Advocating, Building & Integrating

DELIVERY OF MENTAL HEALTH CARE IN RURAL AND REMOTE QLD BY GP’S AND RG’S WITH MH ADVANCED SKILL TRAINING

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RMA October 2017
OUTLINE

• Brief background
  – Mental health in rural and remote Australia
  – Current MH policy + priorities
  – Explaining the mental health AST/ARST
• Examining applications - literature + practice
• Proposed conceptual models
• Benefits + barriers
• Case example
• Summary + future directions
WHY DO WE NEED MH AST/ARST IN RURAL/REMOTE AUSTRALIA?

FACT SHEET - MARCH 2017

MENTAL HEALTH IN RURAL AND REMOTE AUSTRALIA

The reported prevalence of mental illness in rural and remote Australia appears similar to that of major cities. Access to mental health services are substantially more limited than in major cities. Tragically, rates of self-harm and suicide increase with remoteness.
Table 3: Mental Health Hospitalisations (same day and overnight stays), age standardised rate (per 100,000 people), 2013-14

<table>
<thead>
<tr>
<th></th>
<th>Major Cities (High SES*)</th>
<th>Major Cities (Mid SES*)</th>
<th>Major Cities (Low SES*)</th>
<th>Inner Regional</th>
<th>Outer Regional</th>
<th>Remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>All mental health disorders</td>
<td>856</td>
<td>873</td>
<td>874</td>
<td>946</td>
<td>991</td>
<td>1096</td>
</tr>
<tr>
<td>Intentional Self Harm</td>
<td>125</td>
<td>132</td>
<td>147</td>
<td>174</td>
<td>191</td>
<td>231</td>
</tr>
</tbody>
</table>


Notes: SES refers to Socio-Economic Status
# Higher Incidence of Suicide

<table>
<thead>
<tr>
<th>Table 4: Incidence of Suicide, age standardised, 2009-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Rate per 100,000 population</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Males</strong></td>
</tr>
<tr>
<td>Major Cities: 14.7</td>
</tr>
<tr>
<td>Inner Regional: 20.2</td>
</tr>
<tr>
<td>Outer Regional: 21.4</td>
</tr>
<tr>
<td>Remote: 26.8</td>
</tr>
<tr>
<td>Very Remote: 30.0</td>
</tr>
<tr>
<td><strong>Females</strong></td>
</tr>
<tr>
<td>Major Cities: n.p</td>
</tr>
<tr>
<td>Inner Regional: n.p</td>
</tr>
<tr>
<td>Outer Regional: n.p</td>
</tr>
<tr>
<td>Remote: 8.7</td>
</tr>
<tr>
<td>Very Remote: 10.7</td>
</tr>
<tr>
<td><strong>Persons</strong></td>
</tr>
<tr>
<td>Major Cities: 9.7</td>
</tr>
<tr>
<td>Inner Regional: 12.6</td>
</tr>
<tr>
<td>Outer Regional: 13.7</td>
</tr>
<tr>
<td>Remote: 18.1</td>
</tr>
<tr>
<td>Very Remote: 21.5</td>
</tr>
</tbody>
</table>

HIGHER PREVALENCE OF HARMFUL ALCOHOL AND DRUG USE²,³

**Prevalence rates of risky alcohol consumption (AIHW 2011)**

<table>
<thead>
<tr>
<th>Proportion of population who drink at risky levels</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote/Very remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>... for lifetime harm</td>
<td>19%</td>
<td>22%</td>
<td>25%</td>
<td>31%</td>
</tr>
<tr>
<td>... for single-occasion harm</td>
<td>15%</td>
<td>17%</td>
<td>19%</td>
<td>26%</td>
</tr>
</tbody>
</table>

**Recent(a) illicit use of drugs by ASGS remoteness areas, people aged 14 years or older, 2013 (age-standardised percentage)**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Major cities</th>
<th>Inner regional</th>
<th>Outer regional</th>
<th>Remote/Very remote</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illicit use of any drug</td>
<td>14.8</td>
<td>15.1</td>
<td>18.0</td>
<td>18.8</td>
<td>15.3</td>
</tr>
<tr>
<td>Cannabis</td>
<td>8.0</td>
<td>8.6</td>
<td>10.4</td>
<td>11.0</td>
<td>8.4</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>2.6</td>
<td>1.6</td>
<td>1.7</td>
<td>1.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Meth/amphetamine</td>
<td>1.8</td>
<td>1.7</td>
<td>2.1</td>
<td>4.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2.2</td>
<td>0.8</td>
<td>1.0</td>
<td>2.0</td>
<td>1.9</td>
</tr>
<tr>
<td>Pharmaceuticals(b)</td>
<td>3.1</td>
<td>3.2</td>
<td>3.2</td>
<td>5.2</td>
<td>3.2</td>
</tr>
</tbody>
</table>

(a) In the previous 12 months in 2013. (b) For non-medical purposes.

Fact Sheet March 2014 – Alcohol Use in Rural Australia, and Fact Sheet 33 June 2015 – Illicit Drug Use in Rural Australia, National Rural Health Alliance Inc.
Table 2: Per capita MBS expenditure, Mental Health services, 2013-14

<table>
<thead>
<tr>
<th></th>
<th>Major Cities</th>
<th>Inner Regional</th>
<th>Outer Regional</th>
<th>Remote</th>
<th>Very Remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>All professionals</td>
<td>$44.95</td>
<td>$34.67</td>
<td>$21.33</td>
<td>$10.16</td>
<td>$4.51</td>
</tr>
</tbody>
</table>

LESS CLINICIANS AND EXPERTISE

Table 1: Mental Health Professionals, Full time equivalent, by Remoteness, 2014

<table>
<thead>
<tr>
<th></th>
<th>Major Cities</th>
<th>Inner Regional</th>
<th>Outer Regional</th>
<th>Remote/Very Remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>16.6</td>
<td>6.2</td>
<td>4.4</td>
<td>3.0</td>
</tr>
<tr>
<td>Mental Health Nurses</td>
<td>87.3</td>
<td>81.5</td>
<td>51.2</td>
<td>50.9</td>
</tr>
<tr>
<td>Psychologists</td>
<td>92.4</td>
<td>55.5</td>
<td>40.8</td>
<td>29.6</td>
</tr>
</tbody>
</table>

RELEVANT TO CURRENT POLICY

• World Health Organisation’s – Mental Health Action Plan 2013-2020

• National Strategic Framework for Rural + Remote Health

• Fifth National Mental Health Plan (draft)
“There are ongoing calls for a better integrated mental health service system that focuses on the holistic needs of consumers and carers; responds to local needs and circumstances; rebalances efforts towards promotion, prevention and early intervention; and builds workforce capacity to support system change”
THE RG/GP MH AST/ARST PROGRAM

Fulfill pre-requisites

12 months in acute psychiatric facility working as a registrar/PHO (option of part time and RPL for full time practicing rural GPs)

- Logbook of all cases and observed experiences, supervision, specified meetings
- Attendance at CBT course
- Delivery of CBT with appropriate supervision
- Supervisor statement
- Essay
- +/- Masters program externally

Fulfill pre-requisites

12 months in acute psychiatric facility working as a registrar/PHO

- Training Plan
- Level 2 accredited mental health course
- Population Health module online
- Supervisor assessments
- 5 x mini CEX
- MH STAMPS exam
- +/- Masters program externally
OUTCOMES AT THE END OF TRAINING

• Provide expert psychiatric care in emergency and community settings in a rural/remote context

• Similar to level of specialist care provided by GP obstetrician/GP anesthetist's etc.

• Implied support by tertiary centre/specialist as appropriate
“If you build, market and sell it really well they will come”
AIMS

• Examine the available literature and current practice of clinicians with mental health AST/ARST

• Formulate a model(s) that defines and encapsulates the mental health AST role and scope of practice

• Present that model for feedback

• Define the future use of the model and further directions for research
METHODS

1. Literature review
   - PubMed, Medline, Embase, ERIC, Cochrane, SAGE, PsychBITE, PsychINFO
   - 1990-2018, academic articles, English
   - Search terms:
     • Mental health Advanced Skills Training, Mental Health Advanced Rural Skills Training
     • Rural, remote, isolated, regional
     • Rural generalist, General Practitioner
   - Results: 1 article\(^9\) – “Advanced rural skills training - the value of an addiction medicine rotation”
   - No precedent documented in the literature
   - General sweeping statements about non-procedural ASTs improving access to care\(^{10,11}\) - nothing specific
   - Growing body of evidence around delivery of mental health in primary care\(^{12-18}\)

2. Examination of existing case based examples

3. Formulation of a broad model of service based on the above + experience in the role
EXAMINING EXISTING MODELS\textsuperscript{19, 20}
<table>
<thead>
<tr>
<th>Role</th>
<th>Longreach</th>
<th>Warwick/Stanth Orpe</th>
<th>Cooktown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital SMO/SMOPF</td>
<td>✔</td>
<td>0.4</td>
<td>0.2</td>
</tr>
<tr>
<td>On Call</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>MH Advice AHs</td>
<td>✔</td>
<td>✔</td>
<td>✖</td>
</tr>
<tr>
<td>General Practice</td>
<td>25%</td>
<td>0.5</td>
<td>0.8</td>
</tr>
<tr>
<td>MH General Practice</td>
<td>75%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Therapy</td>
<td>✔</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>“Mini Psychiatry” Clinic</td>
<td>✖</td>
<td>0.1</td>
<td>✖</td>
</tr>
<tr>
<td>Work with MH Team</td>
<td>✔</td>
<td>✔ Not formal</td>
<td>✔</td>
</tr>
<tr>
<td>OSP Prescribing</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Education + Advice</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Policy Development/Service Design</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management/Leadership/Strategic Planning Role</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Academic Role</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Advocacy/Community Engagement</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
RESULTS – THE MODELS
TARGET POPULATION

FIGURE 3: MENTAL HEALTH STEPPED CARE LEVELS OF NEED AND SERVICES

- **Well population** (23.1% of population): Mainly publicly available information and self-help resources.
- **At risk groups (early symptoms, previous illness)** (9.0% of population): Mainly self-help resources, low intensity interventions including digital mental health.
- **Mild mental illness** (4.6% of population): Mix of self-help resources including digital mental health and low intensity face-to-face services. Psychological services for those who require them.
- **Moderate mental illness** (3.1% of population): Mainly face-to-face clinical services through primary care, backed up by psychiatrists where required. Self-help resources, clinician-assisted digital mental health services and other low intensity services for a minority.
- **Severe mental illness** (Clinical care using a combination of CQI care, psychiatrists, mental health nurses, and allied health. Inpatient services. Pharmacotherapy. Psychosocial support services. Coordinated, multi-agency services for those with severe and complex illness.}

*Adapted from Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services (November 2015).*  
*Estimates of prevalence derived from National Mental Health Service Planning Framework modelling (unpublished).*
CONCEPTUALIZING THE CONTEXT AND EXTENT OF MH SPECIFIC PRACTICE

RG ---------------- VS ---------------- GP

Key:  
- Orange: General Medicine
- Purple: Mental Health
IN REALITY…

...Once you learn the core skills around communication and engagement fundamental to a MH AST it will inform and infuse every part of your practice in some way...
MH SPECIFIC SKILLS, KNOWLEDGE & RELATIONSHIPS

RG AST MH
- Hospital General Practice
- Primary Health Care Settings

FOCUS OF CARE & INFLUENCE

Patients
Community
Colleagues
Health Service

DIVERSITY OF ROLES

Holistic, high quality, primary and emergency medical care as an SMO including participation in the on-call roster

Expert management of mental illness and substance related presentations across emergency and primary care settings including delivery of psychological therapies and interventions

Facilitate application of the MHA 2016

Participation in MH specific clinics eg. clozapine, OSP prescribing

Co-ordination and integration of care in consultation with community/tertiary/allied MH and general medical services

Building capacity + skills of medical and allied colleagues

Development/review of relevant hospital protocols

Foster a patient centered and recovery focused approach to MH and substance disorder clients within the health service and community

Development of/participation in community programs addressing specific community need, focused on prevention, reducing stigma and promotion of mental health literacy

Advocacy and promotion of future development of MH services Building community resilience + social capital

Other opportunities for additional scope of extended practice Including roles in management, education and research

KEY CONNECTIONS

Community MH Service
- Adult
- Child and Youth
- Alcohol & Other Drugs

Tertiary MH Services
- Consultant Psychiatrist
- Psychiatry Registrar
- Peer review group

Private psychiatric and substance related specialists and facilities

Allied MH services
- Public and private

Community and Government service providers

Community organisations + stakeholders - PCYC, RSL, local council
RURAL GENERALIST MODEL:

• Clinical Applications
• Broader Context Applications
• Other Opportunities
GENERAL PRACTICE MODEL

Key:  
- Orange: General Medicine  
- Purple: Mental Health
MH SPECIFIC SKILLS, KNOWLEDGE & RELATIONSHIPS

GP AST MH
General Practice Setting

FOCUS OF CARE & INFLUENCE

Patients
Community
Colleagues
Practice

DIVERSITY OF ROLES

Holistic, high quality, primary medical care as a private GP
Expert management of mental illness and substance related presentations in primary care settings
Opportunity to cater to specific community need – eg. OSP prescriber, metabolic monitoring, clozapine management etc.
Delivery of expert psychological therapies and interventions
Co-ordination and integration of patient care in consultation with community and tertiary MH services - promoting a recovery focus
Building capacity + skills of medical and allied colleagues
Foster a patient centered and recovery focused approach to MH and substance disorder clients within the health service and community
Development of/participation in community programs addressing specific community need, focused on prevention, reducing stigma and promotion of mental health literacy
Advocacy and promotion of future development of MH services Building community resilience + social capital
Participate in person and team management using specific skills in de-escalation, mediation and understanding of team dynamics
Other opportunities for additional scope of extended practice Including roles in management, education and research

KEY CONNECTIONS

Allied MH services public and private
Private psychiatric and substance related specialists and facilities
Community and Government service providers
Community and Tertiary MH Service Adult Child and Youth Alcohol & Other Drugs
Community organisations + stakeholders - PCYC, RSL, local council
“There are ongoing calls for a better integrated mental health service system that focuses on the holistic needs of consumers and carers; responds to local needs and circumstances; rebalances efforts towards promotion, prevention and early intervention; and builds workforce capacity to support system change”

5th National Mental Health Plan
BARRIERS TO UPTAKE

• MH + Substance not a major focus until recently
• Historically an unpopular area of medicine
• Need not as clearly defined/obvious
• Limited precedent
• HHS priorities in maintaining procedural services
• Limited funds + infrastructure
• Medicare dis-incentives, time pressure
• Risk aversion
• No evidence of impact (yet)
• Impact difficult to measure
• Access + Integration
• Prevention and promotion
• Target at-risk populations
• Collaborative partnerships and planning
• Sustainable health workforce
• Address physical health of mental health patients – whole person
• Minimise stigma and discrimination
PENCANSKY + THOMAS 1981

Transparency
Outreach
Information
Screening

Approachability

Professional
values,
norms,
culture, gender

Acceptability

Geographic
location
Accommodation
Hours of opening
Appointments
mechanisms

Availability and
accommodation

Affordability

Direct costs
Indirect costs
Opportunity
costs

Technical and
interpersonal
quality
Adequacy
Coordination and
continuity

Appropriateness

Health care
needs

Perception of
needs and
desire for care

Health care
seeking

Health care
reaching

Health care
utilisation
• Primary access
• Secondary access

Health care
consequences
• Economic
• Satisfaction
• Health

Ability to perceive

Ability to seek

Ability to reach

Ability to pay

Ability to engage

Health literacy
Health beliefs
Trust and
expectations

Personal and
social values,
culture,
gender, autonomy

Living environments
Transport
Mobility
Social support

Income
Assets
Social capital
Health
insurance

Empowerment
Information
Adherence
Caregiver
support
A case of anorexia + substance use
SUMMARY + FUTURE DIRECTIONS

• The Mental health AST/ARST clinicians ideally placed
  – Flexibly respond to local health care needs and models to improve mental health service delivery in rural and remote Australia

• Conceptual models presented outline potential applications and scope

• Use for research/to strengthen business case

• Need data measuring pre and post impacts
QUESTIONS?
THERE IS NO HEALTH WITHOUT MENTAL HEALTH!
REFERENCES

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