VICTORIAN GENERAL PRACTICE

Number 5. March 2001

QUARTERLY DIVISIONS

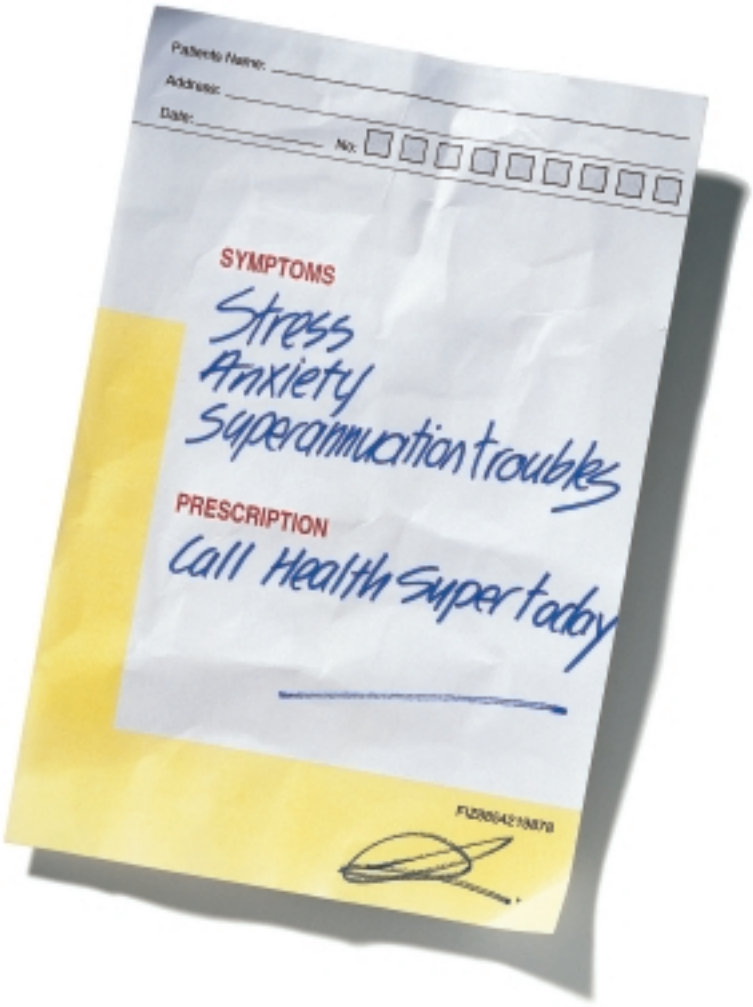
Mental health in practice

Paying the mental health bill

GPs and psychiatrists

Key roles for divisions

GPs, DIVISIONS AND MENTAL HEALTH



If you're sick of superannuation administration problems, then we've got the cure.

Health Super makes administering your employees' superannuation funds simpler, cheaper and easier. In fact, our dedicated Superannuation Advisers are always available to answer staff questions and provide assistance; which takes the pressure off you.

Our workplace seminars and one-on-one interviews mean you no longer have to deal with super queries, because we do it for you. It's our personal, attentive service we pride ourselves on.

You'll also have a choice of four convenient payroll transfer options, and we'll help you select and install the option that best suits your needs.

Of course, with one of the highest annual returns for a health super fund over the last three financial years, your employees will thank you for introducing them to Health Super as well.

Call **1800 13 30 50** to arrange your free consultation today.

HEALTH SUPER

1800 13 30 50

GPs' Accounting & Financial Services

Abe Goldberg & Associates

Certified Practising Accountants
Registered Tax Agents

Shop 4, 378 Glenhuntly Road
Elsternwick VIC 3185

Phone: (03) 9523 5888
Mobile: 0412 240 249
Fax: (03) 9523 0099
email: brilliantbunch@bigpond.com

- ¥ Tax requirements
- ¥ Superannuation
- ¥ Financial Planning
- ¥ Acquisitions/Mergers
- ¥ Business Structures
- ¥ Finance/Refinancing
- ¥ Business Consultants

Principal: Abe Goldberg FCPA
Associates: Lou Stefanetti CPA, Flame Junkeer CPA

QUARTERLY DIVISIONS

CONTENTS

CONTRIBUTIONS

The *Divisions Quarterly* is a journal produced by General Practice Divisions Victoria to enable all Victorian divisions and their GP members to participate in discussion about the changes in general practice that divisions are funded to implement. Others associated with the Divisions Program including consumers are also invited to contribute.

All articles submitted for inclusion in the *Divisions Quarterly* are subjected to a review process by the editorial committee prior to publication. The committee may request changes be made to the article before publication. All changes will be sent to authors for approval before printing if possible. The editorial committee cannot promise that all contributions will be automatically printed in the journal.

Divisions Quarterly will not usually reprint articles that have been submitted to other journals.

Please send your article in either Word 97 or earlier version or Rich Text Format to the following address:

b.newton@gpdv.com.au

If you do not have email facilities, then send a disk copy in one of the formats previously mentioned. If this is not possible, send us a typed copy of your article to the address below.

Feature articles

Feature articles are approximately 1500 to 2000 words long. Please adhere to this length.

Ideally, a *Divisions Quarterly* article will meet as many as possible of the following criteria

- generate debate about the theme
- promote analysis of issues
- inform others about issues in the Divisions Program
- promote and affirm divisions and their work
- contribute to setting the research agenda for the Divisions Program.
- have state-wide relevance

The next issue

The next issue is scheduled for June 2001.

The theme will be GPs and the use of IT and IM. We seek contributions on this theme as well as other articles of interest to the Divisions Program.

Deadline for contributions: 27 April 2001

LETTERS TO THE EDITOR

Divisions Quarterly seeks letters from GPs and others. As part of the purpose of the journal is to generate debate and discussion within the program, the Letters to the Editor section will be a significant feature of subsequent issues. Letters of more than 300 words may be edited to that maximum.

Address letters to:

The Editor
Divisions Quarterly
1st Floor, 458 Swanston Street
CARLTON 3053

Fax:03 9348 1375

Email:b.newton@gpdv.com.au

Editor
Bill Newton

Managing editor
Christine Macdonald

Editorial committee
Dr John McEncroe
Sonya Tremellen
Louise Willis

Cartoons
Simon Kneebone

GPDV is a state-based organisation of divisions of general practice owned by all the 31 divisions in Victoria. It is funded by DH&AC to provide support to Victorian divisions, to develop policy and to represent and advocate for divisions and for general practice.

General Practice Divisions – Victoria
1st Floor, 458 Swanston St
CARLTON VIC 3053

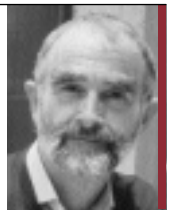
Ph: (03) 9341 5200
Fax: (03) 9348 1375

Email: gpdv@gpdv.com.au

Website: www.gpdv.com.au

DISCLAIMER

Editorial: GPs and mental health



Bill Newton

Although there are many opinions expressed in this issue there are some things on which all contributors agree. The burden of mental health problems in Australia is high and rising and needs urgent attention. GPs have an important role in dealing with the problem. A lot of work needs to be done at all levels to turn this agreement into effective action.

From there on opinions differ.

The Commonwealth

Mental health provides a good example of the perverse incentives of the fee-for-service system. This is not because fee-for-service is bad per se, since it can be used positively to encourage GPs to become involved in new activities. The flaw is that the Medical Benefits Schedule (MBS) has not been used in that way and the status quo is considered by many to be inviolable, even though circumstances have changed since 1983 – and even more since 1975 when the system was first set up as Medibank.

GPs…CANNOT BE EXPECTED CONTINUALLY TO CHOOSE TO DO THE SORT OF WORK FOR WHICH THEY ARE LEAST WELL PAID.

The effect of the incentive given to GPs by the MBS to perform short consultations is explained by both Raymond Martyres and Louise Stone at the start of Jo Chandler's article. Ian Hickie says that the system is fundamentally unsympathetic to management of chronic disease in general practice. Jenny Ouliaris refers to the likelihood that GPs who are known to manage mental health problems well and sympathetically will be 'inundated with people with mental health problems'. The MBS clearly discourages the longer consultations that are required for the treatment of patients with mental illness. To assert that GPs should do the longer consultations anyway is to miss the point. This is a structural issue: GPs respond to material incentives just like everyone else and people who are paid piece-work rates cannot be expected continually to choose to do the sort of work for which they are least well paid.

Changes to the MBS are clearly needed and the minister has indicated that he thinks so too and is prepared to do something about it. What the changes should be is not quite so clear and is under debate as we go to press. GPDV's forum on mental health in November 2000 produced a list of recommended action by all players, including the Commonwealth, and the question of new MBS items for GP work in mental health was keenly discussed.

One objection to new items for MH work is that GPs are generalists and the new items will lead to GPs becoming mini-specialists and so will fragment general practice just when the Divisions Program has given it some unity.

Do GPs want to specialise? It seems that many with preferences or special interests do and are already practising differently from the average. Does it matter? As Jenny Ouliaris says, not all GPs want or need to do counselling, and there is no suggestion that all GPs will have to use the new items, let alone specialise in MH. Nevertheless, times are changing and a group practice comprising several GPs with areas of special interest might be a splendid general practice, even though most of the practitioners 'specialised' in their areas of interest.

GPs with additional training in mental health will provide a much-needed service for mentally ill people in rural and remote areas, where the disgraceful failure of the states to provide basic services is most starkly revealed. The trouble is that, quite apart from the shifting of cost to the Commonwealth through the MBS, it is precisely in the rural and remote areas that GPs say they are already under too much pressure of demand to take on any more specialised training for additional work. The More Allied Health Services (MAHS) Program, which funds rural divisions to employ allied health professionals, may help fill some of the gaps in the state systems but it is a piecemeal solution that could have been far more effective if co-ordinated with the development of state services such as, in Victoria, the recently announced Primary Mental Health Care Teams.

The big question is how to fund new MBS items. Must GPs really accept reduced payments for other services, as Jo Chandler's article suggests, in order to be able to give mental health the priority it deserves ?

Since the signing of the GP Memorandum of Understanding (MoU), the MBS has had a fixed pool of money for GP services. The minister has used this fact to suggest that the provision of funds for MH items is up to GPs who can decide, through the MoU process, to reduce other GP items to provide funds to create new items for mental health. Put clearly this means robbing Peter to pay Paul. (The suggestion, in Jo's article, that one year's unused surplus in the MBS expenditure covered by the GP MoU can be used to create additional permanent items in the MBS is clearly not viable. What happens if there is no 'surplus' the next year to cover the extra cost of the new items?)

So the real issue is whether the government will provide additional funding for new MBS items for MH work by GPs.

To say that GPs themselves can make the decision through the GP MoU is to avoid the policy issue. The advantage of a single national system like the MBS is that it can be used by the minister as a policy tool to provide incentives to GPs to work on national priorities. Mental health is one of the national priorities. The creation of the National Depression Institute shows that the minister believes that mental health is in need of special initiatives. His comments on the success of the GP Immunisation Incentives Program show that he believes that GPs are effective providers of front-line services. He has frequently told GPs that he can only get additional funds out of cabinet if he can show that they are for improved services. GPs with additional skills in mental health and an incentive to use them would be a new, improved – and much needed – service to an increasingly large proportion of the community.

The state level

In recent years the Victorian health system's concentration on Serious Mental Illness and the closure of institutions mentioned by Jenny Ouliaris, has thrown an enormous workload onto GPs – and, incidentally, left the Commonwealth paying the bill. This issue of cost shifting affects adversely all areas in which Commonwealth-state co-operation would be beneficial; unless it is resolved the core problems of the health system will never be overcome.

Another cause of suspicion is the conviction held by many that the millions saved by the closure of Victoria's mental health institutions were kept by the previous state government as savings rather than transferred to community-based services and support for the mentally ill.

The recent announcement by the Victorian government of their investment of funds in the new program for the development of Primary Mental Health Care Teams, described briefly in an insert to Jenni Parson's article, shows that DHS is planning a serious program of work with GPs. In fact, the guidelines for the program list the local division of general practice as one of the four organisations essential to the development and operation of the new teams. This is an important breakthrough because access to and ongoing relationships with the mental health services in the local area are desirable and beneficial to all concerned, but are not always achieved or sustained. Comments from both general practitioners and mental health professionals in Victoria concerning the interface between primary care and mental health services point to the differences in work place practice and difficulty in communicating across services.

THE ADVANTAGE OF A SINGLE NATIONAL SYSTEM LIKE THE MBS IS THAT IT CAN BE USED BY THE MINISTER AS A POLICY TOOL TO PROVIDE INCENTIVES TO GPs TO WORK ON NATIONAL PRIORITIES.

The proposed new teams are also a welcome acknowledgement that early intervention and the prevention of more serious conditions is in the long term more effective – and also much cheaper.

GPs and divisions

Jenny Ouliaris describes the importance of the GP role in her article on mental health at the practice level and believes that it is well done, even if GP culture may persuade GPs otherwise. She sets out well the pressures on GPs and the inadequacy of their training to prepare them for MH work, but shows that divisions can play an important part in supporting GPs. Her comment about the inadequacy of feedback from psychiatrists and other mental health professionals suggests that the massive changes to the mental health system have not yet overcome the 'silo mentality'.

Improvements are essential because, where an ongoing sustained relationship with a patient is established by a mental health service, it is easier to clarify roles for other practitioners and to engage in a shared-care arrangement. This clearly has implications for the development and uptake of the new Enhanced Primary Care MBS items for care planning and case conferencing.

Some of the difficulties encountered between general practitioners and mental health professionals in the linkage, or lack thereof, between their services are obviously compounded by the demands imposed by the short-duration

consultation session in primary care and the high case load carried by staff in community settings.

John Buchanan, looking at the interface between GPs and psychiatrists from the point of view of a psychiatrist, acknowledges the possibilities for mis-perception and poor communication across sectors. John sees them as part of a broader need for improved communication in both directions and has some suggestions for change that GPs will welcome from the chair of the Victorian Branch of RANZCP.

We should also note that many of the projects undertaken locally by divisions and practices, for example in the North West Melbourne Division, indicate that these differences need not be systemic and can be easily overcome.

Jenni Parsons describes some of the successes of divisions in supporting GPs in mental health work and illustrates what divisions can do to enable GPs to improve the quality of their services in mental health. Her description of the programs that the state-based organisation (SBO) in Queensland has persuaded the Queensland Health Department and DH&AC to fund is a good example of the key role of SBOs in advocacy at state level. This successful engagement of the state Health Department in funding and delivering a program aimed at GPs is a model for all other states and should embarrass those state mental health branches that have not been willing to acknowledge the work GPs do to take pressure off under-funded state services.

One of the most heartening aspects of this issue is that it does show how much excellent work is being done by divisions. The wide variety of models and approaches that have been used is most impressive and should give encouragement to those divisions that have been deterred from embarking on a MH program because of the complexity of the area.

A program for GPs in mental health ?

The variety of approaches raises a question that has been at the heart of the Divisions Program from the start: is it the division's role to develop the capacity of all GPs or to focus on those who already have an interest? Most divisional projects and programs have been funded to focus on an interested group of GPs, often rather few, but nationally funded programs, such as the GP Immunisation Incentives (GPII), targeted all GPs. The difference is in the provision of other incentives for GPs and practices than the creation of a new MBS item.

As recently as 31 January the Minister for Health spoke on the ABC of the success of the GPII, which he attributed to 'paying doctors for immunisation'. Paying GPs is part of it, but the GPII Program is much more than that. It is a well-planned national program with practical support for every GP through divisions of general practice. It has been this support that has enabled GPs to make full use of the incentive payments; without the work of divisions the improvement would have been much less.

Ian Hickie told Jo Chandler that new item numbers alone are not enough; there is a whole range of issues. The success of the GPII suggests that these can best be addressed by a program that gives practices an incentive to make the investment in time, equipment and training, as suggested by Raymond Martyres. This would clearly demonstrate the minister's wish to take effective action at the grassroots level where GPs work and where the statistics demonstrate the community's need. The incentives could be based on practice payments, which the minister frequently advocates to GPs, and would complement the proposed new MBS items. Support through divisions would, like the Enhanced Primary Care (EPC) Program's support for GPs in the use of the new EPC items, ensure that the new MH items are used effectively.

The well-funded EPC Program also provides information about the new items to the public, through a communications strategy, and to the other health professionals with whom the new MBS items in the EPC Program enable GPs to work. This approach provides an answer to Ian Hickie's concerns about the need to provide general practice with 'a system that has some chance of being successful'. Hickie's comment that there is not a great deal of evidence as yet that general practice can deliver good mental health outcomes may be correct but there is equally little evidence that general practice cannot. Hickie reinforces John McEncroe's point in our last issue that the research into general practice has not been done.

Michael Wooldridge has created the opportunity to fill this research vacuum. His new Primary Health Care Research, Evaluation and Development (PHC RED) Program could start with research into the GP role in mental health. We need to show what proportion of people with mental illness depend on GPs for their treatment, how this treatment can be made more effective and how it can be better supported by the states, whose massively-reduced mental health services are being propped up by GPs at the Commonwealth's expense.

Bill Newton is the editor of Divisions Quarterly and CEO of General Practice Divisions Victoria.

GPDV FORUM ON MENTAL HEALTH

19 November 2000

Summary of small group recommendations on support for the work of GPs in mental health

Following the main presentations at the forum on 19 November 2000, the participants broke into four small groups to discuss action needed over the next three years to support the work of GPs in mental health (MH). The four groups made the following recommendations for action.

Commonwealth Department of Health & Aged Care

- Ensure adequate remuneration for GP involvement in mental health

  - Develop new item numbers

  - Remunerate psychiatrists and all GPs for time spent on consultation, case conferences and planning

  - Develop MBS items for MH work available only to GPs with some extra skills.

  - Agree some extra skills required for extra fees but not so much it discourages GPs (The aim is to encourage GPs to do MH)

  - Suggest new MBS items be available to all GPs at the start to encourage uptake, but include a sunset provision that makes the items available only to GPs with extra skills after a cut-off date.
- Enable the EPC items for psychiatric patients to be accessed every three months rather than six months
- Support the cost of increased training for GPs undertaking mental health work
- Provide additional funds to divisions for mental health training and clinical attachments
- Involve and fund GP representation on important committees and consultations

Victorian Department of Human Services

- Provide an up-to-date directory of services
- Have a complaints/query process about quality and problems – eg DHS MH staff not using their own protocols
- Improve access to acute crisis services
- Provide adequate funding for services – there are examples of failure to communicate with GPs, or of protocols being used to exclude patients, because of under-funding
- Instruct Adult Mental Health services to start serious communication with GPs
- Build into Adult Mental Health services some performance indicators to measure and evaluate the level of collaboration with divisions/GPs and other primary health services for inpatients, outpatients and discharge planning.
- Examine why there is a shortage of psychiatrists in the public sector and look after psychiatrists better so that they stay
- Use psychologists to do more of the work
- Promote the CLIPP model more
- Adopt Goldberg's program for GPs in Victoria
- Extend the Victorian models of shared care developed in the early 90s.
- Take a population-based approach to mental health – an integrated approach
- Promote a liaison/support role for mental health services. Relationships need to be institutionalised rather than dependent on the efforts and goodwill of individuals
- Canvas regional views of GPs within divisions on specific topics

Royal Australian & New Zealand College of Psychiatrists

- Develop a web-based referral/resource directory
- Ensure access for urgent assessment
- In training and CME inform public psychiatrists of the medications available on PBS
- Promote and extend the code of conduct to ensure psychiatrists write letters back to GPs re future needs and action being taken by psychiatrists
- Explore, with RACGP and universities, education and training in MH for GPs; co-ordinate and, in consultation with GPDV, accredit basic courses similar to shared antenatal arrangements
- In training for psychiatry develop a sub-specialty in liaison psychiatry
- Explore feasibility of shared-care MH card as in current British Journal of Psychiatry
- Develop a job description for psychiatrists to include roles beyond individual contact, such as consultant, mentor to group of GPs, etc.

- Develop an accreditation process for psychiatrists that would include CME, education of GPs, work with psychologists, and blended payment system
- Consider how psychiatrists can work effectively at the local level with psychologists
- Promote Whitehorse approach widely
- Promote clusters of private psychiatrists to do outreach work
- Develop strategies to increase availability of ethno-specific psychiatry either through recruitment or more effective interpreter use

RACGP

- Set standards on referrals and reports
- With RANZCP set standards for GP psychiatry
- Explore, with RANZCP and universities, development and accreditation of education and training in MH for GPs;

Divisions

- Provide good quality education, training, and support
- Provide a local resource directory using IT to cope with changes
- Develop / promote local GP / psychiatrist shared-care arrangements
- Promote the use of EPC items for patient care co-ordination
- Foster MH special interest group / listing of MH GPs to parallel psychiatrists' register
- Tap into private psychologist regional groupings, social workers, community organisations, etc, to promote collaborative arrangements with GPs
- Take some quality assurance role in relation to specialist services

GPDV

- Negotiate with other organisations, including RANZCP, for models of referrals, care, etc
- Identify GPs' specific problems with psychiatrists and feed into psychiatric training
- Lobby DH&AC for item numbers
- Work with RANZCP, RACGP and universities, on development and accreditation of courses in MH for GPs;
- Circulate a list of current State Government MH reviews to divisions

LETTER

While I agree with Teri Snowdon that general practice consultations are problem-centred they more importantly need to be patient-centred (number 4, Spring 2000). While we may argue semantics, it is very common for patients to attend their GP to have risk factors managed. Hypertension is a case in point. Also as the majority of people who suffer preventable events are not at high risk we have a duty of care to these patients as well.

Most of the problems that patients present with are self-limiting and do not have proven effective therapies. A smoker who presents with an upper respiratory tract infection will not respond to any therapeutics but would benefit in the long term from being offered the opportunity to quit should they so wish. We need to manage the presenting problem and the adverse risk factors we subsequently identify that have proven prevention of adverse outcomes.

Dr Mark Nelson
Senior Research Fellow
Department of General Practice
Monash University

Mental health in practice

Jenny Ouliaris

Jenny Ouliaris is a GP with an additional qualification in family therapy. In this article she discusses the sorts of mental health problems normally seen in general practice and explores the pressures that GPs face as they respond to the demands.

Who does the GP see?

People often ask what sort of mental health problems GPs tend to see in their practices. Obviously we are generalists and are the most frequent first point of contact for people who seek assistance for a mental health problem. The presentation may be direct or it may be indirect through a range of physical symptoms or even through a third party such as a child. As a result of deinstitutionalisation we now see more people who have a 'serious mental illness'. However the majority of mental health issues we see are the 'high prevalence disorders' such as anxiety, depression and drug and alcohol problems.

What is special about the role of the GP is that we often know people over many years and stages in their lives. We may well know their families and be able to see transgenerational patterns. We have a context for the symptoms they present. In a way, depression, anxiety, drug and alcohol problems – although diagnoses – are really only symptoms of what is going on in people's lives. GPs are in a very good position to understand what the underlying issues may be. We often have very good and trusting relationships with our patients. As people go through the life cycle changes (such as partnering and having families, children leaving home, retirement, death of family and friends and so on), GPs are often in a good position to predict and assist in the prevention of mental health problems. We know a lot about their personalities, strengths, and the presence or lack of supports.

Another important characteristic of general practice is that patients can open up about other issues in the context of other physical health problems. As a female GP I find when I am doing routine things like PAP smears that I generally take a history of such things as post coital bleeding, contraception, vaginal discharge. The history taking often gives rise to discussion of many psychosocial issues such as a sexual abuse history, sexual dysfunction, relationship difficulties, depression, and drug and alcohol abuse with risk taking behaviours. If you are open to following these 'leads', people may well want to explore the issues. Or they may be content with the fact that they have stated their problems knowing they can be addressed at a later date. One of the other advantages of general practice is that patients can

go at their own pace – without formally committing to seeing a therapist.

Another of the strengths of general practice is our availability. As such we tend to see a lot of people in crisis. If you feel distressed today you can just go in and make an appointment and if an appointment is not available, GPs have a duty of care to see people. And so we do. We fit them in. And then they can come back the next day if they want to. So people who are not able or ready to fit into a routine or committed program of therapy can still access help as they need it. Also it is the nature of certain conditions, personalities or certain age groups that makes it more difficult for people to fit into a structured program. GPs see a lot of people with so-called 'personality disorders'. There was a period of time when such people were not eligible for treatment at a community mental health centre (CMHC), as they did not fit the criteria of serious mental illness. Also due to the nature of the condition they are often unable to fit into a structured program. That applies not only to people with personality disorders. Adolescents can be like that, as can people with drug and alcohol issues. These people are not necessarily ready to go into a program but they will come at intervals, when they are in crisis. We often assist to 'hold' people until they are more ready or able to seek more specialised help.

GPs OFTEN UNDERVALUE THE WORK THEY DO IN THIS AREA – THAT OF ACTIVE, RESPECTFUL LISTENING.

The pressures on GPs

It is often the same characteristics of general practice that are beneficial to patients with mental health problems that can cause a lot of pressure on the general practitioner. People presenting in crisis or in distress require sensitivity and time. People do not necessarily want to be referred on – they may not be ready, they may not want to formally acknowledge the issues or deal with the stigma of seeing a mental health professional. It may be enough for them to speak with their doctor whom they trust but the GP may not feel equipped to deal with the issues as he or she feels an 'expert' would. GPs often undervalue the work they do in this area – that of active, respectful listening. The training in the medical model has focused on the GP finding a solution and this model does not always fit psychosocial issues.

There are also some wider systemic issues that have impacted on the GP in more recent years.

The impact of closing institutions

The community mental health centres (CMHCs) previously managed large numbers of reasonably stable patients. As the less stable patients from the institutions, with their attendant need for more intensive care, shifted into the community, many of those who had been seen by the CMHCs were then shifted to general practice. So GPs began to manage more patients with schizophrenia or bi-polar disorders. That had a huge impact on us. Darebin Community Mental Health Centre for example went from having over 1000 clients to having currently 420. There were no processes put in place for communication or clinical support to the GPs in this transition.

Prior to deinstituionalisation, the CMHCs would also take referrals from GPs of a broad spectrum of conditions of varying severity. Now the tables have turned. The CMHCs discharged hundreds of patients to GPs and have narrowed the type of referrals they will take.

As GPs working at a community health centre, we received a lot of that patient load, but there were also selected GPs in the area that the CMHCs would discharge to. So even though the mental health load increased for some GPs that increase would not have been distributed evenly across general practice. It becomes known that there are certain GPs who are interested in particular sorts of issues but they became very overloaded.

There is a lot of talk and interest in shared care programs with GPs. Sometimes the GP can feel that the agenda is about decreasing the public mental health overload and cost by discharging people from public clinics and from hospital earlier. It increases GPs' workload. At the start of our division's shared care project I went round with the CMHC case managers to interview GPs who had expressed interest in participating. Mostly the GPs wanted assistance with their own patients with whom they felt overwhelmed and out of their depth. The GPs wanted advice. Many of these patients did not want to be referred on to a psychiatrist or other mental health professional but the GPs felt unsure of whether they were doing a good enough job. So it was a plea for support.

Problems of referral

Cost was a significant issue where I worked. Many people could not afford to pay for counselling and it is very difficult to find low-cost or publicly funded counselling. That is another great pressure for GPs. I think a GP's role is in preparing people. It is important to take time to prepare people for what to expect and to help them feel ready. Yet when they are ready money can be a very real barrier. It

is very hard to find bulk-billing psychiatrists. Psychologists' services are obviously not covered by Medicare. The local council services are really useful but they are very overburdened. The hospital based outpatient setting is not usually a favoured option by people for a variety of reasons.

The other pressure for GPs is in knowing to whom and how to refer. Ideally I at least know something about the people I refer to – either personally or by recommendation. But as GPs we do not have very good training in understanding the different modalities of treatment. We don't have a common language and therefore we find it difficult to ask mental health professionals how they work. They can work very differently. Some people work in a psychodynamic way, others with a cognitive behavioural therapy approach or family therapy. Others are very drug therapy oriented. As GPs, to make a successful referral, we must try to match the patient to the therapist. My observation from training GPs is that many GPs do not know how to ask people how they work (because they do not have the frameworks). And therefore when they speak to a psychiatrist or psychologist they are unable to talk it through. It might appear to the therapist that we don't know what we are talking about which is often untrue – we just do not have the psychological language.

The other part of this relationship that adds to the pressures on GPs is the problem of feedback. Firstly, there is the need for feedback from the patient. If the referral has not gone as expected, if a patient has been put off in some way, it is important that they can talk to their GP about it. It would be particularly helpful at this stage for the GP to have had some communication with the mental health professional. But communication back from therapists, whether they are public or private, whether they are psychiatrists, psychologists or social workers, is very scant. It is just not in the culture of mental health services of any description to communicate with the referrer. (There are a few exceptions).

This is a huge problem for GPs. When we talk to mental health professionals about it they raise the issues of confidentiality but I think this is a way of stigmatising mental health. If you refer someone to a renal physician they will write you back a long letter and similarly if you refer to the ENT specialist or anybody but the mental health specialist. The mental health specialist will say the patient would not want us to tell you about this private information but I think this is not generally the case. I think that they do not ask and also that they do not understand that patients often have a very good and trusting relationship with their GP and would be pleased for them to receive feedback from the specialist. You can also give graded feedback which is informative but not disclosing of information that the patient does not want released. The main issue is asking.

The cost to the GP

Apart from the pressures that result from the lack of affordability of services for patients, the other traditional area of pressure for GPs associated with treating mental health problems is that of the cost to the GP. It is not financially viable to spend time with people.

That is a big challenge for general practice. We have been doing family therapy training for about four or five years now with GPs and during the training they would generally raise the concern of cost to their practice. But if you go about it in the right way you can actually contain someone in a relatively short period of time like 10 or 15 minutes and get them back to see you the next day and then you can make a longer appointment if you need to. The Medicare rebate is not great – for a level C you get over $36 and level D is about $60.

The effects of the network

So the pressures on GPs are many and there is one final pressure. I originally had normal general practice training with no special training in mental health issues. However, I was open and alert to them. It is common for people to present with one agenda but they also have a hidden agenda and if you have any skills at all in opening that door, if you have any perception at all, you will be inundated with people with mental health problems. So whatever the style is that invites that (and I think female practitioners seem to have it a bit more than male practitioners do) you will soon be inundated with people with mental health issues. And people will spread the word amongst their friends and also the local agencies come to know about this and you can become overloaded very quickly.

Dealing with pressure and supporting the GP

Improved secondary consultation to GPs

GPs would greatly benefit from improved access to secondary consultation. Ideally this would operate like the CLIPP model where a psychiatrist visits the GP practice to consult with several of the practice's patients. The GP then spends time with the psychiatrist and they discuss the diagnostic and management issues together. Another way of doing this is called supervision. This is where one or more GPs present cases from their practice and guidance is given into the same issues. My experience from participating in many mental health training programs is that GPs are often doing a very good job but lack the confidence to acknowledge it. They underestimate the importance of a trusting

Divisions Quarterly

Subscription Form & **Tax Invoice**

Name: .....

Organisation: .....

Address: .....

.....

Tel: ( ) ..... Fax: ( ).....

Email: ....

O I would like to subscribe for one year (4 issues) to *Divisions Quarterly* at a cost of $44 (inc. GST)

Please provide me with the following back copies of the Journal at $11 per issue (inc. GST):

- O 1st Issue - Taking Stock
- O 2nd Issue - Practice Support
- O 3rd Issue - Integrating Care: GPs in the Health System
- O 4th Issue - GPs and Population Health

PAYMENT

O I enclose a cheque made payable to General Practice Divisions - Victoria Ltd

O Please charge my credit card:

- O Bankcard
- O Mastercard
- O Visa
- O American Express *For Amex only:* Batch Code (3 or 4 digits) ..

Card Number: ..... Expiry Date: __ __ / __ __
Cardholder s Name & Address: Signature:

....
.....
.....

Please note that this journal is provided free of charge to all Victorian Divisions of General Practice and all Victorian General Practitioners who are members of divisions.

Please fill out the subscription form and send it together with payment to:

Journal Subscriptions
General Practice Divisions - Victoria Ltd
ABN. 80 081 371 968
1st Floor, 458 Swanston Street
CARLTON Vic 3053
Tel. (03) 9341 5200
Fax. (03) 9348 1375
Email: subscriptions@gpdv.com.au

Total Payment Enclosed:

$
(total price inclusive of GST)

caring relationship being an important part of the therapeutic process.

The training of GPs is very much, and this is the medical model, about solving people's problems. When dealing with mental health issues often GPs feel overwhelmed and try at the end of the consultation to find a solution. They might do better to accept that they they can just listen a bit and give the patients a bit of time before they together decide what to do about the issues.

There is currently funding available for the establishment of primary mental health teams in local areas. The main purpose is to support GPs and community health centres in the mental health area. There is provision for onsite secondary consultation at GP practices.

Changes to Medicare

I worked for many years at Northcote Community Health Centre and a high percentage of our clientele had mental health problems. It was a fantastic service but we went broke. Partly this is because it is very difficult to sustain a practice on bulk-billing. Sometimes I regret that the co-payment never happened as I can see how people could afford to pay a few dollars on top of bulk-billing. Even an extra two dollars per consultation would have allowed us to be sustainable. The current system is very difficult if the patient is unable to pay upfront. You must give the patient an account that they send to Medicare. At least a month later they receive the cheque which they forward to you with the additional two dollars. It is not cost effective if you think about all the account keeping and chasing up involved. If people can not afford the upfront payment, bulk billing is the best but poor alternative. There has also been discussion for many years about a Medicare payment for GPs to do counselling. We remain hopeful.

The new Medicare items for case conferencing may be useful for very complex issues with multiple professionals involved but most GP phone consultations with other professional are on a one-to-one basis and therefore not eligible.

Conclusion

Before considering how the role should develop, GPs should understand that they actually do a fantastic job in containing an enormous amount of people's distress. They will often say they are not doing anything and they will feel a bit bad about not fixing a person's problem. But just by listening, by being accessible to people who need to offload a little bit, they are providing a great service.

The main ongoing role for GPs in mental health is to build relationships with patients, and to help to predict and prevent problems that might otherwise arise. GPs would often ring up a bereaved person whose husband has just died or make sure that the woman they know is prone to PND comes in more often after the birth of the baby. Every GP should be able to identify the issues with a patient. They should be able to take a good history, to tease out the issues and offer some options. GPs have a role in preparing their patients for a program of therapy with another health professional and matching the need to the skills of the therapist.

However not everyone wants to (or needs to) do counselling so while it is important for all GPs to have some basic counselling skills, those GPs with a special interest should be supported to further develop these skills. It is important that GPs have access to good support and secondary consultation if they are treating people with complex mental health issues on their own.

Jenny Ouliaris is a general practitioner who works in a community health centre and also in private practice. She is the Mental Health Program Manager at the North East Valley Division of General Practice and a member of the GPDV Mental Health Reference Group.

The next issue

The next issue is scheduled for June 2001.

The theme will be information management and technology in general practice

We seek contributions from GPs on the ways in which their divisions have assisted them in IT&IM;

articles that explore issues of data collection and data ownership at the GP, practice, division, state and Commonwealth levels;

articles exploring the pros and cons of increasing computerisation in general practice;

articles that examine the use of IT to improve co-ordination and co-operation between general practice and other parts of the health system.

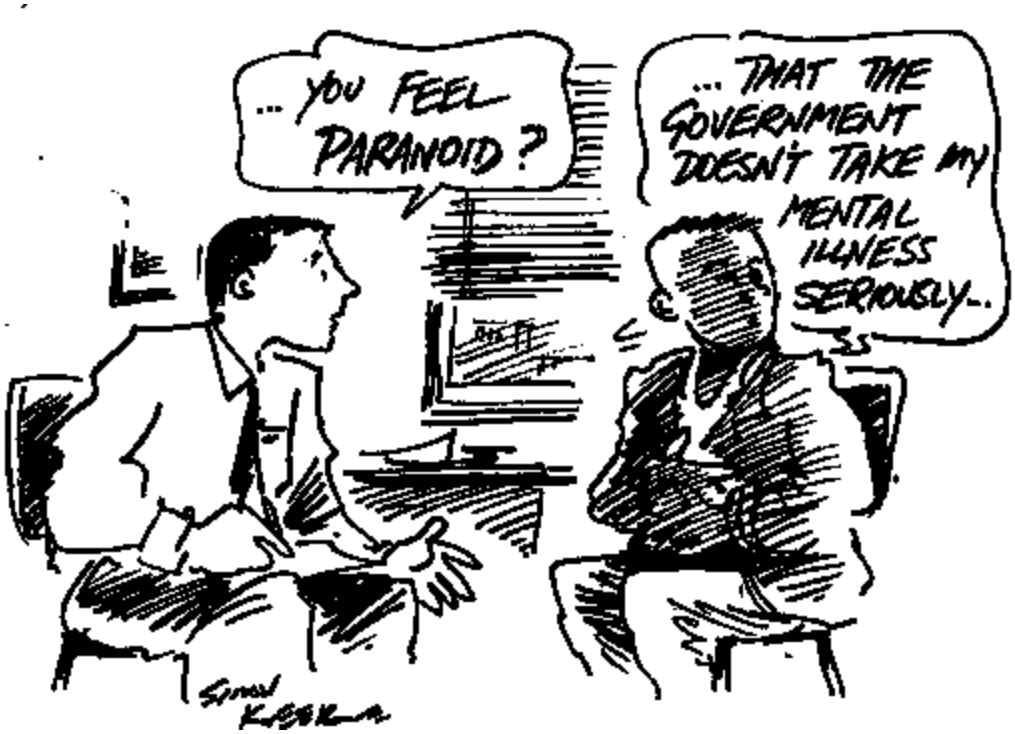
We seek contributions on all of the above and encourage readers to contribute to the discussion of divisional issues by writing letters and articles on any matter of relevance to the Divisions Program.

The deadline for contributions is Friday 27th April.

Paying the mental health bill

Jo Chandler

In 1998, the Joint Consultative Committee in psychiatry established 'incentives and remuneration' as 'priority one' if GPs are to play a serious role in mental health. Now, with a decision pending on the issue of GP payment for mental health consultations, this article asks some of the players for their thoughts on how the issue should be resolved.



He comes in complaining of stomach problems, and then reels off a long list of aches and pains. He can't sleep, he says, and bit by bit, out it comes – he's yelling at the kids, kicking the dog and fantasising about shirtfronting the boss. Meanwhile the waiting room is overflowing, and the meter stopped running 20 minutes ago. This patient is anxious, maybe depressed, and a classic casualty of the modern epidemic. He's also putting general practitioners through the wringer – testing their skills and, many argue, their economic largesse. And there's plenty more where he came from.

Depression affects more than 800,000 Australians each year and clinical depression strikes one in 17 adults. It costs the nation five billion dollars annually. The World Health Organisation predicts that by 2020, depression will become the world's second-leading cause of disability and death, behind heart disease. The burden of mental health is growing heavier, and the question of who will shoulder it is preoccupying health policymakers. The discussion is on several fronts. Who is best placed to manage this epidemic – psychiatrists, psychologists, psychiatric nurses, GPs? What training and skills do they need? How must the health system change if it is to cope?

On the first two issues, the landmark 1997 Primary care psychiatry – the last frontier document presented a powerful argument for GPs to recognise and extend their involvement in caring for their patients' psychological needs. In it, the Joint Consultative Committee in Psychiatry reviewed links with specialist mental health services and spelt out the training GPs would need to be more effective. Then a year later, the committee examined the structural reforms needed to deliver the services on the ground, and the list – published in the 1998 implementation strategy – establishes 'priority one' as 'incentives and appropriate remuneration'. Now, with final arguments from the stakeholders and a decision pending on the prickly issue of GP payment for mental health consultations, this article asks some of the players for their thoughts on how they think the issue should be resolved.

The cost to the GP

Melbourne GP Raymond Martyres was one of the JCC members responsible for the 'Last Frontier' report. The document was an acknowledgment that the system has to change, he says, and many of those changes are underway. There are now efforts to provide more education and resources for doctors. But the financial rewards simply aren't there, Dr Martyres argues.

'As an example of the disincentives facing GPs,' says Dr Martyres, 'let us suppose that in a normal eight-hour working day a GP sees four to five patients per hour (32 to 40 patients per day). If 25 per cent of these patients have a psychological issue co-existing with their presenting complaint, and one spent between five and ten minutes extra with each of these patients, that would amount to an extra 40 to 50 minutes a day. In that time it would be possible to see an extra four to five patients. The financial disincentive is clear: the 40 to 50 minutes spent on psychological issues is unremunerated. In a day, it would be approximately $80 foregone; in a week, $400 and over a year, $20000. The other option is to call the patient back for a longer consultation but you would still earn less seeing one patient in a longer consultation than if you had the normal number of standard consultations. Either way there is a disincentive. And the point is that we need a system solution put in place to allow GPs to participate in mental health. It is not productive just to accuse GPs of not looking after patients with psychological issues.'

Dr Martyres wants to see a structure that delivers more money directly to practices that put in the training, time and effort to care for patients with mental health problems. Whatever that payment is – a practice incentive payment or funding by some other means – it has to be significant, he says. Alongside this he proposes access to a new Medicare item number for GPs who upgrade their mental health skills – for instance, if they qualify for membership of the new College of Psychological Medicine. 'There are GPs who want to deal with mental health issues and they could have a specific item number for putting an hour aside for a patient and be paid $80 to $100 for that hour.'

Louise Stone is one of those GPs with a special interest in mental health. Formerly in practice in rural Victoria, she now works as co-ordinator of the GP–psychiatry program at Monash University. 'If you develop an interest in psychiatry, inevitably you attract more of those sorts of patients ... word gets around and suddenly the prevalence of, say, depression and anxiety in your practice may double.' The effects resonate. Suddenly the waiting room is backed-up with the more lucrative, quicker-fix level B patients while the GP is locked in the surgery dealing with long consultations at $61.10 an hour. In cities, these patients may simply find themselves another doctor. In the bush, a sole practitioner will have to find the time to see them, while a doctor in shared practice will rely on colleagues to pick up the slack. (See box for explanation of consultation levels and fees).

'Then you may find you're losing skills; you can no longer do lumps and bumps because the vast proportion of your work is with psychiatric patients,' Dr Stone explains. 'So then you have a doctor who is unable or unwilling to schedule in suturing or the other craft, procedural skills traditionally favoured under the MBS, and so you lose again.' It is much more than an issue of 'D's versus Bs' in the waiting room, she says. 'Part of the remuneration package has to be that these guys need a break, they need support in practice that is very demanding.'

Dr Stone is not persuaded that practice incentive payments are the answer. 'Mind you, in practices that are actively hostile to people that do not see a particular number of people per hour, it may sweeten things, but I doubt it. I think the incentive would just come in and be absorbed in the practice and the more vulnerable doctors – who tend to be the ones doing the psychiatric service – are pushed to the outskirts.' Specific item numbers are Dr Stone's preferred mechanism for payment. In addition, she wants to see broader public health campaigns to improve community knowledge on mental health issues. 'Me explaining depression over and over is a waste of government money ...We need consumer education kits, materials to work through a program.'

Barriers to a GP role

The chief executive of the National Depression Initiative 'beyondblue', Professor Ian Hickie, picks up the theme. People in the community do not really know what depression is, and someone has to take the time to explain it. 'No-one tries to treat asthma or diabetes without explaining what it is first, but we have evidence that people treated for depression are no more educated about it than people who have never been treated.' If new item numbers are eventually pursued as a solution, they might incorporate access to educational materials and self care programs under GP supervision. And a GP who undertook more training could perhaps be entitled to another item number to deliver more sophisticated interventions.

But Professor Hickie does not want the discussion hijacked by talk about item numbers. The driving issue has to be about good mental health policy,

The MBS consultation levels

Level A

These items are for obvious and straightforward cases and the practitioner's records would reflect this. In this context 'limited examination' means examination of the affected part if required and 'management' the action taken. Example: Triple antigen or Tetanus immunisation

The full Medicare Benefits Schedule fee for a vocationally registered doctor is $12.85. The rebate or fee if the doctor bulk-bills is: $10.95 (ie 85% of the schedule fee)

Level B

The descriptions of these items introduce the words "selective history' and 'implementation of a mangement plan in relation to one or more problems'. …The essential difference between Levels A and B relate not to time but to complexity. Example: Otitis media presenting as earache.

Time: less than 20 minutes

Full MBS fee: $27.00; rebate / bulk-bill rate: $22.95

Level C

Further levels of complexity are implied in these items by the introduction of 'taking a detailed history' and 'examination of multiple systems'. A physical attendance of at least 20 minutes is necessary to qualify for a level C attendance. ….Example: essential hypertension presenting as headache.

Full MBS fee: $48.75; rebate / bulk-bill rate: $41.55

Level D

These items cover the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they should be performed. These items also cover cases which need prolonged discussion. Physical attendance of at least 40 minutes is necessary to qualify for a Level D attendance.

Examples:
Migraine with peripheral neurological signs
Depression presenting as insomnia or headaches
Complex psychological or family relationship problems

Full MBS fee: $71.85; rebate / bulk-bill rate: $61.10

Source: Medicare Benefits Schedule, 1 November 2000, HIC website, February 2001 http: / / www.health.gov.au / pubs / mbs

and he argues that there is not a great deal of evidence as yet that general practice can deliver good mental health outcomes. 'One sceptical view is "don't waste time on general practice" – to somehow provide clinical psychologists or other people directly to the public. This is not the serious point of view ... but it is not fair to test general practice in terms of mental health outcomes until you have a system that has some chance of being successful.'

As he argued in an article published in the Medical Journal of Australia in July, the management of conditions such as depression in general practice is stymied on several fronts – social stigma and a lack of understanding inhibit the patient; the doctor struggles with a lack of training and a reluctance to provide psychological treatments; and the practice structure throws in a few more obstacles in the form of too little time, too little money, too little specialist support and a lack of access to screening and educational materials. But despite all this, 'improvement in the quality of mental health care provided by GPs is now firmly on the national agenda'.

Right now the system is rigged against success, Professor Hickie said when interviewed for this article, because of its emphasis on rewarding short-term work on minor medical problems. The system is fundamentally unsympathetic to management of chronic disease, whether it is diabetes or depression. 'In the current system, the time disincentive is large – there is no time to even start in the current system, so it's not surprising that people talk about time issues first off,' says Professor Hickie. 'But what we're talking about is a much broader issue that relates to item numbers, practice incentives, information technology, quality assurance, patient use of self monitoring – a whole range of issues.' Item numbers alone are not an answer. Practice incentives, for example, could be used to encourage the introduction of basic pencil-and-paper questionnaires to screen for mental health issues in the waiting room, he says.

Negotiating the payment

The Australian Divisions of General Practice – together with the RACGP and the RDAA – are expected to approach Federal Health Minister Michael Wooldridge early this year with a formal proposition on the place of – and payment for – general practice in primary mental health care. 'Beyondblue' also has a voice in the process. But Professor Hickie emphasises that whatever the final proposal is, it 'has to be good mental health policy, it can't just be good for GPs'. When 'beyondblue' was launched in October, Professor Hickie predicted rewarding GPs for work in tackling conditions such as depression would be a 'key political issue down the track'. When the Age then

pursued Dr Wooldridge for a response, he gave a pretty clear signal of his thinking. It was, he said through a spokesman, 'within the power of the medical profession to change the payments for mental health consultations by altering the balance within the existing budget, but that no extra targeted funding was planned'.

Will doctors be willing to give up payments in other areas to get the money they want for providing mental health care? With the proposal she will take to Dr Wooldridge still taking shape at the time this article was being prepared, ADGP chair Dr Julie Thompson wasn't giving as much away. Would the proposal argue for extra funding, or offer a trade-off under the terms of the 1999 Memorandum of Understanding? Will it be urging new item numbers, or look instead at alternatives such as practice payments? 'All I can say is we're looking at both at the moment – at the long consultation item, at whether or not we need to have a specific item number, and at a way of supporting GPs – possibly at practice payment support for community psychiatric work,' Dr Thompson said. But RACGP president Paul Hemming is more forthcoming about what he wants to take to the minister. He told Australian Doctor in December that he wanted to see a new item number that would give GPs at least $70 for spending more time with patients who have a mental illness and co-ordinating their care with other services.

WILL DOCTORS BE WILLING TO GIVE UP PAYMENTS IN OTHER AREAS TO GET THE MONEY THEY WANT FOR PROVIDING MENTAL HEALTH CARE?

Observing the machinations of the various interest groups is Andrew Tongue who – as assistant secretary of the general practice branch of the Department of Health and Aged Care – will play a key role in shaping the policy that emerges from this process. He sees in one corner the mental health lobby pushing for some sort of greater engagement by GPs in mental health issues. In the other, the GPs agreeing, but then raising the fee structure as an obstacle to that engagement. 'The issue is in what context you come up with some sort of item that reflects the aspirations of the community of interest around mental health, but also GPs. And how do you do that in an environment where basically the government is saying "we've got a GP Memorandum of Understanding – if the GPs want to do something they can do it within the context of the Mou".'

So GPs will have to horse-trade another item number in order to come up with more money for mental health? Not necessarily, says Mr Tongue. 'Last year, the MoU underspent, and the GPs decided to put the money into standard consultation items. The money could have just as equally been put into a new item related to mental health ... New money in healthcare is a hard thing to come by. And I guess because the Medicare schedule is such a complicated beast, it isn't as simple as saying "lets have a mental health item". It has to actually be defined and described in an auditable way what it is that the GPs do – that's not easy.'

Andrew Tongue says there is recognition in the policy community that examining the options for mental health care delivery by GPs is a desirable thing. But among those who look after the closely-guarded health coffers, there is caution. For instance, would the money be better spent on mental health nurses in rural areas? 'Because it is the Medicare schedule, it is a big investment decision, and before we make that decision, the whole policy community would need to be convinced,' he says. But 'things move quickly if there is a view that they should, and my sense is the pressure is building'.

In addition to the alternatives of new MBS item numbers, practice payments or a combination of the two, Andrew Tongue floats options such as an 'advanced primary care' item which could broaden the opportunities for GPs working with other health professionals to gain access to case-conference payments at a slightly higher rate because of the complexities of mental health. 'There are a lot of policy choices around – the issue is, what's the best?' he says.

As GPs with plenty of personal experience in mental health management at the coalface, there is a note of exasperation – perhaps desperation – as Dr Stone and Dr Martyres sum up their thoughts. Says Dr Stone: 'One issue that is really important is this moral overtone about psychiatry. If you were just a nice, caring doctor you would care about these people who are terribly emotionally distressed. That's good bedside manner stuff and to an extent that's true – but you can't cover up structural problems. And all the good will in the world can't give me more time in general practice, can't buy me the resources I need, can't get me access to a psychiatric nurse part time to run cognitive behaviour therapy or education sessions.'

And Dr Martyres: 'In the end if the Federal Government is not prepared to bite the bullet and accept that the GP has a defining role in the delivery of mental health services, and we need to remunerate and upskill GPs to undertake those services, we will not make any inroads into the morbidity and mortality that mental health is claiming in Australia.'

Jo Chandler is a journalist and former medical reporter for the Age.

Improving the interface between GPs and psychiatrists.

John Buchanan

Dr John Buchanan writes from the psychiatrist's perspective about the problems of communication and co-operation between psychiatry and general practice. In this article he pinpoints the problems and offers practical suggestions for a way forward.

The burden of mental health disorders in Australia.

Close to one in five people in Australia are affected by a mental health problem within a 12-month period. Young adults are particularly affected, with more than one-quarter of Australians aged 18 to 24 years suffering from at least one mental disorder over a 12-month period. Among adults, some 18 per cent suffer from a mental disorder and the prevalence of anxiety, depression and substance use disorders is 9.7 per cent, 5.8 per cent and 7.7 per cent, respectively. For older adults the prevalence of mental disorders drops to 6 per cent among those aged 65 years and over, although an additional 6.1 per cent are estimated to have dementia.

The co-occurrence of more than one mental disorder is common at all ages and considerably adds to the burden of disorder. Co-morbidity of mental disorder and substance misuse is especially problematic, particularly for young people and increased risk of suicide and self-harm also add substantially to the burden of mental health problems and mental disorders.

However, only 38 per cent of adult Australians with a mental disorder receive help for their problem. Similarly, only 29 per cent of children and adolescents with a mental health problem had been in contact with a professional service in a 12-month period.

It is now well known that the burden of mental health problems and mental disorders is high and rising. It is estimated that depression alone will constitute one of the greatest health problems worldwide by 2020.

These findings pose immediate and serious challenges for governments and the medical profession. There is a compelling need to make prevention and early intervention a priority in primary care, and to develop clear plans for improved co-operation between specialist psychiatrists and general practitioners.

The interface between primary care psychiatry and specialist psychiatry

General practitioners and psychiatrists have a common interest in working together to treat the one in five Australians with mental illness. The Joint Consultative Committee in psychiatry between the RACGP and the RANZCP produced its report Primary care psychiatry – the last frontier (JCC Report) in 1997 and identified some of the issues.

The Victorian Branch RANZCP has participated in discussions with the RACGP, the Whitehorse Division of General Practice, collaborative workshops (especially one with Professor Sir David Goldberg), and GPDV, and has seen evidence of a need to improve the interface between general practitioners and psychiatrists.

The network of private community psychiatrists provides a valuable resource to general practitioners and their patients and treats the majority of citizens seen by specialist psychiatry services. However there are some difficulties at the interface and it is time to work towards improvement.

The Evaluation of the First National Mental Health Strategy noted 'Improving links with GPs holds the greatest potential to improve outcomes for a large number of people with mental health problems. Such links need to go beyond discussions around individual cases and extend to broader issues of training, consultation, and referral pathways….'

What are the issues at the GP/public psychiatry interface?

At the GP/public psychiatry interface the key problems are:

- GPs want to speak to a doctor if they refer to a CAT team, but this usually is not possible;
- some CAT teams have taken the 'serious mental illness' label very literally to mean psychotic illness only;

- there are delays in providing discharge summaries to the GP.

Issues at the GP/private psychiatry interface

- GPs do not have readily available information about private psychiatrists, for example, practice addresses, fax numbers, and type of specialty of local psychiatrists.

- GPs have never personally met most of the psychiatrists to whom they refer.

- The problem of waiting times is exacerbated by the perception of psychiatrists that the patient is being referred for treatment, when often, from the GP's perspective, the patient is being referred for an assessment or opinion.

- It is apparent that some GPs require an urgent opinion but are prepared to continue management of patients who do not immediately need on-going specialist treatment.

- Sometimes letters of opinion or progress from psychiatrists are slow to arrive.

From the private psychiatrists' perspective some of the issues are:

- lack of clarity about the purpose of referral ie. opinion or treatment;

- inadequate information about medical investigations already performed;

- it is difficult for the psychiatrist to gauge the interest of the referring doctor in shared care;

- it is not possible to keep indefinitely adding 'treatment patients' to a busy psychiatric practice when many such patients will need once-a-week appointments, and some twice-a-week.

The way forward could involve change to Medicare items, some divisional initiatives, and the RANZCP liaison project with its referral directory provides a model for improvement of the interface between GPs and psychiatrists.

The way forward

Change to Medicare items

There is a clearly a need to change Medicare items for GP consultations in mental health. At present, any GPs who regularly conduct longer consultations do so at considerable personal cost.

If psychiatrists are to assist GPs with non-patient consultations for 'supervisory' activities, there is also a need to add Medicare items for psychiatrists offering such GP support consultations – personally or via videoconferencing.

Divisional initiatives

A mental health curriculum for GPs could be developed to facilitate upskilling. A training course for GPs in cognitive behavioural therapy, small interactive group sessions for GPs, and clinical meetings with public and private mental health services with shared care agreements are all worthwhile initiatives.

A co-ordinating group based on the Whitehorse Division of General Practice GP Mental Health Reference Group could also be developed. The group could include: a consumer representative, general practitioners, a private psychiatrist, a public mental health service provider and a divisional administrator.

The Victorian Branch RANZCP GP liaison project

A project with three elements to improve the working relationship between general practitioners and private psychiatrists has been developed and is being trialed with the Whitehorse Division of General Practice.

a) Encouragement of consultant psychiatrists to offer one- or two-visit assessment consultations – on the condition that the GP continues to treat the patient. Under this system there are two types of referral to a psychiatrist: referral for assessment and opinion, and referral for personal ongoing treatment.

The GP will need to indicate clearly which type of referral is being made.

b) A referral directory of community-based consultant psychiatrists.

This has recently been published and includes details such as practice address, telephone and fax numbers, with subspecialty areas of interest.

c) Joint clinical meetings, perhaps once or twice per year, between GPs and psychiatrists in a particular region to enable GPs and psychiatrists to establish some personal links to facilitate communication. These meetings between general practitioners and private psychiatrists will facilitate networking, provide a forum to raise issues about management practices, protocols and so on, and offer a mechanism for peer support to the GPs.

Summary

The key issues at the interface of general practice and psychiatry highlight the different perspectives and needs of the two professional groups. The problems are largely problems of communication that could be dealt with in a number of ways. In particular, professional partnerships of collaboration are a priority. GP upskilling, and encouragement of psychiatrists to communicate better are important. A co-ordinating group based on the Whitehorse Division of General Practice GP Mental Health Reference Group could also be developed. The Victorian Branch RANZCP GP liaison project offers some practical means of collaboration. In this project, GPs adopt a more specific referral style making it clear whether they are asking for opinion or for specialist treatment. At the same time, psychiatrists are encouraged to offer both types of service to GPs. The RANZCP Referral Directory and joint regional clinical meetings will assist in co-operation and networking between local GPs and psychiatrists.

Acknowledgements

The author wishes to acknowledge the assistance of:

The Mental Health Reference Group of the Whitehorse Division of General Practice, especially its chair, Dr Phil Hammond; the RACGP Victorian executive, chair: Dr David Dammery, education officer: Dr Caroline Johnson, and the honorary secretary of the Victorian Branch RANZCP, Dr David Barton.

Dr John Buchanan is the chair of the Victorian Branch of the Royal Australian and New Zealand College of Psychiatry (RANZCP).

Acronyms used in this issue

ADTRU	Alcohol, Drug & Training Research Unit
CAT	Crisis Assessment Team
CBT	Cognitive Behaviour Therapy
CHC	Community Health Centre
CLIPP	Consultation Liaison in Primary Care Psychiatry
CME	Continuing Medical Education
CMHC	Community Mental Health Centre
DART	Depression, Anxiety, Research and Treatment
DH&AC	Department of Health and Aged Care
DHS	Department of Human Services
EPC	Enhanced Primary Care
GPAPP	General Practice and Psychiatry Partnerships Program
GPII	General Practice Immunisation Incentives
GMAHS	Greater Murray Area Health Service
JCC	Joint Consultative Committee
MAHS	More Allied Health Services
MBS	Medical Benefits Schedule
MAATS	Mental Health and Advisory Telephone Service
MH	Mental Health
MSTS	Mobile Support Treatment Service
NPMHCI	National Primary Mental Health Care Initiative
NEVDGP	North East Valley Division of General Practice
PBS	Pharmaceutical Benefits Schedule
PHC RED	Primary Health Care Research Evaluation and Development
PIP	Practice Incentives Program
PMHT & EI	Primary Mental Health Teams and Early Intervention
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatry
SBO	State Based Organisation

Supporting GPs in mental health: key roles for divisions

Jenni Parsons

In this article Jenni Parsons argues that divisions of general practice have a unique role to play in supporting GPs in their role in mental health. She reviews some of the major forms of support that divisions can offer.

The Mental health and wellbeing survey in Australia in 1997 revealed that, at some time during the preceding twelve months, almost one in five adults (18 per cent) had a mental health disorder. In this survey the prevalence of

- affective disorders was 7.4 per cent in women and 4.2 per cent in men;
- anxiety disorders was 12 per cent in women and 4.2 per cent in men and
- substance abuse was 4.5 per cent in women and 11 per cent in men.

Of those with mental health disorders, 29 per cent consulted a general practitioner (GP) regarding those problems. This translates to approximately 5.4 per cent of the population consulting their GP about a mental health problem in any 12-month period. In terms of workload, this is a significant burden for GPs. Mental health consultations generally take longer, are less well remunerated than procedural or other consultations and can be personally and professionally challenging.

For GPs the difficulties in undertaking mental health work are associated with time management, funding, training and support.

While time management and funding are largely areas for individual practices and governments respectively, some divisional activities such as training in the use of case conferencing and extended primary care item numbers may assist GPs in these areas. However, divisions of general practice have a significant role to play in training and support.

Training

Training for GPs in mental health can include a wide range of options. The options include one-off education and training sessions with local and specialist providers on specific topics. These sessions often take the form of traditional CME events. Training might also involve use of specifically designed 'module' training programs for management of mental health problems in the general practice setting, for example, the SPHERE program. Divisions of general practice frequently offer specifically targeted programs in response to a local needs analysis. (See inset by Jenny Ouliaris). At the more intensive end of the range are postgraduate university courses. These include general programs such as a Master of General Practice Psychiatry and more specialised courses such as the Graduate Diploma in Alcohol and Drug Studies at Adelaide University.

Specific training programs

Many divisions have offered GPs access to the SPHERE program, a training program for GPs in managing anxiety and depression. The program comprises

- a case identification system for use in primary care
- a four-seminar training program
- a 12-month disease management program for depressive disorders
- ongoing educational and practice support materials.

It has been developed within the Academic Department of Psychiatry, St George Hospital, Kogarah. The inset by Dr John Hodgson of North West Melbourne Division illustrates the way in which divisions may support GPs to undertake the program.

Responding to local needs

In the Central Highland's Division we have recently completed a 12-month program for those GPs who do a significant amount of counselling in their practice. A needs analysis revealed that GPs involved in counselling work felt that they required both further training and support in their role. Professional supervision, while an integral part of

Supporting GPs at North East Valley Division

Jenny Ouliaris

One of the main focuses at the North East Valley Division of General Practice, where I am the Mental Health Program Manager, is in supporting GPs in their mental health work. We attempt to reduce some of the pressures that GPs feel. In the last five years we have had programs including peer supervision groups facilitated by psychiatrists, training in basic counselling skills and family therapy, stress reduction courses for GPs, updates on medical management issues and familiarisation with local support services. We have attempted to build better relationships with local mental health organisations. We have been trying to develop shared care with the community mental health centre. We started off by focusing on basic cultural change, on relationship building and improving communication. We had GPs going on placement to the local CMHC, MSTS and CAT teams. We worked with staff of these organisations in ways to work more effectively with GPs. We did an audit of how many case managers knew if their patients had GPs and the number was very low. Most did not have a GP recorded in the history. Very few had ever communicated with a GP about an existing client of the clinic. They were a bit shocked by the results. So we are trying to ensure that every patient has an identified GP and if they do not then we will help them to find someone who is in the area. We are also encouraging them to send out letters to GPs after the initial consultation with psychiatrists and after the six-month review. And we have also been using the new case conferencing item numbers to encourage them to ring GPs when they are having a six- month clinical review and to use speaker-phone facilities to involve GPs in the review.

As a result of the work we have been doing at the NEVDGP, the community mental health centre has now employed a GP shared-care co-ordinator. We are part of the steering committee to ensure that the project meets the need of GPs.

training and ongoing support for psychologists and other counsellors, is not a part of general practice culture. The program, which received 'Innovations' funding, involved a series of training sessions in counselling skills and techniques, a Balint-type support group for GPs facilitated by local psychologists and access to subsidised individual supervision for the GPs involved.

Another area in which divisions can be involved is in offering training in rational use of medicines along the lines of the National Prescribing Service model. This provides financial benefits to GPs in terms of greater Practice Incentive Payments (PIP).

Support

Support for GPs can occur on many levels. For example, divisions may support GPs to participate in government and other national strategies; to improve linkages with local area mental health services and with other service providers. Some division also offer personal support for GPs in managing their role as mental health service providers.

Many individual divisions and state-based organisations (SBOs) have been involved in strategies of this nature. This article describes some of these as models of the direction individual divisions and SBOs could take. New government initiatives, such as the national depression initiative, and heightened public awareness of the issue of mental health service provision will provide further opportunities in the next few years.

Participation in government initiatives

The Queensland Divisions of General Practice Mental Health Support Strategy, funded by Queensland Health and the Commonwealth Department of Health and Aged Care, is a state-wide program of collaborative mental health. It aims to facilitate effective, sustainable and collaborative ways of working between GPs, specialist mental health and drug and alcohol services to improve care for the consumers.

As well as general features of support, resource development and distribution and consultation and liaison, the strategy has had three major initiatives.

1. General Practice and Psychiatry Partnerships Program (GPAPP), involving

- support to facilitate integration between Queensland Divisions and District Mental Health Services

Primary Mental Health and Early Intervention Services

In response to the Victorian Government's priority areas in mental health service reform the Mental Health Branch, Department of Human Services, has proposed the formation of Primary Mental Health Teams (PMHT) and Early Intervention (EI) initiatives to commence implementation in 2001.

At present there are substantial problems of communication and co-ordination between GPs and other primary care workers in mental health and specialist mental health services. Those who feel the effects of these gaps most keenly are people who suffer disorders such as anxiety and depression, for which they may require a mixture of on-going primary care and brief specialist assistance.

The idea of the PMHT and EI initiatives is that that they should make mental health care more accessible and effective. To do this they will

- help community health centres and GPs to recognise and treat mental health problems and disorders more effectively within shared-care arrangements;
- provide early intervention to people experiencing, or at risk of experiencing, crisis as a result of a mental disorder;
- provide early intervention services to young people who are at risk of or are experiencing significant psychological disturbance, particularly first-episode psychosis, and where multiple risk factors may apply.

Those participating in the formation of the teams are clinical mental health services (including aged, child and adolescent, and adult mental health services), psychiatric disability support services, divisions of general practice and community health centres. The implementation process is in two stages:

- a Memorandum of Understanding that identifies the partnership structure for the development of the initiative, signed by all four stakeholders in February 2001;
- a Planning and Service Proposal which outlines the strategy to develop a local community mental health plan and implement the PMHTs and EI workers to be developed by April 2001.

The DHS expects that 10-15 planning and service proposals will be approved in the 2000/2001 financial year. The new teams will each employ the equivalent of three to five full-time staff. There will be one early intervention worker attached to each team in rural Victoria and the equivalent of nine full-time EI staff across the metropolitan area.

The teams will engage in consultation and liaison with primary care providers; short-term treatment; crisis prevention; and education and training to primary health care providers Direct service delivery will be critical to their success and the department expects that they will take on a significant role in short-term casework in the context of shared care and of the continued involvement of primary care providers. Additionally, the teams will also support CHC staff, GPs and other primary care providers through patient psychiatric assessment and management advice.

It is intended that the clinical, consultative and educative work will be conducted in primary care settings, often on an outreach basis, for example, at general practices. Adult mental health services are likely to be the fund-holders and to have responsibility for the day-to-day management, professional development and clinical support for the new teams.

- workshops on the benefits and models of shared mental health care
- support of pilot metropolitan, remote and provincial pilot projects in shared care
- publication and distribution of the text, A manual of mental health care in general practice.

2. Funding received through the National Primary Mental Health Care Initiative (PMHCI) was used to assist Queensland divisions to develop, implement and evaluate GP education in primary mental health care. Through this program a positive parenting program, Triple P, has been implemented and at least 200 GPs have been trained in the management of childhood behavioural problems.

3. Funding has been obtained to implement two training programs in drug and alcohol use in partnership with the Alcohol, Drug & Training Research Unit (ADTRU).

The national depression initiative ('beyondblue') aims to

- foster awareness and community education to increase the understanding and decrease the stigma of depression
- promote professional training and development, and
- support research into prevention, treatment and management approaches.

Divisions will be well placed to work in partnership with the national depression initiative to achieve these aims.

Linkages with mental health teams

GP liaison officer roles have been successfully used to facilitate shared care in obstetrics with major hospitals. Such roles auspiced within either divisions or mental health services could be similarly successful.

With funding from the Centre for Mental Health (NSW Health), the Greater Murray Area Health Service (GMAHS) has funded a project officer in the Border Division of General Practice to develop sustainable networks and improve collaboration between GPs, GMAHS and other mental health service providers. This position is unique in that most project officers in NSW are employed directly by the local mental health service.

The Consultation Liaison in Primary Care Psychiatry (CLIPP) is a service model developed in the Northwest Melbourne Area Mental Health Service. It links a consultation–liaison model with shared care. Psychiatrists provide consultation services at the GP clinic for any patient referred by participating GPs. These consultations are generally intended to leave the continuing care of the patient with the GP but provide management advice. In the pilot project GPs were paid by divisions for their time in consulting with the psychiatrist about their patients but case conferencing item numbers could now possibly be utilised. The other side of this equation is that chronic but essentially stable patients are transferred to the care of the GP with backup, support and patient tracking by CLIPP. (See inset by John Hodgson)

The Lodden Southern Mallee Region is currently implementing a Depression, Anxiety, Research and Treatment (DART) program. In consultation with divisions, a program of consultation-liaison practice visits will be developed incorporating primary consultation with patients referred, case presentation for secondary consultation, case discussion and education sessions.

As this issue goes to print, Victorian divisions of general practice are working with other local services to negotiate their role in the new Primary Mental Health Teams (PMHTs) and Early Intervention (EI) services. The impact of these teams on general practice services remains to be seen.

Linkages with other service providers

At the Central Highlands Division we have established a Mental Health and Advisory Telephone Service (MAATS) for a trial period. The service gives GPs free telephone advice on management issues for patients from a panel of mental health specialists representing a wide range of interests. The division pays the psychiatrists and psychologists on the team for their time. Although the GPs who have used this service have found it extremely useful, take up of the service has been low. It may be that face-to-face liaison or a one-session consultation with the patient for an opinion would be a more popular model.

The Whitehorse Division of General Practice is developing a project on shared care in private psychiatry. It seeks to address the access to private psychiatrists for patients requiring an urgent opinion. A database of private psychiatrists, including their special interests, prepared to see patients for one or two sessions and then refer back to the GP for ongoing management is being prepared.

Networking meetings between service providers in mental health enhances relationships, puts faces to names, increases mutual support and helps facilitate appropriate referrals. Divisions can play an important facilitation role in this area. At Central Highlands Division we ran two very successful projects on managing postnatal depression and domestic violence. A key feature of both these projects was network meetings between GPs and other service providers, providing the opportunity for case discussion and showcasing local initiatives over lunch. These were of mutual benefit and strengthened links and support.

Supporting a psychiatry special interest group

Dr John Hodgson

North West Melbourne Division of General Practice has a psychiatry special interest group, consisting of 12 local GPs. Last year we participated in the SPHERE program. This whetted our appetites for some more concrete practice skills, so this year a group of 15 GPs participated in a CBT training program. This took place each Wednesday evening for six consecutive weeks, three hours per session. A psychologist, Ms Lindsay Image, and I designed it. She had the skills to teach CBT; I gave her a list of patients from a single day's consulting, pointing out the psychological issues for each (background social issues, specific patients concerns or their unexpressed worries that I felt might be relevant and so on). She was amazed at the scope of the problems! The upshot of this was an extremely useful education program. GPs were able to identify and discuss actual cases and be shown (both by lecture and role-play) how CBT techniques of prioritising problems and problem solving could be applied. There was a lot of discussion about ways of choosing patients to manage in this way (where on the 'cycle of change' were they). We assumed GPs had reasonable consulting skills so there was no wasted time. We were taught breathing and muscle relaxation skills and there was lots of time for questions and side discussions. There was an underlying theme that all we learnt would need to fit into a series of 30-minute consultations.

It was so popular that only one doctor missed one session. We will follow up with a meeting of the original group in six months to discuss how they have coped with putting the skills into practice (getting patients to attend regularly; fitting the appointments into a busy day; how the reception staff cope etc.)

I have also been involved in the CLIPP program (Consultation Liaison in Primary Care Psychiatry). This has two major components.

A consultant psychiatrist attends our practice once per fortnight to see two or three patients for a single consultation each. The reason for the consultation is written by the GP and handed to the psychiatrist while introducing the patient. The patient and psychiatrist spend about an hour together, following which the psychiatrist formulates a management plan which is then discussed for about 15 minutes with all three. This educates the GP and supplies an ongoing management plan. The data about the types of patients seen and the types of consultation requests is available on www.mja.com.au/public/issues/feb16/meadows/meadows.html

Chronic stable patients in the area mental health system are introduced to a GP by a CLIPP nurse and a comprehensive management plan given to the GP. The plan summarises the patient's initial presentation and management to date. It also details the main features to be monitored at each GP consultation, as well as cardinal signs of relapse and suggested drug options for these. All this is on both sides of a single A4 sheet, making it easy to follow. Results of how effective the program is will be published shortly. How to set up a CLIPP program is on the web at www.dhs.vic.gov.au/acmh/mh/clipp

Other areas of both Melbourne and Australia have taken up the model.

Our overall concept is that GPs learn to identify psychological issues (SPHERE). They can then refer patients on, or elect to treat the patients themselves (CBT techniques). Through CLIPP they get new patients and learn how to follow a management plan. They also get into a psychiatric network, enabling them to access services more easily and allowing the system to know and trust GPs' management skills. Specific practice issues and techniques I use are:

- To make use of the 'cycle of change' to decide which patients are ready for CBT.
- To make appointments at the end of a consulting session in case a patient fails to attend as it allows me to do something else.
- To limit myself to two of three patients at a time and be prepared to quickly suggest a 'rest' to the patient if I don't think we are achieving outcomes, so that I can involve another patient.

To use a highlighter colour pen to alert reception staff to appointments that I need to be informed about in the event of non-attendance.

Personal support for GPs

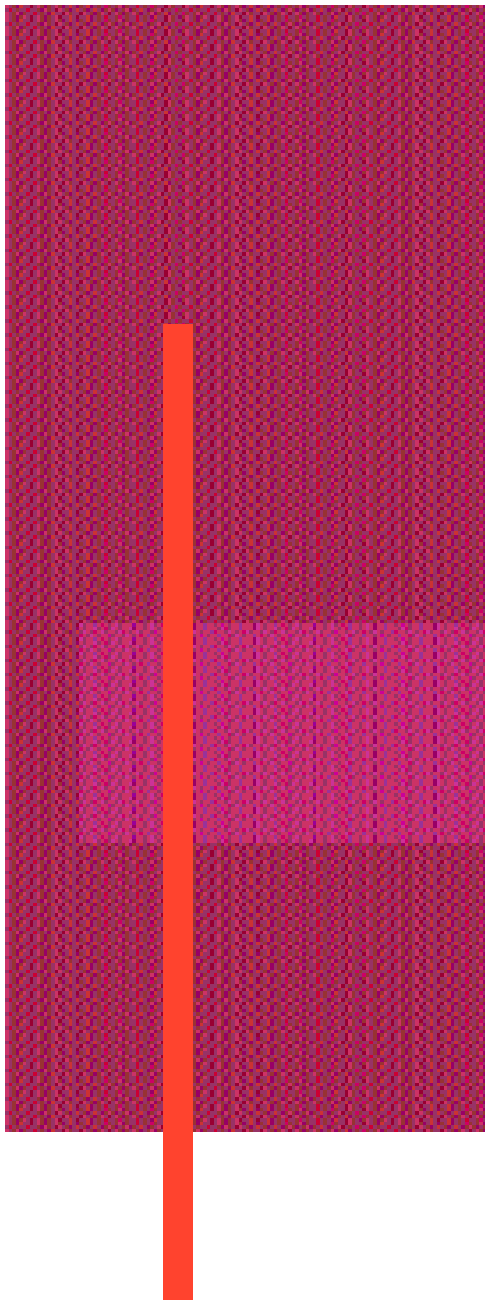
Divisions already have an important role in personal support of GPs by providing a peer group and networking. In the case of the specific needs of GPs doing mental health work some very helpful strategies would include

- encouragement of GPs to consider professional supervision
- providing a forum for local case discussion and support groups for GPs and
- providing access to trauma and critical incident debriefing services.

Conclusion

While there will always be a place for education and training at a division level in mental health, it is in the support role that divisions have a unique contribution to make. Facilitating peer support, networking with other service providers and fostering links and closer liaison with area mental health services will not only greatly assist GPs with mental health work but will lead to a significant improvement in patient care in mental health.

Jenni Parsons is a general practitioner and a GP program manager with the Central Highlands Divisions of General Practice. She is also a member of the GPDV Mental Health Reference Group.



GPDV

GENERAL PRACTICE DIVISIONS

VICTORIA