Partners in Prevention

Mental Health and General Practice

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adgp
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A scoping of mental health promotion, prevention and early intervention activities in the general practice setting

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A collaboration between Auseinet and ADGP

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Australian Divisions of General Practice Ltd (ADGP) is the peak national body representing the Divisions of General Practice across Australia, and was established in 1998. The first local Divisions were established in 1992. About 95 per cent of GPs are members of a local Division of General Practice. ADGP's mission is to provide leadership and support for the Divisions of General Practice to achieve quality and vitality in primary health care.

The opinions expressed herein are those of the authors and not necessarily those of the Australian Government Department of Health and Ageing.

The authors disclaim any responsibility for the consequences of using this report for clinical purposes.

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Foreword

General Practice has increasingly been recognised as the cornerstone of all health care, and more recently particularly for mental health care. General practitioners have always provided such care and their work now is increasingly supported through divisional structures; education and training concerning mental disorders as they present in primary care settings, particularly anxiety and depression; and practice support through programs such as *The National Primary Mental Health Care Initiative* and *Better Outcomes in Mental Health Care Initiative*.

Promotion, Prevention and Early Intervention are key elements of the National Mental Health Strategy as reflected in the *Second National Mental Health Plan 1998–2003*, and the *National Mental Health Plan 2003–2008*.

The Promotion and Prevention Working Party of the National Mental Health Working Group and National Public Health Partnership has identified General Practice as a key setting in the *National Action Plan for Promotion, Prevention and Early Intervention*. A collaborative partnership between the Promotion and Prevention Working Party, Auseinet (the implementation focussed initiative for this) and the Australian Divisions of General Practice, has led to this scoping study of General Practice orientation to and uptake of these core themes for mental health.

The scoping study has highlighted those aspects where there is strongest focus, namely the education of general practitioners about mental health, mental health literacy and destigmatisation; liaison with key agencies such as schools; and early intervention. It has shown both commitment and difficulties including barriers.

The report provides an important baseline from which general practice systems and general practitioners can go forward, both in developing concepts and tools for use in primary care, and structures to add value and improve outcomes. The vital roles general practitioners can play for mental health in terms of promotion, prevention and early intervention are highlighted.

Dr Darcy Smith, the general practitioner who has so strongly reflected general practice issues in his contributions to the Promotion and Prevention Working Party, is to be congratulated for his advocacy and development of this study, its findings and recommendations.

Taking this forward in ways which address the recommendations, the barriers and the great and special strengths general practitioners bring, will be important for the future.

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Chair, National Mental Health Promotion and Prevention Working Party

Executive summary

The Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) and the Australian Divisions of General Practice (ADGP), under the auspices of the National Mental Health Promotion and Prevention Working Party (PPWP), have worked together on a scoping study of mental health promotion, prevention and early intervention (PPEI) activities in the general practice setting. A survey of the Divisions of General Practice and focus groups with general practitioners (GPs) have identified that there is a base of mental health PPEI activity occurring in the general practice setting and enthusiasm for PPEI approaches to mental health. Some of the work is explicitly identified as mental heath PPEI, while much is integrated into more general mental health and shared care strategies. The partnership between Auseinet and ADGP will continue and work in the next period will focus on moving further towards a shared language for mental health PPEI in the general practice setting, and on implementing the recommendations arising from this report.

Background

It is well established that the burden of mental health problems and mental disorders is high. Depression is predicted to be one of the major health problems worldwide by 2020 (Murray & Lopez, 1996). The majority (62%) of people with a mental health problem do not seek any professional help. Of the 38% who do, three quarters visit a GP as a first point of contact (Australian Bureau of Statistics, 1997). GPs and other primary care services therefore deliver the bulk of initial mental health care by direct treatment, shared care, or referral to other health professionals. In 2000-01, almost 11 million visits to GPs were for mental health conditions (Australian Divisions of General Practice, 2003).

About 95 per cent of GPs are members of a local Division of General Practice, the first of which were established in 1992. ADGP, the peak national body representing the Divisions of General Practice across Australia, was established in 1998 to provide leadership and support for the Divisions to achieve quality and vitality in primary health care. The Divisions network is a key part of local health infrastructure and therefore well placed to support mental health PPEI activities.

GPs are now considered to have an established track record in prevention and early identification in 'physical health' areas. Expertise in 'mental health' PPEI is developing. However, compared to physical health, it tends to be more ad-hoc than systematic. This report aims to document current approaches to and attitudes towards mental health PPEI.

Policy context

Primary mental health care is a relatively recent policy development, with significant government investment and policy priority occurring in the last five years. The importance of General Practice as a setting for mental health has been recognised in major policy documents in both the mental health and the general practice arenas.

More recently, PPEI for mental health has become firmly embedded in national mental health policy documents, notably the *Second National Mental Health Plan* and the *National Mental Health Plan 2003-2008* (Australian Health Ministers, 1998; 2003). Two key documents specifically focussing on mental health PPEI emerged from the second plan: the *National Action Plan for Promotion, Prevention and Early Intervention 2000* and its accompanying *Monograph* (Commonwealth Department of Health and Aged Care, 2000a;b). The importance of the general practice setting, and its pivotal role in advancing mental health PPEI, are woven through the documents.

Recent developments in the Divisions of General Practice Network have either elevated mental health PPEI on the general practice agenda or provided the platform through which PPEI can be better explored and undertaken in the general practice setting. Two particular initiatives that are a fusion of general practice and mental health policy have spearheaded primary mental health care developments: the *National Primary Mental Health Care Initiative;* and the *Better Outcomes in Mental Health Care Initiative*.

While the Divisions Network continues to evolve, contemporary discussion about the future of general practice, and Divisions of General Practice in particular, contemplates examples of future opportunities for general practice and Divisions in dealing with issues such as the ageing population and increasing chronic and complex needs. These include a strengthened primary care focus, incorporating a focus on prevention and early intervention, and community participation, understanding and taking into account the social determinants of health (*A Vision for Divisions of General Practice to 2007:* Australian Divisions of General Practice, 2002). In the primary mental health arena more specifically, a number of forums (*Youth In Mind 2002* and the *Primary Mental Health Care Symposium 2003*) and vision documents (*ADGP Mental Health Policy Statement 2003:* Australian Divisions of General Practice, 2003) identify mental health PPEI as a future priority.

The language of mental health PPEI

The conceptual framework that underpins mental health PPEI in Australia derives from the spectrum of interventions for mental health (Mrazek & Haggerty, 1994). As the language of PPEI comes from the mental health sector it may be unfamiliar to the general practice sector, or people working in the sector may articulate similar activities in different ways. The definitions of mental health promotion, prevention and early intervention outlined here are adapted from the *National Action Plan for Promotion, Prevention and Early Intervention 2000* (Commonwealth Department of Health and Aged Care, 2000a). We have applied the language of mental health PPEI to the general practice setting by presenting some examples of activities that can occur in the Divisions of General Practice or by GPs in their everyday work. We hope that we are working towards a shared understanding, but remain acutely aware that more work needs to be done in this area.

Mental health promotion

Mental health promotion is any action taken to maximise mental health and wellbeing in populations and individuals. Activities can occur equally with people showing no signs of illness as those with a long standing illness. Examples in the general practice setting might include Divisions of General Practice being involved in educating GPs about factors that promote mental health, working with the community to improve mental health literacy,

reduce stigma and promote quality of life, and supporting mental health promotion programs. GPs can also provide mental health promotion information in their everyday interactions with people (eg pamphlets in waiting room or personally during a consultation).

Prevention

Prevention refers to interventions that occur before the onset of a disorder, in order to prevent its development. Prevention activities can occur with everyone regardless of their level of risk, or with groups or individuals who are considered to be at increased risk of developing mental health problems or disorders. Divisions of General Practice might be involved in increasing GPs' knowledge about risk and protective factors for mental health, informing the community about the impact of adverse life events on mental health, supporting evidence-based parenting, suicide or other prevention programs, and implementing prevention programs in collaboration with other sectors. GPs can also elicit information about potential risk and protective factors during the consultation, train in and implement effective prevention strategies, or refer appropriately.

Early intervention

Early interventions specifically target individuals displaying early signs and symptoms of a mental health problem or disorder, or those experiencing a first episode of a mental disorder. Interventions occur early in the course of a disorder in order to minimise disruptions to other areas of a person's life (eg school, work or relationships). Divisions of General Practice might be involved in educating GPs and the community about early warning signs and symptoms of mental health problems or disorders, and effective early treatments for mental disorders (eg depression, psychosis). They might also develop shared care plans or referral mechanisms, facilitate access to services, and support and implement early intervention programs. GPs can also elicit information during a consultation about early warning signs and symptoms, implement effective early treatments, or refer appropriately if they are not trained or do not have the capacity to do so.

Objectives

Mental health PPEI in General Practice has been on the agenda of PPWP for some time. PPWP is committed to ensuring that health care providers are equipped to provide effective PPEI interventions for mental health and to develop partnerships within other relevant settings. Conducting a scoping study to document current mental health PPEI activities in general practice was seen as a logical first step in informing future work.

The scoping study is therefore intended to be a first look at mental health PPEI activities in the general practice setting. We have taken a broad view of 'the general practice setting' to include perspectives from the Divisions of General Practice, as well as some GPs and consumers. This report is not a definitive statement, rather it provides a picture of current activities and informs recommendations and future directions. The study had several objectives:

1. To identify key mental health PPEI interventions/initiatives that are relevant to General Practice and where possible to identify good practice initiatives.

This involved examining the literature on mental health PPEI in General Practice and identifying good practice interventions/programs where possible.

2. To document current mental health PPEI activities in General Practice in Australia and identify barriers to and opportunities for mental health PPEI practice in General Practice.

This included a Survey of Divisions of General Practice as well as focus groups with consumers and carers, Divisional Mental Health Officers and general practitioners.

3. To identify priorities for action in progressing mental health PPEI in General Practice, giving consideration to the ways that any new work will best fit with existing frameworks/programs.

A small workshop was conducted with key stakeholders to discuss the findings from the scoping study and to develop recommendations for a mental health PPEI agenda in general practice.

Reference Group

The Reference Group comprised representatives from a range of key stakeholders groups with interests in the area of mental health PPEI in the general practice setting:

- Australian Divisions of General Practice;
- Auseinet;
- Australian College of Psychological Medicine;
- Australian Government Department of Health and Ageing;
- Mental Health Council of Australia;
- Mental Health Development and Liaison Officer's Network;
- National Mental Health Promotion and Prevention Working Party (PPWP);
- Primary Mental Health Care Australian Resource Centre (PARC);
- Royal Australian and New Zealand College of Psychiatrists; and
- Royal Australian College of General Practitioners.

Summary of main findings

Survey of Divisions

The Survey of Divisions of General Practice was circulated electronically in June 2003. Surveys were returned by 71 of the 121 Divisions (59% response rate), with a good representation of urban and rural Divisions. An average 16% of total Divisional activities were reported to be mental health related and about half of these were considered to include PPEI elements. Therefore, the mental health PPEI activities reported in the survey represent on average 8% of total Divisional activities.

Overview of mental health PPEI activity

The majority of Divisions are involved in at least some type of promotion (81.7% of Divisions), prevention (87.1%) or early intervention (91.5%) activity. Forty nine (69%) of the Divisions were involved in all three types of activities. Divisions were involved in a broad range of specific mental health PPEI programs, including MindMatters, Triple P and other programs supported under the *Better Outcomes for Mental Health Care Initiative*.

Most of the work in mental health PPEI centred around education programs for GPs (not surprisingly, given this is part of the core business of Divisions), and also through community and school liaison. Divisions were involved in mental health promotion activities such as education about mental health promotion, increasing mental health literacy, reducing stigma and promoting quality of life. Prevention of mental illness activities included education about risk and protective factors, encouraging help seeking behaviour, and to a lesser extent, involvement in suicide prevention programs and parenting programs.

Most of the Divisions facilitate education for GPs on early recognition and early treatment of anxiety and depression (over 70% of the Divisions) as well as a range of other disorders including psychotic disorders, drug and alcohol problems and suicidal behaviour (50% of the Divisions). About one in five of the Divisions is involved in early intervention through brief interventions and practice support.

Most of the mental health PPEI activities did not focus on any particular age group or special population group. Where age groups were identified, most of the work addressed the portion of the lifespan from young people through to adulthood. About one in five Divisions was involved in activities that addressed rural and remote communities and about one in ten was involved in activities that addressed the needs of Aboriginal and Torres Strait Islanders or people from culturally and linguistically diverse backgrounds. These rates of activity indicate that there is a base of mental health PPEI work upon which to build.

Barriers

Four out of five Divisions identified at least one barrier to incorporating mental health PPEI approaches. The barriers included funding limitations, time constraints, lack of resources, capacity of the Divisions to undertake PPEI work and issues around working cooperatively with other services in an environment with competing priorities. Rural Divisions also identified barriers relating to distance and isolation, heavy workloads and access to services and training programs.

Consumers and carers

Half of the Divisions involved consumers in mental health PPEI activities and a quarter involved carers. Consumers and carers were mostly involved via formal advisory roles and consumers were also involved via community consultation. About one third of the Divisions suggested ways that consumers and carers could be involved in the future, indicating a willingness to involve consumers and carers and a potential capacity to do so.

Workforce development

All but one of the Divisions conduct workforce development (ie mental health education, training or professional development) for GPs as part of their core business and most of the activities (almost 90%) were reported to have mental health PPEI elements to them. Only one third of the Divisions reported workforce development activities for their own staff. While this rate is low, it is encouraging that the majority of those activities were reported to include mental health PPEI.

Other health professionals

Most of the Divisions (88.7%) work with other health professionals (both specialist mental health professionals and health professionals in the community and public health arena). Three quarters of the Divisions work with psychologists, but others professionals include psychiatrists, nurses, social workers and counsellors. Between half and three quarters of the

health professionals were reported to be involved in mental health PPEI activities. Over half of the Divisions (56.3%) are involved in Shared Care programs and all of the rural Divisions were involved in the More Allied Health Services (MAHS) program. Over 80% of both the Shared Care and the MAHS programs reported in the survey were considered to have mental health PPEI aspects. There is potential to build on the capacities and strengths of existing programs.

Urban and rural differences

Few differences were identified between the urban and rural Divisions. Rural Divisions employed more people to work on mental health activities and were more likely to work with other health professionals than were the urban Divisions. However, there were similar rates of mental health PPEI activity, consumer and carer involvement, workforce development activities, and involvement in mental health Shared Care programs.

GP focus groups

Receptivity to mental health PPEI

Five GP focus groups, with a total of 33 participants, were held between May and August 2003. Participants in two of the focus groups were actively involved in mental health in general practice and were therefore familiar with current trends in mental health. Participants in the other three focus groups had experience with mental health issues in their everyday practice, but most did not have a declared interest in mental health. Generally, there were many more points of convergence than divergence in the views of the two types of groups.

Perceptions of how receptive GPs are to mental health PPEI varied from receptive (but don't use the same language to describe their activities) through receptive in principle (but not always able to put into practice) to not receptive.

Many participants reported that GPs often don't ask about or explore mental health problems because it is considered too difficult and time consuming, or they do not feel confident about their skills. Given that the majority of people with a mental health problem visit a GP as a first point of contact, this perceived readiness not to investigate mental health problems raises the issue of whose responsibility mental health is, and warrants further exploration.

There was consistent agreement across the focus groups that GPs should be aware of mental health issues, with training beginning in medical school, and at the very least able to detect and refer appropriately. Similarly, there was agreement that consumers and carers should be involved in a future agenda for mental health in general practice.

Barriers

Several of the barriers to mental health PPEI identified by the GPs are similar to those identified in the survey of Divisions (ie funding and remuneration inadequacies, the time required to do PPEI work, and a lack of resources to direct work in PPEI). The GPs identified additional barriers that reflect their experience in everyday practice in relation to patients (stigma around mental health problems), other professionals (access to allied health services) and bureaucracy (initiatives that don't fit well with the realities of their work).

Progressing the mental health and PPEI agenda

Participants in the GP focus groups put forward recommendations for progressing the mental health PPEI and general practice agenda. A range of themes emerged, including: increased funding and remuneration; sustainability; education and training; evidence-based information; tailored resources; improved access to allied health care; consumer involvement; liaison with GPs; and support of existing structures.

Recommendations

The recommendations that were proposed in the scoping study, particularly in the focus groups with GPs, were discussed and refined at the stakeholder workshop. From these, Auseinet and ADGP have identified three areas that can be advanced in the next phase of the work. The collaboration will continue and both parties have an ongoing commitment, and Auseinet has some existing funds, to progress these recommendations. However, to implement them fully, additional funding and sponsorship will need to be sought. This will be a priority in the immediate future.

Recommendation 1: Evidence-based information and resources

Many professionals working in the general practice setting need to be persuaded about the benefits of mental health PPEI. While the evidence base is growing steadily, it is not necessarily reaching the general practice audience. The enthusiasm for mental health PPEI which was identified in the scoping study may be strengthened if the evidence is collated and disseminated to target general practice audiences in a format that is useful to them.

Recommendation 1.1: Identify priority areas in which evidence-based information is needed and the target groups for whom the information will be prepared.

Recommendation 1.2: Commission individuals or groups to collate the information in a format that is useful to the target groups.

Recommendation 1.3: Disseminate the information to the target general practice audience.

Recommendation 2: Education and training of the general practice and allied health workforce

Improved education and training of the workforce was identified in the scoping study as an area of need. The evidence-based information prepared under Recommendation 1 will form the basis for a comprehensive education and training program for general practitioners and allied health professionals.

Recommendation 2.1: Develop and implement a comprehensive training program in mental health PPEI for general practitioners and allied health professionals.

Recommendation 2.2: Conduct a scoping study of undergraduate medical education courses and relevant postgraduate medical programs to identify mental health PPEI content.

Recommendation 3: Partnerships and referral pathways

Referral pathways that take multidisciplinary approaches, and promote shared care and joint action across sectors, are required. General practitioners need improved access to appropriate psychological consultation, treatment and advice in order to better understand and support people at risk, within a preventive frame. Equally, at the systemic level, there needs to be improved communication and collaboration between general practice, government and non-government organisations and specialist providers (in particular, child and adolescent mental health services).

Recommendation 3.1: Develop partnerships within the general practice setting.

Recommendation 3.2: Develop more effective partnerships between the general practice community and government and non-government organizations.

Recommendation 3.3: Develop partnerships with child and adolescent mental health service providers.

Future directions

The scoping study has identified a base of mental health PPEI activity in the general practice setting upon which to build. The partnership between Auseinet and ADGP reflects the recent convergence of mental health and general practice policy directions. The partnership will continue and work in the next period will focus on implementing (or influencing policy around) the recommendations arising from this report. Other areas of interest include exploring a shared language for mental health PPEI in general practice and increasing the involvement of consumers, carers and allied health professionals in mental health PPEI.

1. Background

Rationale

It is well established that the burden of mental health problems and mental disorders is high. Depression is predicted to be one of the major health problems worldwide by 2020 (Murray & Lopez, 1996). The Australian National Survey of Mental Health and Wellbeing of Adults found that in the year prior to the survey almost one in five adults had a mental disorder, and approximately 3% experienced severe mental illness (Australian Bureau of Statistics, 1997). The child and adolescent component of the National Survey (Sawyer, Arney, Baghurst et al., 2000) reported that 14% of children and adolescents were affected by a mental health problem.

The majority of adults (62%) with a mental health problem do not seek any professional help. Of the 38% who do, three quarters visit a general practitioner (GP) as a first point of contact (Australian Bureau of Statistics, 1997). GPs and other primary care service providers therefore deliver the bulk of initial mental health care by direct treatment, shared care, or referral to other health professionals. In 2000-01, almost 11 million visits to GPs in Australia were for mental health conditions (Australian Divisions of General Practice, 2003). Mental health problems accounted for more than 7% of all problems managed by GPs in 2001-02, with 32% of these related to depression and 15% to anxiety (Britt, Miller, Charles et al., 2002). Many problems are left undetected. While almost half of all people attending general practice have a self-reported mental disorder, only 44% of adults are given a psychological diagnosis, and rates are even lower for young people (Hickie, Davenport & Scott, 2001).

People living with low prevalence disorders also access general practice services on a regular basis. For example, Jablensky, McGrath, Herrman et al. (1999) found that 81% of people living with a psychotic illness made contact with a GP on average 12 times per year, and 7% of them were averaging one visit per week (the visits were not always for mental health reasons, but their frequency indicates that GPs are well placed to have a role in identification and ongoing care).

The National Action Plan for Promotion, Prevention and Early Intervention 2000 (Commonwealth Department of Health and Aged Care, 2000a) identifies general practice as an important setting for promotion, prevention and early intervention (PPEI) activities for mental health. It is vital that GPs are at least able to recognise the signs of mental health problems (Commonwealth Department of Health and Aged Care, 2000b). *The National Action Plan for Depression* (Commonwealth Department of Health and Aged Care, 2000c) acknowledges the critical role of primary health care professionals not only in recognising but also in preventing and treating depression. There is some evidence that even with minimal training GPs are able to screen effectively for mental disorders (Prince & Phelan, 1994). However, detection rates for depression (one of the most common mental disorders) have been found to vary from 25% to 75% (Brown & Schulberg, 1998).

From a general practice perspective, 'mental health' cannot really be considered as separate from 'physical health'. People often present mental health problems as physical rather than psychological symptoms. Furthermore, people with chronic medical conditions are more likely to have a comorbid mental health disorder and, similarly, mental health disorders are a risk factor for physical disease (Davies, 2000).

GPs are now considered to have an established track record in prevention and early identification in physical health areas. While they were traditionally known as treaters of illness, in the 1990s a strong sense of health promotion developed in general practice, in line with mainstream health ideology. Examples include awareness and prevention in the areas of sexually transmitted diseases, drug and alcohol problems, as well as screening and monitoring for conditions such as cardiovascular disease, asthma and cancer. Expertise in promotion of mental health and prevention of mental illness is developing. However, compared to physical health, it tends to be more ad-hoc than systematic.

Objectives of the scoping study

Mental health PPEI in General Practice has been on the agenda of the National Mental Health Promotion and Prevention Working Party (PPWP) for some time. The PPWP is committed to ensuring that health care providers are equipped to provide effective PPEI interventions for mental health and to develop partnerships within other relevant settings. Options for progressing work in this area have included implementing specific, evidence based programs such as Positive Parenting Program (Triple P) and Keep Yourself Alive (KYA). However, it was considered important to first explore how mental health PPEI could be integrated into existing practices.

Conducting a scoping study to document current mental health PPEI activities in general practice was seen as a logical first step in informing future work. The study is therefore intended to be a first look at mental health PPEI activities in the general practice setting. We have taken a broad view of 'the general practice setting' to include persepctives from the Divisions of General Practice, as well as some GPs and consumers. This report is not a definitive statement, rather it provides a picture of current activities and informs recommendations and future directions. The study had several objectives:

1. To identify key mental health PPEI interventions/initiatives that are relevant to General Practice and where possible to identify good practice initiatives.

This involved examining the literature on mental health PPEI in General Practice and identifying good practice interventions/programs where possible.

2. To document current mental health PPEI activities in General Practice in Australia and identify barriers to and opportunities for mental health PPEI practice in General Practice.

This included a Survey of Divisions of General Practice as well as focus groups with consumers and carers, Divisional Mental Health Officers and general practitioners.

3. To identify priorities for action in progressing mental health PPEI in General Practice, giving consideration to the ways that any new work will best fit with existing frameworks/programs.

A small workshop was conducted with key stakeholders to discuss the findings from the scoping study and to develop recommendations for a mental health PPEI agenda in general practice.

2. The conceptual framework

The spectrum of interventions for mental health

The spectrum of interventions for mental health shown in Figure 1 provides the conceptual framework that underpins mental health PPEI in current mental health documents, such as the *The National Action Plan 2000* (Commonwealth Department of Health and Aged Care, 2000a) and the *National Mental Health Plan 2003-2008* (Australian Health Ministers, 2003). These documents (which are described further in the next chapter) consistently identify general practice as an important setting for mental health PPEI. As the language of PPEI derives from the mental health sector, it may be unfamiliar to the general practice sector. In this section, with a view to moving towards a shared understanding, we have applied the language of mental health PPEI to activities that can occur in the general practice setting.

Mental health promotion applies across the entire spectrum of interventions, such that health promoting activities can occur equally with people showing no signs of illness and those with a long standing illness. Prevention and early intervention for mental health cover the earlier sections of the continuum.

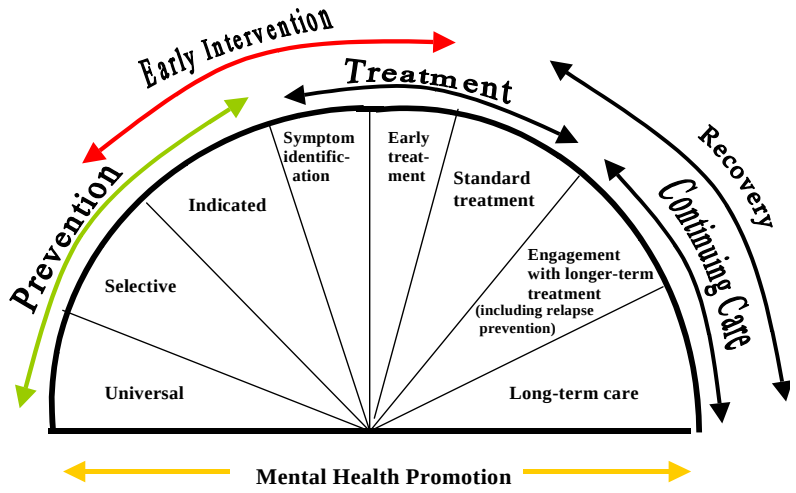

Figure 1. The spectrum of interventions for mental health (adapted from Mrazek & Haggerty, 1994)

Universal interventions are aimed at the whole population, regardless of individual risk factors. Examples include prenatal care and mental health promotion programs that are conducted in schools. *Selected interventions* focus on individuals or groups who are considered to have a higher than average risk of developing mental health problems. Examples include support for children who have a parent with a mental disorder, bereavement support groups, and support for people experiencing physical illness. *Indicated interventions* are aimed at individuals who are showing early signs of a mental health problem, but do not meet diagnostic criteria for a disorder. Examples include parenting programs for parents of children showing some signs of behavioural problems. *Symptom identification* involves

identifying individuals who have clear symptoms that meet the diagnostic criteria for a mental health problem or disorder. *Early treatment* means providing treatment early in the course of a disorder so there is minimum disruption to other aspects of the person's life (eg school, work, relationships).

Examples in the general practice setting

The definitions of promotion, prevention and early intervention for mental health shown in Table 1 are adapted from the *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health* (Commonwealth Department of Health and Aged Care, 2000). To accompany the definitions (and again to move towards a shares understanding) we have presented some examples of how mental health PPEI can occur in the general practice setting.

Table 1. Definitions and examples of mental health PPEI in general practice

Definition	Examples of activities in the Divisions of General Practice	Examples of activities by general practitioners
Promotion Action taken to maximise mental health and wellbeing in populations and individuals (whole spectrum)	➢ Educating GPs about factors that promote mental health ➢ Working with the community to improve mental health literacy, reduce stigma and promote quality of life ➢ Supporting mental health promotion programs	➢ Knowledge of factors that promote mental health ➢ Providing mental health promotion information (eg pamphlets in waiting room or personally during consultation) ➢ Linking with schools or the community to improve mental health literacy, reduce stigma and promote positive mental health
Prevention Interventions that occur before the onset of a disorder, to prevent its development (universal, selected, indicated)	➢ Educating GPs about risk and protective factors for mental health ➢ Informing the community about the impact of adverse life events on mental health ➢ Supporting evidence-based parenting, suicide or other prevention programs ➢ Implementing prevention programs in collaboration with other sectors	➢ Knowledge of risk and protective factors for mental health and illness ➢ Eliciting information about potential risk and protective factors ➢ Knowledge of and/or training in effective prevention strategies ➢ Implementing prevention programs ➢ Appropriately referring if not trained or not able to implement programs
Early intervention With individuals displaying early signs and symptoms or experiencing a first episode of disorder (indicated, symptom identification, early treatment)	➢ Educating GPs and the community about early warning signs and symptoms of mental health problems or disorders ➢ Effective early treatments for mental health disorders (eg depression, psychosis) ➢ Shared care plans or developing referral mechanisms ➢ Facilitating access to services ➢ Supporting and implementing early intervention programs	➢ Knowledge of early warning signs and symptoms of mental health problems or disorders ➢ Eliciting information about early warning signs and symptoms ➢ Implementing effective early treatments for mental health disorders ➢ Appropriately referring if not trained or not able to implement treatments

3. The context

Mental health and general practice policy

Primary mental health care is a relatively recent policy development, with significant government investment and policy priority really only occurring in the last five years. Prior to the mid to late 1990s, there was nothing that resembled a national framework for a primary mental health care system in Australia. Many Divisions of General Practice were still maturing and mental health activity throughout Divisions and general practice occurred via isolated projects, which were often time-limited with no ongoing funding certainty.

The importance of general practice as a setting for mental health has since been recognised in major policy documents in both the mental health and the general practice arenas. Not surprisingly, both agendas have points of convergence. More recently, PPEI for mental health has become firmly embedded in national mental health policy and increasingly is being incorporated into general practice documents.

Mental health

The National Mental Health Strategy

The National Mental Health Strategy, agreed upon by all Australian Health Ministers in 1992, was the first attempt to coordinate national mental health care reform. It comprised three documents:

- *Mental Health Statement of Rights and Responsibilities* (Australian Health Ministers, 1991);
- *National Mental Health Policy* (Australian Health Ministers, 1992a); and
- *National Mental Health Plan* (Australian Health Ministers, 1992b).

The first *National Mental Health Plan* (1993-1998) (Australian Health Ministers, 1992b) largely focussed on severe and disabling low prevalence disorders and on the shift from institutional care to community care. Imperatives at the time centred on reforming the specialist public mental health system and addressing stigma and discrimination. Other concerns included consumer rights, the relationship between mental health services and other sectors (eg the general health sector), legislation, research and evaluation, and monitoring and accountability.

Under the *Second National Mental Health Plan* (1998-2003) (Australian Health Ministers, 1998) there was a change in policy orientation to a broader focus, emphasizing population health issues and interventions and the inclusion of high prevalence illnesses. There was a concern for mental health promotion, illness prevention and early intervention in the wider community, as well as the development of partnerships in service reform. For the first time, primary care, and general practice in particular, was recognised by Health Ministers as a key setting for the prevention, early intervention and treatment of mental illness.

The *National Mental Health Plan 2003-2008* (Australian Health Ministers, 2003) continues the population health framework. It builds on the priorities of the previous two plans and identifies four new priority themes: promoting mental health and preventing mental health problems and issues; increasing service responsiveness; strenghtening quality; and fostering research, innovation and sustainability.

As in the previous plan, general practice is specifically identified as one of many important settings for mental health PPEI. References to general practice include: the GP's unique role in providing for physical and mental health needs and therefore in being aware of the potential impact of one on the other; systemic barriers to accessing GPs that need to be addressed (eg maldistribution of the workforce, reductions in bulk-billing, support for mental health care); and the need to strengthen links between general practice and specialist mental health services.

National Action Plan for Promotion, Prevention and Early Intervention for Mental Health

The focus of the *Second National Mental Health Plan* saw the development of two key documents specifically focussing on mental health PPEI: the *National Action Plan for Promotion, Prevention and Early Intervention 2000* and its accompanying *Monograph* (Commonwealth Department of Health and Aged Care, 2000a;b). Both are invaluable sources of information about current approaches to mental health PPEI in Australia. The *Action Plan* summarises opportunities for mental health PPEI for 15 priority groups including: age groups across the lifespan; other priority populations (individuals, families and communities experiencing adverse life events, rural and remote communities, Aboriginal peoples and Torres Strait Islanders, and people from diverse cultural and linguistic backgrounds); and key strategic priority groups (consumers and carers, media, and health professionals and clinicians). The importance of the general practice setting, and its pivotal role in advancing mental health PPEI, are woven through the documents.

General practice

About 95 per cent of GPs are members of a local Division of General Practice, the first of which were established in 1992. ADGP, the peak national body representing the Divisions of General Practice across Australia, was established in 1998 to provide leadership and support for the Divisions to achieve quality and vitality in primary health care. The Divisions network is a key part of local health infrastructure and therefore well placed to support mental health PPEI activities.

Building mental health capacity and skills in general practice and within relevant programs run by Divisions of General Practice (such as drug and alcohol, mental health and youth health) has been a progressive process – a process of 'evolution not revolution'. Recent developments in the Divisions of General Practice Network have either elevated mental health PPEI on the general practice agenda or provided the platform through which mental health PPEI can be better explored and undertaken in the general practice setting. Two particular initiatives that are a fusion of general practice and mental health policy have spearheaded primary mental health care developments: the *National Primary Mental Health Care Initiative* and the *Better Outcomes in Mental Health Care Initiative* (see www.adgp.com.au/).

National Primary Mental Health Care Initiative

The *National Primary Mental Health Care Initiative* was funded in June 1999 and continues to be funded today. The initiative's main task is to promote and encourage quality primary mental health care through education and training and other capacity building strategies. The initiative comprises the National Coordinator based at the Australian Divisions of General Practice (ADGP), Mental Health Development and Liaison Officers (DLOs) in each State Based Organisation of General Practice (SBO) and the Primary Mental Health Care Australian Resource Centre (PARC) based at the Department of General Practice, Flinders University. The initiative included two phases of National Primary Mental Health Incentive funding. The first round sponsored a number of capacity building projects in Divisions and the second was dedicated to peer support initiatives.

The initiative has provided key mental health infrastructure at the national and state levels (previously lacking in the Divisions Network) and now represents a body of considerable expertise in primary mental health care. The initiative plays a key role in:

- leading and supporting change;
- promoting mental health through national and state-wide conferences and forums, newsletters, regular seminars for Divisional mental health program officers, and other communication strategies;
- promoting innovation, systems linkage and integration, and shared care. These have occurred through partnerships, networks, and sustainable relationships between stakeholders, Divisions, State and Commonwealth governments, non-government organisations and community organisations. Strategies have included the development of Memorandums of Understanding or service agreements, GP liaison positions, and service directories;
- supporting primary mental health care reform through the roll-out out of the *Better Outcomes in Mental Health Care Initiative*, peer support programs in mental health, and skills-based education and training (including in areas of particular need such as parenting); and
- influencing policy and practice through participation and representation on state and national committees.

Better Outcomes in Mental Health Care Initiative

GPs are not always comfortable, nor do they always have the skills, to deliver mental health care. The *Better Outcomes in Mental Health Care Initiative*, introduced in the 2001-02 Federal Budget, offers a *system* of mental health care. The initiative was developed to address the key support issues raised by GPs over many years. These include the need for relevant training, access to specialist support and improved remuneration for the time spent on mental health consultations. The key components of the initiative are:

- education and training for GPs, to familiarise them with the initiative and to increase their mental health skills;
- the 3 Step Mental Health Process, where remuneration is provided to encourage effective management of mental health problems by GPs through a process that includes an assessment, a mental health plan and a review;
- Focussed Psychological Strategies (FPS), to encourage appropriately trained GPs to use evidence based focussed psychological strategies, through the provision of Medicare Benefits Schedule (MBS) rebates;
- Access to Allied Health Services, to enable GPs to access psychological and other allied health services to support people with mental health disorders; and

- Access to Psychiatrist Support, to better enable psychiatrists and GPs to participate in case conferencing and for psychiatrists to provide advice to GPs in urgent situations.

Better Outcomes represents a major change for general practice. Uptake nationally within the first year has exceeded all expectations. Almost one in seven GPs nationally is registered. Participation is almost as high as one in four in some States, such as Western Australia. The allied health component has been a particular drawcard for GPs who have found better access to allied health support has resulted in improved clinical outcomes for patients and improved management in the primary care setting. Access to allied health services under *Better Outcomes* presently covers 76 Divisions of General Practice with 100 per cent uptake envisaged by 2004-05.

Future directions in general practice

While the Divisions Network continues to evolve, contemporary discussion about the future of general practice, and Divisions of General Practice in particular, contemplates examples of future opportunities for general practice and Divisions in dealing with issues such as the ageing population and increasing chronic and complex needs. These include a strengthened primary care focus, incorporating a focus on prevention and early intervention, and community participation, understanding and taking into account the social determinants of health (Australian Divisions of General Practice, 2002).

*A Vision for Divisions of General Practice to 2007 (*Australian Divisions of General Practice, 2002), a futures paper produced by the ADGP in consultation with Australia's network of Divisions of General Practice, refers to the expanding role of general practice. Among other things, it envisages a broadened health management role for general practice, providing the settings for teams of multi-disciplinary providers such as practice nurses and allied health professionals to deliver comprehensive health services, including health promotion and prevention of illness.

In the primary mental health arena more specifically, a number of forums (*Youth In Mind 2002* and the *Primary Mental Health Care Symposium 2003*) and vision documents (*ADGP Mental Health Policy Statement 2003:* Australian Divisions of General Practice, 2003) identify mental health PPEI as a future priority.

Similarly, the Australian Government's report of the review of the role of Divisions, *The Future Role of the Divisions Network* (Commonwealth of Australia, 2003), suggests that the primary health care needs of communities should be the main purpose of the Divisions network and the reason Divisions should support general practice. This requires a strong community orientation, a multidisciplinary approach, collaboration within the primary health care sector and with other sectors, and an appropriate balance between health promotion, disease prevention and treatment issues (Commonwealth of Australia, 2003). The report acknowledges, however, the current variation across the network between Divisions who concentrate on their role of helping GPs with their businesses and patients, and those that take a broader perspective working to address the primary health care needs of their communities.

Recent policy developments in the mental health arena have translated into support for the *MindMatters Plus GP Initiative*. The initiative is an extension of the secondary school based initiatives, *MindMatters* and *MindMatters Plus*. It is preventive in nature and the first national scale mental health PPEI project in the general practice setting. The MindMatters suite of initiatives is described later in this chapter under 'evidence-based programs and guidelines'.

Key mental health and general practice reports

Several other reports from the mental health and the general practice arenas have informed the planning and/or interpretation of the scoping study. Relevant findings have been extracted selectively from the reports and are summarised briefly here.

A Population Health Model for the Provision of Mental Health Care (Raphael, 2000)

The population health model acknowledges that complex social factors contribute to the health and ill health of all people across the lifespan. It accommodates promotion, prevention and early intervention (as well as treatment) approaches to mental health. The model is applied to the three levels of mental health care: primary care, which ideally is accessible to most people in the community; secondary or specialist care; and tertiary care for more complex needs. The author argues that because most people will come into contact with the primary health care sector, it has the potential to cover the full spectrum of interventions and therefore have a positive impact on general and mental health. Professionals working at all levels of care will need education and training to develop their knowledge and skills about risk and protective factors. In the primary care sector, GPs and allied professionals will need to be supported to develop skills in PPEI for mental health, and to appropriately treat or refer people affected by mental disorders.

Out of Hospital, Out of Mind!: A Review of Mental Health Services in Australia - 2003. (Groom, Hickie, & Davenport, 2003).

The authors of this important and timely report consider that mental health services are failing in many respects. These include restricted access to services, variable quality, poor continuity and lack of support for recovery from illness. Their national review process included face-to-face consultations with 60 GPs across Australia. The GPs felt that they had an important role to play in the early detection of mental health disorders, but identified several barriers to involvement. These included the need for further education and training, better access to specialist support and expansion of item numbers to allow them to spend more time with patients with mental health problems. They generally considered that the *Better Outcomes in Mental Health Care Initiative* has been successful in improving some aspects of primary health care as it provides training in psychological strategies and access to allied health professionals. However, they also reported that improved access to training, specialist advice and other forms of support, along with stronger partnerships between health professionals, were needed.

Mental Health Shared Care in Australia 2001 (Holmwood, Groom & Nicholson, 2001)

This is a review of the status of service integration between general practice and specialist mental health services in Australia. The authors surveyed 70 of the then 123 Divisions of General Practice that were identified in the Directory of Divisions as having mental health as a major area of program activity (the remaining Divisions were not contacted in order to minimise demands on their time). The authors found evidence that those Divisions involved in mental health shared care programs were shifting towards a higher level of engagement with mental health services. Approximately half of all Divisions were involved in shared care or partnerships activity with mental health services, and about one third of those had formal shared care arrangements. Half of all programs involved consumers and carers at either planning, management or implementation level. Recommendation arising from the report include: ongoing, collaborative educational activities; closer collaboration between GPs and

the mental health sector; development of service agreements, care pathways and guidelines; evaluation of shared care programs; and continued funding to support the ongoing development of partnerships between the Divisions of General Practice and mental health services.

Ten Years On: Results of the 2001-2002 Annual Survey of Divisions of General Practice (Modra, Whaites & Kalucy, 2003)

The Annual Survey of Divisions of General Practice seeks information from all Divisions on the entire range of activities in which they are engaged, of which mental health is a small part. In the 2001-2002 survey, over 95% of Divisions were active in mental health. The main activity was GP education, but many Divisions were also involved in practice support, community awareness and patient services. Mental health activities were provided to groups across the lifespan, though mostly the Divisions reported that their activities were not directed at any group in particular. Half of the Divisions were involved in mental health shared care programs. About 40% of the Divisions involved consumers when developing their mental health programs. Note that the Annual Survey asks about 'mental health' in the broadest sense, whereas the current scoping study asks specifically and in more detail about 'mental health PPEI' activities.

General Practice Activity in Australia 2001-02 (Britt, Miller, Charles et al. 2002).

Where the Survey of Divisions of General Practice (above) examines activities within the Divisions, this ongoing series of reports examines activities carried out by GPs in their everyday practices. The report presents data recorded by each of 983 GPs on 100 consecutive patient encounters. Information that is recorded includes the characteristics of the patient, reason for the encounter, problems managed, type of management (including non-pharmacological), and referrals. Depression was the fourth most common problem managed (3.4 per 100 encounters) after hypertension, upper respiratory tract infections, and immunisation/vaccination. Anti-depressants were the sixth most commonly prescribed of all medications. Psychological counselling accounted for 6% of all non-pharmacological treatments. About half of contacts for depression and half of contacts for anxiety were managed with a clinical treatment (advice, education, counselling) and most were not prescribed medication. Depression accounted for almost 5% and anxiety for 2% of all referrals to allied health services. This comprehensive report provides a context for mental health activities within the broader general practice agenda (the results that are relevant to mental health service delivery are summarised succinctly by Australian Institute of Health and Welfare, 2003).

Evidence-based programs and guidelines

The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 (Commonwealth Department of Health and Aged Care, 2000a) identifies evidence-based mental health PPEI programs where possible for a range of age and special population groups. The evidence base for mental health PPEI has grown rapidly in the last decade. However, it needs to be developed further, especially for some age groups (eg young adults) and special population groups (people living in rural and remote areas, people from diverse cultural and linguistic backgrounds, and Aboriginal and Torres Strait Islanders) (Commonwealth Department of Health and Aged Care, 2000a).

Some mental health PPEI programs and guidelines that are relevant to the general practice setting are described here. This is by no means an exhaustive list. Furthermore, it should be noted that formalised programs and guidelines are only one approach to mental health PPEI. In the general practice setting, mental health PPEI can be explicitly implemented or it can be integrated into more general mental health and shared care strategies.

Triple P - Positive Parenting Program

The Triple P-Positive Parenting Program is a behavioural family intervention program that aims to enhance family protective factors and to reduce risk factors associated with severe behavioural and emotional problems in preadolescent children. It has five levels of intervention on a tiered continuum of increasing strength (Sanders, 2003). Randomised controlled efficacy trials over a 20 year period have established that behavioural family intervention is effective in reducing conduct and other clinical problems in children (see Sanders, Turner & Markie-Dadds, 2002). Sanders and colleagues have developed a primary care version of Triple P and conducted training programs for GPs (Sanders, Tully, Turner et al., 2003; Sanders, Murphy-Brennan & McAuliffe, 2003). The brief, focussed training course is associated with significant improvements in practitioner consultation skills and increased satisfaction with consultations. For further information see the Triple P website www.triplep.net/.

Keep Yourself Alive

Keep Yourself Alive (Martin, Clark, Beckinsale et al., 1997) is a multimodal, adult education resource to help GPs and community health professionals to deal more effectively with young people who have depressive or suicidal thoughts. The program seeks to change attitudes toward suicidal behaviours, increase knowledge about mental illness in young people, and improve skills at working with young people. The modules are:

1. Recognising the signs and assessing young people
2. Crisis intervention (What do I do?)
3. Therapies (What do I do next?)
4. Postvention (Picking up the pieces).

The resource has been evaluated for GPs (Beckinsale, Martin & Clark, 1999). Further information about *Keep Yourself Alive* can be found on the Auseinet website http://auseinet.flinders.edu.au/suiprev/resources/kya.php

Mindmatters suite of initiatives

MindMatters is a national program that uses a whole school approach to mental health promotion and suicide prevention. It helps secondary schools and their communities (including teachers, parents and students) to create a climate of mental as well as physical health. *MindMatters Plus* is designed to assist students with high support needs by undertaking activities that strengthen life skills and resilience, develop supportive environments; and encourage partnerships between school and community services. *MindMatters Plus GP* is a demonstration project which originally involved 17 Divisions of General Practice across Australia, and has recently been funded to extend to other interested Divisions. The initiative aims to bring schools and the primary health care sector together to develop better referral pathways and networks of care for secondary students with high support needs in the area of mental health and well-being. It will also identify priorities for future national action in terms of school/community and primary care interface. For further information see http://cms.curriculum.edu.au/mindmatters//about/about.htm.

SPHERE

SPHERE was established by Hickie and colleagues to improve the ability of GPs to recognise and manage common mental disorders (depression, anxiety, somatoform disorders). It is a collaborative project between psychiatrists, psychologists and GPs. The project provides GPs with access to training, education and practice support and has four components:

- a clinical practice audit
- an initial 12-hour training program
- a 12-month disease management program
- ongoing education and practice support (Hickie, Scott, Ricci et al., 1998).

For further information see the SPHERE website www.spheregp.com.au, the beyondblue website www.beyondblue.org.au and the *Medical Journal of Australia* (2001, Vol 75 Supplement).

Early Psychosis Prevention and Intervention Centre (EPPIC)

EPPIC is a comprehensive model of care developed by McGorry and colleagues for young people aged 15 to 24 years. It focusses on the early detection and treatment of emergent psychosis. The early intervention approach aims to shorten the course and decrease the severity of the initial psychotic episode, in order to limit damage to personal identity, social networks and role functioning (McGorry, Edwards, Mihalopolous et al., 1996, p311). The service also aims to reduce the probability, frequency and severity of relapse and support the young person through recovery. The EPPIC group has developed two sets of guidelines for the management of early psychosis (see below). For further information see the EPPIC website http://www.eppic.org.au/

Guidelines

Depression in Young People: Clinical Practice Guidelines (National Health and Medical Research Council, 1997b).

Depression in Young People: A Guide for General Practitioners (National Health and Medical Research Council, 1997a).

The Australian Clinical Guidelines for Psychosis (EPPIC, 1997).

The Early Diagnosis and Management of Psychosis: A Booklet for General Practitioners (Orygen Youth Health, 2002)

Guidelines for Prevention Activities in General Practice (Royal Australian College of General Practitioners, 2002).

Putting Prevention into Practice: A Guide for the Implementation of Prevention in the General Practice Setting. (Royal Australian College of General Practitioners, 1998).

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has produced guidelinesfor a range of mental health problems and disorders (schizophrenia, self harm, anorexia nervosa, panic disorder, bipolar disorder). While the guidelines are predominantly treatment focussed, many have elements of PPEI approaches. Information about the guidelines can be obtained from the College's website http://www.ranzcp.org/.

Auseinet has produced an edited series entitled *'Clinical Approaches to Early Intervention in Child and Adolescent Mental Health'* for a range of health professionals, including GPs. The volumes can be downloaded from the Auseinet website www.auseinet.com:

- Attention deficit hyperactivity disorder in preschool aged children (Hazell, 2000)
- Early intervention for anxiety disorders in children and adolescents (Dadds, Seinen, Roth & Harnett, 2000)
- Early intervention in conduct problems in children (Sanders, Gooley & Nicholson, 2000)
- The perinatal period: Early interventions for mental health (Kowalenko, Barnett, Fowler & Matthey, 2000)
- The psychological adjustment of children with chronic conditions (Swanston, Williams & Nunn, 2000).

4. Method

Project team

The Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) and the Australian Divisions of General Practice (ADGP) worked in partnership to conduct the scoping study of mental health PPEI activities in the General Practice setting.

Auseinet is a national project funded by the Australian Government Department of Health and Ageing to support the development and implementation of initiatives and activities that address mental health promotion and the prevention of and early intervention in mental disorder.

Australia's network of Divisions of General Practice is a key part of local health infrastructure and is also well placed to implement community-based strategies that promote mental health and prevent mental health problems. Its work is grounded in primary health care and public health principles such as inter-sectoral collaboration, integration of health services and consumer and community participation. Divisions are uniquely placed to promote mental health literacy and awareness at the local level and to collaborate with schools, other community groups and health service providers on mental health PPEI activities.

A Reference Group was established to provide advice and direction to the methodology and outcomes of the scoping project, and to provide information about activities in mental health promotion, prevention and early intervention in the General Practice setting from their particular stakeholder perspective. The Reference Group comprised representatives from a range of key stakeholders groups with interests in the area of mental health promotion, prevention and early intervention in the General Practice setting:

- ADGP;
- Auseinet;
- Australian College of Psychological Medicine;
- Australian Government Department of Health and Ageing;
- Mental Health Council of Australia;
- Mental Health Development and Liaison Officer's Network;
- National Mental Health Promotion and Prevention Working Party (PPWP);
- Primary Mental Health Care Australian Resource Centre (PARC);
- Royal Australian and New Zealand College of Psychiatrists; and
- Royal Australian College of General Practitioners.

Survey of Divisions

Survey construction

The Survey of Divisions of General Practice is shown in Appendix 1. The survey was developed through consultation with the Project Reference Group, a consumer and carer advisory group, the Development and Liaison Officers of ADGP, and mental health officers based in Divisions of General Practice.

As the concepts and terminology of mental health PPEI were likely to be unfamiliar to many of the respondents, a highly structured and signposted survey was constructed. It was prefaced by an information sheet that defined mental health PPEI and provided examples of activities in the general practice setting. These examples were reinforced throughout the survey. While separate information was sought on promotion, prevention and early intervention activities, it is acknowledged that this is an artificial delineation, as many activities and programs have elements of one or more types of activity.

The general format of the survey was modelled on the Annual Survey of Divisions of General Practice (Modra et al., 2003). The Annual Survey is designed to elicit detailed information on the entire range of Divisional activities (of which mental health is a small part). It provides a useful structure for gathering information about activities in a variety of settings, and with different age groups and special population groups.

The Primary Care Version of the ICD-10 (World Health Organization, 1996) and the *National Action Plan 2000* (Commonwealth Department of Health and Aged Care, 2000a) guided the selection of the mental health problems and disorders that were included in the survey. The delineation of age groups and special population groups is drawn from the framework of the *National Action Plan 2000* (Commonwealth Department of Health and Aged Care, 2000a). The listing of other health professionals is based on those outlined in the *National Practice Standards for the Mental Health Workforce* (National Mental Health Education and Training Advisory Group, 2002). Questions about the involvement of consumers and carers in Divisional activities were developed from discussions with the South Australian Consumer Advisory Group and the Project Reference Group (particularly the consumer representative).

The Survey of Divisions had quantitative and qualitative components. Respondents were asked to check boxes if their Division was involved in the various mental health PPEI activities that were presented in the survey. They also had the opportunity to identify other activities and to enter open-ended comments throughout the survey. The survey had separate sections to elicit information on:

- mental health promotion in a range of settings and population groups;
- prevention of mental illness activities in a range of settings and population groups;
- early intervention activities in a range of settings and population groups;
- perceived barriers to mental health PPEI;
- consumer and carer involvement in Divisional activities;
- workforce development for Divisional staff and GPs;
- other health professionals' involvement in mental health PPEI; and
- PPEI activities occurring in mental health Shared Care and More Allied Health Services programs.

Procedure

Divisions of General Practice were alerted by email to the Survey of Divisions in the week preceding its distribution. They were sent a document that defined mental health PPEI and presented practical examples of PPEI in the general practice setting, and a second document that contained information about the mental health PPEI and General Practice project. The Survey of Divisions was circulated via email in late June 2003 with an initial three week return time. Two extensions were offered and the final survey was accepted in late August 2003.

As Divisions that are more active in mental health PPEI may have been more likely to respond to the survey, further information was sought from non-respondents. In September 2003, Divisions that did not respond to the survey were sent a one page question sheet asking if they do any mental health PPEI activities and why they did not respond to the survey.

Focus groups

Focus groups were conducted with consumers and carers, Divisional Mental Health Officers and GPs to provide an additional source of information about mental health PPEI activities in the general practice setting. Each group was given a standard brief introduction to mental health PPEI, which included a description of the spectrum of interventions for mental health (Mrazek & Haggerty, 1994), examples of mental health PPEI in the general practice setting, and an overview of the scoping project. Data were recorded via notes as the focus groups were not taped. Two project team members recorded independent notes for all but one of the GP focus groups.

Consumers and carers

The mental health consumers and carers focus group was linked to a meeting of the South Australian Consumer Advisory Group in May 2003. It was scheduled as the first of the focus groups as it was considered important to seek guidance on questions and issues to include in the subsequent GP focus groups, and to hear personal experiences with mental health PPEI in the general practice setting. Six consumers and one psychiatrist participated.

Mental health officers

Focus groups were held with 14 Divisional Mental Health Officers in Adelaide in April 2003 and with a further six in Perth in June 2003. The purpose was to seek views on mental health PPEI in general practice and also to gather feedback on the content, format and timeframe of the Survey of Divisions.

General practitioners

Five GP focus groups were held between May and August 2003. It was considered important to canvas views from GPs with varying interests in mental health. Participants in the first two of the GP focus groups shown in Table 2 were actively involved in mental health in general practice and were therefore familiar with current trends in mental health. The Fellows of the Australian College of Psychological Medicine are a specialised group with a high level of expertise in primary mental health care. All have higher qualifications in psychology related fields. The GP Mental Health Reference Group is comprised of experts who provide specialist

advice and direction to the General Practice Divisions of Victoria. Participants in the final three focus groups had experience with mental health issues in their everyday practice, but most did not have a declared interest in mental health.

Table 2. Focus groups with general practitioners

Date	Location	Participants	n
May 2003	Adelaide	Fellows of the Australian College of Psychological Medicine	7
June 2003	Melbourne	GP Mental Health Reference Group of the General Practice Divisions of Victoria	8
June 2003	Perth	GPs from suburban practices not specialising in mental health	5
Aug 2003	Adelaide	" "	7
Aug 2003	Adelaide	" "	6
		Total	**33**

A semi-structured interview schedule was used to guide the GP focus group discussions (see Appendix 2). The format and order were flexible to suit each group and to maximise the flow of ideas. All of the sessions began with a brief presentation to define mental health PPEI and provide practical examples in the general practice setting. The following broad topics were then addressed:

- Prior familiarity with mental health PPEI;
- Perceived receptivity of GPs to mental health PPEI;
- Mental health PPEI approaches used by GPs in everyday practice;
- Consumer and carer involvement;
- Models of mental health PPEI in general practice;
- Barriers to and opportunities for mental health PPEI; and
- Recommendations for shaping the future mental health PPEI and general practice agenda.

Stakeholder workshop

A stakeholder workshop was held in November 2003 in Brisbane to precede the annual Divisions of General Practice Network Forum. The purpose of the workshop was to present the preliminary results of the scoping study for discussion and to refine the draft recommendations.

There were twenty four participants, including GPs, psychiatrists, consumers, carers, mental health program coordinators, DLOs, Divisions representatives, government department representatives, project Reference Group members and the project team.

The draft recommendations were grouped into three overarching themes: evidence-based information; education and training; and partnerships. Participants self-selected into one of the groups and discussed the recommendations, revised them as necessary and identified how each could be implemented, in what settings, and with whom. They were also invited to propose additional recommendations.

5. Results

Survey of Divisions

Survey returns

Surveys were returned by 71 of the 121 Divisions of General Practice, yielding a 59% response rate. Overall, there is a good representation of urban and rural Divisions across the states and territories (see Table 3). The percentage of urban (47%) and rural (53%) Divisions in the sample precisely matches the Divisions Network. Rural Victorian Divisions are slightly over-represented, and NSW rural and SA urban Divisions are slightly under-represented.

Table 3. Surveys returned by urban and rural Divisions in each state or territory

State/	Urban			Rural			Total		
territory	Divs	Ret	%	Divs	Ret	%	Divs	Ret	%
NSW	20	**11**	*55*	17	**6**	*35*	37	**17**	*46*
Vic	17	**10**	*59*	13	**11**	*85*	30	**21**	*70*
Qld	8	**6**	*75*	12	**6**	*50*	20	**12**	*60*
SA	4	**1**	*25*	10	**6**	*60*	14	**7**	*50*
WA	6	**4**	*66*	8	**5**	*63*	14	**9**	*64*
Tas	0	**0**	-	3	**3**	*100*	3	**3**	*100*
NT	0	**0**	-	2	**1**	*50*	2	**1**	*50*
ACT	1	**1**	*100*	0	**0**	-	1	**1**	*100*
Total	**56**	**33**	***59***	**65**	**38**	***58***	**121**	**71**	***59***

Divs = total number of Divisions in the network; Ret = number of Divisions that returned a survey

Respondent characteristics

Respondents had been in their position for 25.4 months on average (sd = 23.9, range one month to six years). Forty percent had been employed in the position for less than 12 months. They were employed to work on mental health on average 0.77FTE (sd = 0.29, range 0.08 to 1.00). Half were employed full time. The majority of respondents were project officers or project coordinators (see Table 4) and most had a professional background in psychology, social work or nursing (see Table 5).

Table 4. Respondent's position in the Division

Position in Division	n	%
Project Officer	29	*40.9*
Program Coordinator	17	*23.9*
Program Manager	13	*18.3*
Executive Officer / Manager	6	*8.5*
Practitioner	5	*7.0*
Not specified	1	*1.4*
Total	**71**	***100***

Table 5. Respondent's professional background

Professional background	n	%
Psychology / social work	20	*28.2*
Nursing	17	*23.9*
Public health / health promotion	9	*12.7*
Medicine / medical science	7	*9.9*
Business / administration	6	*8.5*
Allied health	5	*7.0*
Education	4	*5.6*
Other	3	*4.2*
Total	**71**	***100***

Non-respondent characteristics

Divisions that did not respond to the survey were sent a brief (one page) question sheet asking if they do any mental health PPEI activities and why they didn't respond to the full survey. Question sheet were returned by five urban and ten rural Divisions from New South Wales (n=6), Queensland (n=4), Victoria (n=2) and Western Australia (n=1).

Reasons for not returning the full survey included 'too many demands on time' (n=7), 'not enough staff' (n=3) and 'survey too long' (n=2). Six respondents volunteered other reasons for not returning the survey and these included: 'mental health officer had finished in the position'; 'a new mental health officer had just started'; 'didn't receive the survey'; 'had partially completed and overlooked'; and 'too hard to quantify figures'.

On average, 14.7% of total Divisional activities were mental health related (sd = 9.4, range 5 to 40%), and of these activities 39.1% included PPEI (sd = 37.3, range 3 to 100%). The majority of the Divisions reported being involved in mental health promotion (86.7%), prevention (73.3%) or early intervention (86.7%). These rates are roughly similar to those reported by Divisions that returned the full survey (see below).

Capacity for mental health activities in the Divisions

An average of 2.5 people were employed by their Division to work on mental health activities (ie not PPEI specifically), and an average 1.4 Full Time Equivalent (FTE) was devoted to mental health (see Table 6). Over half of the Divisions employed fewer than two people and 60% of the Divisions devoted less than 1 FTE to mental health. Urban Divisions employed fewer mental health staff (mean = 1.7, sd = 0.8) than the rural Divisions (mean = 3.2, sd = 2.7, t = -2.9, p<.001), and devoted less FTE to mental health activities (mean = 0.8 , sd = 0.6 vs mean = 1.8, sd = 1.7, t = -2.9, p<.001). There were no differences between urban and rural Divisions on the other indices of capacity shown in Table 6.

Table 6. Indices of capacity for mental health activities in the Divisions

Indices of capacity	n responses	Mean	sd	Range
Staff employed for MH activities	70	2.5	2.2	1 – 12
Total FTE devoted to MH activities	67	1.4	1.4	.05 - 7.0
How receptive are Divisional staff to MH PPEI?	69	3.7	0.6	1(not) - 4 (very)
How receptive are GPs to PPEI?	69	3.2	0.6	1(not) - 4 (very)
Div activities that are MH (%)	55	16.2	11.4	0.30% - 55%
MH activities that are PPEI (%)	57	50.2	35.9	1% - 100%

MH=mental health; FTE=Full Time Equivalent, where 1.0 is full time

Perceived receptivity to mental health PPEI of Divisional staff and GPs linked to the Division were measured on separate four-point scales of 1 (not at all receptive) to 4 (very receptive). Respondents perceived that Divisional staff were more receptive to mental health PPEI than were GPs (t = 7.1, p<.001).

Estimates of the percentage of total Divisional activities that are mental health related ranged from 0.30% to 55%, (mean = 16.2, sd = 11.4), and half of the Divisions estimated less than 10%. Of these mental health activities, about half were considered to include PPEI elements, but again there was a very broad range of responses (1% to 100%). Therefore, the mental health PPEI activities reported in the survey represent on average 8% of total Divisional activities.

Overview of mental health PPEI activities

The survey was structured to elicit separate information on promotion, prevention and early intervention for mental health. In each of three separate sections, respondents were first asked the broad question of whether their Division is involved in that type of activity (promotion, prevention or early intervention). If yes, they proceeded to answer more detailed questions about their activities, including the setting for activity, and the age groups and special population groups that the content of the activity addressed. The detailed results are presented in subsequent sections of this report.

The majority of Divisions that returned a survey are involved in at least some type of promotion (81.7% of Divisions), prevention (87.1%) or early intervention (91.5%) activity (see Figure 2). Forty nine (69%) of the Divisions were involved in all three types of activities, while only one reported that they did not do any promotion or prevention or early intervention work. There were no differences between urban and rural Divisions in the extent of their mental health PPEI activities.

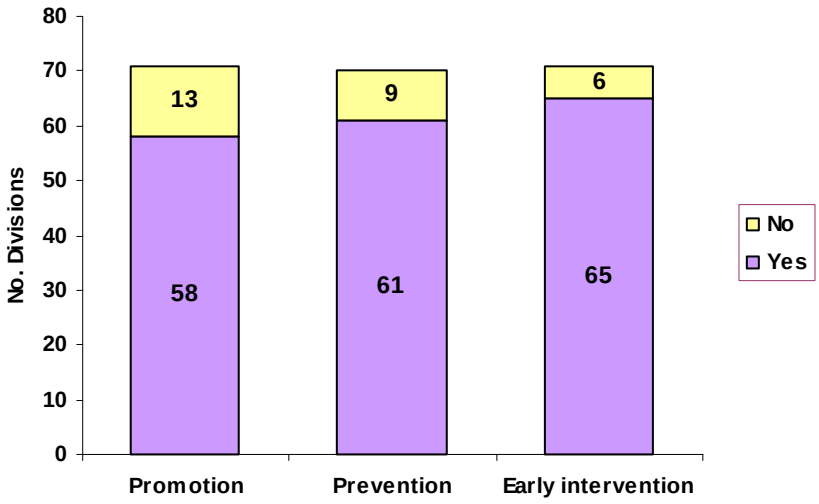

Figure 2. Number of Divisions involved in promotion, prevention or early intervention activities for mental health

Respondents whose Divisions were not involved in promotion, prevention or early intervention activities for mental health were asked to indicate how they could be involved in future. Responses included allocating more funds and time, incorporating mental health PPEI into continuing professional development sessions, organising GP speaker programs and developing materials for GPs. Several Divisions indicated that they were considering or were in the process of planning future mental health PPEI activities. These included a focus group on how prevention could be incorporated into GP education activities, development of relationships between GPs and mental health services, involvement in MindMatters Plus, and seminars for GPs on prevention of and early intervention in postnatal depression.

Mental health promotion

Settings

The 58 Divisions that are involved in mental health promotion activities provided more detailed information about the settings for their activities. Several types of activities were presented to them: education about mental health promotion; increasing mental health literacy; reducing stigma; and promoting quality of life (QOL). Respondents could check multiple settings for each activity. Responses are shown in Figure 3. For each of these activities, the Divisions indicated that most of their work focussed on education for GPs (which is expected as it is part of their core business), followed by community liaison and school liaison.

Other settings for mental health promotion identified by respondents included counselling services (peer support groups, individual client education), media, youth workshops, practice staff education, Mental Health Week Committee and consumer groups meetings.

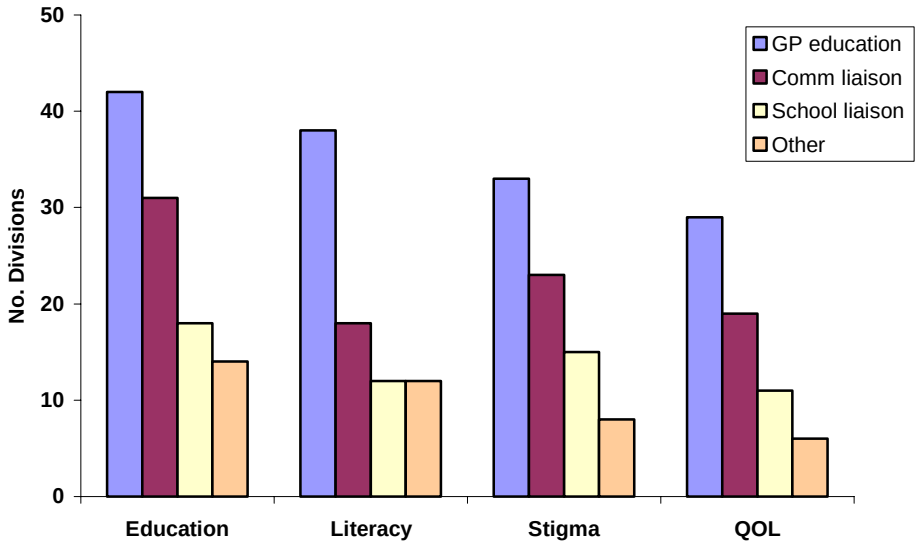

Figure 3. Mental health promotion activities in a range of settings

Age groups

Respondents could choose multiple categories to indicate the age groups that the content of their health promotion activity addressed (see Table 7). Most indicated that the mental health promotion activities in which their Division were involved did not focus on any particular age group, or focussed on the portion of the lifespan ranging from young people (12-17 years) through to older adults (65+ years).

Table 7. Age groups that the content of the mental health promotion activities addresses

Type of activity	No specific age group		Infants (0-2yrs)		Children (3-11)		Young people (12-17)		Young adults (18-25)		Adults (26-64)		Older adults (65+)	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Education re mental health promotion	26	*44.8*	2	*3.4*	7	*12.1*	23	*39.7*	15	*25.9*	16	*27.6*	15	*25.9*
Increasing mental health literacy	29	*50.0*	2	*3.4*	4	*6.9*	15	*25.9*	13	*22.4*	13	*22.4*	12	*20.7*
Reducing stigma	27	*46.5*	2	*3.4*	3	*5.2*	18	*31.0*	11	*19.0*	13	*22.4*	10	*17.2*
Promoting quality of life	26	*44.9*	3	*5.2*	4	*6.9*	17	*29.3*	10	*17.2*	11	*19.0*	11	*19.0*

Special population groups

While most of the mental health promotion activities did not have a specific focus, a substantial number of Divisions reported activities that addressed the needs of rural and remote communities, Aborigines and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds (see Table 8).

Table 8. Special population groups that the content of the mental health promotion activities addresses

Type of activity	No specific group		Aborigines & Torres Strait Islanders		Rural & remote communities		Culturally & linguistically diverse backgrounds	
	n	%	n	%	n	%	n	%
Education re mental health promotion	32	*55.2*	10	*17.2*	16	*27.6*	9	*15.5*
Increasing mental health literacy	29	*50.0*	6	*10.3*	10	*17.2*	7	*12.1*
Reducing stigma	27	*46.6*	10	*17.2*	15	*25.9*	7	*12.1*
Promoting quality of life	26	*44.9*	6	*10.3*	13	*22.4*	7	*12.1*

Specific programs

Thirty eight of the 58 Divisions provided further information about the specific mental health promotion programs that are used within their Division (see Table 9). They identified a total of 56 programs (average 1.5 programs each). Eleven reported that no specific mental health programs were used. Twelve were involved in MindMatters (mental health promotion program for secondary schools) and twelve used Triple P (parenting program).

Table 9. Mental health promotion programs used in the Divisions

Program	*n*	Program	*n*
No programs used	*11*		
Triple P	*12*	Collaborations	*3*
MindMatters	*12*	Allied Health Pilot	*3*
'BOMHCi' *	*4*	Education for GPs	*4*
Other specific programs (Suicide prevention, PriMeD, Changing Tracks, Gatekeeper, Signals, beyondblue, Postnatal Depression, Fit for Life, Taking Stress out of Primary Care, GP Peer Support Program)	*10*	Other education programs (Sexual health, Adolescent Heatlh, Health Access Workshops, Aboriginal MH Program-Remote, Community, Schools)	*6*

*BOMHCI = program supported under the *Better Outcomes in Mental Health Care Initiative.* Respondents did not specify which program.

Prevention of mental illness

Settings

The sixty one Divisions that are involved in prevention of mental illness activities provided further detail about the types of activities and their settings. Several activities were presented to them: education about risk and protective factors; encouraging help seeking behaviour; suicide prevention programs; and effective parenting programs. Respondents could choose multiple settings. As for promotion activities, for each of the activities the bulk of the work centres around education programs for GPs, followed by practice support and school and community liaison (see Figure 4).

Other settings for prevention activities identified by respondents included Aboriginal Community Group meetings, mental health services, service provider networks, practice meetings, counselling for individual clients and youth workshops.

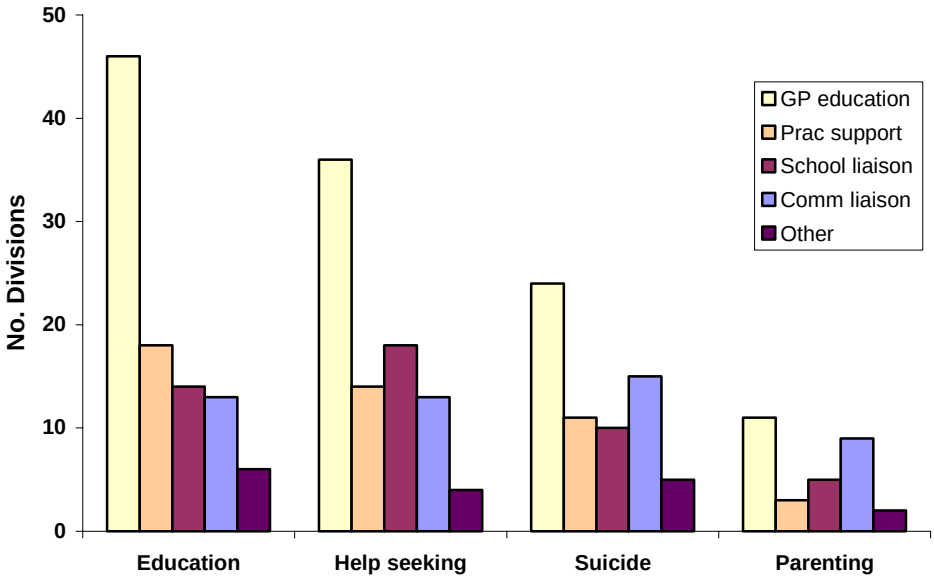

Figure 4. Prevention of mental illness activities in a range of settings

Age groups

Respondents could choose multiple categories to indicate the age groups that the content of their prevention activity addressed (see Table 10). Most indicated that prevention activities in which their Division were involved did not focus on any particular age group, or focussed on young people (12-17 years) and young adults (18-25 years).

Table 10. Age groups that the content of the prevention of mental illness activities addresses

Type of activity	No specific age group		Infants (0-2yrs)		Children (3-11)		Young people (12-17)		Young adults (18-25)		Adults (26-64)		Older adults (65+)	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Education re risk & protective factors	26	*42.6*	2	*3.3*	6	*9.8*	21	*34.4*	20	*32.8*	17	*27.9*	12	*19.7*
Encouraging help seeking behaviour	22	*36.1*	1	*1.6*	3	*4.9*	22	*36.1*	15	*24.6*	12	*19.7*	9	*14.7*
Suicide prevention programs	19	*31.1*	1	*1.6*	2	*3.3*	15	*24.6*	16	*26.2*	10	*16.4*	5	*8.2*
Effective parenting programs	8	*13.1*	3	*4.9*	7	*11.5*	7	*11.5*	7	*11.5*	7	*11.5*	3	*4.9*

Special population groups

While most of the prevention activities did not have a specific focus, a substantial number of Divisions reported activities that addressed the needs of rural and remote communities. Fewer activities addressed the needs of Aborigines and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds (see Table 11).

Table 11. Special population groups that the content of the prevention of mental illness activities addresses

Type of activity	No specific group		Aborigines & Torres Strait Islanders		Rural & remote communities		Culturally & linguistically diverse backgrounds	
	n	%	n	%	n	%	n	%
Education re risk & protective factors	37	*60.7*	8	*13.1*	14	*23.0*	5	*8.2*
Encouraging help seeking behaviour	33	*54.1*	9	*14.7*	15	*24.6*	4	*6.6*
Suicide prevention programs	20	*32.8*	6	*9.8*	11	*18.0*	2	*3.3*
Effective parenting programs	16	*26.2*	3	*4.9*	7	*11.5*	1	*1.6*

Specific programs

Thirty seven of the 61 Divisions provided further information about the specific prevention programs that are used within their Division (see Table 12). They identified 58 programs in total (average 1.6 programs each). Twelve reported that no specific prevention programs were used.

Table 12. Prevention of mental illness programs used in the Divisions

Program	*n*	Program	*n*
No programs used	*12*		
Triple P	*11*	Collaborations	*3*
MindMatters	*10*	Allied Health Pilot	*2*
'BOMHCi' *	*9*	Education for GPs	*5*
Other specific programs (Fit for Life, Extend a Hand, Turning Point, Taking Stress out of Primary Care, Safe Party project, Friends, PriMeD)	*8*	Other education programs (Sexual Health, Youth Health Access workshop, GPs in Schools, GP-school liaison, Aboriginal MH Program, Adolescent Health, own educational activities eg art therapy, conflict resolution, leadership training)	*8*

*BOMHCI = program supported under the *Better Outcomes in Mental Health Care Initiative.* Respondents did not specify which program.

Early intervention

Settings

Sixty five Divisions are involved in early intervention activities for mental health. Respondents were presented with a list of disorders: anxiety; depression (including postnatal); behaviour problems (including ADHD and conduct disorder); drug and alcohol use disorders; psychotic disorders; comorbidity and suicidal behaviour. For most of the disorders, most of the Divisions facilitate education for GPs on detection of signs and early treatment, and many have a role in providing brief interventions (as shown in Figure 5).

Other settings for early intervention work identified by the respondents included shared care mechanisms, partnership with an Aboriginal Health Service and a suicide prevention steering committee. Five respondents indicated that their Division conducted early intervention activity related to disorders other than those presented in the survey; these were borderline personality disorder, dementia, eating disorders (2) and grief reaction.

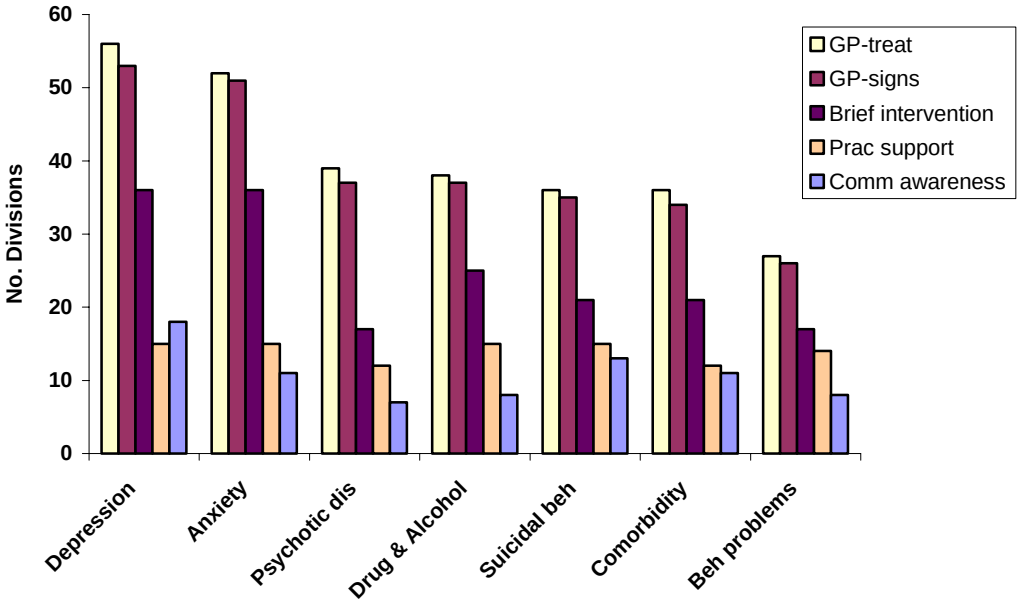

Figure 5. Early intervention activities in a range of settings

Age groups

Respondents could choose multiple categories to indicate the age groups that the content of their early intervention activity addressed (see Table 13). Most indicated that early intervention activities in which their Division were involved did not focus on any particular age group, or focussed on young people, young adults or adults.

Table 13. Age groups that the content of the early intervention activities addresses

Type of activity	No specific age group		Infants (0-2yrs)		Children (3-11)		Young people (12-17)		Young adults (18-25)		Adults (26-64)		Older adults (65+)	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Anxiety	49	*75.4*	1	*1.5*	1	*1.5*	9	*13.9*	12	*18.4*	13	*20.0*	9	*13.9*
Depression (inc. postnatal)	49	*75.4*	2	*3.1*	1	*1.5*	10	*15.4*	14	*21.5*	14	*21.5*	10	*15.4*
Behavioural disorders*	26	*40.0*	1	*1.5*	10	*15.3*	8	*12.3*	6	*9.2*	3	*4.6*	2	*3.1*
Drug & alcohol use disorders	38	*58.5*	6	*9.2*	1	*1.5*	10	*15.4*	12	*18.5*	12	*18.5*	6	*9.2*
Psychotic disorders	32	*49.2*	6	*9.2*	6	*9.2*	8	*12.3*	12	*18.5*	12	*18.5*	5	*7.7*
Comorbidity	35	*53.8*	6	*9.2*	7	*10.8*	10	*15.4*	10	*15.4*	11	*16.9*	7	*10.8*
Suicidal behaviour	31	*47.7*	1	*1.5*	-	-	12	*18.5*	12	*18.5*	9	*13.8*	4	*6.1*

*including ADHD and Conduct Disorder

Special population groups

While most of the early intervention activities did not have a specific focus, a substantial number of Divisions reported activities that addressed the needs of rural and remote communities. Fewer activities addressed the needs of Aborigines and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds (see Table 14).

Table 14. Special population groups that the content of the early intervention activities addresses

Type of activity	No specific group		Aborigines & Torres Strait Islanders		Rural & remote communities		Culturally & linguistically diverse backgrounds	
	n	%	n	%	n	%	n	%
Anxiety	41	*63.1*	12	*18.5*	21	*32.3*	10	*15.4*
Depression (inc. postnatal)	39	*60.0*	12	*18.5*	21	*32.3*	11	*16.9*
Behavioural disorders*	24	*36.9*	8	*12.3*	13	*20.0*	6	*9.2*
Drug & alcohol use disorders	30	*46.1*	12	*18.5*	19	*29.2*	8	*12.3*
Psychotic disorders	30	*46.1*	9	*13.8*	16	*24.6*	8	*12.3*
Comorbidity	25	*38.5*	10	*15.4*	16	*24.6*	9	*13.8*
Suicidal behaviour	29	*44.6*	9	*13.8*	15	*23.1*	7	*10.8*

*including ADHD and Conduct Disorder

Specific programs

Forty one of the 65 Divisions provided further information about the specific early intervention programs that are used within their Division (see Table 15). They identified 46 programs in total (average 1.1 programs each). Nine reported that no specific prevention programs were used.

Table 15. Early intervention programs used in the Divisions

Program	*n*	Program	*n*
No programs used	*9*		
'BOMHCi'	*13*	Education	*4*
MAHS/ Shared Care	*10*	Aboriginal Mental Health Program, Family therapy for GPs; SexualHealth, GP practicums	
Triple P	*3*	Collaborations	*5*
Other specific programs (Healthy Minds, Signals, Gatekeeper, Fit for Life, Taking Stress out of Primary Care, own designed programs)	*5*	Disorder specific programs (Early intervention in Psychosis, Conduct Disorder, ADHD collaborative model of intervention management, postnatal depression, suicidal behaviour)	*6*

*BOMHCI = program supported under the *Better Outcomes in Mental Health Care Initiative.* Respondents did not specify which program.

Barriers and solutions

Respondents were invited to list up to five barriers to incorporating PPEI approaches to mental health in their Division, and also to list solutions to those barriers. Thematic categories were derived from the data. The barriers and solutions, and the total number of times mentioned, are shown in Table 16. For each theme, some examples of barriers and solutions identified by the respondents are shown (the lists are not exhaustive and are not matched).

Table 16. Barriers to PPEI for mental health and solutions

Barrier	(times mentioned and examples)	Solutions (times mentioned and examples)
GP factors	*(n=38)* • lack of time • negative attitudes • disinterest	*(n=15)* • education about the effectiveness of PPEI programs • marketing to 'sell our product' more effectively • encourage GPs to network with local mental health services • identify GPs interested in PPEI to 'spread the word' • identify leaders / champions for PPEI • establish GP peer groups
Funding	*(n=20)* • lack • inadequacy • cost of programs	*(n=32)* • funding to match Commonwealth requirements • targeted funding for PPEI programs • specific PPEI grants, scholarships • private funding
Time demands (Divsion staff)	*(n=19)* • workloads • competing demands • networking	*(n=7)* • allocate time for PPEI • incorporate PPEI into existing activities • include PPEI approaches wherever possible
Lack of resources	*(n=13)* • staffing • materials	*(n=13)* • transfer knowledge to new staff • employ staff specifically for PPEI • allocate staff time to PPEI • buy in specialist services • make use of electronic resources • disseminate packages or set materials to GPs and community
Rurality	*(n=11)* • distance • isolation • lack of resources • access to training • access to services • workloads • stigma in community	*(n=8)* • attract psychologists to rural areas during training and after • incentives for relocating to rural areas • remove unnecessary rural/remote classifications • rural professional development events • funding for Outreach programs
Other services	*(n=9)* • communication • relationships • competition for funds	*(n=7)* • persistence and networking • form networks with established organisations • provide funding for collaborations • integrate Divisional education programs
Divisional capacity	*(n=7)* • priorities • obligations • planning cycles • bureaucracy	*(n=3)* • review committee membership • redress / resolve workforce issues • reduce paperwork
Other	*(n=12)* • reaching target group • access to programs • knowing what works • funding by drug companies	*(n=15)* • youth friendly practices • culturally appropriate training programs • assistance / mentoring with writing grant proposals

Fifty six Divisions of the 71 Divisions (78.9%) identified at least one barrier, 24 of those identified three barriers and two identified five barriers. The Divisions identified an average of 2.3 barriers each. Forty nine Divisions (69%) identified at least one solution, 18 of those identified three solutions and one identified five solutions. The respondents identified an average of 1.9 solutions each.

Consumer and carer involvement

Consumers

Thirty seven of the 71 Divisions (52.1%) involved consumers in their mental health PPEI activities (similar for urban and rural Divisions). Only twenty four Divisions recorded the number of consumers involved and responses ranged from 1 to 10 (mean = 3.3, sd = 3.0). The respondents provided information on the formal roles and consultation mechanisms through which consumers are involved, based on the options that were presented to them in the survey (see Table 17). Consumers were mostly involved via formal advisory roles, focus groups and community consultation.

'Other formal roles' identified by respondents included non-voting position on the Board, representation on a regional Mental Health Reference Group, and presentations at Continuing Professional Development sessions. 'Other consultation mechanisms' included Reference Groups, Steering Committees, client feedback and ad hoc input.

Table 17. Roles and mechanisms through which consumers are involved in Divisional activities

Formal roles	n	*%**	*Consultation mechanisms*	n	*%**
Consumer Advisory Board	18	*25.4*	Community surveys	14	*19.7*
Consumer Adviser	15	*21.1*	Focus groups	22	*31.0*
Rep on Division Board	8	*11.3*	Community forums	13	*18.3*
Other	13	*18.3*	Community education	12	*16.9*
			Other	14	*19.7*

* Percentage of total 71 Divisions in the sample

Twenty one of the Divisions that did not currently involve consumers in mental health PPEI activities suggested ways that consumers could be involved in the future. Five were currently developing formal roles for consumers, seven indicated that formal roles could be explored and six indicated that consumers could be involved via consultation mechanisms. Three respondents raised practical issues that needed to be addressed before consumers could meaningfully be involved:

- *"need to clarify exactly what PPEI activities we want to pursue, then liaise with consumers on specific activity, particularly to avoid stigma/negative reaction to activity"*
- *"Struggle with this - have consumer panel at Division but getting feedback can be challenging, and their is a question about how representative they are"*
- *"consumer involvement depends on direction of Mental Health Advisory Committee".*

Carers

Nineteen (26.8%) Divisions reported that they involve carers in their mental health PPEI activities (again similar for urban and rural Divisions). The number of carers, recorded by only ten Divisions, ranged from 1 to 10 (mean = 2.4, sd = 2.8). Formal roles and consultation mechanisms through which carers are involved are outlined in Table 18. 'Other formal roles' that were identified included Mental Health Reference Group, Steering Committee or Working Party membership and Continuing Professional Development presentations to GPs. 'Other consultation mechanisms' included Reference Groups, Steering Committees and liaison with Division program staff.

Table 18. Roles and mechanisms through which carers are involved in Divisional activities

Formal roles	n	*%**	*Consultation mechanisms*	n	%*
Carer Advisory Board	1	*1.4*	Community surveys	2	*2.8*
Carer Adviser	8	*11.3*	Focus groups	5	*7.0*
Rep on Division Board	0	*0*	Community forums	3	*4.2*
Other	8	*11.3*	Community education	0	*0*
			Other	10	*14.1*

* Percentage of total 71 Divisions in the sample

Twenty five of the Divisions that did not currently involve carers in mental health PPEI activities suggested ways that they could be involved in the future. Three were currently developing plans to involve carers, eleven indicated that formal roles could be explored and nine indicated that carers could be involved via consultation mechanisms. Two respondents were not sure how carers could be involved, and one of them commented:

> *"Not sure. Other than being in a high risk group for becoming consumers themselves, I'm not sure how carers would be involved in PPEI activities".*

Workforce development

General practitioners

All but one of the Divisions (98.6%) indicated that they conduct mental health education, training or personal development for GPs. This is expected, as workforce development is part of the core business of the Divisions. An extensive number of activities was recorded (see Table 19). Sixty six of the Divisions listed at least one workforce development activity for GPs, 25 Divisions listed up to four activities and seven of the Divisions indicated that they were involved in as many as six activities for GPs. A total of 191 activities were recorded across the Divisions and of these 167 (87.4%) were considered to have PPEI aspects.

Table 19. Workforce development activities for GPs

n activities listed	n Divisions	n PPEI aspects
1	66	58
2	46	43
3	34	28
4	25	20
5	13	12
6	7	6

Table 20. Workforce development activities for Divisional staff

n activities listed	n Divisions	n PPEI aspects
1	20	17
2	9	6
3	5	4
4	1	1

The types of workforce development activities that have mental health PPEI elements include Continuing Professional Development sessions (prevention, early intervention, treatment of specific disorders, counselling skills, family therapy), Familiarisation Training (under the *Better Outcomes in Mental Health Care Initiative*), Peer Support programs, SPHERE training, and training in specific programs such as Keep Yourself Alive, Positive Parenting Program. Forty five Divisions (63.4%) reported that they conduct activities that focus on the mental health and wellbeing of the GPs themselves.

Division staff

Only 21 (29.6%) of the Divisions reported that they conduct mental health workforce development for Divisional staff. There were similar rates in the urban and rural Divisions. Twenty of these listed at least one activity and five Divisions listed three activities (see Table 20). While the rate of workforce development for Divisional staff is low, it is encouraging that most of the activities that are occurring involve PPEI. Across the Divisions, 35 activities for Divisional staff were listed and the majority of them (80%) were considered to have mental health PPEI aspects.

The types of workforce development activities conducted with Divisional staff that have mental health PPEI elements include conferences, seminars and workshops, team building, network meetings, invitation to all GP training conducted by Division, counselling weekends, mental health training, further study in mental health, and professional mentorship and supervision.

Other health professionals

Respondents were presented with a list of other health professionals (both mental health specialists and health specialists in the community and public health arena) and asked whether they worked with them in any capacity. If so, they were asked to indicate whether the other health professional was involved in promotion, prevention or early intervention activities (see Figure 6).

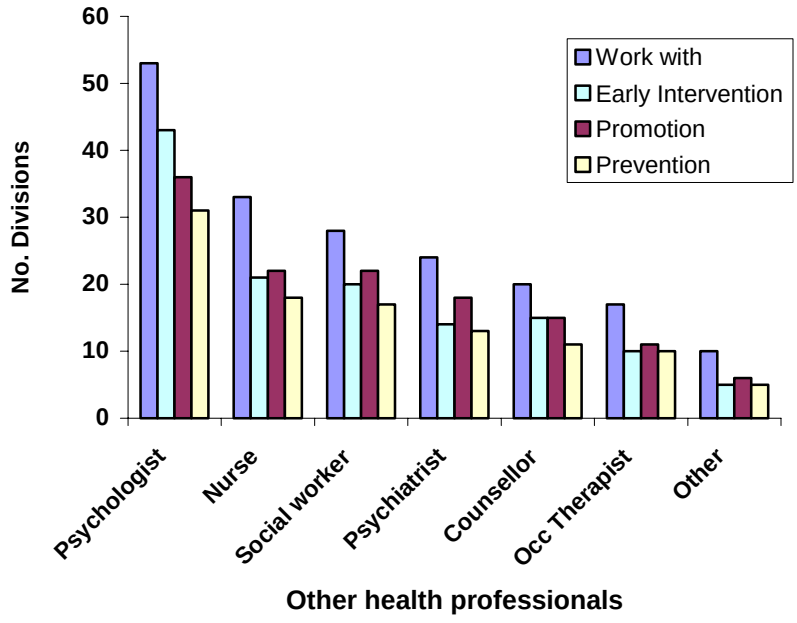

Figure 6. Other health professional involved in mental health PPEI activities

Sixty three (88.7%) of the Divisions indicated that they work with other health professionals, and rural Divisions (97.4%) were more likely than urban Divisions (78.8%) to do so (χ^2 =6.1, p<.05). The majority of work is with psychologists, who are involved in early intervention, promotion and prevention activities for mental health. The few other health professionals that were identified by the respondents included Aboriginal health workers, mental health teams, crisis assessment teams and dietitians.

Mental health PPEI within existing programs

Shared Care programs

Forty of the Divisions (56.3%) are involved in mental health Shared Care programs. There were similar rates in the urban and rural Divisions. Thirty eight Divisions listed at least one Shared Care program and ten listed two programs in which they were involved (see Table 21). A total of 53 Shard Care programs were listed across the Divisions and of these 45 (84.9%) were reported to have PPEI aspects. The shared care activities that were reported to have PPEI aspects included *Better Outcomes in Mental Health Care* training, Pharmacology Prescribing Program, School and GP forums, GP liaison projects, development of care pathways, counselling, and disorder specific programs (eg postnatal depression, suicidal behaviour, eating disorders, chronic diseases).

MAHS programs

Only rural Divisions are eligible for the More Allied Health Services Program. Accordingly, all of the 38 rural (and none of the urban) Divisions reported that they were involved in MAHS programs. Thirty five Divisions listed at least one MAHS program (see Table 22). A total of 46 programs were recorded by the rural Divisions and of these 38 (82.6%) were reported to have PPEI aspects. The types of activities that have PPEI elements include links with child and adolescent mental health services, counselling services, psychologists and other mental health workers, and involvement in indigenous health programs and other projects.

Table 21. Mental health Shared Care programs

n programs listed	n Divisions	n PPEI aspects
1	38	31
2	10	9
3	4	4
4	1	1

Table 22. MAHS programs

n programs listed	n Divisions	n PPEI aspects
1	35	30
2	7	5
3	2	1
4	2	2

Focus groups

Consumers and carers

Consumers considered the GP to be an important point of contact for people experiencing mental health problems. The group identified a range of issues to be considered in the GP focus groups. They were concerned about the shortages of GPs (eg in the Southern regions of Adelaide), recent closures of surgeries and the consequent interruption to ongoing relationships between consumers and GPs. They were also concerned about increasing difficulties in locating GPs who have an interest in mental health care and also bulk bill. They felt that access to such practitioners was difficult because of the growing demands on their services.

Mental health officers

The bulk of the focus group discussions with the Divisional mental health officers in Adelaide and in Perth centred around advice on constructing and administering the Survey of Divisions. Issues identified included:

- divisional staff typically do not conceptualise their activities within a PPEI framework, therefore it is essential to provide concrete examples of mental health PPEI in the general practice setting;
- mental health officers are employed for widely varying fractions of time and have many competing demands on their time, therefore to maximise returns the survey should be kept to a manageable length; and
- results of the survey should be viewed with caution as it is difficult for respondents to provide an accurate picture of mental health PPEI activities in the whole Division.

The mental health officers in Perth were also asked to formulate recommendations for future directions on mental health PPEI in general practice. These included:

- incorporating mental health PPEI into broader health programs;
- allocating adequate funding and resources for mental health generally and for PPEI specifically; and
- providing opportunities for a broad range of training opportunities in mental health PPEI (eg e-learning as well as face-to-face training).

General practitioners

Focus groups were held with two groups of GPs with interests in mental health (n=15) and three groups of GPs with experience in mental health but no specialised interest (n=18). Those with interests in mental health were more familiar with the concepts and terminology of PPEI prior to the focus group, but generally, there are many more points of convergence than divergence in their views. Attributed comments in this section are paraphrases rather than direct quotes (as the data are drawn from notes rather than tape recordings).

Receptivity to mental health PPEI

The participants thought that GPs were mostly receptive to mental heath PPEI. Typically, though, they do not use the terminology of PPEI to describe their work. Some considered mental health care to be integral to all care and, as such, felt that *'GPs must take some responsibility for it'* and that *'general practice is about holistic care – it is misleading to separate mental from physical health'*. One GP commented that *'GPs are not the only ones who need to take a holistic approach – other health professionals can be narrowly focussed too'*.

Others thought that GPs generally have an interest in mental health, as there is a high rate of mental illness in the community and some general health issues clearly have mental health components (eg sleeping problems, new parenthood). One participant commented that *'GPs are better than we think at communication, but need to improve in the area of mental health'*. Participants felt that many GPs are comfortable dealing with the high prevalence disorders (eg depression and anxiety), but are less comfortable with the low prevalence disorders (eg psychotic illness).

However, not all GPs were considered to be receptive to mental health PPEI. One participant commented that *'most GPs recognise the social determinants of and complexity of health, but can't be everything to everyone'*. While GPs *'recognise the symptoms of mental illness reasonably well, they don't necessarily know what to do'*. Other GPs with interest and skills do not have the time to devote to mental health work - those GPs who specialise in mental health are typically in high demand.

Most GPs develop an ongoing relationship with patients and are in a position to pick up early signs, but many are not interested in mental health problems. Others may choose to *'not ask the questions'* or *'not lift the rock'* because of the obligation to pursue the issue further (it was noted, however, that this does not apply only to mental health problems).

Many GPs commented on the time demands of a mental health PPEI approach in the context of many other competing priorities – *'PPEI means actively looking, it takes more time'*. It can be difficult to deal with all issues in a time limited consult, but it is possible to do an initial assessment and schedule another consultation. One participant noted the paradox that a great deal of time is spent treating people with mental illness, but not in detecting the early warning signs that could prevent the onset of illness.

Many mental health promotion activities (eg education in schools, community forums) were seen as relying on the goodwill of individual GPs, but because of the time involved *'the goodwill invariably runs out'*. GPs need to be adequately remunerated if they are expected to take on PPEI activities. One participant commented that many GPs feel that they are *'taking up the slack for unfulfilled government promises of extra support'*.

Consumer and carer involvement

One focus group proposed that consumers and carers should have a role in the development of the future mental health agenda, and another felt that they should be involved to the same extent as GPs and the Divisions of General Practice.

Training in mental health PPEI

All of the focus groups considered that GPs need to know, at the very least, how to recognise mental health problems. Mental health training was seen as a core skill for GPs (and one participant commented *'not only for GPs but for other specialists too'*). Ideally, mental health training should begin in medical school and be integrated with communication skills, but it was acknowledged that it can be difficult to incorporate mental health into a crowded curriculum. Mental health training should then be ongoing through Continuing Professional Development. Some thought it unlikely that all GPs could be trained to treat mental health problems. GPs have the option to deal with mental health problems or refer on, and most work with onsite or sessional allied health professionals. Options are often limited here, for example psychologists are available but can be expensive.

Barriers to mental health PPEI

Barriers to mental health PPEI in general practice were grouped into themes and are summarised in Table 23, accompanied by example comments.

Table 23. Barriers to mental health PPEI in general practice identified in GP focus groups

Barrier	Example comments
Funding constraints	*'Funding is one of the largest barriers to GPs becoming more involved in mental health.'* *'Projects are funded for short time periods – if a project works it should be kept going.'*
Inadequate remuneration	*'Remuneration is not suitable.'* *'Still relying on the goodwill of individual GPs.'*
Time demands to do PPEI work	*'Mental health consults are emotionally draining and time consuming'.* *'Time is a major barrier – GPs work in an environment of being expected to work long hours. They have high patient loads and often little time to focus on mental health problems. General practice is a stressful environment and it is difficult to balance the various needs of patients.'*
Lack of resources to direct work in PPEI	*'Resources are scattered – there is often overlap between projects and no current database – need resource directory.'* *'Need information on local resources and referral pathways. Many GPs don't know what is available in their local area. Some will take the time to keep themselves updated, but information should be easier to access.'*
Access to other health professionals	*'Lack of practice level support for treatment planning and referral pathways.'* *'Lack of continuity - limited access to psychiatrists, especially in rural areas.'* *'Access to services must be timely eg for postnatal depression.'*
Stigma around mental health issues	*'There is stigma in the community around mental health issues. Patients often present with physical symptoms first, then mental health symptoms. Need to make it acceptable to seek help for mental health problems.'* *'Could be a role for GPs in addressing community stigma.'*
Mental health initiatives	*'Initiatives that don't fit'.* *'Better Outcomes for Mental Health Care Initiative has flaws – the GP must be registered for patients to access – third visit follow up is problematic, could combine assessment and initial treatment into first consult.'*

Progressing the mental health PPEI agenda

Participants in the GP focus groups were asked to put forward recommendations for progressing the mental health PPEI and general practice agenda. The recommendations were grouped into the broad themes below (and formed the basis of subsequent discussion and revision at the stakeholder workshop).

Funding and remuneration

- Funding is the underpinning; adequate remuneration is core.
- Better funding for promotional activities (eg in schools and the community).
- Allow longer time for consultations and remunerate appropriately – do not penalise GPs for doing good work.
- Mental health items to reward the complexity of care and time needed.

Sustainability

- Sustainability and momentum can only be achieved through recurrent funding of programs that work.
- Long term structural support is needed – three year funding cycles are too short.

Education and training

- A long term commitment to education over the whole medical spectrum is required. Mental health should be a compulsory component in training for undergraduate, postgraduate and continuing education.
- Involve GPs as part of a team involved in community education to increase mental health literacy.
- Educate mental health specialists (eg psychiatrists and psychologists) to work better with GPs.

Resources

- Support GPs with appropriate resources, advice and skills.
- Develop better immediate (eg online) resources for GPs, including 'detailed, comprehensive, regionalised referral directories'.
- Tailor government documents for GPs: *'a framework is not a guideline – we need clear, tailored, how-to information'*.
- Develop a register of GPs with mental health skills.
- Promote general practice as an accessible resource.
- Acknowledge that GPs are an appropriate referral source – GP skills need to be acknowledged by allied health groups.

Evidence-based information

- If GPs are expected to recognise mental health problems, then an intervention has to exist.
- Need research and guidance for GPs on what early interventions are available in general practice for various disorders (eg eating disorders, early psychosis).
- Programs must be shown to be effective.
- Guidelines and information on what works should be made available to GPs (eg via PARC and the Divisions) – effective dissemination is crucial.

Access to allied health care

- Fund all Divisions to be involved in Allied Health Programs (get away from 'pilots').
- All general practices need to have access to allied health support. Government should supply dedicated on-site staff eg practice nurses, co-located social workers, psychologists.
- Better communication is needed with allied health professionals around referrals – especially for patients without private insurance.

Consumer involvement

- Consumers should have a role in the development of the future mental health agenda.
- Involve consumers and carers to the same extent as GPs and the Divisions.

Liaison with GPs

- Consultation with GPs is needed on any future mental health PPEI agenda.
- Liaise with GPs – be responsive to how they work.

Support of existing structures

- Support existing structures – there is much talent and skill there.
- Nurture and value existing human resources.

Other

- Address bureaucratic barriers such as insurance and public liability.
- Self help and self care for GPs should be considered.

Stakeholder workshop

The recommendations that were proposed in the scoping study, particularly in the focus groups with GPs (above), were grouped to form three main themes:

- evidence-based information and resources;
- education and training; and
- partnerships.

The participants considered the draft recommendations to be relevant to the future direction of mental health PPEI in general practice and identified those that should receive priority. The main discussion points and revisions from the workshop groups are summarised in Appendix 3 as a record of proceedings. The recommendations that Auseinet and ADGP will implement (or influence policy around) are presented in Chapter 7.

6. Discussion

There was a high response rate (almost 60%) for the Survey of Divisions and a good representation of urban and rural Divisions across the states and territories. The response was pleasing given that the survey was long and detailed, and was couched in a conceptual framework that may have been unfamiliar to many of the respondents. Furthermore, the survey was administered during a busy period for the Divisions - it coincided with the end of financial year reports and overlapped somewhat with the Annual Survey of Divisions of General Practice (see Modra et al., 2003).

While the response rate was high, it was unclear whether the results of the survey represent the extent of mental health PPEI activities that are occurring in the Divisions. The Divisions that were more active in mental health PPEI may have been more likely to respond. However, the follow-up of non-respondents indicated rates of promotion, prevention and early intervention activities similar to those reported by respondents to the full survey.

Thirty three GPs were consulted via focus groups, approximately half with and half without a declared interest in mental health. This is a small number of GPs and the opinions expressed may not be representative. The focus groups should be seen as a starting point for more extensive consultation in the future. Again, we point out that this scoping study is not intended to be a definitive statement, but rather it provides a picture of activities and opinions in order to inform recommendations and future directions.

Concrete examples of mental health PPEI in general practice were presented throughout the survey and during the focus groups in an attempt to keep the focus on 'mental health PPEI' specifically rather than 'mental health' more broadly. This was considered to be necessary as general practice has traditionally focussed on treatment and PPEI may present a new or unfamiliar way of thinking about mental health activities. Even with examples of mental health PPEI, the results of the scoping study need to be read with due caution as it may not have been completely possible to elicit responses that apply specifically to PPEI.

Mental health PPEI activities

A very high proportion of the Divisions were involved in some type of promotion (82%), prevention (87%) or early intervention (92%) activity. This equates with the 95% of Divisions reported to be involved in mental health activities, in the broadest sense, in the Annual Survey of Divisions (Modra et al., 2003). Very few differences were identified between the urban and rural Divisions. Rural Divisions employed more people to work on mental health activities and were more likely to work with other health professionals than were the urban Divisions. However, there were similar rates of mental health PPEI activity, consumer and carer involvement, workforce development activities, and involvement in mental health Shared Care programs.

Not surprisingly, given the role of Divisions, most of the work in mental health PPEI centred around education programs for GPs, but was also occurring through community and school liaison. Divisions were involved in mental health promotion activities such as education about mental health promotion, increasing mental health literacy, reducing stigma and promoting quality of life. Prevention of mental illness activities included education about risk and protective factors, encouraging help seeking behaviour, and to a lesser extent, involvement in suicide prevention programs and parenting programs.

Most of the Divisions facilitate education for GPs on early intervention in anxiety and depression (over 70% of the Divisions) as well as a range of other disorders including psychotic disorders, drug and alcohol problems and suicidal behaviour (50% of the Divisions). About one in five of the Divisions is involved in early intervention through brief interventions and practice support.

While the overall rate of mental health PPEI activities was high, Divisions generally reported being more active in early intervention activities than promotion or prevention activities. This may be because of the conceptual proximity of 'early intervention' to 'treatment' on the spectrum of interventions for mental health, and its more obvious applicability to the general practice setting.

Divisions were involved in a broad range of specific mental health PPEI programs, including MindMatters, Triple P and other programs supported under the *Better Outcomes for Mental Health Care Initiative*. There is a great deal of overlap in the programs identified as promotion, prevention or early intervention (see Tables 9, 12 and 15 respectively). This reflects the artificiality of separating PPEI into its component parts; many of the programs contain elements of all (eg Triple P has been developed to address various levels of need).

Most of the mental health PPEI activities did not focus on any particular age group. Where age groups were identified, most of the work addressed the portion of the lifespan from young people through to adulthood. There may be opportunities to take a more focussed, lifespan approach to future mental health PPEI activities in general practice - where it is appropriate and where it will best serve the needs of the people who access services. The conceptual frameworks of the mental health and general practice documents outlined earlier in the report will be useful in shaping this approach and in identifying priority action areas.

Special population groups

Most of the mental health PPEI activities did not focus on any particular special population group. About one in five Divisions was involved in mental health PPEI activities that addressed the needs of rural and remote communities. About one in ten was involved in activities that addressed the needs of Aboriginal peoples and Torres Strait Islanders or people from culturally and linguistically diverse backgrounds. These rates of activity indicate that there is a base of mental health PPEI work upon which to build.

In addition to mental health and general practice policy documents, other recent reports may be useful in guiding activities in these areas. For example, the Transcultural Mental Health Centre recently reported on a GP Shared Care project that aimed to improve partnerships between GPs and mental health services (Herron, 2003). Recommendations arising from the

report include developing a resource guide for GPs and exploring ways to incorporate a transcultural component into existing mental health training programs.

In the 2001-02 Annual Survey of Divisions, one third of Divisions developed at least one of their health programs (but only seven Divisions developed mental health programs) with Aboriginal Community Controlled Health Services (Modra et al., 2003). The Social Health Reference Group (2003) cautions that Aboriginal and Torres Strait Islander people typically access community controlled health services rather than private general practice services, so it is important that mental health activities in the Divisions provide equitable access. They considered collaboration between primary health care and specialist mental health services to be crucial to providing a holistic approach to care for Aboriginal and Torres Strait Islander people.

Barriers and solutions

Four out of five Divisions identified at least one barrier to incorporating mental health PPEI approaches. The barriers covered a broad range of concerns, including funding limitations, time constraints, lack of resources, capacity of the Divisions to undertake PPEI work and issues around working cooperatively with other services in an environment with competing priorities. Rural Divisions also identified barriers relating to distance and isolation, heavy workloads and access to services and training programs. Not all of these barriers apply exclusively to work in mental health PPEI. For example many are similar to the barriers identified in recent reports by Davies (2000), Holmwood (2001) and Groom et al. (2003).

Divisions were given the opportunity to suggest ways in which the various barriers could be overcome. There was a high response rate to this question, with 70% of the Divisions offering at least one solution. Some of the comments were very general (eg increase funding, allocate more time) but many were more considered (eg seek alternative funding sources, identify GP champions for mental health PPEI, ensure transfer of knowledge to new staff, attract allied health professionals to rural areas through incentive schemes, form networks with other established organisations).

Several of the barriers identified in the survey of Divisions were also identified by the GPs in the focus groups (ie remuneration inadequacies, the time required to do PPEI work, and a lack of resources to direct work in PPEI). The GPs identified additional barriers that reflect their experience in everyday practice in relation to patients (stigma around mental health problems), other professionals (access to allied services) and bureaucracy (initiatives that don't fit well with the realities of their work). Many of the barriers and solutions raised in the survey and the focus groups will be addressed in the next phase of work by Auseinet and ADGP.

Consumers and carer involvement

More consumers than carers were involved in mental health PPEI activities in the Divisions. About half of the Divisions involved consumers and a quarter involved carers. Consumers and carers were mostly involved via formal advisory roles and consumers were also involved via community consultation. This is similar to the rate of involvement and the range of roles identified by Holmwood et al. (2001) and slightly higher than the 40% participation rate of consumers in mental health activities identified in the Annual Survey of Divisions (Modra et

al., 2003). About one third of the Divisions that took part in the scoping study suggested ways that consumers and carers could be involved in the future, indicating a willingness to involve consumers and carers and a potential capacity to do so. In the focus groups there was general agreement among the GPs (whether they had a declared interest in mental health or not) that consumers and carers should be involved in a future agenda for mental health in general practice.

Workforce development

The *National Mental Health Plan 2003-2008* (Australian Health Ministers, 2003) acknowledges the critical role of the primary care sector (with its diverse range of health professionals) in providing mental health care in Australia. The Plan focusses in part on improving the attitudes, values, knowledge and skills of the specialist mental health and primary care workforces. All of the Divisions conduct workforce development (ie mental health education, training or professional development) for GPs as part of their core business. Most of the activities (almost 90%) were reported to have mental health PPEI elements to them. Only one third of the Divisions reported workforce development activities for their own staff. While this rate is low, it is encouraging that the majority of those activities were reported to include mental health PPEI. In future, it may be worth exploring the Divisions' capacity to upskill staff (eg by inviting them to attend GP professional development sessions or conducting sessions specifically designed for staff).

National Practice Standards for the Mental Health Workforce (National Mental Health Education and Training Advisory Group, 2002) have been developed for five professional groups involved in delivering mental health care (psychiatry, nursing, social work, psychology and occupational therapy). GPs are recognised as another professional group that could be guided by the standards. The document outlines knowledge, skills and attitudes of health professionals specifically for 'promotion and prevention' and for 'early detection and intervention', and is therefore a useful point of reference in any future workforce development activities in the general practice setting.

There was consistent agreement in the focus groups that all GPs should be aware of mental health issues and at the very least be able to detect and refer appropriately. Their view that training should begin in medical school and continue through postgraduate education and continuing professional development is echoed in the other influential documents (eg Australian Health Ministers, 2003; RACGP & RANZCP, 1997). A recent study explored how well Australian medical schools prepare GPs to care for patients with mental disorders (Sahhar & O'Connor, 2004). The authors reported that while most schools tend to focus on diagnosis and pharmaceutical management of mental health problems, the GPs in the study most commonly applied psychologically oriented treatments. Concerted efforts may be required to incorporate mental health PPEI into the undergraduate medical curriculum.

Other health professionals

Most of the Divisions work with other health professionals. Three quarters work with psychologists, but others include, in descending order, nurses, social workers, psychiatrists and counsellors. Between half and three quarters of the health professionals were reported to be involved in mental health PPEI activities. Almost three in five Divisions (56%) are involved in Shared Care programs. This is roughly consistent with the two thirds of Divisions

reported in the 2001-2002 Annual Survey of Divisions (Modra et al., 2003) and approximately half of Divisions reported by Holmwood et al. (2001). Over 80% of the Shared Care and the MAHS programs reported in the survey were considered to have PPEI aspects. There is therefore considerable potential to build on the capacities and strengths of existing programs.

Receptivity of GPs to mental health PPEI

Perceptions of how receptive GPs are to mental health PPEI varied from receptive (but don't use the same language to describe their activities) through receptive in principle (but not always able to put into practice) to not receptive. Many participants in the focus groups reported that GPs often don't ask about or explore mental health problems because it is considered too difficult and time consuming, or they do not feel confident about their skills. Given that the majority of people with a mental health problem visit a GP as a first point of contact, this perceived readiness not to investigate mental health problems raises the issue of whose responsibility mental health is, and warrants further exploration.

Future directions

The scoping study has identified a base of mental health PPEI activity in the general practice setting upon which to build. The partnership between Auseinet and ADGP reflects the recent convergence of mental health and general practice policy directions. The partnership will continue and work in the next period will focus on implementing (or influencing policy around) the recommendations arising from this report (see Chapter 7). Other areas of interest include exploring a shared language for mental health PPEI in general practice and increasing the involvement of consumers, carers and other health professionals in mental health PPEI.

7. Recommendations

The recommendations that were proposed in the scoping study, particularly in the focus groups with GPs, were discussed and refined at the stakeholder workshop (see Chapter 5: Results and Appendix 3). From these, Auseinet and ADGP have identified three areas that will be advanced in the next phase of the work. The collaboration will continue and both parties have an ongoing commitment, and Auseinet has some existing funds, to progress these recommendations. However, to implement them fully, additional funding and sponsorship will need to be sought. This will be a priority in the immediate future.

The three interrelated key areas that will be developed in the next phase are:
1. collating the evidence base for mental health PPEI in general practice;
2. educating and training the general practice and allied health workforce; and
3. improving partnerships and referral pathways.

For the GPs and other health professionals working in the general practice setting, the respective recommendations will provide: access to resources that are tailored to the general practice setting; skills to identify and treat mental health problems; and improved shared care and referral pathways.

The first two key areas (collating the evidence, and education and training) will be led by Auseinet. Both areas involve clearly defined tasks and therefore have tangible recommendations. The third key area (partnerships and referral pathways) involves systemic change and will be led by ADGP. Some of the recommendations here will inform broader policy and program developments outside Auseinet and/or ADGP's sphere of responsibility, but are essential if mental health PPEI approaches are to be sustained in the general practice setting.

Several principles underpin the recommendations:
- mental health PPEI should be considered as part of the broader health agenda;
- a population health approach should be adopted; and
- Current strengths and activities should be built upon.

A Reference Group of experts in mental health PPEI and general practice will guide the future work in mental health PPEI and General Practice. The Reference Group may include consumers, carers, GPs, mental health professionals, allied health professionals and academics. Members will have specific skills in one or more of the three key areas. In this way, they can contribute to the overall direction of the work, but also form separate working groups as required.

Recommendation 1: Evidence-based information and resources

General Practice has been identified as an important setting for PPEI in mental health policy documents and in primary mental health care policy documents. However, many professionals working in the general practice setting need to be persuaded about the benefits of mental health PPEI. While the evidence base is growing steadily, it is not necessarily reaching the general practice audience. The enthusiasm for mental health PPEI which was identified in the scoping study may be strengthened if the evidence is collated and disseminated to target general practice audiences in a format that is useful to them.

Recommendation 1.1: Identify priority areas in which evidence-based information is needed and the target groups for whom the information will be prepared.

The Reference Group will guide the identification, collation and dissemination of information on mental health PPEI and general practice. The members will:

- suggest priority areas in which information is needed (eg at risk population groups, specific age groups, specific disorders);
- suggest target groups for whom the information will be tailored (eg GPs, staff in Divisions, consumers, carers).
- identify existing literature and other resources on mental health PPEI in the general practice setting; and
- identify expert individuals or groups who could be approached to collate the information.

Recommendation 1.2: Commission individuals or groups to collate the information in a format that is useful to the target groups.

Individuals or groups with expertise in mental health PPEI or General Practice (eg PARC, Departments of General Practice, Divisions of General Practice, consumers, carers, general practitioners) will be commissioned to collate the information for the general practice setting. They will:

- examine the literature in the priority area as it applies to the general practice setting;
- summarise the literature, indicating levels of evidence where possible;
- ask target groups which content and format would be most useful; and
- prepare the information for target groups.

One group may be commissioned to prepare an overview document outlining the rationale for mental health PPEI in general practice, the range of current evidence and some practical examples (eg by extracting information from *National Action Plan 2000* and ADGP documents).

Recommendation 1.3: Disseminate the information to the target general practice audience.

The resources will be disseminated via the methods recommended by the National Health and Medical Research Council (2000). Possible dissemination paths include:

- Divisions of General Practice network and website;
- Auseinet network and website;
- PARC network and website;
- Professional and academic journals; and
- Continuing Professional Development training programs (see Recommendation 2).

Recommendation 2: Education and training of the general practice and allied health workforce

Improved education and training of the workforce was identified in the scoping study as an area of need. The evidence-based information prepared under Recommendation 1 will form the basis for a comprehensive education and training program for general practitioners and allied health professionals.

Recommendation 2.1: Develop and implement a comprehensive training program in mental health PPEI for general practitioners and allied health professionals.

The training program will present an overview of the conceptual framework and principles of mental health PPEI and the evidence base for at risk population groups, specific age groups and specific disorders. It will also identify and overview existing mental health PPEI programs that are relevant to general practice (eg MindMatters Plus, Triple P, Keep Yourself Alive). Modules will explore risk and protective factors, screening, assessment, treatment, and referral pathways.

The training program will evolve in three phases: development, piloting, and implementation. Strategies will include:

- working with the Reference Group to develop the program or modules;
- employing a project officer to write the educational program;
- liaising with appropriate bodies to ensure that the program meets criteria for Quality Assurance and Continuing Professional Development and, where appropriate, accreditation under the *Better Outcomes in Mental Health Care Initiative*;
- determining the most effective method of delivery (or combination of methods, eg face-to-face professional development sessions, online tutorials, CD Rom, video); and
- piloting the training program in conjunction with the Divisions of General Practice, with a view to developing a national implementation program.

Recommendation 2.2: Conduct a scoping study of undergraduate medical education courses and relevant postgraduate medical programs to identify mental health PPEI content.

The training program outlined in Recommendation 2.1 focusses primarily on the existing workforce. We also wish to take preliminary steps towards influencing the future general practice workforce. To determine the mental health knowledge and skills that current medical graduates bring to general practice, mental health PPEI content in undergraduate medical education courses and postgraduate medical programs will be reviewed.

Strategies by which this recommendation could be achieved include:

- surveying undergraduate medical education courses and relevant postgraduate mental health programs to identify mental health PPEI content;
- identifying postgraduate medical programs that currently have mental health content (and PPEI in particular) and those that could benefit from having PPEI content in the future;
- establishing relationships with key university Departments of General Practice; and
- developing a network of interest in mental health PPEI for future curriculum development.

Recommendation 3: Partnerships and referral pathways

Referral pathways that take multidisciplinary approaches, and promote shared care and joint action across sectors, are required. General practitioners need improved access to appropriate psychological consultation, treatment and advice in order to better understand and support people at risk, within a preventive frame. Equally, at the systemic level, there needs to be improved communication and collaboration between general practice, government and non-government organisations and specialist providers (in particular, child and adolescent mental health services).

The high incidence of mental health problems among children and young people is of great concern. There is increasing evidence that mental health PPEI activities, especially those targeting children and young people, are cost effective and yield many social, health and economic gains. This, combined with the fact that recent primary mental health reforms have largely focussed on psychological services for adults, indicates that opportunities for mental health PPEI with children and young people are being missed.

Recommendation 3.1: Develop partnerships within the general practice setting.

The capacity of practice nurses to identify risk factors for mental health problems and early signs and symptoms of mental disorder will be developed. This could be achieved via education, training and other methods focussed on skills development (eg via the training program developed under Recommendation 2.1).

Recommendation 3.2: Develop more effective partnerships between the general practice community and government and non-government organisations.

This could be achieved by:

- Divisions working with relevant non-government organisations to equip practices with improved knowledge of and access to community-based self-help resources and other social supports (eg housing and supported accommodation);
- State-Based Organisations, Divisions of General Practice and Mental Health Services exploring opportunities for collaboration on planning and service delivery at state and local levels; and
- strengthening existing initiatives and referral pathways between general practice and schools working with young people with high support needs in the area of mental health and wellbeing (eg expanding MindMatters Plus GP to include a wider network of schools and Divisions, particularly in high need areas).

Recommendation 3.3: Develop partnerships with child and adolescent mental health service providers.

Strategies by which this could be achieved include:

- consulting with appropriate experts to explore and prepare recommendations for the Better Outcomes Implementation Advisory Group on how the primary mental health care system represented by the *Better Outcomes in Mental Health Care Initiative* can accommodate a PPEI focus, especially for children and adolescents; and
- providing a third phase of National Primary Mental Health Care Incentive funding to Divisions to develop guidelines, other tools (eg referral forms) and service models to promote a coordinated approach to early intervention between general practice and specialist providers, for example child and adolescent mental health services and family therapists.

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Appendix 1. Survey of Divisions

Mental Health Promotion, Prevention and Early Intervention and General Practice

A scoping study by Auseinet and ADGP

SURVEY OF DIVISIONS OF GENERAL PRACTICE

The Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) and the Australian Divisions of General Practice (ADGP) are conducting a scoping study of current activities in promotion, prevention and early intervention (PPEI) for mental health in the General Practice setting in Australia. The project is supported by the National Mental Health Promotion and Prevention Working Party (PPWP).

Why?

Many PPEI for mental health activities are happening in the General Practice setting, but we do not have a clear picture of what the activities are, who is doing them or with whom. This survey aims to:

- identify any activities within the Divisions that have either explicit or implicit mental health PPEI elements;
- identify who is involved in mental health PPEI activities;
- explore how mental health PPEI could be incorporated into existing and future Divisional activities.

Your role

You are participating in this survey on behalf of your Division and will not be individually identified in any reports that arise from this survey.

- Please take the time to complete all sections of the survey. You may wish to consult with other people in your Division to answer some of the questions and this is perfectly acceptable.

- Even if your Division does not currently do any mental health PPEI activities, please work through the survey as it contains questions about how PPEI *could be included in the future.*

- Please focus only on activities that are occurring or supported at the Divisional level. We are conducting separate focus groups with general practitioners to explore PPEI approaches being undertaken by them in their everyday clinical interactions.

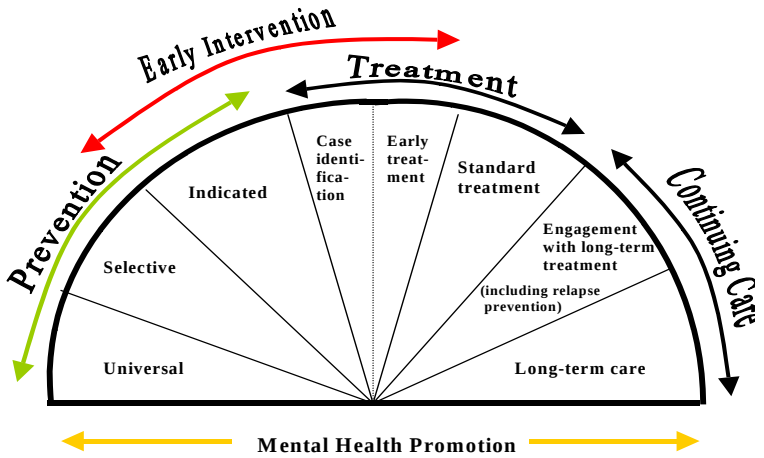
Think laterally!

PPEI for mental health is a relatively new area and possibly requires a new way of thinking. Definitions and examples are shown on the next page and many of the questions in the survey have been structured to guide you in identifying mental health PPEI activities. It is likely that you will be able to identify additional activities and there is space in the survey to record these. It is also likely that mental health PPEI activities may be occurring within existing programs, even if they were not specifically designed for that purpose (eg Education and Professional Development, Shared Care, MAHS), and there is also space for you to record this.

Please COPY THIS SURVEY TO YOUR HARD DRIVE, then complete it electronically. SAVE and KEEP it, then return a copy as an attachment to Anne O'Hanlon at Auseinet (anne.ohanlon@flinders.edu.au) or fax 08 8357 5484

by FRIDAY 11 JULY 2003

WHAT IS MENTAL HEALTH PROMOTION, PREVENTION and EARLY INTERVENTION?*



The spectrum of interventions for mental health (adapted from Mrazek & Haggerty,1994)**

Promotion, Prevention and Early Intervention (PPEI) for mental health mostly covers the early sections of the spectrum of interventions. Mental health promotion applies to the entire spectrum as these activities can occur equally with people showing no signs of illness and those with a long standing illness. The main segments that apply to PPEI are as follows:

Universal interventions are aimed at the whole population, regardless of individual risk factors. Examples include prenatal care and mental health promotion programs that are conducted in schools.
Selected interventions focus on individuals or groups who are considered to have a higher than average risk of developing mental health problems. Examples include support for children who have a parent with a mental disorder, bereavement support groups and support for people experiencing physical illness.
Indicated interventions are aimed at individuals who are showing early signs of a mental health problem, but do not meet diagnostic criteria for a disorder. Examples include programs for children identified at school with signs of behavioural problems.
Case identification involves identifying individuals who have clear symptoms that meet the diagnostic criteria for a mental health problem or disorder.
Early treatment means providing treatment early in the course of a disorder so there is minimum disruption to other aspects of the person's life (eg school, work, relationships).

Definition	Examples in the general practice setting include (but are not limited to)
PROMOTION	
Action taken to maximise mental health and wellbeing in individuals and populations (whole spectrum)	➢ Educating GPs about factors that promote mental health ➢ Working with the community to improve mental health literacy and reduce stigma ➢ Supporting mental health promotion programs
PREVENTION	
Interventions that occur before the onset of a disorder, to prevent its development (universal, selected or indicated)	➢ Educating GPs about risk and protective factors ➢ Informing the community about the impact of adverse life events on mental health ➢ Supporting evidence-based parenting, suicide or other prevention programs ➢ Implementing prevention programs
EARLY INTERVENTION	
With individuals displaying early signs and symptoms or experiencing a first episode of disorder (indicated, case identification and early treatment)	➢ Educating GPs and the community about early warning signs and symptoms ➢ Effective early treatments for mental health disorders (eg depression, psychosis) ➢ Shared care plans or developing referral mechanisms ➢ Facilitating access to services ➢ Supporting and implementing early intervention programs

*Information adapted from Commonwealth Department of Health and Aged Care (2000) *Promotion, Prevention and Early Intervention for Mental Health: A Monograph*. Canberra: Commonwealth Department of Health and Aged Care.
** Mrazek, P & Haggerty, R. (1994). Reducing the Risks for Mental Disorders: Frontiers for Preventive Intervention Research. Washington DC: National Academy Press.

Mental Health Promotion, Prevention and Early Intervention and General Practice

A scoping study by Auseinet and ADGP

SURVEY OF DIVISIONS OF GENERAL PRACTICE

Place cursor in shaded area to insert text or click on a box to check a response

SECTION A. ABOUT YOUR DIVISION

1. **Division name:** _____ **Division ID number:** _____

2. **State or Territory:** ☐NSW ☐Vic ☐Qld ☐SA ☐WA ☐Tas ☐NT ☐ACT

3. **Is your Division:** ☐Urban ☐Rural

4. **How many GPs are in your catchment area?** _____

5. **How many GPs are members of your Division?** _____

6. **How many people (including you) are employed by your Division to work on mental health activities?** _____

7. **What is the total full time equivalent (1.0 FTE is full time) that these people devote to mental health activities?** _____ **FTE**

8. **Approximately what proportion of your Division's total activities are mental health related?** _____

9. **Approximately what proportion of these mental health activities include 'promotion, prevention or early intervention (PPEI)'?** _____

   Even if your Division does not do any mental health PPEI activities, please continue with the survey as it contains questions about how PPEI COULD BE INCLUDED IN THE FUTURE.

10. **To what extent do you think that mental health staff in your Division are receptive to a PPEI approach to mental health?**
    ☐Not at all receptive ☐Very receptive
    ☐Neither receptive nor unreceptive ☐Unsure
    ☐Moderately receptive Comment _____

11. **To what extent do you think that General Practitioners linked to your Division are receptive to a PPEI approach to mental health?**
    ☐Not at all receptive ☐Very receptive
    ☐Neither receptive nor unreceptive ☐Unsure
    ☐Moderately receptive Comment _____

SECTION B. ABOUT YOU (you will not be personally identified in any reports arising from this survey)

For contact purposes **- Your name:** _____ **Phone number:** _____ **Email:** _____

12. **Your position title:** _____

13. **How long have you been in this position?:** _____

14. **For what fraction of time (1.0 FTE is full time) are you employed in this position?** _____ **FTE**

15. **What is your professional background (social work, psychology, nursing etc)?** _____

16. **How do you keep yourself informed about mental health issues?** _____

SECTION C. THIS SECTION REFERS TO MENTAL HEALTH PROMOTION ACTIVITIES

Activities that aim to maximise mental health and wellbeing in individuals and populations

17. Is your Division involved in any MENTAL HEALTH PROMOTION activities?

☐ **No** *(please scan this section before checking 'No')*

17a. If No, how COULD mental health promotion be included in Divisional activities in the future? _____

Now go to Section D.

☐ **Yes** *Please complete the remainder of this section*

17b. Please indicate the TYPES of activity and HOW the activity is conducted.

Type of activity	GP education	Community liaison	Schools liaison	Other ways the activity is conducted (describe)
Education about mental health promotion	☐	☐	☐	
Increasing mental health literacy	☐	☐	☐	
Reducing stigma	☐	☐	☐	
Promoting quality of life	☐	☐	☐	
Other activities (please list)				
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

17c. Which AGE GROUPS does the CONTENT of your mental health promotion activity address? *Please check as many age groups as apply*

Type of activity	No specific age group	Infants (0-2yrs)	Children (3-11)	Young people (12-17)	Young adults (18-25)	Adults (26-64)	Older adults (65+)
Education about mental health promotion	☐	☐	☐	☐	☐	☐	☐
Increasing mental health literacy	☐	☐	☐	☐	☐	☐	☐
Reducing stigma	☐	☐	☐	☐	☐	☐	☐
Promoting quality of life	☐	☐	☐	☐	☐	☐	☐
Other activities (please list to match above)							
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

17d. Does the CONTENT of your mental health promotion activity address any of the following SPECIAL POPULATION GROUPS? *Please check as many special population groups as apply*

Type of activity	No specific group	Aborigines & Torres Strait Islanders	Rural & remote communities	Culturally & linguistically diverse backgrounds	Other groups (describe)
Education about mental health promotion	☐	☐	☐	☐	
Increasing mental health literacy	☐	☐	☐	☐	
Reducing stigma	☐	☐	☐	☐	
Promoting quality of life	☐	☐	☐	☐	
Other activities (please list to match above)					
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

17e. Can you name any specific MENTAL HEALTH PROMOTION programs that are used within your Division (eg Positive Parenting Program, MindMatters) _____

17f. If you have any further comments on mental health promotion activities please enter them here.

_____

SECTION D. THIS SECTION REFERS TO PREVENTION OF MENTAL ILLNESS ACTIVITIES

Interventions that occur before the onset of a disorder, to prevent its development

18. Is your Division involved in any PREVENTION OF MENTAL ILLNESS activities?

☐ **No** *(please scan this section before checking 'No')*

18a. If No, how COULD prevention of mental illness be included in Divisional activities in the future? _____

Now go to Section E.

☐ **Yes** *Please complete the remainder of this section*

18b. Please indicate the TYPES of activity and HOW the activity is conducted.

Type of activity	Community liaison	Schools liaison	GP education	Practice support	Other ways conducted (describe)
Education about risk & protective factors	☐	☐	☐	☐	
Encouraging help seeking behaviour	☐	☐	☐	☐	
Suicide prevention programs	☐	☐	☐	☐	
Effective parenting programs	☐	☐	☐	☐	
Other activities (please list)					
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

18c. Which AGE GROUPS does the CONTENT of your prevention of mental illness activities address? *Please check as many age groups as apply*

Type of activity	No specific age group	Infants (0-2yrs)	Children (3-11)	Young people (12-17)	Young adults (18-25)	Adults (26-64)	Older adults (65+)
Education about risk & protective factors	☐	☐	☐	☐	☐	☐	☐
Encouraging help seeking behaviour	☐	☐	☐	☐	☐	☐	☐
Suicide prevention programs	☐	☐	☐	☐	☐	☐	☐
Effective parenting programs	☐	☐	☐	☐	☐	☐	☐
Other activities (please list to match above)							
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

18d. Does the CONTENT of your prevention of mental illness activities address any of the following SPECIAL POPULATION GROUPS? *Please check as many special population groups as apply*

Type of activity	No specific group	Aborigines & Torres Strait Islanders	Rural & remote communities	Culturally & linguistically diverse	Other groups (describe)
Education about risk & protective factors	☐	☐	☐	☐	
Encouraging help seeking behaviour	☐	☐	☐	☐	
Suicide prevention programs	☐	☐	☐	☐	
Effective parenting programs	☐	☐	☐	☐	
Other activities (please list to match above)					
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

18e. Can you name any specific PREVENTION OF MENTAL ILLNESS programs that are used within your Division (eg Keep Yourself Alive, Positive Parenting Program, MindMatters Plus)

_____

18f. If you have any further comments on prevention of mental illness activities please enter them here._____

SECTION E. THIS SECTION REFERS TO EARLY INTERVENTION IN MENTAL DISORDERS

Activities with individuals with early signs and symptoms, or experiencing a first episode of disorder

19. Is your Division involved in any EARLY INTERVENTION IN MENTAL DISORDERS activities?

☐ **No** *(please scan this section before checking 'No')*

19a. If No, how COULD early intervention be included in Divisional activities in the future?

_____

Now go to Section F.

☐ **Yes** *Please complete the remainder of this section*

19b. Please indicate which types of DISORDERS are focussed upon and HOW the activities are conducted.

Disorders	Community awareness: early signs	GP education: Early signs	GP education: Early treatment	Practice support	Brief inter-ventions	Other ways conducted (describe)
Anxiety	☐	☐	☐	☐	☐	
Depression (inc. postnatal)	☐	☐	☐	☐	☐	
Behavioural disorders (inc. ADHD, Conduct Disorder)	☐	☐	☐	☐	☐	
Drug & alcohol use disorders	☐	☐	☐	☐	☐	
Psychotic disorders	☐	☐	☐	☐	☐	
Comorbidity	☐	☐	☐	☐	☐	
Suicidal behaviour	☐	☐	☐	☐	☐	
Other disorders (please list)						
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	

19c. Which age groups does the CONTENT of your EARLY INTERVENTION activities address? *Please check as many age groups as apply*

Disorder	No specific age group	Infants (0-2yrs)	Children (3-11)	Young people (12-17)	Young adults (18-25)	Adults (26-64)	Older adults (65+)
Anxiety	☐	☐	☐	☐	☐	☐	☐
Depression (inc. postnatal)	☐	☐	☐	☐	☐	☐	☐
Behavioural disorders (inc. ADHD, Conduct Disorder)	☐	☐	☐	☐	☐	☐	☐
Drug & alcohol use disorders	☐	☐	☐	☐	☐	☐	☐
Psychotic disorders	☐	☐	☐	☐	☐	☐	☐
Comorbidity	☐	☐	☐	☐	☐	☐	☐
Suicidal behaviour	☐	☐	☐	☐	☐	☐	☐
Other disorders (please list to match above)							
	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐

19d. Does the CONTENT of your EARLY INTERVENTION activities address any of the following SPECIAL POPULATION GROUPS? *Please check as many special population groups as apply*

Disorder	No specific group	Aborigines & Torres Strait Islanders	Rural & remote communities	Culturally & linguistically diverse	Other groups (describe)
Anxiety	☐	☐	☐	☐	
Depression (inc. postnatal)	☐	☐	☐	☐	
Behavioural disorders (inc. ADHD, Conduct Disorder)	☐	☐	☐	☐	
Drug & alcohol use disorders	☐	☐	☐	☐	
Psychotic disorders	☐	☐	☐	☐	
Comorbidity	☐	☐	☐	☐	
Suicidal behaviour	☐	☐	☐	☐	
Other disorders (please list to match above)					
	☐	☐	☐	☐	
	☐	☐	☐	☐	

19e. Can you name any specific EARLY INTERVENTION programs that are in use in your Division? _____

19f. If you have any further comments on early intervention activities please enter them here. _____

SECTION F. BARRIERS TO PPEI FOR MENTAL HEALTH

20. What are the BARRIERS to incorporating mental health promotion, prevention and early intervention approaches to mental health in your Division? How could the barriers be overcome? *Please list as many barriers and solutions as you can think of.*

Barrier	How could the barrier be overcome?

SECTION G. CONSUMER INVOLVEMENT IN PPEI FOR MENTAL HEALTH

21. Does your Division involve CONSUMERS in mental health PPEI activities?

☐ **No** *(please scan this section before checking 'No')*

21a. If No, how COULD consumers be involved in mental health PPEI in the future?

_____

Now go to Section H.

☐ **Yes** *Please complete the remainder of this section*

21b. How many consumers are involved in mental health PPEI activities? _____

21c. Which of the following formal roles are consumers involved in? *(Check as many as apply)*

☐ Consumer advisory group to Division
☐ Consumer adviser
☐ Representation on Division Board of Management
☐ Other *(please describe)*: _____

21d. Which of the following consultation mechanisms are consumers involved in? *(Check as many as apply)*

☐ Community surveys
☐ Focus groups
☐ Community forums
☐ Community education
☐ Other *(please describe)* _____

21e. How do consumers feed information back to other consumers? *(Please describe)* _____

21f. If you have further comments on consumer involvement please enter them here. _____

SECTION H. CARER INVOLVEMENT IN PPEI FOR MENTAL HEALTH

22. Does your Division involve CARERS in mental health PPEI activities?

☐ **No** *(please scan this section before checking 'No')*

22a. If No, how COULD carers be involved in Divisional activities in the future? _____

Now go to Section I.

☐ **Yes** *Please complete the remainder of this section*

22b. How many carers are involved in mental health PPEI activities? _____

22c. Which of the following formal roles are carers involved in? *(Check as many as apply)*

☐ Carer advisory group to Division
☐ Carer adviser
☐ Representation on Division Board of Management
☐ Other *(please describe)* _____

22d. Which of the following consultation mechanisms are carers involved in? *(Check as many as apply)*

☐ Community surveys
☐ Focus groups
☐ Community forums
☐ Community education
☐ Other *(please describe)* _____

22e. How do carers feed information back to other carers? *(Please describe)* _____

22f. If you have further comments on carer involvement please enter them here. _____

SECTION I. WORKFORCE DEVELOPMENT FOR DIVISION STAFF

23. Does your Division conduct mental health education, training or professional development activities for DIVISION STAFF?

☐ **No** *Go to Section J.*

☐ **Yes** *Please complete the remainder of this section*

23a. Please list the workforce development activities and indicate whether they have any Promotion, Prevention and Early Intervention (PPEI) aspects.

Workforce development activities for Division staff	Does the activity have any PPEI aspects?	
	No	Yes Please describe
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

23b. If any of the activities for Division Staff you have listed above do not have mental health PPEI aspects, how COULD PPEI be included in the future?

_____

23c. If you have any further comments on workforce development activities for Division Staff please enter them here. _____

SECTION J. WORKFORCE DEVELOPMENT FOR GENERAL PRACTITIONERS

24. Does your Division conduct mental health education, training or professional development activities for GENERAL PRACTITIONERS?

☐ **No** *Go to Section K.*

☐ **Yes** *Please complete the remainder of this section*

24a. Please list the workforce development activities, and indicate whether they have any Promotion, Prevention and Early Intervention (PPEI) aspects.

Workforce development activities for General Practitioners	Does the activity have any PPEI aspects?	
	No	Yes Please describe
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

24b. If any of the activities for General Practitioners you have listed above do not have mental health PPEI aspects, how COULD PPEI be included in the future?

_____

_____

24c. Does your Division run any activities that focus on the mental health and wellbeing of the General Practitioners themselves? ☐**Unsure** ☐ **No** ☐ **Yes** *(please describe)* _____

24d. If you have any further comments on workforce development activities for General Practitioners please enter them here. _____

SECTION K. ALLIED HEALTH PROFESSIONAL INVOLVEMENT IN PPEI FOR MENTAL HEALTH

25. Does your Division work with Allied Health Professionals?

☐ **No** *(please scan this section before checking 'No')* *Now go to Section L.*

☐ **Yes** *Please complete the remainder of this section*

25a. Please indicate WHETHER and HOW the allied health professionals are involved in mental health promotion activities.

Check if work with this professional		Is the allied professional with whom your Division works involved in MENTAL HEALTH PROMOTION activities?	
		No	Yes Please describe
☐	Psychologist	☐	☐
☐	Counsellor	☐	☐
☐	Social worker	☐	☐
☐	Nurse	☐	☐
☐	Psychiatrist	☐	☐
☐	Occupational therapist	☐	☐
☐	*Other (please list)*		
		☐	☐
		☐	☐

25b. Please indicate WHETHER and HOW the allied health professionals are involved in prevention of mental illness activities. Complete only for the professionals with whom you work.

	Is the allied professional with whom your Division works involved in PREVENTION OF MENTAL ILLNESS activities?	
	No	Yes Please describe
Psychologist	☐	☐
Counsellor	☐	☐
Social worker	☐	☐
Nurse	☐	☐
Psychiatrist	☐	☐
Occupational therapist	☐	☐
Other (please list)		
	☐	☐
	☐	☐

25c. Please indicate WHETHER and HOW the allied health professionals are involved in early intervention in mental disorder activities. Complete only for the professionals with whom you work.

	Is the allied professional with whom your Division works involved in EARLY INTERVENTION IN MENTAL DISORDER activities?	
	No	Yes Please describe
Psychologist	☐	☐
Counsellor	☐	☐
Social worker	☐	☐
Nurse	☐	☐
Psychiatrist	☐	☐
Occupational therapist	☐	☐
Other (please list)		
	☐	☐
	☐	☐

25d. If you have further comments on allied health professional involvement please enter them here. _____

SECTION L. MENTAL HEALTH PPEI ACTIVITIES THAT MAY BE OCCURRING WITHIN EXISTING DIVISIONAL PROGRAMS

26. Is your Division involved in any mental health SHARED CARE programs?

☐ **No** *Go to Question 27.*
☐ **Yes** **26a. If Yes, do the programs have any mental health PPEI aspects? Please describe.**

Shared Care Program *(please list)*	**Mental Health PPEI aspects?**	
	No	**Yes Please describe**
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐

26b. If the Shared Care programs you have listed above do not have any mental health PPEI aspects, how COULD PPEI be incorporated into them?

Shared Care Program *(please list as above)*	**Ways that mental health PPEI activities COULD be incorporated into the program**
1.	
2.	
3.	
4.	

27. Is your Division involved in any MORE ALLIED HEALTH SERVICES (MAHS) programs?

☐ **No** *Go to Question 28.*
☐ **Yes** **27a. If Yes, do the programs have any mental health PPEI aspects? Please describe.**

MAHS Program *(please list)*	**Mental Health PPEI aspects?**	
	No	**Yes Please describe**
1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐

27b. If the MAHS programs you have listed above do not have any mental health PPEI aspects, how COULD PPEI be incorporated into them?

MAHS Program *(please list as above)*	**Ways that mental health PPEI activities COULD be incorporated into the program**
1.	
2.	
3.	
4.	

28. Are there ANY OTHER EXISTING PROGRAMS that have mental health PPEI aspects, even if the programs were not designed for this purpose?
☐ **No** *Go to Question 29.*
☐ **Yes** **Please describe:** _____

29. Can you identify ANY OTHER PARTNERSHIPS OR LINKS through which mental health PPEI activities could be developed? _____

30. If you have further comments on mental health PPEI in existing Divisional programs please enter them here. _____

HAS YOUR DIVISION DEVELOPED ANY MENTAL HEALTH PPEI RESOURCES THAT YOU WISH TO SHOWCASE?

31. Some Divisions have developed their own mental health PPEI resources (eg training programs, print materials and reports). If you wish to list your resources here, we will compile a catalogue and distribute around the Divisions.

FOR EACH RESOURCE:
Name the resource, the date it was developed and the authors (if applicable).
Briefly describe the resource and its mental health PPEI components.

Name of resource	Date	Authors	Brief description	Mental health PPEI components

HAVE WE OVERLOOKED ANYTHING?

32. Is your Division involved in any other activities, not covered so far in the survey, that have a mental health PPEI aspect?
☐No ☐Yes (Please describe) _____

33. Can you think of any other ways, not mentioned so far in the survey, that your Division could incorporate mental health PPEI into future activities?
☐No ☐Yes (Please describe) _____

34. Are there any individuals or groups that are involved in PPEI activities that have not been identified so far in the survey?
☐No ☐Yes (Please describe) _____

35. Do you have any final comments? _____

ABOUT COMPLETING THIS SURVEY

36. Did you consult with other people from your Division to complete this survey?
☐No ☐Yes **If Yes, what position(s) do they hold in the Division?**

_____
_____
_____

Thank you very much for completing this survey.

Please SAVE and KEEP it, then return a copy as an attachment to Anne O'Hanlon at Auseinet anne.ohanlon@flinders.edu.au or by fax 08 8357 5484

by FRIDAY 11 JULY 2003

(If you are unable to return the survey by the due date, please contact Anne O'Hanlon on 08 8404 2999 or by email to arrange an alternative return date.)

Appendix 2. GP focus groups

Semi-structured interview schedule

Mental Health Promotion, Prevention and Early Intervention and General Practice

A scoping study by Auseinet and ADGP

GP FOCUS GROUP
Semi-structured interview schedule

INTRODUCTION: The MH PPEI in General Practice project

- Background
- What is PPEI?
- Examples of PPEI in the General Practice setting
- Methodology – Survey of Divisions and GP focus groups
- Outputs

FOCUS GROUP DISCUSSION

1. How familiar were you with mental health issues in general and PPEI in particular before this session?

2. Thoughts on the project

3. MH PPEI approaches in the practice setting

- How receptive do you think GPs are to a MH PPEI approach?
- What PPEI approaches are you aware of that GPs are using in their everyday practice? If, possible, discuss Promotion, Prevention and EI separately.
- How are consumer involved in MH PPEI activities?

4. Barriers to and opportunities for MH PPEI

- What are some of the barriers to a PPEI approach?
- What are some of the opportunities for a PPEI approach?
- What resources, existing or additional, are needed to implement a PPEI approach?
- How COULD a PPEI approach be incorporated into individual practice activities?

5. Models of MH PPEI in General Practice – thoughts on these

- All GPs trained and implement – (when should training occur?)
- Specific GPs trained and implement – (how and when?)
- Allied health professionals (onsite or sessional)
- Formal Shared Care programs

FUTURE DIRECTIONS: THE BIGGER PICTURE

- What are your thoughts on future directions in MH PPEI in the General Practice setting (eg should their be an agenda, what should the agenda be, who should set it)?

- Who should be involved in MH PPEI (eg Universities, Colleges, Divisions, individual GPs, other)?

Identify KEY RECOMMENDATIONS you would like to see in the final report.

OTHER ISSUES YOU WISH TO RAISE

Appendix 3. Stakeholder workshop summary

20 November 2003

Summary of small group work

Group 1: Evidence based information and resources

Group 2: Education and training

Group 3: Partnerships

Group 1: Evidence based information and resources

Discuss and clarify the following draft recommendations. Consider where, by whom, and how each could be implemented.

Evidence-based information

1. Programs must be shown to be effective.
2. Need research and guidance for GPs on what early interventions are available in general practice for various disorders (eg eating disorders, early psychosis).
3. Guidelines and information on what works should be made available to GPs (eg via PARC and the Divisions) – effective dissemination is crucial.

Resources

4. Develop better immediate (eg online) resources for GPs, including 'detailed, comprehensive, regionalised referral directories'.
5. Tailor documents for GPs: 'a framework is not a guideline – we need clear, tailored, how-to information'.
6. Promote general practice as an accessible resource; acknowledge that GPs are an appropriate referral source.
7. Develop a register of GPs with mental health skills.

The group proposed that 'evidence-based information and resources' recommendations could be implemented by following a three-step approach:

1. Identify the evidence

Form a Reference Group (of GPs, mental health professionals, consumers, carers, policy makers etc) to identify:

- content that is most needed (ie 'best buys' for general practice)
- key programs and target groups
- gaps in the evidence.

2. Summarise the evidence

Commission experts to search the literature and summarise it in a form that is suitable for a general practice audience. The language used to describe 'mental health PPEI' activities may need to be revised to make it appropriate for the audience. Risk and protective factors should be considered. Levels of evidence should be specified where possible.

3. Disseminate the evidence to GPs and allied health professionals via:

- websites
- forums
- magazines and newsletters
- training programs.

The dissemination methods should follow currently accepted good practice eg as recommended by NHMRC (2000) and make use of existing networks and infrastructures eg Divisions of General Practice Network.

Group 2: Education and training (workforce development)

Discuss and clarify the following draft recommendations. Consider where, by whom, and how each could be implemented.

1. A long term commitment to education over the whole medical spectrum is required. Mental health PPEI should be a compulsory component in training for undergraduate, postgraduate and continuing education.
2 Involve GPs as part of a team involved in community education to increase mental health literacy.
3. Mental health specialists (eg psychiatrists and psychologists) need to be educated to work better with GPs.

The top priorities identified by the group were:

- The Australian Government needs to develop a comprehensive, evidence-based training program in Mental Health PPEI to be rolled out to GPs (and allied health professionals) via Divisions, in collaboration with relevant stakeholders.
- Conduct an audit of existing medical education activities in undergraduate postgraduate and continuing education fields.
- Raise awareness of mental health PPEI across the Divisions network (eg workforce development, capacity building, showcasing work being done in Divisions).
- Develop and resource programs that enable GPs to be involved as part of a team to provide community education with an aim to increase mental health PPEI literacy.

Other comments included:

- 'Mental health PPEI as a *compulsory* component in training' (see draft recommendation 1 above) is unrealistic. Evidence on the benefits of mental health PPEI could be presented to universities to advocate for inclusion in medical courses.
- 'Mental health specialists (eg psychiatrists and psychologists) need to be educated to work better with GPs' (see draft recommendation 3 above) is not a recommendation as such; it could be viewed as a barrier to mental health PPEI in general practice.
- Consumers and carers should be involved in GP training.
- Enhance the capacity of Divisions of General Practice to be involved in mental health PPEI training programs.
- The wellbeing and support needs of Division staff should be considered.
- There need to be specific MBS item numbers developed for Psychiatrists to encourage improved levels of consultation/liaison with general practice. These item numbers need to specify levels of communication required.
- Training programs could include mental health PPEI approaches to child and adolescent mental health problems (including incidence, risk factors, signs, prevention and early intervention, access to services, working in collaboration with other health professionals).

Group 3: Partnerships (allied health professionals, consumers and carers, GPs)

Discuss and clarify the following draft recommendations. Consider where, by whom, and how each could be implemented.

Allied health care

1. Fund all Divisions to be involved in Allied Health Programs (get away from 'pilots').
2. All general practices need to have access to allied health support. Government should supply dedicated on-site staff eg practice nurses, co-located social workers, psychologists.
3. Better communication is needed with allied health professionals around referrals – especially for patients without private insurance.

Consumer and carer involvement

4. Involve consumers and carers in the PPEI agenda, to the same extent as GPs and the Divisions.

Liaison with GPs

5. Liaise with GPs on any future PPEI agenda – be responsive to how they work.

The top priorities identified by the group included:

- Explore options for a second tier of *Better Outcomes in Mental Health Care Initiative* with a specific focus on children and young people (adaptation of Allied Health Professional model to include 8-12 sessions).
- Support linkages between Divisions of General Practice and Child and Adolescent Mental Health Services to improve referrals and shared care.
- Trial a model of GP clinic and school co-location (note: MindMatters Plus GP is currently being trialled).
- Improve discharge liaison eg upskill practice nurses, develop community resources for mental health self-care.
- Develop a register of GPs interested in working with or specialising in child and adolescent mental health.
- Support affordable access to youth friendly GPs.
- Develop or identify mental health PPEI resources for GPs (eg community support services, employment services).

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