



# PARCupdate

Programs for Young People

October 2005 PARC Update Vol 2 Issue 5

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## Farewell Editorial, Tori Wade

This is my farewell editorial, as I am leaving PARC after three years as Director. I have been part of seeing PARC grow from two staff to five, and take on new roles, such as knowledge harvesting, and conducting evaluation: this latter role is increasingly developing into training and mentoring Divisions of General Practice in evaluation skills. Throughout this time, PARC has maintained its interest in co-morbidity and health system integration, particularly as manifested by shared mental health care. Thanks very much to all the team, to Peter, Liz, Sara and most of all Eleanor, our Research Librarian and longest serving staff member, who has been instrumental in helping us adopt a knowledge management framework, which has added cohesion to all of our work. Thank you also to the others in the Primary Mental Health Care Network at ADGP and the State Based Organisations, our closest partners in system development.

PARC will be appointing a new Director in 2006. In this interim period, any enquiries about the management aspects of PARC should be directed to either Peter Drake or Eleanor Jackson-Bowers.

It is important to remember just how unique we are in Australia, with the commitment we have made to the primary mental health system, and how this has been shown concretely by the interest in and uptake of the Better Outcomes in Mental Health Initiative. Initial predictions were that perhaps 10% of general practitioners would

participate, however actual registrations proved to be more than twice that level nationally, and have ranged up to 90% of GPs in some Divisions. Even larger numbers of GPs have taken up mental health education, and almost all Divisions have employed, contracted or in other ways delivered services to patients by mental health workers. Also, accessibility to psychiatrists, both for brief advice and for consultation/liaison assessments of patients has been greatly enhanced by the Initiative. I am very pleased to see that some of the things we only dreamed about 5 years ago have now become reality.

This issue of PARC Update has gathered together information about some of the interesting new programs in the Access to Psychological Services part of the Better Outcomes Initiative. As these services have developed, they have diversified, with a strong theme emerging to provide services to young people. This is very appropriate, as those aged 15 to 25 years have the highest rate of mental health problems of any age group. It has also been hard for GPs to find resources to help this group; many of the state run services have had to concentrate on the young people with very severe problems, leaving a gap in the primary health care part of the spectrum.

The recent announcement by the Australian Government that there is going to be a second National Mental Health and Well Being Study is very welcome, as the first study in 1997 pointed out that there was a large unmet need in mental health, and this was a significant stimulus to the policy and program initiatives described above.

It will be very interesting to see if the extensive development in primary mental



## Stop Press:

Dr Tori Wade has been honoured in the Margaret Tobin Awards for Excellence in Mental Health for "Leadership in and commitment to mental health reform". Congratulations Tori on a well deserved award.

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health care since that time has gone some way towards addressing that need – I certainly hope so! My keen interest in mental health will continue as I move on to increasing my other position as Medical Director of SA Divisions of General Practice from half time to full time. Part of my additional time there will be put towards a mental

health shared care program which will cover all of South Australia, and which has been made possible by significant South Australian Government funding to the SA Divisions Network. There are also new developments in primary mental health care being developed between the State Government, the Australian Government and the Divisions Network in

Queensland, suggesting that this combined approach is one to watch in the future.

To conclude, my very best wishes to all those working with/ associated with/ interested in the primary mental health system, and keep up the good work!

## Refining the Better Outcomes in Mental Health Care Initiative: Quality, Equity and Sustainability

*Dr Grant Blashki*

Dr Grant Blashki MD MBBS FRACGP is a practicing GP, a Senior Research Fellow in the Department of General Practice at Monash University, an Honorary Senior Lecturer in the Health Services Research Department, Institute of Psychiatry, Kings College London and an Honorary Fellow in the Department of General Practice, University of Melbourne.

I believe that the Better Outcomes in Mental Health Care (BOiMHC) initiative is a visionary policy with potential to help an enormous number of people in the community who experience mental illnesses. As the initiative evolves we ought to keep asking ourselves questions such as “How do we know that we are really improving care for people in the community who are suffering from mental illnesses?” and also “Would we be happy for one of our relatives to be managed by this system of care, should one of them become mentally ill?” With these questions in mind, the Consumer/Carer perspective will stay properly in focus, and we will not be distracted by the various professional or political agendas, as we seek to achieve genuine improvements for those in need. In this opinion piece I am making some specific suggestions for refinements of BOiMHC, based on three principles; quality, equity and sustainability.

### Quality

The quality of care is absolutely central to the initiative. Since the program de-

pends entirely on the skills of the health providers, in my opinion it would be sensible if some of the BOiMHC funding was dedicated to proactively supporting the development of high quality training for GPs involved in the initiative, rather than leaving much of this training to the marketplace to develop. This is not in any way to criticise the current providers of training, or the General Practice Mental Health Standards Collaboration who in my opinion have been very rigorous in adjudicating the programs presented to them. (1) However, I’m suggesting that there may be merit in actively commissioning and making widely available high quality educational programs for GPs, for example which address high need groups, specific mental disorders or specific mental health skills.

Precisely how this would be achieved I am uncertain and it would require some navigation of the stakeholders, but I would like to see GPs being able to access a wider range of mental health training that they could undertake locally and at low cost. A related issue is to recognise that short bursts of training are unlikely to be effective without ongoing GP support and supervision. (2) It would be remarkable indeed if GPs were the only providers of mental health care who did not require the type of ongoing support that psychologists, psychiatrists and all other mental health care providers undertake as an integral part of their professional development.

### Equity

Is each person in Australia who suffers from a mental disorder equally likely to receive care from the BOiMHC? At this stage, I don’t believe that this is the case, with underutilisation by those groups most in need such as Indigenous communities, youth and rural and remote communities. The first step to rectify this situation would be to be more inclusive of

GPs, and urgently address hurdles such as the complexity of the paperwork, the payment procedures (“SIP payments”) and revisit the requirement for participating GPs to be based in accredited practices. To support those high need groups who are not currently benefiting from the initiative it is just common sense to bring their local GPs into the initiative as soon as possible.

Another positive step towards improving equity of access would be to remove artificial caps in services such as the limit to 66 three step plans per GP per year, and the inherent cap on Access to Allied Health Services where demand already greatly exceeds funded services.

Finally, in order for people to access the benefits of the initiative, they need to be made aware of it. There is an urgent need to better publicise the initiative as it seems that most people in the community have never heard of it!

### Sustainability

BOiMHC is already attracting international attention as an innovative multidisciplinary model, but will it still exist in 10 years, 20 years or beyond? (3.4) History suggests that worthwhile policy initiatives often have a short life span, and after the initial burst of creativity and enthusiasm they tend to wain or to get lost amongst new initiatives, and there is certainly some risk of this occurring. (Consider the impact that the new Chronic Disease Management items may have on BOiMHC.)

One way of understanding sustainability of health system reforms is to view them as “complex adaptive systems.” (5) This approach, recently publicised by Australian Primary Health Care Research Institute recognises that policy reforms are often a complex organic process yet they are guided by



some simple underlying rules which can be identified and supported. In the case of BOiMHC, ongoing *government funding* is clearly a necessary ingredient for the sustainability of the initiative, but to ensure long term viability we need to be thinking more broadly. For example, *building the capacity* of the GP and specialist mental health workforces is going to be critical. GP registrars, for instance should ideally emerge at the end of their training with recognition to participate in BOiMHC, but currently this is not the case. Similarly, young psychologists and other allied health professionals are more likely to invest in primary care careers if their employment prospects are long-standing rather than based on pilot programs. More generally, if initiatives such as BOiMHC are to become part of standard practice in the long term,

*building trust* between the professions will also be essential (6) and there is some evidence that is already occurring. (7).

In conclusion, I believe that the fundamental components are now in place to develop a strong multidisciplinary primary mental health care system that delivers genuine improvements in care for the community, and real outcomes for those most in need. A commitment to quality, equity and sustainability should help deliver these outcomes for many years to come. More detailed evaluation not just of processes, but of clinical outcomes will be important to monitor our progress towards achieving these aims.

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## TheMHS Conference Adelaide 30<sup>th</sup> August to 2<sup>nd</sup> September 2005

*Liz Osman, Research Officer, PARC*

TheMHS, The Mental Health Services Conference, describes itself as providing "a forum for: the exchange of ideas; professional development; networking and debate, for mental health professionals, consumers, carers (families), and managers. TheMHS aims to promote positive attitudes about mental health and mental illness, and to stimulate debate that will challenge the boundaries of present knowledge and ideas about mental health care." The theme of this year's conference was "Dancing to the beat of a different drum: mental health, social inclusion, citizenship."

The conference puts the experiences of the consumers and carers along side those of service providers, thus allowing the asking of very broad questions – about human rights, citizenship, services that actually meet people's needs, recovery, the relationship between mental health and mental illness, the place of the arts. The three keynote speakers were Robert Mezzina, a psychiatrist from the 24 hour Community Health Centre Mental Health Service in Trieste, Italy, with the topic "Citizenship – the social dimension of recovery," Ron Coleman, a consumer and mental health trainer with an interest in psychosis prevention and resolution, on "Recovery! from rhetoric to reality" and Doris Kartinyeri, a Ngarindjeri woman who has survived removal from her family, institutionalized upbringing, and mental illness, on "Growing up in the stolen generation."

As with many conferences, the breadth and number of simultaneous sessions was enormous, and tantalizing. Some interesting issues – differences in mental health policy focus between Australia and New Zealand, with the NZ Mental Health Commission Blueprint being far more specific in terms of "beds and legs" information than the current National Mental Health plan. There were several workshops by groups of NZ consumers" focusing on consumer peer education in human rights. These NZ workshops also suggested a holistic focus to mental health, using Maori concepts of wellbeing, perhaps somewhat analogous to the Aboriginal Emotional and Social wellbeing focus.

Senator Lyn Allison, in an unscheduled extra session, gave a summary of the progress of the Senate Inquiry into Mental Health – they are (at beginning of September) about half way through the hearings, have received over 500 submissions from individuals, organisations and governments, and have moved the reporting time back from 6<sup>th</sup> October to late this year or early next year. She identified an extensive list of emerging themes, which included the following (not presented in any logical order or order of importance). These issues indicate the breadth of the submissions, and the evidence that has been so far presented at hearings around Australia.

- The National Mental Health Strategy: how well is it working?
- Acute care: amount, kind, and degree

of emphasis on community based services;

- The medicalisation of Mental Health of more holistic approaches (including the differing approaches of psychiatrists and psychologists, and distortions due to Medicare;
- What's normal and what's aberrant behaviour?
- The problem of medicalisation of mental health in relation to increased prescribing, eg for ADHD or anxiety;
- Emergency and crisis responses, including involvement of police and restraint issues, particularly in relation to remote areas transport;
- Incarceration rates of people with mental health problems;
- Mainstreamed or special services? (eg for children), particularly in regional centres;
- Indigenous mental health issues, particularly in remote areas;
- Rights of consumers and carers, and opportunities for involvement of consumers in services;
- Human rights, dignity and respect issues, and stigma – including stigmatisation by mental health professionals;
- Nomenclature issues and implications for consumer credibility (eg personality disorders);

*(Continued on page 20)*

# Activities in Youth Mental Health by the Divisions of General Practice: Results from the 2005 PARC Knowledge Harvesting Survey

Sara Pfeiffer, Research Officer, PARC



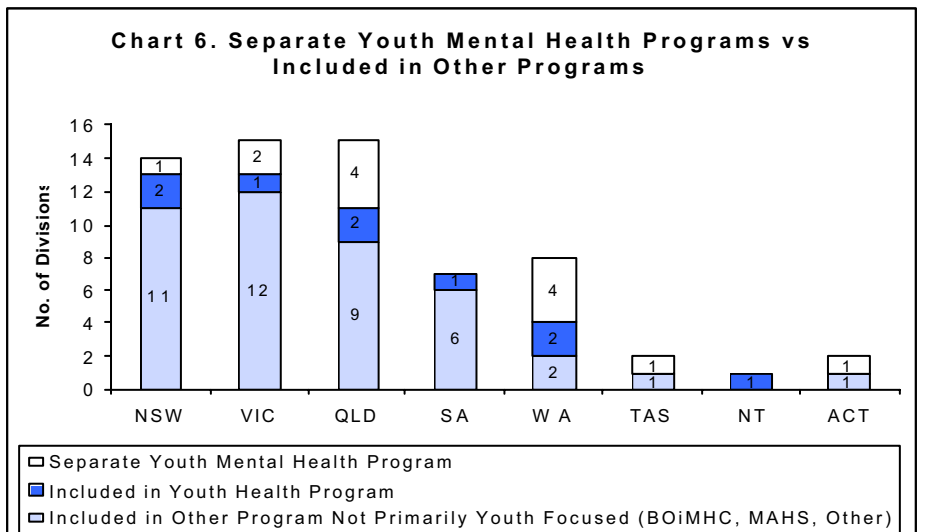
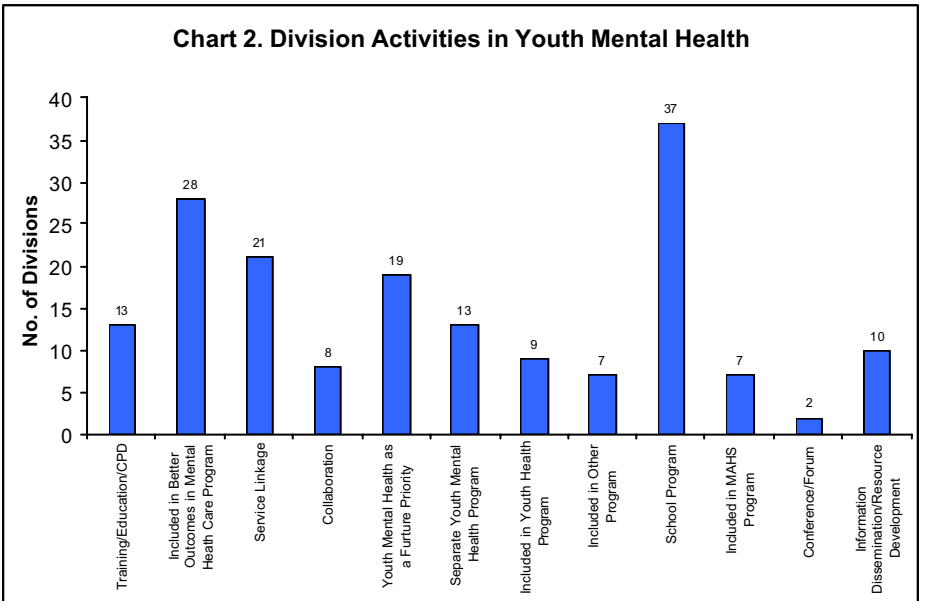
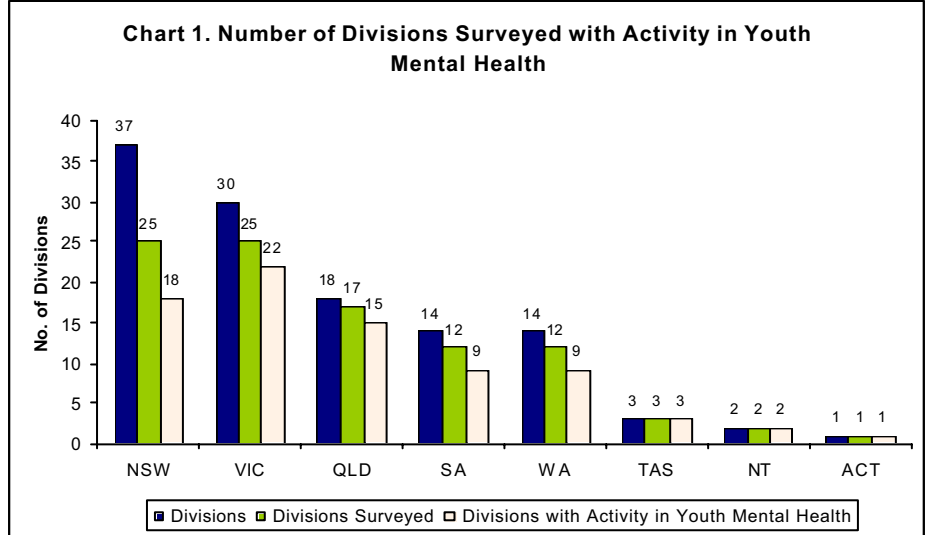
The 2005 PARC Knowledge Harvesting project is now complete and online, with a database of responses from 97 (82%) Divisions and 7 SBOs. The majority of Divisions (60) chose to do the written questionnaire, compared with 37 interviews, although some Divisions actually changed their minds and chose an interview – the advantage of the interview is that it allows interaction and clarification (and therefore better quality data) and may actually take less time. Over the next few months we will present a series of articles analysing aspects of the data, both quantitatively (within the limits of the methodology and the data that was given) and qualitatively. Please let us know if there are any topics you would like to see covered.

This report represents an analysis of the responses of these Divisions in the area of Youth Mental Health.

## Division Activities in Youth Mental Health

79 (81%) of the Divisions that responded to the survey reported at least some activity in relation to Youth Mental Health. Upon closer analysis, however, these activities can be seen to vary substantially in priority, focus, capacity, Division involvement and impact on the community. Chart 2, shows a breakdown of the Divisions' reported activities in Youth Mental Health into twelve common categories. 75% of the Divisions who reported some activity in Youth mental Health had an activity, or activities, that fitted into two or more categories.

Chart 2 demonstrates what is essentially a fairly even spread between the types of activities reported by Divisions to target Youth Mental Health. There are however, a few stand out categories more commonly employed, the most obvious of these being School Programs. As shown in Chart 2, 37 Divisions reported having a School Pro-



gram, making it the most common type of activity. Activities included under the School Program category include MindMatters Plus GP programs, individual GPs giving presentations or education sessions in schools, or more specific, individual Division projects that name Schools as a primary target or location.

Including Youth Mental Health in Better Outcomes in Mental Health Care (BOiMHC) programs was also an activity reported by a large number of Divisions (28). Again this may include a variety of formats, such as separate funding for specific youth mental health, or existing BOiMHC services being available to youth. Such a distinction is, however, not always specified in the responses from Divisions and as such, more specific detail into how Youth MH is included in BOiMHC cannot be reported.

Service Linkages and Youth Mental Health as a Future Priority, a category which includes planned future projects, were also activities reported by a higher number of Divisions (21 and 19 respectively).

Charts 3 through 5 demonstrate a state breakdown of these most common types of activity reported by Divisions with the exception of Service Linkages.

Chart 3 demonstrates that of the Divisions surveyed who reported at least some activity in Youth Mental Health, NSW, had the lowest proportion of Divisions with School Programs. That is, only 24% of the NSW Divisions who reported an activity in Youth Mental Health had a School Program based activity. All of the Tasmanian Divisions, one out of the two Northern Territory Divisions and 48% of the Victorian Divisions with a Youth MH activity reported having an activity that fit the School Program category. 49% of the Divisions who reported a School Program based activity had a MindMatters Plus GP program.

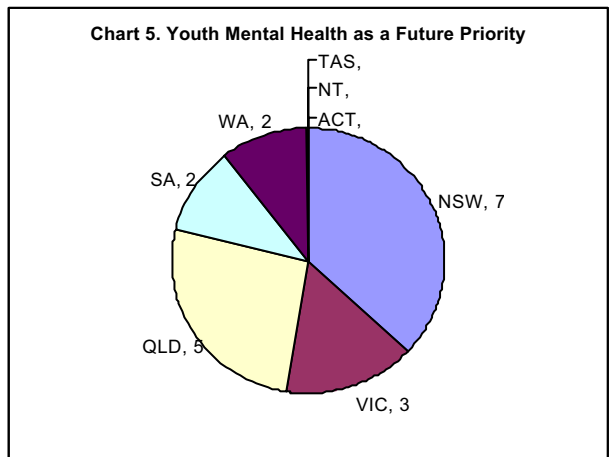
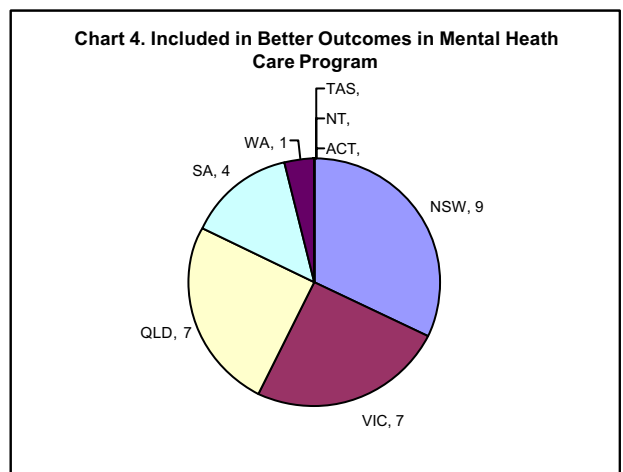
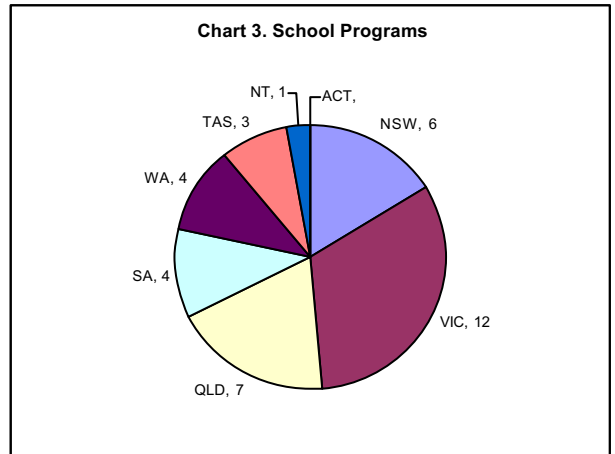
Tasmanian Divisions, Northern Territory Divisions and the ACT Division did not report including Youth Mental Health in BOiMHC programs, as demonstrated in Chart 4. In contrast, 50% of the New South Wales Divisions who reported having an activity in Youth MH, reported including Youth MH in BOiMHC programs.

As can be seen in Chart 5, New South Wales demonstrated the highest number and the highest proportion (39%) of Divisions whose reported activity in Youth Mental Health included having it as a Future Priority. Aside from TAS, NT and ACT, where no reported activity fit this category, Victoria had the lowest proportion of Divisions reporting Youth Mental Health as a future priority.

Demonstrated in Chart 6, the Youth analysis of the 2005 Knowledge Harvesting Database has also demonstrated a tendency for Divisions to include activities based on Youth Mental Health in other programs that may not have a specific Mental Health, or a specific Youth focus (eg. BOiMHC, MAHS etc.). This is rather than having a specific, separate Youth Mental Health Program.

**Divisions’ Focus on Youth Mental Health**

The many and varied activities that Divisions Australia wide have employed to target Youth Mental Health have dealt with a wide array of topics, and targeted a diverse range of groups. In their activities, Divisions have reported targeting groups such as homeless young people, Indigenous youth, ‘At Risk’ youth, and families affected by drug use. The activities have been reported to focus on topics as diverse as ADHD, suicide, drug use, stress management, risk taking behaviour, self-esteem, school bullying, loss and grief, depression, anxiety, resilience building, conduct disorders and comorbidity. There has also been mention of dealing with access issues and communication between General Practitioners and young people, as well as improving the knowledge of young people, teachers and parents, and increasing GP skills in treating, and in particular prescribing for, young people.



The PARC Mental Health Activities of Divisions Database can be found on the PARC website at [www.parc.net.au](http://www.parc.net.au)



# Mental Health - Results from the 2003-04 Annual Survey of Divisions



By Miriam Keane, Research Associate, Primary Health Care Research & Information Service (PHC RIS)

The Annual Survey of Divisions (ASD) is conducted each year by the Primary Health Care Research and Information Service (PHC RIS), on behalf of the Department of Health and Ageing. This survey gathers a complete record of the membership, infrastructure and involvement in programs and activities for each Division. Analysis of the data for 2003-04 resulted in the publication of *Divisions: the Network Evolves*, a comprehensive report which combines and summarises the information gathered with the ASD. This report can be obtained by contacting PHC RIS on 1800 025 882.

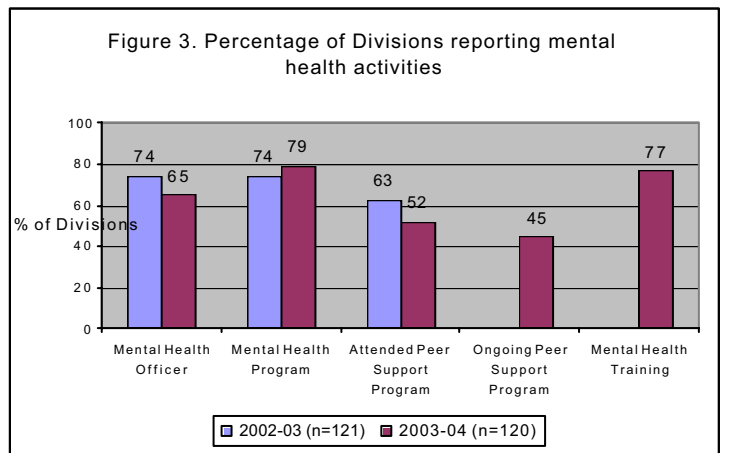
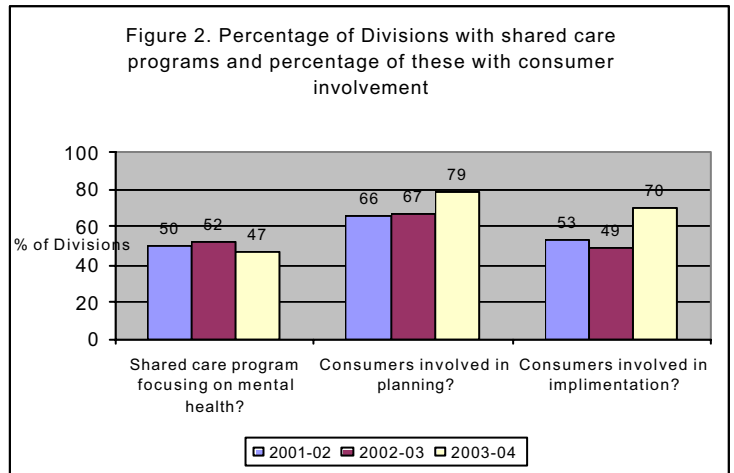
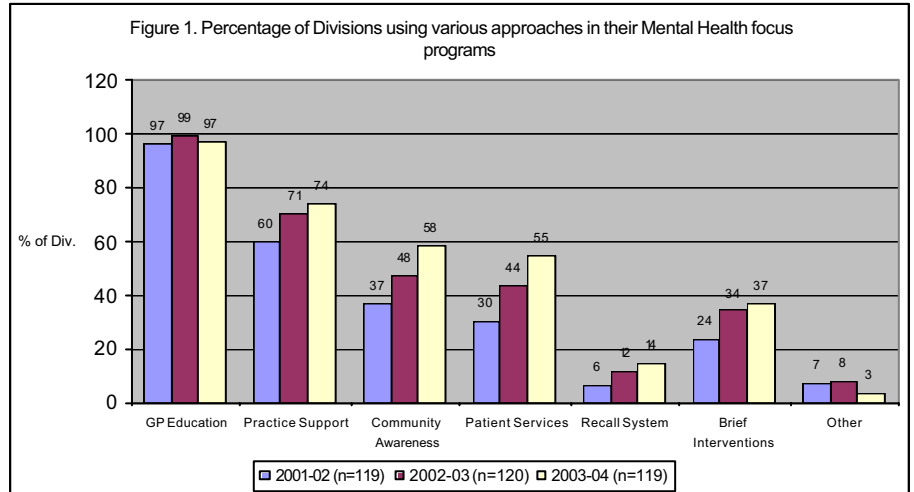
Mental health is one area of health service provision covered in this report. In 2002-03, 99% of Divisions (120/121) reported that they were involved in mental health programs, and this figure has remained the same for 2003-04 (119/120). As was reported in previous years, GP education was the most popular approach, followed by practice support, community awareness and patient services. Though it was still the most used approach, the percentage of Divisions using GP education dropped slightly, as did the number involving 'other' approaches. All other approaches showed an increase in the number of Divisions using them, as illustrated in Figure 1.

The majority of Divisions (82%, 98/119) reported that these programs or activities were aimed at no specific group. The specific group identified most frequently was Children/Youth (25%, 30/119). Culturally and Linguistically Diverse populations were targeted least often (8%, 9/119).

Almost half (49%) of the programs were developed in collaboration with Non-Indigenous consumers. Just under a quarter (24%) of the programs were developed in collaboration with Indigenous consumers and/or organisations.

Responses to questions regarding the provision of services to patients showed that over half (52%) of Divisions directly provided mental health services to patients. This was an increase of 20% since 2002-03 and was more than double the number of Divisions reporting such services in 2001-02 (22%). The number of patients accessing these services has more than quadrupled since 2001-02, as shown in Table 1.

2003-04 saw a small reduction in the percentage of Divisions with shared care programs, but an increase in the involvement of consumers in both the planning and implementation of these programs, as seen in Figure 2.



2001-02 (N=123)		2002-03 (N=121)			2003-04 (N=120)			
Number of Divisions	%	Number of patients	Number of Divisions	%	Number of patients	Number of Divisions	%	Number of patients
29	22	5971	39	32	17782	62	52	27315

Though there was a drop in the percentage of Divisions that had Mental Health Officers, as can be seen in Figure 3, there was actually an increase in the total FTE for mental health officers Australia wide, from 54.57 in 2002-03 to 64 in 2003-04. The percentage of Divisions with a mental health program also increased, though the percentage that had GPs who attended peer support programs decreased. This year, data was collected for the first time on the number of ongoing peer support and mental health training programs. These data are also shown in Figure 3.

The percentage of Divisions with allied health professionals dedicated to mental health also increased over several professions (see Table 2). The greatest increase was in psychologists, with 68% of Divisions reporting that they had at least one working for their Division in 2003-04. There was a slight drop in the number of Divisions employing at least one social worker. This drop appears to be mostly related to social workers funded under the More Allied Health Services (MAHS) program. Mental health nurses were also employed by a larger percentage of Divisions, with the rise funded predominantly by the Better Outcomes in Mental Health Care (BOiMHC) initiative. There was also a positive change in the percentage of Divisions with at least one counsellor, with this figure quadrupling since the 2002-03 reporting period.

Figure 4 shows that there were also considerable increases in the overall Full Time Equivalent staff (FTE) reported by Divisions for mental health focused allied health professionals. The nineteen percent increase in Divisions with at least one psychologist was accompanied by an increase in overall FTE of more than 300% since 2002-03. The greatest per-

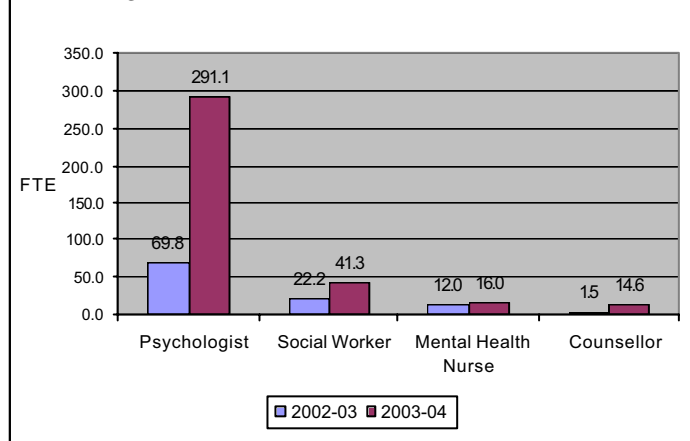
**Table 2. Divisions' with at least one mental health focused Allied Health Professional**

	2002-03 (N=121)	%	2003-04 (N=120)	%
Psychologist	59	49	81	68
BOiMHC	15	12	52	43
MAHS	46	38	47	39
Other	8	7	9	8
Social Worker	29	24	28	23
BOiMHC	5	4	12	10
MAHS	21	17	16	13
Other	5	4	4	3
Mental Health Nurse	12	10	18	15
BOiMHC	2	2	9	8
MAHS	9	7	10	8
Other	2	2	1	1
Counsellor	4	3	14	12
MAHS	0	0	13	11
Other	4	3	2	2

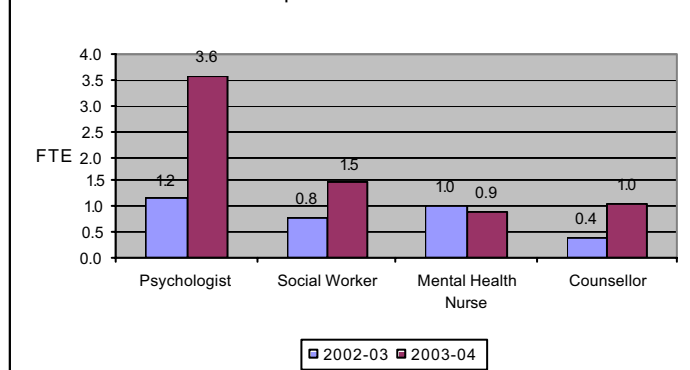
centage rise in FTE since 2002-03 was for counsellors, increasing to 14.58 FTE, an increase of over 850%. Despite the drop in percentage of Divisions with at least one social worker, the FTE for this group of allied health professionals also increased by 86% from the 2002-03 figures. FTE amounts for mental health nurses remained relatively stable, with a 33% increase.

By combining the information shown in Figures 4 and 5, we get a more accurate picture of the changes in these services at the Divisions' level. Figure 5 shows the changes in FTE per Division with that service, for each of the mental health allied health professions mentioned above. From this we can see that Divisions with at least one psychologist had an average of 3.59 FTE psychologists in 2003-04, an increase of 2.41 FTE since 2002-03. Increases are also present for social workers and counsellors; however, the average FTE for mental health nurses has decreased by 0.11 FTE, to less than 1 FTE mental health nurse per Division.

**Figure 4. FTE of Allied Health Professionals**



**Figure 5. FTE of mental health focused Allied Health Professionals per Division with that service**



**Reference**

Kalucy E., Hann K. & Guy, S. (2005). Divisions: the Network evolves. Report of the 2003-04 Annual Survey of Divisions of General Practice.. Adelaide: Primary Health Care Research & Information Service, Department of General Practice, Flinders University, and Australian Government Department of Health and Aging.



## Diagnosis, Management and Outcomes of Depression in Primary Care

Associate Professor Jane Gunn, Director of Research and Deputy Head of Department and Dr Gail Gilchrist, Senior Research Fellow, Department of General Practice, The University of Melbourne



### 1. Building capacity in primary care mental health research and evaluation: The *diamond* Consortium

*What is the diamond Consortium?*

*diamond* is a network of researchers, clinicians, policy makers and consumers co-ordinated by the Department of General Practice at The University of Melbourne. The *diamond* consortium was funded by *beyondblue* Victorian Centre of Excellence in Depression and Related Disorders in 2004, to build on the already established NHMRC funded Diagnosis, Management and Outcomes of Depression in Primary Care (*diamond*) longitudinal study.

*diamond* Vision

Our vision is to contribute to building the evidence base that is required if we are to have a primary care system that promotes emotional well-being and provides Australians experiencing depression with accessible, responsive and effective management options to assist recovery and maintain well-being.

The *diamond* Consortium aims to:

- Co-ordinate & communicate research activities across disciplines, organisations and geographical boundaries;
- Facilitate the open exchange of information and sharing of resources;
- Develop and implement a coherent and integrated research plan building upon the *diamond* longitudinal study;
- Nurture the careers of young researchers and research students;
- Promote a 'community of researchers' with a strong element of mentorship.

#### Who are the *diamond* Consortium?

Associate Professor Jane Gunn chairs the consortium and is assisted by Dr Gail Gilchrist as Senior Research Fellow



Victorian Minister for Health, Ms Bronwyn Pike, announces the award of funding to the *diamond* Consortium in May 2004.

(from left to right: Dr Heather Rowe, Associate Professor Kelsey Hegarty, Associate Professor Jane Gunn, Dr David Pierce, Ms Bronwyn Pike, Ms Leonnie Young, Dr Jane Fisher, Professor Michael Kyrios and Dr Grant Blashki)

and Consortium co-ordinator and Miranda Hindle as the Consortium administrator. Ms Maria Potiriadis as Consortium project officer has recruited 30 GPs into the longitudinal study. The Consortium has over 60 members from Victoria, interstate, New Zealand and the UK.

We are multi-disciplinary and multi-method researchers with qualitative and quantitative expertise. In particular we have a strong focus on the system of primary care and consumer input – one which is not well documented. Our research will contribute evidence to the debate about primary care mental health policy. We are, in the main, primary care researchers with excellent links to our specialist colleagues. We have strength across the life-cycle, the rural/urban locations and practitioners.

*What do we do?*

The *diamond* Consortium structure and key activities are detailed on page 9.

*Progress*

The *diamond* Consortium holds two workshops per year to encourage the open exchange of information and sharing of resources. Our visiting academic program

provides a forum for discussion and debate about the challenges facing depression research in primary care. To date the *diamond* Consortium has hosted eight seminars, three workshops and three visiting academics; Professor Christopher Dowrick from the University of Liverpool, UK; Dr Dan Chisholm from the Department of Health System Financing, Expenditure and Resource Allocation and also the Department of Mental Health and Substance Abuse, WHO Geneva (jointly funded by the *diamond* Consortium and the Primary Care Evidence-Based Psychological Interventions Collaboration (PEP Collaboration)) and Associate Professor Todd Edwards from the University of San Diego, US (funded by The University of San Diego).

*diamond* Consortium members have been successful in obtaining funding for seven collaborative grants for research projects on depression (and related disorders) in primary care.

RE-ORDER -Re-organising care for depression and related disorders in the Australian primary health care setting, funded by the Australian Primary Health Care Research Institute was one



of the seven successful projects. This project will re-examine the way in which people experiencing depression are cared for in the community. By applying complexity theory and the model of the complex adaptive system to our existing research data gathered from patients and practitioners, we will identify the minimum specifications for effective primary mental health care, put these minimum specifications into practice, and monitor the impact on patient and practice outcomes. It is hypothesised that recovery from depression can be improved by a primary mental health care system that is based on minimum specifications and is facilitated to function as a complex adaptive system. We have secured funding to offer a PhD scholarship for RE-ORDER. If you are interested in applying for this scholarship, please contact A/Professor Jane Gunn on (03) 8344 4530 or email [j.gunn@unimelb.edu.au](mailto:j.gunn@unimelb.edu.au)

The *diamond* Consortium provides seed funding for Consortium members to undertake pilot research for projects related to depression in primary care. To date three seed proposals have been awarded funding.

The *diamond* Consortium facilitates opportunities for postgraduate students undertaking research in primary mental health care and is currently establishing a research higher degree (RHD) students' network. A seminar will be held early next year where students can present the methods and findings of their research to our Visiting Academics and other RHD students working in related areas.

For more information visit: [www.diamond.unimelb.edu.au](http://www.diamond.unimelb.edu.au)

**2. Diagnosis, Management and Outcomes of Depression in Primary Care: a longitudinal study**

Diagnosis, Management and Outcomes of Depression in Primary Care (*diamond*) is a 12-month longitudinal study (funded by a 3 year NHMRC grant and *beyondblue*) exploring the patient, practitioner and system factors affecting the diagnosis, management and outcomes of depression in the primary care setting. Leading the group is Associate Professor Jane Gunn. *diamond* is the first extensive exploration of its kind in Australia to map the pathways to and from primary care for people experiencing depression and to investigate the predictors of recovery and relapse. Through this study we will learn about how emotional issues are currently managed and to recommend changes to the system where necessary.

Following a very successful pilot in regional Victoria, the next phase of *diamond* is now underway across rural and metropolitan Victoria. In total, around 18,000 patients aged 18-75 years, who have attended their GP in the previous 12 months for any reason, will be screened for depression using a postal survey. Only those who meet criteria for depression will be eligible to participate in the *diamond* 12-month longitudinal study. Between 600-700 patients with probable depression will be recruited to this study. The cohort is followed up by postal survey at baseline, 3, 6, 9, and 12 months. Participants are also interviewed by phone at baseline about their

experience of depression.

Recruitment of the cohort for the *diamond* longitudinal study began in January 2005 and will continue throughout 2005. Since January this year, the *diamond* Study team have travelled over 4500 km visiting clinics and medical centres in every corner of the state. As of 15 September 2005, over 14,000 patients from 24 GPs have been sent a screening survey, and 500 patients with probable depression have been recruited to the cohort study. *Now that's a lot of mail!*



Here is what some people had to say about participating in *diamond*:

"It was good to be able to express views that may be difficult to put in writing, and know that what you say is validated."

"I enjoyed being a participant and hope that it has helped in some way"

"...knowing this survey could help people and doctors having a better understanding"

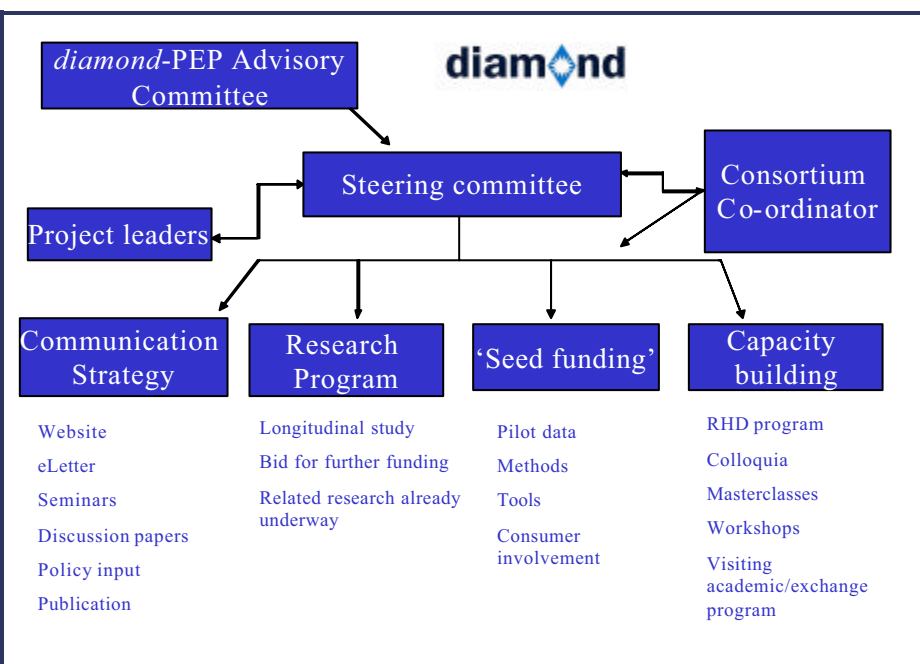
"(the positive aspect to taking part was) the thought that I was doing something good for the community"

"(the experience was) overall a positive one, I felt validated and that my view is important!"

The results of the study will be available from 2007.

Contact:  
Jane Gunn  
Email [j.gunn@unimelb.edu.au](mailto:j.gunn@unimelb.edu.au) or  
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Structure and key activities of the diamond Consortium



## Children of Parents With A Mental Illness (COPMI) Initiative

Elizabeth Fudge, COPMI Project Manager

A previous article about the national COPMI initiative appeared in the December 2002 issue of PARC Update. Since that time we have released a range of resources of potential use to GPs – all of which are accessible via our website at <http://www.copmi.net.au>.

- *"The Best For Me and My Baby"* A booklet developed with and for women with a mental health problem or mental illness – and their partners – who are thinking about having a baby, are new parents or are about to have a baby.
- *"Family Talk"* A booklet written with and for families in which a parent has a mental illness or mental health problem containing tips and information for parents, children and young people and others who care.
- *Baby Care Plan* A downloadable template for parents to complete with a service provider where plans can be documented for a baby's care should a parent become temporarily too unwell to care for their child.
- *"Principles and Actions for Services and People Working with Children of Parents with a Mental Illness"* Providing guidance for organisations and individuals, the document is the culmination of consultations with parents who have a mental illness, their carers and children, service providers and experts.

Both booklets and the key document are downloadable from the COPMI website and orders for free copies of the booklets and document can be made online or by contacting Elizabeth Fudge, COPMI Project Manager. The site also contains specific pages of information for people working in the following

fields - General Practice, Education, Justice, Child Protection, Early Childhood, Child and Family Health, Youth and Community Work and Mental Health Services. The General Practice pages were developed within the first phase of the COPMI project with the assistance of the ADGP and GPs involved with the National Divisions Youth Alliance.

### GP Education

The COPMI project was extended in 2004 to build on the development of the resources, specifically,

- To increase awareness and uptake of the COPMI good practice guidelines among individuals and services working with children of parents with a mental illness and their families in Australia.
- To promote and support education and training of the health and other relevant workforces (eg. teaching, community, media) regarding the COPMI resources.
- To increase awareness of the availability of resource materials complementary to the COPMI good practice guidelines and which are appropriate for children and family members affected by parental mental illness (eg. children, young people, parents, family support people).

Within the second phase, the COPMI project has supported the development and evaluation of two education and training programmes for GPs; the "Feeling Attached; Parent and Infant Mental Health" program (previously reported in 'PARC Update' of February 2005 as part of the PIMHIC initiative) and a 'COPMI' training package currently being developed by one of the WA Divisions of General Prac-



tice, in consultation with Ruah Inreach and the Western Australian COPMI Advisory Committee. The latter of these training programs will focus on needs and responses to families and children affected by parental mental illness where the children are aged over 3 years whilst the former focuses on parents and children in the peri-natal period.

Both training packages have or will be developed and accredited for GP Continuing Professional Development points and at Level 1, Better Outcomes in Mental Health training.

The "Feeling Attached" training package has been developed and pilot tested in South Australia but was recently taken to Western Australia as part of a 'Train the Trainer' approach. Over the next twelve months the trainers in WA will deliver the module, providing knowledge, skills and expertise in perinatal and infant mental health to GPs, mental health workers and other care providers. It is envisaged this will enable those who have participated in the training to be better able to identify and treat mental health problems and attachment relationship difficulties in mothers and babies.

Evaluation of both programs will inform potential future roll out of these training options to GPs and others across Australia. For more information about the COPMI project please contact Elizabeth Fudge [fudgee@aicafmha.net.au](mailto:fudgee@aicafmha.net.au)

Ph: (08) 8161 6859 Fax: (08) 8161 6983 Web: <http://www.aicafmha.net.au/copmi>

## National Youth Participation Strategy (NYPS) Project

Sue Garvin, AICAFMHA

The involvement of young people in the planning and development of policy and

services designed to meet their mental health needs has been limited within Australia. The Australian Infant, Child, Adolescent and Family Mental Health Association Ltd (AICAFMHA) has always recognised the importance of including the voice of young people in service design and delivery.

In 2003 AICAFMHA negotiated with the

Australian Government to ensure that young people were consulted during the development of the Third National Mental Health Plan. Consequently AICAFMHA supported a group of young people (12-18 years of age) to be involved in sharing their experiences and providing feedback. The



experience was positive for both the Department of Health and Ageing and for the young people.

AICAFMHA, following discussion with the Australian Government and with the support of a range of national organisations and programs, developed a proposal to undertake a scoping exercise to identify current models of youth participation and potential models for youth participation in mental health. This proposal was funded and a scoping project was conducted between October 2004 and June 2005.

The aim of the NYPS Project was to develop a strategy or model whereby the voice and perspective young people, aged primarily between 12-17 years, could provide input into programs under the National Mental Health Plan (NMHP) and National Suicide Prevention Strategy (NSPS). The key programs identified for inclusion were: Reach Out, MindMatters, Children of Parents with a Mental Illness (COPMI) Project, Auseinet and Community Life.

The NYPS Project undertook to identify current models for and levels of youth participation in mental health in Australia, and to review good practice principles as discussed in the literature. During the initial information collection phase of the NYPS project, AICAFMHA talked to over 100 young people, adults and organisations across Australia and reviewed national and international literature relevant to youth participation, with a focus on youth participation in health and mental health. This phase of the project resulted in the development, with a group of young people, of draft models for youth participation in mental health in Australia.

The subsequent phase of the NYPS Project involved a comprehensive consultation regarding the feasibility of the draft models and preferences for the different strategies. Comment was sought via an online survey, posting on the website, conference promotions, hard copy distribution and targeted focus groups.

The findings supported the conceptualisation of a model of youth participation in mental health which:

- is flexible;
- can be applied as a whole or in parts without judgment about 'more' being 'better';
- recognises that young people and workers/groups have different skill levels and experience so may access the model in different ways; and
- acknowledges that more complex participation strategies should be based on and implemented in conjunction with simpler strategies enhancing sustainability.

The proposed model incorporates three options for youth participation which build on one another.

1. Step Up: involves seeking information from young people
2. Hook Up: involves a facilitator working with young people and supporting networking
3. Speak Up: involves youth as peer mentors, leaders and researchers

The NYPS Project activities, methodology and findings have been documented in a draft scoping project report. This report acknowledges and discusses supports for workers/organisations in relation to organisational capacity to provide them. The report also recognises that any

model of youth participation will require substantial supports to facilitate involvement from a representative range of young people. The concept of a central supporting organisation to act as a liaison between programs under the NMHS and NSPS and to serve an 'information hub' function is also discussed in the draft report.

The outcomes of the NYPS Project process include:

- a draft guiding charter, incorporating the philosophy of youth participation;
- a proposed 3-step model of youth participation in mental health; and
- a concept for a central organisation constituting an 'information hub' to support youth participation in mental health across Australia.

Publication of the NYPS Project Scoping Report has been delayed pending the outcomes of the recently announced Australian Government initiative, the National Youth Mental Health Foundation, which is currently out for tender. Further details about the NYPS Project will be posted on the AICAFMHA website ([www.aicafmha.net.au](http://www.aicafmha.net.au)) as appropriate.

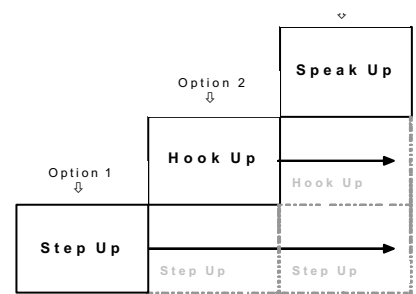


Figure 1. Models of youth participation

## Access to Psychological Assessment – Better Outcomes in Mental Health Care: Our Electronic Referral Pathway

*Sharon Cassar– Galea, Mental Health Program Officer, Westgate Division of General Practice.*



The Better Outcomes in Mental Health Care Initiative (BOIMHCI) has been a highlight initiative for the Westgate Division of General Practice, the collaboration between partners, the enthusiasm of General Practitioners and overall motivation of the Division to keep the program sustainable has resulted in a very successful program.

There are currently 8 General Practitioners and 7 Clinical Psychologists and

Social Workers involved in the Westgate Division Better Outcomes in Mental Health Care initiative. Psychologists and Social Workers were contracted as private practitioners working for a specified fee of \$110 per consultation and for a specified number of 6 sessions predominantly (unless otherwise stipulated by the referring GP). In all cases the allied health professional worked within a

voucher arrangement.

Since commencement of the program in November 2003 we have had over 300 individuals who are or who have



been involved as a patient in the Better Outcomes project. Our recent achievement has been an increase in patient referral rates and, as a result of treatment, patient mental health outcomes have improved for patients involved in the system.

The paperwork issue has always been a barrier for recruiting new GPs into the program and for retaining involved GPs. Whilst thinking about how to implement a paperless system for our panel I spoke to a lot of IT companies and people already involved in electronic referral programs. Fortunately I came across SecureDome, thanks to our IT person Manfred, who had met them at an IT forum and knew I was looking for a company like theirs for our program.

Since meeting with the team, Westgate Division of General Practice has embarked on a Pilot Program for secure electronic patient referral (e-Referral) in collaboration with independent technology provider SecureDome Pty Ltd. The pilot program has successfully employed PDCA (Plan Do Check Act) principles to achieve a solution with high levels of uptake, a high level of security, great workflow improvements and a 350% uptake in patient referrals compared to former non-electronic patient referral processes. The Division is now looking to take what it has learnt from this pilot to embark on future programs. SecureDome is working to employ its technology within other Divisions of General practice and related bodies.

Planning of the pilot BOIMHC Pilot in-

involved consultation with GPs, providers (psychologists), Westgate Division staff, HeSA and SecureDome as well as consideration for requirements of the Department of Health and Ageing. The implementation of the project then involved direct personal interaction with participants to ensure a successful outcome for each group in the pilot program.

The principal focus of the pilot program was to ensure that patient data was shared in a secure electronic environment. The referral solution utilizes HeSA PKI certificates for the identification of GPs, providers (psychologists) and approved division staff. In addition the referral system only uses de-identified data to protect patient privacy. It should be pointed out also that for this Pilot referrals are only made once signed patient consent has been obtained by the GP.

The BOIMHC e-Referral pilot has also achieved greatly improved workflow efficiency, which has had an exponential improvement on manual patient data exchange. Two professionals (GP to Psychologist) can now send and receive a referral within a few minutes compared to an estimated time of up to half and hour required for faxed based communication. Furthermore, I have been able to increase work throughput and focus on program outcomes instead of data management, which is now automatically delivered in various report, tables, graphs and statistical outcomes. The electronic e-Referrals system also introduces prompting and feedback mechanisms for notices of referral, reminders for follow up and even helps in the management of

eReferral decision making and scheduling.

Furthermore, the system connectivity to a wide national network utilizing HESA PKI certificates is ready and capable of integration to existing health systems.

In concluding this report, this pilot program of the BOIMHCI has made substantial achievements for the Westgate Division of General Practice. The implementation of an electronic referral system has not only proved beneficial in increased efficiency and security, but overall, has impacted on the amount of referrals performed across the program and the dynamics of partner contribution.

As the pilot is now complete recommendations have been made to improve the current electronic referral pathway and add detail to referral forms specific in accessing particular patient information. I have also been eager to capture on the electronic system what patient medication pathways are in juxtaposition to their therapy.

The next stage of the project will look at involving other area mental health services, that assist in alcohol and drug treatment in culturally and linguistic diverse communities and also including youth specific groups and indigenous communities. These next steps will ensure that the program provides a continuum of quality mental health care for all patients within the Westgate catchment.

## The Townsville/Thuringowa FRIENDS Implementation Project

*Lynette Russell, Townsville Division of General Practice*

FRIENDS is a world-leading, resilience-building, anxiety prevention and treatment program for children. It has been developed through extensive research and validation over a number of years at Griffith University in Queensland. It is presented in ten easy to follow one hour sessions. Children learn a range of strategies such as problem solving, thinking positive, how to ask for and give support, and they have a lot of fun. The program is used in schools

and clinics throughout Australia and in several overseas countries.

In 2003 the Townsville Division of General Practice received funding, from the Gluyas and Hayles Family trust funds through Perpetual Trustees, to implement a FRIENDS project in the Townsville/Thuringowa area.

### **Features of the Townsville/Thuringowa project**

The project reference group includes representatives from Education Queensland, the Catholic Education Office, the Public Health Unit, James Cook University School of Education and Queensland Health's Child and Youth Mental Health Service. This has ensured that key local agencies are aware of and supportive of

the project and that the project is geared towards meeting local needs.

Classroom teachers and third year School of Education students from JCU jointly implement the project in the classroom. As part of their Professional Development Experience, students need to undertake 50 hours of approved community work. Students can obtain information about approved community work options from the School of Education website. The FRIENDS information includes a registration form that students complete and email to the Division.



The Division Project Officer sent information to all local schools inviting them to become part of the project. Counselors from Education Queensland and the Catholic Education Office followed this up in schools that it was felt would particularly benefit from the project.

All teachers and students who are delivering the program must complete the one day Group Leader training. In the first year of the project (2003), this training was delivered by a clinical psychologist, who is part of the FRIENDS development team at Griffith University. The Townsville/Thuringowa project subsequently assisted two local psychologists to undertake the FRIENDS Train the Trainer program in Brisbane. These two psychologists then ran the 2005 Group Leader Training in Townsville/Thuringowa. Both of these psychologists were already experienced FRIENDS practitioners, who ran FRIENDS clinics as part of their private practices. The project was able to provide the one day Group Leader Training free to teachers and students. Students and teachers received a group leader manual and a copy of the student workbook as part of the training. The Group Leader manual provides detailed lesson plans for each of the 10, one hour long classroom sessions. One of the teachers who participated in the FRIENDS program in 2003 and who has been using it with students ever since, spoke about the program and answered questions. This was very well received by the participants.

The project also supplied participating schools with class sets of student workbooks free.

In its initial year the project also sponsored a parent information and education evening. This was very poorly attended and the decision was made, in 2005, to develop some parent information sheets for distribution by participating schools instead. One school, which has been running the program in a number of classes, has decided to organise a parent evening, which will be run by one of the psychologists who presented the Group Leader training. This evening will also be open to parents and teachers from any of the schools that are participating in the FRIENDS project. The degree to which parents are interested in, and want to learn more about the program, depends largely on how much information the school has presented to families. The project supplied schools with some initial information for parents, some schools have followed this up with lots of positive information and regular updates on the program in the school newsletter.

A project evaluation was carried out during the first year and (ongoing) evaluation of this years project is underway. Some key points to emerge were

- The majority of the teachers felt that co-facilitation worked very well, enabling the class to break into smaller groups for discussion. In a few cases, differing expectations between teachers and students about the level of involvement by the student, caused some problems. The program seemed to work best where time was spent beforehand negotiating roles. The JCU students overwhelmingly valued their participation in the project, with many feeling that it had assisted them in developing a broader range of positive

teaching strategies. When students felt that their contribution was appreciated by the teacher, or where they saw themselves as working in partnership with the teacher, then they usually gave generously of their time and energy to the program.

- Both teachers and students found the one-day Group Leader Training to be very useful. Not only did the training provide them with knowledge and information, but because the training involved them in carrying out some of the activities they would be doing with the children, they were able to see that the program would be fun and workable in the classroom. All participants said that they would make some changes to their class room practices as a result of the training.
- Feedback on the actual delivery of the program in schools has been very positive. The children's workbooks were well received and the mix of activities and small group talk time were seen as being a good combination for supporting children's learning and enjoyment.
- Several schools that participated in the 2003 FRIENDS program sent more teachers along to the 2005 program. The schools where they are teaching have continued to incorporate FRIENDS strategies and ideas into the broader school curriculum.

Lynette Russell from the Townsville Division of General Practice can be contacted on (07) 4725 8921 or by email at [lynette@tdgp.com.au](mailto:lynette@tdgp.com.au)

## Access to Allied Psychological Services Program: Adelaide North East Division of General Practice

*Carolyn Black, Project Manager, Adelaide North East Division of General Practice.*

The Adelaide North East Division of General Practice – Access to Allied Psychological Services Program commenced in July 2003 and is designed to provide those GPs who are registered for the Better Outcomes in Mental Health Care initiative with the HIC, with support from allied health professionals in treating people with a mental health disorder.

The project provides allied health services to people with mental health problems. Two-hour computer assisted group sessions every week for six weeks are available for those people who require therapy for Depression, Anxiety, Panic and Stress. The groups

are facilitated by qualified health professionals with a focus on psycho-education or cognitive behavioural therapy and are tailored to meet the needs of the individual.

The program has grown significantly since its inception with the expansion of services that include therapeutic groups for young people, groups with a focus on eating disorders and groups for older people 65 years plus. The Division has become increasingly aware of the special needs of older and younger people with depression through activities associated with the National Suicide Prevention Project. It is well established that the north east community is an ageing population

with an ever-increasing need for services for elderly people and yet there is also a trend towards an increasing population of young people aged between 12-25 years (2001 census). The Tea Tree Gully Council is particularly concerned



about these two diverse populations and has developed both Ageing and Youth Participation Strategies. The Tea Tree Gully Council calls for increased collaboration in service delivery to these population groups and aims to foster partnerships with the North East Division to achieve its objectives (Ageing Strategy 2001-2011 & Youth Participation Strategy 2002).

A new group **'Time Out To Relax'** has been developed and is now well integrated into the program. It provides relaxation techniques for depression, anxiety, panic and stress. The course addresses stress management and includes a range of techniques that include:

- Mental imagery
- Sleep facts and hygiene
- Changing the way we think
- Creating your own relaxation record
- Physical relaxation

Dr Cate Howell in collaboration with the Department of General Practice has developed a Relaxation CD (Keeping the blues away). This CD is one part of the 'Keeping the Blues away' treatment program which aims to reduce the relapse of depression. There has been a keen interest from GPs who have purchased the CD either for their own use or their patients. The CD is utilised as a part of the relaxation component.

#### **Sleep Facts and Hygiene**

In May 2005 group work expanded to include sleep facts and hygiene sessions with the use of the Insomnia Management Kit developed under the Quality Use of Medicines Program, Drug programs & Population Strategies Branch Department Of Human Services

and Government of South Australia. The relaxation and therapeutic groups now include information about sleep, relaxation and the risks associated with taking medications to assist sleep. This segment has been introduced as a result of a large majority of clients attending the therapeutic and relaxation groups indicating to the therapists that they had difficulty sleeping or irregular sleeping patterns. A significant number of clients were taking medication to help them sleep. It is anticipated that this segment in the group work will help to increase the participant's awareness of the appropriate use of medications for the management of sleep difficulties and increase participant's awareness of the non-drug therapies that can be used for the management of sleep.

#### **Therapy Groups for Patients and a Significant Other**

These groups are a further addition to the Allied Health program and provide therapy for patients diagnosed with anxiety and/or depressive disorders, who would like a significant other to attend the sessions with them. The same format as the Divisions existing therapy groups are used and sessions are specifically tailored to meet the needs of the patient and significant other. A significant other could be a carer, parent, spouse, sibling or friend and will be nominated by the patient. By including a significant other a greater understanding about mental health and how to provide ongoing support can be achieved.

Including a 'significant other' in group therapy is a direct response to suggestions / requests by past participants, and the growing awareness of the important role of carers in managing individuals

with mental health issues. The rationale behind including a significant other in these groups is to provide individuals with ongoing support in their daily life. Like physical exercise, maintaining changes in behaviour / thinking requires regular effort, often helped by support from other people. As far as we are aware, there are currently no services available which meet this demand.

The Division also acknowledges the core principles from the SA Carers Report (Government of South Australia) in recognising the importance of the role of carers, particularly in this case, to work in partnership with service providers.

The Allied health program links well with the ANEDGP Suicide Prevention project where an information resource kit on suicide prevention has been developed along with an information brochure, "Hold On" information resource card and a Level 1 Better Outcomes in Mental Health accredited education program on suicide prevention and self harm. In conclusion it appears the Allied Health Project for the Adelaide North East Division has improved access to quality mental health care for residents of the north east.

We continue to be grateful for support from the University of NSW and Monash University for enabling the Division to access the 'Climate' and 'Panic Online' computer treatment programs.

For further information on the program, resources developed or on how to purchase the relaxation CD contact Carolyn Black at the ANEDGP or email [cblack@anedgp.com.au](mailto:cblack@anedgp.com.au).

## Managing the Mix in Sydney's Inner West: Primary Care Partnerships for Comorbidity

*Jerry Bacich, Mental Health & Drug Health Programs, Central Sydney Division of General Practice*

Managing the Mix in Sydney's Inner West: Primary Care Partnerships for Comorbidity is a collaborative project between Central Sydney Division of General Practice (CSDGP), Canterbury Division of General Practice (CDGP) and Sydney South West Area Health Service

(SSWAHS) Mental Health and Drug Health services.

Central Sydney Division of General Practice (CSDGP) and Canterbury Division of General Practice (CDGP) provide coverage of the eastern zone of the Sydney South West Area Health Service (SSWAHS) region. The CSDGP located in Sydney's geographical Inner West has over 650 GPs practising within 275 practices and is characterised by a large number of solo and small general practices - currently 114 practices are registered for accreditation. CDGP covers the

area from Sydney's Inner West to Bankstown, there are 203 GPs practising within the 136 practices of the Division. Also characterised by a large proportion of solo practitioners, there are currently 58 practices registered for accreditation.

The area covered by the two divisions is generally characterised as being a culturally and linguistically diverse with are a large number of well established



*(Continued on page 15)*

*(Continued from page 14)*

ageing trans-cultural residents. A considerable number of suburbs fall within the lower socio economic band level alongside a significant number of suburbs along the Parramatta River and Sydney Harbour with a higher socio economic status. Of the Sydney South West Area Health Service eastern zone (SSWAHS) population, 196,365 (41.3%) speak one or more languages other than English at home (compared with 18.7% of persons in NSW as a whole). Further advice received from the Department of Veterans Affairs revealed over 4,500 veterans living in the postcodes serviced by the CSDGP alone.

In the SSWAHS Mental Health Service Plan, it was noted that the proportion of people in Central Sydney with a mental illness was above the national average, estimating that between 20-25% may be affected. It was estimated that as many as 118,000 residents in Central Sydney may be affected by a diagnosable form of mental illness. The report also noted that the vast majority of these residents mainly received care from their general practitioner.

This population health data has provided the evidence to support the CSDGP and CDGP in taking the lead in developing and implementing a number of shared care programs, and we currently have programs in place in a number of clinical areas. This shared care approach has been successful in achieving better utilisation of resources for both the Divisions and other stakeholders, development of combined treatment protocols, improved availability and quality of service to both GPs and their patients and cost effectiveness.

The Divisions' experiences have shown that the success factors for the effective shared care model include developing structures and systems that encompass coordinated treatment plans, guidelines and protocols of care, agreed roles and responsibilities, communication mechanisms and outcomes evaluation. Shared Care programs are supported by Memoranda of Understanding (MoU) with SSWAHS Mental Health and Drug Health Services with regard to outcomes, governance and respective responsibilities.

The intention of the Mental Health MoU between the Area Health Service and each Division is to ensure a consistent strategic direction for the Area Mental Health and the Divisions, to identify

current co-working arrangements and develop strategies to enhance the degree of cooperation so as to benefit the community at large. The focus of the relationship between the Divisions and the Area Mental Health Services is on improving referral systems between GPs and the service. A GP Area Mental Health advisory group and Divisional working groups were formed to help coordinate and streamline referral processes, plan future clinical training needs and help initiate specific projects. Additionally SSWAHS MHS employ a dedicated GP Liaison Officer.

The Drug and Alcohol Project continues to expand after it was established with SSWAHS DHS in late 2002 in response to a growing need to address the issues surrounding the treatment of patients with Drug and Alcohol problems in the GP setting. The intention of the MoU undertaken with SSWAHS DHS is also to ensure a consistent strategic direction by the service and the Divisions, to identify current co-working arrangements and to develop strategies to enhance the degree of cooperation and interaction so as to benefit the community. A GP Drug & Alcohol advisory group was formed (in 2003 in Central Sydney Division, and in 2004 in Canterbury Division) to help coordinate and streamline referral processes, plan future clinical training needs and help initiate specific projects. The importance of a dedicated GP Liaison Officer within Drug Health Services and the establishment of Advisory Groups, has resulted in the development of an implementation plan and the signing of a Memorandum of Understanding between the Divisions and Drug Health Services in 2004. This partnership has been presented as a best practice example to the evaluators of initiatives under the Drug Programs Bureau of the Health Department as part of the NSW Government's Plan of Action following the NSW Drug Summit. Unfortunately NSW Drug Health Services decided to cut funding to this dedicated position effective from 1 June 2005. The Division decided to maintain funding two GP Advisors so as to provide the Drug & Alcohol Project with a comprehensive and diverse level of input into the program and to SSWAHS DHS.

Since 1995 the Mental Health and Drug and Alcohol Services of CSAHS have been working together to address the challenge of co-morbidity. In July 1997 a two year Dual Diagnosis Project commenced with the appointment of a Project Officer. The project was met with enthusiasm by staff who provided services to a client group considered to be one of the most disabled in Australia. It

was an aim of the service to have all clinical staff exposed to dual disorder training as part of their required professional development.

DHS has employed a designated Comorbidity Project Officer since 2003 until mid 2005. This Project Officer conducted an extensive service review in relation to assessment and referral into treatment for clients who have co-morbid problems; developing integrated care arrangements for clients with co-morbid problems and improving the capacity of staff to provide services and referral for clients with co-morbid problems. A Mental Health Information and Resources Manual for Drug Health staff and a program of training have been developed.

Currently, both formal and informal referral pathways/protocols exist between the Mental Health and Drug Health Services within SSWAHS. The ongoing co-location of services in both the community and hospital campus settings is helping to facilitate informal communication between the services and additionally formal referral pathways take the form of discharge summary requests from the respective services for follow up of patients by the other service. The discharge summary and communication with GPs is still an area which requires a greater degree of improvement from the SSWAHS and it is hoped that our Comorbidity project will add further evidence for improvement.

A steering committee of representatives from each collaborative partner was formed when we received notice that we had been successful in attracting funding for a local project. The primary role of the Steering Committee is to provide advice on the implementation and ongoing activity within the project – the Steering Committee will also be used to monitor the financial arrangement between the Divisions. Additionally, a monthly meeting is planned between the CSDGP (Jerry Bacich) and CDGP (Christopher Daniel) Project Officers to discuss, plan and review project activity.

The duration of the steering committee will be for the life of the project. An inaugural meeting was held prior to the Adelaide workshop was used as an op-

*(Continued on page 19)*



## Better Outcomes in Mental Health – Youth Access to Allied Psychological Services

*Melanie Seeger, Melbourne Division of General Practice*

The Melbourne Division of General Practice has secured funding under the Better Outcomes in Mental Health – Youth Access to Allied Psychological Services scheme to address the mental health needs of Melbourne's youth who are either homeless or at risk of homelessness.

The consequences of homelessness are far reaching, and include harmful effects on self-worth, long-term physical and mental health problems and a negative impact on the ability to participate in the community. In a recent study of 403 of Melbourne's young homeless, 26% reported mental health problems indicative of a psychiatric disorder with 37% having attempted suicide and 53% feeling dependant on alcohol or drugs. Only half of the sample

sought psychological help, with many reporting that they did not know where to seek help with mental health problems, or that they didn't think anyone could help them (Project i, Australian Research Centre in Sex, Health and Society – *Living well? Homeless young people in Melbourne* [2003] Parity 16(2):13-14).

The new youth service aims to address the mental health needs of homeless young people, providing access to "youth-friendly" GP care and to six sessions of evidence-based therapy from a skilled clinical psychologist provided under the BOiMH Care Program. Working with disadvantaged young people, GPs and clinical psychologists may encounter unique problems that they do not experience in everyday practice. The Division will be providing support and additional

training to help professionals engage young people with mental health services and provide them with positive experiences of mental health care for the future.

Referrals will be sought from youth services, school welfare officers, and self-funded services. The program will help to enhance links between GPs, Primary Mental Health Teams and specialist services to improve the shared care options for GPs and provide better continuity of mental health care for disadvantaged young people.

If you are interested in the project, or have any further questions, please feel free to contact the Melbourne Division of General Practice.



## Macarthur Division of General Practice Better Outcomes in Mental Health Program

*Jane Prain, Macarthur Division of General Practice*

### Background:

The Better Outcomes in Mental Health Care Initiative is funded by the Commonwealth Department of Health and Ageing. The initiative recognizes that most people with a mental health disorder seek help from the GP rather than from a specialist mental health care provider. To support this concept the initiative provides GPs with better education and training opportunities and in doing so improves the quality of care through providing access to focused psychological services to a population group that otherwise might have the opportunity to do so.

The Macarthur Division of General Practice covers the Local Government Areas of Campbelltown, Camden and Wollondilly with a population base of 220,482 as of the 2001 Census. There are currently 91 practices in the Division with a 170 Divisional members.

### The Better Outcomes in Mental Health Care Initiative

#### *Our Mission Statement:*

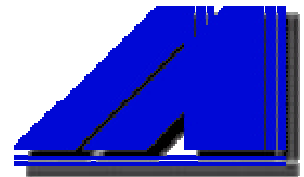
To establish a system framework responsible for ensuring the management within the Macarthur Health Service of the objectives as defined within the Better Outcomes in Mental Health Initiative in a manner that is professional, confidential, fair, equitable, without bias and maintainable within allocated funding arrangements.

The Philosophy of the Macarthur Division of General Practice in initiating the Macarthur Better Mental Health Project was founded on:

- Superior ethical work standards;
- Probity and the principles of patient privacy and confidentiality;
- The development of an appropriate model for the optimal delivery of psychological services to assist GP's in-line with the requirements of the BOiMH project;
- Ensuring accessibility by GPs and Allied Health professionals to members of the project team outside the limita-

tions of normal business hours;

- Ensuring GP access to all appropriate education by facilitating training requirements as determined by the professional body responsible for GP professional development;
- Supporting GPs with an interest in utilising the program whilst at the same time maintaining open communication with those GPs within the area not currently enrolled in the program;
- Encouraging all levels of feedback and viewing of negative comments as constructive criticism and used as a learning exercise for improvement throughout the life of the project and as a measure for ensuring sustainability of the project long-term;
- Encouraging the application of all appropriately qualified Health Professionals with an interest in the program, noting their specialties and availability, and disseminating that information to GPs registered with the program with fairness, equity and without bias;
- Collecting data that is measurable



and valid and providing analysis of the data in a manner that is meaningful to the clinicians;

- Maintaining communication with consumers in a manner that is informative, consultative, collaborative and understandable to facilitate program decision making;
- Undertaking the project within the funding allocation whilst bearing in mind the need to identify sources of additional funding based on a continual needs analysis cycle that supports the evolution of the program beyond the current requirements;
- Noting that the stakeholder body necessary to ensure the success of the project is not limited to the professionals providing the service but includes consumers and their carers.

Since the inception of the program 39

GPs have completed the training required to access the program, with a further 15 having expressed an interest in establishing open dialogue with the Division on how to proceed with registering for the program. Of the 39 GPs 15 regularly refer to the program, prompting the Division to seek additional appropriately qualified Allied Health Professionals to meet the focused psychological interventions offered under the program.

The Division expects to increase its current complement of Psychologists registered with the program to 10 – 15 and in doing so widen the available areas of expertise within the group to better service the demands of the area's diverse multicultural population and mental health needs.

**Recent initiatives undertaken by the Division include:**

- The development of a discreet Mental Health Service for Aboriginal youths and adolescents. The Division is currently seeking additional funding to undertake a formal study that will aim to demonstrate an improvement in the mental health of adolescent Aboriginals within an identified clinical disease group through the implementation of a pre-determined set of psychological interventions;
- Sponsoring Mental Health First Aid training for nursing and clinical staff of the local public hospitals and staff of the Community Mental Health Services;

The Division will continue with its commitment to improving the Mental Health of the community within its boundaries and to seek means and opportunities that will optimally support the visions that we have to achieve this goal.

## Youth Friendly Doctor service for 'at risk' youth

*Amanda Morcom, Perth and Hills Division of General Practice*

The Youth Friendly Doctor service was developed to address a need in the local community. Youth workers in the Swan region of the Perth metropolitan area were finding it increasingly difficult to access a GP for their clients, sometimes having to wait up to three weeks for an appointment. Given that the youth worker may have taken a few weeks to convince the client of the need for medical review, such a delay between contacting the general practice to make an appointment and seeing the GP may mean the client fails to keep the appointment. With this particular target group, who have sometimes taken two weeks to coerce into finally seeing a GP, waiting such a long time to see a GP meant the possibility of losing the client altogether.

Perth and Hills Division of General Practice, after consultation with local GPs with an interest in youth health, devised a system to accommodate young people in need of seeing a GP urgently on a 'same day' basis. It was decided to advertise throughout Perth and Hills Division of General Practice for GPs who liked working with young people, could set aside some time each week to consult with a group of 'at risk' young people and who would bulk-bill for the first consultation.

Those GPs who expressed an interest

were interviewed by the Program Officer who elaborated on the program and what was required of GP participants. GPs who were still interested in participating in the program, allocated a period of time each week or fortnight in their surgeries when they could consult with young people requiring a Youth Friendly Doctor.

These GPs were then placed on a roster and when youth workers, school psychologists and/or nurses contacted Perth and Hills Division of General Practice to access a GP for their client, they were given the name and number of the GPs who were available that day or the next.

The literature has indicated that a major barrier for young people accessing GPs is making an appointment and encountering problems with reception staff. It was therefore decided that as an incentive reward for the GP participation in this program, Perth and Hills Division would train the general practice staff in working with young people.

After consultation with youth workers, a GP, Nurse Coordinator of a youth-specific mobile medical service, Perth and Hills Division Program Officer and a school psychologist/ facilitator developed an effective training program to tackle the issues that reception staff would encounter when working with young people.



**Barriers:**

Although the youth groups and youth workers thought the program was a great idea, they did not utilise it as well as was expected. As a result, GPs lost interest in the program, as their services were not being utilised. The youth workers preferred to have a list of youth friendly doctors who they could phone when required, which risked uncontrolled and overwhelming access to GPs and inhibited evaluation of the program.

**Recommendation:**

The Youth Friendly Doctor service could be adapted and made more flexible to accommodate referrals from youth agencies and schools.



## Murrumbidgee Division of General Practice Access to Allied Psychological Services Employment Model

*Nena Matuska, Mental Health Program Manager, Murrumbidgee Division of General Practice*



Located in South West NSW, the Murrumbidgee Division of General Practice is a rural area located in the Western Riverina District of NSW.

In March 02, I was employed by the Division using both More Allied Health Services funding and local Area Health funding. It was a challenge to take up residence in a rural area and join a Division which previously had not run any specific mental health programs. Like many rural and urban areas we have had a continuous lack of mental health team managers and workers. There are no local private practising psychologists or psychiatrists and typically consumers were forced to travel to Wagga or Albury (2hrs and 3hrs travel respectively) and pay for services. In the first 18 months, the pressure and demands were overwhelming, as I was providing services to eight surgeries. This, combined with travel, made it quite an onerous task. I am still meeting local health workers who are amazed that I have been here three years! I was totally overwhelmed with service delivery and trying to keep up with the waiting lists.

By October 03, we were successful in gaining BOiMHC funding and we employed another 2 FTE psychologists. In June 05 we were successful in obtaining more funding to employ another psychologist to provide interventions to adolescents. The adolescent program will focus on collaboration between school counsellors and the Child and Adolescent Mental Health team and will create referral pathways through these services via the GP. There will also be a focus on Aboriginal education through close work with the Aboriginal Education unit at the local Area Health Service. The service is free to patients and each of the four psychologists provide an outreach service to surgeries.

During this time the program expanded and we contracted two Medical Special-

ist Outreach Assistance Program (MSOAP) psychiatrists who provide clinical consulting services, education to GPs and supervision to our psychologists. The Division also contracted a Community psychiatrist to provide videoconferencing to GPs and psychologist(s) for case discussion and peer support. The program is very collaborative and the employment model works well in a rural area as there are extra benefits for clients. The psychologists also provide mental health education to community health workers, rehab patients and community groups. One of our psychologists received 236 referrals and was booked for 992 sessions in one year.

A significant contribution of our program is to offer GPs the opportunity to register for the Better Outcomes in Mental Health Care Initiative and to facilitate the use of the incentive, as well as providing GPs with a valuable referral option as part of their treatment plan. At present 42 % of GPs are registered for Level 1. The employment model allows for the psychologists to meet with GPs to discuss the 3-step process and provide training in relation to the mental health assessment/plan/review. Through interaction with the psychologist the GP is provided with professional and confidential feedback about a common patient that enables a much faster response time if the patient's needs change. The psychologist is able to meet the needs of an increasing number of patients who request non-drug interventions or who require both pharmacological and psychological interventions. Over time, successful psychologist, GP and patient interaction can increase the confidence and knowledge of the GP and increase GP confidence about making psychology referrals. Our local experience indicates that under the *Better Outcomes* Initiative GPs in clinical practice have gained confidence in making referrals that previously they may have found difficult and time consuming.

Consumer evaluations are easier to organise when the psychologists are employed by the Division. We included a statement of permission in our initial consent form and it is also verbally explained to clients that they may or may not receive an evaluation which they can answer anonymously. The evaluations are returned to the Division.

The last batch of 68 (N) returned consumer evaluations showed that 74% of patients strongly agreed that the skills learnt in therapy helped them cope with their problem. 69% of patients were not able to access another health professional in their area or were unsure if they could (27%).

Some comments from the survey were...*"Excellent service"; "This free service is very important to so many people". "Thank you for the treatment. Being unemployed, I was grateful that it was free". "It was a reassuring experience"; "I am very appreciative this service was available to me, especially free of charge". "Great, life changing service. Provided skills for coping, identified problems logically, stress free and with humour". "...the sessions with my psychologist were so useful to me and helped me more than ever"...;"More psychologists available to decrease waiting time".*

Some of the challenges we meet are not much different to other Divisions. Challenges include difficulties in arranging Level 1 training as typically we don't have the numbers to hold it solely for our Division. GPs seem very prepared to refer to the psychologists but often don't bother to claim SIP payments. Recruiting psychologists can also take some time as all of our psychologists have had to relocate here. When they leave some GPs baulk at the disruption to continued service delivery. But all-in-all, both consumers and GPs express satisfaction with the program.

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# NSW Central Coast Access to Allied Psychological Services Project

*Paul Hussein, Central Coast Division of General Practice*



## Rationale

Data from the National Profile of Mental Health & Well Being (Australian Bureau of Statistics 1997) and the Australian Burden of Disease Study (Mathers & Stevenson 1997) confirm the high incidence of mental health morbidity for the Australian community. Andrews et al (1999 p37) noted that those who did seek help for a mental health problem or disorder (75%) sought help in the first incidence from a GP.

## Project Aim

To support GPs in improving the quality of care provided through general practice to the Central Coast community with a mental health illness through the provision of Allied Health Services.

## Highlights and Achievements

- This year saw a further increase in service providers with a total of 64 GPs and 22 allied health providers (AHP) participating in the program.
- Patient activity through the program has increased by over 100% due to increase in GPs registered with the program and increase in AHP numbers. A total of 566 patients were re-

ferred to see an AHP in 04/05, only 266 have completed their treatment by June 05. In total 3069 sessions of treatment have been delivered at no cost to the patient.

- The Division held a GP & AHP Stakeholders Forum in March 05 and an AHP Meeting in May 2005. The evening gave providers the opportunity to meet and discuss program and clinical related issues. The group agreed these meetings were extremely beneficial and would like them to be held every six months.
- The Division has managed to successfully negotiate access to additional funding from the AGDHA during the 04/05 period with a growth of 53% in income to support patient activity.

## Key Issues

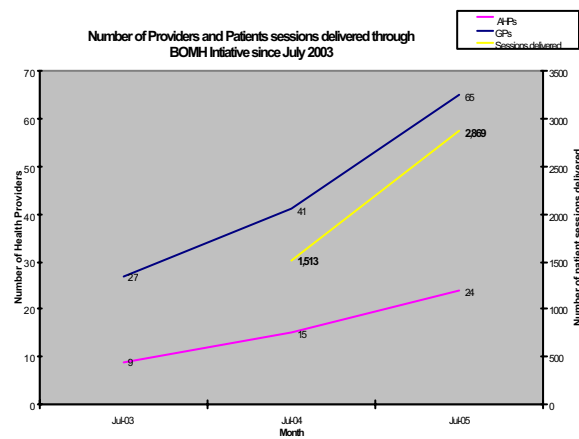
- The main concern continues to be the level of available funding based on the high level of uptake and patient referral activity. Sufficient recurrent funding is required and activity has to be monitored in line with available funds.
- The 3 Step Mental Health Process – the Mental Health Review continues to be a key issue with stakeholders. Patient review is required within 6 months, however AHP treatment is not always completed. A pro - forma was developed so the AHP could provide feedback to the GP after 3 sessions and 6 sessions. This will assist the GP in identifying when the patient is due to return for their mental health review.
- Community awareness is increasing and we have

received numerous enquiries from consumers/ organisations requesting the names of those GPs who were registered. The Division is unable to provide this information without the GPs' permission.

- Discussions have begun with The Eleanor Duncan Aboriginal Centre in ways to implement a clinical model of service to the local Aboriginal community under this program. Another area of the community that also needs to be targeted with this program is Youth Health.
- There have been concerns with the distribution of GPs and AHPs with 75% being in the Gosford Shire. Support and training has been provided to providers in the Wyong Shire over the last year.

## Future Directions

- The Division will continue to reinforce to the AGDHA the increasing expectation and growth in the program and ensure that sufficient funds are made available for the ongoing increase in patient activity. Reporting requirements to the AGDHA allow the Division to provide feedback and concerns over the time-frame restrictions and issues raised by service providers.
- The Division will investigate if any registered GPs are willing to see new patients for a consultation in relation to this service and gain permission to release their contact details.
- Further investigation will be conducted over the next few months with Aboriginal and Youth Health services to allow the access to this program by finalising appropriate service models.
- Ongoing training and promotion of the program will continue in the Wyong Shire to increase providers in that area.



*(Central Sydney MTM Project Continued from page 15)*

portunity to reinforce our commitment to work together to ensure the success of the project. In late November the steering committee met again to receive an update on the outcomes of the National Workshop and Orientation sessions held in Adelaide. Following the festive season we met during January to share an update on the project's progress, to discuss a timeline for implementation, identify a representative to attend the Train the Trainer session

and also to review how the training may be incorporated into the existing CPD calendars of both Divisions. Future meetings of the Steering Committee will be held monthly initially and then at least quarterly for the remaining life of the project.

The strategies that our project will pursue to improve links and joint working between GPs and other services will be to:

- audit existing referral pathways to identify service gaps

- recruit private psychological service providers through our ATAPs projects with knowledge, skills and experience in mental health & drug & alco-

*(Continued on page 20)*



(Central Sydney MTM Continued from page 19)

hol comorbidity

- identify private NGO drug & alcohol services with a capacity to see referred patients – such as the Vietnam Veterans Counselling Service
- improve referral protocols between GPs and secondary services by introducing the BOIMHC 3 Step Mental Health Process as a standard referral mechanism
- review GP and patient resources to ensure they are responsive to local needs (culturally appropriate resources available in most common community languages) to address co-morbid presentations in general practice
- enhance early and accurate identification of patients who have a co-morbid presentation through the skilled use of effective screening tools and brief interventions in the primary care setting
- provide education to GPs by employing our own GP Medical Educators

and local expertise. The education will be provided our team of trainers led by Dr Hester Wilson, local Newtown GP and medical educator, Marcia Sherring, Drug & Alcohol Clinician with SSWAHS Drug Health Services who often works with clients with complex comorbid alcohol & mental health conditions and Bradley Whitwell, Early Intervention Coordinator SSWAHS Mental Health Services who is an experienced educator and clinical advisor of the National GP Mental Health education programs Educational Health Solutions and the Brain & Mind Research Institute.

- The education will cover the use of audit and outcome tools in assessing patients with mental health & alcohol presentations along with the use of the 3 Step Mental Health process and what referral pathways and protocols are available to these patients. A resource directory of available referral & counselling services will also be provided. This project focuses on early intervention strategies and appropriate referral pathways for patients presenting with

mild depression, anxiety & /or stress combined with effective strategies to manage their alcohol intake.

All this activity and up-skilling of GPs in early identification of mental health & alcohol comorbidity will raise the expectations of both GPs and their patients that avenues of care will be made available to all of them if they require further treatment and support. But the results of our audit of referral pathways reveal very little capacity, especially for patients who cannot afford private services and for those from non-English speaking backgrounds. The time has arrived to address the issue of raised expectations from this initiative. Maybe we need to develop strategies that look at possible models of care which incorporate a mix of increased access for low income patients to private service providers through enhancing their capacity with governance and monitoring provided by Divisions.

Contact: Jerry Bacich (02) 9799 0933  
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(TheMHS Conference Continued from page 3)

- Inappropriate media reporting of mental health issues and its consequences;
- Workforce issues, particularly outside cities, for all categories of workers;
- Funding for mental health in remote and regional areas;
- The appropriate role and involvement of the GP in mental health;
- Training – the adequacy of Better Outcomes training and the appropriateness of GP involvement;
- Broad based Mental Health First Aid training, eg for hairdressers;
- Mental health education for young people;
- Evidence based medicine – do we do enough research?
- Attitudes to recovery;
- Influence in mental health debates – the power blocks eg pharmaceutical

companies, medical organisations, consumers and carers, etc;

- The importance of work and work conditions on mental health;
- Commonwealth/State relations and responsibilities in mental health service provision;
- Standards of treatment and adequacy of services;
- the problem for States on coping with increased demand and complexities, particularly with comorbidities/dual diagnoses;
- Suicide rates, self harm and eating disorders – finding solutions;
- Mental health issues in immigration and detention centres.

There were a number of sessions on Children of Parents with a Mental Illness, on various comorbidities, on Indigenous mental health, on arts and mental health (including an art exhibition, a giant puppet walking around the

exhibition, and lunchtime musical performances by participants in The Jam, the Gig, the Mix project), on human rights, mental health and detainees. There were more service focused sessions, including the one presented by ADGP on Better Outcomes and Managing the Mix. There were sessions by consumers describing their experiences in the mental health system, what helped them and what didn't, and some of the anomalies, e.g. if both physical and mental health problems were being treated.

Most of these issues are not new, and will not go away fast. Nor will our responsibility for assisting with service provision. The importance of this conference is the invitation it gives to look wide, and to look at the human side of mental health services – pain and suffering certainly, but also complexity, courage, creativity, great diversity, and finally inspiration. A fascinating and educational four days.



## About PARC

The Primary Mental Health Care Australian Resource Centre (PARC), is located in the Department of General Practice at Flinders University. PARC is part of the Primary Mental Health Care Network of the Australian Government Department of Health and Ageing and provides knowledge management, research, evaluation and information services to support Australian Primary Mental Health Care.

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