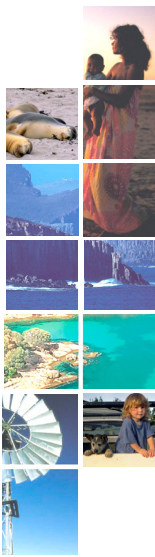


Which way where? Sustainable and flexible models for psychology service delivery in rural New South Wales

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INTRODUCTION



Flexibility has been a catch-cry within rural health circles in recent years. Rural health plans advocate flexibility in both funding arrangements for adaptable, community-specific service delivery and in the management of the health workforce (Humphreys et al 2002, NSW Health 2002; Australian Health Ministers Conference, 1999). This has been part of a shift to recognition of the need for a different approach to rural health services, accompanied by an acknowledgment that the health needs of rural Australia were not being met by traditional metropolitan services and service models (Humphreys et al, 2002; Best 2000). The development of the collaborative document “Healthy Horizons” (Australian Health Ministers Conference, 1999) provided a new mutually agreed framework for development of a plan for rural health, addressing some of the health inequities evident between Australia’s rural and metropolitan residents. Humphreys’ et al (2002) review of the progress of rural health across the past decade found that there are positive changes evident in delivery of some health services, particularly with the advent of services such as rural outreach specialists, the Regional Health Services Programs and the multi-purpose service program which provides a more flexible approach to service funding models in targeted communities (McDonald, Brown and Murphy, 2002). Humphreys et al (2002) assert that whilst the need for flexibility is well recognised, there remains some way to go in the development of truly adaptable, community-driven service delivery models which involve communities at the heart of planning.

One of the well documented barriers to the provision of health services in rural and regional Australia are the difficulties encountered in the recruitment and retention of health professionals. Healthy Horizons (Australian Health Ministers Conference, 1999) included a major focus on the recruitment and retention of a skilled health workforce (SARRAH, 2000). Whilst there is little specific or detailed information available on the allied health workforce (Best, 2000), there is a wealth of documented concerns about recruitment and retention of allied health staff within the rural health system. A survey of rural allied health professionals indicated that 42% of those surveyed had been in their current position for less than 2 years (SARRAH, 2000) which may represent high turnover of staff. Best (2002) found that there are few psychology services available in rural Australia. NSW Health (2002) has described recruitment and retention of allied health professionals in regional and rural areas as “problematic” and indicated that:

Many hospitals have insufficient dental officers, dietitians, occupational therapists, physiotherapists and psychologists to provide the desirable range of acute care and chronic disease services (p 21).

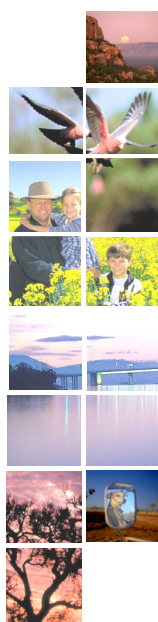


Within NSW increased efforts are planned to attract and retain allied health professionals in rural areas (NSW Health, 2002). These include the establishment of rural health forums, investigating private practice rights for allied health professionals in public facilities and increasing the scope of rural allied health scholarships to include postgraduate scholarships for the rural workforce.

Mental health is of gaining increased attention within Australia. The Australian Survey of Mental Health and Wellbeing (ABS, 1997) demonstrated that almost 20% of adults in Australia were found to have experience a “high prevalence” mental health disorder in the preceding 12 months. Best (2000) when reviewing rural health, specifically noted a lack of mental health services in rural Australia. This is consistent with other studies which demonstrate a profound lack of mental health specialists in rural NSW, with professions such as Psychiatry, Psychology, and even General Practitioners being largely absent from the Western part of the State in comparison to metropolitan areas. In the area of Psychiatry: the ratio of Psychiatrists to population in rural NSW is 1:10,000. The recommended number of available psychiatrists for rural NSW is 143 (Australian Medical Workforce Advisory Committee, 1996) whilst the actual number is 44 (Earle, 2003). Approximately 4% of the nation’s ~2,000 psychiatrists practice and live in rural areas. (Hoolahan and Vines, 2002; McEwin, 1997).

In 2000, the estimated psychologist workforce for NSW consisted of 4,785.4 FTE (full time equivalents). 85.3% of psychologists were found to be located in Metropolitan Area Health Services, with Rural Area Health Services being the main job location for only 14.2% i.e. approximately 680 (NSW Health Department, 2000). In real terms, Community Mental Health Teams and GPs receive the brunt of formal mental health presentations in rural areas but waiting lists are long, costs can be prohibitive (as many GPs in rural areas do not bulk bill) and referral criteria often focus on more acute mental health issues. People with chronic depression, anxiety, stress and relationship problems frequently slip through the net and their needs remain unmet (Hoolahan and Vines, 2002). Alternatively, in some rural areas, other organisations and networks (for example: financial counsellors, clergy, NGOs) outside mainstream mental health services often provide counselling to these clients. Missed opportunities in terms of promotion, prevention and treatment of mental illness in rural communities result from not having an adequately trained mental health workforce available both for patients and to support other rurally-based services.

This paper aims to outline a case example of the development of a range of models for psychological service delivery to general practice in the Central West of NSW, which addresses the need for flexible service delivery, within the constraints of a limited workforce. The aim of this has been to improve primary mental health service delivery in within the general practices in targeted communities.



BACKGROUND

Why one size does not fit all in the NSW central west

The NSW central west covers a large geographical area with a diverse population mix.

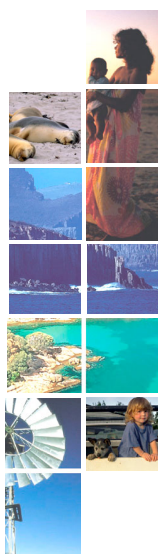
The region lies west of the Blue Mountains and covers an area of 60,287 square kilometres from Lithgow to Lake Cargelligo. The settlement has a population of 178,970 (ABS, 1996) and reflects ARIA classifications from 1.62 in Orange to 5.71 in Lake Cargelligo. The area has a varied make-up, with non-metropolitan cities, towns, villages and isolated rural communities. When compared with NSW state averages, the area has a high proportion of children and young adults under 20 years of age (31.5%) and a low proportion of adults aged between 20 and 40 (27.6%) (ABS, 1996). This trend is exaggerated in the more isolated areas as young adults move from the area or to less remote areas to gain education and employment. The area is home to a significant Aboriginal population (3.03% compared to NSW state average (1.68%) [ABS, 1996]).

Highways link the towns of Bathurst, Cowra, Grenfell, Orange, Forbes and Parkes. However, large sections of the north-western area have no direct access via major roads to urban centres. Rail and country link buses provide services to most of the major towns, however there are many remote centres where public transport is either very limited or non-existent. The cost and inconvenience imposed by these limitations increases pressure on GPs to diagnose and refer appropriately to the limited services available locally in the smaller or more isolated communities.

The economy of the region is principally associated with primary industry (wool, wheat, meat and mining) but also has strong (but localised) secondary industry in the two large regional centres of Orange and Bathurst. Orange has a growing public sector while both Orange and Bathurst have campuses of tertiary institutions.

Consistent with the rest of rural Australia, workforce issues, such as recruitment and retention of medical nursing and allied health staff present regular challenges in providing and sustaining services in this the Central West, particularly in the smaller, more western communities.

This combination of workforce issues, contrasting community needs and characteristics and geographical challenges necessitated some “outside the square” thinking in designing services delivery which could “fit” targeted rural and regional communities. As a result, the NSW Central West Division of General Practice now operates 5 different models for delivery of psychology services across the region, using two Commonwealth-funded programs. This paper aims to provide a case example of the use of funding sources to develop services which are flexible, evidence based and have capacity to shift with changing community requirements and results of evaluation.



Funding sources

The NSW Central West Division of General Practice currently uses two types of funding to operate psychology services.

- The “More Allied Health Services” (MAHS) Program – This program is funded by the Commonwealth Department of Health and Ageing. It aims to improve the health of rural communities through the provision of effective additional allied health services which provide a more integrated approach to health care for rural communities (Department of Health and Ageing, 2002).
- The Better Outcomes in Mental Health Care Initiative (BOMHC) – Access to Allied Health Services (AAHS) Pilot Project funding – This component of the BOMHC initiative aims to enable eligible General Practitioners to access focused psychological intervention from allied health professionals, to support their patients with mental health problems through time-limited interventions. Sixteen pilot projects were initially funded in 2002–2003, with Divisions of General Practice as fund holders, with more projects planned.

Using MAHS funding, the NSW Central West Division of General Practice had been operating 2 models of psychology services to address community needs since 2001. These included provision of a visiting psychologist within the General Practice setting, and tele-health psychology service provision to remote locations. Provision of these services was established on the basis of a community consultation process and needs assessment. The models used will be outlined below.

In 2002, the Division successfully applied for pilot funding under a new Commonwealth Initiative, the Better Outcomes in Mental Health Care Initiative (BOMHC) to create further psychology services in the region for patients of eligible General Practitioners.

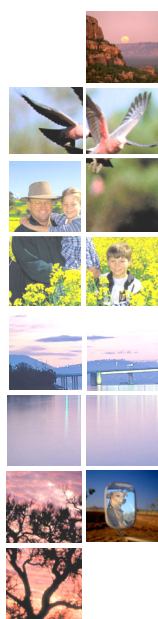
AIM

This paper aims to provide a case example of the use of funding sources to develop services which are flexible, evidence based and have capacity to shift with changing community requirements and results of evaluation.

PROCESS

When the opportunity for operating a psychology pilot project arose, the NSW Central West Division of General Practice had strong established links within psychology circles in the region primarily through 3 means:

- the allied health needs assessment conducted across the region in 2000 as part of the MAHS project development
- involvement with the Clinical Psychology in Rural General Practice Project conducted through Charles Sturt University. This project has been in operation since 1998 and has been supported by commonwealth funding since 2001. The project now operates out of 2 general practices in Bathurst, several rural and



remote towns in rural and remote NSW and in the regional cities of Armidale and Ballarat

- implementation and operation of psychology services to general practices in four communities of the central west through the use of MAHS funding.

When the opportunity arise for Divisions of General Practice to apply for funding through the “Better Outcomes in Mental Health Care” Initiative for an Access to Allied Health Pilot Project in 2002, the NSW Central West Division of General Practice felt that this was a good opportunity to build on the success of the previous activities in the realm of psychology.

One of the strengths of the BOMHC Access to Allied Health Services Pilot call for submissions was the flexibility of the funding. The Department of Health and Aged Care was clear in their exchanges with the Division, that services tendered for should be community and organisation specific – and that there was no “one model fits all” requirement in service planning, rather a capacity building approach was to be taken at a local level.

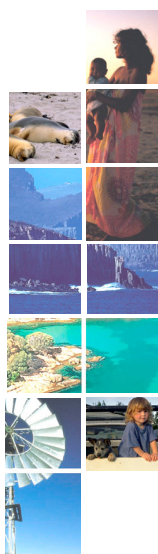
This was consistent with the approach taken by the “More Allied Health Services” Program funding which provided allied health services to general practice on the basis of results of a community needs assessment and consultation process, and workforce availability (Department of Health and Ageing, 2002).

This scope for development of community-specific service models within the funding arrangements for the two programs allowed the Division to match community needs and workforce availability to develop and trial community-specific service delivery models.

When submitting for the BOMHC Access to Allied Health Pilot project, a decision was made to trial a number of service delivery models across the Division. The primary reasons for this decision were:

- to match workforce availability with community need, in line with the flexible approach to services in rural Australia
- and
- to provide a comparative evaluation of the effectiveness and value of different models of service delivery in the targeted communities.

The different models of funding had also been seen to be feasible during service delivery in the “Clinical Psychology in Rural General Practice Project”. Due to time constraints for submission for projects, a comprehensive community consultation process could not be undertaken. However, the most recent MAHS needs assessment, which was based on community and stakeholder consultations, combined with the Divisional strategic planning process provided invaluable community knowledge which formed the basis for the submission. The implementation of the MAHS program had also provided the Division with knowledge of the local workforce structure and issues. This was used as a basis for decision making when models of service delivery were being developed. In addition, a brief survey was undertaken of General Practitioners to investigate the number and locations of those who would be eligible to participate/refer to the pilot projects. Preliminary results and verbal

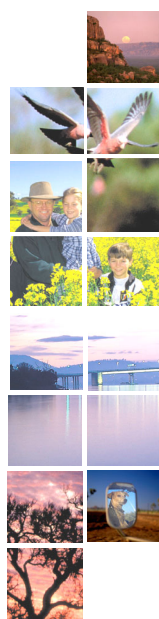


discussions with GPs indicated strong support for increased access to psychology services across the region.

Four models of psychology service delivery were developed and received funding as part of the Access to Allied Health Pilot Project (AAHS). These complemented the psychology services already provided through the MAHS Program. A summary of these models are outlined in Table 1.

Table 1 A brief outline of psychology service delivery models implemented by the NSW Central West Division of General Practice

Service delivery model	Funding source Communities	Rationale and comments
Visiting psychologists The psychologist travels to the community and works (usually) from within the GP practice.	MAHS Canowindra Cowra Rylstone/Kandos AAHS Oberon Parkes Forbes	Preliminary feedback from GPs, psychologists and patients indicate this model is useful for reducing stigma of attending a psychologist, and provides essential networking and collaboration between the GP and the psychologist
Tele-Health Psychology Services The psychologist travels to the community and works from the MPS 1 week of 3. Intervening sessions are held via video-conferencing.	MAHS Trundle	This has been a valuable model for providing continuity of services to a remote community.
"Voucher" system—Use of Private psychologists The GP refers to private providers who have established a contract with the Division. The patient sees the psychologist in the private rooms. The Division pays for contracted services, with no charge to the patient.	AAHS Lithgow and Orange	These services selected for these communities as the workforce survey indicated that there were sufficient private providers to provide GPs and patients with a choice of provider. One of the spin offs of the establishment of this model has been that as a result of this project, additional therapists have been attracted to provide private services in the smaller of the targeted communities.
"Clinical Psychology in Rural General Practice Project" (in partnership with Charles Sturt University) Scholarship payments are provided to clinical psychology registrars undertaking the placement. This aims to encourage increased numbers of students into the placements to provide improved service continuity.	AAHS Bathurst	The provision of supplementary funding to the "Clinical Psychology in Rural General Practice Project" aims to improve the continuity and sustainability of a project which is already achieving positive outcomes for patients and General Practitioners.
Post Natal Depression Treatment Group The Division funds this 10 week treatment group for patients.	AAHS Bathurst—with participants travelling in from surrounding regions	This group had previously operated in the community with good results and strong feedback from participants. There had been difficulty sustaining the group due to lack of funding. The Division provided funding to this group to ensure services were more sustainable.



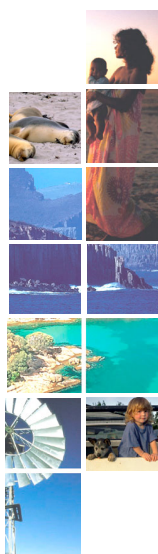
EVALUATION

Access to Allied Health Services Pilot Project

A comprehensive and comparative evaluation of the models of service delivery funded under this project is under way. Evaluation includes both qualitative and quantitative data, and the evaluation framework includes evaluation of process, impact, outcome and financial management. Evaluation is conducted by an independent external evaluation team. There is a strong focus on qualitative data and feedback, with the evaluation team attempting to interview all consenting psychology clients, participating psychologists, general practitioners and other community services, with a view to gathering specific feedback on service delivery and perception of clinical outcomes.

More allied health services

Simultaneously, the More Allied Health Service Program Needs assessment will be revised and current services evaluated. This review of needs for supplementary allied health services to patients of general practitioners will include consultations with general practitioners, allied health service providers (public, private and NGO), health service managers, consumer representatives and other relevant organisations. The needs assessment will also use epidemiological and demographic information, health priority areas and activities within the region, identification of existing services and scoping re: available workforce in small communities to determine local priorities (Department of Health and Ageing, 2002). This will build on the recent work of the Division in development of their strategic plan— which involved extensive community consultations and networking.



FUTURE DIRECTION

The structure of the psychology services described is not static. The comparative review and needs assessment will provide a broad basis for decision making about service delivery models and priorities in this rural area. The ability to re-negotiate contracts for services provided of funding through MAHS and AAHS will allow adaptation of the models of psychology intervention to those which are mutually acceptable; clinically and cost-effective and which meet consumer needs. Future activities will include a review and revision of the services provided based on the evaluation and needs assessment results.

CONCLUSION

This case example outlines the process undertaken to use more than one funding source to enhance and evaluate comparative service delivery models.

Use of more than one service delivery models allows services to shift in response to evaluation or changing needs of the community. Use of such varied models is dependent on the ability to negotiate community-specific services with funding bodies. This flexibility assists to result in better health outcomes for all.



McEwin, K. (1997): "The Medical Specialist Workforce in Rural New South Wales", Rural Doctors Network.

NSW Health Department (2002) *The Report of the Rural Health Implementation Coordination Group. The NSW Rural Health Report*. NSW Health Department, North Sydney.

NSW Health (2002) *Profile of the Psychologist Labourforce in NSW, 2000*. State Health Publication :North Sydney. www.health.nsw.gov.au/jobs

Services for Rural and Remote Allied Health (2000) *A study of allied health professionals in rural and remote Australia*.
<http://www.ruralhealth.org.au/nrhpublic/publicdocs/sarrah/pages/reports/1/chapters.pdf>

PRESENTERS

Karen Wylie co-ordinates the clinical services provided by the Division of General Practice in the NSW Central West, including management of the "Access to Allied Health Service Pilot Project" currently being undertaken by the Division, as part of the commonwealth-funded Better Outcomes in Mental Health Care Initiative.

Karen started her career in health as a speech pathologist over 10 years ago. She has experience in a variety of health service settings, as a clinician and a manager, in both rural and urban settings. Completion of a Master of Public Health has helped consolidate her interest in primary health, health service delivery and evaluation.

Robyn Vines is a Senior Lecturer, Mental Health Education at the University of Newcastle's Centre for Rural and Remote Mental Health in Orange. She is also Senior Research Fellow at Charles Sturt University and Director of the Clinical Psychology in Rural General Practice Project, a national pilot study funded by the Commonwealth Department of Health and Ageing to assess a collaborative model of mental health service delivery in rural areas.

Robyn has over twenty years of experience as a Clinical Psychologist in Britain and Australia, including positions at University College Hospital, London; as Assistant Director and Head of Clinical Services at the Cairnmillar Institute in Melbourne; Swinburne University and the University of NSW. She has also worked in private practice in Melbourne and Sydney.

Robyn was on the Board of Directors of the Australian Psychological Society from 1998 to 2002 as Director of Branch and Regional Operations. She has served on several government committees including the Psychology Committee of the Draft National Practice Standards for the Mental Health Workforce and the Access to Allied Health Services Task Group of the Commonwealth Committee for Incentives for Mental Health under the Better Outcomes in Mental Health Care Initiative.

