Bringing Child and Adolescent Mental Health Services to Rural and Remote Communities

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BACKGROUND
Research has shown that up to 20 per cent of all children and adolescents will experience moderate to severe mental health problems. In South Australia, the Australian Bureau of Statistics Data indicated that 60,000 young people live in the Northern Country Region of South Australia, with 61 per cent of these living in outlying rural and remote areas. Historically rural and remote communities have had limited access to mental health services and service delivery has generally been provided through isolated General Practitioners and other primary health care service providers supported by infrequent visiting specialist services.

The report into the National Inquiry into the Human Rights of People with Mental Illness 1993, repeatedly received evidence regarding the inadequacy of mental health service in rural Australia. "The irony is that many of the areas where the need is greatest, the services are fewest, this is particularly the point in small country communities where mental health services - and certainly mental health services for children and adolescents - are almost entirely non existent". (page 678) The report also noted that training and support for mental health, health and other professionals involved in working with children and adolescents with mental health problems in rural and remote areas were totally inadequate.

The Women's and Children's Hospital Division of Mental Health are 14 months into a two year project to deliver mental health services to children and adolescents in rural and remote areas through the use of Telehealth teleconferencing and Internet technologies. This project has been funded through the Commonwealth Rural Health Support, Education and Training (RHSET) program and The South Australian Health Commission and Northern Territory Health Services.

PROJECT AIMS
The project ‘Bringing Child and Adolescent Mental Health Services to Rural and Remote Communities’ aims to establish, conduct and evaluate the provision of Telehealth services in rural and remote areas of South Australia and the Northern Territory.

The key objectives for the project are:

- to establish telehealth networks between serviced providers in rural and remote communities;
• to improve the accessibility of rural and remote health and other providers to specialist child and adolescent mental health; and
• to evaluate the effectiveness of telehealth as a strategy for providing a broad range of services, related to child and adolescent mental health to rural and remote areas.

PROJECT ADVISORY COMMITTEE

To assist the project develop consistent and equitable services to all rural and remote locations a Project Advisory Committee was formed with representatives from all sites, members of the project team and invited members from State and Territory Health Services. The Project Advisory Committee meets on a bi-monthly basis to provide the overall direction of the project.

Specifically the Project Advisory Committee has:

• provided ongoing advice regarding the development of the RHSET Telehealth project to selected rural and remote sites in South Australia and Northern Territory;
• contributed to project planning by the provision of information and advice regarding particular needs and issues occurring at each site;
• provided comment on the development of evaluative processes to determine the efficiency and efficacy of using Telehealth as a strategy to address the mental health needs of children and adolescents;
• participated in the development of initiatives to further develop Telehealth services to the selected rural and remote sites; and
• ensured the objectives listed in Bringing Child and Adolescent Mental Health Services to Rural and Remote Communities project proposal are met.

ESTABLISHING TELEHEALTH NETWORKS

Discussions between personnel from the Women’s and Children’s Hospital, Division of Mental Health, and health workers in the rural and remote sites specifically shaped the successful RHSET funding submission. This collaborative approach between staff at Darwin, Alice Springs in the Northern Territory and at Coober Pedy, Roxby Downs, Pt Pirie, Pt Augusta, Whyalla and Pt Lincoln in South Australia throughout the project ensured the needs of each site was addressed.

Staff from the Women’s and Children’s Hospital conducted site visits to each rural and remote location before commencing the delivery of Telehealth services. The purpose of the site visits were to:

• personalise the service through face to face contact;
• conduct a needs assessment by interviewing all staff; and
• training staff in the use of video-conferencing and internet equipment; and
• negotiate a service agreement.
Personalised contact at the commencement of the project has greatly contributed to the success of the project to date. It allowed Divisional staff to experience first hand the challenges faced by workers in remote locations. Most remote locations are unable to draw on specialist services and thus develop a generalist approach to addressing Child and Adolescent Mental Health problems.

Conducting a detailed needs assessment at each site and for each worker meant services were tailored for the individual needs described. Some sites had access to Child Psychiatrists, while at the more remote locations generalist health workers managed mental health problems as well as physical medical conditions. The needs assessment also brought out the preferred learning styles of workers. This in turn shaped the modality of service provided (eg: clinical case consultations, training workshops or seminars).

The use of video conferencing equipment and access to Internet varied greatly from site to site. Approximately 50 per cent of the workers in rural and remote sites had not used or been trained in use of Telehealth technologies available to them. Project staff were able to conduct training sessions that enabled local workers to maximise the use of their equipment. At the time of these visits (early 1998), some locations did have problems accessing the Internet and the mental health resources available via that medium. However, this has now been overcome at all sites with the installation of upgraded computing equipment.

The establishment of a service agreement between the agencies involved with the project ensured all parties were clear about what format, time and resources would be required to successfully achieve the objectives of the project. This was an important milestone considering the project linked State and Territory Governments and was of an intersectoral nature.

IMPROVING ACCESS TO CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

All sites initially requested a service that allowed them to discuss the management of cases that were of greatest concern. This raised some significant legal, ethical and confidentiality issues.

Firstly, the client or the client’s guardian would need to have provided specific informed consent before the case could be discussed with other clinicians via Telehealth. Secondly, the legal standing on advice provided by a registered clinician from other State or Territory was under scrutiny. In order to address these issues the project has adopted a cautious approach by seeking registration in both the States and Territories with the appropriate professional registration boards. Informed consent and operational protocols have been developed and continue to be updated and refined as the project progresses.
Clinical case consultations enabled workers from remote sites to access specialist services that previously were unavailable. It also facilitated an improved understanding by metropolitan workers of the variety of clinical challenges faced in remote locations.

The inability to access training and development sessions was sited as a major disadvantage in working in rural and remote locations. To redress this problem, the project conducted a series of training seminars during the second half of 1998.

The themes of these seminars were developed from information gained from the initial needs assessments and by the expressed needs by workers in each location. For example, one small community experienced a series of deaths that had significant repercussions for a number of children and their families. Subsequently the training for this site focussed on managing grief and loss issues.

EVALUATION DESIGN

The project is being externally evaluated by a consultant who has significant experience with Telehealth programs both internationally and within Australia. The evaluation design has sought to gain an understanding of how Telehealth services has impacted on rural and remote health workers and their ability to access Child and Adolescent Mental Health Services (CAMHS).

As part of the needs assessment undertaken by project staff at the commencement of the project, participants were asked to complete a questionnaire. This instrument sought information from the participants about their understanding, previous use, concerns and expected benefits of using the Telehealth technologies available to them.

This instrument was re-administered at the completion of year 1 to ascertain changes in attitudes and beliefs towards the technology. Additionally, the evaluation consultant conducted structured interviews with selected staff from each of the participating sites to examine how the project's objectives were being achieved.

A similar series of questionnaires and interviews will be undertaken during 1999 and at the completion of the project in January 2000. Expressions of interest will be sought from project participants who would like to be written up as case studies. These case studies would endeavour to explore how individuals from the selected rural and remote sites have adapted their clinical practice as a result of being part of the project. Additionally, how this project has translated to improved mental health outcomes for clients.
RESULTS

An initial perceptions questionnaire was completed by 27 participants from the project. They included psychologists, social workers, nursing staff, psychiatrists and administrative staff from the locations of Darwin, Alice Springs, Coober Pedy, Roxby Downs, Port Augusta, Port Pirie, Whyalla and Port Lincoln.

At the time of the questionnaire, 45 per cent of the participants had not previously used video-conferencing equipment. The majority of the remaining 55 per cent only had used the equipment five times or less. With regards to previous use of the Internet, 48 per cent had previously accessed information on the Web.

The participants also described what they believed the benefits from using the video-conferencing system would be. The responses included:

- improved access to training;
- reduced travel costs;
- improved access to specialist services;
- increased competence with technology; and
- improved therapeutic outcomes for clients.

Participants also reported the following concerns with using the video-conferencing equipment:

- reduced relationship (compared with face to face);
- the expense of video-conferencing equipment;
- fear of technological failure (not being able to fix it);
- confidentiality issues; and
- clumsiness in conversation flow

Participants were asked to rank applications of using video-conferencing in order of importance for their location. These are ranked most the most important applications to the least important:

1. Consultation with CAMHS professional.
2. Education/staff development/training.
3. Consultation with child psychiatrist.
4. Administrative meetings.

Information gained by the evaluation consultant via interviews with participants in December 1998, will shape the refinement of service delivery in 1999. The structured interviews sought information from seven participants regarding the three main objectives of the project.

Analysis of the information from the participants has indicated that there has been the establishment of new networks between rural and remote service providers and specialist services from the Women's and Children's Hospital. The participants also reported how at times of crisis they have been able to access support that previously did not exist.
Participants were also able to describe what has been the most helpful Telehealth services to date and how their clinical practice has changed as a result of participating with the project. A number of participants commented on how they believed the multidisciplinary of the presenters has helped them broaden their ideas on mental health interventions for children and adolescents.

Concerns directed at the first year of operation were focussed on problems encountered because of:

- time differences between SA and NT (daylight saving);
- occasional equipment failure;
- being able to access video-conferencing suite (larger hospital); and
- emergencies that occur between scheduled transmissions.

Participants believed the service could be improved by providing more training seminars, extending the services to more remote locations and being able to respond to emergencies.

**SUMMARY AND FUTURE DIRECTIONS**

The enthusiasm of all involved with this project has greatly influenced the success of it to date. Information received via the evaluation processes will shape the coming year’s activities.

A comprehensive Child and Adolescent Mental Health Seminar series is planned to provide a developmental training approach to all sites. The sessions will be recorded and transcripts will be available to be downloaded from the Internet. This will enable more rural and remote workers to participate with the project.

The development of a Web-enabled database for Child and Adolescent Mental Health resources is required. A database where workers can access information, on how to manage mental health problems in a variety of settings. It is envisaged the database would be interactive, so as new resources are developed they can be easily updated and placed on the database.

Staff from the Women’s and Children’s Hospital involved with ‘Bringing Child and Adolescent Mental Health Services to rural and remote Communities’ are committed to improving services to remote sites. This will be done by continuing to maintain high standards in client confidentiality, Telehealth protocols and ensuring that Child and Adolescent Mental Health Services are both accessible and relevant to rural and remote communities.
REFERENCES

