

Mental Health Shared Care in Australia 2001

**Report for the Commonwealth Department of
Health and Aged Care**

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and

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TABLE OF CONTENTS

EXECUTIVE SUMMARY	6
Scope.....	7
Major Findings	7
CHAPTER 1 INTRODUCTION	9
CHAPTER 2 METHODOLOGY.....	11
Validity	11
Literature Review.....	11
Survey of Divisions	12
The interviews with Divisional Liaison Officers	12
Interviews with health professionals working in mental health shared care.....	13
Definitions	14
CHAPTER 3 THE POLICY CONTEXT	17
A Global Increase in Mental Health Problems and Disorders.....	17
The History of Mental Health Care Reform in Australia	19
Summary	30
CHAPTER 4 REVIEW OF THE LITERATURE	32
Levels of Collaboration	33
Evaluation.....	34
Barriers to Collaboration	36
Communication and Relationships	37
GP Training.....	39
Fellowships	41
Time & Remuneration.....	41
Roles.....	43
Target Groups.....	45
Non-English Speaking Migrants	46
Conclusions Derived from the Literature Review.....	47
CHAPTER 5 MENTAL HEALTH SHARED CARE IN DIVISIONS OF GENERAL PRACTICE.....	50
Background to Divisions data and reporting processes.....	50
Overview of the spectrum of shared care from the AOD database and the Directory of Divisions [1999 data]	51
CHAPTER 6 MENTAL HEALTH DEVELOPMENT AND LIAISON OFFICERS (DLOS) INTERVIEWS.....	54
Barriers to Shared Care	54
Effective Supports For Shared Care Arrangements	57

Processes Facilitating Shared Care Initiatives	59
Future Directions – The DLO Perspective	60
CHAPTER 7 INTERVIEWS WITH HEALTH PROFESSIONALS	62
Profiles of the Areas Involved	62
Preparatory Work.....	63
Description of the Shared Care Programs.....	65
Difficulties Associated With Shared Care Projects	69
Process Issues	70
Geographical Issues	71
Benefits from Shared Care Projects	73
The Future	75
CHAPTER 8 RESULTS FROM THE SURVEY OF DIVISIONS.....	78
Numbers and degree of engagement	78
Funding.....	79
The role of GPs in Shared Care	80
Types of activities	81
Who does what in these programs?	85
Education programs.....	89
Special groups	90
Whose agenda?.....	91
Evaluation	94
Conclusions from the Survey	95
CHAPTER 9 DISCUSSION.....	97
Summary	102
CHAPTER 10 RECOMMENDATIONS.....	104
Education.....	104
Organisation	104
Evaluation	105
Funding.....	105
BIBLIOGRAPHY	106
APPENDIX 1 INTERVIEW SCHEDULES FOR DIVISIONAL LIAISON OFFICERS.....	117
APPENDIX 2 INTERVIEW SCHEDULE FOR PROFESSIONALS WORKING IN SHARED CARE	120
APPENDIX 3 THE SURVEY OF DIVISIONS.....	122
APPENDIX 4 SURVEY OF DIVISIONS (ANALYSIS).....	130
APPENDIX 5 DIVISIONS INVOLVED IN SHARED CARE/PARTNERSHIP ACTIVITIES RESPONDING TO THE SURVEY	141

TABLES AND FIGURES

Table 1 Chronology of major reform events in Australian mental health care	27
Table 2 Level of engagement of divisions with shared care	52
Figure 1 Sources of Divisional Mental Health funding	80
Figure 2 Types of Process Activities in Which Divisions are Involved (Numbers of Divisions).....	81
Figure 3 Persons formally involved in shared care programs	86
Figure 4 Numbers and roles of consumers and carers in shared care programs	87
Figure 5 Main group of consumers addressed by the shared care program	92
Figure 6 Outcome measures used by shared care programs.....	94
Figure 7 The dynamics between the different factors that make up the picture of collaboration between GPs and the specialty mental health sector	98
Figure 8 Increasing the reach of shared care programs	101
Figure 9 Type of participation and degree of acceptance of consumers	102

EXECUTIVE SUMMARY

Throughout the 1990s a number of national and international studies provided evidence of a significantly different disease profile than which had previously been described. *The Global Burden of Disease*¹ study conducted by the World Health Organisation in 1996, predicted that by the year 2020 mental illness would account for 15% of disease burden world wide and that depression would be one of the major leading causes of disease burden, second only to ischaemic heart disease. This indicates a possible increase of approximately 50% in the prevalence of neuropsychiatric disorders. Two National studies, the *National Profile of Mental Health & Well Being*² and the *Australian Burden of Disease Study*³ confirmed the high incidence of mental health morbidity for the Australian community and the associated high degree of disability caused by depressive disorders.

Policy makers and health care providers alike have developed a growing awareness of the important role played by GPs in the provision of mental health care. For example, data from the *National Profile of Mental Health & Well-Being* study indicated that approximately 20% (1-5) of the Australian population over the age of 18 years met the criteria for a mental health problem or disorder. The data showed that only 38% of these people sought help and of those who did seek help approximately 75% sought help in the first instance from a GP.

Historically, however, many barriers have stood between GPs and the provision of effective mental health care. Apart from a lack of training in mental health care, the time constraints of general practice, and significant financial disincentives inherent in the current Medicare Benefits Schedule, GPs have also faced a lack of support from their specialist mental health colleagues and a lack of clear policy and systemic changes to guide such support.

The need for GPs to be provided with increased mental health education and training and ongoing support from specialist mental health care providers is clear. As a result of such compelling research evidence many of these barriers and disincentives are now being acknowledged and addressed in *Australia's Second National Mental Health Plan* and specific initiatives funded under a renewed *National Mental Health Strategy*.

Divisions of General Practice have been seen by many as a vehicle for primary mental health care reform. They are ideally placed to facilitate GP training and the development of shared mental health care activities between GPs and specialist mental health care providers.

This review provides a summary of the current policy and research literature on shared care and comments on the current debates around workforce, training and better coordination and integration of care between general practice and mental health services. A key component of the review is a report on mental health programs and initiatives being implemented through Divisions of General Practice.

¹ Australian Bureau of Statistics, *Mental Health and Well-being Profile of Adults*. Canberra: ABS, 1997

² Mathers CD, Vos ET, Stevenson CE, et al. *The Burden of Disease and Injury in Australia*. Canberra: AIHW, 1997.

³ Australian Bureau of Statistics, *Mental Health and Well-being Profile of Adults*. Canberra: ABS, 1997

Scope

Whether or not current mental health policy directives and reform initiatives will produce the desired results is yet to be fully established. This review contributes to the knowledge base on the current state of mental health care reform in Australia. The review focuses specifically on better ways of integrating mental health care across the general practice and specialty mental health sectors.

The review also provides commentary on the points of influence, key players and social, political and economic events, which together have reshaped the culture of mental health care in Australia. Particular attention is paid to key national policy events in Australian general practice and the specialist mental health sector in the last decade, and how policy makers in both contexts have been influential in shaping a shift in emphasis from an isolationist service delivery model to one of partnership and community-based mental health care.

The tension between the newly proposed collaborative structures and the barriers, which traditionally have existed between GPs and other mental health service providers, is highlighted.

Data for this review have been drawn from secondary and primary sources. Secondary data was drawn from key national and international mental health policy documents, research articles and Divisions' project/program reports. The analysis of this secondary data was complemented with primary data drawn from a series of key informant interviews and a National survey. Key informants included the eight Mental Health Development & Liaison Officers from the Primary Mental Health Care Initiative, GPs, staff from the Divisions of General Practice and specialist mental health care providers.

Major Findings

Approximately **70 Divisions** are involved in **mental health** related activities. Of these **56** are involved in **collaborative activities** with specialty mental health services. Approximately one third of the 56 (**18**) have well-developed **shared care** arrangements. Almost all others are involved in collaborative problem solving activities and to a lesser extent, service integration. Nevertheless, these activities are considerable and reflect the growing level of interest an activity in collaborative mental health care.

While overall numbers of Divisions involved in mental health shared care have not changed since the introduction of Outcomes Based Funding, there has been a **significant movement of these Divisions towards higher levels of engagement with mental health services.**

There is good evidence that these activities are addressing the agendas of **both mental health services and general practice** and therefore, a broader range of consumers

Processes that are being developed include the use of service agreements, care planning and case conferencing, development of care pathways and protocols, communication tools and consultation liaison services. Both mental health workers and GPs are being used as key liaison staff for these collaborative activities.

Evaluation is becoming more elaborate but consumer outcome measures are not being used extensively.

About one half of all programs involve **consumers and carers** at some level, most commonly at the management committee level. Consumers and carers are also being used as resource people in education programs and as peer support and educational resources for other consumers and carers. External consumer groups and non-Government organisations can become major stakeholders in these types of programs and should be engaged whenever possible.

There are still **extensive barriers** to collaborative activities despite the considerable activities implemented over the past decade. Trust and respect need to be developed between GPs and mental health service staff. This takes time and staff continuity and programs need to be adequately funded over a long time frame. Most programs have yet to reach a level of systemic change where they are no longer dependent on specific initiative funding.

Consultation liaison activities, education programs, case conferences and other face-to-face activities serve to enhance relationship development and should be promoted, especially in the early stages of shared care programs.

There is ample scope for extending the reach of programs through:

- encouragement of **non-active Divisions** to take up these activities;
- **the extension** of existing programs in active Divisions to **GPs and specialist mental health providers** not currently involved;
- **the application of models** developed to other mental health related areas, such as psycho-geriatrics, children's mental health, and prevention and health promotion programs.

CHAPTER 1 INTRODUCTION

There has been a growing realisation that the current arrangements within the Australian health care system for people with mental disorders and mental health problems are not optimal.

With the *First National Mental Health Plan* mainstreaming of mental health services was a major policy thrust and was responded to by each State and Territory in a variable manner.

The *Second National Mental Health Plan* emphasises prevention and health promotion. Considerable funding has been assigned to State and Territory health services to develop partnerships with primary care providers...and in particular general practice. Funding was also made available through the *National Primary Mental Health Care Education Initiative for Divisions of General Practice* to further develop skills and roles for GPs in the mental health area.

At the same time Divisions of general practice, funded by the Commonwealth, were developing locally based projects and programs in mental health. An important aspect of these was better integration and coordination of services for people with mental disorders and mental health problems. This has meant developing partnerships between GPs and their Divisions and mental health services.

The context of these developments is constantly changing. In the past 12 months the National Depression Initiative has developed wings; the Enhanced Primary Care Items have started to be implemented; the More Allied Health Services Program for rural and remote areas has been launched and there has been a further round of Innovations funding through the Divisions of General Practice. With so many balls in the air it is genuinely difficult for anybody to have a thorough overview of everything that is going on in the mental health shared care/partnerships area.

This review was contracted to look at the current situation in Australia with regards to service integration between general practice and specialty mental health services. Data for this review have been drawn from secondary and primary sources. Secondary data was drawn from key national and international mental health policy documents, the local and international literature, research articles and Divisions' project/program reports. The analysis of this secondary data was complemented with primary data drawn from a series of key informant interviews and a National survey. Key informants included the eight Mental Health Development & Liaison Officers from the Primary Mental Health Care Initiative, GPs, staff from the Divisions of General Practice and specialist mental health care providers.

The authors have tried to place all three sources in perspective so that informed decisions can be made regarding future policy and programs both at a National level and at local and State levels by Divisions and Mental Health Services.

Whether or not current mental health policy directives and reform initiatives will produce the desired results is yet to be fully established. This review contributes to the knowledge base on the current state of mental health care reform in Australia. The review focuses specifically on better ways of integrating mental health care across the general practice and specialty mental health sectors.

The review also provides commentary on the points of influence, key players and social, political and economic events, which together have reshaped the culture of mental

health care in Australia. Particular attention is paid to key national policy events in Australian general practice and the specialist mental health sector in the last decade, and how policy makers in both contexts have been influential in shaping a shift in emphasis from an isolationist service delivery model to one of partnership and community-based mental health care. The tension between the newly proposed collaborative structures and the barriers, which traditionally have existed between GPs and other mental health service providers, is highlighted.

CHAPTER 2 METHODOLOGY

Validity

In order to strengthen the conclusions which can be drawn, this project was designed as a triangulated study. This means that there were three sources of data, a literature review and policy analysis, a survey of Divisions using quantitative methodology, and qualitative interviews with Divisional Liaison Officers and key informants.

The mixed qualitative/quantitative methodology of this project contributes to validity through methodological triangulation. Triangulation was also addressed at the analysis stage through the analysis of the interview transcripts by two researchers.

Literature Review

The first intent of the project was to review the literature on mental health shared care. A literature search was performed in December 2000 with the aim of gathering a comprehensive selection of Australian literature with a focus on shared care between GPs and Mental Health Services, psychologists, nurses, and other professions. A wide selection of US and UK literature and relevant literature from Scandinavia, Europe, Israel and other countries was gathered where appropriate. Literature from developing countries is not seen as relevant.

The Austhealth, Medline, Health Star, PsychInfo, Cinahl, Cochrane bibliographic databases were searched using the search strategy: :

"Primary health care" or "Mental Health services" as subject searches (Medical Subject Headings)

AND

"shared care" or "consultation liaison" or collaborat* or linkages or integrat* or fundholding as free text search

AND

mental or psychiatric or psychosis or schiz* or depression or bipolar or "post traumatic" or PTSD or ADHD or anxiety or panic as free text search OR "Mental Health" as subject search

Searches were restricted to the years 1995-2000 and the English language

Additional sources were the PARC Electronic Library, PARC newsletter collection, Centre for GP Integration Studies website, NH&MRC, DHAC websites, the Mental Health Research Institute of Victoria website, ARCHI, HEAPS and AusEinet databases, library catalogues from Flinders Uni. And a general internet search using Google with above shared care terms.

Over 100 items were gathered for analysis.

Survey of Divisions

The second intent of the review was to gain a snap shot of the current situation in Australia in mental health services/general practice integration.

It was intended that the review team would be able to obtain fairly current data from databases that have already been established. In particular the *Activities of Divisions Database* [collated by the National Information Service], the *PARC Electronic Library*, and to a lesser degree the *Directory of Divisions* published by Australian Divisions of General Practice (ADGP) would be used. It was intended that these sources would identify a panel of key respondents to participate in in depth interviews. This would enable the researchers to explore some of the issues faced by GPs and specialty services in their attempts to work collaboratively.

The emphasis of the process has been to try to obtain as comprehensive a view as possible while not placing unnecessary reporting requirements on the Divisions.

It soon became evident that the *Activities of Divisions* database could not provide the current information that was required. Although detailed and rich in content, the data was based on Strategic and Business Plans from the 1999-2000 year and so was based on activities in the first half of 1999. The intent of the AOD database was that it would be updated annually after Divisions submitted their yearly reports against the various indicators identified in the strategic and business plans. To date between 50 and 60 Divisions' data are available for the NIS AOD database due to difficulties with software use by the Department of Health and Aged Care. Similarly the quality of the information contained in the *Directory of Divisions* while more current, is variable. While the entries from some Divisions are very useful others are not as detailed and fail to give the information that is required. The reporting processes of the Divisions is a major issue that needs to be addressed in the future.

Because of these difficulties the review team decided that it would survey the Divisions with a questionnaire, a methodology that had previously been rejected in order to save Divisions from yet another survey. **It seems that at present the only way of obtaining current information on Divisions' activities in a particular area is through some type of questionnaire or survey.**

The sampling framework was based on the *Directory of Divisions* published by ADGP. This was based on year 2000 data and Divisions were asked to identify their major areas of program activity. Out of the total 123 Divisions 70 were identified from this *Directory* as having mental health as a major area of program activity. Other Divisions were not surveyed, in order to minimise the intrusion on Divisions.

The expert panel together with our consumer and carer consultants developed a set of draft questions for the questionnaire and these were pilot tested by a local Division that was heavily involved in the mental health area. Responses to the interview questions were analysed using SPSS and open-ended questions were post-coded or analysed thematically.

The interviews with Divisional Liaison Officers

At the same time a qualitative approach using a semi-structured interview format was developed for individual interviews with the Development and Liaison Officers of the National Primary Mental Health Care Education Initiative and other professionals.

Eight mental health Development and Liaison Officers (DLOs) from each of the States and Territories were interviewed at the beginning of the project. The interview followed a semi-structured format containing eleven questions. These questions were designed to elicit information regarding any shared care activities undertaken within their region.

Consent was given for the interviews to be taped and they were conducted on the basis that the identity of each interviewee remain confidential. To avoid any conceptual difficulties the interviewer discussed our definition of the term 'shared care' (as collaborative mental health care, in any way other than the traditional referral model, taking place between GPs and any mental health professionals) before commencing the interview. A copy of the interview schedule can be found in Appendix 1. These interviews were taped and full transcriptions made of these recordings. This data was subsequently analysed thematically to explore the processes whereby shared care activities were, or could be, introduced. In addition the barriers, both structural and ideological to the success of these initiatives were examined along with their views on future developments in this area. These interviews were conducted on the basis that the individual identity of the DLO being interviewed was not revealed.

The DLOs all highlighted their perceptions regarding the barriers to shared care and the main elements of effective shared care arrangements. Whilst every effort was made to embody all the views of the different interviewees it was not practical in so short a time frame or within the constraints of the report to do so.

Interviews with health professionals working in mental health shared care

Twenty interviews were conducted with health professionals working within shared care programs in three States, Western Australia (7), Queensland (7) and New South Wales (6). There was also one interview conducted in South Australia and one in Victoria making a total of twenty-two. Due to the brevity of the timeline of the project, five months, we were forced to concentrate on only three States. We chose New South Wales as the most populous State, Queensland because it had a large number of internal migrants and an evolving well-funded shared care program, and Western Australia because of its isolation.

The interviews were semi structured. A copy of the interview schedule is included in Appendix 2. The interviews were conducted on the basis that the informants identity remain confidential. As a consequence, in order to preserve this anonymity we are only able to disclose the interviewee's position within the organisation and the State where they are based. The interviewees names came from amongst a group nominated by the DLOs in each State. It was not possible to contact every person suggested by each DLO due to the brevity of the study. In addition some people were not available to be interviewed during the time that the interviews were being conducted.

The interviewees professional backgrounds were four GPs, seven registered/psychiatric nurses, five psychiatrists, and six health professionals from within the divisions who had various backgrounds such as social work and health promotion. The group was evenly split between those working within general practice/divisions and those working with mental health services.

Half of the participants worked in metropolitan areas of the cities of Brisbane, Perth and Sydney. However, the demographic profiles of these areas differed immensely with one

informant working within a city area of Brisbane with high incomes and many young families while another worked where there was a high transient population of young people with drug and alcohol problems. Two respondents from Sydney and Brisbane described their areas of work as having high numbers of people from non-English speaking backgrounds, and one as having relatively large numbers of Indigenous residents within it.

Seven of the interviewees were involved in shared care programs which were based in the large country towns of Rockingham and Kwinana, in Western Australia, Port Macquarie, Bathurst, Orange, Kempsey, Tweed Heads, Lismore in New South Wales and Warrnambool, in Victoria. Many of the professionals involved in these programs were working with more than one Division or mental health service. This added to the complexity of an already difficult exercise.

Four participants were from rural areas including the Hunter Valley of New South Wales, Longreach in Queensland, Peel in Western Australia and an outreach service to GPs in rural South Australia. Two of these professionals (one in Western Australia and one in Queensland) mentioned that there were high youth suicide rates in these regions.

While virtually all Divisions and interview respondents have been remarkably candid in the information they have given, there have been some isolated instances where important information regarding evaluation of programmes has not been forthcoming.

Definitions

Various key terms recur throughout the body of this report. These include “primary care”, “GP”, “divisions of general practice”, “specialist mental health service providers” and “shared mental health care”. To assist the reader, definitions of these and other terms are provided below.

Primary care is best defined as a system of care that provides ‘front line’ services to the community. Primary care agencies are usually the first point of access for people seeking health care. The World Health Organisation (WHO) defines primary care as:

... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community.⁴

The National Centre for Epidemiology and Population Health⁵ describes primary care as:

...the local or primary level of the health care system, but also to an approach to health care more generally, a broad policy model for health planning”.

GPs are clearly part of primary care along with community health centres, hospital based primary care clinics and other providers such as pharmacists, podiatrists, dentists and a range of other allied health providers.

⁴ World Health Organisation. Declaration of Alma-Ata. Washington: WHO, 1978.

⁵ National Centre for Epidemiology and Population Health. The Role of Primary Care in Health Promotion in Australia. Report Undertaken by NCEPH for the Commonwealth Department of Health, Housing and Community Services under the National Better Health Program. Canberra: 1991.

A GP is defined by the Royal Australian College of GPs as “a doctor who provides primary, continuing, comprehensive whole-person care to individuals, families and the community”.⁶ The relationship between primary health care and general practice has recently been explored by Rogers and Veale.⁷

In the *Second National Mental Health Plan*, the Australian Health Ministers define **mental health services** as “specialised health services which are specifically designed for the care and treatment of people with mental illness”.⁸ Expanding on this definition, specialist mental health care providers are those providers who are specifically trained to provide care and treatment to people with a mental illness.

The Australian Medical Workforce Advisory Committee Psychiatry Workforce Working Party defines a **psychiatrist** as “a medical practitioner with a recognised specialist qualification in psychiatry trained in the assessment, diagnosis, treatment and prevention of mental and emotional disorders, including physical illness with psychiatric components”.

The term “**shared mental health care**” is not easily defined. The term is used loosely, both in the literature and in practice. In a recent review of the literature on “shared care of illicit drug problems by GPs and primary care providers”, Penrose-Wall, Copeland and Harris define “shared care” as:

... both systemic cooperation, about how systems agree to work together...and operational cooperation at local levels between different groups of clinicians”.⁹

Using this definition as a basis for discussion, the authors point out a difference between “shared” and “collaborative” care. **Collaborative care**, they argue, is described in the literature as being more “general in nature”. They suggest that collaborative care is “oriented towards relationship building” and is perhaps a “precursor” to shared care.

Semantics aside, for the purposes of this review, we have chosen to adopt a definition which is encompassing of both stages. That is, by **shared mental health care** we are referring to collaborative care between GPs and other mental health professionals such as mental health workers, psychologists etc. This includes any of the models of care listed below with the exception of the traditional model. Though within this somewhat broader definition of collaborative care we accept that there is a continuum of activity which could be placed anywhere between low collaboration to close collaboration. The concept of a continuum of collaboration is discussed further in the literature review.

Traditional Model: Referral of consumers by GPs to specialist psychiatrists (SP) who will then provide most aspects of the consumers’ mental health care.

Consultation Liaison Model: Regular consultative activities between GPs and specialist mental health workers such as mental health teams which may or may not

⁶ Royal Australian College of GPs. Policy Number 30, RACGP Council: September 1984.

⁷ Rogers W, Veale B. *Primary Health Care and General Practice: A Scoping Report*. Adelaide: NIS, Department of General Practice, Flinders University, 2000

⁸ Australian Health Ministers. *Second National Mental Health Plan*. Canberra: AGPS, 1998.

⁹ Penrose-Wall J, Copeland J, & Harris M. *Shared Care of Illicit Drug Problems by GPs and Primary Care Providers: A Literature Review*. Sydney: Centre for General Practice Integration Studies, University of New South Wales, 2000.

include a specialist psychiatrist. The specialist mental health team members may provide some direct clinical services with the main aim of providing guidance to the GP.

Liaison Model or Link Worker: A designated position is established to assist GPs with communication and access to mental health services for their consumers, as well as advice on clinical matters. This liaison officer may be a mental health worker, psychiatry registrar or specialist psychiatrist.

Liaison-attachment Model or Shifted Outconsumer Clinic: Visiting psychiatrists or psychologists consult within clinics held in primary care settings such as general practices. In this situation, the consumer's GP would not be involved in the consultation.

Attached Mental Health Professional: Mental health workers working within primary care settings but employed by, and thus being ultimately accountable to tertiary and secondary care service sectors.

Shared Base Model: Physical co-location or sharing of premises. This model does not necessarily result in collaboration beyond the referral process.

Employment Model: The general practice employs a mental health professional to work within the practice. In the UK this might be a trained counsellor or psychologist. In Australia funding structures do not favour this type of arrangement, rather co-location of mental health professionals such as psychologists with general practice is more common.

The following section provides background information useful for an understanding of the development of shared mental health care in Australia. The section is divided into two chapters. Chapter Three provides a review of the policy context including reviews of the National Mental Health Strategy and the General Practice Strategy. Chapter Four is a review of the research literature on the application and effectiveness of shared mental health care.

CHAPTER 3 THE POLICY CONTEXT

Within the global health policy context a number of policy trends have emerged which have resulted in moves towards new modes of health service delivery such as an increased emphasis on continuity of care and the formation of partnerships and alliances between primary, secondary and tertiary health care providers. The movement away from tertiary and secondary models of health care to community-based models has in many instances resulted in GPs being placed at the forefront of health care reform requiring them to enter into new working relationships with a broad range of health service providers.¹⁰ In Australia, mental health is one of the five National Health Goals and Targets¹¹, and is one area of national importance in which service providers, including GPs, are now expected to provide health care in a more collaborative way.

The following section summarises key findings of both international and national research on the prevalence of mental health disorders. This discussion highlights the reasons why the Australian Government has established a national policy position on mental health care and why primary mental health care has become a political priority.

A Global Increase in Mental Health Problems and Disorders

Throughout the 1990's a number of national and international studies^{12,13} identified that mental disorders and mental health problems were far more prevalent and were responsible for far more disease burden than was previously recognised.

As a result of these studies a broader and more clearly understood definition of "serious" mental illness has emerged, based on level of disability rather than just diagnosis. Principal amongst these studies was the 1996 World Health Organisation study into the global burden of disease.¹⁴

The *Global Burden of Disease*" study foreshadowed a significantly different profile of disease burden than that previously expected. For example, the study found that by the year 2020 mental illness would account for 15% of disease burden world wide and that depression would be one of the major leading causes of disease burden, second only to ischaemic heart disease. This represents an approximate 50% increase in prevalence of neuropsychiatric disorders.

Unlike traditional health status studies, which have focused on quantifying the number of deaths due to specific diseases in particular populations, the *Global Burden of Disease*

¹⁰ General Practice Strategy Review Group. *General Practice: Changing the Future Through Partnerships*. Canberra: Commonwealth Department of Health & Family Services, 1998.

¹¹ Nutbeam D, Wise M, Bauman A, Harris E, & Leeder S. *Goals and Targets for Australia's Health in the Year 2000 and Beyond*. Canberra: AGPS, 1993.

¹² Murray CJ & Lopez A. *The Global Burden of Disease*. Harvard: Harvard University Press, 1996.

¹³ Mathers CD, Vos ET, Stevenson CE. The Australian Burden of Disease Study: measuring the loss of health from diseases, injuries and risk factors. *Med J Aust* 2000; 172: 592-596.

¹⁴ Murray CJ & Lopez A. *The Global Burden of Disease*. Harvard: Harvard University Press, 1996.

study reports the findings of research, which examined the impact of death, premature death and disability. A quantifiable measure labelled the "Disability Adjusted Life Year" (DALY) was developed to express the number of years of "life lost to premature death and years lived with a disability of specified severity and duration".¹⁵ This unique combined approach of examining disability and death enabled epidemiologists to categorise depression as a potentially serious mental illness because of the number of years consumers suffering severe depression live with a high degree of disability.

Prior to the *Global Burden of Disease Study*, depression was not identified in Australian policy documents as a serious mental illness. Public sector mental health services were expected to meet the needs of clients with "severe" or "serious" mental illnesses though no clear definition of these terms was provided. In the absence of a clear definition of intended client groups, mental health services developed a mistaken association of "severity with diagnosis rather than level of need or disability".¹⁶ In other words, there was a general trend towards the association of seriousness with the diagnosis of a psychotic illness.

It could be argued that such an outcome, though not explicitly defined, was in fact intentionally constructed and motivated by economic and political decision-making. That is, by structuring a set of inclusion/exclusion criteria for entry into public sector mental health services, policy makers were guarding against the over utilisation of public sector resources. Implicit in this was the understanding that the care of consumers suffering from a high prevalence disorder such as depression or anxiety was the responsibility of private sector service providers such as GPs, private psychologists and psychiatrists.

Two Australian studies conducted in the late 1990s mirrored the findings of the *Global Burden of Disease Study*. The Australian Bureau of Statistics conducted the first study, *The National Profile of Mental Health & Well-being, an audit of Australians' Mental Health* in 1997. This study identified an increasing occurrence of mental illness in Australia with approximately 20% of the population above the age of 18 meeting the criteria for a mental health disorder.¹⁷ This report clearly illustrated an escalating need for appropriate and accessible mental health care in Australia. In 1999, the Australian Institute for Health & Welfare released the findings of its *1998-1999 Australian Burden of Disease Study*. The Australian study used methods employed by the Global Burden of Disease Study to "quantify the loss of health from a comprehensive set of 176 causes of disease injury and for 10 major risk factors".¹⁸ The findings of the *Australian Burden of Disease Study* were as compelling as those of the *Global Burden of Disease Study*. The study found mental health disorders to account for 30% of the national disease burden and depression (8% of disease burden) as the leading cause of non-fatal disease burden in Australia.

¹⁵ Murray CJ & Lopez A. *The Global Burden of Disease*. Harvard: Harvard University Press, 1996.

¹⁶ National Mental Health Strategy Evaluation Steering Committee. *Evaluation of the National Mental Health Strategy: Final Report*. Prepared for the Health Ministers Advisory Council, Canberra: AGPS, 1997.

¹⁷ Australian Bureau of Statistics. *Mental Health and Well-being Profile of Adults*. Canberra: ABS, 1997.

¹⁸ Mathers CD, Vos ET, Stevenson CE. The Australian Burden of Disease Study: measuring the loss of health from diseases, injuries and risk factors. *Med J Aust* 2000; 172: 592-596.

Clearly, the results of these studies have jettisoned depression into a priority area for policy makers and health care providers alike. A mental health disorder, once considered to be of little import to policy makers has now become an area of national concern.

The History of Mental Health Care Reform in Australia

Prior to the early 1990s, Australia did not have a national agenda for mental health policy reform. Mental health service provision, funding, policy and planning were primarily the responsibilities of States and Territories.¹⁹ The majority of mental health consumers, particularly those with what has traditionally been termed “serious mental illness”, were treated in large stand-alone psychiatric hospitals. Throughout this period the role of the GP did not figure highly in the care of mental health consumers.

At the beginning of the 1990s, however, the issues of institutionalisation which characterised mental health policy making during the previous decades and saw the physical and conceptual separation of mental health services from the mainstream health system, gave way to the perception that the deinstitutionalisation of mental health consumers would result in improved health outcomes for consumers and financial outcomes for the health system. This decline in institutionalisation along with a movement to community-based care was fostered through strategic mental health reform and was incorporated as policy in 1992 when the Australian health ministers endorsed Australia's National Mental Health Strategy.²⁰

The National Mental Health Strategy: 1992-1998

Australia's National Mental Health Strategy, which spanned the years 1992 to 1998, was expressed in four major documents:

The Mental Health Statement of Rights and Responsibilities 1991;

The National Mental Health Policy 1992;

The National Mental Health Plan 1992; and

*Schedule F1 of the Commonwealth/State Medicare Agreements 1993-98.*²¹

The National Mental Health Strategy provided a national structure for mental health reform in Australia. The overarching objectives of the Strategy are operationalised through the National Mental Health Policy.

The National Mental Health Policy

The *National Mental Health Policy* enunciates a clear policy framework for the mental health service reforms outlined in the Mental Health Strategy. It is essentially an overarching policy document and its success or otherwise in achieving its vision for

¹⁹ Australian Health Ministers. *National Mental Health Policy*. Canberra: AGPS, 1992.

²⁰ National Mental Health Strategy Evaluation Steering Committee, for the Australian Health Ministers' Advisory Council. *Evaluation of the National Mental Health Strategy: Final Report*, Canberra: Mental Health Branch, Commonwealth Department of Health & Family Services, 1997.

²¹ Australian Health Ministers. *Second National Mental Health Plan*. Canberra: AGPS, 1998.

reform will depend upon the way in which it is interpreted and acted upon by key stakeholders. The Policy defines the broad aims and objectives of the Strategy.

The objectives of the National Mental Health Policy are to:

- promote the mental health of the Australian community;
- where possible, prevent the development of mental disorder;
- reduce the impact of mental disorder on individuals, families and the community; and
- to assure the rights of people with mental disorder.²²

The National Mental Health Plan

In comparison with the National Mental Health Policy, the first National Mental Health Plan was an action plan, which incorporated strategies and performance measures to assist State and Territory Governments with the implementation of the aims and objectives of the National Mental Health Policy. The principal aims of the first National Mental Health Plan were to:

- encourage a national approach to mental health policy and service delivery;
- provide the impetus for reform of mental health services; and
- provide a mechanism for addressing agreed priority issues.²³

Shortly after the introduction of this plan concern for the human rights of people with a mental illness sparked a National inquiry.

National Inquiry into the Human Rights of People with Mental Illness

A National inquiry into the human rights of people with mental illness²⁴, released in 1993, painted a bleak picture for the state of mental health care in Australia. The findings of the Burdekin Commissioners' Report showed that mental health consumers were denied their basic rights and services, suffered a high degree of discrimination, and were severely disadvantaged. The Commissioners recommended an increase in community-based mental health care, collaboration across all sectors of the health system including the private sector, and the establishment of a set of national standards for mental health care.²⁵

²² Australian Health Ministers. *Second National Mental Health Plan*. Canberra: AGPS, 1998.

²³ Australian Health Ministers. *National Mental Health Plan*, Canberra: AGPS, 1998.

²⁴ Burdekin Commissioners' Report. Human Rights and Equal Opportunity Commission Human Rights and Mental Illness. *Report of the National Inquiry into the Human Rights of People with Mental Illness*. Canberra: AGPS, 1993.

²⁵ Burdekin Commissioners' Report. Human Rights and Equal Opportunity Commission Human Rights and Mental Illness. *Report of the National Inquiry into the Human Rights of People with Mental Illness*. Canberra: AGPS, 1993.

Under supply and Maldistribution of Specialists

A major Australian study by McKay and Associates into the specialist psychiatry workforce, found Australia suffers from an under supply and maldistribution of psychiatrists.²⁶ A more recent study confirmed the findings of the McKay Report and suggested that little progress had been made in rectifying this situation.²⁷ Both studies found the majority of psychiatrists are located in urban areas, thus creating a severe shortage of specialists in rural and remote Australia. Consumers in urban areas also face difficulties accessing specialist psychiatric care: the majority of psychiatrists are in private practice, have long waiting lists and are costly for the average consumer. Using Australian Institute of Welfare data the Australian Medical Workforce Advisory Committee (AMWAC) reported that 86.1% of the specialist psychiatrist workforce mostly practiced in capital cities. This is in stark contrast to the 4.9% who practiced in a large rural centre and 3.5% who practiced in an “other” rural or remote location.²⁸

Compared with the 23,000 GPs currently practicing in Australia there are only 1,960 psychiatrists. The majority of these psychiatrists provide a direct service to a limited number of consumers. There is compelling evidence indicating a high level of unmet mental health services need in the community. Most consumers select GPs as first line providers of mental health care. Few psychiatrists have departed from direct service provision to consumers to an alternative consultant role supporting GPs by providing advice or assistance with initial assessments.^{29,30} There are significant systemic disincentives within the Medicare Benefits Schedule to their changing their role.

General Practice & Psychiatry Reform Recommendations

Shortly after the McKay review of the psychiatry workforce a study of the primary care psychiatry workforce was conducted. It was during 1996-97 that a strategic alliance was formed between the Royal Australian College of GPs (RACGP) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) through the development of the Joint Consultative Committee on Psychiatry”. This group reviewed possible enhanced roles for GPs in the area of mental health care and the resulting training and support needs for these roles. A report entitled *The Primary Care Psychiatry Report: The Last Frontier* (commonly referred to as the JCC Report), which was released in 1997, confirmed the key role of GPs in Primary Mental Health Care (PMHC). The Councils of both Colleges endorsed the JCC Report. The implications of this report were clear. The traditional system of mental health care was failing to meet consumer need and the

²⁶ McKay B. *Issues and Options: Supplementary Paper: Optimum Supply and Effective Use of Psychiatrists, A Project for the National Mental Health Strategy*, Canberra: AGPS, 1996.

²⁷ Australian Medical Workforce Advisory Committee. *The Specialist Psychiatry Workforce in Australia: Supply and Requirements 1999-2010*. Canberra: AGPS, 1999.

²⁸ Australian Medical Workforce Advisory Committee, *The Specialist Psychiatry Workforce in Australia: Supply and Requirements 1999-2010*. Canberra: AGPS, 1999.

²⁹ Australian Medical Workforce Advisory Committee. *The Specialist Psychiatry Workforce in Australia: Supply and Requirements 1999-2010*. Canberra: AGPS, 1999.

³⁰ McKay B. *Issues and Options: Supplementary Paper: Optimum Supply and Effective Use of Psychiatrists, A Project for the National Mental Health Strategy*, Canberra: AGPS, 1996.

solution lay in a more collaborative approach to mental health care and increased GP training in the diagnosis and management of mental health problems and disorders.³¹

Clearly, the impetus for reform came not only from Commonwealth and State/Territory Governments but also from the medical profession and consumers. The Tolkein Report³² in 1994 advocated reform of the roles of psychiatrists and an acknowledgment of the importance of effective services at the primary care level. Between 1991 and 1997 there were 77 projects funded through Divisions of General Practice that either in part or wholly focussed on mental health partnership development.³³ These were implemented prior to any major governmental policy developments in the area of primary care mental health.

Outcomes of the National Mental Health Strategy

The success of the National Mental Health Strategy in achieving the aforementioned aims was reviewed by the National Mental Health Strategy Evaluation Steering Committee and reported to the Australian Health Ministers Advisory Council (AHMAC) in 1997. Whereas, the Review Committee reported "substantial" or "moderate" progress against many of the objectives under each of these aims it also reported areas of "minor" or "minimal" progress. In particular, little progress was found in the area of improving GPs' attitudes towards specialist mental health service providers or of involving GPs in new modes of mental health care.³⁴ Even though the Review Committee noted that the development of linkages between general practice and mental health services had the potential to significantly improve outcomes for the majority of mental health consumers it found the relationship between these two groups to be "relatively undeveloped in Australia".³⁵ Furthermore, the Final Report highlighted the fact that GPs still reported receiving minimal support from mental health services for the care of their consumers whose diagnoses did not fit the category of "serious mental illness".³⁶

As stated previously, depression has traditionally been disregarded by public mental health services as a "serious mental illness" and therefore, consumers with this

³¹ Joint Consultative Committee on Psychiatry of the Royal Australian College of GPs and the Royal Australian and New Zealand College of Psychiatrists. *Primary Care Psychiatry: The Last Frontier*. Canberra: Commonwealth Department of Health & Family Services, 1997.

³² Andrews G. *The Tolkein Report - A model for matching the available workforce to the demand for services*. Sydney: University of NSW, 1994.

³³ Primary Mental Health Care Australian Resource Centre Electronic Library <http://som.flinders.edu.au/fusa/PARC>

³⁴ National Mental Health Strategy Evaluation Steering Committee, for the Australian Health Ministers' Advisory Council. *Evaluation of the National Mental Health Strategy: Final Report*. Canberra: Mental Health Branch, Commonwealth Department of Health & Family Services, 1997.

³⁵ National Mental Health Strategy Evaluation Steering Committee, for the Australian Health Ministers' Advisory Council. *Evaluation of the National Mental Health Strategy: Final Report*. Canberra: Mental Health Branch, Commonwealth Department of Health & Family Services, 1997, p29.

³⁶ National Mental Health Strategy Evaluation Steering Committee, for the Australian Health Ministers' Advisory Council. *Evaluation of the National Mental Health Strategy: Final Report*. Canberra: Mental Health Branch, Commonwealth Department of Health & Family Services, 1997, p21.

diagnosis have been excluded from receiving care through mental health services. As a consequence, GPs have been left to treat people suffering depressive illnesses with little or no support from public mental health services.³⁷

This practice of mental health services excluding particular consumers from receiving care through the public mental health system based on services' overly narrow definition of what constitutes a "serious" mental illness has been an ongoing major concern for GPs and of more recent concern for mental health policy makers.³⁸

Historically, however, general practice has had little success in gaining access for a broader profile of consumers to public specialist mental health services. As stated previously, mental health services have drawn their inclusion/exclusion criteria from the National Mental Health Policy; a policy which affords priority of services to those consumers with "serious mental illness". According to the Australian Health Ministers this was an "unforeseen consequence" which arose when, in the absence of a stated definition, many services "equated severity with diagnosis rather than level of need and disability".³⁹

A Renewed Mental Health Strategy: 1998-2002

Data from studies such as the *Global Burden of Disease Study*⁴⁰, the *National Profile of Mental Health & Well Being*⁴¹, combined with findings from the review of the National Mental Health Strategy, informed the development of a Second National Mental Health Plan for Australia. The Australian Health Ministers endorsed this Second Plan in July 1998 and the National Mental Health Strategy was concurrently renewed for another five years. Consistent with global health reforms, the content of the Second National Mental Health Plan departs from the first with a movement away from secondary and tertiary levels of care and an increased emphasis on community-based primary mental health care and integration with other sectors.

Second National Mental Health Plan

The Second National Mental Health Plan has three major areas of activity. These are:

- mental health promotion and illness prevention;
- service reform through development of partnerships, and
- quality improvement in service delivery.⁴²

The second of the key areas highlights the Commonwealth's commitment to the integration of mental health with other health services and to the development of strategic partnerships and alliances, which would result in the collaborative, community-

³⁷ Royal Australian College of GPs. *All Things to All People: The GP as Provider of Mental Health Care: Role, Benefits, Problems, Some Solutions*. Toorak: RACGP Victoria Faculty, 1995.

³⁸ Australian Health Ministers. *Second National Mental Health Plan*. Canberra: AGPS, 1998.

³⁹ Australian Health Ministers. *Second National Mental Health Plan*. Canberra: AGPS, 1998, p10.

⁴⁰ Murray CJ, Lopez A. *The Global Burden of Disease*. Harvard: Harvard University Press, 1996.

⁴¹ Australian Bureau of Statistics *Mental Health and Well-being Profile of Adults*, Canberra: ABS, 1997.

⁴² Australian Health Ministers. *Second National Mental Health Plan*. Canberra: AGPS, 1998.

based care of mental health consumers. Particular importance is placed on establishing closer working relationships with GPs. For example, it is stated within the Plan that:

Key strategic alliances will vary according to individual consumer need and preference. However, important partnerships will include: **GPs** [bold in original] who are major service providers for people with mental illness and who assume even greater responsibility in areas of geographic isolation or cultural sensitivity. Productive partnerships are dependent on identifying and addressing funding issues, sharing consumer information, and education and training.⁴³

The commitment of the current Government to enhancing the role of GPs in the provision of mental health care through “productive partnerships” is evident in the development of the National Primary Mental Health Care Initiative.

The National Primary Mental Health Care Initiative

Established under the National Mental Health Strategy in June 1999, the National Primary Mental Health Care Initiative (NPMHCI) is one way the Commonwealth Government is attempting to support GPs in the provision of mental health care.

Coupled with the findings of the national and international research mentioned previously, this initiative was principally a response to the recommendations of the study conducted by the Joint Consultative Committee on Primary Care Psychiatry.⁴⁴ As stated earlier, this study was jointly conducted by the Royal Australian College of General Practice and the Royal Australian and New Zealand College of Psychiatrists. The movement towards primary care psychiatry, then, is not simply a government-initiated process, but is strongly driven from the grass roots by both medical groups.

The NPMHCI has two overarching aims:

- to provide GPs with quality education and training in primary mental health care; and
- to facilitate the development of partnerships between GPs and specialist mental health services – public, private, and non-government.

The initiative is multi-dimensional and includes:

- a National Primary Mental Health Coordinator (from November 2000);
- a national education clearing house on primary mental health care;
- the Primary Mental Health Care Australian Resource Centre (PARC);
- the placement of Mental Health Development & Liaison Officers (DLOs) in all State Based Organisations (SBOs) of Divisions of General Practice from July 1999 to June 2001;
- \$2m “incentive” funding for Divisions of General Practice on a State/ Territory pro rata basis from July 1999 to June 2001; and

⁴³ Australian Health Ministers. *Second National Mental Health Plan*. Canberra: AGPS, 1998, p16.

⁴⁴ Joint Consultative Committee on Psychiatry of the Royal Australian College of GPs and the Royal Australian and New Zealand College of Psychiatrists. *Primary Care Psychiatry: The Last Frontier*. Canberra: Commonwealth Department of Health & Family Services, 1997.

- Identified Coordinators in all State & Territory Mental Health Units.

In April 2001, the Minister for Health & Aged Care approved funding to sustain PARC, the National Coordinator and the Development & Liaison Officer positions for a further two years.

More recently, in its 2001-2002 Federal Budget, the Federal Government approved a further \$120.4 million, for the advancement of primary mental health care in Australia.⁴⁵ At the time of writing, full implementation and structural details of this Budget initiative were yet to be determined. Though yet to be confirmed, it is hoped that this Budget initiative will provide:

- an increase in Medicare Benefits Schedule rebates to appropriately trained GPs for the diagnosis and care of consumers with mental health problems. This means that GPs will be able to undertake longer consultations with consumers presenting with mental health problems without being financially disadvantaged;
- financial assistance to Divisions of General Practice for the development and implementation of quality GP education and training in mental health care;
- improved access for consumers to non-pharmacological care; and
- modification to the Enhanced Primary Care Items under the Medicare Benefits Schedule for case conferencing and care planning between GPs and Psychiatrists.

Depression as a National Priority

As stated previously, depression has been identified as one of the leading causes of disease burden internationally and in Australia.^{46,47} From 1992 to 1996 in the UK, the Royal College of GPs and the Royal College of Psychiatrists jointly developed a National initiative called the *Defeat Depression Campaign*. The campaign was designed to educate the public about depression and improve GPs' skills in the diagnosis and treatment of depression.⁴⁸ Evaluation of the campaign demonstrated significant improvements in community attitude to and experience of depression. However, less positive outcomes were reported regarding the effects of the educational program on GP knowledge.^{49,50}

⁴⁵ Commonwealth Department of Health and Aged Care. *Better outcomes in mental health care, Fact Sheet 2, Budget 2001-2002*, <http://www.health.gov.au/budget2001/fact/hfact2.htm>. 22 May, 2001.

⁴⁶ Murray CJ & Lopez A. *The Global Burden of Disease*. Harvard: Harvard University Press, 1996.

⁴⁷ Australian Bureau of Statistics *Mental Health and Well-being Profile of Adults*, Canberra: ABS, 1997.

⁴⁸ Rix S, Paykel ES, Lelliott P, Tylee A, Freeling P, Gask L, Hart D. Impact of a National Campaign on GP Education: An Evaluation of the Defeat Depression Campaign. *British Journal of General Practice* 1999; 49: (439) 91-91.

⁴⁹ Paykel ES, Hart D, Preist RG. Changes in Public Attitudes to Depression During the Defeat Depression Campaign. *British Journal of Psychiatry* 1998; 173: 519-522.

In Australia, it was not until 1997 that depression became of National interest⁵¹. It was then that depression was identified as the mental health focus of the National Health Priority Areas (NHPA) Initiative and an expert drafting group was commissioned by the National Health Priority Committee to write a report on Depression. The report, *National Health Priorities Areas Mental Health: A Report focusing on Depression* was endorsed by the Australian Health Ministers' Conference in August 1999. It was this report that led to the development of a draft Depression Action Plan for Australia.⁵²

Draft Depression Action Plan

A draft National Action Plan for Depression has been developed under the National Mental Health Strategy. This followed the development of the *National Health Priority Area Report on Depression*. The draft Depression Action Plan provides an implementation framework for mental health promotion, literacy, early intervention strategies, and primary, secondary and tertiary interventions. The plan also provides recommendations for future research and will provide a framework for action by the National Depression Initiative.⁵³

National Depression Initiative

On March 14, 2000, the Commonwealth announced the establishment of the National Depression Initiative. The National Depression Initiative, jointly funded by the Commonwealth and Victorian Governments, is seeking further funding from the corporate sector and from other State/Territory Governments. The main aims of the initiative are to:

- increase community awareness of depression and reduce stigma and discrimination;
- enhance professional training and development;
- support research into prevention, treatment and management approaches;
- enhance access to services; and
- promote partnerships across the health sector and in other sectors.

In the first twelve months of implementation, the National Depression Initiative will focus on having a "major impact on mental health literacy" and creating "major improvements

⁵⁰ Rix S, Paykel ES, Lelliott P, Tylee A, Freeling P, Gask L, Hart D. Impact of a National Campaign on GP Education: An Evaluation of the Defeat Depression Campaign. *British Journal of General Practice* 1999; 49: (439) 91-91.

⁵¹ Commonwealth Department of Health & Aged Care & The Australian Institute of Health & Welfare. *National Health Priorities Areas Mental Health: A Report focusing on Depression*. Canberra: AIHW, 1998.

⁵² Commonwealth Department of Health & Aged Care & The Australian Institute of Health & Welfare. *National Health Priorities Areas Mental Health: A Report focusing on Depression*. Canberra: AIHW, 1998.

⁵³ Commonwealth Department of Health & Aged Care. *Draft Depression Action Plan*. Canberra: Commonwealth Department of Health & Aged Care, 1999.

in general practice by having more GPs who are skilled in identifying and treating depression”.⁵⁴

The preceding section has provided evidence of current reforms in the Australian mental health care system and the new focus on primary mental health care. The events, studies and reports, which have influenced such reform, are listed chronologically in Table 1.

Table 1 Chronology of major reform events in Australian mental health care

Year	Event / Research Study / Report
1991	The Mental Health Statement of Rights and Responsibilities 1991
1992	National Mental Health Policy
1992	National Mental Health Plan
1993	Human Rights and Equal Opportunities Commission Report of the National Inquiry into the Human Rights of People with Mental Illness
1993	Burdekin report
1996	Global Burden of Disease Study
1996	McKay Report into the Specialist Psychiatric Workforce
1997	The Mental Health of Australians: Profile of Adults Study
1997	Australian Health Ministers identify depression as focus of the National Health Priority Areas Initiative
1998	Second National Mental Health Plan
1998	The Joint Consultative Committee Report on Primary Care Psychiatry
1999	National Health Priority Areas 1998 Report, Mental Health: A Report Focussing on Depression
1999	The National Primary Mental Health Care Initiative
1999	Draft National Depression Action Plan
2000	The National Depression Initiative
2000	The Australian Burden of Disease Study
2000	Review of Supply and Requirement of Specialist Psychiatry Workforce in Australia
2001	Federal Budget allocation of \$120.4 million for primary mental health care.

Paralleling the reform movement in mental health care towards greater collaboration with other sectors of the health system and an increasing emphasis on primary care,

⁵⁴ beyondblue: the National Depression Initiative. *Newsletter*, 01, November 2000, Hawthorn West: National Depression Initiative, 2000.

significant reforms have also been proposed by both the profession and government under an evolving General Practice Strategy. It is to a discussion of the restructuring of general practice that the paper now turns.

The History of the Restructuring of General Practice in Australia

Current government policy conveys the view that a more effective and responsive health system would be achieved through closer collaboration with general practice.⁵⁵ Historically, general practice has tended to operate on the periphery of the public health system in Australia with the majority of GPs delivering health care to their consumers in reasonably autonomous and individualistic ways.⁵⁶ The relationship between GPs and their specialist colleagues has in many instances been an uneasy one. Consequently, reforming general practice to encourage collaboration with the broader health system required a strategic approach by Government.

Evidence of such strategic reform to general practice began to emerge in Australia in 1989 when the Commonwealth Government advocated the need for vocational registration of GPs. This event marked the birth of the "General Practice Strategy".⁵⁷

The General Practice Strategy

Following the emergence of the General Practice Strategy, Mr Brian Howe, the then Federal Minister for Health, released a 1991-92 Budget Paper, which recommended a number of Federal Government micro-economic and structural reforms to general practice.⁵⁸ Howe's Budget Paper provoked a joint response from the Royal Australian College of GPs (RACGP) and the Australian Medical Association (AMA) who, together, rejected many of the Minister's recommendations.

Following protracted negotiations, the AMA, the RACGP and the Commonwealth Department of Health, Housing and Community Services (DHHCS) formed a General Practice Consultative Committee and produced a collaborative report entitled, *The future of general practice: a strategy for the nineties and beyond*. The report focused on four main areas of general practice, (i) quality, (ii) workforce, (iii) integration, and (iv) financing.⁵⁹

⁵⁵ Wooldridge M. *The Government's Response to the Reviews of General Practice: General Practice – Foundations for the Future*. Canberra: Commonwealth Department of Health & Family Services, 1998.

⁵⁶ Knight R. An Overview of General Practice in Australia, in Commonwealth Department of Health & Family Services. *General Practice in Australia*. Canberra: General Practice Branch of the Commonwealth Department of Health & Family Services, 1996.

⁵⁷ General Practice Strategy Review Group. *General Practice: Changing the Future Through Partnerships*. Canberra: Commonwealth Department of Health & Family Services, 1998.

⁵⁸ Howe B. *Health Care in Australia: Directions for Reform in the 1991-92 Budget*. Budget Related Paper No 9, Canberra: AGPS, 1991.

⁵⁹ Department of Human Services & Health, Australian Medical Association, Royal Australian College of GPs, General Practice Consultative Committee. *The Future of General Practice: A Strategy for the Nineties & Beyond*. Canberra: Department of Human Services and Health, July 1992.

The Evolution of Divisions of General Practice

Clearly, a key aim of the report, *The Future of General Practice: A Strategy for the Nineties and Beyond*, was the integration of general practice into the broader health system. In order to reap the benefits of such an integrated health system the Commonwealth Government needed to facilitate this action not only in rhetoric but also with adequate resources. To this end, the Commonwealth funded a number of initiatives in its 1992-93 Budget. Principal amongst these was the allocation of \$1 million to facilitate the establishment of divisions of general practice. Commonwealth funding for divisions of general practice has subsequently grown from \$1million in the 1992-93 financial year to in excess of \$200 million in 2000-2001. As defined by the Commonwealth Department of Health & Family Services, divisions of general practice are:

...a new organisational structure designed to enable GPs to work together, and within the wider health care system, to improve the quality and continuity of care, meet local health needs, promote preventive care and respond rapidly to community health needs.⁶⁰

This Government's intention to integrate general practice into the wider health system is reflected in the above definition and in the sustained funding that Divisions of General Practice have received over its term in office. In 1998, the Minister for Health & Family Services, Dr Michael Wooldridge, reinforced the Commonwealth's commitment to this aim:

It is vital that general practice be more closely involved with other health providers in the provision of high quality care to the community. The Government has identified cooperative work with GPs as a priority area for development in the draft Australian Health Care Agreements.⁶¹

Clearly, Divisions of General Practice represent an ideal organisational structure through which other sectors of the health system can develop collaborative arrangements with GPs. In the case of collaboration with mental health providers, some authors suggest Divisions of General Practice are possibly the "best single organisational link through which collaboration with psychiatric services can be initiated".⁶²

Enhanced Primary Care items and mental health

In November 1999, a suite of Enhanced Primary Care (EPC) Items was introduced under the Medicare Benefits Schedule (MBS). The introduction of the EPC Items meant that GPs could be remunerated for non-consumer contact time spent discussing and planning consumer care with other relevant professionals. The symbolic nature of this development cannot be under estimated.

⁶⁰ Commonwealth Department of Health & Family Services. *National Standards for Mental Health Services*. Canberra: AGPS, 1996.

⁶¹ Wooldridge M. *The Government's Response to the Reviews of General Practice: General Practice – Foundations for the Future*. Canberra: Commonwealth Department of Health & Family Services, 1998, p9.

⁶² Keks N, Altson B, Sacks T, Hustig H, Tanaghow A. Collaboration Between General Practice and Community Psychiatric Services for People with Chronic Mental Illness. *MJA Practice Essentials - Mental Health*. Sydney: Australasian Medical Publishing Company, 1998.

However with the exception of the Health Assessment Item for older people there has been low uptake of the EPC Items. Thus far the only published research into this initiative was from data drawn early in 2000.⁶³ It is worth noting that most people with mental health problems and/or disorders do not need complex multi-disciplinary care and therefore do not come under the potential benefits of the EPC items as they currently stand. However it would appear that for people with chronic and complex mental disorders, the care planning and case conferencing items might be very relevant.

Case conferencing is difficult to coordinate. When GPs attempt to communicate with other private providers who are not remunerated for non-consumer contact time the difficulties multiply. There is some potential for the involvement of GPs [as contributors] in discharge case conferences when people are discharged from in-consumer services.

Care planning may be more applicable over time as the contemporaneous input of the different care providers is not required. However as outlined above there may be little spare GP capacity to spend the time to formulate care plans in a pro-active sense when the current workforce is already extended. Even if substantial aspects of the care planning process are devolved to other practice based staff, there is still considerable extra work for the GP.

On a more academic level there is little evidence at the moment that care planning in the Australian context improves consumer outcomes. Care planning may represent an intuitively better way to carry out care but improved outcomes have yet to be demonstrated. The recent coordinated care trials have demonstrated that other self-evident ways of managing care such as care coordination for those with complex needs do not always improve outcomes in the Australian context.

Summary

The general thrust of the key policies, reports and government directives on mental health and general practice reforms, discussed in this chapter, is toward the development of collaborative and integrated ways of delivering health care and an increasing emphasis on primary care.

Whilst the Government's commitment, in both financial and philosophical terms, to a more integrated health system and its desire to incorporate general practice into such a system is explicit in national policy documents and reports, this does not automatically imply that GPs and specialist mental health service providers will passively accept their newly proposed identities and collaborative ways of working. A number of studies^{64,65} suggest that the development of effective relationships between different groups lie at the core of successful collaborative programs.

⁶³ Blakeman T, Harris M, Comino E, Zwar N. Implementation of the enhanced primary care items required ongoing education and evaluation. *Australian Family Physician* 2001; 30: 75-77.

⁶⁴ Welch M, Philip T, Aldridge G, Fisher H, & Cross M. First, Build the Foundations: Practical Considerations in GP-Mental Health Service Liaison. *Australian Health Review* 2000; 23: 52-63.

⁶⁵ Kanter R. Collaborative Advantage: The Art of Alliances. *Harvard Business Review* July-August 1994; 96-108.

Health policy implementation is a complex process where health care providers engage in struggles, and develop different interpretations and responses to policies developed by Government. This is particularly true when integration involves two different sectors of the health system such as mental health and general practice, which are affected by two distinct sets of policies (though both advocating integration), two distinct funding/remuneration systems and different priorities and imperatives. Even so, it could be argued that these documents and policies have created powerful structural frameworks for changes to the health system: a system within which mental health service providers and GPs must work.

Nonetheless, the policy context, whilst important, is simply that, the context. In order to be successful collaborative care requires a range of others factors to be in place including adequate funding, resources, skill development, attitudinal change and a shared philosophy across collaborating organisations.⁶⁶

The following Chapter provides an overview of the literature, which highlights the importance of these and other factors that contribute to the development and sustainability of effective shared mental health care. In essence, it provides a commentary on the degree to which mental health reform policy has been implemented.

⁶⁶ Doherty W, McDaniel S, Baird M. Five Levels of Primary Care/Behavioural Healthcare Collaboration. *Behavioural Healthcare Tomorrow* October 1996; 25-28.

CHAPTER 4 REVIEW OF THE LITERATURE

Much of the research into shared mental health care in Australia has been undertaken in the past 15 years. Prior to the late 1980's, there was some focus on the education and training of GPs in the diagnosis and management of mental disorders but little research was done across sectors addressing organisation and workforce issues. This picture is consistent with the history of policy development described in Chapter One.

However, a different picture is evident in the International literature, particularly in the United Kingdom, where collaborative approaches to mental health care were reported as early as the 1960's.⁶⁷ This international work is clearly very important in contributing to our knowledge of collaborative models of mental health care. To explain why the uptake of shared mental health care commenced so early in the United Kingdom, it is essential to set the United Kingdom experience within a wider context. First, most psychiatrists in the UK work in the public sector and therefore are not constrained by a fee-for-service structure. Second, under the National Health Service in 1948 general practice underwent a series of broad reforms. These reforms resulted in the registration of consumers with specific GPs and a change in the way in which GPs were remunerated. Under this system, GPs moved from a direct fee-for-service model to one of capitation based funding and eventually local fund holding. These reforms resulted in the widespread development of group practices, and the employment by the practices of staff from a range of disciplines, including mental health.⁶⁸ The structure of the group practices and the funding implications made collaboration with the public specialist sector reasonably accessible.

Though initially isolated in nature, these earlier examples of collaboration in the UK soon became commonplace. For example, a survey of all consultant psychiatrists in England and Wales listed in the 1981 Medical Directory found approximately one in five spent some time working in general practices.⁶⁹ It is worth noting that the majority of these liaison-attachment arrangements were initiated by individuals and not by organisations. Benefits identified by the psychiatrists included professional satisfaction, improved liaison, earlier referral, prevention of hospital admissions and greater collaboration with GPs.⁷⁰ Strathdee and Williams reported a generally high level of enthusiasm and commitment of participants. However, they reported that two thirds of the psychiatrists provided this service in addition to their normal work⁷¹ and argued that this lack of dedicated resources for psychiatrists to work in primary care would almost certainly jeopardise long-term sustainability. Drawing on this earlier work, a further study into

⁶⁷ Kaeser A Cooper B. The Psychiatric Consumer, The GP, and the Outconsumer Clinic: An Operational Study and a Review. *Psychological Medicine* 1971; 1: 312-325.

⁶⁸ Meadows G, Nelson K, Wilhelm K. A Conceptual Model for Containing Approaches to Collaborative Work in Primary Mental Health Care. Ed. P. Ellis, Geigy Psychiatric Symposium: Shared Care, Castle Hill: Novartis Australia, 1999.

⁶⁹ Strathdee G, Williams P. A Survey of Psychiatrists in Primary Care: The Silent Growth of a New Service. *Journal of the Royal College of GPs* 1984; 34: 615-618.

⁷⁰ Strathdee G, Williams P. A Survey of Psychiatrists in Primary Care: The Silent Growth of a New Service. *Journal of the Royal College of GPs* 1984; 34: 615-618.

⁷¹ Strathdee G, Williams P. A Survey of Psychiatrists in Primary Care: The Silent Growth of a New Service. *Journal of the Royal College of GPs* 1984; 34: 615-618.

these collaborative arrangements confirmed that many had not been sustained beyond initial implementation.⁷²

Even though in recent years there has been a significant increase in the number of studies reporting on shared mental health care, two distinct but related streams to the literature remain (i) GP education/training, and (ii) collaborative models of mental health care.⁷³ These themes resonate strongly with the key strategies and recommendations put forward by the Joint Consultative Committee on Psychiatry for enhanced GP training in mental health care and improved integration between the primary and secondary sectors.⁷⁴

Levels of Collaboration

What is probably most important in examining shared care/partnerships /collaborative care is the types of relationships that exist between providers themselves and between providers and their clients or consumers. The types of activities engaged in are an important indicator of the level of engagement. The specific arrangements often develop in an opportunistic manner and reflect local resources, personalities and cultures.

It is possible to engage in collaborative activities irrespective of the local environment. For example, a Division of General Practice and a Mental Health Service that meets to discuss the possibility of working collaboratively, is in fact already collaborating. However, collaboration is much harder to sustain unless a culture of collaboration is developed within both organisations/groups at all levels. In this sense, collaboration can be viewed on a continuum from minimal collaboration through to close collaboration in a fully integrated system.

An example of minimal collaboration would be the exchange of letters regarding consumer care between a GP and a psychiatrist. A number of studies have found that at this end of the continuum, the quality of information contained in the letters is variable and the exchange of written information occurs irregularly.^{75,76} At the opposite end of the continuum, an example of close collaboration in a fully integrated system would be where a Division of General Practice and a Mental Health Service have in place a set of agreed standards and protocols, which form the basis of a Memorandum of Understanding (MoU). There would be evidence of regular on-site visits and team meetings. Here, the MoU would not simply be about clinical care but importantly it would also clearly outline how both groups would contribute to the sustainability of a culture of

⁷² Gask L, Sibbald B, Creed F. Evaluating Models of Working at the Interface Between Mental Health Services and Primary Care. *British Journal of Psychiatry* 1997; 170: 6-11.

⁷³ Tobin M, Norris G. Mental Health and General Practice: Improving Linkages Using a Total Quality Management Approach. *Australian Health Review* 1999; 21: (2) 100-110.

⁷⁴ Joint Consultative Committee on Psychiatry of the Royal Australian College of GPs and the Royal Australian and New Zealand College of Psychiatrists. *Primary Care Psychiatry: The Last Frontier*. Canberra: Commonwealth Department of Health & Family Services, 1997.


⁷⁵ Bindman J, Johnson S, Wright S, Szmukler G, Bebbington P, Kuipers E, Thornicroft G. Integration Between Primary and Secondary Services in the Severely Mentally Ill: Consumers' and GPs' Views. *British Journal of Psychiatry* 1997; 171: 169-174.

⁷⁶ Pullen I, Yellowlees A. Is Communication Improving Between GPs and Psychiatrists. *British Medical Journal* 1985; 290: 31-33.

collaboration. Such a culture of close collaboration would recognise and value the roles and expertise of individual providers and the way in which their skills would contribute to a well functioning team. All providers would feel valued and supported in this structure. Consumers would experience continuous and quality care and joint funding structures would be in place.

A more comprehensive description of this continuum of collaboration is presented in Table 1 Clearly, Level 3, as depicted in the table is about systemic and organisational change. It is fair to say that there is a great deal more systemic change that needs to occur before we attain this high level of sustainable collaboration between primary and secondary mental health care providers in the Australian setting.

Table 2 Level of engagement of divisions with shared care

	Types of activities	“Level” of engagement
Increasing degree of engagement 	Discussions between Divisions and relevant mental health services. Workforce and service planning and recruiting.	1
	Development of tools for communication, better referral processes, better discharge processes.	2
	Development of protocols for management of psychiatric emergencies. Delineation of roles and responsibilities.	3
	Structured shared care programs.	4

Evaluation

Much of the research and evaluation of collaborative programs in Australia has focused on process issues such as identifying the necessary elements of, challenges and barriers to genuine collaboration. Few shared care programs have been formally

evaluated with regard to clinical outcomes.^{77,78} It could be argued that this focus on measuring process suggests that, in the Australian context at least, we are still attempting to move from Level 3 collaboration to Levels 4 & 5. Though, there are a number of exceptions.

The CLIPP program in Melbourne is currently being evaluated extensively using client/consumer outcomes. This yet to be published evaluation has found that there has been no deterioration of quality of life and health status as clients have moved from care solely by the specialist mental health service to shared care by the GP with support by the mental health service. However the evaluation has found a high level of carer burden with clients in both systems of care.

Client outcomes were measured also through a number of collaborative programs in Queensland. A shared care program implemented jointly by the Logan-Beaudesert Mental Health Service and the Logan Area Division of General Practice in Queensland employed outcome measures such as the Life Skills Profile; Positive and Negative Symptoms Scale; and the SF-36 to compare the mental health of clients pre- and post-intervention. The Queensland Centre For Schizophrenia Research was contracted to evaluate the program. The evaluation found that the shared care program did not significantly change the mental health outcomes of the shared clients. Outcomes following transfer to the shared care project were equivalent to previous standard treatment as judged on measures related to mental health, physical health, days in hospital and contacts with the case manager. Overall a trend in reduction of intensive care was observed and the inability to attach statistical significance to this is in part due to the small sample size and brief observation period.⁷⁹

A second Queensland program that is measuring clinical outcomes is a collaborative mental health care initiative between the Queensland Divisions of General Practice and Queensland Health. This is a statewide initiative inclusive of rural, provincial and metropolitan pilot sites. The metropolitan site, which spans four Divisions of General Practice and four Mental Health Services, is measuring the mental health status of shared clients at three-monthly intervals.⁸⁰ The metropolitan pilot is based, to a large degree on the CLIPP Program developed by Dr Graham Meadows.

In many instances, Divisions of General Practice themselves have approached the task of evaluating mental health programs with trepidation. They recognise the importance of evaluating programs but are often at a loss to know which clinical outcomes to measure or how to measure them. Evaluation of health care system changes is difficult

⁷⁷ Keks N, Altson B, Sacks T, Hustig H, Tanaghow A. Collaboration Between General Practice and Community Psychiatric Services for People with Chronic Mental Illness. *MJA Practice Essentials - Mental Health* Sydney: Australasian Medical Publishing Company, 1998.

⁷⁸ Shepard M. Primary Care Psychiatry: Health Services Research is Not Enough. *British Journal of Psychiatry* 1995; 166: 1-3.

⁷⁹ Wild S, Davies J, McGrath J, Groom G. Sharing the Care of Existing Clients of a Local Mental Health Service with GPs – A Pilot Study. Brisbane: Unpublished Paper, 2001.

⁸⁰ King R. General Practice and Psychiatry Partnerships Program, Draft Report. Brisbane: University of Queensland, 2001.

methodologically and requires adequate time frames and resources.⁸¹ Dissemination of research findings can be difficult as well. The Primary Mental Health Care Australian Resource Centre (PARC) has been developed to try to assist Divisions and Mental Health Services with accessing these types of information.

Barriers to Collaboration

Many commentators note significant barriers to the involvement of GPs in the provision of effective mental health care.^{82,83,84,85} According to Hickie⁸⁶ such barriers include consumer, doctor and service related factors. The consumer factors he identifies include the stigma associated with health problems, the fact that many consumers have a complex combination of physical and mental health problems and many present to their GP with somatic rather than psychological symptoms. Clearly, the consumer factors identified by Hickie are important when considering how they might impact on the ability of GPs to effectively diagnose and treat mental health problems and disorders, however, these factors do not necessarily pose barriers to collaborative care. Factors that do pose a barrier to collaboration, however, are those Hickie has identified as doctor and service related factors. These include lack of GP skills in the diagnosis and management of mental health problems and disorders, insufficient time, remuneration and specialist support for GPs.

Appleby and her colleagues conducted a series of 12 focus groups with GPs and non-GP primary health care providers in Australia to examine the barriers and solutions to effective collaboration.⁸⁷ Focus group participants perceived the main barriers to collaboration were (i) the split between Commonwealth and State funding of health care and the associated territorial disputes, (ii) the “manner in which the GP’s role is currently defined”, and (iii) the financial and time constraints for GPs inherent within the current Medicare Benefits Schedule.⁸⁸

⁸¹ Commonwealth Department of Health and Aged Care. Interim Report for Evaluation of Coordinated Care: 1999. Canberra: Commonwealth Department of Health and Aged Care. 1999.

⁸² Phongsaven P, Ward J, Oldenberg B, Gordon J. Mental Health Care Practices and Educational Needs of GPs. *Medical Journal of Australia*, 1995; 162: 139-142.

⁸³ Hickie I. Primary Care Psychiatry is not Specialist Psychiatry in General Practice. *Medical Journal of Australia* 1999; 170: 171-173.

⁸⁴ Carr V, Reid A. Seeking Solutions for Mental Health Problems in General Practice. *Medical Journal of Australia* October 1996; 165: (21) 435-436.

⁸⁵ Appleby NJ, Dunt D, Southern DM, Young D. General Practice Integration in Australia. *Australian Family Physician* 1999; 28: (8) 858-863.

⁸⁶ Hickie I. Primary Care Psychiatry is not Specialist Psychiatry in General Practice. *Medical Journal of Australia* 1999; 170: 171-173.

⁸⁷ Appleby NJ, Dunt D, Southern DM, Young D. General Practice Integration in Australia. *Australian Family Physician* 1999; 28: (8) 858-863.

⁸⁸ Appleby NJ, Dunt D, Southern DM, Young D. General Practice Integration in Australia. *Australian Family Physician* 1999; 28: (8) 858-863.

Blewett also draws our attention to the problems inherent in a health system funded by State and Commonwealth Governments. "Nine separate health administrations for 18 million people", he points out, complicates the process of health care reform.⁸⁹

Communication and Relationships

The case for improving relationships between GPs and specialist mental health care providers is well established.^{90,91} As stated previously; it is possible to engage in collaborative activities irrespective of the local environment. An example of this in the Australian context is where private psychiatrists work within general practices in a consultation liaison role; the problem is that they are often disadvantaged financially by doing so.

Collaboration is much harder to sustain unless a culture of collaboration is developed within both organisations/groups. It is essential for GPs and mental health specialists to have the opportunity to get to know each other well in order to build trust and improve communication.^{92,93} This type of trust and relationship building needs to occur across all levels of the service. Indeed, the development of relationships underpinned by effective communication is identified as an essential component of effective collaboration.^{94,95}

Dissatisfaction with communication from mental health services is commonly reported by GPs, particularly regarding a lack of information around consumer discharge from hospital or a change in consumer management.^{96,97,98} A study of traditional mental

⁸⁹ Blewett N. The Politics of Health. *Australian Health Review* 2000; 23: (2) p13.

⁹⁰ Davies J, Ward W, Groom G, Wild A, Wild S. The Case-Conferencing Project: A First Step Towards Shared care Between GPs and A Mental Health Service. *Australian & New Zealand Journal of Psychiatry* 1997; 31: 751-755.

⁹¹ Mitchell A. Psychiatrists in Primary Care Settings. *British Journal of Psychiatry* 1985; 147: 371-379.

⁹² Paulsen RH. Psychiatry and Primary care as neighbors: From the promethean primary care physician to multidisciplinary clinic. *International Journal of Psychiatry in Medicine* 1996; 26: (2) 113-125.

⁹³ Keks N, Altson B, Sacks T, Hustig H, Tanaghow A. Collaboration Between General Practice and Community Psychiatric Services for People with Chronic Mental Illness. *MJA Practice Essentials - Mental Health*. Sydney: Australasian Medical Publishing Company, 1998..

⁹⁴ Doherty W, McDaniel S, Baird M. Five Levels of Primary Care/Behavioural Healthcare Collaboration. *Behavioural Healthcare Tomorrow* October 1996; 25-28.

⁹⁵ Keks N, Altson B, Sacks T, Hustig H, Tanaghow A. Collaboration Between General Practice and Community Psychiatric Services for People with Chronic Mental Illness. *MJA Practice Essentials - Mental Health*, Sydney: Australasian Medical Publishing Company, 1998.

⁹⁶ O'Connor N, Willcock S. Shared care model of mental health care: Idealism meets reality, in *'Weaving the Threads Together'*, THEMHS conference proceedings, Standard Publishing House, 1997; 233-241.

⁹⁷ Oxman TE. Geriatric Psychiatry at the interface of CL psychiatry and primary care. *International Journal of Psychiatry in Medicine* 1996; 26: (2) 145-153.

⁹⁸ Bindman J, Johnson S, Wright S, Szmukler G, Bebbington P, Kuipers E, Thornicroft G. Integration Between Primary and Secondary Services in the Care of the Severely Mentally Ill: Consumers' and GPs' Views. *British Journal of Psychiatry* 1997; 171: 169-174.

health care in London⁹⁹, found a strong correlation between poor communication from mental health care providers about consumer care and low GP satisfaction. An earlier British study compared the attitudes of GPs who had links with the mental health care system and those who did not. Those with closer links were more likely to have made a referral to a mental health service and were generally satisfied with the treatment provided.¹⁰⁰

Participants involved in a shared care program in Queensland, report benefiting from increased communication between GPs and staff of a mental health service.¹⁰¹ Regular contact through this program improved relationships and enabled better consultation and collaboration to occur. The shared care program was seen as a positive and rewarding experience for all service providers. Case-conferencing was carried out in the lead up to the program along with an orientation day. Regular review meetings helped to sustain a culture of collaboration.¹⁰² There was a change in attitudes of all service providers from one of apprehension to one of trust. GPs stated that they were more confident in treating consumers with a mental illness. The role of case manager developed during the project as a liaison and resource person who could be contacted when difficult or crisis situations arose, as well as someone who could manage the follow-up care for clients.¹⁰³

Poor communication between GPs and a mental health service was one of the precipitating factors for the establishment of a collaborative program in NSW between the Southern Area Mental Health Service and the South-East New South Wales Division of General Practice.¹⁰⁴ This initiative resulted in the development and implementation of a set of basic standards regarding effective communication, referral and discharge, shared care, education and training and strategic planning. Preliminary findings included the development of an MoU between the Service and the Division, increased and improved contact between GPs and the mental health service regarding consumer care, and the development of a GP training program.¹⁰⁵

⁹⁹ Bindman J, Johnson S, Wright S, Szmukler G, Bebbington P, Kuipers E, Thornicroft G. Integration Between Primary and Secondary Services in the Care of the Severely Mentally Ill: Consumers' and GPs' Views. *British Journal of Psychiatry* 1997; 171: 169-174.

¹⁰⁰ Thomas RVR, Forney RH. Working with community mental health professionals: a survey amongst GPs. *British Journal of General Practice* 1993; 43: 417-21.

¹⁰¹ Wild S, Davies J, McGrath J, Groom G. Sharing the Care of Existing Clients of a Local Mental Health Service with GPs – A Pilot Study. Brisbane: Unpublished Paper, 2001.

¹⁰² Wild S, Davies J, McGrath J, Groom G. Sharing the Care of Existing Clients of a Local Mental Health Service with GPs – A Pilot Study. Brisbane: Unpublished Paper, 2001.

¹⁰³ Wild S, Davies J, McGrath J, Groom G. Sharing the Care of Existing Clients of a Local Mental Health Service with GPs – A Pilot Study. Brisbane: Unpublished Paper, 2001.

¹⁰⁴ Welch M, Philip T, Aldridge G, Fisher H, Cross M. First Build the Foundations: Practical Considerations in GP-Mental Health Service Liaison. *Australian Health Review* 2000; 23: (1) 52-63.

¹⁰⁵ Welch M, Philip T, Aldridge G, Fisher H, Cross M. First Build the Foundations: Practical Considerations in GP-Mental Health Service Liaison. *Australian Health Review* 2000; 23: (1) 52-63.

GP Training

The need to improve GPs skills in mental health care is a common theme in the literature.^{106,107,108,109,110,111,112} The level of recognition of mental health problems in general practice, particularly the high prevalence disorders, is sub-optimal. Approximately 44% of mental health presentations fail to attract a psychological diagnosis. This figure rises to approximately 54% for the more severe disorders.¹¹³ GPs have received little training in this area and many primary mental health care interventions are not evidence-based and are unlikely to result in the best possible outcome.

GPs themselves express concerns about their lack of skills in mental health care¹¹⁴ and their capacity to diagnose and treat specific mental health disorders such as the diagnosis of early dementia and aspects of dementia management.¹¹⁵ A review of collaborative approaches to care in the UK reported that by and large GPs wanted education from psychiatrists on the sorts of mental health problems and disorders that they commonly see in general practice¹¹⁶

Indeed, there appears to be little synchrony between the mental health skills acquired by medical students during their training and those needed in general practice.¹¹⁷ This situation has arisen because GPs have acquired most of their practical experience in dealing with mental health problems within psychiatric hospitals/wards where the focus is on the treatment of consumers with low prevalence, high severity conditions such as

¹⁰⁶ Horder J. Working with GPs. *British Journal of Psychiatry* 1988; 153: 513-520.

¹⁰⁷ Davies J, Ward W, Groom G, Wild A, Wild S. The Case-Conferencing Project: A First Step Towards Shared care Between GPs and A Mental Health Service. *Australian & New Zealand Journal of Psychiatry* 1997; 31: 751-755.

¹⁰⁸ Holmwood C. Challenges facing primary care mental health in Australia. *Australian Family Physician* 1988; 28: (8) 716-719.

¹⁰⁹ Hickie I. An Approach to Managing Depression in General Practice. *Clinical Practice* 2000; 173: 106-110.

¹¹⁰ Phongsaven P, Ward J, Oldenberg B, Gordon J. Mental Health Care Practices and Educational Needs of GPs. *Medical Journal of Australia* 1995; 162: 139-142.

¹¹¹ Carr V, Reid A. Seeking Solutions for Mental Health Problems in General Practice. *Medical Journal of Australia* October 1996; 165: (21) 435-436.

¹¹² Goldberg D. Training GPs in Mental Health Skills. *International Review of Psychiatry* 1998; 10: (2) 102-105.

¹¹³ Goldberg D, Huxley P. *Common Mental Disorders: A Bio-social Model*. London: Tavistock Routledge, 1992.

¹¹⁴ Phongsaven P, Ward J, Oldenberg B, Gordon J. Mental Health Care Practices and Educational Needs of GPs. *Medical Journal of Australia* 1995; 162: 139-142.

¹¹⁵ Brodaty H, Draper B, Lie D. Psychogeriatrics and General Practice in Australia. *International Journal of Psychiatry in Medicine* 1997; 27: (3) 205-213.

¹¹⁶ Horder J. Working with GPs. *British Journal of Psychiatry* 1988; 153: 513-520.

¹¹⁷ Goldberg D, Gask L. Improving the Mental Health Skills of GPs. *Supplementary Notes to WPA Learning Package*, London: undated.

Schizophrenia. This scenario is in sharp contrast to general practice where consumers are far more likely to present with high prevalence conditions such as anxiety and depressive illnesses.^{118,119}

Goldberg and Gask make an important distinction between GP knowledge and skill level; they argue that it is mental health care skills, not knowledge, that GPs are lacking.¹²⁰ Primary mental health care training, they advise, should focus on skill development. According to Goldberg, training in communication skills is a priority if GPs are to improve their detection and treatment of mental health problems and disorders.¹²¹

The Joint Consultative Committee of the RACGP and the RANZCP report *Primary Care Psychiatry the Last Frontier* recommended that the medical school curricula address the competencies that are required of generic medical practitioners working in a supervised setting in hospitals. Most of these competencies overlap with those required by GPs working in the primary care setting.¹²² The types of skills that are required at this level would be recognition and initial management of the common mental disorders, basic structured problem solving, grief counselling and skills with breaking bad news, motivational interviewing and brief intervention skills for substance use.

This level of basic skill is not taught in a comprehensive manner across all Australian Medical Schools. It is time that this is revisited to ensure that the chance of greatest educational leverage is not missed. Many Divisions of General Practice are now implementing GP training programs in the diagnosis and management of common mental health problems and disorders as a precursor to more collaborative arrangements.^{123,124,125} Moreover, some Divisions have recognised the need to provide GPs with training relating to process issues such as the function of the local Mental

¹¹⁸ Holmwood C. Challenges facing primary care mental health in Australia. *Australian Family Physician* 1988; 28: (8) 716-719.

¹¹⁹ Kerwick S, Jones R, Mann A, Goldberg D. Mental Health Care Training Priorities in General Practice. *British Journal of General Practice* April 1997; 47: 225-227.

¹²⁰ Goldberg D & Gask L. Improving the Mental Health Skills of GPs. Supplementary Notes to WPA Learning Package, London: undated.

¹²¹ Goldberg D. Training GPs in Mental Health Skills. *International Review of Psychiatry* 1998; 10: (2) 102-105.

¹²² Australian Bureau of Statistics. *Mental Health and Well-being Profile of Adults*. Canberra: ABS, 1997.

¹²³ O'Connor N, Willcock S. Shared care model of mental health care: Idealism meets reality, in *Weaving the Threads Together*, THEMHS conference proceedings, Sydney: Standard Publishing House, 1997; 233-241.

¹²⁴ Wild S, Davies J, McGrath J, Groom G. Sharing the Care of Existing Clients of a Local Mental Health Service with GPs – A Pilot Study. Brisbane: Unpublished Paper, 2001.

¹²⁵ Davies J, Ward W, Groom G, Wild A, Wild S. The Case-Conferencing Project: A First Step Towards Shared care Between GPs and A Mental Health Service. *Australian & New Zealand Journal of Psychiatry* 1997; 31: 751-755.

Health Service and the various roles of staff, and interpretation of legislation relating to mental health.^{126,127}

Fellowships

In New Hampshire the medical school responsible for trainee psychiatrists utilised hospital funding to develop three geriatric psychiatry primary care fellowship programs.¹²⁸ The aim of the program was to give psychiatric registrars greater experience in collaborative health care settings that would ensure that they were sensitised to the needs and issues of the other members of the health care teams. As well as making regular visits to general practices the trainee psychiatrists visited some nursing homes on a regular basis. As a consequence, a number of the aged care facilities have been willing to pay for liaison teaching for their staff to ensure that consumer care is high and that their accreditation standing with the government is enhanced.¹²⁹

Whilst there is no evidence in the Australian setting for trainee psychiatrists to access fellowships to participate in primary care psychiatry programs, there is evidence of scholarship programs for GPs to improve their skills in psychiatry. The Melbourne-based SCCAP project recommended the creation of a GP Fellowship that would enable a GP to work with the Child and Adolescent Mental Health Service (CAMHS) outconsumer team for 6-12 months to gain clinical experience and supervision.¹³⁰ More recently, the Commonwealth Department of Health & Aged Care established a GP Scholarship Scheme for GPs completing a Masters level qualification in general practice psychiatry. GPs enrolled in these academic programs and considered to be "students of good standing" are eligible for a one-off grant of \$1,000.¹³¹ The scholarship scheme is managed by the Australian Divisions of General Practice.

Time & Remuneration

The time constraints of general practice consultations and the associated financial disincentives inherent within the current Medicare Benefits Schedule are major barriers to GPs allocating consultations of sufficient length to deal with mental health problems

¹²⁶ O'Connor N, Willcock S. 'Shared care model of mental health care: Idealism meets reality, in *Weaving the Threads Together*, THEMHS conference proceedings, Standard Publishing House, 1997; 233-241.

¹²⁷ Davies J, Ward W, Groom G, Wild A, Wild S. The Case-Conferencing Project: A First Step Towards Shared care Between GPs and A Mental Health Service. *Australian & New Zealand Journal of Psychiatry* 1997; 31: 751-755.

¹²⁸ Oxman TE. Geriatric Psychiatry at the interface of Consultation-liaison Psychiatry and Primary Care. *International Journal of Psychiatry in Medicine* 1996; 26: (2) 145-153.

¹²⁹ Oxman TE. Geriatric Psychiatry at the interface of Consultation-liaison Psychiatry and Primary Care. *International Journal of Psychiatry in Medicine* 1996; 26: (2) 145-153.

¹³⁰ Luk E, Mildred H, Fisher S, Brann P. Shared care in child and adolescent health. The SCCAP Project, Victoria: Mental Health Branch, DHS, Jan 1998.

¹³¹ Australian Divisions of General Practice. GP Scholarships in Mental Health Care. *Internal Documentation*, Canberra: 2000.

effectively. Poor remuneration rates have been discussed at length by a large number of studies as a significant barrier to GP involvement in mental health care.^{132,133,134,135,136,137} According to Keks et al, case-conferencing is critical for effective consumer care. However a lack of appropriate remuneration for GPs, he argues, negatively impacts on their ability to engage in non-consumer contact activities such as this and therefore, the viability and sustainability of collaborative mental health care programs.

Some shared care and GP training programs have overcome financial barriers by remunerating GPs for time spent in training¹³⁸ and non-consumer contact time.¹³⁹ In addition to remunerating GPs for longer consultations one project ensured that GPs were able to claim up to three hours liaison time, two hours training time and one hour administration per month.¹⁴⁰

The SCCAP Program identified poor remuneration as the most significant obstacle for GPs working with children and adolescents with mental health problems.¹⁴¹

A consortium of key stakeholders in mental health care in Australia¹⁴² drafted a proposal that argued for broad systemic reform to the provision of primary mental health care. A

¹³² O'Connor N, Willcock S. Shared care model of mental health care: Idealism meets reality, in *Weaving the Threads Together*, THEMHS conference proceedings, Sydney: Standard Publishing House, 1997; 233-241.

¹³³ Appleby NJ, Dunt D, Southern DM, Young D. General Practice Integration in Australia. *Australian Family Physician* 1999; 28: (8) 858-863.

¹³⁴ Brodaty H, Draper B, Lie D. Psychogeriatrics and General Practice in Australia. *International Journal of Psychiatry in Medicine* 1997; 27: (3) 205-213.

¹³⁵ Hickie I. Primary Care Psychiatry is not Specialist Psychiatry in General Practice. *Medical Journal of Australia* 1999; 170: 171-173.

¹³⁶ Holmwood C. Challenges Facing Primary Care Mental Health in Australia. *Australian Family Physician* 1988; 28: (8) 716-719.

¹³⁷ Keks N, Altson B, Sacks T, Hustig H, Tanaghow A. Collaboration Between General Practice and Community Psychiatric Services for People with Chronic Mental Illness, Ed, N. Keks & G.D. Burrows, *MJA Practice Essentials: Mental Health*. Sydney; Australasian Medical Publishing Company, 1998.

¹³⁸ Nelson K, Cumming J, Duncanson M, MacEwan V. Policy and practical issues in setting up shared care for people with ongoing needs from mental health services, in THEMHS conference proceedings. Sydney: Standard Publishing House, 1997, 209-214.

¹³⁹ Davies J, Ward W, Groom G, Wild A, Wild S. The Case-Conferencing Project: A First Step Towards Shared care Between GPs and A Mental Health Service. *Australian & New Zealand Journal of Psychiatry* 1997; 31: 751-755.

¹⁴⁰ Nelson K, Cumming J, Duncanson M, MacEwan V. Policy and practical issues in setting up shared care for people with ongoing needs from mental health services in THEMHS conference proceedings, Sydney: Standard Publishing House, 1997, 209-214.

¹⁴¹ Luk E, Mildred H, Fisher S, Brann P. Shared Care In Child And Adolescent Health, The SCCAP Project, Victoria: Mental Health Branch, DHS, 1998.

¹⁴² Groups involved in the consortium include the Australian Divisions of General Practice, the National Depression Initiative, the Royal Australian and New Zealand College of Psychiatrists, the Royal Australian College of GPs, the National Mental Health Council of Australia and the Australian Psychological Society.

key component of the consortium's model is the introduction of a new MBS item for mental health consultations in general practice. Such an item would enable GPs to be adequately remunerated for longer consultations for mental health assessments and specific treatments such as Cognitive Behavioural Therapy, Interpersonal Therapy and Problem Solving Therapy. The proposal was put to the Minister for Health & Aged Care for consideration in the May 2001-2002 Budget. On Tuesday, May 20, the Federal Treasurer confirmed a Federal Budget allocation of \$120.4 million, for the advancement of primary mental health care.¹⁴³

Roles

Role clarification is considered to be an important precursor to the establishment of effective shared care programs.¹⁴⁴ Where roles are poorly delineated problems can occur. Some authors suggest that role and territory disputes can result from the funding and administration of services by different government and private authorities.¹⁴⁵ In this study, allied health providers perceived low rates of referral from GPs as evidence of their fear of losing the overall management of consumers.

In New Hampshire, USA, when a consultation-liaison program was introduced psychiatric registrars expressed concerns about the potential impact of the program on their work and required frequent reassurance regarding the role of GPs in the program.¹⁴⁶

The Hornsby Ku-ring-gai Division of General Practice reported a similar outcome in the Australian context. In recognition of the fact that people suffering from chronic mental health disorders had multiple and complex needs and that facilities to meet these needs are often poorly coordinated, the Division developed a shared care program.¹⁴⁷ However, case managers involved in the program felt that the involvement of GPs in collaborative care might undermine their role as case managers. They also expressed concerns regarding the GPs' skills in managing mental health problems.¹⁴⁸ In response to questions regarding roles and responsibilities, the case managers reported they were happy to take sole responsibility for a large range of issues including friendships, social functioning and daily routine along with symptom monitoring, and routine blood tests.

¹⁴³ Commonwealth Department of Health and Aged Care. Better outcomes in mental health care, *Fact Sheet 2, Budget 2001-2002*, <http://www.health.gov.au/budget2001/fact/hfact2.htm> 22 May 2001.

¹⁴⁴ Dowrick C. Improving Mental Health Through Primary Care. *British Journal of General Practice* 1992; 42: 382-386.

¹⁴⁵ Appleby NJ, Dunt D, Southern DM, Young D. General Practice Integration in Australia. *Australian Family Physician* 1999; 28: (8) 858-863.

¹⁴⁶ Oxman TE. Geriatric Psychiatry at the interface of CL psychiatry and primary care. *International Journal of Psychiatry in Medicine* 1996; 26: (2) 145-153.

¹⁴⁷ O'Connor N, Willcock S. Shared care model of mental health care: Idealism meets reality, in *Weaving the Threads Together*, THEMHS conference proceedings, Sydney: Standard Publishing House, 1997, 233-241.

¹⁴⁸ O'Connor N, Willcock S. Shared care model of mental health care: Idealism meets reality, in *Weaving the Threads Together*, THEMHS conference proceedings, Sydney: Standard Publishing House, 1997, 233-241.

GPs on the other hand, reported feeling comfortable with sole responsibility for physical health issues, medication compliance, family relationships and routine blood tests. The degree of overlap was striking and unless clearly delineated had the potential to lead to misunderstandings.¹⁴⁹

Despite a high degree of support and training of key personnel including 46 GPs and 32 case managers only 37 clients were referred to the project over a two-year period. Along with the low referral rate there were refusals by some clients and carers to participate in the project. The research nature of the project and the associated formal consenting process were perceived as the main obstacles to consumer/carer participation. Evaluation of the program showed that consumers were reluctant to change to a new form of care when they perceived their current treatment as successful and satisfactory, both of which were criteria for recruitment. This also posed a difficulty for GPs who perceived that shared care arrangements were most useful for consumers who were significantly functionally impaired, independent of diagnosis.¹⁵⁰

An adolescent mental health program implemented in Victoria established the importance for GPs and the Child and Adolescent Mental Health Service to form a working alliance to enhance and extend each other's knowledge and skills rather than to reduce treatment options for young people.¹⁵¹ An important stage in establishing this program was the implementation of a seminar, which emphasised planning for collaboration and clarification of roles and responsibilities. The program demonstrated an improvement in GP referrals to the Service.¹⁵²

However, a program that failed to meet its aim of producing a change in collaboration between GPs and the community mental health team indicated that staff and GPs continued to work as parallel providers rather than in collaborative ways.¹⁵³

Little is known in the Australian context about the working relationships between practice nurses and GPs.¹⁵⁴ A research project involving ten GPs and ten practice nurses indicated that the practice nurses' expertise in a variety of areas was not fully utilised due to the current funding model. However, some GPs reportedly were concerned that an expanded role for the nurses would erode their role in delivering holistic care to

¹⁴⁹ O'Connor N, Willcock S. Shared care model of mental health care: Idealism meets reality, in *Weaving the Threads Together*, THEMHS conference proceedings, Sydney: Standard Publishing House, 1997, 233-241.

¹⁵⁰ O'Connor N, Willcock S. Shared care model of mental health care: Idealism meets reality, in *Weaving the Threads Together*, THEMHS conference proceedings, Sydney: Standard Publishing House, 1997, 233-241.

¹⁵¹ Luk E, Mildred H, Fisher S, Brann P. Shared Care In Child And Adolescent Health, The SCCAP Project, Victoria: Mental Health Branch, DHS, 1998.

¹⁵² Luk E, Mildred H, Fisher S, Brann P. Shared Care In Child And Adolescent Health, The SCCAP Project, Victoria: Mental Health Branch, DHS, 1998.

¹⁵³ Nelson K, Cumming J, Duncanson M, MacEwan V. Policy and practical issues in setting up shared care for people with ongoing needs from mental health services in THEMHS conference proceedings, Sydney: Standard Publishing House, 1997, 209-214.

¹⁵⁴ Willis E, Condon J, Litt J. Shared care between practice nurses and GPs. Collaborative Grant Report, Adelaide: Flinders University, 1998.

consumers¹⁵⁵ In their study of general practice integration in Australia, Appleby et al also detected a preference by GPs for particular health professionals, such as nurses, not to expand their traditional roles. Appleby et al went on to explain that GPs lacked an understanding of the skills of other professionals such as nurses and to exclude them from areas traditionally dominated by themselves.¹⁵⁶

Target Groups

In the past, many shared care programs have tended to focus on the care of consumers with serious mental illnesses. This approach has done little to assist GPs with the care of consumers commonly presenting in general practice. Through a combination of consultation liaison and shared care approaches the Consultation Liaison in Primary Care Psychiatry Program (CLIPP) was able to demonstrate benefits to both groups.¹⁵⁷

The consultation-liaison model of mental health care has been identified by a number of studies as a mutually beneficial model to consumers, GPs and psychiatrists.^{158,159} Reported benefits of this model include greater consumer acceptability, improvement in GPs' skills, specialist advice on a broader range of consumers than those traditionally seen in a specialist mental health setting, and the development of collaborative strategies/management plans. The CLIPP Program comprised two specific components; consultation-liaison and shared care. In the first instance, consultation-liaison attachments were set up with several GP practices. This involved a psychiatrist conducting fortnightly consultation-liaison visits to the practices. Where possible, care of the consumers remained with the referring GP. After three months of consultation-liaison, the shared care component of the program was introduced to participating GPs. Approximately 90 clients of the Northwest Area Mental Health Service, were transferred into shared care arrangements with 28 GPs.

In a review of working relationships between GPs and psychiatrists in the UK, the liaison-attachment model, described as "shifting outconsumers", was reported to result in little or no collaboration between GPs and psychiatrists and wasteful of some of the "potential advantages" of collaboration.¹⁶⁰ The same review described the consultation-liaison approach as a more effective and acceptable model to GPs. Benefits of the consultation-liaison model included enhanced GP capacity to deal with psychiatric problems and a more convenient and less threatening environment for consumers.

¹⁵⁵ Willis E, Condon J, Litt J. Shared care between practice nurses and GPs. Collaborative Grant Report, Adelaide: Flinders University, 1998.

¹⁵⁶ Appleby NJ, Dunt D, Southern DM, Young D. General Practice Integration in Australia. *Australian Family Physician* 1999; 28: (8) 858-863.

¹⁵⁷ Meadows G. Establishing a Collaborative Service Model for Primary Mental Health Care. *Medical Journal of Australia* 1998; 168: 162-165.

¹⁵⁸ Horder J. Working with GPs. *British Journal of Psychiatry* 1988; 153: 513-520.

¹⁵⁹ Meadows G. Establishing a Collaborative Service Model for Primary Mental Health Care. *Medical Journal of Australia* 1998; 168: 162-165.

¹⁶⁰ Horder J. Working with GPs. *British Journal of Psychiatry* 1988; 153: 513-520.

These findings were supported in a more recent review of models of collaboration between mental health services and primary care in the UK.¹⁶¹

Within the primary care psychiatry division of the Beth Israel Deaconess Medical Centre in Boston the treatment of many consumers is shared. The psychiatric social workers do the bulk of the psychotherapy and counselling and significant number of initial assessments. GPs and nurse practitioners often provide pragmatic counselling such as advice with decision-making. Skilled psychiatric backup is provided by the hospital-based consultation-liaison psychiatrist who is interested in improving the clinical outcome for consumers in the primary care setting. Collaborative team meetings of members from all disciplines help to provide continuity of treatment and sustain collaboration.

Non-English Speaking Migrants

A report into the barriers for the treatment of people from NESB with mental illness in the primary care settings was released in 1999.¹⁶² Mihalopoulos et al identified the language and cultural differences as well as differing expectations in the way in which consumers should be treated as the main problems for these consumers. This report showed that the lack of integration between the primary care sector and the mental health care sector compounded these problems. It was argued that although shared care programs should help to overcome these communication difficulties they stated that few programs had realised this potential for consumers of NES backgrounds.

One exception is the CLIPP Program, which has been described as enhancing the mental health care of consumers from NES backgrounds.¹⁶³ Through this program bi-lingual GPs were in regular contact with specialist psychiatrists and other mental health workers over the care and treatment of consumers discharged from a local hospital. In order to ensure that communication difficulties did not arise a project officer was employed to act as a facilitator between the various mental health workers involved with the consumers and GPs. Due to the high number of bi-lingual GPs involved in the program, it was possible to match NESB consumers with doctors who could speak the same language. As a consequence, individuals from large Greek or Italian communities were relatively easily matched with a GP; however, this was not the case for people from smaller NESB communities such as people from Somalia.

¹⁶¹ Gask L, Sibbald B, Creed F. Evaluating models of working at the interface between mental health services and primary care. *British Journal of Psychiatry* 1997; 170: 6-11.

¹⁶² Mihalopoulos C, Prikis J, Naccarella L, Dunt D. *The role of GPs and other Primary Care Agencies in Transcultural Mental Health*. Melbourne: Australian Transcultural Mental Health Network, 1999.

¹⁶³ Mihalopoulos C, Prikis J, Naccarella L, Dunt D. *The role of GPs and other Primary Care Agencies in Transcultural Mental Health*. Melbourne: Australian Transcultural Mental Health Network, 1999.

Conclusions Derived from the Literature Review

The review of the literature on shared mental health care has identified several important components to the development and sustainability of effective shared care programs. These are summarised below.

What activities work and are sustainable?

The review highlighted the fact that priority setting in areas such as mental health has been strongly influenced by grass roots advocacy¹⁶⁴ and Commonwealth policies.¹⁶⁵

It was revealed that some divisions of general practice in Australia discontinued or invested fewer resources in shared care mental health programs because of the difficulties associated with demonstrating outcome changes. For instance, a number of programs have been difficult to sustain due to a lack of funding or desired outcomes.

For example, one consultation-liaison program was not sustained because it failed to produce a positive effect on GPs' knowledge, skills levels or consumer outcomes.^{166,167} However, others have reported consultation-liaison models to be mutually beneficial to consumers, GPs and psychiatrists.^{168,169} It seems clear that the appropriate role of community consultation-liaison psychiatry may be as one component of a comprehensive service-delivery strategy integrated within ongoing, formal GP training programs.

Organisational culture was found to be an important factor. The culture of the Divisions of General Practice and mental health service must be congruent for successful collaboration and this takes time and sustained effort. A shared culture and vision must develop. The most successful programs have occurred in the context of strong incentives for GPs and specialist services to share care and involved good personal and professional relationships between key individuals and organisations. Unsuccessful programs appear to have been associated with poor commitment by Divisions of General Practice or specialist services, poor continuity of staff or internal cohesion or 'turf wars' between individuals or organisations.

The findings of one study in the Cochrane database of systematic reviews does not support the hypothesis that on-site mental health workers in the primary care setting

¹⁶⁴ Joint Consultative Committee on Psychiatry of the Royal Australian College of GPs and the Royal Australian and New Zealand College of Psychiatrists. *Primary Care Psychiatry: The Last Frontier*. Canberra: Commonwealth Department of Health & Family Services, 1997.

¹⁶⁵ Harris M, Powell-Davies G. Shared care through divisions of general practice: moving forward. *Medical Journal of Australia* 1999; 171: 85-88.

¹⁶⁶ Carr VJ, Faehrmann C, Lewin TJ, Walton JM, Reid AA. Determining the effect that consultation-liaison psychiatry in primary care has on family physicians' psychiatric knowledge and practice. *Psychosomatics* 1997; 38: (3) 217-29.

¹⁶⁷ Carr VJ, Lewin TJ, Reid AL, Walton JM, Faehrmann C. An evaluation of the effectiveness of a consultation-liaison psychiatry service in general practice. *Australian & New Zealand Journal of Psychiatry* 1997; 31: (5) 714-25.

¹⁶⁸ Horder J. Working with GPs. *British Journal of Psychiatry* 1988; 153: 513-520.

¹⁶⁹ Meadows G. Establishing a Collaborative Service Model for Primary Mental Health Care. *Medical Journal of Australia* 1998; 168: 162-165.

causes a significant or enduring change in primary care provider behaviour. Bower and Sibbald suggest that consultation-liaison interventions may cause changes in psychotropic prescribing, but these seem short-term and limited to consumers under the direct care of the mental health worker.¹⁷⁰

Recruitment and training

Role clarification is considered to be an important precursor to the recruitment of participants and the establishment of effective shared care programs.¹⁷¹ Poor role delineation can perpetuate “turf-war” problems.

Necessary components of a successful mental health care collaboration include the involvement of primary care physicians with an interest in and aptitude for psychiatric issues, delivery of service and training based on an assessment of the primary care provider’s needs.¹⁷²

Programs need to have specific educational elements, elements designed for improved communication and for definition of roles and responsibilities and these need to be complementary but distinct in their intent and design. Without these important components programs are less likely to produce sustainable change.

That non-educational interventions should fail to have educational outcomes is not surprising. As Carr¹⁷³ stated:

‘...community consultation-liaison services in family practice....are not an efficient way for improving family physicians’ levels of psychiatric knowledge or altering their practices’.

In the UK and the Netherlands researchers noted that better psychiatric training of GPs, on-site-consultation and better communication between mental health professionals and GPs can improve the recognition, management and referral of psychiatrically ill primary care consumers.¹⁷⁴

Pathways of care, guidelines and protocols

It is difficult to tease out the individual effective components of mental health service reform as programs are usually complex and have several elements that are evaluated en masse. Inevitably, the availability of resources and the need to ensure adequate reach and relative equity of access will influence which activities are adopted.

¹⁷⁰ Bower P, Sibbald B. On-site mental health workers in primary care: effects on professional practice. *Cochrane database of systematic reviews*, 2000.

¹⁷¹ Dowrick C. Improving Mental Health Through Primary Care. *British Journal of General Practice* 1992; 42: 382-386.

¹⁷² Oxman TE. Geriatric Psychiatry at the interface of CL psychiatry and primary care. *International Journal of Psychiatry in Medicine* 1996; 26: (2) 145-153.

¹⁷³ Carr VJ, Lewin TJ, Reid AL, Walton JM, Faehrmann C. An evaluation of the effectiveness of a consultation-liaison psychiatry service in general practice. *Australian & New Zealand Journal of Psychiatry* 1997; 31: (5) 714-25.

¹⁷⁴ Fletz-Cornelis CM, Lyons JS, Huyse FJ. *International Journal of Psychiatry in Medicine* 1997; 27: (1) 1-21.

However, it is clear that guidelines should:

- clearly articulate roles and responsibilities of GPs and other providers;
- provide clear mechanisms for communication and review;
- define triggers for referral, provide clear procedures for transfer of care to ensure adequate preparations of GP and consumer;
- provide clear advice on management of psychiatric emergencies detailing the responsibilities of respective service providers to consumers, carers and other stakeholders in these situations.¹⁷⁵

Funding and sustainability

Sustainability of collaborative mental health care appears to be dependent on dedicated joint funding arrangements between collaborating organisations. Projects and programs funded through one-off grants are rarely sustained beyond their funding period.

Sustainable and effective shared care programs include those that enable GPs and mental health to:

- work on each other's premises;
- share information about consumers;
- have regular face-to-face meetings about clinical care and intersectoral team development;
- share a common language and funding base; and
- develop agreed standards and protocols which include an understanding of each other's roles and responsibilities.

Without each of these elements in place, collaborative programs are likely to fail to produce quality mental health outcomes and unlikely to be sustained beyond the initial funding period.

¹⁷⁵ Integration Support and Evaluation Resource Unit. From Projects to Programs: Sharing Mental Health Care: A guide for Divisions of General Practice, Sydney: UNSW, 1997.

CHAPTER 5 MENTAL HEALTH SHARED CARE IN DIVISIONS OF GENERAL PRACTICE

Background to Divisions data and reporting processes

The project examined various databases to establish which Divisions of General Practice are active in the mental health shared care area and how the funding and reporting processes for Divisions have undergone major changes over the past three years. From 1993 until 1997 Divisions were funded by the Commonwealth Department of Health and Aged Care by way of project specific grants as well as infrastructure funding. Some well-resourced Divisions with entrepreneurial spirits were very successful in attracting funding for projects; others not so successful.

In 1997 it was decided to develop a more equitable funding arrangement where funds were allocated on a population basis. Divisions were to develop strategic and business plans and report against the outcomes and indicators in these. Hence the term Outcome Based Funding.

Prior to these changes Divisions reported to the Commonwealth through annual reports and project specific reports. These have been compiled by the National Information Service in the *Divisions Projects Database 1993-1997*.

The Mental health related reports have been evaluated and compiled into the PARC Electronic Library (Primary Mental Health Care Australian Resource Centre) This is available on-line at: <http://som.flinders.edu.au/fusa/parc>.

The PARC Electronic Library contains all project reports from 1993 to 1997 as well as other more current relevant educational resources for Primary Mental Health Care.

During the 1998-99 transition from project based funding to outcomes based funding some Divisions piloted the OBF process and they reported through the *Transitional Divisions Database*.

With the advent of Outcomes Based Funding, reporting has been through a standard template based on the fields of a business plan and strategic plan.

These are compiled on the *Activities of Divisions Database*.

This Mental Health Shared Care Review project has searched the following:

The PARC Electronic Library	Divisional activities 1993-7
The Transitional Divisions Database	Divisional activities 1998-9
Activities of Divisions Database	Divisional activities 2000 +

The PARC Electronic Library

This database now includes over 350 resource listings in the mental health and alcohol and other drugs areas that are relevant to primary mental health care. These include the reports from 101 Divisional mental health project reports that were carried out in the period 1991 to 1998. These projects were undertaken in 59 Divisions. Of these 101 projects 24 were of a purely educational nature, the remaining 77 were aimed at

improving the integration of mental health care across the general practice and specialty sectors.

This review did not undertake a detailed analysis of these reports but the PARC electronic library enables access to a wealth of information about the process and outcomes from these earlier activities.

Transitional Divisions Database

This database has no mental health related programs of activity.

Activities of Divisions Database

This database includes all of the Business and Strategic Plans for the period 1999-2000. The database is constructed to include all of the general headings that would be expected in such documents as separate fields. While the different fields have to be individually searched, the searches generally reveal quite rich information that is easy to read and analyse. The quality of the entries is fairly uniform and of a high standard.

The aim of the database is to include data from the yearly reports. These data will report progress against various indicators previously identified in the business plan.

At present, due to difficulties with software agreements, the NIS only has access to only 50 annual reports from the 1999-2000 year . Therefore, this review can not readily access current evaluation progress reports on activities in the mental health area.

Overview of the spectrum of shared care from the AOD database and the Directory of Divisions [1999 data]

There are a broad range of activities within Divisions that have developed to better integrate and coordinate mental health care. It is apparent that there is a continuum level of engagement between general practice and the specialist mental health sector. A discussion of these levels of engagement is presented in the following section.

Level 1 Discussions between Divisions and relevant mental health services. Workforce and service planning and recruiting.

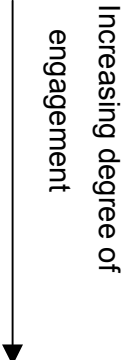
Many Divisions have engaged at this level. As stated above there is a series of requirements for active and effective inter-sectoral integration and in many instances these are not present. In some instances in rural areas there is a shortage of mental health services so the question regarding shared care is "shared with whom?"

In other areas one or either sectors are not interested or prepared to engage in closer collaboration. If both sectors are overstretched through high demand for services and resource shortfalls there is no capacity for innovation and risk taking. If there is substantial mistrust between sectors then collaboration is unlikely to occur.

These activities at this early level represent a first step towards developing relationships between the two sectors. An example of this is where a joint management committee is established with representation from the Division and the mental health service.

From the analysis of the NIS Activities of Divisions Database it appears that approximately 20 Divisions were at this stage of development or were planning activities at this level when the Strategic and Business Plans were developed in 1999.

Table 2 Level of engagement of divisions with shared care

	No. of Divisions	Types of activities	“Level” of engagement
	20	Discussions between Divisions and relevant mental health services. Workforce and service planning and recruiting.	1
	23	Development of tools for communication, better referral processes, better discharge processes.	2
	20	Development of protocols for management of psychiatric emergencies. Delineation of roles and responsibilities.	
		Structured shared care programs.	3

Level 2. Active problem solving. Development of protocols, tools for Communication, clinical pathways, emergency plans, etc

The next tier of engagement represents movement towards practical problem solving. For progress to have been made trust needs to have developed and there needs to be scope for risk taking and innovation.

The degree of activity varies considerably. For example in some rural Divisions in South Australia the collaboration has focused around a multi service approach to the management of emergency psychiatric problems. This agreement included the ambulance service, the police, the regional health services and the Rural and Remote Mental Health Service based in Adelaide. The focus tends to be opportunistic and reflect local resources and areas of strength. From the AOD database it seems that about 23 Divisions were either planning to be or were already involved at this level.

Level 3 *Structured Shared Care Programs*

These types of activity reflect high levels of engagement between GPs, their Divisions and Mental Health Services. From the AOD database it appears that approximately 20 Divisions were either engaged in or were planning activities at this level of structure as of 1999. What can be regarded as “shared care” in this context varies somewhat but the following usually apply:

- There is agreement between groups regarding:
 - roles and responsibilities of each group; and
 - communication.
- There is adequate support for GPs involved and they in turn provide assistance with aspects of consumers’ care that previously were not well attended to e.g. general medical care.
- There are agreed processes for movement of consumers between professionals.
- These movements are based on consumer needs.
- On-site visits are conducted in GP's practices.
- Consultant psychiatrists provide assistance with one off consultations.
- Mental health workers are available for case conferencing and care planning with GPs.

However the degree of engagement within divisions of their GPs is variable. Even the most successful programs involve a relatively small number of GP and there is a need for continued promotion with other GPs.

CHAPTER 6 MENTAL HEALTH DEVELOPMENT AND LIAISON OFFICERS (DLOS) INTERVIEWS

This chapter represents a distillation of opinions as expressed through the interviews with the DLOs. During the interview each DLO was given the opportunity to identify some successful shared care activities occurring within their State/Territory. They were asked to describe what they believed were the essential elements of effective shared care programs. They were then asked to list any barriers that they perceived as obstructing worthwhile outcomes for these initiatives.

Our inquiries then shifted to a series of more specific analytical questions relating to initiatives, programs or projects being undertaken within the State/Territory under review. Each DLO was requested to highlight the types of preliminary work undertaken prior to implementation of any shared care programs and to discuss elements that they believed would make them more effective and sustainable. They were also asked to identify some key people relating to these programs who could be approached to take part in in-depth telephone interviews. At the conclusion of the interview each DLO was asked to deliberate upon the ways in which they saw shared mental health care developing in the future.

Barriers to Shared Care

Ideology as a barrier

A dichotomous relationship between mental health services and mainstream health services including GPs has long existed in Australia. This situation has arisen because, historically, the two services developed in parallel and therefore evolved separate organisational structures and processes for caring for consumers/clients. Therefore, 'there is a high degree of suspicion and animosity between them'. The power relationships, role boundaries and methods of communication that exist between the two groups are thus markedly different. As one DLO succinctly commented:

'GPs don't understand MHS and MHS don't understand the work of GPs there is little understanding of the constraints each is working under and this leads to a mismatch of expectations between the two groups'.

Whereas another DLO commented:

'Mental health services are very much set in tertiary mould. They don't have a primary mental health care framework'.

These differences often lead to both practical and theoretical misunderstandings. For instance, a mental health nurse will sometimes case manage a mental health client. As a consequence, the nurse may be a more appropriate person for the GP to liaise with regarding some aspects of consumer care rather than the Consultant psychiatrist. But this may not be understood, or indeed endorsed, by the GP. As one DLO pointed out:

'GPs send a consumer to the mental health service and they don't understand that they may never see a psychiatrist...that's the way it's set up. Some GPs don't understand the skills of nurses or psychologists nor do they understand their roles'.

'GPs are preoccupied with wanting to see psychiatrists...Even the motivated ones still want access to a consultant psychiatrist'.

Many DLOs felt that the lack of understanding regarding work patterns between the two groups was a focus for tension. Examples included, mental health professionals with little comprehension of the broad health areas that GPs are expected to work across and 'don't understand why they can't just add a little extra time to their consults...which is impossible in rural areas'. On the other hand, mental health professionals complained that they wanted more appropriate and detailed referrals from GPs.

The stigma surrounding the mental health care area was another issue raised by some DLOs. This prejudice meant many consumers were resistant to being diagnosed with a mental health problem. This attitude posed particular problems for some country GPs.

'People can be very resistant to a diagnosis of mental illness and if you are the only GP in town and the consumer is resistant to that diagnosis, where are they going to go for their health care from now on? GPs sometimes want to have the consumer seen, even just once, by someone in mental health services, have the diagnosis made and then go back to the GP'

But as another DLO suggested organising any one-off consultations with psychiatrists also proved to be a challenging exercise:

'It was clear that GPs wanted psychiatrists available for one-off consultations and for phone advice whereas psychiatrists felt that this was too much to expect of them. Psychiatrists felt that it would be extremely tiring to have a stream of one-off consumers and no follow through.'

Mental health workers deal almost exclusively with the mental health care of their clients while GPs are required to treat a vast range of physical problems. This separation of focus can mean a mind/body split for mental health consumers rather than holistic care. One DLO commented that '*mental health clients often have their physical health neglected*'. Also there are cases where GPs are not aware of the mental health issues regarding a consumer and these are left unresolved. Moreover, a number of GPs, particularly those in rural areas, felt unable to adequately address the mental health needs of their consumers if they needed more intense psychological or psychiatric help than they could offer.

Due to these concerns two DLOs argued that:

'The term 'shared care' is a barrier in itself because GPs expectations for support and a high level of involvement cannot be met, the use of the term 'partnerships' therefore overcomes this difficulty...you can't share care if there is no one to share care with'.

'The wait lists are too long so it's been difficult for GPs to think laterally about ways of working when they are so overwhelmed'

These comments lead directly to the next topic on 'time' as a barrier to shared care initiatives.

Time as a barrier

All of the DLOs agreed that time was an important factor in building effective relationships between GPs and people who work within the mental health services. They felt that it took a long period for the two groups to learn to understand and trust one

another so that they could comfortably work together and share consumers/clients. But as time is an expensive and scarce commodity amongst both groups one DLO lamented 'changes are so slow that people may not recognise them'.

In order to develop better rapport mental health service professionals and GPs needed to schedule regular appointment times for meetings. From the GPs (and DLOs) perspective these meetings should be held in general practices to save the GPs time. However, as we will see from the next set of interviews, those working in the mental health teams were not always comfortable with this view.

Length of consultation time is also an important factor for consumers with mental health problems. Sufficient time was needed to counsel consumers in sufficient depth in order to make the consultation meaningful for both parties.

'If the pharmacological intervention is not successful then you are asking GPs to change their practice. You are asking them to look at psycho-social factors as well as medical factors and this takes more time. At the moment there are GPs doing more counselling and getting less income'.

Although the new EPC items will assist GPs financially with additional remuneration for mental health consultations this was considered to be only part of the solution for consumers in regional and remote Australia.

'...I don't think that if you give them (GPs) money they will have more time. In some rural areas there is one GP to 2,500 people. There is a waiting list of three and half weeks in some busy rural centres...so they don't have time to see mental health consumers for longer periods...These GPs want psychologists and allied health professionals on hand...but its also difficult to recruit them for rural areas... Also I don't believe that GPs are supported enough as individual human beings. '

GPs who were working in parts of Australia, which are suffering from economic 'downturns' were often quickly caught within a maelstrom of rapidly developing mental health care issues with their consumers. For instance:

'In one area there is a huge concern because of the economic downturn. Whole families are being made unemployed because of the ripple effect. They are a huge concern for the GPs because the suicide rate climbs and a lot of co-morbidities develop from drug and alcohol use coupled with anxiety'.

Although these GPs can offer some assistance, as economic factors are not within their control, it makes their work time pressured and frustrating.

Structural and procedural barriers

As the structural and process constraints discussed by the DLOs are self-explanatory, rather than describing each in detail they are listed below. Please note that these are the barriers identified through the interviews with the DLOs.

Structural

Many of the Divisions have not usually employed a full-time worker with designated responsibilities regarding shared care arrangements. This makes organising, supporting and co-ordinating these activities difficult. The Divisions sometimes do not see Mental Health as a priority area. The following comments were made:

'Too few GPs are attracted to psychiatric medicine and mental health needs to be marketed better to stimulate more interest'.

'There are too many role boundaries between differing groups of professional health workers, this may lead to some demarcation disputes over the most appropriate worker to undertake a particular task such as case manager.'

'There is sometimes a lack of support for mental health within the State Health Departments'.

'If there is support within the State Health Departments for Mental Health then it is often difficult to push this agenda forward as the health structure itself is too complex which may lead to inertia making health bureaucracies unresponsive to rapid change'.

Outcome based funding is perceived to disadvantage the area of mental health as it is seen that determining and meeting outcomes is more difficult when compared with other, more empirically based services, such as diabetes. This is a further barrier to divisions engaging in mental health activities including shared care.

Procedural

Information Technology systems are mismatched and there is usually no electronic link between GPs and mental health services. Future developments need to ensure confidentiality. There are also:

- few process agreements and Memoranda of Understanding;
- poor feedback systems between GPs and mental health services; and
- little training for other staff working in general practice such as receptionists in the area of mental health. Mental health service clients can therefore feel alienated or discriminated against when visiting a general practice.

Effective Supports For Shared Care Arrangements

Rapport, trust and support

All DLOs considered that ensuring a high level of rapport and co-operation was a mandatory pre-requisite to any successful shared care arrangement. In order to achieve this understanding sufficient time was needed for people from mental health services and GPs to meet together so that they could build effective relationships. This meant that people needed to have time built into hectic work schedules which would allow the two groups to meet together both formally and informally. As one DLO explained '*There needs to be mutual respect and understanding as well as a high level of rapport [between the various groups of health professionals]*'.

From the DLOs' perspective it was important to have a core group of GPs who were interested in mental health with whom to work:

'The big motivator is the GPs' own interest in mental health. Once you have this you need to set in place a support basis for that individual to engage in shared care... GPs sign on to a special interest register here at the Division so that they can be kept informed about developments. Even if you start with only one or two GPs they can become your champions!'

Using this strategy some divisions had identified a few GPs who were paid on a part-time basis to act as a mental health resource people, 'not as experts', for other GPs. In some areas these GPs were acting as educational facilitators whereas in others they were directly helping their colleagues to develop or refine their counselling skills.

GPs themselves they have great rapport with other GPs and know the difficulties experienced in this area....they are also linked together as well (for ongoing support for each other)'. 'We have appointed GPs [as] mental health mentors for the regions for a day a week to work for the divisions. They are employed to work with other GPs.

Some GPs had also formed Balint groups in some urban areas where they could gain support and guidance from their colleagues. Consultant psychiatrists were involved in facilitating some of these groups. Some Balint groups were closed but others had a policy of welcoming new members at any time. As an extension of this successful initiative teleconferencing was also taking place between GPs located in rural and remote parts of some States.

Some DLOs mentioned that a comprehensive 'needs assessment' that canvassed the views of community mental health workers, in-consumer unit staff, GPs and clients should be carried out prior to introducing shared care initiatives. In this way '*cultural differences between GPs, mental health services, [and] private services are acknowledged before people can effectively communicate*'.

Some Divisions have used the creation of a Memorandum of Understandings (MoUs) between Mental Health Services and the local Division of General Practices as a focus to meet with one another and to institute practical changes. '*We are going to do process reviews first, then get together and sort out how we are going to work together*'. As part of this process initiatives such as more informative, and timely, discharge summaries have facilitated easier and more efficient information exchange. Consequently, the actual formulation of an MoU has been the main engine for communication in some divisions.

As communication between GPs and mental health services are not well developed in most areas. Many of the DLOs felt that giving GPs, who had a strong interest in mental health, an opportunity to undertake short term paid work with their local mental health teams was a good strategy for helping to create rapport. This type of initiative facilitates improved mutual understanding of barriers to collaboration and ways in which barriers can be overcome.

Educational Initiatives

Many Divisions throughout Australia had educational seminars and workshops for GPs in specific issues in the area of mental health care. A growing number of these initiatives have included both GPs and mental health staff. In this way people can meet each other and also gain a common understanding of the particular issue being explored.

These educational initiatives have been managed in different ways. For instance at one series of workshops '*mental health services provided the training for GPs and GPs provided mental health services with information about the knowledge they (already) have*'. In a more remote area the two groups were '*looking at having small group discussions around cases but they are also looking at developing this (experience) into content areas*'

A well designed topical and interesting educational program was considered to be a way of engaging GPs and other health professionals. In one region, project staff had used a mixture of training methods. In one region project staff had used a mixture of training methods:

'There is a combination of didactic lecture style presentations about particular diagnostic groups and treatment methodologies followed by specific case discussions presented by local GPs and discussed with a visiting psychiatrist. The best model is one where consent is obtained and an individual is actually assessed in front of GPs so the psychiatrist is undertaking a consultation or a therapy session with the GPs present but [they are] not asking any questions so its not intrusive'.

Case conferences taking place between mental health professionals and GPs had benefited all participants. GPs were upskilled in mental health areas while psychiatrists gained experience by working with a very different type of consumer than those attending mental health services.

'Psychiatrists tend to treat consumers that have been through the entire system and who have been highly categorised whereas in general practice people are presenting who have not been diagnosed with any mental illness and who would be, in many cases, resistant to any such label'.

Other interesting educational exercises, which DLOs mentioned as still evolving at the time of the interview, included developing courses with an Aboriginal college on Aboriginal mental health issues and 'telepsychiatry' where a psychiatrist has a case conference with a group of rural and remote GPs.

Processes Facilitating Shared Care Initiatives

The following processes were identified by the DLOs as elements that facilitated mental health shared care/partnership developments.

- Making sure that people who are involved in managing shared care arrangements have broad experience in working in areas other than mental health care so that they can appreciate various aspects and accommodate disparate views associated with these projects. Moreover, as this work is complex these workers should also have had experience as clinicians in some field such as nursing or social work.
- Good personnel management practices that ensure low turnover and satisfied staff members.
- Having process agreements and 'memorandum of understandings' (MoUs) in place that reflect local policies and practices.
- Having support, follow-up and evaluation mechanisms in place.
- Marketing shared care as a concept to GPs and the wider community.
- Undertaking preliminary work prior to setting up the project such as a needs assessment.
- Conducting on-going education sessions for those interested in being involved in the project.

Structural Changes Facilitating Shared Care Arrangements

The following structures were identified by the DLOs as assisting in the development of successful shared care projects. These are listed below.

- Ensuring that some GPs are integral members of the community mental health teams. This may mean that certain GPs are formally invited to become members.
- Guaranteeing high standard innovative training programs for GPs and others working within the shared care projects. This includes creating structures that will give GPs easy access to mental health care professionals.
- Employing a liaison person to work solely on promoting and managing shared care projects.

Funding

All DLOs considered that having access to sustainable medium to long term funding was a necessary pre-requisite to any successful shared care project. Secure funding would enable efficient and compatible Information Technologies systems to be set up for GPs and their local mental health services. *'Not having email and internet access makes communication difficult. Everyone is time poor so you need innovations such as IT... You also need to resolve issues around security and confidentiality'*.

Adequate funding for shared care initiatives would mean that project staff could be employed to work full time on these projects and then evaluate them. This person/s could then be identified by health workers and their consumers as working within shared care programs rather than having to act in different roles across several projects. Most DLOs considered that shared care projects would not be sustainable unless there was a person employed to co-ordinate, promote and manage them. Comments such as *'I don't think that any of these programs will be sustainable without a central person pushing them'* were typical.

In some areas where shared care initiatives were just beginning start up funding was needed. *'There needs to be a big funding injection to help to really establish them and get some evaluation programs in place'*.

One DLO considered that joint funding made by the Divisions and the local health authority for any future shared care projects was more politically astute as it would ensure that project staff could work more easily with both groups.

Future Directions – The DLO Perspective

The DLO's suggestions about the future direction of shared care arrangements were dependent upon how well advanced these initiatives were within their regions. Nonetheless, all sought to continue to strengthen rapport building exercises between individuals and groups with initiatives such as joint seminars.

Each DLO also wanted to continue to develop and refine MoUs and other process agreements between the local Divisions and their mental health services. As these initiatives were at different stages, even within the same geographical regions, it was generally acknowledged that this was likely to be an ongoing process that will need continuous appraisal and review. Whilst these agreements needed to respond to local

conditions, some DLOs pointed out that they also need to be integrated across some regions. This was particularly important if GPs are working with more than one mental health service or the mental health teams had clients within several Divisions of General Practice.

Several DLOs considered the present State and Federal Government policy shifts towards more integrated primary health care augured well for shared mental health care initiatives. However, they contended that shared mental health care still needed to be strongly promoted with policy makers. In this context one DLO cautioned '*we need to acknowledge the ground work that we have already done [in shared care]*'. Whereas another argued that a change in emphasis needed to occur '*At the moment the focus is on low prevalence conditions and it needs to move to higher prevalence ones...the GPs will need more support in this area*'.

Looking more theoretically at the area of health in general a DLO noted that in her State the Health Department 'Divisions and Area Health Services are working together sensibly and taking a population approach which is better for general practice'. Another commented more broadly 'Health care is no longer a regional issue – it is becoming globalised...corporatisation is in the wings. The role of the GP and the culture of general practice is changing'.

The challenge now is to manage these changes in mental health care to bring benefit to all Australians.

CHAPTER 7 INTERVIEWS WITH HEALTH PROFESSIONALS

Twenty interviews were conducted with health professionals working within shared care programs in three States, Western Australia (7), Queensland (7) and New South Wales (6). There was also one interview conducted in South Australia and one in Victoria making a total of twenty-two. Due to the brevity of the timeline of the project, five months, we were forced to concentrate on only three States. We chose New South Wales as the most populous State, Queensland because it had a large number of internal migrants and an evolving well-funded shared care program, and Western Australia because of its isolation.

These interviews were conducted on the basis that the informants identity remain confidential. As a consequence, in order to preserve this anonymity we are only able to disclose the interviewee's position within the organisation and the State where they are based. The interviewees names came from amongst a group nominated by the DLOs in each State. It was not possible to contact every person suggested by each DLO due to the brevity of the study. In addition some people were not available to be interviewed during the time that they were being conducted.

The interviewees professional backgrounds were four GPs, seven registered/psychiatric nurses, five psychiatrists, and six health professionals from within the divisions who had various backgrounds such as social work and health promotion. The group was evenly split between those working within general practice/divisions and those working with mental health services.

Profiles of the Areas Involved

Half of the participants worked in metropolitan areas of the cities of Brisbane, Perth and Sydney. However, the demographic profiles of these areas differed immensely with one informant working within a city area of Brisbane with high incomes and many young families while another worked where there was a high transient population of young people with drug and alcohol problems. Two respondents from Sydney and Brisbane described their areas of work as having high numbers of people from non-English speaking backgrounds, and one as having relatively large numbers of Indigenous residents within it.

Seven of the interviewees were involved in shared care programs which were based in the large country towns of Rockingham and Kwinana, in Western Australia, Port Macquarie, Bathurst, Orange, Kempsey, Tweed Heads, Lismore in New South Wales and Warrnambool, in Victoria. Many of the professionals involved in these programs were working with more than one Division or mental health service. This added to the complexity of an already difficult exercise.

Four participants were from rural areas including the Hunter Valley of New South Wales, Longreach in Queensland, Peel in Western Australia and an outreach service to GPs in rural South Australia. Two of these professionals (one in Western Australia and one in Queensland) mentioned that there were high youth suicide rates in these regions.

Preparatory Work

Successful shared care projects are often built upon firm foundations that include good rapport building strategies, educational initiatives and sound communication processes. Without attention to these issues initiatives tend to flounder, or even worse, cause antagonisms to develop between various individuals or services which may take years of work to overcome. We will therefore now turn to review these issues in more detail:

Rapport Building

Prior to establishing any form of shared care program many places had undertaken preparatory work to ensure that the transition ran smoothly. Some mental health teams and GPs had begun to meet together both informally and formally around a specific initiative such as the new EPC items or to create a Memoranda of Understanding (MoU). Others have had a less specific approach with a focus such as *'bilateral cultural change'*.

In order to accommodate the busy schedules of all the professionals involved in rapport building exercises, one Division had initiated early morning 'breakfast panels'. In contrast, another Division had offered monthly 'shared care evenings' with a local psychiatrist at a resort hotel.

Many participants stated that they believed that rapport building between the two groups was a lengthy process :

'It took two years of rapport building before the MoU was signed between mental health services and the GPs. There has been a huge effort to establish relationships between the GPs and members of the mental health team'.

'Developing respect between the community psychiatric services and GPs...It has been a slow process of developing relationships between individuals'.

Often shared care initiatives were started by one or two GPs and a few mental health team members.

'We commenced the project in one practice where there were a couple of interested and enthusiastic GPs. Eventually all the GPs in the practice saw the benefits and became involved in it. A couple more practices have seen the benefits and now wish to be included. These practices are in one regional centre but it is hoped that the concept will be introduced to another'.

An alternative approach to preparatory work was adopted by Kempstie Mental Health Services. The service conducted a survey amongst their clients to find that 75% of those with low prevalence conditions did not have a GP and they are now endeavouring to fill this gap.

In many Divisions, GPs were interviewed or surveyed about the mental health aspects of their practice. Once this was completed, steering committees were developed which included GPs, mental health service personnel, consumers and carers. Working groups had also been formed using top down initiatives and which included high ranking health bureaucrats such as *'a medical director, psychiatrist and the manager of the district health services'*.

Conversely, a bottom up strategy included having members of the mental health teams visit GPs at their practices. This initiative was:

'modelled on the way that pharmaceutical reps behave...by sitting waiting for the GPs to speak with them the mental health teams have learned how the practices work...The mental health teams take literature regarding mental health issues with them but endeavour not to let this information dictate the agenda for the meeting'.

At the Gold Coast Division thirty GPs were upskilled in an 'integrated mental health care' project over a two year period funded by a Commonwealth Government grant. As part of this project GPs were able to conduct clinics and ward rounds within the local mental health unit. This project was considered to be successful and when it was completed some of the GPs and mental health team members continued to meet together as a group. They are now hoping to begin to share the care of some consumers with low prevalence conditions in the near future.

As well as GPs and mental health professionals rapport building activities need to include **practice managers, registered nurses and receptionists** who work within general practice and the various mental health services. With this in mind, the liaison nurses from Logan-Beaudesert Mental Health Service developed a written manual explaining the concepts of shared care and consultation liaison for all professional and general staff working within their area. These manuals were then distributed personally by the nurses to mental health staff and to general practices within their region.

Education In Preparation For Shared Care

All participants argued that the upskilling of GPs in the area of mental health was a necessary pre-requisite for any successful shared care initiatives. The forms of educational activities used within these projects were varied and they evolved in the context of local conditions and culture, the resources available as well as the personalities of participants.

Educational initiatives, which included training for GPs around particular themes such as the recognition and management of early psychosis, or the development of CBT skills, had proved to be successful in some areas. Other Divisions such as Bayside in Queensland had organised more formal sessions which required

'GPs to attend 5 hours of educational sessions every 3 weeks for 12 months'

Other educational programs were less intense with

'a series of educational sessions aimed at increasing the knowledge of GPs in treating people with mental disorders. Around 25% of GPs in the Division have completed this project'.

There was, however, a word of warning from one psychiatrist who runs training courses for GPs *'when someone new took over the course it flagged. That's what happens when someone doesn't share your passion!'*

The Northern Rivers Division situated in Lismore negotiated with Sydney **University** to run an Eating Disorders Diploma via teleconference for their GPs. This initiative is ongoing. The Division also has an active area-wide eating disorders group of about thirty people that includes GPs, dieticians and psychologists. They also have another rural youth suicide prevention group which includes representatives from mental health services, General Practice, Schools and the Police.

Mental Health Courses for GPs are also provided by The Centre for Primary Care Mental Health in Fremantle, Western Australia. In addition psychiatric Registrars from

this Centre have also been conducting consultation liaison clinics in about 12 GPs practices - a process which is facilitated by a GP liaison nurse.

Joint training programs involving GPs and mental health professionals had proved useful as *'this enables both groups to gain a common understanding of particular issues'*. In addition to the educational benefits this sort of exercise also acted as a vehicle for developing better social relationships.

Case discussions where GPs presented cases and mental health staff gave presentations on issues such as anxiety or schizophrenia have also been successful collaborations. But all of these educational initiatives rest upon creating efficient channels of communication between the general practices and mental health services and we will now turn to discuss these in the next section of the report.

Initiating Channels of Communication Prior to Commencing Shared Care Projects

Divisional **newsletters** have frequently been used as a communication tool whereby GPs can get information about mental health services in their region. As the information is one-way these newsletters have limited application in their present form unless they are more widely disseminated.

Increasing communication channels between GPs and mental health services was considered a necessary precursor at one Division prior to signing a memorandum of understanding (MoU).

'For instance there was an agreement that Mental Health Services would provide information to GPs about their consumers within an appropriate time frame. The referral forms which GPs sent to Mental Health Services for adult consumers were also re-designed'.

Port Macquarie Division produced a **common data base** which team members from mental health services and local GPs can access. This scheme was well received by all involved as *'this initiative has opened up more channels of communication between different people'*.

Some Divisions have worked on setting up more efficient methods **to allow GPs increased contact with psychiatrists**. Others ensured that *'We now have a system whereby GPs can have phone consultations and fax advice from mental health professionals'*. On the other hand, Mental Health Services have benefited from Divisions who have created a **list of GPs that are interested in mental health** and are *'happy to take people from the service'*. One in-consumer psychiatric unit in central Sydney has listed several local GPs on its emergency plan.

Description of the Shared Care Programs

As previously discussed in the introduction to this report we have used the term 'shared care' broadly to encompass both collaborative and shared care. We have thus incorporated into our definition any aspect of care that is other than the traditional model. As a consequence, the following models have been included: Consultation Liaison, Liaison and Attached Mental Health Professional Models. A description of each of these models for care can be found in Chapter Two of this report.

Consultation Liaison

This model has been operating in many divisions with some success. In Queensland under the General Practice and Psychiatry Partnerships Program (GPAPP) GPs select a consumer that they wish to have reviewed by a psychiatrist. After agreement is obtained from the consumer, a psychiatrist then visits their practice to consult with them in the presence of their GP. A GP involved in this project stated that a psychiatrist had been visiting the practice every fortnight. This initiative had meant that consumers suffering from high prevalence conditions who would not normally be seen by a psychiatrist had received the benefit of a consultation. A similar program is being conducted in Western Australia in the Rockingham/Kwinana area where a psychiatrist sees for the first time, or reviews, three clients per week at a general practice. His services are well utilised, according to a local GP, and he is always booked out.

In Central Sydney it is the GPs who visit one of four Community Mental Health Centres for **case conferencing** activities. This occurs at each Centre once a month. The interaction at these case conferences has been dependent upon the interest and enthusiasm of the psychiatrist involved in these sessions. One participant commented '*It seems to need leadership from above to operate well*'.

The other side to the GPAPP program in Queensland involves mental health services transferring the care of consumers with low prevalence conditions, after they have given consent, to GPs. These consumers were carefully selected by their psychiatrists as being stable and therefore appropriate for GP care. The criteria used in this project was that a consumer was without any episodes requiring inpatient care for 12 months. After these consumers were selected GPs are then '*invited to take over a consumer*'.

Once these formalities are successfully concluded, the Psychiatrist, Case Manager, and Clinical Nurse all meet with the GP for a **formal transfer of care**. The Clinical Nurse remains the liaison person between mental health services, the GP and the client. Consumers without a GP are usually matched to a particular GP on a geographical basis so that they can have easy access to care without transportation difficulties. However, if a client has a particular gender or ethnic preference (perhaps due to language or cultural issues) regarding their GP then these requests are taken into account. A GP involved in this project felt that:

'clients will find the environment of the general practice more convenient and more anonymous...and that the GP will be able to care for the physical needs of these consumers'.

This part of the GPAPP project is still being investigated with consumers presently being randomised into one of two groups. The first group is transferred into the care of the GP immediately and the second group after six months. This project is being fully evaluated at every stage.

Another long established program operating between the Logan Division of General Practice, the local mental health service, and the Logan-Beaudesert District Health Service, involved the GP management of a group of clients with psychotic illnesses. In this case a group of six GPs who had undergone training with the mental health service agreed to take over the medical management of this group of clients. The GPs are supported in this task by a designated Case Manager from Mental Health Services. In addition, GPs were invited to attend **monthly meetings** with a psychiatrist and the Case Manager so that any treatment or clinical issues could be discussed. The Psychiatrist involved in these meetings commented '*These monthly one hour sessions are greatly*

appreciated by all participants'. This project was formally evaluated by the Queensland Centre for Schizophrenia Research (QCSR) and the results have recently been submitted for publication. In many ways this project was a precursor to the shared care part of the GPAPP program being established now.

In the mid north coast area of rural New South Wales, the area health service has organised for a Child and Adolescent Psychiatrist to **fly** into Port Macquarie once a month to consult with a group of GPs. Each month he meets with a group of about 8 GPs to discuss issues involving their consumers. He does not see any individual consumers or their carers.

In Perth a Psychiatrist and Liaison Nurse attend general practices to offer **formal support and education** to individual GPs. This initiative is CME accredited. GPs can also refer consumers to local mental health teams. The team members will then:

‘decide if they will accept it [the referral]. The criteria for acceptance is that they will see the consumers up to four times or if the GP needs help with medication or the management of the consumer’.

This Division is also working on a Division Hospital Integration Program (DHIP). This project was designed to improve the flow of information from a local mental health facility to GPs and based around the concept of **a continuum of care**. As part of this program GPs were given timely discharge information regarding their consumers medication needs and ongoing management. Consumers without GPs were discharged to the care of the local mental health team who helped them find a GP if they wished to do so.

In Central Sydney there are a high number of **boarding houses** with residents who have low prevalence conditions. In order to address both the physical and mental health needs of these clients GPs were successfully linked with mental health services to facilitate this care. *‘This was particularly important if the boarding house management was not very proactive in the care of the residents’.*

Balint support groups where a group of GPs can meet together with a psychiatrist to negotiate issues regarding various consumers have proved popular throughout Australia. These were either open groups where GPs were always welcome to attend or closed groups restricted to members. There were groups mentioned in both Rockingham and Adelaide but there are many others throughout Australia. A GP member of one group had been part of one for five years and found it very beneficial both personally and professionally. A psychiatrist involved in conducting one group said *‘ I think it is important to offer GPs a variety of Balint Group experiences and ongoing access to supervision’.*

Attached Mental Health Professional:

In Fremantle the Division of General Practice, Fremantle Hospital and health service are developing a program aimed at people from low socio-economic groups who need psychological counselling. They are creating a package of up to ten counselling appointments with a psychologist for consumers referred by their GP. The aim of this new venture:

‘is to address the mental health issues presenting in the general practice setting and to improve access for this client group [to counselling] and collaboration across the [health] sectors’.

Clinical psychologists have been working in general practices with GPs for the last 18 months in the Central West Division in New South Wales. **Partnerships** between the

Division, several GPs and the psychology department at Charles Sturt University have been forged and a research project initiated involving all parties.

GPs have also been attached to mental health services in various settings for short periods of time. For instance, in Adelaide GPs can have **clinical attachments** under the supervision of a psychiatrist to the post-natal depression clinic held within a mental health clinic.

Liaison Model

GP Liaison officers have been appointed in many Divisions. For instance the officer in the Central West Division is developing a telepsychiatry project for rural GPs in their Division. It is hoped that as well as GPs this project will also invite other mental health and drug and alcohol workers to be part of these discussions.

Mental health professionals have also been **attached to key general practices** in Fremantle to help to build good professional relationships between the two services and to provide both information resources and a liaison link. It is hoped that this will lead to enhanced communication and on a more practical level make access for GPs to the mental health service providers easier. In addition, these liaison workers will provide assessments for the consumers of GPs if requested to do so, as well as act as a conduit for advice from psychiatrists. These GPs will also run groups on issues such as anxiety or stress for consumers within the general practice setting for consumers referred by their GPs.

In country Victoria, a dedicated care coordinator worked between two Divisions and the acute hospital. A protocol was developed which ensured that when a client presented with a suicide attempt they were seen immediately, assessed and then tracked through the use of a management plan. The GP was formally linked into the plan. Once discharged a **quality feedback loop** was established so that the GP could contact either the care coordinator or the Crisis Assessment Team. A psychiatrist involved in this project stated that:

‘80% of consumers seen through this program had not received an appropriate diagnosis prior to entering the program. Many of them had severe depression’.

The Involvement of Consumers and Carers in Shared Care Projects.

The level of consumer and carer participation at local level in shared care projects was variable. This finding is also reflected in the questionnaire results. The interview questions tried to tease out the subtleties of consumer and carer involvement, especially when decisions regarding transfer of care were being made.

Most consumer/carers participation seems to have been at the instigation of workers from the mental health services. As a consequence, many of these people have perspectives or opinions pertinent to low prevalence conditions such as bi-polar disorders or schizophrenia. They may not be as familiar with issues that affect people with high prevalence conditions.

Consumers and carers who have been associated with, or treated by, mental health services have been involved in many aspects of shared care projects. Some have been involved as consumer/carers representatives on mental health management groups. Through this they have helped in creating management plans for the service.

For instance at the Lismore Mental Health Service, consumers have a bi-monthly forum with mental health workers and GPs. This service also has regular decision-making meetings with consumer-run organisations such as Lifeline. In this instance the consumers on the program management committee or steering committee, serve as bridges to external networks of consumers that make the consultation and participation of consumers and carers potentially more rich.

Where there are strong consumer advisory groups assisting mental health services this strength tends to percolate into shared care and other collaborative arrangements.:*“They are on the Steering Committee for the DHIP and the GP mental health Liaison Officer is now reporting to it. The Consumer Advisory Group in this area is very strong.”*

Consumers have been involved in the creation of the GPAPP project in Queensland; however, from data from the interviews with these respondents, this has been at State level only.

With sophisticated shared care activities where there has been care planning and service agreements underpinning the service arrangements, the individual needs of clients throughout the transfer process are taken into account in decision making.

Many of the interviewees stated that they would be canvassing the opinions of consumers and carers as part of the evaluation process. Also several commented that they hoped to create better processes and structures which would help to increase the involvement of more consumers and carers in more aspects of the shared care projects that they were currently developing.

Difficulties Associated With Shared Care Projects

There were many difficulties regarding the implementation and management of shared care projects mentioned by the interviewees. Some of these difficulties were associated with concern and debates that had evolved over decades, others were due to the geography or the ways in which the health service was structured within their region. Due to the sensitivity of the issues discussed we have omitted any place names as this may identify the speaker. Also these were the views of the individuals interviewed and do not purport to represent a consensus, or ‘official’, opinion of the difficulties facing the service as a whole.

Structural and Management Issues

Lack of sustainable **medium to long term funding** was considered an obstacle for many involved in creating shared care projects. In one region a shared care project which was funded only for a short period ran into difficulties because they did not have sufficient time to orientate GPs into the processes and structures of the local psychiatric hospital. GPs viewed this establishment as

‘ a black hole and they had no idea as to how it worked. There was no rapport between the hospital staff and the GPs. It was difficult to initiate the necessary attitudinal changes as it was a short project’.

Some Divisions of General Practice are required to negotiate with **more than one mental health service** [or vice versa] this can be problematic if the two mental health services function in different ways.

'There are two mental health services who have different infrastructures and philosophies. One has a high structured approach to mental health care in the community, which has existed for many years and is linked to a teaching hospital. The other is more a grassroots organisation without a feeder hospital but with more people working within the community and with GPs'.

To overcome these difficulties the Division has to arrange separate meetings with mental health teams employed by each mental health service.

These difficulties are further complicated if the Division has to negotiate funding and other issues between two different mental health services particularly if one has been newly **privatised**. '*... don't have much experience in running a government one [hospital] and no experience in running a community psychiatric program*'.

GPs routinely consult with consumers who have **co-morbidity** problems and the GPs usually have to decide between mental health services and drug and alcohol services as to who is the more appropriate service. This is never an easy or clear-cut decision.

For some Divisions of General Practice recent:

'structural alterations to the Divisional boundaries has caused some trauma and the mental health service program has suffered as a result of these changes'.

Another difficulty confronting some professionals is **high staff turnover**. For instance, one person interviewed estimated that there had been an 80% staff turnover in a country mental health service in their region due to changes in management. At another city location the interviewee argued '*mental health services are very short staffed and they don't have the resources to meet the needs of their clients*'.

In another region rapid expansion has presented problems:

'The mental health service until recently has been very under-resourced but over the last 12 months it has rapidly expanded with new staff ...so they are still orientating these staff'.

More than one consumer group was mentioned as a problem in one area as they '*overlap and there is a great deal of internal politics between the two groups*' which needed to be negotiated by all health professionals dealing with them.

Process Issues

Ensuring that a process was developed whereby client **loss to follow-up** was minimised posed an issue for several services. One mental health team member was concerned:

'If mental health clients are handed straight to GPs, the GPs have no process to follow them up if they miss an appointment and an injection. The next thing you know the consumer is lost in the system until they are sectioned again...Mental health professionals felt that they are able to visit their clients in their home and thus make a better assessment of their overall mental health. GPs are not able to make these regular house calls'.

Many of the people interviewed stated that there had been difficulties with getting timely discharge summaries from mental health services for GPs. Conversely, GPs had sent poor referral letters to mental health services with little information on them for example '*depressed please see*'. In order to achieve better rapport between these groups of

professionals more efficient and lengthy written and verbal communications had been developed as a first priority. Because of this:

‘Many GPs are finding it arduous to keep up with the necessary paperwork regarding these [mental health] consumers’.

Some GPs were concerned about what they perceived to be the **unpredictability** of some consumers with mental health problems as far as attending pre-booked appointments was concerned. The consequences of this were perceived to be financially quite significant and to serve as a barrier to uptake of work with this client group.

GPs also complained that they were **not getting advice** about the management of consumers with mental illnesses and **could not easily get access** to their case manager, which caused extreme frustration.

Mental health services in one region were aware of these issues but *‘are not always able to attend to referrals by GPs and these delays are not always understood by them...nor can they easily directly access a psychiatrist’*. But due to high pressure of work they were not able to overcome these difficulties.

Finding mutually convenient **times** for meetings for all stakeholders poses a continuing problem. In addition where service demands are high and commitment is not optimal sometimes GPs were

“too busy to sit in with psychiatrists during consultation liaison sessions. This would mean that the consultation liaison service would turn into another referral service and the potential benefit to the GP and the consumer lost.”

Geographical Issues

Large geographical regions pose many difficulties for all of those living in **regional and remote** Australia. For those promoting educational initiatives these distances pose problems. *‘We have GPs in about six different main locations so its hard to organise programs that will involve them all’*. In remote areas educational activities were almost impossible to instigate. In order to attend a session *GPs need to ‘drive for many hours in hazardous conditions, then stay overnight and also possibly to employ a locum to cover their absence’*.

Some mental health teams have responsibility for consumers across vast country regions. They are therefore sometimes perceived by GPs to have *‘little commitment to the local area’* if their area is a long way from the administrative centre of the mental health service or area health service.

On the other hand, some mental health workers and GPs **in inner city areas** have high caseloads of people with psychotic disorders, a group that can at times have very challenging health needs.

Remaining as Generalists

Some GPs are not happy to be identified as having a specific interest in mental health as they *‘don’t want to get a reputation for dealing with these consumers’* - a view not usually understood by those working in the mental health area.

Past Issues Affecting the Present

Given the problematic relationships between mental health workers and GPs in many regions there are varying degrees of suspicion with regard to sharing the care of consumers between the two groups. In some places 90% of mental health staff have '*come on board...only the psychologists have refused to be involved*'. But many of these new relationships between professionals are still evolving and teething problems such as '*some GPs using their resource person [from mental health services] as an emergency referral person*' have needed to be resolved.

In addition, several participants mentioned that GPs were not willing to broaden their referral patterns to encompass members of the community mental health teams to '*People other than the psychiatrist and the one psychologist*':

'GPs have time constraints they are used to making direct contact with an individual in order to make a referral and they are not used to dealing with Multi-D teams. GPs don't have easy access to psychiatrists'

Mental health services for their part were concerned about:

'GPs **lack of knowledge** regarding mental health issues, also their perception of mental illness'.

This perception was exacerbated as mental health teams deal mainly with *clients* who have low prevalence conditions whereas GPs mainly come into contact with *consumers* with high prevalence conditions. Thus '*both groups need to **broaden out their definitions of mental illness***'.

This view is echoed in a comment by a GP who argued:

'People working in mental health services often have "phobic avoidance" of general practice. People working in mental health services are not comfortable in general practice because they are without their support systems and are in unfamiliar surroundings dealing with consumers, they don't know, who are affected with problems and issues that they are not used to treating.

Lack of knowledge regarding the respective roles played by mental health professionals and GPs has led to several misconceptions. For instance, '*some GPs believe mental health teams to be marriage counsellors*'. This perception was endorsed by a GP who stated:

'Some GPs don't understand what psychiatric services can and cannot undertake for instance they do not undertake psycho-social counselling'.

One participant mentioned that there had been a previous attempt in the region to introduce a shared care program. This project had not been successful, as inappropriate and unstable consumers had been discharged into the care of the local GPs. As a consequence, some GPs were now wary of any shared care projects.

Finally, **uneasy power relationships** between different groups of workers posed another area of difficulty particularly when the introduction of a shared care project meant altering these associations. For example, '*some mental health professionals don't like GPs becoming case managers*'. As a consequence these mental health professionals were **threatened** by shared care initiatives where GPs played a more prominent role arguing that '*you can't wipe out community mental health*'. Time therefore needs to be taken to address the concerns of all workers and consumers prior

to the implementation of any new shared care initiative if the project is to receive enough support to make it successful.

Benefits from Shared Care Projects

As formal evaluations of these projects have not been completed this next section of the report will contain comments from participants regarding their perceptions of how shared care projects were beneficial. Again these are subjective remarks from individuals and are not intended to replace formal evaluations that are currently being undertaken. Rather they represent a mosaic of opinion from people directly involved in the projects acting in a variety of roles.

Rapport, Respect and Trust

Most people involved in the shared care projects felt that **communication between mental health professionals and GPs had improved** as they had become more familiar with each others personalities and patterns of work. Relationships, respect and trust had gradually developed between individual workers over a period of years. In one instance **3-4 years** was quoted for the establishment of:

‘An excellent partnership has evolved between the psychiatrist leading the community psychiatric service and some GPs...There is now mutual respect between the two services’.

As another participant succinctly stated:

‘Taking the time to let everyone get comfortable with culture and role changes at their own pace. Its slow building these relationships and it can’t be rushed’.

GPs were pleased when mental health-team members *‘physically visited the practices which is important as it fosters a better relationship’*. A mental health team member felt that *‘one to one contacts have broken down animosity and helped to resolve [longstanding] conflicts’*.

In another instance, when developing a shared care program the staff of a local psychiatric hospital and some GPs:

‘Met for the first time to discuss issues together. They were **able to look at the realities of each other’s work** and dispel some of the myths. They found ways of developing policies which would support GPs and mental health workers...this was enhanced when GPs received more timely discharge letters and separation prescription advice’.

Increased communication meant that GPs in another region had easier **access** to psychiatrists and other mental health professionals. It was hoped that this strategy would mean that they could eventually join together as carers in *‘a mental health loop’*. Many GPs participating in case conferences and Balint Support Groups had found these to be informative and beneficial to their practice.

Other Benefits

During the course of shared care projects many memoranda of understanding have been developed which reflect local issues and conditions. One psychiatric hospital has developed a **better process mechanism for following up** consumers through the

hospital system. **GP guidelines** for assessing and treating mental health consumers in casualty have also evolved in another region. In addition, several areas have developed efficient communication systems to increase co-ordination between various government and non-government organisations.

From the mental health professionals viewpoint the **quality of referral letters/telephone calls and their appropriateness** from GPs had greatly improved. On the other hand, GPs were receiving more timely and information rich discharge correspondence from in-consumer psychiatric units. Both groups were hoping that this would continue to improve:

‘Good relationships between GPs and the mental health service providers will develop so advice will flow better in both directions...it is also hoped that there will better after hours arrangements [for dealing with clients who have mental health problems]’.

The **physical care** of mental health clients was considered by many mental health professionals to have improved once they had a GP involved in their care. They also stated that consumers had found it easier to access their local general practice rather than travelling [sometimes for many hours in country areas] to attend a mental health clinic. Consumers were also happy to have speedy referrals and to be seen in the **non-stigmatised environment** of a local general practice.

Consultation liaison initiatives had benefits for all involved as one mental health professional summarised:

‘Consumers see the psychiatrist as a one-off and the GPs continue the care – this normalises the process for them...GPs can learn from sitting in on the consultation and discussing the cases before and after the sessions...The Consultant psychiatrists report that going into a GP practice is very good for them as they are re-familiarising themselves with the skills needed for GP clients. They are enjoying educating the GPs’.

One psychiatrist considered that consumers had benefited from their involvement in the shared care project because they had *‘improved clinical outcomes and satisfaction’*. And *‘a more efficient use of mental health resources with consequent reduction in waiting times’*.

Several Mental Health Professionals were pleased to note that because of their increasing contact with clients who had low prevalence conditions the knowledge base of GPs in this area was increasing. GPs also felt that their skills and confidence in managing the treatment of these consumers was improving. Moreover, it was hoped that GPs would also become more comfortable with *‘the legal issues surrounding Mental Health Acts such as compulsory treatment’*.

Conversely, GPs had commented that mental health professionals involved in shared care programs had now more information regarding the types of high prevalence conditions they frequently met within their consumer group.

Most of these projects are still evolving and their real benefits are still to be fully evaluated, however, these remarks suggest that at the very least shared care projects are showing promise.

The Future

The aim of any shared care project must be for the development of seamless physical and mental health care of all consumers by caring knowledgeable professionals within an efficient, well resourced health system . However, given the complexities and funding issues of our present system there is still much room for improvement. The following therefore is a list of initiatives that participants hope to encourage or develop in their regions at a future date. Some of these initiatives must be seen as 'wish list' whilst others are well on the way to fruition. The following six themes emerge:

1. Cultural shifts;
2. Reach;
3. Increasing levels of sophistication;
4. Increasing links with multiple stakeholders;
5. Broadening the scope of activities; and
6. Sustainability

These themes are now addressed respectively.

1. Cultural shift

Cultural shift refers to the movement towards shared mental health care being seen as the norm. This involves changes in the way that mental health professionals, GPs and consumers and carers understand the process of shared care and collaboration.

- 'Shared care will become the norm.'
- 'That a cultural change will take place enabling a more productive relationship between the two services based upon understanding and respect.'
- 'That the relationships will develop between a core of GPs and mental health services so that mental health services can permanently discharge stable consumers into the care of the GPs.'
- 'That we will work with consumers so that they gain a better understanding of shared care.'
- '[Shared care] 'needs to be taken out of the realm of the last stage of de-institutionalisation....we need to develop a broader view of consultation liaison psychiatry and integrate GPs into the acute sector...'

2. Spread or reach

The reach of programs should increase to engage greater numbers of GPs, psychiatrists, mental health workers and consumers.

- 'We are hoping to expand the consultation liaison program to include more psychiatrists'
- 'More and more psychiatrists are seeing the value of working with and supporting GPs – this is the way forward'.
- 'Further roll out with more GPs'.

3. Increasing levels of sophistication

Programs should continue to increase in sophistication so that communication, quality improvement and referral processes are improved.

- 'We want the Primary Care items increased and to take into account case conferencing etc'.
- 'We need to develop appropriate mental health outcome measures for use in shared care programs with the community/primary care setting. Currently the available evaluation measures have been designed mostly with the acute care sector in mind. Evaluation needs to be simple and workable within a general practice setting.'
- 'That data regarding the physical and mental health of clients will be centralised with general practices'.
- 'We hope to have one referral form for the whole metropolitan region.'
- 'That we will develop an emergency mental health plan'

4. Increasing links with multiple stakeholder groups.

- For shared care programs to be sustainable, links with a broad range of stakeholders need to be established:
- 'We hope to create more formal links with non-government organisations and consolidate ties with the local University'.
- 'That we will work more actively with Indigenous People and develop an assessment model for Aboriginal health issue'

5. Broadening the scope of the activities:

Shared Care programs should be beneficial to a broad range of consumers and should encompass the full spectrum of care from promotion and prevention through to all treatment modalities:

- 'That everyone will see mental health in its broadest context for prevention and promotion'
- 'That we will work more closely with mental health and the elderly and not just in the area of dementia'
- 'May be secondary/primary prevention will be aimed at the children of consumers'.

6. Sustainability

The recurring theme regarding this is funding and there was a general groundswell of opinion that there needed to be sustained funding for these collaborative activities for some time yet.

- 'A lack of funding is a real problem'.
- 'This program has been cost effective so this should help with its sustainability'

- 'Once this program is finished the work already done will dissipate unless there is a worker driving it.'

This sustainability needs to be supported through appropriate policy.

'Sustainability will only be achieved through policy drivers that link funding to intersectoral collaboration so that funding is available both through general practice and mental health services'

'Systematic and sustainable change needs to be based within a realistic and long-term framework'

There was still concern for the structural disincentives to GPs spending more time with their consumers with mental health related problems.

'There is still lack of remuneration for GPs in mental health and we are still relying on their goodwill'

CHAPTER 8 RESULTS FROM THE SURVEY OF DIVISIONS

This chapter is based on the responses from the survey that are tabulated in appendix 4.

Numbers and degree of engagement

The response rate of 66 out of 70 was pleasing and indicates the high level of interest of Divisions who are involved in this area of activity. 10 Divisions thought that their activities did not fall into the category of “shared care/ partnership development”.

Currently at least 56 Divisions are involved in activities that are designed specifically to enhance integration between the general practice sector and specialised mental health services. These figures are possibly an underestimate. The authors were aware that at least one of the Divisions which indicated that it was not involved in mental health partnership activities had in fact been involved in the multi-sectoral development of emergency plans and protocols for the management of psychiatric emergencies. In addition we have not received responses from 4 Divisions and it is difficult to know what level of activity in which they are involved.

The review team also feels that this might be an underestimate because the questionnaire was sent only to Divisions who had identified themselves as being involved in mental health activities in the 2000 Directory of Divisions published by the ADGP. In retrospect the survey should have been sent to all Divisions in order to pick up those few Divisions who might have decided to develop mental health related programs over the past 10 months since the Directory was developed. However it was always the intent of the review team to minimise the demands on Divisions by not asking them to complete questionnaires about areas of activity in which they were not significant stakeholders.

Data from the 1991-1997 mental health projects that are reported in the PARC Electronic Library indicate that over that 7-year period, 77 projects had shared care/partnership building as one of their major foci. These were conducted by 59 Divisions over that period of time.

There certainly has been some progress since that time frame. The data from the NIS Activities of Divisions Database [that contains data from the strategic and business plans from mid 1999] indicate that there were 63 Divisions that intended to be involved in partnerships/shared care developments either in that year or the strategic planning timeframe of 1999-2002.

From the survey undertaken as part of this review in 2001, there were a total of 66 Divisions currently involved in mental health. 10 of these stated that their activities were not in shared care/partnership development. This then leaves at least 56 Divisions involved in shared care/partnerships but as commented upon earlier, this may be an underestimate.

The survey also has indicated that there is quite high utilisation of care planning (64%) and case conferencing (70%) development of service agreements (55%) and clinical pathways/use of clinical practice guidelines. (59%) These will be detailed later in this section.

When the new Outcomes Based Funding structure was established there was some concern that because outcomes were more difficult to measure in the mental health area, Divisions might be discouraged from continuing their mental health activities. Indeed some Divisions did reconsider their commitment to mental health in light of the changed funding structures¹⁷⁶.

Given that the absolute figures might be underestimates the review group feels that the change to Outcomes Based Funding has not had a negative effect on the quantity or quality of mental health shared care/partnership oriented programs.

Funding

Of the 41 Divisions who answered this question the average amount of funding was \$132,000. The total amount being spent in these activities is \$5.43 million.

Funding sources are diverse. Although all activities seem to be government funded in one way or other, reliance on Outcomes Based Funding, if you like “core funding” of the Divisions, only accounted for 30% of Divisional activities in this area.

The Primary Mental Health Care Initiative Funding accounts for another 23%. This is particularly significant because this Divisions incentive funding continues only until the end of the 2000-2001 financial year. This is reflected in the answers to q 5 where similar proportion of programs was proceeding only until the end of the 2000-2001 financial year. Divisions were not asked about possible developments regarding funding sources once the PMHCI funding was exhausted. The discontinuation of this funding may seriously threaten a significant proportion of the activities that Divisions have been involved in over the past two or more years.

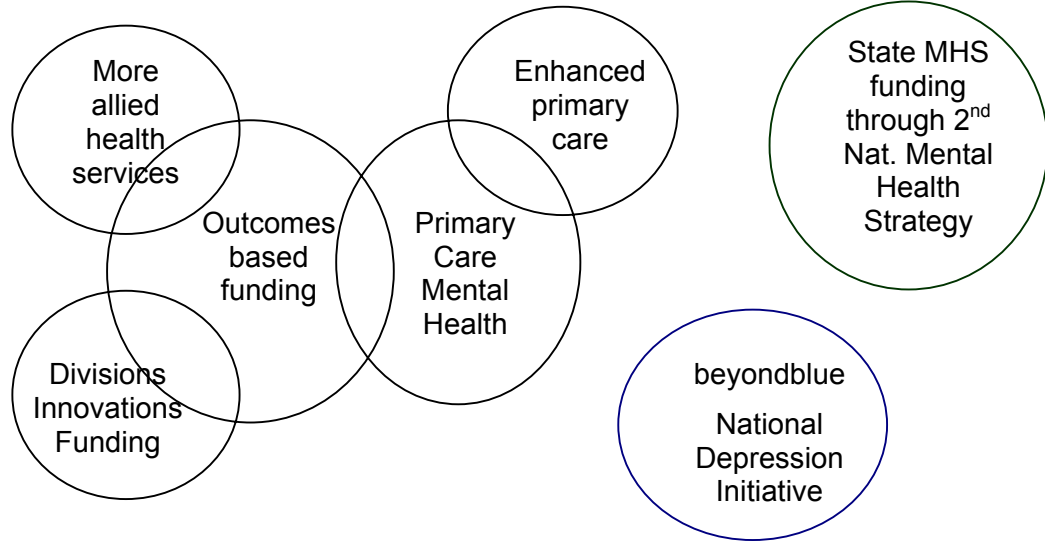
Other sources of funding accounted for 21% of activities; presumably this funding is from state mental health strategy funding that had been earmarked for partnership development.

Eighteen percent of projects were funded from several sources. This reflects the development of real partnerships where risk and benefits are shared between the various interested parties. It also augurs well for sustainability as activities that are jointly funded tend to be more robust due to diversification of their funding sources.

Thirty nine percent of Divisions’ mental health partnership activities will be continuing at least until the end of this strategic planning round. 34% had other termination dates.

The diagram below demonstrates the complexity of funding in this area. There are probably other sources of funding that are not identified here.

¹⁷⁶ Veale B., Rogers W. *Strategic Evaluation of Divisions of General Practice, Adelaide*: General Practice Unit, National Information Service Flinders University Adelaide, 1999.

Figure 1 Sources of Divisional Mental Health Funding

The Diversity of funding in some ways explains the difficulties in accessing information through the normal Divisional reporting channels such as the Activities of Divisions database. Funding sources are diverse and resorting channels are similarly diverse.

The role of GPs in Shared Care

The findings from q 7 regarding the roles of GPs in shared care indicate a diversity of roles. Besides the obvious role of clinician, GPs are involved as educators for other GPs, educators for Mental Health Services staff, community educators, and as liaison staff between the various sectors involved in the programs.

The role of opinion leaders in general within the profession, is important in changing attitudes and hence behaviour¹⁷⁷. General practices within Divisions represent a flat structure and there is no line of accountability between Divisions and their membership GPs. Change by edict as used within hierarchical structures such as government services is possible but it cannot work in general practice. GPs who are respected (and this means GPs who are seen to be clinically competent and of the right "tribe") in their roles as educators and agents of change at least in some instances can have significant effect, although this effect is not well evaluated¹⁷⁸.

It is interesting that in half of the programs, despite their additional cost, GPs are utilised as liaison persons between services and GPs. In the other half of programs, mental health workers are used as the liaison person. It seems plausible that in the early stages of a collaborative program using a GP may be cost effective, but that later on as trust and respect develop, a mental health worker could assume this role very effectively. On

¹⁷⁷ Cox K. Persuading colleagues to change: fifteen lessons learned from more than 20 years of tryin" *Education for Health* 12: 3; 1999, 347-353.

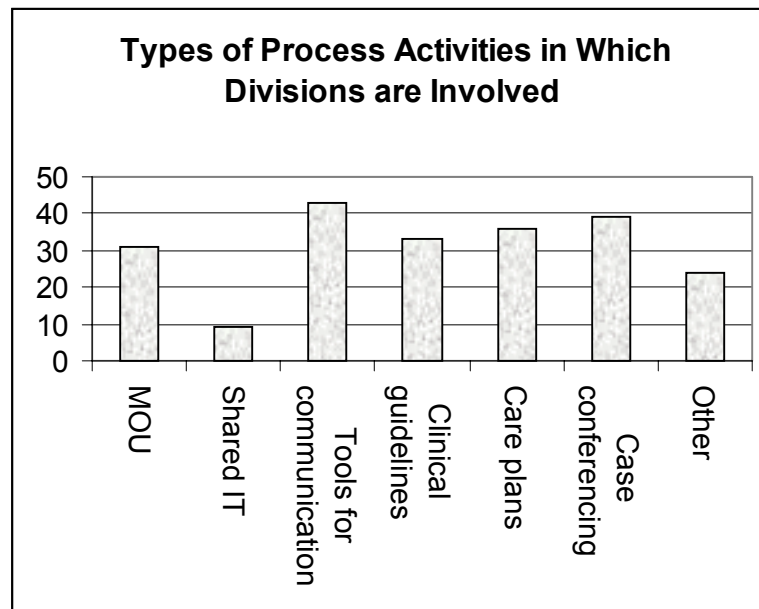
¹⁷⁸ Thomson O'Brien MA, Oxman AD, Haynes RB, Davis DA, Freemantle N, Harvey EL. *Local opinion leaders: effects on professional practice and health care outcomes* (Cochrane Review). In: The Cochrane Library, Issue 2, 2001. Oxford: Update Software.

the other hand use of the GP as liaison person may delay the development of GPs' trust and respect for other health professionals in the community. The interviews conducted as part of this study still identified mistrust between sectors as a major issue. [see interviews results and discussion section] The key role of the liaison person in greasing the mechanism of shared care programs can not be underestimated.

Types of activities

Some of the most interesting data from the survey relates to the type of integrative activities Divisions and mental health services have been engaged in. These are depicted diagrammatically in Figure 2.

Figure 2 Types of Process Activities in Which Divisions are Involved (Numbers of Divisions)



Memoranda of understanding/service agreements

Over half of the respondents indicated they have developed Memoranda of Understanding or Service Agreements. There has been much interest in this area over the past 12 –18 months. The Primary Mental Health Care Australian Resource Centre has received many enquiries about MoUs and a recent General Practice/Mental Health conference in Broome had the development of MoUs as its main focus.

The development of MoUs reflects an interest in formalisation of the relationship between General Practice and MHSs at the service management level

There are several elements to the formalisation of these relationships. Commonly these agreements give an overview of the way that the services work together. The rhetoric then needs to be operationalised and inevitably complementary documentation must be developed that outlines care pathways, criteria for movement of clients between one

sector and another and responsibilities regarding clinical care, communication and ensuring continuity of care and adequate follow up.

Several resources have been developed through the National Demonstration Hospitals Program that might be useful for Divisions and Mental Health Services involved in drawing up service agreements ¹⁷⁹.

Clinical guidelines, pathways and emergency plans

As can be seen from the survey data a similar number of Divisions are using clinical guidelines, pathways, and emergency plans and this may reflect this second tier of documentation that allows meaningful operationalisation of the MoU.

Of the 31 Divisions, which had MoUs or service agreements, 18 also were using clinical practice guidelines, pathways of care and/or emergency plans as well as care planning.

What does this latter number indicate? What we were not able to do from the survey was to separate out each of the components of the section of question 8. Whether these were singular areas of mutual activity, or whether Divisions and Mental Health Services were addressing all these elements together as part of an 'integration package', remains unclear.

In either case the figures reflect levels of practical problem solving and engagement that perhaps MoUs alone do not.

One of the strong messages that arose from a recent mental health partnership conference¹⁸⁰ was that for MoUs to work, and for organisational change to occur, there needed to be commitment at all levels within the organisation. This commitment at the operational level can be reflected by documentation such as care pathways, CPGs and emergency plans that have a specific practical bent.

Shared Information Technologies

Only a small number of programs were addressing the problem of shared information technologies. This is not surprising as the level of computerisation of general practice has recently soared ahead but similar developments have not occurred in the specialty mental health sector.

There are significant obstacles to closer IT related links, especially in the area of clinical care records. Diagnostic systems that are accepted in the mental health sector are not seen to be as relevant in general practice^{181,182}. Agreement on issues such as minimal

¹⁷⁹ Wilson B, Popplewell R *Enhancing Integration through the Formalisation of Collaboration between Hospitals and Divisions of General Practice: a guide to smooth sailing in developing a service agreement*. FLINDERS MEDICAL CENTRE, available on line at <http://www.health.gov.au/hsdd/acc/ndhp/pubs/ndhp2sam.htm>

¹⁸⁰ UWA Department of Psychiatry and Behavioural Science. Primary Care Mental Health Unit *Primary Care Mental Health Partnerships Conference*. Broome, 2001.

¹⁸¹ Hickie I. Primary care psychiatry is not specialist psychiatry in general practice. *Medical Journal of Australia*; 170: 1999, 171-173.

¹⁸² New England Health Service (NSW) *What do GPs need to know?* Armidale: Mental Health Education Unit, 1994.

data-sets that seem to be possible in other areas such as diabetes, will be a long time coming in the mental health area.

One of the barriers to better system integration is that the funding and accounting processes are so different across sectors. Mental health services are part of state health funded services. Their IM systems have to be compatible with both the clinical support systems used in those settings (including in-consumer care settings) and the accountability and reporting systems used within the public health sector. General practice systems are designed around small to medium sized business needs and different clinical support systems from what is required in primary care. These latter are unique. On the other hand general practice is part of a greater health system and information management systems need to be compatible across sectors. Current work is being done in Australia with the Good Electronic Health Record, a framework for software design, which will (amongst other things) enable this sharing of information across sectors¹⁸³. There is definitely a perceived need for common clinical information structures across sectors¹⁸⁴ that need to be further explored in the mental health area.

There is enormous scope for the development of better communication systems that transfer fairly germane information such as medication updates, contact people's details, the presence of treatment orders, etc even in the absence of high tech developments.

Communication tools

Communication between GPs and specialised mental health service personnel has been a major stumbling block and has in the past been cited as one of the reasons for lack of integration^{185,186}.

In the interview section of this present study, again after 9 years of programs aimed at developing better partnerships, communication has been identified as a significant problem by both sectors.

It is entirely appropriate therefore that 77% of programs have involved the development and use of communication tools. These systems are usually paper-based, using technologies such as telephone, fax, etc. Information technology obviously has a role here but more elaborate information management systems will be far down the track. Improved communication between health care providers is seen as one of the major outcomes of shared care programs. The level of activity in this area is indicative of the importance that Divisions and mental health services place on improving communication.

¹⁸³ Heard S, Schloeffel P, Beale T *The Good electronic Health Record in Australian General Practice Background Paper on the GPCG implementation trial*. <http://www.gehr.org/Gehroz.pdf>

¹⁸⁴ Appleby N, Dunt D, Southern D, Young D. General Practice integration in Australia. *Australian Family Physician*. 28: 8; 1999, 858-863

¹⁸⁵ RACGP RANZCP Joint Consultative Committee Report 1997 *Primary Care Psychiatry-the Last Frontier* Canberra

¹⁸⁶ Alsop M, Battye K. Integration of GPs and mental health services: the North Queensland Integrated Mental Health Program *Australian J of Primary Health-Interchange*. 15: 2; 1999, 20-26.

Care planning and case conferencing

Based on data from the survey of Divisions, the majority of Divisions involved in shared care/partnership activities are now focusing on care planning and case conferencing. The survey did not ask about the numbers of care plans and case conferences being undertaken.

While these case conferencing and care planning are complementary they are not the same and can occur in isolation without one necessarily leading to the other.

However one of the defining characteristics of “shared care” arrangements is the development of care plans for consumers/consumers/clients involved in the shared care arrangements¹⁸⁷. Care plans allow clarity of responsibility and of the tasks to be done. Consumer expectations can be met if the care plans are consumer centred¹⁸⁸. There is evidence that care planning based on collaborative problem definition improves outcomes¹⁸⁹. The degree of consumer involvement in all processes of these mental health shared care programs was examined in later questions in the survey as well as through the interviews.

The development of the Enhanced Primary Care Items has been timely and has given these types of activities an extra incentive that was not there previously. However the most recent data on use of the EPC items indicates that there has only been slow uptake of the case conferencing and shared care items. The case conferencing and care planning items require multi-disciplinary input and by their very nature signal a type of collaborative pattern of practice with which GPs have not been familiar.

The fact that so many of the Divisional mental health programs are involved in care planning augurs well for the uptake of these types of activity in the long run.

One of the most efficient methods of developing a care plan might seem to be case conferencing. However there are significant logistic difficulties in getting all of the health professionals and preferably the consumer and carer together at the same time (even if they are geographically dispersed and are teleconferenced)

Earlier activities with case conferencing as a component of mental health collaboration provided incentives and removed barriers through funding through the Divisions programs. The Mental Health Case Conferencing Seeding Project coordinated through the South Australian Rural and Remote Support Agency¹⁹⁰, the Logan Area Division of General Practice Case Conferencing Project¹⁹¹ and Hornsby Ku-ring-gai Division of

¹⁸⁷ Wilhelm K, Redenbach J, Savellis J, Hume F, MacDonald P, Pugh S. The Evolution of a mental health shared care project in Eastern Sydney. *Geigy Psychiatric Symposium, Wellington: Novartis Australia*, 1997.

¹⁸⁸ Holman H, Lorig K. Consumers as Partners in Managing Chronic Disease: Partnership is a Prerequisite for Effective and Efficient Health Care. *British Medical Journal*, 320: 2000, 526-7.

¹⁸⁹ Wagner, EH, Austin, BT, Von Korff, M. Organising Care for Consumers with Chronic Illness, *The Milbank Quarterly*, 74: (4); 1996.

¹⁹⁰ South Australian Rural Divisions Coordinating Unit. *Mental Health Case Conferencing Seeding Project. Project evaluation report*. Project 96-0550.5.

¹⁹¹ Logan Area Division of General Practice *Logan Area Division of General Practice Case Conferencing Project*. Twelve month progress report Project 95-0404.02.

General Practice's shared care project¹⁹² are just three of over twenty examples that used case conferencing prior to the introduction of the EPC items.

The EPC item development has allowed these activities to continue, but funded through mainstream general practice funding.

The previous mental health case conferencing projects within Divisions provided a high level of infra-structural support for GPs involved in case conferencing. This will continue to be necessary, even with the EPC items being available, as most general practices do not have the resources to arrange these case conferences. In addition coordination and payment of the other professionals to attend these case conferences is often not possible under current arrangements for EPC, but is a significant issue when they are working in the private sector.

Who does what in these programs?

The study group was particularly interested in the roles of various people within the programs. There are numerous descriptions of the models of care and the labels mean different things to different people. What the investigators did was rather than trying to ask Divisions what models were used, they asked what types of activity were involved and what the roles of the various key staff were. See .Figure 3

Consumers and carers

There was consumer involvement in 27 of the 56 programs (48%) at either the planning, management or implementation level. This was meant to provide an overall measure of involvement of consumers although more detailed analysis regarding the quality of the participation is required to qualify these bald figures.

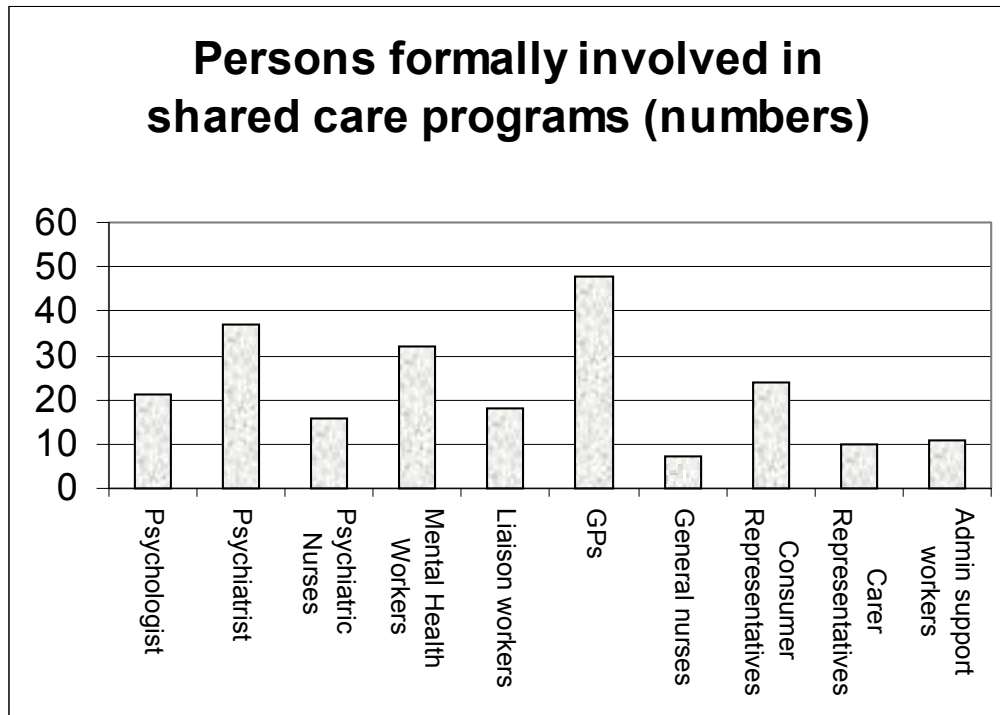
The key role of consumers and carers in mental health service development has been detailed in the recent report by the Mental Health Council of Australia *Enhancing Relationships between Health Professionals and Consumers and Carers*¹⁹³. Besides the obvious need for a better focus on consumers and carers in the clinical area, this needs to be directly modelled in the way that services and partnerships are developed. There is a key role for consumers and carers in the planning and implementation of shared care/partnership development programs. This need is not just philosophically driven; rather it is based on sound quality improvement principles where the outcomes that matter to society at large are the focus of the endeavours of the programs rather than outcomes that are of value only to the services themselves¹⁹⁴.

The role of consumers in quality improvement aspects of general practice and community and other primary health care services has been accepted.

¹⁹² Hornsby Ku-ring-gai Division of General Practice's *Shared Care Project Draft final report* 93-0401.5.

¹⁹³ Mental Health Council of Australia. *Enhancing Relationships between Health Professionals and Consumers and Carers. Final Report June 2000* Canberra ACT Commonwealth Department of Health and Aged Care.

¹⁹⁴ Berwick D. A Primer on Leading the Improvement of Systems. *British Medical Journal*, 1996, 619-622.

Figure 3 Persons formally involved in shared care programs

In both the Standards for General Practice¹⁹⁵ used in the general practice accreditation process, and in the Manual of Standards used in the Community Health Accreditation and Standards Program¹⁹⁶, consumer outcomes and perceptions are key elements.

Given these developments in other areas of both general practice and public sector community health services, the universal inclusion of consumers and carers in planning and implementation of mental health partnership development programs is not too much to expect in the near future.

The respondents were asked for more detail about the types of consumer engagement that was occurring in their programs. See Figure 4

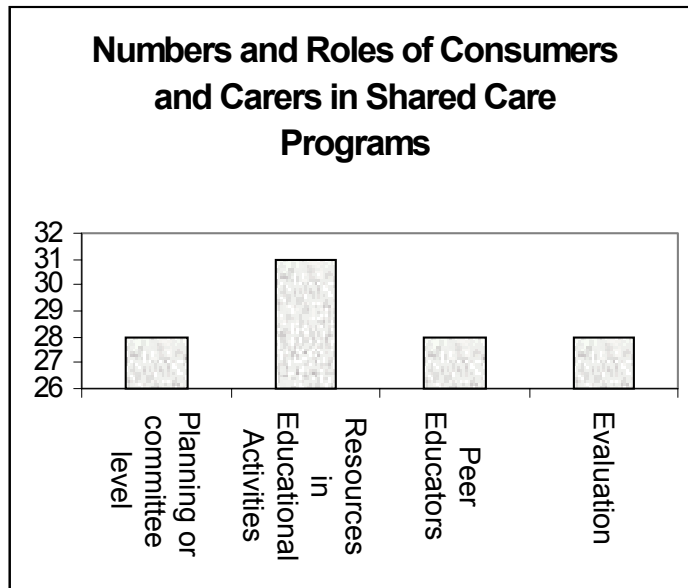
All 27 of the Divisions that did have consumer involvement had them involved at the planning or management level.

31 Divisions reported consumers were involved as resource people in educational sessions for GPs and mental health professionals. This number exceeded the total number of Divisions who reported any consumer involvement in their programs. It is unclear whether this discrepancy reflects a misunderstanding of the question or a more appropriate indication of consumer involvement.

¹⁹⁵ The Royal Australian College of GPs. *Standards for General Practice*, Melbourne: RACGP, 2000.

¹⁹⁶ Australian Community Health Association. *Manual of Standards for Community and Other Primary Health Care Services*, Bondi Junction: 1993.

Figure 4 Numbers and roles of consumers and carers in shared care programs



In half of the projects (28/56) consumers were involved as peer educators for other consumers of mental health services and their carers.

In half of the programs consumers were involved in the evaluation. This is pleasing and reflects the degree of influence that consumers have on the orientation of these programs. More is said about evaluation later in this section.

Consumers and carers were also involved in the programs “in other ways” in 7 out of the 56 programs. These included being consulted through consumer advocacy groups outside of the normal committee system for the programs. For instance the program management committee might need to consult with and develop partnerships with various consumer organisations external to the normal management system. This might be better done by going out to these groups to engage them on their territory at one of their regular meetings.

There are various models of collaboration with consumer groups that have been outlined in the literature. They range from token input through to equal partnerships at all levels within the health service. It was beyond the scope of this review to examine the detailed nature of the engagement of consumers and carers. However the interviews of the key informants offer some insight into the engagement within these programs.

The Consumer Focus Collaboration has developed a manual for assisting consumers carers and health professionals increase their capacity for improving consumer involvement in service planning, implementation and evaluation¹⁹⁷. This and other resources can be accessed through the National Resource Centre for Consumer Participation in Health at LaTrobe University¹⁹⁸.

¹⁹⁷ Consumer Focus Collaboration *Education and Training for Consumer Participation in Health Care; Final Project Report*. <http://nrccph.latrobe.edu.au/Text/etfreport1.pdf>

¹⁹⁸ <http://nrccph.latrobe.edu.au/offer.htm>

Consultation liaison type activities

31 of the 56 programs used psychiatrists in general practices in case discussions and GP education. ...what could loosely be called consultation liaison type activities. There is some argument about this label and its meaning¹⁹⁹.

However the investigators thought it reasonable to find out to what extent psychiatrists were working at the work site of the general practice, doing things other than seeing consumers on their own in a "shifted clinic" model. (to coin yet another label)

Data on caseload and types of problems seen and discussed were not explored. However the model that allows one-off problem based assessments with referral back to the GP for ongoing care is well accepted. There is evidence that GPs prefer this type of responsive care to the more traditional model of referral for ongoing (and long term) treatment²⁰⁰. Interestingly, when consultation liaison activities were implemented in isolation, evaluation outcomes were poor. That is, this model alone has not been shown to improve GP knowledge, skills or to change their behaviour^{201, 202}. However, there is evidence that GPs prefer this type of responsive care to traditional care. The lesson, it seems, is that consultation liaison programs should be broadened to incorporate formal skills-based GP training, a focus on relationship/team building and the development of formal protocols for two way communication and role definition. The symbolic importance of moving into GPs "turf" cannot be underestimated and is useful in meeting some of their perceived needs for clinical support. The provision of this type of service early on in any collaborative activities is a key enabling outcome in itself.

In addition there is some evidence that these types of arrangements, particularly as part of a more comprehensive set of interventions (as is usually the case in a shared care type program), does have positive effects of several consumer outcomes^{203, 204}, and service usage²⁰⁵.

¹⁹⁹ Gribble R. Shared Care but not Consultation-Liaison Psychiatry, *Australian & New Zealand Journal of Psychiatry*, 32 (2): 311-313.

²⁰⁰ Barber R, Sved Williams A. Psychiatrists Working In Primary Care: A Survey of GPs' Attitudes. *Australian & New Zealand Journal of Psychiatry*, 1996 30:278-286.

²⁰¹ Carr V, Carr VJ.; Faehrmann C; Lewin TJ; Walton JM; Reid AA. Determining the effect that consultation-liaison psychiatry in primary care has on family physicians' psychiatric knowledge and practice. *Psychosomatics*. 1997 May-Jun; 38 (3); 217-29 (ISSN: 0033-3182).

²⁰² Carr VJ, Lewin TJ, Reid AL, Walton JM, Faehrmann C. An evaluation of the effectiveness of a consultation-liaison psychiatry service in general practice. *Australian & New Zealand Journal of Psychiatry*. 1997 Oct; 31(5): 714-25, discussion 726-7 (ISSN: 0004-8674).

²⁰³ Katon W, Robinson P, Von Korff M et al. A multi faceted intervention to improve the treatment of depressions in primary care, *Arch of Gen Psychiatry* 1996, 53:924-932.

²⁰⁴ Katon W. Von Korff M. Lin E. A Randomised Trial of Psychiatric Consultation with Distressed High Utilisers. *General Hospital Psychiatry*. 1992, 14:86-89.

²⁰⁵ Jackson G. Gater R. Goldberg D et al A New Community Mental Health Team Based in Primary Care: A Description of the Service and its Effects on Service Use in the First Year, *British Journal of Psychiatry*, 1993, 162: 375-384.

Liaison workers

As mentioned above, all programs had liaison workers. The person chosen for this role was evenly distributed between a GP or a mental health worker. The person involved in this type of activity has a difficult role to fill. They need credibility within both sectors, good clinical skills and knowledge of how both systems and cultures work. There is no real data on what the best arrangements are. The key is probably the skill-set of the individual and their interpersonal problem solving capacity rather than their particular professional background. In addition, in making a choice, Divisions and mental health services involved in the programs would need to consider where the greatest barriers may be and fine tune the appointment to address this appropriately.

In a subsequent question Divisions were asked whether there was anyone employed within the Division to work solely on any mental health shared care/partnership programs. 35 of the 56 employed a person within the Division, 17 did not. (4 non-responses to this question).

Interestingly of those 35 Divisions that did employ someone to work solely on mental health partnerships, 9 responses were for full-time, 27 were for part-time (1 extra response).

Obviously the role of the person employed within the Division would be broader than just liaison. However it could be inferred that a significant number of liaison staff are in fact employed by the mental health services involved.

Education programs

The majority (45/56) of the programs had education programs for GPs as part of the overall program structure. Conventional education programs alone have been found to have little effect on clinician behaviour. However there is evidence that complex program based continuing medical education does alter clinician behaviour²⁰⁶. Many of these programs have GP education, consultation liaison activities, development and promotion of clinical tools for detection, assessment and referral bundled together and it is likely that many of them have had an effect on clinician behaviour (both GPs and mental health workers). This is consistent with the comments above regarding consultation liaison being effective within the setting of a complex program of reform. It would seem that changing the way we do things in practice depends on the complexity of the intervention. There are no “magic [single] bullets”.

Similar comments could be made for the extent of the education programs for mental health staff. Although the proportion of programs with educational activities for MH staff was less (50%) than for GPs, again this number reflects a commitment by mental health services to change. Interestingly about half of the programs had joint educational activities involving mental health staff and GPs. The content of these was not examined in the survey. There is evidence from the interviews that these are viewed as valuable. However a recent review in the Cochrane Library cast doubt on the effect of multi-

²⁰⁶ Oxman AD. Thomson MA. Davis DA. Haynes RB. No Magic Bullets: A Systematic Review of 102 Trials of Interventions to Improve Professional Practice. *CMAJ*, 1995, 153(10): 1423-31 Nov 15.

disciplinary education programs²⁰⁷ on inter-professional interactions or consumer outcomes. The review found that this may be due to the inadequate quality of the evaluation rather than a lack of effect per se. With a substantial number of multi-disciplinary education programs this is an area that could be examined more fully in the mental health area.

There was some discrepancy between the results from two related questions. Only 15 out of the 56 Divisions had “formal involvement of mental health carers/consumers in these education sessions” and yet in an earlier question 31 out of the 56 said that they had “consumers or carers as resources in educational activities for GPs or mental health professionals”. This is difficult to reconcile from the questionnaire responses.

Special groups

The survey asked the Divisions to indicate whether they were specifically designed for any special groups.

People from Non-English Speaking Backgrounds

Four Divisional programs had people from non-English speaking backgrounds as their major focus.

[Brisbane Inner South, ACT Division, Central Queensland and Western Sydney]

Aboriginal and Torres Strait Island people

Six programs were designed to meet the needs of Aboriginal and Torres Strait Islander people. [Mid North Coast NSW, Adelaide Northern DGP, Swan Hill DGP, Top End DGP, Sunshine Coast, Central Queensland]

This is likely to be an underestimate of total activities in this area as many Community Controlled Health Organisations have activities in these areas that include multi-disciplinary approaches to mental health problems and substance use problems. GPs working in these organisations are very much a part of these activities although Divisions themselves may not be major partners. The mental health of Aboriginal people is intertwined with their spiritual and physical health. This is the case for all people but many of us in the mainstream fail to realise these interconnections. Health promotion and illness prevention programs as well as illness related services in the Aboriginal and Torres Strait Islander setting, work across these elements and may not necessarily be ear-marked as “mental health” related services or programs. This may present difficulties with tracking of programs that in fact do address [amongst other things] mental health.

Children

The needs of children with parents with mental disorders have recently been recognised.

²⁰⁷ Zwarenstein M, Reeves S, Barr H, Hammick M, Koppel I, Atkins J. *Interprofessional Education: Effects on Professional Practice and Health Care Outcomes (Cochrane Review)*. In: The Cochrane Library, Issue 2, 2001. Oxford: Update Software.

In addition the needs of children with behavioural problems/mental disorders as distinct from the needs of adolescents and young adults has started to be recognised. This has been exemplified through the publications of AusEinet such as *Attention Deficit Hyperactivity Disorder In Preschool Aged Children*, *Early Intervention For Anxiety Disorders In Children And Adolescents*, and *Early Intervention In Conduct Problems In Children*.²⁰⁸

Nine addressed specifically the needs of children (including children of people with mental disorders). Of these at least three addressed the specific diagnosis of Attention Deficit Hyperactivity Disorder. (Greater Southern [WA], Swan Hill DGP, and Mid North Coast).

The behavioural and mental health of young children has been identified as a priority by Queensland Divisions of General Practice (QDGP). QDGP used its PMHC incentive funds to train GPs from each of the 20 Queensland Divisions in the Positive Parenting Program (Triple P).

Other projects addressing needs of children: Sunshine Coast, Adelaide Northern Divisions, Otway, Western Tasmania, Southern Queensland, ACT).

Whose agenda?

There has been some concern that shared care activities might be meeting the agenda of specialised mental health services without meeting the needs of general practice. Mental Health Services are under pressure to discharge clients who no longer require secondary level multidisciplinary care. This pressure has arisen because of demand from consumers “outside the system” for access as well as a movement away from “cradle to grave” comprehensive care for mental health service clients as part of the main-streaming of services that was a central plank of the first National Mental Health Plan²⁰⁹. This comprehensive approach where the MHS met all the health care needs of consumers was a legacy of the institution based care of the last century. Shared care has been seen as a tool for appropriate allocation of resources by transferring the bulk of the responsibility for care of many clients to the GP. In this situation clients of mental health services who are stable and not requiring the multi-disciplinary care provided by the MHS have their case management transferred to the GP with variable back-up by the specialist service. While some GPs have had an interest in taking up this type of responsibility there has also been some resistance to these changes.

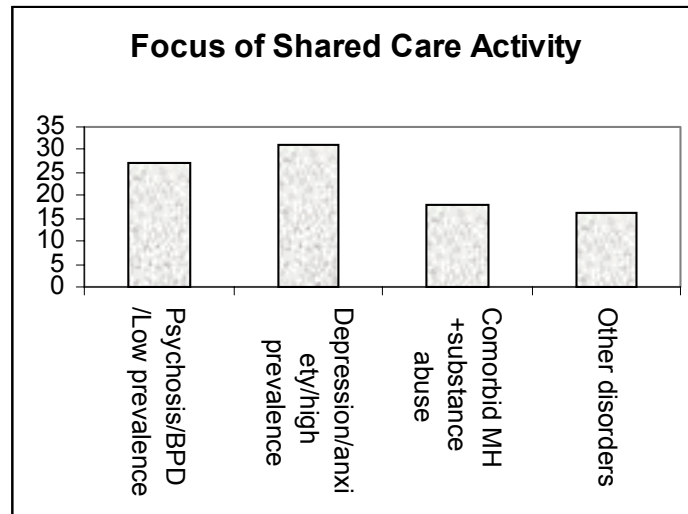
On the other hand there has been for the past decade an increasing demand for a responsive specialist mental health sector that was able to provide support for the types of mental health problems that GPs face every day in the course of their work. That is, GPs need advice and consultation services to help them manage their consumers with “high prevalence disorders” such as depression, anxiety and somatiform disorders. These people have mostly been denied access to public sector services unless they are suicidal. The services have largely seen their role as dealing with people with the so-called “serious mental disorders” such as the psychoses and bi-polar disorder, regardless of the disability that people with the higher prevalence disorders have been experiencing.

²⁰⁸ These publications are available on the AusEinet website <http://auseinet.flinders.edu.au>

²⁰⁹ Australian Health Ministers (1992) National Mental Health Plan, 1992, Canberra: AGPS.

The project group wanted to find out just whose agenda was being addressed in the shared care/partnership programs. The survey asked what main group of consumers the program addressed. This is depicted in Figure 5.

Figure 5 Main group of consumers addressed by the shared care program



The responses to this question are re-assuring and signify the development of true partnerships with several agendas being addressed.

- Several Divisions' activities addressed more than one client/consumer/consumer group. Therefore the total will be over 100%.
- 27 out of 56 Divisions (48%) addressed the needs of people with psychosis/BPD/"severe mental disorders" (the so-called low prevalence disorders, traditionally the domain of the specialised mental health services).
- 31 (55%) Divisions addressed the needs of people with depression/anxiety (or high prevalence disorders, traditionally the domain of general practice or primary care).
- 18 (32%) Divisions addressed the needs of people with comorbid mental health and substance abuse disorders/problems. These comorbid problems are not usually addressed appropriately within specialised mental health services and so GPs and other primary care providers have traditionally had to serve these clients.
- 16 (28.5%) Divisions' programs were addressing other groups. For example those Divisions with activities with ADHD or eating disorders.
- 21 out of 56 Divisions had programs that addressed the needs of BOTH people with low prevalence disorders and high prevalence disorders.

These figures reflect diversity. They also reflect the development of true partnerships where each group is assisting the other.

GPs have been calling for a more responsive specialist mental health sector. GPs require assistance with many of their consumers with high prevalence disorders. This need arises when diagnosis or approaches to management are unclear, when responses to treatment are slow, when there is significant risk of harm or when there is a need for a multi-disciplinary response. There has been some significant work being done in this area especially overseas²¹⁰. Efforts here in Australia through consultation liaison activities in a few key areas have had significant success but limited reach [see above 31 Divisions have consultation liaison type activities].

Structured approaches to the management of people with higher prevalence disorders including stepped care if required have started to be developed, particularly in the managed care setting in the US^{211,212}.

From the survey figures it can be inferred that there is significant activity with high prevalence disorders that now involves both general practice and specialty sectors. Because of current reporting processes it has been difficult for this review to obtain detailed accounts of these activities apart from the published literature and resources that have been tendered to PARC for inclusion in the Electronic Library.

Whether the agenda of the clients, their carers and families is being met is another question. This was explored to some degree through the questions on the role of consumers within the programs dealt with in the sections above. The consumer/carer agenda was also examined in the questions regarding the evaluation outcome indicators used in the programs (See Figure 6).

In 16 out of 56 programs (28.5%) consumer and/or carer satisfaction with arrangements are being used.

In 12 out of 56 programs (21%) consumer outcomes such as changes to health status, acute admissions, medication usage, etc were being used.

These low figures are disappointing. It is unclear what the reasons for the low usage of consumer outcomes are. There has been significant work in the area of development of mental health consumer outcome measures²¹³. Recent evaluation of the CLIPP program used HoNOS, the Role Functioning Scale and the Life Skills Profile in a shared care/consultation liaison setting²¹⁴. It is fair to say that many of the shared care partnership programs are still in the developmental stage. The lack of uptake may reflect lack of knowledge about or confidence with such measures. However even self-

²¹⁰ Gask L, Sibbald B, Creed F. Evaluating Models of Working at the Interface Between Mental Health Services and Primary Care. *British Journal of Psychiatry* (1997) 170:6-11.

²¹¹ Katon W, Von Korff M, Lin E, et al. Stepped Collaborative Care for Primary Care Consumers with Persistent Symptoms of Depression: a Randomized Trial, *Archives of General Psychiatry*, (1999) 56: 1109-1115.

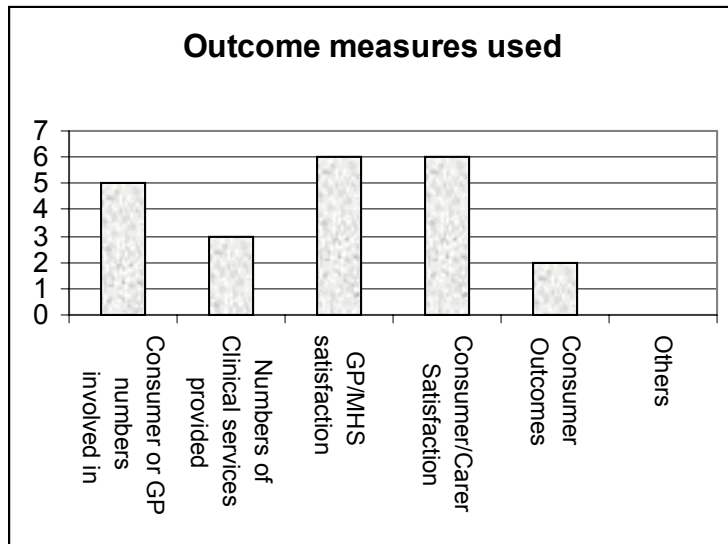
²¹² Price D, Beck A, Nimmer C, Bensen S. The Treatment of Anxiety Disorders in a Primary Care Setting, *Psychiatric Quarterly* 2000 71: 31-45.

²¹³ Steedman T, Yellowlees P, Mellis G, Clarke R, Drake S. *The Measurement of Consumer Outcomes in Mental Health* Canberra: ACT Department of Health and Family Services, 1997.

²¹⁴ Meadows G, Joubert L, Adamopoulos V, Harvey C (1999) *GPs Caring for the Long Term Mentally Ill: Is shared care quality care?* General Practice Evaluation Program project 518 Poster presentation GPEP Conference 1999.

completed measures of consumer/carer satisfaction [far less methodologically intimidating] have not been adopted by the majority of the programs.

Figure 6 Outcome measures used by shared care programs



The only conclusion that can be drawn from these figures is that the consumer and carer agenda still needs to be emphasised and given the recognition it deserves. The review group feels that this is an area where there will need to be further activity as programs become more sophisticated and established.

Evaluation

The survey asked respondents to indicate what types of evaluation indicators were being used. These indicators reflect the objectives of the program and to some degree the depth of development. The consumer outcome aspects of this question were mentioned above.

Process indicators

Numbers of consumers or GPs involved were used in over half of the programs (35/56 or 62.5%)

Actual numbers of clinical services were used in 13 of the 56 programs (23%).

Acceptability of programs to participants

GP/Mental health professional satisfaction with arrangements was evaluated in 36 out of 56 programs (64%).

Consumer/carer satisfaction with arrangements was evaluated in 16/56 programs.

Consumer Health Outcome Measures

As discussed above consumer health outcome measures were evaluated in only 12 of the 56 programs (21%).

The Centre for General Practice Integration Studies has undertaken considerable work in developing approaches to evaluation in mental health that are acceptable and applicable to general practice Divisions settings²¹⁵. Now that such measures have been established and that there has been some experience with their use in the shared care/partnership type programs it will be worthwhile exploring how their uptake can be further encouraged.

Other indicators used

Ten of the Divisions responded that they were using other outcome measures. These include GP knowledge, levels of confidence and attitudes, case note audit, and consumer involvement in case conferences.

Conclusions from the Survey

The survey data has revealed several important issues regarding current collaborative activities between Divisions of General Practice and mental health services.

First, approximately **half of all Divisions are involved** in shared care/partnerships activity with mental health services. The data provides evidence of an increase in the development and implementation of collaborative mental health programs by Divisions. This is contrary to earlier research, which predicted a decline in this area due to the shift from program to outcomes based funding in the late 1990s.

Second, of these, about **18 out of 123 Divisions have well developed “shared care” arrangements** which are multifaceted in nature. By this we mean that the more comprehensive programs incorporate a range of strategies including care planning, the development of service agreements/MoUs, clinical pathways and service plans. What this means is that many Divisions and mental health services have recognised and are addressing the need to improve communication across sectors and to establish strong organisational links.

The survey data also show a **trend towards the development of programs with the potential to benefit a broader range of consumers**. The tendency in the past has been toward the development of shared care programs aimed at improving outcomes for consumers with low prevalence disorders such as Schizophrenia. However, the survey data indicated an equal number of programs are aimed at meeting the needs of consumers with high prevalence disorders such as depression and anxiety. These are the consumers which GPs see more frequently. There is also clear evidence that many programs now have a dual focus on improving outcomes for both groups of consumers. Clearly then, the agendas of both general practice and specialised mental health services are starting to be met through these programs.

²¹⁵ Penrose-Wall J. Harris M. Hickie I. Aloizos J. *The Mental Health Agenda and Divisions of General Practice: Core Planning Issues in an Outcomes Planning Environment*. Sydney: Integration Support and Evaluation Resource Unit Centre for GP Integration Studies, October 1998.

Consumer participation in planning implementation and evaluation, while evident in a significant proportion of programs, still **needs to be developed further**.

The **sustainability of many of these programs remains questionable**. Whilst some programs are jointly funded across sectors, many still rely on specific initiative funding, such as the PMHCI, and there is little evidence that the collaborative activity will continue beyond the set funding periods. This is perhaps best explained in terms of the timeframes needed to effect cultural and systemic change. Similarly, a lack of rigorous evaluation has resulted in a poor evidence base for the sustainability of many programs. Without solid evidence of improved outcomes, whether they are clinical or structural outcomes, leaves Divisions with little bargaining power to access ongoing financial support from local and State health services.

CHAPTER 9 DISCUSSION

The overwhelming impression from the interviews is that the experience of the respondents reflects the published literature. There is considerable optimism tempered by practical realism about the challenges of health system change and collaboration.

Change is slow

The **cultural changes** that are required of both sectors need **time** to take effect. There is a series of steps that are required for that cultural change to occur. Figure 7 below outlines the dynamics between the different factors that make up the picture of collaboration between GPs and the specialty mental health sector. These dynamics are not isolated to the mental health setting but rather are common to various areas of the health system that are now needing to work better with one another because of structural changes to health care and the need to improve consumer health outcomes.

The time required is variable for good relations to develop. Opinions vary but “several years” is often mooted as the time required.

A common set of goals is also a crucial ingredient. In the early stages these goals need not be that ambitious. The absolute level of agreement is not paramount. There needs to be sufficient agreement across the stakeholders so that decisions can be made, resources allocated and changes put into effect but the “visions” do not need to overlap 100% early on in these developments. As early successes come about and relationships develop, the level of agreement is likely to increase.

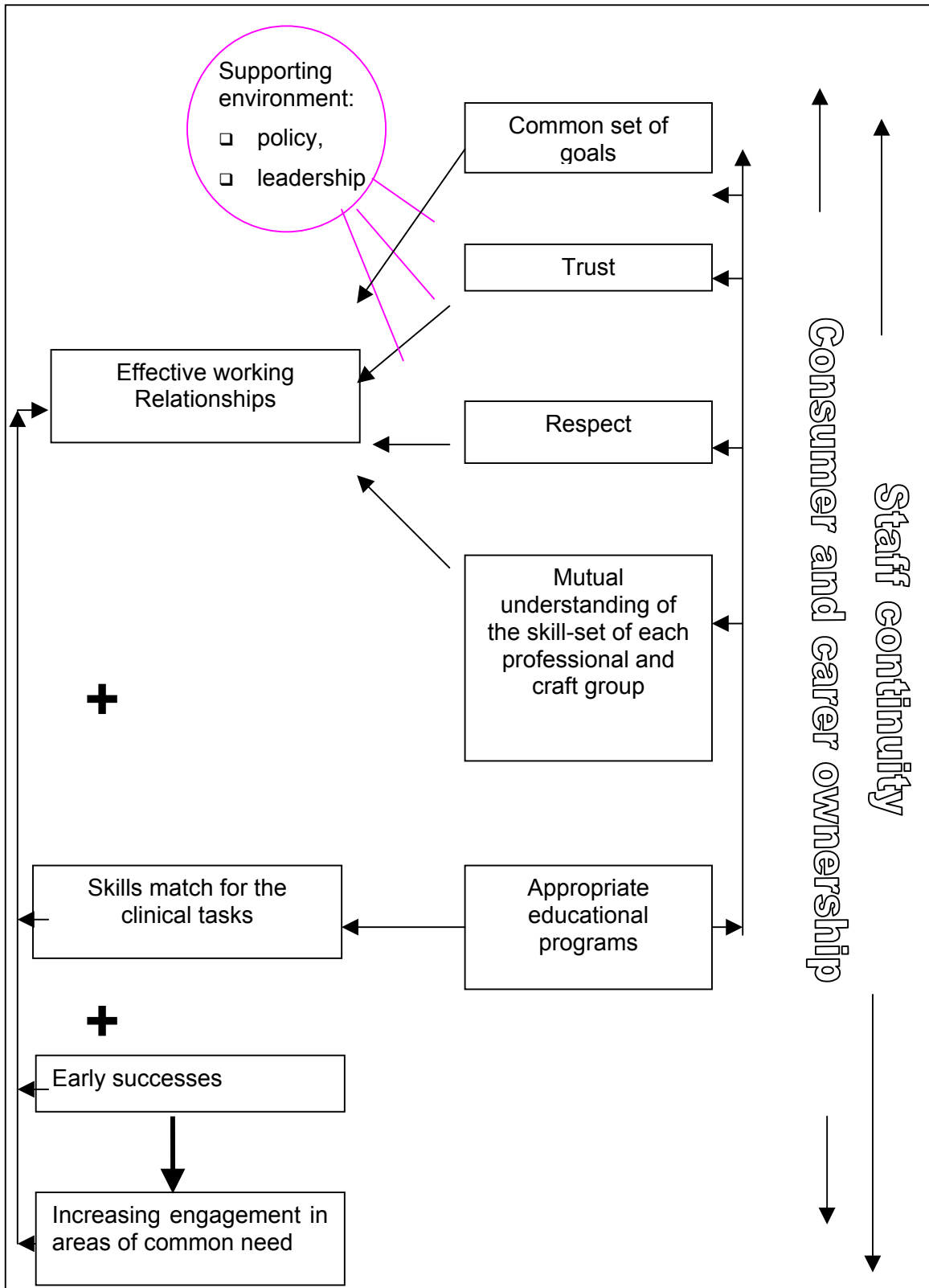
The critical element is the development of **good working relationships**. However **systems of care need to support** these relationships and the adoption of new roles for the different stakeholders, providers as well as consumers and carers. There is a limit to how much good partnership relationships can be sustained without a supportive environment. There will always be groups of enthusiasts. The challenge is to construct systems so that the reluctant majority becomes involved.

These and other dynamics which influence collaboration between GPs and specialist mental health providers is depicted diagrammatically in Figure 7.

Mutual understanding of roles and skill sets.

Traditionally GPs in Australia, especially in metropolitan areas, have not had significant experience working across disciplines. It is therefore not surprising that they are reluctant to change, given that they have had low levels of exposure to working this way. Comments that GPs prefer to work with psychiatrists solely reflect this type of pattern of behaviour. However, this may as much be due to lack of understanding of the role and skills of other mental health professionals as it is to professional chauvinism.

Figure 7 The dynamics between the different factors that make up the picture of collaboration between GPs and the specialty mental health sector



From the interviews it is clear that as understanding of each other's roles and skill-sets developed so too the relationship became more functional. Similarly lack of this type of understanding was identified as a major problem in some cases.

The respondents in the interviews frequently referred to the personal interactions they had as being important. Case conferences, case discussions, Balint groups, cross-discipline educational programs and clinical attachments all enable participants to better understand each others roles and skills. These types of outcomes are not usually measured when evaluating these activities as the primary focus is often on other educational content or clinical objectives.

As the complexity of the care that is delivered in the community increases (and not just in the mental health area) the need for multi-disciplinary teams increases. GPs are an important component of these as their generalist skills mix enables them to perform an often eclectic mix of tasks. Having these tasks and their required skills well recognised and agreed is another important pre-requisite of effective teams*.

Education

By definition GPs are exposed to "low prevalence conditions" infrequently [with a few exceptions such as GPs in inner urban areas with high case loads of people with schizophrenia and other psychoses]. In shared care type activities with these consumer groups, the need for GPs to increase their knowledge and skills is obvious. But this works both ways. It is evident from the survey that there are many shared care programs that also address the needs of people with high prevalence conditions. Specialist mental health professionals from the public sector who have not had much exposure to this group will similarly have educational needs in order to fulfil their new roles supporting GPs in the management of the more disabled people with these problems.

Supportive environment and structures

As discussed above relationships are important but the types of systems which encourage the "reluctant majority" to engage in closer collaboration with mental health services are equally important. In this sense there is a need to consider relationship development at an individual, organisation and system level.

The respondents commented in the final questions on expectations for the future and sustainability that more GPs needed to be involved and that shared care needed to be established as the "norm" for care of suitable people with mental health care needs.

Some respondents regarded the development of **MoUs or service agreements** as essential to more formal partnership arrangements. This reflects the similar findings in the survey of Divisions. While effective collaboration depends on many factors the formal development of service agreements indicates some commitment at senior management level. The challenge is then translating the ideas embedded in the agreements into practice. This requires some commitment and ownership at all levels of the services and general practices involved.

Continued funding to assist this process was seen as necessary to overcome the systemic barriers to working in this collaborative way. Most shared care activities are relatively recent and as stated above the trusting relationships are slow to develop and can be eroded easily. Even in the presence of well-established relationships, it is likely that such funding needs to continue to undertake the activities that are needed in a shared care setting. Client follow-up, organisation of case conferences, educational

meetings, liaison between members of a complex system of health care all take time and dedicated personnel and is unlikely that these tasks will become automatic and embedded within current practice without these additional resources.

One final word on supportive environments. Several respondents raised **staff continuity** as being crucial to sustaining shared care arrangements. The very basis for the collaborative work of shared care is the relationships between individual clinicians of the different disciplines. Staff turnover itself is often an indicator of an unsupportive environment. Turnover itself acts against close collaboration as it erodes the confidence and trust that the different parties have in each other.

Reach of programs

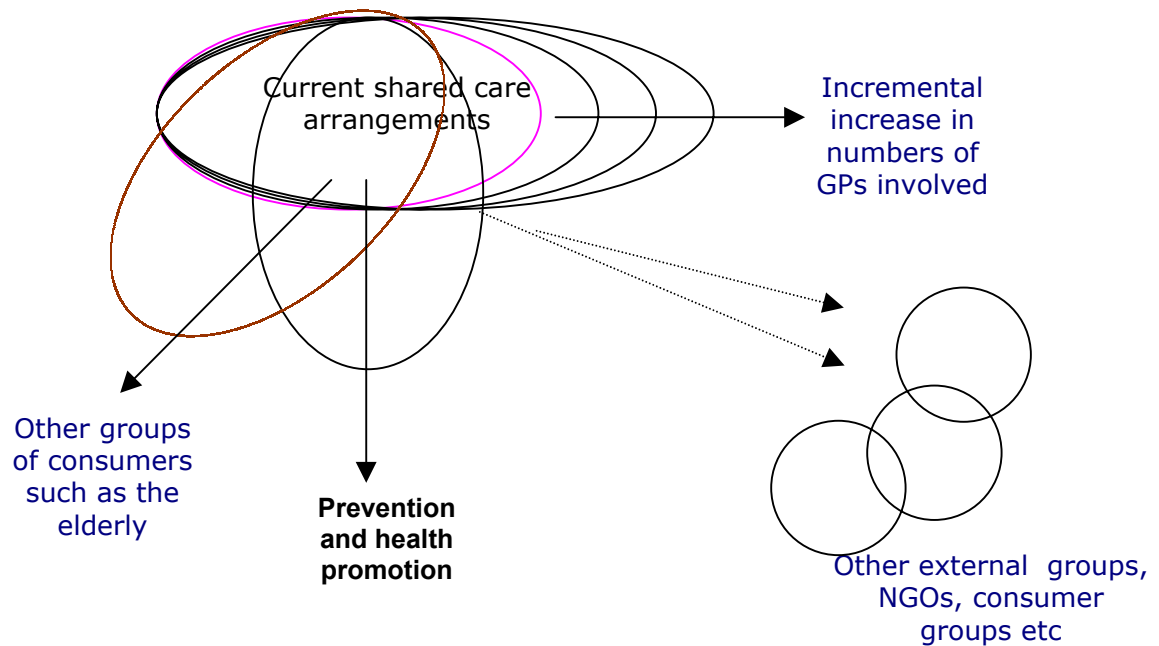
The current activities of Divisions with mental health shared care have limited reach. Those 18 or so Divisions with well established programs identified in the previous chapter, with a few exceptions, have relatively small numbers of clients and GPs involved.

If we were to take the proportion of client load that CLIPP has been able to engage in shared care as a benchmark then approximately 20% of public sector long term mental health clients could be suitable. Most shared care programs have fallen far short of this target. It is unclear whether this type of target is reasonable. On the other hand, it is also unclear whether an even greater proportion of clients could be involved. This would obviously depend on the skill set of the GP, the demographics of the locality and the amount of support that the mental health service could provide.

The comments from the respondents in the interviews seem to indicate an increase in reach in various ways:

- through incremental increases in the numbers of GPs and psychiatrists,
- through increased links with external agencies such as NGOs, consumer groups and other service providers,
- through development of the scope of the activities to include other client groups such as older people with mental health needs, people with severe depression or anxiety or somatoform disorders requiring multi-disciplinary services;
- through development of preventative and health promotional activities.

Figure 8 gives a diagrammatic representation of how the reach of programs might be extended.

Figure 8 Increasing the reach of shared care programs

Many of these comments reflect confidence arising from past experience and a willingness to look outside the area of current activity, to see where the processes of collaboration that have been developed can be applied in other areas of need.

Other comments acknowledge the current limited scope of activities and the need to expand operations to include more people with similar needs.

This variation of vision is entirely understandable given the variation in levels of development of programs across Divisions, even in this select group of respondents.

Consumer involvement

Consumer and carer involvement in health service planning and evaluation is here to stay. Orientation towards consumer-focused outcomes is an essential part of the quality improvement process.

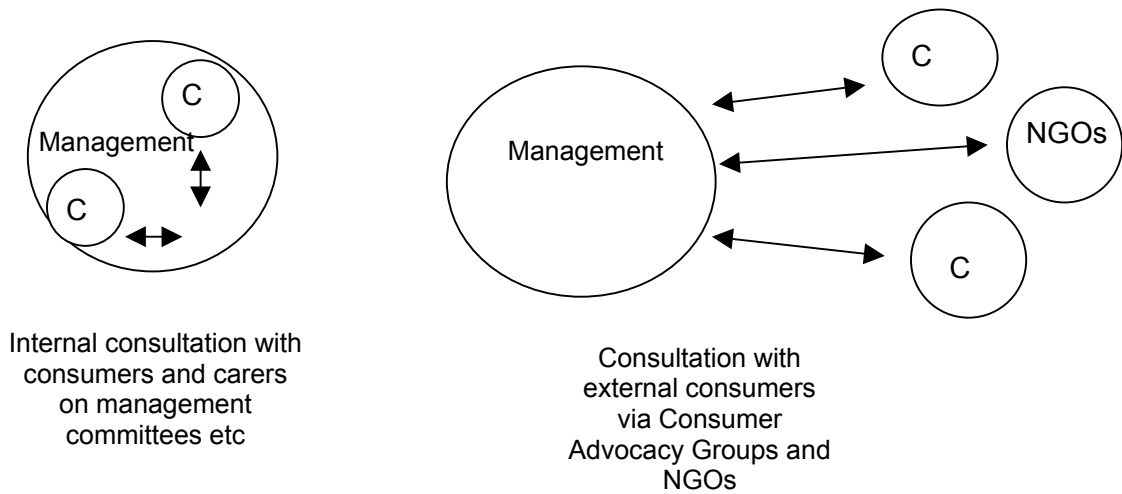
Along the continuum of consumer engagement it seems from the interviews that current mental health shared care activities engage consumers at the “consultation with” stage. True consumer driven changes where the consumer/health service relationship is one of full equality have not yet developed.

Nevertheless, there is evidence from the interviews that many programs do engage consumers at some level and that evaluations will increasingly involve consumer oriented outcomes.

The exact patterns or methods of consumer consultation or engagement are varied. As detailed in the section above on the outcomes of the Divisions survey, consumers may be involved in the management or steering committees or they may be consulted with externally or a combination of both.

Figure 9 Type of participation and degree of acceptance of consumers

C= consumers and carers, NGOs = Non government organisations



The type of participation and degree of acceptance of consumers within the planning structure is also difficult to assess from the methods that we have used in this review. The review did not interview consumers involved in the programs. This is an area worth exploration in the future.

Similarly, the degree to which consumers and their carers have been involved in decision-making regarding their care in shared care was not really clarified by the interviews. That having been said there are several examples of thorough procedures for involvement of consumers and carers in the care transfer process. Formal evaluation in some programs, for example CLIPP, has found high levels of consumer satisfaction with these arrangements.

Summary

The findings from the interviews are consistent with the literature and with the responses from the survey of Divisions.

Development of shared care arrangements requires time to develop good working relationships at several levels within mental health services and general practice.

Educational activities serve to ensure that the skills required are obtained. They also serve to enhance the relationships between GPs, mental health staff and at times consumer and carer organisations.

Consumers and carers need to be involved in all programs at various levels and evaluation needs to include consumer outcome measures.

There is ample scope for increasing the reach of mental health shared care/ partnership development by increasing the numbers of GPs involved and by broadening the scope of the activities.

While alternative sources of funding are now available through the Enhanced Primary Care items, there is still a need for resources to drive the use of these items and to continue to drive shared care activities.

CHAPTER 10 RECOMMENDATIONS

Education

Education is an important component of successful collaborative activities. Collaborative mental health care programs should include ongoing educational activities for all stakeholders including consumers, GPs and specialist mental health providers. Refresher training programs should be implemented annually. The education programs should:

- be based on adult education/learning principles;
- be developed, implemented and evaluated with input from all stakeholders including consumers;
- include joint education sessions with GPs and specialist mental health providers;
- include training activities which are skills based and focus on improving;
 - ♦ clinical knowledge i.e. diagnosis and treatment of mental health problems and specific mental disorders;
 - ♦ process knowledge/skills i.e. multidisciplinary case conferencing and care planning;
 - ♦ organisational knowledge/skills i.e. understanding of specific roles, relationships, responsibilities, team development and dynamics.

Organisation

Divisions not involved in mental health related activities should be encouraged to commence activities in this area. The implementation of the primary mental health care initiatives announced in the recent Federal Budget will necessarily involve all Divisions. Closer collaboration between GPs and the mental health sector, public, private and non-government, should be encouraged to support the uptake of these initiatives.

Integrated care for people with complex mental health care needs should be supported through:

- ongoing education for all participants including consumers;
- easy access for GPs to advice and clinical support by specialist mental health providers;
- improved communication practices between GPs and mental health providers. This will require improvements in information management and technology across the primary, secondary and tertiary sectors;
- encouragement of care planning and case conferencing using wherever possible the Enhanced Primary Care Items;
- development of service agreements; and
- development of care pathways and guidelines.

Programs should address the needs of the consumers of both GP services (i.e. mostly people with high prevalence conditions) and mental health services (i.e. mostly people with low prevalence conditions).

Programs should involve dedicated liaison and coordination staff who are preferably funded full-time.

Programs need to be implemented and have ownership at all levels of mental health services and should involve GPs at all stages of planning and implementation.

Consumers should be involved at all levels in the planning, implementation and evaluation of programs.

Collaborative programs should include integration with non-government and private sector providers.

Evaluation

All aspects of shared care programs should be evaluated including pre- and post-measures of:

- consumer satisfaction and consumer health outcomes;
- participant satisfaction;
- process measures such as communication, relationship development, types of meetings and numbers and nature of participants; and
- knowledge and skill development.

Divisional activities in mental health shared care should be re-evaluated in three years using a survey instrument similar to the one used in this review.

Funding

Primary mental health care incentive funding should be continued to support the ongoing development of partnerships between Divisions of General Practice and specialist mental health providers. Without an ongoing commitment to such funded a decline in collaborative activities is anticipated. It is not sufficient to expect that use of the EPC items alone, will foster closer collaboration.

Programs in mental health shared care should have a realistic funding time frame of at least three years. Shorter time frames are not conducive to the development of staff continuity and effective working relationships.

In order to ensure the sustainability of shared care programs and the development of systemic change, all participating organisations should contribute funding. This diversity ensures ownership of and commitment to the objectives of shared mental health care.

BIBLIOGRAPHY

- Allen RS. and Read J. 1997 Integrated mental health care: Practitioners perspectives. *Australian and New Zealand Journal of Psychiatry* 31(4) :496-503.
- Alsop, M. and Battye K. 1998 Integration of GPs and mental health services: the Northern Queensland integrated mental health program. In: Robertson, S. et al, eds. *THEMHS Conference 137* :132-137.
- Alsop, M. and Battye K. 1999 Integration of GPs and mental health services: the Northern Queensland Integrated Mental Health Program. *Aust J Prim Health Interchange* 5 (2) :20-6.
- Andrews G. 1994 *The Tolkein Report - A model for matching the available workforce to the demand for services*. Sydney: University of NSW, .
- Appleby NJ, Dunt D, Southern DM, Young D. 1999 General Practice Integration in Australia. *Australian Family Physician* ; 28 (8) :858-863.
- Australian Bureau of Statistics 1997 *Mental Health and Well-being Profile of Adults*, Canberra: ABS, .
- Australian Community Health Association 1993 *Manual of Standards for Community and Other Primary Health Care Services* Bondi Junction.
- Australian Divisions of General Practice. 2000 GP Scholarships in Mental Health Care. *Internal Documentation*, Canberra: .
- Australian Health Ministers 1992 *National Mental Health Plan*, 1992, Canberra: AGPS.
- Australian Health Ministers. 1998. *National Mental Health Plan*, Canberra: AGPS,
- Australian Health Ministers. 1998 *Second National Mental Health Plan*. Canberra: AGPS, .
- Australian Medical Workforce Advisory Committee, 1999 *The Specialist Psychiatry Workforce in Australia: Supply and Requirements 1999-2010*. Canberra: AGPS .
- Barber R, Sved Williams, A1996 Psychiatrists working in primary care: a survey of GPs attitudes. *ANZ Journal of Psychiatry* 30:278-286
- Basinski, D. 1996 . Ports in a storm: a postnatal depression rural support services project. *Proceedings of the 17th Conference of the Health Information Management Association of Australia, Sydney Convention and Exhibition Centre, Darling Harbour, 16-18 October Sydney, N.S.W.* Health Information Management Association of Australia .
- Berwick D. A primer on leading the improvement of systems. *BMJ* 1996 :619-622
- beyondblue: the National Depression Initiative. 2000 *Newsletter* 01 November 2000, Hawthorn West: National Depression Initiative,.
- Bindman J, Johnson S, Wright S, Szmukler G, Bebbington P, Kuipers E, Thornicroft G. 1997 Integration Between Primary and Secondary Services in the Severely Mentally Ill: Consumers and GPs Views. *British Journal of Psychiatry* ; 171: 169-174.
- Bird, D. C., D. Lambert, et al. 1995 . *Rural models for integrating primary care, mental health, and substance abuse treatment services*. Portland: ME RHRC 62.
- Blakeman T, Harris M, Comino E, Zwar N. 2001 Implementation of the enhanced primary care items required ongoing education and evaluation. *Australian Family Physician* ; 30: 75-77.
- Blewett N. 2000 The Politics of Health. *Australian Health Review*; 23: 2 p13.
- Blount, A. 1998 . Introduction to integrated primary care. Blount, Alexander Ed ; et-al. 1998 . *Integrated primary care: The future of medical and mental health collaboration*. pp. 1-43 . New York, NY, USA: W.W. Norton & Co, Inc.

- Bodlund, O., S. O. Andersson, et al. 1999 . Effects of consulting psychiatrist in primary care. 1-year follow-up of diagnosing and treating anxiety and depression. *Scandinavian Journal of Primary Health Care* 17 (3) :153-7.
- Bower P, Sibbald B. On-site mental health workers in primary care: effects on professional practice. *Cochrane database of systematic reviews*, 2000.
- Bower, P. and B. Sibbald 2000 . Do consultation-liaison services change the behavior of primary care providers? A review. *General Hospital Psychiatry* 22 (2) :84-96.
- Bower, P. and B. Sibbald 2000 . On-site mental health workers in primary care: effects on professional practice. [Systematic Review] Cochrane Effective Practice and Organisation of Care Group. *Cochrane Database of Systematic Reviews*: 3.
- Brodsky H, Draper B, Lie D. 1997 Psychogeriatrics and General Practice in Australia. *International Journal of Psychiatry in Medicine* 27 (3) :205-213.
- Burdekin Commissioners Report. Human Rights and Equal Opportunity Commission Human Rights and Mental Illness. 1993 *Report of the National Inquiry into the Human Rights of People with Mental Illness*. Canberra: AGPS, .
- Carey, M. 1998 . Communities of shared experience. *Aust Health* 6 :75-114.
- Carr V Carr VJ; Faehrmann C; Lewin TJ; Walton JM; Reid AA 1997 *Determining the effect that consultation-liaison psychiatry in primary care has on family physicians psychiatric knowledge and practice* *Psychosomatics* May-Jun 38 (3) :217-29 ISSN: 0033-3182
- Carr V, Reid A. 1996 Seeking Solutions for Mental Health Problems in General Practice. *Medical Journal of Australia* October 165 (21) :435-436.
- Carr VJ, Faehrmann C, Lewin TJ, Walton JM, Reid AA. 1997 Determining the effect that consultation-liaison psychiatry in primary care has on family physicians psychiatric knowledge and practice. *Psychosomatics* 38 (3) :217-29.
- Carr VJ, Lewin TJ, Reid AL, Walton JM, Faehrmann C. 1997 An evaluation of the effectiveness of a consultation-liaison psychiatry service in general practice. *Australian & New Zealand Journal of Psychiatry* 31 (5) :714-25.
- Carr, V. J., C. Faehrmann, et al. 1997 . Determining the effect that consultation-liaison psychiatry in primary care has on family physicians psychiatric knowledge and practice. *Psychosomatics* 38 (3) :217-29.
- Carr, V. J., T. J. Lewin, et al. 1997 . Consultation-liaison psychiatry in general practice [see comments]. *Australian & New Zealand Journal of Psychiatry* 31 (1) :85-94.
- CLIPP Manual on line <http://www.dhs.vic.gov.au/acmh/mh/clipp/apps.htm>
- Commonwealth Department of Health & Aged Care & The Australian Institute of Health & Welfare. 1998 *National Health Priorities Areas Mental Health: A Report focusing on Depression*. Canberra: AIHW.
- Commonwealth Department of Health & Aged Care. 1999 *Draft Depression Action Plan*. Canberra: Commonwealth Department of Health & Aged Care, .
- Commonwealth Department of Health & Family Services. 1996 *National Standards for Mental Health Services*. Canberra: AGPS, .
- Commonwealth Department of Health and Aged Care. *Better outcomes in mental health care, Fact Sheet 2, Budget 2001-2002*, <http://www.health.gov.au/budget2001/fact/hfact2.htm>. accessed 22 May 2001.
- Commonwealth Department of Health and Aged Care. 1999. *Interim Report for Evaluation of Coordinated Care*: Canberra: Commonwealth Department of Health and Aged Care. 1999.

- Connolly, P. M. 1995 .Transdisciplinary collaboration of academia and practice in the area of serious mental illness. *Aust NZ J Ment Health Nurs* 4 (4) :168-80.
- Consumer Focus Collaboration *Education and Training for Consumer Participation in Health Care; Final Project Report*. <http://nrccph.latrobe.edu.au/Text/etfreport1.pdf>
- Cox K 1999 Persuading colleagues to change: fifteen lessons learned from more than 20 years of trying *Education for Health* 12 (3) :347-353
- Creed, F. and B. Marks 1989 . Liaison psychiatry in general practice: a comparison of the liaison-attachment scheme and shifted outconsumer clinic models. *Journal of the Royal College of GPs* 39 (329) :514-7.
- Cummings, Nicholas A. Ed ; Cummings, Janet L. Ed ; et-al. 1997 . *Behavioral health in primary care: A guide for clinical integration*. pp. 37-58 . Madison, CT, USA: Psychosocial Press/International Universities Press, Inc.
- Davies J, Ward W, Groom G, Wild A, Wild S. 1997 The Case-Conferencing Project: A First Step Towards Shared care Between GPs and A Mental Health Service. *Australian & New Zealand Journal of Psychiatry* 31 :751-755.
- Deans, K. E. 1997 . Service agreements: an effective tool for managing resources, expectations and performance -abstract. *Australian Pharmacy* 15 (11) suppl :1-2.
- deGroot, C.-S., D.-W. Price, et al. 1998 . Lessons learned: A collaborative care demonstration project. *Families, Systems and Health* 16 (1-2) :127-138.
- DeLeon, P.-H. and J.-G. Williams 1997 Evaluation research and public policy formation: Are psychologists collectively willing to accept unpopular findings? *American Psychologist* 52 (5) :551-552.
- Department of Human Services & Health, Australian Medical Association, Royal Australian College of GPs, General Practice Consultative Committee. 1992. *The Future of General Practice: A Strategy for the Nineties & Beyond*. Canberra: Department of Human Services and Health,
- Doherty W, McDaniel S, Baird M. 1996 Five Levels of Primary Care/Behavioural Healthcare Collaboration. *Behavioural Healthcare Tomorrow* October :25-28.
- Dowrick C. Improving Mental Health Through Primary Care. 1992 *British Journal of General Practice* 42 :382-386.
- Dyer, J. G., K. Hammill, et al. 1997 The psychiatric-primary care nurse practitioner: a futuristic model for advanced practice psychiatric-mental health nursing *Archives of Psychiatric Nursing* 11 (1) :2-12.
- Ettner, S. L., R. C. Hermann, et al. 1999 . Differences between generalists and mental health specialists in the psychiatric treatment of Medicare beneficiaries. *Health Services Research* 34 (3) :737-60.
- Falloon, I. R., B. Ng, et al. 1995 . The role of GPs in mental health care: a survey of needs and problems. *New Zealand Medical Journal* 109 (1015) :34-6.
- Firth-Cousins J 1998 Celebrating teamwork *Quality in Health Care* 7 suppl s3-s7
- Fischer, L.-R., R.-L. Heinrich, et al. 1997 . Mental health and primary care in an HMO. *Families, Systems and Health* 15 (4) :379-391.
- Fletz-Cornelis CM, Lyons JS, Huyse FJ. 1997 *International Journal of Psychiatry in Medicine* 27 (1) :1-21.
- Fridgant, Y., G. P. Powell Davies, et al. 1998 . Integration of GPs with hospitals and community health services: a qualitative examination. *Aust J Prim Health Interchange* 4 (4) :68-78.
- Gask L, Sibbald B, Creed F Evaluating Models of working at the interface between mental health services and primary care. *British J of Psychiatry* 1997 170:6-11

- General Practice Strategy Review Group. 1998 *General Practice: Changing the Future Through Partnerships*. Canberra: Commonwealth Department of Health & Family Services, .
- Gersons, B. 1990 . The competitive relationship between mental health services and family practice: Future implications. In Goldberg, David Ed ; Tantam, Digby Ed ; et-al. 1990 . *The public health impact of mental disorder*. pp. 214-220 . Goettingen, Germany: Hogrefe & Huber Publishers.
- Goetz, R.-R., D.-A. Pollack, et al. 1999 . *Advancing mental health and primary care collaboration in the public sector*, San Francisco CA USA: Jossey-Bass Inc Publishers. 1999 .
- Goldberg D, Gask L. undated Improving the Mental Health Skills of GPs. *Supplementary Notes to WPA Learning Package*, London: .
- Goldberg D, Huxley P. 1992 *Common Mental Disorders: A Bio-social Model*. London: Tavistock Routledge, .
- Goldberg D. 1998 Training GPs in Mental Health Skills. *International Review of Psychiatry* ; 10 (2) :102-105.
- Goldberg, D. 2000 . Plato versus Aristotle: Categorical and dimensional models for common mental disorders. *Comprehensive Psychiatry* 41 (2) Suppl 1 :8-13.
- Goldberg, D., G. Jackson, et al. 1996 . The treatment of common mental disorders by a community team based in primary care: A cost-effectiveness study. *Psychological Medicine* 26 (3) :487-492.
- Goldberg, R. J. ? date . Financial incentives influencing the integration of mental health care and primary care. *Psychiatric Services* 50 (8) :1071-5.
- Goldberg D & Gask L. undated. Improving the Mental Health Skills of GPs. *Supplementary Notes to WPA Learning Package*, London:
- Gribble R Shared Care but not consultation-liaison psychiatry *ANZ Journal of Psychiatry* 32 (2) :311-313
- Gribble, R. 1998 . Shared care but not consultation-liaison psychiatry. *Australian and New Zealand Journal of Psychiatry* 32 (2) :311-313.
- Hall, D. and J. Tomlinson 1999 . Mental health and a mature society: who cares? *Aust J Prim Health Interchange* 5 (1) :8-20.
- Harding, C. M. 1997 . The limited resources debate: changing the rules of the game to a win-win scenario. *Australas Psychiatry* 5 (6) :271-3.
- Harding, T. W., C. E. Climent, et al. 1983 . The WHO collaborative study on strategies for extending mental health care, II: The development of new research methods. *American Journal of Psychiatry* 140 (11) :1474-80.
- Harris M, Powell-Davies G. 1999 Shared care through divisions of general practice: moving forward. *Medical Journal of Australia* 171 :85-88.
- Heard S, Schloeffel P, Beale T *The Good electronic Health Record in Australian General Practice Background Paper on the GPCG implementation trial*. <http://www.gehr.org/Gehroz.pdf>
- Herman, S.-E., K.-A. Frank, et al. 2000 . Longitudinal effects of integrated treatment on alcohol use for persons with serious mental illness and substance use disorders. *Journal of Behavioral Health Services and Research* 27 (3) :286-302.
- Hickie I. 1999 Primary care psychiatry is not specialist psychiatry in general practice. *Med J Aust*; 170 :171-173.
- Hickie I. 2000 An Approach to Managing Depression in General Practice. *Clinical Practice* 173 :106-110.

- Hickie, I. B., E. M. Scott, et al. 1999 . An agenda for psychiatric education in primary care. *Australas Psychiatry* 7 (3) :133-6.
- Hilty, D.-M., M.-E. Servis, et al. 1999 . The use of telemedicine to provide consultation-liaison service to the primary care setting. *Psychiatric Annals* 29 (7) :421-427.
- Hoagwood, K. 1997 . Interpreting nullity: The Fort Bragg experiment--A comparative success or failure? *American Psychologist* 52 (5) :546-550.
- Hoge, M.-A. and R.-A. Howenstine 1997 . Organisational development strategies for integrating mental health services. *Community Mental Health Journal* 33 (3) :175-187.
- Holman H, Lorig K. 2000; Consumers as partners in managing chronic disease: Partnership is a prerequisite for effective and efficient health care. *BMJ* 320:526-7
- Holmwood, C. 1998 . Challenges facing primary care mental health in Australia. *Australian Family Physician* 27: 716-719.
- Honeyman, A. 1998 . Can general practice meet consumer needs? *Aust Health Consum* 1: 20-1.
- Horder J. 1988 Working with GPs. *British Journal of Psychiatry*; 153: 513-520.
- Hornsby Ku-ring-gai Division of General Practice *Shared Care Project Draft final report* 93-0401.5
- Howe B. 1991 *Health Care in Australia: Directions for Reform in the 1991-92 Budget*. Budget Related Paper No 9, Canberra: AGPS, .
- Huxley, P. 1996 .Mental illness in the community: The Goldberg-Huxley model of the pathway to psychiatric care. *Nordic Journal of Psychiatry* 50 Suppl 37 : 47-53.
- Integration Support and Evaluation Resource Unit. 1997 *From Projects to Programs: Sharing Mental Health Care: A guide for Divisions of General Practice*, Sydney: UNSW, .
- Jackson, G., R. Gater, et al. 1993 . A new community mental health team based in primary care: A description of the service and its effect on service use in the first year. *British Journal of Psychiatry* 162: 375-384.
- Jessop, N., J. Hassall, et al. 2000 .Community treatment for heavy users of private mental health services: who benefits? *Australas Psychiatry* 8 (1) :56-8.
- Joint Consultative Committee on Psychiatry of the Royal Australian College of GPs and the Royal Australian and New Zealand College of Psychiatrists. 1997 *Primary Care Psychiatry: The Last Frontier*. Canberra: Commonwealth Department of Health & Family Services.
- Kaeser A Cooper B. 1971 The Psychiatric Consumer, The GP, and the Outconsumer Clinic: An Operational Study and a Review. *Psychological Medicine* 1: 312-325.
- Kanter R. 1994 Collaborative Advantage: The Art of Alliances. *Harvard Business Review* July-August ; 96-108.
- Kates, N., M. Craven, et al. 1997 . Integrating mental health services within primary care: A Canadian program. *General Hospital Psychiatry* 19 (5) :324-332.
- Katon W, Robinson P, Von Korff M et al A multi faceted intervention to improve the treatment of depressions in primary care *Arch of Gen Psychiatry* 1996 53:924-932
- Katon W, Von Korff M Lin E A randomised trial of psychiatric consultation with distressed high utilisers. *Gen Hosp Psychiatry* 1992 14:86-89
- Katon W, Von Korff M, Lin E, et al Stepped Collaborative Care for Primary Care Consumers with Persistent Symptoms of Depression: a Randomized Trial *Arch Gen Psych* 1999 56: 1109-1115

- Katon, W., C. M. Rutter, et al. 2000 . Are there detectable differences in quality of care or outcome of depression across primary care providers? *Medical Care* 38 (6) :552-61.
- Katon, W., M. Von Korff, et al. 1995 . Collaborative management to achieve treatment guidelines. Impact on depression in primary care. *JAMA* 273 (13) :1026-31.
- Katon, W., M. Von Korff, et al. 1997 . Collaborative management to achieve depression treatment guidelines. *Journal of Clinical Psychiatry* 1: 20-3.
- Katon, W., M. Von-Korff, et al. 1999 . Stepped collaborative care for primary care consumers with persistent symptoms of depression: A randomized trial. *Archives of General Psychiatry* 56 (12) :1109-1115.
- Keegan Julie, A. 1998 . The nurse practitioner in community-based mental health services : a shared care model. *Australian & New Zealand College of Mental Health Nurses. Conference:* 387-393.
- Keegan, J. 1998 . Community-based mental health care: bridging the gap between community care and primary care. *Aust NZ J Ment Health Nurs* 7 (3) :95-102.
- Keks N, Altson B, Sacks T, Hustig H, Tanaghow 1998 A. Collaboration Between General Practice and Community Psychiatric Services for People with Chronic Mental Illness. *MJA Practice Essentials - Mental Health*. Sydney: Australasian Medical Publishing Company .
- Keks, N. A., B. M. Altson, et al. 1997 . Collaboration between general practice and community psychiatric services for people with chronic mental illness. *Medical Journal of Australia* 167: 266-271.
- Kendrick, T., T. Burns, et al. 2000 . Are specialist mental health services being targeted on the most needy consumers? The effects of setting up special services in general practice. *British Journal of General Practice* 50 (451) :121-6.
- Kerwick S, Jones R, Mann A, Goldberg D. 1997 Mental Health Care Training Priorities in General Practice. *British Journal of General Practice* April 47:225-227.
- King R. *General Practice and Psychiatry Partnerships Program, Draft Report*. Brisbane: University of Queensland, 2001.
- King, R., M. Bentley, et al. 2000 . Regional health development partnerships. *Med Today* 1 (3) : 156-8.
- Knight R. 1996 An Overview of General Practice in Australia, in Commonwealth Department of Health & Family Services. *General Practice in Australia*. Canberra: General Practice Branch of the Commonwealth Department of Health & Family Services .
- Lawler, L., A. Phillips, et al. 1998 . Innovative partnerships in the delivery of mental health care: GPs in a community rehabilitation setting. In: Robertson, S. et al, eds. *THEMHS Conference* 361: 355-361.
- Liu, L., A. Stiffman, et al. Organizational assessment of mental health service delivery networks [abstract]. *Abstract Book/Association for Health Services Research* 15: 242.
- Llewellyn Jones, R., S. Castell, et al. 1995 . A collaborative shared care program for late life depression. In: Kellhear, K. et al, eds. *THEMHS Conference* 74: 68-74.
- Logan Area Division of General Practice *Logan Area Division of General Practice Case Conferencing Project*. Twelve month progress report Project 95-0404.02
- Luk E, Mildred H, Fisher S, Brann P. 1998 *Shared Care In Child And Adolescent Health, The SCCAP Project*, Victoria: Mental Health Branch, DHS, .
- Magruder, K.-M. and G.-S. Norquist 1999 . Structural issues and policy in the primary care management of depression. *Journal of Clinical Psychiatry* 60 Suppl 7 :45-51.

Marzillier, J. 1987 . Clinical psychology and primary health care. Marzillier, John Ed ; Hall, John Ed ; et-al. *What is clinical psychology?* 3rd ed. pp. 294-317 . New York, NY, US: Oxford University Press.

Mathers CD, Vos ET, Stevenson CE. 2000 The Australian Burden of Disease Study: measuring the loss of health from diseases, injuries and risk factors. *Med J Aust* ; 172: 592-596.

McAuley, I. 1998 . Funding general practice. *Aust Health Consum* 1: 22-3.

McKay B. 1996 *Issues and Options: Supplementary Paper: Optimum Supply and Effective Use of Psychiatrists, A Project for the National Mental Health Strategy*, Canberra: AGPS .

Meadows G, Joubert L, Adamopoulos V, Harvey C 1999 GPs Caring for the Long Term Mentally Ill: Is shared care quality care? General Practice Evaluation Program project 518 Poster presentation *GPEP Conference 1999*

Meadows G, Nelson K, Wilhelm K. 1999 A Conceptual Model for Containing Approaches to Collaborative Work in Primary Mental Health Care. Ed. P. Ellis, *Geigy Psychiatric Symposium: Shared Care*, Castle Hill: Novartis Australia

Meadows, G. N. 1998 . Establishing a collaborative service model for primary mental health care. *Medical Journal of Australia* 168: 162-165.

Mental Health Council of Australia 2000 *Enhancing Relationships between Health Professionals and Consumers and Carers. Final Report June 2000* Canberra ACT Commonwealth Department of Health and Aged Care.

Merkes, M. 1998 Examples of exemplary practice in adolescent primary health care. *Aust J Prim Health Interchange* 4 (1) :37-48.

Mihalopoulos C, Prikis J, Naccarella L, Dunt D. 1999 *The role of GPs and other Primary Care Agencies in Transcultural Mental Health*. Melbourne: Australian Transcultural Mental Health Network,

Mildred, H., P. Brann, et al. 2000 . Collaboration between GPs and a child and adolescent mental health service. *Australian Family Physician* 29 (2) :177-81.

Minkoff, K. 1997 . Integration of addiction and psychiatric services. In Minkoff, Kenneth Ed ; Pollack, David Ed ; et-al. 1997 . *Managed mental health care in the public sector: A survival manual. Chronic mental illness*, Vol. 4. pp. 233-245 . Singapore: Harwood Academic Publishers.

Mitchell A. Psychiatrists in Primary Care Settings. 1985 *British Journal of Psychiatry* 147: 371-379.

Mullan, J. R. 1999 . Community liaison pharmacy: working with the Illawarra Division of General Practice and the Illawarra Area Health Service in 1998. *Aust J Hosp Pharm* 29 (4) :217-9.

Murray CJ & Lopez A. 1996 *The Global Burden of Disease*. Harvard: Harvard University Press

National Centre for Epidemiology and Population Health. 1991 *The Role of Primary Care in Health Promotion in Australia*. Report Undertaken by NCEPH for the Commonwealth Department of Health, Housing and Community Services under the National Better Health Program. Canberra: .

National Mental Health Strategy Evaluation Steering Committee. 1997 *Evaluation of the National Mental Health Strategy: Final Report*. Prepared for the Health Ministers Advisory Council, Canberra: AGPS

Nelson K, Cumming J, Duncanson M, MacEwan 1997 V. Policy and practical issues in setting up shared care for people with ongoing needs from mental health services, in *THEMHS conference proceedings*. Sydney: Standard Publishing House 209-214.

New England Health Service NSW 1994 *What do GPs need to know?* Mental Health Education Unit.

Nutbeam D, Wise M, Bauman A, Harris E, & Leeder S. 1993 *Goals and Targets for Australia's Health in the Year 2000 and Beyond*. Canberra: AGPS

Ochocka, J., G. Nelson, et al. 1999 Organizational change towards the empowerment-community integration paradigm in community mental health. *Canadian Journal of Community Mental Health* 18 (2) :59-72.

O Connor, N. and S. Willcock 1997 . A shared care model of mental health care: idealism meets reality. In: Miller et al, eds. *THEMHS Conference Tapestry: weaving the threads together*. Balmain, NSW: The Mental Health Services Conference Inc. of Australia and New Zealand, 1998: 233-238.

O Connor, N., J. Barry, et al. 1995 Shared mental health care at Hornsby Ku-ring-gai, Sydney. In: Kellehear, K. et al, eds. *THEMHS Conference* 101: 92-101.

Onyett, S. 1997 Collaboration and the community mental health team. *Journal of Interprofessional Care* 11 (3) :257-267.

Owen, C. and et al. 1999 . A model for clinical and educational psychiatric service delivery in remote communities. *Australian and New Zealand Journal of Psychiatry* 33: 372-378.

Oxman AD; Thomson MA; Davis DA; Haynes RB 1995 No magic bullets: a systematic review of 102 trials of interventions to improve professional practice. *CMAJ*, 153 (10) :1423-31 Nov 15

Oxman, T. E. 1996 . Geriatric psychiatry at the interface of consultation-liaison psychiatry and primary care. *International Journal of Psychiatry in Medicine* 26 (2) :145-53.

Parker, G. 1997 Public mental health service delivery: a modified model. *Australas Psychiatry* 5 4 : 167-9.

Paton, M., M. Tobin, et al. 1999 . Integrating public and private psychiatric practice: from national agenda to personal experience. *Australas Psychiatry* 7 (3) :143-6.

Patterson, D. Y., D. Happ, et al. 1998 . Dialogue. Carve-out or HMO: which will serve public sector beneficiaries better? *Behavioral Healthcare Tomorrow* 7 (2) :32-8.

Paulsen RH. 1996 Psychiatry and Primary care as neighbors: From the promethean primary care physician to multidisciplinary clinic. *International Journal of Psychiatry in Medicine* 26 (2) :113-125.

Paykel ES, Hart D, Preist RG. 1998 Changes in Public Attitudes to Depression During the Defeat Depression Campaign. *British Journal of Psychiatry* ; 173: 519-522.

Penrose-Wall J, Copeland J, & Harris M. 2000 *Shared Care of Illicit Drug Problems by GPs and Primary Care Providers: A Literature Review*. Sydney: Centre for General Practice Integration Studies, University of New South Wales.

Penrose-Wall, J., Harris, M. Hickie, I., Aloizos, J. October 1998 *The Mental Health Agenda and Divisions of General Practice: Core Planning Issues in an Outcomes Planning Environment* Integration Support and Evaluation Resource Unit Centre for GP Integration Studies

Phelan, D. 1995 .The psychiatrist in primary care: Let s look before we leap. *Irish Journal of Psychological Medicine* 12 (1) :17-21.

Phongsaven P, Ward J, Oldenberg B, Gordon J. 1995 Mental Health Care Practices and Educational Needs of GPs. *Medical Journal of Australia* 162 : 39-142.

Polivka, B.-J., C. Kennedy, et al. 1997 Collaboration between local public health and community mental health agencies. *Research in Nursing and Health* 20 (2) :153-160.

Price D, Beck A, Nimmer C, Bensen S 2000 *The Treatment of Anxiety Disorders in a Primary Care Setting* *Psychiatric Quarterly* 71 :31-45

- Price, D., A. Beck, et al. 2000 . The treatment of anxiety disorders in a primary care HMO setting. *Psychiatric Quarterly* 71 (1) :31-45.
- Primary Mental Health Care Australian Resource Centre Electronic Library
<http://som.flinders.edu.au/fusa/PARC>
- Provan, K.-G. 1997 . Services integration for vulnerable populations: Lessons from community mental health. *Family and Community Health* 19 (4) :19-30.
- Pullen I, Yellowlees A. 1985 Is Communication Improving Between GPs and Psychiatrists?. *British Medical Journal* 290 :31-33.
- RACGP RANZCP Joint Consultative Committee Report 1997 *Primary Care Psychiatry-the Last Frontier* Canberra
- Radley, A., D. Cramer, et al. 1997 . Specialist counsellors in primary care: The experience and preferences of GPs. *Counselling Psychology Quarterly* 10 (2) :165-173.
- Rand, E.-H. and T.-L. Thompson, II 1997 Using successful models of care to guide the teaching of psychiatry in primary care. *Psychosomatics* 38 (2) :140-147.
- Reilly, J. 1997 An evaluation of the effectiveness of a consultation-liaison psychiatry service in general practice : Comment. *Australian and New Zealand Journal of Psychiatry* 31 (5) :726-727.
- Ridgely, M. S., J. Giard, et al. 1999 Florida s Medicaid mental health carve-out: Lessons from the first years of implementation. *Journal of Behavioral Health Services and Research* 26 (4) :400-415.
- Rix S, Paykel ES, Lelliott P, Tylee A, Freeling P, Gask L, Hart D. 1999 Impact of a National Campaign on GP Education: An Evaluation of the Defeat Depression Campaign. *British Journal of General Practice* 49 (439) :91-91.
- Rizzoli, H. 1998 The mainstreaming of psychiatric services in Victoria: Rome wasn t built in a day or even a week . *Aust J Prim Health Interchange* 4 (4) :68-78.
- Rogers W, Veale B. 2000 *Primary Health Care and General Practice: A Scoping Report*. Adelaide: NIS, Department of General Practice, Flinders University
- Rohland, B.-M., J.-E. Rohrer, et al. 1999 Substitution of psychiatric care by primary care physicians: Impact of the Iowa Medicaid managed mental health care plan. *Administration and Policy in Mental Health* 26 (5) :369-371.
- Rost, K., P. A. Nutting, et al. 2000 . Designing and implementing a primary care intervention trial to improve the quality and outcome of care for major depression. *General Hospital Psychiatry* 22 (2) :66-77.
- Royal Australian College of GPs. 1995 *All Things to All People: The GP as Provider of Mental Health Care: Role, Benefits, Problems, Some Solutions*. Toorak: RACGP Victoria Faculty
- Royal Australian College of GPs. 1984 *Policy Number 30*, RACGP Council: September .
- Rupert R. Ed ; Pollack, David A. Ed ; et-al. 1999 . *Advancing mental health and primary care collaboration in the public sector. New directions for mental health services*, No. 81. pp. 7-15 . San Francisco, CA, USA: Jossey-Bass Inc, Publishers.
- Saltman, D. C. 1995 . Primary health care: the role for pharmacists and GPs. *Aboriginal Isl Health Work J* 19 (1) :30-2.
- Scott, Robert A. Ed ; et-al. 1990 . *Mental health care delivery: Innovations, impediments and implementation*. pp. 61-68 . Cambridge, England UK: Cambridge University Press.
- Sechrest, L. and M. Walsh 1997 . Dogma or data: Bragging rights. *American Psychologist* 52 (5) :536-540.

Secker, J., F. Pidd, et al. 2000 . Mental health in the community: Roles, responsibilities and organisation of primary care and specialist services. *Journal of Interprofessional Care* 14 (1) :49-58.

Shepard M. 1995 Primary Care Psychiatry: Health Services Research is Not Enough. *British Journal of Psychiatry* 166: 1-3.

Smith, G. C. 1998 . From consultation-liaison psychiatry to psychosocial advocacy: maintaining psychiatry's scope. *Australian & New Zealand Journal of Psychiatry* 32 (6) :753-61; discussion 762-6.

South Australian Rural Divisions Coordinating Unit *Mental health case conferencing seeding project. Project evaluation report.* Project 96-0550.5

Starfield, B. 1996 . Public health and primary care: a framework for proposed linkages. *American Journal of Public Health* 86 (10) :1365-9.

Steedman T, Yellowlees P, Mellsop G, Clarke R, Drake S 1997 *The Measurement of Consumer Outcomes in Mental Health* Canberra ACT Department of Health and Family Services

Strathdee G, Williams P. 1984 A Survey of Psychiatrists in Primary Care: The Silent Growth of a New Service. *Journal of the Royal College of GPs* 34: 615-618.

Stroup, T. S. 1997 Managed behavioral health care in the public sector. *Harvard Review of Psychiatry* 5 (1) :47-49.

Strozier, M. and M. Walsh 1998 . Developmental models for integrating medical and mental healthcare. *Families, Systems and Health* 16 (1-2) :27-40.

The Royal Australian College of GPs 2000 *Standards for General Practice* Melbourne : RACGP.

Thomas RVR, Forney RH. 1993 Working with community mental health professionals: a survey amongst GPs. *British Journal of General Practice* ; 43: 417-21.

Thomson O'Brien MA, Oxman AD, Haynes RB, Davis DA, Freemantle N, Harvey EL. 2001 *Local opinion leaders: effects on professional practice and health care outcomes* Cochrane Review . In: The Cochrane Library, Issue 2, 2001. Oxford: Update Software.

Tobin, M. and G. Norris 1998 .Mental health and general practice: improving linkages using a total quality management approach. *Australian Health Review* 21 (2) :100-10.

Tobin, M. J. 1996 Rural psychiatric services. *Australian & New Zealand Journal of Psychiatry* 30 (1) :114-23.

Topping, S., R. Boothe, et al. The provision of mental health services: linkage behavior in rural areas in the deep south [abstract]. *Abstract Book/Association for Health Services Research* 14: 96.

Turner, T. and A. de-Sorkin 1997 Sharing psychiatric care with primary care physicians: The Toronto Doctors Hospital experience 1991-1995 *Canadian Journal of Psychiatry* 42 (9) :950-954.

Uestuen, T. B. 2000 . Unmet need for management of mental disorders in primary care. In Andrews, Gavin Ed ; Henderson, Scott Ed ; et-al. 2000 . *Unmet need in psychiatry: Problems, resources, responses.* pp. 157-171 . New York, NY, US: Cambridge University Press.

University of Western Australia 2001 Department of Psychiatry and Behavioural Science Primary Care Mental Health Unit *Primary Care Mental Health Partnerships Conference*

Van der Feltz-Cornelis, C. M., J. S. Lyons, et al. 1997 . Health services research on mental health in primary care. *International Journal of Psychiatry in Medicine* 27 (1) :1-21.

Van Hook, M. P. and M. E. Ford 1998 The linkage model for delivering mental health services in rural communities: benefits and challenges. *Health & Social Work* 23 (1) :53-60.

- Veale, B. Rogers W 1999 *Strategic evaluation of divisions of general practice* General Practice National Information Service Flinders University Adelaide
- Wagner, EH. Austin, BT. Von Korff, M. 1996 *Organising Care for Consumers with Chronic Illness*, The Milbank Quartely 74 (4)
- Walker, Z., M. McKinnon, et al. 1999 .Shared care for high-dependency consumers: mental illness, neurological disorders and terminal care--a review. *Health Services Management Research* 12 (4) :205-11.
- Weingarten, M.-A. and M. Granek 1998 . Psychiatric liaison with a primary care clinic: 14 years experience. *Israel Journal of Psychiatry and Related Sciences* 35 (2) :81-88.
- Welch M, Philip T, Aldridge G, Fisher H, & Cross M. 2000 First, Build the Foundations: Practical Considerations in GP-Mental Health Service Liaison. *Australian Health Review*; 23 (1) :52-63.
- West, M.-A. and B.-C. Poulton 1997 . A failure of function: Teamwork in primary health care. *Journal of Interprofessional Care* 11 (2) :205-216.
- Wild S, Davies J, McGrath J, Groom G. 2001 *Sharing the Care of Existing Clients of a Local Mental Health Service with GPs – A Pilot Study*. Brisbane: Unpublished Paper.
- Wilhelm K, Redenbach J, Savellis J, Hume F, MacDonald P, Pugh S 1997 *The Evolution of a mental health shared care project in Eastern Sydney* Geigy Symposium
- Willis E, Condon J, Litt J. *Shared care between practice nurses and GPs. Collaborative Grant Report*, Adelaide: Flinders University, 1998.
- Wilson B, Popplewell R *Enhancing Integration through the Formalisation of Collaboration between Hospitals and Divisions of General Practice*. Flinders Medical Centre
- Wooldridge M. 1998 *The Government's Response to the Reviews of General Practice: General Practice – Foundations for the Future*. Canberra: Commonwealth Department of Health & Family Services.
- World Health Organisation. 1978 *Declaration of Alma-Ata*. Washington: WHO
- Yuen, E. J., J. L. Gerdes, et al. 1996 . Patterns of rural mental health care: An exploratory study *General Hospital Psychiatry* 18 (1) :14-21.
- Zwarenstein M, Reeves S, Barr H, Hammick M, Koppel I, Atkins J. Interprofessional education: effects on professional practice and health care outcomes *Cochrane Review* . In: *The Cochrane Library*, Issue 2, 2001. Oxford: Update Software.

APPENDIX 1 INTERVIEW SCHEDULES FOR DIVISIONAL LIAISON OFFICERS

DLO Interview Schedule

Preamble

Thanks very much for agreeing to be interviewed for this study. We are undertaking a review of mental health shared care in general practice. By shared care we are referring to collaborative care between GPs and other mental health professionals including psychiatrists, mental health workers, psychologists in any way other than the traditional referral model.

At the end we will also be looking briefly at care for people with co-morbidity, or coexisting mental disorder and substance use related problems.

Information from these interviews will be de-identified for the report. If the investigators wish to attribute comments to you by quotation or other means they will seek your permission prior to doing so.

Would you mind if I audiotaped the interview for recording purposes? If you do not want the interview audiotaped during all or part of the interview please let me know.

Demographic Details

Name:

State:

Number of Divisions in State:

Commencement date as DLO:

Questions

Is there any evidence of commitment to shared mental health care by your State/Territory Health Department?

If yes, please describe including any state/territory level funding?

If no, can you explain why?

Who is your key State/Territory Health Department contact (name and contact details)?

What do you consider to be the barriers to effective shared mental health care?

What do you consider to be essential elements of an effective program of shared mental health care?

How many Divisions in your State/Territory are involved in shared mental health care (please list names of Divisions and a key contact in each)?

What would you describe as the most successful shared mental health programs in your State/Territory?

Can you describe the elements of this program, focussing on what it is that you consider make it successful?

What preliminary work was undertaken in preparation for this shared care program eg workforce training, acquisition of resources etc?

Do you consider this program to be sustainable and why?

Who might be the key people related to these programmes (in Divisions/in mental health services)

What developments do you see in the future?

We are also interested in comorbidity....that is co-existing mental disorder and substance use disorder.

Are you aware of any Divisional or other programmes for GPs that address this area?

Who might the key people be in local Divisions that might have some information on this?

Who might be key people in local mental health services or drug and alcohol services that might have information on this?

What opportunities do you see in this area?

Is there anything else you'd like to discuss?

Thank you for your time. We will send you a copy of the issues raised in this interview for comment.

Contact details.

APPENDIX 2 INTERVIEW SCHEDULE FOR PROFESSIONALS WORKING IN SHARED CARE

[some of the answers for these questions will already be available from the questionnaire]

Respondent name?

Respondent professional background?

Respondent involvement/role in shared care program? How long have you been involved?

Which Division and/or mental health service involved?

What are the socio-economic groups that the program addresses? *Prompts: low SES, NESB, issues of children or adolescents.*

Describe the program. (What happens?)

Number of GPs involved?

Numbers of clients/consumers/carers involved?

Range of types of consumers involved. (ie people with schizophrenia/BPD/low prevalence disorders OR people with depression/anxiety/somatic problems/alcohol OR other)

How is the model funded?

How are decisions made about what services/coordination / consumers or clients/carers are involved in the program and about how this is done? Is this a shared responsibility between Mental Health Services and GPs/the Division? *[whose agenda is this addressing?]*

Is there a formal service agreement or memorandum of understanding?

What preparatory work has occurred to support the organisational change? With GPs? With MHS staff? With consumers and carers?

Has there been involvement of consumers and carers in these training activities?

To what degree have the wishes of consumers and carers been taken into consideration in the planning and implementation of the program?

To what degree has it been ensured that GPs have the required knowledge and skills for their new roles?

To what extent has it been ensured that there is a good trusting relationship between the consumer/consumer and carer/family prior to transfer or discharge?

Evaluation:

What outcomes were anticipated?

What outcomes have been achieved?

What were the difficulties you encountered?

What worked well?

Describe how care is better with this arrangement?


Were consumers/carers involved in the evaluation?

Given your experience so far, what developments can you foresee in further *partnerships or shared care* in your local area?

What are your feelings about the sustainability of this program?

Are there any other comments you would like to make?

APPENDIX 3 THE SURVEY OF DIVISIONS

 <p>Primary mental health care Australian Resource Centre</p>	<p>Department of General Practice Flinders University of South Australia Bedford Park SA 5042</p>
<p>Telephone: +61 (08) 8204 5917 Fax: +61 (08) 8204 4690 Email: sally-anne.nicholson@flinders.edu.au</p>	

MENTAL HEALTH SHARED CARE/ PARTNERSHIPS QUESTIONNAIRE FOR DIVISIONS

The Primary Care Mental Health Australian Resource Centre (PARC) is undertaking a review of mental health shared care/partnerships to get some idea of the progress that has occurred over the past three years.

By shared care or partnerships we are referring to formalized collaborative care between GPs and other mental health professionals including psychiatrists, mental health workers, psychologists in any way other than through the traditional referral model.

This questionnaire is part of a process including interviews of key respondents, review of various databases and an Australian and international literature review.

This questionnaire looks at the types of activities that Divisions are involved in with mental health services in their local areas. This process will result in a report that will inform future developments in this important area. All Divisions will receive a copy of the report.

We would greatly appreciate your completing this questionnaire and faxing it back to us on the number at the top of the next page. We have tried to reduce the burden of the questionnaire by using tick boxes as often as possible. It should only take a few minutes to complete.

There is space left at the end of the questionnaire should you wish to comment on any aspect of mental health shared care or partnerships taking place within your division.

Should you wish to discuss any aspect of this questionnaire please contact Sally-Anne Nicholson on 08. 8204.3133 or 08.8293.4199. It would be very much appreciated if you

could please **fax this questionnaire back** to us on **08 8204 4690** by **Wednesday 21st March**.

Thanks very much for completing this questionnaire. We should have the report available early June.

Dr Chris Holmwood
Senior Research Fellow
Department of General Practice
Flinders University

SURVEY OF DIVISIONS

08 8204 4690

ATTENTION: SALLY ANNE NICHOLSON

Name of the Division:

State:

Name of person answering questionnaire:

Position in organisation:

Contact telephone number:

email:

What is/are the title/s of any mental health shared care/ partnership programs taking place in your Division?:

.....

.....

What is the name of the mental health service or hospitals involved in the program/s?

.....

.....

Which people are formally involved in these mental health shared care/ partnership programs? Please tick appropriate boxes and then indicate the *approximate* number of personnel involved.

Administrative support workers

eg GP receptionists

Number.....

Carer Representatives

Number.....

Consumer Representatives

Number.....

General Nurses	Number.....
GPs	Number.....
Liaison Workers	Number.....
Mental Health Workers	Number.....
Psychiatric Nurses	Number
Psychiatrist	Number.....
Psychologist	Number.....

4. Where did the funding for these program/s come from:

Please tick one or more box/es

- OBF Funding
 Primary Mental Health Care Initiative
 Innovation funding
 Other.....

5. Approximately how much funding is involved? \$.....

6. How long is the funding for?

Please tick appropriate box

- Until end of 2001 Financial Year
 End of strategic plan (mid 2002)
 other

7. What are the roles of the GPs in these shared care programs

Please tick one or more box/es

- clinician
 educator for other GPs
 educator for Mental Health Services
 community educator
 liaison person
 other

If other please state.....

8. In what types of process activities is your division involved with respect to mental health shared care/partnerships program/s. Tick any of the boxes

	YES	NO
Memorandum of understanding or formal service agreements between mental health services and the Division.	<input type="checkbox"/>	<input type="checkbox"/>

- Shared Information Technologies
- Development of tools for communication
Eg referral forms, discharge process forms
- Development of clinical guidelines/pathways/
emergency plans
- Development of care plans
- Case conferencing
- Other (*please specify*)
.....

9. With regard to the people involved in these mental health shared care/partnerships programs do you have

Tick any of the boxes

- | | YES | NO |
|--|--------------------------|--------------------------|
| Formal consumer/carer input into planning,
managing or implementing | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychiatrists working in Gen.Pracs on case
discussions and/or GP education? | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental health worker acting as liaison person | <input type="checkbox"/> | <input type="checkbox"/> |
| GP acting as liaison person | <input type="checkbox"/> | <input type="checkbox"/> |
| Development of clinical guidelines/pathways/
emergency plans | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other..... | | |

If you have consumers or carers involved in planning, management and implementation of your Division's mental health shared care/partnerships program/s what role do they take? Tick any of the boxes

YES NO

Representation at planning or management committee level

Participation as resources in educational activities for GPs or mental health professionals

Participation as peer educators for other consumers/carers of Mental health services

Participation in evaluation of the program

OTHER *please*
describe

.....

11. With regard to your division's educational programs for mental health shared care/partnerships programs do you have any:

Tick any of the boxes

Education for GPs as part of mental health Integration/shared care YES NO

Education for mental health staff

Joint mental health staff/GP education

Formal involvement of mental health carers/consumers in these education sessions

12. Is there any one person in your division employed to work solely on any mental health shared care/partnership programs?

YES NO **IF YES ▶** F/T P/T

13. Do any of your programs on mental health shared care/partnerships address *specifically*

Tick any of the boxes

- People from non-English speaking backgrounds
- Aboriginal and Torres Strait Islanders
- Issues involving children including children of clients

14. What is the main mental health consumer group that the mental health shared care/partnerships activity focuses on? *Tick any of the boxes*

- People with psychosis/BPD/"severe mental disorders" (low prevalence)
- People with depression/anxiety (or high prevalence disorders)
- Consumers with comorbidity mental health and substance abuse disorders/problems
- People with other disorders eg ADHD (please specify).....

15 What outcomes have been used in the formal evaluation of these mental health shared care/partnerships programs?

Tick if these evaluation methods used in your Division

	TICK HERE
Consumer or GP numbers involved in programs	<input type="checkbox"/>
Numbers of actual clinical services provided for consumers/carers	<input type="checkbox"/>
GP/Mental health professional satisfaction with arrangements	<input type="checkbox"/>
Consumer/carer satisfaction with arrangements	<input type="checkbox"/>
Consumer outcomes such as changes to health status, acute admissions, medication usage, etc	<input type="checkbox"/>
Others (<i>please describe</i>)	<input type="checkbox"/>

APPENDIX 4 SURVEY OF DIVISIONS (ANALYSIS)

Mental Health Shared Care/ Partnerships

Questionnaire For Divisions

DATA FROM THE SURVEY OF DIVISIONS n=56♣

Free text responses are at the end of this appendix.

Which people are formally involved in these mental health shared care/ partnership programs? Please tick appropriate boxes and then indicate the approximate number of personnel involved.

Administrative support workers	11 (20%)
eg GP receptionists	
Carer Representatives	10 (18%)
Consumer Representatives	24 (32%)
General Nurses	7 (12.5%)
GPs	48 (86%)
Liaison Workers	18 (32%)
Mental Health Workers	32 (57%)
Psychiatric Nurses	16 (28.5%)
Psychiatrist	37 (66%)
Psychologist	21 (37.5%)

4. 3. Where did the funding for these project/s come from:

Please tick one or more box/es

17 (30%)	OBFFunding
13 (23%)	Primary Mental Health Care Initiative
3 (5%)	Innovation funding
12 (21%)	Other
1 (2%)	None
10 (18%)	several sources

* 66 responses in total from 70 sent out. 10 stated that they did not feel that their activities in mental health constituted partnership development or shared care

5. Approximately how much funding was involved ?
 average \$ 132,000. Total from responses \$5.43 million. (n=41)

6.. How long is the funding for?
 13 (23%) Until end of 2001 Financial Year
 22 (39%) End of strategic plan (mid 2002)
 19 (34%) Other

7. What are the roles of the GPs in these shared care projects

15 (27%)	clinician
3 (5%)	educator for other GPs
2(3.5%)	educator for Mental Health Services/Community educator
3 (5%)	liaison person
4 (7%)	other
2 (3.5%)	None
27 (48%)	multiple roles

If other please state role.....

8. In what types of shared care/partnership process activities is your division is involved
 Tick any of the boxes

	YES
Memorandum of understanding or formal service agreements between mental health services and the Division.	31 (55%)
Shared Information Technologies	9 (16%)
Development of tools for communication Eg referral forms, discharge process forms	43 (77%)
Development of clinical guidelines/pathways/ emergency plans	33 (59%)
Development of care plans	36 (64%)
Case conferencing	39 (70%)
Other (please specify)	24 (43%)

9. With regard to the people involved in these mental health shared care/partnerships programs do you have

YES

- Formal consumer/carer input into planning, managing or implementing program 27 (48%)
- Psychiatrists working in Gen.Pracs on case discussions and/or GP education? 31 (55%)
- Mental health worker acting as liaison person 28 (50%)
- GP acting as liaison person 28 (50%)
- Development of clinical guidelines/pathways/emergency plans 26 (46%)

Other...7 (12.5%).....

10. if you have consumers or carers involved in planning, management and implementation of your Division's mental health shared care/partnerships program/s what role do they take? Tick any of the boxes

YES

- Representation at planning or management committee level 28 (48%)
- Participation as resources in educational activities for GPs or mental health professionals 31 (55%)
- Participation as peer educators for other consumers/carers of Mental health services 28 (50%)

Participation in evaluation of the program 28 (50%)

OTHER please describe

7 (12.5)

11. With regard to your division's educational programs for mental health shared care/partnerships programs do you have any:

Tick any of the boxes

YES

Education for GPs as part of mental health
Integration/shared care 45 (80%)

Education for mental health staff 27 (48%)

Joint mental health staff/GP education 30 (53%)

Formal involvement of mental health
carers/consumers in these education sessions 15 (27%)

12. Is there any one person in your division employed to work solely on any mental health shared care/partnership programs?

35 (62.5%) YES

17 NO (4 missing)

IF YES ▶ 9 (16%) F/T 27 (48%) P/T (20 Missing)

13. Do any of your programs on mental health shared care/partnerships address specifically

4 (7%) People from non-English speaking backgrounds

6 (11%) Aboriginal and Torres Strait Islanders

9 (16%) Issues involving children including children of clients

14. What is the main mental health consumer group that the mental health shared care/partnerships activity focuses on? Tick any of the boxes

27 (48%) People with psychosis/BPD/"severe mental disorders" (low prevalence)

31 (55%) People with depression/anxiety (or high prevalence disorders)

18 (32%) Consumers with comorbidity mental health and substance abuse disorders/problems

16 (28.5%) People with other disorders eg ADHD (please specify).....

	High prevalence +ve	High prevalence -ve	
Low prevalence +ve	19	7	26
Low prevalence -ve	10	20	30
	29	27	56

15 What outcomes have been used in the formal evaluation of these mental health shared care/partnerships programs?

Tick if these evaluation methods used in your Division

TICK HERE

Consumer or GP numbers involved in programs 35 (62.5%)

Numbers of actual clinical services provided for consumers/carers 13 (23%)

GP/Mental health professional satisfaction with arrangements 36 (64%)

Consumer/carers satisfaction with arrangements 16 (28.5%)

Consumer outcomes such as changes to health status, acute admissions, medication usage, etc 12 (21%)

Others (please describe) 10 (18%)

Is your Division involved in any activities relating to co-morbidity/dual diagnosis (by this we mean a mental disorder plus a co-existing substance use disorder) programs/s? 16 (28.5%) YES

Survey of Divisions: answers to open ended questions

3

No formal programs

All mental health staff employed by Southern Area including Public Psychiatrists

4

Alcohol and other drug funding

CLIPP – DHS special allocation, DISH pilot from Western Hospital Federal and State funding still being sought

Funding is in the third year

Funding shared by both SENSWDGP & SAMHS

National mental health reform incentive funding through the WSAMHS

DHAC and other funding via general submissions

DHAC and Victorian mental health branch

National health development funding

Health Dept WA

Part suicide prevention/part GP/MH partnerships

Division of general practice – commonwealth funded projects

Mental health education incentive funding via DHAC

The programs source funding from a variety of sources, including all of the above, and the Psychiatric service (indirectly – psychiatrist time and some administration from psychiatric service)

Also funding came out of our infrastructure budget, and education evenings were sponsored

They are funded by the Logan Area Division of General Practice (ie the money comes out of the divisions own coffers)

QLD health (state government)

Division funding for liaison

South Australian DHS – funds psychiatrists and mental health workers time to be involved in the programs

Territory government

NSW health centre for mental health “GP partnerships project”. Division does not have a direct role in this program – it is being coordinated by Illawarra Institute for Mental Health.

SHE had funding for 1 FT PO for 12 months to cover 4 Divisions ie St George share was 0.25 worker plus the Divisions applied for and received an innovation funding grant to pay for GP involvement and PO time. Plus joint education activities

Inner city mental health

State funds – GP project

Second national mental health plan

PMHCI funding for “hotline”

CHIYP, EPC

Queensland health

Australia Transcultural Mental health Centre

DHAC

QLD Division of general practice

Commonwealth funding

GP liaison program DHHS

Division funds of an independent nature

TAS DHHS GP

7

Student

Participant in learning

Project manager

Primary care provider, care manager (if approp)

Reference/steering committee

Clinical

Educator

Liaison

Program adviser

Lighten the load on the Logan – Beaudesert Mental Health Service

GP Manager

Supervisory role

5 are involved with program advisory group

Upskilling/education

Steering committee at this stage only

The GPs roles have been appropriate to the different stages of the project ie advisory committee, working party, GP adviser on SHE Committee as well as clinicians. The aim of the project was to set up case conferences and care plans as part of routine care for consumers who used MH services and GP services. The project is still progressing.

Normal referral role to clinical psychologist

Organiser and participant in case conference

GP project

Steering committee

Steering committee

GP input into direction of program

Adviser to Divisional activities as well as mental health services management

Advisers

Planning and overseeing divisional mental health program

Consultant and clinicians

Participants in multi-disciplinary education activity

8

Networking & Familiarisation of services and service providers

Discharge Procedures

Assessment protocols

Education

Promoting GP perspective to mental health services

Development and implementation of basic standard for integration of GPs and MHS

GP placement program

GP upskilling

Liaison with AMHS re appt of GP liaison officer and multiple meetings with the appointed person

Networking

Shared care protocols and procedures

Joint development of education programs

Standards for service integration in one of the pilot studies

Development of referral networks

Clinical attachment

Health Promotion

Resources for GPs

Shared educational events

Regular lunchtime meetings between MH teams and GPs

Mental health liaison officer

Joint consultations between GPs/Psychiatrists/consumers

Education of GPs

Strategies not fully developed

Mental health liaison GP to commence shortly

MH staff on Divisions MH steering committee

Joint presentations at conference/area meetings

Training of GPs

Mentoring of GPs to provide support to other GPs to provide mental health management of consumers

GPs acting on state health committees

9

Too numerous to mention. We are trying to break new ground.

Not formal positions – this is the role of each case manager

At breakfast care panel meetings

All MH workers work collaboratively in the community to strengthen ties with GPs

Some of the above are currently being developed

Psychiatrist and GP educators

We will have mental health liaison GP at Royal Perth hospital in near future – but not involved in clin psych service

Divisional project officer

Consumers participating in projects evaluation

Evaluation

Jointly run forums

10

Are looking at ways to include consumers/carers

Consultation by attendance of project officer at mental health community consultative committee

I meet with Divisions consumer reference group once a year

Liaison between community support groups and the project committee

Consumer reference group have input into business plan

12

This program took the view that all individuals were entitled to an integrated approach regardless of age, ethnicity, diagnosis

14

School refusal

Personality disorders

Deliberate self harm is not always the PDs or just depressives. We are trying to find out more so a correct diagnosis can be made.

Behavioural – child/adolescent

Elderly

This program embarked on developing the 'basics' for integration and from there are now building on the development of more sophisticated or specific models of 'shared care'

Eating disorders

Depression

D&A

All psych services client group

Any aged person with a mental health condition

We are offering educational events to cover diverse areas as indicated to us by our members eg psychosis, depression/anxiety, substance abuse, eating disorders, people suffering from childhood abuse, ADHA, PHD etc

ADHA

Obsessive compulsive disorder

Anxiety

The target group has not been defined by disorders rather it has been with clients in common. Out comes evaluation in terms of improved are will come later.

The reference group focuses on a broad spectrum of mental health problems

The GP peer circle selects a different topic each month and discusses case examples eg depression, dementia, personality disorders etc

The pilot shared care protocol will include consumers with a wide range of disorders

15

Improved objective knowledge in GPs

Improved subjective awareness of services and comfort level of providing consumer care and management

Not evaluated yet

Regular extensive file audits to measure the degree of communication between services and co-working

Workshop evaluation

Self reported change in GP knowledge and understanding

Position just started therefore evaluation still being put together

Upskilling of GPs to enhance provision of health care through diagnosis, treatment, referral etc of persons suffering from mental illness and comorbidities

Outcomes not developed as yet

Number of consumers agreeing to case conferences

Audit to monitor change in GP management strategies

Count of number of recorded contacts between GPs and the mental health service on a selection of consumer files at the MHSs

Random MHT file audit to measure communication

APPENDIX 5 DIVISIONS INVOLVED IN SHARED CARE/PARTNERSHIP ACTIVITIES RESPONDING TO THE SURVEY

Sunshine Coast (Qld)	Tweed Valley Division	
Perth Central Coastal	Dubbo Plains	
Shoalhaven NSW	St George Division	
Riverland Divison	Illawara Division	
Central Sydney	Central Coast NSW	
Murrumbidgee Divison	Mid North Coast Division	
Mid-North Division (SA)	Hunter Rural Division	
Otway Division	Fairfield Division	
South East NSW Division	Western Sydney DGP	
Southern Tasmania Div	Wagga Wagga	
Northern Tasmania Division	Bankstown	
North West Tasmania Division	Westgate	
Murray Mallee	Inner East Melbourne	
Adelaide Northern	Geelong Division	
Limestone Coast Division (SE South Australia)	Greater South East Division	
Adelaide Southern Division FQ Rural Div	Knox Division	
Bundaberg and district	Melbourne Division	
Brisbane Inner South	Great Southern MH (WA)	
Southern Queensland Rural Division	Swan Hills Division	
Logan Divison	Perth Division	
Bayside Division	Osborne Division	
Macarthur	Rockingham/Kwinana	
S.E Sydney	ACT Division of GP	
Blue Mountains	Top End Division of General Practice	
Port Macquarie	Toowoomba and District	
Sutherland Division	Peel South West	
Northern Rivers Division (NSW)	Central Queensland	
	Pilbara	Division

