Abstract

This paper discusses innovative mental health work being provided in a regional community health centre where values, setting and a wellbeing model have challenged traditional understandings of specialised mental health care. Comprehensive primary health care is a universal approach that transcends traditional boundaries; however, its value is often not appreciated in developed countries where technology and economics can limit its potential. Indigenous Health workers and Women’s Health workers have long understood that psychiatric diagnosis is not always helpful for some of the people who access their services, and have developed ways of working that are respectful and empowering without the use of diagnostic labels. In Murray Mallee Community Health Service (MMCHS), a Health and Wellbeing Team was established, combining Aboriginal Health workers, Women’s Health workers and Mental Health workers. Through strategic planning, a common philosophy and values base was developed. Some of the outcomes have been programs within limited resources and partnerships across health disciplines. Workers’ skills and confidence have increased in every area with the resulting understanding that ‘mental health is everybody’s business’. This paper presents a brief historical overview of primary health care, outlines the MMCHS model, and calls for policy to be formulated and implemented in the comprehensive primary health care framework.

Keywords

primary health care, mental health services, mental health promotion, consumers, recovery

Introduction

Almost thirty years have passed since the origins of the primary health care (PHC) concept. Debate about the model has continued as policy has been developed in many countries. This paper describes the origins of a team model in a regional town that set out to provide specialist mental health support within a comprehensive PHC framework. The team approach facilitated strong working partnerships across disciplines. Organisational support proved invaluable in responding to some of the systemic challenges. This paper is a preliminary overview and discussion of the model; subsequent papers will evaluate and critique the approach using data from focus groups with service user and provider participants.

Murray Mallee Community Health Service (MMCHS) is an organisation accredited through the Quality Improvement Council (QIC) as a PHC service. The Health and Wellbeing Team model was developed through incorporating the principles of comprehensive PHC. It was strongly influenced by an holistic view of health, particularly the social determinants of health, and Aboriginal descriptions of social and...
emotional health and wellbeing. Collaboration and co-working between team members, and the individual or family in question, clarified the usefulness or otherwise of proceeding within a defined diagnostic, psychiatric model.

A brief historical perspective of primary health care

The Declaration of Alma-Ata (World Health Organization: WHO, 1978) has been acknowledged as a major turning point in health care ideals. It calls for 'urgent and effective national and international action to develop and implement primary health care throughout the world' (Section X) as well as calling on all governments to formulate policies, strategies and plans of action that would sustain PHC. Internationally, there is a continuing call for political will to reorient services and allocate funding to the PHC approach (Chowdhury & Rowson, 2000; Cueto, 2004; Hall & Taylor, 2003; Kekki, 2003; Wass, 2000; WHO, 1986).

Difficulties in defining comprehensive PHC have sometimes led to the polarisation of a debate that originated in a desire to work together (Taylor & Jolly, 1988). Comprehensive PHC principles emphasise health-impacting social changes where medical treatment may play a minor role. The principles encourage a positive wellbeing view of health with the locus of control being situated in communities and individuals. The major focus is health through equity and community empowerment. Multi-disciplinary (or multi-dimensional) teams work in partnership with other agencies using a population health approach rather than the more familiar individualised medical interventions (Rogers & Veale, 2000; Wass, 2000)

Recent WHO guidelines (WHO, 2003) acknowledge the challenges of definition and propose that PHC is both a set of principles and a set of activities. The principles include:

- local providers working together as a team and trained socially as well as technically.

The minimum core activities are listed as:

- education in prevention and control of health issues;
- adequate food, nutrition, water and sanitation;
- maternal and child health care;
- immunisation, prevention, control and treatment of disease; and
- provision of essential drugs.

Reduction of the principles into particular health problems, prioritised according to the views of foreign consultants, made the original ideals of PHC unsustainable and led to the term selective PHC (Hall & Taylor, 2003). Selective PHC is seen by some to maintain a ‘medical expert’ position which tends to be technology and urban focussed (Cueto, 2004). According to Wass (2000, p.13) ‘selective primary health care operates in a way that assumes that medical care alone creates health and ensures that control over health is maintained by health professionals’.

The Ottawa Charter for Health Promotion (WHO, 1986) was the outcome of the first WHO International Conference on Health Promotion. Building on the Declaration of Alma-Ata, it set out the action required to achieve the goal of ‘Health for All’ by 2000. It called for more balance between curative services and health promotion; however, challenges to reorient the developed world’s focus away from high technology and drug treatments are great. Pertti Kekki (2003, p.12), Professor of General Practice and PHC at the University of Finland, suggests that barriers in moving towards the implementation of PHC may include ‘a lack of practical guidance, poor leadership and insufficient political commitment, inadequate resources and unrealistic expectations’ - as well as ineffective referral systems and weaknesses in information systems.

There are considerable challenges to implementing PHC programs, yet Australia is seen internationally as progressive in its health care approach (Parham, 2005; Wass, 2000). In reality, most Australian health spending continues to go to hospitals and other treatment services (Baum, Duffy & Jolley, 2003; Mental Health Coalition of South Australia, 2005; Wass,
This is despite mounting evidence that early years’ health promotion has a positive effect on mental health outcomes (Commonwealth Department of Health and Aged Care, 2000; Council of Australian Governments: COAG, 2006). PHC principles clearly encourage health promotion as an effective means of increasing population health.

The Jakarta Declaration (WHO, 1997, p.5) called for ‘documentation of experiences in health promotion through research and project reporting... to improve planning, implementation and evaluation’ – yet health promotion remains hampered by a lack of research, limited funding, and confusion about how and where to provide health promotion services (Department of Health and Ageing, 2005; Wass, 2000). Health promotion activities require different kinds of measurement than traditional treatment programs, so primary health care programs and approaches often remain largely invisible and unsustainable (Baum et al., 2003; Onken, Dumont, Ridgway et al., 2002; Raphael, 2000; Steering Committee for the Health Ministers' Advisory Council, 2003).

In Australia, the National Mental Health Strategy and subsequent strategic plans show some sympathy with the comprehensive PHC approach yet often fail to follow through with actions that reflect the overall principles. In South Australia, the result has been the Emergency Demand Management Policy (Department of Human Services, 2003a), which is aligned to the selective PHC approach.

The Murray Mallee Community Health Service perspective

Murray Mallee Community Health Service (MMCHS) is based in Murray Bridge, a regional city in South Australia, eighty kilometres from the city of Adelaide. The Murray Mallee region services a population of 30,000. It includes the main town of Murray Bridge, with a population of 17,000, and other towns such as Mannum, Tailem Bend and Wellington. The region has a rich Ngarrindjeri culture, the Aboriginal nation who are the traditional custodians of the area, and many ethnic groups contributing to its identity.

MMCHS provides a wide range of services including Aboriginal health, aged care assessment, community nursing, diabetes, dietetics, domiciliary care, mental health, occupational therapy, palliative care, physiotherapy, podiatry, speech pathology and women’s health. MMCHS provides the specialist mental health services in the town and region, with general practitioners (GPs), a visiting consultant psychiatrist, and Child and Adolescent Mental Health Services (CAMHS) also fulfilling a role. The local hospital has a psychiatric registered nurse working closely with the team.

In 2002, restructuring at MMCHS led to teams being established, incorporating the major services such as Domiciliary Care, Community Nursing and Allied Health. There was consultation with staff whose service provision was not so clearly aligned and the result was the Health and Wellbeing Team. A strong working relationship was already well established at MMCHS between Women’s Health and Mental Health (Briskman, Lynn & La Nauze, 1999) and workers chose to align themselves more formally within the same team. Disciplines incorporated in the team were social work, counselling, mental health nursing, nursing, community development, Aboriginal social and emotional health and wellbeing, Aboriginal health, Aboriginal women’s health, occupational therapy and speech pathology.

In 2003, the South Australian government released a Primary Health Care Policy Statement (Department of Human Services, 2003b) listing action points including reorienting health care, sustainable funding, partnerships with general practice, development of a research agenda based on social and structural determinants of health, and supporting PHC approaches in workforce planning. This policy confirmed some of the changes that were already taking place at MMCHS.

The Health and Wellbeing Team: model, values and practice

The team began accepting referrals from GPs, psychiatric institutions, other agencies and individuals. Through promotion of the new model, it became understood locally that the team was open to descriptions of psychological distress that need not necessarily be defined through a psychiatric diagnosis. It quickly
became apparent that many of the women attending the service were living with past or current trauma in the form of domestic violence and/or sexual assault. Subsequent groups were formed to address these specific issues. Many men described as having depression or ‘anger management’ issues were offered group opportunities and sometimes referred on to private counselling services in domestic violence.

In the early days of its existence, the Health and Wellbeing Team participated in planning days where workers explored their values and principles and established a common vision incorporating a mission statement that reflected the intention of its work:

*We aim to support and contribute to the development of strong communities, by the promotion of interconnectedness, resilience and participation, including all cultures and lifestyles within the region.*

The workers discovered that they were united in a strong commitment to principles of social justice, community participation, health education and equity – principles absolutely grounded in the PHC philosophy. Team members also discovered that their common values far outweighed, but did not negate, the skills, training and experience that they brought from their individual disciplines. The ‘professionalisation processes’ have not limited the teams commitment to partnerships and co-working (Human Resources Development Unit, 2003).

MMCHS as an organisation operates from an overt and stated values base and its culture has changed noticeably over recent years. Changes include the introduction of training in both cultural and violence awareness. Cultural Awareness training is provided in three levels over several days, incorporating Challenging Racism and local Aboriginal culture and history. Aboriginal workers often work in partnership with the team and non-Aboriginal team members are in consultation with Aboriginal health workers. The organisation’s work in the area of violence awareness has led to the organisation being the first Australian partner with the WHO’s Violence Prevention Alliance. MMCHS and its workers have been the recipients of numerous local, regional and state awards in recent years.

**Prevention, treatment and continuing care**

At MMCHS, Mental Health workers are guided by Mental Health Standards (Australian Health Ministers' Advisory Council's National Mental Health Working Group, 1997). Mental health work is carried out in a way that acknowledges the spectrum of mental health interventions (as adapted from Mrazek & Haggerty, 1994: see Figure 1 below). This spectrum continues to be cited in major policy documents, for example, *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000* (Commonwealth Department of Health and Aged Care, 2000) and *National Mental Health Plan 2003-2008* (Australian Health Ministers, 2003).

![Figure 1. The spectrum of interventions for mental health (adapted from Mrazek & Haggerty, 1994)](image)

Recent plans and policy emphasise the need for a recovery orientation to mental health (Australian Health Ministers, 2003; COAG, 2006) and when recovery is understood as an approach rather than a model, it can be seen as applicable across the whole spectrum of interventions for mental health. In the Health and Wellbeing Team, a recovery approach is fundamental and can be seen across the range of services.

The prevention segment of the spectrum includes universal, selective and indicated strategies targeted in the *National Action Plan* to various identified groups.

*Universal* strategies target the general public or population groups not necessarily identified on the basis of individual risk – that is, everyone. Examples of mental health promotion provided
through MMCHS include a community choir and Tai Chi groups, activities that are not necessarily facilitated by a mental health worker, and that are designed to enhance the emotional health and wellbeing of participants.

Examples of promotion and prevention strategies utilised by the team for the *selective* group (described in the *National Action Plan* as at higher than average risk of developing mental disorders) include groups for women who have experienced child sexual abuse (Everett & Gallop, 2001), men who want to stop their violent behaviours in their families, and women living with violence and/or abuse in their homes (Department of Human Services, 2004).

Traditionally, mental health services are not provided to the *indicated* group (described in the *National Action Plan* as ‘high-risk individuals who have minimal indicators but not yet meeting diagnostic criteria’). A recent national report titled *Not for Service* (Mental Health Council of Australia, 2005) describes the often tragic effects of these limitations.

Workers in the Health and Wellbeing Team, who have adopted a comprehensive PHC approach, include the universal, selective and indicated groups as part of their standard focus with a recovery approach overarching the whole spectrum. Murray Mallee CHS accepts self referrals from any individuals in distress requesting help, seeing this as a vital early intervention approach where individuals are supported in taking responsibility for their own health care needs (Rickwood, 2004).

**Paradigm shift**

Commenting on the South Australian response to the *Health for All Australians* report (Health Targets and Implementation [Health for All] Committee, 1988), Martin and Davis (1995) point out that reorienting mental health services to a promotion and prevention stance is not easily achieved. The current *National Mental Health Plan 2003-2008* (Australian Health Ministers, 2003, p.28) is clear that new and improved models of service delivery will be supported.

Workers at MMCHS have been supported by the organisation through leadership that is reflective of a learning organisation (Senge, 1990; WHO, 2003), one that has a vision and a clear set of values that have been developed with worker participation.

The model takes a pluralist approach and calls on various models and strategies in response to the person’s situation. Individual workers draw on a range of specialist skills and approaches including, but not limited to, cognitive behavioural therapy (CBT), narrative therapy, psychiatric nursing, crisis and trauma counselling, sexual abuse counselling, solution focus counselling and systems therapy. The integrated team model recognises and affirms the community development approach, implementing the principles of the *Declaration of Alma-Ata*, the *Ottawa Charter* and the *Jakarta Declaration*. Community development as a way of working has been central to the work of Aboriginal health and Women’s health historically and to date (WHO, 2005). Mental Health workers in the Health and Wellbeing Team have been informed by these practices, which provide a foundation for the current methods used.

**Consumer focussed services**

The change from a diagnostic, medical model way of working in MMCHS has not been easy. There is a long history in psychiatry of the ‘professional expert’ position that conflicts with emerging consumer choice and partnership views (Frese, Stanley, Kress & Vogel-Scibilia, 2001; Kalinowski & Risser, no date) and although the recovery approach is gaining ground, there is considerable tension between psychiatrists who hold differing views of recovery (Fisher & Ahern, 2002). Some workers and service users at MMCHS who were comfortable with a case management model were reluctant to give this up. However, some of those same people have stated recently:

> I now realise the limitations of the pathologising ways of working and am committed to recognising distress within a social context as well as a biological phenomenon

(Community Mental Health Nurse who has worked in the organisation for eight years and also in psychiatric institutions for a number of years).

If I hadn’t had access to Swanport House and Spotlight I wouldn’t be feeling any different to what I was three or four years ago. I’ve got my self confidence back and feel that I would like to help others who are in the same situation that I was in...
four years ago (F: diagnosed with depression, anxiety and panic disorder twenty years ago – now completed peer worker training).

The way things are working now is better. It’s a more humane, caring way. The way Swanport House works is out of dignity and care. There is a loving kindness and support there that wasn’t there in the early years. The person is treated as a person not an illness. It’s putting the person first. I am doing my own therapy through journaling, managing my own health. M comes first, the illness comes second (M: diagnosed with stress induced anxiety, schizo affective disorder and major depression eleven years ago).

Quotes used with permission

Workers in the team believe that case management practices can be stressful and unsustainable for both workers and service users and do not encourage self management of mental health issues (Muir-Cochrane, 2001). The Health and Wellbeing Team model works towards practical outcomes in people’s lives, which concur with the PHC determinants of health, secure housing, employment and social connection, among others. Traditional mental health assessment may describe a person’s reluctance to agree with the clinician’s view as ‘lack of insight’ (Barker & Buchanan-Barker, 2005; Read, Mosher & Bentall, 2004) whereas the members of the team work to gain insight into the person’s experience of distress (Barker & Buchanan-Barker, 2005).

The model recognises and aims to maintain service users’ power (Canadian Collaborative Mental Health Initiative, 2005). However, conflict can arise with the structural and systemic power that surrounds the organisation. Workers attempt to overcome tensions by making their own ‘power’ explicit, overt and transparent to service users. Workers are clear about the codes of practice that are aligned with their professional disciplines and conscious that they remain in a privileged position due to their opportunities and employment (Steering Committee for the Health Ministers’ Advisory Council, 2003).

The team has developed a comprehensive assessment form which aims to share power in assessment. The form includes questions that ask about symptoms or complaints that may be bothersome to the individual or family members (Bentall, 2003; Culturally Sensitive Depression Guideline Team, 2004; Menadue, 2003; Sheldon, 1997). It is completed with the service user after a rapport has developed and allows them to follow their own progress. It includes a crisis and relapse prevention plan which can be shared with persons designated by the service user.

Women’s experience of psychosis is often seated in domestic violence or sexual abuse, where there has been a systematic and intentional process of depowering (Department of Human Services, 2004). Diagnosis in this instance is much less useful for the woman than developing an awareness of power and control in relationships. Workers who sit in a position of judgement and assessment are at risk of colluding with abusers and iatrogenically contributing to distress. Subjugation to violence and abuse, and disempowerment, are becoming more recognised as causes of distress and unwellness (Department of Human Services, 2004; Everett & Gallop, 2001) and these need to be acknowledged and addressed.

Regional and remote areas have had to pull together in the face of scarce resources and rising levels of acknowledged psychological distress. Individuals who are seen as experiencing distress rather than an illness can be supported by any member of the Health and Wellbeing Team, and indeed workers from other teams, for example, Youth, or Children and Families. Promotion, prevention and early intervention are not only viewed in a diagnosed context, but also in terms of healthy living and maintaining wellness. It is expected that, over time, the model will lead to destigmatisation of mental distress enabling individuals to seek support without embarrassment or fear of ridicule. Future standards will see all individuals, including health workers, speaking of individual self care plans that are designed to maintain wellbeing. The Canadian Collaborative Mental Health Initiative (2004) describes its PHC partnerships approach as providing the opportunity to increase system capacity.

Challenges and barriers for workers

The team regularly receives criticism from providers of traditional mental health care as the model is not well understood. Because there is a waiting list for services (which is regularly
monitored in terms of risk level and not diagnosis) there is a fear that acute mental health services will not be provided. Some more traditional mental health service providers are concerned that workers not specifically trained in mental health care will fail to recognise acute signs of distress requiring hospitalisation. However, the close working partnerships of the team members mean that consultation is frequent and commonplace and if anything, there is potential for workers to become more experienced in, and less fearful of, acute distress, suicidality and psychosis or dissociation. Health and Wellbeing Team workers recognise individual workers’ particular skills, interests, experience and expertise and are able to work in close partnership with confidence. A natural cross-fertilisation of skills and knowledge eventuates, which does not diminish skill levels but adds to them. Morale in such a supportive environment is high.

The model moves from the traditional stance in which psychiatric diagnosis defines the work of the ‘mental health team’ and from which follows a system expectation requiring National Outcomes Casemix Collection (NOCC) data. Workers find questions in the required HoNOS, LSP16 and K10 documents problematic, lacking in useful data and counter to their ways of working. Internationally, Women’s health workers and Aboriginal workers have long understood that a psychiatric diagnosis can be a deterrent to individuals’ participation in their health care (WHO, 2005). Health and Wellbeing workers acknowledge the individual’s description of their distress (Berwick, 1998; Glover, 2005; The Mental Health Foundation, 2000) and look for ways to support them in working through that distress. Workers in the team are frustrated by data collection systems which limit their innovative and PHC focussed work (Department of Health and Ageing, 2005; Government of Victoria, 2005; Raphael, 2000).

Current methods of data collection are problematic within the broader view of health as noted in the Mental Health Information Priorities Report (Department of Health and Ageing, 2005) where it is acknowledged that information collection in the areas of promotion and prevention is significantly less progressed than in other areas linked to diagnosis. Current data collection systems that focus on diagnosis and treatment are not specifically designed to capture PHC partnership work (Bentall, 2003; Coombs & Meehan, 2005; Government of South Australia, 2003; Mental Health Consumer Outcomes Task Force, 1991, reprinted 2000; WHO Working Group on Health Promotion Evaluation, 1998). There is a developing view of the incompatibility of current data systems with the PHC focus in health care (Australian Primary Health Care Research Institute, 2003; Berwick, 1998; Kekki, 2003; Lakeman, 2004). Systems that measure service users’ indicators of recovery would encourage self management as well as provide meaningful data to a developing evidence base around recovery (Onken et al., 2002).

Non-metropolitan areas have no access to emergency services available in the city, such as Assessment and Crisis Intervention Service (ACIS), Mobile Assertive Care (MAC) or Community Care teams. Workers in rural and remote areas usually provide all of these services from the one central location, relying heavily on the already stretched emergency services of police and ambulance for support in acute situations. Current data collection systems fail to recognise this comprehensive care provided by rural and regional mental health teams, and data comparisons with metropolitan sites will be difficult and lacking in meaning.

Conclusion
The PHC model has been articulated with its philosophy and ideals since the Declaration of Alma-Ata more than 25 years ago. Australia is often seen as a world leader in terms of primary health care policy, but it is time for implementation. At MMCHS an understanding of, and commitment to, PHC principles has led to the development of a team that is skilled and professional in its practice. Information systems that capture PHC approaches need to be created in consultation with service users and workers. Measures that are about consumer perceptions of service provision are well overdue (Noble & Douglas, 2004; Onken et al., 2002) as is research into PHC approaches and programs (Jorm,
Incentives and rewards for undertaking such research are limited (Kekki, 2003) despite international calls by Health Ministers for significant investment in health research (Ministers of Health, 2004). Clinicians cannot be expected to provide services, collect data, undertake research and evaluate programs without the necessary support and increased resources. The call is for a different way of working. It is time for systems and policies to be developed to support the innovative work that is happening and to increase it (Australian Primary Health Care Research Institute, 2003).

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References


