THE AUSTRALIAN NATIONAL UNIVERSITY

APHCRI DIALOGUE

The bulletin of the Australian Primary Health Care Research Institute

Issue 2, 2006

Building evidence - mental health care in primary health care settings

Jane Gunn

Understanding how the mental health care system really works holds the key for successful implementation of the National Action Plan for Mental Health.

Professor Jane Gunn

Professional rivalry and a lack of communication between health professionals and health sectors treating mental health patients could undo the good intentions of the National Action Plan on Mental Health, unless governments work to overcome these barriers.

While the National Action Plan (NAP) agreed by the Council of Australian Governments (COAG) last week provides a unique opportunity for real mental health reform, it must be based in general practice to achieve real results in improved mental health care services and outcomes for patients.

I lead a team investigating exemplary models for a primary health care response to depression, Australia's most common mental illness. This work – **re-order** - is funded by the Australian Primary Health Care Research Institute (APHCRI). In order to develop exemplary models of care we are seeking to better understand how the primary care mental health system really works. To do this we are synthesising existing research and undertaking a longitudinal study of depression in primary care followed by testing exemplary models in practice.

General Practitioners have, in the past, been accused of failing to diagnose and adequately treat mental illness. But international evidence from New Zealand[1&2] and the United Kingdom[3] suggests that GPs are able to and do, diagnose depression in those patients who are most likely to benefit from treatment, especially in patients they see over time. These attributes make primary care an ideal setting for the NAP implementation and it is refreshing to see the plan is founded on emphasising co-ordination and collaboration rather than a knowledge deficit model.

For the NAP to achieve the best outcomes for people experiencing mental health problems we must ensure that every person with a mental health problem has a regular general practice. Because physical, alcohol and drug abuse and psychiatric co-morbidity is the norm, rather than the exception, the Plan must focus on integrating whole person care and not only mental health care. General practitioners are trained to deal with undifferentiated and complex presentations with a biopsychosocial person-centred approach, making general practice well placed to provide holistic, continuing health care to people experiencing mental health problems. Yet the general practitioner alone cannot provide the total health care package and successful implementation of the NAP will require decisions to be made about expansion of the practice nurse role and innovative ways to ensure that the primary medical care team is well integrated with the other mental health care providers. Identifying the 'key ingredients' for effective mental health care is essential to the successful implementation of the plan.

Our **re-order** project, is already underway in defining the key ingredients for depression care and examining some of the issues governments will have to address in terms of inter-professional relationships. To provide best-practice mental health care GPs should be aware of, and in contact with, every other professional involved in the care of that person. But while our system is funded on a service-by-service basis Australia will struggle to achieve this goal.

Communicating effectively between sectors takes time and commitment. To achieve it will require funding mechanisms to facilitate this activity and require a re-think on how general practice functions. Particular focus must be given to the role of the practice nurse in the delivery of general practice/primary care mental health care.

The NAP provides further opportunities to explore these issues in-depth as long as we address the limitations of existing information technology, taking into account privacy concerns. At present primary, secondary and tertiary care operate in parallel universes whereby information sharing is rare and ad hoc at best. Achieving timely information sharing and effective communication present a major challenge to the implementation of the NAP.

The NAP also aims to increase collaboration between sectors and professional groups. Attempts at health care reform are more likely to succeed when implementers recognise that health care acts in ways that appear to be unpredictable, without clear boundaries or 'rules' for functioning[4&5].

A key factor that could be the undoing of the NAP is inter-professional rivalry. The NAP introduces new ways of funding mental health professionals and introduces some new roles. Identifying and agreeing existing and new roles and responsibilities and creating a culture of respect for the strengths of each group involved in the NAP will be essential. Specific strategies must be designed to achieve functional inter-professional relationships.

COAG meeting July 2006

The Council of Australian Governments (COAG) meeting on July 14th of this year endorsed a National Action Plan for Mental Health directed at achieving four outcomes:

1. Reducing the prevalence and severity of mental illness in Australia;
2. Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery;
3. Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention; and
4. Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

The limited effectiveness of many of the reform attempts to date is likely to be due, at least in part, to a focus on re-modelling and improving the 'formal system of medical care' and ignoring the underlying, so called 'shadow system'[6] that may be the main driver of the mental health care system. The NAP will need to draw these systems into the development of the organisation to improve quality of service delivery[7].

The NAP provides a platform for improved mental health care in Australia. Successful implementation requires serious consideration and understanding of the way the health care system really works, warts and all, if we are to make the most of the investment.

Helen Christensen

The need for broader, consumer focused models of primary health care for depression and anxiety.

Professor Helen Christensen and Associate Professor Kathleen Griffiths

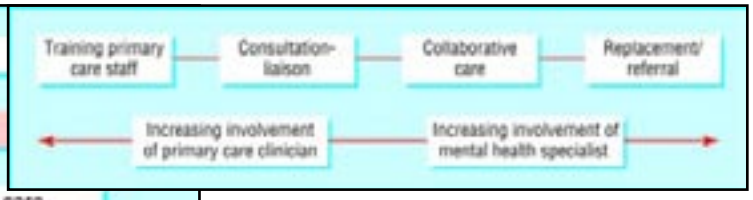
Consumers with mental disorders access a variety of services when seeking help for their illnesses, but models of primary mental health care continue to be focused in the narrow field of general practice and to see consumers as passive recipients of care.

From a research and policy perspective, models of primary health care must incorporate consumer management of mental health and embrace a broader range of settings. There should be a focus on the consumer, both in directing health care and defining appropriate health outcomes and in determining best practices.

The most famous model of how mental health care is delivered is Goldberg and Huxley's 'pathways to care' model (updated in 1995)[1] (Fig 1). A more recent model has been proposed by Bower and Gilbody[2] (Fig 2).

Figure 1

Figure 2



There are two major problems with these models. First, they point to a circumscribed definition of practice that focuses only on the general practitioner- specialist interface. Secondly they exclude a focus on patient self-management.

General practice is well recognised as the first port of call for people seeking help for mental health problems. But a true 'primary care' model offers a broader range of settings where contact between providers and consumers occur.

These settings include: counselling centres, pharmacies, workplaces, psychologist practices, and, increasingly, the Internet. Primary care also includes community services such as crisis lines and prevention/early interventions in schools.

Epidemiological studies show mental health conditions – particularly the disorders of anxiety, depression and dementia - are common. But about 60% of individuals do not or cannot seek assistance for mental health problems[3]. Others seek care not offered in general practice, including assistance from counsellors, bulletin boards or other community groups. Young people typically seek care from friends and family[4]. Given the small GP workforce in Australia and the magnitude of the burden produced by the common mental health problems, non-medical services in the community are essential to reduce the prevalence of common mental disorders.

Models such as those provided by Bower and Gilbody provide some description of the components of general practice, but do not correspond to current help-seeking practices or sources of mental health assistance.

The models of care in Figures 1 and 2 place little emphasis on the patient's role in the management of their (often chronic) condition. However, newer visions of health care shift the burden of care away from individual clinicians, to consumers actively maintaining their good health and managing their ill health[5]. Jorm and Griffiths[6] noted seeking health care is not a passive process and self help and community support are other ways in which individuals proactively reach help. In discussions, particularly in the United States, the role of consumers in directing their own health care is incorporated, with an emphasis on consumer managed care. Models of care need to adequately reflect the multiple interacting paths to care, and the range of settings and delivery modes involved in mental health primary care.

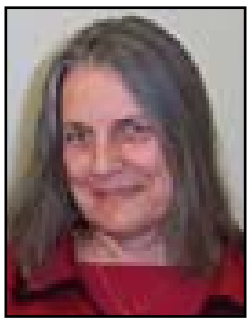
Broader models should be developed that underpin an increased emphasis on integrative research. Silo mentality and patch protection are strong in mental health. Recognition of the existence of multiple paths to mental health care will promote greater integration of services. Stepped care approaches will also underscore the need for intersecting and integrated pathways. And consumers will benefit.

General practitioners cannot, should not, and do not carry alone the burden of averting or treating all mental health disorders in the community. There is a need for community programs to receive equal recognition as providers.

Our recent review of 68 studies of primary health care mental health models for APHCRI found that almost 80% of papers were concerned with evaluating collaborative care and shared models in general practice. Community-based projects constituted less than 20% of the research focus. There must be an increased interest in funding and researching community-based programs.

The focus should shift from doctor-support to patient/consumer support. Previous research has asked what components in general practice[7 & 8], contribute to better care. The focus has been on up-skilling primary health care physicians to identify and respond to patient symptoms and needs. Apart from the provision of patient education, there has been little interest in developing patient or consumer skills, through the provision of decision support systems, assistance and patient directed care plans. This provision is increasing in managed-care environments in the United States, but there is little public research within primary care to evaluate the effect of these components.

Research should focus on consumer outcomes, initially collecting mental health outcome data (like data on whether consumers improve as the result of the care offered) and later incorporating consumer defined outcomes (consumer's criteria for what constitutes improvement, whether this involves their mental health outcomes or other outcomes such as their quality of life).



Kathleen Griffiths

During the course of our review for APHCRI we undertook a comprehensive audit of existing primary health care programs (broadly defined) using major databases and websites. Our aim was to identify efficacy data, which required we review papers with patient outcome data. For these reports, the quality of the evaluation studies was low. Interestingly, only seven percent of this literature addressed consumer/patient health outcomes. The focus was on the implementation of various models and the most common outcome measure was data on the process and, often the satisfaction of providers. An increased focus on consumer self-management in models of care will lead to an increase in interest in core consumer outcomes, including those defined by consumers themselves. This in turn may lead to better care and outcomes for consumers.

A key challenge for the primary health care sector will be to develop new models that more accurately reflect pathways to mental health care.

AN EYE ON THE MEDIA – APHCRI Comment

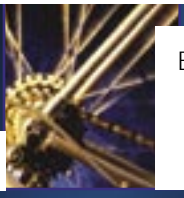
Media reporting of care and treatment of Australia's mentally ill has come a long way in a relatively short time in this country's media.

Once an issue that painted suffers as criminals, scandals like the Cornelia Rau detention centre debacle and the resignation earlier this year of Western Australia's Premier Geoff Gallop due to depression, have seen a softening in newspapers, which have taken to championing the mentally unwell and demanding better treatment. The Federal Government and some of the State Governments have also taken up the call, acknowledged past oversights in this area and pledged vast sums of money to combat the issue.

In a scroll of near to 600 articles in newspapers, magazines, on radio programs and television on mental health articles focus largely on money being invested by governments – generally angled as a vote-buying exercise. "Winners all round in $2bn spree" from the Age at the end of May is typical of these. Very few stories examine how the mental health funding might be spent.

Of several searched only the Australian Financial Review on 8 June 2006 offers the Mental Health Council of Australia's plea that a: "National Approach(is) Needed" in mental health.

While the media is now covering, championing and is less likely to deride the mentally ill, there persists a belief that: 'money will make it better'.



If you do not wish to receive *APHCRI Dialogue* in future, please email the editor.

Editor: Frith Rayner
E: frith.rayner@anu.edu.au
T: +61 2 6125 2026
W: www.anu.edu.au/aphcri

REFERENCES FROM GUNN ARTICLE

1. MaGPIe Research Group. The nature and prevalence of psychological problems in New Zealand primary healthcare a report on Mental Health and General Practice Investigation (MaGPIe). *N Z Med J* 2003; 116(1171):
2. MaGPIe Research Group. The effectiveness of case-finding for mental health problems in primary care. *Br J Gen Pract* 2005; 55(518):
3. Thompson C, Ostler K, Peveler RC et al. Dimensional perspective on the recognition of depressive symptoms in primary care: The Hampshire Depression Project 3. *Br J Psychiatry* 2001; 179:
4. Miller WL, Crabtree BF. Understanding Change in Primary Care Practice Using Complexity Theory. *The Journal of Family Practice* 1998; 46(5): 369-376.
5. Sweeney K, Griffiths F. Complexity and Health Care: An Introduction. Abingdon: Radcliffe Medical Press; 2003.
6. Stacey RD. Strategic Management and organisational dynamics. Harlow: Prentice Hall; 2000.
7. Miller WL, McDaniel RR. Practice Jazz. Understanding variation in Family Practices Using Complexity Science. *The Journal of Family Practice* 2001; 50(10): 872-879.

REFERENCES FROM CHRISTENSEN AND GRIFFITHS ARTICLE

1. Goldberg D, Huxley P. Mental Illness in the Community: The Pathway to Psychiatric Care. 1980 London Tavistock Publications.
2. Bower P, Gilbody S. Managing common mental health disorders in primary care: conceptual models and evidence base. *BMJ.* 2005; 330: 839-42.
3. Andrews G, Henderson S. Unmet need in psychiatry: problems, Resources and Responses. 2000. Cambridge, Cambridge University Press.
4. Booth M, Bernard D, Quine S, et al. Access to health care among Australian adolescents young people's perspectives and their sociodemographic distribution. *Journal of Adolescent Health,* 2004; 34: 97-103
5. Coiera E. Four rules for the reinvention of health care. *BMJ.* 2004; 328: 1197-9.
6. Jorm AF, Griffiths KM. Population promotion of informal self-help strategies for early intervention against depression and anxiety. *Psychol Med.* 2006; 36: 3-6.
7. Tsai AC, Morton SC, Mangione CM, et al. A meta-analysis of interventions to improve care for chronic illnesses. *Am J Manag Care.* 2005; 11: 478-88.
8. Gilbody S, Whitty P, Grimshaw J, et al. Educational and organizational interventions to improve the management of depression in primary care: a systematic review. *JAMA.* 2003; 289: 3145-51.

The authors of these articles are involved in APHCRI funded research work.