Stresses On Rural Communities

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The current rural crisis has drawn attention to the fact that services for rural communities are generally inadequate to deal with the common troubles of everyday life, let alone the uncommon troubles. In general, health services in rural areas suffer the same fate as the patients they serve - they are isolated and they have to meet multiple needs, often through a single resource. This is why rural services are generic by necessity - a wide range of skills and knowledge is required across a broad spectrum of need. This need to be generic-based is reinforced by the unavailability of specialist services in rural areas.

Many rural communities experience significant problems of inequity with respect to access and provision of health services. Serious health problems are widespread as a result of many factors including: socio-economic conditions arising from economic recession, unemployment, low education, pre-existing lifestyle, isolation, lack of transport and cultural attitudes to health care. While need can be shown to exist, the structural, economic, social and personnel resources are insufficient and/or appropriate.

The GPs who work in these communities are also under stress. Most primary health care in rural areas is provided by GPs, despite their maldistribution in rural areas compared with metropolitan areas. Most of the care is curative rather than preventive, because of time constraints. This in itself is a problem given the lack of preventive services (such as counselling) in rural areas. Country GPs are over-utilised and worn out - especially those in solo practices; they cope alone, with few supports, especially locum support for holidays, education or training. The lack of specialised services, such as psychiatric and counselling services, coupled with GPs' lack of time to listen, leaves many families to cope as best they can. Might this be a reason the rural suicide rate is so high?

Although the ethic of self-help and self-reliance is still strong in the country, it is not able to maintain strong, self-sufficient communities meeting the needs of all of its members. The family and the farm appear to be in conflict while at the same time being indispensable to each other. Lack of time for family recreation and the importance of interpersonal communication are recurrent themes. Ways have to be found to preserve our rural communities.

Travelling away from towns and homes to larger centres and cities for health care and other services has a negative impact. Visiting specialists in the long run can tend to de-skill local communities, although they do have an important part to play. So local solutions, local alliances, clusters, linkages and bridges have to be found - to pursue common goals, meet local needs, and build strong, viable rural communities.

The GP - Primary health care in action

Despite the recent and rapid growth of health, education and welfare services outside the primary care sector, many rural families continue to take their problems to the GP. The GP is both an identifiable person and one with a well-understood role. These are valued attributes in a complex and increasingly bureaucratic world. The GP carries none of the stigma associated with government means-tested services, or agencies associated with health and welfare. There is still sensitivity in conservative rural communities in admitting there is a need for help and seeking help from outside. The GP remains a vital link in enabling communities to be self-reliant and self-sufficient.

However, GPs have also become casualties - isolated, marginalised and alienated from mainstream health care planning and provision. Many rural GPs practise more like a corner shop business or a small cottage industry. This has resulted in falling esteem, a feeling that General Practice was being pushed aside and was no longer relevant. Many GPs wanted to take on a broader role in patient care and patient management but the narrow system of remuneration (fee for service) did not allow for this: poor quality, rapid turn-over medicine gets remunerated more than comprehensive care.

In 1991-2, the Federal Government set up Demonstration Practice Grants to enhance the quality and scope of general practice by fostering new approaches for the delivery and funding of GPs. These Grants are about GPs forging strong links with other health workers, programs and community organisations - a way of integrating GPs back into the mainstream of health care. And the operative word here is quality - quality practice: quality outcomes.

The Southern Downs Community Care Project (SDCC Project) is funded under the Division and Projects Grants Scheme which grew out of the Demonstration Practice Grants. The Project is funded for $57,000, which covers the social worker's salary; GP payments for co-ordination and supervision; minimal administrative costs and a travel allowance. Premises at each general practice are offered rent-free. Our Project is now sponsored by the Southern Rural Queensland Division of General Practice (SRQDGP); all participating GPs are members of either the Warwick or Stanthorpe Chapter of the SRQDGP.

The SDCC Project is pitched at this Primary Health Care level of care - it is grass-roots, community-based care; a small, user-friendly, flexible, patient-focussed model; a clinically-driven service, not a management-driven agenda. Its focus is on health (prevention and promotion, rather than illness); and Social Justice - accessible, affordable, appropriate and acceptable services. As one GP put it: “This service is more real to patients' everyday lives than one delivered from a larger, more impersonal organisation” - where the service is often built around the convenience of the service provider rather than the needs of the patient.

A social view of rural health

Redefining health, away from illness and towards prevention and promotion of health for all, is looking at health care with a wide angle lens. It is an all-of-government approach; it is planning based on community need rather than professional or agency-driven power struggles. It is inter-sectoral collaboration that is supportive of health; integrating health services to promote continuity of care and efficiency in the use of scarce resources. It is building self-reliance on a personal and community level. The social and economic logic of this view of health is hard to argue against. This is the new public health model of care: multiple level, integrated approaches that recognise the value of culturally sensitive programs at the local level.

Specifically, the SDCC Project is about the more predominant role GPs can play in the whole primary health care movement - how they can join with others to re-orient health services towards a more participatory, community-based model of health care. Indeed, it is saying that primary health care in rural communities is not possible without GPs.

Warwick District Profile

The city of Warwick, population approximately 10,000, is the major commercial centre of the Southern Darling Downs. It is situated on the main north/south highways to Brisbane, Sydney and Melbourne as well as to Toowoomba, the major inland provincial city of the Downs. Warwick is surrounded by the Shires of Rosenthal, population 1,700, Glengallan, population 3,000 and Allora, population 2,000, a region which includes many small but important towns: Killarney, Dalveen, Yangan, Maryvale, Tannymorel and Allora. The economy of the region is predominantly dependent on primary industry - cattle, crops, dairy, sheep and mixed farming. The area is not heavily industrialised and is noted for its clean air, tourism, national parks, educational facilities and as a quiet rural centre, popular for retirees as well as young families.

The proportion of the Warwick city population aged 60 years and over is 18.52% compared with a State and national average of around 11%. The frail, aged and chronically disabled are high users of health care services, with the GP acting as the first port of call. A priority here is to prevent the premature or inappropriate admission to hospital or nursing home of this at-risk group.

There are also significant numbers of new arrivals from southern States settling in the rural areas, putting further strain on health services in particular. Many of these settlers are retirees or young families with children, both high users of health, education and welfare services. Many are buying small acreage blocks that are either poorly planned and serviced or are located at some distance from mainstream services. These at-risk groups are often isolated geographically, socially and personally from their extended family network, from their local community or neighbours who are often slow in accepting newcomers, and from local services of which they are ignorant.

Stanthorpe District Profile

This region has approximately 10,000 residents, many of whom are socially and economically disadvantaged.

The district has a high proportion of its workforce engaged in seasonal work. This produces peak demands on health services during the harvest season between December and March and higher unemployment levels during the winter months. These itinerant workers display a set of social problems not normally evident in a stable population and look to the hospital as a source of solving these problems.

The downturn in the rural economy has forced once self-sufficient people to become dependent on the social welfare system, often for the first time during their lives. The stress of this situation causes both distress in the family and physical and psychological symptoms in the patient.

Stanthorpe has a large non-English speaking community with its attendant cultural mores which differ from those of Western society. These patients often only present when problems have become overwhelming and they feel compelled to seek aid.

The Project is able to provide a highly mobile, flexible and efficient service because the distances between practices are small - 60km at the most. Travelling time is kept to a minimum and so are costs - I use my own car, for which I receive a modest travelling allowance.

Visiting services

Several visiting teams come into the area on a monthly basis - for example, Aged Care Assessment Teams, Community Mental Health, Spastic Children's Welfare League, Guide Dogs for the Blind and Child Guidance; but their role is limited to assessment, gate-keeping, liaison and review, no on-going support or counselling. As mentioned earlier, one wonders about the long-term value of visiting services to local communities - are they a solution or a sell-out? In the short-term, of course, they are better than nothing.

Local counselling services

A number of social workers already work in the area, within government departments and agencies, but in general they are working too far away from the point of delivery of primary health care. When you work within an institution you see your role in terms of that institution; you are paid to service its needs and its agendas - sometimes to the detriment of the patient or community. Professional rivalries and management-driven agendas all seem to take over. There are the problems of role confusion and boundary conflicts and the patient is lost sight of.

The increased demand for services these Departments face, coupled with limited funding, have also led several agencies in our community to prioritise their functions and devolve some of their tasks to GPs, community groups or whoever will pick them up so that these core, essential services such as counselling and support are now not being provided by the State.

Several private psychologists do provide counselling services on a sessional basis, but generally their service is limited to those who can afford to pay. The services are not easily accessible or available in an open, flexible way.

I think you can see from all of the above that this Project is providing a qualitatively different service - it is not duplicating what is already available. This is also confirmed by the feedback we are getting from the local community.

One final word about counselling: although counselling has to be accountable in terms of outcomes (for too long it was a private affair, a closed shop, because of issues about confidentiality), this Project is not evaluating the efficacy or cost-effectiveness of counselling or of social work. It is less about casework than about case co-ordination/case management and case consultation - it is about integrating GPs with the mainstream health care system, working with other health care professionals, and delivering a more holistic care to the consumer.

General Practice-Based Community Health Care

Statistics

The number of referrals has been very high - as one GP said: "I don't know how we managed before this Project." I have been known to see eight people in a day, but I'm more comfortable with five or six; most interviews are about one hour long and they may involve an individual, couples or family groups. Home visits are made where transport, age, disability or confidentiality are issues. Slightly more women than men are referred and the average number of interviews per referral is two to five.

Characteristics of cases

The nature of the cases referred is very broad; we are by necessity generalists ie. all-rounders, rather than specialists, although some people are now seeing rural practice as a speciality in its own right.

Up to 50% of patients presenting to GPs suffer psychosocial stress; and up to 33% of patients have a psychiatric illness as defined by DSM-IV - of which anxiety and depression are the most common.

My own subjective appraisal, which is confirmed by independent studies, is that we are faced with an epidemic of need related to such things as violence, abuse, addiction, family breakdown, anxiety, depression, grief and loss. These things may be hidden, but they are devastating in their effects.

If I was to describe my role apart from that of generalist, I would have to say it was that of a grief counsellor. Grief counselling takes time - something that most rural

GPs have very little of. It's quite an impossible situation for most rural GPs to cope with the full range of mental health and common disorders of everyday living. People with practical problems want practical solutions. I think social work, which has always been a practical profession, ie. community-based, is ideally placed to meet this need.

Early intervention

This means patients are coming into contact with counselling and supportive services much earlier than they would if they had to seek them out when their problems are more entrenched. This also reduces time demands on other established agencies by preventing full-blown crises developing - this is cost and time efficient.

Counselling referrals

- Relationship counselling - individuals, couples, family.
- Bereavement counselling - SIDS, suicide, trauma, loss.
- Alcohol and substance abuse.
- Adjustment to chronic disabilities.
- Parent-Child management problems.
- Adolescent acting out, teenage pregnancy, homelessness, disorders in eating.
- Aged care - domiciliary services, carer support, respite care.
- Child care, family day care, fostering, family support.
- Domestic violence, child abuse and neglect.
- Family law issues - separation, custody, access.
- Stress management, relaxation, coping skills.
- Psychiatric after-care and support.
- Patient education, health promotion, self-help and support.
- Accommodation - crisis, refuge-supported, long-term.
- After-hours cover.
- Emergency relief, income support, Social Security.

The interface of care

Historically, GPs did not work together (in Warwick) although there was much scope to do so. Now several GPs are functionally linked together through this Project. They meet together fortnightly over lunch for clinical meetings, which also facilitate information sharing, inter-practice referrals and shared care arrangements. The meetings, as one GP put it, have provided a catalyst and common goal which have greatly facilitated GP relations; another GP felt the Project had enriched the quality of his practice as working with other people was important to him. The Project has also introduced GPs to the many community services that are available to them. My role in all of this has been as a facilitator and secretary, organising the meetings, speakers, catering and follow-up, something that individually the GPs would be hard-pressed to do.

This Project is a simple model of community care that creates an interface across many individuals and groups. It is simple because it is based on minimal infrastructure and it builds on what is already there - it is not about pulling down existing structures and starting all over again. It is a model that can be duplicated using other contexts of need; other allied health personnel; other aims and objectives. It fosters innovation and local ownership; it is simply good professional practice; it is cost-effective and it is consistent with National Health goals and targets. It is also non-controversial and straight-forward; inclusive rather than exclusive.

For me, professionally, the Project is very fulfilling; I enjoy working with the GPs and I enjoy their support and commitment. I in turn have great respect for their expertise and dedication.

This Project is only a small beginning - but as a social worker, I am always looking for and encouraging the small beginning, the new shoot, the developing individual personality. This I think is what primary health care is all about.

Evaluation

If evaluation of a project such as this shows it to be cost-effective, who should fund it? Should it be the Government, the GPs, the patients; or should the Project be self-funding, partially if not wholly by private means?

Noting that the greater proportion of clients receiving counselling from this service are healthcare card-holders, it is extremely unlikely that a project of this type will ever be sustained without some government subsidy. This contention is supported in a book titled "Counselling in General Practice", which notes the UK experience; where initiatives of this type have been in place for some years, whenever government funding has been withdrawn, the project has not been sustained.

Two implications which arise from this Project are:

- funding outside fee-for-service is needed to facilitate GPs working together and becoming more integrated with many of the other local health services; and

- some services that GPs need to offer cannot be adequately provided through existing fee-for-service avenues.

We are presently evaluating the Project by asking patients to complete a questionnaire. Our sample to date is only small, about sixty, but already some clear patterns have emerged. All patients believe the service should be available, but better advertised and promoted. Nearly all respondents preferred the Project to be co-located with their GP - they felt it was more personal, private, comfortable and confidential. An evaluation of the preliminary results follows.

Evaluation: What The Consumer Says

- "It" was a necessary part of my recovery from an episode of mental illness.
- I needed to speak to someone outside of my situation.
- I needed to have someone to talk to and listen to me objectively.
- I couldn't afford to pay for counselling.
- I found the Government service too impersonal - and I had to fit into their system - this was the only option I found acceptable.
- I felt comfortable going to a counsellor via my GP - but I would not have gone to a hospital or other Government agency - there is more trust in a private facility.
- You have my history and my family's history there if it is needed.
- When a person is distressed, it is not helpful to have to travel a long way for help.
- I found the surroundings comfortable, private and personal - the combination of family Doctor and Social Worker worked very well for me.
- I can foresee there will always be a need for this service, it must be continued, extended.
- The Project should have more counsellors - especially female counsellors.
- The Project should have advertised more.
- The Project should have groups for specific needs.

I have already referred to GPs the comments about the Project. Clearly it saves them time and provides more holistic care to patients. And it does help integrate GPs into a more cohesive team.