

*ILLAWARRA AND SHOALHAVEN SURVEY OF
MENTAL HEALTH CARE IN GENERAL
PRACTICE*

Illawarra And Shoalhaven Survey Of Mental Health Care In General Practice

Vicki Biro

Frank P. Deane

Coralie J. Wilson

Illawarra Institute for Mental Health

University of Wollongong

February 2002

A report for the Illawarra Division of General Practice,
the Shoalhaven Division of General Practice and
the Illawarra Area Mental Health Service

**Additional copies of this report can be obtained by contacting:
The Secretary, Illawarra Institute for Mental Health
University of Wollongong, Wollongong, NSW, 2522, Australia**

Suggested citation:

Biro V., Deane F. P., Wilson C. J. (2002). Illawarra and Shoalhaven survey of mental health care in general practice. (Report for Illawarra Area Mental Health Service, Illawarra and Shoalhaven Divisions of General Practice, NSW). Wollongong, NSW University of Wollongong, Illawarra Institute for Mental Health.

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ACKNOWLEDGEMENTS

The work undertaken for the Mental Health Care in General Practice Survey would not have been possible without the support, interest, valuable feedback and commitment of clinical and administrative staff from the Illawarra Division of General Practice (IDGP), Shoalhaven Division of General Practice (SHDGP), the GP Mental Health Services Partnership Project Steering Committee, the Shoalhaven GP Mental Health Partnerships Committee, the Illawarra Institute for Mental Health (iiMH) and the Illawarra Area Mental Health Service (IAHS-MHS).

Specific thanks are extended to the following people:

Dr. John Cheung, GP & IDGP representative

Mr. Andrew Dalley, Chief Executive Officer, IDGP

Ms. Kristine Smith, Mental Health Program Officer, IDGP

Dr. Anna Di Marco, GP & IDGP representative

Dr. Dominic Frawley, GP & SHDGP representative

Ms. Wendy Preston, Suicide Prevention Project Officer, SHDGP

Mr. Frank Flannery, Acting Director IAHS-MHS

Mr. Michael Cox, Manager Shoalhaven MHS

Mr. Tim Kent, CNC Shoalhaven MHS

Mr. Steven Maron, Mental Health Integrated Project Officer, IAHS-MHS

Mr. Jon Strang, Senior Consumer Consultant, IAHS-MHS

Ms. Marie Johnson, Administrative Assistant, iiMH

The Youth Mental Health component of this survey was supported in part by a grant from the National Health and Medical Research Council of Australia, Grant YS060.

Vicki Biro
GP & MHS Partnership Project

Frank Deane
Director, iiMH

Coralie Wilson
Youth Help-Seeking Project

EXECUTIVE SUMMARY

Aim

- A survey of General Practitioners who were members of the Illawarra and Shoalhaven Divisions of General Practice was undertaken in order to obtain data regarding; their work with people who have mental health problems, educational priorities in mental health and, the nature of collaborative working relationships with other mental health providers. This data will inform the strategic planning under the Mental Health and General Practice Partnerships project.

Method

- A 114-item survey was developed based on prior research. The questionnaire was divided into two sections assessing:
 - Section 1, estimates of patients presenting with mental health problems as the focus of care, current management and referral practice for a range of disorders, attitudes toward treatment of mental illness in general practice, satisfaction with public mental health services, preferred collaborative care arrangements and priorities for mental health education and training.
 - Section 2, estimates of young people presenting with mental health problems as the focus of care and referral practices when working with young people.
- Three hundred and twenty-nine GPs were surveyed and there were 62 responses providing a modest 19% response rate.
 - Whilst the response rate was low, it was not dissimilar from other GP surveys conducted in other regions (e.g. 23% to 35% response rates)
 - Respondents had a mean age of 47 years, 70% were male, 68% were in full-time practice and 74% were in group practices. These descriptive characteristics were broadly consistent with Divisional membership demographics (IDGP, 1998).
 - The participants had an average of 17.5 years experience in General Practice.

Results

- Depression and Anxiety Disorders were the most frequently encountered disorders in General Practice.
- Depression, Anxiety disorders and Family/Relationship Disorders were the mental health problems most frequently endorsed as treated by GPs
- Major Psychotic disorders, Bipolar disorder and Suicidal behaviour were most frequently referred to other mental health professionals.
- Major Psychotic Disorders, Drug and Alcohol Disorders and Personality Disorders were considered the most difficult to treat.

Attitudes

- Overall, GPs' attitudes toward treating mental health problems were generally positive with the main barrier to such care being the time consuming nature of treatment/counselling.
- Compared to similar studies of GPs from other regions:
 - Illawarra/Shoalhaven GP respondents found a lack of time for counseling more problematic.
 - Higher numbers of Illawarra/Shoalhaven GPs believed that GP counselling is effective.

Satisfaction

- 70% of GPs were satisfied with access to the Mobile Treatment Team whereas only 27% were satisfied with access to Psychiatrist Services.
- Overall, 58% of respondents were satisfied with the quality and appropriateness of Mental Health Services.

Collaborative Care

- 92% agreed that overall care for patients with long-term mental illness should be shared between a psychiatrist and GP with 82% agreeing that patients should be monitored for relapse by GPs.
- There was much greater uncertainty regarding who should case manage this patient group with 59% indicating the GP and 55% indicating a Community Mental Health Professional.
- There was high agreement that these patients often only came to GP attention when in crisis, created increased work in general practice and had difficulty re-accessing Mental Health Services (at least 80% agreement).
- About 38% of GPs were occasionally using standard mental health questions, checklists or screening tools.

Training

- About 41% of respondents felt at least "quite well" trained in managing a range of psychiatric disorders.
- Training priorities for
 - Skills training were: (1) Identification and management of self-harm and suicidal behaviours (2) Psychological skills (especially CBT and brief interventions) and, (3) Psychopharmacology
 - Specific populations were: (1) Youth Mental Health Care (2) Geriatric Mental Health Care.
 - Specific diagnostic groups were: (1) Psychosis and schizophrenia, (2) Personality Disorder, (3) Anxiety.

Youth Referral Practices

- Referral practices when working with young people could be improved.
 - GPs consistently explain to patients why they think referral to a mental health professional might be useful, the likely benefits of referral and choice related to referral.
 - GPs do not consistently discuss issues of confidentiality, obtain and record consent for referral, clarify costs or what to expect in the first mental health consultation (e.g. duration).
 - 42% of GPs rarely or never worked with the young person to develop a list of problems to specify mental health needs and goals.

Recommendations

Divisions of General Practice

- The survey provides clear directions for training of GPs to support their management of mental health problems in general practice.
- Division-wide training in the assessment and treatment of Depression and Anxiety disorders will capture the most frequent disorder presentations in general practice.
- Division-wide training in good referral practice and clarification of collaborative care pathways and arrangements for psychotic disorders, bipolar disorder and suicidal behaviours are needed.
- Division-wide training in good referral practice when referring young people to mental health specialists.
- Division-wide training in identification and management of self-harm and suicidal behaviours and drug and alcohol abuse.
- Specialist training and support for ongoing professional development (e.g. supervision) for GPs who already have some prior CBT or counselling training.

Illawarra Area Mental Health Service

- Greater clarification of case management arrangements and role functions of GPs and mental health service staff particularly for people with serious and recurring mental illnesses such as schizophrenia.
- Strategic direction that ensures increased support and consultation-liaison for GPs in the ongoing management of mental illness.
- Mental Health Service-wide training and education for staff in good referral practice and liaison skills with General Practitioners and their practice staff.
- Clarification of collaborative care pathways and arrangements for psychotic disorders, bipolar disorder and suicidal behaviours are needed.

Overall considerations

- There is a need for not only training, but also ongoing consultation between management in the Illawarra Area Mental Health Service and Divisions of General Practice to clarify and promote workable Shared Care arrangements.
- A number of these recommendations can be progressed by working collaboratively within a range of existing initiatives including:
 - Illawarra Mental Health Integration Project will provide demonstration and development of protocols for Shared Care, GP CBT Supervision, Consultation-Liaison.
 - GP and Drug and Alcohol Partnerships program.
 - Development of a Dual Diagnosis Educational Package for GPs (Depression/Anxiety and Drug Misuse).
 - Youth-friendly GP Program (IDGP).
 - Existing priorities within the GP and Mental Health Services Partnerships program (e.g. development of a Psychological Services Directory).

SECTION ONE:

MENTAL ILLNESS AND EDUCATIONAL PRIORITIES IN GENERAL PRACTICE

INTRODUCTION

Mental health problems are widespread within the community with almost one in five Australian adults experiencing mental health problems (Andrews, 2000). General Practitioners are now providing services to a growing number of people with mental health problems. While many people do not seek help for their mental health problems, most that do so will seek help from a GP (Andrews et al, 1999; ABS, 1997; Davies, 2000). The burden of mental health care is falling increasingly to GPs. GPs service a significant percentage of people with mental health needs, are frequently the first health care service accessed by people experiencing mental health problems and in many cases are the sole treatment provider (ABS, 1997; Weir & Penrose-Wall, 1999).

Davies (2000) identified some of the difficulties facing GPs in assessing and managing their patients' mental health problems such as, time and financial constraints, lack of clarity from the patient about their psychological needs and unclear diagnostic presentations. He also identified difficulties and concerns associated with liaising with local mental health services. Welch et al., (2000) found that GPs, mental health service providers, consumers and carers are generally dissatisfied with the standard and quality of continuity of care and co-working relationships between each other. Perceived difficulties in accessing mental health services, poor communication and feedback between services, lack of clarity concerning the delineation and definition of roles between GPs and mental health services and varying levels of expertise, knowledge, skill and experience of specialist mental health care practitioners contribute to these difficulties.

Within the Illawarra and Shoalhaven mental health problems and difficulties with provision of specialist mental health care have been identified by GPs (Illawarra Divisions of General Practice, 1998; Shoalhaven Division of General Practice, 1999).

BACKGROUND

In July 2000, the GP & MHS Partnership Project commenced in the Illawarra. One of the goals of this project was to establish baseline data concerning local GP and mental health related needs and issues, and current practices in mental health care. The GP & Mental Health Services Partnership Project Steering and Shoalhaven GP Mental Health Partnership Committees agreed to develop and conduct a survey of GPs in the region. Although both of the Divisions' Need Assessments (1998; 1999) had previously identified mental health, particularly depression and anxiety as a high priority for GPs and identified general dissatisfaction with mental health services in the region, it was felt a more detailed survey was necessary.

OBJECTIVES

The purpose of the survey was to:

- Identify difficulties associated with the provision of mental health care by GPs and describe current mental health practice used by GPs in treating their patients;
- Inform the development of a strategic plan to both prioritise and implement initiatives to improve collaboration between GPs and mental health care providers in the region; and
- Identify specific domains for training and gauge GP readiness to undertake further education and training to assist in the provision of mental health care.

Specifically, the survey of mental health care in general practice was developed in order to provide a clearer picture of:

- The extent to which GPs are managing and referring mental health problems;
- Satisfaction with public mental health services;
- GP attitudes toward working with patients who have mental health difficulties and current GP collaborative arrangements with mental health care providers;
- Use of mental health assessment and screening tools; and
- Knowledge and education needs specific to a range of mental health problems.

METHOD

Development of the GP Survey Tool

The GP & MHS Partnership Project Officer (Vicki Biro) engaged in an extensive literature review of reports and journal articles to locate several GP survey tools and items suitable for inclusion in a survey questionnaire. In the first instance, all the located items were compiled together and presented for discussion to the Illawarra Institute for Mental Health and the Project's Steering and Shoalhaven Committees. This consultation commenced a review and development process that included discussion with research staff from the Illawarra Institute for Mental Health, GP representatives, Mental Health Service staff representatives and Divisional Mental Health Project Officers.

During the above period the SHDGP Suicide Prevention-Mental Health Project Officer and the Youth Help-Seeking Project Officer from the Illawarra Institute for Mental Health were also compiling a youth mental health help-seeking survey for GPs to complete. While there were several youth specific items, many of the survey items were similar to those on the GP Partnerships Project Survey. Discussions between the project officers saw the collaborative development of the survey, resulting in a combined survey containing general and youth specific items that could be used within each of the projects. The Youth Mental Health Survey focuses on GP referral practices with young people is analysed as a separate section in this report.

Over a period of 5 months the committee members and project team regularly reviewed and updated the survey tool. The process of review involved determining:

- Which items to include, exclude or modify for the survey;
- How best to format and present the survey to GPs; and
- How and when the survey should be administered.

Feedback concerning the suitability of questions, survey length, format, clarity and appropriateness of questions was invaluable provided by Committee Members. GP representatives providing consultation in the development and administration of the survey recommended consideration be given to the following issues:

- GPs are asked to participate in many surveys and questionnaires.
- Time constraints impact on whether GPs complete a survey. For this reason the shorter and easier to complete the greater likelihood of completion.
- Personal interest in the subject of the survey also influences a GP's decision to complete a survey.

Questionnaire Items

The questionnaire (see Appendix 1) covered the following broad domains:

- A. Demographic Data
- B. General Practice and Mental Health – Referral & Management Practices; Prevalence; Frequency and Difficulty of Mental Health Problems; Attitudes to Mental Health Care
- C. Satisfaction with Access to Public Mental Health Services
- D. Integration and Collaborative Care Issues
- E. Education and Support Needs
- F. Youth Mental Health and referral practices for GPs.

Section A – Professional Details:

This section used standard items for the collection of demographic information (Barber & Williams, 1996a, p.280; Barber & Williams, 1996b; Britt et al, 2000, pp.11-12); Philip, 1998; Phongsaven et al, 1995, p.140).

Section B – Mental Illness in General Practice:

Items concerning estimate of mental health problems in general practice and management and referral practices for a number of mental health problems were developed from a summary of GP surveys and reports cited by the Joint Consultative Committee in Psychiatry (JCCP, 1997, pp.109-113). Items on the most frequent and the most difficult mental health problems encountered in general practice were taken from two studies (Philip, 1998; Barber & Williams, 1996a, p280; Barber & Williams, 1996b). Thirteen of the statements concerning GP attitude to mental health care in general practice were taken from a study undertaken by Phongsaven et al (1995, p.141). An additional two statements were included from other studies reported by the JCCP (1997, p.112).

Section C – Satisfaction with Mental Health Services

In view of concerns raised by GPs about access to mental health services (Barclay, 2000; IDGP, 1998; JCCP, 1997, p.123; SHDGP, 1999) GPs were asked to rate their level of satisfaction with access to specific mental health services in the region. A general question about satisfaction with overall quality and appropriateness of services was also included (Harmon, 2000).

Section D – Integration Issues/Collaborative Arrangements with Mental Health Services

This item was taken from the GP questionnaire designed by Barber and Williams (1996b) in which GPs were asked to rate their preference for the clinical care and responsibilities of long-term mentally ill patients in the community.

Section E – Mental Health Support & Resources

Items concerning use of standard screening tools for mental health problems were adapted from two questionnaires (Philip, 1999, Appendix 7; Preston, 1998). The item on how adequately trained the GP felt in dealing with a range of psychiatric disorders was adapted from Barber and Williams (1996b). Areas for further mental health education and training were adapted from a number of survey tools and reports (JCCP, 1997, p.127-132; Philip, 1998; Phongsaven, 1995, p.141; Preston, 1998).

Section F – Youth Mental Health

The youth mental health survey was divided into two parts including questions to ascertain the extent of youth mental health problems encountered in general practice and referral and management practices of GPs working with young people in need of specialist mental health services. Items in this section were developed from the Help Referral Survey (Deane & Wilson, 2000) that comprised items drawn from sources including “Enhanced Primary Care Case Conferences at a Glance” - Items 740-773 (Commonwealth Department Health & Aged Care). More detail regarding these items is provided in the section on Youth Mental Health Survey which follows.

Administration of the GP Survey

The Illawarra Institute for Mental Health, the Divisions of General Practice and the Illawarra Area Mental Health Service provided extensive support for the survey, with

the Illawarra & Shoalhaven Divisions of General Practice allowing the survey to be administered as part of their Divisional activities. Hence, ownership of the data is to be shared between the GP & MHS Partnership Project and the local Divisions of General Practice. Feedback of findings is to be provided to GPs through the Divisions' newsletters and forums and to Mental Health Service staff through existing forums and communication pathways.

Based on the feedback of the consultative committees a 3-page GP survey and 2-page youth survey was distributed to Shoalhaven GPs in early April 2001. Two weeks later a 4-page GP survey and 2-page youth survey was distributed to Illawarra GPs. The shorter Shoalhaven surveys had items removed from the education and training section that asked GPs to prioritise mental health associated areas and client groups for which they would like education and training. Instead, this group of GPs was asked a general question about the sort of mental health education and training they would like.

The questionnaires and covering letter were sent out with postage paid return addressed envelopes in April 2001. Surveys were distributed to a total of 329 GPs in the region – 250 from the Illawarra Division of General Practice and 79 from the Shoalhaven Division of General Practice. Returned surveys began arriving from mid-April to early May 2001. Questionnaires were coded and entered into an SPSS 10.0 (Statistical Package for the Social Sciences) database.

RESULTS

Participation and Response Rate

Overall, 62 surveys (19%) were returned. 49 (20%) from the Illawarra and 13 (17%) from the Shoalhaven. Whilst the response rate is low it is comparable to those of other GP samples in other studies using a general mailout.

Table 1:

Comparison of Response / Participation Rates of Other Australian GP Studies

Study	Number of Participants	Response Rate
Barber & Williams (1996a) – Rural & Urban GPs	128	23.0%
Britt et al (2000) – Rural & Urban GPs	1047	35.2%
Britt et al (2001) – Rural & Urban GPs	999	27.6%
Philip (1999) – Rural GPs	41	26.5%
Phongsaven (1995) – Rural & Urban GPs	534	74.0% *

Note. The Phongsaven study provided a follow-up phone call and 2 follow-up letters

Demographic Data & GP Characteristics

Demographic findings in this study did not differ greatly from the IDGP Need Assessment (1998) or other larger Australian GP studies. There was between 4.8% and 8.1% missing demographic variables except years in general practice that had a non-response rate of 24.7%. Reported findings reflect only valid percentages.

GP Ages

The ages of responding GPs ranged from 28 years to 71 years with an average age of 47 years (SD = 10.88). The median age was 45 years.

53.5% were aged between 35-54 years. This compares with between 63%-65% of GPs aged between 35-54 years in other larger studies (Britt et al, 2000, p.12; Britt et al, 2001, p.9; Phongsaven et al, 1995, p.240).

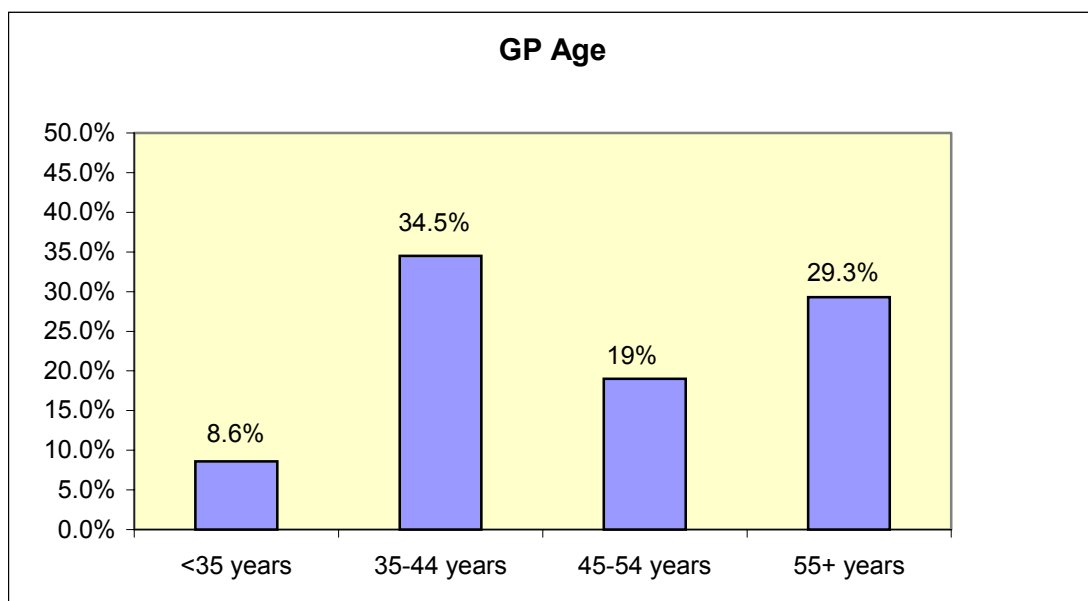


Figure 1: Age of Participating GPs

GP Gender

- 69.5% of respondents were male and 30.5% were female. The IDGP Need Assessment (1998) reported 77% of the GP population were male. Study participants in other GP surveys have varied between 63% - 79% males (Barber & Williams, 1996a, p.280; Britt et al, 2000, p.12; Britt et al, 2001, p.9; Phongsaven et al, 1995, p.240)

General Practice Information

- 67.8% of responding GPs practice fulltime and 32.2% part-time. The IDGP Need Assessment (1998) found 68% of GPs in the Illawarra region practiced full-time and 31% part-time.
- Years of experience in general practice ranged from 1 year through to 41 years. The mean number of years in general practice was 17.5 years (SD 10.4).
- 79.9% of participating GPs had >10 years experience in general practice. This compares to 61% in the Phongsaven study (1995, p.240) and 75% in the BEACH Project (Britt et al, 2000, p.12).

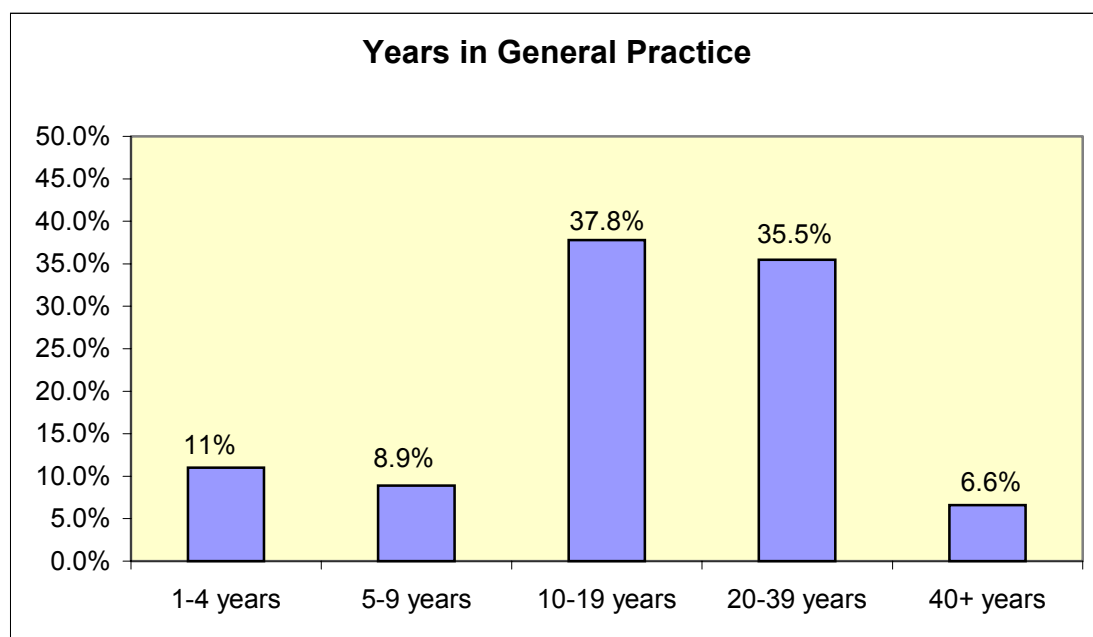


Figure 2: Years of General Practice Experience of Participating GPs

- 73.7% of respondents work in group practices and 26.3% work in solo practice. The IDGP Need Assessment (1998) found 73% of Illawarra GPs work in group practices and 25% in solo practice. Findings from larger Australian studies ranged from 18-33% of GPs working in solo practice (Britt et al, 2000, p.12; Britt et al, 2001, p.9; Phongsaven et al, 1995, p.240).

- Of the GPs working in group practices in the Illawarra and Shoalhaven, 70% have between 2-4 GPs and 30% have >5 GPs.

- 81% of responding GPs indicated no other health care professionals worked in their practice, 16.2% had 1-2 health professionals working in their practice, 2.7% had 9 health professionals working in their practice and 40.3% did not respond to this item.

MENTAL ILLNESS IN GENERAL PRACTICE

Management & Referral Practices

In order to obtain a picture of management and referral practices for mental health problems in the region, GPs were asked to indicate how often they would treat mental health problems themselves and how often they would also refer these problems to other mental health workers (such as psychiatrists or the public mental health service). Missing data on management and referral practices ranged from 1.6% to 12.9 %. Reported findings reflect only valid percentages.

Mental Health problems that GPs indicated they would treat themselves and also refer onto a mental health worker are ranked in Table 2 along with means and standard deviations.

Table 2:

Mental Health Problems GPs treat themselves and refer to a mental health worker

<u>Mental Health Problem</u>	<u>Treat Myself</u>		<u>Also Refer</u>	
	Mean	SD	Mean	SD
Depression	3.45	.64	2.20	.66
Anxiety Disorders	3.31	.64	2.19	.55
Family / Relationship Problems	2.85	.76	2.61	.64
Organic disorders (delirium, dementia)	2.63	.87	2.90	.86
Drug and Alcohol Related Disorders	2.61	.71	2.86	.82
Child & Adolescent Disorders	2.42	.76	2.95	.83
Personality Disorders	2.16	.90	2.90	.96
Eating Disorders	2.10	.79	3.19	.88
Suicidal Behaviour	2.10	.84	3.58	.70
Psychological Consequences of physical or sexual trauma	2.02	.83	3.33	.83
Bipolar Disorder	1.97	.68	3.78	.68
Major Psychotic Disorders	1.66	.68	3.78	.68

Note. 1 = never, 2 = occasionally, 3 = often, 4 = almost always

Most Frequent Mental Health Problems in General Practice

GPs were asked to name the three most frequent mental health problems they encounter in their general practice. The non-response rate for this item ranged between 3.2% to 11.3%. All the mental health problems identified were totalled to identify the most frequent mental health problems in general practice. There were 175 separate problems listed by GPs. These were organised into the problem types outlined in Table 3. Table 3 reports the percentage of problems falling in each category. In keeping with findings from the Divisions' Need Assessments (IDGP, 1998; SHDGP, 1999), the four most frequently encountered mental health problems in general practice in the Illawarra and Shoalhaven are depression, anxiety, relationship problems / life crisis and drug and alcohol/substance abuse problems.

Table 3:

Most frequent mental health problems in General Practice

	Mental Health Problem	%
1.	Depression	34.0%
2.	Anxiety States/Disorders	31.7%
3.	Relationship Problems / Life Crisis	8.6%
4.	Drug & Alcohol	8.0%
5.	Major Psychotic Disorders (eg. Schizophrenia)	4.6%
6.	Personality Disorder	4.0%
7.	Dementia / Organic Disorders	4.0%
8.	PTSD	2.3%
9.	Bipolar Disorder	1.1%
10.	Child & Adolescent disorders	1.1%
11.	Eating Disorder	0.6%

Most Difficult Mental Health Problems in General Practice

GPs were also asked to identify which mental health problems caused them the most difficulty. Some respondents identified more than one mental health problem. There was a total of 92 identified problems listed by GPs. The non-response rate for this section was 9.6%. All identified problems were totalled to profile the most difficult mental health problems in General Practice. Table 4 lists the percentage of responses falling in each mental health problem category.

Major psychotic disorders, substance abuse disorders and personality disorders were the three most difficult mental health problems identified by the responding GPs.

Table 4:

Most difficult mental health problems in General Practice

	Mental Health Problem	%
1.	Major Psychotic Disorders (including schizophrenia)	19.6%
2.	Drug & Alcohol	16.3%
3.	Personality Disorder	13.0%
4.	Child & Adolescent disorders	8.7%
5.	Depression	6.5%
6.	Suicidal	6.5%
7.	Any needing a psychiatrist or admission	4.3%
8.	Anxiety States/Disorders	4.3%
9.	Relationship Problems / Life Crisis	4.3%
10.	Bipolar Disorder	4.3%
11.	Eating Disorder	4.3%
12.	Most – All	2.2%
13.	Trauma / sexual abuse	2.2%
14.	Dementia / Organic Disorders	1.1%
15.	Chronic Pain	1.1%
16.	Psychosomatic	1.1%

Major psychotic disorders were regarded as the most difficult mental health problem for GPs while also being the most referred and least treated mental health problem by GPs.

Prevalence of Mental Health Problems in General Practice in the Illawarra

Missing data on prevalence ranged from 1.6 – 3.2% non-response rate. Reported findings reflect only valid percentages.

On average up to 20% of clients seeing Illawarra GPs are treated predominantly for mental health problems. However, 5% of GPs see a 30-40% per week of people requiring treatment for predominantly mental health problems. Most GPs (73.7%) see up to 150 clients/week with the remaining seeing between 151-250 clients per week.

Table 5:

Average number of patients treated / week by participating GPs

Average patients seen / week	No. GPs responses	%
0-50	8	13.1
51-100	15	26.2
101-150	21	34.4
151-200	11	18
> 201	5	8.2

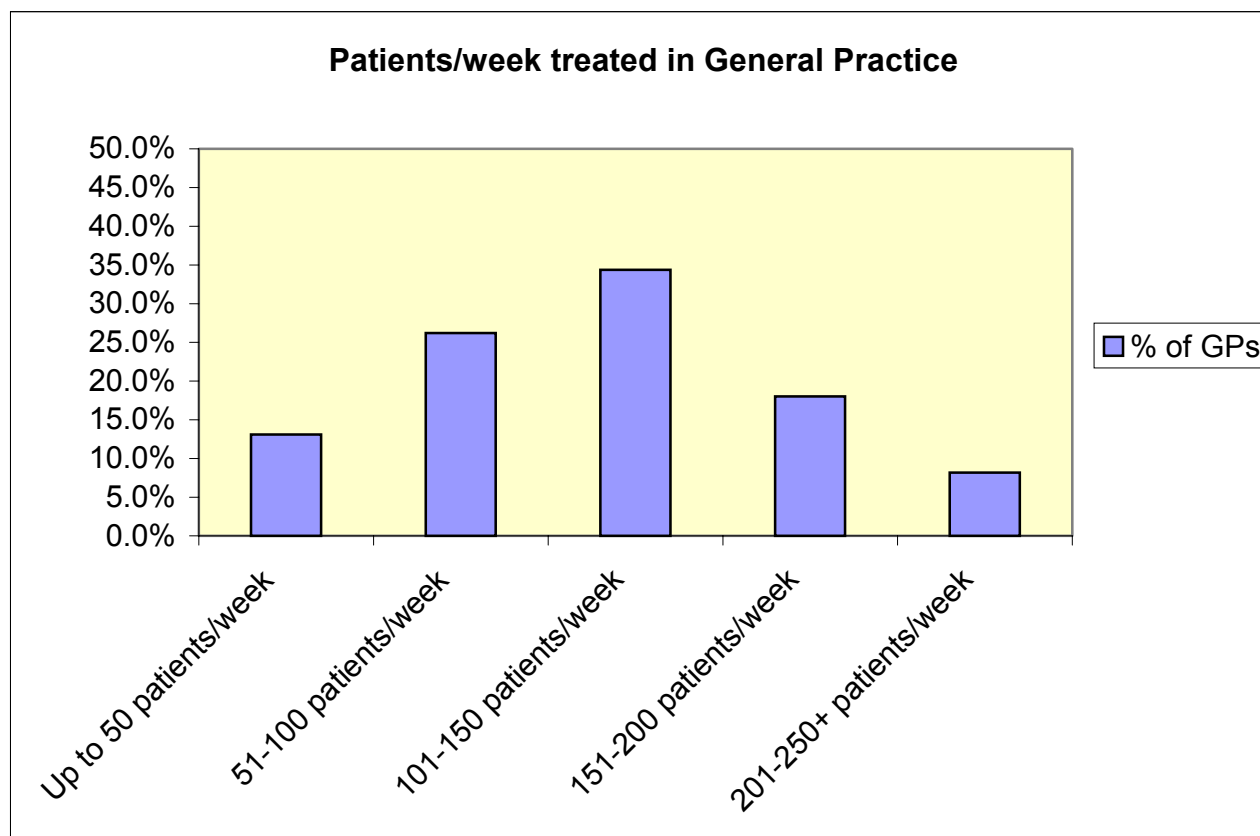


Figure 3: Average number of patients treated / week by participating GPs

Table 6:

GP estimate of patients treated predominantly for mental health problems / week

Average patients seen / week predominantly for mental health problem	No. GPs responses	%
0-10	31	51.7
11-20	18	30.0
21-30	7	11.7
31-50	4	6.7

Note: Not separated by part-time or full-time practice.

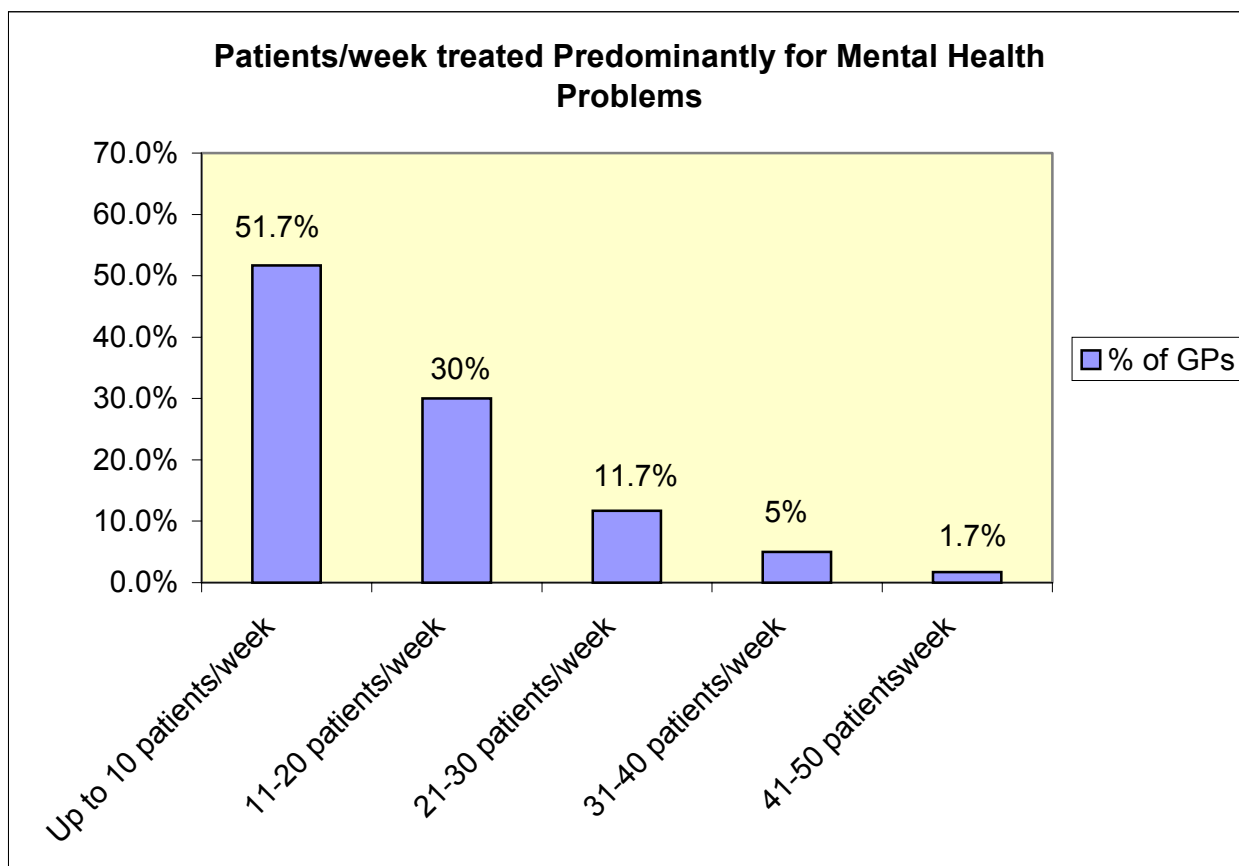


Figure 5: Estimate of patients treated predominantly for mental health problems / week

Attitude to Mental Health Care

GPs were surveyed about their attitudes to mental health care in general practice and were asked to rate their level of agreement with a number of attitudinal statements using a four-point scale ranging from strongly disagree to strongly agree. Domains covered in this section concerned time issues; attitude to role in diagnosing and managing patients with mental health problems; attitude to counselling and effectiveness of GP interventions; and remuneration issues. Overall, GPs in the Illawarra and Shoalhaven region have attitudes to mental health care that are both positive and encouraging. Missing data on attitude items ranged from 1.6% to 3.2% for this section. Reported findings reflect only valid percentages.

Table 7:

GPs agreement with attitude statements

Attitude Statement	Overall % of GPs Agreeing with statement	% Strongly Agree	% Agree
Time Issues			
▪ Treating patients with mental health problems is time consuming	95.2	50.0	45.2
▪ I have very little time to spend on counselling.	71.0	11.3	59.7
Attitude to Role in Diagnosing & Managing Mental Health Problems			
▪ Mental health problems are difficult to treat in general practice	41.9	3.2	38.7
▪ Diagnosis of mental health problems is part of my professional responsibility	91.9	54.8	37.1
▪ Management of mental health problems is part of my professional responsibility	95.2	37.1	58.1
▪ I am better qualified in the management of physical disease	72.6	16.1	56.5
▪ GPs should develop the necessary skills to deal with mental health problems	93.5	29.0	64.5
▪ I feel comfortable discussing a patient's mental health problems with him	88.5	18.0	70.5
▪ I believe patients do not want GPs asking them about their mental health problems	8.1	3.2	4.8
▪ Many of my patients would feel uncomfortable if obviously disturbed people were in the waiting room	57.4	13.7	44.3
Attitude to Counselling & Effectiveness of GP Interventions			
▪ I get job satisfaction from counselling my patients	88.4	11.7	76.7
▪ I believe that GPs counselling patients is usually ineffective	8.1	1.6	6.5
▪ I believe people with mental health problems are more likely to follow the advice of a counsellor than that of a GP	12.9	1.6	11.3

Attitude Statement	Overall % of GPs Agreeing with statement	% Strongly Agree	% Agree
Remuneration Issues			
▪ Better remuneration for counselling would increase my readiness to provide counselling services /her	83.6	36.1	47.5
▪ I am concerned about being accused of 'over-servicing' if I charge too many level C, or long consultations for counselling services	54.1	16.4	37.7

Satisfaction with Mental Health Services

Satisfaction with Access to Illawarra Area Mental Health Services

GPs were asked to rate their level of satisfaction with access to specific public mental health services in the IAHS-MHS. Generally, responding GPs expressed some level of dissatisfaction with access to most public mental health services. As a specific mental health service, the Mobile Treatment Team / Nowra Extended Hours Team (MTT/NEHT) rated the best with 68% of responding GPs expressing some level of satisfaction with access. Missing data on satisfaction items ranged from 3.2 – 11.3%. Reported findings reflect only valid percentages.

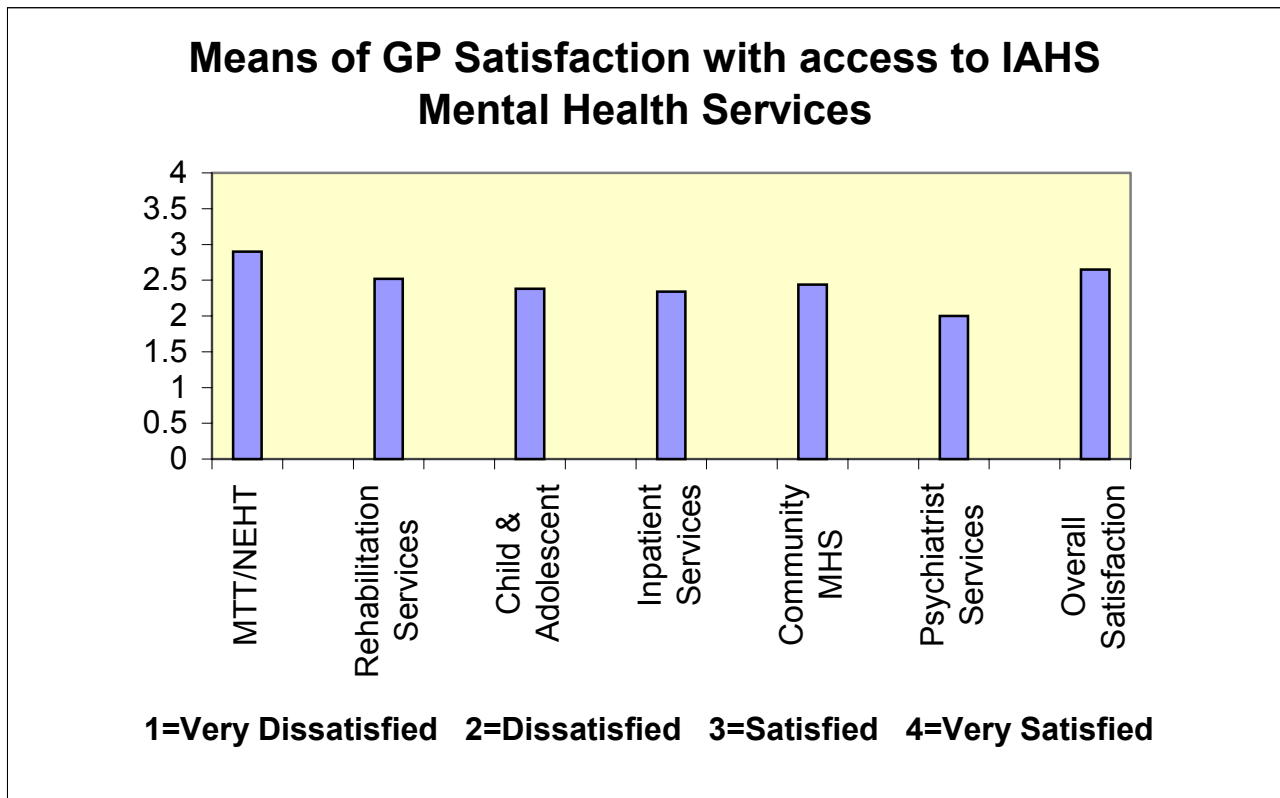


Figure 5: Mean satisfaction with access to IAHS Mental Health Service

Table 8:

Satisfaction with access to IAHS- Mental Health

	% Overall Satisfaction*	Mean	SD
1. MTT/NEHT	70.0%	2.90	0.84
2. Rehabilitation Services	55.6%	2.52	0.64
3. Child & Adolescent Services	48.2%	2.38	0.68
4. Inpatient Services	48.2%	2.34	0.72
5. Community MHS	43.9%	2.44	0.68
6. Psychiatrist Services	27.1%	2.00	0.87
Overall satisfaction with Quality and appropriateness of Mental Health Services	58.2%	2.65	0.87

Note. Scored either 3 (satisfied) or 4 (very satisfied)

At the time of the survey there were no Child & Adolescent Services in the Shoalhaven area, which may account for the level of dissatisfaction with this service. Several GPs did not rate selected services because they had not utilised these services for their patients or were new to the area and did not feel able to evaluate their satisfaction with services.

Satisfaction with Quality / Appropriateness of Public Mental Health Services

58% of responding GPs were satisfied (5.5% very satisfied and 52.7% satisfied) with the quality and appropriateness of treatment provided to their patients by mental health services. These results indicate that while access into the IAHS-MHS is a problem for GPs, once a service is accessed the quality of that service is perceived as satisfactory by just over half of the responding GPs.

The findings are still cause for concern with 38.2% expressing various levels of dissatisfaction with the quality and appropriateness of public mental health services in the Illawarra (9% of GPs were very dissatisfied with quality and appropriateness of public mental health services). Another 4% indicated they were neither satisfied or dissatisfied with the quality or appropriateness of mental health services. Several Australian GP studies (JCCP, 1997) have also reported a general lack of GP satisfaction with access to mental health services across the country.

Integration issues / Collaborative Arrangements with Mental Health Services

GPs were asked to rate their agreement with several statements relating to the clinical responsibilities and collaborative care of patients with long-term mental illness in the community. The statements considered preferences for overall care, physical care and case management of long-term mentally ill patients in the community. There were also some questions to ascertain GP agreement with problems relating to collaborative care arrangements. The non-response rate per this section ranged from 1.6 –12.9%.

Table 9:**Order of preference for collaborative care between GPs and mental health services for long-term mentally ill patients**

In Order of Preference	Overall Agreement	Mean	Standard Deviation
GPs agreed that Overall Care for long-term mentally ill patients should be:			
1. Shared between the psychiatrist & GP	92.0%	3.13	.59
2. Monitored for relapse by GP	82.3%	2.89	.48
3. Monitored for relapse by psychiatrist	62.3%	2.74	.70
4. Organised by GP with psychiatric backup as necessary	57.4%	2.69	.67
5. Primarily responsibility of psychiatric team	42.6%	2.51	.74
GPs agreed that Physical problems of long-term mentally ill patients should be:			
1. Screened for by GP	98.4%	3.24	.56
2. Managed by GP	95.2%	3.32	.62
3. Screened by psychiatrist	16.1%	2.02	.56
GPs agreed that reliance should be on:			
1. GP as case manager	59.3%	2.65	.59
2. Community Mental Health Professional as Case Manager	55.4%	2.55	.69
3. Other psychologist/social worker as case manager	36.9%	2.35	.58
GPs agreed that problems relating to collaborative care include:			
1. Long-term mentally patients often come to attention of their GP only when there is a crisis	93.6%	3.15	.51
2. Creates increased work for practice	88.5%	3.05	.53
3. Patient becomes unwell and has difficulty re-accessing the Mental Health Service	79.7%	2.90	.55
4. Communication difficulties between doctor and patient	65.6%	2.67	.63
5. Long-term mentally ill patients have poor prognosis whatever is done for them	32.2%	2.27	.67
6. Long-term mentally ill patients rarely cause difficulties for their families or carers	30.5%	2.19	.68

Note. 1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree

Mental Health Support & Resources

Standard Checklists / Screening Tools

GPs were asked to rate how frequently they used standardised questionnaires or checklists when investigating mental health problems in their patients. They were also asked if there were any screening tools they used regularly in their practice and to provide details on these screening tools. Non-response for these items ranged from 4.8% to 8.1% for this item. Valid percentages are reported.

- 28.8% *Never* use standard questions or checklists
- 30.5% *Rarely* use standard questions or checklists
- 32.2% *Sometimes* use standard questions or checklists
- 8.5% *Often* use standard questions or checklists

Overall, 38.6% of responding GPs indicated that they regularly use screening tools for mental health problems. However, only 23 (37%) of respondents identified the type of screening tool(s) they used. These tools are ranked below from the most nominated to the lowest: (some respondents identified more than one measure)

1. Mini Mental State Examination	14 responses
2. Unnamed Depression/Anxiety Screening Tools	6 responses
3. SPHERE Checklists	5 responses
4. Hamilton Rating Scale	2 responses
5. Prime MD	2 responses
6. DSM IV; Edinburgh Post-natal Depression Scale, Social Anxiety Scale	1 response each

Education & Training in Mental Health

GPs were asked how adequately they felt trained to deal with a range of psychiatric disorders

- 4.9% reported being **very well** trained to deal with a range of psychiatric disorders
- 36.1% reported being **quite well** trained to deal with a range of psychiatric disorders
- 57.4% reported being **a little** trained to deal with a range of psychiatric disorders
- 1.6% did **not** feel **adequately** trained to deal with a range of psychiatric disorders

Preferred Mental Health Topics

In order to gauge the areas that GPs would like further education and training about mental health associated topics GPs were asked to rate their level of priority to several topics and client groups on a 4-point rating scale (none to high priority). Missing data on priority for mental health subject items ranged from 17.7 – 21% on all but one item. The non-response rate for specific mental disorders was 60%. For this reason this item will be reported separately. All other items will be reported as valid percentages. Missing data on priority for education on client groups ranged from 17.7 – 27.4%.

Table 10:

Preferred Mental Health Subjects - Ranked by Level of Priority

	High Priority	Moderate Priority	Combined High & Mod Priority	Mean	SD
Identifying & Managing Patients with Self harm / Suicide intent	54.0%	30.0%	84.0%	3.34	0.85
Assessment & Diagnostic Skills	30.0%	44.0%	77.0%	3.04	0.75
Early Intervention	30.0%	36.0%	66.0%	3.12	0.65
Psychological Skills	27.5%	56.9%	84.4%	3.08	0.67
Psychopharmacology	26.0%	56.0%	82.0%	3.04	0.71
Engaging patients in Mental Health treatment	24.5%	57.1%	81.6%	2.9	0.77
Current Mental Health services in your area	20.4%	53.1%	73.5%	2.88	0.94
Health Promotion	18.0%	32.0%	50.0%	2.7	0.61
Practical application of Mental Health Act	6.0%	60.0%	66.0%	2.62	0.85
Youth Mental Health Care	47.1%	49.0%	96.1%	3.43	0.57
Geriatric Mental Health Care	30.6%	53.1%	83.7%	3.08	0.81
Non-English Speaking Mental Health Care	15.6%	33.3%	48.9%	2.57	0.76
Child Mental Health Care	10.2%	42.9%	53.1%	2.49	0.94
ATSI Mental Health Care	10.9%	30.4%	41.3%	2.33	0.92

Note. 1 = none, 2 = low priority, 3 = moderate priority, 4 = high priority

Twenty-five (40%) of the 62 responding GPs indicated their priority for further education and training on specific mental disorders. Of these 25 GPs, 68% indicated a high priority, 24% moderate priority and 8% low priority for specific mental disorders. GPs were asked to indicate the specific disorders for which they desired education. Nominated subjects included (in order of priority):

1. Psychosis and Schizophrenia (including management and how to reassure an acutely psychotic patient in the surgery)
2. CBT and other brief psychotherapy
3. Personality Disorder
4. Anxiety
5. Depression (particularly psychotic and post-partum depression)
6. Social problems and life crisis
7. Bipolar Disorder
8. Alcohol and other Drugs
9. Effective liaison with psychiatrists
10. Eating Disorders
11. Hypnotherapy

YOUTH MENTAL HEALTH PRESENTATIONS IN GENERAL PRACTICE

The youth mental health survey asked participating GPs about prevalence of youth mental health problems in general practice and the referral and management practices they use when dealing with young people. Youth in this survey were defined as being aged 15 years to 29 years. Missing data accounted for a non-response rate of 11.3-14.5%. Reported findings reflect only valid percentages.

Table 11:

GP estimate of young people seen / day

Average young people seen / day	% of GP responses
Up to 20	86.8%
21-40	11.3%
> 50	1.9%

Note: Not separated by part-time or full-time practice.

The survey asked GPs to estimate how many young people they spoke to per week about a range of mental health related problems. Table 13 indicates the percentage of responding GPs that spoke about each nominated mental health problem with young people in their practice. Drug and alcohol problems rated the highest followed by mental health problems associated with relationships.

DISCUSSION

Mental Health in General Practice

The response rate of 19% for the survey was lower than anticipated. GP representatives during the consultation phase of the survey highlighted the demands on GPs to complete a variety of questionnaires and surveys, and the low response rate likely reflects lack of time or interest. In addition, GPs did not receive follow-up contact after the survey in an effort to increase the return rate. It may be that the survey is based towards these GPs who had an interest in mental health and therefore made the time to complete the questionnaire. However, despite the low response rate most of the findings are generally consistent with larger Australian studies that also investigated mental health care in general practice using equivalent measures.

Specifically, the current survey is consistent with prior reports outlining management, referral and frequency of mental health presentations in general practice. Emotional problems such as depression and anxiety were treated by a large percentage of GPs, whereas psychiatric disorders such as bipolar disorder and psychotic disorders were treated least and mostly referred on to mental health specialist services (JCCC, 1997, p.109-115; Phongsaven, 1995, p.140). The BEACH (Bettering the Evaluation and Care of Health) found that depression is the 4th most frequently managed problem with anxiety the 16th most frequently managed problem in general practice (Britt et al, 2000, p.38-9). The BEACH project also found that depression was the 4th most common problem referred to a specialist, the 3rd most common problem referred to an Allied Health Professional and the 8th most common problem referred to hospital by Australian GPs (Britt et al, 2000, p.82-84).

Drug and alcohol problems rated between the fifth and tenth most frequent mental health problems in general practice (JCCP, 1997, p.109-11; Phongsaven 1995, 140). This compares to the Illawarra GP survey that rated drug and alcohol related disorders as the 4th most frequent mental health problem in general practice, suggesting either that Drug and Alcohol problems are more frequently identified in the Illawarra or there has been an increase in these problems since earlier studies.

It is worth noting that while GPs found drug and alcohol related disorders difficult to manage over half will often or almost always treat these patients themselves while also referring to specialist care providers. It is also notable that in this study the three most frequent mental health problems encountered in general practice were also those conditions that GPs treat most often and less frequently refer to mental health workers.

The JCCP (1997) reported several studies that identified time constraints on GP time as the greatest barrier for GPs in managing mental illness in general practice. Lack of MHS support, the need for improved access into mental health services, poor communication between providers and poor remuneration for care provided to patients with mental health problems were also among the barriers reported (JCCP, 1997).

The results regarding attitudes to mental health in general practice by GP respondents in the Illawarra GP Survey were similar to results reported by Phongsaven et al (1995, p.140-141). Respondents in the Illawarra & Shoalhaven areas appear to have attitudes that are positive and indicate a willingness to work with patients that have mental health problems. As with the Phongsaven study (1995) respondents “agreed that detection and management of mental health problems were important parts of their job [however] they were less convinced that time to spend on management and counselling was sufficient” (p.140). Almost identical proportions of GPs in the Illawarra/Shoalhaven Survey (95%) and the Phongsaven et al. (1995) survey (96%) agreed that treating mental health problems is time consuming. However, 71% of Illawarra/ Shoalhaven GPs agreed they had very little time to spend on counselling whereas only 44% of GPs in the Phongsaven study agreed with this statement. Despite the time constraints experienced by Illawarra/Shoalhaven GPs, only 42% of respondents agreed that mental health problems are difficult to treat in general practice.

Table 12:

Comparison of GP attitude responses between the Illawarra GP study and the Phongsaven Study

Attitude Statements	Illawarra GP Study (n=62)		Phongsaven Study (n=534)	
	Agree	Disagree	Agree	Disagree
a) I have very little time to spend on counselling *	71.0%	29.0%	44%	56%
b) I am better qualified in the management of physical disease	73.0%	27.0%	71%	29%
c) Mental health problems are difficult to treat in general practice	42.0%	58.0%	50%	50%
d) Treating patients with mental health problems is time consuming	95.0%	5.0%	96%	4.0%
e) Diagnosis of mental health problems is part of my professional responsibility *	92.0%	8.0%	97%	3.0%
f) Management of mental health problems is part of my professional responsibility	95.0%	5.0%	95%	5.0%
g) I believe that GPs counselling patients is usually ineffective *	8.0%	92.0%	19%	81%
h) GPs should develop the necessary skills to deal with mental health problems	94.0%	6.0%	94%	6.0%
i) I believe patients do not want GPs asking them about their mental health problems	8.0%	92.0%	11%	89%
j) I believe people with mental health problems are more likely to follow the advice of a counsellor than that of a GP	13.0%	87.0%	19.0%	81%
k) I get job satisfaction from counselling my patients	88.0%	12.0%	89.0%	11.0%
l) I feel comfortable discussing a patient's mental health problems with him/her	89.0%	11.0%	90.0%	10.0%
m) I am concerned about being accused of 'over-servicing' if I charge too many level C, or long consultations for counselling services *	46.0%	54.0%	61.0%	39.0%

* Positive differences in percentage scores

The section on integration and collaboration with mental health services indicated a willingness on the part of the surveyed GPs to have greater involvement in the care of long-term mentally patients. Respondents particularly supported managing the physical care needs of these patients. However, the **willingness for responding GPs to engage in collaborative care was contingent on improved access for their mentally ill patients into mental health services, greater support and the sharing of care with the patient's treating psychiatrist, community mental health team and allied health workers. This was particularly important given the increased workload a general practice incurs when they enter into mental health collaborative care arrangements.** The findings of Barber and Williams (1996, p.281-82) highlighted the obstacles perceived by GPs in engaging in collaborative care arrangements for patients with long-term mental illness, including financial and time constraints and limited support and mechanisms to set up and maintain links. As with the Illawarra survey, GPs in the Barber and Williams study were also positive about developing closer working arrangements with mental health service providers but were concerned about ease of access to specialist mental health services, concerned about undermining the GP's primary care role by specialist mental health service providers and difficulties associated with continuity of care for their patients.

Poor GP satisfaction with access to IAHS Mental Health Services in combination with the current practice of GPs mostly referring patients with major psychotic and mood disorders to mental health workers rather than treating these patients themselves, suggests that collaborative care arrangements in the Illawarra region are restricted. This may be due to poor referral pathways, access and a perceived lack of support for GPs regarding their patients with mental health problems from mental health staff. The findings of this survey indicate it is these factors rather than a lack of willingness on the part of the GP to work with this group of clients that limits integration of mental health and GP services for shared patients with long-term mental illness.

It was encouraging to note that most responding GPs did not perceive a bleak future for people with long-term mental illness and recognised that the mental health care they provide is helpful and of value. This suggests relatively high levels of "hope" which is increasingly being recognised as a key component on supporting recovery, particularly of patients with serious and recurring mental illness (e.g., schizophrenia) (Hoffman, Kupper & Kunz, 2000; Russinova, 1999; Torrey & Wyzik, 2000). In keeping with their primary care

role, most GPs recognise the difficulties and burden faced by the families of patients with long-term mental illness.

Of concern, is the finding that most GPs believe they only see patients with long-term mental illness when there is a crisis rather than routinely. This finding has implications for routine monitoring and management of physical conditions – a role that GPs perceive to be significant and important in the care of mentally ill people.

GPs & Mental Health Education

The results indicate that screening tools are not often used by GPs in their practice. This finding is highly similar to reported findings in other studies (Barber & Williams, 1996a, p.278; JCCP, 1997, p.113; Philip, 1999). Other studies suggest this may be because GPs are concerned about interference with comprehensive patient history taking and the time commitment associated with the use of screening tools (JCCP, p.24-25).

About 40% of GPs said they sometimes or often used screening tools. In the Illawarra/Shoalhaven GP study, 5 out of 23 responding GPs who indicated that regularly use screening tools for mental health problems used the SPHERE anxiety and depression checklists. This suggests there has been practical application of the SPHERE program into routine practice for some GPs. The emphasis on anxiety and depression measures is consistent with these problems being most frequently treated by GPs.

The top three mental health topics identified by responding GPs as having highest priority were:

1. Managing suicidal / self harming patients
2. Psychological skills
3. Psychopharmacology in the management of mental health problems

The highest priority for education concerning client groups was youth with mental health problems followed by the aged with mental health problems.

Anecdotal evidence suggests that suicidal youth are particularly problematic for GPs. They appear to want skills in how to manage these presentations in addition to increased psychological therapy skills.

These results support the direction of the Illawarra and Shoalhaven Divisions of General Practice to provide education and training in youth mental health and the priority that has been given to education on psychological skills by the Illawarra Division of General Practice through the SPHERE and CBT training program for GPs. The findings of the survey would suggest that GPs continue to want education in psychological and counselling skills.

The high priority given to identifying and managing patients who show indications of self-harm and suicide intent indicates the need for a specific education program for GPs on this subject. The recently published and distributed desktop manual (*Assessment & Intervention Strategies for Patients 'At Risk' of Suicidal Behaviour*) by the Shoalhaven Division of General Practice will be of benefit to Shoalhaven GPs and to some degree will meet this need.

Youth Mental Health Presentations in General Practice

The findings of the survey suggest youth mental health problems present regularly in general practice. The main mental health problems discussed between GPs and young people concern substance abuse and relationship issues. Managing a suicidal young person in general practice is also an issue for GPs with most respondents estimating they identified up to five suicidal young people within a 3-month period. Most GPs are in the practice of referring young people to other services for psychological difficulties but while the majority of respondents believe young people benefit from seeing a health professional, three quarters of responding GPs believe that half the young people they treat will get better without help from a mental health professional.

The findings that highest training priorities were related to the youth population and for suicidal behaviour, in conjunction with suicidal behaviour being the third ranked problem most frequently referred out to other mental health professionals, suggests youth mental health and referral practices of GPs are important issues to pursue. The next section focuses on the youth referral practices of GPs.

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SECTION TWO:

YOUTH MENTAL HEALTH SURVEY

General Practitioners' mental health referral practices when working with young people.

Frank P. Deane, Coralie J. Wilson and Vicki Biro

Mental health problems are widespread within the community with almost one in five Australian adults experiencing mental health problems (Andrews, 2000). General Practitioners are now providing services to a growing number of people with mental health problems. While many people do not seek help for their mental health problems, most who do so will seek help from a GP (Andrews et al, 1999; ABS, 1997; Davies, 2000). The burden of mental health care is falling increasingly to GPs. GPs service a significant percentage of people with mental health needs, are frequently the first health care service accessed by people experiencing mental health problems, and in many cases are the sole treatment provider (ABS, 1997; Weir & Penrose-Wall, 1999).

Given the vital role in managing the needs of many patients with mental health issues, there is a significant need for GPs to work collaboratively with other mental health providers and in some cases, they choose to transfer care completely. For young people there are two significant factors which impact on the success of this referral process. The first relates to the general reluctance of young people to seek help for psychological problems and even greater reluctance to seek help from mental health professionals (Deane, Wilson & Ciarrochi, 2001). The second factor is the referral skills of the GP.

There is increasing evidence that adolescents who are the most distressed may hold the most negative attitudes toward service-seeking (Garland & Zigler, 1994). Potentially more troubling are findings that adolescents with the highest levels of suicidal ideation have the lowest intentions to seek professional help (Carlton & Deane, 2000).

The Australian Psychological Society discussion paper on suicide highlighted the urgent need for research and training in referral processes (Graham, Reser, Suderi, Zubrik, Smith & Turley, 2000). They noted that "...making an effective referral is a complex process, and this is a neglected topic in the psychological and psychiatric literature" (p.19). There is preliminary evidence that certain referral practices can improve the success of the referral

(Victorian Suicide Prevention Task Force cited in Graham et al., 2000; King, Nurcombe & Bickman, 2001).

One of the few authors to comprehensively discuss the referral process is Sharon Cheston (1991). She points out that many helpers consider the act of a referral as simply telling clients that they are recommending they see another health provider and then offering a list of names. She argues that referral involves active participation by both the helper and the client in identifying the client's requirements for the involvement of a new healthcare provider. She also distinguishes between a referral involving the relinquishing of primary responsibility for the client's care and "network referral" where in this case, a GP may continue to be the primary therapeutic agent while coordinating the client's work with other supportive professionals for specific assistance. The referral process itself has several steps: (1) the decision to refer, (2) contact with referral source to explore whether an effective referral can be made and how it should be worked out, and (3) sharing this information with the client and completing the appropriate paper work (Cheston, 1991). Cheston goes on to specify a range of specifics within each of these stages (e.g. "Assisting the client in contacting a new therapist," p.11; "Help the client identify the specific problems with which he desires help," p.87).

Care with referral practice is arguably even more important for adolescents who may have a poorer knowledge of the nature of psychological problems and their treatments and less understanding about reasons for referral to mental health providers than adults. Often adolescents are uncertain about whether their emotional problems warrant contact with a mental health professional (Wilson & Deane, 2002). Adolescents participating in focus groups identified a number of factors that might help reduce barriers to seeking professional help. These would also serve as useful points for GPs to consider when referring young people to mental health professionals. For example, students wanted to know that "they are a good counselor" and cost was a consideration reflected in the comment, "they're going to have to either have good free services or really cheap" (Wilson & Deane, 2002, p. 354). These adolescents frequently identified trust and confidentiality as important considerations when seeking help (e.g., "It's a trust thing, you go to people who you know have an obligation to keep what you say to them...", (p. 352). Other studies in Australia have identified obstacles to referral including the risk that young people would experience referral as being "brushed off" (King et al., 2001). Despite these findings we could locate no data that described the referral practices of GPs for young people in need of mental health services.

The present study aimed to provide a preliminary description of the extent to which GPs followed various aspects of ideal referral practice.

METHOD

Participants and Procedure

Surveys were distributed to all members of the Illawarra and Shoalhaven Divisions of General Practice as part of their routine divisional activities. In the case of the Shoalhaven (N = 79) the surveys were mailed along with this Division's newsletter. In the case of the Illawarra (N = 250) the questionnaire was distributed with a recently completed area Mental Health Directory. Postage paid, return addressed envelopes were provided for the return of questionnaires. All respondents remained anonymous. Overall, 62 surveys were returned constituting a 19% return rate. This return rate is slightly lower than similar GP surveys that did not have an active follow-up procedure (e.g., Britts et al., 2001, 28% and Philip, 1999, 27%). We believe this was in part due to the relative length of the survey in the present study. The Youth Mental Health section had a total of 28 items and constituted approximately 20% of the 144-item survey. This section was also the last section of the survey and had the highest amount of missing data. The section was sufficiently discrete that we decided to analyse this data separately.

Forty-nine GPs completed the Youth Mental Health section of the questionnaire. The average age of these GPs was 48 years (SD = 11 years) and ranged from 28 to 71 years. Most were male (70%) and 68% of the sample was in fulltime practice with the remaining 32% in part-time practice. For those in fulltime practice, 65% saw up to 150 patients per week and 77% estimated that up to 20 patients per week were treated predominantly for mental health problems. For those in part-time practice, 67% saw up to 10 patients per week. There was a wide range of time in general practice (1 to 41 years) with the average duration of 18 years (SD = 11 years).

MEASURES

In addition to descriptive variables outlined above, respondents were asked to estimate the number of young people they saw per week presenting with five broad problem domains. GPs were also asked to rate their willingness to refer, the number of young people

they referred to other services, and the percentage they felt were helped by seeing mental health professionals.

Referral practices were explored based on 16 items extracted from the literature on good referral practice (e.g., Cheston, 1991) and based on Enhanced Primary Care guidelines on Case Conferences that are organized and coordinated by GPs (Commonwealth Department of Health and Aged Care, 2000). Table 1 provides an abbreviated stem for each of the items along with means and standard deviations. Under the "Referral and Management Practices" section, GPs were asked to indicate the frequency at which they "currently" conduct each of the practices when "working with a young person to try and convince them to seek help from a mental health professional." Each item was rated on a Likert-type scale ranging from (1) Never to (5) Always. Reliability analysis was conducted on the 16-items and Cronbach alpha in the present study was $r = .89$ indicating a high level of internal consistency and suggesting the items together relate to a single underlying construct. For some analyses the mean of these 16 items was used to reflect overall consistency of ideal referral practice.

RESULTS

Table 1.

Descending Means (M) and Standard Deviations (SD) of GPs Referral and Management Practices

Referral Practices	Mean	SD
▪ Explain why seeing a mental health professional might be helpful.	4.45	0.65
▪ Explain there is a choice in seeing a mental health professional.	4.33	0.88
▪ Discuss the benefits of seeing a mental health professional.	4.20	0.82
▪ Explain that I will continue to support the young person.	4.02	0.90
▪ Organise an appointment with a mental health professional.	4.02	0.88
▪ Explain that the young person will need to share information.	3.84	1.09
▪ Allow young person to specify information they don't want shared.	3.71	1.02
▪ Discuss issues of confidentiality.	3.67	1.07
▪ Make a referral phone call with a young person.	3.65	1.11
▪ Explain any costs that might be incurred.	3.43	1.31
▪ Explain the benefits and success rates of professional mental health help.	3.30	1.10
▪ Explain what to expect in an initial mental health consultation.	3.29	1.11
▪ Explain the likely duration of a mental health consultation.	2.80	1.10
▪ Develop a list of problems to specify mental health needs and goals.	2.71	0.94
▪ Obtain and record consent for referral.	2.52	1.46
▪ Might accompany a young person to their first appointment.	1.43	0.79

Note. 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Always.

We would argue there are some referral practices that should be conducted "Always" by GPs. These are listed in Table 2 along with the frequency that GPs indicated they followed these practices.

Table 2**Percentages of GPs who conducted referral practices that should always be completed (n = 49)**

Referral Practices	Always	Often	Sometimes to Never
▪ Explain why seeing a mental health professional might be helpful.	53%	39%	8%
▪ Explain there is a choice in seeing a mental health professional.	53%	31%	16%
▪ Discuss the benefits of seeing a mental health professional.	43%	37%	20%
▪ Explain that the young person will need to share information.	29%	43%	29%
▪ Discuss issues of confidentiality.	24%	35%	41%
▪ Explain any costs that might be incurred.	22%	33%	45%
▪ Explain what to expect in an initial mental health consultation.	13%	35%	42%

In addition, we believe there are referral practices that should be conducted at least "Often" by GPs, dependent on the presentation of the patient and context of the referral. Table 3 provides the frequency with which the current sample at least "Often" followed these referral practices.

Table 3**Percentages of GPs who followed referral practices that should often be completed**

Referral Practices	Always	Often	Sometimes to Never
▪ Explain that I will continue to support the young person.	37%	33%	30%
▪ Organise an appointment with a mental health professional.	29%	53%	18%
▪ Allow young person to specify information they don't want shared.	24%	37%	39%
▪ Make a referral phone call with a young person.	24%	37%	39%
▪ Explain the benefits and success rates of professional mental health help.	13%	34%	53%
▪ Obtain and record consent for referral.	12%	19%	69%
▪ Explain the likely duration of a mental health consultation.	4%	25%	71%
▪ Develop a list of problems to specify mental health needs and goals	0%	23%	77%

In order to test whether there were significant differences between those GPs who had high efficacy beliefs in health professionals and those who did not, we divided GPs into two groups. Those who estimated 25% or less young people with mental health problems were helped by seeing a health professional and those who estimated over 25% were helped. A t-test found a small but significant difference in mean referral practice scores between high efficacy beliefs ($M = 3.61$, $SD = .60$, $n = 29$) and low efficacy beliefs groups ($M = 3.25$, $SD = .64$, $n = 20$), $t(47) = 1.96$, $p < .05$, 2-tailed. This suggests that those who believe young people are helped by seeing a health professional tend to follow ideal referral practices more consistently. We retested this effect by grouping GPs based on their estimates of the percentage of young people with mental health problems that they thought got "better without help from a mental health professional." Again, the cutoffs for the groups were those who estimated 25% and below and those over 25%. Whilst the direction of the means were in the expected direction with the low efficacy belief group ($M = 3.40$, $SD = .73$, $n = 22$) having lower referral practice scores than the high efficacy group ($M = 3.52$, $SD = .56$, $n = 27$), this did not reach significance ($p > .05$).

DISCUSSION

The results suggest that on average GPs in this sample follow a range of recommended referral practices with young people most of the time. These include, explaining why they think a referral to a mental health professional might be useful and what benefits might accrue, explaining that they have a choice about whether they see the mental professional or not, then organizing the appointment for the young person. Referral practices that might ideally be conducted all of the time but were followed only some of the time by 41% of GPs included discussing issues of confidentiality, clarifying any costs associated with seeing a mental health professional and explaining what to expect in the initial consultation. Referral practices that should ideally be conducted "often", were followed only some of the time by GPs and included, explaining the likely benefits and success of seeing a mental health professional and recording consent for referral. Only 29% of GPs "often" explained the likely duration of a mental health consultation and 39% indicated that they "rarely" or "never" explained this.

Cost has been found to be an important component in potential client preferences for psychological services (e.g. Lowe, Howard & Dawson, 1986) and particularly so for adolescents (e.g. Wilson & Deane, in press). Several of these practices can be relatively

easily integrated into referral processes. It is unclear why GPs do not follow these practices consistently. It may be that they lack the relevant information. For example, it may be that they are not sure how long initial assessments by different mental health professionals take or the fees that they charge. Whilst GP knowledge of these services likely influence their referral behaviour (e.g. Kincey & Creed, 1991), the responsibility for informing GPs about what local mental health services provide and for which patients, rests equally with those services. Ross and Hardy (1999) strongly advocate that clear referral guidelines be developed by local mental health services and "At the most general level, GPs should be made more fully aware of the respective skills and approaches used by mental health specialists" (p. 83). In an Australian survey of 83 general medical practitioners and 100 of their patients, 76% of GPs did not know the qualifications of the psychologist they were referring to (Franklin, Foreman, Kyriakou & Sarnovski, 1998). In addition, there was considerable confusion by both GPs and their patients as to the meanings of the various degree titles and qualifications of psychologists. When asked the factors that influenced the selection of a psychologist, 73.5% of GPs identified "Reputation/recommendation" as the primary factor followed by "Specialization" (66%). This finding also confirms the need for GPs to spend more time on developing good quality referral networks (also suggested by Cheston, 1991). Franklin et al. (1998) concluded by highlighting the need for the psychologists' professional organization, the Australian Psychological Society, to mount a much more active educational campaign to the general public and key referral groups, particularly GPs (Franklin et al., 1998). Our data confirm this need and also raise serious questions about whether GPs have sufficient knowledge of other mental health professionals' practice, to be able to follow best referral practice.

Nonattendance rates at initial intake appointments for community mental health centers range from 15% (Noonan, 1973) to 55% (Hochstadt & Trybula, 1980), with most falling in the 20% to 40% range (Larsen et al., 1983; Carpenter et al., 1981). Several studies have found that nonattendance rates are even higher for younger adults (e.g. Deane, 1991). Providing information to clients about what to expect of psychotherapy has been found to reduce their levels of anticipatory anxiety (e.g. Deane, Spicer & Leathem, 1992). Cheston (1991) cites research by Gould et al., (1970) which "found that those clients who have the most clearly defined reasons for seeking help tend to show up for the first appointment following referral, while those with the vaguest reasons tend not to show" (p. 164). Thus, a referring GP can assist the referral process by helping a client clarify the problems for which they are being referred and in doing so, potentially increase the success of the referral (i.e.

attendance). However, in the present study, only 23% of GPs said they often "Develop a list of the problems with the young person to specify their mental health needs and goals." Thirty-five percent sometimes engaged in this activity and 42% rarely or never did this.

The present study also found some evidence that those GPs with low efficacy beliefs regarding the helpfulness of seeing a mental health professional may be less likely to follow ideal referral practices. This effect was small and not consistent, but does signal the potential effect that beliefs or attitudes may have on referral practices. Further research is needed to assess the relationship between attitudinal and belief variables on referral practices.

The present study had a number of limitations. Perhaps foremost was the relatively low response rate and the unknown representativeness of the GP sample. In addition, the responses regarding referral practice were based on self-report. Whilst some GPs may indicate they "always" follow certain referral practices, this does not indicate the quality or thoroughness with which they follow these practices. It would be useful to obtain behavioural data to support some of these self-report ratings. This could be accomplished by obtaining permission to audiotape patient-GP interactions around referral to mental health professionals. Despite these limitations, it is clear that several relatively simple interventions could increase the consistency with which "ideal" referral practices are followed. For example, the utilisation of existing patient information materials for some mental health professionals (e.g., Australian Psychological Society, February 27, 2002, see Appendix B), use of pretherapy preparation procedures (e.g. Deane et al., 1992), and training and development of referral skills and resources (e.g. local Psychological Services Directory).

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ACKNOWLEDGEMENTS

We wish to thank staff at the Illawarra Division of General Practice and the Shoalhaven Division of General Practice. This study was supported in part by a grant from the National Health and Medical Research Council of Australia, Grant YS060.

RECOMMENDATIONS

Illawarra Area Health Service – Mental Health Service

- The IAHS-MHS is currently undergoing significant restructure of its services. Serious consideration is being given to strategies that will improve access into the service for clients of GPs and that will also promote greater support from Community Mental Health Teams to General Practices within their service boundaries. The results of the Illawarra/Shoalhaven Mental Health Care in General Practice Survey give impetus and support to this focus. It is recommended the IAHS-MHS continue in the development of these strategies and the development of guidelines, protocols and practices that facilitate collaborative arrangements in which the GP plays a pivotal role in the overall care of patients with long-term mental health problems with improved support from the IAHS-MHS
- The IAHS-MHS as part of its restructure of community mental health services develop clear pathways and protocols concerning referral, access, clinical care of patients and service delivery models. These pathways, once developed should be clearly explained to GPs with flowcharts and information sheets provided to GPs about the IAHS-MHS.
- Greater clarification of case management arrangements and role functions of GPs and mental health service staff particularly for people with serious and recurring mental illnesses such as schizophrenia.
- Strategic direction that ensures increased support and consultation-liaison for GPs in the ongoing management of mental illness.
- Mental Health Service-wide training and education for staff in good referral practice and liaison skills with General Practitioners and their practice staff.
- Given the level of readiness of GPs to provide counselling services if there was better remuneration for consultations involving mental health care, there should be greater effort made to engage GPs in collaborative care arrangements using the Enhanced Primary Care Items.

- Clinical staff within the IAHS-MHS should be provided with education about GP mental health issues, collaborative care and management of shared clients, how to effectively liaise with practice staff and GPs and working knowledge of the EPC care planning and case conferencing items in order to facilitate improved integration, support and working links between GPs and the MHS.
- The desire for education on suicide prevention and management provides an opportunity for the IAHS-MHS to extend its Suicide Prevention Education Program to GPs and share the knowledge and expertise of educators within the service. This may be an area where joint education programs can be developed. Alternatively, a strategy could be developed that enables the Illawarra and Shoalhaven Divisions of General Practice to utilise the expertise of educators within the IAMHS to facilitate and co-run education on mental health issues (particularly suicide prevention and management of suicidality) for GPs within Division education programs. There is a need to clarify the collaborative role of the GP in working with patients who have these problems. (e.g. new Personality Disorder clinic – GP protocols).

Division of General Practice

- The survey provides clear directions for training of GPs to support their management of mental health problems in general practice.
- While GPs have demonstrated confidence in managing depression and anxiety problems, referral and management practices of more difficult mental health problems such as major psychotic disorders and personality disorder present a greater challenge to GPs. Education that focuses on identification and management of these more difficult mental health problems (psychotic disorders, personality disorder, application of the Mental Health Act) should also be incorporated into the Divisions' Mental Health Education Program.
- Division-wide training in good referral practice and clarification of collaborative care pathways and arrangements for psychotic disorders, bipolar disorder and suicidal behaviours are needed.

- Emphasis by the Divisions in providing support and education on depression, anxiety and psychological counselling skills should be continued. The SPHERE Education program in the Illawarra has been well attended and well received. Continued education on depression, anxiety and psychological counselling skills for GPs is recommended along with ongoing supervision appointments for those who have already completed introductory levels of training.
- The survey findings have demonstrated that substance abuse issues and mental health problems are both frequent and difficult to manage in general practice. Youth mental health problems associated with substance abuse were also identified in the study. The Dual Diagnosis Education Project in developing education modules and resources in the identification and management of dual diagnosis in general practice is vital in addressing the needs of General Practitioners and the community in this area. This program should also help with the development of a referral practices module.
- Division-wide training in good referral practice and clarification of collaborative care pathways and arrangements for psychotic disorders, bipolar disorder and suicidal behaviours are needed.
- Division-wide training in good referral practice when referring young people to mental health specialists.
- A high priority for youth mental health education for GPs should focus on developing and enhancing GPs referral practices and particularly management of dual diagnosis, substance use problems and relationship problems. GPs would benefit from education on the importance of each of the highlighted aspects of referral, in addition to processes of effective referral. The GP youth friendly program and Divisional Education sessions concerning youth health are existing activities that can be utilised to facilitate ongoing education about youth mental health care and related issues.
- It is recommended strategies be developed that facilitate the utilisation of expertise of Mental Health and Alcohol and other Drug Educators and staff within the IAHS in the ongoing education of GPs about mental health problems, effective intervention strategies and related issues. The Illawarra MHIP also provides the region with the opportunity to involve private psychiatrists in education and peer support activities with GPs.

- Specialist training and support for ongoing professional development (e.g. supervision) for GPs who already have some prior CBT or counselling training.

Overall Considerations

- There is a need for not only training, but also ongoing consultation between management in the Illawarra Area Mental Health Service and Divisions of General Practice to clarify and promote workable Shared Care arrangements. Networking opportunities and forums for dialogue and discussion between the Divisions, GPs, IAHS-MHS and clinical staff should be continued. Existing committees within the Divisions of General Practice and IAHS and periodic combined information evenings can be utilised and further developed to raise and discuss mental health issues and provide opportunity for consultation and shared decision making about mental health care in this region.
- A number of these recommendations can be progressed by working collaboratively within a range of existing initiatives.
- Dissemination of the survey findings to GPs and Mental Health Service staff through existing newsletters and forums. Early findings of the study have already been provided to GPs through the IDGP newsletter (see Appendix C), and in a draft report given to the Shoalhaven Division of General Practice in preparation for developing their three year strategic plan. However, further dissemination and discussion of findings is now required.

APPENDIX A: GP SURVEY QUESTIONNAIRE

SECTION A - PROFESSIONAL DETAILS

1. Name: (optional) _____
2. Age: _____
3. Gender: (please tick) i) Male ii) Female
4. Do you practice? i) Full time ii) Part time
5. Number of years in general practice: _____
6. Type of practice? i) Solo ii) Group
7. If group, number in practice: _____
8. Postcode: _____
9. How many mental health care professionals work in your practice? (please give details - eg. clinical psychologist, psychiatric nurse, social worker, counsellor, none)

SECTION B - MENTAL ILLNESS IN GENERAL PRACTICE

i) MANAGEMENT & REFERRAL PRACTICE

For each of the problem groups shown in the table below indicate how often you would treat the problem yourself, and how often you would also refer to mental health workers (eg. psychiatrist, public MHS). Please circle the appropriate number.

Rating code: 1 = Never 2 = Occasionally 3 = Often 4 = Almost Always

	I. Treat myself				II. Also refer to other mental health workers			
	1	2	3	4	1	2	3	4
a) Anxiety Disorders	1	2	3	4	1	2	3	4
b) Depression	1	2	3	4	1	2	3	4
c) Major Psychotic Disorders (eg. Schizophrenia)	1	2	3	4	1	2	3	4
d) Bipolar Affective Disorder	1	2	3	4	1	2	3	4
e) Personality Disorders	1	2	3	4	1	2	3	4
f) Eating Disorders	1	2	3	4	1	2	3	4
g) Psychological consequences of physical or sexual trauma	1	2	3	4	1	2	3	4
h) Suicide behaviours	1	2	3	4	1	2	3	4
i) Organic Disorders (delirium, dementia)	1	2	3	4	1	2	3	4
j) Family / relationship problems	1	2	3	4	1	2	3	4
k) Child & Adolescent disorders	1	2	3	4	1	2	3	4
l) Drug / alcohol related disorders	1	2	3	4	1	2	3	4

ii) ESTIMATES

The following questions seek to ascertain the extent of mental health problems that you encounter in your practice. Please circle the number that most closely reflects your situation.

1. On average, how many patients do you treat per week in your practice?

0-50	51-100	101-150	151-200	201-250	>250
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2. On average, how many patients do you treat predominantly for a mental health problem or mental disorder each week?

0-10	11-20	21-30	31-40	41-50	>50
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3. On average, how many of the patients you see each week receive public mental health services

0-10	11-20	21-30	31-40	41-50	>50
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4. What are the three most frequent mental health problems that you encounter in your general practice?

a) _____ b) _____ c) _____

5. What type of mental health problems cause you the most difficulties?

SECTION B - MENTAL ILLNESS IN GENERAL PRACTICE

iii) ATTITUDE TO MENTAL HEALTH CARE

Please indicate the extent to which you agree with each of the following statements as they apply to you (please circle)

	1 strongly disagree	2 disagree	3 agree	4 strongly agree
a) I have very little time to spend on counselling	1	2	3	4
b) I am better qualified in the management of physical disease	1	2	3	4
c) Mental health problems are difficult to treat in general practice	1	2	3	4
d) Treating patients with mental health problems is time consuming	1	2	3	4
e) Diagnosis of mental health problems is part of my professional responsibility	1	2	3	4
f) Management of mental health problems is part of my professional responsibility	1	2	3	4
g) I believe that GPs counselling patients is usually ineffective	1	2	3	4
h) GPs should develop the necessary skills to deal with mental health problems	1	2	3	4
i) I believe patients do not want GPs asking them about their mental health problems	1	2	3	4
j) I believe people with mental health problems are more likely to follow the advice of a counsellor than that of a GP	1	2	3	4
k) I get job satisfaction from counselling my patients	1	2	3	4
l) I feel comfortable discussing a patient's mental health problems with him/her	1	2	3	4
m) Better remuneration for counselling would increase my readiness to provide counselling services	1	2	3	4
n) I am concerned about being accused of 'over-servicing' if I charge too many level C, or long consultations for counselling services	1	2	3	4
o) Many of my patients would feel uncomfortable if obviously disturbed people were in the waiting room	1	2	3	4

SECTION C - SATISFACTION WITH MENTAL HEALTH SERVICES

i) Satisfaction with Public Mental Health Services

Please rate your level of satisfaction with the following public mental health services

	1 Very Dissatisfied	2 Dissatisfied	3 Satisfied	4 Very Satisfied
1. Please rate your satisfaction with ease of access to the following Mental Health Services:				
a) Mobile Treatment Team (Illawarra) or Extended Hours Team (Nowra)	1	2	3	4
b) Inpatient Psychiatric Units (Shellharbour Hospital)	1	2	3	4
c) Community Mental Health Services	1	2	3	4
d) Child & Adolescent Services	1	2	3	4
e) Rehabilitation Services	1	2	3	4
f) Psychiatrist Services	1	2	3	4
2. Please rate your satisfaction with the quality and appropriateness of treatment provided to your patient by the public Mental Health Service	1	2	3	4

SECTION D - INTEGRATION ISSUES / COLLABORATIVE ARRANGEMENTS WITH MENTAL HEALTH SERVICES

1. Please complete the following questions regarding the clinical responsibilities for the care of the long term mentally ill patients in the community. Please circle the appropriate number according to your preference:

	1 Strongly disagree	2 Disagree	3 Agree	4 Strongly agree
1. Overall Care				
a) Should be primary responsibility of psychiatric team	1	2	3	4
b) Should have overall care organised by general practitioner with psychiatric backup as necessary	1	2	3	4
c) Should have overall care shared between the psychiatrist and general practitioner	1	2	3	4
d) Should be monitored for relapse by psychiatrist	1	2	3	4
e) Should be monitored for relapse by general practitioner	1	2	3	4
2. Physical Care				
a) Should be screened for physical problems by psychiatrist	1	2	3	4
b) Should be screened for physical problems by general practitioner	1	2	3	4
c) Should have their physical problems managed by general practitioner	1	2	3	4
3. Case Manager				
a) Should rely on the community mental health professional as case manager	1	2	3	4
b) Should rely on other psychologist / social worker as case manager	1	2	3	4
c) Should rely on general practitioner as case manager	1	2	3	4
4. Problems relating to collaborative care arrangements include:				
a) Communication difficulties between doctor and patient ..	1	2	3	4
b) Creates increased work for practice	1	2	3	4
c) Rarely causes difficulties for their families or other carers	1	2	3	4
d) Often come to attention of their general practitioner only when there is crisis	1	2	3	4
e) Have poor prognosis whatever is done for them	1	2	3	4
f) Patient becomes unwell and has difficulty re-accessing the Mental Health Service	1	2	3	4

SECTION E - MENTAL HEALTH SUPPORT & RESOURCES

1. How frequently do you use standardised questionnaires / checklists when investigating mental health problems in your patients? (Please circle)

Never	Rarely	Sometimes	Often	Always
1	2	3	4	5

Are there any particular screening tools that you use regularly? i) Yes ii) No

Please give details:

SECTION E - MENTAL HEALTH SUPPORT & RESOURCES

ii) EDUCATION & TRAINING IN MENTAL HEALTH

3. How adequately do you feel you are trained to deal with a range of psychiatric disorders? *(please circle)*

Not at all	A little	Quite well	Very well
1	2	3	4

4. For each of the following mental health associated areas please indicate the priority you would give to further education and training?

	1 None	2 Low Priority	3 Moderate Priority	4 High Priority
a) Assessment & Diagnostic skills	1	2	3	4
b) Practical applications of the Mental Health Act	1	2	3	4
c) Psychological skills	1	2	3	4
d) Health Promotion	1	2	3	4
e) Early Intervention	1	2	3	4
f) Current Mental Health Services in your area	1	2	3	4
g) Psychopharmacology	1	2	3	4
h) Engaging patients in mental health treatment	1	2	3	4
i) Identifying and managing patients who show indications of self harm and suicide intent	1	2	3	4
j) Specific Mental Disorders (Please give details)	1	2	3	4
.....	1	2	3	4
.....	1	2	3	4

5. For which of the following client groups would you like mental health education, training and information? (Please number in order of priority for you)

	1 None	2 Low Priority	3 Moderate Priority	4 High Priority
a) Paediatric	1	2	3	4
b) Adolescent	1	2	3	4
c) Geriatric	1	2	3	4
d) Aboriginal & Torres Strait Islander	1	2	3	4
f) Non English Speaking	1	2	3	4
g) Other (please specify)	1	2	3	4
.....	1	2	3	4
.....	1	2	3	4

YOUTH MENTAL HEALTH & REFERRAL

Below are some questions concerning young people (aged 15-29 years). Please answer each question as accurately as you can.

i) **ESTIMATES**

The following questions seek to ascertain the extent of youth mental health problems that you encounter in your practice. Please circle the number that most closely reflects your situation.

1. On average how many young people do you treat in your practice each day:

0-10 | 11-20 | 21-30 | 31-40 | 41-50 | >50

2. Estimate how many young people you have identified as being suicidal over the last 3 months:

0-5 | 6-10 | 11-15 | 16-20 | 21-25 | >25

3. Estimate how many young people you talk to each week about each of the following problems:

a) Difficulties managing emotions

0-10 | 11-20 | 21-30 | 31-40 | 41-50 | >50

b) Disturbing thoughts

0-10 | 11-20 | 21-30 | 31-40 | 41-50 | >50

c) Relationships

0-10 | 11-20 | 21-30 | 31-40 | 41-50 | >50

d) Drug/alcohol abuse

0-10 | 11-20 | 21-30 | 31-40 | 41-50 | >50

e) Problem behaviours

0-10 | 11-20 | 21-30 | 31-40 | 41-50 | >50

4. Estimate the number of young people who come to your practice each week that you refer to other services for help with psychological difficulties:

0-10 | 11-20 | 21-30 | 31-40 | 41-50 | >50

5. Estimate the percentage of young people you see with mental health problems that you think are helped by seeing a health professional:

0-25 % | 26-50 % | 51-75 % | 76-100 %

6. Estimate the percentage of young people you see with mental health problems that you think get better without help from a mental health professional:

0-25 % | 26-50 % | 51-75 % | 76-100 %

ii) REFERRAL & MANAGEMENT PRACTICES

Below are some statements about what you might do if you are working with a young person to try and convince them to seek help from a mental health professional. Circle the number that most closely describes what you currently do.

	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
a) I would be willing to accompany a young person to their first appointment with a mental health professional					1 2 3 4 5
I would make a telephone call <u>with</u> the young person in order to schedule an appointment with a mental health professional					1 2 3 4 5
c) Identify and discuss the benefits of seeing a mental health professional					1 2 3 4 5
d) Inform the young person about any costs they might incur					1 2 3 4 5
e) Inform the young person about the need to share information with the mental health professional					1 2 3 4 5
f) Allow the young person to specify any information they do not want shared					1 2 3 4 5
g) Obtain and record the young person's consent to be referred					1 2 3 4 5
h) Develop a list of problems with the young person to specify their mental health needs and goals					1 2 3 4 5
i) Organise an appointment for the young person with a mental health professional					1 2 3 4 5
j) Discuss issues of confidentiality and any concerns that the young person might have about privacy in their mental health consultation					1 2 3 4 5
k) Let the young person know that they have a choice about whether they see a mental health professional or not					1 2 3 4 5
l) Let the young person know why I think that seeing a mental health professional might be helpful					1 2 3 4 5
m) Explain to the young person what is involved in their first visit with a mental health professional					1 2 3 4 5
n) Explain to the young person what the probable benefits and success rates are in seeing a mental health professional					1 2 3 4 5
o) Explain how long a visit with a mental health professional is likely to take					1 2 3 4 5
p) Let the young person know that even though they will be seeing a mental health professional, I will continue to be there for them					1 2 3 4 5
q) I might not be willing to refer a young person to a mental health professional because I don't think it will help					1 2 3 4 5
r) I might not be willing to refer a young person to a mental health professional because I think it will take too long to get an appointment					1 2 3 4 5

Thank you for taking the time to complete this questionnaire.
Please return in the postage paid return addressed envelope before 13th April 2001

APPENDIX B:

Australian Psychological Society
(http://www.psychsociety.com.au/member/fr_member.htm)

Psychologists and Patient Care

Indications for Referral

Medical Practitioners may decide to refer patients to a Psychologist for:

- Psychosomatic disorders and medical conditions responsive to psychological treatment
- Stress, phobias and anxiety disorders
- Eating disorders
- Depression
- People requiring assessment for educational, legal or diagnostic purposes
- The assessment and management of neuropsychological conditions
- Rehabilitation, including pain management and life planning
- Parents requiring help with children's behavioural and emotional problems
- Families, couples and children with relationship problems; couples wishing to enhance their relationship
- People adjusting to life events and transitions such as pregnancy and childbirth, marriage, separation and divorce, ageing, retirement and death
- Issues of personal development and lifestyle management
- Career and employment issues including vocational assessment and planning, redundancy and retirement.

Working Together

Psychological issues should be considered if patients' health needs are to be properly met.

While some Medical Practitioners enjoy the primary counselling aspects of their practice, most prefer referral when more time-consuming or specialist psychological practice is required. This allows the Medical Practitioner to remain the primary provider of medical care.

Patterns of co-operation between the referring Medical Practitioner, the Psychologist and the patient may vary with circumstances. If the patient gives permission for release of information, consultation between the Medical Practitioner and Psychologist may occur at the beginning of treatment and at its conclusion, with occasional consultation during treatment in

regard to progress and appropriate medication. The patient may see the Psychologist frequently.

In contrast, a referral from a Medical Practitioner seeking to improve a patient's management of lifestyle and behavioural changes (for example, weight and exercise management for hypertensive patients), may include frequent contact between the Medical Practitioner and Psychologist, with only occasional contact between the Psychologist and the patient.

Making a Referral

The manner in which the Medical Practitioner co-ordinates the referral may determine the success of the Psychologist's involvement. It is advisable for the Medical Practitioner to discuss the reasons for the referral with the patient. Appropriate family involvement should also be considered.

Medical Practitioners may elect to telephone the Psychologist directly to discuss the referral or to write a referral letter. Information that is helpful includes the reason for the referral (whether this is for opinion or management), treatment history, medication and any relevant medical or social history.

Generally, it is preferable for patients to arrange the appointments. However, in some cases, appointments may be made by the Medical

Practitioner.

The referring Medical Practitioner can expect to receive an opinion and management plan from the Psychologist soon after the initial assessment. Further reports will be sent as treatment progresses or as need arises.

Information for Patients

Patients who are unfamiliar with the work of Psychologists may have questions about this type of referral. The following points may help prepare patients for referral.

Sessions usually last 50 to 60 minutes. For certain kinds of treatment, and in the case of psychological testing, sessions may be longer. The first session will usually involve a

discussion of the problem and some initial treatment planning may be undertaken. This will be discussed with the patient (or family where appropriate).

The reason for referral and the Psychologist's orientation will determine the content of the sessions. Sessions may include discussion, testing, behavioural tasks, or other relevant activities. Psychologists are trained to use a wide range of assessment and therapeutic strategies. Patients will sometimes be asked to complete various assignments between sessions. Family members may also be involved in sessions.

Typically, patients may expect to need only four to ten sessions with a Psychologist, because of the effectiveness of short-term treatment procedures. Occasionally a single session will be sufficient to provide patients with appropriate and useful information. Some Psychologists practise on a long-term basis and some patients require long-term support.

Patients should expect that the Psychologist will talk with them about the number of sessions and the type of therapy which is likely to lead to an effective outcome for their problem. It is important that patients understand the relevance of their treatment plan and raise any other issues they wish to clarify.

Locating a Psychologist

Psychologists practise in numerous settings. These include government, corporate, private and community employment. Psychologists may work in general and psychiatric hospitals, medical clinics, community health centres, industry, rehabilitation clinics, forensic services, sport organisations, at all levels in educational institutions and in private practice.

The Australian Psychological Society (APS) offers a referral service should you wish to contact a Psychologist. There is also an APS listing in the Yellow Pages.

Medical Practitioners making referrals should ensure that Psychologists to whom their patients are referred are registered with the Psychologists Registration Board in the State or Territory where the service will be delivered.

Specialist Psychologists

Information on areas of professional specialisation in Psychology is available from the APS. (Please refer to "Psychologists - What do they do? How can they help?" or the APS brochure)

Fees

The APS reviews the recommended fee for Psychologists annually. For details of the current recommended fee, call the APS National Office.

There may be variations between individual Psychologists' fees because of patient circumstances and proposed length of treatment.

Many private health insurance funds offer partial rebates for these fees. To claim a rebate for Psychological consultation, patients need to be covered by ancillary benefits insurance (extras table) and the Psychologist needs to be approved by the health insurance fund. Some health funds require a medical referral. Rebates are not available through Medicare.

Psychologists' fees may be rebatable through workplace and accident compensation systems. The Commonwealth Department of Veterans Affairs (DVA) will pay for veterans' consultations with Psychologists registered with that Department. Call the DVA for details.

Further Information

The APS is the premier body representing the interests of both the science and the profession of Psychology nationwide. With more than 11,000 members, the APS is the main organisation to which Psychologists belong. Members are required to observe a Code of Professional Conduct as a condition of membership. Full Members, Fellows, and Honorary Fellows of the Society have the right to use the initials MAPS, FAPS and Hon FAPS after their name.

For further information, please contact the APS National Office.

APPENDIX C: REPORTED FINDINGS IN GP NEWSLETTERS.