

Remote and Rural Mental Health Services

Background

Through the Remote and Rural Project process of engagement with clinicians and others working in remote and rural areas, a number of issues were raised around the management by generalist practitioners of patients experiencing mental health crisis. In order to begin to address these concerns, a Project Initiation Document (PID) was developed. It identified that the previous research project carried out under the Remote and Rural Areas Resource Initiative (Bid 79)¹ banner should be revisited in conjunction with the national standards recommended for mental health crisis services. It was recommended that a small group be established to take forward this work. The objectives of the PID are aimed specifically at the support of generalist staff working in remote and rural areas and are listed below:

1. Establish operational protocols for mental health crisis in each remote area. These should include availability of who, what, and where over the 24- hour period and should be agreed in partnership with all relevant services, agencies and service users.
2. Identify minimum target for response times agreed based on available resources including staffing levels.
3. Ensure that protocols are in place for links with NHS 24 and other out of hours telephone response services
4. Identify minimum levels of training and skills development for all staff directly involved in crisis prevention, response or resolution.
5. Ensure that responsive transport systems are in place to support the transfer of the patient experiencing acute mental health problems.
6. Ensure that systems are in place to utilise the Community Hospital or Rural General Hospital are utilised as a 'place of safety' for acutely ill mental health patients.
7. Establish Managed Clinical Networks to support staff and patients in remote and rural areas.

The outcomes for the group to achieve were:

1. Operational protocols for mental health crisis will be available in each remote area.

¹ (2003) "Recommendations for the Safe Management of acutely disturbed psychiatric patients in Scotland's Remote and Rural Areas" December 2003, Bid 79, Report of a Consultation sponsored by RARARI www.elib.scot.nhs.uk/remotearural

2. Minimum target response times are agreed.
3. Protocols are in place for links with NHS 24 and other out of hours telephone response services
4. Minimum levels of training and skills development for all staff directly involved in crisis prevention, response or resolution are identified.
5. Responsive transport systems are in place to support the transfer of the patient experiencing acute mental health problems.
6. Systems are in place to utilise the Community Hospital or Rural General Hospital are utilised as a 'place of safety' for acutely ill mental health patients.
7. Managed Clinical Networks are established to support staff and patients in remote and rural areas.

A group was established in March of 2007 with membership from clinicians and managers in the remote and rural areas, along with Scottish Executive Health Department representation

Introduction

Over recent years, various groups and initiatives have explored the most appropriate and sustainable mental healthcare provision for patients experiencing mental health crisis in remote and rural areas in Scotland. These include the Kerr Report and subsequent government policy in Delivering for Health, the Remote and Rural Areas Resource Initiative (RARARI) Bid 79 Project, and recently, The Mental Health Delivery Plan including the National Standards for Crisis Service^{2,3,4,5}.

These reports are consistent in their recommendations in the types of models recommended for providing health services locally which are safe and appropriate for the management of patients experiencing mental health problems. The approach taken is on crisis prevention and avoidance of unnecessary hospital admission. Nevertheless, there will be occasions when mental health crisis do occur, and national standards have therefore been set by the Scottish Government Health Department (SGHD), for attainment by 2008⁶. These standards will be particularly challenging for remote and rural areas to meet, and the Mental Health Delivery Group are currently considering this.

The common themes emerging from these reports, and from feedback from remote and rural focus group participants include:

² (2005) Ibid

³ (2005) Ibid

⁴ (2003) Ibid

⁵ (2006) "Delivering for Health: Delivering for Mental Health: National Standards for Crisis Services" November 2006, Scottish Executive

- Difficulties faced by local clinical staff in providing high quality care for patients experiencing mental health crisis given the small number involved and infrequent exposure to such situations, and the lack of immediate specialist support, including access to a Mental Health Officer (MHO);
- Difficulty in identifying local 'Places of Safety' in remote and rural areas;
- A perceived lack of understanding on the part of the clinicians working in dedicated mental health centres of the particular circumstances faced by staff in remote and rural settings;
- Delays in obtaining transfer of patients requiring specialist hospital care.

The main recommendation to emerge from the RARARI Bid 79 Project in 2003 and endorsed by the Code of Practice accompanying the Mental Health (Care and Treatment) (Scotland) Act 2003, was that NHS Boards should be responsible for ensuring that a Psychiatric Emergency Plan (PEP), endorsed by all appropriate agencies and professional groups, is in place in each locality. This PEP should include statements on: the skills and competences required of staff, minimum staffing levels, and clear arrangements on the availability of Mental Health Officers (MHOs). This would allow potential local difficulties to be addressed and contingency procedures put in place before they arise for real. The development and aim of such a plan would be to:

- Agree procedures that would manage the transfer and detention process in a manner which minimises distress and disturbance for the person and to ensure as smooth and safe transition as possible from the site of the emergency to the appropriate treatment setting⁷.

The Remote and Rural Mental Health Crisis Group felt that the first step in the achievement of their objectives would be to establish the status of these PEPs. A letter was subsequently written to the NHS Rural Boards in order to identify whether a PEP had been developed, and if so where it had been disseminated and what training had accompanied the distribution. Although the National Mental Health Crisis Standards do not have to be achieved until 2008, the group felt it sensible to enquire as to NHS Rural Board's progress towards the attainment of these Standards. This information was requested in the same correspondence. Four out of six Boards responded, all of which had developed PEPs in conjunction with the relevant stakeholders. There was little detail provided on the training accompanying the dissemination of the PEPs. Of those Boards who responded, although little progress had yet been made, all were working towards the National Mental Health Crisis Standards, but concerns were raised that these standards would not be achievable in many remote and rural areas.

⁶ (2006) Ibid

⁷ (2003) '*Draft Code of Practice*' Volume 1 2003, para 3

Remote and Rural Mental Health Crisis Service - The Model of Care

The focus of mental health services within remote and rural communities must be on the early detection of disease, with pro-active case finding targeting difficult to reach people and those in need, the aim of which is to prevent disease escalation. One such example is Guided Self Help Workers in NHS Highland who identify people with depression at an early stage and focus upon the prevention of escalation of disease. There is also an opportunity for remote and rural areas to develop creative solutions in prevention of mental health crisis by utilising Choose Life Co-ordinators, and pulling on the work being done by the Mental Health Foundation, SAMH and the Mental Health Collaborative improvement programme on reducing hospital re-admissions.

Despite the focus upon early detection and prevention of disease escalation, there will inevitably be situations where individuals will experience a mental health crisis and these will require management, sometimes by generalist practitioners. Accepting the National Standards for Crisis Services⁸ there are well documented challenges for remote and rural areas in meeting those standards. CHPs must, therefore have contingencies in place which support practitioners in remote and rural areas to manage a mental health crisis and ensure that individuals receive a response which meets their needs in a timely and professional manner. This may include containment and stabilisation within a place of safety, which may be in a Community Hospital or an RGH where these exist, until onward transfer to a specialist centre. Mental Health services should be organised as part of a network, with a specialist centre and there should be appropriate retrieval arrangements to allow access to inpatient care. Locally available services should include a crisis service and assertive outreach to sustain, as far as possible, patients in their home environment. Contingencies which should be in place to support the management of mental health crisis in remote and rural areas would usually include:

- Specific arrangements for the management of mental health crisis in remote and rural areas to be included in NHS Boards' Psychiatric Emergency Plans (PEPs);
- The requirement to review the need for the extension of current mental health service provision to cover out of hours;
- The development of networks with specialist psychiatric centres, including communication across the system involving case management and critical incident reviews;
- Responsive retrieval systems for patients experiencing mental health crisis;
- The need to establish robust e-health links between remote and rural healthcare settings and larger psychiatric centres.

⁸ (2006) "Delivering for Mental Health National Crisis Standards" Nov 2006 SEHD

In order to ensure that generalist practitioners in remote and rural areas have the necessary skills to appropriately manage an individual experiencing mental health crisis, there is an urgent need for the development of a pre-hospital psychiatric care course, delivered utilising a 'BASICS' type approach.

What benefits would care on a network basis provide?

- Guaranteed access to expert opinion to inform clinical decision-making.
- Peer group support, training and education.
- Rotation for skills maintenance.
- Development of shared protocols and patient pathways.
- Transfer debriefs.
- Increased practitioner confidence.
- Clinical Audit.
- Good e-health links.
- Improved discharge planning.

Based on historical referral pathways and taking into account geographical considerations it is proposed that these networks be established as follows:

Remote and Rural Area	Networked Psychiatric Centre
Argyll and Bute	Argyll and Bute Hospital, Lochgilphead
Borders	Royal Edinburgh Hospital
Stranraer and Wigtownshire	Chrichton Royal Hospital, Dumfries
Skye, Lochaber, Fort William, North West Highlands, Caithness	New Craigs Hospital, Inverness
Orkney	Royal Cornhill Hospital, Aberdeen
Shetland	Royal Cornhill Hospital, Aberdeen
Western Isles	New Craigs Hospital, Inverness

Emerging Staffing Models

Healthcare for patients experiencing mental health crisis in remote and rural settings is currently delivered by a range of professionals, often working in isolation and sometimes working in teams. The emerging models for healthcare in remote and rural areas will vary from area to area dependant upon population need, geographical considerations and the types of practitioners available. However, all areas will deliver a service utilising an integrated team approach, demonstrated by a range of competencies. Teams may comprise of locally based individuals, outreach specialists or a combination of both. For example, management of a patient experiencing mental health crisis may be carried out by a Community Psychiatric Nurse. In another area, care may be provided by a Consultant Physician within the Rural General Hospital (RGH) supported locally by practitioners from the multidisciplinary team and at a distance by a specialist in a psychiatric centre through e-health clinical decision support. Another area may provide similar support for the care of the patient experiencing mental health crisis from a GP, again supported locally by the multidisciplinary team and at a distance by a specialist. Regardless of the type of practitioner delivering mental health crisis management, all remote and rural mental health teams must be an integral part of a formal network with a psychiatric centre. The Western Isles and Greater Glasgow and Clyde Health Boards have developed this network in the area of paediatrics, taking the concept a stage further by proposing the appointment of a shared consultant paediatrician post between the Western Isles Hospital and the Royal Hospital for Sick Children, Yorkhill. This consultant would therefore obtain support from the paediatric centre along with regular rotation for skills update. It is proposed that such a model is transferable to Mental Health.

Community Health Partnerships and Rural General Hospitals should define the composition of their local psychiatric teams based on the required competences.

In order to ensure that the networked specialist psychiatric services can respond to requests for support from remote and rural practitioner who are managing a patient experiencing a mental health crisis, it is proposed that the specialist centres 'front load' their evening shifts so that staff are available to respond.

The voluntary sector is already involved in Mental Health Care in Scotland. However, there is opportunity to develop other support models such as those delivered in rural England by the charitable organisation called Rural Emotional Support Team (REST)⁹. This community mental health charity supports farmers and agricultural workers in Staffordshire by working alongside the client experiencing severe distress and

⁹ (2007) Gould, M 'Cold Comfort Farm' Health Service Journal March 1st 2007

contemplating suicide, and has been commended as an example of good practice by the National Institute for Mental Health in England.

Learning and Development

Practitioners in remote and rural settings currently demonstrate a wide range of generalist competences. There are few specialist psychiatric trained staff based in remote or rural settings. This situation is compounded by the low mental health crisis activity which presents challenges, particularly in gaining and maintaining practitioners' competences in managing such situations. We therefore need to provide our rural staff with skills and knowledge to support their work with those in Mental Health crisis. The Remote and Rural National Workstream project team undertook 34 Focus Groups with staff who work in remote areas. All Focus Groups reported that the management of the patient experiencing a mental health crisis was particularly challenging for rural practitioners. They also highlighted that they felt inadequately prepared and had difficulty in sourcing training to supplement their education. A survey of Higher Education institution prospectuses has shown that Mental Health education is difficult to access for rural staff¹⁰. Patients experiencing mental health crisis should expect to receive care from generalist rural practitioners who are equipped to accurately assess the situation prior to contacting specialist services that are not available locally. This report recommends, therefore, that as a minimum, all front-line non specialist trained staff working in remote and rural communities should receive training on pre-hospital psychiatric care of the patient experiencing mental health crisis. During the consultation phase of the Remote and Rural Interim Report, there was strong support for such training and for it to be delivered locally, utilising the approach developed by The British Association of Immediate Care Skills (BASICS). It is proposed that the development of this type of training be a priority for The Remote and Rural Healthcare Educational Alliance (RRHEAL).

When psychiatric networks are formalised, education of remote and rural practitioners should form an integral part of this network. This could be achieved through outreach teaching from larger centres, rotation to psychiatric centres, and e-learning.

Medical Rural Training Pathways

The Rural Training Pathways Steering Group should ensure that the future curriculum for medical remote and rural practitioners incorporate specific elements of mental health crisis training, particularly for General Practitioners and Physicians.

¹⁰ (2003) "Recommendations for the Safe Management of acutely disturbed psychiatric patients in Scotland's Remote and Rural Areas" December 2003, Bid 79, Report of a Consultation sponsored by RARARI www.elib.scot.nhs.uk/remotear rural

Technology

E-health solutions are increasingly being utilised for clinical decision support and for the provision of outreach services. Mental Health networks should explore e-health solutions. For example, a telemedicine link between the Emergency Department in the RGH and the Psychiatric Centre Admission Unit could improve clinical decision support and could potentially allow the retrieval to be safely delayed in the case of adverse weather conditions, or cancelled altogether if the patient were seen to improve. Links such as this will only work with commitment from each side and with a willingness to use the technology. The use of video-linking for specialist input should also be expanded, for example, this has been successfully trialled in the area of cognitive therapy.

A mapping exercise is required to establish what e-technology equipment is available within the remote and rural settings and the networked psychiatric centres, so that gaps can be identified and filled.

Transport and Retrieval Systems

Should the patients require transportation then a robust responsive system of transport is key to a sustainable model of a remote and rural mental health crisis service. This will include ambulance transport, retrieval systems and the wider transport infrastructure. Minimum standards should be set for responding to transfer of patients experiencing a mental health crisis who require hospital care. It is proposed that there should be a 30 minute response standard set for the collection of the specialist Mental Health Team who are being despatched to attend the patient experiencing a mental health crisis.

Where possible, it is recommended that separate vehicles are available to respond to mental health crisis, in order to maintain patient anonymity. There is already an example of this system working within NHS Highland Mental Health Services in partnership with the Scottish Ambulance Service (SAS).

Implications

Local

- CHPs and RGHS should ensure that their PEP is current and that their staff have received the necessary training in the management of mental health crisis.
- Rural NHS Boards should work with regional partners to establish a formal psychiatric service network.

- Rural NHS Boards should incorporate out of hours psychiatric services in their workforce plans.
- Rural NHS Boards should consider working with charitable organisations such as REST.
- Rural NHS Boards should prioritise telemedicine and e-health equipment in their capital plans to ensure that remote teams have adequate access to timely clinical decision support.

Regional

- Regional Planning Groups should facilitate the establishment of formal psychiatric service networks to support remote and rural mental health services.
- Regional Planning Groups should incorporate the support of psychiatric services in remote and rural areas within their service development and workforce plans. For example, in ensuring that evening shifts are 'front loaded' in order to be able to provide support teams to remote and rural areas.
- Regional Planning Groups should commission the prioritisation of e-health links between networked psychiatric centres. Regional Planning Groups need to be flexible in the traditional boundaries in order to facilitate this commissioning.
- Psychiatric Centres should work with remote and rural areas to establish a formal psychiatric network for support of remote and rural mental health services.
- Psychiatric Centres should work with the remote and rural areas to determine the shape of local service delivery and to ensure that the PEPs are current.
- Psychiatric Centres should take cognisance of the increased workload involved in supporting the remote and rural mental health service in their workforce plans.
- Psychiatric Centres should identify a named consultant responsible for the support of remote and rural mental health services in terms of the provision of outreach services, development of protocols, training and education.

National

- The Mental Health Delivery Group should take into consideration remote and rural areas the ability to achieve the Mental Health Crisis Standards.
- The Scottish Ambulance Service (SAS) should review their transport arrangements for responding to mental health crisis, and also ensure that the 30 minute response target for picking up specialist psychiatric support teams is met.
- E-health links between networked psychiatric centres should be prioritised at a national level.
- NES through RRHEAL should ensure that the appropriate pre – hospital psychiatric care course is developed and delivered in a 'BASICS' type approach.

- The Rural Training Pathways Steering Group should ensure that future curriculum for medical remote and rural practitioners incorporate specific elements of mental health crisis management.

Forward Issues

This report demonstrates that whilst the remote and rural mental health crisis group have made significant progress, there are a number of outstanding issues to be addressed. These are:

- Facilitate the establishment of formal psychiatric networks for those areas who have not yet made progress.
- After approval of this report by the Remote and Rural Mental Health Group and the Remote and Rural Steering Group, distribute the report to NHS Boards, and Regional Planning Groups, and undertake awareness sessions.
- Liaise with RRHEAL to ensure the development of a pre – hospital psychiatric care course and that it is delivered using a ‘BASICS’ type approach.
- Liaise with the Rural Training Pathways group to ensure that the future curriculum for medical staff working in remote and rural settings incorporates specific elements of mental health crisis management training.
- Liaise with the Scottish Centre for E-health to map the available e-health resources within remote and rural settings and to prioritise those areas which do not yet have e solutions.
- Liaise with the ambulance service to ensure continued robust and responsive transport services for the patient experiencing mental health crisis.

Risk Assessment

There are a number of risks which may affect the achievement of the objectives of the Remote and Rural Mental Health Project. These have been listed under the headings below.

Workforce

If we do not adequately prepare practitioners to look after patients experiencing mental health crisis in remote and rural areas we run the risk of being unable to recruit and retain practitioners within remote and rural areas. This is a particular risk where there is a specialist resident in the remote and rural area, but the wider team have not been developed to support this higher level of service expected.

The workload implications of supporting remote and rural mental health networks, particularly for consultants in the psychiatric centres may require additional resource. If this resource is not available, this may jeopardise the establishment of networks.

Sustainability

Sustainability of remote and rural mental health services in terms of local access and quality of service is dependent upon the establishment of formal psychiatric networks. Meeting statutory requirements, particularly for compulsory detention remains a risk, as this cannot be undertaken by a distant practitioner. The Place of Safety for mental health patients in remote and rural areas remains to be resolved, although it is being addressed through the PEPs and Mental Health Crisis Standards work.

Robust responsive transport and retrieval systems are also key to the support of rural mental health crisis services. If local healthcare systems in rural areas collapse, then all patients experiencing mental health crisis will require transfer which will place additional pressure on transport systems along with the consequential impact on the person and their family.

Networks

There is a cultural change needed to ensure that all larger psychiatric centres see the support of remote and rural mental health services as their responsibility. Also, the additional workload component may preclude the setting up of networks.

Delays in the e-health roll out will impact upon the clinical decision support available between networked psychiatric centres.