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PROJECT REPORT

Improving the skills of rural and remote generalists to manage mental health emergencies

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ABSTRACT

Context: People living in rural and remote areas have been found to suffer higher rates of mental illness and psychological distress than their urban counterparts. However, rural and remote Australians also suffer from a lack of specialist mental health services. Mental health consumers are concerned about the lack of access to specialist mental health care and report poor service quality and stigmatizing staff attitudes when presenting with mental health emergencies at acute care facilities. Standards for the Mental Health Workforce released in 2002 promote respect for the individual, their family and carers; best practice in the assessment, early detection and management of acute illness; promotion of mental health and safety; and the prevention of relapse. These standards are for generalists providing care to mentally ill patients; their family and carers in the acute care setting; as well as specialist mental health professionals. Up-skilling generalists in rural and remote areas to respectfully and effectively manage mental health emergency care is a priority.

Issues: A short course, 'Managing Mental Health Emergencies' was developed by the Australian Rural Nurses and Midwives in 2002. Almost 750 participants had completed the course at the time of the evaluation. The objectives of the course were to: develop an increased knowledge of mental health presentations and gain confidence in managing and assessing mental health clients; gain an understanding of the referral processes in the local environment; gain an insight into the impact of mental health emergencies on individuals, their family and carers; and identify strategies to minimise the impact of managing mental health emergencies on the healthcare team. The model of training matched what is known to be best practice in rural and remote health practitioner development in emergency care, being local, interdisciplinary, and engaging local expert service providers while being overseen by

a national steering committee. The evaluation consisted of a pre- (n=456) and post-course (n=163) survey, and follow-up interviews with participants between 3 and 6 months post-course (n=44).

Lessons learned: The pre- and post-survey identified that, as a result of the course, participants had improved confidence in seeking information about suicide ideation, were significantly more able to differentiate between substance intoxication and psychosis (χ^2[df=1, n=619] =140.9, p<.000); and between dementia and delirium (χ^2[df=3, n=619] =126.5, p<.000). The follow-up interview notes were analysed using thematic analysis. Three themes were used: changing attitudes; changing clinical practice; and communication. Participants had reflected on their attitudes following the course and recognized how these had been stigmatizing. Many participants reported putting their new skills into practice and reported better recognition of non-verbal cues and better information seeking from family members, past history and police. The Managing Mental Health Emergencies course is a valuable addition to the emergency courses available to rural and remote healthcare providers.

Key words: Australia emergency care training, mental health, mental health emergency.

Context

In Australia, mental health is one of the national health priorities. The Australian National Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics identified the extent of mental health issues affecting the population[1]. Anxiety, affective or substance-use disorders were very common and experienced by 18% of the adult population in the 12 months prior to the survey; psychotic disorders were experienced by up to 0.7% of the adult population. The national survey, however, was a blunt measure for rural mental health, only identifying people as metropolitan and non-metropolitan.

A recent survey of 1563 rural residents from south-west and north-west Victoria and south-east South Australia found that psychological distress was experienced by 31% of the adult population, and was experienced equally by men and women[2]. These authors also found that depression was reported by 10% of respondents with 3-4% experiencing moderate to severe depression or anxiety. The highest prevalence of psychological distress was found equally in men and women in the 45 to 54 year age group.

It is now widely recognised that Indigenous Australians suffer high rates of psychological distress[3,4]. In the period 1997 to 1999, Indigenous males had a suicide rate 2.6 times higher than the expected rate, the highest being 108 per 100 000 in the 15 to 24 year age group, compared with 27 per 100 000 for all males in the same age group[5]. Indigenous people make up 2% of the total Australian population, but comprise 12% of the population in remote areas and 45% of the population in very remote locations[6]. The conclusion can be drawn that increasing rurality comes with increasing rates of psychological distress in the population.

Mental health services have undergone significant change in the last 45 years in Australia. This has been driven by a national policy agenda. Since 1989 The National Mental Health Strategy has driven reform in mental health service delivery after a crisis in mental health care. This crisis was the result if 30 years of de-institutionalisation, during which the number of beds in psychiatric facilities reduced nationally from approximately 30 000 to 8000, with minimal funding for alternative community based services[7]. Two of the key objectives of the first National Mental Health Plan released in 1992 were the mainstreaming of mental health services and the integration of care. Funding for in-patient psychiatric beds in stand-alone facilities continued to be reduced, but community mental health service funding was significantly increased[8], and by 2002 80% of all acute psychiatric beds were in general acute care facilities[7].

The evaluation of the first 5 years of the National Mental Health Strategy reported consumer concerns about lack of

access to services, poor service quality and stigmatising staff attitudes[8]. In 2000, the National Mental Health Education and Training Advisory Group was established to systematically improve the quality of mental health services to consumers, their families and carers. The Advisory Group released Standards for the Mental Health Workforce in 2002[9]. These Standards are recommended for use by the range of disciplines involved in the specialist care of mental health consumers and their support networks; they are also recommended for 'general professionals… hospital staff providing acute care'[9]. The standards promote respect for the individual, their family and carers; best practice in the assessment, early detection and management of acute illness; promotion of mental health and safety; and the prevention of relapse.

Most specialist services are difficult to maintain in rural and remote areas. The small and often widely dispersed communities of outback Australia are difficult to service due to a lack of infrastructure, such as accommodation for resident and visiting staff, adequate clinic space and reliable telecommunications. Evidence suggests that it is difficult to attract and retain mental health experts in rural and remote areas of Australia[10], with only 4% of psychiatrists, 12% of practising psychologists and 30% of mental health nurses living and working in these locations[11]. The reality of mental health service provision in rural and remote areas is that it must be a partnership between resident generalist healthcare providers and community agencies, supported by a range of specialist service options, including telehealth, outreach services and emergency transport/evacuation provided by groups such as the Royal Flying Doctor Service (RFDS).

Up-skilling generalist clinicians to meet the needs of clients facing mental health emergencies is a priority for all acute healthcare settings, but it is imperative in rural and remote areas due to the lack of readily available specialist mental health services and the many challenges facing rural and remote practitioners of all disciplines.

Educating rural and remote health professionals throughout Australia, where a change in clinical practice is the desired outcome, presents a challenge logistically, operationally and educationally.

A systematic review of education models in obstetric emergencies by Black and Brocklehurst noted that health services have difficulties in sending all relevant staff to distance learning courses, 'the courses are expensive and an average hospital would find it difficult to train all its labour ward staff in this way'[12] . They noted that locally run courses are more effective in training greater numbers of staff and are better able to address local issues in a way that a national course cannot; however, there is 'substantial risk that locally run courses would have variable quality'. They suggest that emergency courses should be overseen nationally to ensure best practice in teaching and training standards.

Issue

The Mental Health Emergencies Course

The Australian Rural Nurses and Midwives (ARNM) first secured a grant from the Department of Health and Ageing in 2003 to develop the 'Mental Health Emergencies' pilot course. From the time of this pilot until 2007 a total of 745 rural and remote clinicians, representing every Australian state and territory, completed the course.

As with other training courses developed to manage emergency situations (eg Major Incident Medical Management and Support; Early Management of Severe Trauma; Advanced Life Support in Obstetrics; Remote Emergency Care; and the Maternity Emergency Care course), the Mental Health Emergencies course was designed for a diverse clinical audience. The course, overseen by a National Steering Committee of mental health experts and experts in rural and remote health, uses adult learning principles and reinforces learning with scenarios and case studies. Practice sessions are introduced using a role play

format. The course has been designed to be conducted over 2 days. A user-friendly workbook complements the course and this is given to participants on the first day of the course.

Course evaluation methods

Preliminary course evaluations were conducted to refine the workbook and the delivery methods. In 2008 a comprehensive evaluation was conducted examining 24 courses held over the previous 2 years. The evaluation used a mixed methods approach. The instruments were pre- and post-workshop questionnaires for all participants and follow-up semi-structured telephone interviews to a representative sample of course participants.

From the 475 participants 456 pre-test questionnaires were completed before the commencement of the workshop and 163 post-workshop questionnaires were returned after the workshop. The questionnaire consisted of 7 structured questions requiring participants to rank their skill levels pre- and post-workshop by indicating on a four-point scale if they agreed that they possessed the relevant skill. The scale ranged from 1 (true) to 4 (not true).

All participants were invited to nominate themselves for a follow-up telephone interview 3 to 6 months after attending a workshop. A stratified sample of participants was chosen to represent at least one participant from each workshop and the range of participating professional groups. A total of 44 participants were interviewed. One researcher conducted all interviews and kept comprehensive notes from each interview, including verbatim quotes. Thematic analysis was conducted on the notes.

Lessons learned

A total of 475 people participated in the 24 courses. The participating sites included rural and remote towns in South Australia, Northern Territory, Queensland and Western Australia. The participants reflect the general demographic breakdown of the rural and remote health workforce: 11.3% male; 58% registered nurses; 19% enrolled nurses; 7% Aboriginal health workers; and 15% other allied health professionals including counsellors and paramedics.

The workshop's main focus was the management of mental health emergencies, with an important learning objective being participants learning how to differentiate between substance intoxication and psychosis. Only 21% of the pre-workshop respondents felt that they were 'skilled' or 'tentatively skilled' at differentiating between substance intoxication and psychosis, compared with 71% of the post-workshop respondents. Only 4% of pre-workshop respondents felt skilled at differentiating between delirium and dementia; 73% felt either not skilled or that their skill level was low. Of the post-workshop respondents, 74% felt either skilled or partially skilled at differentiating between dementia and delirium. Participants were not asked to include their names with their pre- and post-workshop responses so it was not possible to make a direct comparison between the pre- and post-responses. Chi-squared analysis was used because it tests the difference in proportions in two independent groups. Each of the learning domains was analysed, being: suicide risk assessment (χ^2[df= 3, n=619]= 90.4, p<.000); assessing a violent or potentially violent situation (χ^2[df= 3, n=619]= 78.4, p<.000); assessing psychotic symptoms (χ^2[df= 3, n=619]= 117, p<.000); differentiating between delirium and dementia (χ^2[df= 3, n=619]= 126.5, p<.000); differentiating between substance intoxication and psychosis(χ^2[df= 3, n=619]= 140.9, p<.000) and communicating effectively with people with a mental health issue(χ^2[df= 3, n=619]= 71.4, p<.000) and conducting a mental status examination (χ^2[df= 3, n=619]= 100.5, p<.000) . In each of these domains there was a statistically significant difference between the pre-workshop response group and the post-workshop response group.

The limitations of the pre- and post-workshop survey meant there was no way of matching the pre- and post-responses and bias is possible because responders in the post-survey may have been more likely to report a difference because they were potentially the more enthusiastic attendees.

Changed attitudes

Almost all interview participants felt they had changed their attitude towards mental health clients as a result of the course. Many recognised that they had been stereotyping and stigmatising clients. They used the words pre-judging, stereotyping and labelling:

> *I have learnt to keep an open mind, in particular with 'frequent flyers'. In the past it would have been 'here we go again'* (p5).

Nearly all interview participants said they had changed their clinical practice in some way. In general, participants felt better able to assess mental health clients. More confidence assessing suicide risk and confidence in asking clients about their suicide ideation was a common response. One participant reported that a client who had attempted suicide was able to be cared for in the local hospital, with other staff reassured that they could manage the client locally. The participant negotiated with the client to sign a 'safety contract', whereby he agreed not to harm himself while in hospital.

Some participants were able to put newly learned techniques into practice:

> *A client presented with a mental health issue and was intoxicated. I used distraction and de-escalation techniques and she settled in* (p14).

Communication

Participants talked about their improved ability to read non-verbal cues and their increased patience when listening to acutely unwell clients. They described being more confident in approaching clients and diffusing potentially 'volatile situations'. They also commented on improvement in their written communication, particularly in documenting in greater detail in the case notes and information-seeking from files, family members and police.

Discussion

The Mental Health Emergencies course was well received by participants who were very affirming of the content and facilitation model. The course provided participants with information, engaged them in learning, and facilitated appropriate mental health practice. Although the sample sizes differed, there was a significant improvement in knowledge and self-assessed skill concerning the seven identified areas for skill development in the post-workshop responses.

As a result of attending the workshop, interviewed participants identified a change in their attitude towards people suffering mental illness. They expressed an increase in confidence in managing mental health emergencies and potential emergencies. Consistent with previous research findings, participants reported that their attitudes towards mental health patients in the general hospital setting prior to the workshop were potentially stigmatising[13]. Reflecting the Australian rural nurses in Reed and Fitzgerald's study[13], prior to the workshop the nurses said that they were afraid of mental health patients and would 'avoid' them. This avoidance leads to feelings of isolation, discrimination and marginalisation, as has been expressed by young adults from rural areas suffering mental illness[14].

Improved confidence in asking about suicide ideation was a notable outcome, in that almost all 44 respondents to the phone interviews commented on being able to commence a dialogue and ask questions about suicide, which they had been unable to do prior to attending the workshop. This alone will improve the outcome for many people with mental health issues. Engagement is a crucial element in suicide risk assessment, and early detection of suicide risk and appropriate referral and intervention is widely recommended for all health staff as health service policy[15].

Conclusion

The Mental Health Emergencies course is a valuable contribution to the courses offered to rural and remote health

professionals. The model adopted by ARNM which uses a local, two day, face-to-face workshop run by the ARNM coordinator and co-facilitated by local mental health professionals, is consistent with good practice in emergency care training. It is local, interdisciplinary and engages with local expert service providers while maintaining the quality and oversight of a national expert steering committee.

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