

# **GP and hospital mental health care integration issues in rural and remote South Australia**



## **Summary of findings**

## **Australian Rural Health Education Network**

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## **ACRONYMS**

ABS	Australian Bureau of Statistics
AHW	Aboriginal health worker
A&E	Accident and Emergency
AIHW	Australian Institute of Health and Welfare
ARHEN	Australian Rural Health Education Network
CMHN	Community mental health nurse
CMHW	Community mental health worker
DoHA	Australian Government Department of Health and Ageing
EBM	Evidence-based medicine
ETLS	Emergency Triage and Liaison Service
GP	General Practitioner
GPHIRRA	General Practice Hospital Integration in Rural and Remote Australia project
MHHLN	Mental Health Hospital Liaison Nurse
MSOAP	Medical Specialist Outreach Assistance Program
PATS	Patient Assistance Transport Scheme
PMHC	Primary Mental Health Care
RFDS	Royal Flying Doctor Service
RRMHS	Rural and Remote Mental Health Service
RAH	Royal Adelaide Hospital
SGRHS	Spencer Gulf Rural Health School
SA	South Australia

## **EXECUTIVE SUMMARY**

This report presents a summary of the 'General Practice and Hospital Mental Health Care Integration Issues in Rural and Remote South Australia' project. This study examines the issues associated with the transfer of people who live in rural, regional and remote South Australia (SA) to Adelaide to obtain acute mental health care. The findings supplement those of the General Practice Hospital Integration in Rural and Remote Australia (GPHIRRA) study. They also inform the development of an evidence-base to underpin the provision of integrated mental health care in rural and remote locations in Australia.

### **Literature review**

Although the policy and demographic context is quite different there appear to be similar issues around the provision of mental health services in rural and remote areas in the UK, United States, and Australia. A literature review identified that the following themes were evident in the UK, the United States and Australia:

- The lack of a skilled mental health workforce to deliver services in rural and remote areas;
- Issues with the availability and accessibility of mental health services; and
- The acceptability of mental health services to rural dwellers.

While this study found evidence of these themes, it discovered that the rural mental health workforce in country SA was focused on adapting and adjusting services to fit consumer's needs. Specialist mental health care was often accessed through Telemed<sup>a</sup>. However, pathways to care for rural residents in our study were consistent with those reported in the UK, United States and Australia where care can be conceptualized as being delivered by a three tier system. First level care includes the support volunteered by families and friends; second level care consists of local primary care and community organisations, and the third level consists of specific formal mental health services.

Consistent with the international literature, our study found that both consumers and primary care workers perceived that there is a stigma associated with disclosing a mental illness in rural and remote communities. The solutions to overcome problems with mental health service provision in rural and remote locations include:

- The use of Telemed;
- Treatment for serious conditions in the home community
- The utilisation of 'lay' and informal care systems; and
- Assessing community strengths to provide non-medicalised mental health care.

### **Method**

Six case studies of transitions of mental health care in rural, regional and remote communities in SA were undertaken. A case was defined as the system of care, encompassing all formal

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<sup>a</sup> The term Telemed is used to refer to the practice of health care delivery, diagnosis, consultation, treatment, assessment and discharge planning between metropolitan and country practitioners using telecommunications (2)

and informal service and support systems available in the community. Case studies were conducted in two regional centres (RRMA 3), three remote locations (RRMA 7), and a small rural town (RRMA 5)<sup>b</sup>. All of these locations were at least a three hour drive from Adelaide. Interviews with consumers and primary care workers were undertaken in these locations. In addition, interviews were conducted with metropolitan hospital staff where acute mental health care is provided. Key stakeholders knowledgeable about transfers were also interviewed. Finally, a workshop, to present and discuss the findings of the study, was held in Adelaide in May 2005 (Appendix 1).

### ***Summary findings***

Findings are presented under the following headings:

- Consumer perspectives;
- What is working well to integrate primary, secondary, and tertiary mental health care in SA;
- Staying in the home community longer for mental health care;
- Issues for Aboriginal and Torres Strait Islander people, and
- Improved transitions of care including transport.

#### *Consumer perspectives*

We found that overall the six consumers interviewed were satisfied with their acute mental health care and transfer. They were happy with the transport arrangements to Adelaide although transfer back to their community by bus was not their preferred option. Maintaining contact with family and friends by telephone and carers being able to accompany the consumer and stay in Adelaide with them was highly valued. In some cases, consumers were unhappy with the uncertain pathway into acute mental health care with long waits at the metropolitan hospital where the consumer entered the system.

#### *What is working well in SA*

Our study found that there were some approaches to the integration of mental health care between the primary, secondary and tertiary sectors in SA that work well for consumers located in rural remote and regional communities. Elements of 'rural primary care psychiatry' are well established in SA and are focused around the Rural and Remote Mental Health Service (RRMHS). This approach results in coordinated care at different levels of the mental health care system, up-skills local providers, and may result in more effective transitions of care. Specialists, working in a tertiary setting provide acute in-patient care, but they ensure overall continuity of care for consumers through working relationships with local key workers. These relationships provide support, information, and consultation with primary care providers (general practitioners [GPs], community mental health providers, nurses and non-government organisations) in the home location. Telemed is used for consultations, assessment and review of consumers, and for ongoing specialist treatment in association with the local GP

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<sup>b</sup> The Rural Remote and Metropolitan Areas (RRMA) classification is used in this report to describe rurality. In this report RRMA 1-2 is a metropolitan area, RRMA 3 is a regional area, RRMA 4 is a rural area, RRMA 5 is a small rural area and RRMA 6-7 is a remote area ( 1)

and other team members. In addition there is a 24 hour Emergency Triage and Liaison Service which was well used and highly valued by locally based staff.

However, not all country consumers access this approach in SA. Entry to the metropolitan acute mental health system is firstly to a metropolitan hospital for medical review. If an urgent mental health admission is required and no beds are available at RRMHS then the person is admitted to whatever bed can be accessed in another acute metropolitan hospital. Travelling to Adelaide is the only option for those who are detained as beds are only approved in metropolitan hospitals. Metropolitan and rural mental health care providers suggested systems improvements, such as streamlining and reducing the numbers of entry points into the system.

#### *Staying in the home community longer for mental health care*

Some creative options are available in SA that may enable people to stay in their communities for longer periods. These include dedicated mental health beds in the local hospital and specific mental health liaison staff. Using country hospitals as a transitional point of care for people prior to admission and after discharge from a metropolitan treatment facility were highly valued by both consumers and rural mental health care workers, although this approach requires increased resources. In some situations this 'step down' arrangement has worked well for consumers who wish to return to their community but have not had time to fully recover.

The RRMHS discharge planning process was highly regarded in that it provided opportunities for consultation with GPs, and primary care workers, often using Telemed, prior to the consumer's discharge. A discharge summary, with follow up information, was always provided to the GP and to the key worker. GPs and mental health care workers thought that there were very few instances (if any) where communication between the RRMHS and themselves had left them unaware of plans for consumer's discharge. However the process does not work as smoothly with other metropolitan hospitals and it was reported that it may be difficult to access discharge summaries.

GPs or mental health care workers as case managers were seen to be responsible for the coordination of mental health care overall. However there were participants who thought the consumer themselves is also responsible. Several consumers recognised what made them well and unwell and had a strong desire to be more involved in the management of their illness. Study participants thought that one way to achieve this was through effective care planning and having care plans available to team members with the consumer's consent. Care planning tools are available in SA but some study participants were unconvinced that care planning was being used to give consumers a voice in their care.

#### *Aboriginal and Torres Strait Islander consumers*

The views about whether or not there were particular problems for Aboriginal or Torres Strait Islander consumers were varied. Some non-Aboriginal care providers who were operating primarily in hospitals thought that there were no particular issues for Aboriginal consumers. However, others, who were familiar with some contexts in which Aboriginal people live, were aware of two over-riding issues. Aboriginal people function within a kinship network and many of the issues were about the need for integration, from the consumer perspective, between the home community, family and friends, and the metropolitan hospital environment. Secondly, it was thought that there was only an embryonic understanding of how to integrate the frameworks of Ngangkari Tjuta (traditional healers) and socio-emotional wellbeing with the western medical model. There are views that these models are currently simply overlaid rather than there existing a really good understanding of how and where they might more effectively blend.

#### *Improving transitions of care*

Effective transitions of care for consumers between the primary, secondary, and tertiary sector were a particularly problematic aspect of mental health care according to the majority of study participants. So much so, that on occasions GPs and mental health workers avoided transfer when possible. One problem is that some GPs are inexperienced in detaining patients, and they may be unable to obtain clarity about the type of mental health care that will be available once the consumer reaches Adelaide. Transfers are costly and may involve out of pocket expenses for consumers, their carers and their families. In some rural communities, informal supports are available to help care for children and continue farming activities; however these supports may not always be available. Financial assistance for transport for voluntary consumers was sometimes paid retrospectively and this in some cases imposed hardship.

#### *Transport*

In some instances transport was reported to work well, especially in centres where there was a commitment from police, ambulance, and RFDS to work together to overcome obstacles. However, even when people co-operated, achieving coordination between services, having timely transfers and avoiding down-time for staff, there are persistent problems. The delays in transportation may be unavoidable due to weather conditions, staff availability, or RFDS emergencies. However the burden placed on those caring for the consumer who has been detained, usually police, the GP, and the local hospital staff, is considerable. Maintaining an appropriate level of sedation for the consumer is difficult and there is down time for the police, hospital staff, and the GP.

#### ***Implications for integration of mental health care***

There are findings from this about the factors that assist the integration of mental health care that are relevant nationally. These are:

- Keeping people in their home community longer
- Evidence- based rural primary care psychiatry

- Better program integration
- Community capacity building for mental health

Local approaches in the case study sites keeping people in their 'home community' for longer periods were generally highly regarded. Keeping people at home for longer periods will require improved infrastructure at the local hospital and staff (both within and external to the community) who are comfortable with the approach. Creating better knowledge of the services available in local communities comes about through effective liaison mechanisms and these require personnel. The evidence-base about at home treatment for serious mental illness needs to be accessed and developed and national leadership is required, for example through the National Institute for Clinical Studies in order to achieve this..

'Rural primary care psychiatry' is of importance nationally because it is an approach that demonstrates how effective integration of the tertiary, secondary and primary sectors may occur. In SA the approach is embedded systemically using Telemed and an Emergency Triage and Liaison Service for advice, consultation and review, and collaborative discharge planning. However, rural primary care psychiatry needs to be promoted and strengthened nationally, through the development of an evidence-base to demonstrate its efficacy. Strong leadership through the PARC (Primary Mental Health Care Australian Resource Centre) and through the Royal Australian and New Zealand College of Psychiatry in implementing the rural primary care psychiatry approach is warranted.

Increasing awareness of the relevant DoHA programs and initiatives will assist in integrating the acute mental health sector with primary care in rural and remote communities. For example, if psychiatrists who are providing outreach consultations using the MSOAP program are using the rural primary care psychiatry approach, then consultation with local GPs and other primary care workers will occur. The Divisions of General practice state based organisations, rural Divisions of General Practice, and the state based DoHA officers should be involved in increasing awareness. Incentives, such as the item numbers available through the Medical Benefits Scheme, are already in place.

In Australia generally, a community capacity building approach is essential if there are to be improvements in rural and remote communities' awareness of, and capacity to cope with, mental health issues. At the local level reducing the stigma of mental illness in rural and remote communities will involve partnerships and skilled leadership from local community development organisations, regional and local government, Divisions of General Practice, and the primary care sector.

Community capacity building involves developing the infrastructure and resources, access to information, networking and partnerships, and external links relevant to the particular topic. There are numbers of community capacity building initiatives occurring funded by different government departments at both the state and Commonwealth level. In SA, for example, Primary Industries and Resources SA, has worked with the UniSA Whyalla campus to

develop a web based community capacity audit. This audit, designed for rural communities to assist socio-economic development, audits all sectors including health. The co-ordination and dissemination of the variety of community capacity building initiatives already in place requires leadership and coordination by a 'lead government agency' nationally.

## **1. INTRODUCTION**

The Australian Government Department of Health and Ageing commissioned an Australia-wide study of the integration of services for people from small rural and remote communities who have to travel to larger regional and metropolitan hospitals for the acute medical care – the General Practice/Hospital Integration in Rural and Remote Australia project (GPHIRRA). This summary report presents the findings of a smaller, adjunct study also commissioned by the Department of Health and Ageing specifically examining the integration of mental health care between rural, regional and remote locations and metropolitan hospitals in SA. While the commissioned project is called General Practice and Hospital Mental Health Care Integration it is equally concerned with integration between hospitals and non general practitioner (GP) primary care providers, including community mental health nurses and Aboriginal health workers. This study, using a consumer<sup>c</sup>-centric approach, replicated the method of the GPHIRRA.

### **1.1. The context of mental health care in rural and remote SA**

South Australia has 26% of its population outside Adelaide<sup>3</sup>. While this figure is not dissimilar to Australia as a whole with 30% of the population outside capital cities, it is the settlement pattern of SA that is different<sup>4</sup>. There are no regional centres<sup>d</sup> in SA with a population greater than 25,000. Rather the predominant pattern is scattered settlement in small towns with populations of up to 3,000. The geography of the state is such that the populations of these small dispersed centres rely on road travel either to Adelaide or to the nearest centre that has commercial flights. There are no commercial flights between SA regional centres without first flying to Adelaide.

This settlement pattern has led to the perception that SA is a city state, with the population outside Adelaide being referred to as 'the country'. Specialist mental health service delivery, with some exceptions<sup>e</sup>, historically has been located in the city. Currently there are no approved treatment centres for detained patients outside of Adelaide, although there are dedicated mental health beds in several regional centres, regional mental health coordinators, mental health hospital liaison nurses in hospitals in some settings, and, in one setting, a staff consultant in psychiatry who is regionally located. For detained people, and those who cannot be managed in their country town, transfer to the city is the only option.

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<sup>c</sup> In this report the term consumer is used in preference to patient or client.

<sup>d</sup> A regional centre is one that sustains administrative and service structures for a surrounding defined geographical area

<sup>e</sup> For some years a psychiatrist was located in Port Lincoln.

The mental health service system in SA is complex. SA has seven country health regions providing the full range of health services including mental health to consumers living in rural, remote and regional areas of the state. The Rural & Remote Mental Health Service (RRMHS), located within a separate administrative structure, and part of a larger campus, is the primary provider of acute mental health specialist services, directly and indirectly, to people living in rural and remote areas of SA <sup>5</sup>. The service is metropolitan based and does not structurally include GPs, rather it relies working together with GPs and other primary care professionals to achieve positive consumer outcomes under the 'primary care psychiatry' <sup>6</sup> model. It provides acute inpatient services, a Telemedicine and Telepsychiatry service and an emergency triage and liaison service that can be accessed in all rural and remote SA. This service was highly valued by all participants in this study and this finding is consistent with previous research <sup>7</sup>.

Metropolitan hospitals admit detained and voluntary consumers with acute mental illness from the country both for assessment and treatment. While the RRMHS acts as the 'front end' of the pathway into mental health care for rural and remote consumers, it does not provide all the care. Pathways are driven by bed availability. If an urgent mental health admission is required and no beds are available at the RRMHS then the person is admitted to whatever bed can be accessed in another acute metropolitan hospital.

In summary, there are features of the geography and settlement patterns in SA that have impacted upon the way mental health care has been provided. The service system is complex and integration of services and transitions of care between rural and remote locations and metropolitan hospitals is problematic. While this study is focused in SA, there are unique service responses assisting transitions of care for rural and remote residents seeking acute mental health care that may have national significance. These findings complement those of the GPHIRRA study and inform the development of an evidence-base to underpin the provision of integrated mental health care in rural and remote locations in Australia.

## **2. PROJECT METHOD**

The study included:

- A comprehensive Australian and international literature review about mental health care integration;
- Case studies of mental health care integration in six rural, remote, and regional locations in SA, including a consumer perspective;
- Interviews with metropolitan hospital staff;
- Interviews with key stakeholders knowledgeable about transfers and rural/remote mental health care integration, and

- Interviews with Aboriginal people knowledgeable about both Aboriginal socio-emotional wellbeing and the integration of mental health care for Aboriginal and Torres Strait Islander people.
- A workshop for key stakeholders and those who had participated in the study to discuss phase 1 findings, identify gaps, and alternative perspectives.

The case was defined as: a consumer participant, the 'home community' – the rural/remote location from which they were admitted, the mental health care system available in the 'home community', and the people in the 'home community' who were knowledgeable about integration issues and patient transfers to Adelaide. Consumers were selected by the RRMHS who wrote to those people who had been discharged between October 2004 and March 2005 and invited their participation.

Metropolitan hospital staff who provided acute in-patient care were also interviewed in addition to key stakeholders who were considered knowledgeable about the system of transfers for country people when they required acute mental health care. A workshop was held in Adelaide on May 17<sup>th</sup> 2005 to discuss phase 1 findings with key stakeholders and study participants.

Interviews were conducted using a semi-structured interview schedule, transcribed, and analysed for emergent themes. Six consumers were interviewed, 21 rural mental health care providers, 7 metropolitan hospital providers, and 8 key stakeholders. In addition, 22 people attended a workshop in Adelaide. The study received ethics approval from the University of SA Human Research Ethics Committee and the Aboriginal Health Council of SA.

### **3. SUMMARY FINDINGS**

The findings of this study will be presented using a similar framework to that used in the main GP/Hospital Integration study:

- Consumer perspectives of key issues in transitions of care: traveling to and from Adelaide for acute mental health care
- Practice perspectives - Issues in integration of acute mental health care in Adelaide with primary care for people living in country SA
- Enabling consumers to stay in their community for mental health care
- Mental health integration issues for Aboriginal and Torres Strait Islander people
- Better transfers for acute mental health care for country consumers

#### **3.1 Consumer perspectives**

Our study included consumer interviews to obtain key issues involved in having to travel from their communities to Adelaide for acute mental health care. We found that overall the six consumers interviewed were satisfied with their care and transfer. However, we are aware

that the consumers interviewed were self selected and as such their views cannot be generalised to the consumer group as a whole.

### **3.1.1 Consumer vignettes** (pseudonyms are used)

#### **Karen**

Karen is a woman in her twenties, who lives with her husband and two young children on a farm about thirty minutes drive from the nearest town. Karen had been depressed and prior to her admission had been seeing a visiting psychiatrist who had prescribed medication. However, her depression continued to escalate and Karen felt she could no longer carry on. She contacted an Aunt, a nurse at the local hospital, who helped organize her admission there. Subsequently, she voluntarily flew to Adelaide and spent three weeks at the RRMHS and then spent a few days in her local hospital. Karen had follow-up appointments with a psychiatrist via teleconference arranged. She also regularly sees a local CMHW.

#### **Serge**

Serge is an unemployed Aboriginal man in his early twenties, who lives in a regional city, several hundred kilometers from the state capital. Serge had been having symptoms of anxiety and depression and was being treated by a local GP. He was not particularly compliant with his medication regimen, however. While on a visit to Adelaide, Serge was alarmed by his symptoms and presented at the accident and emergency department of a major teaching hospital. He spent approximately four weeks in hospital. Before he was discharged, follow-up care was arranged in his local community with a General Practitioner and a CMHW. He is currently taking his medication, but does not like its side-effects.

#### **Mandy**

Mandy is a woman in her late thirties who lives with her husband and two children, in an isolated community about seven hundred kilometers from Adelaide. Mandy's condition is a long standing one that usually does not disrupt her life. Until recently, Mandy refused to see her local GP. She felt they did not understand or respond well to her condition and she preferred to drive three hundred kilometers to consult GPs in another town. When Mandy had an acute episode she presented to her local hospital in the early hours of the morning and was sent home and told to return when a doctor was on duty. When she returned she was immediately detained. After transfer to Adelaide, she spent several weeks at RRMHS. Mandy was returned to her community under the care of the Guardianship Board. She has regular appointments with the CMHW and follow-up with a GP.

#### **Kylie**

Kylie is in her early thirties and has had a long-standing mental health problem. She is unemployed and lives in a regional city several hundred kilometers distance from the state capital. Prior to her last admission, Kylie had been seeing a local CMHW regularly. Her family noted that she was becoming increasingly unwell and contacted the police, who took Kylie to the local hospital. She was detained and transferred to Adelaide. Kylie was discharged back to her home under the care of the Guardianship Board. She has had regular appointments with a new CMHW, who she does not feel particularly comfortable with. She has regular, though infrequent, contact with a visiting psychiatrist.

#### **Todd**

Todd is an unemployed man in his late teens. He had been diagnosed with a mental health problem prior to this admission. At that time, he consulted a local GP. He also had contact with a CMHW who was located in a town a bit over an hour's drive away. Todd sometimes drove to see the CMHW; at other times, Todd could see CMHW in his local community during outreach visits.

Todd's mother noticed that his symptoms were becoming more acute and contacted his CMHW, who suggested he see a GP. He was detained and transferred to Adelaide, where he spent three weeks. Since returning to his community, he has had consultations with a psychiatrist via teleconferencing and has regular appointments with his CMHW.

## Bill

Bill is a middle aged man who has a long standing mental health problem. He is married with children and is employed. Bill lives in a small town a few hundred kilometers from Adelaide. When Bill noticed that he was becoming unwell, he could not get an appointment with his GP, or with a CMHW, who is located about one hundred kilometers away. Bill drove himself to Adelaide, where he was admitted to a major tertiary hospital, before being transferred to RRMHS. On discharge, Bill was referred to a CMHW. Bill, however, has not kept the appointments that were made for him, and relocated.

### 3.1.1. Pathways, transport and follow-up care

The following tables present the pathways into and out of acute mental health care for these consumers

Karen	Pathway	Family à à GP/Local Hospital à à Adelaide Hospital à à RRMHS à à Local Hospital à à Home
	Transport	Commercial flight to Adelaide Commercial flight to home community
	Ongoing Care	Initial psychiatric consultation via Telemed Regular appointments with CMHW
Serge	Pathway	Self à à A&E Department Adelaide Hospital à à Home
	Transport	Presented while visiting Adelaide Commercial bus to home community
	Ongoing Care	CMHW General Practitioner
Bill	Pathway	Self à à A&E Department Adelaide Hospital à à RRMHS à à Home
	Transport	Drove own car to Adelaide Drove own car to home community
	Ongoing Care	Referred to: General Practitioner (not kept) CMHW (not kept)

Todd	Pathway	Mother à à CMHW à à GP/Local Hospital à à Adelaide Hospital à à RRMHS à à Home
	Transport	Royal Flying Doctor Service to Adelaide Commercial Bus to home community
	Ongoing Care	CMHW General Practitioner
	Pathway	Friend à à Local Hospital à à Home à à GP/Local Hospital à à Adelaide Hospital à à RRMHS à à Aunt's Home à à Home

Mandy	Transport	Royal Flying Doctor Service to Adelaide Commercial Bus to Aunt's home Own car from Aunt's home to own home
	Ongoing Care	Initial psychiatric consultation via Telemed CMHW General Practitioner
Kylie	Pathway	Family ↔ Police ↔ GP/Local Hospital ↔ Adelaide Hospital ↔ RRMHS ↔ Home
	Transport	Royal Flying Doctor Service to Adelaide Driven by mother back to home community
	Ongoing Care	Initial psychiatry consults via telepsychiatry CMHW General Practitioner

### 3.1.3 Consumer perspectives of care

#### *Satisfaction with transfer and care overall*

Consumers expressed satisfaction with their care. It is important to specify to what this expressed satisfaction refers. Many consumers did offer critical observations of hospital organization and procedures. For instance, some consumers were critical of the attitudes of some nursing staff and felt that the ward environment was not a particularly therapeutic one. However, these comments centred primarily on the environment in which care was delivered and consumers felt that in many instances it applied more to other inpatients than to themselves. They rated the care they themselves received highly and felt that their stay in RRMHS, or, in one instance another tertiary hospital, had benefited them overall.

#### *Discharge planning*

Consumers reported that their discharge planning was highly efficient. All consumers had appointments made for them with appropriate health professionals before they left RRMHS or the other tertiary hospital. In many instances, there were consultations between them, their psychiatrists and the treating team in their local community via Telemed. This boosted consumers' confidence about returning to their community since they knew that local health professionals had up-to-date information about them. They also knew that they would have follow-up contact with local health professionals because appointments were made before discharge.

#### *Telephone contact while in Adelaide*

While in the RRMHS, consumers found it easy to maintain telephone contact with their family and friends. This contact made their hospitalization much easier, provided them with valued support and was a feature of their inpatient stay that they commented favourably on.

#### *Transitional care after discharge*

Two consumers did not return to their homes immediately after discharge. One consumer was discharged back to her local hospital for two days and had some 'staggered' contact with her children before returning home and resuming her full domestic responsibilities. Another consumer spent a few days with a member of her extended family before returning to her husband and children. This small rehabilitation phase was welcomed by both consumers.

#### *Community and family support while in hospital*

Most consumers reported that their families received considerable informal support while they were in hospital. This primarily involved care of children and spouses and help with farm chores.

#### *Waiting time at interim hospital*

Five of the six consumers interviewed were assessed at a tertiary hospital in Adelaide before being transferred to the RRMHS. Almost unanimously, they reported disliking the time they spent there. In many instances, they were kept on stretcher beds in the Accident and Emergency Department and they reported delays in seeing a psychiatrist or psychiatric nurse. They were rarely informed about how long they would have to wait at the assessing hospital and this increased their sense of anxiety.

#### *Bus journeys back to local communities*

With only one exception, consumers reported a strong dislike of this method of transport. They considered it inappropriate for people who have recently had a mental health problem.

#### *Out-of-pocket expenses*

Consumers whose carers had accompanied them to Adelaide and who stayed for the duration of their hospitalization said that they incurred significant out-of-pocket expenses. They were grateful for the PATS contribution to their carer's travel and accommodation. However, it did not meet the cost of accommodation and the other costs carers accrued by being in Adelaide.

#### *Pre-admission information*

A number of consumers reported that they were not given information about what they should and should not bring into hospital with them. This inconvenienced them because they either did not have access to things they needed or because possessions they had bought with them had to be locked away.

### 3.1.4 Case study locations

Brief information is provided about the case study locations and their mental health care services.

#### **Town A**

RRMA 5<sup>1-</sup> A primarily agricultural community (population approximately 2,000 located on an arterial route in the east of the state.

The town has one general practice and a local hospital that provides 27 acute beds and a longer stay wing for aged care. There are no specialist in-patient facilities for people with mental illness. The RRHMS Emergency Triage and Liaison service is well used. The mental health services are provided through fortnightly visits from the regional health services, a two hour drive away. A community welfare worker in the town provides support and undertakes follow up work. There is a church run mental health support group.

#### **Town B**

RRMA 7<sup>-</sup> An industrial community (population approximately 2,000) located in a remote section of the state – 7 hour drive from Adelaide.

The town has one general practice and a local hospital that provides 12 acute beds, with no specialist mental health care in-patient facilities. There is a community mental health nurse 0.5 shared between the town and the regional health services based in a distant location. The RRMHS Emergency Triage and Liaison service is used. There are community health workers who assist with primary mental health care.

#### **Town C**

RRMA 3<sup>-</sup> A regional centre with a population of approximately 12,000 people. It is a service and administrative centre for the surrounding region.

The town has a regional hospital that has 2 dedicated mental health beds and a Mental Health Hospital Liaison Nurse. There are general practice services and a community mental health team. There is also a Clinical Director and a Regional Mental Health Coordinator employed by the Regional Health Services. There is an Aboriginal Community Controlled Health Service that employs GPs.

#### **Town D**

RRMA 7<sup>-</sup> A remote small town (population 250) based around an industry.

The town has one general practice and a local hospital without specialist in-patient facilities for people with mental illness. A community mental health nurse visits from a location a one hour drive away.

#### **Town E**

RRMA 3 - A regional centre (population 14,000) approximately five hours drive from Adelaide.

This location has a regional hospital with 1 dedicated mental health bed and a Mental Health Hospital Liaison Nurse. There are general practice services and a community mental health team and other regional mental health coordination and treatment facilities, including a staff consultant in psychiatry.

#### **Town F**

RRMA 7 C A small, isolated town of about 3,500 people in a remote section of the state.

It has a hospital with acute care beds and longer stay beds for aged care. The town has 4 general practitioners. It also has one resident community mental health worker. In addition, there is a regular visiting psychiatry service. There is a community controlled Aboriginal health service, providing substance misuse and emotional and social well-being services.

### **3.2. Practice perspectives - Issues in integration of acute mental health care in Adelaide with primary care for people living in country SA**

This section identifies some of the facilitators and barriers to integration of mental health care for rural and regional and remote people living in SA, from the perspectives of those working in the field.

#### **3.2.1. A 'rural primary care psychiatry' approach in SA**

In Australian mental health care, the community mental health care systems, the primary care, and tertiary sectors do not regularly interact. While there is much rhetorical emphasis given to the benefits of developing partnerships to bring about more integrated mental health care, in practice they are not routine<sup>8,9</sup>. The second Australian National Mental Health Plan<sup>10</sup> emphasised the need for partnerships to respond effectively to mental health problems and recommended partnerships between:

- Psychiatrists and general practitioners
- Tertiary treatment centres and community-based services, including GPs
- General practitioners and community-based mental health teams
- Community-based mental health teams and other community-based services
- Health services and emergency services (notably police and ambulance officers)

'Rural primary care psychiatry'<sup>11 12 13</sup>, originating in the World Health Organisation primary care movement in the 60s and 70s, is one approach that addresses this need for partnerships. The underlying principle of the approach is to support better system integration between rural primary care providers (GPs, community mental health providers, nurses and non-government organisations), and secondary and tertiary specialist services. Tertiary specialists, when using this approach, ensure overall continuity of care for consumers through working relationships, support, information, and consultation with primary care providers in the location in which the consumer lives.

*The strength of this service [RRMHS] is in its primary care focus. I think in general, the service sees itself as an extension of the local services - we are here to augment those services – to strengthen those local communities by having staff and teams adding to their clinical expertise with a good understanding and intimate knowledge of the regions in which they work - We up-skill rather than de-skill. This is how we see how this service can facilitate and work out a plan that is actually 'do-able'. (Key stakeholder)*

Our study found that elements of rural integrated primary care psychiatry have consolidated and are working well in SA. There are historical, demographical, and geographical factors operating in SA that explain the emergence of the approach. Its success lies partly in the fact that much of the acute mental health care to rural and remote consumers has been coordinated through one service. Other mental health services often juggle the needs of multiple constituencies. The findings about rural primary care psychiatry are important nationally in that they add to the evidence-base about the integration of care between the primary and tertiary sectors which has been an intransigent problem. The following elements have been identified as important to the SA approach.

*Understanding consumers' as people and the contextual elements that affect their mental illness*

*The crucial thing is understanding the individual within the context of their own community – it is their understanding of their situation that is important (Key stakeholder)*

Our study found that to provide effective rural primary care psychiatry<sup>f</sup> for individuals and their families and carers, it was necessary for metropolitan specialists to have an in depth understanding of the particular community in which the consumer lived. This enables consumers to be maintained in the community for as long as possible and discharge planning to be 'do-able'. There was agreement that maintaining this working knowledge of rural communities was challenging even if there were liaison officers in metropolitan hospitals. The further away the community was, the more difficult it was to maintain close links. This finding is consistent with those of the GPHIRRA study<sup>14</sup>.

The RRMHS builds up this community knowledge by maintaining working relationships with GPs, consumers and other primary carers through outreach visits by psychiatrists to Aboriginal communities, the RRMHS Emergency Triage and Liaison service (ETLS), Telemed, and discipline specific face-to-face meetings. Realistic discharge planning occurs

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<sup>f</sup> In this study rural primary care psychiatry is used to include GPs and all primary care workers or other workers in rural communities.

when the RRMHS understands the priorities and the strengths of service providers in the local area. There has been an attempt to strengthen this approach through attaching liaison responsibilities with one ETLs staff member for each of the 7 country health regions.

#### *Working relationships with general practitioners*

The rural primary care psychiatry approach depends on the responsibility for continuum of care remaining in the rural location rather than being transferred to the tertiary facility<sup>11</sup>. All participants in our study confirmed the central role of the GP in coordinating care. However the study found that GPs' interest, capacity and capability in mental health care varied markedly across country SA. This variability in GP services is to be expected given complex demands on GPs time and that they are the first port of call in rural and remote locations for all kinds of emergencies<sup>9</sup>. In some locations GPs had extensive experience and a lifelong commitment to effective mental health care, while in other locations GPs were unfamiliar with the mental health care system and processes for detaining patients.

One consequence of this is that there may be transfers to metropolitan hospitals which are inappropriate. This will result in the consumer not being admitted or being promptly discharged back to the home location. On the other hand, GPs may be reluctant to detain because of inexperience and unfamiliarity with the system. Furthermore, the multiple entry points into the system and the ordeal of transport may mean that some GPs are unwilling to transfer. If the patient is detained, GPs may not be able to control where acute care will be accessed because of uncertainty over bed availability.

According to study participants, a rural primary care psychiatry model would focus on GPs and primary care workers needs and provide the supports required to maintain the consumer in the community where possible. GPs report that they would like to have more on-line information and training about mental health care, possibility for consultations and reviews for consumers, and relevant up to date discharge information. The 'More Specialist Outreach Assistance Program' (MSOAP), funded through the Department of Health and Ageing was reported to have been of value in enabling psychiatrists to visit rural and remote communities. In addition the MSOAP has funded a highly regarded one-off mental health training program administered through Divisions. However, this needs to be ongoing given the movement of GPs in and out of country SA. The take-up in SA for the Department of Health and Ageing (DoHA) Better Outcomes in Mental Health Initiative has been higher in rural areas than urban areas and been highest in the regional centres. This initiative has contributed to GPs gaining more knowledge about mental health care.

As with many aspects of primary care, the complexity around the different funding models and differences in operating between the public and private sectors must be overcome in order to make a seamless service for consumers.

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<sup>9</sup> Examples were given of the role of GPs in the Lower Eyre Peninsula bush fires in 2005.

### *Building relationships amongst teams*

*The team work is working very well – we've managed [.....] for 24 days [in a remote location]. We use the hospital, GP, inpatient staff, the Aboriginal Health Worker. Actually we use the lot. Basically we use what we have to do the job (Community mental health worker).*

The co-dependence and close working relationships amongst those involved in health care in some rural and remote locations in SA make it easier to use a rural primary care psychiatry approach. There were several examples given of workers working closely together (usually accessing Telemed) not only to keep people in their community, but also to create planned transfers to Adelaide when appropriate. Occasionally, teams involved social care and non-government workers without specific mental health training. In many small rural and remote locations, existing working relationships, and a 'can do attitude' may provide opportunities for effective teamwork to achieve a positive outcome for a consumer. However, this is not universally the case. One example was given of an accommodation service in a town that would not accept people with mental illness. In some rural and remote communities the problems associated with the stigma of mental illness limit access to services and acceptance within the community<sup>15</sup>.

### *Telemed and Emergency Triage and Liaison*

There are well established Telemed facilities and an Emergency Triage and Liaison service available in SA that study participants found to be both appropriate and accessible. The Emergency Triage and Liaison service is available 24 hours a day and consumers can access it. Telemed enables psychiatric consultations for rural and remote consumers, consultations for GPs, CMHN, and other primary care staff, reviews of consumers, and mentoring. Some staff reported that they had initially been skeptical of using Telemed videoconferencing but now were strongly in favour of it. Universally, the Telemed services and the Emergency and Triage Liaison Service provided by the RRMHS were very highly regarded. It was thought that a further step would be to have Telemed available for Emergency Triage and Liaison. It was also suggested that the capacity to revoke a detention order via Telemed would be helpful and would aid local management.

### *Information flow between country and metropolitan services*

Study participants thought that efficient information exchange, and contact as early as possible in the course of the person's illness, enabled proactive rather than reactive management and ensured that readmissions did not occur. Effective dissemination of discharge plans and feedback to GPs and CMHWs about the consumer's admission were central to this. However, there are still problems with timely consumer discharge information from metropolitan hospitals other than the RRMHS. Some problems are related to the inability of different computer systems to interface between country and metropolitan services. This problem is now being addressed.

A particular difficulty was identified in relation to receiving information about people admitted to metropolitan hospitals from interstate and the Anangu Pitjantjatjara (AP) lands via Alice

Springs. Also there is no central point to transfer information when a consumer is discharged interstate and has not provided the name of a GP.

### **3.2.2. *Systems improvements to overcome barriers to integrated mental health care***

There was consensus that using a rural primary care psychiatry model, as does the RRMHS, provides for an excellent service. However, participants acknowledged that not all rural and remote patients are able to access the RRMHS. It was noted that most rural consumers go through the RRMHS because their entry point to the mental health care system is usually a GP. However, if police in rural areas have concerns about a person they take them to the nearest hospital, where a GP and Telemed with the RRMHS may or may not be involved. There are multiple entry points into the system and consumers may or may not have access to the RRMHS.

Streamlining or reducing the number of points that people enter the acute mental health care system may result in greater preparedness of individuals to seek the resources of the system more effectively. It may also result in more effective coordination of care. For example, it was suggested that there should be one point of contact with the acute mental health system for rural and remote consumers and this should be through the RRMHS. If there was an outreach liaison arrangement for the RRMHS beds that are in other hospitals then there may be a better connection between the rural community, the consumer, and the referring GP and CMHW.

Another option would be to have some country centres, particularly the larger ones, act as centralised points within their own regions to provide more specialised care, up to a certain level. Then there could be a coordination point within each region. However, those hospitals and health services would have to be appropriately resourced to take on this role.

### **3.3 *Staying in the home community longer for mental health care***

#### *Service responses*

Enabling rural consumers to remain in their home location or to have as short a stay in hospital as possible requires appropriate resources and facilities in the home community and proactive rather than reactive management. The threshold for local management to work varies from region to region and any protocols for local management need to reflect their specific needs. Increasing the number of specialist mental health care professionals in rural Australia is frequently canvassed as response to increased local management<sup>16</sup>. While this is clearly a necessity, our study found that some rural communities will find a way to provide solutions if access to specialist services is difficult or if it is unacceptable in the community. This is confirmed by a previous SA study<sup>17</sup>.

Some creative options are available in SA that may enable people to stay in their communities for longer periods. In one regional location, dedicated mental health beds in the

local hospital and a Mental Health Hospital Liaison Nurse (MHHLN) to provide consultation at Accident and Emergency (A&E) services have resulted in transfers to the city being halved. Smaller hospitals have much more limited capacity to handle people with a mental illness and are far more likely to transfer them, even if it is not always clinically warranted. However, identifying in advance the appropriate 'threshold point' for each consumer - where transfer might be necessary - and providing consultation through Telemed to the GP, hospital and CMHW concerned, has assisted in consumers staying longer in their community.

Using country hospitals as a transitional point of care for people prior to admission and after discharge from a metropolitan treatment facility could provide a 'step down or step up' facility. There was considerable support for this option amongst study participants. Our study, as did the GPHIRRA project, found that country people stayed longer in metropolitan hospitals for acute care than would be the case if they were Adelaide residents. 'Step down' arrangements may reduce the length of stay in Adelaide.

#### *'Wrapping around' services on discharge*

The RRMHS discharge planning process was highly regarded in that it provided opportunities for consultation with GPs, and primary care professionals, often using Telemed, prior to the consumer's discharge. A discharge summary, with follow up information, was always provided to the GP and to the key worker. GPs and mental health care workers thought that there were very few instances (if any) where communication between the RRMHS and themselves had left them unaware of plans for consumer's discharge. However, the process does not work as smoothly with other metropolitan hospitals and it was reported that it may be difficult to access discharge summaries.

Wrapping around services on discharge requires an in-depth knowledge of the community concerned in order to choose support services that are accessible as well as available. This also means working with families, carers, primary care workers, and GPs as part of discharge planning, rather than waiting until the person is back. While clearly it is impossible for every metropolitan hospital to have the ability to do this it is important to recognise where the system is working well, and strengthen and resource it. This may reduce the incidence of, and the costs associated with readmission.

#### *Self management of mental illness*

*"There is an example of a consumer saying 'I would really like to come off medication- If I get sick again I don't want to go to this hospital and please don't give me that drug again' "(Key stakeholder).*

GPs or case-managers were seen to be responsible for management of mental health care integration overall. However, there were participants who thought the consumer themselves is also responsible. Several consumers recognised what made them well and unwell and had a strong desire to be more involved in the management of their illness. One way to do this is through care planning. If written care plans were available to consumers then the point in their illness at which they may need transfer could be made explicit. Information could be shared

amongst team members if appropriate. Care planning tools are available in SA but some study participants thought that care planning with consumers might not be a common approach.

There are other strategies to involve consumers in their care. One metropolitan hospital holds a regular discussion group for consumers to assist them and become more aware of their illness, their diagnosis, medication options, and the things that make them unwell and keep them well. Consumer advocacy groups operate in some regional centres. Another suggestion was that the 'peer education' model – consumers providing support to other consumers – may help in demystifying mental illness.

Key stakeholders made it clear that there is a need for simple but useful consumer education material in a variety of formats. A checklist for what to take, and what not to take to hospital was one example of the type of information that needed to be produced.

#### *Increasing community capacity to address mental health issues*

There are complex cultural variables in rural and remote communities that may impact on the provision of mental health care and whether or not people with acute episodes can remain within the community. Many communities have dense, informal social networks which act as mechanisms for social control and there may be negative attitudes towards mental illness<sup>18</sup>. There may be fear and anxiety of mental illness resulting in later presentations of problems to specialists when the local capacity to deal with the problem is exhausted.

Because of this, there may be extreme demands on committed GPs and other trusted individuals and the burden of mental illness in the community may be severe and the extent of it unknown. Sometimes, because of the dependence on a few key individuals, those people who supply the services may be at risk of mental health issues themselves. In several case study sites, local hospital staff perceived mental illness to be the most problematic condition that required in-patient treatment partly because of the fear and anxiety that surrounded it. Consumers then may prefer to travel outside the community to maintain anonymity when they have a mental health condition.

These issues, while problematic in SA, are also apparent in rural Australia more generally. There are factors about rural and remote communities and the ways they function that can both assist, and work against, effective social and health care for people with mental illness. Tapping into resources and developing community capacity requires in-depth knowledge of the community and a capacity to work in holistic and developmental ways. Mental health trained professionals may not have this orientation. It is not within the capacity of the country mental health system in SA to do this alone. Collaborations across regional development organisations, communities, consumer groups, government departments, and Divisions of General Practice are required.

### **3.4 *Mental health integration issues for Aboriginal and Torres Strait Islander people***

*'We have to draw on what is already there - at the core of Nunga life'* (Key stakeholder)

The views about whether or not there were particular problems for Aboriginal consumers were varied. Some non-Aboriginal care providers who were operating primarily in hospitals thought that there were no particular issues for Aboriginal consumers. However, others who were familiar with some contexts in which Aboriginal people live were aware of two over-riding issues. Aboriginal people function within a kinship network and many of the issues were about the need for integration, from the consumer perspective, between the home community, family and friends, and the metropolitan hospital environment. Secondly, it was thought that there was only an embryonic understanding of how to integrate the frameworks of Ngangkari Tjuṭa (traditional healers) and socio-emotional wellbeing with the western medical model. There are views that these models are simply overlaid rather than there being a really good understanding of how and where they blend.

It is especially difficult to assess Aboriginal and Torres Strait Islander people, who may arrive at the metropolitan hospital without family or friends. Often Aboriginal people don't engage in the same way with structured verbal interviews and it is difficult to gather information using the standard mechanisms.

There are some specific issues in mental health care integration for Aboriginal people:

- Enabling choices of service providers for Aboriginal people. Sometimes there may be confidentiality issues in accessing care at the local Aboriginal Health Service – Aboriginal people may, on occasions, prefer non-Aboriginal personnel in visiting services.
- Often it is more appropriate to work with families and kinship networks rather than individuals. It may be necessary to work with whole communities when dealing with grief and loss issues.
- Mental health care specialists at RRMHS are asking for upskilling in Aboriginal socio-emotional wellbeing concepts and practice.
- The RRMHS wished to make the buildings and services more culturally friendly – and make strong connections with Aboriginal communities, decreasing the psychological distance between the home community and the hospital.

### **3.5 *Better transfers for acute mental health care for country consumers***

*It is really hard to get to hospital from some remote places. From Oodnadatta people need to drive to Coober Pedy, then fly to Port Augusta and then to Adelaide. Another issue is that family can't get there. Then family background information is not taken into account (Key stakeholder)*

Effective transfers were a particularly problematic aspect of mental health care according to the majority of study participants. Transfers between rural and remote locations and Adelaide are costly, are very difficult to coordinate when they involve police, ambulance and the RFDS, and will result in inconvenience to consumers and their families. Our study found that there are barriers and facilitators to achieving effective transfers of consumers to and from Adelaide.

### **3.5.1 Problems with transfers and transport**

*It must be an extremely traumatic experience for patients [transfer]. Being unwell, traveling late at night – being sedated – not to mention the void that the family member at home sees their partner or relative going into. That would be really awful - really scary. And then having to go to three or different points to actually get an inpatient admission. Leaving behind things that are important to you in the ambulance – having to change modes of transport” (Key Stakeholder).*

Reports about the effectiveness of transport for both voluntary and detained consumers were varied. In some instances transport was reported to work well, especially in centres where there was a commitment from police, ambulance, and RFDS to work together to overcome obstacles. 'Being in the country we have to make it work – if everybody got militant it probably wouldn't work' (Police interviewee). However, even when people co-operated achieving coordination between services, having timely transfers, and avoiding down-time for staff, there are persistent problems. Some study participants, who had been exposed to the system over years, were aware of the burden it placed on consumers and avoided transfer where possible. Barriers to effective transfers were identified in the following areas:

#### *Delays*

Often there are delays in transportation between Adelaide and the rural/regional/remote community, especially when they require coordination of the RFDS, police, and ambulance. Some of these were unavoidable due to weather conditions, staff availability, or RFDS emergencies. However, the burden placed on those caring for the consumer who has been detained, usually police, the GP, and the local hospital staff, is considerable. Maintaining an appropriate level of sedation for the consumer is difficult and there is down time for the police, hospital staff, and the GP. Ambulance transport was seen to be problematic when it required that consumers move between ambulances when ambulance regional boundaries were reached.

#### *Transfers back to the home community*

Discharge back to the home community by the most cost effective means is problematic when the location is remote from Adelaide and requires changing buses with delays in between.

Travel by bus may not be consistent with appropriate care and in some remote locations there are no bus services. Community mental health teams (where they exist) will try to meet consumers who are sent back on the bus to their community and help them to get settled in. Sometimes when consumers are sent home Friday evenings or Saturdays, team members are not available until Monday. It was thought that metropolitan hospitals might need to be aware that there are no emergency mental health teams in the country to look after consumers on the weekend, so the client really requires a Thursday or Monday discharge.

### *PATS*

The GPHIRRA report identified some of the limitations of PATS in relation to how the criteria and rules were occasionally barriers to good patient care <sup>6</sup>. While there are 'special circumstances' that may be applied with PATS the following issues were identified in this study.

- PATS may be paid by cheque retrospectively for voluntary patients seeking admission to metropolitan hospitals. Transport costs for consumers living in remote locations going to be hospitalised voluntarily may be considerable. If the consumer cannot afford the bus fare then the only option may be for transport by workers or family in order to retain the bed.
- PATS may not always cover transport for family or friends who might be able to accompany the consumer.

### *Consumers meeting their own costs*

In some cases consumers travelled by car to hospital meeting the costs of petrol themselves. In other cases family members or carers assisted by transferring consumers. Accommodation for family members who choose to travel to Adelaide and stay with their family member may be difficult to access and costly.

## **3.5.2 Overcoming transport problems**

There were some suggestions about systems that may facilitate better transfers. Police interviewees suggested that the responsibility for coordinating transport should rest with one agency, the Police, Ambulance or RFDS. If this was the case then it was thought that the problematic areas under the current arrangements would be resolved. They also thought that having Police accompany consumers, where the consumer was sedated, and likely to remain so throughout the transfer, was unnecessary. It was thought that increased use of road transport, with a dedicated vehicle, would allow easier management of transfer and would enable family or carers to travel with the consumer.

## **4 IMPLICATIONS FOR BETTER INTEGRATION OF MENTAL HEALTH CARE**

While this study was conducted in SA, the findings inform a number of general conclusions about critical success factors to improve the integration of mental health care between the rural and remote primary care sector and the metropolitan hospital and tertiary sectors. These are:

- Better management of people in their home community so that they can be cared for longer in this setting
- An increased uptake of evidence-based rural primary care psychiatry
- Better marketing and integration of DoHA funded programs such as MSOAP and chronic illness self management initiatives
- Across sector community capacity building for rural and remote mental health

#### **4.1 Keeping people in their home community longer**

Local approaches in the case study sites to keeping people in their 'home community' for longer periods were generally highly regarded. These findings have importance nationally as they may result in more integrated mental health care. Treatment for serious mental illness in the patient's home <sup>19</sup> or assertive community treatment rather than hospital in-patient treatment <sup>20</sup> has been found to be effective. A Cochrane systematic review on this topic found that in-home treatment for serious mental illness compared with standard community care resulted in ACT patients remaining in contact with services longer. People allocated to ACT were less likely to be admitted to hospital than those receiving standard community care and spent less time in hospital if they were admitted (Martin & Lockwood 1998). This evidence needs to be supplemented with Australian studies and result in practice guidelines.

Keeping people at home for longer periods will require improved infrastructure at the local hospital and staff (both within and external to the community) who are comfortable with the approach. Creating better knowledge of the services available in local communities comes about through effective liaison mechanisms and these require personnel. Up-skilling local staff including GPs and other primary care personnel also requires resources, as do the modifications that might need to be made to local hospitals.

#### **4.2 Evidence-based rural primary care psychiatry**

'Rural primary care psychiatry' is of importance nationally because it is an approach that demonstrates how effective integration of the tertiary, secondary and primary sectors may occur. In SA, rural primary care psychiatry it is led by a specialist mental health care facility that provides acute tertiary care for country clients. The approach is embedded systemically using Telemed and an Emergency Triage and Liaison Service for advice, consultation and review, and collaborative discharge planning. These services provide support for local GPs, hospital staff and community-based mental health teams to provide effective, locally-based care. Specialists based in the city regard themselves as part of the primary care team and have an in-depth knowledge of many of the rural and remote communities from which consumers come. Knowledge of particular communities aids effective discharge planning, For

instance, it is recognized that consumers should not be discharged on Fridays because the community mental health team will not be available to provide support over the weekend.

However rural primary care psychiatry needs to be promoted and extended in SA and strengthened nationally, while at the same time developing an evidence-base to demonstrate its efficacy. Encouraging organisations such as the National Institute of Clinical Studies to target primary care psychiatry in a research funding round would be of benefit. Also strong leadership through the PARC (Primary Mental Health Care Australian Resource Centre) in implementing the rural primary care psychiatry approach is warranted.

#### **4.3 Better marketing of DoHA programs to integrate with state initiatives.**

Increasing awareness of the relevant DoHA programs and initiatives will assist in integrating the acute mental health sector with primary care in rural and remote communities. For example, if psychiatrists who are providing outreach consultations through MSOAP are using the rural primary care psychiatry approach, then consultation with local GPs and other primary care workers will occur. However this integration requires strong leadership perhaps through the Royal Australian and New Zealand College of Psychiatry. The Divisions of General practice state based organisations, rural Divisions of General Practice and the state based DoHA officers may all assist in creating awareness of the ways in which state and Commonwealth initiatives can mesh. Incentives, such as the item numbers available through the Medical Benefits Scheme, are already in place.

Other initiatives sponsored and promoted through DoHA such as the self management of chronic illness should be applied to mental health conditions. There were some participants in this study who regarded individuals as also responsible for the integration of their care. An innovative web and paper based tool, the Self Management and Recovery tool is in the public consultation phase in SA <sup>21</sup>.

#### **4.3 Across sector community capacity building for rural and remote mental health**

In Australia generally, a community capacity building approach is essential if there are to be improvements in rural and remote communities' awareness of, and capacity to cope with, mental health issues. Creating this increased awareness should not be seen to be the mandate of the mental health sector alone. At the local level, reducing the stigma of mental illness in rural and remote communities will involve partnerships and skilled leadership from local community development organisations, regional and local government, Divisions of General Practice, and the primary care sector. It is the connections between the mental health sector and organisations already engaged in forms of community capacity building that will be most effective.

Community capacity building involves developing infrastructure and resources, providing access to information, developing partnerships and networks, and creating external links relevant to the particular capacity. There are numbers of community capacity building

initiatives funded by different government departments at both the state and Commonwealth level. In SA, for example, Primary Industries and Resources SA, has worked with the UniSA Whyalla campus to develop a web based community capacity audit <sup>22</sup>. This audit, designed for rural communities to aid socio-economic development, audits all sectors including health. It would not be difficult to develop this tool to audit infrastructure, information, attitudes, resources and links, to promote mental health. Following this, relevant initiatives would be designed aimed to build on strengths and supplement weaknesses. The co-ordination and dissemination of the variety of community capacity building initiatives already in place requires leadership and coordination by a 'lead government agency' nationally.

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# **GP/ Hospital Mental Health Integration Study**

## ***Stakeholder Workshop***

***To discuss***

***The first phase findings***

***Gaps in first phase findings***

***Your input as a stakeholder***

***Facilitated by Dr Kim Webber***

***May 17<sup>th</sup> 2005***

***At***

***The Art Gallery of South Australia***  
***(Function Room 2)***

***1-3 pm***

***Please RSVP Tuesday 10<sup>th</sup> May to***  
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