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The effect of context in rural mental health care: Understanding integrated services in a small town

Scott J. Fitzpatrick[a], David Perkins[a], Teresa Luland[b], Dale Brown[b], Eamonn Corvan[b]

[a]Centre for Rural and Remote Mental Health
The University of Newcastle
Locked Bag 6005
Orange NSW 2800 Australia
scott.fitzpatrick@newcastle.edu.au

[b]Mudgee Community Health Centre
PO Box 29
Mudgee NSW 2850 Australia

Abstract Unequal health care outcomes for those with mental illness mean that access to integrated models is critical to supporting good physical and mental health care. This is especially so in rural areas where geographic and structural issues constrain the provision of health services. Guided by a conceptual framework about rural and remote health, this study draws on interviews with health providers and other staff and examines the dynamics of integrated primary and community-based specialist care for people with severe and persistent mental illnesses living in rural Australia. Findings show that the facilitation of sustainable linkages between general practice and community mental health requires the skilful exercise of power, knowledge, and resources by partners in order to address the social and structural factors that influence local health situations. These findings suggest that incremental processes of integration that are responsive to patients' and stakeholders' needs and that build on success and increased trust may be more effective than those imposed from the 'top down' that pay insufficient attention to local contexts.

Keywords Integrated care, mental health, primary care, rural health, qualitative research

1. Introduction

The case for integrating physical and mental health care is well established in the research literature and premised on five key concerns: i) high rates of chronic disease among people with a mental illness; ii) reduced life expectancy among people with severe and persistent mental illnesses, largely attributable to poor physical health; iii) elevated rates of mental illness among people with chronic physical health problems; and iv) increased risk of physical ill-health due to the use of psychotropic medications (Naylor et al., 2016) While the meaning of integrated care is variable and multifaceted, at its simplest it refers to "an approach that seeks to improve the quality of care for individual patients, service users, and carers by ensuring that services are well coordinated around their needs" (Goodwin et al., 2011, p. 3). Accordingly, there is widespread consensus among policymakers and health service providers that care at the interface of primary and secondary services must be improved if health inequalities are to be reduced (Butler et al., 2008; Mitchell et al., 2012; Planner et al., 2014).

This is particularly true in rural Australia where health inequalities are compounded by structural conditions that affect the availability, affordability, and timeliness of health services required to meet community needs (Fuller et al., 2004; Francis, 2012; Russell et al., 2013). Given that most Australian adults visit a general practitioner (GP) at least once a year, it has been argued that they may be best positioned to coordinate and integrate care (Bywood et al., 2015). This view is reflected in Australia by initiatives such as the Federal Government*'s Better Outcomes in Mental Health Care* (BOiMHC) that supports the role of GPs in mental health care delivery through training, development of new Medicare items for mental health care, and as gatekeepers to MBS subsidised psychological services (Bywood et al., 2015).

Those with severe and persistent mental illnesses (SPMI), however, can experience difficulties in accessing primary care services. Booking systems can be hard to navigate, and services may not be obtainable in a timely manner (Planner et al., 2014; Russell et al., 2013). Further, some GPs report feeling ill-equipped to care for patients with SPMI or see it as beyond their remit (Lester, 2005; Planner et al., 2014). For these reasons, integration of primary health care into specialty mental health services may be more appropriate for these patients (Planner et al., 2014).

As well as issues regarding different models of integration of physical and mental health care, structural, institutional, and clinical factors also impact care coordination and provision. Policy, governance structures, staff recruitment and retention, alignment of financial incentives, and professional roles and culture can both constrain and enable collaborative arrangements (Bourke et al., 2012b; Davies et al., 2009; Fuller et al., 2004). The impact of these various factors on the contexts in which healthcare occurs, in turn, shape experiences of health services, future use, and help-seeking (Kovandžić et al., 2012).

One reason for the difficulty in establishing effective, sustainable, coordinated care is that many efforts at integration have focused on organisational rather than on clinical or service level integration (Burns and Pauly, 2002; Curry and Ham, 2010). This may reflect a division between policymakers and practitioners in the design of complex service models that minimises practitioner knowledge and involvement (Hawe, 2015). However, evidence indicates that organisational integration is often powerless to change the way that health care professionals work together (Burns and Pauly, 2002). Since the most effective programs for SPMI are those that integrate delivery of patient care and include multidisciplinary care/case management and physician involvement, it may be more productive, in the first instance, to concentrate on integration around the patient pathway and frontline team (Burns and Pauly, 2002; Curry and Ham, 2010).

In light of these challenges, a strong case has been made for developing place-based systems of care to facilitate integrated care (Ham and Alderwick, 2015). Place-based systems have several advantages. Primary amongst these is their ability to take into account local contexts. This includes both local social relations and the broader health systems in which health and health service responses are produced (Bourke et al., 2012b). As well as ensuring that solutions are adapted to the local circumstances in which the problem and services are located, place-based systems of care also enable the development of collaborative care models that are financially and clinically sustainable through greater focus on local resources, skills, and knowledge (Ham and Alderwick, 2015; Moon, 1995).

This research was undertaken to understand the dynamics of best practice integrated care for people with SPMI living in a small rural community in Australia. Because this takes place in a context where policy, structure, and alignment of incentives favour ‘normal’ fragmented

services, an understanding of these dynamics is important for developing new service models and achieving better physical and mental health outcomes in rural communities.

2. Methodology and methods

We used a case study approach to examine the integration of primary and community based specialist care for people with SPMI in a small rural town in Australia to better understand the dynamics of integrated care. The empirical research underpinning this case study was conducted as part of an evaluation of a novel and well-established integrated care service in rural New South Wales (NSW) that provides comprehensive (primary) health care to people using community mental health services. The service was established in 2007 following concerns by the local community mental health team (CMHT) about poor access to general practice services for their clients. At the instigation of a local GP and a CMHT member, it was agreed that a regular monthly clinic (hereinafter GP Clinic) would be run by that GP at a local general practice (private sector and federal subsidy) with appointments and attendance managed by the CMHT (state and public sector). A formative evaluation of the service was conducted in 2009 two years after it was established. Findings from this study showed that the service provided improved access for clients to primary care services and led to better collaboration between health care providers (Perkins et al., 2010). This study was conducted to address questions relating to the sustainability of the service and to further examine the factors that have driven successful collaborative practice in this rural location.

2.1 Theoretical framework

In Australia, where descriptions of rural communities are often homogenised, and where a prevailing deficit discourse undermines the diversity and complexity of rural lives, identities, and practices, an exploration of local context is important (Bourke et al., 2012a; 2012b; Malatzky and Bourke, 2016). To explore these issues, we employ a conceptual framework developed by Bourke and others (2012a; 2012b). The framework has been developed specifically for the Australian rural context and provides an overarching conceptual tool for analysing particular rural health situations. Drawing on Giddens' (2009) theory of structuration, the framework comprises six key concepts for examining the complex interrelationships underpinning rural models of health care: (i) geographical isolation, (ii) the rural locale, (iii) health responses in rural locales, (iv) broader health systems, (v) broader

social structures, and (vi) power relations. Structuration emphasises the connection between structure and agency. That is, where people's actions (agency) are both enabled and constrained by structural properties. "Structuration," explain the authors, "is an appropriate lens because it simultaneously connects individual actions, community level responses and broader influences of policy, resource allocation, health systems and dominant discourses entrenched in rural health" (Bourke et al., 2012b, p. 498). Because rural models of care in Australia vary between communities, greater understanding of the dynamic processes that foster collaboration and generate actions to address local problems is important in order to better understand and support them (Bourke et al., 2012b; Kuziemsky and O'Sullivan, 2015).

2.2 Setting and participants

Mudgee is a rural town of approximately 10,000 residents. It is located 125km from the nearest regional centre with over 32,000 residents and more services, including a mental health inpatient unit. The main industry is coal mining employing 13.4% of the local labour force. The region is home to a growing viticulture and tourism industry with accommodation and food services accounting for 8.6% of the local labour force. Mudgee is served by a hospital with an emergency department; a community health centre offering a range of allied health, nursing, and counselling services; and two group general practices. Specialist mental health care is provided by the CMHT which cares for around 200 clients with support from two visiting psychiatrists who visit 1 day each week on alternate weeks, and the Mental Health Emergency Care-Rural Access Program (MHEC-RAP) that provides support via phone and video. The GP Clinic provides primary health care services for CMHT clients.

The sample for this study was drawn from health care providers and other staff associated with the GP Clinic including CMHT members, GPs, medical centre staff, and visiting psychiatrists. Potential participants were identified by a co-investigator (TL) at the site and asked if they consented to their work contact details being provided to the lead investigator (SF). Those who consented were sent an invitation letter and Participant Information Sheet. Written consent was obtained before the interview. Ethical approval of the study was granted by the local area health service and the university concerned.

2.3 Data collection and analysis

Face-to-face, semi-structured interviews were conducted with 16 participants between December 2015 and April 2016. Participants were asked a diverse set of questions including how the service meets the needs of the local rural population; how different health providers and professionals work together; the benefits of the service for the clients and health providers involved; and the personal, organisational, and structural factors needed to sustain and maximise the success of the GP Clinic. Specific probes to these responses enabled further exploration of these issues and allowed for clarification and elaboration (Marshall and Rosman 2010). Interviews were recorded on a digital voice recorder, transcribed verbatim, and de-identified.

Analysis was conducted using the Framework Method. This is a flexible analytic tool that enables classification and organisation of qualitative data before a more focused analysis in which relationships within and across different parts of the data are mapped (Gale et al., 2013; Ritchie et al., 2005). First, an inductive approach was applied in which coding focused on finding recurring themes or ideas generated from the data. This led to the construction of an index of descriptive categories and themes for labelling and grouping the data, with which interview data from each participant was summarised and added to the chart. Second, a more deductive approach was taken where the codes identified in the inductive phase were analysed using the six key concepts of the framework developed by Bourke and others. These concepts not only draw together seemingly diverse observations, they also provide a way of connecting individual perspectives and broader systemic and structural factors. This approach enabled us to keep the analytical process grounded in the data, while increasing the depth of our analysis to better explain certain themes and build on existing theoretical understandings of rural and remote health (Gale et al., 2013; Ritchie et al., 2005). Interpretive rigour was ensured by the mutual confirmation of data and analysis by the investigators whose research backgrounds are in the sociology of health and illness, health policy and systems, and clinical mental health.

3. Findings

In order to better understand the local contexts in which rural service models operate, the findings are organised under the six elements of the conceptual framework (i) geographical isolation, (ii) the rural locale, (iii) health responses in rural locales, (iv) broader health systems, (v) broader social structures, and (vi) power relations. Although the concepts are

presented sequentially, connections between different components are identified in order to illustrate points of action and change (Bourke et al., 2012a; 2012b). An understanding of these contexts and the ways they shape health and models of care is key to achieving better integrated care for people with SPMI in rural settings.

3.1 Geographical isolation

The concept of geographical isolation does not imply any single definition of 'rural' but instead focuses on spatial proximity to other places and services and how this, in turn, influences accessibility and social relations (Bourke et al., 2012b). Geographical isolation is important for understanding the establishment of the GP Clinic as a response to local health care needs.

The absence of in-patient mental health facilities and local psychiatric and drug rehabilitation highlights the impact of spatial isolation on service responses.

> Not having the [in-patient] mental health unit and psychiatry available in Mudgee, I think the GP and the mental health team really are the frontline of mental health services. I think that relationship's invaluable. [034]

Problems of access to primary care for their clients were described by a majority of participants as a major impetus for action.

> Originally 70% of the people that were coming in here [CMHT clients] didn't have a GP, or weren't able to nominate someone that they saw regularly. So that sort of brought questions up in your mind as to what was happening to their physical healthcare. [050]

While clearly impacting upon the daily activities of the CMHT, these geographic and systems issues arguably provided the conditions for developing better integrated care practice. As one participant explained:

> … in bigger areas, you've also got that layer of your registrars and things. And they change so frequently… I think the bigger number of providers that go through a person's treatment, the more disjointed it can get. [050]

In addition to supporting less hierarchical and fragmented service structures, several staff talked about the location of Mudgee in relation to other regional centres in view of their career prospects and the impact of spatial isolation on the development of professional team culture, stability, and collaborative working relationships.

> Most of us aren't going to move. Most of us are older. We're staying here; we've got families… So if you've worked in Orange [regional centre], if you get sick of your job and you think, oh, well, I'll go and find a job in something else. Here you stay, work it out and keep doing it. [042]

The co-location of the CMHT with other services operating within the Community Health Centre facilitated further the development of collaborative and productive working relationships.

> We're really lucky in the sense that we are in a building with a complete cross-section of health services, everything from your diabetic educator to your chronic complex care, women's health, drug and alcohol, mental health; we've got the gamut here. There are very few services we don't actually have within the building. So there's the benefit of informal discussions with other colleagues about certain things. [38]

The proximity to the Medical Centre where the GP Clinic is run (in an adjacent building) was described as highly advantageous. These geographical elements influence social processes and relations in the community, and, in turn, shape the actions and interactions of residents (Bourke et al., 2012b).These dimensions of the rural locale are the focus of the next section.

3.2 The rural locale

Social relations shape local meanings, knowledge and norms that, over time, impact on the actions and interactions of residents in regards to their health and models of care (Bourke et al., 2012b). Previous negative experiences with services and a preference for self-reliance

were seen as contributing to certain patterns of help-seeking behaviour among CMHT clients. But participants were also careful to explain how people with a SPMI were often marginalised by local primary care services that were over-subscribed and hard to navigate.

> There's not the shortage there used to be, but the appointments do fill up. So there's times when you phone up for a medical appointment and they say, "We've got nothing this month. You have to phone back next week when we get the on-call roster for the hospital, we'll find out who's got what appointments." And our clients are going to struggle with that. [050]

Concern was also expressed over penalty fees levied to those who missed appointments and how this contributed to people avoiding primary care services and/or accessing free emergency services in their place.

> For most of my clients, the reason they can't access normal GPs is they've made numerous appointments, not turned up and haven't paid their bill. So then they're kind of blacklisted and they get told, yes, well, you've got to pay 50 bucks because that's what you owe us, and they just won't do that. [039]

Knowledge of the barriers effecting persons with SPMI accessing primary care services meant that a strong focus on advocacy and service equity was found in many descriptions of the objectives of the GP Clinic.

> I suppose just having the drug and alcohol team as an advocate for them at a GP [general practice] – where they can often get labelled as a 'druggie' – makes it a lot easier for them to get proper treatment for medical conditions. [046]

> So, they're [CMHT clients] actually getting the service that people without a mental illness get all the time. And these guys just need a bit of extra advocacy, really; and stability. [050]

The exchange of information and interaction between local health professionals and CMHT clients have been important drivers of change reshaping local practices, social norms, and patterns of behaviour. The invitation to clients for a CMHT staff member to accompany them

during the GP consultation, for example, is seen by providers as a way of both improving clients' attitudes toward health services, as well their capacity to engage with them.

> A lot of people are first timers when they come here, they don't know what to expect, [so it's about] trying to make it as comfortable as possible so they come back. [027]

> We make the initial contact for them, but after a period of time they then may decide, 'I don't need the team to do it for me, I can do it myself,' so they may make individual appointments with not only [name of doctor] that runs the GP Clinic, but through some of the newer GPs to the medical centre and start a relationship with them as well. [053]

Similarly, formal and informal networks were also a way of communicating important knowledge about physical and mental health care to clients and health professionals.

> Clients have really benefitted from the GP clinic and that's going back to looking after themselves; looking after their physical health. Unfortunately as I said, a symptom of mental health/drug and alcohol is that they don't have that self-care, their health care is usually not adequate, they have multiple ailments, teeth, digestive, cardiac, those sorts of things, liver in particular. [027]

These social relations can be interpreted as a range of actions aimed at improving health services and practices. The following section outlines these responses.

3.3 Local health responses

As Bourke (2012b) and others have noted, a primary health care approach underpins most rural health service models as it is patient-centred, locally driven, and involves less hierarchical governance structures than specialist care. Participants also considered these factors important to the development and sustainability of the GP Clinic.

> The advantage of this is its grass roots up, so you've got a GP and a mental health team that really wants what's best for the patient rather than people in an office in Sydney saying, "We're going to do this across the state" – where often things get lost. [060]

Again, the importance of developing close working relationships was considered critical in order to establish realistic aims and expectations. But so too was the provision of basic infrastructure, leadership, and management.

> You've got to start by developing a real working relationship with the GPs…. So you've got to start with a question, "What could we do for you?" and they may give you all sorts of unrealistic answers, but once you get those answers you can then say, "Well, actually we can't do that, but we could do these things," and once you show them that you've got something you can offer them then you can develop that relationship. [055]

In particular, the decision for the CMHT to take over organisation and booking of the GP Clinic each month was considered essential.

> So basically they [GP] blot out a whole day for the mental health team and usually one person on our team will organise those clients, and it's usually prioritised to who needs it the most on the day. [046]

This involves considerable planning, follow-up of clients, preparation of patient files, as well as communication with the medical centre to maximise client attendance and support of the GP.

> The critical thing is having one hinge person who takes on the responsibility with the GP – makes sure his or her books are full – make sure they get easy access to a psychiatrist so the GPs never left holding a very difficult patient by him or herself. [060]

> I think our non-attendance would be more if we didn't have [CMHT member] doing it. I really do think that they actually minimise the non-attendance… It would be an administration nightmare for reception staff to have to do it. [054]

While team culture, relationships and leadership have played a key role in sustaining the clinic since its inception, the capacity of the clinic to meet service provider and professional needs is also important. An improvement in clients' health, the variety the GP Clinic offers, and the improvement in skills and knowledge that working with the CMHT and people with

SPMI affords were seen as additional benefits.

> I think most GPs will actually like being a part of a team, because when you're part of a team there's more strings you can pull to get your patients well and there's much – the big reward in any field of medicine is seeing patients get better and, I think, once GPs work with the community team, they're much more likely to see patients improve. [060]

As well as attending to the physical health care needs of clients, the GP Clinic has also provided the CMHT with an additional resource for managing acute care in the community by overcoming the institutional barriers that make the prescribing of specialist drugs difficult.

> We all had some people that we wanted to start on clozapine, but were just so fearful about going into a psychiatric hospital to start. And I think [visiting psychiatrist] rang [GP] and said, "Look, if I supported you during that period of time, with the knowledge and all that sort of stuff, would you be prepared to do it?" And again, he's [GP] that personality. He's like, "Oh, look if it saves them having to you know, I'll give it a go." [050]

This extended to the prescribing of other medications to alleviate a potential crisis – an often time-consuming and frustrating endeavour for the CMHT and with enormous organisational and cost-saving benefits.

> Before the clinic, there's times when people would come in, they'd run out of medication, you can't get an appointment, you ring the medical centre, they're not helping you, even as a worker you can't help. So you had to take them over to emergency and sit over there for three hours, before they get the shits and go home with no medication. ….Whereas if someone comes in, they've run out of medication, even if it's not a clinic day, there's times when you can ring up and say, "Can you see this person, because X, Y and Z?" More often than not, he'll squeeze them in. Or if he can't do it that day, he'll do it the next day. [050]

> We don't have a high rate of hospitalisations here for our mental health clients. We do manage a lot in the community, but I think that's because we have that good

> relationship with the GPs and we get onto things early, so yeah, there's big organisational benefits as well. [046]

These actions and responses must be understood within broader health systems that influence agency and that both enable and constrain local health responses (Bourke et al., 2012b). These are the focus of the following section.

3.4 Broader health systems

Health systems comprise a complex interaction of organisations, policies, resources, values, and power structures that influence rural health priorities, decisions, and funding (Bourke et al., 2012b). These, in turn, are implicated in the nature, quality, and outcomes of rural health care practice. For example, concerns over physical health issues resulting from the use of antipsychotic medications were instrumental to the formation and ongoing running of the GP Clinic, and one that it had proven highly successful in meeting.

> I don't know too many mental health teams that do pathology on their patients. They're always referred to the hospital or to their GP for their pathology. And without that, you don't know what their cholesterol's doing. So you don't know what the liver function tests are doing. So you're constantly chasing a range of doctors to try and get pathology. [050]

> Because I see the Clozapine patients once a month I can check their blood pressure and I can see all their other metabolic issues that are happening because of their medications. And I find that they are healthier than maybe the cohort that is on more traditional antipsychotics because they're not being seen nearly as frequently. [031]

Certainly an important factor in the running of the GP Clinic has been the availability of bulk-billing (no fees), both as a way of safeguarding patient access to the service, as well as ensuring its efficient operation. Programs that incentivise GPs through the availability of training and new Medicare benefits schedule items that support case-conferencing and the development of mental health plans are important for encouraging GPs, however, concern was expressed about what effect freezes on Medicare rebates might have on the GP Clinic.

He [GP] is a little bit disadvantaged, for instance, if he booked a full day of patients for other reasons. But at the moment it's most probably still very viable. But if Medicare doesn't increase the rebate in the next couple of years I can see that it could be that he would be asked to do it for less than what he would be doing if he saw private patients for the day. [054]

Macro-level health systems such as the undersupply of GPs and the precariousness of Medicare funding mean that bulk billing options for rural residents are limited and continually under threat. In addition to these broader health system issues, other societal-level structures impact on how mental health is understood and the role of health professionals and health services in addressing it.

3.5 Broader social structures

There are multiple societal level structures that interrelate with mental health care. Of particular importance are the social and professional understandings and perceptions about mental health that impact on service provision and care. The marginalisation of those with mental health and alcohol and other drug issues from primary care services, either through the imposition of sanctions for non-attendance or through judgements regarding drug-seeking behaviour, show how pervasive and institutionalised stigma has become with regards to these groups.

Health professionals are also strongly influenced by medical and political discourses and language that privilege income and the capitalisation of health care (Bourke et al., 2012b). The importance of informing local practitioners about the wider benefits of collaborative mental health care was seen as crucial to driving broader health systems change.

I think you're much better to look at grass root projects like this and say, "How can we encourage people to replicate that where they are?"…. I think, if you're going to replicate that (the GP Clinic), you'd be much better finding interested GPs, explaining to them they're not going to make as much money, [but] they're going to be part of a team… they're going to get the benefits [of] seeing patients get a lot better [and] getting more proficient… This is a vulnerable part of the – as vulnerable as Indigenous people in terms of their health outcomes… I actually think that kind of pitch is very powerful

> to most medical professionals and I think it's under recognised by service planners who think more about money. [060]

Widespread concerns by GPs about their ability to care for clients with complex SPMI, reinforced by their understanding of normal professional practice and a poor alignment of incentives and payments with patient needs were seen as reinforcing established practice, effectively excluding people with SPMI. Recounting a discussion about the GP Clinic with an interested party from another service, one participant explained how as soon as "it got to the stage where [I told them] there's a staff member sitting in on all consultations… the response was, 'oh god no, we'd never do that'" [028]. Rather than viewing this as an example of working in partnership with other health professionals, and improving continuity of care, there is a perception that "you're not actually working. You're sitting with the doctor all day [050]." This view that it is not normal practice or a waste of time needs reframing.

Despite its far reaching benefits for patients, the continuation of the GP Clinic appeared constantly under siege by the political and economic understandings that determined what should be considered as cost-effective and efficient practice.

> Whether you're going to the doctor's appointment when it's a clinic day, or if you need to go the doctor's appointment for something else, or you need to pick somebody up and take them to Centrelink (federal agency for social and health related payments and services) as part of case management because for some reason they can't get there on their own. I think that's part of being a case manager with mental health. [050]

Different approaches can create barriers to integrated care (Lee et al., 2013). These tensions and their negotiation by the CMHT in their daily actions and interactions lead us to a discussion of power, the final concept in the framework.

3.6 Power

Power is present in all social actions and relationships and operates at multiple levels (Bourke et al., 2012b). It can therefore be a resource for achieving or restricting change, reinforcing established ways of doing things or leading to the development of innovative projects

(Bourke et al., 2012b). One of the most commonplace descriptions of the GP Clinic was that it was a simple model that just needed a mental health team and a GP to make it happen.

> I would actually suggest anybody trying to do this, don't put it in as a full day's clinic or something, just take it – one worker who's got a good relationship with a GP, book in a couple of their clients together, do joint consults and that effectively is the – that's the cell of a GP clinic. It starts simple and then it actually can grow. If you have a really good relationship with a GP and you've got a few clients in common, go for it and then you actually see the benefits and then you expand it out beyond that and hopefully the GP will promote that amongst his colleagues and the mental health worker can promote it as well amongst their colleagues. [038]

Because power operates through systems, with political and health system structures providing established ways of acting, power is entrenched in the actions of the CMHT, GP and visiting psychiatrists in challenging systems and existing ways of doing things. For example, close working relationships between the CMHT, local GPs, visiting psychiatrists, and the Mental Health Emergency Care-Rural Access Program (MHEC–RAP) – a video and telephone assessment and triage service – is a way of exercising power within the constraints imposed by the absence of in-patient mental health facilities, child and adolescent psychiatric, and drug rehabilitation services.

> It's really comforting for me to know that if anything does – that if I do have huge concerns – I can talk to MHEC-RAP, I can get feedback from them. I can feed that onto a GP and stuff like that. It's not the best, but at the end of the day, I know I can probably rely on that more than some of the other services. [028]

While it may be argued that the qualities exemplified by the CMHT, GP, and visiting psychiatrists such as nimbleness, flexibility, resourcefulness, and persistence might suggest acceptance of broader regulatory and fiscal constraints and power relations, power is not a zero-sum concept in which agents exert no choice. All forms of dependence provide resources whereby those in subordinate positions can influence activities, and these actions will differ between social contexts (Giddens, 2009). Our example shows active and incremental use of power by the CMHT, GP, and visiting psychiatrists to bring about intended outcomes. The parties exercised power in developing a new model of integrated care

for those with SPMI that addresses issues of structural disadvantage and cultural stereotypes experienced by this group. The parties exercised power by providing the GP with a booking system, secretarial support, and ensuring that it is financially viable through maximising attendances. The parties also exercised power through providing double appointments and allocating an entire day to see patients with SPMI. This innovative use of available resources enabled improvement of existing services and was a way of achieving intended outcomes of actions in a 'different' way given the structural constraints of specialist access.

4. Discussion

This research used a case study approach to improve understanding of the dynamics of integrating primary and community based specialist care for people with SPMI in a small rural town. Based on empirical investigation of an integrated health service, and using a conceptual framework for specifically understanding rural health, we were able to generate a detailed understanding of the spatial, system, and social structures and relations specific to a small rural community and their impact on local health services for people with SPMI. To this end, the conceptual framework developed by Bourke and others (2012b) provides an empirically based and theoretically informed lens for examining the interrelationships between health, health systems, and context in specific rural communities. The work here is aligned with ongoing research on place–based health practice, and in particular, the importance of understanding networks of power, values and political economy and their local effects (Escobar, 2001; Kelly, 2003).

Because this is a case study of a single geographic locality it is not intended to be generalisable, nor to endorse a particular model of integrated care. Rather, as community practitioners and researchers we are interested in identifying the dynamics of innovative, promising, and effective practice and finding ways to implement and test this knowledge to achieve better care for vulnerable clients in rural settings. Locally-driven approaches have several advantages over 'top down' approaches (that is, those where the focus is primarily on structures and governance). They are designed within local resource capacity limits and so are financially and clinically sustainable. They also embody the shared values of local practitioners and organisations (Hawe, 2015). Small populations mean a shortage and inequitable distribution of services for those with SPMI, while fee-for-service models conflict with equal access to services. Addressing equity for people with SPMI therefore requires

advocacy and the incremental development of a shared set of values and obligations. The capacity to address the social structures and norms that reinforce these inequities is also likely to be an advantage of locally-driven approaches where good provider relationships and advocacy can reduce the degree to which those with SPMI become alienated from services.

As this case study illustrates, creating integrated care is more an organic than predictable or predetermined process (Ahgren, 2012); where building provider relationships is progressive and requires collaborative activities and time. Structural support (such as the availability of administrative, financial and technological resources) and co-location or close proximity of providers can be advantageous in facilitating these collaborative relationships when conditions are favourable, yet by themselves these factors may not be sufficient, especially if integration is viewed with suspicion among stakeholders (Ahgren, 2012), For Ahgren, the generation of mutual benefits is of crucial importance to successful implementation and sustainability of integrated care.

Because local health models depend on the collaboration of organisational partners who face different objectives and constraints, different organisational arrangements, different motivators and rewards, and who have access to different resources, the lack of mutually recognised benefits can result in dissatisfaction and antagonistic interactions. This is borne out by previous research on collaboration in rural and remote primary mental health care that showed that despite a willingness from GPs and CMHTs to collaborate, a number of tensions existed between them over service protocols, funding arrangements that determined which clients were seen, levels of support provided to GPs to manage clients with SPMI, and inappropriate increases in referrals to the CMHT for those with less severe illnesses (Fuller et al., 2004).

These tensions and dissatisfactions point to the distinct set of challenges involved in developing linkages between general practice and community health, and in particular, the importance of employee stability and positive team culture in undertaking the ‘behind the scenes’ work needed to support and maintain care coordination (Davies et al., 2009). But as this example shows, when the structural and financial constraints under which providers operate are understood and responded to, when professional and organisational relationships are fostered and clear roles and expectations agreed, there is the possibility for collaboration to be mutually beneficial. Increased responsiveness to patients and to organisational partners,

improved professional support for clinicians, and the provision of high quality care with potentially better patient outcomes were several of the benefits derived from the integrated model of the GP Clinic.

Despite continued interest in the GP Clinic from other services, replication in other communities is perceived as difficult. Because agency takes place within structure, knowledge of system and social structures and the ways resources can be mobilised and creatively deployed within them is critical to understanding the continuation of the GP Clinic and its replication (Sewell, 1992). Continuation of the service and its replication was, therefore, thought to require the skilful exercise of power and influence by the partners. The integrated model addressed these constraints by sharing resources, and in doing so, enabled practitioners to transform the scope of practice to include clozapine prescribing and the inclusion of drug and alcohol patients. However, challenges from the broader health system including the current freeze on MBS fee increases for GP services may be a barrier to its uptake in other communities.

A further challenge to the operation of the clinic was the limited capacity of the clinic to collaborate with other community and social services to provide recovery-oriented mental health practice. Despite incorporating key aspects of recovery-oriented practice such as advocacy, social inclusion, and the support of individuals and their families to self-manage their physical and mental health, the study found less evidence for the necessary infrastructure and supportive relationships required to strengthen the recovery orientation of service delivery to include housing, employment, and income and vocational training support – elements that are key to achieving recovery outcomes. This suggests that despite growing support for the recovery model, it is yet to make a significant impact in mental health practice and that chronic care remains the dominant framework (Lester and Gask, 2006). To address these challenges, mechanisms that enhance and reward collaborative practice between primary health, mental health, and non-health services are needed to develop a truly integrated model of care that facilitates pathways to recovery (Bywood et al., 2015).

5. Conclusions

This paper analyses a place-based solution to improving access to integrated primary and specialist care for people with SPMI living in a small rural community. While the key

structures and financing of state based specialist and federal primary care remain the same, the service model overcomes the weakness of both systems through improving linkages and by addressing multiple rather than single morbidities. The service model was not designed by policymakers or researchers but is the result of local providers recognising serious service shortcomings and working together to address issues incrementally. The solution of first order problems such as access to GP services was followed by the gradual inclusion of clients with alcohol and other drug problems and developed over time to the treatment of patients with psychotic disorders using Clozapine treatment which is usually provided in hospital settings. Local solutions such as these need the tacit approval of managers and perhaps policymakers at higher levels of authority and may be easier in small populations that are used to shortages of specialists and finding local solutions. Policymakers may need to recognise and enable local solutions which meet systemic and community objectives such as improved access to services, providing patient centred and holistic care, and promoting recovery for those with chronic and complex conditions.

Key observations of interest to providers include the incremental pattern of integration starting with simple problems and solutions and building on success and increased trust to address more complex issues. It is notable that staff from primary care and from the CMHT developed a strong understanding of the resources and constraints available to, and faced by, the other party, and were well aware of the implications of failing to address them. The limits of private practice and fee-for-service general practice were partly addressed by the planning activities undertaken by CMHT members to ensure that the clinic sessions were a success, that patients and staff attended, and that follow up actions took place. The general practice took calculated financial risks through bulk billing and the use of other MBS items. The importance of shared values centred on patient wellbeing cannot be over emphasised, and the provision of high quality services helped to build trust and encourage ambition. The threat of external actions such as the MBS fee schedule freeze was recognised by all parties who conceded that despite high levels of trust, the service model could be damaged by external factors, in this case federal government policies and decisions.

For researchers, a key lesson follows from Bourke and other's (2012b) observation about the dangers of homogenising rural communities or in this case rural services. Distinctive observations were structured around all six theoretical concepts, and the history of action within a particular community revealed important insights into local health problems and

their responses. In a context where short term pilot studies are commonplace, a service development which extends for a decade and integrates primary and specialist services is unusual and instructive. The detailed analysis of successful service models which overcome common barriers and which may hinge upon local conditions – including local systems and power structures – is a necessary step and perhaps more important than evaluations of short term pilots which pay insufficient attention to structure and context and from which we have little to learn.

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