Designing and Developing a Mental Health System in the Central Wheatbelt of Western Australia

Helen Morton, Regional Director, Central Wheatbelt Health Region

2nd National Rural Health Conference
Ardendale, 12-14 February 1993
Proceedings
Designing and Developing a Mental Health System in the Central Wheatbelt of Western Australia

Helen Morton
Regional Director
Central Wheatbelt Health Region

Introduction

In the early 1970s a policy of non-institutionalisation was adopted for mental health services. Since 1988, the Health Department of Western Australia (HDWA) has progressed the concept of decentralisation, promoting operational decision making, service management and allocation of resources to the local level. At the beginning of 1990, no government psychiatric services were being provided in the Central Wheatbelt Health Region of Western Australia (CWB).

During 1990, a planning summit in the region identified, as a high priority, the need to develop an improved system for providing mental health services. Some early initiatives were implemented and a commitment made to design and commission a study to assist the region lobby for a better share of the mental health resources by highlighting the need, the paucity of existing resources, and to recommend options for improvement to the current inadequate service.

The early initiatives included the recruitment of a consultant psychiatrist to visit the region one day per week, the recruitment of a regional community mental health nurse, and the purchase of one public session of clinical psychology per week. The tokenism of these initiatives is clearly acknowledged.

Profile of the Central Wheatbelt Health Region

The HDWA has managed health services through seven country regions since 1988 (see Appendix 1). The CWB covers 110,262 square kilometres and has 50,000 people in 29 shires. It is an evenly dispersed population with no major regional centre, ranging up to about 250 kms from Perth. Demographic factors roughly correspond to State averages. The region experiences a major 'leakage' of hospital services to the metropolitan area. In the west, industries include fishing and tourism, with the remainder of the region being predominantly wheat and sheep farming.

There are 16 hospitals, with an approximate bed capacity of 400, staffed for 241. Half are utilised by nursing home type patients. There are 29 GPs, no salaried medical practitioners and no resident specialists, although a wide variety of visiting specialists. There is an extensive network of community health services managing nursing posts and providing community, child and school health services throughout the region. The region is relatively well off, with small 4-6 bed hostels on hospital sites, but no dedicated nursing homes. HACC services are becoming more widespread throughout the region, although there are still communities which get no HACC funding. Dental health is provided predominantly by visiting services. All emergency transport is via volunteer services.
The Study

The region commissioned a joint study by the Department of Public Health at the University of Western Australia and the Institute for Social Program Evaluation at Murdoch University (Health Department of Western Australia 1992). In addition, an experienced GP, completing his final year as a psychiatry registrar, joined the team and carried out the GP survey. The study was designed to:

1. assess regional need for mental health services;
2. describe current service provision and resources, and
3. identify options to improve services.

(see Appendix 2)

Pre-existing Data

Hospital Morbidity Data

A data file of hospital separations between 1980 and 1991 of patients with a CWB postcode and a main diagnosis of psychiatric problem (ICD9 Codes 290-315), was analysed in terms of total separations, daily bed occupancy, by diagnostic groups, by age and by place of hospitalisation.

In the ten year period, on any one day, there was an average of eleven people with a psychiatric diagnosis who lived in the CWB, in general hospital beds (ie, excluding approved psychiatric hospitals). Of these eleven, four were in metropolitan hospitals and seven were in local hospitals. The largest number of beds was accounted for by patients with a diagnosis of psychosis who occupy approximately three beds on any one day. In general, those psychiatric patients in the metropolitan hospitals stayed in hospital longer than those who were in local hospitals, probably because the more serious cases are being treated in the metropolitan area. Over the ten years, separations had reduced by 20% and bed days by 17.5%.

Mental Health Register Data

The records for individual patients with a CWB postcode who, during the period 1986 to the end of 1990 had an episode, resulted in data files pertaining to 348 individuals and 216 of the 348 had, at some time, been inpatients.

For the complete CWB cohort, the data showed that there was an average of 25 new admissions and 37 re-admissions a year. More than half of these were for people diagnosed as either psychotic or as having a dementia, the proportions being 31% and 23% respectively. The number of re-admissions has been increasing. In 1986 and 1988, 17% had more than one admission; in 1989 and 1990 the figure had risen to 40%.

Consequently, over the five years 1986 to 1990 there were, on any one day, approximately 16 residents of the CWB with a psychiatric diagnosis, occupying a hospital bed. Seven of these beds were within the region and 6 of the 9 metropolitan beds were in mental health service facilities. There was no reason to believe from this, or other data collected in the study, that patients hospitalised for any length of time locally, need a specialised psychiatric facility. The occupied bed figures for metropolitan hospitalisations include at least one bed occupied by a person with dementia who might be more appropriately treated in a psychogeriatric unit rather than a psychiatric facility. The number of specialised psychiatric beds required on a daily basis by the region is, therefore, approximately 8. This low figure, together with the dispersion of the patients throughout the region, does not indicate a need for a single inpatient psychiatric unit within the region.

Regional Mental Health Service Data

In June 1991, the region started using the Client Registration/Individual Service Plan (CRISP) (Melvin 1990) to record details of all clients with a mental health problem who were being seen by the community health services in the region. This data, together with a summary of similar data, requested from hospitals for the period June to November 1991, was examined in the present study.
Medicare Data
Data was requested from Medicare on both the number of psychiatric consultations given to people with a postcode address in the CWB and the number of people involved in these consultations. The same data was also requested for long GP consultations. Both sets of data were supplied by the Health Insurance Commission.

Patient Assisted Travel Scheme (PATS) Data
PATS is a scheme whereby patients can claim travel expenses to see a specialist. This data was requested from the region for people being referred to see a psychiatrist.

The data collected on outpatient services showed that the numbers of CWB residents already consulting with psychiatrists, both inside and outside the region, either as a public or a private patient, would be sufficient to support a private psychiatrist for 80% of his time. GP data indicated they each saw an average of 3 people a week who needed more intervention than they could provide at the time of consultation. The data from the regional data base showed that in a four month period, 245 individuals had contact with community health services or the local hospitals because of a mental health problem. The community survey not only indicated that significant proportions of the sample had experienced mental health problems, but also that only 35% had actually sought help about these problems. Collectively, the results indicated a substantial need for outpatient services for people with mental health problems and reflected only the 'tip of the iceberg'.

Community Survey
The community survey was conducted by the Institute for Social Program Evaluation at Murdoch University. The survey included telephone interviews with one adult at each of 314 households selected from within the region.

The initial questions were concerned with determining the importance of mental health services within the broader context of health services and the community's satisfaction with current services.

The second set of questions was concerned with the particular illnesses experienced by respondents during the last 12 months. It also sought information about preferred treatments.

The third set of questions sought views on the importance of a range of mental health services and where they should be accessed from.

Information was analysed by age, gender, location of the respondent and household type.

There are three main conclusions regarding the importance of mental health services that were drawn from this community survey. Firstly, mental health services generally are seen to be substantially less important than services related to physical health. Secondly, among mental health services, those which provide some form of relief for the carers of people with mental health problems are seen to be the most important. Thirdly, women tend to assign a greater, or at least the same, degree of importance to both physical and mental health services than do men. It is also apparent that the degree of importance assigned to both physical and mental health services varies with other characteristics of the respondents, including their age, which in this study is reflected in their 'household type' classification. A substantial proportion of the respondents (78%) expressed overall satisfaction with the health services provided in the CWB. However, those who reported having had a 'mental health' problem in the past year were less likely to be satisfied than were those who had experienced a physical illness.

Almost one third of the respondents (30%) reported having experienced a physical illness in the past year, but a substantially greater proportion, 48%, reported having experienced a mental health problem. Among the mental health problems, those most commonly reported were high levels of stress (29%), fears and anxiety (20%) and depression (14%), with women, young people, and single parents being more likely to report having had a mental health problem in the past year. About one half of those reporting a mental health problem had more than one type of problem.

Designing and Developing a Mental Health System
Almost all of those who had experienced a physical problem had been to see someone about it, but less than half of those with a mental health problem had done so. In only a small proportion of cases had the person seen someone other than a doctor. In addition, more than half of those who had seen someone about a mental health problem had done so in Perth. Among those who had not seen someone, more than one third said they would have liked to have done so.

The mental health services rated the most important by the respondents included respite care, care for the confused elderly, and hospital care for the mentally ill. These were followed by a variety of counselling and therapy services of which alcohol counselling was the most frequently endorsed (65% of the respondents) as being 'very' or 'extremely' important.

While most people who felt able to give an opinion about the need for an improvement in services said 'a lot' or 'a great deal' of improvement was needed, about three quarters of the respondents could not offer any suggestion as to how services might be improved.

Interviews with psychiatric clients and their families consisted of a small sample. Their opinions included:

- the need for more community mental health nurses;
- the need for GPs to be better trained;
- the need for general counselling services, and
- improved services for the confused elderly.

Interviews with Providers/Resource Personnel

Twenty-four GPs, 114 other service providers who have direct client contact, and 33 service providers and members of community organisations who do not have direct client contact, were interviewed. Separate interview schedules were developed for GPs, allowing for the incorporation of a side study into GP education needs in the region. Both interview schedules were semi structured and included both open and closed questions and were designed to obtain information on current services, gaps in service provision and the needs of the community in relation to mental health problems as perceived by the providers. Main issues raised included:

- Gaps in services - more services are required locally for counselling services (most pressing need), services for behaviourally or emotionally disturbed elderly, psychotic patient management, services for children and adolescents with social/emotional problems, and services for people with alcohol problems. The main overall criticism of current services was simply that services did not exist.

- Education/training plus ongoing support and consultation for service providers in the assessment and treatment of mental health problems.

- Education of the community about mental health services and resources.

Call for Submissions

Despite a well published media release and extensive call for submissions, the response was negligible.

Survey of Resources and Services

A survey questionnaire was designed to elicit information from all the non-government community resources and organisations about their services and the types and numbers of clients they serviced who had mental health problems. All shires in the region were contacted by telephone and asked for a list of community groups or organisations in their locality. A questionnaire was then sent to each resource that was identified.

One month to 6 weeks after the initial mail out, 94% (123) organisations responded to the questionnaire.
Options for the Development of Mental Health Services in the CWB

Three possible options for service development, which were defined in terms of their main objectives, were presented. These were:

1. The provision in the region of all mental health services needed by CWB residents.
2. A reduction in the numbers of CWB residents who use services outside the Wheatbelt for the treatment of mental disorders or mental health problems.
3. Improvement of current regional mental health services by the filling of identified gaps in service provision and better use of current resources.

The resources required for providing a comprehensive regional mental health service were far in excess of what is available to the CWB.

Three approaches were described in relation to the objective of reducing the numbers of people using mental health services outside the CWB. The first of these, the improvement of community care services, could be successfully achieved by adopting an indirect service model in which mental health consultants primarily provide consultation, education, and community organisation. The local primary care givers (GPs and community nurses) would be trained to provide the majority of the assessment and treatment of mental health problems and, subsequently, the consultants support by supervision and consultation.

The second approach suggested to reduce the numbers using metropolitan services is to increase the use of local hospitals by training hospital staff and GPs, again using regional mental health staff for ongoing support, supervision and consultation. Mental health professionals would be used on an 'as needs' basis rather than keeping them permanently on staff. Hospital and community care could be integrated by using regionally employed community mental health nurses to help provide inpatient care and to continue this care into the community after discharge.

The third approach suggested involved increasing the numbers of mental health consultants in the region so that they can provide both direct services themselves and also train and support other service providers, so that the level and range of services available is increased and assistance is made accessible locally.

The final option for service development is to fill those gaps in service provision that were identified by the service providers in the present study. The gaps identified were:

- counselling services;
- child and adolescent services;
- psychogeriatric services;
- alcohol related services;
- day places for people with mental health problems;
- publicity and education directed to the general community, and
- education of service providers in assessment and treatment of mental health.

Designing the System

In September 1992, a 16-strong reference group, including community representatives, general service providers, specialist mental health service providers and voluntary service providers, met to consider the options from the study.

At that time, the Country Regional Directors Council had been successful in approaching the MOH about the inequity of mental health resources in the country. The country regions represented 27% of the state population and were receiving $1.33 million (1.5%) of the state's
psychiatric services budget. Two point two million dollars were immediately relocated to country regions in the budget handed down at that time, $350,000 going to the CWB. This is clearly insufficient to implement a satisfactory service, however, it was decided to develop the best affordable model combining options to reduce the number of people who use services out of the region, and options to fill identified service gaps.

The reference group determined objectives, principles and policies for the service which mirrored those contained in the National Mental Health Policy (Australian Ministers Conference, April 1992).

The strategies were developed by a process of identifying all possible options to meet the varied needs identified by the study. These were then grouped into broad strategies, and a matrix of importance and a gap analysis developed. Finally, the reference group considered affordability. The main strategies are grouped under the following headings:

1. Short-term Employment of a Program Manager
2. Promoting Case Management
   - purchase of case conferencing
   - specialist support
3. Improving Access to Specialised Mental Health Services
   - recruitment of community mental health nurses
   - additional visiting specialist services
   - provision of day places in local hospitals
   - travel assistance
4. Increasing Local Expertise and Enhancing Existing Services
   - professional support
   - development of counselling skills and other training
   - liaison with Alcohol and Drug Authority
   - re-orientation of HACC and Extended Care Services
   - special alterations to enable facilities to better care for people with dementia
5. Mental Health Promotion
   - improved community knowledge and understanding via geriatric staff
   - mobile mental health promotion program
   - additional health education office
   - development of promotion materials and a resource booklet
6. Determination of Accommodation Options
7. Crisis Intervention Strategies
8. Evaluation
   - strategy progression
   - program outcomes

References

1. Health Department of Western Australia, Central Wheatbelt Health Region, 1992. Mental Health Service Needs and Resources in the Central Wheatbelt Health Region of Western Australia.
APPENDIX 1
Health Department of Western Australia
Country Health Service Management Regions
### Overview of Study Methodology

<table>
<thead>
<tr>
<th>Task</th>
<th>Data Source</th>
<th>Data Collected</th>
<th>Need Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Needs Assessment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analysis of pre-existing data</td>
<td>Hospital Mortality Data</td>
<td>Hospital discharges both in and out of region</td>
<td>Expessed need</td>
</tr>
<tr>
<td></td>
<td>Mental Health Register</td>
<td>Description of Psychiatric clients from CWB</td>
<td>Expessed need</td>
</tr>
<tr>
<td></td>
<td>Regional Mental Health Service Data</td>
<td>Description of clients referred to service</td>
<td>Expessed need</td>
</tr>
<tr>
<td></td>
<td>Medicare</td>
<td>Psychiatric and long GP consultation statistics</td>
<td>Expessed need</td>
</tr>
<tr>
<td></td>
<td>Patient Assisted Travel Scheme Data</td>
<td>Numbers given PATS for Psychiatric Consultation</td>
<td>Expessed need</td>
</tr>
<tr>
<td>Community Survey</td>
<td>Community Surveys of randomly selected community</td>
<td>Past and present use of mental health services</td>
<td>Expessed need</td>
</tr>
<tr>
<td></td>
<td>Sample of CWB clients</td>
<td>Perceived need for and opinions about services</td>
<td>Felt need</td>
</tr>
<tr>
<td>Interviews with Psychiatric clients</td>
<td>Sample of CWB clients</td>
<td>As above in more detail</td>
<td>Felt need</td>
</tr>
<tr>
<td>Interviews with Service Providers</td>
<td>Sample of Service/Resource providers</td>
<td>Service usage. Perceived need for services and resources. Opinions on present resources, gaps in services and development of new ones, etc.</td>
<td>Expessed need</td>
</tr>
<tr>
<td>Submission analysis</td>
<td>Responses to Media releases</td>
<td>Opinions on needs and services</td>
<td>Felt need</td>
</tr>
<tr>
<td><strong>Resource Assessment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Survey of resources and services</td>
<td>CWB community services/resources</td>
<td>Description of service and of usage</td>
<td>Expessed need</td>
</tr>
<tr>
<td><strong>Option Identification</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of related literature</td>
<td>Worldwide literature</td>
<td>Information on planning, development and operation of mental health services</td>
<td>Comparative need plus</td>
</tr>
</tbody>
</table>

Note: The table details the methodology for assessing needs and resources, identifying options, and reviewing related literature in a study.