

# Chapter 15

## Case Study:

### Mental Health Emergency Care Rural Access Project: Assessing Rural and Remote Emergency Mental Health in Western New South Wales Australia by Videoconference Technology

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#### **ABSTRACT**

*The MHEC-RAP project involves the innovative application of video conferencing to mental health assessment in rural NSW. The preliminary evaluation findings of the project are presented. Mental health emergencies in rural and remote settings cause particular problems and are not amenable to conventional health service solutions. Patients and local health care staff may be isolated from specialist mental health staff and from acute inpatient services. Decisions to transport patients for specialist assessments or treatment may be required at night or at weekends and may involve families, police, ambulance services and local health staff. Such decisions need to be made promptly but carefully and the ability to obtain a specialist assessment may assist in making a decision about how best to care for the patient bearing in mind the need to provide a responsive, high quality and safe service to patients and local clinicians. In this chapter we examine a novel approach which uses audio-visual technology*

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*to conduct remote emergency mental health patient assessment interviews and provide consultations to local clinicians in rural communities in western NSW. The Mental Health Emergency Care – Rural Access Project or ‘MHEC-RAP’ was developed in 2007 following a series of consultations held in rural towns and implemented in 2008 within the Greater Western Area Health Service (GWAHS), New South Wales, Australia. GWAHS is a primary example of a rural and remote health service. It serves 287,481 people (8.3% of whom are Indigenous Australians) in an area that is 445,197sq km or 55% of the state of New South Wales (Australian Bureau of Statistics, 2001; Greater Western Area Health Service, 2007, 2009). The communities within GWAHS are mostly small, the towns are widely dispersed and local services are “limited by distance, expense, transport, and the difficulty of recruiting health professionals to these areas” (Dunbar, 2007 page 587). The chapter focuses on the design of the service, its implementation and its performance in the first year. We conclude with a discussion about the service, its broader relevance, transferability and its sustainability.*

## **INTRODUCTION**

Mental health is one of the national health priorities in Australia and currently one in five people report suffering from a diagnosable mental health disorder each year (Australian Bureau of Statistics, 2007; Australian Institute of Health and Welfare, 2009a). This need is exacerbated in rural and remote settings where access to specialist services is traditionally poor.

Many communities in GWAHS receive specialist health care via occasional fly-in services because they do not have resident specialists; there are only 14 resident psychiatrists serving the remote areas throughout Australia (Australian Institute of Health and Welfare, 2009b). While fly-in services make a valuable contribution (Perkins, Roberts, Sanders, & Rosen, 2006), they are usually not available when emergency care is needed. A need exists for an effective and efficient method of providing round the clock emergency mental health care to these communities.

Barriers to accessing health care for rural and remote residents are not limited to the vast distances necessary to travel in order to access health care (FK Judd, 2006; F. Judd, et al., 2002). There may be practical concerns that impact on access to care: financial (paying the doctor’s bill and for the petrol to drive to the consultation), time constraints (arrangements around work for travel and appointments, the effect upon family

and other activities), availability of transport (there are few rural public transport services), and provision of care (there may be only one medical practitioner in town). People may not be aware of what services are available to them or how to access them (some new mental health services are internet based, but not all remote residents have access to internet services); others may be worried about confidentiality or stigma (a neighbour may be the receptionist at the doctor’s surgery).

Mental health patients often present to the nearest Emergency Department (ED) in crisis, either alone or with assistance from family, carers, ambulance or police officers. Approximately one in ten ED presentations are for mental health conditions (Kerrison, 2007). Emergency Department staff are trained for a fast paced triage and care system while mental health patients may need one-on-one prolonged care which may disrupt the flow of the ED. A mental health presentation may lead to ED staff feeling ill-equipped in training or resources to provide care resulting in undue stress for both patient and provider (Clarke, Brown, Hughes, & Motluk, 2006; Kerrison, 2007).

Bonyng et al suggests that inconsistencies in caring for mental health emergencies have complicated efforts to improve mental health emergency interventions (Bonyng, 2005). Stuhlmiller et al found that “inappropriate management” of mental health clients in the ED was due to a lack of consistent triage guidelines, staff that are

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