PRIMARY MENTAL HEALTH CARE SYMPOSIUM

Better Outcomes in Mental Health Care Initiative: Building on Success

Canberra, 7 May 2003

Summary of Proceedings

Foreword

The burden of disease associated with mental illness and mental health problems in Australia is a profound public health issue and one that challenges the general practice community.

75% of those who seek help for a mental health problem see a GP first. In fact, in 2000-01, close to 11 million visits to GPs were for mental health conditions.

From the GP's perspective, mental health cannot be considered in isolation. Those with chronic medical conditions are more likely to have a co-morbid mental health disorder. Equally, mental health disorders are a risk factor for physical disease as well.

Australia's *Better Outcomes in Mental Health Care* Initiative was developed between the Australian Government and mental health stakeholders in response to the barriers experienced by GPs in delivering primary mental health care. These include inadequate access to specialist clinical support, finance models that fail to recognise the complexity of mental health care and poor access to relevant primary mental health training.

Uptake of the Initiative is promising. Over 14% of Australia's GP workforce is now participating in the Initiative and all Divisions of General Practice will have the opportunity to run allied health services by 2004-05.

Primary mental health care reform in Australia is in its infancy. The Primary Mental Health Symposium hosted by ADGP in collaboration with the Mental Health Council of Australia and beyondblue was designed to discuss the successes, challenges and future priorities for primary mental health care reform. The event brought together national experts drawn from general practice, public policy, psychiatry and consumer and carer advocacy groups and featured specialist guests Professor Sir David Goldberg and Professor Andre Tylee, international experts in primary mental health care from the UK Institute of Psychiatry.

This is a summary of proceedings from the Primary Mental Health Care Symposium hosted by ADGP in May 2003 in conjunction with *beyondblue*, the National Depression Initiative and the Mental Health Council of Australia.
For policy makers, we hope these resources contribute positively to future policy development. For Divisions, who are at the forefront of leading and promoting change in mental health service delivery, this summary is testimony to the role you have played in mental health care to date. We hope that they assist you to promote and advance a quality primary mental health care agenda.

Dr Rob Walters
Chair
Australian Divisions of General Practice
December 2003

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ADGP would like to acknowledge the funding support made available by the Mental Health and Suicide Prevention Branch, Australian Department of Health and Ageing for the Symposium.

Where possible this summary of proceedings contains a verbatim version of each presentation. Where this has not been possible, highlights from the relevant session are included. The summary is accompanied by a video of highlights from the Symposium and a CD of the PowerPoint presentations.

Organising Partners

Mental Health Council of Australia

beyondblue, the National Depression Initiative

The Australian Primary Mental Health Care Resource Centre, Department of General Practice, Flinders University (PARC)

The National Primary Mental Health Care Initiative Network

The Symposium was conducted as part of a quarterly series of workshops of the National Primary Mental Health Care Network. The Network comprises:

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Introductory Remarks

Dr Julie Thompson, Chair, Better Outcomes Implementation Advisory Group and general practice representative, Australian Health Ministers' National Mental Health Working Group

This Primary Mental Health Care Symposium is a collaboration between the Australian Divisions of General Practice, *beyondblue* and the Mental Health Council of Australia. On behalf of these partner organisations, I would like to welcome you all to the Symposium.

Today is a unique opportunity to bring together a diverse mix of participants to discuss primary mental health care innovation and reform – GPs, staff from Divisions of General Practice, policy makers, consumers, carers and academics as well as international and national experts.

Considerable investment in primary mental health care under the 2nd National Mental Health Plan has triggered an unprecedented focus on mental health activity in general practice and Divisions.

Over 2,500 GPs are registered with Better Outcomes – around 10 per cent of the GP population - a higher than expected rate within the first 12 months of implementation. By July 2003, 70 per cent of Divisions will have allied health services under Better Outcomes adding to the broad range of mental health activity already occurring in Divisions such as peer support and services funded under the More Allied Health Scheme (MAHS).

The imperative is to keep up the momentum of primary mental health care reform in Australia. The Symposium is an opportunity to:

- Review the implementation of Australia's National Primary Mental Health Care and Better Outcomes in Mental Health Care Initiatives
- Provide GPs and others with an interest in mental health to engage with an expert panel, including our two international guests, Professor Sir David Goldberg and Professor Andre Tylee from the UK
- Begin to consider future directions for primary mental health care reform

Most importantly, the Symposium is timely. Many of us were only involved last Friday in a National Summit to give advice to Health Ministers on future priorities for national mental health policy and planning.

Key questions for the Symposium are:

- What are the next incremental steps for primary mental health care innovation in Australia?
- How do we take that forward in the same important partnership framework that delivered Better Outcomes?

ADGP will do a summary of proceedings in which we will try to capture the wisdom of the group. We would hope that that thinking could then be of some policy value to the Department of Health and Ageing and the Better Outcomes Implementation Advisory Group.

On behalf of partner organisations, I hope you enjoy the Symposium. I would like to ask Dr Rob Walters, Chair of ADGP to make some opening remarks.

Official Welcome

Dr Rob Walters, Chair, Australian Divisions of General Practice

Today's Symposium aims to bring together both the local and international experience of primary health care reform - to help us reflect on the successes of the current initiative, to analyse where changes are required so that we can better assist Divisions to support general practitioners in education and training that is evidence based, accessible and locally relevant and to develop models of care that are collaborative and better support general practitioners to care for the mental health of their local communities.

This Symposium is the significant event that has brought together GPs from all around the country who are leaders in driving primary mental health care with members of the national primary mental healthcare network, key primary mental healthcare policy makers within the Department of Health and Ageing, as well as our international mental healthcare experts. As Julie has said on the eve of a new mental health policy and plan for Australia, this is a timely opportunity to review Australia's experience in primary mental healthcare and to consider our future directions.

I too am particularly pleased to welcome our guests from the UK, Professor Sir David Goldberg who is the Professor Emeritus of the Institute of Psychiatry at Kings College London and Professor Andre Tylee who is the Chair of the Primary Care Programme Board of the National Institute of Mental Health in England and is also Professor of Primary Care Mental Health at the Institute of Psychiatry which is a world first position.

For those of you who don't know me, I am Rob Walters, I am a GP in Hobart, Tasmania. I personally have had a long-term interest in the mental health side of practice. I have been involved in more committees than I care to remember in Tasmania regarding mental health, lately however playing a role in the restructuring of the mental health system in that state and the appointment of state and regional directors of mental health. Through that I have been able to ensure that the importance and the role of general practice in the delivery of primary mental healthcare is recognised.

ADGP, for our guests, represents 121 Divisions of General Practice in Australia at a national level. Over 95% of Australian GPs are members of Divisions, which makes us the largest general practitioner group in the country. We are responsible for advocating for and representing general practice in policy discussions with government and also for leading implementation of numerous national programs, one of which of course if the better outcomes in mental healthcare initiative. Since 2002 nearly all Divisions have been involved in providing support to the over 4000 GPs who have decided to take up the various mental healthcare initiatives.

Leanne Wells, who is our principal advisor on mental health, will be talking about the Better Outcomes program later this morning so I will leave her to give you the details. As Chair of ADGP however I am proud that we are part

of a world leading effort to reduce the burden of disease from mental health problems by supporting the involvement of general practitioners and general practice in primary mental healthcare policy.

We are committed to providing ongoing leadership for divisions and GPs in this country to ensure that they have the capacity and the support they need to deliver that quality mental healthcare to their patients. Mental healthcare is central to the services GPs provide to their community. We know that the majority of people presenting with mental health problems see a GP first, in fact around one in ten of all general practitioner visits are from people seeking help from a mental health problem. It stands to reason that the increasing burden of disease from mental illness along with the increasing willingness of people to seek help when they have a mental health problem will put added pressure on general practice and GPs who and we must all be aware from current media are already overloaded and to provide that extra care is just another burden. This means that they will need additional support to enable them to provide a quality service.

Added to this there is some recent research published for instance in the MJA that is now showing that depression is equivalent to smoking as a key risk factor for cardiovascular disease. So it is the prevalence of co morbidities with mental health problems that are highlighting just how important it is becoming to integrate the delivery of mental healthcare with chronic disease management and to continue building strong links between general practice and specialised mental health services. Linking funding for primary mental healthcare with Divisions' funding for chronic disease management has been a very positive step in this direction and the message is filtering through. Some grass root GPs have taken the initiative towards integrating care in their practices. These GPs are using active templates that interface with all the current modern software and allow current Medicare items for care planning, chronic disease management, medication review etc including the mental health incentives to be effectively integrated. By using such tools they have been able to reduce the burden of paperwork, all that dreadful red tape on the practice whilst providing comprehensive planned care for their patients. The Better Outcomes in Mental Health Program has made a start in overcoming some of the barriers to general practice involvement in integrated effective and high quality primary mental health care.

But it is important, as Julie has said that we now take stock of what we have learned so far, make improvements where necessary and build on achievements that have been gained. This Symposium provides us with an excellent opportunity to just do that.

The key achievement of the program is that all stakeholders, GPs, mental health professionals and consumers and carers came together to jointly develop and negotiate the program. This has meant that it is broadly supported by all mental health stakeholders and delivers unprecedented funding in primary mental healthcare for general practice. We acknowledge the fundamental support of the Department of Health and Ageing for this.

We also value the partnerships that have been developed at all levels in the system. Nationally between the groups here today, ADGP, the Mental Health

Council of Australia, *beyondblue*, carers and consumers. But more importantly the ground level - locally, between Divisions of General Practice and the community health services and between GP, patients and carers.

It is through these partnerships that we are best placed to meet new challenges and to ensure that Australian GPs continue to lead the world in delivering primarily high quality primary healthcare and reducing the burden of disease on our community. Once again, thank you all for coming, I am looking forward to a very stimulating and productive day.

Setting the Scene: Primary mental health care reform and the global context

Sir David Goldberg, Professor Emeritus, Institute of Psychiatry, London, UK

I was last in Australia two years ago and spent some of that time teaching Australian GPs. It is marvellous to come back because this is a world first for Australia. No other country is doing what you are doing and it seems to have had a tremendous start, this program. The uptake by Australian GPs in learning mental health skills exceeds my most optimistic predictions and I have already discerned a very much-changed attitude towards collaborative working in mental health and making a positive contribution to the mental health needs of any community.

If you went to your doctor and said to your doctor that you were feeling depressed, you might as well have thought of flying to the moon. That wasn't the job of our general practitioners in England in my youth. And those days have changed. They haven't just changed in Australia and England; they are changing all across the world. It was about those changes that I wanted to talk to you today.

Thank you. I start my lecture by talking to you about differences between Australia and England because unless I do that some of the things that I am going to say will be incomprehensible. I am sure that many of you will know what these differences are but if there are any people who don't, I think I have to make them clear. I wanted to mention briefly the possible ways there are of relating specialist mental health services to the mental health work of a primary care physician. I want to finish by telling you about the work I am doing internationally and the changes that are occurring in other places.

Changing times

There are great changes occurring across the world. In the developed world, the changes are of course of two things. First, there is awareness in many countries that the burden that mental illness poses upon physical illness and upon the general population is a very real problem and the primary care physician is the person who is best placed to deal with it.

Secondly, governments across the world have been keen to reduce health expenditures and they have done that by closing down people who have been in hospital for long periods of time. Of course, when you look at the health economics of medical care the most expensive item is a night in hospital and if you can reduce that you can free up monies for cardiac surgery, for new treatments for cancer and for paediatric services.

In the developing world, they never did have a mental health service anyway. Governments who have to manage on tiny budgets compared with the

budgets of Australia or England have had to manage by skimming up their medical officers in clinics across the world in very scattered places.

Now if I review the changes in different countries, in the developed world, collaboration is least where the two services are both fee-for-service and are independent of one another. Collaboration is greatest where the services are salaried and there is no money changing hands.

In the developing world, what remains of mental health services are in capital cities. They are near the capital city and sometimes the second biggest city. The medical officers have to be enabled. Now in the United Kingdom, primary care trusts are collections of 40 to 60 GPs. They are responsible for the entire health needs of the population they serve. They typically serve a population of approximately 200,000 or quarter of a million and they get the whole of the money for health. So out of the money that a primary care trust is paid they not only have to divvy it out between the different GPs who are members of that trust, but they have to pay the costs of their staff, the costs of all the drugs they prescribe, the costs of all treatments in hospital, the costs of all mental illness services and the costs of all specialist care that they send patients for. These last functions I have mentioned - the cost of the treatments in hospital and the mental illness services - are what we call the gatekeeper functions of primary care.

Doctors work with many paramedical staff. They out number doctors very considerably. There is not only receptionists and practice nurses, there are district nurses, health visitors, counsellors, practice managers and more recently mental health works who are graduates the government are pressing into services to assist GPs with their mental health work. As I am sure all of you know each member of the population is registered with a particular GP or a group of GPs and the medical care is free at the point of delivery. And it is quite common to have specialist clinics in big group practices.

Differences between our countries

Now the differences between Australian and the United Kingdom have meant that GPs in the United Kingdom are even more motivated that they are here to become as independent as possible because the fewer patients who are referred to hospital and the few patients you send to the mental illness services, the more cash there is to run the rest of healthcare. Thus the pressure to learn mental health skills is very high in the United Kingdom and Andre is going to be telling you about that this afternoon.

Psychiatrists, on the other hand, are as dependent on GPs as GPs are on them because without the GPs referring us patients and asking us to help them, we would cease to exist. By common parlance in the United Kingdom, we divide mental illnesses into two large groups: common mental disorders like anxiety, depression, and alcohol dependence on the one hand, and severe mental disorders which are schizophrenia, bipolar illness and dementia on the other with drug dependence. The situation, which is emerging, is that, by and large, common mental disorders are always treated in primary care unless the GP needs some special help. Severe mental disorders are also treated in primary care but there is a different kind of

relationship between the specialist services and the GP for patients with severe illnesses.

Stepped Care

The flavour of the month in the UK is ‘stepped care’. Some years ago Peter Huxley and myself produced a model for the distribution of mental disorders in the population which we called our ‘five level’ model. If you want to know what step tier is, you turn it upside down and you’ve more or less got it. It deals with who needs treatment, who should give it, and when should a patient be referred to a more expensive level of care. So there it is, there is the ‘wedding cake’. In the middle of that ‘wedding cake’ you have the forms of the disorder and why movement occurs up the cake. On the left, you have who is responsible for care at each level and, on the right, what do they do.

At the bottom you have recognition where not all mental illnesses are picked up in primary care. If they are picked up, the least sort or the commonest sort on this particular slide is about depression is mild depression and mild depression can be dealt with mainly by the GP and practice nurses and practice counsellors deal with it and active review self help computerised CBT and exercise are all good in mild depression. If you ‘step up’ admitting depression is worse than that, the GP will again be a key worker but the counsellors, primary mental care health worker, social workers and psychologists have a role to play and medication now makes its appearance with psychological intervention and support groups.

If the patient has frequent recurrences or treatment resistance then there is a case for sending to the specialist service. The community mental health team outpatient departments, crisis teams and day hospitals are involved and we use various lethal combinations of drugs and complex psychological interventions with prolonged CBT. If there is a risk to life, you do still go on the acute wards of the psychiatric unit although that unit will be in a general hospital now and medication ECT and nursing care will be offered. So that is ‘stepped care’.

Primary care and specialists: possible relationship between the two services

Now there are various possible relationships between the specialist service on the one hand and primary care on the other. They could be virtually independent services, the only contact being a formal doctor’s letter that comes through the post. That is the least exciting form of contact.

There can be ‘active liaison’ with visits by psychiatrists within primary health care and there can be active liaison with members of community mental health team visiting primary care from time to time.

Where psychiatrists are concerned, there are many different models. Because it isn’t a terribly practical model and there are twelve times as many GPs as there psychiatrists and the psychiatrist has got to look after the patients in the inpatient unit and all their severely sick patients who are being cared for partly by them and partly by the GPs, they are greatly practices, most community

psychiatrists in England will use one of these four models and the assisted outpatient model where you see your own old patients when you visit the group practice and you just do what you want done in outpatients but you do it in the practice. There is a 'consultant model' where you actually see patients on your visit that the GP is worried about and wants you to see, there is a consultant model with meeting the entire primary care team and describe and asking them to discuss with you difficult cases and the most ambitious which is the consultation liaison model where there are joint interviews between patient GP and psychiatrist and the patient never becomes a patient of the psychiatrist.

The 'shifted outpatient model' is easily the most prevalent model. It is good from our point of view because fewer patients default. When a patient does default, which isn't very often, it is a good opportunity to see your community psychiatric nurse who is seeking other patients well known to you in that practice. But again, there is really very little contact with GPs and I reviewed the shifted outpatient model, there wasn't a single interview between the psychiatrist and the GP they were virtually, they were in the same building but in different worlds. And the contact was still one letter.

The consultant model where you referred patients was very good because it widens the range of patients the psychiatrist sees. The GPs like it and it is possible to combine it with patient review. But it does give the psychiatrist additional work beyond the normal range and its time consuming.

In the consultation model where you meet the whole practice, you go to a practice meeting, you not only see the whole practice, you see several GPs at once and you can discuss problem patients. And there is not much against it really except, as far as I am aware, it is not very much practised. But Andre may tell us differently.

The consultation liaison model where you see patients jointly with the GP and the great interest of that is it does improve the mental health skills of the GP, providing the psychiatrist has any himself, and the care of the patient remains with the GP. But others don't benefit and it is easily the most time consuming model.

What is tending to happen, I would say, across the country now is that various members of the community mental health team will go into a clinic in primary care and that extends the range of mental health services available to GPs. It produces better liaison between the services but there are severe logistic problems only large group practices receive the service, all the doctors who are working in pairs, they cannot possibly be included.

A few years ago the Professor of Mental Health Nursing of the Institute and myself wrote a review where we came to the conclusion that the usual arrangements between specialist mental health care and primary care weren't all that good. That is because the chronic patients there were looked after generally in England by community nurses and were reviewed from time to time by psychiatrists. But it is the way in which patients get to the community nurse which causes the problem because when a new patient comes to the

service the manager of the mental health team says 'Well, who has got the fewest patients, the smallest caseload? Oh, she has. You take this new one". The only exception to that is when the patient is particularly disturbed or particularly dangerous and disruptive when a more experienced nurse is chosen to see that patient. That has some pretty dire results in terms of the way the two services interact with one another because, from the GPs point of view, if you have got twelve different patients who are severely mentally ill registered with you there maybe eight or nine different nurses looking after those patients. You never get to know any of them and, as the nurses have a certain turnover rate, it is a blur, the relationship with the nurse. And it is not very satisfactory.

We came up with a better model where the same 'link' worker looks after the patients of a particular GP. A link worker can manage about two GPs in terms of what is practical. Within that mental health team there will be a single psychiatrist and single psychologist, usually at least one social worker, an occupational therapist and a lot of nurses. Most of the link workers are nurses who are doing the day-to-day work of specialist mental health service, but the GP is getting to know a single nurse.

That link worker with is a 'carrier' between the two teams. They carry out a plan for each patient with severe mental illness and they are trained helpfully in specific therapeutic skills.

We divided the mentally ill into four large groups. The first group being the most important from the mental illness point of view which of the severe disorders associate with high disability. Then there were group of illness where there were not only drug treatments available but also non-drug treatments. There is a large and disturbing group which will be familiar to all of you in practice where only non-drug treatments work, and there are disorders where no specific treatment has been shown to be affective. With the severe mental disorders these are conditions that aren't going to submit ……They have severe disabilities the disorders I have mentioned already, and what we recommended for them was shared care and they needed to be managed jointly by the community mental health team and primary care.

Shared Care

Shared cared means that a care plan has been drawn up in practice. I was asked this in Sydney yesterday, in practice a care plan is usually drawn up in the mental health team and is negotiated with the GP because GP are to busy to be attending all meetings of the community mental health team just as the mental health team is to busy to be attending every GP that has patience in there area. The shared care plan differs from place to place but the things I have put on this slide are a sort of bare minimum there are often other things as well but what prescribed and who prescribes it what the best alternative drug would be if that one ceases to work the likely systems if the patience relapses who to contact in a emergency and how to obtain hospital admission will always be part of shared care plan and about 70% of GP reported shared care plans when I surveyed them last year.

Royal College Survey

I surveyed them (GPs) with a Royal College Survey and we found in that survey that 14% of the primary care trusts were reporting the link workers that we had advocated in a discussion paper 5 years earlier. You never know what will happen when you throw a new idea out but it has been taken up. And even more gratifying, most of the practices that have link workers are satisfied with the mental illness service whereas only 54% of those with community nurses, or a range of different nurses looking after their patients, were satisfied with what they were having. So tremendous increase in GP satisfaction which was just what we predicted.

Now the common mental illnesses are partly here. These are well-defined disorders: the more symptoms you have, the greater the disability. There is a roughly [positive] relationship between the number of symptoms and the degree of disability and when the disorder remits so does the disability. I have got the disorders on that slide and our prescription was they all had to be managed in primary care, but when the patient fails to respond to treatment that is the moment when the mental health service comes in.

I must say when I was last in practice a few years back, the fresh patients I saw had all had a least 2 treatments for depression given by their GP before the GP threw their hands up and asked me for some help. The most disturbing group, which was one of the things our paper was about, are these disorders where the drug treatments aren't all that effective, to be honest, and where there are effective non-drug treatments. The problem is how to get them to the patients ….. Here are disorders where a drug doesn't do much good and we have to consider how best to get those treatments, whether to use computerised treatments, whether to use mental health workers or whether to skill up counsellors remains one of the practical problems in the area.

In the survey I mentioned earlier, it was a huge national survey with representative samples of trust and primary care groups. We asked them to look to the future and asked them who was going to provide routine care for patients with schizophrenia and bipolar illness in the future. To our amazement but pleasure, 95% of not just the GPs but of the psychiatrists as well said primary care will be responsible in the future for these patients. If that isn't the case, the mental illness services will become over burdened until they burst. New patients are coming in all the time and if you never send them back to the GP, there has to be a problem. The bubble will have to burst; either the budget will have to go up each year (and that never looks likely the way the mental illness services go at the moment). So there we take the new problems that don't respond to treatment and people who have relapsed but we send back the patients who have stabilised to the GPs.

The Virtual Group

Well I want to finish my talk by telling you about the virtual group. A year or two back Andre Tylee assisted me and Linda Gask as well in producing instructional tapes for teaching mental health skills to GPs. We managed to

get the WPA to produce these for us - that is the World Psychiatric Association.

I have been seeing whether there are people in other countries who have an interest in teaching mental health skills to GPs and, my goodness, there are! The members of the group at the moment - we have 28 members and they are growing all the time. They are right across the world in very different countries and I celebrated our first year by sending a questionnaire out. 20 of the members actually completed it and sent it back to me. These relate to services in 13 of the countries, so Australia, for example, is one of the countries where there were several different members who replied to me

I asked them what the present relationship was between the 2 services, who would they refer and who would they treat themselves, what opportunities there were in each country for training primary care staff and in mental health skills and what training methods they used.

Well, shared care was usual nowhere. I was glad that it was frequent in United Kingdom and somewhat surprised, as I have actually taught doctors in Russia, to find the Russian federation telling me it was frequent there. But I think they didn't understand the question. It (shared care) was said to be sometimes the case in Australia. Many other countries that are listed on that slide also told me that they sometimes had shared care arrangements with the mental illness services. There were a disturbing amount of countries where the relationship between the 2 services was pretty poor and it was never the case that a shared care arrangement existed. So GPs in all those countries, of course, have psychotic patients barging in saying they are unhappy with the drugs and expecting the doctor to change the drug. Sometimes it isn't clear just what to change it to or from.

The next question I asked was if the GP asked for someone in the mental health team to visit a patient at home, will they go? Psychiatrists will go in the UK but also in Italy, Austria, Holland, Denmark, Pakistan, Romana, Russia and Spain. Psychiatrists will go in the other countries if they want and a nurse will go in many countries. One of my Australian respondents said a nurse will go, and another said he wouldn't. But in the UK a nurse will always go if asked….. Holland, Romana, Russia, Singapore and one of my United States respondents said a nurse could be sent. But there where places like the Unites States and one of my Australian respondents who indicated that nobody from the mental health team would go if a GP asked them to, which astonishes me.

I was then interested in the extent to which these clinics which I described earlier in my talk exist in primary care. Psychiatrists did them (clinics in primary care) not only the UK - I knew about that - but in the United States, Austria, Denmark, Pakistan and Spain. Nurses are doing them in the UK, Holland and the United States. Psychologists are involved in the UK, Holland, Australia, United States and Pakistan. Then there are quite a few countries where there is not real contact.

I gave them 7 examples [of disorders] because you get better information if you think of 7 well chosen examples. I said: would you treat these disorders or

would you send them to the mental illness service? There was general agreement the drug dependence cases would be sent to the mental illness service. And everybody said acute psychosis would also be sent to a mental illness service. Treatment resistant depression everybody said would be referred except Pakistan. Pakistan is a very interesting developing country because it has the most advanced community care in the world for a developing country. The distances in Pakistan are so great and the number of psychiatrists is so small that the only practical solution is to teach GP not just mental health skills but to teach them how to manage treatment resistant depression. And so it is included in their normal mental health training and treatments of acute depression. Everybody except the old eastern block of Soviet Union would treat acute depression in primary care but Russia and Romania both said, no, send them away, just as they would have done in England in 1950.

There was very little agreement about the rest in terms of treatment in primary care. Phobia would be treated in UK, Italy, Denmark, Australia and Spain Some of my Australian respondents, my UK respondents, US, Denmark and Pakistan said they would expect to manage controlled bipolar illnesses in primary care. And controlled schizophrenic illnesses - again UK, Australia, US, Denmark, Austria and Spain said they would be managing them. So this is an enormous change. You would only have to go back 10 years and I would not have had those answers.

That's all I wanted to say to you today. I wanted to introduce you to the notion we are living in times of change. We still don't know how the systems will come to rest and how much the services will be developed. It is an exciting time to be alive and I am delighted to be here and look forward to hearing the other papers that will be presented today.

The National Picture: successes, challenges and future directions

Ms Leanne Wells, Principal Adviser, Mental Health, Australian Divisions Of General Practice and the Mental Health Development and Liaison Officer Network.

Australia's National Primary Mental Health Care Initiative Network is an important forerunner to the Better Outcomes Initiative. It has played an important role promoting primary mental health care, setting the agenda around primary mental health care reform and supporting and building capacity in Divisions to implement *Better Outcomes* and other mental health initiatives.

Funded by the Department of Health and Ageing, the Network is responsible for:

- Providing infrastructure and opportunity for primary mental health
- Building mental health capacity in the primary care sector
- Leading and driving change in primary mental health care
- Promoting innovation in primary mental health care
- Supporting primary mental health care reform
- Influencing policy and practice.

Prior to the Initiative, mental health in the Divisions Network lacked a national framework and activity was largely characterised by isolated projects, lacking sustainability. After 3 years of the Initiative, there has been a system-wide impact towards increased attention to mental health in Divisions, and a culture of innovation and leadership around primary mental health care reform.

Achievements of the Network include relationship building, an increased mental health focus in Divisions, an increased commitment commitment to mental health, capacity development, a culture shift towards mental health being regarded as central to chronic disease agendas, education and training initiatives, better service integration and shared care, State-wide co-ordination and leadership. Over 95% of Divisions now have a mental health program.

Specific examples of state-level projects taken forward by the DLOs include MOU development (WA), GP Liaison positions, peer support programs, and Triple P in primary care (QLD), peer circles and Mental Health Mentors (TAS), and the 'State of the Art' Manual (NSW).

The DLO presence in State Based Organisations of General Practice has also given rise to State Government investment in primary mental health. For example, the Commonwealth and State governments jointly fund the DLO role in Tasmania, and Queensland implemented the GPAPP initiative.

What is unique about Australia's primary mental health care reform experience is that it has been a process of 'evolution not revolution'. Many commentators have made this observation. It is like a progression of building blocks. First we had the Commonwealth funding the National Primary Mental

Health Care Initiative as the forerunner. Then we had the development of Better Outcomes, which represents the beginnings of a system of primary mental health care. Better Outcomes represents:

- An integrated package
- Unprecedented funding for primary mental health care
- A unique collaboration between all mental health stakeholders

And then we see Divisions playing a central role as an important part of the implementation arm. A key success factor in the implementation of Better Outcomes, in the fact that Divisions are at the heart of the reform process. The unique place Divisions occupy in the Australian health system is acknowledged, well harnessed and supported by the Initiative through their involvement in roll-out through the linking of mental health funding with Divisions' funding for chronic disease management. They are powerful brokers and agents of change. In particular, they:

- Deliver national outcomes through local implementation
- Deliver population health outcomes through flexible primary care solutions
- Provide a system of support in primary mental health care
- Span the Commonwealth-State funding divide
- Engage community stakeholders at the local level
- Forge relationships and links between general practice and other service systems
- Assist to build practice capacity via education and training, practice support, peer support etc.

As each DLO presentation demonstrates[1], nationally the uptake has exceeded expectations. Other success factors included the involvement of GP leaders and champions. We are also beginning to see that the allied health component, which offers participating GPs with access to low-cost focused psychological strategies on referral to appropriate qualified allied health specialists, is also the key drawcard for GPs. The policy mandate given to primary mental health care reform, via a fusion of mental health and general practice policy has also laid a strong foundation for the initiative as has the partnerships, networks and sustainable relationships formed during its development and implementation.

Better Outcomes is an ambitious initiative that requires substantial practice change. Some of the barriers include:

- Understanding and negotiating the complexity and 'newness' of the initiative
- Multiple players
- Funding
- Distance
- Workforce – supply, distribution, demands of competing priorities
- Limited engagement by State Health

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[1] Presentations by each State and Territory Mental Health Development and Liaison Officer are included in the companion CD Rom.

- GP engagement
- Loss of organisational learnings

The Network has regular and ongoing contact with Divisions, practice staff and GPs. They hear all the time the feedback about the Initiative and, as a result, are a useful repository of information from the field about implementation issues and ideas about future directions. Based on feedback to the Network to date, the following consensus about future directions and priorities appear to be emerging. They fall under four broad categories:

Partnerships

- National framework for PMHC via the Australian Health Care Agreements
- Explore role of practice nurses
- Promotion, prevention, early intervention: getting the population health approach into PMHC

System integration

- Consolidating shared care
- Access to psychiatry services
- Priority target groups eg. Child & adolescent, indigenous
- Allied health services are a major sustainer for GPs and requires expansion

Research and Innovation

- Promoting access and equity eg. Improved psycho-education, e-health, models for rural/remote service delivery
- Overcoming deficits in knowledge management and research
- More integrated approaches to 'whole of person' care: physical and mental health co morbidity

Quality

- Education, training and peer support
- Consumer & carer participation
- Funding: realistic investment buys quality

Integrating Mental Health Care into a Continuous Primary Care Framework

Dr Chris McAuliffe, ADGP GP Adviser, Mental Health and Dr Trina Gregory, ADGP GP Adviser, Home Medication Management Review

This presentation was the basis for an article published in a recent edition of *PARC Update*, the newsletter of the Australian Primary Mental Health Care Resource Centre. It is reproduced here.

Our sense of wellbeing is dependant on both our physical and mental health. There is now increasing interest internationally in better defining the nature of the relationship between physical and mental illnesses and exploring the implications of these types of co morbidities. There is increasing evidence that failing to treat people holistically results in poorer health outcomes and quality of life for consumers, and increases the overall costs of health service provision. This has implications for consumers, clinicians, policy makers, service planners, health economists, and for us as a nation.

It has been well documented in recent years that mental health disorders or illness occurs commonly in the Australian community. What is beginning to be better understood are the wider health implications of having a mental health disorder or illness. These include:

- Mental health Disorders operating as an ***independent risk factor*** for the development of physical disease;
- A higher ***incidence*** of ***mental health*** disorders/illness in those with chronic ***physical*** disease; and
- A ***higher incidence*** of ***physical disease*** in those with ***mental health*** disorders /illness

The recent position statement from the Expert Working Group of the National Heart Foundation published in March 2003 in the Medical Journal of Australia highlights the significance of mental health for the development of coronary heart disease (CHD), a leading cause of morbidity and mortality. The Expert Working Groups concluded that there was “strong and consistent evidence of an independent and causual association between depression, social isolation and lack of quality social support and the causes and prognosis of coronary heart disease”. This increased risk was found to be of a similar order to the currently acknowledged risk factors of smoking, dyslipidaemia and hypertension. Although there are not yet published studies on whether treating depression and other psychosocial risk factors reduces CHD morbidity, the expert working party did conclude that those with CHD and depression are more likely to have poorer outcomes. These findings highlight the importance of mental health as a predictor for the development of a common and significant medical condition and raises whether consideration

should also be given to screening for psychosocial factors in addition to blood pressure, cholesterol, diabetes and smoking.

Many studies have demonstrated an increased risk for depression in those with chronic medical conditions. The increased risk varies from double that in the general population to up to 10 times the risk in selected chronic diseases. This means that 10 - 50% of those with chronic medical illness will also have depression. Those with diabetes for example are 3 times more likely to have depression. People who suffer from both diabetes and depression are more likely to have poorer glycaemic control, and a higher incidence of microvascular and macrovascular complications. Conversely if depression is treated in this population there is improved glycaemic control and improved quality of life.

It is also well documented that if you have a mental illness you are likely to have poorer physical health. Unfortunately medical comorbid conditions may go under-recognised and under-treated. The health outcomes for this group tend to be poorer not only with respect to physical health outcomes, but also for psychological outcomes at 1 year follow up according to a UK study.

It is important to acknowledge that physical and mental morbidity go hand-in-hand and both need to be addressed effectively. This approach has the potential to improve not only health outcomes and quality of life, but also appears to be cost effective and likely to contribute to a reduction in overall health costs. In a population-based sample it has been found that depressive symptoms predicted greater medical care utilization, and that this utilization was independent of a number of medical severity measures

These findings raise questions about the need to consider how to adequately resource and support our health workforce to better identify and more effectively address the health needs of those with mental health disorders and illnesses, including for those with coexisting medical conditions. The recognition that mental health is a significant independent risk factor for CHD, in addition to being a leading cause of morbidity for the Australian community in its own right, again highlights the importance of mental health as a population level priority.

In an era when the acute care sector and state health departments are exploring strategies of demand management and how to make a finite health dollar stretch further it could be argued that increasing funding in real terms to support mental health services, especially in the community and general practice, could well be a cost effective strategy.

In summary it is apparent that clinicians, policy makers and funders will need to carefully consider the implications of the emerging evidence base about the wider health implications of mental health disorders and illness. Effectively addressing the needs of consumers of health services however will require not only a holistic approach from clinicians, but demands greater integration at a policy and funding level to develop models that facilitate access to more streamlined integrated care for people. This has the potential to improve health outcomes and quality of life for consumers, and to improve the cost effectiveness of the health system.

The UK and Australian Experiences Compared

Andre Tylee, Professor of Primary Care Mental Health, Institute of Psychiatry, London, UK and Chair, Primary Care Programme Board, National Institute of Mental Health in England

I have been a general practitioner myself for over 21 years now in the UK and I have always wanted to be reimbursed for doing mental health work. In fact, one of the things I started doing back in 1980 was looking at how to improve talking treatment within my practice and so I had to bring people in to be able to do that. But in order to encourage people in the way that the *Better Outcomes* program has done so has never been possible to date in the UK.

Now that we have a primary care program in the UK, I am over here to look at how successful this project obviously is the first year and take back some of the messages to the UK on how we can institute a similar systems of encouraging significant proportion of our general practitioners to do mental health work in the same way that the *Better Outcomes* project is managing to do.

Fortunately for me, this is the second year running I have been able to come over and meet many of you and share in events with you and do some training and so it is a great opportunity. It is very true that I have been a GP myself for 21 years before the current position that you see there. When I went into general practice in 1980, it really was the case that I went into general practice after really having boned up on cardiovascular work and all sorts of biomedical stuff but none of the psychosocial stuff.

So I went into primary care and I was completely unprepared for the long stream of people that I saw who were coming in to see me with their problems and depression and anxiety. So I sort of panicked and ran around like headless chicken trying to get myself some training. In those days, there wasn't a lot of training to be had. I had to hunt far and wide to get some CBT training. I joined the Balint group at Tavistac (?) Hospital where the Balint tradition started and found that absolutely illuminating because I learnt a lot about myself and actually how I was affecting the dynamic with the patient and how I needed to look very closely at myself just as much as what I was doing in the consultation. So that was very informative but really got me thinking how, back in the early 80's, we needed to do more about primary mental health training.

So I went to see David Goldberg up in Manchester and he was incredibly helpful, as you can imagine, and has been a mentor to me ever since. It was David who got me interested in the whole field and helped me with my research around depression in primary care and to thinking about why is it that some people come and tell us about depression but some people don't? Why is it that we acknowledge depression in some people but not others? And then, even if we acknowledge depression, why is it that quite a significant

number of those people, perhaps as high as 50%, don't come back a month later despite our best efforts?

And so I go really interested in that whole area and then that lead into the things that you have just heard about. However, I have been talking now for about 15 years in our country about the need for incentives or reward for people like myself who had an interest in primary care mental health. I found right back then that I was spending long sessions with people. I was devoting half a day a week to doing CBT and relaxation training - all the sort of things that were completely unrewarded and, in fact, were quite an irritant to my partners in practice. I'm sure what happens is that those of you in practice that are really interested in mental health and who actually listen and run over time, actually causing stress in your partners. I am getting some nods here. People still want to have their queries answered and things done but if you a sort of immersed in a long consultation with someone that often falls to your partners. It happened in my practice where the two partners had a huge interest in mental health were often at odds with the three partners that didn't have a interest in mental health but who nevertheless played a valuable part in the practice. I didn't want to do minor surgery … and wanted to spend time doing CBT type things.

So practices in the UK certainly need a mixture of people but certainly in the UK we need to think quite long and hard about how you value those partners who do mental health work appropriately. I suppose if I had been bringing some money through a *Better Outcomes* type project into the practice then I would have actually had a much easier ride with my partners in the practice.

UK/Australia observations

Let's just make some observations. I will make some observations and then I will tell you about the primary care program that we have just started in England in the National Institute for Mental Health in England. The program has only just started and is a similar sort of age to your *Better Outcomes* project. Then I will finish by telling you how I would like to work a little bit more closely with Australia to look at some of the common factors between us and look at the impact on patient outcome and the process of primary care.

I think we have heard quite a lot today about the fact we do have similar prevalence, similar morbidity, similar presentations similar approaches to acknowledgement. Acknowledgement means not just recognising depression but doing something about it or recognising mental health doing something about it. And concordance appears to be quite similar in the two countries.

You have heard already that in the UK we have an increasing reliance on primary care teams. We have nurse practitioners who are soon, I would expect, be allowed to prescribe. It is a very limited list at the moment but there is a drive towards allowing nurses to prescribe increasingly. Counsellors were mentioned earlier. We did get up to a point where 50% of our practices had attached counsellors who could be psychologists, psychological counsellors, psychotherapists and clinical psychologists - any of the 3 different disciplines. There was a stage where we had 50% and certainly, in my practice, when we were allowed to be fund holding, one of the

things we did was to get a get a clinical psychologist and a counselling psychologist into a practice because of our particular interests.

But then what happened when we became primary care trusts, which you heard from David earlier, was that one of the first priorities was to have equity of access. So those practices like our own which had a lot of psychological services within the practice had to actually give some of our psychologists to neighbouring practices who had none. We actually ended up with about a quarter of the psychological provision that we had built up ourselves, which is a great shame…. Across the country I would suspect that this means everybody now is getting a little bit of something rather than some practices having what would be probably an adequate level. So that is one of challenges for us.

You might well know that we have an increasing emphasis on non-medical new workers as well to the extent that Lewis Appleby, who is our mental health tsar in England, identified 30 million pounds of new money for non-medical primary care graduates workers with psychological training to work in brief interventions and psycho-education, for example

The challenge now is to see whether the 1000 primary care graduate workers that are going to be almost parachuted into primary care are going to be effective. Really there is quiet a lot of debate in our country about what their role should be. There is some evidence that they can deliver brief interventions, psychological interventions and there is certainly some evidence that they can do sign posting and some psycho- education and some supportive work. But we really are introducing this measure with a very weak evidence base and it will be very interesting to those of us that are getting pilot funding to look at this work and to see what the potential is.

I suspect one of the potentials will be to immerse these new workers in stepped care. When David showed you the wedding cake picture, these workers will probably be at the first step or the very beginning of the first step as it were doing evidence-based interventions.

That is the direction that we are going in the UK and we have 500 ‘gateway’ workers who are to be employed to help people in crisis to get into mental health services because we know there has been quiet a lot of difficulty in some of the pathways to care. Of course, a lot of our policy is driven by the high profile that accrues when there are the sorts of disasters usual with patients with severe and injuring mental illness who get into our press. It creates a lot of noise as it were and a natural sort of response is to do something about that which often means trying to reorganise mental health services into various teams, to providing more outreach care, and facilitating getting people into emergency beds more smoothly than has sometimes been the case.

We also have GPs with special interests - GPWSI, ‘gypsy’ is the local term for that. There again, money has been identified for 1000 of these people but these are generic GPs across the board so could just as easily be a GP with a special interest in ENT work or gastro, or any other speciality. So it is likely that mental health will get just a small chunk of that funding for the 1000

people. But these are people who would essentially be leaders in primary care mental health and will provide perhaps a clinical service that is the second step on the stepped care model so that, if a GP is perhaps struggling with somebody's health, they might want to go to a specialist colleague before they go to a mental health service for help. So that is another direction we are going in and, because that seems quite an attractive proposition certainly to the 5% or so of people that have a strong interest in mental health, quite a lot of those will take advantage of this possibility and get funded accordingly.

We, as you well know, have a centralised, national, free at-the-point of contact, funded system. It operates mainly by a capitation based contract system between primary care trusts and GPs. As Cate Howell asked this morning, that does have implications. If the majority is capitation- based, it does mean there is a drive towards larger lists than perhaps might make primary care mental health more feasible. So if a GP has a list of lets say 3500 patients, which is the maximum list size, the average is about 2000, then it is very difficult to provide a good primary care mental health system particularly at the moment when there is a dive towards better access for the public. One of Tony Blair's big policies at the moment is very much about that. Anybody in the general public should be able to see a GP the same day or possibly the next day for anything that they need to be seen for. But, of course, in a system where nobody has to pay anything up front, it does mean that we have huge numbers of people wanting to see us. Certainly in my practice that I left a year ago they have had to employ a couple of extra doctors to be able to provide that level of response within 48 hours for the majority of people. So there is this balance about having a list that gives you the income that you want but also having to provide the service accordingly. So that is quiet a significant difference I would imagine.

We have a new General Medical Service (GMS) contract which would apply to about half of the GPs whereas there is a Personal Medical Service (PMS) contract for the other half which allows more flexibility. So, for the personal medical services contracts, these are organised in negotiation with primary care trust and allow some flexibility so that if, for example, there is a population need, the primary care trust might give some money for quality treatment lets say for depression in a particular area or they might direct money to asylum seekers if there's an area with a lot of asylum or refugees for example. And they can shift money whereas the general service contract is a national contract much less flexible but they are trying to make it more flexible at the moment. It has been negotiated between the GP committee and the Department of Health, however there is nothing within that contract to do with common mental health service provision. It really only focuses around SMI so the rewards would be for keeping registers for people with SMI and running lithium clinics for people with SMI. There is nothing in there for doing good work for people with anxiety and depression who, of course, are the majority and I hope I have got your system right there.

National Service Frameworks

In the UK we have a huge focus on revalidation and national guidelines. A picture that I nearly put in and didn't get a chance to put it in is one of a GP sitting on about 2000 pieces of paper. The GP is sitting cross-legged on the

top of it, the point being that an average GP gets about 2000 pages of journals, guidelines and protocols every month in the UK. Now how on earth, when you are getting deluged with these national service frameworks, can you even pick out or do anything other than put them in the right pile let alone read them?

Mental health was the first of our national service frameworks but we have had a series and we are going to get a long series of national service frameworks each of which have 7 or 8 guidelines / standards within them. Of course, the other thing that has happened to us is the cardiovascular ones are much sexier than the mental health ones so the cardiovascular ones come in and they are all about measuring cholesterol and things like that. Of course, people can find that very easy to focus on and count in a way that you can't count mental health. What has happened now, although the mental health national service framework was the first, is it is going down in the pecking order and being taken over by the diabetics, asthma and heart and stuff like that. It is not a bad thing that there should be frameworks about those conditions but we have to be cognisant about the effects of all these continuous frameworks.

We certainly have different access arrangements. We have mostly larger practices but we have whole teams as David told you earlier and so it is quite possible now to go to different people within a practice so that you never see the same person twice or three times running. That can lead to difficulty within our system with continuity of care.

National Institute of Mental Health, England (NIMHE)

We are looking at improving access so we have walk-in centres. We have telephone lines and we have lots of different ways now trying to get people into the system as well. I mentioned the National Instate for Health in England. Well, this was set up after our National Plan as part of our modernisation agency to really sort of modernise the National Health Service.

The National Institute for Mental Health is within that new modernised agency which is just as well because, if it hadn't been, it might have been axed in the parallel system which is going through a lot of change at the moment. The National Institute is all about improving the quality of care working beyond the NHS with anybody that is involved in mental health and really sort of being there for anybody that wants to know about mental health.

We have eight development centres and eight regions in England which have roughly 4 to 5 million population each. We also have eight national programs within that National Institute and I'm very glad to say it took quite a bit of lobbying from about 20 or 30 of us in GP land to make sure that primary care was one of those eight programs at work!

NIMHE Primary Care Programme

The aim is really to have service users at the very heart of policy and practice, to champion achievements and promote more flexibility and better partnerships. The aims of the primary care program are really to help primary

care practitioners to improve the standard and consistency of service, so it is about doing a difficult job better and it is about improving the life for service users so that they have a better journey in the labyrinth of our systems.

But it is primarily to facilitate and encourage innovation. Where innovations exists around the country, being able to really support that so that it is very much a bubble up philosophy rather than a top down one. It is also about encouraging innovation that is natural innovation by leading edge practices. So we are on the hunt around England for good practice we probably know quite a bit of it but we are thinking of ways of really highlighting good practice and developing that.

Our values are, well, does it make sense to the user? That's the first question to ask of anything that we do. It is about emphasising strengths, not deficits, as I have just indicated and mutual respect across generalist and specialist perspectives. One of the largest parts is putting people from primary and mental health services together to share perspectives.

[The 2 of the 8 development centres that have traditionally taken a huge lead on primary care mental health manage the primary care programme}. They are based in West Midlands and London. There is an independent chairman, that's myself, not employed by the Department of Health and then we have got other national agencies to do with supporting the development of the primary care trusts and GPs which are called NATPACT and Primary Care Collaboratives respectively.

What we are trying to do is to get the regional development centres to take lead responsibility for each bit of the project so we have five components to our project and we want the regions to lead on these with our support. We have a program manager who will facilitate that process, a steering board but also a huge reference group which involves all the national colleges and organisation that get involved in Primary Care Mental Health.

The five areas are:

- Staff development
- Commissioning and developing effective partnerships
- Creating a primary care user prospective which might be a bit different in that we are encouraging people that only go into primary care to get involved rather than people who have been through the whole system
- Integrating care and services for severe mental health problems
- Research and development.

With staff development, we are very much interested in core training skills. At the College of GP's we have master classes using the package that David Goldberg has produced with Linda Gask and myself. The training covers skills training modules in anxiety management, dementia and chronic fatigue, for example and, in each of those situations, we have vignettes, just like on your familiarisation packages, particularly your CD ROM where you have a section that demonstrate specific skills. We use the same process and several of you looked at that particular program last summer when I was out in Melbourne, demonstrating that program.

We are interested in leadership particularly something we call 'trail blazers' which, again, is a way of getting primary care and mental health service people together as teaching pairs or leadership pairs around the country. We have about 350 who have been through this process which is a modular course. Basically it demonstrates primary and secondary care working together, joint teaching, joint leadership and joint service development. The National Health Service has a leadership centre that is going to be assisting with that. There is an emphasis on shared and multi professional learning and I have already said about the new workers and one of the challenges for the new workers is that they are going to need a lot of support training, supervision and mentoring if they are straight out of a psychology degree and expected to work in a primary care setting.

Myself, Ray King and Liz Armstrong back in 1996, developed the teachers or 'trailblazers' course and those are the people who have undertaken it so far. So it is for a whole range of people but you have to have a pair so nobody can come on it themselves they have to have a partner. They have to commit to working with that partner from the other discipline and working with practices and mental health services accordingly. It has taken off so far in about half of England so it's well established now throughout four of the regions that I mentioned earlier and it has had a positive external evaluation.

The trailblazers ethos is that it is embedded in every day practice. We are not trying to teach people to do anything extra in primary care other than to use a few skills in 10-minute consultations or even 6-minute consultations. It is within the context of this continual bombardment with national service framework guidelines and about steps we can all take to involve people with mental health experience. It is a very 'bottom-up' course although we try and predict what sort of training people are going to need. We have the training for a whole range of things available but it depends on what the participants want. The interesting thing is that it started with people wanting training on the recognition of depression back in the middle 90's. But the training emphasis now is on change management. People want to know how on earth you get the primary care trust to change their policy so that they will allow more primary care mental health work. It is at that sort of level now and it is also about how can you influence partnerships and developed partnerships where they don't already exist. It allows a lot of time for the unpredicted, it allows a lot of time for the individuals to value their expertise to allow them to talk and teach the others and of course they learn from each other more than they learn from us.

It is also about primary care users. I mentioned earlier that focusing on primary care users is one we are struggling with a little bit. One of the projects we have at the Institute at the moment is to engage young people 16 to 21 years from all backgrounds. So this is people who are rough sleepers, African Carribean young men, Asian young women, young girls who have a high suicide rate in our country, and involves really working together with them so they can tell us how to re-design primary care. So I have had to take a back seat in this being sort of grey-haired and the wrong generation. I have a young service user who leads the project and she runs it jointly with other youngsters. It has taken a year to engage people in the project but now that

we have got them we now have a consensus or focus groups initially to really help us redesign primary care and make it more youth friendly. They are going to develop a youth assessment of needs instrument as well, but it does take some time to do.

In terms of people with severe mental illness, I won't say too much about that. As we heard earlier, there are plenty of people with severe and enduring mental illness who only see people in primary care and particularly, as we have heard in your rural settings, there are also some people who only see mental health services who have physical care needs that aren't being met. So it is a two-edge thing that we are trying to improve. We are trying to improve that by better registers and better proactive care.

In terms of research and development, well, we know that several ideas will emerge during this program. This is a 3-year program initially and we need to be able to collect those ideas and the Institute of Psychiatry and the University of Manchester are jointly running a mental health research network to assist with this process.

Commissioning - you heard that the primary care trust commission 75% of our health services but we have people who really have very little expertise in this. They have only been doing it a year or two and they have a lot of training needs. They don't really know how to commission effectively and there isn't a great evidence base in commissioning primary care mental health services. One of our early actions is really to work with the managers who commission mental health services to really help them to understand how to assess need and how to meet it. Again, that revolves around the change management that I mentioned earlier. So that is really what the primary care program is.

Finally, I want to finish on a project that Eugenia Cronin is leading. She is a public health specialist in my section and comes from Melbourne. She is very keen and she has already contacted Grace about a study exploring perceived relative impact of macro level factors and how they impact on service delivery, .the process and the input. We can't look at outcome but we can look very closely at the processes of primary care mental health and do some comparisons work between the Australian system and the UK system. One of the things we want to focus on is access and continuity of care. Eugenia has put her email there she would be very grateful for anybody who would like to help us with this because what we want to do is to get a group of Australian people and group of people in London we also want to look at the city and suburban differences as well. I'm not sure that we can look at rural differences in the UK perhaps but maybe that is a possibility in Australia.

I think that is probably a good place for me to finish and thankyou very much indeed for your attention.

Primary Mental Health Care: Successes and Challenges

Panel Discussion facilitated by Professor Ian Hickie, CEO *beyondblue*. Panellists were:
Professor Goldberg, UK Institute of Psychiatry,
Professor Andre Tylee UK Institute of Psychiatry,
Dr Julie Thompson (Chair, BOIAG),
Dr Rob Walters (Chair, ADGP),
Dr Liz Scott (a psychiatrist with a strong interest in primary mental health care and GP education),
Mr Keith Wilson (Chair, Mental Health Council of Australia),
Ms Ingrid Ozols (*bluevoices*),
Mr Dermot Casey (Assistant Secretary, Mental Health and Suicide Prevention Branch, Department of Health and Ageing).

This section also includes key points made by the 'GP and allied health perspectives' involving Dr David Monash, Dr Di Symonds and Ms Cindy Wall

Panellists were asked to consider the following questions:

- What have been the successes in Australia's primary mental health care experience?
- What challenges and opportunities does primary mental heatlh care reform face in the future?
- What are the gaps and opportunities – where should we put our energies now?
- If you were to design a 5-point primary mental health care plan for the next 5 years to build on the Better Outcomes in Mental Health Care Initiative, what practical and desirable measures would it include?

Highlights from the discussion included:

- Many consumers and carers are unaware of Better Outcomes. The consumer carer movement recommend that the Initiative should be consumer and carer driven, that consumers should be encouraged to check whether GPs have had training in mental health care and that, most importantly, consumers need to be better educated on mental health issues. Until this occurs, there is likely to be continued misinformation in the community about the Initiative.

- Consumer feedback of positive experience with the Initiative. However, consumers have not been informed about the Initiative for fear of overwhelming GPs with demand. Several participants called for more community information about the Initiative and for consumer feedback to be considered as a most important outcome in any evaluation framework.

- The decision not to advertise Better Outcomes was a collective decision taken in consultation with the stakeholders, as there was not sufficient capacity in the current system. It will be an option once there is a greater cohort of GPs participating in the Initiative.

- The consumer and carer movement made the point that health service managers are always more positive than the people receiving the services. The issue of integration remains a problem. The States see that the Commonwealth should provide co-ordination of mental health services, but they often do not see GPs as providing these services. This needs to be addressed under the National Mental Health Plan 2003-2008 so that States are obliged to contribute to providing better integration. It was stressed that the major barrier to present delivery is that the States are not engaged and integration remains poor. There are also problems integrating with other services such as housing.

- Some GPs are still unaware of the Initiative. GPs are often working so hard that they have little time to explore how they can participate in new things. The Divisions of General Practice are well placed to educate GPs on the new initiatives and this sort of activity is core business for Divisions. Currently only 40% of people with a mental illness are seeking help and this is a challenge for general practice to take up.

- Some panel members commented that it was difficult to engage psychiatrists in primary mental health care since they have limited experience in this area and there remain profound differences in culture across primary and specialist care. To achieve improved services and shared care between GPs and the psychiatry workforce, it would be necessary to take a partnership approach, forge local links and an education program across the general practice and psychiatry disciplines.

- The Government explained that the responsibility for health care is laid down in the Constitution. In the case of mental health, systems across State and Commonwealth jurisdictions play a role in service delivery – Medicare in the case of the Commonwealth, public mental health services and public hospitals in the case of State Governments. For mental health, the planning and co-ordination of mental health services rests with the Health Ministers of all jurisdictions.

- With the foundations of primary mental health care reform in place through the National Primary Mental Health Care Initiative and Better Outcomes, it is timely to focus on wellness, promotion, prevention and early intervention for mental health in the primary care setting. General practice and Divisions are well placed to take forward initiatives in this area.

- The initial estimate of uptake in 4 years was 10% of the GP workforce. This has already been exceeded. The Minister is very pleased with the Initiative to date.

- However, some GPs remain unsure about the Initiative and ongoing support will be required for those already participating to ensure the Initiative works for them and their patients. For sustainability of education and hence uptake of *Better Outcomes*, we need to teach GPs the things they want to learn and will use in their everyday work, and produce easy to use interventions.

- Support for GPs and practices are a product of capacity at the Divisional level. To date, funding to Divisions for mental health has been pooled in funding for better chronic disease management (CDM). CDM contracts for 2002-03 included funds to support familiarisation training. However, this was not only inadequate for supporting the range of mental health support activities Divisions need to undertake in order to keep level 1 GPs subscribed, it was also unclear to Divisions that CDM contracts included mental health funding. This resulted in an inherent risk that mental health action would be superseded by other CDM activities, which is not desired given the major practice change required under Better Outcomes. While some Divisions could access supplementary funding to support education and training, such as pharmaceutical sponsorship, this was not often feasible for provincial, rural and remote Divisions. This limits the capacity and opportunity for rural and remote GPs to up skill in mental health and is further compounded by shortages of allied health professionals and psychiatrists. Government representatives agreed that there is often market failure in rural and regional service delivery and that alternative approaches are needed.

- The 3-step process doesn't always fit within some consultations but, generally, it does. While its rationale as a clinical good practice is sound and can be easily integrated into practice, the incentives need to be paid at each step rather than at the review stage. Often, if a patient is well after receiving psychological services, they do not return for the third review visit and the GP is unable to claim the SIP. Some GPs reported a decline in earnings as a result of becoming active users of the Initiative.

- It is vital to maintain and increase funding for mental health at the Divisional level, if a broad range of support activities are to be sustained such as ongoing education and training, peer support and service integration.

- There was discussion about the merits of a national primary mental health care policy. On balance, participants felt that a separate policy was not needed, as it did not foster collaboration and whole of person care. Primary mental health care, to be effectively embedded, needs to be written into all major relevant policies with a community, consumer-carer and population health focus rather than service

delivery emphasis. This is also important to mental health being seen as central rather than something ‘other’.

- Funding beyond 2004-05 will depend on what has been achieved, budget pressures and how successful the Initiative has been. There was broad agreement that refinements to the model under funding regimes beyond 2004-05 should continue to be developed in consultation with stakeholders.

- In terms of evaluation, participants agreed that what mattered most was whether the ‘compass was registering success’. We need to know from consumers whether they have had improved access to services and whether an impact on stigma has been made. We need to know if GPs are comfortable with the Initiative and are seeing benefits for their patients and practice. We also need to know whether we have struck an appropriate balance between quality and access.

Recommendations for future direction

Plenary Discussion

Recommendations discussed through the course of the Symposium fell into the following four broad themes:

Partnerships

- Re-invorgorate a primary mental health care leadership and advocacy mechanism in general practice, via a re-orientation of the Better Outcomes Implementation Advisory Group and building and supporting GP leaders
- A national framework for primary mental health care reform to be mandated in the Australian Health Care Agreements
- Explore the role of practice nurses in primary mental health care delivery
- Promotion, prevention and early intervention: getting the population health approach into primary mental health care via integration and partnerships, not the individual GP

Systems integration

- Better integration between state-funded public mental health services and the general practice sector. Promote state government 'buy-in' to a co-ordinated, shared care agenda via an initial joint meeting of primary mental health care stakeholders with State Mental Health Directors
- Access to psychiatry services, particularly better private psychiatry workforce engagement in primary mental health care reform
- Priority target groups eg. child and adolescent, indigenous
- Expanding and consolidating allied health: major sustainer

Quality and leadership

- Education, training and peer support, giving priority to nuturing level 1 GPs, encouraging ongoing quality via peer support and promoting opportunities for further training via improved access to level 2 training
- Training in mental health assessment, care planning and review should be an integral part of undergraduate and registrar training. Registrars to be supported by a mentorship program
- Mental health education should occur across disciplines eg. allied health workforce to be educated about primary mental health care and vice versa
- Formal involvement of consumer and carers as educators
- Funding: realistic investment buys quality

Research and Innovation

- Targeted research to look at how GPs are or can respond to high and complex needs patients
- GP and consumer-carer centred evaluation and review and future design
- Promoting access and equity eg. e-health, models for rural and remote

- Overcoming deficits in knowledge management and research
- Promoting systems and practices that result in whole of person care and better management of physical and mental health comorbidity

Appendix A

Symposium Program

PRIMARY MENTAL HEALTH CARE SYMPOSIUM

Better Outcomes in Mental Health Care Initiative: Building on Success

RYDGES HOTEL, CAPITAL HILL
FORREST ACT 2603
7 May 2003
9.00 am – 5 pm

Chair

Dr Julie Thompson
Chair, Better Outcomes Implementation Advisory Group

Objectives

- To provide a national overview of implementation of Australia's *Better Outcomes In Mental Health Care* Initiative focusing on best practice in GP education and training, peer support and allied health service delivery
- To provide GPs with an interest in mental health with the opportunity to interact and engage with an expert panel, including international commentators, Professors Goldberg and Tylee, on primary mental health care reform in Australia, the experience and role *Better Outcomes* has played and future directions
- To explore the global context and trends in primary mental health care reform and discuss the Australian experience with international and national experts

Participants

The Symposium is a collaboration between the Australian Divisions of General Practice, the Mental Health Council of Australia and *beyondblue*: the National Depression Initiative with funding from the Department of Health and Ageing. The symposium is an unprecedented and timely opportunity to bring together key policy makers, lead GPs in primary mental health, international experts and staff from the National Primary Mental Health Initiative to appraise Australia's primary mental health care reform experience and, on the eve of the introduction of a new mental health policy and plan 2003-2008, consider future directions.

Program

8.45 – 9 am	*Registration and morning tea on arrival*
9.00 – 9.15 am	Welcome and Introduction *Dr Rob Walters, Chair, Australian Divisions of General Practice*
9.15 – 9.45 am	Setting the Scene: Primary mental health care reform and the global context S*ir David Goldberg, Emeritus Professor, Institute of Psychiatry, London, UK*
9.45 – 10.00 am	Questions and Discussion
10.00 – 10.30 am	Better Outcomes in Primary Mental Health Care: The National Picture *Summation by Principal Adviser, Mental Health ADGP, and presentations by the Mental Health Development and Liaison Officers Network*
10.30 – 10.45 am	Morning Tea
10.45 - 11.15 am	DLO Presentations continued
11.15 – 11.30 am	Questions
11.30 - 12.00	GP perspectives
12.00 – 12.30 pm	Integrating Mental Health Care Into a Continuous Primary Care Framework: Presentation and Questions *Dr Trina Gregory and Dr Chris McAuliffe (ADGP GP Advisers)*
12.30 – 1.30 pm	Lunch: Fig Café, Rydges
1.30 – 2.00 pm	The UK and Australian Experiences Compared *Professor Andre Tylee, Institute of Psychiatry, London, UK*
2.00 – 2.15 pm	Questions and Discussion
2.15 – 3.45 pm	Panel Discussion: Primary Mental Health Care Successes, Challenges and Future Priorities *facilitated by Professor Ian Hickie, Chair, Better Outcomes Evaluation Working Group and featuring a panel of international and national experts drawn from public policy, research, general practice, psychiatry and consumer/carer advocacy domains*

3.45 – 4.30 pm	Open Discussion *Lead by Professor Ian Hickie, Chair, Better Outcomes Evaluation Working Group*
4.30 – 4.45 pm	Closing Remarks *Dr Rob Walters, Chair, ADGP and Mr Dermot Casey, Branch Head, Mental Health and Suicide Prevention Branch*
4.45 pm	Refreshments

Appendix B

Symposium Participants

Name	Organisation
Ms Chris Aitken	Hornsby-Kuringai Division of General Practice
Ms Shirley Anastasi	Queensland Mental Health Development and Liaison Officer
Ms Carolyn Andrews	South East New South Wales Division of General Practice
Dr Anne Bicknell	GP, ACT
Dr Grant Blashki	Psychiatry Research Unit, Monash University
Mr Mark Brommeyer	Chronic Disease Principal Adviser, ADGP
Dr Peta Carr	GP, WA
Mr Dermot Casey	Assistant Secretary, Mental Health and Special Programs Branch, Department of Health and Ageing
Dr Stephen Castle	Director, Partnerships and Service Reform Section, DoHA
Ms Anne Croft	Partnerships and Service Reform Section, DoHA
Ms Anne Diamond	Victorian Mental Health Development and Liaison Officer
Dr Peter Frost	GP, SA
Dr Steve Fryman	GP, Victoria
Ms Margo Field	Education Development Officer, General Practice Mental Health Standards Collaboration
Professor Sir David Goldberg	Institute of Psychiatry, London
Dr Trina Gregory	GP, NSW
Dr Grace Groom	Mental Health Council of Australia
Professor Ian Hickie	Beyondblue, National Depression Initiative
Dr Cate Howell	GP, SA
Ms Eleanor Jackson-Bowers	Australian Primary Mental Health Care Resource Centre, Flinders University
Dr John Kastrissios	GP, Qld
Ms Lyn Littlefield	Australian Psychological Society
Ms Irene Matthews	Tasmanian Mental Health Development and Liaison Officer
Dr Meg Marsden	GP, Qld
Dr Chris McAuliffe	GP, Qld
Ms Julie McCormack	Director, Quality Assurance and Continuing Professional Development, RACGP
Ms Gael Menzies	Consumer
Dr Monica Moore	GP, NSW
Dr David Monash	GP, Vic
Ms Trish O'Neill	NSW Mental Health Development and Liaison Officer
Ms Ingrid Ozols	Consumer representative, bluevoices
Ms Elizabeth Pohlmann	Townsville Division of General Practice
Professor Jeff Richards	Director of Primary Care Research Department of General Practice

	Monash University
Ms Dawn Roberts	ACT Mental Health Development and Liaison Officer
Ms Anna Roberts	WA Mental Health Development and Liaison Officer
Dr Clare Roberts	GP, Tas
Ms Bronwyn Russell	NT Mental Health Development and Liaison Officer
Dr Liz Scott	psychiatrist
Ms Anne Schober	Sunshine Coast Division of General Practice
Dr Darcy Smith	GP, WA
Ms Patricia Smith	SA Mental Health Development and Liaison Officer
Dr Guy Streeter-Smith	GP, Tas
Dr Di Symonds	GP, NT
Dr Julie Thompson	Chair, Better Outcomes Implementation Advisory Group and immediate past chair, ADGP
Professor Andre Tylee	Institute of Psychiatry, London
Dr Tori Wade	Manager, Australian Primary Mental Health Care Resource Centre, Flinders University
Ms Cindy Wall	Psychologist, NT
Dr John Wallace	Australian College of Psychological Medicine
Dr Rob Walters	Chair, ADGP
Dr Marli Watt	AMA
Mr Keith Wilson	Mental Heath Council of Australia
Ms Leanne Wells	National Primary Mental Heath Co-ordinator, ADGP
Ms Jane Westley	SA Mental Health Development and Liaison Officer

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