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The Far West Mental Health Integration Project Model

Centre for Equity and Primary
Health Research in Illawarra and Shoalhaven

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INTRODUCTION

The 1992 National Mental Health Policy¹ highlighted several failures in integration:

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

A 1993 National Health Strategy issues paper argued: ²

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

It made the case for significant reform including new service models, case management, a multi-disciplinary service delivery, 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 and resourcing services.

The Second National Mental Health Plan 1998 stated: ³

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 (p16).

The Third Plan 2003 ⁴ was designed to consolidate the progress made on its predecessors and to address gaps. (p.7). It affirmed that the overarching aims of the First and Second National Mental Health Plans had not changed (p.8).

The first principle of the third plan is that:

All people in need of mental health care should have access to timely and effective services, irrespective of where they live (p. 10).

The Mental Health Integration Projects (MHIP) followed this stream of policy with the following aim:

To establish and document approaches to integrating private psychiatrist and public mental health services. The purpose is to create a more flexible integrated framework within which mental health can be delivered.⁵

In 1998 a national advertisement sought expressions of interest from Area Mental Health Services that were to demonstrate the following:

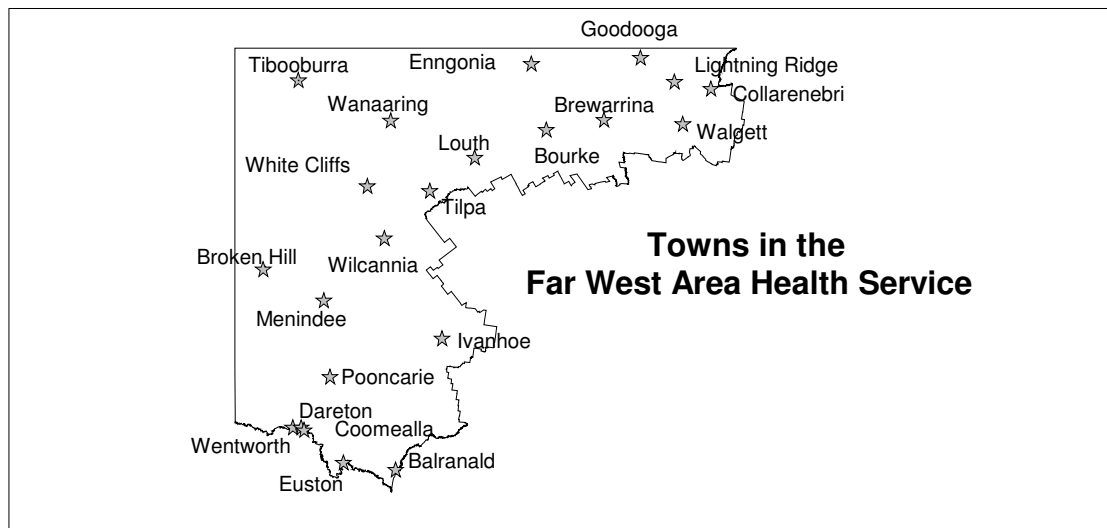
- Evidence of broad interest from public and private sectors in developing a detailed proposal for a demonstration project;
- Description of the extent of current integration mechanisms;
- Outline of broad integration strategy to be followed; and
- Demonstration of a broad agreement between stakeholders to collect routine patient outcomes.

The Far West Area Health Service was selected to receive planning and then project funds. The live phase of the project commenced in 2000 and the evaluation was published in December 2003.⁶ This report describes the model of care and research conducted in the evaluation process.

CONTEXT AND OBJECTIVES

The FWAHS was the largest area health service in NSW occupying one third of the total landmass, but with about 50,000 people it has less than one percent of the State's total population. Almost half of the population live in Broken Hill. The remainder live in 20 small towns and communities scattered across a wide area (see Figure 1).

Figure 1: Far West Area Health Service



The entire Far West Area has been classified by the Australian Bureau of Statistics as remote. Approximately 13 percent of the population are Aboriginal, compared to 1.7 per cent of the State as a whole.

The area rated lowest in Australia in the Index of Relative Socio-Economic Disadvantage (IRSED) suggesting that it is the most disadvantaged area in the country.⁷

According to the Commonwealth publication *Mental Health Needs and Expenditure in Australia 2002*,⁷ about 12% of the population have needs that are usually treated by public mental health services i.e. affective disorders, personality disorders, psychosis or cognitive impairment. About 20% have needs usually treated by private mental health practitioners i.e. affective disorders, anxiety disorders and substance abuse. Only eight Areas in Australia had a higher prevalence of these disorders.

It is clear that the Medical Benefits Scheme (MBS) does not work in areas where there are no resident doctors whether specialists or GPs. The Australian Medical Workforce Advisory Committee reported a serious maldistribution of psychiatrists:

A comparison of RANZCP defined psychiatrist-to-population benchmarks and AIHW 1997 labour workforce survey data indicated a maldistribution of psychiatrists with an oversupply in capital cities (1:6,610) and an undersupply in all other locations (viz. 1:14,270 in other major urban centres, 1:20,593 in large rural centres and 1:41,283 in other rural and remote locations).⁸

This observation fits closely with the FWAHS experience of one resident public psychiatrist based in Broken Hill serving 50,000 people. Filling this appointment is not always easy and there are significant periods when the position is vacant.

This area provides a challenging context for all health care providers. There is high staff turnover and vacancy rates, staff have relatively low levels of experience and there are a high proportion of interns.

A small group of metropolitan psychiatrists have been visiting for many years fulfilling a clinical role which is largely, focused in and around Broken Hill.

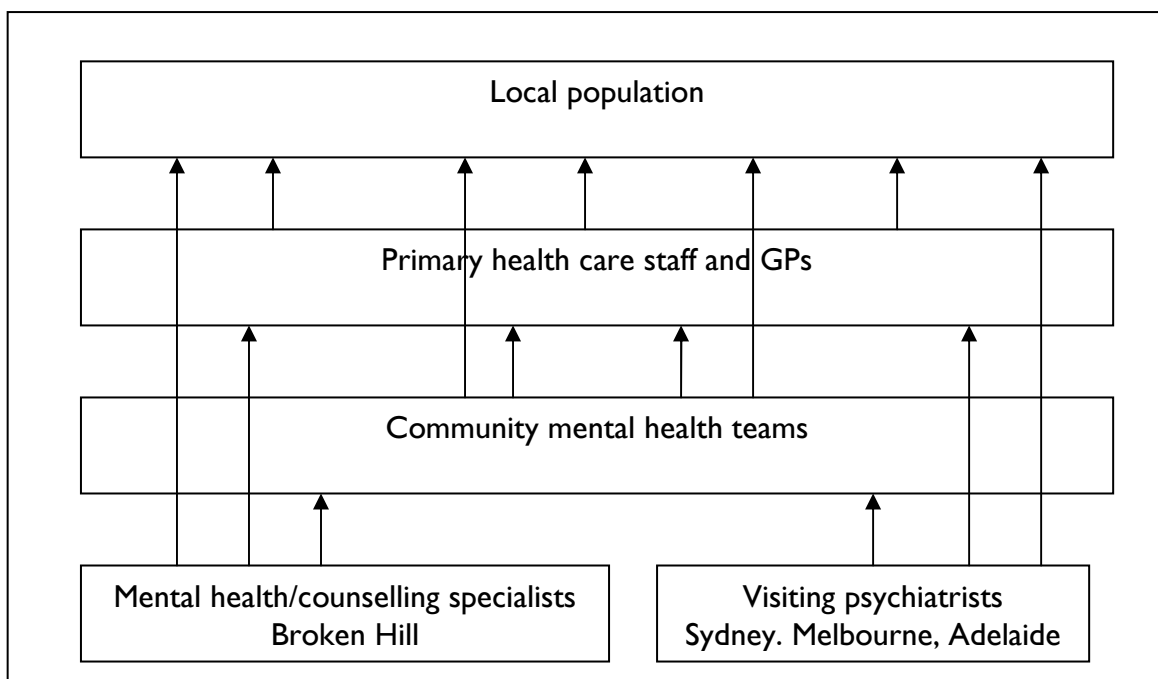
The project objectives fell into the following categories:

- To provide residents with access to a comprehensive mental health service,
- To encourage multi-professional collaboration and coordination of activity,
- To increase the focus on prevention of disorders and promotion of mental health,
- To develop a coherent funding mechanism,
- To enable consumer participation, and
- To provide local education and support for mental health workers and other health professionals.

THE FW-MHIP MODEL

The Area Strategic Plan⁹ (FWAHS, 1998) argued that a different approach to health service delivery was needed because the population was scattered over a large area; resources were limited and health problems increasingly lifestyle-related. A population health approach to planning and a primary health care model of service delivery was adopted. The Far West Mental Health Integration Project (FW-MHIP) model ensures that mental health services are an integral part of primary health care and population health. Figure 2 outlines the model:

Figure 2 FW-MHIP Service Delivery Model



Primary health care (PHC) staff and GPs provide basic mental health services to their local population. They are supported by community mental health teams (CMHTs) based in hubs in local regional centres. The CMHTs and PHC staff are supported by regular visits from metropolitan psychiatrists and by visits from specialist allied health staff based largely in Broken Hill.

There are four hubs in Broken Hill, Lightning Ridge, Bourke and Dareton each with a Community Mental Health Team. The mental health and counselling specialists from Broken Hill support all the hubs but visiting psychiatrists are linked to a single hub and meet together twice a year for service development and quality improvement activities.

The core philosophy and key elements of the model are described in figure 3.

Figure 3: Elements of the FW-MHIP Model

Core philosophy	Elements of model
<p>The local resident mental health team, general practitioners (GPs) and other providers are supported by specialist mental health and counseling staff and by the visiting psychiatrists</p>	<p><i>Primary care strategy</i> – Services provided by local generalist staff supported by specialists from hubs and visitors from outside area.</p> <p><i>Hub structure</i> – CMHTs support general health staff and provide specialist services to patients</p> <p><i>Funding mechanism</i> - Cashing-up the level of MBS payments to what would be available if Area had its “fair share” of private psychiatrists and state funds.</p> <p><i>Management process</i> - Local mental health services are provided by a CMHT working with GPs, generalist health staff and others managed by a team leader who reports to the Director of Mental Health and Counselling.</p> <p><i>Visiting Patterns</i> – An increase in the quantum of visiting psychiatrists was achieved. The pattern of visits was altered encouraging psychiatrists to stay for one or more nights in the communities they visited.</p> <p><i>VMO roles</i> – Specialist psychiatrists were appointed as Visiting Medical Officers and encouraged to undertake a mix of primary and secondary activities to meet the needs of the teams and the communities serviced and to contribute to the wider service.</p> <p><i>Governance mechanism</i> – The project was treated as core business, covered the whole mental health and counselling service and was subject to the normal governance mechanisms of the FWAHS.</p>

Core philosophy

The role of visitors is to support resident providers who provide ongoing care and respond to crises. This “support” takes the form of primary activities, such as clinical assessment or consultation, where a patient is present and secondary activities including secondary consultation, caseload review, mentorship and education.

Primary care approach

At the community level there are Primary Health Care staff (nurses and Aboriginal health workers) and nursing staff providing care on a community, outpatient (including emergency department) and inpatient basis. These staff are crucial in screening and providing brief interventions in relation to mental health and counselling issues and referring to specialist services, where appropriate. One of the objectives of FW-MHIP was to provide these workers with appropriate skills and resources to undertake these tasks.

Hub structure

PHC staff are supported by the local community mental health team based in the hub towns. The size of the CMHT varies depending on the size of the local population and their needs.

Funding model

This model required additional resources provided by cashing out and cashing up Commonwealth Medicare Benefits Scheme and State funds to national and state average. This gave FWAHS flexibility in their use of the pooled mental health funds. The Area spent much of this money to purchase VMO services to support local resident staff. The cashed out MBS component was very small resulting in an additional \$270,360 over two years. Of more importance was the cashing up of \$702,050, together with project administration funds of \$279,400. Thus, the Area was given the funds that had been claimed on average by its residents who received MBS psychiatry services in the previous two years but also a cashed up element that provided FWAHS residents with a “fair share” of resources for the first time. The administrative component was to meet the development and reporting costs of the new project. These funds were provided for two years operation. Funds were not adjusted for the extra costs of providing services in a difficult context.

Management process

All referrals for mental health care are directed through the team. The team leader plays a crucial role in the model as the key contact with visiting psychiatrists, FWAHS, and the most experienced resident mental health worker. Team leaders are accountable to the Director of Mental Health and Counselling.

Visiting patterns

It is common for visiting specialists to fly in and out of rural communities on the same day, focussing on patient assessments and consultations with little time for important secondary activities. This was recognised at the beginning of the project and plans agreed for visitors to stay for one or more nights in the communities they visited. This allowed a new balance of work and was important in underpinning the core philosophy of FW-MHIP namely, supporting local providers.

VMO roles

The distinctive contribution of the VMOs lies in the range of activities undertaken, both primary consultations with patients, and also secondary activities with CMHT members, GPs, Aboriginal Health Services and providers in other agencies.

FW- MHIP adopted a generic model whereby visiting psychiatrists would incorporate primary consultation, secondary consultation, clinical supervision, education, and health promotion/liason activity into their schedules. Reporting of activity improved with the development of a proforma completed by the VMO following each visit and submitted to the Project Manager.

Where psychiatrists accompany visiting Mental Health and Counselling (MH & C) staff, secondary consultation often occurs during the journey. Direct consultation with patients occurs where VMOs travel to a larger community for a scheduled clinic, via videoconferencing, or where patients are flown out courtesy of RFDS.

A medium-sized community (Walgett, Collarenebri, Wentworth) is characterised by a large population with a resident GP service and a health service that operates 24 hours per day with visiting services from mental health workers. In these communities, psychiatrists have provided a consultant service to GPs, mental health workers and to generalist nursing staff and regularly provide direct clinical care to patients.

The larger-sized communities (Dareton, Broken Hill, Bourke, and Lightning Ridge) have resident GPs, MH & C teams and 24-hour health facilities. The role of psychiatrists in these communities has encompassed direct clinical care, secondary consultation to GPs and MH & C staff, and provision of training and supervision to GPs, MH & C and generalist staff.

Governance mechanism

Experience from the National Coordinated Care Trials highlighted the importance of good governance procedures to ensure that the project was not lost within the wider concerns of an Area Health Service.¹⁰ To that end, the project was part of core activities, made accountable through the Director, Board, and normal Area mechanisms and there was a representative steering committee chaired by the CEO which included providers and consumers.

RESULTS

The implementation of the FW-MHIP model in the non-Broken Hill sectors provided regular local access to a specialist psychiatrist for the first time. Table 1 shows the number of new patients seen by psychiatrists at each hub as reported for the quarters January 2002 - June 2003. The figure in brackets shows new referrals as a percentage of all referrals seen by the visiting psychiatrists.

Table 1: New referrals seen by visiting Psychiatrists by hub

Sector	Jan-Mar 02	Apr-Jun 02	Jul-Sep 02	Oct-Dec 02	Jan-Mar 03	Apr-Jun 03	Total 02/03
Broken Hill	3 (60%)	36 (61%)	31 (47%)	32 (52%)	29 (67%)	19 (40%)	150
Dareton	6 (35%)	5 (20%)	6 (28%)	6 (25%)	6 (26%)	10 (41%)	39
Lightening Ridge	17 (44%)	17 (53%)	10 (28%)	9 (34%)	14 (32%)	21 (47%)	88
Bourke	11 (55%)	18 (56%)	13 (52%)	23 (58%)	17 (60%)	21 (51%)	103
Total	37	76	60	70	66	71	380

Figures for the first quarter are low for a number of reasons. The start-up of new service and the need to introduce and manage the psychiatrist reporting process took some time to embed. While new referrals are important, they represent about half of the patients seen.

Access is more than the number of new patients seen and CMHTs report that it is usually possible for the team to ensure that those requiring a specialist consultation are able to see the psychiatrist on his/her next visit.

The team leader makes decisions about the urgency and importance of patient needs and plans the psychiatrist visit accordingly ensuring “access” to the specialist for CMHT members, GPs and other providers for a range of secondary activities.

In the second year of the project the target of for specialist consultations with Aboriginal persons was exceeded.

As the resident service the CMHTs saw a large number of clients with a wide range of mental health and other disorders. Table 2 shows the number of new referrals seen by CMHTs in each hub. Many of these patients will have been seen at some time by the visiting psychiatrist and therefore also be recorded in table 1.

Table 2: New Referrals seen by CMHTs by Hub

Sector	Jul- Dec 00	Jan-Jun 01	Jul- Dec 01	Jan-Jun 02	Jul- Dec 02	Jan-Jun 03	Jul- Dec 03	Total
Broken Hill	348	248	290	312	192	161	140	1691
Dareton	143	97	81	62	72	79	64	598
Lightening Ridge	89	64	73	116	110	123	95	670
Bourke	172	193	133	160	96	89	106	949
Total	752	602	577	650	470	452	405	3908

Secondary Activity

Secondary activities are defined as those activities undertaken by a visiting specialist where there is no patient present and where the objective is to assist a local provider in some way. This may include members of the CMHT, GPs, Acute Services Staff, and members of Aboriginal Health Services or other agencies.

Secondary activity accounted for about 10-20% of specialist activity throughout the project and included the following activities: case review and mentorship, caseload review, educational activities, and broader outreach to the local population and resident agencies.

DISCUSSION

It is not surprising that an increase in resources and a new flexibility in their use makes it possible to improve access to mental health services in a remote context although it does warrant some reflection. There is a considerable difference between establishing a position and recruiting and retaining an individual to provide a service.

Access improvements are demonstrated by the number of patients seen by psychiatrists and CMHTs, reductions in waiting times, and seeing patients locally rather than at regional or metropolitan centres.

GPs in remote centres reported that local access was critically important for some Indigenous and non-Indigenous patients who typically refused to travel for specialist assessment or treatment. As a secondary consideration medical evacuations are an expensive option for all concerned both in terms of direct and opportunity costs.

Of particular note is that fact that there has been a disproportionate improvement in access for Aboriginal persons who make up 13% of the FWAHS population. In Lightning Ridge and Bourke about half of patients seen identify themselves as Aboriginal.⁶

While access is important, the key to FW-MHIP is the balance of primary and secondary activities. A key objective concerned collaboration and coordination of CMHTs, GPs, and specialists. In practice, success was not spectacular for a number of reasons. GPs were in short supply and reported that they were overworked with little time for non-core activities. GP turnover was significant and relationships with any visiting specialist take some time to build. Many GPs were happy to refer to the CMHT, and through the team to a psychiatrist, and to await a letter from the specialist in a traditional manner.

However, GPs reported high quality instances of secondary consultation ranging from regular meetings with visiting psychiatrist to discuss issues such as treating patients with personality disorders to one-off instances of valuable secondary consultations.

The strongest evidence of the value of secondary activity is the relationship of visiting psychiatrists and CMHTs. This included mentorship, case and caseload review, educational activities, and joint consultation. In all cases the visiting psychiatrists were experienced practitioners and many had longstanding rural experience.

This broad ranging role was possible because of flexibilities in the FW-MHIP model. Visitors acted as general psychiatrists in most cases but were able to contribute their specialist expertise through the medium of tele-education sessions broadcast to the four hubs and attended by CMHT members, acute services staff, and some members of other agencies where appropriate.

Given the demands placed on the team leader and the shortage of experienced staff able to take on mentorship roles, the regular visits of the psychiatrist provided a new opportunity for CMHT and primary health staff to consult an experienced practitioner.

Interviews with CMHT staff suggest that opportunities for mentorship, education and support are important factors in recruitment and particularly retention of staff in the early years of their career particularly in the light of the professional and social isolation they experienced.

The sustainability of this model depends on a number of factors working within a broadly agreed set of goals and values.

FW-MHIP depends on the availability and support of resident staff and visitors. Well-designed roles are needed to attract and retain staff recognising that only a minority of staff will spend their careers in such locations.

The practice of visiting rural or remote locations is not uncommon. The key is what happens before, during and after the visit and the way in which a series of visits contributes to the local service. The motivation of visitors needs to be monitored recognizing factors that improve their experience and addressing matters such as administrative and organizational problems that might detract from their experience.

It is clear that this model could not have developed and is not sustainable under normal MBS fee for service arrangements. Its operation depends on both the quantum of funds and on the flexibility in the use of those funds. In essence the financing mechanism transfers a risk that private sector psychiatrists are unwilling to bear to the public sector.

This model focuses on the needs of local populations and providers; hence the role of local management and the team leaders is of particular importance. FW-MHIP is not over-specified since it must fit the needs of populations in different contexts such as Broken Hill and Bourke. In each hub the team leader is the local manager and plays a similar role despite differences in team size and composition.

While outcome data is scarce, information on activity is critical to assess the access improvements, quantify the extent of secondary activities, and see how the model is working.

The governance of this project was informed by findings from the general coordinated care trials.¹⁰⁻¹⁵ The project was managed as part of core business and therefore the FW-MHIP model became the service model.

Generalisability can only really be assessed empirically but there are a number of findings that suggest it warrants investigation. The FW-MHIP model has been shown to be flexible and to fit a variety of circumstances in Far Western New South Wales. It has proved attractive to each of the provider groups and has won support from related health and other services. It has achieved improvements in access for residents of remote communities at low cost.

In conclusion the model does require a significant investment in the planning, design and set up stage and the best test would be to attempt to replicate it in other remote or rural contexts.

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REFERENCES

1. Australian Health Ministers' Conference, *National Mental Health Policy*, Australian Government Publishing Service, 1992, Canberra.
2. Commonwealth Department of Health and Family Services, *Help where help is needed: continuity of care for people with chronic mental illness*, National Health Issues Strategy Paper no 5, 1993, Canberra.
3. Australian Health Ministers' Conference, *National Mental Health Plan*, Australian Government Publishing Service, 1998, Canberra.
4. Australian Health Ministers. *National Mental Health Plan, 2003–2008*. Australian Government, 2003. Canberra.
5. Eagar, K., Owen, A., & Perkins, D., Burgess, P., Epstein, M., Adamson, L., & Quinsey, K., Discussion Papers 1-6, *Planning Guidelines for the National Demonstration Projects in Integrated Mental Health Care*, 1999, Commonwealth of Australia, Canberra.
6. Perkins D.A., and Lyle, D., *Far West Mental Health Integration Project Evaluation Report*. Australian Government Department of Health and Ageing, 2003, Canberra.
7. Burgess P., et al., *Mental Health Needs and Expenditure in Australia*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Ageing, 2002, Canberra.
8. Australian Medical Workforce Advisory Committee, *The Specialist Psychiatry Workforce in Australia*, AMWAC Report 1999.7, 1999, Sydney
9. Far West Area Health Service, *Area Strategic Plan*, 1998, Broken Hill, NSW.
10. Perkins, D.A. and Owen, A., Lessons in Governance from Care Net Illawarra pp. 105-113 in *The Australian Co-ordinated Care Trials: Reflections and Lessons*, Commonwealth Department of Health and Aged Care, 2001, Canberra.
11. Fine, M., Perkins, D.A., Owen, A., and Warner, M. *Coordinated Care on Trial: Background to the Emergence of the National Coordination Agenda in Health Care*, Australian Studies in Health Service Administration No 90, University New South Wales, 2001, Sydney.
12. Perkins, D. A., Owen A., Eagar K., Adamson L, Quinsey K, Harvey R and Green J (2001). The Illawarra Co-ordinated Care Trial: better outcomes with existing resources? *Australian Health Review*, 2001, vol. 24, no 2, pp161-171

13. Blandford, J., Perkins, D. A. and Stoelwinder, J., Towards Integrated Service Delivery Systems chapter 12 of MG Harris et al, *Health Service Management Practice*, McClennan and Petty, 2002, Sydney.
14. Perkins, D. A., and Owen, A. GPs and the Care Net Trial, in *The Australian Coordinated Care Trials Book 5*, Commonwealth Department of Health and Aged Care, 2002, Canberra.
15. Owen, A. and Perkins, D.A., The Impact of Care Net Illawarra on the Wider System, in *The Australian Co-ordinated Care Trials Book 5*, Commonwealth Department of Health and Aged Care, 2002, Canberra.