Rural intermediate care in South Australia: a perspective on the first 12 months

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The South Australian rural mental health context

The South Australian rural mental health service manages a large population of approximately 475 000 spread over a large area of 983 482 km^2. This area is serviced by 52 local hospitals with limited ability to manage mental health emergencies and limited rural GPs with variable mental health experience. Involuntary patients are managed in tertiary psychiatric units in Adelaide. The distances involved lead to a number of logistical challenges in providing mental health care and invariably retrievals for mental health clients are difficult to co-ordinate.

The health care of Rural South Australians is now managed by 5 local mental health networks, under a centralised governance, Country Health SA. With local mental health teams including visiting psychiatrists, nursing and allied health staff. The LHN provide all levels of outpatient care and support local hospital inpatient care with limited resources.

The central mental health service for Country SA is based at Glenside Campus, a dedicated mental health facility situated on the South Eastern corner of central Adelaide. It consists of one 23 open bed inpatient unit. Closed ward admissions and overflow of acute admissions are managed in the metropolitan system. An average of 10-15 patients are generally managed by outlying metropolitan psychiatric units.

The distance consultation service (DCS) uses telemedicine to provide a Consultation Liaison Psychiatric Service to rural hospitals across and outpatient rural community teams across South Australia. This may include:

- mental state assessment and determination of the appropriate care site based on the least restrictive safe place of care. This may require the use of South Australian Mental Health Act (currently includes the initiation of level 1 CTOs and DTOs)
- liaison with rural GPs
- multidisciplinary team assessment and planning
- medication management
- psychological therapies (eg: a Narrative Therapy team is active within the service)
- family meetings.

A network of visiting psychiatric clinics is also active within the SA Mental Health Network. This includes Rural and Remote Mental Health Service Staff Specialists, Registrars and Visiting Psychiatrists. This visiting network is supported by Commonwealth funding in addition to funding via Country Health SA. There are a number of limitations of this model of care when compared with a metropolitan service, in particular, access to psychiatrists due to limited time available with monthly visiting clinics. This is accounted for via the greater availability of telepsychiatry, where possible.

The Emergency Triage and Liaison Service (ETLS), located within DCS, acts as a triage service, provides bed management and support to visiting psychiatric clinics as well as local mental health services and general practitioners. This service operates 24 hours a day and there is a built in capacity to provide after-hours support to clients in difficulty, including access to an on-call psychiatrist.

The gaps and broad model for rural intermediate care in South Australia:

Intermediate care services have developed in the South Australian rural context, out of a need to reduce the gap between metropolitan and rural health care provision. The initial plan, to provide facility-based services was changed in favour of home based care services, similar to those provided by hospital-at-home services in metropolitan Adelaide. As of the larger centres in South Australia, the service in Mt Gambier was funded to provide up to 7 packages of care over a limited period with the maximum length of stay aimed at 21 days.

The new intermediate care services are designed to provide a level of care between hospitalisation and outpatient case management to safely reduce the need for hospitalisation. Consumers may step up from their local GP or community mental health service or step down from rural or metropolitan tertiary hospital presentations.

The model for rural intermediate care is nursing led. Practically this means that based on specific criteria nursing staff make decisions to admit, discharge and to request psychiatric or GP review of consumers outside of multidisciplinary plans made at weekly case discussions. Psychiatric input may be via telemedicine or via visiting team members. Within this model non-government organisations are contracted to provide support staff that work under nursing supervision. These services are designed to complement local resources such as local hospital psychiatry consult liaison teams, community mental health teams, GP's, allied health and other community resources.

There are a number of versions of this model in operation across rural and metropolitan areas that span functions similar to the acute crisis intervention and assertive care modes that the South Eastern Intermediate Care Service (SEIC) aims to fulfil. Adelaide-based Hospital at Home Teams have more recently integrated with other acute services, such as the Acute Crisis Intervention Service, Community Mental Health Services and Mobile Assertive Care Teams, with the aim of providing a more seamless acute care service across metropolitan Adelaide. This development has occurred during a phase of expansion in the capacity to provide residential Intermediate Care Services, with the development of three units in the central, Southern and Western regions. Each have a 14 bed capacity, giving a total of 42 sub-acute beds allocated to step-down and step-up care.

Rural intermediate care teams have similarly integrated with their respective community mental health teams, during a time of development and change for rural psychiatric services. The governance of mental health services has changed in 2010, to fall under a broader Country Health SA network, which has allowed for significant change, in terms of the provision of psychiatric care in rural SA. Part of the reforms have included the development of plans for four hospital-based 6-bed Integrated Mental Health Units, which are currently in the process of development. This will add a capacity of up to 20 gazetted mental health beds situated in strategic locations, including Mt Gambier, Whyalla, Berri and Port Lincoln. This will follow the implementation of Mental Health Act assessments via videoconferencing; a key addition to the process of administering the Mental Health Act, following the proclamation of a revised Mental Health Act, in July 2010.[1] Finally, the stepped model of care includes a plan to develop two Community Rehabilitation Centres (CRC's), both with a 10 bed capacity, in Mt Gambier and Whyalla. The aim is to develop a more integrated service with access to all levels of care, as would be equivalent to that of metropolitan mental health services.

South Eastern Intermediate care service

The South East area of South Australia encompasses 23,000 square kilometres, bordered by the ocean to the west and south and Victorian border to the east. The northern boundary is defined by the towns of Bordertown, Keith and Kingston. The population of the catchment is approximately 66,000 (45,700 in the lower SE).

The intermediate care service in Mount Gambier has been implemented as a mobile outreach team with no bed-based facilities. The team provides variable levels of short term care equivalent to an acute crisis or assertive service, usually limited to weeks for patients in a stable home environment nearby the

city of Mount Gambier. Evidence for the benefits of home-based treatment, in terms of a preference by many clients for this type of service, as well as reduced need for inpatient care, can be found within the literature associated with community-based psychiatry.[2,3]

Referrals the SEIC team are accepted for step up from the community mental health team, local GPs and health care professionals and general referrals from the community. Referrals for step down admissions are accepted from metropolitan and local hospitals. Referrals are coordinated via the central Mount Gambier Mental health triage service. A daily intake meeting and weekly clinical meeting assist to prioritise referrals.. The SEIC team may discharge to ongoing case management and outpatient psychiatry, to other appropriate services such as those covering perinatal or old age mental health, or to local GP and psychology services. Consumers may also step up to hospital services if they become unstable. The team in Mount Gambier has strong links with the local consult liaison psychiatry service that covers all hospital wards with on site mental health nursing and remote and visiting psychiatrists. It is sited within the community mental health service at Mount Gambier hospital and is part of the Riverland and South East local mental health network.

The SEIC service was developed following a period of significant scarcity of staffing resources within the region, during 2010. At one stage, the mental health service across the region was a total of 8.9 FTE below full capacity. The departure of two visiting psychiatrists and two visiting trainee psychiatrists during this period, added to the lack of capacity. Although it could have been considered ambitious to develop a service within this environment, the impact of the awareness of a new service, was substantial, in terms of the role it has played in reversing this staffing crisis. A renewed interest in mental health care as a prospective career choice was certainly noted, following a period of publicity attached to the service in development. Concerns raised in regard to the service's ability to attract trained mental health nursing staff were rapidly dispelled when the team was fully staffed within approximately three months. This increased the overall capacity of the team and resulted in a number of positive flow-on effects, including an increased capacity for the mental health service as a whole, to respond to acute presentations, improved management of clients in crisis and improved post-discharge care following both tertiary and local hospital admissions, all leading to reduced readmission rates. The presence of improved service capacity also served to reduce the level of angst previously expressed by the local media and clinical teams.

Throughout the first 12 months of its operation, the SEIC team underwent a number of changes and developments, in terms of its structure and practice. During the initial phase, the number of packages of care was limited to three, with a focus on step-down care from the inpatient unit. This phase was successful, in that the expansion of the service to four then six packages of care was possible over the following three month period. Due to additional funding identified, the number of active clients was increased to seven, at this time, which has remained stable to the present day. The service was then able to manage a total of approximately 120 admissions over the first 12 months, with variable monthly intake of approximately 8-13 new admissions per month. The length of stay varied from as little as 3-4 days up to 20-30days, with the estimated average LOS 14-18 days). In order to manage escalating demand on the service and variable client needs, an assertive care arm was established, in order to provide a longer period of care for clients with greater need. A greater number of clients were managed during this period, up to 12-14 at times. This served to skew the LOS figures, during this brief period, but was successful in managing service demand until the intake process was refined and the number of active clients reduced to an average of 6-9 at any given time. The most common diagnoses recorded, in terms of referred clients included: Chronic Schizophrenia, Mood disorders, Mixed Substance-use disorder/adjustment disorder/situational crisis. The service was successful in maintaining a substantial number of clients referred in the community, many of which have avoided the need for ongoing psychiatric care with assertive biopsychosocial intervention and support.

The role of the ESTP registrar

Central to the process of developing intermediate care services across country SA, was the recruitment of a psychiatric registrar via the Expanded Settings Training Program. This program, under RANZCP administration, provides federal funding to support recruitment of psychiatric trainees on a full-time basis, into areas of need. The Intermediate Care ESTP position was created specifically for this role, although it encompasses a broad range of rural psychiatric care. The role provides pivotal support between the inpatient, consult liaison and community mental health services, and on to local rural GP and allied health professionals.

- liaison with the acute ward Rural & Remote multidisciplinary team in the assessment and management of patients from the assigned local rural network
- management of outpatients as part of a rural Intermediate care team
- consultation-liaison psychiatry as part of the local hospital team
- rural outpatient clinic
- teaching—via the local psychiatry hospital lecture program and teaching of medical students on placement in the South East Region
- clinical systems and leadership development.

Challenges

The implementation of any new service will invariably encounter many pitfalls.[4] The unique opportunity provided by this innovative development provided fertile ground for many insights into the complexity of rural psychiatry services. In overview possibly the most salient feature of the design and implementation processes was the need to think through problems at multiple levels: the social and political environment, the health systems level, the team and interpersonal level and the clinical sphere. Each of these areas posed its own particular issues at different phases of development and implementation.

To some extent the early high media profile of the development of the IC in Mount Gambier complicated its adaptation from a broad based model to a site-specific service. This led to confusion over terminology and over the structure of the final local model. The simultaneous implementation of differing models of intermediate care across multiple rural sites added these incorrect assumptions about the nature of the service in Mount Gambier. In turn this impeded communication within the service and between the service and the general public. For example, the initial general IC model referred to consumer support packages as “beds”, which led to the assumption that IC would be facility based rather than home support. A shift to the use of the term “packages” helped reduce some of this confusion.

Discussion between implementation sites revealed multiple perspectives on the “true” nature of intermediate care. These were often associated with the local interpretation of the broad service guidelines based on available resources. They were at times referred to in-terms of similarity to familiar existing structures such as Hospital in the Home, Assertive Care, or Acute Crisis Intervention. We would argue that while there is a significant difference between facility and home-based care, that IC at times may resemble any of the standard models of community-based mental health care depending on the unique match between the local service, the consumer and the acuity of their condition. The ultimate goal being to provide safe and effective care outside of hospital and step up or down as appropriate.

At the coal face there was some negotiation of the individual roles for medical, nursing and NGO staff. As the nursing team grew along with consumer numbers the service developed from more medically intensive to a nurse-led structure. This led to some discussion about the definition of a nurse-led service,

the division of duties and medico-legal responsibility. There were some difficulties in establishing the interface between the IC and existing community and consult liaison teams. Moving the referral pathway to the whole-of-service morning triage meeting assisted with clarity and reduced redundancy. When bottlenecks in step down referral pathways to the community team became an issue, largely due to understaffing in the community team, the IC team experimented with resource usage and split into an assertive care and IC arm. Key to the successful function of this expanded service was the implementation of a journey board that mapped important details of each consumer's care and recorded tasks to be completed. Unfortunately this split structure led to a significant increase in overall consumer numbers, a blow out in length of stay, and to some extent duplication of the service of the existing community team. When IC staff numbers dwindled toward the end of the year there were no longer enough staff to cover both arms and the team reverted back to the previous model. Although the team was ultimately unable to cover the planned 12 hour (8am-8pm), 7 day nursing roster, due to limitations on staffing, the STP registrar, central triage team and after hours consultant helped bridge limited availability out of business hours. The demand for out of hours cover was found to be less significant than expected, such that issues arising were well managed by the after-hours team.

The integration of NGO staff was relatively smooth. The team generally worked in pairs combining a mental health nurse with a NGO support worker. There was a clear demarcation of roles based around nursing duties. This, however, limited the role of the NGO worker during the absence of nursing staff on leave.

There were a number of problems with information transfer between the Adelaide and Mount Gambier sites. We attempted to implement IT based solutions for the sharing of an electronic version of the journey board, and of daily electronic medical records. Separate paper-based records are currently kept in both Adelaide and Mount Gambier, with psychiatrist reviews documented by form of a GP letter. Unfortunately, the current South Australian rural mental health computer-based patient record was not accessible at Rural and Remote Mental Health Services in Adelaide. There was access to a shared computer drive between sites, however IT services were unable to adequately secure consumer information from other areas of the Country Health Service. This has led to inefficient long email chains. At the time of writing access issues to the mental health electronic record have been resolved, however, local business rules and training for electronic documentation are yet to be implemented.

Booking and access to limited local telemedicine facilities (2 machines shared across the hospital) posed a problem for consumer reviews and weekly team case discussions. Unfortunately, a planned new telemedicine unit was not available for installation to increase capacity. In some cases there was also an initial reluctance from staff to book sessions, due to limited training in the use of telemedicine technology.

Despite significant challenges the intermediate care team were able to work together to provide a safe service that has significantly contributed to the prevention of the need for transport to Adelaide for tertiary psychiatric admission and the recovery of rural mental health consumers in an area of high need.

The path ahead

The South Eastern Intermediate Care Team is likely to continue to evolve and develop in the current environment of reform and change. There has been a cultural paradigm shift toward integrating such teams to form a single, multidisciplinary network, rather than teams operating independently of one another. This process has commenced in the South East region, with the team now joining a weekly clinical meeting on a regular basis with the community team. The team's leadership has similarly integrated with a single team-leader, responsible for maintaining cohesion with the hospital consultation-liaison team and other clinical teams involved in day to day patient care. There is an emphasis on the use of Telepsychiatry, which brings the central hub into the care process and maintains ongoing communication across the interfaces of primary care, local hospital care, community-based care and tertiary care.

The implementation of intermediate care teams has led to a successful expansion of the capacity of rural mental health services across the state. This has been enhanced by monthly statewide ICC meetings, aimed at maintaining consistency between the five teams as well as providing a forum for comparing effective and ineffective strategies over time. This will ensure the governance and integrity of intermediate care retain a high standard as this innovative practice in rural psychiatry continues to develop.

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