

ORIGINAL RESEARCH

Creating a sustainable and effective mental health workforce for Gippsland, Victoria: solutions and directions for strategic planning

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A B S T R A C T

Introduction: The Gippsland region of Victoria, in common with other Australian rural and regional areas, is experiencing a shortage of qualified mental health professionals. Attracting mental health professionals to work in such areas is a major concern for service providers, policy-makers and rural/regional communities. Previous studies have focused on identifying factors contributing to the maldistribution of the health workforce, principally medical practitioners. Recent reviews have highlighted the strengths and weaknesses of evidence for the effectiveness of initiatives designed to address workforce shortages in underserved locations. The reported study sought the views of mental health organisation leaders from Gippsland to identify current approaches and potential solutions to the challenges of workforce recruitment, retention and training. A key goal of the study was to inform a strategic regional approach to the development of a more sustainable and effective mental health workforce.

Methods: Investigators conducted semi-structured individual interviews with 26 administrators, managers and senior clinicians from public and private sector mental health organisations throughout Gippsland. Thematic content analysis of the transcribed interviews identified current approaches and potential solutions to the recruiting, retaining and training problems in the region.

Results: The study categorised solutions as focusing on factors external or internal to organisations. Solutions external to organisations included efforts to enhance the pool of available workers, improve intra-sectoral collaboration and cross-sectoral linkages, make funding more flexible, and to institute a contemporary curriculum and take innovative pedagogical approaches to training. Internal solutions included the need for strong leadership and quality organisational culture, flexible and adaptable



approaches to meeting individual worker and community needs, promoting the organisation and local area and adopting models of care. Informants indicated that individual organisations are limited in their capacity to address recruitment, retention and training issues and highlighted the potential benefits of a regional mental health workforce recruitment, retention and training strategy.

Conclusion: This study provides a unique insight into the creative approaches adopted by managers in Gippsland to recruit and retain mental health workers. It brings a new perspective to the literature due to the reflections of managers, grounded as they are in day-to-day work.

Keywords: rural mental health workforce, management, leadership, organisational structure, organisational culture.

Introduction

Attracting mental health professionals to work in Australian rural and regional areas is a major concern for service providers, policy-makers and rural/regional communities. In common with other rural and remote areas of Australia, mental health services in Gippsland struggle to attract and retain suitably qualified professionals. Located in the south-east of the state Victoria, Gippsland covers 41 524.2 km² and consists of 6 local government areas with a combined population of 238 907, 1.3% of whom are Indigenous Australians¹. Unlike other Victorian rural regions, Gippsland does not have a major provincial city; the population is dispersed in townships, the largest of which Traralgon with a population of approximately 22 000². Although a central transport corridor provides good access to the state capital Melbourne, the size and geography of the region together with a poor public transport infrastructure means that some regional locations are comparatively isolated and difficult to access. Local industries include power production, agriculture, forestry, fishing, tourism, education, health and retail. Public mental health services are provided by a state funded regional clinical mental health service, 5 psychiatric disability and rehabilitation support services, 6 community health generalist counselling services, 4 alcohol and other drug services, a regional social and emotional wellbeing service for the Indigenous population and a regional school support service. Medicare funded services are provided by GPs, psychologists and a very small number of consultant psychiatrists.

A good deal of the rural and remote workforce literature has focused on the recruitment and retention of the health workforce, in particular doctors. Identified key attractions and barriers to working in rural and remote areas are summarised (Table 1).

This information, which provides insight into issues of rural and remote workforce recruitment and retention, has been substantially qualified by two recent systematic literature reviews. One of these sought interventions to increase the number of health professions practicing in rural and remote areas¹² but found no publications that met the Cochrane selection criteria. The subsequent review by Wilson et al¹³ used a less exacting inclusion criterion for research studies and the findings are summarised (Table 2), with weak evidence found for:

- education/training
- support
- coercion
- incentive strategies.

While the studies reviewed by Wilson et al¹³ suggested moderate evidence for 'incentives', this applied to short-term recruitment strategies and so is weak in the longer term. It is also important to note that when in students are in rural locations they value support and this is an important component in rural and remote placements, regardless of outcome¹⁴.



Table 1: Summary of attractions and barriers to working in rural and remote settings, with references for each factor³⁻¹¹

Key area	Factors highlighted in previous research
Attractors and reasons to extend work in rural and remotes areas	<ul style="list-style-type: none"> • importance of job satisfaction[3] • nature of the work, including variety and autonomy[3,4] • positive patient contact[3] • rural lifestyle, recreation and environment[4, 5] • proximity to other family members[5] • perception of greater career opportunities[4] • desire to complete professional goals[4, 6] • extension of contract/tenure[4]
Barriers to rural and remote recruitment and reasons for leaving rural and remote areas	<ul style="list-style-type: none"> • lack of support in government systems[3] and sole practice[7] • lack of access to, and dwindling services[3], and availability of mental health care and access to services[8] • lack of workforce/interagency cooperation[8] and lack of team work with other providers such as GPs[3,7] • issues associated with rural life such as cultural awareness[9] and isolation[3] • client practice issues including perceptions and expectations of consumers[8], workload[7,9] and acuity of clients and threat of litigation[7] • personal and family issues such as lack of spousal employment, housing and/or poor quality schools[9] • high distress and low quality work[10] and heavy workloads and burnout[4] • lack of professional support[10,11] • workplace problems[4] • lack of access to professional development and training[11]

Table 2: Levels of evidence (graded convincing to strong, moderate, weak and absent) according to type of interventions to increase recruitment and retention of professionals in rural and remote areas¹³

Intervention		Evidence	Comment
Type	Definition		
Selection	Inclusion of participants in professional training based on 'geographic origin, ethnicity, gender, career intent and service orientation' (p.3)	Strong	Participant rural background is very important (defined by completion of primary and/or secondary education in rural location) of individual non-specialist professional and spouse strongly linked to practice in rural area
Education/training	Use of pre- and post-vocational training to stimulate interest in long term rural practice; exposure of health students to rural or remote work in training	Weak	Exposure through training in rural settings apparently important, but evidence biased by other factors, eg student choice of rural placement often on basis of rural origin
Support	'...different ways to support the health professional while practicing in rural locations' (p.3)	Weak	Supportive measures valued by students regardless of follow up
Coercion	Government and other bodies' attempts 'to force health professionals into rural practice' (p.3)	Weak	'... address short term recruitment needs but little evidence supports their long term impact' (p.12)
Incentives	Financial schemes such as bursaries 'linked to rural service agreements' (p.3)	Moderate	'...address short term recruitment needs but little evidence supports their long term impact...' (p.12)



There is some evidence that pre- and/or post-vocational placements (eg clinical rotations) in rural areas impact on recruitment, although this evidence is biased by other factors such as student choice of placements¹³ and the confounder of participant rural origin has not been accounted for in some studies. Ranmuthugala et al¹⁵ raised similar concerns regarding the evidence for the effectiveness of rural medical and nursing workforce initiatives reported in Australia. However Rabinowitz et al¹⁶ concluded that in the USA, medical school rural programs have been highly successful, with an average of 53% to 64% of graduates working in rural settings.

The only 'strong' evidence found was in regard to student selection, indicating that 'rural applicants with a stated interest (or 'career intention') in general practice, and a service orientation, is the strategy with the greatest likelihood of reducing the rural-urban gap'^{12,13}. Similarly, Stagg et al¹⁷ reported that some key influences on medical graduates' choice of a rural career pathway are:

- their own geographic location prior to entering medical school
- having a spouse/partner with a rural background
- having an extended rural based undergraduate learning experience.

Wilson et al also commented that the rural location of medical schools seems to lead to more rural doctors¹³, although this may be contingent upon the rural background of students, rather than the location of the medical school. While the quality of research is low, minimal evidence supports the successful relocation of urban professionals to rural and remote positions without consideration of additional intrinsic factors, such as having a partner from rural background.

Surprisingly, only three rural studies have gained the perspective of such senior rural informants. The single Australian study⁸ focused upon general issues for rural and remote health providers rather than specific issues of

recruitment and retention in mental health. Two US studies examined the views of hospital CEOs from rural Illinois¹⁸, and then compared them with those of a similar rural Arkansas cohort¹⁹. The CEOs were surveyed for their perception of needs, barriers and strategies regarding recruitment and retention of rural health care professionals. They found that communities need to be 'attractive' to health professionals, where 'attractive' included such things as the community being collaborative, instilling hope and being supportive of families (eg being 'family friendly'). The most important recruitment and retention predictor was a positive perception of the public school system¹⁹. Unfortunately the survey design in this study was based on previous worker perceptions and not those of CEOs or managers. While the survey was rated by managers, the items were designed for workers. It is therefore unclear whether the findings represent the expansive and unfettered views of these key regional informants or are merely answers to a worker prescribed rubric. Consequently, the views of senior personnel are an important gap in the mental health recruitment and retention literature.

The present study sought to add to the literature by gaining the views of managers and leaders from mental health service providers throughout Gippsland. It was considered that their interface with workers and structural factors that influence regional employment together with their 'bigger picture' viewpoint would provide a region wide perspective on recruitment, retention and training. It was hypothesised that solutions determined from their perspective would enable the development of a well-founded regional mental health workforce strategy. In interviews, the participants were asked to consider key regional issues and current and potential solutions. This article explores these solutions.

Methods

Potential interviewees were selected on the basis of their expertise as either a manager of a mental health service, their role in policy development and/or implementation, or a



direct involvement in the provision of mental healthcare services.

The Director of Mental Health, Latrobe Regional Hospital, facilitated the nomination of participants from the clinical mental health service. Those from all other sectors were recruited by an initial phone call. Each participant was sent a detailed background information sheet. Each participant was interviewed in his/her place of work during working hours, according to a semi-structured interview that explored issues and solutions relating to mental health workforce recruitment, retention and training in Gippsland generally and also their particular organisation. Interviews were recorded and transcribed. A record of interview validity check was undertaken with each participant²⁰ by returning a brief summary of their interview for comment, correction and refinement. The research was approved by the Monash University human research ethics committee.

Data were analysed using intra- and cross-interview analyses. Initial analyses identified the central themes within each transcript. The first and third authors then analysed the data across transcripts, breaking each into units of meaning comprised of single or grouped phrases and sentences. This was undertaken independently with as little interpretation as possible in order to preserve the integrity of participants' meanings.

The analysis identified a number of recurring themes exhibiting internal consistency and distinction²¹. Comments that differed from the majority informed the researchers of issues otherwise not identified or differently interpreted. Interpretation was aided by reference to the research literature. The emergent themes were also examined by sector and sub-region to identify any variation in patterns within the region.

Results

Twenty-eight potential informants were identified and considered to be representative of management and clinical

leadership of mental health service providers in the region. Two people declined to be interviewed as they did not consider they had sufficient background and understanding of the issues to contribute meaningfully. The remaining 26 informants (seven male and 19 female) were interviewed, included representatives from the clinical mental health service, Psychiatric Disability Rehabilitation And Support Services, community health, Divisions of General Practice, small rural health services, non-government agencies, professional groups (eg Australian Psychological Society, Australian Association of Social Workers) and private practitioners from the region. Informants included nurses, psychiatrists, medical practitioners, social workers, psychologists and administrators who had between 10 and 30 years experience in mental health and/or the Gippsland region.

The 10 themes that emerged from the data (Table 3), were aggregated at a higher level as factors external or internal to the organisation. The data indicated that while recruitment, retention and training are conceptually distinct, they are also intertwined (eg training is a significant factor in both recruitment and retention). The weight of commentary that led to the emergence of each theme is indicated by the number of 'units of meaning' that contributed to it, with the value suggestive of a crude hierarchy of importance and urgency (the authors acknowledge the philosophical tension in this position and use it with circumspection).

Themes external to the organization

Pool of available workers: The 'pool of available workers' refers to the need for reform of the regulatory, industrial and training environment to increase the pool of available workers. Participants advocated reform to address shortages such as the development of nurse practitioners, enhancement of the role of Division 2 nurses and the restructuring of basic nurse training to better prepare them for mental health care and increase the pool of suitably trained potential workers. They also proposed the creation of links with potential recruits through the regional GP training program and development of traineeships for allied health assistants.



Table 3: External and internal themes according to recruitment, retention and training solutions

Themes		Solutions		
		Recruitment	Retention	Training
External	Pool of available workers	32	19	–
	Intersectoral collaboration	26	36	35
	Cross-sectoral linkages	7	4	10
	Flexible funding	3	2	1
	Educational principles: curriculum/pedagogy	–	–	35
Internal	Promotion of area and organisation	42	6	–
	Adaptability to individual and community needs	40	19	–
	Leadership and management	24	73	8
	Quality of organisational structures and cultures	5	5	9
	Model of care	4	2	–
Total		183	166	98

The second theme, that of inter-sectoral collaboration, links to the issue of the pool of available workers, with a number of participants suggesting that enabling ‘secondment opportunities’ and rotations across positions in the region would create career pathways within the region, while ‘sister relationships’ with metropolitan services would create new training and professional development opportunities.

Inter-sectoral collaboration: Cross-agency collaboration was highlighted as a core means to address training and professional development needs as well as issues of retention. Several participants identified the need to ‘improve communication between agencies’ by ‘exchanging’ and ‘sharing’ relevant information and resources. Organisations that had established ‘joint positions with universities’ and/or ‘connections’ with research agencies advocated the benefits of this approach. Other suggested mechanisms to improve retention include working together ‘in a co-ordinated way’ with ‘a common language and complementary treatment programs’, developing ‘streamlined referral pathways that everyone is aware of’ and ‘co-location with other health services’ to ‘build networks and relationships and reduce isolation’.

A number of participants advocated for ‘joint training, secondment opportunities or rotations with other services’, ‘trying to take a more strategic approach to training and

professional development’ and adopting an ‘area based planning approach’ based on ‘identified local needs’. Some suggested that a regional structure, perhaps similar to the Gippsland Mental Health Alliance (a 2006 Victorian Department of Human Services initiative that aimed to provide a ‘more cohesive recovery and rehabilitation mental health system’ through formal partnership arrangements between state funded clinical mental health services and psychiatric disability rehabilitation support services in each area mental health service catchment) could co-ordinate such joint initiatives. The Dual Diagnosis Initiative was highlighted as an exemplar of the mix of organisational initiative and central seeding envisaged in the approach (this initiative was instituted to support the development of better treatment practices and collaborative relationships between drug treatment and mental health services; key activities include the development of local networks, the training, consultation and modelling of good practice through direct clinical intervention, and shared care arrangements).

Cross-sectoral linkages: The term ‘cross-sectoral linkages’ relates to establishing linkages with external organisations, bodies and sectors. Informants suggested that ‘links to institutions who do basic training of mental health professionals’ and ‘links to research and academia’ would increase the exposure and appeal of organisations. Others suggested that ‘access to support networks’ (eg the East



Gippsland Counsellors Network and the Australian Psychological Society) was important. Also suggested was that 'strong networking and linkages with other sectors, for example Child Protection and Department of Education and Early Childhood Development' could help in retaining geographically isolated workers. It was widely thought that social networks have a similarly beneficial effect on attracting new graduates to move into the region.

Flexible funding: A participant highlighted the benefit of flexible funding, 'we're also an MPS ...which means we have flexible money, which means we can respond' creatively to recruitment and retention issues. Another informant advocated that 'flexibility in relation to targets' would provide greater capacity to support staff gain access to training and professional development.

Educational principles – curriculum/pedagogy: The two most commonly proposed training solutions were the need for inter-sectoral collaboration and use of innovative educational principles. Collaboration with other agencies was seen as a critical means of combining resources and bringing trainees together, thereby reducing the need for travelling long distances for training in Melbourne. The use of innovative educational curriculum and pedagogical techniques, including applied learning approaches such as scenarios and interactive 'second life' programs, were recommended as ways to make learning engaging and effective. 'Online learning and new technology' such as video-conferencing were suggested as ways of 'overcoming the tyranny of distance [and] ... the barrier of the generation gap'. However it was made clear that training had to be relevant to current practice, complement current models of service delivery, and be evidence-based.

Themes internal to the organization

Promotion of the area and organisation: Informants stressed the importance of the promotion of region and organisation to improve recruitment. They reported that many organisations currently did this by providing support for short- and long-term accommodation and making use of

available rural incentive programs. One participant indicated that their organisation had:

...developed a DVD that sells the area, you know, the beauty of it, sells the health facility, takes you through, shows you that it's a nice clean, well equipped, friendly facility and with the doctors we have our financial package that we can offer them.

Others suggested that recruitment can be enhanced by highlighting the organisations profile: '...we were able to offer staff this really exciting way of working' and 'we...talk about the models of service we deliver'. An informant emphasised the need for agencies to 'become learning organisations which [are] committed to career development'. The exposure of students to rural practice through placements was regarded as similarly important in organisations' recruitment and retention strategies. It was suggested that program areas such as child and adolescent mental health services would benefit from highlighting the career opportunities that these areas offer.

Adaptability to individual and community need: A core component of management practice found to be favourable to recruitment and retention has been the development of structures and processes that foster organisational adaptability to accommodate each (current and potential) employee's specific circumstances and characteristics. Such responsiveness has included flexible working arrangements in terms of 'hours of work, job share and part-time positions' and offering the '48/52' option (in some Australian industrial awards staff can exchange salary for an additional 4 weeks annual leave, while retaining their full rights and entitlements). Several managers spoke of the need to make appointments based upon a very clear idea of the 'profile of the person that would live in places like this', and of applicants' personal attributes – their 'interpersonal skills, attitude, motivation, communication skills and fit with where the organisation is heading' – rather than being tightly constrained by 'the right professional background'. They also spoke of their use of unorthodox recruitment methods



such as 'head hunting', using the recruitment process to 'engage' the potential recruits, the use of recruitment agencies and, to reach younger workers, using the internet. A number suggested that exit interviews should be a key component of a planned approach, although this approach 'takes more effort... [it] is worthwhile because in the end you're not recruiting as often'.

Participants suggested the importance of a carefully structured approach to the support of particular cohorts of workers, in the form of targeted orientation and induction programs, social support (eg for young professionals) and essential training for those who lack qualifications or experience. This approach extends to the adaptation of routine practice to attract specific professional groups, as one organisation did by extending its model of care to attract more nurses. By modifying role expectations to suit the skills and experience of one cohort of workers, the organisation became the local employer of choice, while also retaining the services of older staff who found change difficult. Participants also said that organisations must adapt to meet the needs of the community in which they work. In one instance, a large sub-regional provider and a much smaller service in a remote hinterland community had developed and jointly funded an arrangement in which the larger service provides regular outreach psychological services to the smaller.

Leadership and management: Leadership and management were indicated as crucial in the implementation of the above strategies. It was suggested that high quality managers clearly outlined roles and expectations through orientation/induction programs and provided access to accredited training and/or professional development programs. One manager said:

...actually make people who come and work here feel as though they are getting something value-added...they're learning stuff, they're getting better, they feel supported, they feel...encouraged, empowered and able...to really progress in their professional development.

The importance of 'linking the aims and goals of personal professional development plans to core competencies and mental health workforce standards' was emphasised by another participant. One organisation has 'a strategic plan' with 'a whole section which is called *supporting our people*'. In this and other instances, managerial leadership was highlighted, with a key element being the ability to continue supporting change in the face of the difficulties. Consistent with this theme, one organisation has implemented a 'leadership training program' for managers.

The quality of organisational structures and cultures: Participants from the larger organisations highlighted the importance of mental health program representation on senior organisational administrative bodies. A respondent suggested that 'management structures can hinder or enable recruitment and retention'. Another participant suggested that regional program providers should 'ensure' that operational governance structures and administrative processes 'engender a sense of team' so 'that staff do not feel isolated' and thereby avoid problems of retaining staff. Several participants suggested that a 'centralised system' is a 'more efficient' way to coordinate recruitment, traineeships and training.

Model of care: A small number of participants indicated that implementing an evidence-based model of care influences recruitment and retention. One informant indicated that this involves 'delivering an intervention or interventions...based in evidence and validated by research'. Another suggested that 'implementing evidence based models of treatment and support' contributes to the retention of current staff and recruitment of new staff.

Discussion

The interviewed Gippsland mental health leaders made a clear distinction between workforce solutions that were internal and external to the service that they represented. This distinction focused on the difference between factors under their influence and others that were out of their



control. This is an important distinction not found in the literature. It demonstrates the complexity of the issue that those in leadership positions face as they struggle to recruit and retain staff while also meeting service needs. It also highlights the important role leadership has in developing organisational attributes that promote the area and organisation to prospective employees, and also the critical need for leaders to be able to collaborate with other organisations and sectors.

The workforce literature rarely mentions the centrality of such management and organisational structures and cultures to rural and remote health organisations' ability to attract and retain employees. However, this study found them to be vitally important. Management flexibility is necessary so organisations can adapt to meet the personal and professional needs and aspirations of current and potential employees and their families. Rural mental health services have to aspire to become employers of choice, which includes providing information and incentives, individualising induction programs, and accommodating the practice preferences of different generational cohorts and needs in different localities²².

This organisational adaptability extends to building collaborative relationships with other organisations, establishing linkages with training, and research institutions, and forging links to local professional and social support networks. These approaches help enhance the support of trainee and student placements, tailor mentorship²³ and preceptorship arrangements to meet individual needs²⁴, and facilitate access to ongoing professional development. This approach to collaboration and intersectoral partnership is best represented in the implementation of the Victorian Dual Diagnosis Initiative in Gippsland.

The benefits of such a progressive and innovative management approach is demonstrated by organisations in Gippsland who successfully manage workforce recruitment and retention, and is a key to building and maintaining an effective and sustainable mental health workforce in the region. If well organised and well supported¹⁴, such human

resource management has been found to enhance organisational stability and productivity by retaining interested and productive employees and building the organisation's capacity to meet the needs of clients and local communities^{3,4}. The exposure of students and registrars to rural practice has been found to have similar outcomes²⁵, and exposure to an intensive course on psychiatry has been found to influence students' decisions to undertake psychiatric residency programs²⁶.

The findings of this study both support previous research and contribute to the existing knowledge base. Previous literature from the perspective of workers highlights that agencies must be flexible in recognising personal and family needs when recruiting personnel^{4,5,9}. This finding also supports the studies by Glassen et al¹⁸ who found that US rural hospital CEOs believed communities need to be supportive of families (eg providing good schools, being 'family friendly'). The present study findings and previous literature illustrate the importance of considering the individual applicant and their family in recruitment strategies, thereby ensuring that the location is attractive to the prospective employee.

Conclusion

The solutions explored in this paper highlight the creative way in which managers of mental health organisations in Gippsland are responding to the workforce recruitment and retention challenges they face. These solutions also indicate possible future regional strategies that can be expected to address the ongoing shortage of mental health workforce in Gippsland. While this study adds a new perspective to the mental health workforce literature through the reflections of managers grounded in their day to day work, it also highlights the paucity of evidence regarding effective approaches to dealing with rural mental health workforce shortages. It is important therefore that further consideration be given to implementing and evaluating evidence-informed mental health workforce development strategies, and linking



local regional strategies to State and National mental health workforce strategies.

References

1. Department of Human Services. *Aboriginal statistical profiles: statistics collected by local government area on the Aboriginal population of Gippsland*. (Online) 2008. Available: http://www.dhs.vic.gov.au/__data/assets/pdf_file/0006/383910/GS103.pdf (Accessed 11 October 2010).
2. Victorian Department of Planning and Community Development. *Population trends and the Gippsland region*. (Online) 2008. Available: http://www.dpcd.vic.gov.au/__data/assets/pdf_file/0016/32164/RegionalForums_Gippsland_Traralgon_1_47.pdf (Accessed 15 December 2010).
3. Eley D, Young L, Shrapnel M. Rural temperament and character: a new perspective on retention of rural doctors. *Australian Journal of Rural Health* 2008; **16(1)**: 12-22.
4. Perkins D, Larsen K, Lyle D, Burns P. Securing and retaining a mental health workforce in Far Western New South Wales. *Australian Journal of Rural Health* 2007; **15(2)**: 94-98.
5. Lau T, Kumar S, Robinson E. New Zealand's psychiatrist workforce: profile, recruitment and retention. *Australian and New Zealand Journal of Psychiatry* 2004; **38(7)**: 547-553.
6. Meyer D. Technology, job satisfaction, and retention: rural mental health practitioners. *Journal of Rural Health* 2006; **22(2)**: 158-163.
7. Gibb H, Livesey L, Zyla W. At 3 am who the hell do you call? Case management issues in sole practice as a rural community mental health nurse. *Australasian Psychiatry* 2003; **11(Suppl1)**: S127-S30.
8. Eley RM, Baker PG. Rural and remote health research: key issues for health providers in southern Queensland. *Australian Journal of Rural Health* 2007; **15(6)**: 368-372.
9. Roger AR, Andrilla CHA, Thomas C, Hart LG. Shortages of medical personnel at community health centers: implications for planned expansion. *JAMA* 2006; **295(9)**: 1042.
10. Gardiner M, Sexton R, Durbridge M, Garrard K. The role of psychological well-being in retaining rural general practitioners. *Australian Journal of Rural Health* 2005; **13(3)**: 149-155.
11. Hodgins G, Murray G, Donoghue A, Judd F, Petts A, Hodgins G et al. Introducing a professional development programme to a rural area mental health service: the importance of context. *Australasian Psychiatry* 2004; **12(2)**: 153-160.
12. Grobler L, Marais BJ, Mabunda SA, Marindi PN, Reuter H, Volmink J et al. Interventions for increasing the proportion of health professionals practising in rural and other underserved areas. *Cochrane Database of Systematic Reviews* 2009; **(1)**: CD005314.
13. Wilson NW, Couper ID, De Vries E, Reid S, Fish T, Marais BJ et al. A critical review of interventions to redress the inequitable distribution of healthcare professionals to rural and remote areas. *Rural Remote Health* **9(2)**: 1060. (Online) 2009. Available: www.rrh.org.au (Accessed 11 October 2010).
14. Lea J, Cruickshank M, Paliadelis P, Parmenter G, Sanderson H, Thornberry P. The lure of the bush: do rural placements influence student nurses to seek employment in rural settings? *Collegian* 2008; **15(2)**: 77-82.
15. Ranmuthugala G, Humphreys J, Solarsh B, Walters L, Worley P, Wakerman J et al. Where is the evidence that rural exposure increases uptake of rural medical practice? *Australian Journal of Rural Health* 2007; **15(5)**: 285-288.
16. Rabinowitz HK, Diamond JJ, Markham FW, Wortman JR. Medical school programs to increase the rural physician supply: a systematic review and projected impact of widespread replication. *Academic Medicine* 2008; **83(3)**: 235-243.



17. Stagg P, Greenhill J, Worley PS. A new model to understand the career choice and practice location decisions of medical graduates. *Rural and Remote Health* **9(4)**: 1245. (Online) 2009. Available: www.rrh.org.au (Accessed 11 October 2010).
18. Glassen M, Peters K, MacDowell M. Rural Illinois hospital chief executive officers' perceptions of provider shortages and issues in rural recruitment and retention. *Journal of Rural Health* 2006; **22(1)**: 59-62.
19. MacDowell M, Glasser M, Fitts M, Fratzke M, Peters K. Perspectives on rural health workforce issues: Illinois-Arkansas comparison. *Journal of Rural Health* 2009; **25(2)**: 135-140.
20. Lincoln Y, Guba E. *Naturalistic inquiry*. London: Sage, 1985.
21. Marshall C, Rossman G. *Designing qualitative research*, 3rd edn. Thousand Oaks, CA: Sage, 1999.
22. Hart LG, Salsberg E, Phillips DM, Lishner DM. Rural health care providers in the United States. *Journal of Rural Health* 2002; **18(Suppl)**: 211-232.
23. Mills J, Francis K, Bonner A. Live my work: rural nurses and their multiple perspectives of self. *Journal of Advanced Nursing* 2007; **59(6)**: 583-590.
24. Cleary M, Happell B. Promoting a sustainable mental health nursing workforce: an evaluation of a transition mental health nursing programme. *International Journal of Mental Health Nursing* 2005; **14(2)**: 109-116.
25. Hodges B, Rubin A, Cooke RG, Parker S, Adlaf E, Hodges B et al. Factors predicting practice location and outreach consultation among University of Toronto psychiatry graduates. *Canadian Journal of Psychiatry* 2006; **51(4)**: 218-225.
26. Lofchy J, Brunet A, Silver I. The psychiatry institute for medical students: a novel recruitment strategy. *Academic Psychiatry* 1999; **23(3)**: 151-156.
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