resources (Bourke et al., 2012; Mitton, Dionne, Masucci, Wong, & Law, 2011; Petrich et al., 2013). Management structures are often flatter enabling more flexible and creative use of resources (Bourke et al., 2012). Collaboration is more likely to occur through informal networks (Crotty, Henderson, & Fuller, 2012) and rural service providers often act as community leaders in other community services (Farmer et al., 2012b).

The broader health system refers to the policy context and the institutions that deliver health care (Bourke et al., 2012). As the mental health of older people cannot be addressed by health services alone, the health system must be considered alongside social systems (Cummings & Kropf, 2009). Co-ordinated or integrated care is the favoured model for service delivery to older people with mental health problems in Australia. Banfield et al. (2012) argue that integrated care has been on the mental health policy agenda since the release of the first National Mental Health Plan in 1992 but became a priority from the Fourth Plan released in 2008. To support integrated care in mental health the 2011 Federal Budget targeted resources to support service planning through Medicare Locals (organisations coordinating primary health services at a regional level) (Henderson & Fuller, 2011). The change of government in 2013 resulted in the replacement of Medicare Locals by larger planning bodies called Primary Health Networks (PHNs), which are responsible for commissioning primary mental health services (Department of Health & Ageing, 2015).

Success in achieving integrated care in mental health has been mixed (Petrich et al., 2013; Townsend, Pirkis, Pham, Harris, & Whiteford, 2006). Service delivery has been hampered by systemic and ideological fragmentation (Petrich et al., 2013). Systemic fragmentation arises from the division in responsibility for funding and service provision between the Federal and State governments. The provision of specialist mental health services is a State government responsibility, and the provision of primary care the province of general practice funded by the Federal government through rebates for medical and selected nursing services (Department of Health & Ageing 2010). The Federal government is also responsible for funding support packages for older people primarily through Home and Community Care (HACC) with services provided by State and non-government service providers. The Federal

government provides welfare payments, including the aged pension and is responsible for funding Aged Care. Additionally, there is an organisational separation between metropolitan and rural health services in South Australia (Taylor et al., 2009). The result is the involvement of multiple governmental departments and agencies in care delivery.

Ideological fragmentation reflects the different political ideologies between the major parties with regards to public and private service provision (Petrich et al., 2013). For Petrich et al. the focus of the public/private mix shifts in relation to the party in power, with the more conservative Coalition favouring private over public service provision. We argue that there are greater similarities than differences in approach with both major parties adopting an approach to governance of mental health featuring accountability for public funding; the privatisation of services; accountability to consumers; and personal responsibility for health (Oster et al., 2016; Rose, 1996). These features are reflected in the placement of private and not-for-profit service providers and general practice at the centre of community mental health service delivery.

This paper explores the impact of policy and funding models on capacity to deliver integrated care for older people with mental health problems in rural communities in South Australia. We focus on the ways in which service delivery models are seen to enhance or inhibit service delivery, and how participants work within and respond to these models and to rural locale in delivering services.

Methods

Design

The data for this paper are drawn from a mixed methods case study undertaken in rural South Australia to improve integration of service delivery for older people with mental health problems. It reports one aspect of the data, namely 31 interviews conducted with service providers (25 with local service providers and six leadership interviews with senior managers from major service providers) (Fuller, Oster, & Dawson, 2014).

Ethics approval

Ethics approval was granted by the South Australian Health Department Human Research Ethics Committee and Flinders University Social and Behavioural Research Ethics Committee.

Data collection

The case study was conducted in the southern part of the Adelaide Hills, the Fleurieu Peninsula and Kangaroo Island in 2013-14. This region has a growing older population with a 52% increase in those aged 65 years and over from 2001 to 2011 (Australian Government, 2014). This region fell under the administrative auspices of the SAFKI (Southern Adelaide Fleurieu and Kangaroo Island) Medicare Local at the time data was collected. Specialist mental health services are delivered to older people in the region by three community-based mental health teams with a consultation liaison service and acute inpatient care available from the capital city, Adelaide. The mental health teams operate in different contexts. The Adelaide Hills and Fleurieu Peninsula teams have a visiting psychiatric service. These communities have greater reliance upon private service provision for older people. Not only can they access a greater range of NGOs, but residential aged care services are primarily provided by NGOs rather than the state. The third community, Kangaroo Island, has less NGOs and general practitioners to draw upon. Access to specialist services is limited and made more difficult by geographical isolation. Service delivery on Kangaroo Island is more centralised with greater dependence upon government services.

The interview participants for the study came from a variety of service backgrounds including mental health, community health, general practice, residential aged care, private practice, NGOs and local government; from a range of disciplinary backgrounds and roles; and from the public and private sectors (see Table 1). The initial participants were identified by a governance group set up at the beginning of the project with additional participants identified during data collection.

Interviews were semi-structured and of 30–60 minutes duration. The interviews were audio taped and transcribed verbatim. They addressed existing linkages between services; whether these are informal or formal; policies and procedures that support linkages; barriers and enablers to service delivery; and changes that would enhance service delivery. Written consent was obtained from all participants prior to data collection and transcripts were returned to participants for verification.

[Insert Table 1]

Data analysis

The interviews were entered into NVivo 10, and subject to thematic analysis by the research team. Initial codes were based on the interview schedule and project aims. These were discussed with the team and additional codes added. Each interview was then coded

independently by two members of the team using open codes, which identify concepts and their properties, and later subjected to axial coding, to make links between the concepts (Braun & Clarke, 2006).

Results

The results highlight the manner in which geographical isolation and rural locale affect the delivery of mental health services for older people (health responses to rural locale). We outline how local service providers view policy responses to rural older persons' mental health and identify three aspects of service delivery, namely funding, fragmentation of responsibility, and the bureaucratisation and centralisation of services that hinder and help service delivery in these communities.

Rural locale and health responses

Participants identify three interconnected aspects of rural locale that affect service delivery: sense of community; self- sufficiency; and the role of informal networking. Sense of community is associated with greater commitment by service providers to the mental health and well-being of the community. A senior manager states that 'rural versus metro is so different … the professionals in the rural areas seem to do stuff more for the love and for benefit of the community' (I30). Sense of community is associated with a greater role for neighbours in providing care. One mental health worker notes:

> *In country communities you tend to know your neighbours a bit more than in metro areas … And so when we're looking at mental health and well-being there is a real role for community to provide psycho-social support to one another that perhaps doesn't present itself in metro areas. (I13)*

Sense of community is particularly important in smaller communities with limited access to other resources. In smaller, more geographically isolated communities, working together becomes a necessity. A service provider on Kangaroo Island notes that 'The local services work together… .out of necessity rather than good management or planning… . Because we have a wall…the water' (I20). As a consequence, these communities become more self-reliant. A senior manager says:

> *I think Kangaroo Island is probably a different mindset …because they are such a community orientated community that they are used to being self-supporting and making things happen with the resources that they've got. (I30)*

Service providers also discuss the self-sufficiency of smaller towns on the Fleurieu Peninsula. A service provider from a local NGO says ‘because they're a small community [smaller towns] they tend to take care of their own, so you know neighbours and friends will support each other… they're quite contained’ (I1).

Informal networking facilitates information sharing and referral between agencies. A service provider from aged care describes relying on ‘a lot of informal networking, local community you tend to know everybody and you often ring up for advice or a chat or whatever so there's a fair bit of that’ (I5). Informal networking is facilitated by long-standing relationships and co-location of services leading to business being done in corridor conversations. The role of long-standing relationships is reflected in the following quote from a provider of social support services:

> *I guess when you've worked in a community for sixteen plus years and get to know people and they get to know you and because the community is in a lot of ways so small, we get to know different people informally first but sometimes we get included formally because there's ongoing needs or support needed or whatever. (I10)*

Informal networking creates awareness of what each service provides, allowing service providers to identify gaps in service provision. This is particularly evident in smaller communities with fewer service options. A mental health manager notes that on Kangaroo Island ‘there's a very good understanding of roles and responsibilities and sharing of those roles and responsibilities where there's a gap’ (I26). Conversely, reliance upon informal networks creates difficulties for service providers who are new to the region. A participant from general practice states that ‘it takes a long time to understand the informal processes because a lot of people just know how it happens,…there's a lot of unwritten rules’ (I7).

Reflections on policy

Service providers identified two aspects of policy that directly impact local service provision: gaps in service delivery related to access to specialists (e.g. psychiatrists, geriatricians), and the impact of the change of Federal Government. A Community Health manager says:

> *… we do have a very inequitable access to geriatricians, and I guess they're important in terms of … assessing for dementia, and I guess that whole thing about discriminating between dementia and mental health and delirium. (I8)*

This is related to policy through a lack of co-ordination of dementia services. A respondent from community health says:

> *The coordination of dementia services from a national study level has been really poor, there hasn't been a plan, there have been numerous attempts at setting up dementia plans across the State, numerous attempts by both the Commonwealth [Federal government] and the State to establish a coordinated management approach to dementia and memory loss services and that continues to fail. (I16)*

Separation in jurisdictional responsibility between the State Government, which manages mental health, and the Federal Government, which has primary responsibility for aged care, is seen as leading to people with dementia falling through the gaps 'in-between [services] for older people and mental health' (I28).

The change of Federal government contributed to concerns about the future of the Medicare Local that co-ordinated and provided mental health services. The move from Medicare Local to PHNs was associated with the cessation of direct service delivery by Medicare Locals and the channelling of primary mental healthcare funding, including funding for community services, through PHNs. Much of this funding is tied to specific programmes leading to uncertainty about continued funding for community programmes and services directly provided by Medicare Locals. This concern is expressed by a service provider from primary care:

> *…we're all up in arms at the moment because of the Federal Government changes with [the] Medicare Local being disbanded and we're unclear as to what's going to be happening with some of the mental health services. (I24)*

These changes are viewed as being associated with a retreat from health promotion and community development activities and result in fewer opportunities for networking leading to greater reliance on the goodwill of local service providers to maintain relationships.

Service providers also highlighted aspects of health and social policy that directly affect the delivery of integrated services. These are the fragmentation of service delivery, funding models, and the centralisation and bureaucratisation of service delivery.

Fragmentation of service delivery

Fragmentation of service delivery between Federal and State Governments was identified as leading to difficulties in determining responsibility for services. One manager states:

> *I think we've got with this sort of stuff is around who's responsibility is this…there's the state government, there's the federal government, then there's the things that those people fund like local government, like Medicare Locals, so who does it actually fall to (I30).*

For some, recent funding cuts have contributed to greater demarcation of responsibilities. A manager from community health argues that the State government is retreating from primary care and social welfare activities to focus upon 'the acute sector or chronic disease' (I28):

> *State Health used to be involved with health promotion…now, there's been a retreat from primary health care to much more focus on chronic disease and acute care and heads… health promotion and primary health care is now seen as a Commonwealth [Federal Government] responsibility. (I28)*

These changes impact on service providers who have difficulties in accessing services leading to accusations of 'double-dipping'. An aged care provider says:

> *We constantly get told by the State system 'you're funded to look after these people, look after them', and we go 'we can't look after them for the funding we get.' So it's that State, Federal push-pull all the time. (I27)*

A second point of demarcation is between the public and private sectors. Reliance upon private service providers increases complexity of service provision. A community health employee says:

> *…if I go back say ten years there was ourselves as the only provider of nearly all of those services… . And so there were high levels of coordination of care, a high level of common understanding of that continuity of care… that has become highly fragmented over the last ten years, so you've got multiple agencies, you've only got the one Government health service, but we're now dealing with multiple agencies and there…are multiple smaller businesses now being set up to provide this level of care. (I16)*

This division may result in difficulties in formalising relationships. A primary care service provider notes difficulties in establishing a Memorandum of Understanding (MOU) around information sharing with GPs as 'general practices are private practices and they're not part of that MOU' (I9). The public/private divide is also identified as a problem in creating joint plans:

> *I think when your work as a GP is a private, they're private enterprises, we have no influence or control,… it still comes back to the individual providers or practice in how they work around their clients' needs. (I31)*

Decisions in general practice and for profit services are made with respect to profit. Therefore, it can also be difficult to engage GPs in time consuming programmes and meetings due to the 'cost pressure to them running their business' (I30).

Funding models

Funding is an ongoing issue within this region exacerbated by cuts to health budgets. A number of services identify shortfalls in funding. The mental health team has insufficient resources to take new community referrals from inpatient facilities (I26) while mangers of Aged Care Facilities argue that they 'don't receive any additional funding for people with mental health issues unless they have [difficult] behaviours and we can generate in-residential [funding] through ACFI [Aged care funding model based on acuity]' (I27).

Budget constraints result in services focussing upon core business leading to greater gaps in service delivery. A representative of local government notes that:

> *…people do their best to push the boundaries of their service but as service demands increase, as funding decreases…they're forced to look inward and narrow[ly] at the way they're able to respond. So instead of trying to narrow the gap, the gap in fact widens as a result of those service demand pressures. (I29)*

This has two consequences for integrated care. It may result in clients being shuttled between services. An Aged Care service provider states:

> *…you could work purely to the funding model or you could say no because I think that funding model still means you still have a responsibility for X, Y and Z and so you still have to just fit that in or find another way of doing it, …so then it becomes someone else's. (I18)*

Handballing of clients has the potential to erode goodwill between service providers. A community health manager states, ‘in a very tightened, constrained financial climate everyone pulls back to their discreet funding buckets and the lines of demarcation and the goodwill tends to evaporate’ (I28).

Budgetary restraints and a focus upon core business are also reflected in funding strategies that tie funding to the performance of direct care tasks. A community health manager identifies performance indicators that establish ‘how much direct contact client time versus non-direct time’ is appropriate (I28). Likewise, a mental health worker identifies movement towards funding models in which the:

> *…number of direct clinical services will direct how much money you get from the Government, and so there very much is a push in our particular agency to see people …and then make sure that you've written down in triplicate…that you've seen that person so that we're guaranteed the funding. (I13)*

A focus upon direct care activities comes at the expense of other activities including opportunities for networking. The mental health worker continues:

> *But all of that comes at the expense of having the opportunity to go to that community meeting to meet those people and to link with those agencies to build that network and to build those good solid relationships that are grounded in trust based on knowing a face and knowing that that person is someone I can talk to. (I13)*

A third funding issue relates to the impact of short term funding on service delivery. For services competing for HACC [Home and Community Care] funding:

> *…it's an uncertain time at the moment because the whole HACC and everything is coming into line for the middle of next year so everyone feels a bit nervous and do we start programmes, the funding uncertainty does impact…on willingness of people to set new things up or to put a lot of energy into things when you don't if it's going to continue. (I18)*

Insecure funding also affects capacity to attract and retain qualified staff. A community health employee states that ‘recruiting into positions if there's a vacancy, that's a huge problem’ (I8). An unintended consequence of funding insecurity is that many GPs will not refer to local services that ‘get funded from year to year, they might be there one time and

don't exist the next so they'd rather deal with…services that they know are going to be there' (I14).

A final feature of the funding model that undermines integrated care is competition for funding. This is particularly evident when services tender for Commonwealth funding to deliver services. A service provider from a NGO argues that competition results in 'a lot of services [being] very guarded because they don't want you getting involved in their area because that's the area that they're trying to get funding for' (I14).

Bureaucratisation and centralisation

A final theme relates to the increasing bureaucratisation of service delivery. Respondents identify 'an absolute plethora [of operational policies] in fact there are so many policies and procedures … there's a procedure for following a procedure' (I4). The bureaucratisation and formalisation of relationships is viewed as undermining informal relationships and the service flexibility needed in rural regions. A community service provider says for example:

> *… because we take that grass roots approach a lot of it can be quite informal but then there are those barriers when we get further up the food chain…[we] have all these bureaucratic processes that can be a barrier…so it's really flexible how we do it. (I6)*

One issue identified by respondents is the centralisation of administration of services. There is a perception that services work more effectively with minimal interference from management. This view is promoted by one community health manager who says that '…they get on and do it, if we keep out of the way…bureaucracy can just drown those processes that I think people make happen' (I28).

Another issue for local service providers is the development of standards of practice. Strict adherence to the standards is viewed as limiting who can receive services and the range of services that can be provided. This is exemplified by the following quote:

> *… so we have to adhere to the home care standards and all the discussion within those standards is about flexibility, individualised care, meeting the needs of the individual…So I find that really difficult, if you've got someone who's under eighty and they might not be doing as well as someone who's over eighty they immediately get stopped from receiving the service. (I6)*

Discussion

This paper has drawn upon a model developed by Bourke et al. (2012) to explore the interaction of local and policy context upon the manner in which service providers deliver care to older people with mental health problems in rural Australia. This model is based on Giddens (1984) structuration theory, which views agency occurring in relation to norms and rules of conduct arising from social context; in this case, the rural locale and health and aged care policy context and norms underpinning mental health and aged care service delivery.

The Australian policy context is marked by fragmentation of responsibility and service delivery between State and Federal governments. In response, mental health policy has promoted integrated care provided by public and private service providers (Banfield et al., 2012). Integrated care has been identified in mental health policy as a means of improving access to care and preventing people from falling through service gaps, of overcoming clinical siloing and improving the physical health of people with mental health problems (Henderson & Fuller, 2011). The study was undertaken at a time of upheaval. The Federal government was taking a greater role in the organisation and funding of primary mental health care through PHNs, leading to a retreat by the State government from primary health care and uncertainty about service continuity and funding. In response, services retreated to core business. Furthermore, the centralisation of HACC services created difficulties in timely access to community aged care services.

We argue that rural context makes a difference to the approach to service integration. Limited resources require rural service providers to be innovative and flexible in how services are used. Our respondents identified cultural norms such as a sense of community, self-reliance and the role of informal networking. These values promote service providers stepping outside of prescribed roles and working together in creative ways to plug service gaps and meet local needs. These norms arise from and promote service integration as a solution to service provision with limited resources (Bourke et al., 2012; Petrich et al., 2013).

Despite this, there is evidence that the current health and social policy context inhibits service integration in rural areas. In this study, state service providers argue that the development of PHNs has resulted in a change in the focus of their work away from social support towards chronic disease management, leaving less time for collaborative activities. Second, greater reliance on private service providers and the creation of service linkages between publicly and privately provided services is complicated by different cultures and ways of working. Different cultures in this study result in difficulties in establishing

procedures across the public and private sectors and in attracting GPs to meetings to plan collaborative activities It also creates difficulties for consumers and carers who are required to navigate a fragmented system, leading to people falling through the gaps (Dawson et al., 2017).

Funding was also identified as inhibiting integrated care. Engagement maintains commitment and builds trust between community members (Fuller, Hermeston, Passey, Fallon, & Muyambi, 2012). Current funding restrictions have contributed to a retreat to core business, which has been exacerbated by the tying of funding to direct care activities. Both preclude the social networking that promotes integrated care. In addition, services compete for funding to deliver services through a tendering process. Carson and Kerr (2012) associate the tendering of services with the 'hollowing' of government departments in an effort to achieve value-formoney with public funds. This process has consequences for NGOs who may have difficulties in retaining staff, capacity building and with excessive reporting mechanisms. Our respondents identify job and programme insecurity and an unwillingness to share information between service providers as barriers to service integration.

Another factor is the increasing formalisation and centralisation of services. The capacity of rural services to deliver care depends upon the flexibility and creativity to fill service gaps (RANZCP, 2011). Our respondents argue that bureaucratisation and centralisation of service delivery prevents informal problem solving between services as relationships are mediated by bureaucracy, preventing creative solutions for people who do not fit comfortably within service parameters. As a consequence, the rules and procedures established to promote understanding between services and increase integration have a negative effect through undermining local norms that promote informal ways of working together.

There are limitations to this study. Case studies are designed to explore a particular case within its social context using a variety of research methods to triangulate data (Munhall, 2001). While this provides thick description of a case or community, data cannot be generalised. Despite this, the analysis has identified issues that warrant exploration in other settings to determine how effective policy is in promoting service integration in other locations.

Conclusion

This paper explores the manner in which service providers in three rural communities have negotiated local context and social norms to provide services to meet the needs of older

people with mental health problems in light of the current policy and funding context. We argue that many of the features of the current policy context work against integrated care in these communities as the formalisation and bureaucratisation of working relationships and activity based funding models hinder the informal networking and creativity that is a feature of health service delivery in rural communities. It is also evident that there are differences between the communities in terms of how they respond to the boarder health and social policy context, with smaller communities identified as being more coherent and self-sufficient. As such, policy models that may promote integration in metropolitan services may inhibit the integration and performance of rural services.

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References

Australian Bureau of Statistics [ABS]. (2014). Where do Australia's older people live? Retrieved from http//www.abs.gov.au/austats/abs@.nsf/Lookup/2071.0main+feature602012-2013

Australian Government. (2014). My Region. Adelaide Hills, Fleurieu and Kangaroo Island. Retrieved from http://myregion.gov.au/profile/adelaide-hills-fleurieu-and-kangaroo-island/data/population/age

Banfield, M., Gardner, K., Yen, L., McRae, I., Gillespie, J., & Wells, R. (2012). Co-ordination of care in Australian mental health policy. Australian Health Review, 36, 153–157.

Bourke, L., Humphreys, J., Wakerman, J., & Taylor, J. (2012). Understanding rural and remote health: A framework for analysis. Health & Place, 18, 496–503.

Bourke, L., Sheridan, C., Russell, U., Jones, G., De Witt, D., & Liaw, S. (2004). Developing a conceptual understanding of rural health practice. Australian Journal of Rural Health, 12, 181–186.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3, 77–101.

Carson, E., & Kerr, L. (2012, July). Marketisation of human service delivery: Implications for the future of the third sector in Australia. Paper presented at ISTR conference, Siena.

Collins, J., Winefield, H., Ward, L., & Turnbull, D. (2009). Understanding help seeking for mental health in rural South Australia: Thematic analytical study. Australian Journal of Primary Health, 15, 159–165.

Crotty, M. M., Henderson, J., & Fuller, J. D. (2012). Helping and hindering: Perceptions of individual, contextual and organisational barriers and enablers within a rural South Australian mental health network. Australian Journal of Rural Health, 20, 213–218.

Cummings, S., & Kropf, N. (2009). Formal and informal support for older adults with severe mental illness. Ageing and Mental Health, 13, 619–627.

Dawson, S., Gerace, A., Muir-Cochrane, E., O'Kane, D., Henderson, J., Lawn, S., & Fuller, J. (2017). Carers' experiences of accessing and navigating mental health care for older people in a rural area in Australia. Aging & Mental Health, 21(2), 216–223.

Department of Health and Ageing: Building a 21st Century Primary Health Care System. (2010). Australia's First National Primary Health Care Strategy. Canberra: Commonwealth of Australia.

Department of Health and Ageing. (2015). Primary Health Networks Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/PrimaryçHealthçNetworks

Farmer, J., Bourke, L., Taylor, J., Marley, J., Reid, J., Bracksley, S., & Johnson, N. (2012a). Culture and rural health. Australian Journal of Rural Health, 20, 243–247.

Farmer, J., Prior, M., & Taylor, J. (2012b). A theory of how rural health services contribute to community sustainability. Social Science & Medicine, 75, 1903–1911.

Fuller, J., Hermeston, W., Passey, M., Fallon, T., & Muyambi, K. (2012). Acceptability of participatory social network analysis for problem-solving in Australian Aboriginal health service partnerships. BMC Health Services Research, 12, 152.

Fuller, J., Oster, C., Dawson, S., O'Kane, D., Lawn, S., Henderson, J.,… Muir Cochrane, E., (2014). Improving the network management of integrated primary mental healthcare for older people in a rural Australian region: Protocol for a mixed methods case study. BMJ Open, e006304. doi:10.1136/bmjopen-2014-006304

Giddens, A. (1984). The constitution of society: Outline of the theory of structuration. Cambridge: Polity Press.

Henderson, J. (2005). Neoliberalism, community care and mental health policy. Health Sociology Review, 14, 242–254. Henderson, J., & Fuller, J. (2011). "Problematising" Australian policy representations in responses to the physical health of people with mental health disorders. Australian Journal of Social Issues, 46, 183–203.

Mitton, C., Dionne, F., Masucci, L., Wong, S., & Law, S. (2011). Innovations in health service organization and delivery in northern rural and remote regions: A review of literature. International Journal of Circumpolar Health, 70, 460–472.

Munhall, P. (2001). Nursing research a qualitative perspective (3rd ed.). Sudbury, Mass: Jones and Bartlett.

Oster, C. T., Henderson, J., Lawn, S. J., Reed, R. L., Dawson, S. K., MuirCochrane, E. C., & Fuller, J., (2016). Fragmentation in Australian Commonwealth and South Australian State policy on mental health and older people: A governmentality analysis. Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 20, 541–558. doi:10.1177/1363459316644490

Petrich, M., Ramamurthy, V. L., Hendrie, D., & Robinson, S. (2013). Challenges and opportunities for integration in health systems: An Australian perspective. Journal of Integrated Care, 1, 347–359.

Pierce, D., & Brewer, C. (2012). Factors promoting use of mental health services in a rural area of Australia. Journal of Community Medicine and Health Education, 2(11), 190.

Polain, J., Berry, H., & Hoskin, J. (2011). Rapid change, climate adversity and the next big dry older farmers' mental health. Australian Journal of Rural Health, 19, 239–243.

Rose, N. (1996). Governing "advanced" liberal democracies. In A. Barry, T. Osborne, & N. Rose (Eds.), Foucault and political reason: Liberalism, neo-liberalism and the rationalities of government (pp. 37–64). London: UCL Press.

Royal Australian & New Zealand College of Psychiatrists [RANZCP]. (2011). Position Statement 71: Priority must be given to investment that improves the mental health of older Australians. Retrieved from:

https://www.ranzcp.org/Files/Resources/CollegeçStatements/Posi tionçStatements/ps71-pdf.aspx

Taylor, J., Edwards, J., Kelly, F., & Fielke, K. (2009). Improving transfer of mental health care for rural and remote consumers in South Australia. Health and Social Care in the Community, 17, 216–224.

Townsend, C., Pirkis, J., Pham, A., Harris, M., & Whiteford, H. (2006). Stakeholder concerns about the Australia's mental health care system. Australian Health Review, 30, 158–163.

Vagenas, D., McLaughlin, D., & Dobson, A. (2009). Regional variation in the survival and health of older Australian women: A prospective cohort study. Australian and New Zealand Journal of Public Health, 3, 119–125.

Table 1. Profile of interview participants

	Sector/Role	**Public/private**	**Region**
Interview 1	NGO	Private	Fleurieu
Interview 2	NGO	Private	Fleurieu
Interview 3	Social support services	Public (Local govn)	Fleurieu
Interview 4	Mental health	Public	Fleurieu
Interview 5	Aged care	Private	Fleurieu
Interview 6	Social support services	Public (Local govn)	Fleurieu
Interview 7	Primary care	Private	Fleurieu
Interview 8	Community health	Public	Regional
Interview 9	Primary care	Public	Regional
Interview 10	Social support services	Private	Fleurieu
Interview 11	Community health	Public	Regional
Interview 12	Primary care	Private	Fleurieu
Interview 13	Mental health	Public	Fleurieu
Interview 14	NGO	Private	Fleurieu
Interview 15	Primary care	Private	Fleurieu
Interview 16	Community health	Public	Fleurieu
Interview 17	Aged care	Public (Local govn)	Fleurieu
Interview 18	Aged care	Private	Fleurieu
Interview 19	Mental health	Public	Kangaroo Island
Interview 20	Community health	Public	Kangaroo Island
Interview 21	Primary Care	Private	Kangaroo Island
Interview 22	Primary Care	Private	Fleurieu
Interview 23	Primary Care	Private	Fleurieu
Interview 24	Primary Care	Private	Fleurieu
Interview 25	Hospital	Private	Regional
Interview 26	Mental health	Public	Regional
Interview 27	Aged care	Private	Regional
Interview 28	Community health	Public	Regional
Interview 29	Local government	Public	Fleurieu
Interview 30	Primary care	Public	Regional
Interview 31	Community health	Public	Regional