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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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

NATIONAL RURAL HEALTH ALLIANCE INC.

...good health and wellbeing 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.

HIGHER RATES OF HOSPITALISATION[1]

Table 3: Mental Health Hospitalisations (same day and overnight stays), age standardised rate (per 100 000 people), 2013-14

	Major Cities (High SES*)	Major Cities (Mid SES*)	Major Cities (Low SES*)	Inner Regional	Outer Regional	Remote
	Rate per 100 000 population					
All mental health disorders	856	873	874	946	991	1096
Intentional Self Harm	125	132	147	174	191	231

Source: http://www.myhealthycommunities.gov.au/our-reports/mental-health-and-intentional-self-harm/september-2016 ***Notes: SES refers to Socio-Economic Status***

HIGHER INCIDENCE OF SUICIDE[1]

Table 4: Incidence of Suicide, age standardised, 2009-13

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
	Rate per 100 000 population				
Males	14.7	20.2	21.4	26.8	30.0
Females	n.p	n.p	n.p	8.7	10.7
Persons	9.7	12.6	13.7	18.1	21.5

Source: http:://www.aihw.gov.au/deaths/mort/

HIGHER PREVALENCE OF HARMFUL ALCOHOL AND DRUG USE[2,3]

Prevalence rates of risky alcohol consumption (AIHW 2011)

Proportion of population who drink at risky levels	Major cities	Inner regional	Outer regional	Remote/ Very remote
… for lifetime harm	19%	22%	25%	31%
… for single-occasion harm	15%	17%	19%	26%

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

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

(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.

LESS MONEY SPENT/AVAILABLE[1]

Table 2: Per capita MBS expenditure, Mental Health services, 2013-14

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
All pofessionals	$44.95	$34.67	$21.33	$10.16	$4.51

Source: https://mhsa.aihw.gov.au/resources/expenditure/

LESS CLINICIANS AND EXPERTISE[1]

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

	Major Cities	Inner Regional	Outer Regional	Remote/Very Remote
	FTE per 100 000 population			
Psychiatrists	16.6	6.2	4.4	3.0
Mental Health Nurses	87.3	81.5	51.2	50.9
Psychologists	92.4	55.5	40.8	29.6

Source: https://mhsa.aihw.gov.au/resources/workforce/

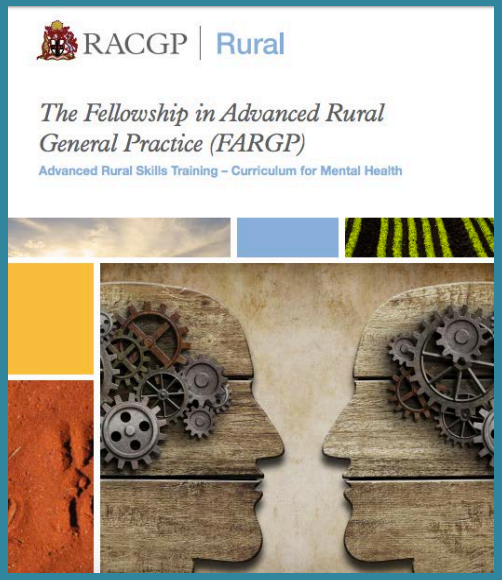
RELEVANT TO CURRENT POLICY

- World Health Organisation's – Mental Health Action Plan 2013-2020[4]
- National Strategic Framework for Rural + Remote Health[5]
- Fifth National Mental Health Plan (draft)[6]

"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"

Draft 5th National Mental Health Plan[6]

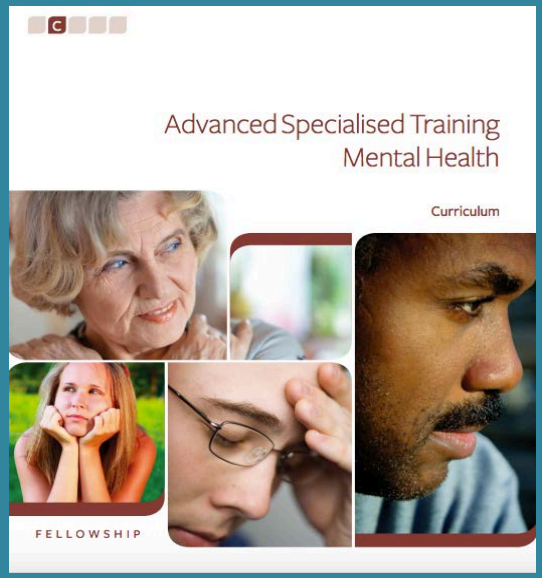
THE RG/GP MH AST/ARST PROGRAM[7,8]



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 it they will come"
"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[19, 20]

	LONGREACH	WARWICK/STANTHORPE	COOKTOWN
Hospital SMO/SMOPF	✔	0.4	0.2
On Call	✔	✔	✔
MH Advice AHs	✔	✔	✖
General Practice	25%	0.5	0.8
MH General Practice	75%	30%	30%
Therapy	✔	Hoping to expand	✔
“Mini Psychiatry” Clinic	✖	0.1	✖
Work with MH Team	✔	✔ Not formal	✔
OSP Prescribing	✔	✔	Hoping to expand
Education + Advice	✔	✔	✔
Policy Development/Service Design	✔	Hoping to expand	Hoping to expand
Management/Leadership/Strategic Planning Role	✔	Hoping to expand	Hoping to expand
External Academic Role	✔	✔	✔
Advocacy/Community Engagement	✔	Hoping to expand	Hoping to expand

RESULTS – THE MODELS

TARGET POPULATION[6]

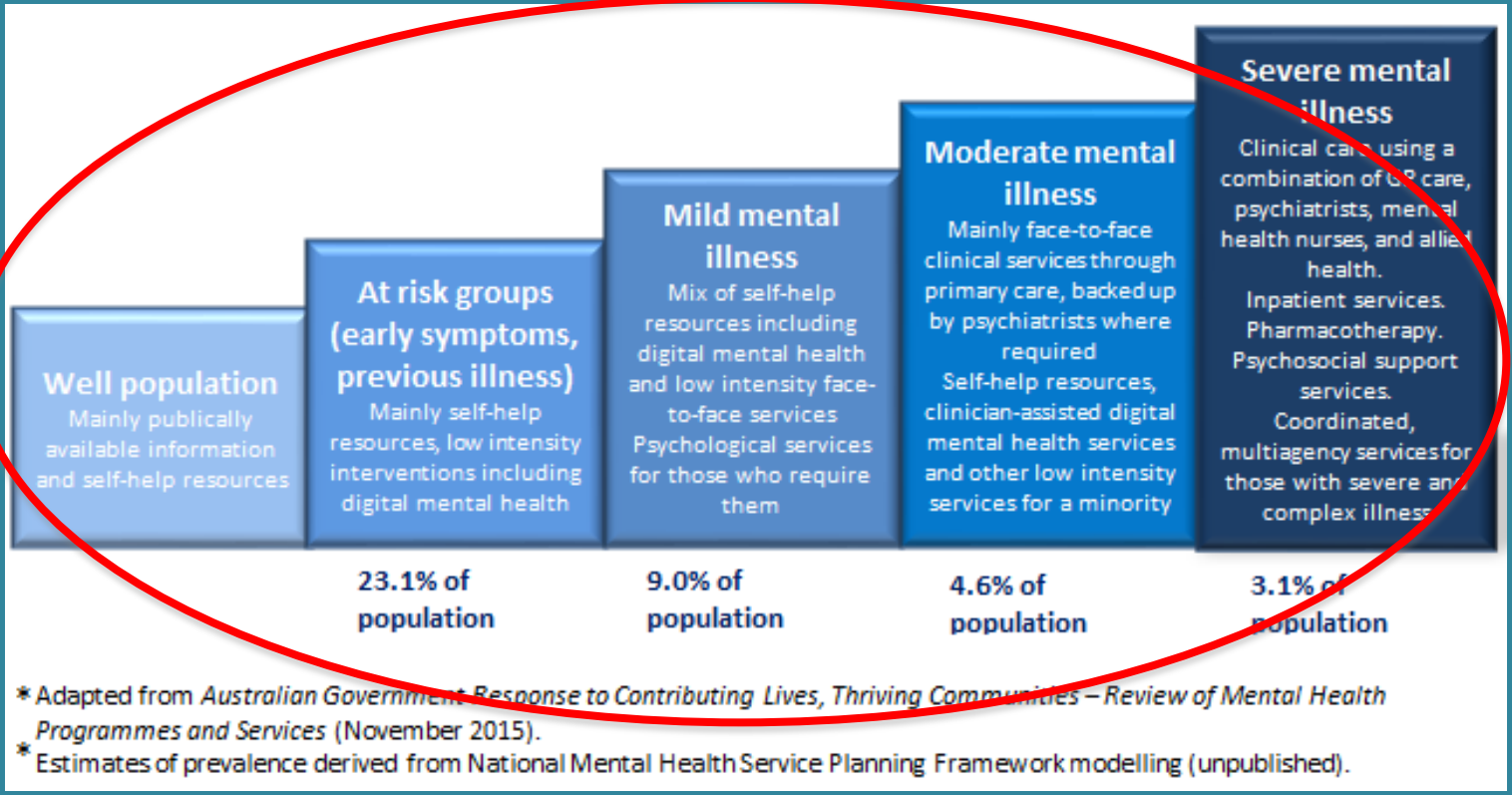
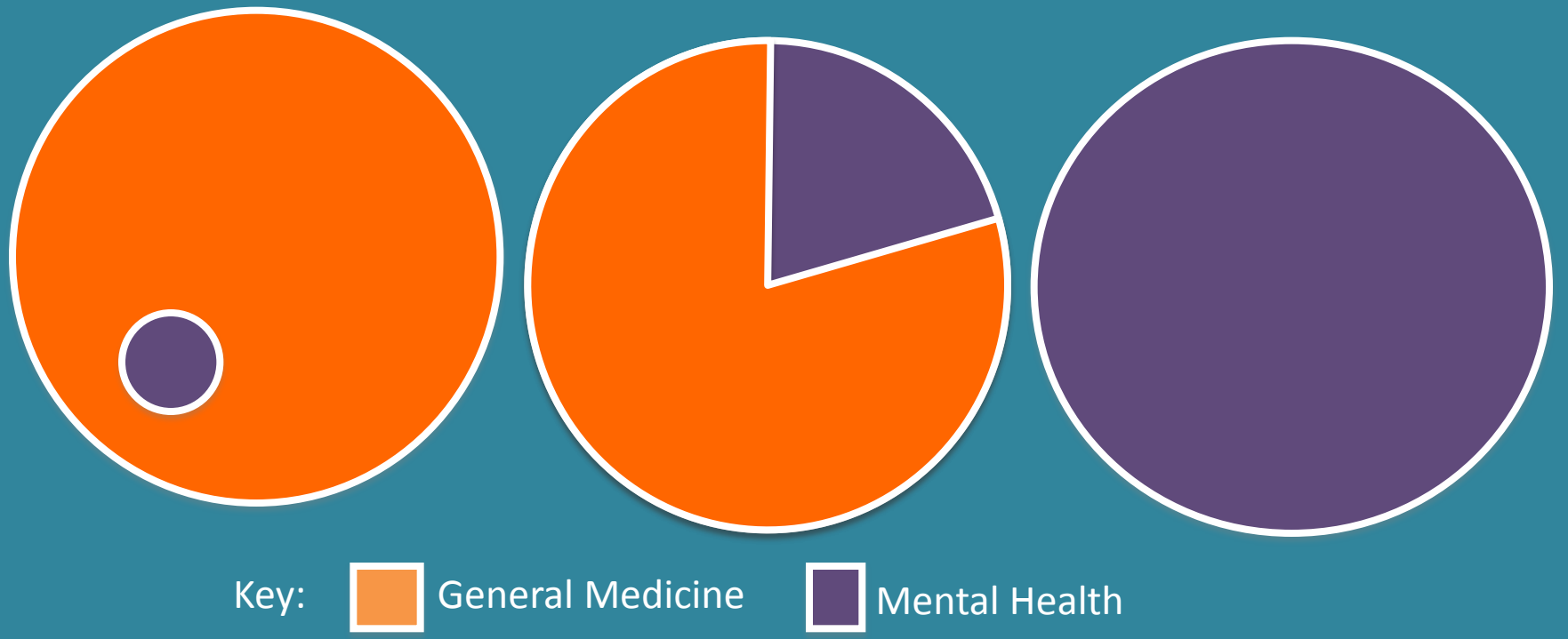


FIGURE 3: MENTAL HEALTH STEPPED CARE LEVELS OF NEED AND SERVICES

CONCEPTUALIZING THE CONTEXT AND EXTENT OF MH SPECIFIC PRACTICE

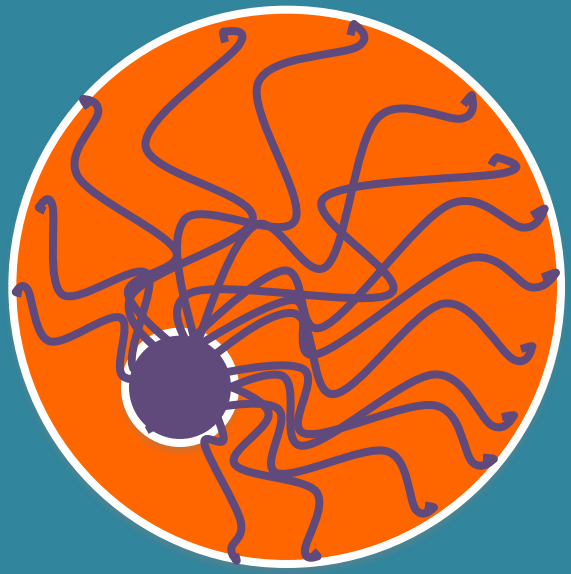
RG ----------VS---------- GP



RURAL GENERALIST MODEL

Key: General Medicine 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…

Key: General Medicine Mental Health

MH SPECIFIC SKILLS KNOWLEDGE & RRLATIONSHIPS

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

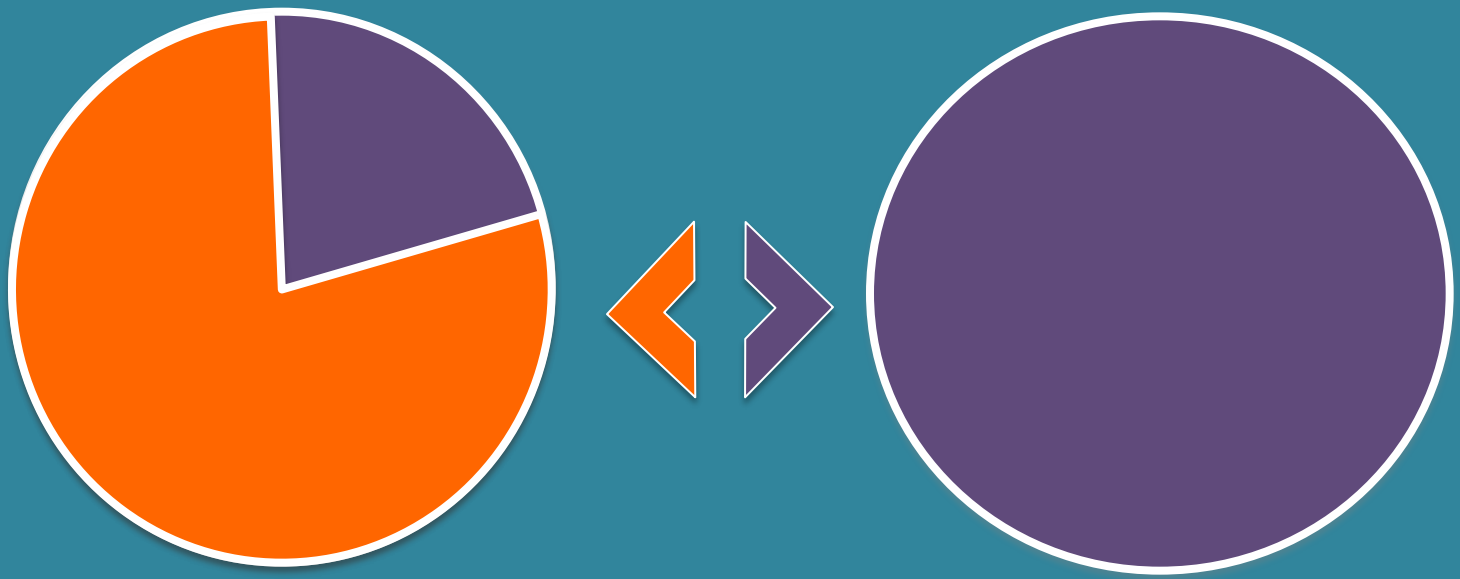
Community and Government service providers

Community organisations + stakeholders - PCYC, RSL, local council

RURAL GENERALIST MODEL:

- Clinical Applications
- Broader Context Applications
- Other Opportunities

GENERAL PRACTICE MODEL



Key: General Medicine 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

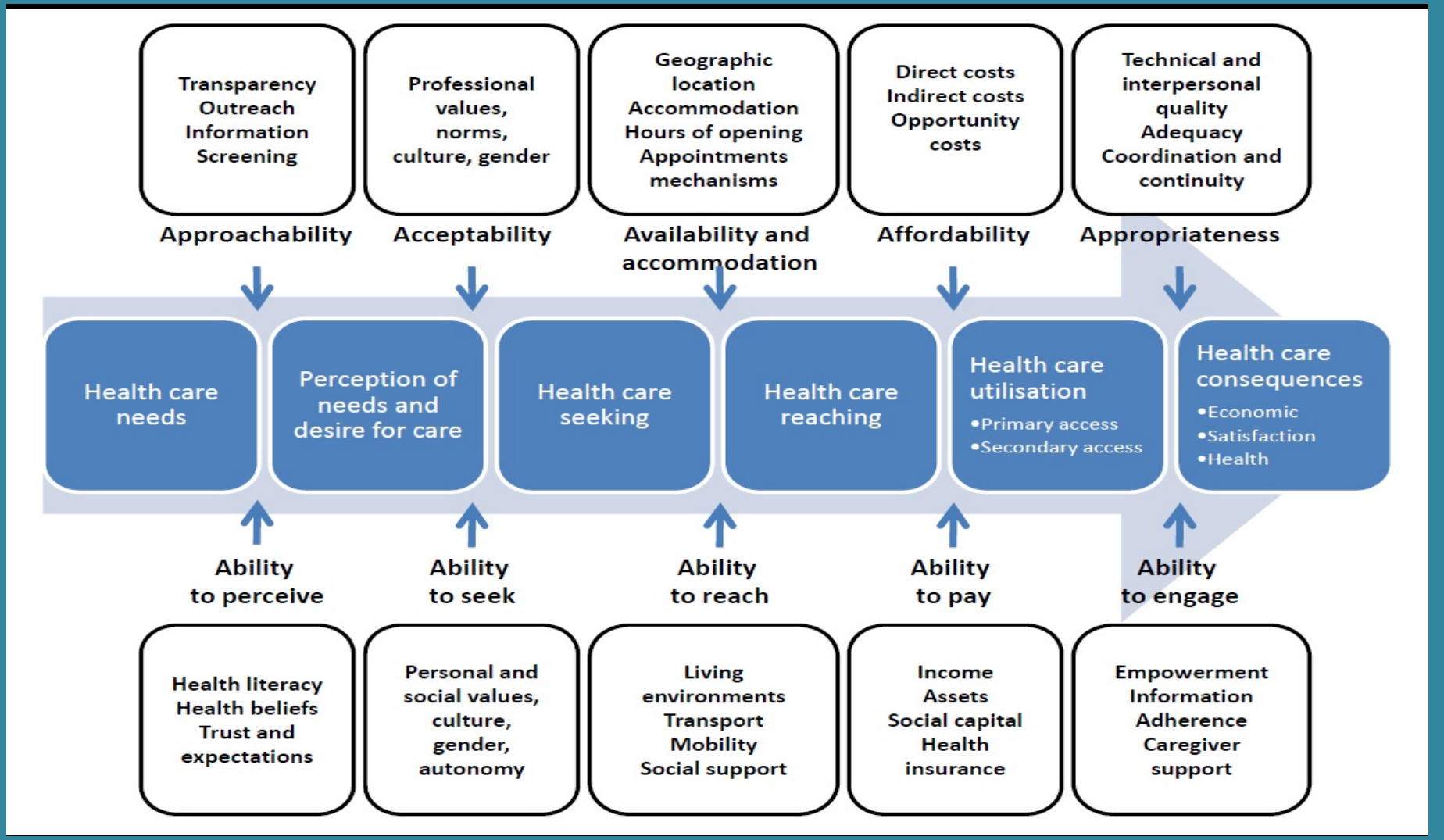
BARRIERS TO UPTAKE

- 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

BENEFITS + NATIONAL PRIORITIES

- 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

PENCHANSKY + THOMAS 1981[21,22]



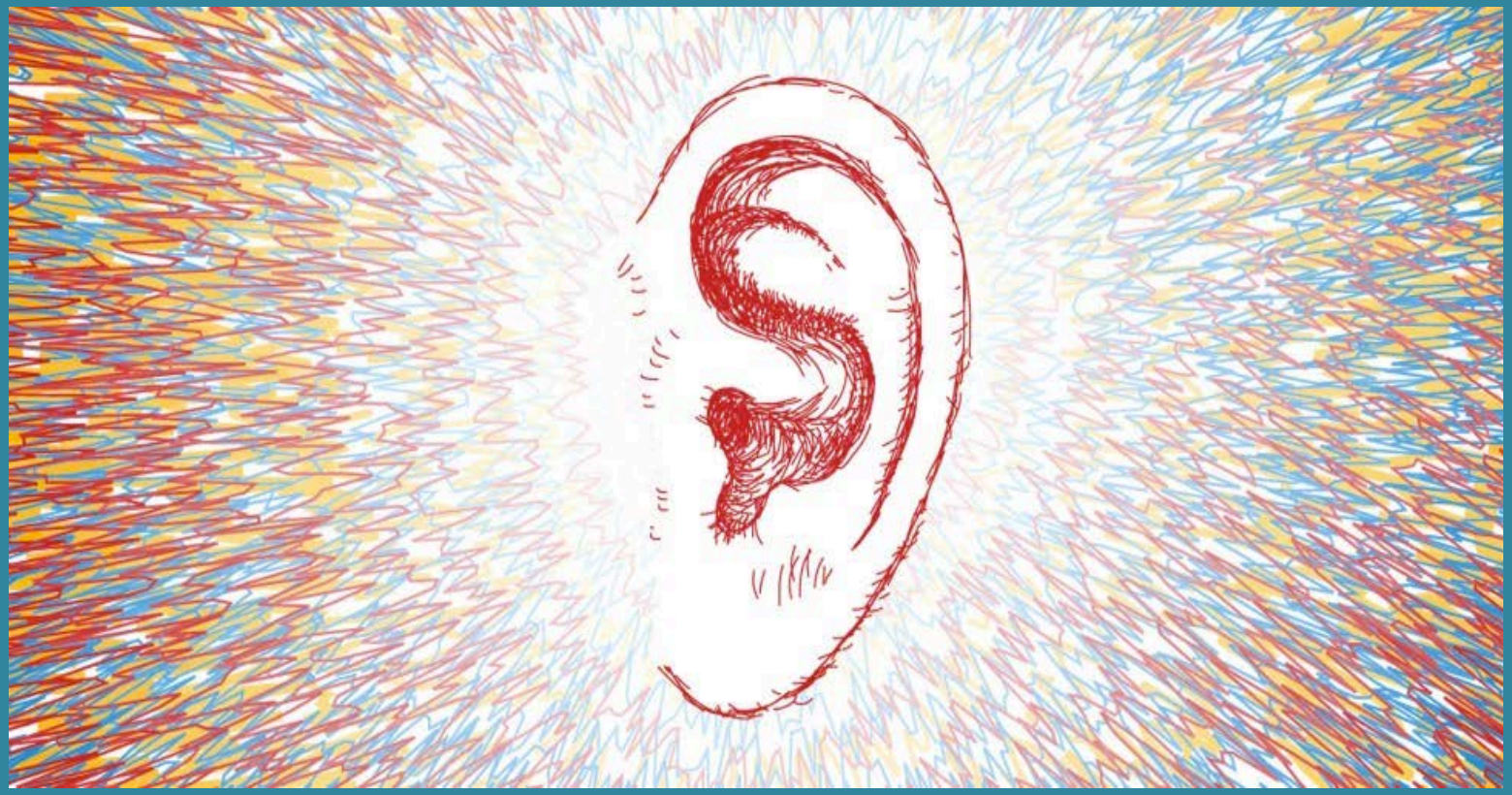
CLINICAL EXAMPLE

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

1. National Rural Health Alliance Inc. Fact Sheet –March 2017 – Mental Health in Rural and Remote Australia –http://ruralhealth.org.au/sites/default/files/.../nrha-mental-health-factsheet-2017.pdf
2. National Rural Health Alliance Inc. Fact Sheet –March 2014 - Alcohol Use in Rural Australia - http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-alcohol.pdf
3. National Rural Health Alliance Inc. Fact Sheet –June 2015 - Illicit Drug Use in Rural Australia - http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-illicit-drugs-0615.pdf
4. World Health Organisation – Mental Health Action Plan 2013-2020- http://www.who.int/mental_health/publications/action_plan/en/
5. National Strategic Framework for Rural + Remote Health - http://www.health.gov.au/internet/main/publishing.nsf/content/A76BD33A5D7A6897CA257F9B00095DA3/$File/National%20Strategic%20Framework%20for%20Rural%20and%20Remote%20Health.pdf
6. Fifth National Mental Health Plan (draft) - http://www.health.gov.au/internet/main/publishing.nsf/content/8F54F3C4F313E0B1CA258052000ED5C5/$File/Fifth%20National%20Mental%20Health%20Plan.pdf
7. RACGP Mental Health ARST Curriculum - https://www.racgp.org.au/download/Documents/FARGP/ARST-Curriculum-for-Mental-Health-October-2016-.pdf
8. ACRRM Mental Health AST Curriculum - http://www.acrrm.org.au/docs/default-source/documents/training-towards-fellowship/curriculum-advanced-specialised-training-mental-health.pdf?sfvrsn=4
9. Allan J. Advanced rural skills training - the value of an addiction medicine rotation. Aust Fam Physician. 2011 Nov;40(11):927-9.
10. Sen Gupta T, Manahan D, Lennox D, Taylor N. “The Queensland Health Rural Generalist Pathway: providing a medical workforce for the bush.” Rural and Remote Health. 13: 2319. (Online) 2013.

REFERENCES

11. Ernst and Young. Evaluation and Investigative Study of the Queensland Rural Generalist Program. Queensland Health, February 2013, available at http://www.health.qld.gov.au/ruralgeneralist/content/background.asp
12. Lynch J, Askew D, Mitchell G, Hegarty K. Beyond symptoms:Defining primary care mental health clinical assessment priorities, content and process. Social Science & Medicine 2012; 74: 143-149.
13. Kirkengen A, Thornquist K. The lived body as a medical topic: an argument for an ethically informed epistemology. Journal of Evaluation in Clinical Practice 2012; 18: 1095–1101.
14. Stone L., Managing the consultation with patients with medically unexplained symptoms: a grounded theory study of supervisors and registrars in general practice. BMC Family Practice 2014; 15: 192.
15. Reeve J. Interpretive Medicine: Supporting generalism in a changing primary care world. The Royal College of General Practitioners. January 2010 (88).
16. Usten TB & Sartorius N (Eds). Mental illness in general health care: An international study (1995). Wiley: Chichester
17. Lawrence D, Holman CDJ, Jablensky AV (2001) Preventable Physical Illness in People with Mental Illness. Perth: The University of Western Australia. Available at www.dph.uwa.edu.au
18. Kelly BJ, Stain HJ, Coleman C et al. Mental health and well-being within rural communities: The Australian rural mental health study. Aust J Rural Health 2010; 18(1): 16-24.
19. Personal Communications with Dr David Walker September –October 2017.
20. Personal Communication with Dr Matt Ruhl September –October 2017.
21. Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. Med Care. 1981 Feb;19(2):127-40.
22. Levesque JF, Harris M, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International Journal for Equity in Health 2013; 12:18.