

# Linking general practice with mental health and drug and alcohol services

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- Various roles, Divisions of General Practice



# Linking 3 sectors

Language

Work hours

Philosophy

Belief

Resources



# Mental health services

- ➔ Hugely under-resourced
- ➔ Priority urgent and “very mad”
- ➔ How to “turf”
  - “Drugs are not core business”
  - “self-inflicted”
- ➔ “Just get me the resources, I don’t have time to deal with them!”
- ➔ Fear of opening the floodgates



# Drug and alcohol sector

- ➔ The forgotten sector
  - disconnected because of structures
  - NGOs often have to compete for funding
- ➔ Everyone else doesn't get it
  - Drug use & the psychosocial context and choice
  - Just say “no” vs harm minimisation.
  - Not “The medical model”
- ➔ Struggling with
  - Resources for the “non-sexy” sector
  - The “mad”, especially with amphetamines
  - Doctors are not friendly to these clients! What's the point of talking with them?
  - Want “an understanding doctor who knows about AOD”

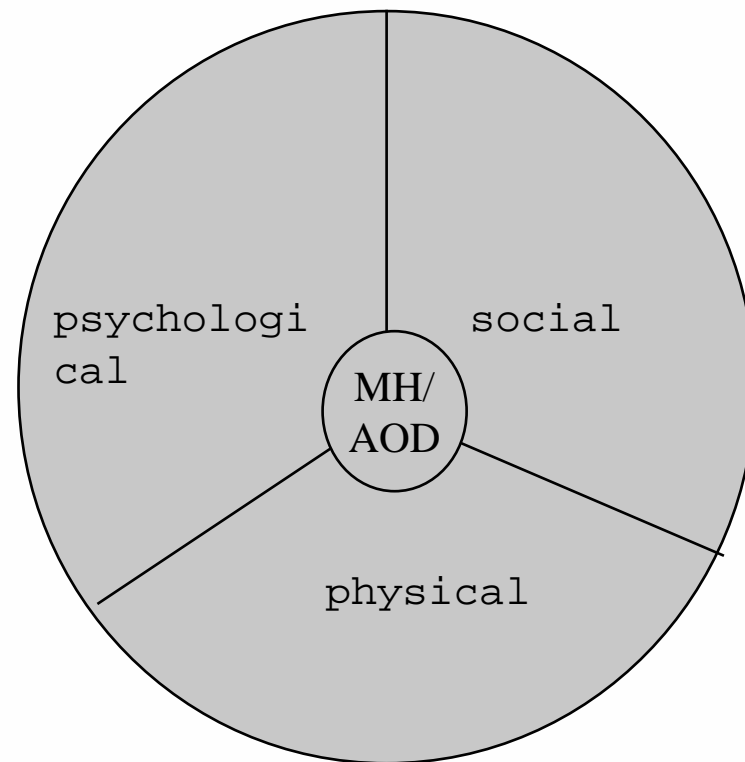


# General Practice

- ➔ Red tape
- ➔ “Everyone wants me to do everything”
- ➔ Under-resourced
- ➔ Patients don’t fit other people’s boxes, no help
- ➔ Complexity means time and bad finances and solutions involve more red tape
- ➔ I don’t need this group of patients
  - “doctor shoppers”, attendance, bills, effect on others
- ➔ “I don’t feel confident that I can make a difference here, so why do anything?”

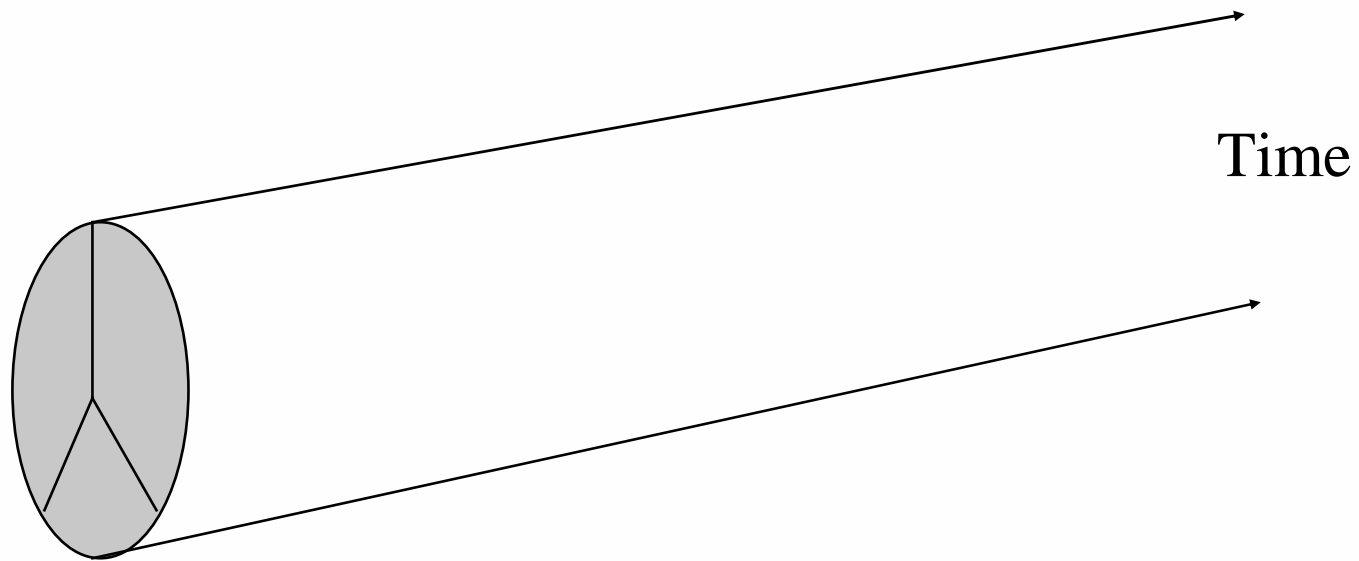


# Duty to Care/Health Right





# Duty to Care/Health Right





# Duty to Care/Health Right

- ⇒ Whole person care is missing for people with mental health problems (including comorbidity)
  - Meeting psychosocial needs and Mental Health and/or AOD related health issues is not enough
  - Late diagnosis and higher death/complications, not just increased risk
  - Whole person care means providing access to the breadth of primary care
  - Specialist services and the “understanding GP” who has become specialised in D&A does not = whole person care



# Commonality

- ➔ All feel under-resourced and unrecognised
- ➔ Comorbidity doesn't fit the boxes
  - Hard work for us all
- ➔ We want common things
  - Communication, support from team which helps (hard to deal with alone)
  - Access to each other
    - but not too much access back!!
- ➔ Often the same patients using multiple services



# What does each sector want?

## ⇒ Mental health

- More information in referrals
  - Means making sure that more information doesn't mean the patient gets turned away more often
- More appropriate referrals
  - Not sending people who could go elsewhere, need process for helping GPs find the “elsewhere”
- GPs to take people back
  - but also to be able to hang on to some (continuity)



# What does each sector want?

## ⇒ Alcohol and drug sector

- Access for clients
- Understanding of what they offer
  - Recognition for their unique contribution
- Communication
  - Being taken seriously by the medical world
- Client autonomy and consent issues very important



# What does each sector want?

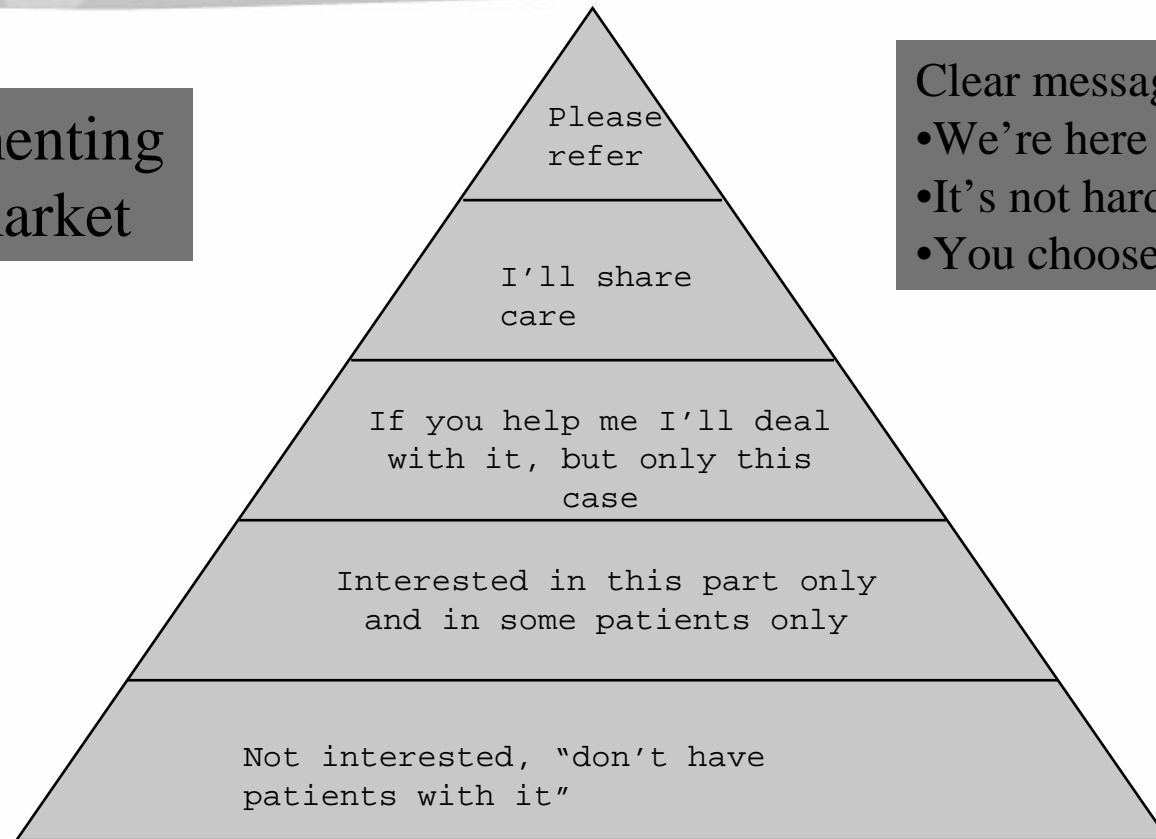
## ➔ General practice

- Practical stuff about service
  - Things that won't go into the round filing cabinet
  - Things that are easy to access and read
  - Things that tell me where, how, how much, how long is the wait list?
- “I'll look after my own patient” but don't want to lose my “generalist” status by attracting everyone else
- “Tell me when I need to know”, be available when I have a patient
- Easy to refer
- Feedback on the patient
- Start with the comfort zone of “what I believe is my job”
  - Alcohol, family support, depression
- Willing to work in team with trusted people

# Drug and Alcohol Office GP Program

## The Strategy: Understanding our GPs

Segmenting  
the market



Clear messages

- We're here to help
- It's not hard
- You choose how much



# The GP program

- ➔ Working with everyone on education
- ➔ Innovative projects
  - comorbidity projects with divisions of general practice
    - one project allocated part of the time of the GP liaison mental health person to D&A
    - GP funded to build bridges with and provide GP input into referral/feedback processes in AOD agency
    - GP lunch time visits by D&A and MH services
    - Establishment of resources/pathways
- ➔ Working with the AOD sector



# Working with the A&D sector

- ➔ Slow process of breaking in and gaining credibility
  - Partnership with AOD peak body
  - Providing dedicated resources (GP Liaison position) to do surveys and interviews with the sector and executive support for working group
  - Working with many parts of the sector on little things
    - funded a small resource project \$5K to develop agency referral sheet for GPs
    - Provided brochure on why patients should have their own GP
    - Spoke at every opportunity, never said “no”
  - Involve everyone in sector and Divisions.
  - Linked to key initiatives in the sector (eg Quality Assurance)
  - Empowering champions and collecting information on their own strategies to working with GPs
  - Now the champions are promoting strategies and leading the call to work with GPs



# Survey of WANADA agencies

(WA Network of Alcohol and Drug Agencies)

WANADA agencies said there is:

- ➔ potential for increased collaboration & a role for GPs
- ➔ room for improvement in communication
- ➔ lack of knowledge of the role of GPs and the role of AOD agencies
- ➔ a need to develop strategies to implement shared care programs.

Survey of Innovation in Practice (face-to-face interviews)

- ➔ confirmed these views



# WANADA forums

- Series of collaborative workshops on working with GPs
  - Divisions of GP including BOMHC providers & project officers
  - The champions in the A&D sector
- About GPs, their organisation and the landscape they work in
- Key focus
  - Collaboration
  - Communication
  - Workforce development (education)



# Key points

- ➔ Language
- ➔ What does each group want?
- ➔ Start small
- ➔ Support the champions
- ➔ Never say “no”
- ➔ Have a long-term plan