Matilda Regional Health Service Longreach: new and creative service

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Introduction

The Matilda Regional Health Service (MRHS) “social-emotional program” commenced operations at Longreach in July 2004 and has created a positive impact on the surrounding community folk.

The model is one of a “hub and spoke” operating from Longreach to the 9 shires surrounding it from Winton in the west, to Alpha in the east, south to Tambo and Yaraka and north to Muttaburra. The team of regularly visits these centres on a cycle of 2 to 4 weeks using road transport. This “model of service delivery” (MoSD) has been developed over some time to meet the needs of client referrals and the community as a whole.

Longreach is situated some 1200 kilometres northwest from Brisbane and approximately 700 kilometres east of Rockhampton. Although in the Tropic of Capricorn it does not have the same monsoonal weather as that of the coastal areas in the same latitude—perhaps due to its inland location. The area does however depend on “summer” monsoonal rains for the bulk of its rain. Over the last 4–5 years this has been a problem and the area is currently very much drought affected.

This small “social-emotional well-being team covers the area of 178, 739 square kilometres and has a “varying” population of 10 861. During the “dry” season from April to November the population swells considerably with tourists mainly “grey nomads” on their outback adventure. This sometimes causes concern for a number of service providers including our own.

The MRHS works with folk from many backgrounds whether they be town based or from properties or stations in the area. At times problems have arisen because of boundaries and “out of area” referrals. The team accepts referrals from individuals, families, medical folk, government and non-government agencies.

In the beginning

In 1993 the Royal Flying Doctor Service conducted a review of their current services and potential for expansion into other health related areas. This review highlighted some non traditional areas that the RFDS could undertake using their current access via aircraft and knowledge base of bush requirements. In 1993 The RFDS was essentially seen as an evacuation/retrieval service, urgent patient transfer or an air ambulance organisation. At this time the organisation was also undertaking a move towards the provision of clinic services to more remote rural areas where regular medical visits were unavailable. This report identified a number of areas that the RFDS could become more involved in and one of these was that of mental health awareness and literacy. With this in mind the RFDS employed a psychologist to work towards providing a combination of clinical expertise but more importantly develop a resource base to promote mental health awareness and literacy to staff within the organisation along with others needing to know about mental health issues.

The chronology of events that led to the Matilda Regional Health Service commencing is:

• 1995—Robert Williams a psychologist was employed by RFDS-Qld section to conduct a feasibility study into the provision of mental health services—mainly to the Cape York area (The Cape)

• 1996—Robert set up and commenced the Mental Health program in the Cape

• 1996—A CD based “Psychological First Aid Kit” was produced and released
• 2000—The Cape mental health program commenced in earnest and a regular Model of Service Delivery (MoSD) commenced to 5 Cape communities and 7 Tablelands locations. This has since expanded to include other communities.

• 2001—Geoff King, Brenda Masutti, Robert Williams and Estelle Goo Goo presented a paper on the 7 years following the release of the “The Best for the Bush” paper at the 2001 Regional Health Services Conference. During this presentation a focus was evident regarding the need for health promotion and prevention and relapse strategies for people presenting with mental health related problems.

• 2002—Kristine Battye conducted a health needs and requirements survey for the far and central west of Queensland

• 2003—The “GRAPPLE: coming to grips with mental health” on DVD was released which is an interactive program mainly directed towards young people.

• 2004—Mt Isa Minds came on line to service the combined clinical and non-clinical needs of the lower Gulf of Carpentaria region.

• 2004—Matilda Regional Health Service commenced operations in July to service the needs of the 9 shires surrounding Longreach. This is a Commonwealth funded project that combines both clinical services and health promotional activities.

Why Longreach?

Longreach was selected after a study was completed by Dr Kristine Battye in 2002. In essence this study examined the needs and expectations of health service delivery in the central west and far western corridors of Queensland. The result of this study determined that one of the main issues following wide consultation elicited was the need for increase mental health services being present to address a broader range of mental health disorders in a planned and sustainable manner. The area to be covered in this region is huge and this causes real concerns in terms of logistics and sustainability. To cover the total area of 396,638 km² and to service a population of 12,062 was thought to be an unworkable proposition.

With this in mind it was decided to look at a way of providing the required services using more than one agency. The Commonwealth being keen to provide funding to support a sustainable service model that addressed needs appropriately. North West Queensland Primary Health Care secured commonwealth funding to deliver a wide range of services in the Boulia, Diamantina and Barcoo shires. The RFDS secured similar funding to cover the 9 shires of Aramac, Barcaldine, Blackall, Ilfracombe, Isisford, Jericho, Longreach, Tambo and Winton. Within these shires there are 12 towns for which the RFDS will provide social-emotional well-being services.

The population of the 9 shires covered by the Longreach based MRHS is approximately 10,861 with the major population centres being the shires of Barcaldine, Blackall, Tambo and Winton. As mentioned earlier this population changes during the year between the “wet” and “dry” seasons.

The commencement

The recruitment process started in February 2004 and was completed within 4 weeks. At this stage a team leader from a mental health nursing background, 2 psychologists and a base administrator were employed to establish the base in Longreach. The base initially occupied the old library at the Longreach Hospital from July, 2004 until November of the same year. This was a difficult period of time as our IT and communication section consisted of all 4 people sharing one room that was not air-conditioned and privacy was negligible. There was only one phone link with a splitter to a “portable” phone and an “old” Toshiba laptop along with an old Canon bubble jet printer.
We did however begin to get access to equipment and by the time we moved to our present location in November we were generally well equipped. Some months prior to our move we were fortunate to recruit a local woman by the name of Heidi Ross who assisted our move and provided a valuable insight into the area, its people, road conditions and connections.

By the time we had moved into the current base location in Eagle Street, Longreach we had covered many miles “whoops” kilometres in our 3 Suzuki Vitaras to get some understanding of the area, the folk we would be involved with and the planning of a MoSD. The latter aspect was essential to gain trust, an on the ground presence and to make the service a sustainable proposition to communities.

**The first six months**

The first 6 months from commencement was mainly one of getting to know the area and the people we would most likely be dealing with on a regular basis. This was done via an extensive ‘meet n greet’ process across the 9 shires and the towns within. This involved many cups of tea, coffee, and a lot of “sticky” buns, savoury rolls and fortunately the odd beer. The agencies we contacted were:

- Anglicare
- Police
- Queensland Ambulance Service
- Primary Health Care Centres
- hospitals
- schools
- GPs and surgery staff
- Queensland Health staff
- Shire Councils and staff
- pub owners and managers
- business people
- employment agencies
- Remote Area Family Service (RAFS)
- Remote Area Planning and Development (RAPAD)
- Agforce
- church groups and people
- Blue Care
- St Luke’s Nursing
- Home and Community Care (HACC)
- Barcoo Living
- Child Protection
- Winton Health Action Team (WHAT)
- Spiritus
- Desert Channels Queensland
- Relationships Australia Queensland (RAQ).

Many other individuals and agencies were contacted across the 12 towns visited. The towns consisting of Alpha, Aramac, Barcaldine, Blackall, Ilfracombe, Isisford, Jericho, Longreach, Muttaburra, Tambo, Winton and Yaraka.

During this phase the team was reluctant to take on “clinical” referrals as processes for recording these and proving the best care outcomes was not in place. This time did however afford some valuable insight into the nature and type of referrals that we as a team may receive. These would appear to deal
with anxiety and depression combined with substance use/abuse disorders and marital related problems. The latter is quite a significant observation and provided the spring board for another development.

It is worth noting that the “meet n greet” intervention is very much an ongoing process in terms of profile raising and maintenance with the definite aim of engaging people in mental health literacy, self care management and community acceptance of sensitive issues. The folk in our part of the bush are generally very private, proud and most concerned about confidentiality. It was with this in mind that the team has strived to maintain a “very human” presence in the press, a variety of newsletters, along with television and radio appearances mainly with the assistance of the ABC.

Current staff profile

- Stuart W Hart – Team Leader
- Michael Arthur – Psychologist
- Sue Sweeney – Art Therapist
- Jocelyn Stewart – Psychologist
- Catherine Parfitt – Base Administrator
- Dr Harry Health – Social worker
- Megan Ross – relieving Base Administrator
- Emma Ross – Cleaner

Clinical work and referrals

The team received its first referral on 7 August 2004 and this was “a man from the land” requiring support to deal with his partner who was diagnosed with a quite serious mental health disorder. Since this time we have received a total of 614 referrals, many being of a serious mental illness requiring onward referral directly to the Queensland Health Team based in Longreach or to the visiting psychiatrist from Rockhampton. Referrals to the psychiatrist need to be made via a GP and this sometimes causes some concern.

It is likely that number of clinical referrals will continue to increase and that our “gate-keeper” processes will need to be alert to not taking on referrals for management that require the appropriate intervention under the Queensland Mental Health Act. Our team is working on a model of “social-emotional well-being” that where possible does not include serious mental illness requiring intervention by “authorised mental health practitioners”. This has created some concerns especially when staff shortages in the Longreach Mental Health team (Queensland Health) have necessitated urgent referrals to our team. We do not have the legislative ability to deal with these referrals.

A survey using our very basic intake list was done for the last financial year and the following results are quite enlightening.
Table  
RFDS Longreach frequency of client’s presenting problems, 1 July 2005 to 30 June 2006

<table>
<thead>
<tr>
<th>Presenting problem</th>
<th>Number of clients</th>
<th>Clients grouped</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression (D)</td>
<td>93</td>
<td>95</td>
</tr>
<tr>
<td>Stress</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Anxiety (A)</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>Drug and alcohol (DNA)</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Behaviour problems</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Relationship issues</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Bipolar</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Children assessments (WISC)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Loss and grief</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Eating disorders—bulimia</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Work issues</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Personality disorder—borderline</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Post natal depression (D)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Anger management</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Suicide (SC)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Domestic violence</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Obsessive compulsive disorder</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Post traumatic stress disorder</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Justice drug and alcohol (DNA)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Situational crisis (SC)</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Specific phobia (A)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Panic attacks (A)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Family conflict</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Complex issues</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>210</td>
<td></td>
</tr>
</tbody>
</table>

The above is by no way absolute or definitive however it does provide some understanding of what is being dealt with on a regular basis and provides a means of titrating services to meet needs. These figures assist in the planning of service delivery and assist in implementing approaches to health promotion, early intervention, awareness raising and improving mental health literacy.

Generally most communities are very keen to have people looked after at home in preference to going to hospital and thus support the notion of providing care in community settings. This has given the team an opportunity to advocate and be part of innovative projects and funding submissions. This is mainly in relation to discussions about respite accommodation, post discharge care from the mental health unit in Rockhampton and referral pathways. The latter point becomes somewhat confusing when 2–3 providers appear to offer very similar services.

We have recently employed an Art Therapist to work with a range of people across the age spectrum and this has been a most successful move to proving another dimension in the provision of care. Sue the Art Therapist works with individuals and in group settings. The results and the feedback have been encouraging and we expect further positive developments in the future. We are hopeful that we will be able to retain this position when a funding renewal is successfully applied for in the near future. This position has now established the role of front line intervention in dealing with presenting social emotional well-being issues and should NOT ONLY be seen as an alternative or diversional process alone.
Health promotion

This has not been an easily undertaken task by the team as working with rural folk who are generally quite private in nature have not readily taken to the notion of health promotion especially in relation to “mental health”. Over the past 2½ years that the base has been operating changes has taken place. Health promotion opportunities have presented themselves, generally in conjunction with another activities. Thus far these activities have been:

- the running of stalls, sausage sizzles, breakfasts and competitions during and in line with mental health week themes—these have taken place across all the 12 communities over the past 3 years
- men’s health sessions on 5 occasions at Alpha, Barcaldine, Blackall, Isisford and Yaraka
- stalls conducted at rural events—these being the Tambo Stock show, Barcaldine Rural Expo, Longreach Show, Longreach Rodeo, Yaraka horse and motor bike gymkhanas
- presentations at schools using Mental Health Week themes
- conducting of Mental Health First Aid training courses
- a drought impact reduction program has been conducted at Yaraka and plans are in place to conduct the same program early next year in Longreach and Winton—these were initiated by the Queensland Department of Primary Industry and involve both government and non-government agencies
- many informal and short notice program events have also taken place like the Longreach Health Expo, International Women’s Day and similar occasions
- involvement in and assisting the planning along with implementation of a “family fun day” using Queensland Country Womens Association drought relief money at Muttaburra
- the team also participates in public discussions involving both radio and television mediums
- Matilda Regional Health Service staff have been interviewed for radio, television, and the local press (Longreach Leader)
- numerous art therapy groups have been established in the area we cover.

Two staff members have completed their Certificate IV in Workplace Assessment and Training. These mentioned staff members are also accredited trainers in Mental Health First Aid and plans are in place to conduct further training on 4 occasions during 2007. Training will take place in Blackall, Charleville, Emerald and Mackay. To date the training has been given to professional folk, agency staff and those directly working with people experiencing problems with social and emotional well-being. It is planned to expand this program as opportunities arise.

As mentioned above, our team recently employed an Art Therapist to work with clinical presentations and to add another dimension to out team’s health promotion plans. It is envisaged to expand art therapy at a community level with further involvement of staff and using a community development model. Sue has already accomplished presenting her program across a wide range of people, along with its benefits and is able to extol the virtues of using this “gentle” approach to problem solving.

The future for the team appears bright and even brighter in relation to health promotion, prevention and early intervention. Options are being explored to expand the good work being done to assist rural folk dealing with drought, addressing the emotional highs and lows that drug usage causes, the impact of rural decline especially in regard to relationship discord and breakdown. Our team will meet the challenges associated with working in the bush to provide care and optimum outcomes using a balance between clinical interventions and empowerment with health promotion programming.
Challenges

Many challenges have presented and many more are likely to be present in the future:

- establishing a “mental health” type service in a traditionally conservative, private and generally reluctant community setting who are willing to acknowledge the presence of mental health issues
- overcoming the distrust of mental health services run by the Queensland Government
- assuring the integrity, privacy and confidentiality of our “new” service
- defining the role of our team in relation to “social-emotional well-being” compared to traditional mental health services, ie. Queensland Government: Mental Health Unit services
- convincing the 9 Shires that our service will remain here for the “long” haul, and be sustainable. This will of course be dependant on Commonwealth funding
- establishing a credible and maintainable MoSD that the community is able to respond to with referrals for service, assistance with health promotion and the team being part of meeting each communities needs
- gaining the trust and respect of local medical practitioners, nurses and a whole range of other health care providers, not to mention the host of human care service agencies and individuals
- the bottom line is being accepted as part of the health care network as a credible and knowledgeable service provider.

Successes

The team has had many successes, these being:

- establishing a good working relationship with the local health care providers
- being a part of community events from a planning, implementation and representation and event representation
- gaining the trust of the medical community in the area
- being at the forefront on discussion about mental health issues
- delivering high quality mental health programs of awareness raising and mental health literacy
- assisting in advocating for the needs of communities, especially in relation to drought and rural decline
- recognition as a viable and pre-eminent prover of high quality mental health (social-emotional well-being) services
- the establishment of a regular MoSD that both agencies and individuals in our operational area are able to rely on
- an intake system that tracks and is accountable within the team for easy review
- respect from many agencies and individuals throughout our catchment area
- an open and transparent method of operation by our team
- no service complaints received in our 2½ years of operation
• a generally stable team
• an open and realistic approach to staff development
• willingness to listen and learn
• ease of access to our team.

The future

As mentioned earlier, our team is looking forward to a bright and productive future. This will be dependant upon our ability to substantiate and re-enforce our ability to provide a worthwhile service. The RFDS is working on a complete review of allied health and the mental health programs particularly in relation to:

• standardisation of documentation
• standardising access, intake and discharge processes
• establishing a record of library resources available across the RFDS organisation
• improving the recording of clinical involvement and health promotion activities
• attracting further funding to promote and expand services where possible to assist our operational activities
• establishing an advisory or reference group to assist with planning for improved service delivery on both clinical and health promotion matters
• a continuing commitment to staff development to ensure clinical ability and competency
• a commitment to have all staff trained to deliver appropriate programs and interventions
• a continuing worthwhile presence in our operation area.

Conclusion

Our small team has had an extremely positive impact on the well-being of the community we cover. As a team we recognise the need to keep in touch with our community and provide services that are appropriate and relevant to particular and specialised circumstances. Realistically we need to be alert to change, assist our staff to keep up to date, listen to our clients and above all maintain trust. It is important to maintain a sustainable service by having a continual presence, retaining our staff and be forever creative in progressing opportunities to assist our communities. Our team as a whole is very confident and strongly believe we can deliver the goods.

References


Presenter

**Stuart Hart** is the Team Leader of the Matilda Regional Health Service (RFDS-QLD) based in Longreach. He has worked in the field of mental health for 20 years with experience in both in-patient and community care settings. He initially qualified as a nurse and has progressed to complete a Bachelor of Science in Nursing, a BA (Welfare) and a Postgraduate Diploma in community education and program development. Stuart has worked across urban, rural and remote settings with experience with both Indigenous and non-Indigenous folk. Stuart now wishes to work on areas of prevention and early intervention processes to assist clients, carers, service consumers and agencies to deal with social/emotional well-being. Over recent years Stuart has developed a good insight into the needs of rural folk through community involvement and advocacy. He is most keen to have people access services that meet their needs and in so doing encourages their involvement in their own community. It is with this in mind that Stuart has been part of the recruitment process for an art therapist in central-west Queensland, undertaken training as a trainer for mental health first aid and has now successfully advocated that a second trainer complete the Mental Health First Aid Train the Trainer Course. Stuart now believes the Matilda Regional Health Service team is a true inter/multi-disciplinary team able to meet the challenges of rural/remote practice in a comprehensive and diverse manner. The team is a solid little creative working unit.