Systems development

The often complex nature of comorbidity means that both clients *and* clinicians may benefit from the support of more than one service or health professional. A critical component of Managing the Mix was developing systems to strengthen interagency relationships thereby improving the local capacity to better manage comorbidity. Divisions also undertook activities and developed resources aimed at maintaining long-term sustainability. The following pages highlight models of shared care and sustainability.

Models of shared care and local partnerships

In Managing the Mix, divisions were engaged in shared care programs to enhance partnerships between GPs and other health professionals to provide a more effective combination of patient care. Shared care is particularly important in the context of comorbidity issues, since general practice clients may benefit from treatment and support from other, more specialist services.

Local partnerships were a critical aspect of Managing the Mix in the development of local resources, as well as opportunities for networking and education and training across disciplines and agencies.

For this purpose, divisional projects frequently worked in conjunction with multi-agency reference and advisory groups. The following resources are examples of models of shared care and partnerships developed under Managing the Mix.

Sustainability

A common and legitimate concern with projects of this kind is that gains and positive outcomes cannot always be sustained once funding has been spent. Managing the Mix sought to address this issue by requiring divisions to consider sustainability issues when developing and implementing their activities and resources. One of the significant outcomes of the project has been improved links and relationships between the division and GPs and other services. This has enhanced the capacity for interagency working on issues of comorbidity.

In addition, Managing the Mix has helped to reinforce the theme of “comorbidity” into divisions’ existing mental health and drug and alcohol programs.

Examples - shared care and local partnerships

1	MoU between a division and local health service – Townsville DGP
2	Team Care Arrangements – Dandenong DGP Project
3	Holistic health care/shared care program – Adelaide Northern DGP
4	Pathways of comorbidity management – Adelaide Northern DGP
5	Referral options pathways and partnerships – Capricornia DGP
6	Regional Comorbidity Task Force – Capricornia DGP
7	MoU with alcohol and other drug services – Canning DGP

MoU between a division and local health service

The Memorandum of Understanding (MoU) developed between the Townsville Division of General Practice and the Townsville Health Service District illustrates how MoUs can cover the treatment and management of clients with mental health and substance use issues, and the roles of GPs, mental health and alcohol and other drug services.

Memorandum of understanding

Extension of MoU
between
Townsville Health Service District
and
Townsville Division of General Practice Ltd

THIS AGREEMENT is made the day of 2006

BETWEEN: TOWNSVILLE DIVISION OF GENERAL PRACTICE LTD of Unit 3/106 Dalrymple Service Road, Currajong, in the State of Queensland, 4812 (hereinafter called "TDGP")

AND: INTEGRATED MENTAL HEALTH SERVICE AS PART OF THE TOWNSVILLE HEALTH SERVICE DISTRICT, The Townsville Hospital, of Angus Smith Drive, Douglas, in the State of Queensland, 4814 (hereinafter called "IMHS")

AND: ALCOHOL AND OTHER DRUGS SERVICE AS PART OF THE TOWNSVILLE HEALTH SERVCIE DISCTRICT, North Ward Campus of Community Health, in the State of Queensland , 4810 (hereinafter called “ATODS”)

WHEREAS:

A. TDGP and Townsville Health Service District recognise that IMHS, ATODS and general practitioners play important roles in the delivery of mental health and substance use services.

B. The parties acknowledge that the optimal delivery of mental health and substance use services to patients often requires collaboration between general practitioners, ATODS and the IMHS.

C. The parties are desirous of working in cooperation with one another so as to improve the delivery of mental health and substance use services to patients.

D. The parties wish to work together wherever possible and practical, on matters and issues of common interest and concern.

E. The parties have agreed to execute this Agreement.

NOW THIS AGREEMENT WITNESSES and the Parties agree as follows:-

1. THE AGREEMENT

1.1 The parties agree to explore an enhanced relationship, based on an equal partnership of mutual respect and understanding, in order to improve mental health and substance use services for patients.

1.2 The parties agree to establish and support a joint process to achieve mutually agreed objectives.

1.3 The parties agree to critically appraise and update the objectives included in this agreement at no less than twelve monthly intervals.

1.4 The parties agree to develop communication strategies, which facilitate the transfer of information useful in the strategic and business planning of the parties.

1.5 The parties agree to pursue a strategy of integrated projects specifically related to improving systems of care in both community and hospital settings.

2. OBJECTIVES

2.1 To identify areas in which IMHS and ATODS systems of patient care can be improved through collaboration with general practitioners.

2.2 To identify areas in which general practice systems of patient care can be improved through collaboration with IMHS and ATODS.

2.3 To devise mutually agreed strategies, which use best available evidence to address the areas identified for improvement.

2.4 To improve the communication between TDGP, IMHS and ATODS such that both are provided with important information to assist in its strategic and business planning.

2.5 To improve communication between general practitioners and IMHS particularly with respect to the care of patients as inpatients, outpatients or immediately prior to admission or following discharge and with respect to ATODS to improve the communication between general practitioners and ATODS in the care of their patients.

2.6 To improve information to IMHS and ATODS about general practice activities in Townsville.

2.7 To provide information to general practitioners about the services available at IMHS and ATODS and the appropriate indications for their use.

2.8 To explore methods of improving communications using available technology such as fax, e-mail or other appropriate methods.

2.9 To explore and be involved in 'shared care' programs between IMHS and ATODS and general practitioners and in improving discharge planning for patients attending IMHS services.

3. OPERATION OF THE AGREEMENT

3.1 IMHS, ATODS and TDGP will nominate two representatives each to cooperate in this agreement. Those positions will be service coordinator and/or team leader Community Mental Health and clinical coordinator and/or team leader of intake and assessment for IMHS, Senior clinician ATODS and Manager ATODS, GPLO and Mental Health Project Officer for TDGP.

3.2 Any change in the level of commitment on either side must be agreed to by all parties.

3.3 IMHS, ATODS and the TDGP will consider the provision of additional resources for mutually agreed strategies.

3.3 Representatives of IMHS and the TDGP will meet regularly as the Mental Health Liaison Group to monitor the GP/IMHS liaison process, and to discuss areas and strategies identified for improvement. ATODS members will be invited or will attend from time to time as appropriate.

3.4 Patients attending IMHS or ATODS will be encouraged to nominate a general practitioner with whom communication can be established.

3.5 Treating Health Professionals and general practitioners will be encouraged to communicate with one another soon after each patient's admission and prior to discharge from IMHS, and in a timely manner for ATODS patients particularly for those patients with complex mental health issues (IMHS) or substance use issues (ATODS)

3.6 The GP Liaison Officer will be the main conduit for day-to-day communications with the TDGP, the service coordinator will be the main conduit for IMHS and the manager will be the main conduit for ATODS.

3.7 The existing Townsville Health Service District mechanisms, such as contact with the Director of Mental Health and the manager of ATODS will continue to be used in the case of concerns over the management of individual patients.

3.8 The TDGP will participate in the education program for Treating Health Professionals and will develop avenues of shared Continuing Professional Development (CPD) that will assist in achieving the objectives of this MoU. Likewise, IMHS will participate in the education programme for GPs developed through TDGP and ATODS will also participate in information sharing for TDGP.

4. REVIEW OF THE AGREEMENT

4.1 The TDGP and THSD agree to meet once annually to review the Agreement, and to determine whether or not the Agreement will be altered or continue.

4.2 Any alteration to the Agreement will be made by mutual agreement of the Parties.

5. DISPUTE RESOLUTION

5.1 If there is a dispute as to the quality or quantity of activities undertaken under the Agreement or what activities are covered under the Agreement it is anticipated that the Operations Director of the Institute of Mental Health at The Townsville Hospital or Operations Manager of Institute of Primary Health and Ambulatory Care will raise these with the CEO of the Townsville Division of General Practice (or vice versa), outlining in writing the nature of the issues and the preferred resolution for the other party.

5.2 Should the matter remain unresolved, either party may subject the dispute to determination by the GPLO Focus Group.

6. TERMINATION OF THE AGREEMENT

6.1 This agreement may be terminated at the annual review meeting, provided that agreed arrangements are made for finalising the activity.

Team Care Arrangements (TCA)

Dandenong project

In partnership with Greater South Eastern, Monash and Central Bayside divisions, Dandenong division developed a team care arrangement (TCA) proforma for use between GPs and other services.

The TCA (Medicare Benefits Schedule Item Number 723) concerns team care planning and management between GPs and mental health and drug and alcohol services.

The proforma on the following pages includes the following features:

- history taking
- options for referral/shared care
- treatment planning with the patients.

CHRONIC DISEASE MANAGEMENT
TEAM CARE ARRANGEMENTS (MBS ITEM No. 723)

Multidisciplinary Team Care Arrangements
– Mental Health + Drug & Alcohol Services –

Patient's Name: ....

Date of Birth: ....

Contact Details:
....
....
....

Medicare or Private Health Insurance Details:
....
....
....

Details of Patient's Usual GP:
....
....
....

Details of Patient's Carer (if applicable):
....
....
....

If the patient has a previous or existing care plan, when was it prepared and what were the outcomes?
....
....

Other notes or comments relevant to the patient's care planning:
....
....

MEDICATIONS
....
....

ALLERGIES
....
....

Patient's Name: ……

I have explained the steps and costs involved, and the patient has agreed to proceed with the service. The patient also agrees to the involvement of other health providers and to share their clinical information without / with restrictions (identify).

……………………………………………………………………………………………………*(GP's Signature & Date)*

TEAM CARE ARRANGEMENTS		
Goals - changes to be achieved	**Required treatments and services including patient actions**	**Arrangements for treatment/services (when, who, contact details)**
1. PHYSICAL HEALTH: specifically ❑ …………………………………………… …………………………………………… ……………………………………………	GP services: ❑ Pathology: …………………………… ❑ Radiology: …………………………… ❑ Pharmacology: ………………………	Regular GP visits - Frequency: ……………………… Pathology: …………………………………………… Radiology: …………………………………………… Pharmacist: ……………………………………………
2. IMPROVED PSYCHOLOGICAL STATE: specifically ❑ Depression management ❑ Anxiety reduction ❑ Harm minimisation ❑ Drug/alcohol counselling ❑ Relationship counselling	❑ Psychologist assessment ❑ Provision of supportive psychotherapy and/or cognitive behavioral therapy. ❑ Motivational interviewing for increased physical activity and pleasurable activity ❑ Structured problem solving exercises and straight thinking exercises ❑ Coping strategies to deal with major life changes and/or personal conflict ❑ Muscle relaxation exercises and breathing exercises ❑ Consider referral to psychiatrist ❑ Other: …………………………………… *Service contacted and agreed to provide specified services:* *(Date: ……………………………)*	❑ **Option 1:** Referral to Access To Allied Psychology Service provider (Item # 2574 or 2577): …. …………………………………………… *(Limited to GPs registered with Health Insurance Commission for Better Outcomes in Mental Health Care initiative, and psychologists with a specific service agreement with the Division of GP)* ❑ **Option 2:** Referral to psychologist (EPC - Allied Health Services) (Item # 10968) …. …………………………………………… *(Available to all GPs, services provided by psychologists registered with HIC)* ❑ **Option 3:** **Other referral:** ……………………………………
3. MANAGE/CONTROL ALCOHOL/DRUG CONSUMPTION ❑ Reduce alcohol/drug consumption ❑ Abstain from using alcohol/drugs ❑ Minimise harm from alcohol/drug consumption	❑ Drug counselling ❑ Alcohol counselling ❑ Withdrawal/detoxification (inpatient/outpatient/homebased) ❑ Dual diagnosis ❑ Support group ❑ Specialist services (other language, Aboriginal outreach) ❑ Family support ❑ Pharmacotherapy *Service contacted and agreed to provide specified services:* *(Date: ……………………………)*	Referral to: **SOUTH EAST ALCOHOL & DRUG SERVICE** **229Thomas St** **Dandenong 3175** **Tel: 8792 2330** *(refer using Victorian Statewide Referral Forms*)* **DHS Service Coordination Tools*

Copy of TCA offered to patient? YES / NO
TCA added to the patient's records? YES / NO

Copy / relevant parts of the TCA supplied to other providers? YES / NO
Referral forms for Medicare allied health and dental care services completed? YES / NO

[For referral forms call 1800 067 307 or go to www.hic.gov.au/providers/forms]

Date service was completed: .... **Review Date:** ....

Patient's Name: ....

TEAM CARE ARRANGEMENTS (additional services)		
Consider other allied health and community services relevant to the complexity and chronicity of the patient's condition (e.g. housing services, disability services, HACC, education providers, other welfare services including probation officers, etc)		
Goals - changes to be achieved	**Required treatments and services including patient actions**	**Arrangements for treatment/services (when, who, contact details)**
4.		
5.		
6.		

Holistic health care/shared care program

Northern Wellbeing

The Adelaide Northern Division pathways of comorbidity management (see flow chart) is linked to the Northern Wellbeing Co-Link. Northern Wellbeing is a service that promotes holistic health care for the patient, and supports the GP and others who are involved in providing the best possible mental health care for the patient.

Northern Wellbeing offers a range of support in GP management and referral pathways for patients presenting with comorbid mental health and alcohol dependence problems. A flowchart and referral forms have been incorporated into these pathways which clearly explain the referral process for GPs to access various services.

Shared care program

The shared care program consists of:

- consultation with a psychiatrist using the item numbers under chronic disease management
- case conferencing
- lunchtime meetings
- continuing professional development for GPs and GP Liaison.

The team works collaboratively to develop a management plan to identify whether the GP can manage the patient with comorbid mental health and alcohol problems in their practice or whether referrals to other agencies such as Drug and Alcohol Services South Australia (DASSA), specialist detoxification services, mental health services or Northern Wellbeing are necessary for further intervention.

There is always the opportunity for a review after six months (earlier if necessary) to ensure the GP is managing and is supported in the practice.

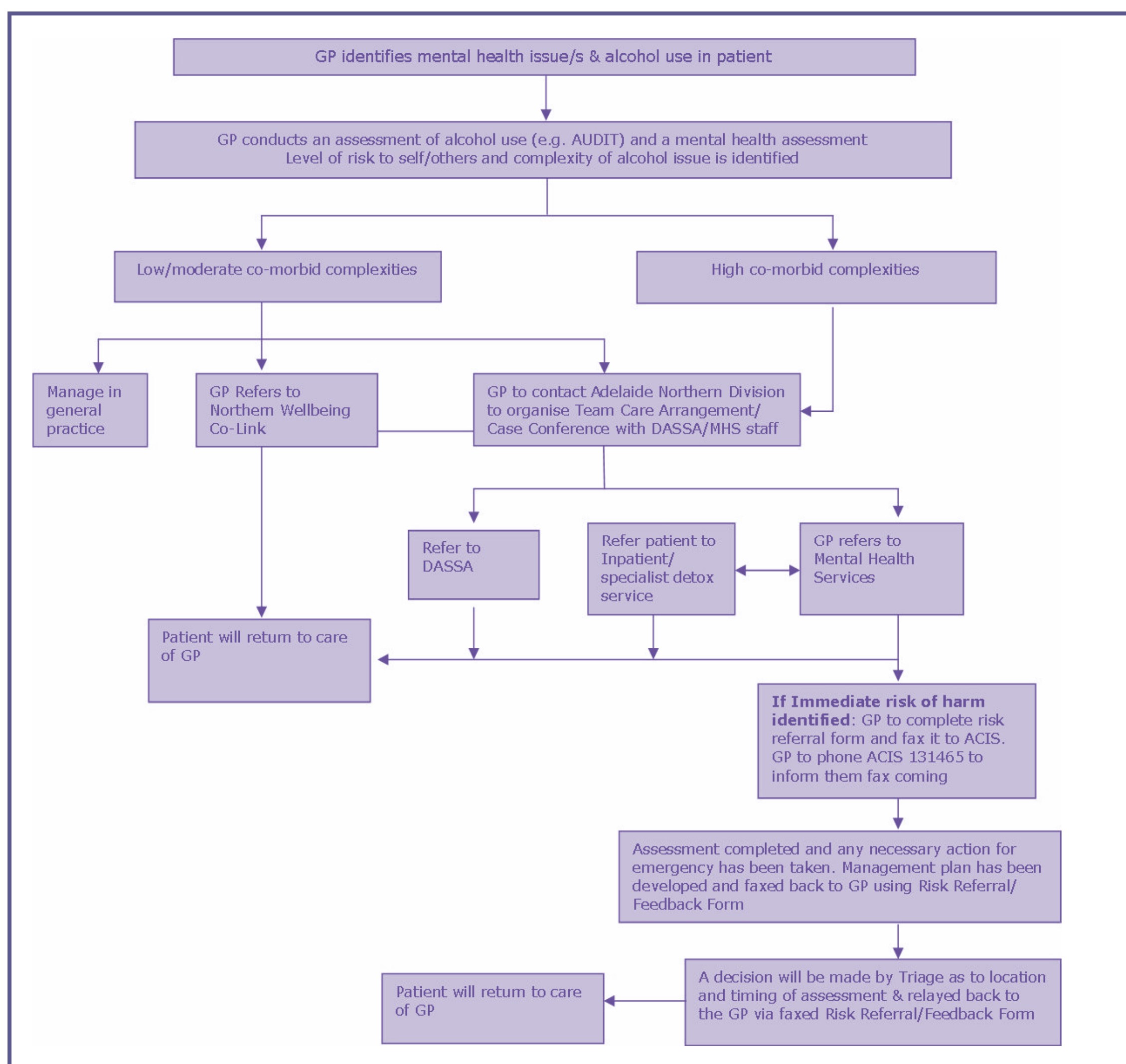
Related resources

GPs are supported with related resources including:

- a **flowchart** developed to highlight all referral pathway options
- **referral form** used to refer patients to a range of services
- **at Risk Referral Feedback form** for GPs to access Mental Health Services when the patient is at high risk of suicide or self-harm
- **consumer resources** (information booklet and fact sheet on the effects of comorbidity of alcohol and mental health) developed nationally for Managing the Mix, for GPs to distribute to patients presenting with comorbid mental health issues and alcohol misuse. A consumer flyer has also been developed by SA Division of General Practice, highlighting the importance of having a GP.
- **Northern Metro Area quick reference tool** developed collaboratively with Elizabeth Drug Action Team, which provides a quick reference guide to drug/alcohol services in the northern metropolitan area of Adelaide
- **Northern Area mental health community resource** - Adelaide Northern Division's resource directory has been updated to include mental health and drug and alcohol services for all age groups.

Pathways of cormorbidity management

Adelaide Northern Division care pathways



The Adelaide Northern Division flowchart on pathways of comorbidity management described above provides a clear process for GPs, drug and alcohol and mental health services to communicate and provide better service outcomes for patients. It is intended to be a working document to be reviewed at six monthly intervals by a committee of key stakeholders. This care pathway is linked to the Northern Wellbeing Co-Link.

Referral options pathways and partnerships

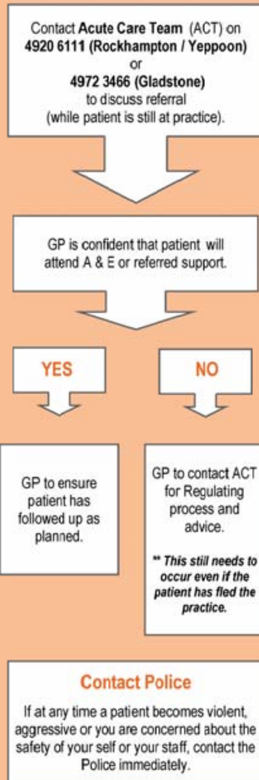
Capricornia Division agreed care pathways

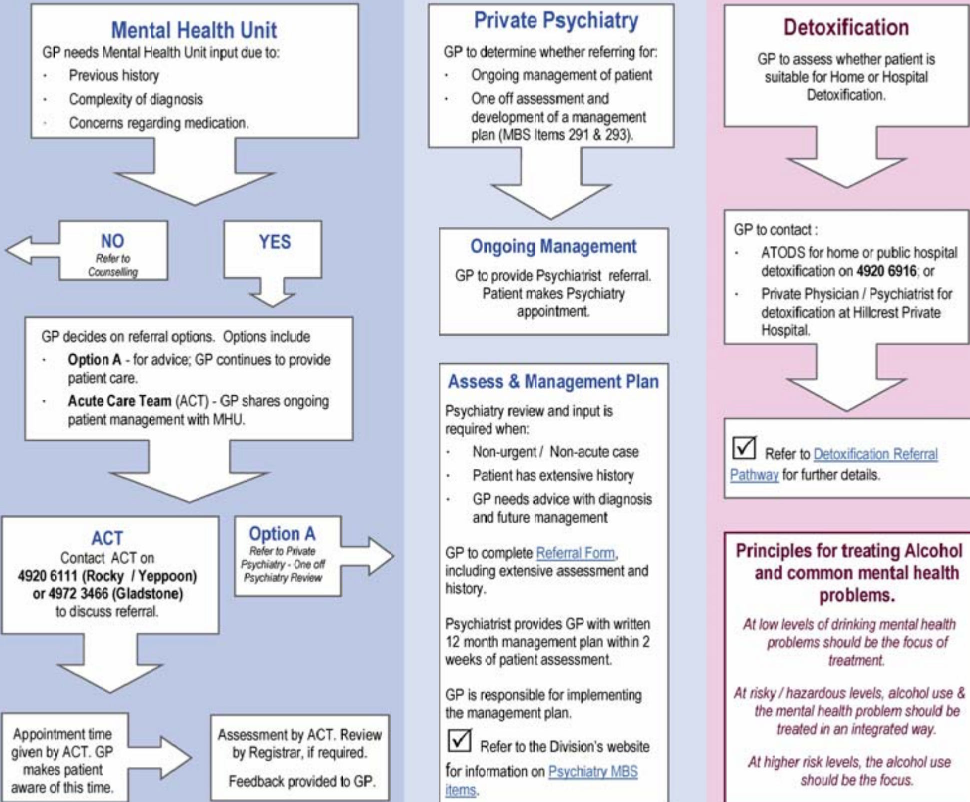
The Capricornia division worked with local partners to develop regionally agreed care pathways to enhance shared care.

Mental health referral options pathway

This sample mental health referral options pathway (on following page) describes the network of services available to GPs to support patient management and treatment, depending on patients' conditions.

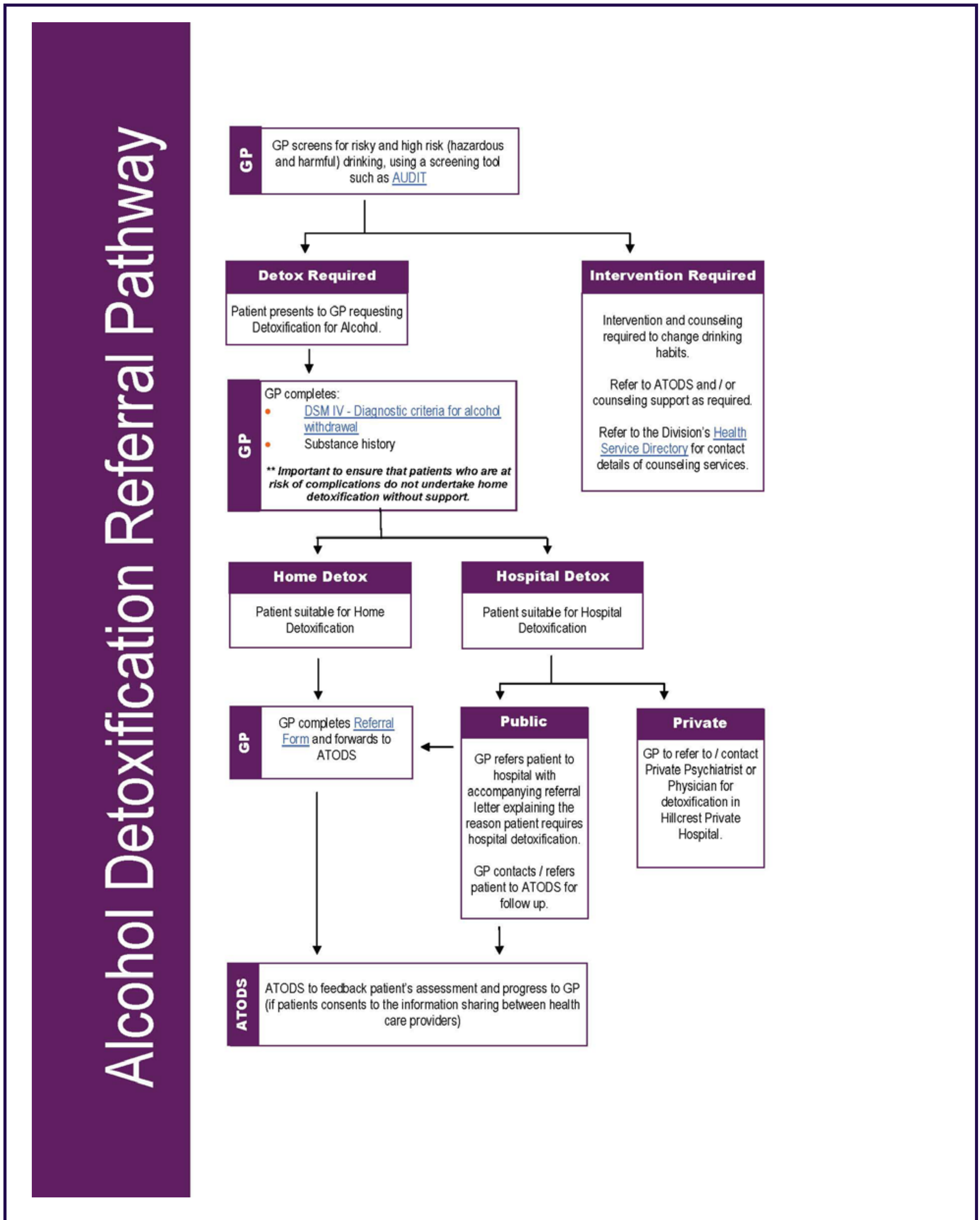
Mental Health Referral Options Pathway





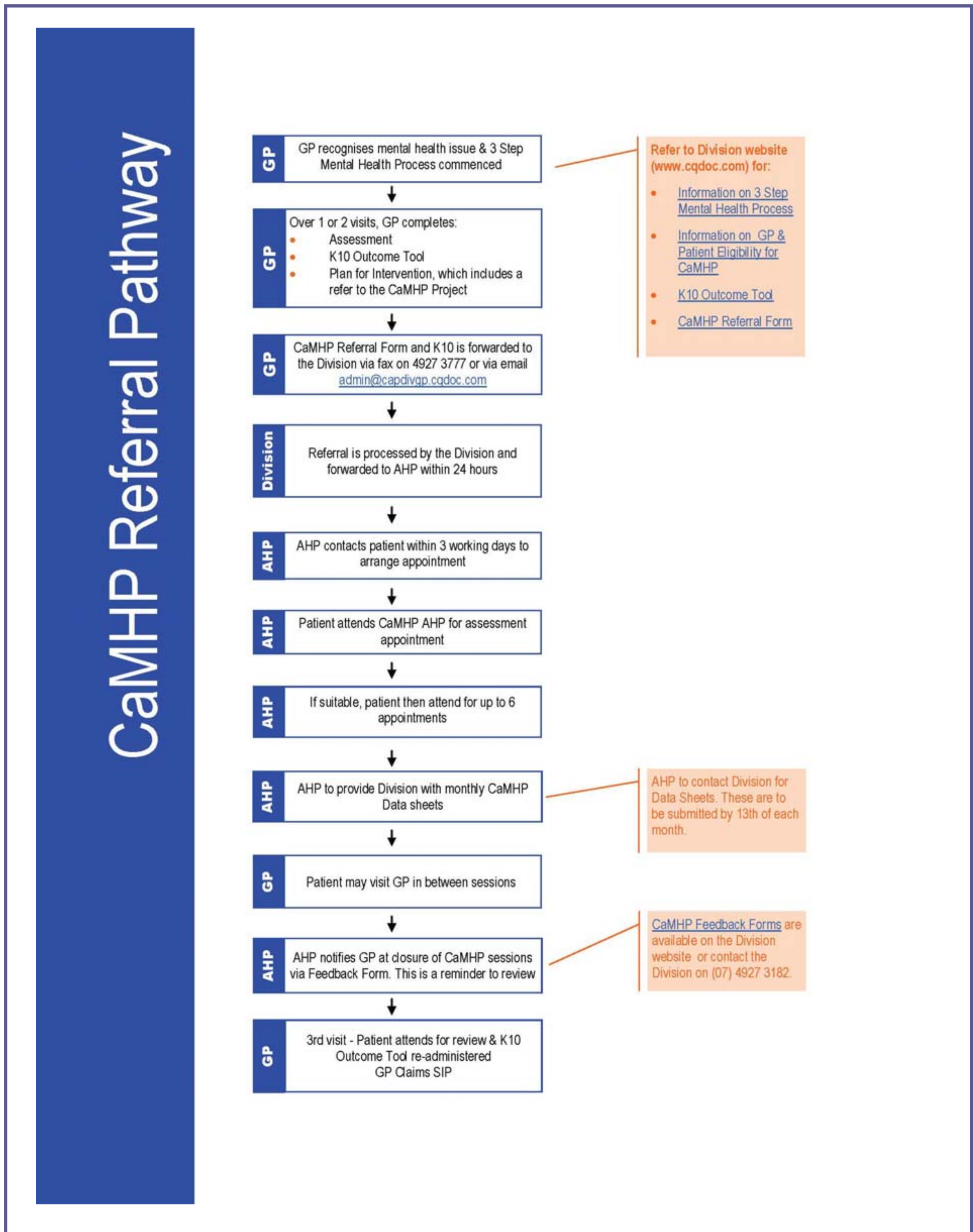
Alcohol detoxification referral pathway

The alcohol detoxification pathway relates specifically to options for this treatment.



Mental health partnerships referral pathway

The mental health partnerships project referral pathway provides guidance for GPs on use of the BOiMH initiative and how to work with allied health professionals in patient management.



Regional Comorbidity Task Force

Capricornia Regional Comorbidity Task Force

The Capricornia Regional Comorbidity Task Force was established to direct the activities of specific components of the division's Mental Health and Alcohol Comorbidity project. The Taskforce provided strategic and operational advice to the division and all key stakeholders to ensure the development, implementation and evaluation of activity as outlined in the Mental Health and Alcohol Comorbidity Project.

Objectives, strategies, activities and indicators

Project objectives relevant to this Task Force were:

- initiate Comorbidity Task Force to build and improve local coordinated sustainable infrastructure and systems for shared care of people with mental health and alcohol comorbidities
- increase the coordination and communication between key stakeholders
- establish support services for GPs as well as develop and promote resources/tools for prevention and treatment in general practice.

Strategies, activities and indicators are detailed below:

Strategy	Activities	Indicator
Task Force to identify best practice approaches to caring for people with mental health and alcohol co-morbidities and to review appropriate services already offered by local agencies (May 2005)	■ Task Force to conduct research regarding best practice	■ Evidence of Best Practice research incorporated into shared care model

Strategy	Activities	Indicator
Task Force to identify local pathways for care (May-Sept 2005)	■ Task Force to determine roles of all stakeholders and develop a Regionally Agreed Care Pathway for patients within Capricornia Region ■ Task Force to endorse Agreed Care Pathways for referral of patients	■ Key Stakeholders demonstrate commitment to Regionally Agreed Care Pathways ■ Survey of stakeholders will identify impact on service provision and care for patients
Task Force to establish regular meetings between stakeholders and to encourage joint initiatives where appropriate (ongoing throughout project)	■ Progress and review outcomes in areas of mutual interest – eg, health professional and consumer group education ■ Review and enhance communication between stakeholders, particularly in regards to quality of information shared and referral protocols ■ Responsibilities of this group will be: – establishing agreed referral and communication tools (including reviewing current processes) – ensuring uptake of resources/tools consistently across Capricornia region in each service – facilitating the uptake of secure electronic communication – establishing a governance process for critical incidences by the end of the project.	■ Evidence of collaborative initiatives undertaken ■ Stakeholders continue to report improved and consistent communication between services ■ Increased use of secure electronic email between providers (baseline = 0 uptake) ■ Governance procedures for identifying and resolving critical incidences developed
Task Force to develop recommendations for content of GP "Care Tool". This would include Regionally Agreed Care Pathway and information regarding evidence based interventions for the general practice setting (Oct 2005)	■ Task Force to advise Division of the development of a "GP Care Tool" that encompasses prevention, diagnosis, treatment, referral and long term management for patients ■ Task Force to endorse content of "Care Tool" ■ Division to promote and encourage the uptake of the "GP Care Tool" ■ Division to orient GPs to "GP Care Tool" through practice visits	■ GP Care Tool developed and endorsed ■ Promotion through Division's newsletter and weekly 'News in Brief' to all practices and key stakeholders ■ Distribution of GP Care Tool to 100% of GPs in Capricornia ■ Practice Visits to 100% of practices in Capricornia

Strategy	Activities	Indicator
Division to identify and establish additional opportunities to support GPs including establishing a phone support service for GPs who would like management advice (June-Sept 2005)	▪ Division to establish phone support network through other key stakeholders for GPs wanting patient management advice ▪ Division to conduct needs analysis on GP preferred support structures and report to Task Force ▪ Task Force to develop strategies for additional GP support that are sustainable within local service capacity including opportunities for one-off consultations for GPs to refer patients to specialist mental health and alcohol services for advice and support	▪ GP survey indicates reduced perception of isolation and increased feeling of support. Based line data to be collected ▪ Phone Support Service established within sustainable framework ▪ Need analysis conducted with report to Task Force completed ▪ Development and implementation of additional support strategies in response to GP need

MoU with alcohol and other drug services

Canning Division MoU

The Canning Division MoU with Alcohol and Other Drugs Services in the South Eastern Metropolitan Corridor of Perth covers access to alcohol and other drug services, communication, collaboration and shared care. This sample document pays particular attention to a shared care approach for clients with comorbid substance misuse and mental health problems.

Memorandum of Understanding

Access to Alcohol and Other Drug Services, Communication, Collaboration and Shared Care

Mission statement

The Canning Division of General Practice and Alcohol and Other Drug Services in the South East Metropolitan Corridor encourage supportive structures of care through liaison, communication and networking with each other to promote an integrated service based on collaborative partnerships.

Purpose

The purpose of this memorandum is to improve services to clients with co-morbid mental health and alcohol and other drugs related issues by encouraging a shared care approach between General Practitioners (GPs) and Alcohol and other Drug Services in the south east metropolitan corridor. A shared care reference group, on behalf of the Canning Division of General Practice, Drug and Alcohol Withdrawal Network (DAWN), a service of St John of God Hospital, Subiaco and SE Community Drug Services Team (Mission Australia), has developed this information. The purpose of this development has been to identify the roles and responsibilities of the service providers, and how they can be supported. The intention is to better integrate health care delivery in the local area and to achieve the best possible use of the resources of the parties for the benefit

of the local community. It represents a commitment to improving access to services, communication, collaboration and shared care across the region.

Objectives of this memorandum

- To optimise the quality and continuum of client care through liaison between GPs and community based alcohol and other drugs services.
- To develop a more integrated approach to the provision of dual diagnosis health care services in the local area.
- To cooperate to identify dual diagnosis health service needs in the local area on an ongoing basis.
- To seek the best achievable service delivery attainable from available resources having regard to identified needs.
- To explore collaborative initiatives between the parties concerned.

Shared care

Definition

Shared care is a collaborative cooperative partnership for client care, encouraging the client to take an active role in managing their health and health care. Shared care utilises the particular strengths of each participant in the health system. GPs are a stable point of contact for patients, their families or carers and are therefore well placed to provide ongoing management for people with co-morbid mental health and alcohol related issues. Shared care provides a collaborative approach to coordinating client care between specialists and primary health care providers, assisting people with co-morbid mental health and alcohol related health issues to gain access to the right services and the right blend of services.

Principles of shared care

- Good communication between all parties
- Client involvement
- Clear protocols in place and utilised
- Commitment to working cooperatively
- Respect for other health professionals
- Providing competent and consistent care
- Demonstrated evidence based best practice

Roles and responsibilities of all service providers

- For organisations and agencies engaged in service delivery to persons affected by comorbid mental health and alcohol and other drugs related issues to show sensitivity and understanding for each other's role, mandate and service model
- Ongoing development of guiding principle and a shared understanding in working collaboratively and effectively in service delivery to clients and carers
- For community alcohol and drug services and the Canning Division of General Practice to participate in an ongoing forum for the purpose of:
  - general inter-agency liaison
  - information exchange
  - resource updates
  - identifying gaps and barriers in services, and
  - policy development
  - to have clear inter-service processes with each other for inter-agency referral, working with co-clients and conclusion of defined work with individuals.
- service provision to the defined client group that is:
  - respectful and timely
  - family and culturally sensitive
  - carried out in close liaison and agreement with the individual
  - service delivery to be in a manner that is congruent with the National Mental Health Standards.

Roles and responsibilities of division/GPs

Division

- Participate in the development of agreed protocols
- Coordinate GP education in the area of co-morbid mental health and alcohol and other drugs related issues
- Disseminate all relevant information to local GPs (about shared care and co-morbid mental health and alcohol and other drugs related issues)
- Encourage GPs to become part of the shared care arrangements
- Participate in evaluation of the shared care arrangement
- Participate in ongoing development of shared care arrangements
- Participate in dispute resolution processes if required
- Act as conduit for information flow between GPs and community alcohol and drug services

General practitioners

GPs provide timely, appropriate, safe and comprehensive health care to individuals and families. In addition it is noted that:

General Practice Principles

- ☑ *Confidentiality is paramount.*
- ☑ *Only pertinent information is divulged between interacting health professionals.*
- ☑ *The provision of care is unfettered by consideration of race, creed, intellect, wealth or circumstance.*
- ☑ *Care may be reactive (ie. once illness has commenced) or proactive (eg illness prevention).*
- ☑ *All treatment modalities are explained in terms of risks and benefits to the patient.*
- ☑ *Continuing medical education is necessary across a broad spectrum of knowledge.*
- ☑ *Referral to other individuals / agencies with particular skills is facilitated when appropriate.*
- ☑ *A careful record of patient symptoms, investigations, diagnoses, treatments and outcomes is mandatory.*
- ☑ *The doctor-client relationship is critical, delicate, mutually respectful and enduring.*

Services provided by GPs

GPs provide initial assessment, treatment, ongoing support and referral for individuals and families with co-morbid mental health and alcohol related issues.

Services provided include:

- assessment and enduring record of past and present medical history, family history, occupational history, medications and allergies
- point of first contact when illness is perceived
- holistic evaluation of all factors involved in an illness
- diagnosis, prioritisation of problems and management
- referral to other agencies as appropriate

- provision of ongoing care, which may involve a coordinating role between agencies
- access to diagnostic tools, including medical imaging and pathology, for diagnosis and/or monitoring
- provision of statutory papers for employers, commonwealth and state authorities and legal purposes
- prescribing medication, including monitoring of adverse effects, over use and abuse
- authoritative links with client's contacts (eg. family, employer)
- provision / facilitation of hospital care when appropriate
- statutory authority for detention of patients under the Mental Health Act (1996)
- provider of after-hours care when other services are unavailable
- GPs provide supportive counselling for many issues that cannot be dealt with by public health services, as well as general mental health and alcohol and drug information. GPs may provide psychotherapy, behavioural and cognitive therapy.

Accessing GPs
GPs do not require a referral but will accept referrals from any agency. Detailed referral information will assist assessment and management and enhance feedback if required.

GPs will usually be available within 3 working days (or same day for emergencies) and provide services primarily from their practice. In some instances care may be provided at the client's home or other chosen environment. GPs generally require a longer appointment time for co-morbid health issues and this should be mentioned when making an appointment.

Roles and responsibilities of community based services

Community based alcohol and drug services in the southeast metropolitan area will:

- accept referrals from general practitioners and provide services as appropriate. (please refer to service descriptions and referral processes in the appendix).
- liaise with general practitioners and/or other non-government support services as to the needs of mutual clients
- identify gaps in services and bring it to the attention of the general practitioners as appropriate
- communicate with other health service providers about available resources and changes in protocols and procedures
- be part of an ongoing forum in order to maintain updated information on services and policy developments
- partake in on-going reassessment of current policies, procedures and protocols in order to provide feedback to policy makers, e.g. quality framework.

Conflict resolution

In such cases where a difference of opinion evolves concerning direct service provision between two agencies, the following steps should be entered into:

- a Representative from both services will attempt to reach a satisfactory resolution of the issue
- if a pattern of conflict is evident – it may be appropriate to refer the matter to the Shared Care Reference Group
- the best interest of the client should be foremost in any decision made. The client has the right to choose to be involved in any/all steps adopted during the course of the process.

Inter-agency partnership protocol

As an on-going commitment to the Memorandum of Understanding, the Agencies will endeavour to:

- invite input to future planning and service delivery
- meet regularly through the Reference Group
- provide information on relevant co-morbid mental health and alcohol and drug related issues
- monitor shared care arrangements
- ensure all information shared is treated with respect and confidentiality.

Working together for clients with comorbid mental health and alcohol and drug related issues	
Referral protocol – alcohol and drug services	■ The first point of contact for referrals to DAWN will be to the Subiaco office (93826049). A telephone referral will be sufficient as the nurse will liaise with the GP (working on the principles of shared care) ■ Referral to SE Metropolitan Community Drug Services Team is by completion of a referral form provided by the service.

Working together for clients with comorbid mental health and alcohol and drug related issues	
Referral protocols – general practitioner	- Case manager contacts the General Practitioner who: - agrees to discuss shared care - agrees to meeting with client and case manager in his/her practice - as part of the agency visit decides role in shared care - contacts Community Alcohol and Drug Service to arrange assertive follow-up OR provides assertive follow-up - liaises with Community Alcohol and Drug Service over specific needs of client (eg. referral to another agency) OR refers to another GP
Client introduction protocol	- Wherever possible, when referrals are being made by alcohol and drug service workers to GPs, the worker will endeavour to personally introduce the client to the GP
Client consent and confidentiality	- Routine client consent and confidentiality practices apply. Workers will ask clients as a matter of course for their permission and signed consent
Communication protocol	- In regards to shared care clients, and without breaching confidentiality requirements, GPs will keep alcohol and drug services informed regarding client attendance and progress: likewise, alcohol and drug workers will keep GPs informed regarding client progress by using the standardised paperwork system - Where multiple services are involved, workers will maintain frequent liaison and communication
Networking protocol	- continue to explore opportunities for staff exchange - regularly inform each other of major change issues - to ensure the commitment to ongoing communication, invitations to attend regular business or educational meetings will be offered

Statement of intent

There is a clear statement of intent by all parties concerned to use their best endeavours to implement this memorandum.

Case studies – sustainability

Managing the Mix sought to address the issue of sustainability by requiring divisions to consider this issue when developing and implement their activities and resources. A number of mechanisms were identified including:

- maintaining local reference and advisory groups
- ongoing education, networking and professional development activities
- maintaining relationships with local services, keeping comorbidity on the agenda of capacity building and linkages
- ongoing distribution of consumer and carer resources
- promoting web-based comorbidity resources
- committing to revisit and review resources, protocols and relationships with other services, covering areas such as:
  - care pathways
  - shared care protocols
  - referral proformas
  - service directories.

The case studies from the divisions listed below highlight sustainability and how the Managing the Mix influenced the building of local capacity:

1	Capricornia
2	Westgate-Western Melbourne
3	Eastern Goldfields
4	Illawarra

Capricornia Division

From the outset of this project, the division and the Regional Comorbidity Task Force (RCTF) attempted to establish strategies and foster outcomes that would be sustainable beyond its funded timeframe. Outlined below is an overview of how the various activities implemented throughout the project will be sustained.

Community awareness and resource dissemination

The division's conscious decision to work in collaboration with local services/ agencies to engage in community awareness was a strategic approach to facilitate sustainability beyond the life of the project.

The division is fortunate that the key service providers in the region as well as carer and consumer representatives meet on a regular basis as the Mental Health Promotions Committee (MHPC). The membership of this committee included, but was not limited to:

- District Mental Health Services
- public health unit
- Capricornia Division
- local government
- Association of Relatives and Friends of the Mentally Ill (ARAFMI),
- Adult Consumer Advisory Group (ACAG), Anglicare, Centrecare, Women's Health Centre
- Aboriginal Medical Service
- Child and Youth Mental Health Services (CYMHS).

As increasing community awareness of mental health issues is the principal role of the MHPC, this is an ideal platform for continued community awareness and resource distribution regarding mental health and alcohol comorbidities. A large proportion of the MHPC membership was also represented on the RCTF and provided a commitment to continue to promote mental health and safe alcohol use messages to the community.

GP education and training

In preparation for the close of the project, the division commenced the development of a mental health education plan for the next 12 months. This education plan is based on the needs identified during the project and includes the ongoing support of the

Capricornia Coast Mental Health Special Interest Group (small group learning), provision of CBT - Level 2 BOiMH training (June 2006), an update on mental health comorbidities/dual diagnosis and post-traumatic stress education (both of which will be delivered at the division's bi-annual conference in April 2006).

The division has a commitment through its Population Health Program to provide ongoing GP education on mental health and lifestyle issues and to support GPs maintain their Level 1 and Level 2 BOiMH registration. The division will also be surveying local GPs regarding the need for an update on the Managing the Mix education content and general mental health education needs, via the division's annual Education Survey.

Better mental health website

It was a strategic approach of the RCTF to develop the *Better Mental Health* component of the division's website. This approach was taken to ensure that responsibility was appointed to the division for the ongoing maintenance and update of the website content and Health Service Directory.

The electronic format of the GP Care Tool (*Better Mental Health* Website) and the Health Service Directory will facilitate ongoing easy maintenance at minimal cost to the division. The division will continue its annual commitment to update the Health Service Directory by surveying the local health care providers and community agencies.

As a result of this project, the division has also established a 12 month plan to seek additional information from each service in the community to enhance the level and integrity of information provided in the Health Service Directory across all areas.

Regionally agreed care pathways and communication tools

Assuming the key stakeholders continue to operate within the region, the regionally agreed care pathways and communication tools are resources that should not date significantly. The RCTF is conscious that the pathways and referral/feedback forms may need review and a refinement based on feedback from stakeholders after a couple of months of implementation. To address this, the RCTF has agreed to meet again at six and twelve months following the completion of the project.

Regional Comorbidity Taskforce

The value and achievement of the RCTF has been self identified by the membership of the committee, and can be demonstrated by representatives having expressed interest and commitment to continue to meet as a committee and progress issues of mutual interest following the completion of the project. The RCTF will meet at six and twelve months following the completion of the project to:

1. review and refine the pathways, communication tools and the content of the *Better Mental Health* Pathway, based on feedback from stakeholders
2. explore opportunities for future collaboration.

Communication between stakeholders on the RCTF will also continue through existing forums such as the Mental Health Promotions Committee as well as the email network established as a result of the project.

In addition, through its Integration Program the division has an ongoing commitment to sustain and improve communication and collaboration between service providers.

Westgate-Western Melbourne Divisions

Building Bridges[1] website

The website's use will be monitored independently by each division, with a survey disseminated to GPs and patients for feedback on website content and usefulness. Stakeholders will also be directed to the website and their feedback invited. A further meeting will be held between stakeholders and GPs to organise a forum that addresses the foundations for integrated shared care. This may also be available on line for GPs. The website will also later offer online training for GPs and a listserver that posts messages between GPs and between GPs and specialist mental health and drug and alcohol services. Eventually the website will offer GPs the opportunity to refer to services online. This will be monitored via the development of a database.

Website sustainability

Divisions to promote the site:

1. as an information and clinical tools resource for GPs and allied health providers
2. to secondary schools, for its content of dual diagnosis articles and research
3. as a resource database for allied health professionals
4. as a resource database for consumers
5. to GPs to use in electronic referral to psychologists and other allied health professionals for mental health and drug and alcohol patients and streamlined within the Better Outcomes Initiative and the new Medicare Chronic Disease Management items.
6. as a listserver for opening channels of communication between GPs and allied health providers
7. for its video conferencing component – online training for all health professionals that is central to the Building Bridges project.

[1] Building Bridges was the local divisional name for the Managing the Mix project.

Feel Good DVD

This educational resource DVD will be disseminated to a wider population after its public launch in April and May 2006. The DVD launch will involve schools, local government and health and social care services. The DVD will be available to order via the Building Bridges website, on which a short demonstration will be available on line. Media will be invited to attend the launch to help ensure further exposure.

Assessment of secondary school use of the DVD will take place via random school surveys: the same schools that have already been involved in the evaluation process will be surveyed again mid year, with responses sought from both teachers and students. This will provide data on measure enforcing attitude change among students and retention of information after six months.

Clinical attachment program

GPs will be surveyed six and twelve months after their clinical attachment to measure the impact of the attachment and whether skills and knowledge have been retained. If desired, GPs will be free to join another program if funding permits. Once again, GPs will be able to attract continuing professional development points.

Local mental health forum

For GPs there is often a lack of clarity about how to respond to people with mental health and substance misuse comorbidity. The proposed Forum aims to enhance cooperation and collaboration between GPs, practices and area mental health services.

The Forum will address the issues of:

1. service shortages
2. barriers to services
3. what is working
4. what is not working
5. solutions for working with people who have alcohol and mental health comorbidities?
6. future action.

The Forum will commit to action on:

1. education and training
2. improved access to services
3. improved communication between service providers
4. unravelling referral pathways and commitment to referral protocols
5. increasing knowledge and understanding of services available.

Anticipated outcomes for GPs and area mental and allied health services:

- an effective shared care arrangement between alcohol, tobacco and other drug services (ATODS) and GPs
- improved communication between general practice and IMHS
- improved communication between ATODS and general practice
- development of a memorandum of understanding between services
- establishment of referral pathways that are sustainable
- clarification and documentation of current practice and means of improvement.

Eastern Goldfields Division

Eastern Goldfields built sustainability into many of its activities to ensure that project gains have longevity.

Some of the actions outlined below took place over the course of the project, while others are planned for the future.

In the latter case, they build on the work conducted during the project timeframes, including relationships and capacity building exercises.

- *Better Outcomes in Mental Health Care (BOiMH) program in Kalgoorlie:* the Managing the Mix program was a precursor to the establishment of the BOiMH program in Kalgoorlie. This program will help provide sustainable services and support for the GPs within the region.
- *Website*: the division is currently developing a Mental Health and Drug and Alcohol focussed website that will provide information about/access to local organisations, articles of interest, and related division program details.
- *Memoranda of Understanding (MoUs)*: the division is currently updating MoUs with the key stakeholders in the centres of Esperance and Kalgoorlie. These 'formal' relationship statements will contribute to the ongoing development of positive linkages between key stakeholders.
- *Relationships*: Managing the Mix initiated the development of relationships between key stakeholders. These relationships will continue to develop, with stakeholders verbally committing to work together to regularly assess local service pathways and to work collaboratively to improve these on an ongoing basis.
- *Education*: the education that has been provided to GPs and other key stakeholders within the region has had a positive impact on levels of knowledge and confidence in treating patients with comorbid issues. The division has committed to working with other key stakeholders to include alcohol and mental health comorbidity issues on future education agendas. GPs have requested the return of several of the education providers as part of the Division's ongoing education program.
- *Refinement of pathways*: referral pathways have been refined through the course of the program and key stakeholders have made a commitment to continue to assess and refine services in the long term.

- *Peer support networks/program*: the Esperance Peer Support Program has developed as a 'spin off' from the Managing the Mix program. The network of GPs in the Esperance area has strengthened, meeting regularly to discuss patient issues, as well as accessing the services of a Perth-based psychiatrist to assist them with difficult issues. The Peer Support Program will be funded by the division on an ongoing basis and provides education and support with patients from a Perth-based psychiatrist.
- *Increased community awareness*: Managing the Mix included initiatives aimed at increasing community awareness of comorbidity through linkages with other community programs and community events such as Mental Health Week activities.
- *Knowledge and encouragement to utilise local and state services available*: Managing the Mix increased the knowledge of key stakeholders regarding available support systems and services in each local area. Participants at education events indicated an intention to utilise local services more regularly through patient referrals on an ongoing basis.
- *Clinical attachments* between GPs and relevant local health services will continue to be promoted and completed in the region, contributing to an ongoing relationship development strategy between health sectors/services.

Illawarra Division

Building on existing priorities of the Illawarra Division of General Practice (IDGP), that include youth health, mental health and drug and alcohol, has meant that many of the initiatives of the Youth SMART comorbidity project[2] will be sustainable in the long term. While additional funding is required to enhance these further, the IDGP regards youth mental health as a priority for the division.

Having developed a strong evidence-based youth health and GPs in School Program, the IDGP will continue to convene the Building Bridges[3] Committee. This committee features representatives from a wide variety of stakeholders, including the Illawarra Institute for Mental Health (iiMH), Lifeline, the Salvation Army, local high schools, Department of Education and Training, Illawarra Drug and Alcohol Service, Illawarra Child and Adolescent Mental Health Service and Illawarra Aboriginal Medical Service. This committee will convene bi-monthly to progress current and new youth mental health initiatives covering the spectrum of promotion, prevention and early intervention. Discussions have commenced on developing a pathway of care that links in with the Clinical Psychologist Service, however, further funding will be necessary to support this project.

The Community Service Announcement (CSA) will continue to be aired on Prime TV beyond the life of the Youth SMART Comorbidity Project. A four-year agreement with Prime TV provides an opportunity for the CSA to be publicised again in the future. The development of youth specific comorbidity information pamphlets for display in general practice aims to complement the Youth SMART CSA. Funds from the National Prime Minster's Award for Community Business Partnerships will be used to develop these and reinforce the mental health and alcohol message.

Efforts are also under way to approach 11 other Divisions that may be interested in accessing the CSA developed for radio in their regions. These Divisions include:

- Shoalhaven (NSW)
- Southern Highlands (NSW)
- Hunter Rural (NSW) South East NSW (NSW)
- GP Association of Geelong (VIC)
- Ballarat and Districts (VIC)
- Murray Mallee (SA)

[2] The local divisional name of the Managing the Mix project.

[3] The local youth mental health project.

- Top End (NT)
- Southern Tasmania (TAS)
- Perth & Hills (WA)
- ACT (ACT).

Key messages for the Mental Health Council of Australia consumer resources will continue to be adapted and provided to young people, parents, the community, GPs and other health professionals as part of the Building Bridges program. Remaining funds from the Youth SMART project have been acquitted to duplicate and disseminate these resources.

Education will continue to be delivered in the Illawarra as the two presenters, GP Dr Robert Watson and Program Development Manager Kellie Marshall, have agreed to provide training as required. Some of the remaining funds from the Youth SMART project will be used to support any further implementation of this training program.

The division is also considering a research project that evaluates the referral process to the area health service, child and adolescent mental health service, and youth drug and alcohol services. The aim is to identify positive outcomes and barriers which will be followed up by a collaborative presentation and workshop to local GPs and area health service staff. The promotion and evaluation of the referral form enhanced under the Youth SMART initiative will also form part of this research project.

The IDGP is continuing to work with Lifeline to disseminate to GPs "The Good Mood Guide", a self-help guide for depression. Instructions on how GPs can coach patients through this treatment are currently being developed and will be disseminated along with the guide, after the completion of the Youth SMART project.

The IDGP aims to communicate to GPs findings from the Illawarra Institute for Mental Health study, to better inform them of the barriers people with comorbidities face when seeking care. The IDGP will also continue to work collaboratively with the Salvation Army to improve the support they provide to families. The Salvation Army themselves are aiming to expand their initiatives by developing a website for young people to use for communication, in addition to activities that will build relationships between young people and their grandparents. Part of the funds remaining from the Youth SMART project, have been acquitted to support this process.