Multiple partners for mental health

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INTRODUCTION

This paper presents the experience of a mental health (MH) service addressing the challenges faced providing a comprehensive service across a sparsely populated, large geographical area. Initially, to contextualise the discussion, an overview of the Eyre Region is provided. A brief outline of the National Mental Health Strategy is followed by discussion of difficulties inherent in provision of health services in rural and remote areas. Building and maintaining a skilled multi-disciplinary workforce is seen to be a key challenge. The Eyre Regional MH service has established a range of partnerships in an effort to address this and other challenges. These partnerships have enhanced the capacity of the service to provide coherent consistent mental health care across the region but have not been challenge free. Partnership is seen to be fundamental to effective and efficient health service delivery.

THE EYRE REGION

The Eyre Regional Health Service Inc. covers the Eyre Peninsula, South Australia, excluding Whyalla. Public health services are provided by five independently incorporated health units under the Regional umbrella. Ten small hospitals comprise the backbone of the health service and each incorporates an aged care facility. There are five community health programs, and a multi-purpose health service. There are 46 GPs in the region concentrated in Port Lincoln. Visiting specialists provide a range of outpatient services, generally at Port Lincoln and Ceduna. Alternatively, specialist services are accessed in Adelaide. Health service funding is principally provided through the State ($34 million approx) with a significant contribution ($6 million) through the Commonwealth Rural Health Service program.

Typical of rural and remote areas, the Eyre Region is characterised by significant distance to metropolitan centres and low population density. Adelaide, approximately 7 hours drive from Regional centres, is also accessible by air from Port Lincoln and, less frequently, Ceduna. The Region, encompassing multiple local council areas, covers 72 354 square kilometres (7.4% of SA land mass) with a population of approximately 34 000 giving a density of 0.4 people per square kilometre (the second lowest in SA). The median age is around 35 and nearly 15% are aged 65 years and over. The largest population centres are Port Lincoln (40.2%), Ceduna (14%), Tumby Bay and Streaky Bay.[1]

There is considerable cultural diversity within the region. Approximately 5.5% of the population identifies as Aboriginal. The majority of Aboriginal people live in Ceduna and surrounds where they comprise 22% of the population. Just over 1000 people (3.1%) identify as being from culturally and linguistically diverse backgrounds, primarily Eastern- and Mid-European.[1]

The region has a SEIFA index of 964 (SA average 984). Because Port Lincoln has more millionaires per capita than any other area in Australia there is an illusion of wealth. Average annual income, however, is less than $30 000. Agriculture and fishery are the major industries with support industries for these providing a significant amount of employment. Regional unemployment runs at around 8%.[2]

Anecdotally the population is outgoing and friendly supported by strong social fabric. However Regional communities can be exclusive of those who do not so easily belong. Shire Councils place emphasis on economic success, arguably at the expense of social justice.

Health workers describe a conservative community with 'traditional values'. Mental health issues are hidden or denied by many. Community consultation indicates that low levels of mental health literacy. A marked reluctance to seek 'outside' help is apparent and MH consumers report experiencing stigma in the community and health services.

NATIONAL MENTAL HEALTH STRATEGY

The National Mental health Strategy agreed to by Commonwealth, Sate and Territory governments in 1992 sets the direction for development and reform of mental health care in Australia. The National Strategy has been operationalised through the First and Second National Mental Health Plans, and most recently the National Mental Health Plan 2003–2008. National Standards for mental Health Services (1996) provide a framework for service development detailing standards related to universal issues such as human rights and community acceptance, MH service organisational structure, and care delivery.

Partnerships are recognised a priority area in the National Strategy documents. The relationship between mental health and general health services and linking mental health with other sectors are two of the 12 priority areas established under the Strategy.[3] National Standards stress collaboration with consumers and other care providers to ensure continuum of care and development of partnerships is identified as a key theme in the Second National Mental Health Plan. Clearly partnership is fundamental to achieving well under the four priority themes of the National Mental Health Plan 2003–2008[4]:

- promoting mental health and preventing mental health problems and mental illness
- increasing service responsiveness
- strengthening quality
- fostering research, innovation and sustainability.

CHALLENGES IN RURAL HEALTH SERVICE DELIVERY

The barriers to health service delivery in rural and remote environments are well documented (cf Kelly, 1998; Judd et al, 2002). Distance and sparse population, community characteristics, resourcing issues, the structure and changing role of health services, and governance arrangements create challenges. Arguably workforce issues are among the greatest challenges to delivery of relevant service in rural areas such as the Eyre Region.

Human resources are fundamental to health service delivery. Difficulties educating, recruiting and retaining qualified competent staff, and workforce maldistribution are among challenges to service provision and access identified in the literature[5] relevant in Eyre.

In summary provision of general and mental health services in the Eyre Region is affected by:

- population characteristics
  - Minimal population growth
  - limited catchment population

- population distribution
- changing demographics

- geography and distance
- the number and viability of small country hospitals and their capacity to deliver or access specialist services
- competing (as opposed to complementary) services
- workforce issues
  - recruitment and retention
  - access to training and supervision.

MENTAL HEALTH SERVICES IN THE EYRE REGION

Community based MH services were founded in the Eyre Region in 1994 when a single position was locally funded. The service grew gradually and in 2000 the Community MH Team comprised 6FTE including a co-ordinator role, growing to 9FTE in 2003. 'Owned and operated' by two Regional health units — Port Lincoln and Ceduna — outreach was provided on a needs basis. The co-ordinator reported to the PLHS Director of Community Health and while the role was 'regional' lines of reporting made it difficult to effect region-wide service development.

The lack of a regionalised service model meant that clinical processes and pathways were inconsistent and informal and service delivered to consumers was somewhat dependent on location. Stakeholders reported confusion regarding service 'core business'.

Staffing presented a challenge for the service. Three positions were vacant and with the exception of the co-ordinator who had a social work background the team was comprised of nurses. Multi-disciplinary input to consumer care was not possible without referral to an external service.

Evaluation of the Second National Mental Health Plan revealed that South Australia had fallen significantly behind in MH service reform.[6] Subsequently State funds become available to support introduction of Regional Program Manager and Principal Clinician positions. The Program Manager position, reporting directly to the Regional General Manager, was to provide a single point of accountability for MH services and resources in the Region. Development and implementation of a comprehensive strategic plan was fundamental to the role. Resources (financial and human) were retained by the Regional Health Service (as opposed to being dispersed to Health Units) and in February 2004 the service became Regional.

SUMMARY STATEMENT OF THE CHALLENGE

The challenge facing the newly regionalised service was to develop and implement a model of care that afforded people of the Eyre Region equitable access to a comprehensive mental health service utilising existing resources. The service needed to address the full continuum of care encompassing promotion, prevention and early intervention through to acute inpatient support to meet mental health needs of the population and address challenges posed by distance, sparse population, workforce issues, and regional service structure.

PARTNERSHIPS – VARIOIUS TYPES

Resources were finite and it was essential to derive maximum return for every dollar invested in MH care in the region. Creative employment strategies needed to be used to fill vacant positions and partnerships were necessary to avoid duplication of infrastructure costs (eg office accommodation, administration support, IT) and to build complementary services and provide multi-disciplinary input to care within existing financial constraints.

Various types of partnerships have been established to address identified needs and maximise use of available expertise and resources. In some cases services have been 'purchased' and in others memoranda of understanding and service agreements have facilitated collaborative program design and delivery. Models of shared care are being developed to enhance consumer access to a range of psychosocial rehabilitation and primary care services.

National standards for Mental Health Services[7] stress the importance of multi-disciplinary input to care of mental health consumers. Enhancing the capacity of the MH service to provide multi-disciplinary care was recognised as a priority by the team and consumers during the strategic planning process undertaken early in 2004. Creative employment strategies and establishment of a Regional psychosocial service network (still in early stages of development) have been used to address the problem.

Recruiting

Filling existing positions was identified as a high priority. Advertising locally and nationally was unsuccessful so alternate strategies were employed in the interim. Contacts with inter- and intra-state services were utilised to offer allied health staff locum positions in Eyre. Clinicians taking up these offers used their time with ERHS MH team to develop skills in rural and remote service delivery, broaden clinical experience thereby enhancing opportunities for further rural and remote employment. Stronger links between services have been developed and employee exchange programs are being explored. There have been challenges to team coherence and structure related to staff turnover. Potential threats to continuity of care have been managed through careful caseload allocation and management. Employment of locums allowed the service 'space' while extensive recruiting was undertaken and all positions are currently filled permanently.

Another strategy employed to enhance multi-disciplinary care was formation of a clinical network. The network aims to improve the delivery of health services through co-ordination and integration utilising principles of co-operation and partnerships between health care providers and key enabling stakeholders. Negotiation with community health managers resulted in the formal linking of sole-practitioner community social workers from two health units with the MH team. This offered multiple benefits to stakeholders with minimal organisational restructure. Consumers benefit through timely access to formal mental health services through locally based workers and multi-disciplinary input to care; workers benefit through active participation in a team providing professional and collegiate support and clinical leadership while maintaining professional identity; the mental health team benefits through increased team participation and discipline specific input provided and the mental health service benefits through reduced pressure on current services providers enhancing effectiveness and efficiency. There is considerable potential for further development of the network to facilitate integration and continuity of care through of other psychosocial service providers in the network.

Aboriginal social and emotional well-being

Aboriginal people and communities face multiple challenges to mental health and well-being as a result of colonisation. Consistent with National documents the ERHS MH Strategic Plan identifies enhancing the mental health and social and emotional well-being of Aboriginal people as a key result area. The plan identifies promotion of partnerships and collaboration with Aboriginal health services in building social and emotional well-being in the Aboriginal community and improving access to culturally safe mainstream mental health services as strategic directions. An Aboriginal mental health portfolio has been allocated within the team to ensure accountability for operationalising the strategic directions.

Informal relationships with community controlled Aboriginal Health Services established over time are being formalised at the request of Aboriginal Health Services. Synergistic partnerships are enhancing the capacity of each service to meet identified goals and providing opportunities for shared learning. Mentoring relationships have been established between members of each team to foster shared understanding of service priorities and roles and to assist in professional development of team members. Additionally a mental health clinician is based at the Aboriginal health service premises one day each week providing ready access to formal mental health services for Aboriginal people who choose not to attend at non-Aboriginal health facilities. This relationship promoting strategy also provides multiple informal learning opportunities.

The mental health service is receiving ongoing cultural awareness training from the Aboriginal Advocate employed by PLAHS to improve the cultural safety of the mental health service. Aboriginal health workers are invited to participate in all service training and education activities. Together the mainstream and Aboriginal services are delivering care to promote mental health of Aboriginal community members.

Drug and alcohol services

Until the end of 2004 clinical drug and alcohol services across the Eyre Region were the responsibility of a .5FTE Drug and Alcohol Services Council (DASC) worker based in Port Lincoln with some non-clinical work undertaken by a .4FTE community based worker. The DASC worker was tasked with providing a comprehensive alcohol and other drug service including promotion and prevention, assessment, counselling and referral of people with drug related problems and their significant others (REFERENCE). Clearly resources were inadequate to meet the needs of population of around 34000.

Specific concerns for the MH service related to accessing support to address the needs of consumers with co-morbid drug and alcohol and mental health problems. Consistent with national and international evidence consumers with dual diagnosis comprised a significant percentage of service consumers. Referrals between DASC and MH services were problematic for clients and services. As attempts to secure funding for a dedicated dual diagnosis position were unsuccessful alternate options were explored.

Regional funding to support implementation of a drug diversion program was utilised to increase the DASC position to full time. The redeveloped role, in addition to co-ordination of the diversion program, includes provision of support to the MH service. The DASC worker attends all clinical and quality meeting Shared care protocols, reciprocal training and clinical pathways have been developed ensuring that clients with dual-diagnosis have equitable access to holistic care.

Adult survivors of child sexual abuse

A clinical audit demonstrated that a number of mental health service referrals involved adult survivors of child sexual abuse. The mental health service lacked expertise in the area and the only government service providing relevant counselling and support had extensive wait lists. A service agreement was entered into with a local NGO with expertise in the area to provide the mental health service with appropriate support. 'Top up' funding was provided to the NGO ($10 000) to enable an appropriately skilled worker to be employed for additional hours. In addition to direct client services the partnership has 'upskilled' mental health workers through collaborative service delivery, supported development of a training program for workers, and a will a deliver a program of public seminars.

Mental health care for older people

There are no specialist mental health services for older people available in the Eyre Region. The mental health service provides assessment and management of people over 65 with major mental illness but there is clearly a gap in provision of support to older people with sub clinical mental health problems. To begin addressing this gap the service has entered into a service agreement with a local private aged care facility. The facility has developed its Day Care and respite programs to promote social inclusion and mental health of isolated older people. Group programs facilitate activities planned to promotes self esteem, maintenance of residual skills and provides an opportunity for enjoyment and social contact. Mental health workers participate in the programs from time to time and provide specific mental health information as needed.

Child and youth mental health

Child and youth mental health is a priority area requiring both promotion, prevention and early intervention (PPEI) and specialist interventions. In ERHS specialist services to those under 18 are provided by Child and Adolescent Mental Health Services (CAMHS) and non-government agencies provide sub-clinical support services. Funding limitations and service demands preclude comprehensive service across the Region.

ERHS receives limited state expansion funding ($80 000) to support mental health care of children and young people. Having previously employed a sole child and youth worker and encountered the difficulties associated with isolated practitioners including lack of relevant professional and clinical support, limited access to training and development and having that worker move on, options warranted exploration.

A service agreement was negotiated with CAMHS whereby ERHS contracts a full time worker through CAMHS. This worker receives full clinical and professional support from CAMHS and provides well received visiting services as needed. The partnership is enhancing links between adult and CAMHS services, facilitating development of clinical pathways and family centred models of practice.

Additionally as the service lacked the specialised skills and entrees to the community of interest it has entered into a partnership with an NGO to provide early intervention services to at risk young people. A well established youth service with existing 'street cred' has been provided with additional funding ($10.000) to top up 'top up' an existing position to support extension of group programs promoting resilience in at risk young people and support to their families.

General practitioners

First point of health service contact for 75% of people with mental health problems is a GP (REFERENCE) making GPs major stakeholders in MH care. The goal of the Eyre Regional MH service is to provide services collaboratively with GPs, providing specialist input as required to facilitate return to primary care services for follow up as soon as possible. A recent initiative has seen mental health services being provided from a major GP clinic in Port Lincoln two days per week. The role of the mental health worker based in the surgery is to provide defined intervention to people with high prevalence disorders. Having the worker based in the surgery will enhance networking opportunities, facilitate provision of input to client care promote appropriate referrals. This will work toward addressing concerns of GPs regarding confusion around the role of the MH service and communication difficulties elicited by a survey in March 04. A model for formal shared care is currently being developed to further facilitate best practice mental health care.

Psychosocial rehabilitation

The emergence of recovery paradigm in MH care has focused attention on the need for psycho-social rehabilitative services. Access to such services is frequently limited in rural and remote areas and the Eyre Region is no exception. The service has entered into a partnership with an NGO to provide community based skill development and recovery program. For the very modest contribution of $3000, to fund support workers and the program development skills of an Occupational Therapist recently recruited to the team the service has been able to facilitate consumer access to a well structured rehabilitation program. This has reduced pressure on service clinical staff to deliver non-clinical care.

CONCLUSION

This paper has outlined two strategies used to address challenges to mental health service delivery in a rural and remote region of SA. Following a brief discussion regarding employment of locum staff a number of partnerships have been explored. These partnerships have been seen to provide a range of benefits to consumers, other stakeholders and the mental health service. It is important to note, however that while partnerships and service agreements provide multiple benefits but are not a simple 'one size fits all' solution to wide ranging service issues. Utilisation of partnerships in mental health service delivery poses a range of challenges that must be addressed in order that services be delivered in a sustainable and responsive manner. It is important that agreements be well negotiated with particular attention paid to governance and reporting arrangements. The duration of contracts needs due consideration too, with capacity to build services being limited when contracts are relatively short. In this quality focused health climate it is also essential that appropriate quantitative and qualitative evaluation of outcomes be undertaken.

Comments on this paper and ongoing evaluation of service outcomes will be used to refine and develop partnerships to facilitate equitable access to mental health care in the Eyre Region.

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PRESENTER

Sue Patterson is a psychologist with a background in (among other things) management and mental health in public, non-government and private sectors. She also has postgraduate qualifications in rural and remote health practice. Three years in service management in country areas provided first-hand experience of the challenges and opportunities of service delivery outside metropolitan areas. Currently employed as program manager for mental health services in the Eyre Regional Health Service she is dedicated to finding innovative solutions to the barriers posed by geography, funding limitations and bureaucratic structures. Sue believes that partnerships are fundamental to building creative service models that meet population needs.