# Queensland Mental Health Commission
# Strategic Planning Issues Paper

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- **Topic**

**Too Much, Too Little, Too Late!**
Interagency Models for Cooperation in Rural and Remote Areas

- **Current Situation**

As a practicing Mental Health Nurse and Manager of an NGO site in a rural town in Queensland, I hear from all sectors of health care, consumers and community members that our town does not have any services!

One of the main strengths of this NGO surrounds care coordination and knowing what services are available and maximising these services. In our rural town we actually have 28 different services that can provide some degree of mental health support to our client cohort – Too Much!

The challenge is that there is limited knowledge that these services exist and that the majority of the services are provided by 'visiting' providers/organisations that do not have any brand recognition in the community. They often have complex inclusion and exclusion criteria (with the exclusion criteria often far greater than the inclusion criteria), inaccessible mandatory referral forms, no coordination of visits to town - so prospective clients are having to travel long distances over multiple days to access these services, unreliability of the visiting schedule due to lack of demand and then ultimately a lack of trust in these services causing the above scenario to spiral down – Too Little!

Well-meaning efforts to address this issue by organisations obtaining funding to 'map the services' results in frustration to service providers based in these towns as we provide our information again and again. This has resulted in a standard response of 'here is the contact details of the person who I provided my information to last week, please contact them!' If I do get a copy of the resource directory (which is very rare!) it is then well out of date.

Local efforts to address this scenario through monthly network groups results in the 1.5 hours going around the circle yet again introducing our service and name, what we do etc before it is time for most of these well-meaning staff to each jump in their own separate work vehicles and do the 1.5 hour drive home again. Efforts to leverage change at this level are generally met with 'I will have to gain approval from my line manager prior to any decision being made' and that is the last we hear from them. Local providers disengage as they still have patients in the waiting room. Whilst they were entertained by hearing the names and roles of yet another new staff member and program, they have missed out on income!

When we do eventually manage to track down the organisation and referral pathway, discuss with the clients if they think the services matches their needs and send the referral away – guess what happens? We wait and wait and wait. A lack of accountability surrounding acknowledgement of referral, outcome of referral or even that the client has been seen exists – Too Late!

Concerted efforts have been made by many local providers over many years to address this issue with suggestions of community health hub sites, web-based resource directories, central points of referrals, but the challenges lie around who takes ownership of this issue. Most of the 'motivated ' and engaged organisations are funded on 3 year funding contracts all on different funding cycles with many unable to spend on capital infrastructure, private practitioners are faced with time spent engaging in community development activities meaning no income and longer waiting lists, with local government crying poor and stating 'health is not core business'.

Meanwhile our community members living with mental illness are facing more and more stressors as the barriers to access as explained above are experienced and of course their risk of relapse is greater. Acute health here we come, but where do we go? No access to out of hour's acute specialist mental health services is available in most rural areas. Ring the crisis support line, 20 minutes wait, too late, lives are lost!

- **Models and Precedents for Innovation and A Better Way Forward**

**Better Resources**
It is not a case of throwing more money at the problem and bringing in yet another service. The resources are all there but they are not utilised! The fact is that due to the complexity of the 'coal face', GPs and other primary health care providers stick to the one referral pathway that they know. Most services are situated too far away from the focal point of primary health care and that is the GP surgery. This is geographically the case as well as for building relationships, referral pathways and integration of treatment plans. If services were more coordinated and integrated around their service delivery approach or funding was allocated to fewer providers (those already well respected and established in the communities), cost savings could be represented across vehicles/travel, information management infrastructure and software, efficiencies around the transfer of information between service providers and improved shared-care arrangements. A central point of service delivery in rural areas would go a long way to address this. Efficiencies can be realised by the fund holders as well as providing a focal point of access for the consumer.

**Better Services**
As above the services are generally all there! With the advent of the telehealth MBS incentive items this has introduced another medium for the provision of service delivery which is becoming well accepted. The divide between the Federal funded initiatives and the State based initiatives often causes some confusion in the rural areas. We often find that the visiting services do not really have a grasp of the intimate issues that impact on small rural communities and the services are tailored for a more 'city based' approach. We know that if our community wants to access funding for a specific service or event we approach the large fund holders such as Medicare Locals to consider supporting these events in the last quarter of the financial year! An idea to improve this is to ensure that all stakeholders are engaged in a process of a local needs analysis and then tailoring each organisation's service delivery to address these issues with regular review meetings to ascertain progress against goals. Who takes ownership of this process? The answer is potentially Queensland Health, in collaboration with Local Government, as they will always be funded and have a presence in the community.

**Better Accountability and Transparency**
It is amazing that some organisations can get through their reporting process the way they do. What do they report? How many meetings they attended? How they have updated their resource directory? We seem to be happy to measure outputs rather than outcomes. The funding bodies are too far removed from the communities that they service. If the funding was given to a local body who then administered this across organisations that are

actually engaged in the community and doing good work, then the accountability is easier to monitor. One solution to this was supposed to be the onset of Medicare Locals, but this has not worked due to numerous reasons. They have too large an area to cover off on and do not really seem to want to support local providers who are doing a good job. Instead, they, like other organisations challenged with survival and continuity, attempt to grow their own centralised empire. State-based mental health services are rarely seen outside of the hospital setting so they have no community accountability as the community does not know what they are supposed to be doing.

At least with the private practice model, or models that have a blend of private practice and government funding to ensure some degree of sustainability, there is the advantage of providers wanting to see patients in order to get paid. Services that receive funding no matter how many patients they see or how many community engagement events they participate in run the risk of experiencing negativity when a patient attends. There is no incentive to see them; in fact that means a whole lot more paperwork and the culture becomes entrenched!

**Better Engagement**
This is an area in major need of improvement. It is my belief through experience that service provision needs to be as close to General Practice as possible. Having had the opportunity to work with the NHS in England (and whilst it had its faults), the many benefits to patients and primary health care providers came through a 'community of practice approach' developed around the GP surgery. Community Mental Health Nurses employed by the NHS were based at the GP surgery, alongside Midwives, Dieticians, Speech Therapists, Psychologists etc. Each discipline had the professional credibility that can only be gained by a close working relationship. Each discipline had their own scope of practice that provided patients with the opportunity for expert care and all this feeding in to the one plan.

Patients knew where to go to access health care, health professionals knew what was available, who and how to access services and the follow up arrangements. Issues were identified across all disciplines which fed in to the development and implementation of early intervention strategies.

- **Implications for the Reform and Change Agenda in Queensland**

Queensland Health community funded services should be located in the community and co-located with other relevant service providers, engaging in identification of local issues and developing a community of practice to address these issues. This will result in improved access, better uptake of programs, less hospital admissions and improved health outcomes. Improving ownership of individuals to manage their own health needs.

Minimise the number of NGOs being funded to those that are already well established service providers in the community or have strong links to that community and the services they will to deliver. This will result in maximising of scale of economies and reducing cost of service delivery, less administrative burden.

Incentive-based funding based on outcomes rather than outputs, ensuring that the exclusion criteria is not great than the inclusion criteria. This will result in a system that does encourage services to consult with people and improve health.

Local Health and Hospital Boards potentially contribute to ensuring a more cohesive and streamlined service by contributing to the selection/screening of new providers wishing to provide services in their community. This will improve in the ability to identify local health needs, target services and community response to address these needs.