General Practitioners' Peer Support Needs in Managing Consumers' Mental Health Problems: A Literature Review and Needs Analysis

Eleanor Jackson Bowers

And

Dr Chris Holmwood

Primary Mental Health Care Australian Resource Centre

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Flinders University

Department of General Practice

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Executive Summary

PARC was asked late in 2001 to review the literature on the issue of peer support of practitioners providing mental health services as envisaged in the *Better Outcomes in Mental Health* program. The views of PARC are not necessarily the views of the Commonwealth. The report was commissioned by the Commonwealth Department of Health and Ageing and the opinion of the author is not necessarily the opinion of the Commonwealth. This document does not reflect Commonwealth policy. The development of *the Better Outcomes in Mental Health* Program must inevitably meld what is known from research with what is possible in an organisational, political and fiscal sense. This paper is just one important input into the final program design.

Why peer support?

People with mental illness have a long history of abuse and marginalisation. This culminated in the National Inquiry into the Human Rights of People with Mental Illness in 1993 [The Burdekin Inquiry]. This came not long after the Royal Commission into Deep Sleep Therapy reported on the abuses that occurred at Chelmsford Private Hospital during the 1960s and 70s and the investigation of incidents in the psychiatric ward of Townsville Hospital.

The National Mental Health Strategy, which was endorsed in 1992 around the same time that the findings of these enquiries were becoming known, provided a five-year plan for major reform of mental health care. Priority areas for reform under this strategy included consumer rights, standards, monitoring and accountability.

The move towards placing the care and management of persons suffering mental disorders and mental health problems into the hands of general practitioners requires as much diligent consideration of safeguards as has been shown in the mental health services.

Current programs

At present there is no specific framework for the provision of peer support for GPs involved in mental health related work; however there are many activities across the Divisions operating under various descriptors that are trying to address this need for peer support. These include peer support groups, case conferencing, Balint groups, various education and training activities and in some instances distance based activities such as tele-conferencing and videoconferencing.

Details of what is happening in each state are sketchy and incomplete; however a collation of the information provided indicates that nearly all groups are led by a psychiatrist and the vast majority focus on case discussion. Case discussion type groups out-number Balint Groups 2:1.

What is peer support?

Peer support is a concept with multiple elements and multiple names. It is most commonly referred to in the literature as supervision however the term ‘supervision’ is not meant to imply a managerial model of overseeing a junior practitioner by a more senior practitioner. One useful way of conceptualising peer support is based on its aims. One model that has considerable currency sees the aim of peer support as having three elements, Normative, Formative, and Restorative. These dimensions are often pictured as overlapping, and, in practice, peer support can contain elements of all dimensions.

Normative	This function focuses on ensuring that the general performance of the clinician is "normal" compared with peers. Its purpose is to reliably ensure that standards are maintained.
Formative	The formative dimension of peer support involves an emphasis on professional development and education.
Restorative	Involves emotional support and consideration of the stresses and interpersonal tensions which arise in the therapist role. Balint groups take this perspective.

What is the evidence for the need for peer support?

Normative

Professional isolation seems to be an underlying factor when medical practitioners come under the attention of the "impaired practitioner" activities of regulatory bodies such as the state Medical Boards. There is a pattern of isolated practice (usually working as solo practitioners) and little engagement in continuing medical education and peer review processes. Whether the isolation and lack of engagement with peers is a cause or effect is unclear.

Formative

The need to improve GPs skills in mental health care is noted frequently in the literature and rightly or wrongly the ability of general practitioners to recognise mental health problems has been called into question by a number of studies. There has been much progress in educating GPs but no evidence that the level of education has reached a standard where efforts can cease. Many Divisions of General Practice are implementing education programs in the diagnosis and management of mental health problems.

Restorative

Evidence of restorative need comes from the reported mental health of doctors themselves. There is evidence for high levels of stress, depression and alcohol abuse in doctors. The major psychological problems experienced by doctors are depression and alcoholism, and there is strong evidence that these occur at higher rates than in most other professions. There is an alarming amount of research demonstrating that doctors experience a highly stressful combination of personal and occupational factors which lead to a high rate of adverse consequences. However peer support appears to go some way towards ameliorating these problems. .

What form should peer support take?

Groups clearly have cost advantages. Isolation is reduced. Participants receive comments and reflections from more than one person, gain the benefit of a wider range of life and clinical experience and avoid the problem of dependency, which can arise with a single supervisor. There is also the opportunity for role-play in groups; this can be more difficult and limited in one to one peer support settings. Group peer support reduces the hierarchical issues between supervisor and student, and if well run, will provide a sense of psychological safety. Disadvantages include group dynamics, which need to be made overt within the group and discussed, and that there is less time for each individual. Groups also have the potential for instability over time.

While group peer support is supported by the literature, individual peer support is still the dominant method in most professions. Psychologists and psychiatrists in private

practice often make their own peer support arrangements. In all likelihood, practitioners expect to pay market rates for peer support time.

Peer support for rural and remote clinicians is an important issue that needs be examined. Lack of support and professional isolation are often cited as reasons for burnout amongst rural and remote practitioners. Videoconferencing is now being used in several states for clinical purposes, particularly in the mental health setting and has been used for peer support. There is some anecdotal evidence about on-line peer support of general practitioners involved in mental health related activities.

What issues need to be addressed?

Evaluation of peer support

Despite all of the above demonstrating need, as well as testaments to the benefit of peer support, hard evidence that appropriate peer support has a beneficial effect in improving quality of care, preventing excessive "deviation" in clinical behaviour, and preventing clinician mental health problems, is lacking.

A literature review, completed for the RANZCP in 1999 sees the problem as inherent in the difficulties in quantitatively examining the quality and effectiveness of clinical practice in terms of patient outcome. Factors which make this difficult are the definition of quality, the relative importance of clinician and treatment variables in determining patient outcome, the variation in the dependent variables of interest between populations, and other factors such as patient understanding of and adherence with treatment and other unrelated patient behaviours.

Changes in community values over time, also turn definitions of quality into shifting goal posts. Should the benefit of peer support be measured through patient outcome, cost containment or through the improvement of a profession's skill base? Should the emotional health of practitioners be seen as a goal relevant to a publicly funded system?

Ethics

A Code of Ethics underpins peer support in the psychology, psychiatry and counselling professions and underpins their peer support requirements. A similar Code of Ethics with a requirement for peer support could be considered for GPs delivering the counselling services through the *Better Outcomes In Mental Health* initiative.

Special issues relevant to the general practice context

The literature gives some specific recommendations for counsellors (other than GPs) employed in general practice.

The general practice setting is seen as having some particular problems for counsellors. These include a culture of limits and scarcity, with pressure to be time effective and to provide services to as many clients as possible, a high proportion of clients with multiple social and health problems, a need for an awareness of somatisation issues, the triangular relationship of referral which complicates confidentiality, and issues of professional autonomy and accountability.

General Practice is thus a different environment to that which much of the peer support literature was developed. A supervisor thus needs to be aware of, trained and skilled in negotiating and supporting counsellors in this culture. Boundaries, responsibilities, accountability, relationships and structures of the context give rise to issues specific to the general practice environment.

Barriers to the establishment of peer support

Barriers to peer support lie in the in the medical culture and its emphasis on knowing (ie there is a perfectionistic knowledge based culture). In the medical culture doctors learn not to expose their weaknesses because they may be used against them.

Medical training is directed towards establishing the practitioner as the knowledgeable person in the doctor/patient relationship. Peer support questions this position. Discomfort with self-questioning is an important factor behind resistance to participation in peer support.

Conclusions

These conclusions are made in the context of the *Better Outcomes in Mental Health* initiative.

The notion of peer support is new to general practice, although many of the quality assurance and continuing education activities in which GPs are involved serve some of the purposes of peer support.

However especially for those GPs involved in delivering more specific psycho-therapies there would seem to be a need for more formal levels of peer support. This need is widely acknowledged by many GPs who provide mental health services as an area of special interest. This peer support may address normative, formative and restorative needs. In less obscure language this peer support could ensure that:

- there is peer scrutiny of the GPs clinical activities.
- there is ongoing education and training. These processes need to use evidence based learning methods and address skills as well as knowledge and attitudes/insights.
- there is support for the GP to ensure that his or her own mental health is optimised.

It would seem reasonable that GPs providing the more intensive psychotherapies in parallel with allied health professionals providing the same services should be subject to the same requirements regarding peer support. Various Codes of Ethics underpin peer support requirements in the psychology, psychiatry and counselling professions.

The main options to consider regarding peer support are:

- group vs 1:1
- face to face vs distance
- focus and process of learning activities

Groups vs 1:1

The strength of groups is that from a normative perspective the range of referencing behaviours is broader and therefore the opportunity for practitioners and supervisors becoming isolated is less. They are less costly in terms of supervisor time but on the other hand are perhaps less robust and less stable.

For groups to fulfil the normative function there needs to be a level of trust and respect. Disclosure and adequate peer scrutiny needs to occur in safe environments. Groups should be established on a local level and be stable. There should be facilitation by clinicians experienced with group work who themselves need to have appropriate levels of peer support.

Face to face vs distance

In rural and remote settings peer support needs to occur just as in larger centres. The costs of infrastructure in rural areas is greater (telephone or video conferencing). There should be equal opportunity for rural and metropolitan GPs to be involved in these activities. While distance technologies can yield immense benefits in bringing people together participants need to have developed a trusting environment. This usually requires some face to face activities, at least initially. In many instances these trusting environments may have already have developed.

Actual focus of the peer support groups.

While a number of activities have some peer review/supervisory functions (eg formal education programs, case conferences) these are not sufficient to address all the needs of a formal supervisory system. These activities are primarily directed at competency development or clinical service provision. Formal processes specifically for peer support should be in place.

On the other hand there should be some liberty regarding the specific activities of the supervisory meetings. These could include activities to stimulate reflection such as journaling, Socratic questioning, as well as case presentations, and review of audio or videotapes of clinical encounters. The important issue is that the normative and restorative functions are addressed.

Direct observation of GPs and/or debriefing of video or audiotape recordings provide a valid substrate for discussion of performance within the group or between supervisor and supervisee. This allows the discussions to be rigorously based.

There is little evidence regarding the optimal frequency of these activities.

The Small Group Learning option of the RACGP's Quality Assurance and Continuing Professional Development Program provides a flexible structure that could facilitate the meshing of these peer support activities with the requirements for registration as a general practitioner.

Scope and objectives

PARC was asked to review the literature on the issue of peer support of practitioners providing mental health services as envisaged in the *Better Outcomes in Mental Health* program. Under this program, there will be some practitioners providing targeted and evidence based time limited psychotherapeutic services for patients with mental health problems. These practitioners may be GPs or other suitably qualified health professionals, such as psychologists, mental health nurses, social workers, Aboriginal and Torres Strait Islander Health workers, etc.

There are several other terms for this peer support process that have currency in the literature. Peer review, supervision and quality assurance are terms that are more frequently used.

While there is a tradition of peer support within the psychology profession and within psychiatry, this is much less the case with general practitioners. This paper will look at the issues as they pertain to general practitioners in the first instance, but it will inevitably draw on the literature of the other professions.

By peer support what is meant is a process of accountability in which practitioners are involved. From the literature it seems that peer support has several functions:

1. quality improvement or quality assurance purposes
2. professional education
3. professional support

Therefore the purpose of this literature review is:

1. To provide an overview of the literature from all of the health professions on peer support
2. To examine the different purposes for peer support
3. To examine the different theoretical frameworks for peer support
4. To examine the different peer support type activities that might address these purposes and frameworks
5. To provide some options regarding the development of systems of peer support that would assist the development of the *Better Outcomes for Mental Health* initiative.

Introduction

"Peer review is a process involving assessments by clinical colleagues of one another's handling of cases. There are no universally accepted parameters. Nor is it clear what, if any, sanctions exist for clinicians who do not participate in such a process or for those whose handling of cases is found to fall below acceptable standards. Indeed, even the question of what standards are to apply will usually be a matter for agreement among the participants."

(Human Rights and Equal Opportunity Commission 1993) Vol 2 p 875

Peer support is a concept that is by and large unfamiliar to general practitioners. Medical practitioners in the community tend to work as sole practitioners. Even when working in multi-disciplinary teams doctors are often perceived to be at the top of the pyramid and see themselves as being the supporters rather than requiring peer support themselves. It is only in the discipline of psychiatry that the notion of peer support has much standing within the medical profession. Professional autonomy has been one of the dominant principles underlying medical practice. Efforts to introduce accountability and peer review within medical practice have had limited success.

The *Better Outcomes in Mental Health* will institute a system whereby some general practitioners with adequate skills will be able to provide specialized therapies for people with mental disorders requiring these treatments. However at present there is no specific framework for the provision of peer support for GPs involved in this type of work. Interestingly there are many activities across the Divisions movement [operating under a broad range of names] that are trying to address this need for peer support. These include actual peer support groups, case conferencing, Balint groups, various education and training activities and in some instances distance based activities such as tele-conferencing and videoconferencing.

To understand the impetus for peer support one needs to understand the context of mental health services and psychiatry over the past twenty or so years and the disasters that have resulted from lack of regulation and lack of peer review.

People with mental illness have a long history of abuse and marginalisation. The National Inquiry into the Human Rights of People with Mental Illness in 1993 found that "People affected by mental illness are among the most vulnerable and disadvantaged in our community. They suffer from widespread, systemic discrimination and are constantly denied the rights and services to which they are entitled." (Human Rights and Equal Opportunity Commission 1993) Vol 2 p980

This National Inquiry came not long after the Royal Commission into Deep Sleep Therapy reported on the abuses that went on at Chelmsford Private Hospital during the 1960s and 70s. In deep sleep therapy a coma was induced, using either barbiturates or insulin. The Commission found that deep sleep therapy had no benefits, but carried substantial risks including permanent brain damage and death. In all 24 patients died at Chelmsford as a result of DST between 1963 and 1979. There were a large number of cases of deep vein thrombosis, infections, skin breakdown, pneumonia, and other conditions resulting from coma. In many cases consent for this and other treatments, including ECT was non existent or fabricated. Despite concerns and documented reporting of concerns to a number of controlling bodies dating back to 1970, deaths continued until 1979. It was not until 1980 when a 60 Minutes programme investigated Chelmsford and a letter from an eminent psychiatrist and a QC was received by the Attorney General that an investigation was instigated. This case raises questions not only over the system of accountability which permitted these practices not to be investigated, but the failure of medical

profession to monitor itself by peer review. The Royal commission recommended sweeping changes to regulation, monitoring, and control of mental health services and changes to the formal control and complaint structures of mental health professionals, including the medical profession. (New-South-Wales and Slattery 1990)

This case was not isolated. A Commission of Inquiry into events at Ward 10B of Townsville General Hospital described the psychiatric care as "negligent, unsafe, unethical and unlawful". It also raised questions over the professional solidarity which resulted in the failure of the many Townsville doctors, who were aware of conditions, to notify their professional associations. (Simpson 1991).

The National Mental Health Strategy, which was endorsed in 1992 around the same time that the findings of these enquiries were becoming known, provided a five-year plan for major reform of mental health care. Priority areas for reform under this strategy included consumer rights, standards, monitoring and accountability. A Mental Health Statement of Rights and Responsibilities, first published in 1991, was developed as part of the strategy. As part of this statement consumers have the right to "have services subjected to quality assurance to identify inadequacies and to ensure standards are met" and have services which "comply with standards of accountability to consumers, the community and governments" (Mental Health Consumer Outcomes Task Force 1991) p11.

The Evaluation of the National Mental Health Strategy in 1997 found that although mental health legislation had been reviewed in all States, anti-discrimination legislation had been put into place and consumer advisory groups established, consumers were continuing to report significant stigma, discrimination and related breaches of their rights.

It is important to realise that the context of the above crises was a mental health service that was both professionally and organisationally isolated from mainstream health services, and from the community as a whole. Significant changes have occurred through the movement of mental health services into the community and better integration with other health services in the community. At the same time there has developed a robust network of mental health consumer advocacy groups and non-government organisations. Nevertheless because of the vulnerability of people with mental disorders, transparency and quality assurance are still very important issues requiring specific endeavour.

The move towards placing the care and management of persons suffering mental conditions into the hands of general practitioners requires as much diligent consideration of safeguards as has been shown in the mental health services.

Current Quality Assurance Arrangements in General Practice

Peer group review and Balint groups

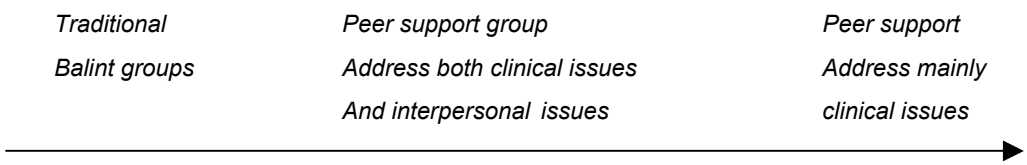
In late 2001 Development and Liaison Offers from the Primary Mental Health Care Initiative were asked to compile information on the range of peer support activities in their home states. The results are included as Appendix 1 of this report.

Details of what is happening in each state are sketchy and incomplete; however a collation of the information provided indicates that nearly all groups are led by a psychiatrist and the vast majority focus on case discussion. Case discussion type groups out-number Balint Groups 2:1.

There are single examples only of groups that focussed on journal reading, reflection/discussion or cognitive behaviour therapy. Only a few groups are led by a psychologist, Mental Health Worker or GP Mentor. Payment for the group is infrequently reported. However there are two examples of groups being subsidised by a drug company, one where the GPs share the full cost of the psychiatrist's time and another where a mental health service pays the psychiatrist and the Division pays the GPs for their time.

Discussion with interested persons in the course of this project has revealed a number of relevant comments regarding peer support groups.

- The Balint Group is a good model but it needs experienced leadership. The focus is exploration of and resolution of interpersonal difficulties between clinician and patient. There is potential for the process being undermined by dominant group members and by lack of group stability and continuity.
- There are two types of peer support groups, ones that provide support for the GP in the context of clinical practice and ones which focus specifically on patients mental health needs.
- These could be represented along a continuum.



- The function of each type of group varies somewhat. What is important to note is that for the function to be addressed, there needs to be specific activities prescribed and agreed to by the group. *Things don't just happen*.
- Groups tend to be difficult to sustain.
- Sustainability seems to relate to:
    - The ability to define the focus of the group
    - A defined process which prevents one person's issues dominating the group
    - A regular time which is mutually convenient
    - Compatibility of group members

- Groups convened along geographical or time considerations without consideration of compatibility or interests of members.

RACGP Quality Assurance and Continuing Professional Development Initiatives

All recognised general practitioners (Fellows of the RACGP recognised by the Health Insurance Commission and Vocationally Registered medical practitioners) have a legislative requirement to participate in, and meet the minimum requirements of the RACGP Quality Assurance and Continuing Professional Development Program.

The aim of the program is "to assist general practitioners in Australia maintain and improve the quality of care they give to patients and guarantee the highest possible standards of care to the community" (RACGP 2001)

Under the current plan for the 2001-2004 triennium GPs must accumulate a total of 130 CME points. Of these, a minimum of 30 points must come from Group 1 Options which are clinical audits, Accredited Provider education activities, Supervised Clinical Attachments, Small Group Learning or Learning Plans. The remainder can be from 2 points per hour education activities, university courses or other professional development. (RACGP 2001)

RACGP Small Group Learning

Of relevance to this review is the RACGP Small Group Learning option. "Small Group Learning" is a process by which groups of GPs utilize peer support, interaction and reflection to enhance their own clinical competence (knowledge, skills and attitudes) and performance".(RACGP 2001) Characteristics of these small groups are that they consist of 4 to 10 GPs with a facilitator. Facilitators can attend an optional half-day Facilitator Training Workshop to improve their skills in group dynamics and facilitation. The facilitator maintains a reflective diary as do the participants. The schedule consists of:

- an orientation meeting (2 hours) to reflect on personal learning needs and to complete needs assessment tools provided by the RACGP;
- a subsequent planning meeting to develop a program of activities and to complete a RACGP Small Group registration form;
- a minimum of eight hours of meetings at a minimum of one hour each;
- and an evaluation form to be returned to the RACGP.

Practice Accreditation

In 1992 a discussion paper titled The Future of General Practice: A Strategy for the Nineties and Beyond was released by the General Practice Consultative Committee comprised of members of the RACGP, the AMA and the Commonwealth. The paper proposed that a system of accreditation of general practices be developed in order to enhance service delivery and facilities in general practices through a system of continuous quality improvement. During the 1990s a task force developed the proposal further and in 1997 Australian General Practice Accreditation Ltd was incorporated, governed by a board which included representatives from the AMA, RACGP, Rural Doctors' Association of Australia (RDAA), Australian Association of General Practitioners (AAGP), ADGP, Australian College of Rural and Remote

Medicine (ACRRM), Australian Association of Practice Managers (AAPM) and the National Association of Medical Deputising Services (NAMDS). The Consumers' Health Forum and the Federal Health Minister have nominees to the Board of Directors.

AGPAL is not-for-profit and is owned and led by the medical profession and "provides general practitioners and their community with a mechanism for acknowledging the quality of a general practice". (RACGP 2000)

Under AGPAL procedure a surveyor visits the practice and evaluates the level of compliance with a comprehensive series of standards which broadly come under the headings of

- Practice Services including quality consultations, communication, diagnosis and management of specific illnesses, record keeping, and continuity and integration of care;
- Rights and needs of patients;
- Quality assurance and continuing education;
- Practice administration;
- Physical facilities; health and safety requirements, accessibility and appropriate medical equipment and resources.

Assessment is through staff interviews, audits, observation, patient feedback, review of medical records and HIC and practice data. Accreditation is for three years and during that time the practice is committed to maintaining continuous quality improvement. In 2000, 52% of Australian practices were accredited.

Medical Complaints Procedures

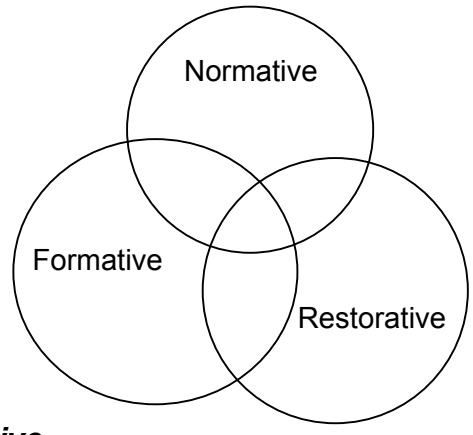
Complaints about medical practitioners are received by the State Medical Registration Boards which are the only institutions legally empowered to investigate allegations. If a case warrants investigation the doctor is invited to attend for an interview with a committee of two doctors and a layperson. The committee can make it a condition of continuing registration that the doctor undertakes remedial education. An unwell doctor can be asked to undergo medical assessment, to undergo medical treatment or to agree to peer support as a condition of registration.

If the matter is considered serious enough to warrant deregistration it is referred to the Medical Tribunal of the Supreme Court in each State where the matter is heard by a judge in a public hearing with full legal representation..

Indicators of GP Need for Peer support

Purposes of Peer support

Peer support is a concept with multiple elements. It is evident in the literature that the concept is used in different ways in different contexts. It is useful to examine the concept from the perspective of the purpose of peer support. One model that has considerable currency sees the purpose of peer support as having three elements, Normative, Formative, and Restorative. These dimensions are often pictured as overlapping, and, in practice, peer support can contain elements of all dimensions. (Proctor 1991; Fowler 1998; Rose and Boyce 1999)



Normative

This function focuses on ensuring that the general performance of the clinician is "normal" compared with peers.

At its most extreme is the Panopticon model, developed by Bentham in the 18th Century for the design of workplaces. It consisted of a circular building with a courtyard at the centre. A worker in the peripheral building ring can be easily seen by the supervisor in the central courtyard, but is unable to know when he is being observed. So they must always act as if they are being observed- a form of self-policing.

More positive aspects of this model are developed by Presbury et al (Presbury, Echterling et al. 1999)**;** they include the development of an 'inner vision' or guiding intuition. The goal of Presbury et al's Developmental Supervision is for therapists to proceed through a progression of developmental stages and establish a therapist identity of their own, replacing an external supervisor with an internal one.

Normative peer support is evident in some of the nursing literature. Its purpose is to reliably ensure that standards are maintained in an organisational setting. Inevitably most professional normative regulation is self-regulation. How the quality of this self-regulation is controlled is the crux of the issue.

Formative

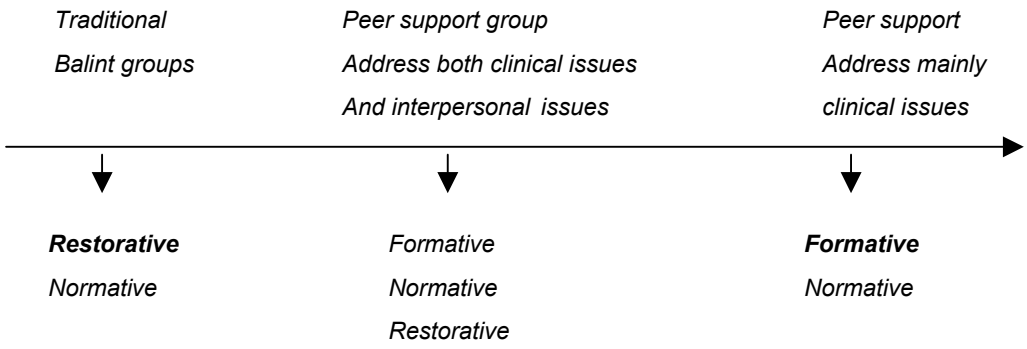
The formative dimension of peer support involves an emphasis on professional development and education. This is the dominant model in Australian general practice. Examples are the RACGP Small Group Learning program or the many case discussion groups, which have arisen around Australia, led by a psychiatrist.

Restorative

The restorative aspect of peer support involves emotional support and consideration of the stresses and interpersonal tensions that arise in the therapist role. Balint groups take this perspective. A psychiatrist leads Balint groups and discussion focusses on the doctor -patient relationship rather than on the medical management of the patient. There have also been peer support groups specifically designed to assist with participants' personal health and wellbeing rather than focussing on the specifics of the doctor/patient relationship. Some of these have been evaluated. (Winefield H, Farmer E, Denson L 1998)

How do the current activities fit in with this model?

There is a broad range of activities occurring throughout Australia that loosely come under the banner of "peer support" although their emphasis is often at the formative/competency/skills development end of the spectrum.



- The function of each type of group varies somewhat. What is important to note is that for the function to be addressed, there needs to be specific activities prescribed and agreed to by the group. *Things don't just happen*.

  Balint groups have processes that emphasise the restorative role. Largely clinically based groups address the formative role. Some groups fall in the middle. Probably all of them have some normative role although the smaller the group, the more opportunity for disclosure and comparison the greater the potential for this role being addressed. Obviously at the extreme, lecture based programs where the lights are dimmed, the expert spouts forth and the audience nods off have no normative function whatsoever.

Evidence of Need

Evidence of Normative need

The introduction to this report gave a review of the events at Chelmsford Hospital, ant at Townsville Hospital and the subsequent National Inquiry into Human Rights and Mental Illness . These events revealed widespread abuse of the mentally ill in Australian institutions.

The Evaluation of the National Mental Health Strategy in 1997 found that although mental health legislation had been reviewed in all States, and although anti-discrimination legislation had been put into place and consumer advisory groups established, consumers were continuing to report significant stigma, discrimination and related breaches of their rights.

The move towards placing the care and management of persons suffering mental conditions into the hands of general practitioners requires as much diligent consideration of safeguards as has been shown in the mental health services.

A search of cases in the Supreme Courts has not revealed any cases involving the medical management of persons with mental illness. However discussion with Mr David Wilde, Registrar of the Medical Board of South Australia (30/10/01), revealed that professional isolation is seen to be an underlying factor with many medical practitioners coming under the attention of the "impaired practitioner" activities of the Board. These activities involve medical practitioners themselves with a mental or substance use disorder whose competence has been called to question.

There is a pattern of isolated practice (usually working as solo practitioners) and little engagement in continuing medical education and peer review processes. The majority of these cases seem to be with specialists rather than with GPs. Whether the isolation and lack of engagement with peers is a cause or effect is unclear.

As far as medico-legal/litigation and complaints are concerned the majority are related to communication difficulties between the doctor and the patient and/or family, rather than to quality of care or the "impaired practitioner". .

Evidence of educational need (Formative)

National Mental Health Benchmark (Wirthlin Worldwide Australasia)reported on a nationwide mental health survey of 1014 persons aged 18+. Major findings were that GPs were considered the first point of call for those suffering from depression by 59% of respondents, however only 65% consider GPs qualified to diagnose depression and only 38% believe GPs are qualified to treat depression.

The need to improve GPs skills in mental health care is a noted frequently in the literature. (Horder 1988; Phongsavan, Ward et al. 1995; Carr and Reid 1996; Davies, Ward et al. 1997; Goldberg 1998; Holmwood 1998; Hickie 2000) The ability of general practitioners to recognise mental health problems has been called into question by a number of studies. Phongsavan (Phongsavan, Ward et al. 1995) reviews a range of literature and concludes that at least half of all cases in Australia go unrecognised. Phongsavan concludes that inadequate training in both diagnosis and management of mental health problems may influence low rates of diagnosis and diagnostic accuracy. In a 1995 needs analysis study undertaken by four Divisions of General Practice in South Australia (Holmwood, Magarey et al. 1995) the findings were similar. The study found that GPs who were less confident in managing mental health conditions estimated that these conditions were less prevalent in their practices.

GPs themselves recognise their lack of skills in mental health care (Phongsavan, Ward et al. 1995) and their capacity to diagnose and treat specific mental health disorders such as the diagnosis of early dementia and aspects of dementia management. (Brodaty, Draper et al. 1997)

Several Divisions have undertaken needs analyses. South East NSW Division of General Practice (PARC ID 513) conducted a mental health education and liaison needs analysis in 1998 which recommended that the Division find ways of obtaining clinical support for GPs to assist in the management of people with mental illness.

Mallee Division of General Practice in their 1997 (PARC ID 589) needs assessment recommended an education program in mental health for GPs as did a number of earlier studies (PARC ID 519, 666, 790).

Since the studies by Phongsavan and Holmwood in 1995 and the above needs analyses conducted by Divisions there has been much progress in educating GPs.

Many Divisions of General Practice are now implementing training programs in the diagnosis and management of common mental health problems and disorders. (Davies, Ward et al. 1997; O'Connor and Willcock 1997; Wild, Davies et al. 2001) The Primary Mental Health Care Initiative has encouraged and supported the education of GPs as one of its main areas of activity, through the efforts of the Development and Liaison Officers and through the activities of the Primary Mental Health Care Australian Resource Centre.

Recent educational needs analyses have not been available for this review, however the continued importance of GP education in mental health can be inferred from the plethora of CME programs in mental health being provided across the country. The importance of the Formative aspect of peer support to the Divisions is also evident in the form that many peer support groups now take. Both the Peer Mentor program in Tasmania and the DART program at the University of Ballarat focus on education (Hodgins 2001).

Restorative Need

Evidence of restorative need comes from the reported mental health of doctors themselves. There is evidence for high levels of stress, depression and alcohol abuse in doctors. Firth-Cozens (Firth-Cozens 2001) reviews the literature on this. The major psychological problems experienced by doctors are depression and alcoholism, and there is strong evidence that these occur at higher rates than in most other professions.

These findings have been elaborated by a 1999 literature review on doctors mental health completed (NSW Doctors Mental Health Implementation Committee 1999). This found an alarming amount of research demonstrating that doctors experience a highly stressful combination of personal and occupational factors which lead to a high rate of adverse consequences. Of relevance are personality factors:

> "Survey reports reveal that doctors tend to be obsessional, perfectionistic, ambitious, self-sacrificing and rigid. They often place high expectations on their own performance, have a low tolerance for uncertainty and difficulty with emotional expression. Researchers have reported that doctors appear to have inadequate coping skills to deal effectively with stress. They may share a dynamic of replacing their own needs with those of their patients.
>
> Doctors with mental disorder have a tendency to deny, minimise and rationalise their own symptoms and behaviours. There are numerous forces for doctors to defend against. There is the narcissistic injury of a tainted self-image caused by mental disorder, where they may perceive themselves as flawed and inadequate. This may be unacceptable because of the collective denial of the medical community and because of society's fantasy of doctors as omnipotent and invulnerable. There is the guilt and shame that arise as a result of the stigma of mental illness, which also occurs within medical subculture. Mental illness represents helplessness and loss of control, which is particularly threatening to doctors accustomed to positions of power, authority and control. Doctors with 'illusions' of grandiosity and indispensability do not wish to give up these defences." (NSW Doctors Mental Health Implementation Committee 1999)

The literature that was reviewed found that there is controversy in the medical literature about whether or not doctors' prevalence rates for mental disorder are higher than that of other professional groups, however the report quotes research evidence that:

- the medical profession being more prone to suicide than the general population. The NSW Medical Board's statistics reported a suicide rate of 19.1 per 100,000 registered doctors between 1992-1997 (compared with a community rate of 12 per 100,000).
- Alcohol consumption appears to be higher in the medical profession than the general population. This has been associated with adverse childhood experiences, older age, disappointment with career, high levels of stress and 'burnout', and high rates of smoking and benzodiazepines use.
- Doctors have consistently been found to have higher rates of drug dependency than pharmacists, dentists and veterinary surgeons.
- Doctors' mortality from motor vehicle accidents has been found to be twice as high as that of the general population.
- Doctors experience continuous exposure to traumatic stimuli in the face of clinical responsibility to relieve suffering.
- They are frequently confronted with ethical dilemmas in the course of their work.
- Australian doctors have not been spared the economic climate of rationing and waning resources that has occurred in other industrialised countries. At the same time they have been exposed to a climate of increasing demands for accountability, with medico-legal consequences." [NSW Doctors Mental Health Implementation Committee, 1999 #153]

Another study (Hawton, Clements et al. 2001) which reviewed patterns in physician suicides found that the highest rates of suicide were amongst community based doctors, general practitioners and psychiatrists.

However peer support appears to go some way towards ameliorating these problems. In 2000 an in depth qualitative study of peer support for GPs was undertaken by the University of Otago (WIlson 2000). Seven GPs who were 'key informants' were interviewed. The data was analysed using grounded theory with rigorous consideration of validity and research philosophy.

The peer support was both for emotional support and professional support. One to one and group support are both acknowledged as viable methods of peer support, providing support and ongoing education about interpersonal relationships, but both varieties are seen as distinct from educational peer group learning. In this study the GPs all received fortnightly one to one peer support.

The research identified how peer support was helpful for the respondents and how models developed in other professions can be used in medicine. Feelings of insecurity, inadequacy or guilt can be worked through in the forum, which can also provide training on specific learning needs. Peer support was also a useful method of learning counselling skills, and it helped the GPs attend focus equally on the psychological and physical aspects of disease in their patients.

The study found that validation and support of GPs by a trusted and respected supervisor allowed professional and personal growth and enabled these particular doctors to survive and flourish while other GPs had been complaining of low morale and work related stress. However this evidence is anecdotal only as the study did not use a control group and certainly was not randomised.

Barriers to the implementation of peer support included unawareness of the concept by doctors, vulnerability to perceived criticism, emphasis on "knowing" in a knowledge-based culture, and constraints of time and cost. The authors recommend that peer support may gain acceptance only by the example of those enjoying it as a method of support and development.

Arrangements in Other Professions

Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) have a Maintenance of Professional Standards (MOPS) program for professional development. The program is for all psychiatrists and is not limited to members. Members must accumulate 1,000 points over five years with a minimum of 100 points per annum. At least 600 points must be from peer review groups, structured improvement projects, or practice visits.

A Peer Review Group is defined as " a small group comprising yourself and other psychiatrists you consider your peers for the purpose of this activity…The purpose of the meeting is to discuss and provide advice to each other on the work you do, to discuss difficult or worrying aspects of your work, to seek support from each other and to provide opportunities for improvement." Peer review through telephone or video link is acceptable and is encouraged for those in remote areas.

To achieve 100 MOPS points a psychiatrist must attend 6 meetings over a year and present his/her work on 4 occasions.

This is considered different from receiving individual or group peer support which is characterised by the peer support being provided by another professional. A group can consist of other health professionals as well as the psychiatrist.

MOPS points for peer support are granted at the rate of 2 per hour of peer support. Why peer support is rewarded at a lower rate than peer review is not explicit, however there is explanation that those activities, which require active participation and reflection on their performance as a psychiatrist, are given more points.

Feature of the MOPS program which has not been seen elsewhere is that activities are protected by quality assurance legislation (Part VC of the Health Insurance Act 1973 : Quality Assurance Confidentiality Amendment Act 1992). This legislation prevents disclosure, including under legal compulsion, of any information about another doctor's practice of behaviour gained solely through the participation in a declared quality assurance activity. That means that any information gained in the course of peer review cannot be disclosed or reported. This protection has been provided to the MOPS program so as to encourage disclosure for free and open review where the psychiatrist is likely to receive assistance rather than censure.

More information about the MOPS program is available from the RANZCP website. http://www.ranzcp.org./mops1.htm

Psychologists

Psychologist have well established system of peer support, which they call supervision. Legally, the only persons who can use the title of "Psychologist" are those who are registered with one of the individual State and Territory Psychologists Registration Boards. In order to register as a psychologist a person requires four years of education in a recognised course plus either post graduate education in psychology or supervised practice. The period of peer support required depends on the qualifications of the applicant. An applicant who has completed four years of accredited study requires a period of two years full-time supervised experience whereas an applicant who has completed five years of accredited study requires one year full-time supervised experience.

Once an applicant has achieved the requirements for registration peer support is optional, although the Society recognises that peer support is relevant at any stage of the psychologist's development. The Australian Psychological Society maintains a professional development program, which is essential to maintain some levels of membership, however, the PD activities are educational and do not include peer support.

Peer support is also optional in Britain and in the US once the psychologist achieves registration although, in the US, the American Psychological Association Code of Ethics stipulates that "Psychologists provide services, teach, or conduct research in new areas or involving new techniques only after first undertaking appropriate study, training, peer support, and/or consultation from persons who are competent in those areas or techniques" (American Psychological Association) .

While it is, in principle, optional the literature strongly endorses psychologists making their own arrangements for peer support and it is not reserved only for new graduates or those entering a new field. (Kaslow p 143, Roth p 159, both in (Kaslow 1986)

The concept of peer support has undergone substantial theoretical development in the discipline of psychology. This will be discussed in context.

Nurses

Peer support has been discussed in the nursing literature throughout the 1990s. Some Australian hospitals have set up peer support or preceptorship programs for nurses, mainly for new graduates, and these are usually discussed in the context of professional development and clinical teaching, but little information is available on the form they take.

Peer support appears to be viewed with suspicion by nurses, or even seen as stigmatising (Cheater and Hale 2001). Northcott in (Spouse and Redfern 2000) p 10 analyses this in detail and details a history of poor staff appraisal practices in nursing. He describes a UK study of appraisal in nursing in which few of his respondents were able to describe a positive experience. He quotes one of his respondents as saying that 'peer support will never succeed in nursing unless nurses are convinced it's not another means to check on what they are doing.'

The more philosophical nursing literature largely reflects the Normative/ Formative/ Restorative model first proposed for nursing by Procter, (Proctor 1991) and all three aspects are present to some degree in many studies of the concept of peer support in nursing. Reflection as a methodological component is also developed as a theme (Fowler 1998).

However, in the UK literature which describes peer support as implemented and evaluated, the flavour of the Normative aspect dominates; in the stated purposes of peer support, where terms such as 'safeguarding standards', 'safe and accountable practice', 'responsibility to the public', 'development of professional expertise', 'improved patient care' , 'reduced turnover of staff', tend to dominate (Bishop 1994; Butterworth, Bishop et al. 1996; Griffiths 1999; Cheater and Hale 2001); in the methods of evaluation which include, rates of sickness, patient complaints, staff retention, critical incident maps, (Butterworth, Bishop et al. 1996) and the goals of evaluation (to assess levels of uptake and factors influencing that uptake and to evaluate how peer support has influenced quality of care, organisation of care and professional development) (Cheater and Hale 2001). Bishop (Bishop 1994) links the rise of peer support for nurses to the new flattened health service hierarchies and the demand for quality and cost effective criteria.

Primary Care Counsellors in the UK

In the UK the place of counsellors in primary health care is now well established. The profession of Primary Care Counsellor has emerged and a professional association, the Association for Counsellors and Psychotherapists in Primary Care, has been established. The Counselling in Primary Care Trust performs research and has developed standards and guidelines to support this initiative. Many resources are available on the web sites of these organisations at http://www.cpct.co.uk.

The Association of Counsellors and Psychotherapists in Primary Care believed that it was untenable for counsellors to continue as an unregulated profession and believed that the public was at risk through untrained counsellors working in GP surgeries. This led to the formation of the Association of Counsellors and Psychotherapists in Primary Care in 1998 (Foster 2001). The UK Department of Health has recently published a document looking to regulate psychology, psychotherapy, counselling and other related professions. Among its requirements are that the profession maintains a register of members who have met defined training standards, that it has a code of ethics and a complaints procedure. The CPC has these structures in place and their code of ethics and complaints procedures are available on their web site.

The Counselling in Primary Care Trust has issued some guidelines, derived from the British Association for Counselling Code of Ethics and Guidelines, regarding the training and experience required as a primary care counsellor. They recommend a three-year training program leading to accreditation with the British Association of Counsellors. This training would include skills and knowledge specific to the medical context. eg diagnosis and management of psychosomatic illness, knowledge of how the NHS operates, dealing with time pressure and waiting lists, and experience of at least 250 hours and preferably 300+ hours of supervised practice over at least 2 or preferably three years .

It is a symptom of the importance of counsellor peer support that there are no British articles to be found arguing that peer support is necessary. Einzig in 1995 and Mellor Clark in 2001(Einzig, Curtis-Jenkins et al. 1995; Mellor-Clark, Simms-Ellis et al. 2001) both found that almost 100% of counsellors had regular meetings with a supervisor. Peer support arrangements are many and varied. Some supervisors are appointed, other counsellors choose their own. Some supervisors are paid and some counsellors pay for their own peer support (Foster 2001). The contract between the counsellor and the supervisor is formalised with a signed document setting out expectations including complaints procedures, code of ethics to be followed, note keeping, payment, responsibility, performance, confidentiality.

Curtis-Jenkins and Henderson (Curtis-Jenkins and Henderson No date) propose a four-fold model of counsellor peer support/supervision. This involves:

- peer support between counsellors in an area,
- managerial supervision through a line of management inside the practice,
- counselling peer support for 1.5 hours/month or in the case of less experienced counsellors one hour per six fifty minute counselling sessions
- availability of expert consultation by telephone in order to gain specific advice.

There is substantial discussion in the literature regarding the training of supervisors and what qualifications and experience they should have. Required competencies include: knowledge specific to the setting of primary care, basic supervisor training as a minimum, knowledge of the organisational structures of the NHS, understanding power and authority structures within the medical team, confidentially issues with the practice team, ethics and accountability with in a medical setting, knowledge of

medication therapies, knowledge of time limited work practices and many other aspects specific to counselling in primary care.

Models of Peer support

A variety of models of peer support have been used in medical and other health professions. Again it is difficult to find hard empirical evidence as to which particular model is better; by and large the arrangements are made by the participants to suit their perceived needs and learning preferences.

Small or large group or individual?

Ray and Altekruse (Ray and Altekruse 2000) investigated the relative effectiveness of small group, large group and individual peer support through a study of 64 masters level psychology students in three groups. Their quantitative study found that both small and large groups and combined group and individual peer support all produced similar results in counsellor effectiveness, however there was a preference for individual sessions by students. These results duplicate the results of two earlier studies cited by the authors.

Hawkins and Shohert (Hawkins and Shohet 1989) examine the advantages and disadvantages of group peer support. Groups clearly have a cost advantage. There is also the advantage that peers can share stories and realise they are not alone. They can also receive comments and reflections from more than one person, gain the benefit of a wider range of life experience and avoid the problem of dependency which can arise with a single supervisor. There is also the opportunity for role-play that multiple members gain in groups. This is more difficult and limited in a one to one setting. Disadvantages include group dynamics, which need to be made overt within the group and discussed, and that there is less time for each individual.

Ray and Altekrise (Ray and Altekruse 2000) also point out the advantages of group peer support. Their review of the literature supports the above arguments and gives the additional observations that group peer support reduces the hierarchical issues between supervisor and student, and provides a sense of psychological safety. Ray and Altekruse point out, however that while group peer support is supported by the literature, individual peer support is still the dominant method within the psychology setting.

Psychologists and psychiatrists often make private peer support arrangements. Kaslow (Kaslow 1986) strongly endorses the responsibility of practitioners in private practice to make arrangements for peer support. She gives advice on choosing a supervisor, establishing a contract and payment. Practitioners may have to pay market rates for peer support time.

Roth (Kaslow 1986) outlines a number of different models for use by groups in community health. These range from a guest lecturer model, a case conference model where difficult cases are discussed by the whole staff, collegial-peer peer support, where peers informally offer each other support and advice, and a model called 'peer support in the extreme', in which everybody in an organisation is randomly paired with another person, regardless of superiority, experience or discipline for feedback and discussion, with pairings being switched periodically.

Other models

Peer support for rural and remote clinicians is an important issue that needs be examined. Lack of support and professional isolation are often cited as reasons for burnout amongst rural and remote health professionals. This is particularly the case amongst mental health staff. Over the past 10 years there have been significant

improvements in communication between rural general practitioners through the efforts of the Rural Doctors' Association. These communications have had myriad functions from political through to educational and peer support.

Videoconferencing.

This is now being used in several states for clinical purposes, particularly in the mental health setting. There is experience with satellite based broadcasting (as distinct from conferencing). There are informal networks of rural GPs using desktop cameras for videoconferencing.

The Rural and Remote Mental Health Service, in Adelaide has completed an evaluation of its telepsychiatry service. A large network of rural videoconference facilities is now in existence throughout South Australia and a great deal of experience has been gained. The system has been successfully used for peer support and educational purposes (Hawker and Kavanagh 1997).

While the infrastructure is largely in place it remains relatively undeveloped for clinical peer support use. Videoconferencing is also an issue which concerns the Psychology profession who have been lobbying for funding to set up the infrastructure for peer support for rural psychologists by videoconference (Crowe 1999).

Telephone:

Allied health and mental health workers in rural and remote areas work in isolated circumstances and sometimes lack a network of peers with whom to share experiences and at times responsibility. This has been a significant factor in staff turnover. Support and validation of the allied health professionals in their role is also essential to maintain good service delivery. Rurally located workers need to be identified within, and actively supported by a larger team, especially to ensure counsellor 'burn out' does not occur. In addition clinical peer support needs have to be addressed in a systematic way.

Peer support either in groups via teleconference or 1 to 1 by normal telephone are easy to establish. These are thought to work well once confidence and trust has been established between group members, generally in the face to face setting. For example the South Australian Rural GP networking project (through the Primary Mental Health Care Incentive Funding) coordinated teleconference based peer support activities using a psychiatrist as facilitator. Those groups that did get established were well received. Participants wanted the project to continue beyond the funding period.

Peer support by teleconference is also a feature of the peer circles which operate in Tasmania although they do not involve clinical peer support as developed in this review. Peer circles are made up of 8 or more GPs together with a mental health worker and a psychiatrist. Sessions are held by teleconference or face to face and are chaired by a GP Mentor or facilitator who is employed to work with the mental health services. This project aims to foster greater understanding and collaboration between primary care providers and mental health services in Northern Tasmania through providing clinical support, by improving communication, and providing education and support for MHS intake and discharge planning processes. It further aims to integrate GPs through involvement in tele-psychiatry, case conferencing and care planning.

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Internet

There is some anecdotal evidence about on-line peer support of general practitioners involved in mental health related activities. The issues above regarding the initial development of a good relationship between group members or between supervisor and clinician are important for this type of peer support as well. Web based communication may be slower but on the other hand may be more convenient as participants do not need to communicate at the one time to participate. There is some experience with this in other countries with similar problems with remote and isolated psychologists (Hudnall Stamm 1998).

While no information is available about outcomes from web based peer support, on line counselling is promising success in treating some mental problems. The University of Ballarat's Panic On-line program is one example http://www.ballarat.edu.au/ruralhealth/panic/. The evaluation, which is in progress, is examining the efficacy of on line cognitive behavioural therapy for panic disorder provided by email by a Masters student in Psychology.

Early results have been favourable for on line treatment, compared with use of a self-help manual, although both groups have shown substantial improvement in their condition. The service is free and addresses inaccessibility issues for those in rural or remote areas or those who cannot access a counsellor for financial or other reasons.

Success with the process of on-line structured therapies augurs well for on-line peer support.

Techniques and Guiding Theories

The literature on peer support is vast and methods and theories of peer support have been developed using a wide range of psychotherapeutic techniques (Watkins 1997) and adapted to different environments. The techniques described here have been selected on the basis of their relevance to general practice and previous discussion in the health literature.

Developmental Models

The Australian Psychological Society prefers a peer support model based upon developmental principles. Such a model assumes that:

- learning involves a staged sequence of developmental tasks,
- these tasks may be defined, and
- that the learning taking place results in professional competence as deemed essential for psychologists.

Developmental models of peer support have been described by Friedman and Kaslow in (Kaslow 1986) and by Hawkins and Shohert (1989).

Hawkins and Shohert have developed a four-stage model describing the stages trainee counsellors or psychologists progress through in developing professional competence and the type of peer support which is appropriate at each level.

- Level 1 is characterised by anxiety and by dependence of the trainee on the supervisor. The supervisor need to provide a structured environment which includes positive feedback and encouragement.
- In Level 2 trainees fluctuate between dependence and autonomy, coping and not coping. It is time or realisation of the complexities of therapy and a loss of early confidence. Some have likened this stage to adolescence. Peer support needs to be less structured but need to provide emotional support.
- In Level 3 the trainee shows increasing self-confidence, flexibility of approach and ability to see the client in context. Peer support becomes more collegial augmented by professional confrontation.
- In Level 4 the practitioner has reached personal autonomy with an awareness to confront his or her own personal and professional problems.

Friedman and Kaslow in (Kaslow 1986 p29) develop a six level classification:

1. Excitement and anticipatory anxiety
2. Dependence and identification
3. Activity and continued dependency
4. Exuberance and taking charge
5. Identity and independence
6. Calm and collegiality

Reflection

There is a huge literature on reflective practice in the health professions. The movement has strong theoretical and ethical links with the push towards critical

thinking in clinical practice. In turn one manifestation of the critical thinking movement has focussed on evidence-based medicine. However on a personal level for the health practitioner the “easy stuff” is the searching and analysis of empirical evidence…the focus of the EBM movement. The “hard stuff”, the real personal challenge, is the self-criticism and self-awareness that is essential for health professionals.

The reflective practice movement has tried to address this latter challenge. Donald Schon (Schon 1995) explains the process by which senior practitioners can assist colleagues achieve better insights into practice, in particular the aspects of practice that present real challenges. The reflections serve as a basis for future action and re-evaluation:

> *In this reflective conversation, the practitioner's effort to solve the reframed problem yields new discoveries which call for new reflection-in-action. The process spirals through stages of appreciation, action, and re-appreciation. The unique and uncertain situation comes to be understood through the attempt to change it...(Schon 1995, p 132)*

The ethical under-pinnings, the ethical necessity for reflective practice for all health professions can be found in a landmark paper by Karl Popper and Neil McIntyre (McIntyre and Popper 1983) that is now almost twenty years old but still as pertinent today as in 1983:

> *"Re improvement and learning from errors. This requires a willingness to admit that one has erred and to discuss the factors that may have been responsible. It calls for a critical attitude to one’s own work and to that of others". (McIntyre and Popper 1983, p1919)*

The following sections briefly outline various approaches to fostering reflection in action.

Socratic questioning

This is a process by which insights are encouraged through awareness raising questioning. It moves beyond the strict educational mantra of knowledge skills and attitudes towards reflection and intuitive practice. Socratic questioning can be use to explore various aspects of clinical behaviour, beliefs and values. In practice Socratic questioning’s aim is to deconstruct the assumptions that underlie various behaviours and thoughts. In a time of crisis or in a difficult situation that is being explored with the supervisor, that state where implicit inconsistencies become explicit, is sought. New approaches can then be explored on a theoretical level and can inform future approaches to practice.

Journaling

Journaling is a process of reflective writing, based on interpretations of clinical experiences. These journals can be kept privately or used with groups or in peer support as a basis for, or adjunct to, discussions. Journaling lends itself to distance based technologies. Amongst students there is often a mixed reception to journaling, reflecting preferred learning styles and to an equal degree how these journals are dealt with by the supervisor/teacher/group. Some love it, some hate it.

Cognitive Behavioural Therapy

Cognitive behavioural therapy is a group of therapies that aim to reduce problematic emotions and behaviour by altering behaviour and by altering thinking patterns. The

underlying assumption is that problematic learnt patterns of thinking and behaving result in adverse consequences. These patterns can be "unlearnt" and more adaptive ways of thinking and behaving can be used. Practice and repetition of these new approaches to thinking and behaving have a consolidating effect and if they result in better outcomes the process is self sustaining.

Similar approaches can be used to understand problematic clinical transactions. Learnt patterns of clinician thinking and behaving can be analysed and alternative approaches tried and if successful, practiced and adopted. This requires a safe environment. It can be done in groups or in the one to one setting.

Case conferences

Case conferencing while used mostly in the clinical setting has some supervisory function. There is a degree of normative surveillance of clinical behaviour and some opportunities for education. However largely the focus of case conferencing is the organisation of clinical care and the other functions come a distant second in emphasis, somewhat vicariously in fact. Unless the normative, formative [educational] and supportive objectives are made explicit and processes put in place to ensure these are met in the case conference, then it is likely that these agendas are not met in any material way.

If the desired outcome is normative or educational or supportive then the activities need to reflect these desired outcomes. If the outcome is better organisation of care then the process needs to reflect this.

Balint Groups

Balint groups were initiated by Dr Michael Balint - a psychoanalyst in London during the 1950's. He worked with groups of GPs to discuss the psychological aspects of their patients' illnesses and the impact that working with these particular people and their problems was having on the GPs.

Unlike a case discussion group, the Balint group concentrates only on the presented patient and his/her doctor. Unlike a support group, Balint groups do not consider the GPs personal difficulties in relation to colleagues, family or personal psychological history.

Balint groups recognise that a doctor is a person and that he or she can find some cases personally troubling. Some do not cope with difficult and distressing matters, some exhibit defensive behaviour, some become overwhelmed, others over-identify with the patient or exhibit inappropriately cheerful behaviour.(Samuel 1989)

Balint group training is a well-established method of exploring the physician-patient relationship, becoming more self aware of habitual responses and finding alternative ways of responding. Balint groups provide a forum in which doctors can present and attempt to resolve stressful situations with other professionals in a 'safe (confidential) environment'. Doctors generally become more aware of how their own stresses, attitudes and values can influence patient care. Balint groups can also provide an outlet for anxieties and frustrations and group leaders can provide support and supervision. (Salinsky 1997)

The group leader is crucial, particularly in the early stages to ensure the group stays focussed on the Balint group principles and address the relationships and not get sidetracked on clinical issues. Often the group leader is a psychiatrist, a psychologist or 'Balint group' experienced GP. The role of the group leader is not to teach or give advice, but rather to encourage participants to gain greater understanding and to expand their repertoires for handling difficult situations. Ideally groups range in size from 6-12 members and remain together for about 3 years, meeting approximately

monthly for approximately 1-2hrs. Group longevity is seen as important in order to establish trust between members. (Samuel 1989)

Balint groups have become widespread worldwide and have a reputation as being helpful and supportive. However one study, important to this review, was undertaken in Finland (Joukamaa, Lehtinen et al. 1995). The study, which was rigorously quantitative, found that GPs who have participated in Balint Groups have a lesser ability to detect mental illness in their patients than other GPs. The reasons for this are unclear. The authors suggest that this is because the emphasis of Balint training is on the management of all patients rather than on the diagnosis of mental disorders. This study's findings may reflect confusion regarding the objectives and processes of Balint groups and a mismatch of evaluation rather than lack of success per se.

Techniques for review of clinical performance

Most techniques referred to above rely on indirect evidence of clinical performance. Discussions are based on recollections of transactions between practitioner and patient/client. They rely on recall and interpretation with all their inherent inaccuracies. Such approaches have been criticised in the educational literature as being tantamount to teaching someone to drive via a mobile phone, with the supervisor at one end in a room without windows and the clinician driving with a mobile phone at one ear telling the supervisor what's happening.

Most health care educators involved in teaching clinical skills would accept that for clinical behaviour, to be adequately reviewed needs to be observed. This can be done either in real time through direct observation or at another more suitable time via audiotaping or videotaping of consultations (with client/patient consent). Direct observation does not need any advanced technology but the presence of the observer can be problematic. The use of recordings allows clinicians to look at their own clinical performance in a much more objective manner than can be achieved from recall based case discussions.

Of course these types of activities must be based within groups that are stable and safe for the members in order for disclosure to be optimal. Use of such recordings and structured analysis and feedback can be coupled with many of the other techniques listed above. They are not exclusive and distinct options; their combination lends depth and flexibility to a difficult but valuable process of reflection on clinical practice.

Issues

Evaluation and Outcome Measurement

Despite all of the above demonstrating need, as well as testaments to the benefit of peer support, hard evidence that appropriate peer support has a beneficial effect in improving quality of care, preventing excessive “deviation” in clinical behaviour, and preventing clinician mental health problems, is lacking. Studies of the standard usually expected by the clinical and educational research community, which could demonstrate benefit, are currently very difficult to conduct with established clinicians.

Bambling in a recent article examines thoroughly the evidence for peer support leading to greater competence in the supervisee. He concludes that "The basic questions as to the degree that supervision increases supervisee's skills in their client work and improves client outcome are yet to be answered." (Bambling 2000 p62) . He cites three studies, one of which had negative findings and two of which had positive findings but methodological limitations. He found a predominance of subjective studies but a lack of controlled trials and longitudinal studies.

Two findings however, appear to be robust; these are:

1. "A positive supervisory alliance increases the supervisee's level of trust and tendency to model, accommodate, challenge and explore supervisor approach and training input.
2. Supervision is effective in systematically teaching basic counselling skills, but not necessarily helpful in the development of more complex skills." (Bambling 2000 p62)

A further literature review was completed for the RANZCP in 1999 (Rose and Boyce 1999). This review had similar findings to Bambling's review however sees the problem as inherent in the difficulties in quantitatively examining the quality and effectiveness of clinical practice in terms of patient outcome. Factors which make this difficult are:

- how to define quality,
- the relative importance of clinician and treatment variables in determining patient outcome,
- the variation in the dependent variables of interest between populations, and
- other factors such as patient understanding of and adherence to agreed management and other patient behaviours (Rose and Boyce 1999).

Changes in community values over time, also make definitions of quality shifting goal posts. Should the benefit of peer support be measured through patient outcome, cost containment or through the improvement of a profession's skill base? Should the emotional health of practitioners be seen as a goal relevant to a publicly funded system?

When examining the evidence on efficacy of peer support one has to be clear about the particular objectives of the peer support activities. If the outcome on a systemic level is fewer severe adverse events (generally low in frequency) then this is generally quite difficult to measure using conventional research methods. If the desired outcome is education and training, then this can be measured but the group process needs to involve evidence based learning activities. If the outcome is happier, less stressed and more positive clinicians then this can also be measured but what it means within the health system itself is conjectural.

It is not surprising that most of the evaluative research on peer support has been qualitative. A number of peer support programs have been evaluated qualitatively with the following results:

A New Zealand project conducted in depth qualitative research with seven participants in a program of individual peer support (WIlson 2000). Attention to validity and methodology was rigorous. The study found that support of GPs by a trusted and respected supervisor allowed professional and personal growth, even in a period of considerable uncertainty and change, which allowed supervised GPs to flourish even when other GPs had been experiencing stress and low morale. One key theme identified was 'validation and affirmation of the GPs role,'. GPs wanted feedback on how they were doing. They wanted to be to be not just told they were doing OK; they wanted to be critically examined and evaluated. Peer support contributed to 'high morale' however this effect only occurred after considerable commitment to the peer support process. Peer support provided professional maintenance and ongoing education about interpersonal relationships. The author describes how the professional can survive the multiple pressures from patients and work situations by being held in a supportive supervisory relationship. The research also found considerable barriers to peer support in the culture of medicine in which works against personal disclosure, seeing vulnerabilities as a sign of weakness which can be used against you. The author believes that peer support will only become more widespread through the example of those enjoying it as a means of support.

The Centre for Rural Mental Health (University of Melbourne) Depression Anxiety Research and Treatment Program (DART) (Hodgins 2001) is another program which is currently being trialed and evaluated with GPs in the Bendigo region (personal communication Gene Hodgins). This involves a clinical psychologist visiting a GP practice for 6-8 sessions of 1 1/2 hours. The peer support is focussed on the clinical management of patients however there is an option for support based on Cognitive Behaviour Therapy. Evaluation is incomplete, however feedback has been positive and constructive allowing for further development of the model.

Ethical Considerations

RANZCP has legal immunity for psychiatrists participating in peer review groups. If a practitioner learns of poor practice in a peer group he or she is not permitted to report it unless the Health Minister gives permission. This legal immunity has been granted in the interests of encouraging practitioners to talk about their mistakes and to receive help rather than censure. It is unclear whether this type of arrangement has improved disclosure and self-monitoring or not. Whether this immunity is available and appropriate for GPs participating in peer support needs to be publicly debated. Nevertheless it is in accordance with organisational literature on reducing adverse outcomes in complex health systems. (Brent CJ, 2001)

A Code of Ethics underpins peer support in the psychology, psychiatry and counselling professions and underpins their peer support requirements. A similar Code of Ethics with a requirement for peer support could be considered for GPs delivering the counselling services through the *Better Outcomes In Mental Health* initiative.

Peer support of Allied Health Practitioners/Counsellors General Practice Settings

Penny Henderson (Carroll and Holloway 1999 p 85) gives some specific recommendations for counsellors (other than GPs) employed in the setting of general practice. She sees the general practice environment as having some particular problems for counsellors. These include: a culture of limits and scarcity, with pressure to be time effective and to provide services to as many clients as possible, a high proportion of clients with multiple social and health problems, a need for an awareness of somatisation issues, the triangular relationship of referral which complicates confidentiality, and issues of professional autonomy and accountability.

General Practice is therefore a different environment to that which much of the peer support literature was developed. Supervisors need to be aware of these idiosyncrasies; they need to be trained and skilled in negotiating and supporting counsellors in this culture. Boundaries, responsibilities, accountability, relationships and structures of the context give rise to issues specific to the general practice environment.

Barriers

Peer support is a concept that is by and large unfamiliar to general practitioners. Medical practitioners in the community tend to work as sole practitioners. Even when working in multi-disciplinary teams doctors are often perceived to be at the top of the pyramid and see themselves as being the supporters rather than requiring support themselves. It is only in the discipline of psychiatry that the notion of peer support has much standing within the medical profession. Professional autonomy has been one of the dominant principles underlying medical practice. Efforts to introduce accountability and peer review within medical practice have had limited success.

The issue of the barriers to the implementation of peer support programs has been discussed by Wilson (WIlson 2000) in his study of a peer support program for GPs. Enduring barriers to peer support in the medical culture lie in the 'shame based' teaching methods that until recently have been common in medical schools, the 'pecking order' in medicine which encourages the exploitation of another's weaknesses, the tradition of observer detachment, and an emphasis on knowing in a perfectionistic knowledge based culture.

In the medical culture doctors learn not to expose their weaknesses because they will be used against them. Wilson concludes that peer support will gain acceptance only by the example of those enjoying it as a method of support and development.

Robert Craig, in an unpublished paper, gives another view that medical training is directed towards establishing the practitioner as the knowledgeable and congruent person in the doctor/patient relationship. Peer support questions this position. Discomfort with self-questioning is an important factor behind resistance to participation in peer support.

Craig recommends this resistance must be acknowledged and a variety of options should be offered.

Conclusion

Peer support and peer support activities are accepted amongst various professions as being necessary safeguards for clinicians working in the mental health field. Their desired function within these professions is largely restorative and normative. It can

be argued that specific competency development requires different techniques from those commonly used in true peer support groups. These functions are best addressed through training, certification and accreditation procedures.

The winds of change are upon us, however. Medical schools and some Colleges have been endeavouring to overcome the barriers to the development of the open and self-critical culture that Popper and McIntyre proposed in their paper of 1983 cited above. The development of formal structures, at least in this setting of GPs engaged in specific therapies in mental health, is potentially an important step to promote better and safer practice.

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Appendix I Peer Support Programs

NSW

Division	Activity
Bankstown	
Barrier	
Barwon	
Blue Mountains	Hold monthly meetings for up to six GPs for case discussion. Each month invite a local psychiatrist plus a member of the local Mental Health Team. Each GP is invited to bring along a case for discussion by the whole group.
Canterbury	
Central Sydney	Several peer support groups of ten sessions, at a cost of approximately $2500 each, covering psychiatrists' time, project officer time, and catering.
Fairfield	
Dubbo/Plains	
Eastern Sydney	
Hawkesbury	
Hornsby Ku-ring-Gai Ryde	Currently running monthly case management/discussion groups with in two locations; one is facilitated by a psychiatrist with the MHS and the other by a GP with a Master in Psychological Medicine; facilitators' remuneration is from a drug company.The numbers are small (2 - 6 in any session) but the GPs are enthusiastic.
Hunter Rural	
Hunter Urban	
Illawarra	CBT peer support for GPs by clinical psychologists, Balint groups, consultation-liaison shared care in GPs rooms being funded over the next 2 years as part of the Illawarra Mental Health Integration Project. We have previously held Balint groups over 6 consecutive weeks facilitated by a psychiatrist, but they ceased because of a lack of GP numbers due to length of program and inability to commit to that time.
Liverpool	
Macarthur	
Manly Warringah	
Mid North Coast	

Murrumbidgee	
Nepean	
New England	
North West Slopes	
Northern Rivers	
Northern Sydney	A series of peer support groups. Currently running are 2 sets - one is the Adult Mental Health Peer support Group the other the Child and Adolescent Mental Health Peer support Group. Each series runs for four months. A public / private psychiatrist meets with up to 8 GPs and mental health service staff for an hour each month to discuss case studies brought along by GPs/mental health service staff. The groups are sponsored by a drug company and the psychiatrists are paid an honorarium.
NSW Central Coast	
NSW Central West	
NSW Outback	
Port Macquarie	Monthly GP case discussion meetings with public Child & Adolescent psychiatrist – involves 8 GPs. Four evening "Counselling in General Practice" training program with private psychiatrist includes reflection and discussion of personal styles etc.
Riverina	
Shoalhaven	
South East NSW	
South Eastern Sydney	
Southern Highlands	
St George	
Sutherland	
Tweed Valley	
Western Sydney	

WA

Division	**Activity**
Canning	Regular case discussions around EPC
Fremantle	Youth health case discussions Developing a reflective practice program for 10 GPs Assisted by psychologists/social workers trained in

	reflective practice
Perth	Program of brief solution focussed therapy – 4 GPs participated. GP wellness program – training GPs to be peer supports to other GPs – linking GPs.
Rockingham-Kwinana	Monthly Balint groups (case discussions) with a visiting psychiatrist.
?	Rural/remote monthly breakfast meetings, which involve formalised case discussions. NWMHS remunerates the psychiatrist facilitator and the Division remunerates GPs for their time.

SA

Division	**Activity**
Adelaide Hills	A private psychiatrist visits GP surgeries to provide education and discuss cases. A MH nurse employed by the Division with MAHS funding also attends practice visits.
Northern Division	Regular case discussions
Yorke Peninsular & Mid North	Development of Division-wide emergency response plans. Involves GPs and allied health and assisted by psychiatrist from rural and remote MH Service. Ceased due to lack of funding.
Riverland	Monthly visit by psychiatrist to GP practices for case discussions
Southern	GP attachments to MH Service 2 psychiatrists visit GP practices to provide some consultation liaison and lunchtime meetings for case discussion. Balint groups
ACE	Balint groups

NT

Division	**Activity**
To be reported	

QLD

Division	Activity
Sunshine Coast	Regular peer support groups – on average attended by 20 GPs though memberships changes.
Bayside	A private psychiatrist holds case discussions with 8 GPs
Logan Area	Monthly group case conferencing with psychiatrists – public and private. Shared care Balint group discussion with senior case manager and psychiatrists– public and private.
Gold Coast	Monthly GP meetings with local public psychiatrist
Brisbane North	GP cluster groups meet regularly to discuss cases Balint type groups with Holy Spirit Hospital
Ipswich	Monthly lunchtime meetings with psychiatrist to discuss journal readings
Capricornia	Monthly case conferences with 12 GPs to discuss effective management. Private psychiatrist and psychiatrist and allied health from the MH Service facilitate.
Far North Queensland	Monthly breakfast meeting facilitated by private psychiatrist – 6 GPs
Central West Queensland	Monthly breakfast meeting facilitated by public psychiatrist – 6 GPs

ACT

Division	Activity
ACT	6-8 GPs with an interest in mental health meet at a residence to discuss cases. GPs who have completed SPHERE have regular case discussions of difficult cases. Discussions preceded by half hour case presentation. Discussions lead by clinical psychologists and two lead GPs.

TAS

Division	Activity
All	3 peer circles operating in Tasmania – 1 circle in each region. Psychiatrist, allied health and GPs involved in peer circles. GPs now want more focussed Balint type approach.

?	1 circle operates by phone every 6 weeks – 8 GPs
Northern	Circle operates with 14 GPs and GP Mentor. GP mentor employed one day per week.
Southern	Circle includes 19 GPs

VIC

Division	**Activity**
Mornington	Monthly GP case discussion meetings with psychiatrist – involves 5 GPs
Geelong	Monthly case discussion meetings on shared care clients. Facilitated by psychiatrist
North West Melbourne	Special interest group meetings for psychiatrists and GPs involved in CLIPP
Whitehorse	Regular case discussions with private psychiatrist and GPs
North East Valley	Balint groups facilitated by psychologist – focus on patients and therapeutic orientation.
Melbourne	St Vincent's Project