Towards Integrated Mental Health Services in Rural and Remote Australia

David A Perkins,
Senior Lecturer in Health Policy and Management,
Dept of Public Health and Nutrition, University of Wollongong

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Poor integration of mental health services (MHS) is a problem which has concerned policymakers, clinicians, and most importantly patients and their carers throughout the 1990s. The integration and co-ordination of services is portrayed as the means to produce good quality services, continuity of care, and improved outcomes for consumers. The basic policy position seems to be that we want integrated, continuous, accessible, comprehensive services but that requires that we solve some problems that are currently in the “too hard basket” e.g. changing fee for service payment, organising services by program rather than institution, and moving from fragile ad hoc methods to more sustainable methods of co-ordination.

WHAT IS THE CURRENT POLICY CONSENSUS?

The 1992 National Mental Health Policy aimed to:¹,²

...improve the quality and range of assessment, treatment and rehabilitation services available to people with mental health problems.

The policy identified the following failures in integration:

• integration of elements of mental health services;
• integration of prevention, promotion and treatment;
• integration with primary care services;
• integration with the general health system;
• integration of mental health services with non-health sectors; and
• integration with consumers and NGOs.

The theme was taken up in a 1993 National Health Strategy issues paper, which concluded that:

There are few financing incentives for the integration of public and private specialised mental health services to ensure wider access and continuity of care for people with chronic mental illness.³

The paper suggested that significant reform was needed including: new service models, case management, a multi disciplinary approach to service delivery, an assessment program which offers a single point of entry into an integrated
service, an information system to support the continuity and integration of service delivery, and major reforms in financing, organising and resourcing of services.

This theme was continued in the Second National Mental Health Plan which states that:

... The main challenge in service reform and delivery is to achieve an appropriate and coordinated system of care that meets the needs of individual consumers across the life span. (p 16)  

This is to be achieved through empowering consumers, and formally entrenching partnerships at both the system and service level through policies, procedures, protocols and funding. Appropriate and co-ordinated services are to be achieved through strategic alliances between some or all of the following stakeholders depending on context and consumer preference:

- consumers/families/carers;
- GPs;
- private psychiatrists and the private mental health sector;
- emergency services;
- the wider health sector;
- other government services;
- non-government agencies;
- community support services; and
- the broader community.

These concerns are clearly defined in the National Standards for Mental Health Services (1997). The health framework for regional and remote Australians (Healthy Horizons, 1999) emphasises 4 key criteria which underpin the strategy - community participation in local health services; education and information of the population on actions to improve health; collaboration between community members, health professionals and others to determine local action priorities; and action to ensure that health improvements are sustainable.

In short, there is a consistent policy assumption that health services are intended to be locally acceptable, built on services delivered in an integrated fashion and designed so as to be sustainable. To date it might be argued that rhetoric exceeds reality.

**Mental Health Integration Demonstration Projects (MHIP)**

The MHIP follows directly from this policy stream and provides an opportunity to identify best practice and learn from experience in addressing some of these integration problems. The somewhat modest aim ... is to establish and document approaches to integrating private psychiatrist and public sector mental health services. The purpose is to create a more flexible integrated framework within which mental health can be delivered.
A national advertisement sought two page expressions of interest which were to demonstrate the following:

- evidence of broad interest from public and private sectors in developing a detailed proposal for a demonstration project;
- description of the extent of current integration mechanisms;
- outline of broad integration strategy to be pursued; and
- demonstration of a broad agreement between stakeholders to collect routine patient outcomes.

The method was designed to permit a wide range of applications ranging from highly integrated services wishing to document progress and ensure sustainability, to services which are low integrators and seek support to make progress.

This resulted in 27 expressions of interest of which two failed to meet the basic criteria. Of the remainder, eight were urban services, nine urban and rural, six rural, one rural and remote, and one remote. Only eight applications had no rural or remote component.

The proposals were limited to two pages and therefore the information was in broad form and not elaborated. A number of key characteristics can be identified:

- range of stakeholders involved;
- range of services included;
- integrating mechanisms identified;
- existing degree of integration; and
- particular local problems.

From these characteristics we can identify a number of typical approaches to the integration of services.
INTEGRATION PROPOSALS BY RANGE OF STAKEHOLDERS AND SERVICES

<table>
<thead>
<tr>
<th>Stakeholder Range</th>
<th>Service Range</th>
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<tr>
<td>Narrow</td>
<td>Narrow, Middle Range, Broad</td>
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<td>e.g. AMHS, Private Psychiatrists</td>
<td>1 Specialist Psychiatry, 2 Service Development, 3</td>
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<tr>
<td>Middle Range</td>
<td>4 Shared care models single diagnosis, 5 Shared care models range of diagnoses, 6</td>
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<tr>
<td>e.g. AMHS, Private Psychiatrists, GPs</td>
<td>7 Diagnosis based, Care-group based, 8</td>
</tr>
<tr>
<td>Broad</td>
<td>9 Comprehensive Integrated Service</td>
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<td>e.g. Full range of Stakeholders</td>
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Cell 1 – Proposals concerned employing specialists as VMOs or trying to attract a resident psychiatrist to a rural location. It may be that resident posts are unattractive in low integrators characterised by high workload, professional isolation, and poor support. (3 proposals)

Cell 2 – Proposals focussed on the attraction of specialist staff but permitted a broader definition of the service to be provided. This might include a range of professional activities such as research, supervision, the opportunity for private practice for a resident psychiatrist, and the development of a team approach to care. (4 proposals)

Cell 4 – Proposals included a wider range of stakeholders frequently involving GPs and consumers. It focussed on a narrow range of services or conditions and was often thought to be the precursor for a broader form of integrated service. It provided opportunities to build relationships and trust, to develop the sorts of systems required in a shared care approach without making unrealistic assumptions about experience or systems for communication and collaboration. (4 proposals)

Cell 5 – These Areas proposed a larger range of stakeholders than cell 2 and identified specific services which were targeted for integration. (5 proposals)

Cell 7 – Proposals often had a strong academic or research component and frequently involved prospective tracking of a group of patients across a wide range of services. Based on clear research protocols and specific “contracts” they balanced complexity of stakeholder group with well defined target. (1 proposal)
Cell 9 – These represent the most ambitious proposals with stakeholder groups that include 2 or more AMHS’s, private psychiatrists, private clinics, public hospitals, GP divisions, NGOs and consumer groups. They concern the full range of services and require sophisticated integration processes such as stakeholder contracts, pooling of funds, new administrative arrangements, steering committees, and dedicated project management. They tend to originate from services with a track record of integrated activities. One proposal adopted the model strategic alliance between the private clinic and coterminus public community services. These cell 9 proposals resemble the objectives of the policymakers outlined above. (5 proposals)

CO-ORDINATION MECHANISMS

The proposals include co-ordination mechanisms which vary in complexity and cost. The simplest (which ironically, can also be the most complex) is termed mutual adjustment. One proposal commented that the contacts between the AHS and private psychiatrists were ad hoc and infrequent which did not promote integrated services or continuity of care. While we might expect this to be adequate at very low levels of interdependency, it is unlikely to foster an integrated service. 7

A second form of integration termed standardisation comes in several forms. Standardisation of inputs in services implies common education, training or common skills among staff. Such commonality is unusual at pre-registration level and is not common at post registration although there is some evidence of joint education and training in the proposals. Standardisation of processes is the most common integration process proposed. Whether through shared care arrangements, clinical pathways, case management, or other forms of protocol stakeholders seek to provide reliable, predictable and robust services systems by the use of common processes which cross agencies, professions and organisations. They cannot be implemented consistently without other supporting mechanisms.

A third form of standardisation refers to service outputs. This includes the recording of activity and outcomes. The collection, analysis, and interpretation of complex data is a problem in rural and remote organisations with few discretionary resources who seldom have the skills and technology available in larger, usually urban, services.

More complex needs for integration rely on integrating roles where individuals are charged with physical liaison between stakeholders. Such roles were proposed for mental health liaison nurses, GPs with a special interest in mental health and various forms of case manager. While the ability of such roles to overcome the structural difficulties outlined above must be limited, they do meet the objective of a single point of access and may provide a continuity not otherwise available. Existing models of case management can imply a special category of staff or a role to be taken by the most appropriate locally available health or related professional.
The most complex co-ordination tasks require formal or structural solutions and proposals included structural redesign such as the creation of a new department, an outreach or crisis team by extending the role of one of the stakeholder organisations. The use of formal contracts between groups of stakeholders underpinned the development of funds pooling or purchaser/provider arrangements. It is suggested that such integrating mechanisms are essential if cell 9 type proposals are to become integrated services.

These most complex forms of integrated service will require considerable investment in the development phase approximating to the most complex form of integration in which mutual adjustment takes place, not as ad hoc contacts, but as a form of real time problem solving in which complementary expertise and interests are represented to develop a unique solution to particular circumstances.

**The impact of rural contextual factors identified in the proposals**

In several submissions the precipitating factor appeared to be the loss of a resident specialist psychiatrist or the loss of local private psychiatrists and associated VMO sessions. Where solutions are based upon contracts with individual practitioners, services may ride a roller-coaster which dips when individuals change jobs.

The proposals demonstrate that rural mental health services are under funded in comparison with their urban counterparts. Despite policy pronouncements to the contrary it appears that mental health services have not been successful in quarantining resources.

Given the complexity of developing integrated care in rural contexts and limited resources, rural mental health services experience difficulty in funding expertise and the IT, research and other systems needed to manage comprehensive integrated care systems. Another feature of scale is that discretionary resources are limited and new developments designed to improve continuity can be lost when key staff are fully occupied in acute or crisis intervention,9-12

**HOW THEN DO WE MOVE TOWARDS THE INTEGRATION OF MHS IN RURAL/REMOTE AUSTRALIA?**

Progress towards integrated mental health services in rural and remote Australia will depend on a series of local solutions which are able to solve some of the following problems:

- how to create and sustain a strong “contract” between stakeholders;
- how to protect, develop and perhaps pool funds so as to ensure appropriate resources and incentives within services;
- how to develop locally agreed service models, clinical pathways, and protocols which the full stakeholder group can implement and develop;
- how to develop and maintain adequate information systems and feedback which permits continuity of care and quality of service;
how to secure consumer participation and support; and
how to ensure responsive problem solving mechanisms which allow all members of the service to deal quickly and effectively with difficulties.

Perhaps it is not surprising that policy pronouncements have proved elusive in practice. The MHIP projects are designed to provide models for integration but solutions must inevitably be crafted locally.

REFERENCES