Primary Care Mental Health Strategy

General Practice NSW

This paper was prepared for the Mental Health Commission of NSW to support the development of the Strategic Plan for Mental Health in NSW 2014 – 2024

October 2014
GP NSW

Primary Care Mental Health Strategy

FINAL DRAFT

December 2013
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1. EXECUTIVE SUMMARY

This Primary Care Mental Health Strategy is based on interview findings and a literature review, and is aimed at informing the development of a strategic plan for the NSW mental health system.

Background

The Mental Health Commission of NSW (MHC) has recently begun the process of developing a strategic plan for the NSW mental health system. The role of primary care in mental health is increasingly recognised as a vital component of the mental health system.

The Mental Health Commission has engaged GPNSW to outline the role General Practice and primary care plays in the NSW mental health system, the constraints they face and strategies that could be implemented to support General Practice, both as a gateway to mental health services for people with co-morbid physical conditions and in on-going service provision to this population cohort.

Key messages/findings

Many General Practices are characterised by a high rate of predominantly short consultations. This environment, particularly in large corporate practices where patients may see different doctors at each visit, creates a barrier to developing the trust relationships that are needed to optimise mental health care. GPs in theory provide a gateway to many mental health services and also have a primary responsibility for ensuring that both physical and mental health conditions are effectively managed. Routine physical health monitoring of people with mental illness by GPs has the potential to reduce the harm from risk factors such as smoking, obesity, drug interactions.

However, many GPs have little knowledge of mental health conditions and little experience or support in managing these patients. Lack of early intervention at the point when the ‘red flag’ symptoms of mental illness appear means that treatment is often delayed until after a crisis has occurred and needs to be provided in an acute setting rather than the community. Many GPs focus on drug over behavioural therapy and referral to acute mental health services, rather than to psychologists and community managed mental health organisations. It was reported that many GPs are unsure what information and support they can provide to families and carers due to privacy concerns, although a lack of information about strategies for dealing with mental illness creates compounding stress on families. All interviews highlighted a need for additional continuing professional development in mental health and mental health placements for GPs.

When a patient’s needs cannot be managed in a General Practice setting, GPs need to have access to a range of referral options in their local community, encompassing Community Managed Organisations (CMOs) specialising in mental health, psychologists and acute services. Once referred, GPs need to have access to on-going information about the treatment provided in these services, opportunities for discussion with other health professionals and supporting eHealth systems to ensure information exchange is secure and timely.

The fragmentation of mental health services provided by GPs, public health and community managed organisations and lack of adequate case management, poor communication and co-ordination between providers was highlighted as a major concern. There is a critical need more structured escalation pathways from GPs to mental health services and for GPs to have more information available on alternative referral options.

Co-location of GPs with specialised mental health services, such as psychologists or community based mental health services, was seen as a preferable model. However, at a minimum improvements in use of eHealth to support communication and case management, referrals, and access to best practice guidelines were seen as critical to improving communication...
between GPs and mental health services. Current funding mechanisms were seen as a significant disincentive to GPs to provide care to mental health patients.

Our review of the Australian and international literature indicates that successful primary care mental health models are initiated at the local level rather than through attempting whole-of-system reforms. It indicates further that different severities of illness demand different models of care, and that adopting an inappropriate model can have negative outcomes for patients.

**Implications for change**

The outcomes of the literature review and the interviews held identify implications for a number of aspects of primary care. These include:

**Implications for service delivery models**: To maximise mental health outcomes, changes are needed to current GP service delivery models to facilitate early intervention and prevention strategies, holistic physical and mental health care and improved case management and collaboration across GPs, CMOs, other specialist mental health and acute services.

**Implications for funding**: The current GP fee for service model creates significant disincentives for GPs to provide mental health services. Once alternative models of care are evaluated, a review of alternative funding mechanisms that best support proposed service delivery models needs to be considered, such as capitation funding. It is recommended that COAG identify opportunities to address the barriers that divided State/Commonwealth funding and responsibilities create in delivering effective integrated or at least collaborative care.

**Implications for training, on-going professional development, accreditation standards**: GPs need additional continuing professional development in mental health to assist with early diagnosis of mental health conditions, on-going training in emerging therapies as well as opportunities for placements in mental health services. Accreditation standards should be reviewed to ensure they encompass minimum standards in relation to mental health.

**Enabling legislation**: There is a need for guidelines to assist GPs to identify their obligations in relation to consent and sharing of information with carers, and when it is appropriate to schedule a patient under the Mental Health Act. COAG agreements or MOUs might need to be amended to enable modifications to current Commonwealth / State funding arrangements to facilitate integrated delivery of services.

**Expansion of role of Medicare Locals**: Medicare Locals need to be actively involved in co-ordinating services and facilitating case management and referrals from GPs. Ideally they should act as a co-ordination point between services as well as supporting GPs to determine escalation points when more acute services are required. They should also take an active role in working with GPs on mental health promotion and awareness building of available mental health services.
Workforce and resources

To broaden the capacity of GPs to best treat mental health patients there is a need to increase the GP workforce specialising in mental health. This will require both additional incentives to provide these services and a change to the current business model, as well as additional training. Options to increase the use of practice nurses with mental health experience working with GPs to provide increased capacity in mental health services should also be evaluated.

Reviewing options to reform the current episodic fee for service funding for GPs to an alternative or parallel / complementary approach that would better support co-ordinated care, early intervention and preventative care and more holistic mental/physical health services would help to address the reluctance of GPs to provide mental health services. This reform might also have parallels with chronic and complex disease care.

Implementation of models of care that involve better case management, co-ordination, integration, stepped care and improved referrals depends on implementation of effective and ubiquitous technology. There are still substantial improvements required in the areas of eHealth, such as widespread access to and utilisation of the PCEHR, broader application of electronic Discharge Referral systems to provide true transfer of care capability, as well as enhanced general practice management systems to streamline assessment, referral and development of mental health plans.

Populations

Implementing new models will have challenges for rural and regional primary care providers and may require aggregation of services.

Recommendations/strategic directions

As General Practice is largely a federally managed domain many of the recommendations do extend into areas of federal responsibility. However, it is anticipated that the connections between the NSW and National Mental Health Commission will be able to be leveraged and processes put in place to enable recommendations that do not sit within the NSW sphere of responsibility to be progressed.

<table>
<thead>
<tr>
<th>Change</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>Models of Care</td>
<td>5-10 years</td>
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<tr>
<td>- Develop models of Primary Care that appropriately address the different needs of patients according to the severity of their mental health disorder, distinguishing the care of people with mild mental health issues from those with moderate and those with severe illness.</td>
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<tr>
<td>Co-location</td>
<td>5-10 years</td>
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<tr>
<td>- Optimise access to services by including co-location as a critical component of any primary care mental health model developed.</td>
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<tr>
<td>Resourcing</td>
<td>1-3 years</td>
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<tr>
<td>- Identify incentives for GPs to engage mental health nurses/nurse practitioners in practices to help support mental</td>
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health patients.

- Reinstate the Mental Health Nurse Incentives Program to embed additional skilled resources in general practice and increase capacity for treatment, prevention and early intervention activities.

### Funding

- Evaluate implementation of additional MBS item numbers to enable tele-health consultations with GPs and psychologists, both individually and through joint consultations.
- Review alternatives to the current GP fee for service model, such as a capitation model, to facilitate GPs taking on a broader co-ordination role and potentially engaging nurse practitioners to undertake more mental health activities. This would need to consider the incentives required to persuade GPs to change their current business model.
- Review options to integrate State and Commonwealth funds for mental health services into a single funding pool and assess the feasibility and effectiveness of this through a regional pilot co-ordinated by a Medicare Local.
- Review financial incentives that are currently available to encourage GPs to participate in professional development in mental health.
- Review differential in remuneration rates for GPs and psychiatrists providing similar mental health services.

### Technology

- Improve and implement mechanisms for information sharing through eHealth (both PCEHR and point to point between hospitals, GPs and CMOs).
- Investigate the potential for patients to use tablets to complete mental & physical health screening assessments prior to seeing their GP, enabling the results to be compiled ready for discussion with the GP.
- Assess potential to enhance GP systems to provide better access to best practice guides for mental health conditions.

### Education and training

- Investigate options to increase access to Continuing Professional Development in the area of mental health for GPs.
- Identify incentives for GPs to visit / work part time at organisations such as HeadSpace, OnTrack Community Programs, The Station to increase awareness of mental health services and treatment options.
- Provide incentives for GPs to participate in additional training in mental health (e.g. Institute of Psychiatry GP Postgraduate Education Program).
- Provide incentives for GP participation in Medicare Local Continuing Professional Development Training and lectures and training held by Community Managed Mental Health Organisations on working with people with mental health conditions (with CPD points).
- Review existing programs that have had limited success in engaging GPs (such as Mental Health Professionals Network) to identify and address reasons for lack of participation.
- Use multiple approaches to mental health training for GPs, including web based training modules as well as face to face options.

### Referral processes

- Review and streamline the current referral process from GPs to psychologists.
- Adopt a structured Stepped Care approach for escalation.

### Co-ordination and integration

- Engage Medicare Locals to take on an active role in broadening GP knowledge of Community Managed Mental Health Organisations, in co-ordinating services, facilitating case management and referrals from GPs and acting as an escalation point when more acute services are required.
- Engage Medicare Locals to take on a management role to provide support for GPs and mental health providers, defining program standards, assist in training and negotiation over funding.
- Implement improved transfer of care processes that provide information to all participating providers on transition of a patient from one health service to another\(^1\).
- Investigate and implement resources and training to support improved collaboration between GPs and other private and public mental health specialists.

### Accreditation

- Include knowledge of the mental health system in the basic standards for GP accreditation.
- Incorporate training for GPs on working with people with mental health issues and trauma informed care\(^2\) and practice in basic standards for accreditation.

### Consent to treatment and information sharing

- Develop clear guidelines for GPs to identify information that can be communicated to family members to ensure carers get practical assistance and strategies to cope.
- Develop guidelines to assist GPs to determine when it is appropriate for an individual to be scheduled.
- Educate GPs in the importance of routinely obtaining consent to provide information to carers when patients are well and incorporate these wishes in the mental health plan.
- Clarify rights of patients to access their own records and communicate this to GPs.

\(^1\) (see [http://www.archi.net.au/resources/safety/clinical/nsw-handover/gp](http://www.archi.net.au/resources/safety/clinical/nsw-handover/gp))

Changes to services offered

- Develop additional services targeted at family members and carers to support them to manage family members with a mental health condition.
- Promote routine Physical Health Checks for patients presenting with mental health issues at GPs.
- Investigate alternative service delivery options (and funding options for these), such as tele-health consultations for follow up to increase the frequency of contact with patients without travel and waiting times and reducing demand on GPs.

Promotion of GP services

- Promote the idea that GPs are able to provide mental health services to offset the perception that GPs are not a provider of mental health services.
- Engage GPs as an information point for broader services by providing access to brochures and information on local CMOs that provide services for mental health, drug and alcohol and youth services.
- Facilitate access to information for consumers on which GPs provide expertise in mental health and who have capacity to take on new patients.

Measurement and monitoring

Change and progress in primary care mental health, and establishing whether and how well such change was making a difference to people’s lives, may be measured on the following generic indicators. Please see Section 6 for potential indicators for key dimensions of care.
2. INTRODUCTION

Scope of this document

This strategic document describes the development and outcome of a primary care component for input to the NSW Mental Health Strategy.

Background

The Mental Health Commission of NSW (MHC) has recently begun the process of developing a strategic plan for the NSW mental health system. The role of primary care in mental health is increasingly recognised as a vital component of the mental health system.

The MHC commissioned GPNSW and Doll Martin Associates to complete a short, focused research and interview exercise that considered the evidence relating to the role of primary care in mental health care. From this, to develop content for a draft Strategic Plan, for input to the NSW Mental Health Strategy, which could be used to build on and complement existing mental health related strategies and initiatives in the primary care sector.
3. **METHODOLOGY**

The project involved the following tasks:

1. Establish the project, determine consultation requirements and organise interviews and participants.
2. Interview 11 stakeholders selected by GP NSW for their concerns and contribution.
3. Research literature for prior mental health strategies and evidence of what might have been effective in other jurisdictions.
4. Analyse interview and research findings to determine key result areas for primary care in mental health.
5. Develop strategies for primary care for subsequent incorporation into the MHC Strategic Plan.
4. LITERATURE SCAN

Literature scan summary

The topic of Primary Care in mental health service delivery has generated a substantial body of literature, both in the grey literature (mainly policy and strategy) and in the peer-reviewed literature (mainly research and case studies).

A recent commentary in the peer-reviewed literature provides a brief but comprehensive overview of the emerging need for reform in the role of primary care in mental health care delivery.3

A systematic review and meta-analysis of collaborative care for depression can be extrapolated to other mental health disorders.4 This comprehensive study concluded,

“Collaborative care models are effective in achieving clinically meaningful improvements in depression outcomes and public health benefits in a wide range of populations, settings, and organisations. Collaborative care interventions provide a supportive network of professionals and peers for patients with depression, especially at the primary care level.”

Key findings from the literature scan

- A robust body of literature exists on the role of Primary Care in mental health service delivery, ranging from international studies5, to national strategy documents from Canada, the US, UK, European countries, and Australia. The literature is overwhelmingly supportive of what is generally known as ‘collaborative care’ or ‘shared care’. There was wide variance in use of common terms such as collaboration care, shared care, and integrated care. A setting that focuses on treating the entirety of a patient’s needs was sometimes referred to as the ‘medical home’.6

- A range of models is described. The US Millbank Memorial Fund report identifies 8 models.7 Models that are mentioned consistently include some or all elements of: co-location, shared care, integrated care, team care. Many of these models explicitly or implicitly incorporate a Stepped Care process. Stepped Care formalises the process for treating escalation of illness, beginning with the least intrusive approach that will deliver an optimum outcome. Generally speaking, Stepped Care makes explicit the often ad hoc process of GP referrals to, and between, specialists or allied health service providers.

- A number of models have been identified as having applicability to Australia in a major study conducted for Medibank by the NOUS group8. This review notes, “Successful whole-of-system reforms are rare internationally, with mixed relevance to Australian circumstances”. Successful models are overwhelmingly initiated at the local level and, after testing and where appropriate, extended to other sites.9 A model proposed by Australian primary care providers and mental health clinicians suggests local initiatives for integrated care can be based around Medicare Locals.10

- Studies of successful implementations acknowledged the necessity of organisational changes at the healthcare system level.11

3 (Miller 2013)  
4 (Anilkrishna, 2012)  
5 (World Health Organisation [nd])  
6 (Petterson, 2008) (Kates N 2011)  
7 (Collins 2010)  
8 (Medibank; Nous Group, 2013) p.80  
9 (Kates N 2011)  
10 (Brown April, 2013)  
11 (Anilkrishna 2012, p.536)
A distinction is made between the care of people with mild mental health issues from those with moderate to severe illness. In appropriately addressing the different needs of patients according to the severity of their mental illness, models of Primary Care need to accommodate different approaches. All international studies that were discovered recognised this need.\textsuperscript{12, 13} When models are used inappropriately, one study from Finland\textsuperscript{14} for instance, found that integrated community care had a measurable negative outcome for suicidal patients. In Australia, the granularity of responses needed is acknowledged in the Medibank study.\textsuperscript{15}

Additionally, Primary Care providers are the frontline providers for patients with complex needs who also need mental health care. These are people with chronic or on-going diseases, people with a disability, with neurodevelopmental disorders, or who have a substance abuse condition. The Chronic Care Model (CCM) forms the basis of the physical health treatment combined with a service coordination model. Such an approach has been the focus of a major project in Victoria.\textsuperscript{16}

Integrating primary care and mental health services has particular characteristics and implications when applied to rural and remote communities, where initiatives are constrained in isolated communities or areas with sparse populations. This has been addressed in Australia largely by local programs.\textsuperscript{17, 18, 19}

Examples of collaborative care for disadvantaged groups (apart from rural/remote) are addressed mainly in the peer-reviewed literature. There is a vast body of literature in this area, overwhelmingly from the US. Most of these studies describe a model for treating specific illnesses (e.g. depression) among specific cultural or demographic groups (e.g. Hispanics). A dedicated literature search for each particular cultural and demographic group could inform strategies for specific groups in NSW.

Funding models for primary care/mental health collaborative care in the literature are scarce and largely reflect the complex nature of the US experience. In Australia, the need for system redesign is acknowledged as essential to delivering substantial reform in this area.\textsuperscript{20} In rural and remote Australia, “population size and distribution are critical factors in designing PHC [Primary Health Care] services – ‘successful’ models have invariably addressed diseconomies of scale by aggregating a critical population mass, whether it is a discrete population in a country town or a dispersed population across a region”.\textsuperscript{21}

**Emerging trends in the literature**

**Technology**

The use of information technology and the Internet to facilitate shared care – for both consumers and practitioners - is a developing area of study. The use of technology is viewed as an adjunct to models of shared or integrated care, not as a model in itself.\textsuperscript{22, 23}

\textsuperscript{12} (British Columbia. Ministry of Health., 2012)
\textsuperscript{13} (Ireland. Health Service Executive Working Sub Group on Mental Health in Primary Care, 2010)
\textsuperscript{14} (Pirkala, Sund, Sailas, & Wahlbeck, 2009)
\textsuperscript{15} (Medibank; Nous Group 2013, p.79)
\textsuperscript{16} (Davidson 2010)
\textsuperscript{17} (Bidargaddi 2011)
\textsuperscript{18} (Harte & Bowers, 2011)
\textsuperscript{19} (Humphreys, [nd])
\textsuperscript{20} (Medibank; Nous Group, 2013)
\textsuperscript{21} (Humphreys, [nd])
\textsuperscript{22} (Butler, 2008)
\textsuperscript{23} (Bidargaddi)
Evaluation

While there is substantial material available on performance measures of mental health programs, evaluation methods for Primary Care Mental Health care models are still developing. The need for these was recognised in the strategies from New Zealand, Ireland and South Australia, with some evaluation mechanisms suggested. The South Australian Noarlunga report offers an overview of the challenges of integrated primary and mental health care; it notes the risks and limitations of the integrated model, as does a wide-ranging 2013 report from an international project on the topic.

Literature scan methodology

There is a wealth of literature on the topic of models for Primary Care Mental Health care. A significant volume is comprised of policy and strategy documents in the grey literature and narrowly focussed articles in the peer-reviewed literature.

For the purposes of this report, the literature scan was highly selective and focussed on information that met the criteria of being: practical and/or with demonstrated success, recent (mainly from 2006), and applicable to Australia. The Bibliography at the end of this report is representative rather than exhaustive.

Grey literature

Grey literature produced most directly useful results from simple Google searches and following ancestry citation pathways. The search looked for topic terms initially, which produced a huge body of information and revealed the major reforms in the area – usually government or large policy body publications. Topic terms were then linked with particular countries that had been suggested by GP NSW or in stakeholder interviews: Australia, Canada, Finland, Ireland, New Zealand, and the United Kingdom countries. Previous knowledge of the literature meant that the US Department of Veterans Affairs was also included in the search strategy.

This approach produced the bulk of the references that are cited in this report and/or included in the Bibliography.

Peer-reviewed literature

The search of PubMed for peer-reviewed articles revealed that there has been a significant growth in publications on this topic from 2001 (370) to 2012 (1059).

Overall the search of recent (2006-) peer-reviewed literature did not result in the discovery of practical useful models for this report. The majority of peer-reviewed literature advocates reform in the area of Primary Care Mental Health care. These references were not included in the Bibliography unless there was some practical application for Australia. This did occur with articles about evaluation methods and the use of information technology.

A substantial volume of articles was about highly specific topics and consequently was largely not useful for this report, due to its sheer volume and level of detail. The range of specific subjects included particular cultural or demographic groups, specific mental illnesses, care at different life stages, e.g. paediatric, maternal health, undergraduates etc. or with mental health aspects associated with physical illnesses, e.g. cancer, diabetes, HIV.

24 (Mathieson, Finlinson and Barr 2010)
25 (South Australia. Division of Mental Health. 2006)
26 (Mental Health Commission 2012 pp.35)
27 (Ireland. Health Service Executive Working Sub Group on Mental Health in Primary Care 2010)
28 (Mathieson, Finlinson and Barr 2010)
29 (Patel 2013)
In addition to evaluation methods and the application of information technology, the peer-reviewed literature was useful for discovering systematic reviews of models of primary care in mental health but again these mostly focussed on particular interventions or targeted groups, research models, or policy directions and development.
5. KEY FINDINGS FROM INTERVIEWS

Introduction

This section summarises the major issues identified during the interviews. It was acknowledged in all interviews that increased participation in mental health care by GPs provides significant benefits to people with mental illness:

- Improved early identification and intervention to avoid crisis responses and dependency on acute care
- Better detection and treatment of physical illness for people with mental health issues
- Less focus on acute care and hospital based care and more support in the community
- GPs taking a more active role in integration and coordination of services
- More holistic care for people with mental health issues leading to better physical and mental health outcomes.

GPs are a primary gateway for many people to specialist mental health services, and are also increasingly managing patients with a range of mental health conditions, often complicated by physical health and/or addiction issues. As demand for specialist mental health services has grown, many providers are reaching capacity, particularly in the public sector, creating long waiting times and limited referral options for GPs. While GPs are ideally placed to holistically manage the physical and mental health care of their patients, and to build up the long term trust relationship that is critical for mental health care, there are multiple barriers:

- The current funding model acts as a disincentive for the longer consultations required for mental health patients and for collaboration between services
- The Commonwealth / State structure of the health system and divided responsibilities for acute and primary care creates challenges for funding and integration/collaboration between services
- Long waiting times for specialists and difficulty referring patients meaning GPs do not have adequate specialist support when they need it. Easier access to psychologists through ATAPS has increased demand to the point where there are now long waiting lists
- Conflict for GPs in weighing up the broader community good that can be achieved by treating multiple patients for physical conditions in the time it takes for a single mental health consultation
- For many GPs, less job satisfaction in managing complex patients who often do not have clear outcomes
- Time pressures or lack of continuity in GPs mean that patients with mental health issues presenting with physical symptoms often do not get help with their mental health issues, or the reverse – mental health issues are treated but other medical symptoms are not
- GPs' lack of confidence and support in treating mental health patients
- Poor communication between mental health, primary care and acute services
- A lack of understanding of and support for the role of the GP in delivering mental health care.

To address the challenges faced by GPs in providing mental health services a new business and funding model for delivering mental health care is needed that will enable:

- More collaborative and integrated treatment options that enable GPs to be actively involved in managing both the physical and mental health care needs of their patients
- Easy access to on-site support from mental health specialists that may include mental health nurses, psychologists and other allied health to reduce the need to refer most patients to acute mental health services, reducing ED admissions or resorting to crisis services
• Increase the number of GPs with mental health skills and capabilities
• Improved transfers between primary care practices, stand alone mental health services and community programs
• Better integrated and co-ordinated services provided to patients and their family and carers
• Models that enable health resources to be used more effectively and efficiently for early intervention and prevention activities to reduce the high cost crisis, acute services.

Challenges

There are however, a number of challenges faced both by consumers in accessing GP services and in relation to the capacity of GPs to provide mental health services that will need to be addressed. These include:

• Difficulties in accessing GPs and in particular bulk-billing non-corporate practices
• Increasing GP demand and decreasing nursing numbers increase the pressure on GPs and limit their capacity to take on more complex mental health patients
• Limited referral options for mental health services and supporting allied health services across the spectrum of care. Poor access to GPs and other services consumers may be referred to is compounded by limited community transport options, particularly in rural and regional areas. It is particularly difficult to access psychiatrists in the public health system. If a referral to specialist care is delayed issues can escalate, leaving GPs under significant pressure to manage the patient without adequate support.
• Many GPs may not have a good understanding of working with people with mental health issues or have the time to spend on often longer and more complex consultations on mental health issues.
• There is a high incidence of drug and alcohol use by individuals with mental illness and managing both issues in tandem is critical. Many GPs however do not see management of drug and alcohol related issues as part of their core role.
• Many GPs focus on medical care and referral to psychiatrists and refer less often to broader community-based services and psychosocial rehabilitation
• The process for referrals to psychologists even through ATAPS takes longer than referrals to other specialists and this acts as a deterrent
• Communication between sectors is not effective and is still very dependent on patients taking paper referrals between providers
• Areas with a large proportion of people of non-English speaking background have lower utilisation of mental health services, partly for cultural reasons where mental health issues are not discussed and because of a reluctance of providers in these areas to refer patients to mental health services.

What can be done?

• Access to mental health nurses/nurse practitioners in practices to help support mental health patients would help to address the time constraints faced by GPs as a consequence of the current GP business model
• Streamlining the process of referral to psychologists
• Implementation of eHealth systems that facilitate communication between all members of a care team.
• Increase access to Continuing Professional Development in the area of mental health for GPs
• Increase access to training opportunities for GPs in specialist mental health services.
What is the role of primary care in mental health?

- GPs are a key entry point to mental health services. Knowledge of warning signs and appropriate referral patterns is very important. GPs need to be able to address the spectrum of mental health issues and refer appropriately when they cannot provide treatment. In rural areas with limited access to private psychiatry, GPs have a broad role covering both diagnosis and treatment.
- GPs have an important role in managing the risk that people with physical issues may develop mental health issues and vice versa.
- Through prevention, early intervention and management of mental illness GPs can take the pressure off the hospital system and Emergency Departments and increase the level of care provided in the community.
- Primary care services should make it easier for all people to access health services. GPs taking a primary role in mental health care will facilitate more people with mental health issues to get holistic care including regular check-ups and physical health screenings. GPs act as a focal point to provide better access to other health professionals such as Practice Nurses and psychologists.
- GPs could take a broader role in mental health promotion to address stigma that can be another barrier to accessing services.
- To address the early mortality rates and poor physical health outcomes of people with mental health conditions. Many health professionals are failing to take people with mental illness seriously when they raise concerns about their physical health. The Lethal Discrimination Report by Rethink Mental Illness noted that people with serious mental illness die on average 20 years prematurely.30
- With the coordination role of Medicare Locals and LHDs, GPs will benefit from:
  - Improved coordination and integration of services, including Community Managed Organisations.
  - Working with organisations across sectors to improve linkages and referral pathways.
  - Identifying local health needs and gaps.
  - Supporting GP understanding of community based services and recovery approach.

What do consumers want from primary care?

Consumers want:

- Their GPs to listen to their issues in a non-judgemental way.
- Their mental and physical health issues to be managed holistically not as silos of care.
- To establish and maintain a trust relationship with their GPs.
- Their GPs to be the gateway to all mental health services and to have a comprehensive knowledge of what service options are available in their community.

These needs are not always being met by General Practice. A number of common issues were raised by consumer groups:

- A need for GPs to be more aware of the “red flag” signs of mental health issues. It was felt that many GPs do not recognise the early stages of mental illness, particularly signs of depression. Symptoms are treated medically without addressing the underlying mental health issues.
- A concern about the way GPs approach discussions about mental illness with patients. There needs to be more focus on managing mental health issues and strategies for recovery, not addressing it in the early stages as a life long issue. By suggesting to patients that their condition will affect them throughout their life, GPs fail to

30 Rethink Mental Illness (2013) online source
acknowledge that recovery often does occur. This can be confronting and can prevent people seeking further services.

- Poor referral practices from GPs to other services, because of lack of services available in the local community, a tendency to refer to psychiatrists over other mental health specialists and because of a lack of knowledge of the services that are available.
- Perceived lack of confidentiality is a major barrier to access to mental health services, particularly in rural areas. There is still a perceived stigma for many patients which prevents them from seeking help. Addressing this is critical to improve willingness of consumers to seek help. Primary care could play a major role in education and health promotion to help remove the perceived stigma.
- Concern that GPs focus on either mental health or physical health issues, but do not often enough take a holistic view. A common concern among patients is that when they have been treated for mental health issues and then present to their GP with physical symptoms these are too often dismissed as being symptoms of the mental health problem and not adequately investigated. This has resulted in serious medical conditions being overlooked (e.g. cancer not being diagnosed).
- There is concern that the nature of General Practice today, characterised by high volumes of often brief consultations, makes it difficult for patients who want to discuss mental health issues. At the same time it is easy for GPs to miss cues that could indicate risk factors for mental health issues.
- The nature of General Practice makes it very difficult to build strong relationships with a GP which is important in mental health, particularly in large practices where one may see a different doctor each visit.
- All clinicians (even those in specialist mental health services) need to improve their relationships with people to make intervention successful. Turnover of GPs makes it difficult to build trust relationships.
- Many patients are afraid of losing control once they enter mental health services. GPs need to be able to provide accurate information on likely care pathways, understand the concerns people have and be able to reassure people with this fear.
- There is a varying level of understanding among GPs about how the mental health system works.

Skills required for GPs

- GPs need additional skills in diagnosing mental illness generally (identifying the ‘red flag’ symptoms), and depression in particular.
- GPs need to focus on relationship building – trust is important in achieving good outcomes.
- Training to ensure that GPs have a base understanding of psychological therapies.
- Good social skills in working with people with mental health issues, e.g. communication, respect, non-judgemental, person-centred care and a strong capacity for empathy.
- Awareness and understanding of local community managed services to support people with a range of social issues.
- Knowledge of Recovery Oriented Practice and Trauma Informed Care\(^31\) approaches.
- Duty of care to address both physical and mental health including medication options and support around symptoms.
- Knowledge of how to develop a comprehensive and meaningful treatment plan for consumers and systems that facilitate proper follow through.
- Continuing Professional Development with focus on Recovery Oriented Practice e.g. tailored version of MHCC’s Mental Health Connect – 2 trainer model.

- Training for escalation/referral pathways for GPs via the Medicare Locals.

**What can be done?**

- Medicare Locals could take on a greater role in broadening GP knowledge of Community Managed Mental Health Organisations.
- Include knowledge of the mental health system in the basic standards for GP accreditation.
- Practice placements for GPs in mental health services (e.g. MHCC partnership - *Professional Entry Practice Placements in the Community Managed Mental Health Sector* initiative, which exposed emerging health professionals to recovery oriented service provision, enhance future service coordination and encourage new entrants into the community managed mental health workforce.  


- Incentive to visit / work part time at organisations such as HeadSpace, OnTrack Community Programs, The Station.
- Provide incentives for GPs to participate in additional training in mental health (e.g. Institute of Psychiatry GP Postgraduate Education Program  


  which covers techniques such as Motivational Interviewing; cognitive behavioural therapy; relaxation therapy; structured problem solving and supportive psychotherapy).  

- Provide incentives for GP participation in Medicare Local Continuing Professional Development Training and lectures and training held by Community Managed Mental Health organisations on working with people with mental health conditions (with CPD points).

**Family/carer support**

- The impact on families is significant and long term creates additional mental health issues among family members. This can have a compounding effect when families are not able to receive adequate support.
- There is limited capacity for carers to make appointments with GPs to talk about the person they care for and get practical advice. This is absolutely critical – There is a need to tackle the issue that many patients do not believe they need help and refuse treatment even when family members are requesting the patient be scheduled. GPs tend to be very reluctant to schedule patients.
- Carers feel they have very little influence and are given little support. Many GPs do not ask patients if they consent to their family being given information at all.

**What can be done?**

- GPs need to understand what information they can communicate to family members so that carers can get practical assistance and strategies to cope.
- Assistance is needed for GPs to determine when it is appropriate for an individual to be scheduled.
- Consent to provide information should be routinely sought when patients are well. These wishes need to be covered in the mental health plan.
- More services need to be targeted at family members on how to manage and support a person with a mental health problem.
The role of primary care in early intervention

- Early intervention is integral to reducing the poor physical health and early mortality rates of people with mental health issues. GPs have a lead role in early intervention through:
  - Providing holistic health care
  - Asking people about their physical health and encouraging practical steps to better physical health
  - Providing people with mental illness tailored support to stop smoking and increase exercise
  - Routine health screenings and regular physical health checks
  - Providing information about physical care
  - Referrals to physical health supports / specialists as required
  - Referrals & information about local community managed organisation services / community based supports and care.

What can be done?

To increase the effectiveness in early intervention for people with mental health issues GPs need to:

- Look beyond the mental illness and address both physical and mental health. Mental health and physical health are inextricably linked. People with mental health issues are often hesitant to ask for additional support and the services they are given often do not include physical health support. GPs providing mental health services also need to provide information on physical health care and screening with referrals to specialists as required.
- Have mental health training and an understanding and appreciation of recovery oriented practice.
- Demonstrate respect for consumers and their right to choose, and actively listen to their needs and concerns.
- Participate in Continuing Professional Development that includes compulsory training on support for people with mental health issues.
- Promote the idea that GPs are able to provide mental health services – many people, particularly younger people, do not see GPs as a provider of mental health services.
- GPs can also act as an information point by giving patients and carers brochures and information on broader services including local community managed organisations that provide services for mental health, drug and alcohol and youth.

Relationships between physical and mental health

There are differing approaches that GPs need to be aware of in treating patients with chronic disease who develop mental health disorders as opposed to patients whose primary presenting condition is mental illness who may develop physical illnesses.

GPs need to be aware of the high rates of anxiety and depression associated with chronic health problems and to be able to respond to these appropriately. GPs tend to resort to medication but should also consider psychological interventions and other supports. It is equally important that GPs do not over diagnose mental illness when people are actually suffering from a normal grief or trauma response.

People with existing mental health issues are also likely to suffer a higher than usual rate of chronic conditions associated with, for example, smoking and obesity as well as issues caused by interactions between medications.
What can be done?

- Training for GPs on working with people with mental health issues and trauma informed care and practice.
- Routinely conducting Physical Health Check for patients presenting with mental health issues. For example, Rethink Mental Illness has developed a tool to help consumers work with health professionals to identify any physical needs they may have.\(^{34}\)
- Enabling longer GP appointments that enable GPs to focus on both mental and physical health issues. While item numbers for longer consultations are available for the development of care plans, the actual consultation required for the development of a plan can be twice as long as allowed under this item number. There are also few incentives for GPs to actively follow up and review care plans.
- Awareness of the role of carers in supporting people with mental illness and expanding the level of support and information available for carers.

Consent

Management of consent is a significant issue for GPs when treating patients with mental illness. In younger adolescents the capacity of GPs to gauge developmental age is important to determine if they can be treated without parental consent. However, for patients of all ages there is a need to improve consent processes for treatment and for GPs to have better strategies to encourage patients to accept treatment. The issue of the patients’ consenting to have information about their condition provided by the GP to their family members/carers was also highlighted as a concern. Many GPs are unsure what information can be provided to family members who need information in order to provide support at home. It is critical that consent processes are better defined and understood by GPs to enable carers to be more involved in treatment.

What can be done?

- Obtain consent from patients to clarify what information can be provided to family/carers when they are well.

Information sharing

- Shared information and communication between GPs and other providers is critical but the way this is occurring currently is very limited. When information is provided (a discharge summary for example) it is only provided to one nominated GP, not to other members of a care team such as the psychologist and pharmacist.
- Access to records is contentious – there are still many GPs who will not provide patients with access to their records.
- Technology is not being used adequately to support mental health – even simple things like distribution of transfer of care reports is not routinely occurring.
- While tele-health consultations increase access to specialist mental health services in rural areas this is currently limited to psychiatrists.
- GP software does not adequately support chronic disease management and mental health. Technology needs to be more effective at facilitating the development of mental health plans.

What can be done?

- Improve and implement mechanisms for information sharing through eHealth (both PCEHR and point to point between hospitals, GPs and CMOs).
- Clarify rights of patients to access their own records and communicate this to GPs.

\(^{34}\)http://www.rethink.org/media/511734/physical_health_check_tool_2013.pdf
• Investigate the potential for patients to use tablets to complete mental health assessments prior to seeing the GP, enabling the results to be compiled ready for discussion with the GP. This may be less confronting than the doctor asking questions, particularly if incorporated in standard chronic disease screening, and may help with early intervention.

• Enhancement to GP systems to provide better access to best practice guides for different mental health conditions.

• Extend MBS item numbers to enable tele-health consultations with psychologists.

**Funding**

• Funding is currently focused on high cost acute services. There needs to be greater recognition of the value and long term cost effectiveness of investing in prevention and early intervention activities. There needs to be a cost/benefit analysis of investing in early intervention programs in addition to treatment of acute/severe illness focus.

• Item numbers for longer consultations to develop adequate mental health plans should be promoted, as well as item numbers for support consultations by psychologists.

• Funding must be available to all appropriate providers including community managed services that are particularly effective at servicing marginalised and ‘hard to reach’ groups who may not access mainstream health services (similar to the Partners in Recovery program).

• Changes are needed to the financial model to allow nurse practitioners and/or mental health nurses to take on more mental health activities to support GPs.

• To be most effective in delivering mental health services the separate streams of State and Commonwealth funds need to be consolidated and trialled in selected Medicare Locals.

• New models of funding are needed that will encourage members of a care team to do case conferences – there is a need to create sufficient incentives for GPs and allied health professionals to participate.

• Financial incentives that are currently available are not adequate to persuade GPs to change their current business models. There is no incentive for GPs to participate in professional development in mental health as the differences between rebates for the standard fee and for GP with psychological training are too low.

• ATAPS has been very successful for patients with lower level mental illness. However, there needs to be capacity to increase the number of funded sessions for people with more severe mental illness who are difficult to engage.

**Integration of healthcare services**

The need to better integrate and co-ordinate mental health services provided by GPs, Community Managed Organisations and the public health sector, as well as integrating the care provided for mental and physical health conditions, was seen by all interviewees as essential to improving outcomes for patients with mental health issues. The role of the GP as a central figure in this care and the potential for Medicare Locals to take on a co-ordinating/case management role was a recurrent theme.

• Medicare Locals were established to coordinate primary health care delivery and identify local health care needs and service gaps. They have the mandate of driving improvements in primary health care and ensuring that services are better tailored to meet the needs of local communities.

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• Poor care coordination following the transfer of patient care out of hospital into community settings is a common problem and creates issues for GPs in providing continuing care post discharge.  

• Communication, referrals and information sharing is not well established between GPs and public health services. There need to be much better connections between hospitals, GPs, community health services and NGOs. Discharge summaries are a start but there need to be connections made across the patient journey, not just at the end point of a hospital stay. There needs to be a change in culture to recognise the role all services play in an integrated way to get the best outcome for the patient.  

• Health services need to be complemented with other support services (housing, social activities etc.) if they are to be effective.  

• There needs to be a broader range of support services available for GPs to refer to, and better processes to ensure that GPs have a good knowledge of these services.  

• Integration of admission points has to involve GPs; in other words there should be ‘no wrong door’. It is critical that any GP can provide appropriate referrals to a specialist mental health service or provider if they are not able to provide a service.  

• Pharmacy could be used more effectively to disseminate information about mental health services as some people have closer relationships with their local pharmacist than they may with GPs.  

• For children and teenagers the role of the school counsellor is important. Only 30% of teenagers are accessing services through a GP.

What can be done?  

• Medicare Locals need to be actively involved in co-ordinating services and facilitating case management and referrals from GPs. Ideally they should act as a co-ordination point between services as well as an escalation point when more acute services are required. They should also take an active role in promotion and awareness building of available services and their role and access.  

• Implement improved transfer of care processes that provide information to all participating providers on transition of a patient from one health service to another.  

• Investigate and implement resources and training to support improved collaboration (e.g. resources developed by the Ministry of Health - See The Linking physical health and mental health ... it makes sense, initiative website at http://www.cadre.com.au/nsw_health/).

Patient management

A number of issues were raised in relation to GP approaches to managing mental health conditions. These related primarily to delays in diagnosing mental illness, favouring drug over behavioural therapy, the referral patterns that tend to be followed favouring psychiatry over psychologists and community-based specialised mental health services, and lack of routine follow up by GPs of their patients diagnosed with mental illness. Issues included:  

• GPs often do not diagnose issues early enough and treatment is delayed until the situation becomes critical. The capacity to diagnose mental health issues is not always good. This is partly a result of training, partly the nature of consultations and demands on GPs, and sometimes due to the lack of a real relationship between the patient and the doctor.  

• There needs to be better knowledge of early warning signs for patients of different ages/stages of life so that a shift can occur from crisis management and treatment in acute services to early intervention that can be provided in community based mental health services.

36NC OSS to DoHA in ‘Regionally Tailored PHC initiatives through Medicare Locals Fund.  
• There needs to be a bigger focus on prevention, promotion, and early intervention activities. GPs need to be able to take on this role but this is not easily supported given current GP workload, funding and business model.
• There needs to be a much greater focus on non-drug treatment regimes. Behavioural therapy has been shown to be very effective for some conditions but GPs tend to be less comfortable with non-clinical treatment – there needs to be regular training available for GPs on what approaches are successful.
• GPs need to be able to help people develop coping mechanisms and acknowledge there is not always a cure. GPs need to be able to work with patients on strategies to manage the condition.
• It is very important that GPs regularly follow up patients diagnosed with any form of mental illness but this does not happen consistently.
• GPs generally are reluctant to develop mental health plans for their patients. This may be a result of lack of training/knowledge of what is involved or that there are inadequate financial incentives to make this worthwhile. When developed, mental health plans are often inadequate. GPs need to have the skills and the knowledge of available services to identify the most appropriate services for the specific needs of the patient. GPs need to have a good knowledge of the services available in the local community including community managed mental health services.
• There needs to be collaboration between GPs and other mental health providers in medication review and symptom support. Almost all antipsychotic medications, especially clozapine and olanzapine significantly increase appetite, food cravings and weight gain. Weight gain during antipsychotic treatment has been reported in up to 60% of people. The second generation antipsychotic medications are also highly associated with diabetes, dyslipidaemia, insulin resistance and the metabolic syndrome. Patients should be told about the side-effects of antipsychotic medication so they can look out for warning signs, and GPs should monitor their physical health closely.

What can be done?

• Increase access to information for consumers on which GPs provide expertise in mental health. Beyondblue now has a list of GPs who specify that they have skills in mental health.

Current models of care

Recovery Models of care are very positive and starting to gain traction in general practice. The Partners in Recovery program is seen as a very positive step forward. However this is still seen as focussed on specialist mental health services and thus a need to engage more GPs in this program is seen as critical. While the program is intended to expand the role of primary care, GPs are not being adequately engaged in the development of case management plans and as a result this program to date has not filled the case management gap.

Sydney Local Health District has implemented a stepped care model to improve the integration of public mental health services and general practice, and have also recruited GP liaison officers to co-ordinate services with general practice. There are three levels in the model:

• Patients who are stable and whose care can be transitioned to a GP. These patients remain in the care of the Local Health District although the day to day management is transferred to the GP, but a service is guaranteed if requested by the GP.
• Complex shared care where GPs form part of the Mental Health team and are responsible for the physical health care of the individual.
• High need, complex patients who don’t have a personal GP – GPs are co-located with the mental health team. To provide incentives to GPs, the Local Health District

37 Morbidity and Mortality in People with Serious Mental Illness. (2006) online source
provides facilities and administrative support for the GP and GPs receive 100% of the bulk billed fees.

Various co-location models were seen as potentially beneficial, particularly options around engaging mental health or practice nurses who may enable both the longer duration consultations and the opportunity for mental health patients to build a trust relationship with the nurse, or by co-locating psychologists in General Practices. The evaluation of the Mental Health Nurse Incentive Program indicated that this was a successful model and reduced acute episodes and hospitalisation.

There are a number of trials occurring in Australia that involve partnerships between GPs and specialist mental health NGO services. For example, a trial in Victoria is occurring where NGOs are employing GPs and implementing profit share arrangements to provide GP services focused on mental health. Other trials are using partnerships between GPs and mental health NGOs in an approach similar to the Aboriginal Medical Service model. A trial in Mudgee where mental health clinics are operating in GP surgeries is also showing promise. Similar approaches are starting to be used in the aged care sector where GPs have rooms located within the aged care facility.

Services like Headspace work well for adolescents as they focus on a holistic approach and support, not just on mental health issues. NSW Health is developing adult hubs with a similar intent (e.g. for perinatal depression, drug/alcohol dependency).

There is a particular need for these types of services for older age groups which is made more complex by the boundaries between health and aged care services. GPs could provide a key role in better integration between health and aged care services.

A number of programs that increase the level of consumer and peer worker involvement in mental health services are being implemented and showing signs of success. For example an ‘Open Dialogue’ Model in Finland in which the consumer is placed in control of setting their own goals and given professional support to reach these has had a very good success rate (a similar model is being trialled in NSW (Project Air)).

There are examples of very effective programs in the USA in which Community Health programs are run by consumers with support from mental health professionals. These support patients and carers through treatment using peer support workers and the results have been very positive. A trial in the Central Coast has found the referral to peer workers has been effective for patients who are reluctant to accept they need mental health services. The first few visits the peer worker meets with family members to build a relationship in the hope that the individual will gradually participate. The Central Coast trial has been successful (70-80% success rate). This approach can be particularly useful in situations where the family has identified a serious issue but the individual concerned does not accept that they need help.
6. **POTENTIAL MODELS FOR NSW**

The following summarises models of care that are consistently mentioned in the literature, for which there is evidence of success, and for which there was support among the stakeholders who were interviewed for this strategy document.

The models are presented according to intensity of the coordination of service providers and according to the severity of needs of the population that the models have been found to best serve.

The consideration of these models does not preclude the on-going need for Primary Care providers to have access to adequate training in assessment and treatment of mental health issues and self-management tools as well as tools for screening and assessment.

**Terminology**

The terms ‘collaborative care’ and ‘integrated care’ tend to be used synonymously in the literature and in general discussions of the role of primary care in mental health. They do, however, represent different approaches to multi-provider, coordinated service delivery. Both collaborative care and integrated care are evident in the models described below. The term ‘shared care’ is problematical as it often occurs as a synonym for both collaborative and integrated care.

This clarification is important to outline. For many clients/patients, an integrated approach may be the most appropriate and effective route to improve the health of the population, and enhance the client/patient experiences, through delivery of cost-efficient services.

However, collaborative approaches may also be appropriate for some client/patient populations (e.g. individuals experiencing mild to moderate depression) and/or may be a stepping stone towards the development of more integrated service systems, given the massive change management that would need to accompany a system-wide service re-alignment.

**Collaborative care**

The term ‘collaborative care’ acknowledges the need for various providers to partner, communicate, and provide services through means that support each other’s components of a holistic care plan. Here, providers have independent services and care plans but have agreed to work together for the betterment of comprehensive client care.

Collaborative care may also include specific modes of consultation such as stepped care, which is typically the application of algorithmic applications to determine the least intrusive approach for the best possible outcomes. The PARC program in Victoria utilises aspects of the stepped care approach.

The term collaborative care is most commonly applied to treating individuals with chronic conditions and to those with less complex health conditions where comorbidity does not necessarily confound the appropriate treatment.

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38 (Peek 2011)
39 (Canada. Ministry of Health, British Columbia 2012 p.21)
40 Prevention and Recovery Care
Integrated care

Integrated care refers to those models of care where one care plan and a multi-disciplinary team is responsible for the overall care of an individual and often goes beyond the particular area of specialisation to address numerous health and social needs. Individuals who require integrated care models would likely have complex health and social needs that require specialists, various health providers and support workers to work as a team to address and improve the determinants of health for these individuals.

Models for mild mental disorders

Communication models

These models are generally referral-based approaches providing limited care management or on-going collaboration between providers. They are similar to any other traditional specialist referral that a primary care practitioner would make.

They are communication-based models and are not considered to be integrated, and, depending on the formalisation of the relationship and/or amount of consultation, may or may not constitute a collaborative model.

In communication models of care, the family physician is the primary provider and access to/involvement of mental health practitioners (psychiatrists and/or clinicians) is provided in a less formalised collaboration of care. For individuals whose health and mental health needs are mild or sporadic, this model is often adequate to address the individual’s needs and is quite an appropriate use of health resources.

Cognitive Behaviour Therapy (CBT)

These models deliver evidence-based psychological therapy for people with anxiety and depression disorders. Some applications incorporate a stepped care model, where patients are started on low intensity treatment using guided self-help or computerised CBT sessions. Escalation up the stepped grades of treatment occurs if the patient does not improve.

In the UK via the IAPT program, services are delivered primarily within GP surgeries to help improve access. Similar models are used within the US Veterans’ Administration, although are most effective when delivered as part of combined approach, along with co-located care and the TIDES depression model.

In the UK, this model showed good recovery rates (52%) and it has high applicability to Australia, requiring only limited system or payment changes. In New Zealand, a similar model also provided “in PCP offices” has produced improvements for patients. ATAPs and the Better Access Initiative have introduced a mechanism for these models. The Medibank study comments:

“Services need to be seen as a partnership between primary care and mental health and primary care, rather than as a traditional referral process, and embedded into the primary care system” (p.101)

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41 (Canada. Ministry of Health, British Columbia 2012 p.14)
42 (Davidson 2010) Improving Access to Psychological Therapies
43 (Pomerantz and Sayers 2010 p.80)
44 (Medibank; Nous Group 2013 p.102),
45 (Medibank; Nous Group 2013 p.101)
46 (Taylor and Briggs 2012)
Models for moderate mental disorders

The models that follow of collaborative primary and community care have evidence to support their effectiveness with individuals with mild or moderate mental disorders.47

A major Australian study identified 3 key components from the US experience for successfully treating people with moderate mental illness in a primary care setting:

- Standardised programs with customised implementations
- A centralised care manager, not necessarily located in primary care practice, who retains overall responsibility for patient care
- A psychiatrist who supervised the care manager and provided guidance and advice to the physician

The Medibank study concluded, “These initiatives could be translated to the Australian context”48.

Co-location

Co-location of primary and mental health care refers to provision of independent services at a common physical location. This model can be a first step in creating relationships between programs/providers resulting in improved collaboration and client/patient physical access to services. As well as managing assessments, support for referrals etc., practice nurses, for example, could also assist in co-ordinating other services (social, housing) that are essential for enhancing mental health.

Co-location has value as a component in successful primary care mental health service delivery rather than as a comprehensive model. It was found to be crucial to the success of the US DVA programs49, as it was for the Ontario based Hamilton Family Care Team program50 and in the New Zealand program where it allowed “for continuity of service for patients and opportunities for immediate discussions with the PCP, if needed.”51

A major Canadian study concluded “Co-location improves access to services but on its own will not create collaborative or integrated care.”52

Where co-location of services is not seen as viable, alternatives such as holding case conferencing sessions that have the patient, GP, community mental health and specialists available in one location were seen as a potential option. Tele-health connections that will be assisted by access to the national broadband network offer a further alternative.

To be effective, co-location would require changes in the way specialist teams are allocated patients because it would need to be driven by the patient’s GP. Co-location would only be effective if a GP had a sufficient number of mental health patients to enable regular clinics to be held.

Shared care

Shared care involves a partnership between primary care and mental health practices wherein the general practitioner remains the primary care provider, accessing consultation, assessment, and educational/self-management tools from the mental health system. In Australia, this model is most evident in the CLIPP53 model.

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47 (Canada. Ministry of Health, British Columbia 2012)
48 (Medibank; Nous Group 2013 p.16)
49 (Pomerantz and Sayers 2010)
50 (Kates N 2011)
51 (Taylor and Briggs 2012 p.E2)
52 (Canada. Ministry of Health, British Columbia 2012 p.15)
53 Consultant Liaison in Primary Care Psychiatry
This model has been found effective for those with mild to moderate depression, some anxiety disorders, for older depressed adults, and those using substances. It has also been found effective with individuals with severe mental illnesses (e.g. bipolar disorder, severe depression) where symptoms and functioning have been stable for a good period of time, and where primary care providers have been trained to identify and assess the signs of deterioration.

By formalising the partnership between primary care and the mental health sector, Shared Care provides a mechanism that would address some of the complex boundary issues that arise for GPs when they must engage with the aged care system.

This model is most effective when primary care providers have received training in mental health problems and have access to education resources and self-management tools for patients.

In the largely successful Hamilton Family Health Team Mental Health Program this model is enhance by co-locating the members of the team.\textsuperscript{54}

**Reverse shared care**

Reverse shared care is a newer, less studied model that has developed to better serve those with severe mental illness and problematic substance use who are already engaged with the mental health system but who are not well connected with the primary care system due to a number of reasons such as: inability to access a general practitioner, stigma, location of services, negative past experiences. Here, the mental health clinician is the primary service provider and primary care services are brought into the mental health setting.

By receiving care in their environment, surrounded by providers who are known and comfortable to them, individuals are more likely to engage with primary care providers and follow through with health treatment regimes.

Reverse shared care holds promise for those individuals who will not access the traditional primary care services and/or have experienced difficulties attaching to a GP and are actively receiving mental health care.\textsuperscript{55}

The proposed changes to NGO funding arrangements and planned transition of clinical services to NGOs may open opportunities to bring about a cultural change among GPs and increase the referrals to community based rather than acute mental health services. Services that run along the lines of early childhood centres or women’s health centres with GP involvement would be valuable.

**Specialised hub and outreach team**

The specialised hub and outreach team approach recognises that there are specific populations that require specialised assessment and treatment services. These populations tend to be a small demographic, but their treatment needs require specialised training that might not be generically available. Because of this high level of specialisation, these multidisciplinary, specialised teams cannot provide on-going treatment in the community, but rather conduct assessments, coordinate and direct care planning for the variety of providers involved in an individual’s life, and provide education and consultative services to community providers on an on-going basis.

\textsuperscript{54} (Kates N 2011)
\textsuperscript{55} (Canada. Ministry of Health, British Columbia 2012)
These models integrate a chronic care model with collaborative mental health principles (a depression model, for example) to provide comprehensive care for co-morbid patients. This model is used in sites across Canada and the US and has high applicability to Australia. An example of this model is the Multiple and Complex Needs Initiative established in 2001 in Victoria. To support the initiative, new legislative and service frameworks were developed.56

There is evidence to support this approach to care with individuals who have a dual diagnosis of chronic disease, developmental disabilities, mental illness complicated by substance use, young adults experiencing first episode psychosis (i.e. Early Psychosis Intervention), and psychogeriatric services.

**Severe and complex mental health disorders**

Models of treatment for people with severe and complex mental health disorders are usually tertiary services that do not engage primary care providers. The following models have shown evidence of success with these patients by engaging primary care providers in a whole-of-health approach towards recovery.

**Unified care**

Unified care is a full-service health and mental health/psychiatric service available within the same setting involving full administrative integration in billing, single client file and care plan. Typically this approach is necessary for those with severe and complex mental illness and problematic substance use and embodies co-location and care collaboration, and, from a health perspective, it provides the whole of health needs through one care plan/location.

**Patient-Centred Medical home**

A recent development of the unified care model in the literature is the patient-centred medical home (PCMH) or primary care home. This team-based model of care is led by a family physician who provides continuous and coordinated care throughout a patient’s lifetime to maximise health outcomes. The PCMH practice is responsible for providing for all of a patient’s health care needs or appropriately arranging care with other qualified professionals. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues.

In Australia, The RACGP definition of General Practice encompasses the characteristics of the Medical Home.

> “General practice provides person-centred, continuing, comprehensive and coordinated whole person health care to individuals and families in their communities.”

According to its Australian advocates, the medical home “acts as a gateway for each person to access the rest of the health system. One of the goals of a medical home is to create an integrated care team that meets each person’s health needs. People who belong to a medical home are more likely to receive care ‘from a range of allied health care providers, and to have this care feel ‘joined up.’”57

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56 (Medibank; Nous Group 2013 p. 85)
Primary care mental health team

The primary care mental health team embodies a population health approach to treat the whole person, including working to address all determinants of health. The team providers do not have any particular specialty (i.e. all team members are expected to have a strong knowledge base of mental health/substance abuse disorders), focus on at risk individuals, and provide brief, solution-focussed care.

This model is also known as Assertive Community Treatment and has been widely implemented in Australia, Canada, England, and the US by the DVA. There is good evidence of its effectiveness and is “the most cost effective for individuals with a history of multiple hospitalisations” as well as being appropriate for hard-to-reach individuals and reluctant patients. In Australia, Partners in Recovery and peer worker programs such as the one on the NSW Central Coast are based on this model.

However, while there is significant support for this model among consumers and the mental health care sector, it utilises the mental health care workforce, and the role of the primary care provider is not well defined. A higher level of collaboration between GPs and mental health services, and integration with other existing programs would augment the benefits of this program. Fully-integrated system of care models utilise teams that are all-inclusive and ‘wrap-around’ the individual, ensuring all determinants of health are either provided for directly or through formal partnerships with other organisations/providers (e.g. housing providers, employers, education/training, family reunification).

“This is the most intensive model of care that many individuals will require for an extended period. The evidence supporting various team approaches within this model differs. There is over 20 years of evidence supporting assertive community treatment, often considered to be a tertiary level service provided in the community, at a much lower per diem cost and impacting rates of hospitalisation with a population that has typically been served primarily in the acute system.”

Measuring Progress and Performance

The Noarlunga project in South Australia developed outcome indicators that assessed six dimensions of care and also evaluated partnership processes. The following dimensions, based on the Noarlunga project, would appear to provide a useful starting performance evaluation model for NSW.

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>MEASURE</th>
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</table>
| 1. **Safety** of care relating to avoidance of harm to consumers arising from either actions or workers or from the environment, and minimising risks arising from care processes | Sentinel events:  
  - Suicides  
  - Medication errors  
  - Reduction in the need for acute/crisis services |
| 2. **Appropriateness of care** - based on likelihood that interventions will produce the desired outcomes, according to available evidence. | Stakeholder ratings on overall satisfaction with care  
  - Progress through pathway of care  
  - Changes in referral patterns with greater emphasis on care in the community. |

58 (Medibank 2013, p.86)  
59 (Canada. Ministry of Health, British Columbia 2012 p.18)
### 3. Effectiveness of care - relating to the extent to which consumers actually obtain measurable benefit from care they receive

- HoNOS, LSP scores
- Focus of care
- Admissions to ED
- Admissions to psychiatric inpatient unit
- Use of mental health services by discharged consumers
- Increase in routine physical health assessments for mental health patients

### 4. Consumer participation - referring to provision of input by consumers in planning, delivery, monitoring and evaluation of service delivery.

- Participation by representatives in project
- Complaint system
- Percent of consumers signing care plans
- Record of early warning signs in care plan

### 5. Efficiency of service provision referring to the use of resources in achieving value for money

- Number of contacts made in each phase of care
- Reimbursement for general practitioner
- Increase in number of GPs specialising in mental health.
- Number of GPs taking part in CPD in mental health.

### 6. Access - referring to the equitable availability of services to people according to consumer need, irrespective of geography, socio-economic group, ethnicity, age or gender

- Participation in collaborative care arrangement
- Number of consumers receiving collaborative care service
- Proportion of consumers with a nominated general practitioner
- Percent of consumers in each phase of care
- Involvement of Aboriginal consumers
- Consumers with other disabilities
**Partnership processes** – evaluated by questionnaire to stakeholder groups: consumers, carers, general practitioners, non-government disability support agencies, mental health clinicians.

Quantitative answers were rated on a six point scale:
NA Not applicable
0 Needs a lot of improvement
1 Needs some improvement
2 Acceptable
3 Good reasonable service
4 Very good service
5 Exceptional service

Two outcome measures:
- Satisfaction ratings from stakeholders on 6 topics: communication, working together, instruments of communication, confidence of practitioners, sharing information, & reimbursement
- Standards of care. Communication using preferred care plan instrument

Evaluation of partnership processes - conducted independently of the project officer and service providers. Evaluation carried out by a mental health professional with experience in conducting evaluations, with assistance from both consumer representatives and a carer representative who received training both in objective interviewing and in use of the questionnaires.

**Leveraging existing change activity**

The NSW MHC strategic plan could support existing activities in the following ways:

<table>
<thead>
<tr>
<th>Strategy area</th>
<th>Existing activity</th>
<th>NSW MHC Strategic plan support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service delivery</strong></td>
<td></td>
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<tr>
<td>ATAPs</td>
<td>Increase mental health workforce to reduce current long waiting times.</td>
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<tr>
<td>Better Access Initiative</td>
<td>Reinforce by trialling co-location of mental health professionals in GP facilities</td>
<td></td>
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<tr>
<td>Beyondblue</td>
<td>Extend, formalise, and publicise list of GPs who specify that they have skills in mental health.</td>
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<tr>
<td>Headspace</td>
<td>Work with NSW Health in developing adult hubs with a similar intent (e.g. for perinatal depression, drug/alcohol dependency).</td>
<td></td>
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<tr>
<td>Mudgee NSW co-location trial</td>
<td>Monitor outcomes with a view to extending and implementing in other Health Districts.</td>
<td></td>
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<tr>
<td>NGO partnerships trial (Victoria)</td>
<td>Initiate trials in NSW where NGOs employ GPs and implement profit share arrangements to provide GP services focused on mental health</td>
<td></td>
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<tr>
<td>NGO peer support trial (NSW Central Coast)</td>
<td>Monitor outcomes with a view to extending and implementing in other Health Districts</td>
<td></td>
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<tr>
<td>NSW Project Air</td>
<td>Monitor outcomes with a view to extending and implementing in other Health Districts</td>
<td></td>
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<tr>
<td>Physical Health Check</td>
<td>Promote and increase routine Physical Health Checks for patients presenting with mental health issues at GPs</td>
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<td>-----------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Rethink Mental Illness</td>
<td>Make this and similar tools available to consumers</td>
<td></td>
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<tr>
<td>Sydney Local Health District stepped care model</td>
<td>Investigate appropriateness and expand this model to other Health Districts</td>
<td></td>
</tr>
</tbody>
</table>

**Funding**

| Commonwealth/state funding | Evaluate causes for decline in level D consultations and identify strategies to arrest this  
|                           | Identify potential incentives for extended GP delivery of mental health services  
|                           | Initiate action for item numbers for longer consultations to develop adequate mental health plans, as well as item numbers for support consultations by psychologists  
|                           | Review the divided responsibilities for acute and primary care that create challenges for funding and integration/collaboration between services |

**Training and accreditation**

| Institute of Psychiatry GP Postgraduate Education Program | Provide incentives for GPs to participate in additional training in mental health |
| Professional Entry Practice Placements in the Community Managed Mental Health Sector | Encourage GP participation in this program. Extend and encourage similar practice placement programs |
| Recovery Oriented Practice and Trauma Informed Care | Facilitate broader GP participation and collaboration with other clinical groups through continuing professional development in these programs |
| Medicare Local Continuing Professional Development Training with mental health focus | Provide incentives for GP participation via CPD points |
| Lectures and training held by Community Managed Mental Health | Identify and implement incentives such as CPD points to expand attendance |

**Service coordination and governance**

| Medicare Locals | Structural review to broaden role:  
|-----------------|• Co-ordinating services and facilitating case management and |

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referrals from GPs
- Act as a co-ordination point between services as well as an escalation point when more acute services are required
- Take an active role in promotion and awareness building of available services and their role and access
- Investigate opportunities to extend funding and collaborative relationships outside the federal health domain

<table>
<thead>
<tr>
<th>PCEHR</th>
<th>Encourage widespread access to and utilisation</th>
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<tbody>
<tr>
<td>Electronic Discharge Referral systems</td>
<td>Broaden application to provide true transfer of care capability</td>
</tr>
<tr>
<td>Mental Health Professionals Network</td>
<td>Review with focus on increasing GP engagement</td>
</tr>
</tbody>
</table>

**Who to engage, on which issues and how should we do this?**

The following diagram summarises the major primary care stakeholders that should be engaged in implementation of the mental Health Strategic Plan.

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Which issues</th>
<th>Best approach</th>
</tr>
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<tbody>
<tr>
<td>RACGP</td>
<td>• Implementation of new models of care</td>
<td>• Leverage existing governance processes, working parties, programs</td>
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<tr>
<td></td>
<td>• Resourcing options</td>
<td></td>
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<tr>
<td></td>
<td>• Funding options</td>
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<tr>
<td></td>
<td>• Accreditation</td>
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<tr>
<td>AMA</td>
<td>• Implementation of new models of care</td>
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<td></td>
<td>• Accreditation</td>
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<tr>
<td>Doctors</td>
<td>• Implementation of new models of care</td>
<td>• Build on existing partnerships</td>
</tr>
<tr>
<td></td>
<td>• Resourcing</td>
<td>• Collaboration through trials and pilot/local programs</td>
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<tr>
<td></td>
<td>• Use of technology</td>
<td>• Opportunistic promotion through existing programs</td>
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<tr>
<td></td>
<td>• Education and training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Co-ordination, integration and referral</td>
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<tr>
<td></td>
<td>• Service options and delivery</td>
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<tr>
<td></td>
<td>• Promotion of services</td>
<td></td>
</tr>
<tr>
<td>Medicare Locals</td>
<td>• Implementation of new models of care</td>
<td>• Build on existing partnerships</td>
</tr>
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<td>Stakeholder group</td>
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<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• Resourcing • Use of technology • Education and training • Co-ordination, integration and referral • Service options and delivery • Promotion of services</td>
<td>• Collaboration through trials and pilot/local programs • Opportunistic promotion through existing programs</td>
</tr>
<tr>
<td>CMOs</td>
<td>• Implementation of new models of care • Referral processes • Co-ordination and integration</td>
<td>• Build on existing partnerships • Collaboration through trials and pilot/local programs • Opportunistic promotion through existing programs</td>
</tr>
<tr>
<td>Consumer groups</td>
<td>• Implementation of new models of care • Referral processes • Co-ordination and integration • Service options and delivery</td>
<td>• Engage through existing consumer group forums • Focus groups • Participation in trials/programs</td>
</tr>
<tr>
<td>Medical Media</td>
<td>• Implementation of new models of care • Training and education • Promotion of services</td>
<td>• Formal contact through press releases</td>
</tr>
<tr>
<td>Education and training organisations</td>
<td>• Training and education</td>
<td>• Formal approach on specific issues</td>
</tr>
<tr>
<td>Federal Dept. of Health</td>
<td>• Funding • Accreditation • Consent and information sharing • eHealth</td>
<td>• Leverage existing governance processes, working parties, programs • Formal submissions</td>
</tr>
</tbody>
</table>
7. **APPENDIX 1 LIST OF INTERVIEWEES**

Dr Jenny Beange, CEO Western NSW Medicare Local  
John Feneley, Commissioner, NSW Mental Health Commission  
Jonathan Harms, CE, ARAFMI  
Stephanie Maraz, Policy & Partnerships Officer, Mental Health Coordinating Council  
Dr Michael Moore, CEO Inner Western Sydney Medicare Local  
Dr Keith McDonald, Director of Clinical Services, South Western Sydney Medicare Local  
Elizabeth Priestley, CEO, Mental Health Association  
RACGP  
  - Dr Jill Gordon  
  - Dr Nigel Hawkins  
  - Dr Hester Wilson  

Peri O'Shea, CEO, NSW Consumer Advisory Group
8. **APPENDIX 2 BIBLIOGRAPHY**


Humphreys, J. and Wakerman, J. ([nd]). *Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform*. [Bendigo]: Australia. National Health and Hospitals Reform Commission.

Ireland. Health Service Executive Working Sub Group on Mental Health in Primary Care. (2010). *Advancing the Shared Care Approach between Primary Care and Specialist Mental Health Services*. Dublin: Health Service Executive, Ireland.


Mental Health Foundation of New Zealand. (2011). Mental health and primary care from a health promotion perspective. Auckland: Mental Health Foundation of New Zealand.


**Online sources**

http://www.archi.net.au/resources/safety/clinical/nsw-handover/gp)

http://medicalhome.org.au/)


http://www.rethink.org/media/511734/physical_health_check_tool_2013.pdf
