

# **Implementing Recovery Oriented Transfer of Mental Health Care in Country South Australia**

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# Introduction

- A project initiated by Rural and Remote Mental Health Services as a part of the South Australian Mental Health Improvement Initiative to:
  - Develop principles that underpin recovery orientated transfer of care between metropolitan and country locations that would lead to system improvement, and
  - Identify the change triggers that may assist in the uptake of strategies.



# Methodology

- Action research
- Literature review of the key success factors for recovery oriented transfer of care
- Consumer pathway analysis
  - 5 consumer pathways identified mapping discharge planning, transport home, shared care, follow-up care, re-entry to community, relapse prevention.



- Strengths and limitations of transfer of care interviews/focused group discussion
  - 3 focused group discussions with consumers and carers in rural/regional locations
  - 1 focused group discussion with Aboriginal Health Workers at a community controlled health service in a regional area
  - 1 interview with Aboriginal consumer
  - 4 interviews with clinicians/NGOs in rural/regional locations



- Interviews with metropolitan clinicians/managers regarding triggers for change
- Workshop with the guiding coalition to interpret these data and develop key principles for improving transfer of care.



# Results

- Consumer Pathways
- Key success factors for recovery orientated transfer of care



# Consumer Pathways


## **Current pathway strengths**

- Contact from GP whilst inpatient
- Telemed
- Family member, carer or key worker is aware of when service user will arrive back in community
- NGOs & key workers in home community providing follow up care; assisting with community re entry; relapse prevention

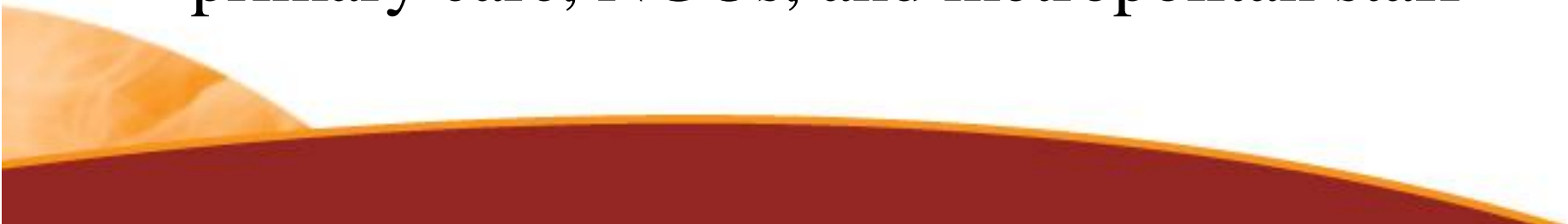


# Consumer Pathways

## Current pathway limitations

- Discharge notes take up to 3 months to be sent to relevant community agency
  - Lack of knowledge of local resources and no system in place to bridge the knowledge gap
  - Little follow up post discharge
  - Accommodation issues in community of interest -having to use caravans and women's shelters on discharge
  - Little shared care or communication between metro hospital and GP/community mental health team/NGOs
  - Limited involvement in care planning of consumers and carers
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# Key success factors for ROTC

- Enhance participation by consumers and carers in discharge planning and recovery in home community
  - Improved knowledge of family circumstances and home community services by metropolitan staff
  - Effective working relationships between primary care, NGOs, and metropolitan staff
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# Key success factors for ROTC

- Effective information flow between primary care providers and metropolitan staff
- Effective discharge planning
- Reducing the stigma about mental illness in rural, regional and remote communities



# Workshop framework

- Key stakeholders from country and metropolitan areas one day workshop to:
  - Test the relevance and extend research findings
  - Develop strategies for change
  - Identify key areas for implementation



# Conclusion

Improving service integration for rural and remote people with a mental health problem is achievable through integrated research evidence with practice experience

