

Mental health services in rural and remote South Australia: from “awful neglect” to gaining respect

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In 1994 John Hoult made a damning assessment of Mental Health Services in country South Australia (SA) when he stated in a review:

We offer our sympathy to those who suffer from serious mental illness and to their relatives in rural South Australia (SA). The situation reflects an awful neglect, an embarrassment to the South Australian government with not a single thing to praise in the rural services except the perseverance of staff, who have to go to work each day facing an impossible task. Leave Adelaide and you leave behind mental health services.¹

In 1996 the Rural and Remote Mental Health Service (RRMHS) of SA was established to help address the issues raised by Hoult.

The article reviews the how the RRMHS using a Consultation-Liaison (C-L) model in primary care is delivering an integrated mental health service to the rural and remote areas of SA.

DEVELOPMENT OF THE RURAL AND REMOTE MENTAL HEALTH SERVICE OF SOUTH AUSTRALIA

Rural and Remote area of South Australia has a population of 422 000 constituting just under 30% of the South Australian population.

Hoult’s review highlighted that the unique health needs of this population had been ignored, overlooked or met as if the whole area was simply an “outer suburb of Adelaide”. Frameworks for city based services had tended to get “imposed” on country SA and simply didn’t work.

RRMHS emerged out of extensive consultation process and was formed using an evidence base of well researched papers and principals established as far back as the time of Premier Don Dunstan and the report of Justice Bright in 1993. The final blueprint was outlined in the document entitled *Country Mental Health Services for South Australia – A framework for Service Delivery*.²

In 1996 RRMHS was funded as a unique and innovative service that used telecommunications flexibly to enable specialist psychiatric services to support and validate community based primary carers. It continues to fills a niche that metropolitan services never addressed.

RRMHS has been a champion of the Consultation-Liaison (C-L) approach in primary care as outlined in the Report “Primary Care Psychiatry: the Last Frontier”.³ It has been developed as the service delivery model for all of the components of the service and has been extended to the visiting psychiatrists it supports.

The four major objectives in the C-L approach utilised by the RRMHS are to:

- facilitate a seamless integrated mental health service for the State of South Australia

- provide consultative support to enhance the ability of locally based care providers to appropriately care for patients within the patients own community. The local health care providers remain actively involved in the ongoing care of their patients even if that care is transferred to Adelaide
- enhance general practitioners and other primary care worker's skills in the detection and management of mental illness. There has been an emphasis on changing specialist psychiatric input from clinical "hands on" work with small numbers of patients to the C-L approach. In this way routine psychiatric care is delegated to professionals outside the specialist mental health service, reserving direct clinical work in the service to the most complex and problematic presentations
- improve outcomes for patients and their carers.

Overview of the current service

The current service integrates Triage/Liaison, Telepsychiatry and Inpatient care. All components are collocated at the Glenside Campus of the Royal Adelaide Hospital.

RRMHS offers:

- access to expert psychiatric advice 24 hours a day, 7 days a week, 365 days a year. Continuity of care with the inpatient services seen as an extension of community care. It encourages the care and management of patients in regional centres of SA and within the patient's own community
- a visiting psychiatrist service which augments the services of private psychiatrists who visit regional South Australia as well as the Medical Specialist Outreach Service Program
- availability of a specialist psychiatric opinion over videoconferencing without long waiting lists or the 'books being full'
- validation of the professional roles of both the GP and regional health workers with ongoing support
- facilitation of a multi-disciplinary approach within the service but also in the primary care networks the service supports
- community resource development
- specialised teaching with the emerging speciality of "Rural Health" at both undergraduate as well as postgraduate level
- research opportunities.^{4,5,6,7}

Staffing establishment

The full staffing establishment for Rural and Remote Mental Health is 57.21 fte.

Current staffing consists of 55.02 fte split across the following disciplines:

- 32.8 fte – nursing
- 5.19 fte – consultant psychiatrist/clinical director
- 4.6 fte – medical

- 3.3 fte – social work
- 1.4 fte – psychology
- 1.8 fte – occupational therapy
- 0.13 fte – music/art therapy
- 5.8 fte – management/administrative/clerical.

Service activity

A brief snap shot of each component of the service is as outlined below.

Emergency triage liaison services

RRMHS interfaces with the 7 regional areas of SA, which have 25 community mental health services/agencies scattered across 20 rural locations. They are serviced by over 100 regionally based clinical staff. Rural SA has 10 Divisions of General Practice with approximately 360 General practitioners who have access to 66 regional hospitals.

The ETLs service is telephone based service with a videoconferencing component.

An open access, toll free 131465 is available to any person in rural and remote SA. It is manned 24 hours a day and a Consultant Psychiatrist is always on call for this component of the service.

Activity for the past 3 years is as documented, highlighting the diverse range of functions undertaken.

Table 1 Telephone calls

	2001-02		2002-03	
	Total calls	Monthly average	Total calls	Monthly average
Crisis intervention	319	27	386	32
Assessment	595	50	684	57
Treatment advice	291	24	347	28
Counselling	2 256	188	2 232	186
Professional liaison	10 346	862	10 808	900
RRMH Telemed triage	131	11	220	18
After hours support	88	7	610	51
Other/bed management	5 987	500	4 300	358

The telephone service is augmented by videoconferencing which has been well researched and previously reported.^{4,5,6,7}

Table 2 Total videoconferencing sessions undertaken:

	2000-01	2001-02	2002-03	2003-04
Total	733	820	877	872

Videoconferencing is undertaken for a diverse range of reasons in addition to core clinical activity.

Table 3 Purpose of videoconferencing session

	2000-01	2001-02	2002-03	2003-04
Administration	26	12	15	13
Case conferencing	21	7	25	15
Discharge planning	54	48	52	63
Discharge follow up	-	14	22	19
Education	9	16	25	15
Other service user	58	63	42	28
Family conference	-	-	1	4
Guardianship Board Mtg	-	1	1	3
Inpatient assessment	180	111	122	107
Inpatient support	2	5	6	1
Integrated care patient	17	5	8	1
New patient	349	347	391	377
Other	3	1		
Private review	-	1	2	1
Psychology	-	1		4
Review	174	160	147	205
Professional supervision/peer review	26	21	43	80
Immigration detainee	-	7		1

Inpatient service

RRMHS has 29 acute inpatient beds which operate at almost 100% occupancy with an average length of stay in 2004 of 21 days. There is also access to intensive care and longer stay rehabilitation beds on the Glenside campus.

Twenty-three of the beds are on the Glenside campus and the inpatient clinical team is regionalised to ensure continuity of care and close collaboration and with the community of origin of the patient. The other 6 beds are located in 2 mainstream metropolitan public hospitals.

Table 4 Service activity for all admissions 2002-03

	Intensive care	Rural and Remote	Rehabilitation Services
Total admissions	209	439	60
Total transfers in	57	169	53
Direct admissions	152	270	7
Total discharges	63	355	65
Total transfers out	147	86	28
Detained direct admissions	99	59	71
1st registered contact	31	146	0
Admission > 30 days	4	5	33
Admission > 9 months	0	1	0
Average length of stay	5.9	20.94	134.19
Readmission < 28 days	11	29	4

Evaluation of the service

In 1998 the Commonwealth Department of Health and Aged Care awarded a grant to the Department of Psychiatry at Flinders Medical Centre to evaluate the work of visiting psychiatrists program in South Australia as well as the RRMHS ETLs and Inpatient Services.

The executive summary of that report “Evaluation of specialist psychiatric services in rural and remote South Australia”⁸ acknowledged the enormous strides taken in the provision of mental health services in South Australia following the formation of RRMHS.

In the report the RRMHS was seen as:

- an innovative framework to deliver a seamless service to country SA
- utilising principles consistent with the Australian Mental Health Strategies and having a strong emphasis on community and primary care
- having “enormous” consumer and carer support
- being highly valued by all groups that used the service (professionals, consumers and carers).

The report concluded:

Given the relative youth of RRMHS (3 years old in 1998) the level of development was impressive. It is pleasing to note the high level of user satisfaction with all aspects of the service. Many of the criticisms are reflective of the limited resourcing of all aspects of the service under examination.

There has not been a further systematic evaluation of the service since that time. The Bisset report⁹ added further qualitative information which has guided strategic planning for 2004–2007. The need to more systematically evaluate our service and to report our findings is a major objective for this period.

Governance

Over the past ten years there has been significant organisational restructuring and “change” in the delivery of mental health services in South Australia. There have been reviews of the changes, reviews of the reviews and then demand for further “change”.

There have been a few constants, ie the patients, carers and the dedicated clinicians within the mental health services trying to meet the demand. There has been constant debate about number of beds, models and leadership within SA. There has also been a constant flow of different “administrators”, who never seem to stay long enough to evaluate and take responsibility for the “change” they initiated.

Fortunately for the RRMHS the service has been allowed to evolve although the commitment to its ongoing existence at times has waived. This is reflected by no increase in real funding or manpower resources following the 1998 review.

However with the appointments of Dr Jonathan Phillips as Director on Mental Health in SA in 2003 and Ms Fiona Kelly as Director in 2004 there has been a renewed energy and vision for the service.

Clinicians have also felt that policy has been driven from the “top down” and been “Adelaide centric”.

Lipsky¹¹ argued that services are largely governed by “street bureaucracies” in which key staff involved in direct provision of services set their own rules and norms about access and services delivery regardless of formal policy and procedures. This certainly has applied in country SA.

RRMHS is valued State-wide by local service providers and consumers. The service model compliments primary care and with its capacity to cross interfaces has enabled key policy initiatives and necessary change to become more palatable and implementable in regional areas.

Interface with primary care

In country SA there is essentially no mental health service with General Practitioners (GP). RRMHS augments all primary care services but GPs in particular. The focus is to up skill GPs and to build further capacity in the regions.

Lambert¹² argues that rural primary care remains the “defacto mental health system” in many rural areas. This view was supported by Tobin¹³ who in attempting to meet the mental health needs of an isolated rural community in the Grampians reported that the model had to involve the General practitioner as they constituted the most highly trained professionals, were located in proximity to the patients and were already providing a comprehensive – albeit limited – with respect to mental illness management

Herzig¹⁴ in reviewing rural service innovations noted the need to closely involve and adapt to existing agencies and community systems. He suggested that by identifying, training and collaboration with the right local people and by providing them with ready access to specialist help and advice, a service can extend to reach the most remote places and most socially isolated individuals.

This is one of the major achievements of the RRMHS of SA.

However of great concern is the reliance of overseas trained doctors in South Australia coupled with the recently released report “Viable Models of Rural and Remote Practice”.¹⁵ With one in two general practices likely to be “non viable” within 5 years and 37% of the regional GP workforce planning to leave rural practice we are facing enormous challenges in the provision of health care in SA.

The implications for mental health services in country South Australia are obvious.

Resident psychiatrists in South Australia

By World Health Organisation standards (1 psychiatrist for 10 000 people) there should be 42 residents psychiatrists outside of Metropolitan Adelaide. The only recent resident psychiatrist in country SA has recently returned to Adelaide. This situation clearly needs to be addressed.

Burville¹⁶ claimed that in most Australian states the major problem is not one of too few psychiatrists but rather the distribution of specialist resources between states and between city and rural areas. He concluded: “ the College would be better advised to expend more time and effort in attempting to overcome these misdistribution problems...than producing more psychiatrists.” However when psychiatrists have ventured into the country they have often been viewed as “outsiders”¹⁶ “urban transplants” who encounter a degree of distrust from rural clients and colleagues.

In a national survey of Canadian psychiatrists Kates¹⁷ found that the greatest obstacle to improving this situation was the lack of importance placed on collaborating with primary care by supervisors. This was followed by a lack of teachers and role models who could train psychiatry residents. Kates concluded that if one wants to train psychiatrists who will be useful in a primary care orientated system, one must have psychiatric supervisors who can model the behaviour and actually work in that environment.

RRMHS has developed an infrastructure to support and train potential resident psychiatrists. There is now a core group of consultant psychiatrists and other staff skilled in C-L primary care psychiatry, videoconferencing and who have extensive professional networks by visiting the regional areas.

RRMHS has developed the competencies and capacity to support regionally based psychiatrists and trainees and to assist in their integration into the existing regional services

Nursing and allied health

RRMHS has been developed using a strong multi-disciplinary team approach to service delivery. Many of the staff that have worked within the Adelaide based service have subsequently taken up senior clinical and administrative roles in the regions.

This has helped build regional capacity and to strengthen the model of service delivery.

There is also enormous potential for training, supervision, peer support and up skilling of isolated nursing and allied health staff working in country SA through the ETLs and videoconferencing service.

A current service work group is investigating the impact of the RRMHS in the recruitment and retention of allied health staff in regional SA.

DISCUSSION

There is an increasing emphasis on regionalising and decentralising services in SA, which is welcomed at many levels. To date there has been little acknowledgment that in mental health, you do not always have to be “in” the region to provide a much needed and quality service to that region.

RRMHS is a centralised, Adelaide based service that is dedicated to rural and remote SA. It fulfils a niche that will be difficult to replicate locally.

Theoretical models and lessons from other successfully integrated programs are not easily reduced to a “how to do” list¹⁸ that can be applied to a new service.

RRMHS was developed incorporating the best available evidence base and practice models at a time when there was a desperate need for change.

The service has been tailored to local SA needs in partnership with consumers, carers and the local professionals. The initial wide consultation has meant that the service model has been “owned” by the professionals who implement it and by the consumers who continue to use it.

CONCLUSION

Many of the practical constraints and problems in providing mental health services to rural and remote regions are common to all specialist services in these regions.

Professor Hollows¹⁹ was world renowned as a man of great vision. He emphasised four principles in the provision of effective specialist services to remote communities in Australia:

- The need for credible and competent services providers.

- Regular services.
- Good liaison and communication with the local community.
- Empowering local health care professionals so that they are better able to advocate for and manage their patients.

In 1994 Hoult highlighted that SA mental health services had failed on all four counts.

A decade latter the RRMHS strives to continue to meet these objectives. It demonstrates that by using a C-L approach in primary care you can bring psychiatric services to “the last frontier”.

ACKNOWLEDGMENT

To the tireless dedication of past and present staff of RRMHS for their passion, energy and their “can do” attitude in developing and delivering the services of RRMHS to the people of country SA.

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PRESENTER

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