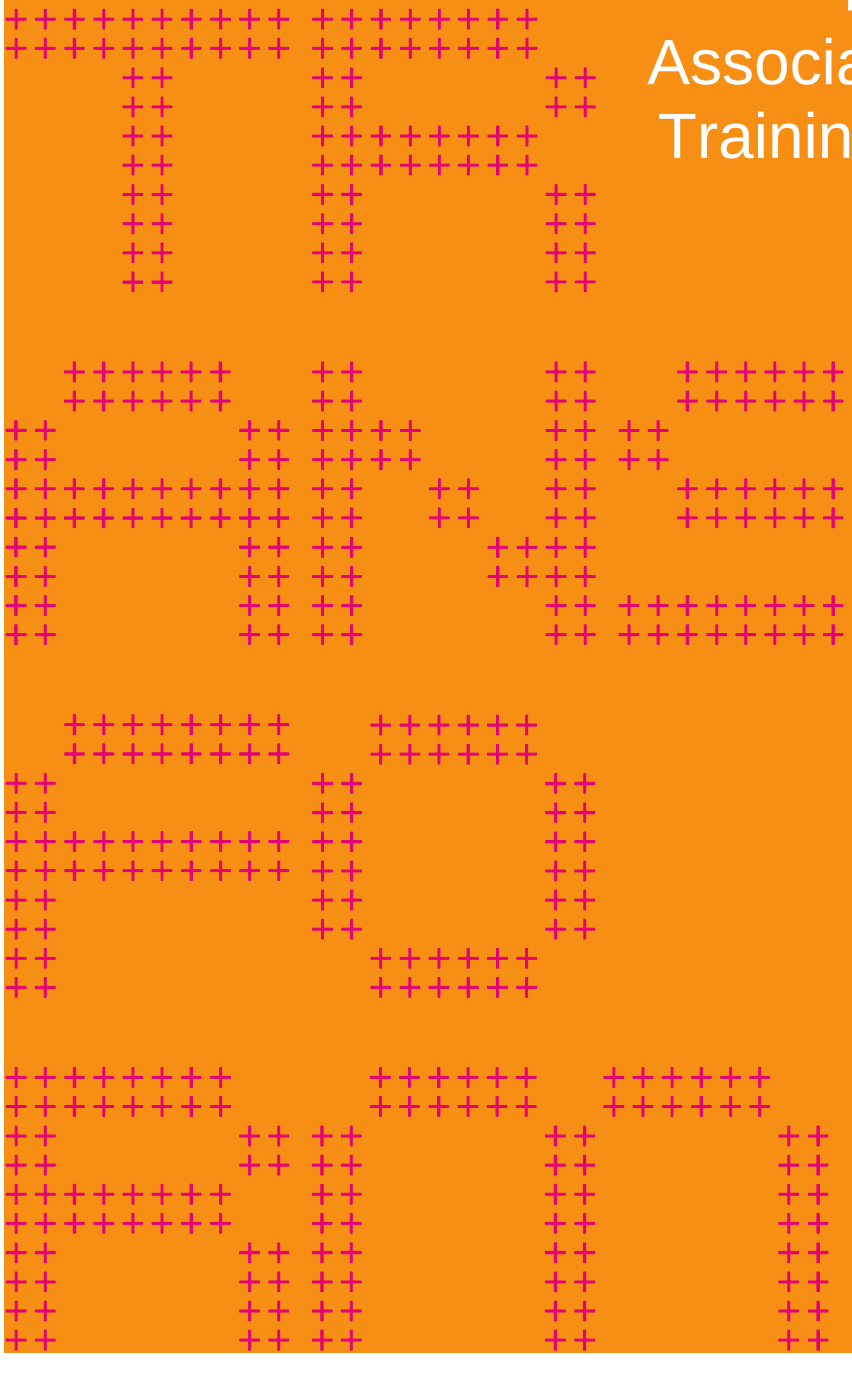
Environmental Scan Component of the Mental Health Professionals' Association Multidisciplinary Training Resource Program

Final Report January 2008



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Environmental Scan Component of the Mental Health Professionals' Association Multidisciplinary Training Resource Program

Final Report

Prepared for The Royal Australian and New Zealand College of Psychiatrists

309 Latrobe Street
Melbourne VIC 3000

January 2008

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TABLES:

Executive Summary

In July 2006, the Council of Australian Governments (COAG) endorsed a National Action Plan on Mental Health (2006 – 2011). All jurisdictions have committed funds to progress the aims of the Plan which include: a greater focus on promotion, prevention and early intervention; collaboration between professionals; and increasing the capacity of the health workforce to deal with mental health issues.

There are many new initiatives that form part of this National Action Plan. One of these is the Better Access to Psychiatrists, Psychologists and GPs through the MBS initiative (the Better Access initiative) introduced under COAG to further improve access to psychiatrists, general practitioners, paediatricians, and some allied health professionals, namely, social workers, occupational therapists and psychologists, through the Medicare Benefits Schedule. Since November 2006, these seven professionals have had access to the new Medicare items under the initiative (COAG 2006).

Collaborative care in the field of primary mental health care is the focus of the Better Access initiative. Currently different mental health professionals provide different kinds of support to clients with a mental illness under this initiative. Ideally this support should be provided in a collaborative manner to enable better mental health for the individual and their carer.

The Mental Health Professionals' Association (MHPA) is a unique professional collaboration which has been engaged by the Australian Government Department of Health and Ageing to provide training, and develop multidisciplinary education and information resource packages for mental health professionals who use the Better Access, to assist them to collaborate more effectively in the delivery of mental health care. The Mental Health Interdisciplinary Networks (MHIN) project is the first project of the MHPA and primarily aims to foster interdisciplinary collaboration.

Urbis was commissioned to undertake a thorough environmental scan of current workforce issues, referral pathways and working relationships between mental health professions, in the context of the Better Access initiative.

The following is a short summary of the key findings from the research.

Professional roles and responsibilities

- All seven professional groups reported confidence in their own roles and responsibilities under the initiative.
- There are, however, knowledge gaps for mental health professionals regarding the roles and responsibilities of OTs and social workers in the Better Access initiative, and this affected referral practices as well as collaboration.
- The allied health professionals' roles in Focused Psychological Strategies in particular are not well understood.
- The GP is universally considered to have an important role in the care and support of a client with a mental illness. Their role is seen as central to care planning and referral, as they are the one professional who is seen to have an overall understanding of the clients' mental health needs. Clients and other health care providers all indicated their reliance on the GP.
- OTs were perceived to have the least role in the initiative, and most likely, the least understood role.
- General practitioners, psychiatrists, and psychologists provide the majority of therapeutic intervention.
- Professionals are committed to involving the professional groups they think will be able to assist them most appropriately in the care of their clients.

- Clients as well as their carers/families did not have an understanding of the roles of OTs and social workers in metal health.

Enablers and barriers for collaboration and delivery of collaborative care

Enablers

- Respect for the knowledge each professional has to offer.
- Effective communication including electronic communication through email and online case conferencing facilities.
- Documents and templates that legitimise collaborative care models.
- Willingness of clients to consent to care planning and the involvement of other professionals.
- Participation by clients and carers in developing successful models of collaborative care.
- Having a trusting working relationship with the GP.
- Coordination and administrative support for clinical networks.
- Knowledge of roles and what the various professionals can offer.
- Willingness to participate in collaborative care and the accessibility of professionals involved.

Barriers

- Insufficient role delineation was considered a barrier to collaborative care, particularly mental health nurses, OTs and social workers.
- Costs to clients for whom the gap in the fee payment and the rebate is unaffordable.
- Access to the appropriate mental health care professionals in the local area.
- Lack of opportunities for professionals to network.
- There are reported tensions between the professional groups that are considered barriers to collaboration, these are:
  - the inequity of Medicare rebates for allied health professionals
  - competition for clients between professionals, which is a feature created by private practice
  - mental health professionals have the perception that OTs and social workers have little relevance under the initiative
  - exclusion of the mental health nurses from the initiative.

Preferences, expectations, incentives and preferred delivery of training

- The main preferences, expectations and incentives for professional training are: skill and calibre of the presenter; close proximity to the work place; no cost or remuneration for training; training which counts towards professional accreditation; developed professional skills; benefits for the client; and that the training is practical in nature.
- Over four in five mental health professionals (83%) identified at least one disorder/condition they would like to know more about. This included 70% who identified one or more of the low prevalence disorders, as well as 68% who identified one or more of the high prevalence disorders (see Figure 2 for details of low and high prevalence disorders).
- Face to face training is considered most useful with the provision of written materials.

Benchmarking – current collaborative care arrangements and practices under Better Access

- Item 296 (initial consultations with a new client) is used most often and item 293 (review of management care plan) is used the least.
- Item 2710 (preparation of a GP mental Health care plan) is used most often.
- Use of the allied health items is variable. Psychologists claim most often, followed by social workers and OTs.
- The most commonly used Focused Psychological Strategies were: cognitive behavioural therapy, anger management, psycho-education, relaxation training, stress management, and problem solving skills.
- Professions reporting the most significant change in their day-to-day practice following the introduction of the new Medicare items are: psychologists (39% 'major change') and social workers (30% 'major change'), followed by GPs (28% 'major change').
- There is low awareness of the range of services that can be provided by mental health nurses under the MHNIP.
- The MHNIP has had little impact on the day-to-day private practice of most mental health professionals.

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1 Introduction

In July 2006, the Council of Australian Governments (COAG) endorsed a National Action Plan on Mental Health (2006 – 2011). All jurisdictions have committed funds to progress the aims of the COAG Plan which include: improving mental health and facilitating recovery through a greater focus on promotion, prevention and early intervention; integrating and improving the care system; increasing participation in the community and education; addressing the accommodation and housing needs for clients with a mental illness; better coordinating care; and increasing the capacity of the health workforce to deal with mental health issues.

Under the COAG Plan, the Australian Government is implementing new initiatives to improve services for clients with a mental illness, their families and carers through:

- Increasing clinical and health services available in the community and providing new teamwork arrangement for psychiatrists, GPs, psychologists and mental health nurses.
- Providing new non-clinical and respite services for clients with mental illness, their families and carers.
- Increasing the mental health workforce.
- Providing new programs for community awareness.

One of the flagship initiatives under the COAG Plan which all jurisdictions are currently progressing involves a new system of linking care for clients with a severe and persistent mental illness and complex needs. This system will provide a more seamless and coordinated set of health and community services for these clients who are most at risk of falling through the gaps. The aim is to ensure that clients in this target group are more able to manage their recovery through better coordination of their care needs.

Further information on the initiatives the Australian Government is progressing under the COAG Plan is available from www.mentalhealth.gov.au

1.1 Context

Australian and international public health policy has seen a dramatic shift from isolated models of health care towards 'new governance' health care arrangements that support local health systems that are collectively responsible and accountable for the health needs of a community (Lomas et al. 1997). This trend towards interagency collaboration is no more evident than at the clinical level where the increasing complexity of health care has generated an expectation and a need for health professionals to work as an inter-disciplinary team. There is growing evidence to suggest that effective interdisciplinary practice improves client health outcomes (Stone 2007). Notwithstanding, there is also a recognition that effective collaborative practice doesn't 'just happen' (Craven et al. 2006).

Western health systems worldwide are seeking to define the key criteria and strategies to maximise, promote and support collaborative practice (Hall 2005). The development of effective collaborative practice necessitates multifaceted strategies that address both the structural (systems, tools) and relational factors (human relationships) at a local level (Hornby 1993; Craven et al. 2006). Effective networks offer the potential to identify and resolve systemic barriers to collaboration, such as development of referral protocols to improve bilateral communication between primary and secondary care, and encourage the development of productive working relationships between service providers.

The modern era of mental health care reform in Australia began in 1992 with the endorsement by all Australian health ministers of a National Mental Health Policy, to be implemented under a five year National Mental Health Plan, subsequently followed by a second and third Plan. The priority areas identified within the plans included explicit recognition of the need to better integrate mental health services and with the general health and other sectors, and the need to develop partnerships in service reform. Most recently, the third National Mental Health Plan for 2003-2008 confirmed these priority areas, and consolidated the previous priority areas within four priority themes, set within a population

health framework that acknowledges the integration of the biological, psychological, social, environmental and economic factors at all level.

The four themes identified were: promoting mental health and preventing mental health problems and mental illness; increasing service responsiveness; strengthening quality and fostering research; and innovation and sustainability.

- An emphasis on increasing the capacity and support to the primary care sector in dealing with mental illness reflects the trend both within Australia and internationally towards community based care for chronic diseases, including mental health. The capacity of primary care in Australia to support prevention and early intervention strategies has also been recognised.
- The Better Outcomes in Mental Health Care (BOMHC) initiative, funded in the 2001 Commonwealth budget represented a significant step towards increasing supports for general practice to better manage mental health care. The BOMHC initiative incorporated funding streams to support education and training for GPs, incentives to manage care within a chronic disease mode, and to provide evidence based psychological treatments.
- It also recognises the need for improved support from and linkages with other mental health professionals, providing for improved referral access to allied health professionals, and improved access to consultation-liaison psychiatric support from the private psychiatric sector and a national advisory service for GPs (for example, the GP Psych Support Program).

The capped funding model for psychological services and mandatory training on GPs requirements to access services has limited the effect of BOMHC. The Better Access initiative introduced under COAG aims to further improve access to psychiatrists, GPs and some allied health professions, namely, social workers, OTs and psychologists, through the Medicare Benefits Schedule. Collaborative care in the field of primary mental health care is the focus of the Better Access initiative. This represents a significantly greater investment in private sector mental health care, incorporates a similar approach to supporting provision of managed care, and provides new or improved Medicare rebates for general practices, psychiatric and psychological services. The new Medicare items associated with the Better Access initiative were implemented in November 2006 (COAG 2006) (for more information see http://www.health.gov.au/internet/wcms/publishing.nsf/Content/coag-mental-overview.htm)

Another major initiative of the COAG reforms has been the establishment of the Mental Health Nurse Incentive Program (MHNIP). The MHNIP provides a non-MBS incentive payment to community based general practices, private psychiatrist services and other appropriate organisations (such as Divisions of General Practice) that engage or retain mental health nurses to assist in the provision of coordinated clinical care for clients with severe mental disorders in the community. Mental health nurses engaged under this initiative will assist GPs in managing patients with severe mental disorders in the community and provide a package of services that are tailored to the person's needs. These may include periodic review of the patient's mental state; medication monitoring and management; providing information on physical healthcare to patients; integrating services from GPs, psychiatrists and allied health workers (such as psychologists) including arranging access to interventions from other health professionals when these are required and undertaking home visits (including family interventions if needed).

These initiatives, and others emerging from the COAG reforms, such as the Personal Helpers and Mentors Program, implicitly recognise: the interconnectedness of client need; the challenge is to ensure that the programs are delivered in an integrated fashion; and the importance of sound collaboration between policy makers, organisations and services, clinicians and clients.

1.2 The Mental Health Professionals Association

The Mental Health Professionals Association (MHPA) forum is a unique professional collaboration which is well aligned with the growing paradigm shift away from care provision by isolated professions and organisations towards decentralized new governance arrangements that support local health systems that are responsible to and accountable to the needs of their communities (Lomas 1997).

The MHPA has been engaged by the Australian Government Department of Health and Ageing to develop a multidisciplinary resource package for mental health professionals. The MHPA provides support and resources to mental health care professionals. The major aim of the MHPA is to provide opportunities for mental health professionals who can use the Better Access mental health care items to establish interdisciplinary networks, so that general practitioners, psychiatrists, paediatricians, psychologists, mental health nurses, social workers, and OTs collaborate effectively in their delivery of mental health care.

The Mental Health Interdisciplinary Networks (MHIN) project has as its primary aim the fostering of interdisciplinary collaboration in both educational and clinical settings, whilst also recognising that the suitability of collaborative mental health care varies with circumstance.

The MHIN project, is the first project of MHPA, involves the following three key actions:

1. An environmental scan to examine how the seven professional groups, that is, psychiatrists, psychologists, general practitioners, mental health nurses, occupational therapists, social workers and paediatricians are currently working in the context of the Better Access initiative.
2. Development of a comprehensive multidisciplinary education and training package.
3. Development and maintenance of a multidisciplinary web based resource portal, which will contain material developed in the training package, information and tools about Better Access, and references and links to other web sites, as well as other approved training courses.

Urbis was commissioned to undertake a thorough environmental scan of current workforce issues, referral pathways and working relationships between mental health professions, in the context of the Better Access initiative.

1.3 The Environmental Scan

The environment scan focused on six key themes including:

- collaboration
- current practice
- professional roles
- interdisciplinary care
- clinical networks
- clinical education in mental health.

1.4 Structure of this report

This report contains the findings and analysis of the environmental scan. The analysis is divided into the four main outcomes. These outcomes form the main chapters of this report, and include:

- Professional roles and responsibilities in collaborative care.
- Enablers and barriers for collaboration and delivery of collaborative care.
- Preferences, expectations, incentives and preferred delivery of training.
- Benchmarking – current collaborative arrangements and practices under Better Access.

Each chapter includes a short introduction, the key findings, and a discussion of the findings.

1.5 Methodology

The project was supported with advice from the project steering group made up of the following people:

David Stokes – Project Leader (APS)

Harry Lovelock – National Policy Director (RANZCP)

Helen Lindner – Project Leader (APS)

Ian Cassie – Senior Project Officer (ACMHN)

Juliette Begg – National Program Manager – MHPA (RANZCP)

Julian Elliott Thomas – Senior Project Officer (RACGP)

Kim Ryan – Executive Officer (ACMHN)

Stefanie Colella – National Program Manager – MHPA (RACGP)

The methodology included quantitative and qualitative research. The quantitative phase was in the form of an on-line survey, and the qualitative phase included a series of consultations with the members of the seven professional groups, and key strategic stakeholders, including clients of mental health services and carers. There was also site visits to current clinical networks. Both the quantitative and qualitative elements explored how the knowledge, perceptions and behaviour of mental health professionals impacts on collaboration and the delivery of collaborative care. There was also a review of the literature relevant to partnerships and collaborative care in primary mental health care.

1.5.1 Quantitative research phase

In line with the aims of the project, an on-line survey was developed in conjunction with the project steering group. There were extensive iterations of the survey to ensure that there was adequate input and consensus from the project steering group and clinicians. The final instrument explored the following areas:

- occupation and workplace profiles
- use of the Better Access items and the MHNIP
- practice trends for the seven professional groups
- allied health clinical boundaries and scope of clinical practice
- care planning and co-ordination
- triggers, barriers and enablers for multi-disciplinary work
- clinical networks

- training about collaborative care using the Better Access items
- demographic data.

The on-line survey went live on 2 November 2007. The survey was taken off-line for the addition of fields at the request of the project steering group on the 22 November 2007. The additional fields allowed extra information to be gathered from the mental health nurses. The survey closed for all professional groups on the 25 November 2007, except mental health nurses who could continue to complete the survey until the 30 November 2007. Details of the survey questions and responses can be found in Appendix B.

1.5.2 Qualitative research phase

Ideally the qualitative inquiry would have preceded the on-line survey; however, with parallel projects and timeframes the survey was brought forward with early results being made available to inform a pilot of the education and training package.

The purpose of consultations with members of the seven professions and the site visits was to gather the experiences, impressions and practice examples in mental health care. This information provided illustrative data that supported and enriched the quantitative data from the on-line survey. Participants in the qualitative phase were recruited in three ways:

- through their involvement with MHIN
- self nominated
- referred by another participant.

The qualitative phase of the project included:

Client and carer discussions groups

A discussion group was facilitated through SANE, a total of seven clients of mental health services and carers attended. This consultation was scheduled to precede interviews with the professions. The aim was to orient the researchers to the perspectives of the group of clients and carers and to bring their experience to the study. Time constraints limited the opportunity for greater client consultation.

In-depth interviews

In-depth interviews were completed with selected representatives of the seven professional groups, each of whom is considered by peers to be well established and credentialed in collaborative care.

Site visits and discussions with practitioners at six sites:

- Victoria - GP (1), mental health nurse (1), and practice nurse (1), a psychologist was going to attend but was delayed.
- Victoria - OT (4), other allied health and medical staff could not attend due to work commitments on the day, this clinical practice also works with CALD communities.
- South Australia - GP (1), mental health nurse (2) (one of the mental health nurse is also a social worker). Separate discussion with Psychiatrist who could not take part on the day, who works with Aboriginal and/or Torres Strait Islanders and diverse communities/clients in remote and rural South Australia.
- Queensland - psychologist (5), clinical psychologist (3).
- Queensland - GPs (5), mental health nurse (1), registered nurse (1), practice manager (1), a psychologist was going to attend but did not work that day.
- New South Wales - GP (1), mental health nurse (1) social worker (1), with focus on Aboriginal and/or Torres Strait Islander clients.

Selected strategic stakeholder consultations

- Barbara Hocking - CEO of SANE Australia
- Jane Westley - Coordinator National Primary Mental Heath Care Network, Australian General Practice Network.

Literature review

The literature referenced in the report has been drawn from the work of the literature review writing team, led by the RACGP, who collated materials provided by all MHPA organisations and the affiliate bodies. It is supplemented with material reviewed by the Urbis study team.

1.6 Analysis and reporting

The on-line data was weighted, this means that the data collected from survey respondents is adjusted to represent the population from which the sample was drawn. The weight does not change a respondent's answer rather it gives appropriate relative importance to the answer. Weighted data is essential in generalising findings from survey respondents to the population covered by the survey. If weights are not used in data analyses, estimates for the subgroups covered by the survey will be biased because some population subgroups are under or over-represented in the respondent group.

The final analysis of the data was conducted in an internal workshop of the study team. Information gained from the on-line survey was compared with results of the consultations. Grounded theory was used to construct the data to go beyond static analysis to multiple layers of meaning. Open coding of the qualitative data and content analysis was used to make comparisons and allow for categorisation in order to interpret, understand and propose explanations for findings. Content analysis is helpful as it can break down information, and assisted in making connections between concepts.

This report contains an integrated write up of the quantitative and qualitative data.

Following drafting of the report a workshop with the project steering group and the Urbis team was convened to test the research findings. Further feedback from the MHPA, MINH and the Department of Health and Ageing was incorporated into the final report.

1.6.1 Overview of respondents

Demographics of mental health professionals in Australia

The seven mental health professional groups identified in this report make up a significant proportion of mental health professionals working in private practice in Australia. The total has been estimated at 65,000. The largest groups are GP and psychologists, followed by mental health nurses. Psychiatrists and clinical psychologists make up a smaller proportion, and social workers and OTs make up the smallest proportion.

1.6.2 Sample size, composition and weighting

The survey was online during November 2007, and took 30 minutes to complete (median duration).

A total of 2,264 responses were received from mental health professionals. The professional breakdown for the raw sample is seen in the two left hand columns of Table 1 below.

This research had to be conducted over a relatively short time frame, which represented challenges for the breadth of distribution of the survey. In an effort to address this limitation the on-line survey was circulated to the mental health professionals by the relevant professional associations and networks, who also were responsible for promotion of the survey. This method of distribution was considered adequate as the survey was not a work force audit.

To adjust for under/over sampling of certain professions, weights were applied in the analysis. GPs, mental health nurses and paediatricians were weighted up (because they were underrepresented in the sample), while OTs, psychiatrists, clinical psychologist and social workers were weighted down. The weights and weighted sample sizes are shown in the columns to the right of Table 1 below.

Table 1 - Sampling and weighting by professional group. *The data in the table below was provided by each of the relevant professional associations, the MHPA, the MHIN and Government web sites)*

Professional	Raw sample		Population estimate		Weight applied	Weighted sample	
	n	%	p	%		n~	%
GPs (Department of Health and Ageing 2007)^	267	12%	25,146	39%	3.35	878	39%
Mental health nurses (ACMHN 2007)	254	11%	10,216*	16%	1.40	357	16%
OTs (OT Australia 2007)	50	2%	148#	<1%	0.11	5	<1%
Paediatricians (RACP 2007)	36	2%	1,411	2%	1.38	49	2%
Psychiatrists (RANZCP)	224	10%	2,206	3%	0.34	77	3%
Clinical psychologist s(APS 2007)	420	19%	2,007	3%	0.16	70	3%
Psychologists (APS 2007)	761	34%	22,979	35%	1.05	803	35%
Social workers (AASW 2007)	252	11%	698#	1%	0.10	24	1%
Total	**2,264**	**100%**	**64,811**	**100%**		**2,264**	**100%**

*Number of mental health nurses eligible to work under Mental Health Incentive Program

#Numbers indicate practitioners currently registered to provide services under Better Access, not the number of practitioners eligible to register

All other population estimates p = the total population eligible to participate in the Better Access initiative.

^http://www.health.gov.au/internet/wcms/publishing.nsf/Content/4F4DB38797665644CA256FFE000C3C7F/$File/Table%201_Jan%2029%2007.pdf

1.6.3 Characteristics of the sample

Workload characteristics

Respondents worked an average of 22 hours in private practice and 10 hours in public community settings per week.

Some professional groups spent most (if not all) of their practicing hours in private practice. This included GPs (71% reported only doing private practice), clinical psychologist (63% private practice only), psychologist (66% private practice only), psychiatrists (47% private practice only) and social workers (45% private practice only).

However others were quite the opposite: 83% of mental health nurses surveyed did no private practice hours at all – this was also true 46% of OTs and 25% of paediatricians.

Mental health professionals in private practice provided care for an average of 24 private clients with a diagnosed or suspected mental disorder each week. This figure was much higher for psychiatrists (58 clients) than others, particularly social workers (11 clients) or OTs (13 clients).

Table 2 - Private practice hours per week (A2)

	Average hours worked per week			Private hours as a % of total hours				Mean weekly number of private clients with a mental illness*
	In private practice	In public/ community setting	Total	Zero	1%-50%	51%-99%	100%	
GPs	30.3	3.6	33.9	4%	6%	19%	71%	29
Mental health nurse	3.2	30.3	33.5	83%	8%	2%	7%	16
OTs	9.6	18.3	27.9	46%	22%	6%	26%	13
Paediatricians	11.7	23.5	35.2	25%	45%	17%	14%	18
Psychiatrists	29	10.1	39.1	0%	26%	27%	47%	58
Clinical psychologist	23.9	8.5	32.4	2%	25%	10%	63%	21
Psychologist	22.1	7.1	29.2	3%	20%	12%	66%	17
Social workers	15.3	12.6	27.9	12%	35%	9%	45%	11
Total	**22.3**	**10**	**32.3**	**17%**	**14%**	**13%**	**56%**	24

* This figure represents the mean number of *private clients* cared for by mental health professionals who do at least one hour of private practice per week. It includes clients with a diagnosed or suspected mental disorder.

Workplace characteristics

Out of the mental health professionals who do private practice work:

- 41% had a multidisciplinary place of private practice
- 44% had a single-disciplinary place of private practice – i.e. there were other people working with them, but they were all of the one profession (e.g. all GPs or all social workers)
- 15% were lone practitioners (in their private work).

Looking at specific disciplines represented in places of private practice:

- 53% of private practices had a GP
- 33% had a psychologist
- 24% had a clinical psychologist
- 10% or fewer had a psychiatrist
- fewer than 10% had a social worker providing mental health services (7%); mental health nurse (6%), paediatrician (4%), OT providing mental health services (2%)
- 20% had other professions not listed above.

Demographic characteristics

- overall, 70% of mental health professionals were female, and the average age was 48 years
- psychiatrists were the only professional group that was not majority female (63% male, 37% female)
- OTs was the only professional group with a markedly different average age (41 years – i.e. younger than other professions).

Table 3 - Age and sex profile of mental health professions

	Sex		Age				
	Male	Female	Under 35	36-45	46-55	56+	Mean (yrs)
GPs	39%	61%	12%	27%	41%	20%	48
Mental health nurses	26%	74%	7%	30%	50%	14%	48
OTs	12%	88%	30%	40%	20%	10%	41
Paediatricians	36%	64%	8%	25%	39%	28%	49
Psychiatrists	63%	37%	6%	27%	42%	25%	49
Clinical psychologist	27%	73%	16%	24%	34%	26%	48
Psychologist	20%	80%	16%	24%	35%	25%	48
Social workers	19%	81%	8%	20%	44%	28%	50
Total	**30%**	**70%**	**12%**	**26%**	**40%**	**22%**	**48**

Geographic characteristics

- Consistent with the Australian population, two thirds of mental health professionals live in either a capital city (54%) or another major metropolitan area (11%). This leaves 17% in regional centres, 15% in rural regional or regional areas, and 3% in remote areas.
- Certain professional groups were particularly concentrated in capital cities – this included psychiatrists (81%), paediatricians (81%), clinical psychologist (70%) and OTs (64%)
- By contrast, mental health nurses were more often found in rural, regional or remote areas (23% total) than other professional groups.

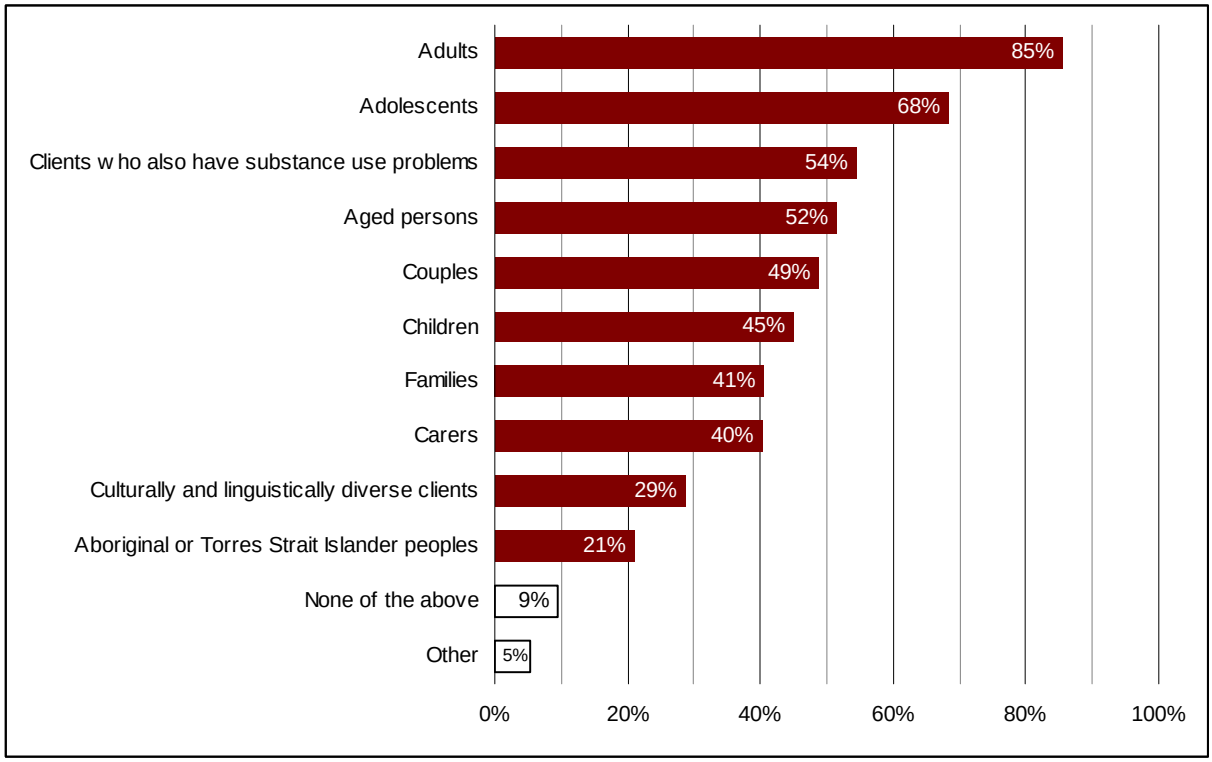
Table 4 - Geographic details of mental health professionals

	Capital city	Other major metro	Regional centre	Rural or regional area	Remote area
GPs	52%	9%	16%	17%	6%
Mental health nurses	46%	17%	15%	21%	2%
OTs	64%	8%	16%	12%	0%
Paediatricians	81%	8%	6%	6%	0%
Psychiatrists	81%	5%	9%	4%	0%
Clinical psychologist	70%	9%	13%	9%	0%
Psychologist	54%	13%	21%	12%	0%
Social workers	52%	15%	16%	16%	1%
Total	**54%**	**11%**	**17%**	**15%**	**3%**

1.6.4 Break down of areas of private practice

The survey respondents indicated that the majority of the 7 professional groups work with adults and adolescents, and over half their work is with aged persons and clients that also have substance abuse issues. Nearly half of the respondents indicated that they work with couples, families and carers. About one third worked with CALD clients and one in five worked with Aboriginal and/or Torres Strait Islanders. The figure overleaf provides a graphical representation of the breakdown.

Figure 1. Populations groups dealt with as part of private practice mental health care/interventions care / interventions



*****Other client types included clients with physical or developmental disabilities, criminal offenders, defence personnel/veterans, refugees, overseas students, gay and lesbian clients, infants, and rural populations, victims of crime and people who are homeless.

2 Literature review

2.1 Introduction

Australian and international public health policy has seen a dramatic shift from isolated models of health care towards 'new governance' health care arrangements that support local health systems and that are collectively responsible and accountable for the health needs of a community (Lomas 1997).

Over the past two decades public policy makers have increasingly introduced partnership and collaborative models of working to enhance social and economic outcomes (Morgan 1997; Considine 2004). These models currently underpin public sector policy framework for health care, 'through which it is visioned that all relevant actors pertinent to a sector may be brought together and contribute to improving a given situation on an equal basis' (Brownie 2007).

A key assumption informing public policy trends is that inter-organisational and interdisciplinary collaboration and partnership-based service delivery is a more effective means of yielding improved outcomes for clients of mental health services and their families (D'amour, Ferrada-Videla et al. 2005; Brownie 2007; Stone 2007).

The trend towards interagency collaboration is evident at the clinical level where the increasing complexity of health care has generated an expectation and a need for inter-disciplinary health professionals to work collaboratively.

Western health systems worldwide are seeking to define the key criteria and strategies to maximise, promote and support collaborative practice (Hall 2005). The development of effective collaborative practice requires multifaceted strategies that address both the infrastructure of healthcare systems and the training needs of participating health practitioners through an improved understanding of the barriers and enablers for collaborative practice (Hornby 1993; Craven et al. 2006).

It is further recognised that effective collaborative practice does not 'just happen' but is facilitated by the proactive engagement of the professionals involved who share an understanding of the benefits of collaborative practice and have skills to draw on to give effect to a collaborative care model (Craven et al. 2006).

In keeping with policy trends at the Australian Mental Health Policy level, networking across disciplines and working collaboratively underline the formation of the MHPA partnership and subsequent construction of the MHIN project whose primary aim is to foster interdisciplinary collaboration in both educational and clinical settings.

The MHPA forum is a unique professional collaboration which is well aligned with the growing 'paradigm shift' away from care provision by isolated professions and organisations towards decentralized 'new governance' arrangements that support local health systems that are responsible and accountable to the needs of their communities (Lomas 1997).

The current collaborative care model in Australia (the Better Health Access Program) enlists seven mental health professions (noted above), each having different understandings, perspectives and practice norms regarding their roles and responsibilities in mental health care. The literature notes that interdisciplinary collaboration is assisted by an understanding of the roles and responsibilities of the various professions; collegiality which is characterised by mutual trust and respect; knowledge of others' expertise, skills and responsibilities; a commitment by professions to the principles of collaborative care; and an infrastructure and leadership which supports collaboration, communication, and the sharing of knowledge and resources.

2.2 International perspectives

The 1978 international conference on primary care which promoted “Health for All” by the year 2000 is considered a key trigger for the shift in primary health care policy towards more collaborative models (Baum, 2002). Key elements of this strategy were:

- To recognise the importance of global cooperation and peace in primary healthcare
- To adapt primary healthcare to the requirements of the country
- That the health status of each country reflects economic and social developments
- That primary health care should be perceived as the ‘backbone’ of each country’s health strategy
- That education should assist involvement in planning, organisation, operation and control of primary healthcare

Developments in the implementation of collaborative models continue to inform mental health policy and practice in Western countries with a focus on traditional medical doctors as the usual entry pathway to health care systems.

The College of Family Physicians of Canada released a co-joint discussion paper in 2006 highlighting the issues surrounding the relationships between family physicians and other specialists with the goal of improving working and learning relationships to enhance client care, and patient and physician satisfaction.

The paper notes collegial relationships, practice environments, changing models of care and collaboration, education and physician resourcing as the five key themes central to improving relationships in the interests of improved outcomes for clients. Also noted were the enabling roles that information technology / management and communication skills play in improving intra-professional relationships. Importantly, collegiality was highlighted as at the core of relationships which enable collaboration. Specifically, mutual trust, respect, and knowledge of the others’ expertise, skills and responsibilities are important in establishing collegial relationships; but there is a lack of evidence about what makes these relationships work.

Finding the balance between appropriate role delineation and enhancing a culture of collaboration across disciplinary differences is indeed the unique challenge for the success of collaborative care models.

2.3 Australian perspective

Albeit a little slower than the rest of the world, this trend is also occurring across the Australian healthcare system (Stone 2007). The modern era of mental health care reform in Australia began in 1992 with the endorsement of a National Mental Health Policy by all Australian health ministers, to be implemented under a five year National Mental Health Plan, subsequently followed by a second and third Plan. The priority areas identified within the Plans included explicit recognition of the need to better integrate mental health services with the general health and other sectors, and the need to develop partnerships in service reform. Most recently, the third National Mental Health Plan for 2003-2008 confirmed these priority areas, consolidating them into four themes, set within a population health framework that acknowledges the integration of the biological, psychological, social, environmental and economic factors at all levels. The four themes identified were: promoting mental health and preventing mental health problems and mental illness; increasing service responsiveness; strengthening quality; and fostering research, innovation and sustainability.

An emphasis on increasing the capacity and support to the primary care sector in dealing with mental illness reflects the trend both within Australia and internationally towards community based care for chronic diseases, including mental health. The capacity of primary care in Australia to support prevention and early intervention strategies has also been recognised.

The BOMHC initiative, funded in the 2001 Commonwealth budget represented a significant step towards increasing supports for general practice to better manage mental health care. The BOMHC initiative incorporated funding streams to support education and training for GPs, incentives to manage care within a chronic disease model and to provide evidence based psychological treatments (National Mental Health Plan 2003-2008). The BOMHC has undergone extensive evaluation between 2003 and 2007.

The need for improved linkages and reciprocal support between mental health professionals, providing for improved referral access to allied health professionals is also recognised, along with a need for improved access to consultation-liaison psychiatric support from the private psychiatric sector and a national advisory service for GPs (GP Psych Support).

The Better Access to GPs, psychiatrists, psychologists, OTs, paediatricians, and social workers through the Medicare Benefits Schedule initiative represents a significantly greater investment in private sector mental health care. The program compliments the BOMHC program and follows a similar approach in that it supports the provision of managed care, and provides new or improved Medicare rebates for general practice, and allied mental health services.

A second major initiative of the COAG reforms has been the establishment of the MHNIP. The program provides funding to support mental health nurses to work from general practices, psychiatric practices and divisions of general practice to provide care to clients with a severe mental illness living in the community.

These initiatives, and others emerging from the COAG reforms (such as the Personal Helpers and Mentors Program) implicitly recognise the interconnectedness of client need. The challenge is to ensure that the programs are delivered in an integrated fashion, supporting sound collaboration between policy makers, organisations and services, clinicians and clients.

The BOMHC program has undergone extensive evaluation with the most recent report noting among the key findings: a consistent increase in the participation rates by GPs and allied health providers between July 2003 and December 2006; a significant increase in the uptake rate of clients of mental health services; consistency in the profile of clients using the scheme; and evidence that the program is achieving positive outcomes for clients in terms of alleviating symptoms, improving levels of functioning and well being.

While evidence as to positive outcomes for clients is encouraging, the demographic profile of clients has been consistent over time, (approximately three quarters are female with a mean age of 41, and two thirds are on low incomes), indicating that pathways to the Better Health Access Program for clients from more diverse backgrounds are currently impeded. While this requires further analysis, it is worth noting in this report as an indicator of challenges to access.

2.4 Collaborative practice

The concepts of inter-organisational and inter-professional partnership have been accepted as logical manifestation of the current public policy trend toward collaborative practice, however, it is noted that implementation of collaborative care models remain highly challenging (Brownie 2007).

Furthermore, few evaluative studies providing evidence of the outcomes and impact of different forms of partnership can be drawn upon for the purpose of determining what works. Discussions note the general support for networks of partnership however mechanisms enabling the transformation towards collaborative practice are invisible (Brownie 2007).

Understanding both what collaborative practice is and how it can be best implemented is at the forefront of developing professional practice norms across relevant disciplines which embrace collaborative care principles and practice.

Collaborative practice is commonly described in the literature in terms of multidisciplinary, interdisciplinary, and transdisciplinary collaboration, representing different levels of engagement across professional boundaries, and along a continuum of decreasing autonomy (D'Amour and Oandason 2005b). A review of theories of collaboration by D'Amour and Oandason (2005

b) identified five underlying issues which were generally common to the different models:

- **sharing**: variously shared responsibilities, decision making, health care philosophy, values, data, planning and intervention, and/or sharing of professional perspectives
- **partnership**: two or more actors jointly working towards common goal, within a 'collegiate' relationship; open and honest communication, and shared respect for the knowledge and perspectives of the other parties
- **interdependency**: recognition of mutual dependency to achieve collaborative goals, and clinical autonomy that decreases with complexity of the clinical scenario
- **power**: shared, based on knowledge and skills rather than functional roles or titles
- **process**: collaboration is an evolving, interactive and dynamic process, with transformational potential.

Although there is minimal direct evidence for collaboration alone improving health care, the literature identifies a number of key enabling factors which increase the likelihood of collaboration facilitating improved outcomes for clients.

Specifically, better outcomes occur where there are structured guidelines and referral tools along with strategies for engaging specialists in professional education to improve referral practices (Grimshaw et al. 2006). A review of the coordinated primary health care and other sectors by Powell Davies et al (2006) further indicate that strategies to strengthen relationships and links between service providers assists collaborative practice. The report also recommends the development of tools that can be used by multiple providers and integrated into the care provided by different services. The examination of a 'cluster' model that fosters multidisciplinary collaboration between general practice and primary mental health services by Miller et al (2005) suggests increased client acceptance of referrals to primary mental health services and increased likelihood that the client would attend the service. Miller attributed this to the GPs' increased willingness to 'sell' the referral to the client and to better explain the role and function of the service.

Collaboration was also noted to be enhanced when paired with disorder specific treatment guidelines, and where systems are implemented to support broad based follow up extending beyond adherence to medication (Craven et al. 2006).

Collaborative practice itself is more likely to occur when built on existing networks and relationships, or where providers are co-located (Craven et al. 2006). However, while utilising existing networks increases the likelihood of collaborative success, a repeated theme in the literature is that an active strategy is required; collaboration does not 'just happen' (Craven et al. 2006; Barker et al. 2005). Leadership is a necessary and important factor in successful collaboration, and should occur in the policy context, the organisational context (Brown 2000; Robinson 2005;) and within individual teams (Craven et al. 2006). Effective support from local opinion leaders has been shown to support the implementation of evidence-based practice (Doumit 2006), while leadership within teams has been clearly linked to greater team effectiveness (West et al.1998). Leadership from professional associations may also support better practice in collaborative care (College of Family Physicians of Canada 2006).

3 Professional roles and responsibilities in collaborative care

3.1 Introduction

This chapter reports on health professionals' perceptions, knowledge and behaviours regarding their professional roles and responsibilities in collaborative care. Four main areas are covered. First, there is an exploration of the issues about professional perceptions of who plays important roles in client assessment, care planning and co-ordination, and the provision of psychological therapeutic interventions. This is followed by an investigation of who is providing Focused Psychological Strategies (FPS), as well as the frequency of use and the extent to which high and low prevalence disorders make up caseloads is reported. Finally, observation on the areas in which mental health professionals would like more information is noted.

3.1.1 Literature Review

Frequently mentioned in the literature are the cultural and attitudinal characteristics of different disciplines which impact on the way in which professions engage in the process of collaborative practice. Noted are the socialising influences during and after professional training that encourage a discipline specific view of 'their' clientele and the services they provide (D'Amour and Oandason 2005a; D'Amour and Oandason 2005b; Hall 2005, Fossey 2001; Robinson 2005). These factors influence professionals to see their relationship with a client as unique to their discipline (Jones 2006). The process of collaboration challenges these beliefs, and without local leadership and 'buy in' can exacerbate role delineation and 'boundary issues' tensions that may actually reinforce professional silos (Jones 2006).

Health professionals also operate in environments with organisational constraints that act as barriers to collaboration (Craven 2006). In this regard leadership is especially important to address policy and organisational issues that impact negatively on or constrain collaborative practice. A review of research into coordination of care by the Australian Primary Health Care Research Institute (2006) found that in general, interventions that provided systems and structural support were more likely to deliver better health outcomes.

Within the Australian context, one such constraint is the fee-for-service Medicare model, which has historically remunerated practitioners only for work undertaken directly with the patient. In recent years, the introduction of specific Medicare items to support collaborative practice in chronic disease, and now mental health, through the BOMHC program and Better Access initiative have provided remuneration for GPs and psychiatrists to work more collaboratively through case conferencing and supporting team care arrangements. Differential rebates for other participating professions (OTs, paediatricians, mental health nurses, social workers and psychologists), however, remain a problem. Similarly, perceptions of hierarchy among disciplines impede an ethos of equal partnership in working collaboratively with other professions.

In preparation for this study, MHPA collated a comprehensive explanation of the roles and responsibilities of each professional group both in a disciplinary context and in the context of mental health care. This is provided in Appendix C.

3.2 Key points

The following points reflect the key findings about the overall perception and role in collaborative care:

- It is widely agreed amongst the seven professional groups that GPs play a significant role in the stages of assessment/diagnosis, care planning and co-ordination but less so in the provision of psycho-education and the provision of FPS.
- There is a perception amongst the seven professional groups that mental health nurses play some role in assessment and diagnosis, care planning, provision of psycho-education, supporting co-ordination and compliance, and monitoring progress, but less of a role in the assessment and provision of FPS.
- There is a perception amongst the seven professional groups that OTs play less of role in any of the stages when compared with all of the seven professional groups.
- There is a perception amongst the seven professional groups that paediatricians play a role in assessment/diagnoses and to some extent in care planning, and less of a role in the provision of psycho-education, FPS, service co-ordination, supporting compliance, client monitoring or review.
- There is a perception amongst the seven professional groups that psychiatrists play a major role in all stages of assessment/diagnosis, care planning, provision of psycho-education, provision of FPS, supporting compliance and monitoring progress, but to a lesser extent that the GPs.
- There is a perception amongst the seven professional groups that clinical psychologists play a role in all stages of assessment/diagnosis, care planning, provision of psycho-education, provision of FPS, supporting compliance and monitoring progress, but play less of a role in co-ordination of other supports.
- There is a perception amongst the seven professional groups that psychologists, like the psychiatrists and clinical psychologists, play a major role in all stages of assessment/diagnosis, care planning, provision of psycho-education, provision of FPS, supporting compliance and monitoring progress, and to some degree they play less of a role in co-ordination of other supports.
- There is a perception amongst the seven professional groups that social workers mostly play a large role in co-ordination of supports, but much less of a role in the other areas.
- All seven professional groups reported that they felt they played a significant role in assessment/diagnosis, care planning, provision of psychological education, provision of FPS, co-ordination of supports, supporting compliance with treatment, as well as monitoring and review of a client's care plan. This is not evident in the results from the total analysis of the responses to this question.
- When clinical psychologists, psychologists, social workers, OTs and mental health nurses were asked what FPS they provided under Medicare, there was considerable variation between professional groups regarding what FPSs were used and by whom. All five professional groups used all the FPS provided under Medicare, but some used them more than others. The highest users of most of the FPS were clinical psychologists followed by psychologists. Social workers and OTs used about half of the FPS most of the time, and mental health nurses generally used the least.
- Allied health professionals used all the FPS provided under Medicare, but some used them more than others.
- The highest users of the FPS were clinical psychologists and followed by psychologists. Social workers and OTs used about half of the FPS most of the time, and mental health nurses generally used the least.
- The least used FPS for all groups was narrative therapy for Aboriginal and/or Torres Strait Islanders clients, followed by parent management training.

- As part of their private practice, over 80% of mental health professionals were treating clients for depression (86%), generalised anxiety (84%) or a mix of the two (83%).
- Several low prevalence disorders were also reasonably common in private practice caseloads, particularly bipolar disorder (56%), eating disorders (43%) and schizophrenia (38%).
- Most significantly over four in five mental health professionals (83%) identified at least one disorder/condition they would like to know more about.
- As part of their private practice, over 80% of mental health professionals were treating clients for depression (86%), generalised anxiety (84%) or a mix of the two (83%). The next most commonly treated conditions were panic disorder (74%), followed by post traumatic stress disorder (69%), adjustment disorder (66%), bereavement disorder (65%) and sleep problems (64%). All of these are classified in this study as 'high prevalence disorders'.
- Several 'low prevalence disorders' were also reasonably common in private practice caseloads, particularly bipolar disorder (56%), eating disorders (43%) and schizophrenia (38%).

Data from the cross tabulations indicated that:

- All seven professional groups felt that they played an important role in assessment/diagnosis, care planning, provision of psycho-education, provision of FPS, co-ordination of supports, supporting compliance with treatment, as well as monitoring and review of a client's care plan. These scores do not always correlate with the general total findings for some of the professional groups.
- All seven professional groups felt that GPs generally played an overall important role in assessment/diagnosis, care planning, co-ordination of supports, supporting compliance with treatment, and monitoring and review of care plans.

3.3 Discussion of findings

This section provides a discussion of the qualitative and quantitative data collected in relation to professional roles and responsibilities.

3.3.1 Care planning and co-ordination

Quantitative research findings

Participants in the on-line survey were asked which professional group/s they felt should play an 'important role' in this element of mental health assessment and care. They provided a variety of responses, but what was most significant was the 'ranking' of relative importance of roles related to the provision of mental health care.

The results of this question are illustrated in Table 5 below. These rankings indicate each profession's perception of the others' relative importance at certain stages of client care. Each professional group has been ranked from 1-8 according to the data, a ranking of 1 indicating a perception that the professional should play a 'most important' role through to a ranking of 8.

Table 5 - Ranking of seven mental health professional groups according to survey responses

	a) Assessment and diagnosis of a client's mental health	b)Care Planning	c) Provision of Psycho-education	d) Provision of Psychological Therapies and Focused Psychological Strategies (FPS)	e) Coordination of other supports	f) Supporting compliance with treatment	g) Progress monitoring and review of a client's mental health
GP	1	1	3	4	1	1	1
Mental health nurse	6	5	4	5	3	2	5
OT	8	8	7	7	7	8	8
Paediatrician	5	7	8	8	8	7	7
Psychologist	2	3	5	3	6	5	3
Clinical psychologist	3	2	1	1	5	3	2
Psychologist	4	4	2	2	4	4	4
Social worker	7	6	6	6	2	6	6

There was agreement that GPs, psychiatrists, clinical psychologists and psychologists play a significant role in all stages of assessment/diagnosis, care planning and coordination, and monitoring progress. Psychiatrists, clinical psychologists and psychologists were also perceived to play a role in the provision of psycho-education, FPS, and monitoring progress.

GPs, psychiatrists, clinical psychologists and psychologists are perceived to play a lesser role in the coordination of supports. Coordination of supports was thought to be mostly done by social workers.

Mental health nurses were thought to play some role in assessment and diagnosis, care planning, provision of psycho-education, support coordination, supporting compliance and monitoring progress, but less of a role in assessment and the provision of FPS. Similarly paediatricians do not play a role in the provision of FPS but do play a role in assessment/diagnosis. Paediatricians were thought to not play a significant role in the provision of psycho-education, service co-ordination, supporting compliance or monitoring or review.

It is difficult to determine whether this is an accurate reflection of the actual roles undertaken by the professional groups, or whether perceptions of the roles performed by other professions is informed by limited knowledge as to the particular expertise of the different professional groups. This is discussed further in the next section, taking into consideration the qualitative data.

Quantitative research findings

- All seven professional groups reported that they felt they played a significant role in assessment/diagnosis, care planning, provision of psycho-education, provision of FPS, co-ordination of supports, supporting compliance with treatment, as well as monitoring and review of a client's care plan. This is not evident in the results from the total analysis of the responses to this question.

As one social worker indicated "all professionals have different perspectives. Mental illness cuts across all professional barriers. It would be naïve to think that anyone could deal with it".

The central role of the GP was affirmed during the consultations. Their role was seen as central to care planning and referral, as they were considered to be the one professional to have an overall understanding of the clients' mental health needs. Clients and professionals all indicated their reliance on the GP:

> *It is important to work collaboratively with GPs as they have a good understanding of what is going on and any medication the patient is taking.*(Social worker)

It was noted that GPs are generally used to collaboration and multidisciplinary care as it is 'part of their core business'. However, many practitioners observed that they were more likely to collaborate with practitioners they knew or professionals within their own local network. Regular communication with the GP was considered very important by the majority of professionals consulted as they were generally the most consistent and regular provider of mental health care interventions, particularly in the Better Access initiative. Indeed, one OT stated that "the GP had become the de facto case manager and instigator of care planning and most of the referrals".

It was noted however that the knowledge of care planning and mental health assessment skills amongst GPs remains variable. Approximately 25% of GPs have been trained in mental health care planning under Better Outcomes (AGPN 2007).

Clients and carers are reliant on professionals for advice and guidance, particularly the GP, who can be the 'gateway' to referrals and service support. Clients and carers both reported that in their experience some GPs, psychiatrists and psychologists did not seem to understand the service system enough to be able to help clients and carers negotiate the system. Both carers and clients acknowledged that while the GP "cannot know everything", they did expect GPs to have some training in mental health and knowledge of the service system.

The qualitative data indicated that some of the professional groups believed they had a very clear understanding of their own roles and responsibilities in mental health. For example, a psychiatrist reported that:

> *I think GPs, paediatricians, and psychiatrists are the most appropriate to do psychiatric diagnosis, management planning and physical therapy (e.g. drug) interventions. Obviously these doctors should also be involved in monitoring progress, enhancing compliance and psycho-education. Many psychiatrists will have special skills in psychotherapies. Clinical psychologists, psychologists, mental health nurses, OTs, social workers and other clinicians (e.g. drug counsellors) are very important for non-physical therapy interventions (psychotherapies and other interventions), psycho-education, monitoring of compliance, and linking patients to other resources.*

However at other site visits this was not the case. For example there was a commonly held perception that OTs and social workers did not have a role in the provision of psychological interventions. During one site visit these perceptions were well summarised by a psychologist:

> *If there were Medicare items for them to do OT stuff instead of psychological interventions, they would use them, but there aren't. We need someone who is going to address those social worker issues– everyone's trying to do the same thing as us but they are not qualified to do what we do. Social workers should stick to social work… and we need Occupation Therapists doing occupational therapy.*

There is also an obvious delineation between the medical profession and allied health. The doctors saw their role as medical assessment, diagnosis, medication prescription and treatment planning. Psychiatrists and paediatricians indicated they generally become more involved in difficult or complex cases, or have ad hoc involvement for a 'one-off' assessment for the purpose of diagnosis or opinion. However, there was some acknowledgment that a number of GPs, like psychiatrists and some paediatricians, have skills in psychotherapy. Some GPs too have interest, skills and training in mental health assessment, and providing psychological interventions. GPs can and do manage very complex cases particularly in rural and remote regions where access to psychiatrists is difficult. However, some psychiatrists expressed concern about the role of psychologists in this initiative. One psychiatrist noted that "(psychologists) do not have a role in diagnosis", and "that in some regions GPs have stopped

referring to psychologists because of negative experiences and poor patient outcomes" (SA site teleconference).

It is apparent that there are knowledge gaps regarding an appreciation and understanding of the roles of OTs and social workers in this initiative, and in mental health care, both in the private and public sector. These gaps are predominantly among the medical professions and psychologists. Some GPs and GP practices are not clear on what role OTs and social workers play in mental health in terms of clinical assistance, and were reluctant to refer for this reason. This is an area that may need to be considered in the development of any training packages. Psychologists in particular believed that social workers and OTs did not always have a role in providing psychological therapies and interventions. Psychiatrists and paediatricians indicated that they would refer to OTs and social workers for interventions as needed. There is much variability among the professional groups as to how much value is placed on postgraduate experience and postgraduate education. During a site visit in Victoria, an OT stated that:

> *the way in which this new program has been funded, differentiating between the three allied mental health disciplines, encourages a focus on the professional background, rather than the clinical experience, specialist expertise and skill set … Choosing professionals for your patients based on a good match between therapist and patient, clinical expertise and skill set being key factors. Clearly all three disciplines have the academic qualifications and training to provide focused psychological strategies, so the focus is on accessing the right match for your patients.*

Several explanations were given for knowledge gaps regarding the roles of the professions within this initiative. First, that this was a new initiative and social workers and OTs were not used to working in the private system, and the size of the work force was relatively small, with significantly fewer practitioners in private practice. Secondly, it was also noted at the consultations that there were widely held stereotypes about the roles of social workers and OTs, this issue was mainly related to the association of the responsibilities of OTs and social workers with undergraduate training. However, the social workers and OTs were strongly of the view that the psycho-social paradigms and structural analysis of clients in their environment were critical to holistic mental health care.

Of interest too was that mental health nurses, OTs and social workers often stated that there was a blurring' between their roles and responsibilities, and that they often took on generic roles in mental health, for example, the role of a mental health worker or case manager. According to those interviewed, the role of the case manager in mental health has become a generic position with no requirement to be an OT, social worker or mental health nurse. Indeed, this has led to OTs and social workers not promoting themselves and their discipline. OTs and social workers reported that they saw their roles in mental health as much more than their undergraduate training, that is, they did not see their roles as very different from psychologist in that they also provided and receive a Medicare rebate for FPS under the Better Access initiative, and there is no rebate for other services that an OT or social worker may traditionally provide.

The role of the clients and their carers/family in collaborative care

The involvement of the client and carer is critical to effective collaborative care. During the consultations carers reported that they often need to be able to speak with a GP but feel ignored and dismissed. Clearly the involvement of the client in care planning is vital - they have to agree to have a mental health care plan completed, and their agreement to ongoing treatment and other therapeutic interventions is reliant on the skills and capabilities of the professionals involved. The importance of building trust in the therapeutic relationship was raised by both clients and their carers during the consultations. Some carers found they need help with day-to-day care, like assisting with medication, taking clients to appointments and so on, and without this assistance the care plan would fail. However, some carers had discovered that they were not included in the care planning process, and often vital information, like changes to medication, were not passed onto the carer. This raises some concerns about health professionals training and knowledge of privacy legislation.

Client participation has been associated with improvements in the quality of health care and improved health outcomes. The Department of Health and Ageing National Mental Health Strategy emphasises the role of the client in training of mental health workers to improve outcomes (see http://www.health.gov.au/internet/wcms/publishing.nsf/Content/A6A9123C4FA8E49FCA257230001F3C41/$File/safety.pdf). Any training provided by the MPHA will have to actively include input from clients of mental health services and their supports, particularly regarding effective communication skills with clients and their family/carers. Also, the development of any models of collaborative care must include the client in order to be successful.

There are some excellent resources already available regarding the role of clients and carers in participating in the development of training packages, and providing input regarding the client perspective on collaborative care approaches. The National Resource Centre for Client Participation in Health has produced some very helpful fact sheets (see for example http://www.participateinhealth.org.au/Clearinghouse/Docs/nrcfactsheetkeyresourcesmay02.doc)**.**

3.3.2 Allied health clinical boundaries and scope of clinical practice

Quantitative research data

Clinical psychologists, psychologists, social workers, OTs and mental health nurses were asked what FPS they provided under Medicare. There was considerable variation between professional groups regarding what was used and by whom.

- All five professional groups used all the FPS provided under Medicare, but some used them more than others.
- The highest users of most of the FPS were clinical psychologists followed by psychologists. Social workers and OTs used about half of the FPS most of the time, and mental health nurses generally used the least.
- The least used FPS for all groups was narrative therapy for Aboriginal and/or Torres Strait Islanders clients, followed by parent management training.
- Clinical psychologists indicated that the five most utilised FPS were: cognitive behavioural therapy, psycho-education, relaxation strategies, stress management and cognitive therapy.
- Psychologists also most often used cognitive behavioural therapy, followed by psycho-education, relaxation, and stress management.
- Social workers indicated that they mostly used interpersonal therapy and psycho-education, followed equally by stress management and cognitive behavioural therapy. Social workers were the only professional group that used interpersonal therapy significantly more than the other professions.
- OTs mostly used stress management, social skills training, skills training, relaxation strategies, psycho-education, activity scheduling, and problem solving skills. There was generally an equal distribution regarding the use of these FPS by OTs.
- Generally, mental health nurses mostly used stress management, psycho-education, relaxation strategies and problem solving skills.

Table 6 below provides a complete breakdown of which FPS are used by each of the professional groups identified.

Table 6 - Focused Psychological Strategies (FPS) provided under Medicare (selected professional groups only) (D1)

Multiple responses allowed	Clinical psychologists	Registered psychologists	Social workers	Occupational therapists	Mental health nurses*
Raw n=	419	754	250	48	21**
Activity scheduling	73%	61%	34%	69%	43%
Anger management	74%	78%	69%	42%	48%
Behaviour modification	73%	70%	42%	33%	48%
Cognitive interventions	83%	76%	60%	56%	52%
Cognitive therapy	82%	73%	52%	35%	33%
Cognitive-behavioural Therapy	96%	94%	77%	54%	62%
Communication training	67%	70%	71%	50%	52%
Controlled breathing	79%	75%	57%	56%	52%
Exposure techniques	73%	51%	30%	25%	29%
Interpersonal Therapy (especially for depression)	50%	64%	81%	33%	43%
Narrative therapy for Aboriginal and/or Torres Strait Islander people	2%	6%	13%	4%	5%
Parent management training	44%	51%	53%	33%	38%
Problem solving skills and training	81%	84%	78%	71%	62%
Progressive muscle relaxation	65%	71%	46%	58%	29%
Psycho-education (including motivational interviewing)	90%	89%	82%	71%	71%
Relaxation strategies	85%	89%	72%	71%	62%
Skills training	70%	70%	52%	79%	38%
Social skills training	59%	68%	58%	69%	33%
Stress management	81%	88%	77%	73%	76%

Qualitative research findings

> *There is a lot of misunderstanding of other professions – particularly the 'allied health' professions, especially from doctors. OTs are excellent across all areas and Doctors don't understand that…There are some professional groups that understand mental health better than others and therefore groups that understand why communication is beneficial. Those who understand mental health also understand that the role of helping people shop and cook and have friends is every bit as important as addressing voices in your head.*(Client agency*)*

During consultations with clients and carers, the issues around holistic care and interventions were raised. They also indicated that sometimes clinical intervention was not always a priority for them. For example, a representative from a client agency stated that:

> *If someone can get an appropriate treatment package that addresses their unique life and circumstances, sometimes you don't need a clinical component of care – community support may be more appropriate for some people at different times.* (Client agency)

Mental illness affects all the functions of daily living which in turn affect mental health, providing supports in these areas enhances health care.

Social workers, OTs, mental health nurses and psychologists all expressed the view that they provide holistic care, as well as psychological therapeutic interventions. One OT in particular expressed a view that they "are evidence based specialists in assessing and treating the functional implications of health problems from a developmental and holistic perspective".

Clients of the mental health system have varying needs and some cases are more complex than others. In the case of more complex clients, a person may be accessing support from many different types of professionals and services. During the site visits and in the interviews, professionals frequently commented on the fact that they need to know much more detail about the larger service system, and particularly "who was doing what".

It is apparent that GPs refer among themselves and to clinical psychologists and psychologists. Not coincidentally, these disciplines are easily recognised as specific to mental health from their qualifications and from their visibility in the mental health sector. They further share congruence with GPs in the use of clinical frameworks and language. Other allied health, OTs, social workers and mental health nurses are less understood by their qualifications and particularly in the detail of what they do and are more defined by post graduate qualifications and experience in mental health. In a general sense they are identified as more holistic than clinical.

In part, the misunderstanding of the 'non-clinical' professions highlighted in the consultations, might provide an explanation for referral patterns. That referrals from GPs are weighted in favour of clinical practitioners, even when clients thought they would have benefited from a referral to an OT, social worker or mental health nurse, may be due to a greater confidence in GPs knowledge of the roles of those professions over the more 'holistic' or less obviously 'clinical' professions.

Clinical psychologists and psychologists are also more aligned with private models of health, having had a longer and more established history in the provision of private health care, and have developed a stronger profile in the mental health sector.

While not definitive, a greater understanding of the holistic/clinical divide might illuminate pathways to successful collaborative care. Information, education and training for health professionals will also need to address the psychosocial and economic/cultural determinants of health and how other providers can assist in overcoming these barriers, often within the community, not just in the clinical setting.

Many professions commented that they had little experience with the MHNIP or with mental health nurses. Most were interested in gaining a greater understanding of the scheme and of the role of mental health nurses.

GPs and psychiatrists thought that the skills, expertise and unique placement of mental health nurses (i.e. home visits) were a valuable contribution to improved mental health care, however complained that they are difficult to access and there is a shortage of mental health nurses.

Clinical and registered psychologists expressed concern that mental health nurses were under-qualified to provide psychological interventions.

OTs and social workers were unable to comment extensively about their experience with MHNIP because they had had little contact with them. Both professions reported an interest in gaining more knowledge of the role of mental health nurses and an enthusiasm for working collaboratively with mental health nurses.

Mental health nurses themselves commented that their role provided flexibility for people experiencing mental health issues and that people could access mental health support while avoiding any social stigmas that may otherwise be a barrier to seeking help. As one mental health nurse indicated during consultations:

> *Patients are willing to discuss their problems in detail and are reassured that the nurse will visit at home if or when necessary. It is early days but it is encouraging clients also have the option of meeting a mental health nurse in the GPs surgery thus avoiding stigma*.

They further commented that there is a lack of understanding of the role of mental health nurses by some professions and they felt undervalued and disrespected by some members of different professions.

3.3.3 Scope of mental health disorders treated

Quantitative research findings

This section covers the research about which frequently high and low prevalence disorders were managed in private practice.

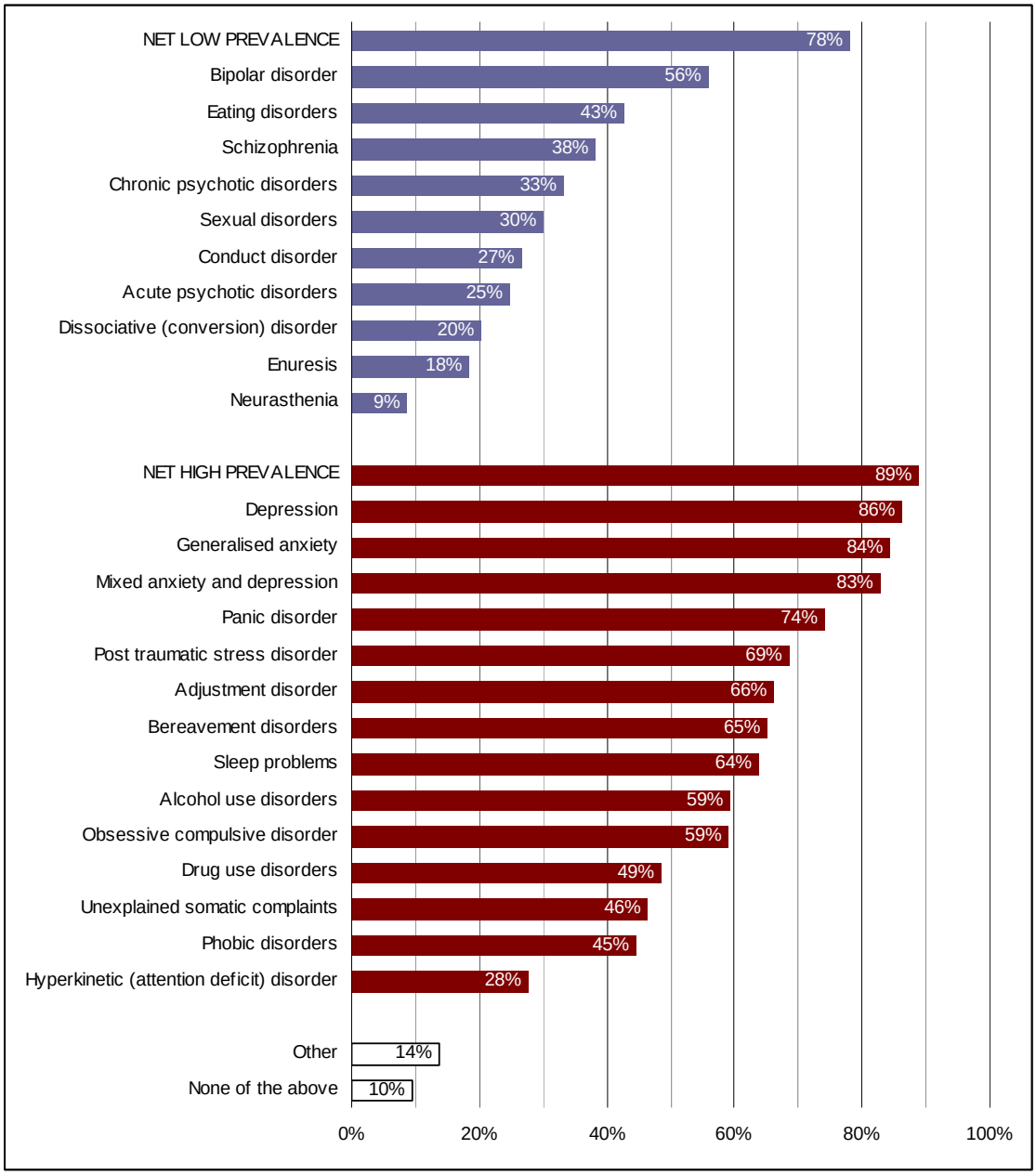
As part of their private practice, over 80% of mental health professionals were treating clients for depression (86%), generalised anxiety (84%) or a mix of the two (83%). The next most commonly treated conditions were panic disorder (74%), followed by post traumatic stress disorder (69%), adjustment disorder (66%), bereavement disorder (65%) and sleep problems (64%). All of these are classified in this study as 'high prevalence disorders'.

Several 'low prevalence disorders' were also reasonably common in private practice caseloads, particularly bipolar disorder (56%), eating disorders (43%) and schizophrenia (38%).

Even the least commonly treated disorder (neurasthenia) was cited by 9% of mental health professionals as being on their private practice case list. This is represented in Figure 2 below.

Figure 2 - Disorders/conditions represented in private practice client base (D2a)

n=2264 (multiple responses allowed, except for 'none of the above')



* Other disorders/conditions treated include Autism Spectrum Disorder, Asperger's disorder, personality disorders, abuse (e.g. childhood sexual abuse, domestic violence), pain management, dementia, gambling addiction, learning disorders, Pervasive Developmental Disorders, post natal depression

3.3.4 Diverse communities

Some of the professionals consulted had skills and expertise in managing clients from Culturally and Linguistically Different Backgrounds (CALD) and Aboriginal and/or Torres Strait Islanders background and communities. This naturally adds even greater complexity to mental health care.

Aboriginal and/or Torres Strait Islanders

Having access to such professionals and providing high quality mental health care for Aboriginal and/or Torres Strait Islanders clients was difficult and it was the opinion of the professionals consulted that mainstreaming "just does not work" because:

> *You can't put someone [mental health professional] in here and expect people to come straight away, there has to be a build up in trust first. You can be here for months and only have one patient, but if they see you here all the time they start to trust that you are going to stick with it.* (NSW site visit)

Aboriginal and/or Torres Strait Islander services employing Aboriginal workers was considered a critical success factor as well as liaising closely with the local Aboriginal Health Service and community.

There are also other psychological services that provide support for Aboriginal and/or Torres Strait Islander peoples. These include Aboriginal Community Controlled Health Services (ACCHS) and Aboriginal Mental Health Services. There are support services located within each ACCHS that have been developed to provide primary care and support for: aged care, child and family services, drug and alcohol services, counselling, domestic violence, education and training. Within these services there are also services that specifically meet the psychological support needs of members of the Stolen Generations. These include Link-Up services, Bringing Them Home (BTH) programs, and Social and Emotional Well Being Centres (SEWB).

Link-Ups were created in response to community demand for reunion services. Link-Ups aim to provide a State wide service including tracing, reunion, case management, general counselling and public education services. Link-Up works with clients over the age of eighteen who have been removed from their families and have confirmed their Aboriginal or Torres Strait Islander heritage. Link-Up is predominantly focused on reunion services. They also provide some education, some family history tracing and general counselling. The BTH Program provides counsellors within ACCHS for Stolen Generations members. To access services within the ACCHS people need to have their Aboriginality confirmed, although this is not a requirement of the BTH program. Counsellors, or BTH Workers as they are also called, respond to the needs of a broad range of Stolen Generations clients and those affected by separation practices. Historically these services have operated closely with the local community and within regions, and have developed different practices and approaches in dealing with the needs of the Stolen Generations and their community.

The main purposes of SEWB are: to provide professional support, including to BTH Counsellors and Link-Up workers; delivering training to support workers; developing appropriate cross-sector linkages and interagency cooperation; and maintaining information systems to clarify the level of need in the region.

Unfortunately, it was noted during the consultations that services for Aboriginal and/or Torres Strait Islander clients were reported to be under-resourced and in high demand, whilst mainstream services remain under-utilised.

While assumptions should not be made that all Aboriginal and/or Torres Strait Islander clients will want to see Indigenous service providers or practitioners, the links between the specific and the mainstream systems are critical. Indigenous people often have complex and different needs over time, and prefer to use services at their discretion, at their own pace. They have to negotiate the pathways in and out of a complex system, and back and forth between services. Specialised mental health services and mainstream agencies do not always offer a co-ordinated system, which places particular importance on the role of professionals as advocates in negotiating access.

Culturally and Linguistically Different backgrounds

Equally, clients from diverse and different cultural backgrounds can present practitioners with many challenges. Access to bilingual professionals or people that have particular expertise in managing clients from diverse backgrounds was reported by practitioners in this research to be difficult. In some regions the local GP division have reportedly developed resources for local GPs regarding mental health workers in the area, highlighting professionals with expertise in CALD communities.

In order to address collaborative care in mental health for Aboriginal and/or Torres Strait Islander and CALD clients, the MHPA will need to consider working closely with both local communities, services and regional centres when providing training to mental health professionals and developing models of collaborative care and practice.

4 Enablers and barriers for collaboration and delivery of collaborative care

4.1 Introduction

This chapter provides an analysis of the qualitative and quantitative data collected concerning mental health professionals' perceptions, knowledge and behaviours regarding enablers and barriers for collaborative care. The quantitative data collected regarding collaborative care was extensive, and this is obviously an area that interests all of the mental health professional groups. There were several themes that emerged as well as information regarding barriers and enablers for collaboration and the delivery of collaborative care. Three main areas are covered. First, there is an exploration of the issues about the triggers for initiating communication with other mental health professionals. This is followed by an investigation of some of the key barriers for multidisciplinary care. The chapter closes with a review of the enablers for collaborative care and networking.

4.1.1 Overview

The literature points to a number of common barriers to collaborative practice. Robinson (2005) suggests that these barriers can be characterised by the 'Five Ps'; people, professional cultures, policies, politics and practicalities. This conceptualisation generally agrees with the description provided by the National Institute of Clinical Studies (2005) of the types of barriers that impede implementation of evidence based practice more generally, but which also specifically identifies a sixth domain – the client. Most authors agree that collaboration is most effective with the appropriate engagement of the client, who is after all the focus of collaborative efforts in the health care context; while some suggest an explicit role for some clients in delegated care coordination (D'Amour 2005b). Significantly, perceptions, attitudinal differences and a lack of understanding between different professions are frequently cited as impeding barriers to collaborative care.

Factors that have been identified as key to overcoming the various barriers to collaborative practice are: interdisciplinary education, leadership and quality frameworks.

Interdisciplinary education is highlighted as a strategy to address barriers between professions. Fielding et al (2002) argue (in the context of primary mental health services) that sound professional development processes carried out collaboratively created joint ownership of processes that were likely to become part of service culture. Other authors have noted that collaborative education exercises can be productive in developing shared understandings and a common language (Stone 2007), a feature of most models of collaboration. Fossey (2001) and Bailey (2002) argue that carefully planned joint education that establishes a common agenda for training may lead to more integrated approaches to care.

Leadership has been an emerging theme within discussions of collaboration. Baron, Earhard and Ozier (1995) suggest leadership is not easily defined even though it is something people easily recognise. The authors attempt to conceptualise leadership as a process through which an essential member (or members) of a group influence other group members by encouraging shared goals, values and practices. Much of the literature is vague about leadership within a collaborative framework but consistently acknowledges distinctions between clinical leadership and other types of leadership. In many cases, general practitioners are the most appropriate team managers in an interdisciplinary context, but this does not necessarily usurp the role of other practitioners as clinical leaders. It is generally advocated that interdisciplinary teams have a coordinator and this role is commonly filled by a mental health nurse. However, Glasby and Lester (2004) suggest that there is support in the literature for the partnerships to have a 'power broker' (often a consultant psychiatrist) to facilitate greater collaboration in the local area. These arrangements can however be vulnerable to a departure of key practitioners thus impacting on continuity.

Quality (in general practice terms) operates within a business environment. The cultural milieu, education, training and aspirations of GPs and a highly regulated marketplace is representative of the general practice environment (Booth et al. 2005). Runciman defined quality in health care as "the extent to which a healthcare service or product produces a desired outcome or outcomes" (2006, p. 42). Extending the definition further, Leatherman and McCarthy (2002) described quality as a multifaceted concept that is best understood by multiple stakeholder interpretations - stating that GPs view quality in a 'technical' way by checking that accurate diagnoses were made, surgical procedures were done competently and the patient's health status has improved (Leatherman and McCarthy 2002).

Quality in healthcare can also be understood in terms of errors, or the 'risk' of errors (Booth et al. 2005). Both quality assurance and risk management are required in general practice (Nisselle 2004). Risk management in general practice is achieved by designing and implementing programs or procedures that identify, avoid, or minimise risks and liabilities (Runciman 2006). The implementation of risk management strategies implies that all the various components of practice governance are managed more effectively (Nisselle 2004).

Previous research (Donabedian 1988, 1989) acknowledging the need for GPs to provide care of the highest possible quality, identified three factors:

(1) structures (material resources, facilities, equipment and the range of services at the practice level that reflect quality standards)

(2) processes (what is done in giving and receiving best care)

(3) outcomes (the effects of the care provided on the health status of the patient and the community). Ferlie and Shortell (2001) took an independent look at the quality strategies in the United Kingdom and the United States and argued that the quality strategies in both countries will fail to realise their potential unless the policy advisors and GPs consider and implement additional comprehensive, multi-level approaches to change. The researchers argued that most efforts to date have relied on narrow, single level programmatic change strategies, which have been largely unsuccessful.

Therefore initiatives to improve quality should proceed at each of the following four levels:

(1) GP

(2) group or team working for the GP

(3) organisation

(4) system.

The researchers also identified organisational dimensions or 'domains' (leadership, culture, team development, and information technology), which they see as playing a crucial role in the management of quality general practice (Ferlie and Shortell, 2001)[1]. Similarly, Makkela, Booth and Roberts (2001) proposed a 'framework' to help design activities that enhance quality. GPs, general practices, local or regional areas and national or public policies were each identified in the framework as levels for 'quality improvement'. A quality framework is a tool that facilitates the systematic analysis of the clinical setting (in this case general practice) in terms of the quality of care, current status, activities for enhancement, barriers to achievement and initiatives for future improvement (Booth et al. 2005).

[1] For example, see the Smoking Nutrition Alcohol and Physical framework (SNAP) for general practice produced by RACGP, available at http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-about-gp-index.htm

4.2 Key points

The following points reflect the key findings regarding the enablers and barriers for collaboration and the delivery of collaborative care. Although there are clinical networks and evidence of collaborative practice currently in place, there were some key enablers and barriers identified during the research.

- The most significant trigger for initiating communication with another mental health professional was the complexity of client need (82%). The next three most commonly cited triggers were personal knowledge of other practitioners who had skills in managing the client issues (65%), previous experience with other professionals (64%), and client difficulty (60%).
- Major barriers for collaboration were: low availability of specialised services, costs of access to services, and low availability of general mental health services. Factors that were considered to be least of a barrier relative to the other options were: co-location, poor understanding of professional roles, lack of agreed protocols and lack of confidence in other care providers.
- The following issues were reported to have created tension between mental health professionals: the parity of Medicare rebates, the exclusion of mental health nurses, and the perceptions that OTs and social workers were not valued for their knowledge and skills in the therapeutic management of clients with a mental illness. These factors were considered a barrier or disincentive to the delivery of collaborative care.
- Competition created by private practice was considered to be a barrier to collaboration.
- Generally, brokerage services were considered to be established in primary care and made multidisciplinary care possible.
- The positive enabling effects of interdisciplinary knowledge of each others' professional roles and supported networking activities knowledge were considered the top two enablers for collaboration.
- Client and carer co-operation in care planning was considered to be a critical enabling factor. The service system requires the user to be: mobile (that is, has a car, and able to easily travel); have enough disposable income to meet gap payments for private services; and have, in this context 'mental health literacy'.[2]

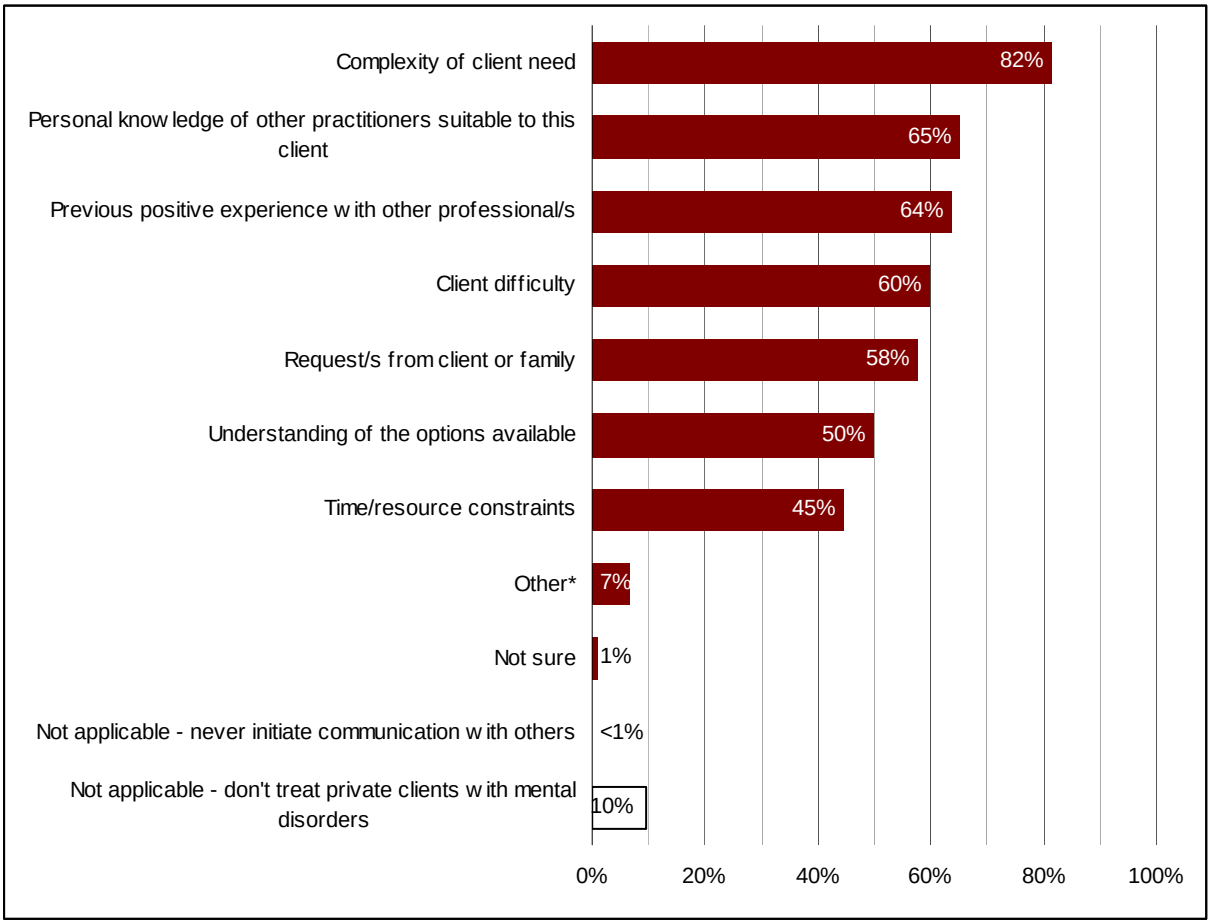
4.3 Discussion of findings

The following is a discussion of the qualitative and quantitative research findings.

Survey respondents were asked what they considered were the most common triggers for initiating communication with other mental health professionals in their treatment of clients with a mental illness. The most frequently reported trigger was the complexity of client need (82%). The next three most commonly cited triggers were personal knowledge of other practitioners who had skills in managing the client issues (65%), previous experience with other professionals (64%), and client difficulty (60%). Of least relevance relative to the others were time constraints (45%) This is represented in the graph in Figure 3 below.

[2] Mental health literacy refers to knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking (Jorm et al. 1997 p.166).

Figure 3 - Common triggers for initiating communication with other health professionals when treating private clients with mental disorders (F1) *(n=2,264)*



* 'Other' triggers included: worsening symptoms, risk issues (particularly suicidally), need for medication, anticipation that this client will 'fall between' services, need for treatment/expertise/support other than that which the respondents can provide (e.g. hospital care, employment support), relating to professional supervision/support, when required by Medicare (eg 6 and 12 session up-date report), to get a second opinion.

Respondents from different professions varied in terms of their level of contact with private clients. For example, over 50% of mental health nurses stated that they do not treat private clients with mental disorders, whereas the vast majority of GPs (99.3%) do. Notwithstanding, there were no notable differences in the triggers for practitioners from each profession that do see private clients with mental disorders. Similarly, there were no notable differences in the triggers for professionals who work in a lone, uni-disciplinary or multidisciplinary work setting.

Respondents located in different geographic areas report that particular triggers are common to a similar extent, with the exception of those located in remote areas. Notably fewer respondents located in remote areas commonly initiate communication with another health professional due to; personal knowledge of other practitioners suitable to a client, a previous positive experience with other professional/s, or their understanding of the options available. In contrast, a larger proportion of respondents located in remote areas commonly initiate contact with other health professionals due to time/resource constraints (see Table 7 overleaf). This result is not surprising given the relative isolation and lack of resources experienced by health professionals in remote areas.

Table 7 - Reponses to “When treating private clients with Mental Disorders, what are the common ‘triggers’ for you to initiate communication with another health professional” by geographical area.

Multiple responses allowed	Capital City	Other Major Metropolitan Centre	Regional Centre	Rural or Regional Area	Remote Area	Total*
Raw n=	1337	255	362	285	25	2264
Complexity of client need	84%	76%	81%	80%	74%	82%
Client difficulty	62%	55%	59%	59%	62%	60%
Time/resource constraints	43%	40%	44%	50%	60%	45%
Understanding of the options available	52%	50%	41%	54%	38%	50%
Personal knowledge of other practitioners suitable to this client	68%	58%	62%	67%	44%	65%
Previous positive experience with other professional/s	66%	57%	61%	67%	46%	64%
Request/s from client or family	60%	56%	55%	57%	45%	58%
Other (specify below)	7%	6%	7%	7%	11%	7%
Not sure	1%	2%	0%	2%	2%	1%
Not applicable - I never initiate communication with others	0%	1%	0%	0%	0%	0%
Not applicable - I don't treat private clients with mental disorders	9%	12%	11%	10%	13%	10%
WTD. RESP.	1227	259	380	339	59	2264

Percentages based on weighted responses

From the consultations, professionals indicated that they saw a variety of clients with mental health disorders. GPs indicated that the role of the psychiatrist was as a key practitioner they referred to when they encountered a complex client, even if it was for a single consultation for advice and opinion. The relationship between the medical professionals and allied health professionals was considered to be very important - especially when there were complicated social issues that were affecting a client’s treatment. Although the issues around perceived roles and responsibilities indicated that the professionals involved did relate to their knowledge of professional roles. A psychiatrist stated that, “(my) work involves considerable collaboration with GPs, other psychiatrists, nurses, and psychologists, but not so much with OTs or social workers”.

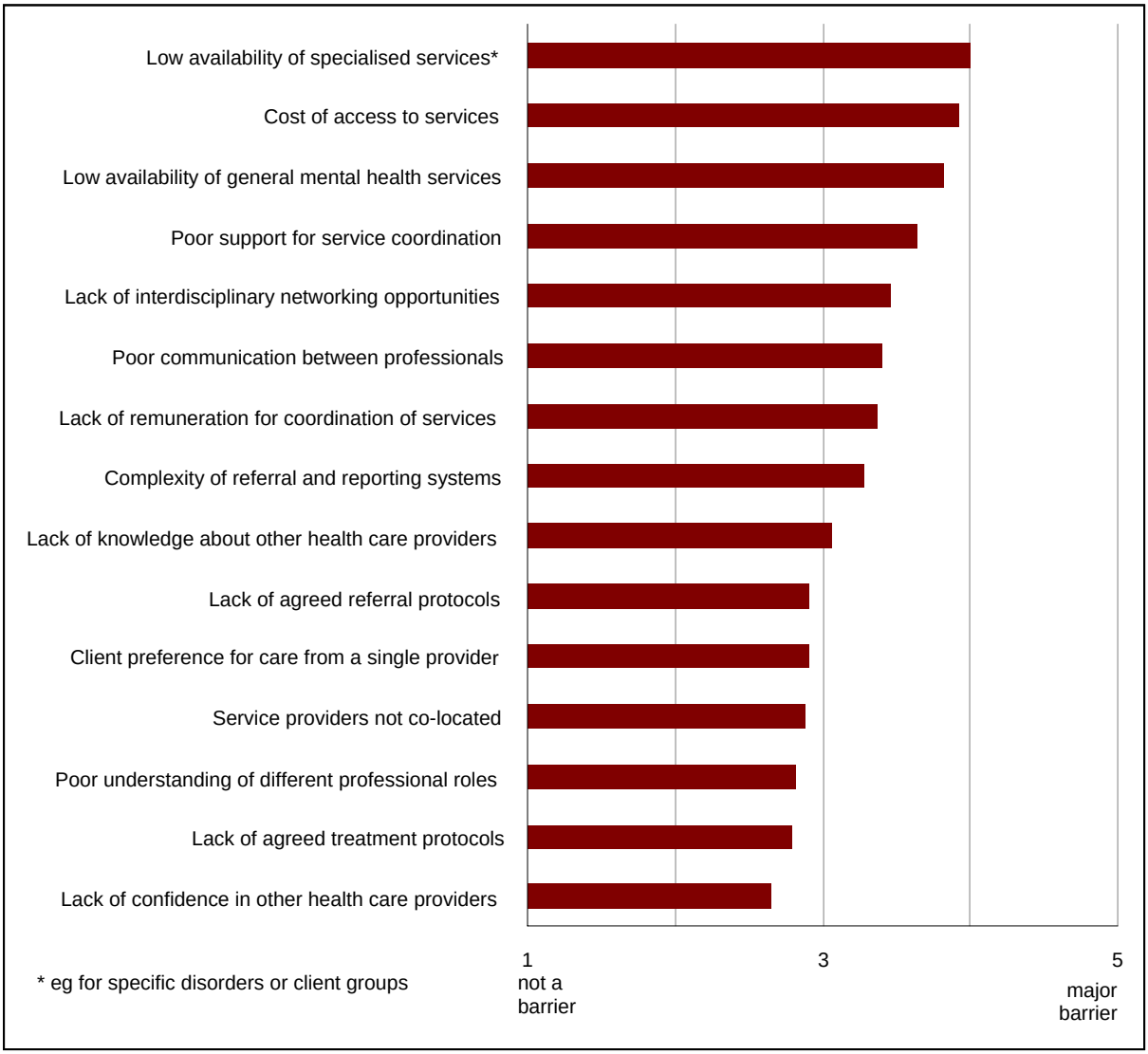
Clients and carers stated that they were often proactive at seeking referrals to see psychiatrists and psychologists. However, there was a wide spread belief that ‘finding the right one’ was a significant challenge. This was a particular issue regarding referral to psychologists, as GPs indicated they were not always aware of what a psychologist’s particular specialty might be, and this could lead to problems for the client. As one carer pointed out “you have to see a person you can get on with and who can help you. Clients with a mental illness are often wary of seeing other professionals and telling their story again and again - they get put off and will not go back”.

4.4 Barriers

4.4.1 Quantitative research findings

Respondents to the survey were given a range of possible barriers to interdisciplinary care. The most major barriers were: low availability of specialised services, cost of access to services, and low availability of general mental health services. Factors that were considered to be least of a barrier relative to the other options were co-location, poor understanding of professional roles, lack of agreed protocols and lack of confidence in other care providers. This information is displayed in the Figure 4 below.

Figure 4 - Barriers that impede effective multidisciplinary care in cases where this would be of significant clinical benefit (F2) (*Mean scores across full weighted sample; excludes 'not sure' responses)*

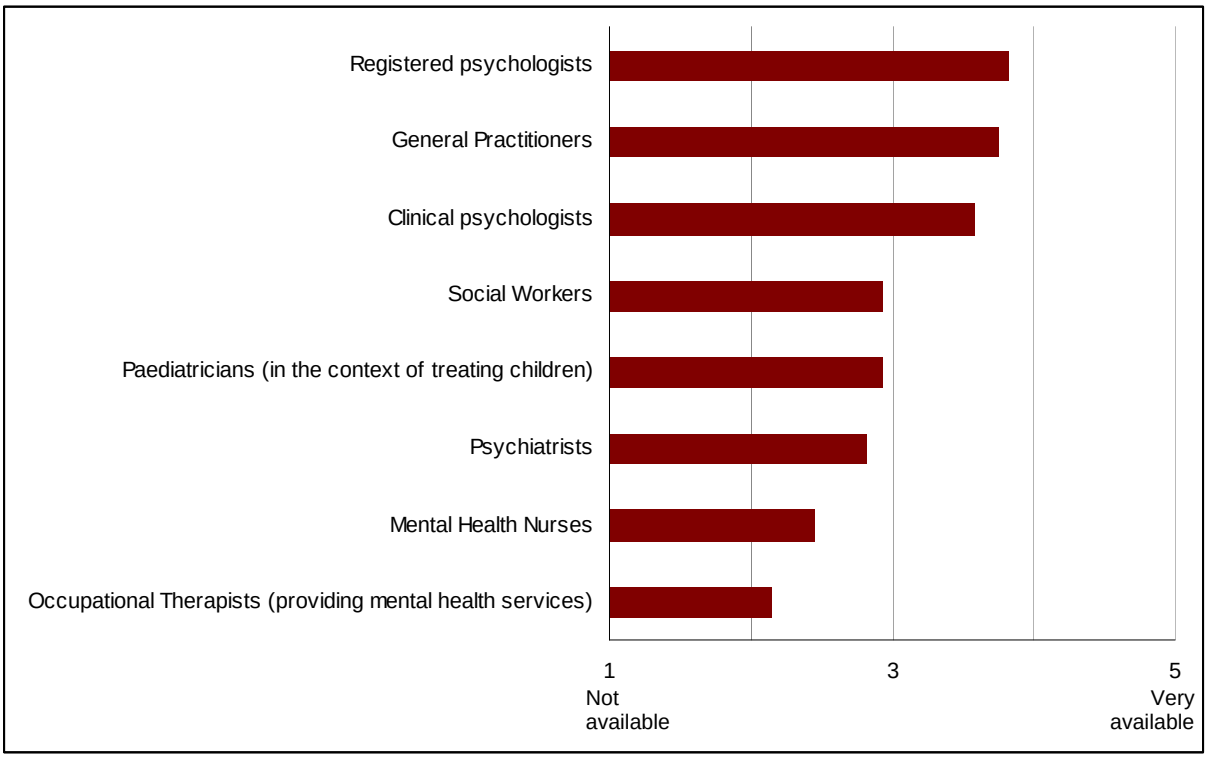


Overcoming some of these barriers will represent a challenge to the MHPA, particularly the availability and cost of services. However, support for service coordination, facilitating networking opportunities, assisting with communication, improving practitioners' knowledge of the service system, and providing information on the respective roles of mental health professionals, could be addressed through the provision of training and resources by the MHPA. The MHPA will also have to ensure that there is

close collaboration with clients of mental health services, their carers or families as well as mental health advocacy groups.

Respondents to the on-line survey were asked about their perceptions and knowledge regarding the availability of professionals and the provision of multidisciplinary care. Figure 5 indicates that on average psychologists, GPs, and clinical psychologists were considered mostly available but that other allied health professional were not, and OTs were considered to be the least available overall.

Figure 5 - Availability of the professionals in the local region for provision of multidisciplinary mental health care (F6)



4.4.2 Qualitative research findings

From the consultations, very similar issues were raised regarding the barriers of cost and access. However, there was a difference regarding issues raised about the importance of trust and relationships in collaboration. This was also raised in the previous section regarding 'positive professional experiences' as being a trigger for collaboration between practitioners regarding management of complex clients.

Other barriers were raised and discussed in the consultations that were significant and unexpected. These were related to the provision of private practice in mental health, as well as clinical role delineation. A lack of understanding and respect for other disciplines, communication problems across disciplines, and the 'discriminatory' nature of the different levels of remuneration were all cited in open text responses as significant barriers. The absence of services to refer to clients with specific cultural needs or in relation to specific disorders (e.g. eating disorders) was also raised, along with constraints on the length of sessions, and difficulty accessing training about the complex (end of) care.

Cost to the client

> *The people with less access to services are those with ongoing mental health problems who aren't financially resourced – the model doesn't benefit the truly disadvantaged people – the gap is prohibitive.* (Client agency)

The issues surrounding costs for services came up many times in consultations with clients and carers. With the reported shortage of 'bulk billing' GPs, clients with a mental illness have to find extra money for even basic support from their GP. Having to find extra money to meet the costs of private psychologists as well was considered too much. Some clients stated that they "just prefer to see a GP – due to the costs".

As in the quantitative data, cost was considered one of the main barriers to collaborative care. The cost issues that were raised covered two main areas: costs to the client, that is, the client being able and willing to meet the 'gap' payment for private services from different providers; and the costs that were incurred by practitioners because of lack of remuneration for coordination of services.

Many clients and carers talked about the gap being prohibitive to their access to health care quoting between $20 and $100 as costs they have to bear themselves after the Medicare rebate. While the rebate for FPS is $75 for a 50+ minute consultation, the Australian Psychological Society recommends a fee of $192 for a 45 – 60 minute session. Clients generally agreed that they had not found a psychologist who charged the rebate fee only, and all clients said the fees were unaffordable. Clients also thought that as finding a practitioner appropriate for their needs was difficult, "shopping around" is an expensive process with limited guarantee of value for money.

Access

Even though the quantitative data indicated that professionals thought that psychologists, GPs and clinical psychologists were, on average, available for the provision of multidisciplinary care, the majority of professionals consulted stated that access to and availability of mental health professionals in private practice was difficult and a hindrance to inter-disciplinary work and care planning, especially for specialist services like child psychiatrists.

Furthermore, as one professional noted:

> *There is a poor understanding regarding the Medicare Items. One downside is - as a public paediatrician, I cannot refer to private psychiatrists. Instead the patient has to go back to their GP and may not get a referral. This means the opportunity for early intervention is lost.* (Paediatrician)

The two main reasons given for limited access were: first, that they are unfamiliar with the system; and second that they too were often very busy. Some practitioners reported that it can be difficult to have a telephone consultation. This was also compounded by the opinion that public mental health services were difficult to access and had long waiting lists. In rural and remote areas there was reportedly a wait of nearly twelve months to see a psychiatrist. Access issues were also noted by all of the clients and carers consulted.

A further issue frequently raised in the open text responses were concerns that services are not reaching chronically ill and disadvantaged people, with the reason cited being practitioners opting to see the 'worried well' rather than people with significant and chronic illness.

A mental health nurse raised the issue of an increased role of mental health nurses to address this shortage:

> *There are a number people waiting for services - when there are nurses that are equally as competent and able to achieve the same outcomes as psychologists and psychiatrist. This avenue should be explored as, at the end of the day, clients are waiting and waiting for service and eventually may not pursue treatments, and may then end up in crisis mode. If nurses work in an interventionist model and are able to respond, this could prevent the need for more intensive services.*

Clinical role delineation

> *Role delineations could be a barrier to collaborative care, and professionals can't get past the historical associations and stereotypes regarding the roles of OTs, social workers and mental health nurses, as well as the roles of psychologists and medical professions.* (Site visit Victoria)

While there were mixed responses from the survey data regarding knowledge of other health professionals as a barrier to multidisciplinary care, this was not the case with the qualitative data as previously discussed. As previously noted in the first section of this report, generally there is limited understanding of the specific roles that OTs and social workers have in regard to the Better Access initiative. Mental health nurses, OTs and social workers involved in consultations indicated a perception that a relative value was placed on their undergraduate training by the medical professionals and psychologists that did not take into account allied health professionals' postgraduate experience and education. As well as this issue, allied health professions all raised concerns about the tensions that had been created by the lack of parity regarding Medicare rebates for FPS, especially between psychologists and clinical psychologists as well as OTs and social workers. Mental health nurses stated they feel excluded from Better Access initiative. The separation of the mental health nurses was also reported to create further tension.

These various tensions were considered a barrier and a disincentive to the delivery of collaborative care.

In addition, the use of language in Better Access initiative information noted the distinction made between psychologists and "other allied health professionals". This differentiation, albeit unintentional, had created a perception in the minds of some OTs and social workers that their contribution to Better Access was less important, and was poorly promoted. The initiative seeks to promote increased interdisciplinary care and coordination of support services to the benefit of the client, however these interdisciplinary tensions could pose a significant barrier.

As noted in the above quote from the paediatrician, the referral system itself creates a barrier to professionals being proactive.

Relationships, trust and confidence

> *Collaborative care in rural and remote areas is very important, but equally very frustrating. This means it's harder to find a suitable allied health professional to care for people with mental illness. Doctors and other allied health professionals working in rural and remote areas need experience. Care planning is very different in rural and remote areas, especially when there are limited numbers of mental health professionals. In effect, GPs do most of the care planning, and actually act as case managers. This means that referrals to allied health professionals and psychiatrists have to be done carefully. Referral practice has worked best when the GP knows, trusts, and has a pre-existing relationship with that professional.* (SA site teleconference)

Interestingly, the consultations revealed a slightly different perspective of professionals regarding confidence in other practitioners' skills. In fact, the majority of the discussions indicated that practitioners had a definite preference for referral to other practitioners they knew and trusted, that is, they had confidence in those practitioners' skills.

Mostly these relationships had appeared to develop organically, for example, in one GP practice in Melbourne, there is a crossover between the private and the public sector. The GP has a good relationship with the (local) Area Mental Health Service, and is inclined to contact them for advice, especially when it comes to referrals to psychologist and psychiatrists. They will also have regular clinical meetings at the surgery/practice with the Area Mental Health workers. Others relied on 'word of mouth' information, or flexible working relationships.

In rural and remote areas practitioners indicated that:

> *Relationships and trust between colleagues is very important, especially when some of the specialist only fly in six times a year. In these cases informal networking works best, but it also has to suit peoples' working style, and some people prefer more formal and rigid structures. The informal networking has been an organic process and probably is due to distances.* (SA site teleconference)

Private practice

> *This system has created competition in some professionals' minds, particularly allied health.* (SA site teleconference)

Other professionals identified the essentially competitive nature of private practice and the added impact of allied health providers' formally entering private practice under Better Access:

> *…in the city there can be an absence of cooperation because of 'turf wars' and the private model doesn't make for good collaboration because it's a profit driven individual professional approach.* (Client agency)

It was also acknowledged that collaboration in private practice was more difficult than in the public sector, and that mostly collaboration was ad hoc and informal in nature. There were various reasons given for this, including lack of facilities, level of activity, access, travel and costs. Whilst there was some written communication, most collaboration takes place over the telephone or in e-mails, but this relied on people having time and the inclination. As one psychiatrist pointed out, 'you can't have collaboration when you are the only one wanting to do it'.

The relationships between mental health professionals do not appear to come easily, particularly for professionals working in private practice. Practitioners stated that these relationships take time and a willingness of 'all parties to come to the consultation table' (mental health nurse), and it is much harder to work collaboratively, as private practice is by nature competitive. One service that was consulted summarised the issues:

> *Apart from these internal collaborative working relationships, the service has created many external collaborative working relationships, particularly with the local GP divisions. They have worked hard to build relationships with local GPs to explain the service and to describe to them the benefits that they may be able to provide for their patients. This has been a long-standing relationship and predates Better Access. Most of the referrals come from GPs or from word-of-mouth. It takes time to build and continue these relationships, and most networks are established primarily because one individual has been proactive and had the initiative.* (Victorian site visit)

4.4.3 GP Psych Support Line

'GP Psych Support' is a service providing access to advice for GPs from psychiatrists regarding mental health care. The GP Psych Support program is funded by the Australian Government as part of the Better Outcomes in Mental Health Care program. This service is available 24 hours a day, 7 days a week to GPs. It is not intended for emergency situations or clients assessed as high risk. Enquires can be made either over the phone or via email (see https://www.psychsupport.com.au/default_home.asp).

During consultations GPs were asked about their use, awareness and impression of this program. All those consulted were aware of the program, but the use was variable. The GPs that had used the service commented that it was helpful, and that it could be more useful for less experienced GPs. Most GPs stated that they prefer to know the person/professional they are seeking advice from. For example, one GP working in remote areas of South Australia noted that they would only contact a psychiatrist that they knew for advice, especially when there was advice needed about Aboriginal and/or Torres Strait Islander clients, stating that GPs 'prefer to speak to people that they know, and have confidence in the skills and capabilities of that professional'. Another GP working in a metropolitan region preferred to contact the psychiatrist at the local area mental health service, whom they knew, and was able to get advice straight away. For less urgent cases they would refer the client to a psychiatrist for an opinion, in order to get a more comprehensive assessment and recommendations. Some GPs noted that a limitation of the program was the up to 24 hour delay in getting a response. GPs that had used the service indicated that they preferred to speak with a psychiatrist rather than use email, but that they could not choose who they could speak with, whereas on line requests for information could be directed to a choice of three psychiatrists.

Generally the impression from the consultations was that GPs were ambivalent about the GP Psych Support program, and, as previously noted, were more inclined to seek advice from psychiatrists with whom they have a relationship.

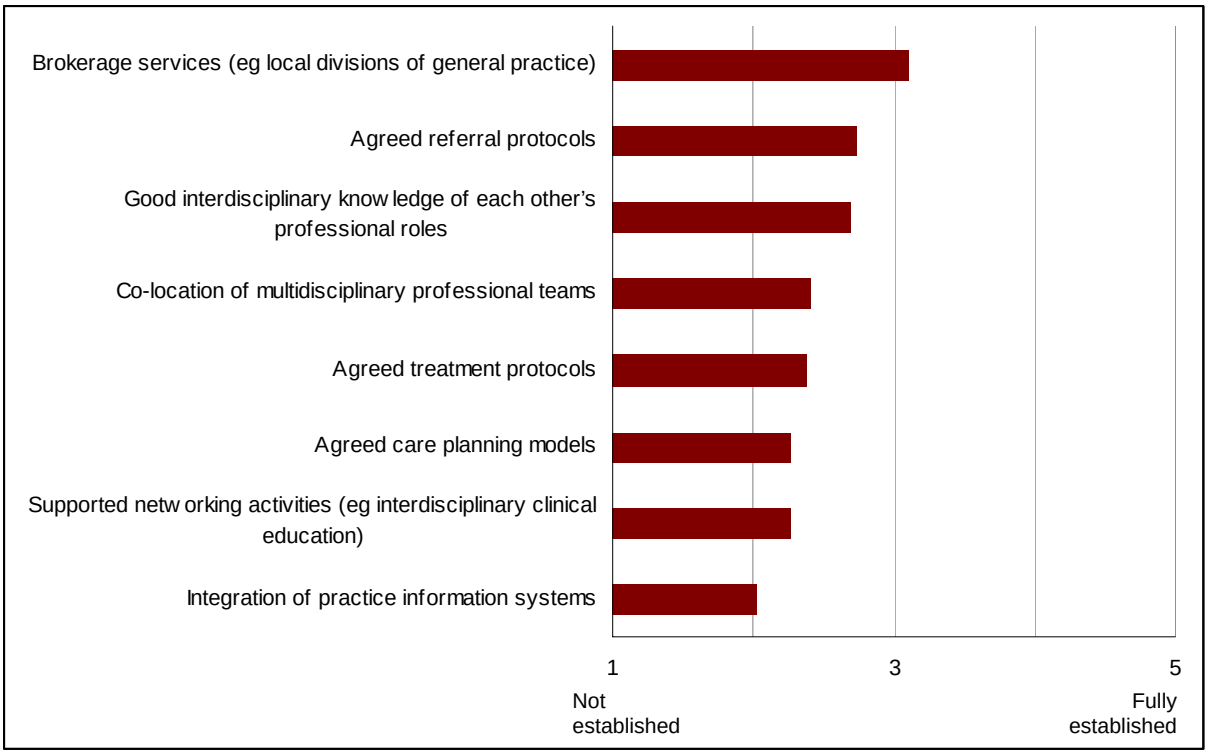
4.5 Enablers

Understanding the barriers to collaboration is, of course, critical to the success of the Better Access initiative. Equally important, however, is to understand the arrangements already in place which enable collaborative care to be delivered. This section provides a discussion of the data that was collected regarding enablers for collaboration and the delivery of collaborative care.

4.5.1 Quantitative research findings

The survey listed a number of enabling factors and asked respondents to rank each factor in terms of the extent to which it was 'established' in their local area. Refer to Figure 6 below.

Figure 6 - Current establishment of enabling factors that can make effective multidisciplinary care possible or easier in the local region (F4a)
(Mean scores across full weighted sample; excludes 'not sure' responses)

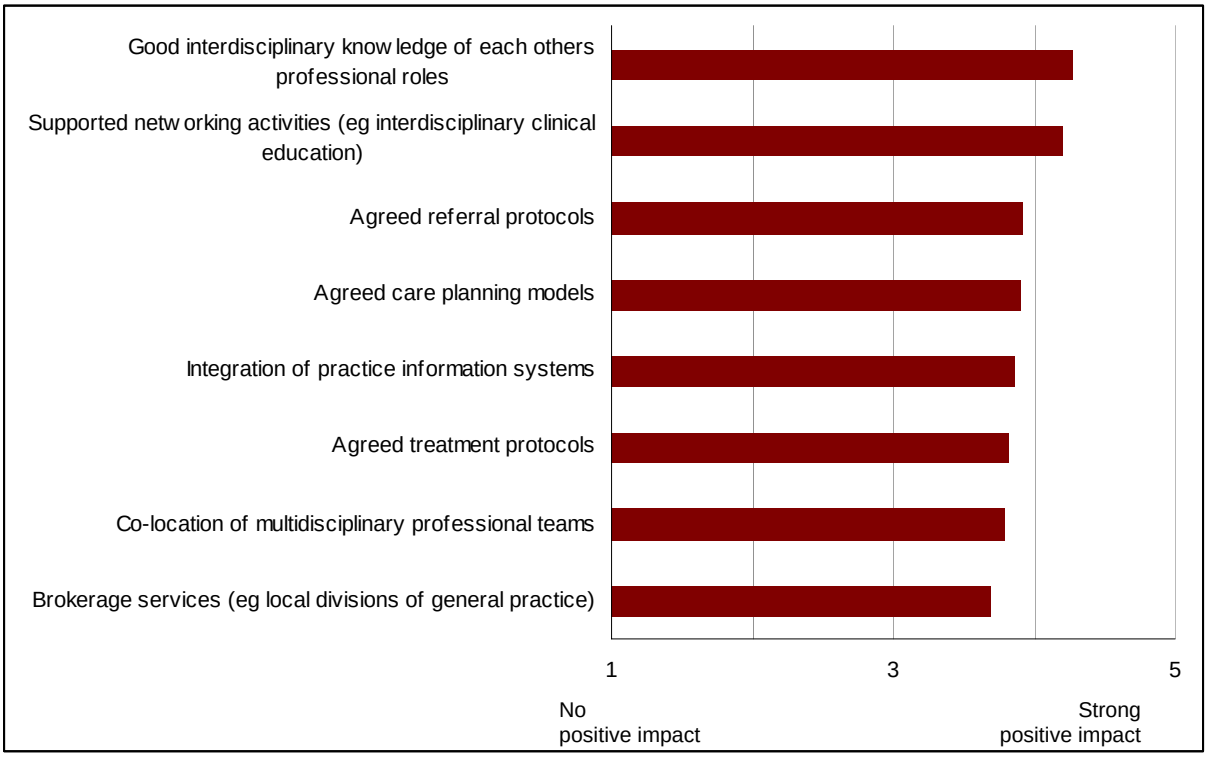


It is interesting to note that most of the factors put forward in this question were generally considered to have a positive enabling effect on increasing and enhancing collaborative care. The top two factors, however, were good interdisciplinary knowledge of each others' professional roles and supported networking activities. Other factors were considered to have almost equal impact on enabling collaborative care. Figure 7 below provides a representation of this data.

When asked to identify other factors that would make a major positive impact on effective and appropriate multidisciplinary health care (F5), a major theme that emerged in the open text responses was the time and resource costs associated with establishing cross disciplinary links and maintaining interdisciplinary communication for client care. Respondents supported the introduction of a system in which they would be remunerated for this. A number of respondents also commented that they did not feel co-location was necessary to achieve effective multidisciplinary care. Rather, they felt that skills in

networking and communication were more important than working in close proximity. Others suggested that perceptions of a hierarchy in skills and expertise between different professions may be a barrier to effective multidisciplinary work as it discourages a sense of respect and trust between clinicians. Breaking down this perception of hierarchy through creating opportunities for clinicians to develop understanding of various professional approaches could encourage more effective work across disciplines. As a final point, a number of respondents noted that standardised paperwork, including standard referral forms, would assist interdisciplinary communication.

Figure 7 - Potential positive impact of enhancing or introducing things that are not (fully) established in your region on facilitating effective and appropriate multidisciplinary mental health care. (F4b) *(Mean scores across valid sample; excludes 'not sure' responses and those who already have this fully established in their area)*



4.5.2 Qualitative research findings

Consultations revealed that practitioners who had worked in public health were very familiar with the concepts of collaborative care, multidisciplinary care and clinical networks. The translation of collaborative care into private practice appeared to present practitioners with some challenges. Lack of opportunities to network was also noted, as within the survey data, as a barrier to collaborative care.

A psychiatrist noted that:

> *… people have to be willing to listen and appreciate what each of the professions can bring to the situation or problem. People all have unique knowledge based on their experiences, especially knowledge of the service systems and, importantly, how to access them.* (SA site teleconference)

There were other key enablers for collaboration and the delivery of collaborative care raised during the consultations. These are listed below, and fall into operational and attitudinal issues:

Operational enablers

- Medicare Item 291– has assisted to some degree according to the consultations, however, this was reported as being variable and not everyone can claim this
- Respect for the knowledge each professional has to offer
- Co-location or close proximity of service providers
- Medicare Access funding for all professionals involved with collaboration and interdisciplinary care
- Effective communication – including electronic communication through e-mail and on-line case conferencing facilities. While this was argued to assist with interdisciplinary care, many professionals note that many would not receive remuneration for this
- A consistent system for assessment and referral
- Willingness of client to consent to care planning and the involvement of other professionals
- A central location for resources and information about 'who is out there and what they can do for my client
- Promotion of local networks and the development of local resources
- Tip sheets, tests, questionnaires, or a document / template that legitimises the collaborative care model.

Attitudinal Enablers

- Working closely with the GP
- Having enough time
- Knowledge of roles and what professionals can offer
- Willingness and accessibility of professionals involved.

Support for carers as a key enabler of collaboration

Carers reported that they would benefit from increased support from GPs, especially as the stress of caring can also affect their mental and physical health needs. One carer disclosed that "there was a time when I was looking after three people unwell in my family. I found myself driving down the wrong side of the road… I kept it a secret because I know that if I went down, there would be no-one to look after my family". There was a strong view that if carers do not receive the support they need, they may be become clients of the mental health system themselves.

The service system requires the client to be: mobile (that is, has a car, and able to easily travel); have enough disposable income to meet gap payments for private services; and have, in this context 'mental health literacy'. Each of these requirements can translate into burdens for the client and their supports.

The importance of involvement of the client and their carer, and even family, in collaboration was also raised many times during discussions, including any support services they may be accessing, like other medical specialists (not related to mental health), case managers, and Centrelink (for example, return to work support services). It was pointed out that the degree of involvement of these parties may vary over time. The connection between a client's mental and physical health was highlighted, and that they had to be treated as a 'whole person'. Again the importance of knowing and understanding professionals' background, skills and expertise was highlighted. Practitioners wanted to involve the professionals that will be able to assist most appropriately.

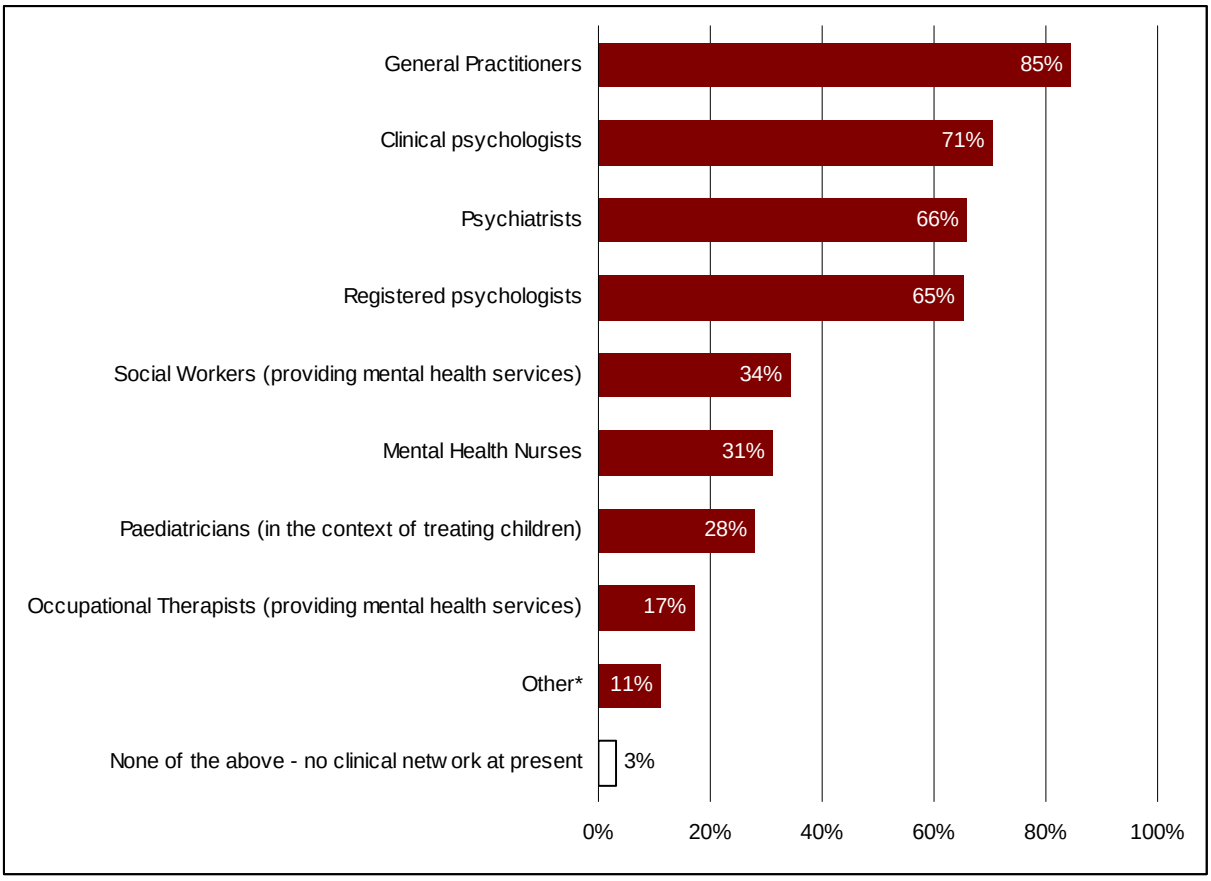
4.6 Clinical networks

Survey respondents were asked 'which disciplines are part of your current formal or informal clinical networks' – defined as a group of two or more mental health professionals who may possess different skills, who work collaboratively in the provision and coordination of mental health care in a particular clinical case.

Almost all respondents (97%) said they currently had a clinical network. As seen in Figure 8 below:

- five out of six mental health professionals (85%) had a GP in their clinical network
- approximately two in three had a clinical psychologist (71%), psychiatrist (66%) or psychologist (65%) in their network
- approximately one in three had a social worker (34%), mental health nurse (31%) or paediatrician (28%) in their clinical network
- fewer than one in five had an OT (17%) in their clinical network.

Figure 8 - Disciplines that are part of your current formal or informal clinical networks (G1)
(n=2,264, multiple responses allowed apart from 'none of the above')



* Other disciplines included Aboriginal health workers, drug and alcohol specialists, case managers, child care workers, counsellors, dieticians, gynaecologists, medical specialists, naturopaths, massage therapists, physiotherapists, psychotherapists, school counsellors, speech therapists/pathologists, teachers, and youth workers.

Table 8 - Responses to 'Which disciplines are part of your current formal or informal clinical networks?' by profession

	GP	Clinical psychologist	Psychiatrist	Psychologist	Social worker	Mental health nurse	Paediatrician	OT	Total*
Raw N	267	420	224	761	252	254	36	50	2264
GPs	90%	91%	87%	90%	77%	63%	53%	60%	85%
Clinical psychologist	82%	87%	85%	58%	56%	65%	89%	52%	71%
Psychiatrists	70%	71%	86%	52%	49%	82%	67%	72%	66%
Psychologist	62%	60%	42%	85%	54%	39%	31%	20%	65%
Social workers (providing mental health services)	26%	25%	34%	26%	80%	68%	50%	38%	34%
Mental health nurses	29%	13%	40%	12%	21%	88%	6%	44%	31%
Paediatricians (in the context of treating children)	40%	24%	17%	21%	14%	9%	92%	20%	28%
OTs (providing mental health services)	10%	13%	21%	10%	11%	48%	22%	66%	17%
Other (specify)	11%	10%	13%	11%	12%	13%	11%	10%	11%
None of the above - I have no formal or informal clinical network at present	3%	1%	4%	2%	6%	5%	6%	10%	3%
WTD. RESP.	878	70	77	801	25	358	50	5	2264

*Percentage calculated based on weighted responses

There was substantial variation across respondents working in different disciplines regarding the range of disciplines within their current clinical network (see Table 8 above). For example, only 31% of paediatricians that responded to the survey have psychologists in their clinical networks, compared with a weighted average of 65% for all respondents. An interesting observation, although perhaps not particularly surprising, is that respondents are more likely to have within their current clinical network, persons from their professional background as opposed to persons from other backgrounds. This trend is particularly obvious within professions that feature less frequently in professional networks overall, such as OTs.

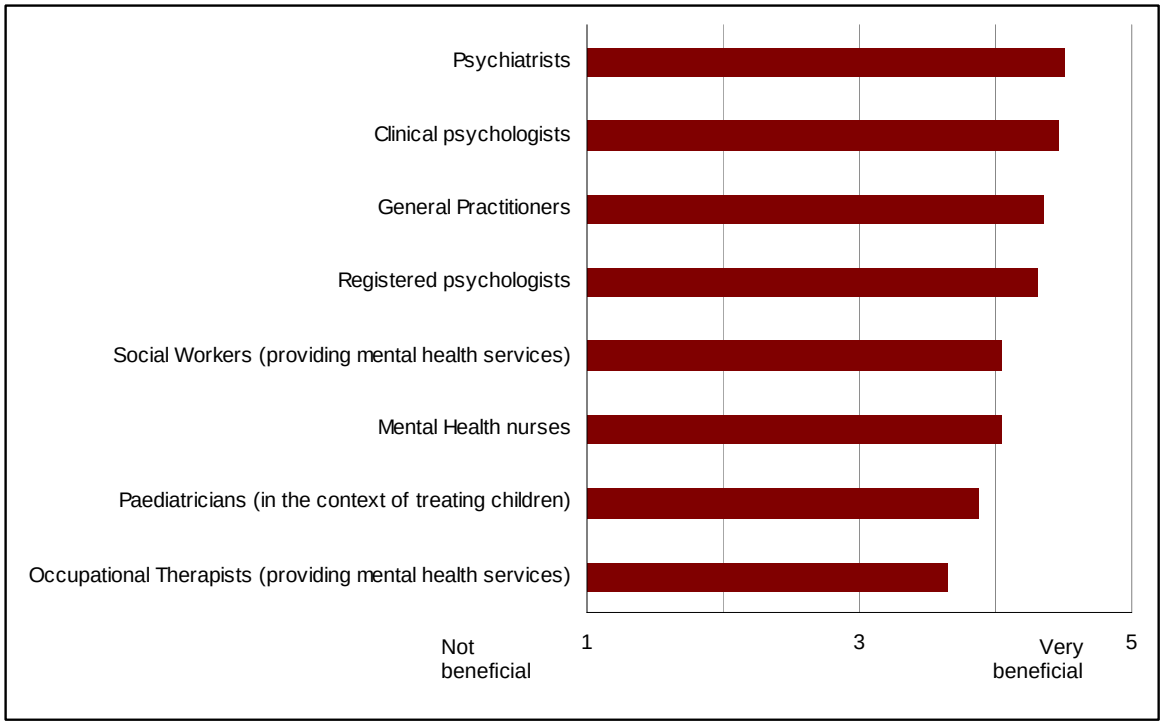
Variation between respondents in different geographical areas in terms of the inclusion of certain disciplines in a respondent's clinical network is not as wide as is the case between professions. However, it is worth noting that respondents from remote areas were less likely to have psychologists in their network than the weighted average (46% compared with 65%) and more likely to have a mental health nurse in their network (49% compared with 31%).

Professionals working in a lone, uni-disciplinary or multidisciplinary work setting had a similar clinical network profile, or rather, were most likely to have GPs in their network, followed by clinical psychologists and so on. However, overall, those operating in a lone practice were slightly less likely to have a particular discipline in their network.

Survey respondents were also asked how beneficial they thought it would be to have clinical networking activities with different professions. As Figure 9 below shows (see Appendix B, Table G2 for further details):

- Each profession listed was seen as being beneficial to network with.
- The greatest benefit was seen to be derived from clinical networking with psychiatrists and clinical psychologists, followed by GPs and psychologists.
- Compared with other professional groups, there was less perceived benefit from clinical networking with OTs or paediatricians.

Figure 9 - Perceived benefit from clinical networking activities with different professions (G2a) *(Mean scores across full weighted sample; excludes 'not sure' responses)*



When the data is sorted by profession, it is clear that, in the main, respondents working in each profession consider that it is highly beneficial to network with members of their own profession, and in most cases more beneficial than with those in working in other disciplines. All professional groups were subject to this bias, with the exception of GPs (see Table 9 below).

Table 9 - Mean scores by profession for responses to 'How beneficial would you find clinical networking activities with the following professions?'

	General Practitioner	Mental Health Nurse	Occupational Therapist	Paediatrician	Psychiatrist	Clinical Psychologist	Registered Psychologist	Social Worker	Total*
Raw N	267	254	50	36	224	420	761	252	2264
General Practitioner	4	4.5	4.5	3.9	4.3	4.6	4.7	4.6	4.3
Mental Health nurses	3.9	4.7	4.2	3.8	3.6	3.5	3.9	4.1	4
Occupational Therapists (providing mental health services)	3.6	4	4.7	3.6	3.2	3.2	3.5	3.9	3.7
Paediatricians (in the context of treating children)	3.9	3.7	3.8	4.4	3.1	3.7	3.9	4	3.9
Psychiatrists	4.4	4.7	4.6	4.6	4.4	4.6	4.5	4.5	4.5
Clinical psychologists	4.5	4.5	4.4	4.7	4.2	4.7	4.5	4.2	4.5
Registered psychologists	4.3	4.1	3.9	4.1	3.5	4.1	4.6	4.2	4.3
Social Workers (providing mental health services)	4	4.4	4.4	4	3.6	3.7	4	4.6	4

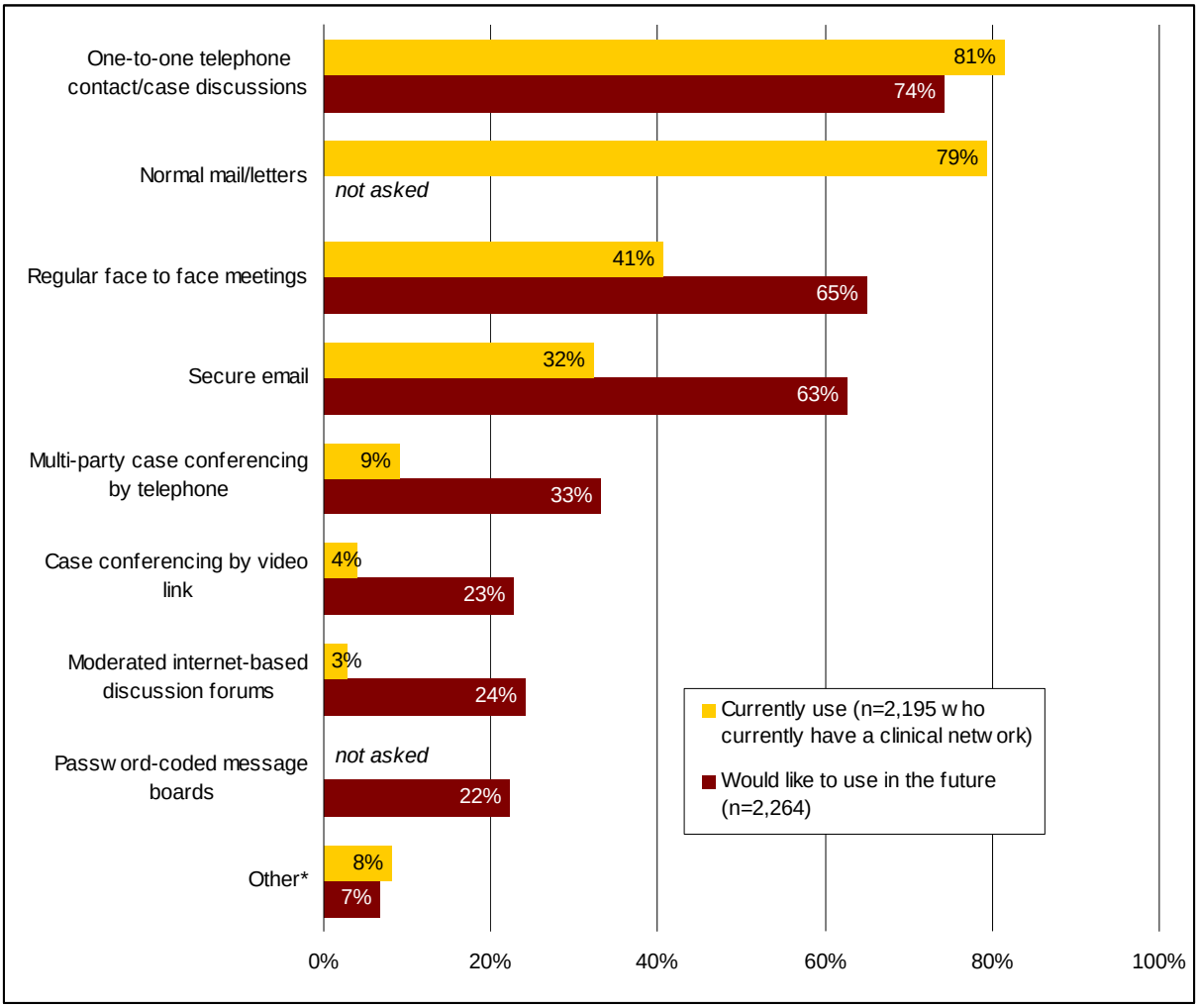
*Means calculated based on weighted responses

There were no notable differences in the benefit attributed to networking with particular disciplines by respondents located in different geographical locations or in different work settings.

Survey respondents were asked how they currently communicated in their clinical networks, and how they would like to communicate in the future. As Figure 10 overleaf shows:

- The two main communication methods currently used were one-to-one telephone conversations (81%) and print mail (79%).
- Other common communication methods included regular face to face meetings (41%) and secure email (32%).
- It was reasonably rare to see multi-party case conferencing (9%), videoconferencing (4%) or moderate internet-based discussion forums (3%).
- Of the communication modes offered for future clinical networking, one-to-one telephone conversations were still the most popular (74%). However, the idea of regular face-to-face meetings (65%) and secure e-mail (63%) were not far behind.
- There was interest in web-based options from one-quarter of respondents, e.g. password-coded message boards (22%), or moderated internet-based discussion forums (24%).

Figure 10 - Means of communication currently used in clinical networks (G3) and preferred for future use in clinical networking (G4)



* Other current means of communication included fax, occasional/irregular face to face meetings, referrals letters and in supervision meetings

* Other preferred means of communication for the future included traditional paper mail.

There was some variation between professions regarding the use of the different means of communication (see Table 10 below). For example, a much higher proportion of mental health nurses and OTs use regular face-to-face meetings, and mental health nurses are the only profession where a notable proportion of respondents make use of case conferencing by video link.

The proportion of respondents who used each different means of communicating was varied by geographic area. A smaller proportion of respondents located in remote areas use regular face-to-face meetings (33%) than the weighted average (40.5%). However, a higher proportion of respondents located in remote areas make use of multi-party case conferencing by telephone (22.3%) and case conferencing by video link (10.9%) than the weighted average (8.9% and 3.9% respectively).

No notable variation was evident between respondents working in lone, uni-disciplinary or multidisciplinary work settings.

Table 10 - Means of communication currently used in clinical networks (G3) by profession

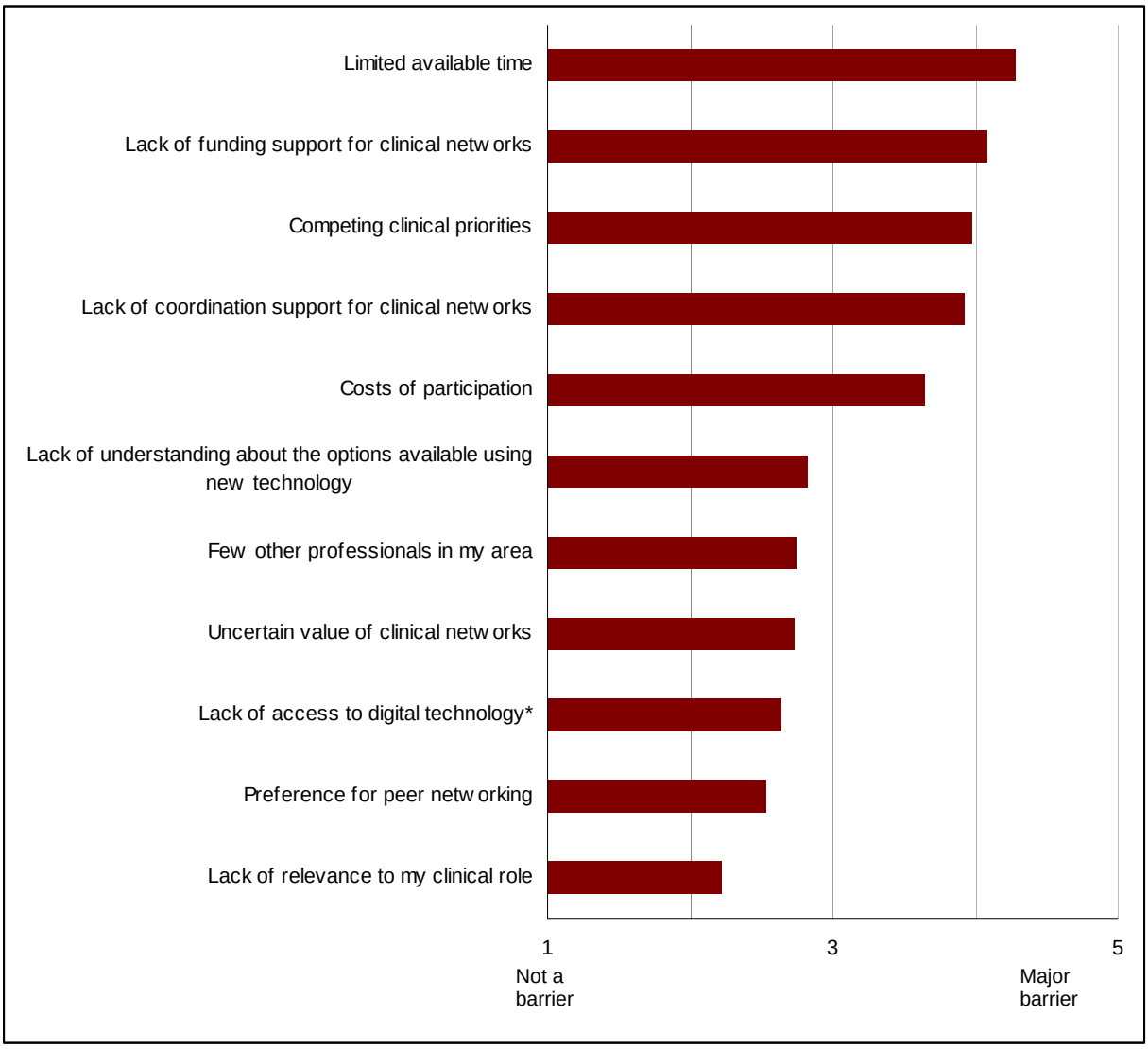
Multiple responses allowed	Total	General Practitioner	Mental Health Nurse	Occupational Therapist	Paediatrician	Psychiatrist	Clinical Psychologist	Registered Psychologist	Social Worker
Raw n=	2195	258	241	45	34	216	416	749	236
One-to-one telephone contact/case discussions	81%	71%	90%	84%	91%	95%	88%	87%	91%
Normal mail/letters	79%	87%	56%	73%	88%	90%	85%	79%	70%
Regular face to face meetings	41%	21%	77%	64%	47%	46%	45%	45%	50%
Secure email	32%	17%	58%	53%	41%	29%	35%	37%	34%
Multi-party case conferencing by telephone	9%	5%	23%	13%	15%	8%	8%	7%	7%
Other (please specify)	8%	10%	5%	7%	9%	8%	6%	8%	11%
Case conferencing by video link	4%	1%	20%	4%	0%	1%	1%	1%	3%
Moderated internet-based discussion forums	3%	2%	6%	7%	6%	2%	1%	2%	4%
WTD. RESP.	2195	849	339	4	47	74	70	789	23

Survey respondents were shown a list of barriers that can impede effective clinical networking and asked how significant each barrier is for them. As Figure 11 below shows (see Appendix B, Table G5 for further details):

- The two main barriers were seen to be time and money, followed by competing clinical priorities and clinical networks needing too much coordination support.
- Of the various barriers listed, the one that was seen as the smallest impedance was perceived lack of relevance to the respondent's clinical role.

There was very little variation in responses according to profession, location and/or work setting. A notable exception is that respondents from rural or regional areas and remote areas see 'few other professionals in my area' (means of 3.6 and 4.5 respectively) as a more significant barrier than respondents in other geographic locations (weighted average of 2.7).

Figure 11 - The significance of barriers that can prevent or impede effective clinical networking (G5)
(Mean scores across full weighted sample; excludes 'not sure' responses)



Factors identified in the open text responses that do or would discourage involvement in clinical networks of mental health professionals (G6b) included:

- A mandatory or imposed network.
- Unwieldy or unstructured meetings.
- Other groups demonstrating a reluctance to participate.
- A sense that the skills, qualifications or therapeutic techniques of some professional groups may not be respected by others.
- The perception that some professional groups will dominate the network.
- The perception that professional boundaries will be difficult to define.
- Uncertainty about the clinical benefit for clients and concerns about the lack of evidence regarding the efficacy of multidisciplinary work.
- Lack of interest in participating in a network.

Factors that do or would *encourage* involvement in clinical networks of mental health professionals (G6a) included:

- Regular, structured meetings held in an easily accessible location.
- A person appointed to coordinate the network, who had time to do so and was remunerated for their work.
- The benefit to the client of multidisciplinary work was clear, or if there were more evidence/studies produced which demonstrated the benefits to clients.
- An opportunity to develop referral networks.
- Meetings that achieve practical outcomes.
- Food provided at meetings so they could be held during meal times.
- Recognition of the time commitment required for active involvement in clinical networks in the form of professional development points or remuneration.

5 Preferences, expectations, incentives and preferred delivery of training

5.1 Introduction

Imperative to the engagement and success of collaborative mental health care is the shared knowledge and understanding of the role of the various professionals in the provision of care (D'Amour 2005b).

The appropriate framework for translating theoretical underpinnings and understandings of collaborative care into clinical practice include adult learning principles employing learner experience and knowledge; self-directed learning; defined goals, relevancy of material; and practical learning tools.

Inter-professional education and training initiatives are seen as a fundamental precursor to the establishment, maintenance and success of collaborative care in all areas of health including mental health. The emergence of inter-professional education is credited to the World Health Organisation (WHO) which in 1973 advocated this approach to professional education as the means by which a more comprehensive and integrated approach to patient needs could be achieved. In this chapter of the report, understandings of inter-professional education are presented and inter-professional education models are described. The national and international literature is also reviewed to identify current knowledge of the effectiveness of this type of education and training.

Inter-professional education can be variably defined. According to the United Kingdom Centre for the Advancement of Inter-professional Education (CPAIE), inter-professional education (IPE) “occurs when two or more professions learn with and from each other to improve collaboration and the quality of care” (CPAIE. available at www.cpaie.org.uk, accessed December 2007). CPAIE advocates an inclusive definition of IPE that incorporates all related learning in academic and work-based, pre, and post registration settings, and also involves purposeful interaction with service users and carers. This latter inclusion is considered particularly important in the shift towards ‘patient centred’ collaborative care. The term IPE is synonymous with the traditional reference to multi-professional education. A key component of IPE is also the facilitation of work-based learning which, in addition to reinforcing key adult learning principles referred to earlier, encourages interdependence amongst mental health professionals such that they learn from each other as they provide their respective and sometimes overlapping aspects of care. Using this rationale, inter-professional practice is considered a subset of IPE.

The implementation of IPE is reliant on a complex interaction of key stakeholders and sectors at a number of levels including (Stone 2007):

- academic teaching and research
- individual health
- acute health
- professional associations
- health systems
- regulatory and accreditation bodies
- national, state and local governments
- community health
- client bodies
- private and public health bodies
- health practitioners and international networks.

IPE has been adopted worldwide in various forms over the past three decades. Examples of popular models of IPE include 'Learning Together to Work Together for Health' (WHO 1988). More recently, in 2001 the National Health System in the United Kingdom mandated IPE as a core component of all health professionals training. The European Union has also now established the European Inter-professional Education Network (EIPEN) and an International Association for Inter-professional Education and Collaborative Practice (InterEd). According to Stone (2007), despite the extensive international focus on IPE in Europe and the United States for at least five years, promising IPE developments in Australia include;

- A collaborative project between the ACT and University of New South Wales to inter-professionalise the ACT health system.
- A recently held national conference on interdisciplinary learning.
- The release of a Productivity Commission report which identified the significant social, financial and health risks of continued fragmented health care.
- The formation of the Mental Health Professionals' Association which is the seminal collaboration of the key mental health professionals to establish Mental Health Interdisciplinary Networks at a national level and for which this review has been compiled.
- Centres for Remote Health (Alice Springs and Mt Isa) have built expertise in multidisciplinary education and training for rural and remote practitioners.

The opportunities facilitated by the implementation of IPE are numerous. At the most basic level, IPE creates an opportunity for health professionals to come together and create a network from which they can subsequently develop further local professional connections and links. Beyond these networking opportunities availed by IPE are the implications of this type of education for improving communication between professions and professionals, and therefore improving the understanding of (overlapping and unique) roles within the provision of health, including mental health. Barr et al. (2005) conducted a review of IPE models and found that inter-professional practice is associated with more effective inter-professional communication, a reduced prevalence of miscommunications, reduced conflict and preventable adverse events. Such studies highlight the importance of more clearly understanding the impact of IPE on the more complex issue of quality of care. Whilst few studies have directly examined this association in any sector of health, the ensuing discussion will highlight some of the key findings of the outcomes IPE as they relate to health care in general and, where available, mental health care more specifically.

Prior to examining these impact studies, however, it is important to contextualise the association between IPE and improved quality of care through the description of a key model of outcomes of IPE. Freeth et al, (2005) adapted Kirkpatrick's model of educational outcomes to propose a four-tiered model of the dynamics underpinning potential IPE outcomes. This model highlights the transitions in attitudes and professional behaviour that in turn affect organisational practice change and in turn improve quality of care. Freeth et al's model can be readily applied to the potential for collaborative mental health care.

5.2 Key points

The following points reflect the key findings regarding preferences, expectations, incentives and preferred delivery of training.

- Over four in five mental health professionals (83%) identified at least one mental health disorder/condition they would like to know more about. This included 70% who identified one or more of the low prevalence disorders, as well as 68% who identified one or more of the high prevalence disorders. However, Better Access is aimed primarily at 'high prevalence disorders'.
- The main preferences, expectations and incentives for professional training are: close proximity to work place, no cost or remuneration for training, training counts towards professional accreditation, developed professional skills, benefits for the client, and that the training is practical in nature.

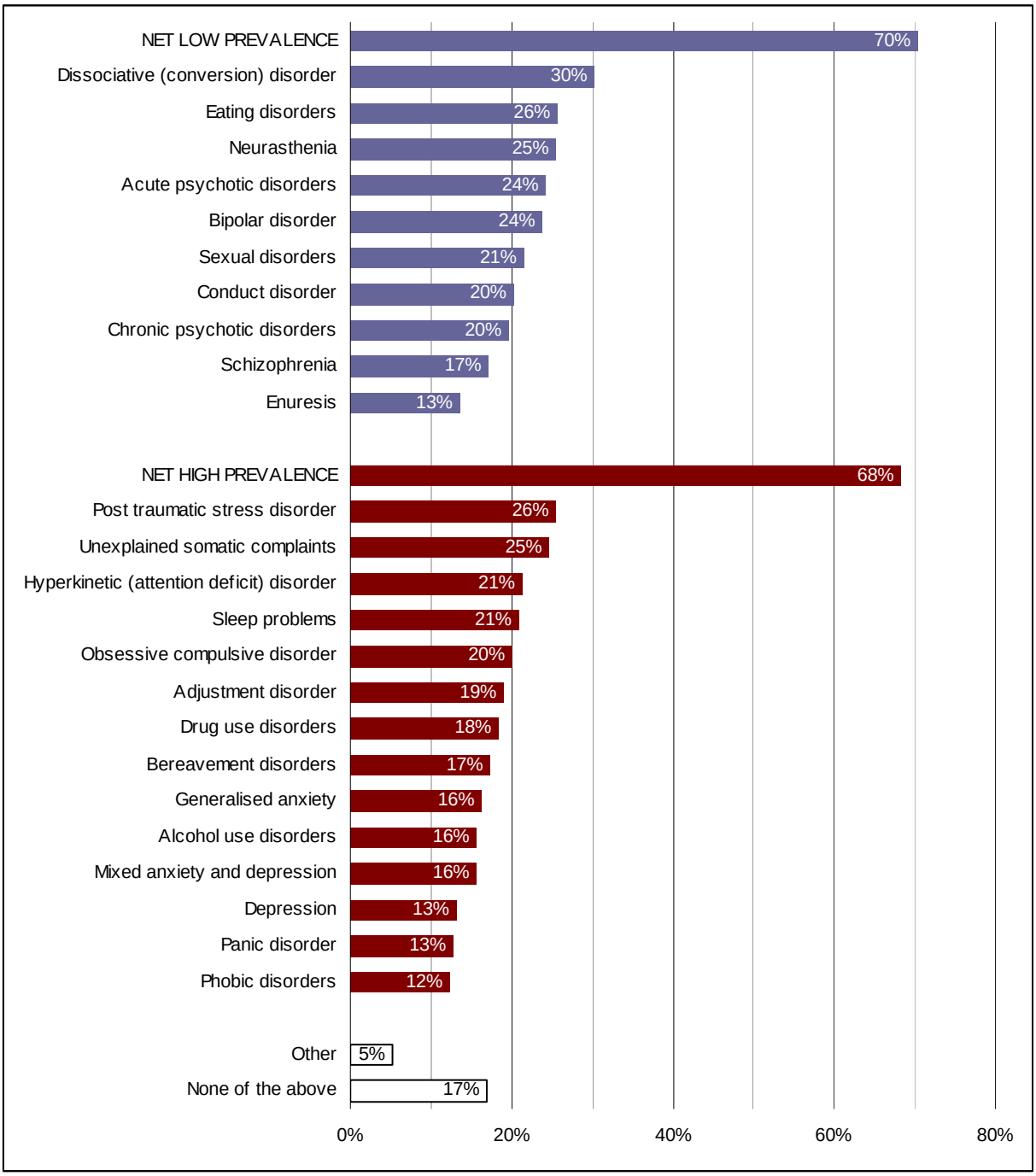
- There were mixed responses from the data regarding whether training should be multi-disciplinary or profession specific. Survey data indicated that there was a slight preference for discipline specific training; however consultations with professionals indicated a greater preference for multi-disciplinary training.

5.3 Areas mental health professionals would like to know more about

Over four in five mental health professionals (83%) identified at least one disorder/condition they would like to know more about. This included 70% who identified one or more of the low prevalence disorders, as well as 68% who identified one or more of the high prevalence disorders. This is clearly a very significant finding and would indicate that any future training offered to practitioners as part of this program should not focus on single mental health disorders but must take a broad and comprehensive approach.

Each disorder attracted the interest of between 12% and 30% of mental health professionals. The most popular were disassociate (conversion) disorder (30%), eating disorders (26%), post traumatic stress disorder (26%), neurasthenia (25%), unexplained somatic complaints (25%), acute psychotic disorders (24%) and bipolar disorder (24%).

Figure 12 - Disorders/conditions I would like to know more about (D2b)
n=2264 (multiple responses allowed, except for 'none of the above')



***** Other disorders/conditions to learn about included Autism Spectrum Disorder, Asperger's disorder, personality disorders, pain management and post-natal depression.

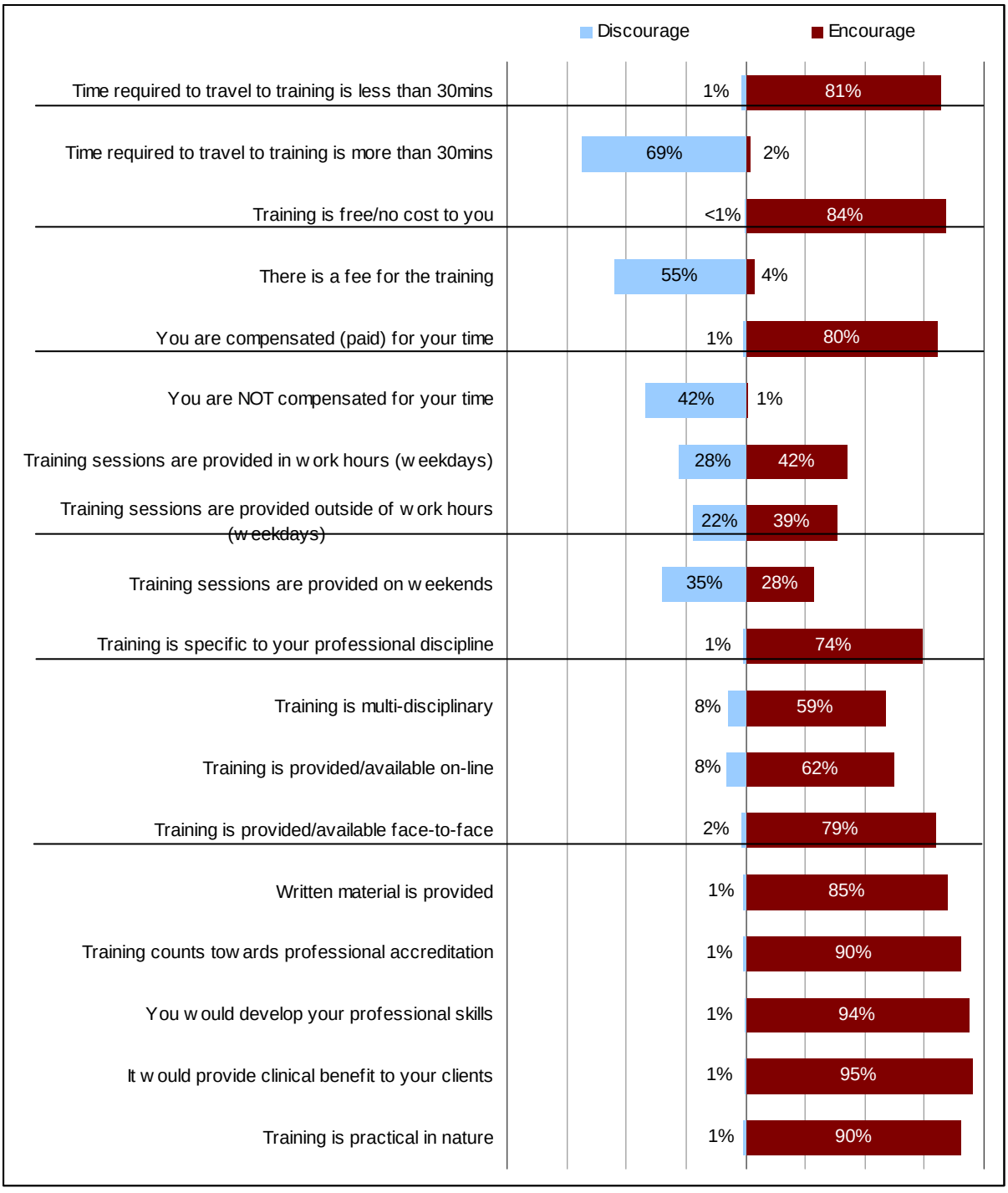
5.4 Discussion of findings

5.4.1 Quantitative research findings

Respondents were given a range of possible options for how training about the Better Access initiatives and the new Medicare items could be provided, and asked whether each would encourage or

discourage their participation (there was also a neutral option). Responses are summarised in Figure 13 and discussed further below.

Figure 13 - Responses to possible options for conducting training about the Better Access initiatives and the use of the new Medicare items (H1). *(n=2,264; respondents indicated whether each suggestion would 'encourage' or 'discourage' them to participate in training – there was also a 'neutral' option):*



Other factors that respondents felt would encourage their participation in training (H1b-a) included:

- opportunities to provide/deliver training as well as attend
- high level training rather than basic
- training opportunities in the local area
- high quality or well known trainers/presenters
- food and drink provided
- childcare facilities available
- opportunities to meet other clinicians from local area
- short sessions (less than one day).

Factors which discourage participation in training (H1b-b) included:

- no choice in training topic
- poor speakers/presenters
- short notice
- long days/long sessions
- mandatory training
- training level too low or basic
- training funded by a drug company
- no child care.

Cost, remuneration and travel time

Cost, remuneration and travel time were all major predictors of willingness to participate in training. Perhaps predictably:

- Shorter travel times were attractive – 81% said they would be encouraged to participate in training if the travel took less than 30 minutes; 69% said they would be discouraged by travel of more than 30 minutes.
- Free training was attractive – 84% said they would be encouraged to participate in training that was free; 55% said they would be discouraged if there was a cost.
- Payment/remuneration was attractive – 80% said they would be encouraged to participate in training where they got paid for their time; 42% said they would be discouraged if they were not paid (see below for more details on payment/remuneration).

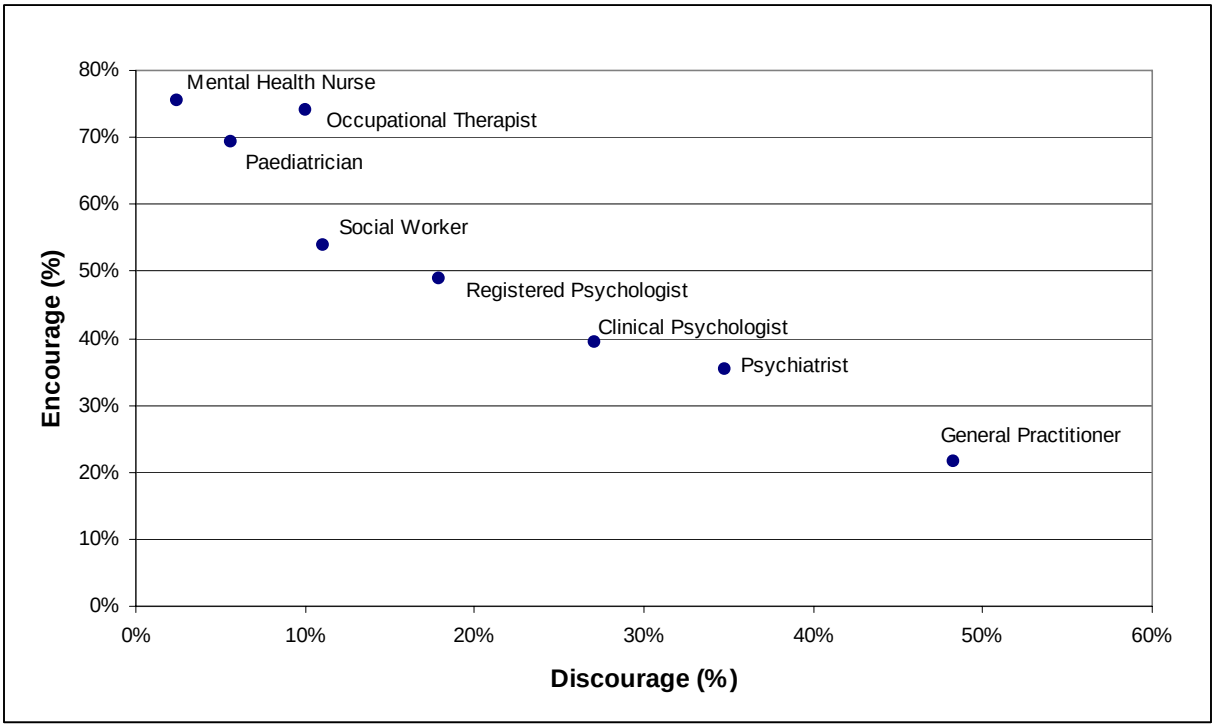
Time/day of the week

Time/day of the week attracted mixed feedback.

- 42% said that they would be encouraged to participate in training during business hours on weekdays, 39% said outside of business hours on weekdays, and 28% said on weekends
- Meanwhile, 28% were discouraged by the idea of weekday training in business time, 22% by the idea of training outside of business hours on weekdays and 35% by weekend training.

- If the data is analysed on the basis of profession, some clear trends emerge. For example, as Figure 14 shows, there are clear differences in the attitudes of respondents working in different professions to training that is conducted during work hours. In general, those professionals working in salaried positions see the training within working hours as an incentive to participate. The opposite is true of professions where self employment is the norm.

Figure 14 - Plot by profession of 'encourage' versus 'discourage' for training sessions being provided in work hours (weekdays)'.



Specificity was a more minor predictor of participation

- 74% said they would be encouraged to participate in training that was specific to their professional discipline.
- 59% also said they would encourage the idea of multi-disciplinary training and 8% said that the offer of multi-disciplinary training would discourage them.

Teaching mode was another minor predictor of participation

- 85% said they would be encouraged to participate in training if written material was provided.
- 79% said that they would be encouraged to participate in training that was presented face-to-face.
- 62% said they would be encouraged to participate in training that was provided on-line and 8% said that the idea of online training discouraged them.

Value to the trainee was important – over 90% said they would be encouraged to participate in training that counted towards professional accreditation, developed their professional skills (94%), provided clinical benefit to their clients (95%) or was practical in nature (90%).

Duration of the training

Respondents were asked how they felt about the idea of a 2.5 hour training session.

- 70% said they felt this duration was 'about right'.
- 13% felt that 2.5 hours was too long – the average duration suggested by these respondents was two hours.
- 9% felt that 2.5 hours was not long enough – the average duration suggested by these respondents was 10 hours (and ranged up to 500 hours in one case).
- 8% were 'not sure' how they felt about a 2.5 hour training session.

Payment/remuneration for participating in training

As seen above, payment for training is a major motivator of participation. The suggestion of $150 for a 2.5 hour training session divided respondents fairly evenly:

- 46% said they felt this amount was 'about right'.
- 21% felt that $150 was too much – the average amount suggested by these respondents was $60.
- 22% felt that $150 was not enough – the average amount suggested by these respondents was $300 (but ranged up to $900).
- 12% were not sure what they felt about the cost.

5.4.2 Qualitative research findings

> *Training should play an enormous role in promoting collaborative care and for managing expectations and hose down any concerns that it will give them more work to do. Training should aim to facilitate greater understanding.* (Client agency)

The qualitative research revealed that the majority of the professionals consulted had very similar views about expectations, preferences and incentives for training. There was broad agreement that professional development and training was essential in mental health. As one mental health nurse pointed out "there is a need for integration and to stop working in silos – education is fundamental in where we want to go".

The following is a list of the professionals' expectations, preference and incentives for attending training and professional development identified from the consultations.

Preferences and expectations

- Keep in line with continuous development program for the professional groups.
- Must be practical, pragmatic, relevant, academic and evidence-based.
- Training designed and planned according to needs and attendees.
- Have other practitioners attend who are at the same level – there may be a variety of levels so may need varying degrees of difficulty.
- Accommodate the varying interests of the different professional groups.
- Highly relevant, competent facilitators, with opportunity for discussion in a 'workshop style'. There should also be the opportunity to 'skill share' and network.

Incentives

- Offer financial remuneration. Some respondents also raised the issue of providing resources to allow back-fill of positions.
- Well trained and well known presenters, or experts in the material.

- Hands on practical demonstrations are good.
- Offer professional development points.
- Hold after hours or on weekends.
- Offer refreshments and food.
- Hold locally (this would also assist with getting to know professionals in the local area).
- Allow time to spend networking and building relationships.

Preferred delivery

- Should ideally be multi-disciplinary.
- Preferably face-to-face, but for professionals in rural and remote areas this may need to be web-based or on-line. Face-to-face education gives people an opportunity not only to learn but to share each others' knowledge and to meet, talk and network.
- Interactive, workshop and discussion-based role-plays and scenarios.
- Training in small groups.

Discussions held during the site visits indicated that practitioners working in remote and rural areas were very similar to those in metropolitan regions. Clearly providing training in remote areas will represent challenges for MHPA, particular regarding time and the use of resources. To address this, the MHPA could also consider working in association with regional university campuses when providing training.

5.4.3 Other issues that were raised regarding training

Interestingly, during the qualitative phase, several other professional training issues were raised with respect to the Better Access initiative. These were unexpected, however were considered to be of value and have been added to this report.

Professionals asked for training around the following areas:

- The use of referral and communication tools, care planning frameworks, other resources like documentation, data bases and so on.
- How to better understand clients' needs.
- The service system – what are the support services that exist for clients with a mental illness.
- How better to meet the needs of CALD and Aboriginal and/or Torres Strait Islander clients.
- Communication and listening skills.
- Training in 'dual diagnoses' and management of complex and 'difficult' clients.
- Explaining the roles of each of the professional groups that are part of this initiative including mental health nurses and where/how they can be accessed.
- How to make a private business work – skills in setting up and promoting business as a sole practitioner in mental health and how to promote themselves.
- How to form and maintain clinical networks.
- How to find support and professional supervision when working in sole private practice.
- What collaborative care is and how it can be delivered.
- Training on a 'step-by-step processes' through the system covering the processes and paper work.

- Training should have direct relevance to paediatricians – increasing their knowledge would improve the outcomes for patients.

Another form of training that was suggested was “attachment training”, for example, where the GP spends some time in a mental health service working with a psychiatrist. This has great advantages and is very popular with some general practitioners, and could potentially be used for other professionals as well. Training could also include the “near to peer” approach, which shows how a professional is working and their successes.

6 Benchmarking – current collaborative care arrangements and practices under Better Access

6.1 Introduction

The chapter provides the data analysis and findings regarding the current level of use of the Better Access items. It also provides information collected from the professional groups about familiarity with the new item numbers. The current levels of engagement in collaborative care are also reported. Mental health professionals' perceptions about the impact the initiative has had on their day-to-day practice, and general perspectives on Better Access, derived from open text responses to the survey, are also reported.

A list of the relevant Medicare items is provided in Table 11 below. Please note that mental health nurses cannot claim any MBS items under the Better Access initiative.

Table 11 - List of Better Access Medicare items

Medicare item	Explanation
Item 291	Referred assessment and management plan
Item 293	Review of management care plan
Items 296, 297, 299	Initial consultations with a new client (psychiatrist items)
Item 2710	Preparation of a GP Mental Health Care Plan
Item 2712	Review of a GP Mental Health Care Plan
Item 2713	Mental Health Consultation
Items 80000, 80010, 80100, 80110, 80125, 80135, 80150, 80160	Provision of Focused Psychological Strategies
Items 80020, 80120, 80145, 80170	Group Therapy
Items 80000, 80010, 80120	Clinical psychologist items
Items 80100, 80110, 80120	Psychologist items
Items 80125, 80135	OT items
Items 80150, 80160, 80170	Social worker items

6.2 Key points

- There is variable uptake and understanding of the Better Access items.
- Item 296 (initial consultations with a new client) was used most often and item 293 (review of management care plan) was used the least.
- Item 2710 (preparation of a GP mental Health Care plan) was used the most.
- Use of the allied health items was variable. Clinical and other psychologists claimed most often followed by social workers and OTs.
- The most commonly used FPS were: cognitive behavioural therapy, anger management, psycho-education, relaxation training, stress management, and problem-solving skills and training.
- Psychiatrists were generally familiar with the items relating to initial consultation with a new client (items 296, 297, 299). Psychiatrists' familiarity with the other items was lower – only 30% said they were 'very familiar' with the item for referred assessment and management plans (item 291); 23% with the item for reviewing a management plan (item 293).
- GPs were generally familiar with the item for preparing a GP mental health care plan (item 2710 – 67% 'very familiar') and reviewing a GP mental health care plan (item 2712 – 52% 'very familiar'). They were somewhat less familiar with item 2713 – mental health consultation (46% 'very familiar', 14% 'not at all familiar').
- Clinical psychologists were generally familiar with items 80000 and 80010 for provision of Psychological Therapy (76% 'very familiar'). However, familiarity was more mixed with item 80020 for group therapy provided by clinical psychologists (22% 'very familiar', 21% 'not at all familiar').
- The item numbers for provision of FPS (80100, 80110, 80125, 80135, 80150, 80160) were reasonably well known among psychologists (53% 'very familiar') and social workers (41% 'very familiar'), but less so among OTs (20% 'very familiar', 26% 'not at all familiar').
- The group therapy item numbers (80020, 80120, 80415, and 80170) were relatively unknown among psychologist, social workers and OTs alike (8%-16% 'very familiar', 25%-28% 'not at all familiar').
- Professions reporting the biggest change were psychologists (39% 'major change') and social workers (30% 'major change'), followed by GPs (28% 'major change'). Psychiatrists reported less change than others (7% 'major change', 38% 'no change').
- There is a relatively low awareness of the range of services that can be provided by mental health nurses under the MHNIP.
- The MHNIP has had little impact on day-to-day private practice of most mental health professionals.

6.3 Discussion of findings

6.3.1 Quantitative research findings

The following section provides an analysis of the quantitative research findings. In instances where 'not applicable' was available as a response option, percentages have been calculated excluding the number of 'not applicable' responses.

Current use and take up

Practice trends for psychiatrics – items 291, 293 and 296

(See Appendix B, Tables C1-1, C1-2, C1-3, C1-4 and C1-5)

Of the 85% of psychiatrists that had used the Better Access items in the last month:

- 79% had seen new clients in their private practice under item 296 (Initial consultations with a new client)
- 38% had referred patients for Better Access allied mental health services
- 32% had prepared and referred Assessment and Management Plans (item 291)
- 9% had undertaken reviews of Review Assessment and Management Plans (item 293).

Of the 79% of psychiatrists who had been asked to be involved in the management of a new client in the last month under item 291 or item 296:

- 76% stated they had been approached by GPs
- 25% had been approached by other private psychiatrists
- 21% had been approached by other[3] referral services
- 18% had been asked by a government mental health service
- there was no request made by nurses working in primary practice under the MHNIP.

Of the 65% of psychiatrists that had prepared a mental health care plan in the last month that involved referral to or from other mental health professionals:

- 59% stated that they had involved a GP
- 15% reported that they had involved another referral source
- 9% indicated that they had other involved private psychiatrists
- 9% indicated that they had involved a government mental health service
- no psychiatrists reported that they had involved nurses working in primary practice under the MHNIP.

Medicare data

A request for Medicare data was made in October 2007 for the following cross-tabulations:

- Services delivered by patient location cross-tabbed with patient state. Services delivered by practitioner location cross-tabbed with practitioner state
- Services delivered by patient gender cross-tabbed with patient location
- Services delivered by patient age cross-tabbed with patient location or services.

Medicare were unable to provide this because this “data is not currently published at the levels sought. Any change to current arrangements to make data available at these levels would need to be considered by an incoming Government”. As a result, the only other data was that available from the Medicare web-site.[4]

[3] Several psychologists (clinical or otherwise) as well as a small numbers of lawyers, insurance companies, community nurses, disability services, rehabilitation services, drug and alcohol services, child protection agencies, emergency wards, physicians and other medical specialists.

[4] The Medicare Benefits Schedule statistics used in this report are available from http://www.medicareaustralia.gov.au/about/stats/index.shtml

Tables 12, 13 and 15 below provide a breakdown of Medicare data statistics of the Better Access item numbers (as previously described) from the beginning of the initiative in November 2006 to August 2007. Table 12 indicates that the most commonly claimed item was 296.

Table 12 - Medicare data for the period Nov 2006 – Aug 2007

Item	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
									Services
291	3,568	1,863	1,542	1,075	274	263	74	84	8,743
293	350	166	153	62	14	20	3	3	771
296	22,796	18,463	13,558	6,365	5,506	1,146	1,035	300	69,169
297	2,369	1,574	1,483	395	481	210	45	15	6,572
299	479	145	41	66	12	6	7	0	756
Total	29,562	22,211	16,777	7,963	6,287	1,645	1,164	402	86,011

Referrals from GPs to psychiatrists

Around 95% of psychiatrists reported that GPs had referred patients to them in the last month; however this referral was rarely reported to be accompanied by a copy of an existing Mental Health Care plan. For example, among those who had received a referral from a GP in the previous month, 76% said they had never (45%) or rarely (31%) received a complete plan; 82% said they had never (59%) or rarely (23%) received a partial plan. If anything, the referral tended to be accompanied by a detailed letter (15% always, 18% mostly) (see Appendix B, Table C1-4). This will have implications for the provision of training in the importance of effective communication between mental health professionals by the MHPA.

Referrals from psychiatrists to other health professionals

Around three in four psychiatrists had made referrals to other health professionals as part of ongoing client management or shared care arrangements over the month prior to the survey. Almost half of the psychiatrists (63%) had accompanied the referral with a detailed letter – only a minority had accompanied their referral with a partial (19%) or complete (15%) copy of an existing Mental Health Care Plan (See Appendix B Table C1-5).

Practice trends for GPs 2710, 2712 and 2713

(See Appendix B Table C2-1, C2-2, C2-4, C2-5, C2-6)

Of the 86% of GPs that had used the Better Access Items in the last month:

- 83% had prepared a GP Mental Health Care Plan using item 2710
- 54% had undertaken a formal review of GP Mental Health Care Plans (item 2712)
- 53% had provided mental health consults (item 2713)

Of the 76% GPs that had received recommendations to see new clients with a mental illness in the past month:

- 58% of these had been a client initiated referral
- 37 % had come from privately practising psychologists, OTs or social workers
- 23% had come from other GPs

- 22% had come from another referral source[5]
- 17% had come from a government mental health service
- 8% had come from privately practising psychiatrists
- a total of 3% had come from mental health nurses (2%) and nurses working in primary care under the MHNIP (1%).

Of the 83% of GPs that had completed a Mental Health Care Plan (item 2710) in the last month, 48% stated all of them had made referral to other mental professionals, 20% reported most of them had, 12% indicated that some of them had, and 3% said that none of them had involved referrals to other mental health professionals.

According to the Medicare data (refer to Table 13 below) items 2710 and 2713 have been claimed most often.

Table 13 - Medicare data for the period Nov 2006 – Aug 2007

Items	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
									Services
2710	157,988	134,096	78,438	26,881	38,839	9,981	6,696	1,715	454,634
2712	30,277	27,082	13,821	4,494	7,705	1,611	996	233	86,219
2713	128,044	102,253	64,261	27,810	34,089	7,160	4,116	2,157	369,890
Total	316,309	263,431	156,520	59,185	80,633	18,752	11,808	4,105	910,743

Referrals to GPs from other mental health professionals

Just over half of the GPs surveyed said they had received a referral from another mental health professional in the last month. As with psychiatrists, these referrals were rarely accompanied by a copy of an existing Mental Health Care plan: 88% said they had never (79%) or rarely (9%) received a complete plan; 91% said they had never (84%) or rarely (7%) received a partial plan. If anything, the referral tended to be accompanied by a detailed letter (12% always, 11% mostly), however such letters were by no means guaranteed (42% never) (see Appendix B, Table C2-5).

Referrals from GPs to other health professionals as part of a GP Mental Health Care Plan

Around nine in ten GPs had made referrals to other health professionals as part of a GP Mental Health Care Plan over the previous month. Most of these GPs (71%) said that they always accompanied their referrals with a complete copy of a prepared Mental Health Care Plan, and 66% said they always provided a detailed referral letter (see Appendix B Table C2-6). This is an interesting contrast to what was noted previously by the psychiatrists regarding receiving care plans from GPs.

Clients and carers also reported that they were not aware of the extent, if any, of the level or type of communication that existed between mental health professionals, for example, their GP and psychiatrist. One client stated “My GP and psychiatrist have never talked, and I have been seeing them both for 20 years!” This will have implications for any training or resources provided by MHPA, especially regarding the involvement in clients of mental health services and coordination of care, referral, and care planning.

[5] The two most common ‘other’ sources were the Beyond Blue web site (13 references) and friends/family of the patient (8). Other sources included other patients, Centrelink, drug and alcohol services, child/maternal health services, school counselors, dieticians/eating disorder clinics, aged care facilities, prison health services.

Practice trends for clinical psychologist, psychologist, OTs and social workers

(see Appendix B, Table C3-2, C3-3, C3-4).

Table 14 below shows Medicare items for psychological therapy, FPS and group therapy that were claimed by clinical psychologists, psychologists, OTs, and social workers over the last month. Of note is the low number of claims for group therapy by allied health, and no claims at all by OTs. Furthermore, only 38% of OTs had made claims for FPS.

Table 14 - Practice trends for clinical psychologist, psychologists, OTs and social workers

(multiple responses allowed, excluding 'none of the above') Raw n=	Clinical psychologist	Psychologist	OTs	Social workers
	420	761	50	252
Claimed for psychological therapy under items 80000 and 80010	93%	na	na	na
Claimed for FPS under items 80100, 80110, 80125, 80135, 80150, 80160	na	90%	38%	73%
Claimed for group therapy under items 80020, 80120, 80145, 80170	2%	2%	0%	3%
None of the above	6%	9%	62%	26%

These trends are also reflected in the Medicare data represented in Table 15 below.

Table 15 - Medicare data for the period Nov 2006 – Aug 2007

	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
									Services
80100	5,922	8,049	5,472	994	1,281	226	296	38	22,278
80110	240,375	269,287	146,213	30,024	31,155	15,458	10,591	2,040	745,143
80125	241	69	23	37	5	1	0	0	376
80135	1,460	1,477	829	636	885	302	11	1	5,601
80150	156	439	60	19	60	23	0	15	772
80160	12,605	10,121	6,376	2,162	2,508	489	181	33	34,475
Total	260,759	289,442	158,973	33,872	35,894	16,499	11,079	2,127	808,645

Item	State							Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	
								Services
80020	620	1,005	305	56	315	21	106	2,428
80120	637	900	590	56	181	42	19	2,425
80145	42	0	13	20	20	0	0	95
80170	73	33	0	45	0	0	0	151
Total	1,372	1,938	908	177	516	63	125	5,099

Items	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
									Services
80000	1,947	3,297	776	397	944	90	41	5	7,497
80010	116,864	104,755	35,412	22,486	70,248	11,757	6,155	811	368,488
80020	620	1,005	305	56	315	21	106	0	2,428
Total	119,431	109,057	36,493	22,939	71,507	11,868	6,302	816	378,413

All of the above material could be used to target the various professionals with information and training to improve their practice.

Involvement of allied health professionals by other mental health professionals

Almost all psychologists (96% of clinical psychologists, 91% of psychologists) had been invited to get involved with new clients over the last month as part of their private practice to deliver the new Medicare-funded services. This was also the case for the majority of social workers (79%) and around half of the OTs surveyed (48%). This appears to indicate that OTs are the least involved.

Most psychologists (92% clinical, 89% psychologists) said that GPs had involved them with new clients over the last month for provision of the new Medicare-funded services. Fewer than half reported having been involved by privately practising psychiatrist (40% clinical psychologists, 22% psychologists) or paediatricians (17% clinical psychologists, 11% psychologists) – fewer than 5% were approached by mental health nurses (see Appendix B, Table C3-2).

Around two in three social workers (69%) and one in three OTs (36%) said that GPs had involved them with new clients over the last month for provision of the new Medicare-funded services. Fewer than a quarter reported having been involved by privately practising psychiatrists (13% social workers, 20% OTs) or paediatricians (7% social workers, 10% OTs). As with psychologists, fewer than 5% of OTs or social workers were approached by mental health nurses (see Appendix B Table C3-2).

Recommendations/referrals from allied health professionals to GPs, psychiatrists and government mental health services

Around two-thirds of clinical psychologists (80%), psychologists (78%) and social workers (74%) had recommended that a client speak to a GP, a privately practising psychiatrist or a Government mental health service for mental health care over the last month. Across these professional groups, this included:

- 62%-64% recommending clients speak with a GP
- 32%-49% recommending clients speak with a privately practising psychiatrist (social workers at the low end, clinical psychologist at the high end)

- 29%-34% recommending clients speak with a government mental health service.

OTs were less likely than the other groups to have made any recommendations along these lines (66%). However, they were the only group to have more than 1% recommending clients to mental health nurses (6%). Also, OTs were likely to have recommended clients to Government mental health services (40%) than the other groups (29%-34%) (see Appendix B, Table C3-3).

Referrals to allied health workers from other mental health professionals

Receipt of referrals from other health professionals (under Medicare) was reported by around 95% of clinical psychologists, 93% of psychologists, 80% of social workers and 50% of OTs. Again, this reflects the trend as aforementioned of a low involvement of OTs.

Psychologists and social workers generally received more detailed referrals than OTs. For example (see Appendix B, Table C3-4):

- A complete copy of the client's written Mental Health Care Plan was always/mostly received by 66% of clinical psychologists and psychologists, 56% of social workers and 34% of OTs
- A partial copy of the client's written Mental Health Care Plan was mostly/always received by 37% of clinical psychologists, 34% of psychologists and 30% of social workers, compared with only 8% of OTs
- Detailed referral letters were mostly/always received by 59% of clinical psychologists, 62% of psychologists, compared with 53% of social workers and 49% of OTs. This also indicates that OTs are not only the least involved but they also do not receive the least written information. This observation has implications for the MHPA are considering training in respect of the importance of communication and collaboration between all members of the mental health professionals and also about their respective roles.

Reporting back to referral sources

Apart from GPs, the majority of mental health professionals said they 'always' provide a written report back to the referring practitioner – 72% of clinical psychologists, 71% of psychologists, 64% of OTs, 57% of social workers and 55% of psychiatrists (reporting back specifically to GPs) (see Appendix B, Table C1-4 and C3-4). However, this practice of reporting back was less commonly reported by GPs (25% always, 37% never) (see Appendix B, Table C2-5). However, it should be noted that this is a requirement for further treatment under Medicare.

This is consistent with the result that 69% of GPs and 56%of psychiatrists who had made referrals in the last month said they received a subsequent report from the other health professionals at least half of the time (see Appendix B, Tables C1-5 and C2-6).

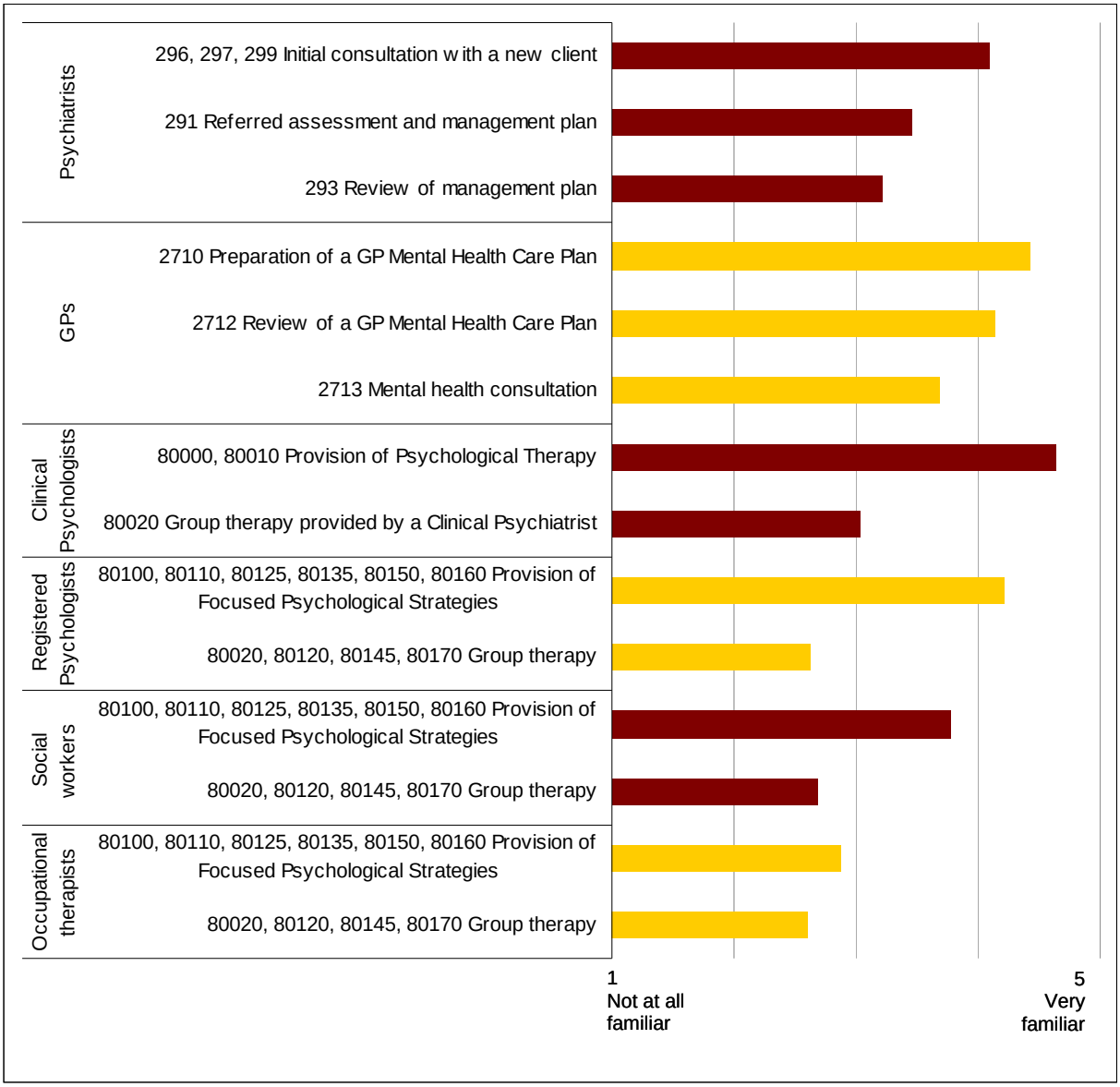
Practitioners' familiarity regarding the Better Access Medicare items

Figure 15 below shows a mixed level of familiarity among mental health professionals with the items that they are able to claim (see Appendix B table B1 for more details). These findings indicate the provision of information thus far for some of the items has been very successful, however, that there is further training required regarding some items numbers, particularly those for the provision of group therapy.

- Psychiatrists were generally familiar with the items relating to initial consultation with a new client (items 296, 297, 299) – 51% said they were 'very familiar' with the services provided under this item. Psychiatrists' familiarity with the other items was lower – only 30% said they were 'very familiar' with the item for referred assessment and management plans (item 291); 23% with the item for reviewing a management plan (item 293).
- GPs were generally familiar with the item for preparing a GP Mental Health Care Plan (item 2710 – 67% 'very familiar') and reviewing a GP Mental Health Care Plan (item 2712 – 52% 'very familiar'). They were somewhat less familiar with item 2713 – mental health consultation (46% 'very familiar', 14% 'not at all familiar').

- Clinical psychologists were generally familiar with items 80000 and 80010 for provision of psychological therapy (76% 'very familiar'). However, familiarity was more mixed with item 80020 for group therapy provided by a clinical psychologist (22% 'very familiar', 21% 'not at all familiar').
- The item numbers for provision of FPS (80100, 80110, 80125, 80135, 80150, 80160) were reasonably well known among psychologists (53% 'very familiar') and social workers (41% 'very familiar'), but less so among OTs (20% 'very familiar', 27% 'not at all familiar').
- The group therapy item numbers (80020, 80120, 80415, 80170) were relatively unknown among psychologists, social workers and OTs alike (8%-16% 'very familiar', 25%-28% 'not at all familiar')

Figure 15 - Each professional groups' own familiarity with the services provided under new Medicare items introduced under the Better Access to Mental Health Care initiative (B1)
(mean scores – see Appendix B table B1 for details)



Reported changes in day-to-day practice following the introduction of the new Medicare items

Figure 16 below shows the extent to which each professional group feels that the introduction of their new Medicare items has changed their day-to-day practice (see Appendix B table B2 for more details). It shows that the professions reporting the biggest change were psychologists (39% 'major change') and social workers (30% 'major change'), followed by GPs (28% 'major change'). Psychiatrists reported less change than others (7% 'major change', 38% 'no change'). These findings are significant especially regarding referrals and the GP care planning. This needs to be considered by the MHPA in the provision of information and resources, and needs to be addressed via training.

Figure 16 - Overall change in day-to-day private practice work as a result of the introduction of the new Medicare items – only thinking about the items that their profession can claim (B2)
(mean score, excludes 'not sure')

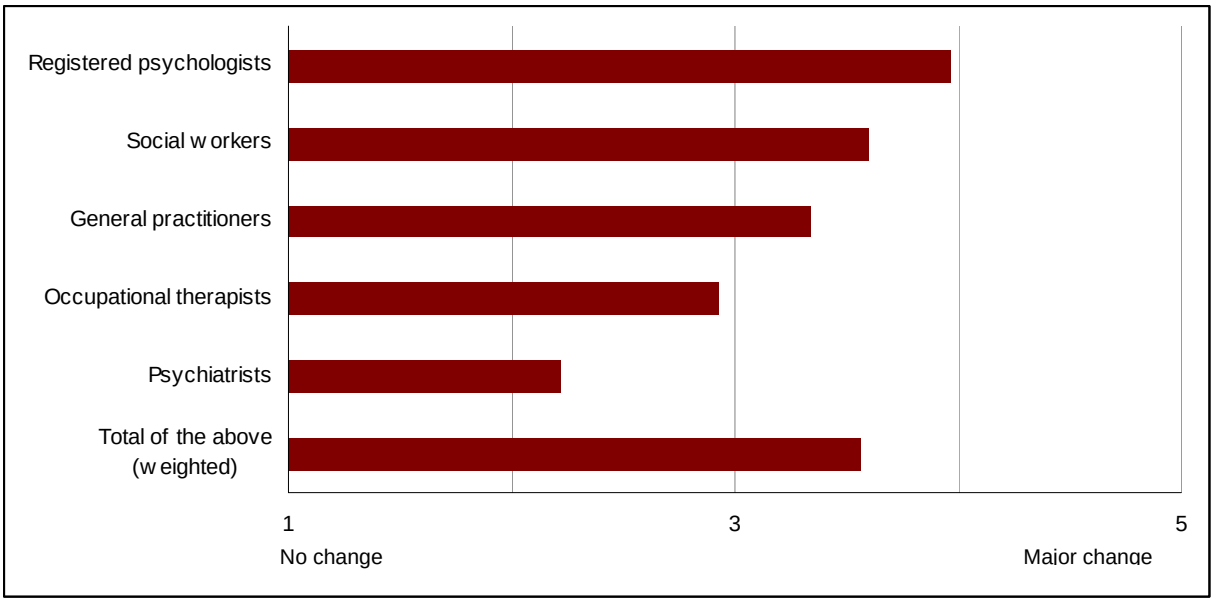
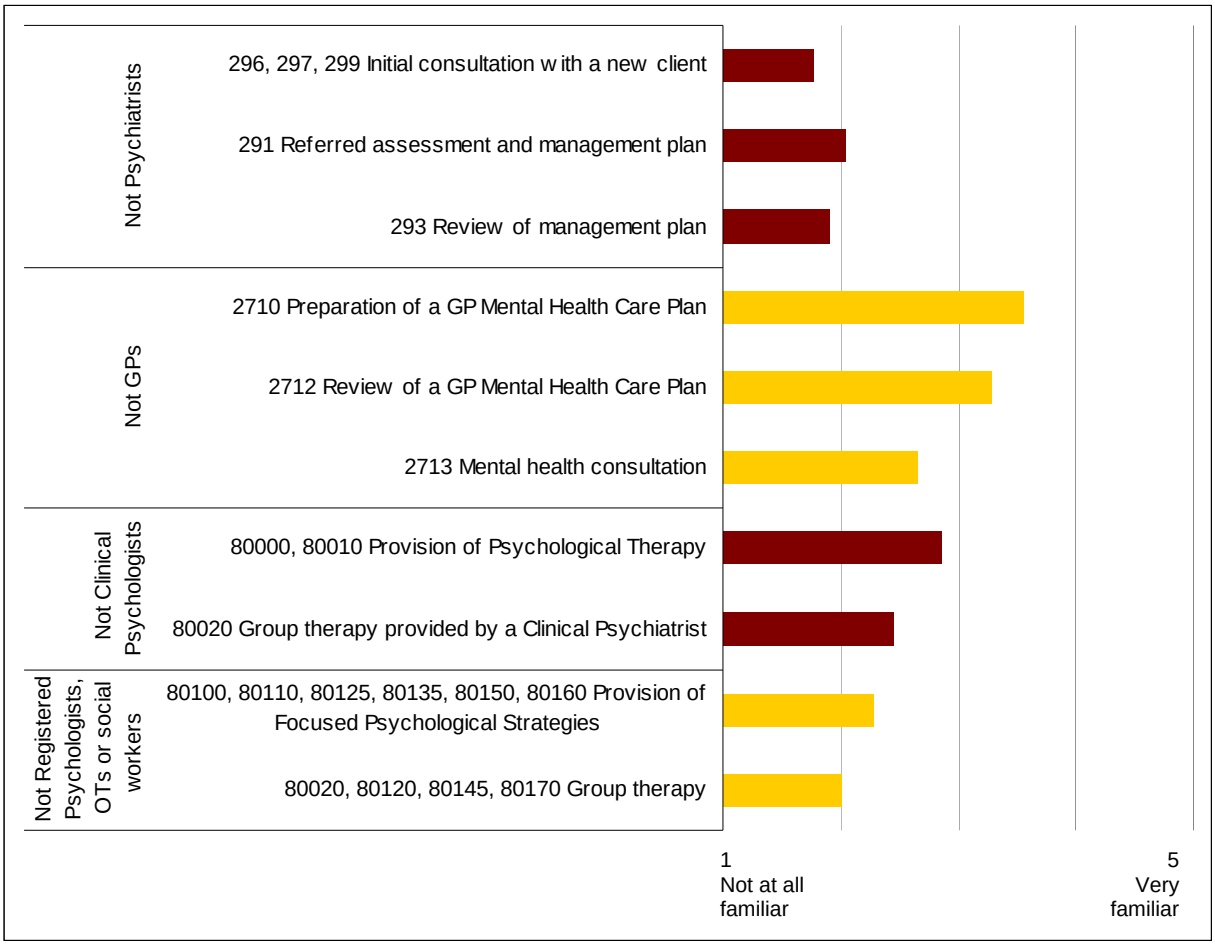


Figure 17 below shows relatively low awareness of the new Medicare items outside of the professional groups that could claim them. The one exception to this was GP items relating to preparing and reviewing Mental Health Care Plans – these were 'very familiar' to around two-thirds of non-GPs (40% regarding preparing and 32% regarding reviewing). See Appendix B, Table B1 for details. These low levels of awareness will obviously affect the way a GP care plan is drawn up and the contribution of the various professions and mix of services to the client's overall care package.

The MHPA will need to consider addressing these knowledge gaps when providing training, information and resources. An improved knowledge of what other professionals can claim under the Better Access program will assist in practitioners understanding each others' roles in this initiative, and also help facilitate collaboration.

Figure 17 - Other professional groups' familiarity with services provided under new Medicare items introduced under the Better Access to Mental Health Care initiative (B1)
(mean scores – see Appendix # table B1 for details)



All professional groups were also asked to rate the degree of change they had experienced in their day-to-day private practice from the introduction of *all* of the new Medicare claim items (i.e. items they could claim, as well as items for other professional groups).

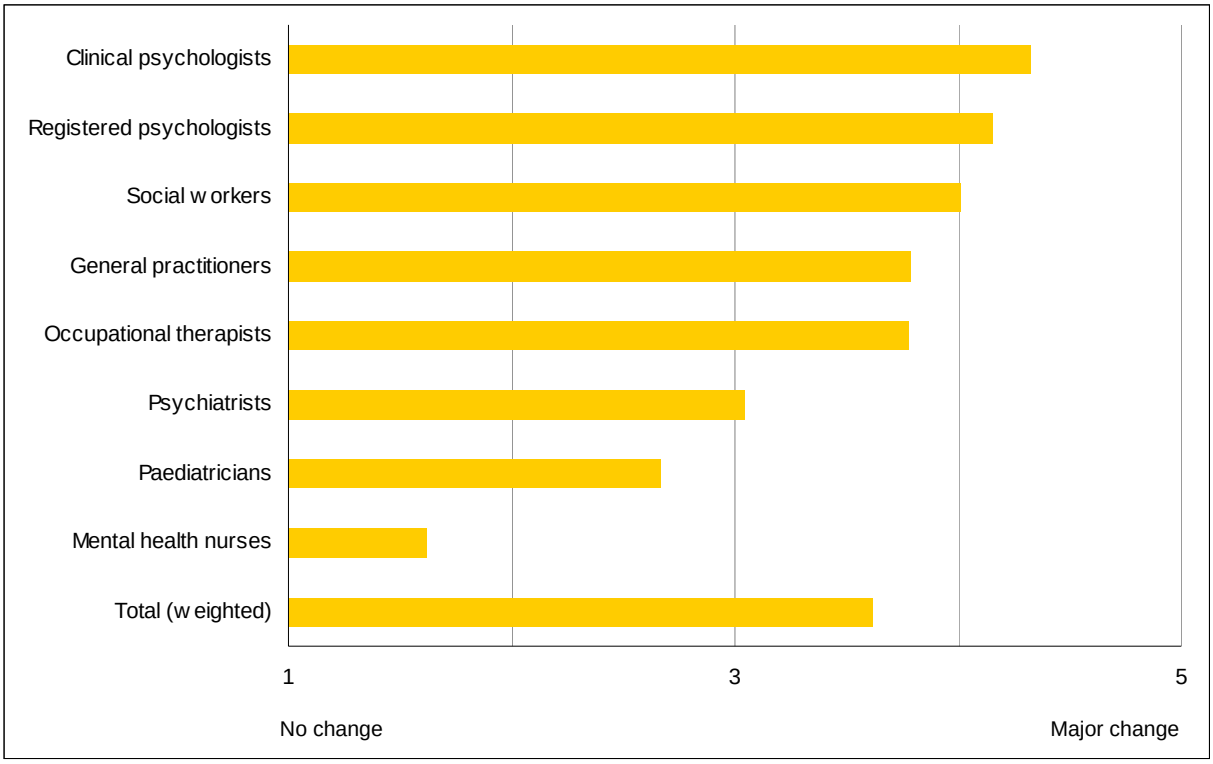
Figure 18 below (and Appendix B Table B2a) shows that:

- the greatest change was reported by psychologists – both clinical (56% 'major change') and other psychologists (49% 'major change')
- considerable change was also reported by social workers (43% 'major change'), GPs (36% 'major change') and Occupational Therapists (31% 'major change')
- mixed reports were given by psychiatrists (14% 'major change', 14% 'no change')
- little change was reported by paediatricians (13% 'major change', 25% 'no change') or Mental Health Nurses (4% 'major change', 57% 'no change').

Review of mental health care plans

During the qualitative phase of the research, GPs were asked about reviews of mental health care plans and when this usually took place. GPs indicated that they would always review a plan if there was a change in a clients' condition or circumstances, but generally, in clinically stable clients, this would take place on an annual basis. Mental health nurses employed in GP practices noted that they were often looking at the client care plans and were monitoring their progress, feeding back to the GP whenever they saw a client. GPs noted that effective care planning and monitoring was an ongoing process, and was something they considered very important.

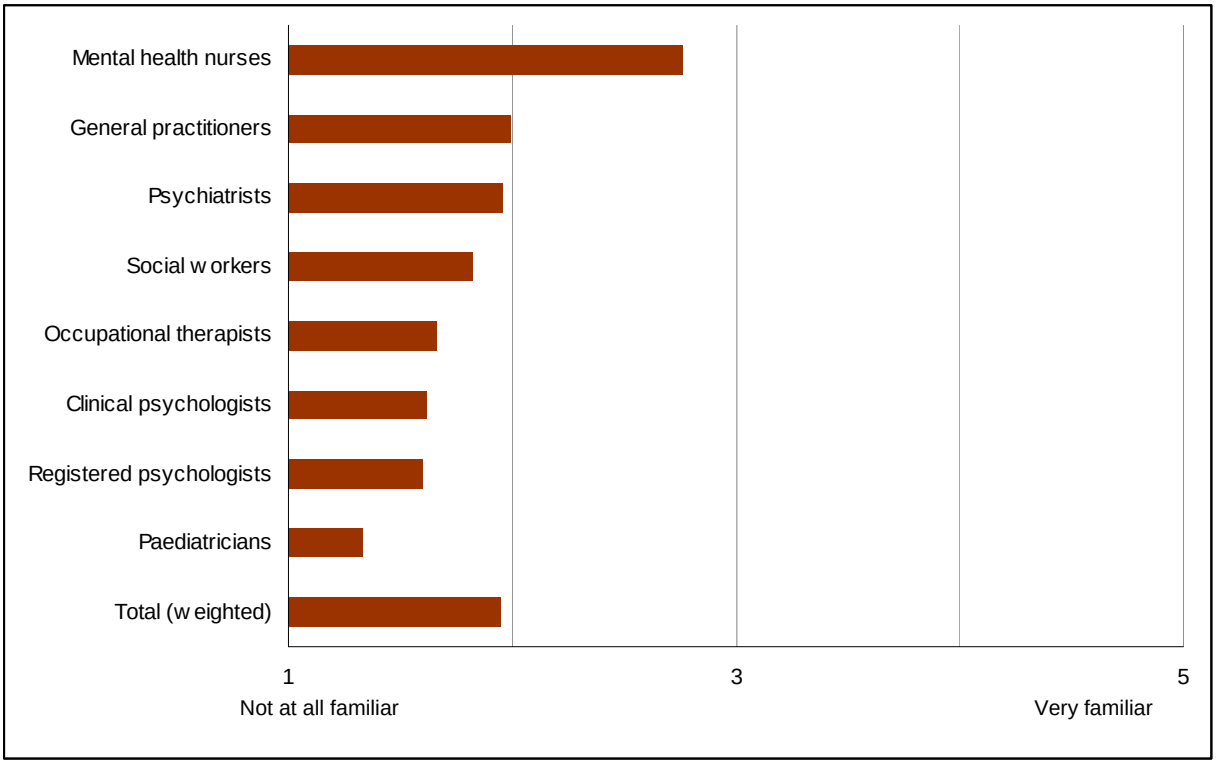
Figure 18 - Overall change in day-to-day private practice work as a result of the introduction of all the new Medicare items together (B2) *(mean score, excludes 'not sure')*



Awareness of the Mental Health Nurse Incentive Program (MHNIP)

Figure 19 below shows that there is a relatively low awareness of the range of services that can be provided by mental health nurses under the MHNIP. Just about half of the respondents (49% of the weighted total) were 'not at all familiar' with the services available – this figure ranged from a high of 72% for 'not at all familiar' among paediatricians down to 44% for GPs. Even mental health nurses themselves showed only partial familiarity with the services they can provide under the MHNIP (14% 'very familiar', 24% 'not at all familiar'). This again is an area for education/training/information development.

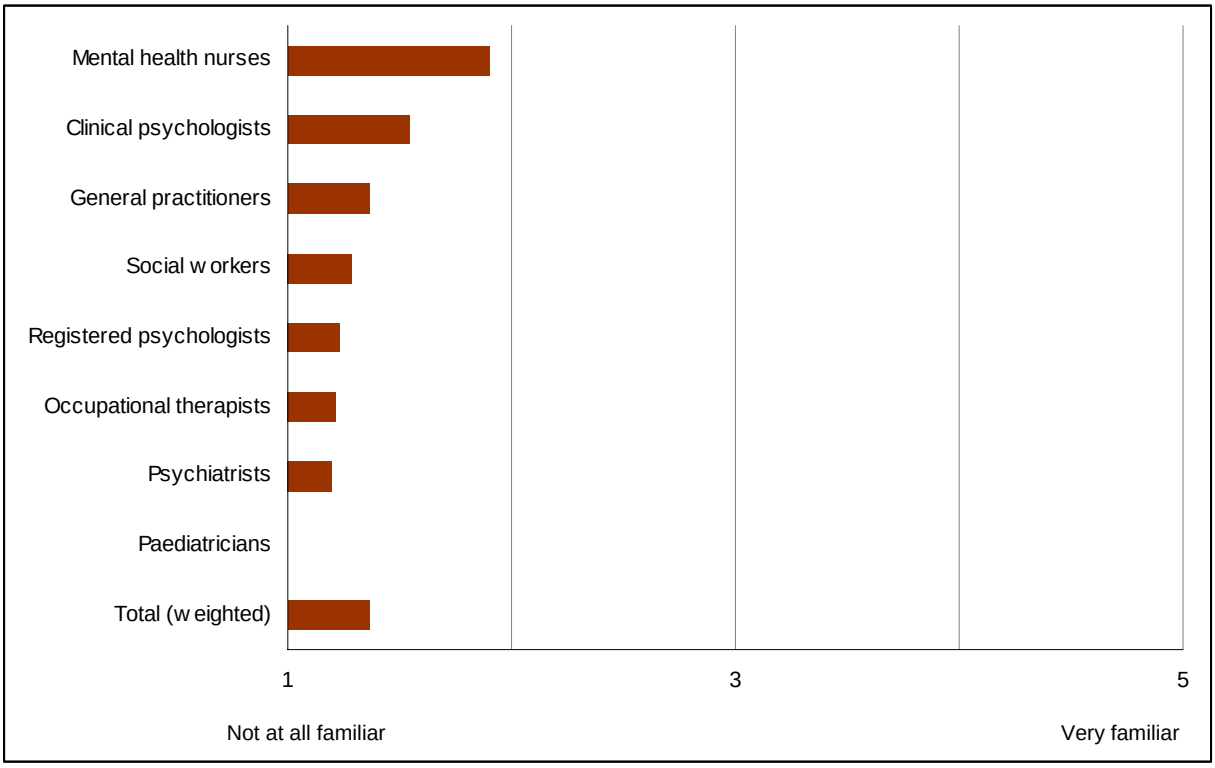
Figure 19 - Familiarity with the range of services that can be provided by mental health nurses under the MHNIP (B3)
(Mean score; see Appendix B Table B3 for details)



Reported changes in day-to-day private practice as a result if the MHNIP

Figure 20 below shows that the introduction of the MHNIP has had little impact on day-to-day private practice of most mental health professionals. This is consistent with the low levels of familiarity and awareness discussed above.

Figure 20 - Overall, how much change have you seen in your day-to-day private practice work as a result of the introduction of mental health nurse services?



6.3.2 Qualitative research findings

During consultations there were many and varied responses to the use of the Better Access Medicare item numbers. The site visit to the services that support Aboriginal and/or Torres Strait Islander clients indicated low usage of the Better Access item numbers, although item 2713 had been reportedly used occasionally. During one site visit, a psychiatrist stated that they considered there

> *…has been variable uptake… and it does seem to depend on who people work with. Some GPs just like to refer to people they know, especially psychiatrists and psychologists. This system has created competition in some professionals' minds, particularly allied health.*

As has been previously mentioned, referral to social workers and OTs was reported to be limited when compared to referrals to psychologists.

An interesting issue was raised during a Queensland site visit regarding the willingness of a person to have a Mental Health Care Plan completed. During one site visit a practitioner indicated that:

> *A lot of clients are worried to get a mental health plan - they are scared they are going to get it on their record. I have even heard GPs saying they are advising people against getting mental health plans because they say it is going to impact on their ability to get insurance. Insurers are asking for it. I don't know if it's true or not, but it's a serious issue. When it comes to me, I want to say to the client "I am not sure if it will impact you. But I have heard that the insurance companies are able to investigate you". This has also led to people paying cash and not using the health plan*.

This issue was raised regarding the intersection between a mental health diagnosis and insurability. This issue requires further inquiry and the provision of accurate information to metal health professionals as part of the MHPA's communication strategy.

Most significant change to practice

In open text responses to the question 'what was the most significant change to practice since the introduction of the Better Health Access Scheme?', there was a general agreement that access and affordability to mental health services were improved and quality of care enhanced. Further comment included that the scheme created a heightened awareness in the community about mental health services and a greater likelihood to seek counselling and other support for mental heath issues.

Many participants thought that the increase in administrative requirements was overly onerous with some noting that this took time away from patient care (GPs, mental health nurses, OTs, social workers); others commented that remuneration should extend to administrative requirements (clinical and registered psychologists).

While some participants noted an increase in diversity in their caseloads, for example, more clients from low socio-economic backgrounds and clients with alcohol and drug issues. Others were concerned that the scheme failed to reach chronically mentally unwell clients and those experiencing economic disadvantage. One GP stated:

> *There is more capacity for referral of patients to private psychologists; however the gaps are often still quite prohibitive to the patients who need the services most. It is also difficult to develop a good referral base and ensure that patients are getting well tailored services…. Most people with a mental health problem will often be short of money due to many reasons, loss of job, family disharmony etc…. all the publicly available psychologists are no longer available as they are treating the 'worried well' privately… psychologists increased their fee when the rebate was introduced so the gap means that people with significant mental illness still can't afford to get help.*

Psychologists (clinical and registered) reported an increase in referrals waiting lists and remuneration, while psychiatrists reported a decrease in referrals for longer treatment. OTs, mental health nurses and social workers reported an increase in referrals however noted that their roles were not as clearly understood by GPs as psychiatry and psychology. Some thought that this may be due to the profession of psychology being more successful in marketing itself in the private sector but that over time a greater understanding of other roles would occur.

Client and carer awareness of the Better Access initiative

During consultations, clients and carers were asked about their awareness of the Better Access initiative, as well as their expectations. They indicated they were not aware of the Better Access initiative, but they had noticed an increase in referrals to psychologists by GPs. Clients and their carers stated that their expectations of any mental health professional were that they provide accurate advice and treatment, as well as genuine support. It was generally agreed that if a psychologist could assist them, then this would be of great value.

Referrals to other professionals can cause some anxiety for clients, and they want to see professionals that have the skills to help them. One carer advised that her daughter had to see several different psychologists before they found one with the specific skills required. This finding suggests that there is the need to distinguish between the different therapies available from different psychologists. Given that the GP is required to make these referrals, the MHPA may need to consider how best to inform the GPs about the interests and specialisations of psychologists within their local area. A good example that the MHPA may wish to consider are the local directories developed by the Divisions of General Practice.

The use of the item numbers was not something that the clients or clients were able to comment on. None of the participants were able to comment on their use of social workers and OTs in mental health, but they did indicate that it would be "a good idea". Most thought that their GP would not know how these two professionals could assist as referrals had not been made. Again, this has implications for the MHPA regarding the promotion of allied health professionals and their role in mental health.

Overall perspectives reported through open text responses

Clinical psychologists

In the main, clinical psychologists reported Better Access is providing positive benefits for clients experiencing mental health, mostly noted as increasing access to private psychologists. There was also general support for training and enhanced support within the Better Access health scheme and improved communication between professional groups. Many commented that they were not appropriately paid for the administrative burdens of the scheme. There were a number of people in this group who felt that treatment for clients with mental health issues should be provided by GPs and clinical psychologists because they believed that the other professions did not have the appropriate training. Some, however, noted that other professions involved had a role to play, and they would welcome working collaboratively with those professions. At the same time there was a general recognition of little knowledge or awareness of the roles of the other allied health professions.

GPs

GPs generally thought that collaboration with other mental health professions was a positive approach to care for clients experiencing mental health issues. There was, however, concern about the practical implications in terms of administration, time constraints, practitioner availability, and communication with practitioners. There was significant comment that Better Access is not assisting clients with long term complex mental health issues and/or those with financial difficulties. These comments were often couched in recognition of the inadequate levels of funding for the public sector, and that private practitioners, particularly psychologists tend to see the 'worried well' rather than those with complex needs. Many thought the health care plans were an administrative burden with little benefit for the client. GPs were keen to have more resources to facilitate greater inclusion of mental health nurses and more affordable psychiatrists. They tended to refer mostly to psychologists because they did not have access to information about other professions. There was general enthusiasm for good quality education and training which would assist communication and understanding of the roles of other professions.

Mental health nurses

Mental health nurses generally welcomed the scheme as an approach which could potentially benefit the care of clients experiencing mental health issues. Administration, availability of practitioners and problems for clients with financial problems were cited as barriers to success. Mental health nurses also felt their profession was misunderstood by other professions and that their skills and expertise were at times demeaned. Differential remuneration across allied health professionals was noted as a problem. There was general enthusiasm for the opportunity to share information and knowledge with other mental health professions and for further training and education.

OTs

OTs generally thought the scheme was a positive initiative for improving access to mental health services. While OTs were generally positive about their relationship with GPs, the lack of time to provide thorough assessments was noted. The difference in remuneration for the same service was cited as a problem, particularly between allied health professionals. There was common interest in and enthusiasm for training and education.

Paediatricians

Paediatricians commented that access to psychiatrists and services for children is limited. They were also keen for more mental health nurses with paediatric expertise to be employed.

Psychiatrists

Psychiatrists recognised some benefits of the scheme but expressed concern about the lack of accountability and appropriate training of some of the allied health professionals involved in the scheme and the risk of poor quality service provision. The potential for mental health funding to be 'rorted' as a result was also a concern for this group. Access for rural and other disadvantaged communities and individuals was noted as a significant concern, as was access for clients with severe and chronic mental

health issues with financial difficulty. There was general support for and interest in working with mental health nurses.

Psychologists

There was general support among this group and a belief in the benefits for clients with mental health problems – noted specifically as allowing access to psychologists for those clients who could not otherwise afford them. A lack of parity in remuneration with clinical psychologists was noted as discriminatory and 'insulting' to the skills and expertise of registered psychologists. There was a general interest in the role of OTs, social workers and mental health nurses and an enthusiasm for training to develop better understanding of the roles of other professions and particularly mental health nurses. A lack of access to professionals in rural settings was noted as a problem as well as additional travel costs and other related expenses for rural practitioners.

Social workers

Social workers were generally supportive and felt that it was particularly positive in facilitating counselling opportunities for clients to assist managing mental health challenges. There was support for other allied health professions and an interest in training which brought together other professionals to develop a better understanding of what each other does.

It was noted that the APS has been particularly effective in 'marketing' psychology which might explain why GPs think to refer to psychologists more so than other professions. A greater understanding of other professions by GPs was thought to improve the scheme more generally. Similarly differential remuneration was described as not appropriately recognising the skills and expertise of other professions. Improved communication between referring professions was desired as a way of enhancing the benefits for clients.

6.3.3 Benchmarking for collaborative care

The MHPA has expressed an interest in benchmarking (or rather conducting a longitudinal study of) knowledge, perceptions and behaviours of medical professionals in primary mental health as they relate to collaboration. Such an investigation clearly has the potential to inform the design of training initiatives that support collaboration and schemes to incentivise the type of collaboration thought to be beneficial and enable their impact to be assessed.

The survey conducted as part of this project provides useful data that relate to the degree of collaboration between a limited set of professional groups, the circumstances under which this collaboration occurs and the perceived benefits. In particular Part E Care planning and co-ordination, Part F: Triggers, barriers and enablers for multidisciplinary work and Part G: Clinical networks posed a series questions to respondents that relate to collaboration. For example, the most frequently reported trigger for a respondent to initiate communication with another health professional was the complexity of client need, whereas the most commonly reported barrier to multidisciplinary care was low availability of specialised services.

Each question in the on-line survey effectively provides a benchmark, or a point of comparison, against which changes in knowledge, perception and behaviour of the 7 professional groups can be monitored.

Given that there are numerous questions in the survey which elicit large volumes of data, analysis of future surveys should be targeted based on a specific question. For example, a finding of this survey was that OTs are not considered as important as other practitioners in mental health in the primary sector. If the MHPA decided to provide training to the sector regarding the role of OTs in collaborative care, the MHPA could determine the success of these initiatives by running and analysing questions in the survey that relate to perception of OTs by other mental health professionals. In this way, each question run on this occasion is a potential bench mark.

It should also be noted that the survey was not distributed to representatives of all professional groups working in the area of mental health. Insights gained through the qualitative phase of the project indicated (not surprisingly), that there are numerous other important actors that determine the overall quality of a client's experience of the mental health system and that these actors may or may not be collaborating.

The qualitative data regarding knowledge, perceptions' and behaviours also provided a rich source of information. We would recommend that any future research should include a quantitative component that replicates that undertaken for this project, especially consultations with clients of mental health services.

7 Recommendations

The MHPA have formulated the following recommendations based on the findings of the environmental scan research:

- Collaboration in mental health care involves many different services and organisations, non-government organisations. Accordingly these need to be incorporated and integrated into clinical networks.
- Professional groups should lead the establishment of these networks along with the ongoing development of required training packages and resources
- Peak professional bodies should collaborate to generate a joint statement regarding scopes of practice for various professions under the 'Better Access Initiative'.
- The process of establishing collaborative networks should involve linking networks with CPE programs.
- To facilitate the development of collaborative models of care, funding should be provided for:
    - → Network Development: The establishment and development of systems and tools to facilitate collaboration and supportive interdisciplinary networks.
    - → Training and Development: The refinement, ongoing development and evaluation of training packages, systems and tools to facilitate networking and collaboration.
    - → Enhanced Resource Portal: To allow the resource portal to be truly multi-disciplinary and include, online learning capabilities; virtual networks and multidisciplinary chat rooms, and information about the other agencies and organisations that support people with a mental illness and their families.
    - → Further Research into the scope of support needed for people with a mental illness and their families as well as what is currently being provided.
    - → Further Research into the current workforce in mental health – who is providing support and for how long?
- Future work should continue to incorporate the client and carer perspectives.
- Future work should include networks for Aboriginal and/or Torres Strait Islander services and agencies in both health and mental health.

Appendix A List of references

List of references

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Appendix B Survey data

Part B: Better Access and the Mental Health Nurse Incentive

B1 **In 2006, a range of new Medicare items were introduced under the Better Access to Mental Health Care initiative.**

How familiar are you with the SERVICES provided by *each* of the professional groups under the new items?

Please indicate your familiarity with *every* item – including those not directly applicable to your discipline. Note: allied mental health item numbers are yet to be included.

(Select one option in EVERY row. If you don't know what the item is, select 'not at all familiar')

Items for psychiatrists

Familiarity among psychiatrists (raw n=223)*	Not at all familiar				Very familiar	*Mean score*
	1	2	3	4	5	
Item 296, 297 and 299 : Initial consultation with a new client	3%	9%	14%	23%	51%	4.09
Item 291: Referred assessment and management plan	9%	18%	21%	22%	30%	3.46
Item 293: Review of management plan	12%	22%	21%	21%	23%	3.21
Familiarity among non-psychiatrists** (raw n=#)						
Item 296, 297 and 299 : Initial consultation with a new client						
Item 291: Referred assessment and management plan						
Item 293: Review of management plan						

* One psychiatrist missed this question.
** These responses are taken from a refiled of the questionnaire, so only represent a sample of all respondents. Respondents in the refiled were *reweighted* to ensure representativeness.

Items for GPs

Familiarity among GPs (raw n=267)	Not at all familiar				Very familiar	*Mean score*
	1	2	3	4	5	
Item 2710: Preparation of a GP Mental Health Care Plan	3%	4%	6%	18%	67%	4.42
Item 2712: Review of a GP Mental Health Care Plan	5%	7%	9%	26%	52%	4.14
Item 2713: Mental health consultation	14%	12%	12%	16%	46%	3.68
Familiarity among non-psychiatrists* (raw n=#)*						
Item 2710: Preparation of a GP Mental Health Care Plan						
Item 2712: Review of a GP Mental Health Care Plan						
Item 2713: Mental health consultation						

* These responses are taken from a refiled of the questionnaire, so only represent a sample of all respondents. Respondents in the refiled were *reweighted* to ensure representativeness.

Items for clinical psychologists

Familiarity among clinical psychologists (raw n=420)	Not at all familiar				Very familiar	*Mean score*
	1	2	3	4	5	
Items (80000; 80010): Provision of psychological therapy	0%	3%	5%	16%	76%	4.64
Items (80020): Group therapy provided by a clinical psychologist	21%	15%	25%	17%	22%	3.03
Familiarity among non- clinical psychologists (raw n=#)						
Items (80000; 80010): Provision of psychological therapy						
Items (80020): Group therapy provided by a clinical psychologist						

Items for psychologists, social workers and OTs

Familiarity among psychologists (raw n=761)	Not at all familiar				Very familiar	*Mean score*
	1	2	3	4	5	
Items (80100, 80110, 80125, 80135, 80150, 80160): Provision of FPS	3%	5%	14%	25%	53%	4.20
Items (80020, 80120, 80145, 80170): Group therapy	27%	25%	20%	15%	13%	2.63
Familiarity among social workers (raw n=64)*						
Items (80100, 80110, 80125, 80135, 80150, 80160): Provision of FPS	11%	8%	16%	25%	41%	3.77
Items (80020, 80120, 80145, 80170): Group therapy	25%	19%	27%	22%	8%	2.69
Familiarity among OTs (raw n=50)						
Items (80100, 80110, 80125, 80135, 80150, 80160): Provision of FPS	26%	22%	10%	22%	20%	2.88
Items (80020, 80120, 80145, 80170): Group therapy	28%	28%	16%	12%	16%	2.60
Familiarity among non-registered psychologists, social workers or OTs (raw n=#)**						
Items (80100, 80110, 80125, 80135, 80150, 80160): Provision of FPS						
Items (80020, 80120, 80145, 80170): Group therapy						

* Due to a coding anomaly, 188 of the 252 social workers skipped this question.
** These responses are taken from a refiled of the questionnaire, so only represent a sample of all respondents. Respondents in the refiled were *reweighted* to ensure representativeness.

Table B2a: Overall, how much change have you seen in your day-to-day work (in private practice) as a result of the introduction of these new Medicare items? *(Select one)*

Thinking only about *their* items	No change				Major change	*Not sure, can't say*	*Mean score (excludes can't say)*
	1	2	3	4	5		
Psychologists	4%	8%	15%	27%	39%	8%	3.97
Social workers	9%	11%	16%	21%	30%	13%	3.60
General practitioners	15%	16%	15%	22%	28%	3%	3.34
Occupational therapists	14%	8%	12%	8%	12%	46%	2.93
Psychiatrists	38%	29%	12%	13%	7%	2%	2.22
Total of the above (weighted)	11%	13%	15%	24%	32%	6%	3.57

Table B3: How familiar are you with the range of services that can be provided by mental health nurses under the Mental Health Nurse Incentive Program? *(Select one)*

	Not at all familiar				Very familiar	*Mean score*
	1	2	3	4	5	
Mental health nurses	24%	22%	22%	18%	14%	2.76
General practitioners	44%	29%	16%	7%	4%	1.99
Psychiatrists	50%	22%	16%	8%	5%	1.96
Social workers	52%	25%	13%	7%	2%	1.82
Occupational therapists	64%	16%	12%	6%	2%	1.66
Clinical psychologists	60%	26%	7%	4%	2%	1.62
Psychologists	63%	22%	10%	3%	2%	1.60
Paediatricians	72%	22%	6%	0%	0%	1.33
Total (weighted)	49%	25%	14%	7%	5%	1.95

Table B4a: Overall, how much change have you seen in your day-to-day private practice work as a result of the introduction of mental health nurse services? *(Select one)*

	No change				Major change	*Not sure, can't say*	*Mean score (excludes can't say)*
	1	2	3	4	5		
Mental health nurses	31%	7%	6%	7%	2%	47%	1.90
Clinical psychologists	65%	5%	3%	6%	5%	17%	1.55
General practitioners	74%	5%	3%	2%	4%	13%	1.37
Social workers	69%	6%	3%	2%	1%	19%	1.29
Psychologists	70%	6%	2%	1%	1%	19%	1.23
Occupational therapists	50%	2%	2%	2%	0%	44%	1.21
Psychiatrists	84%	6%	2%	1%	1%	5%	1.19
Paediatricians	69%	0%	0%	0%	0%	31%	1.00
Total (weighted)	66%	6%	3%	3%	2%	21%	1.37

Part C1: Practice trends for psychiatrists

C1-1 Over the last month, have you… *(Select all that apply) 85%*

Raw n=224 Psychiatrists *(multiple responses allowed, excluding 'none of the above')*	
Seen any new clients in private practice under item 296	79%
Prepared any Referred Assessment and Management Plans (item 291)	32%
Undertaken any Reviews of Referred Assessment and Management Plans (item 293)	9%
Referred any patients for Better Access allied mental health services	38%
None of the above	15%

C1-2 In your private practice over the last month, did any of the following people/groups seek to involve you with any NEW clients to your PRIVATE practice in relation to management of a mental disorder under either item 291 or item 296? *(Select all that apply) 79%*

Raw n=224 Psychiatrists *(multiple responses allowed, excluding 'none of the above')*	
GP/s	76%
Other privately practising psychiatrist/s	29%
Government mental health service	18%
Nurse working in primary practice under MHNIP (e.g. with a GP)	0%
Other referral source*	21%
None of the above – no new referrals under 291 or 296 (exclusive code)	21%

* several psychologists (clinical or otherwise) as well as small numbers of lawyers, insurance companies, community nurses, disability services, rehabilitation services, drug and alcohol services, child protection agencies, emergency wards, physicians and other medical specialists.

C1-3 Over the last month, how many mental health care plans prepared by you involved a REFERRAL TO OR FROM… *(Select all that apply) 75%*

Raw n=224 Psychiatrists *(multiple responses allowed, excluding 'none of the above')*	
GP/s	59%
Other privately practising psychiatrist/s	9%
Government mental health service	9%
Nurse working in primary practice under MHNIP (e.g. with a GP)	0%
Other referral source*	15%
None of the above – no new referrals under 291 or 296 (exclusive code)	35%

* several psychologists (clinical or otherwise) as well as small numbers of drug and alcohol services, social workers, legal aid/lawyers, pain specialists, occupational rehabilitation, aged care services, community nurses and a specialist psychological assessment service

C1-4 In your PRIVATE PRACTICE over the last month, when you have received REFERRALS FROM GENERAL PRACTITIONERS, how often did you… *(Select one per row)*

	Never				Always	*Not sure*	*Not applicable**
Receive a detailed referral letter?	12%	25%	28%	17%	14%	0%	5%
Receive a **complete** copy an existing Mental Health Care Plan?	43%	30%	14%	6%	2%	0%	5%
Receive a **partial** copy an existing Mental Care Health Plan?	54%	21%	11%	3%	1%	2%	7%
Provide a prepared report on treatment progress back to the referring GP?	7%	4%	9%	18%	55%	0%	5%

* ie haven't received any referrals from GPs over the last month

C1-5 In your PRIVATE PRACTICE over the last month, when you MADE REFERRALS TO OTHER HEALTH PROFESSIONALS as part of ongoing client management or shared care arrangements, how often did you… *(Select one per row)*

	Never				Always	*Not sure*	*Not applicable**
Provide a detailed referral letter?	4%	3%	7%	16%	49%	0%	22%
Provide a complete copy of the prepared Mental Health Care Plan?	61%	8%	1%	2%	4%	2%	23%
Provide a partial copy of the prepared Mental Health Care Plan?	63%	6%	2%	2%	2%	2%	24%
Receive a subsequent report from the other health professional?	21%	13%	23%	13%	8%	0%	22%

* ie haven't made referrals to other health professionals as part of ongoing client management or shared care arrangements over the month

Part C2: Practice trends for GPs

C2-1 Over the last month, have you… *(Select all that apply) 86% have done one of the 3*

Raw n=267 GPs *(multiple responses allowed, excluding 'none of the above')*	
Prepared any GP Mental Health Care Plans using item 2710	83%
Undertaken a formal review of any GP Mental Health Care Plans (item 2712)	54%
Provided any mental health consults (item 2713)	53%
None of the above	14%

C2-2 Over the last month, did any of the following people/groups recommend any NEW clients to your PRIVATE practice in relation to management of a mental disorder? *(Select all that apply)*

Raw n=267 GPs *(multiple responses allowed, excluding 'none of the above')*	
Other GP/s	23%
Privately practising psychiatrist/s	8%
Privately practising psychologists, OTs or social workers	37%
Government mental health service	17%
Nurse working in primary practice under MHNIP (e.g. with a psychiatrist)	1%
Mental health nurse	2%
Client-initiated referral	58%
Other referral source*	22%
Not applicable – no new referrals in relation to management of a mental disorder	24%

* the two most common 'other' sources were the Beyond Blue web site (13 reference) and friends/family of the patient (8). Other sources included other patients, Centrelink, drug and alcohol services, child/maternal health services, school counsellors, dieticians/eating disorder clinics, aged care facilities, prison health services.

C2-4 Over the last month, how many of the GP Mental Health Care Plans (item 2710) prepared by you involved a referral to other health professionals? *(Select one)*

Raw n=267 GPs *(multiple responses allowed, excluding 'none of the above')*	
All of them	48%
Most of them	20%
Some of them	12%
None of them	3%
Not applicable – not prepared any Plans at C2-1 (question not asked)	17%

C2-5 In your PRIVATE PRACTICE over the last month, when you RECEIVED REFERRALS FROM OTHER MENTAL HEALTH PROFESSIONALS, how often did you… *(Select one per row)*

Raw n=267 GPs	Never				Always	*Not sure*	*Not applicable**
Receive a detailed referral letter?	24%	10%	9%	6%	7%	0%	44%
Receive a **complete** copy of an existing Mental Health Care Plan?	40%	4%	2%	1%	1%	1%	49%
Receive a **partial** copy of an existing Mental Health Care Plan?	43%	3%	1%	1%	1%	1%	49%
Provide a written report on treatment progress back to the referring mental health professional?	19%	6%	7%	7%	13%	0%	48%

* i.e. haven't received any referrals from other mental health professionals over the last month

C2-6 In your PRIVATE PRACTICE over the last month, when you MADE REFERRALS TO OTHER HEALTH PROFESSIONALS as part of a GP Mental Health Care Plan, how often did you… *(Select one per row)*

Raw n=267 GPs	Never				Always	*Not sure*	*Not applicable**
Provide a detailed referral letter?	8%	4%	4%	13%	60%	1%	9%
Provide a **complete** copy of the prepared Mental Health Care Plan?	10%	3%	3%	9%	64%	0%	10%
Provide a **partial** copy of the prepared Mental Health Care Plan?	57%	3%	4%	3%	6%	1%	26%
Receive a subsequent report from the other health professional?	10%	16%	18%	27%	17%	2%	10%

* i.e. haven't made any referrals to other mental health professionals over the last month.

Part C3: Practice trends for clinical psychologists, psychologists, OTs and social workers

C3-1 Over the last month, have you… *(Select all that apply)*

(multiple responses allowed, excluding 'none of the above') Raw n=	clinical psychologists	psychologists	OTs	Social workers
	420	761	50	252
Claimed for psychological therapy under items 80000 and 80010	93%	na	na	na
Claimed for FPS under items 80100, 80110, 80125, 80135, 80150, 80160	na	90%	38%	73%
Claimed for group therapy under items 80020, 80120, 80145, 80170	2%	2%	0%	3%
None of the above	6%	9%	62%	26%

C3-2 Over the last month, did any of the following people/groups involve you with any NEW clients to your PRIVATE practice for either of these Medicare-funded services? *(Select all that apply).*

(multiple responses allowed, excluding 'none of the above') Raw n=	clinical psychologists	psychologists	OTs	Social workers
	420	761	50	252
GP/s	92%	89%	36%	69%
Privately practising psychiatrist/s	40%	22%	20%	13%
Paediatrician/s	17%	11%	10%	7%
Nurse working in primary practice under MHNIP (eg with a psychiatrist or GP)	1%	3%	2%	4%
Community based mental health nurse	4%	4%	2%	4%
Privately practising mental health nurse	0%	0%	2%	0%
Client-initiated referral	65%	59%	16%	54%
Other referral source*	27%	23%	8%	25%
None of the above – no new referrals in relation to Medicare-funded services in the	4%	9%	52%	21%

* Includes previous clients, friends/family, web sites (e.g. Beyond Blue, APS Referral Database), other practitioners in the same discipline, women's domestic violence service, Area Mental Health services, Carers associations, Centrelink, cultural workers, clinical psychologists, community agencies, community mental health services, lawyers, correctional services/court, crisis accommodation services, religious ministers, child protection agencies, Veterans' Affairs, dieticians/eating disorder services, disability services, drug and alcohol services, employee assistance services, word of mouth, WorkCover,

gynaecologists/obstetricians, community agencies, insurance companies, naturopaths, OTs, massage therapists, speech pathologists, psychiatrists, rehabilitation services, school staff/counsellors, victims of crime services.

C3-3 Over the last month, have you recommended any clients to any of the following people/groups for mental health care? *(Select all that apply)*

(multiple responses allowed, excluding 'none of the above') Raw n=	clinical psychologists	psychologists	OTs	Social workers
	420	761	50	252
A GP	62%	64%	44%	62%
A privately practising psychiatrist	49%	43%	32%	32%
Government mental health service	34%	29%	40%	30%
Nurse working in primary practice under MHNIP (e.g. with a psychiatrist or GP)	0%	1%	4%	0%
A privately practising mental health nurse	0%	0%	2%	0%
None of the above	20%	22%	34%	26%

C3-4 In your PRIVATE PRACTICE over the last month, when you RECEIVED REFERRALS FROM OTHER HEALTH PROFESSIONALS UNDER MEDICARE, how often did you… *(Select one per row)*

clinical psychologist *Raw n=420*	**Never**				**Always**	*Not sure*	*Not applicable**
Receive a detailed referral letter?	6%	12%	21%	33%	23%	0%	4%
Receive a **complete** copy of the client's written Mental Health Care Plan?	3%	7%	22%	42%	21%	0%	4%
Receive a **partial** copy of the client's prepared Mental Health Care Plan?	23%	19%	16%	26%	9%	0%	6%
Provide a prepared report on treatment progress back to the referring medical practitioner?	2%	1%	6%	16%	69%	0%	5%

* i.e. haven't received any referrals from other mental health professionals under Medicare over the last month

psychologist *Raw n=761*	**Never**				**Always**	*Not sure*	*Not applicable**
Receive a detailed referral letter?	5%	11%	19%	29%	29%	0%	7%
Receive a **complete** copy of the client's written Mental Health Care Plan?	6%	7%	18%	40%	21%	1%	7%
Receive a **partial** copy of the client's prepared Mental Health Care Plan?	20%	20%	17%	25%	7%	2%	9%
Provide a prepared report on treatment progress back to the referring medical practitioner?	4%	3%	5%	15%	66%	0%	7%

* i.e. haven't received any referrals from other mental health professionals under Medicare over the last month

OTs *Raw n=50*	**Never**				**Always**	*Not sure*	*Not applicable**
Receive a detailed referral letter?	4%	6%	12%	10%	16%	6%	46%
Receive a **complete** copy of the client's written Mental Health Care Plan?	12%	10%	6%	8%	8%	4%	52%
Receive a **partial** copy of the client's prepared Mental Health Care Plan?	18%	2%	18%	2%	2%	4%	54%
Provide a prepared report on treatment progress back to the referring medical practitioner?	6%	0%	4%	4%	32%	4%	50%

* i.e. haven't received any referrals from other mental health professionals under Medicare over the last month

social workers *Raw n=50*	**Never**				**Always**	*Not sure*	*Not applicable**
Receive a detailed referral letter?	13%	10%	14%	17%	26%	2%	17%
Receive a **complete** copy of the client's written Mental Health Care Plan?	10%	10%	13%	26%	19%	4%	17%
Receive a **partial** copy of the client's prepared Mental Health Care Plan?	24%	14%	14%	19%	4%	4%	21%
Provide a prepared report on treatment progress back to the referring medical practitioner?	9%	6%	6%	12%	45%	2%	20%

* i.e. haven't received any referrals from other mental health professionals under Medicare over the last month

Part C4: Practice trends for mental health nurses

C4-1 Over the last month, have you provided services for any community based clients with a <u>SEVERE MENTAL ILLNESS</u> in liaison with… *(Select all that apply)*

Raw n=254 mental health nurses *(multiple responses allowed, excluding 'none of the above')*	
GP/s	46%
Privately practising psychiatrist/s	26%
Government mental health service	49%
Other*	20%
None of the above – have not done this work in the last month	28%
None of the above – have done this work in the last month, but not in liaison with any other professions	4%

* Aboriginal health services, churches, drug/alcohol services, medical specialists (e.g. pain management), mental health assessment teams, Aged Care Assessment Teams, community health, community support agencies (e.g. provide transport, home maintenance), disability services, Centrelink, eating disorder support, emergency departments, in the university system, private hospitals, schools and support services, pharmacists, paediatricians, social housing agencies, employment services, sexual assault counselling services, child protection agencies, courts, police, psychologists, women's refuges.

C4-2 Over the last month, have you recommended any of the following people/groups for mental health care to any clients? *(Select all that apply)*

Raw n=254 mental health nurses *(multiple responses allowed, excluding 'none of the above')*	
A GP	61%
A privately practising psychiatrist	41%
Government mental health service	56%
Other*	25%
None of the above	19%

* Aboriginal health services, drug and alcohol services, community agencies, private psychologists and social workers, community health services, depression self help group, local crisis housing services, dietician, Lifeline, relationship counselling, nurse practitioners, brokerage services, neuro-psychologists, nursing services, school psychologists, child care providers, women's refuges.

Part E: Care planning and co-ordination

Table Ea: Which professional group/s do you feel should play an 'important role' in this element of mental health assessment and care?

n=2,264 multiple response (apart from 'none of the above')	a) Assessment and diagnosis of a client's mental health	b) Care Planning	c) Provision of psycho-education
GPs	91%	87%	63%
mental health nurses	50%	52%	59%
OTs	22%	28%	30%
paediatricians	51%	36%	29%
psychiatrists	89%	63%	57%
clinical psychologists	84%	69%	84%
psychologists	69%	62%	76%
social workers	39%	47%	45%
other	8%	7%	6%
None of the above	0%	1%	1%

Table Ea continued: Which professional group/s do you feel should play an 'important role' in this element of mental health assessment and care?

n=2,264 multiple response (apart from 'none of the above')	d) Provision of psychological therapies and FPS	e) Coordination of other supports	f) Supporting compliance with treatment	g) Progress monitoring and review of a client's mental health
GPs	33%	79%	82%	89%
mental health nurses	31%	57%	63%	56%
OTs	16%	26%	22%	20%
paediatricians	8%	22%	26%	29%
psychiatrists	45%	25%	49%	67%
clinical psychologist	92%	34%	56%	73%
psychologist	80%	36%	55%	66%
social workers	25%	64%	42%	36%
other	3%	6%	8%	5%
None of the above	1%	1%	2%	0%

Part F: Triggers, barriers and enablers for multi-disciplinary work

Table F2: Prior research has identified a number of barriers that can impede effective multidisciplinary care in cases where this would be of significant clinical benefit. In your region, how significant are the following barriers in IMPEDING EFFECTIVE MULTI-DISCIPLINARY CARE? *(Select one per row)*

n=2,264 (full sample)	Not a barrier 1	2	3	4	Major barrier 5	Not sure	Mean score (excl not sure)
Low availability of specialised services*	5%	8%	14%	22%	46%	4%	3.99
Cost of access to services	7%	10%	13%	22%	45%	3%	3.92
Low availability of general mental health services	9%	10%	13%	21%	43%	3%	3.82
Poor support for service coordination	7%	12%	19%	27%	30%	5%	3.63
Lack of interdisciplinary networking opportunities	12%	13%	20%	25%	28%	3%	3.45
Poor communication between professionals	8%	16%	24%	27%	23%	3%	3.41
Lack of remuneration for coordination of services	16%	12%	15%	23%	29%	5%	3.37
Complexity of referral and reporting systems	15%	16%	18%	23%	25%	3%	3.28
Lack of knowledge about other health care providers	15%	21%	22%	23%	17%	2%	3.06
Lack of agreed referral protocols	20%	18%	20%	19%	16%	8%	2.91
Client preference for care from a single provider	18%	21%	23%	20%	14%	5%	2.90
Service providers not co-located	28%	15%	14%	18%	20%	5%	2.88
Poor understanding of different professional roles	21%	22%	21%	18%	14%	3%	2.82
Lack of agreed treatment protocols	23%	19%	21%	17%	14%	7%	2.79
Lack of confidence in other health care providers	25%	22%	22%	16%	11%	3%	2.64

Table F4a: Prior research has also identified a number of ENABLING FACTORS that can make effective multidisciplinary care possible or easier. HOW ESTABLISHED (if at all) are the following things IN YOUR REGION with regard to multidisciplinary mental health care? *(Select one per row)*

n=2,264 (full sample)	Not established 1	2	3	4	Fully established 5	Not sure	Mean score (excl not sure)
Brokerage services (e.g. local divisions of general practice)	13%	16%	19%	18%	17%	18%	3.11
Agreed referral protocols	22%	19%	21%	19%	10%	10%	2.73
Good interdisciplinary knowledge of each others professional roles	16%	26%	27%	17%	7%	6%	2.70
Co-location of multidisciplinary professional teams	25%	26%	23%	11%	6%	10%	2.41
Agreed treatment protocols	28%	22%	20%	12%	6%	12%	2.38
Supported networking activities (e.g. interdisciplinary clinical education)	29%	28%	18%	12%	4%	10%	2.27
Agreed care planning models	30%	24%	18%	11%	5%	13%	2.27
Integration of practice information systems	39%	21%	13%	7%	4%	15%	2.02

F4b Below is a list of the things that you said were not (fully) established in your region. HOW MUCH POSITIVE IMPACT (if any) do you think the enhancement or introduction of these things would make on facilitating effective and appropriate multidisciplinary mental health care in your region? *(Select one per row)*

	Valid Raw n=	No +ve impact 1	2	3	4	Major +ve impact 5	Not sure	Mean score (excl not sure)
Integration of practice information systems	1,932	2%	3%	13%	28%	52%	2%	4.27
Supported networking activities (e.g. interdisciplinary clinical education)	1,929	3%	4%	14%	28%	50%	2%	4.21
Brokerage services (e.g. local divisions of general practice)	1,791	4%	7%	18%	28%	39%	3%	3.92
Agreed care planning models	1,816	4%	7%	19%	30%	36%	4%	3.90
Agreed treatment protocols	1,785	5%	8%	18%	27%	37%	5%	3.87
Agreed referral protocols	1,834	5%	9%	19%	27%	35%	4%	3.82
Co-location of multidisciplinary professional teams	1,866	4%	12%	18%	26%	36%	4%	3.80
Good interdisciplinary knowledge of	1,455	6%	9%	21%	28%	29%	6%	3.69

each others professional roles

F6 HOW AVAILABLE (if at all) are the following professionals IN YOUR REGION for provision of multidisciplinary mental health care?

	Not avail-able				Very avail-abler	Not sure	Mean score (excl not sure)
n=2,264 (full sample)	1	2	3	4	5		
psychologist	4%	9%	17%	28%	33%	9%	3.83
GPs	2%	14%	20%	28%	32%	4%	3.75
clinical psychologists	4%	16%	19%	29%	25%	7%	3.59
paediatricians (in the context of treating children)	10%	23%	20%	15%	11%	22%	2.94
social workers	9%	20%	19%	13%	10%	29%	2.94
psychiatrists	9%	35%	23%	16%	10%	7%	2.83
mental health nurses	17%	23%	14%	8%	6%	32%	2.46
OTs (providing mental health services)	23%	23%	11%	5%	4%	35%	2.14

Table G2: How beneficial would you find clinical networking activities with the following professions? *(Select one option per row)*

	Not benefi cial				Very benefi cial	Not sure	Mean score (excl not sure)
n=2,264 (full sample)	1	2	3	4	5		
psychiatrists	2%	3%	8%	19%	67%	2%	4.50
clinical psychologists	2%	3%	8%	20%	65%	3%	4.47
GPs	3%	4%	12%	16%	63%	2%	4.35
psychologists	4%	3%	10%	21%	57%	6%	4.31
mental health nurses	5%	6%	13%	18%	44%	15%	4.04
social workers (providing mental health services)	5%	6%	13%	21%	44%	10%	4.04
paediatricians (in the context of treating children)	8%	8%	13%	17%	42%	12%	3.87
OTs (providing mental health services)	7%	10%	16%	17%	30%	19%	3.65

Table G5: Prior research has identified a number of barriers that can prevent or impede effective clinical networking. In your clinical networking, how significant are the following barriers? *(Select one option per row)*

n=2,264 (full sample)	Not a barrier 1	2	3	4	Major barrier 5	Not sure	Mean score (excl not sure)
Limited available time	5%	4%	10%	18%	61%	2%	4.29
Lack of funding support for clinical networks	5%	6%	12%	24%	46%	7%	4.09
Competing clinical priorities	8%	5%	11%	26%	44%	5%	3.98
Lack of coordination support for clinical networks	6%	7%	14%	29%	38%	6%	3.92
Cost of participation	11%	10%	15%	24%	35%	5%	3.65
Lack of understanding about the options available using new technology	26%	15%	16%	21%	15%	6%	2.83
Uncertain value of clinical networks	25%	15%	24%	18%	11%	7%	2.74
Few other professionals in my area	27%	17%	21%	16%	15%	5%	2.74
Lack of access to digital technology	34%	15%	15%	14%	18%	4%	2.65
Preference for peer networking	26%	19%	24%	15%	7%	10%	2.53
Lack of relevance to my clinical role	36%	22%	18%	10%	6%	7%	2.22

{ TC "APPENDICES: ." \l5 }

{ TC "APPENDICES: ." \l5 }

Appendix C Perspectives of roles and responsibilities

Professional roles in the context of primary mental health care

General practice

In Australia, general practitioners (GPs) are the first port of call for the significant majority of patients seeking healthcare. GPs are both care providers and 'gate keepers' to secondary health services. The Royal Australian College of General Practitioners (RACGP) defines general practice as "the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities" (2007). Whole-patient care in this context encompasses a bio-psychosocial approach to health care, recognising that each of these strands contributes to more effective, holistic care. A key characteristic of general practice is continuity which includes a relational continuity, enacted by attributions to 'my doctor' and 'my patient'.

Australian consumers have identified GPs as their preferred source of professional help for mental health problems, and this is evidenced in practice by the high rate of first presentation to a GP (Highet et al. 2002). The role of general practice in treating mental illness is increasing both in terms of the national policy since the first National Mental Health Plan and in the 'real world'. In 1990-91, depression was reported by GPs to be the tenth most frequent problem (Bridges-Webb et al. 1992). In 2005-06, depression climbed to be the fourth most common condition requiring general practice attention (Britt et al. 2007). In addition, general practitioners have been reported as the most common providers of mental health services (Parslow et al. 2000). This growing trend reflects the significant co-morbidity of metal illness with other chronic diseases.

Clients with a mental illness are also more likely to have poor physical health. Advocacy groups have voiced concern about the poor integration of physical and mental health care (Groom et al. 2003). Research has clearly documented the importance and complexity of managing mental health issues in general practice (Booth, Snowdon and Lees 2005; Meadows et al. 2001). A growing understanding of the complexity of mental health in general practice has affected a change in policy in relation to quality frameworks, standards and systems of collaborative mental health care in Australia. Despite this, little research has been undertaken to document collaborative health care practices currently operational within the Australian system (Meadows et al. 2001).

General practice in collaborative mental health care

This section of the review describes some of the key research into mental health collaborative practices involving GPs and general practice (both globally and locally).

A study by Minas, Klimidis and Kokanovic (2005a) examined approaches to mental health management, levels of confidence in managing mental health issues, attitudes and service improvement opportunities of 598 Victorian GPs. A self-report questionnaire was disseminated to a sample of GPs who were registered with the Better Outcomes in Mental Health Care (BOMHC) program as well as a sample of GP's not registered with BOMHC. There were responses from 170 (28.4%) GPs registered with the BOMHC. This proportion of respondents was 11% higher than the national registered rate (15% to 17%), warranting caution in the examination of this study's results. The overall response rate of the study was (23.9%). Despite these limitations, the study yielded important findings. Minas et al found that neuro-psychiatric, psychotic and personality disorders were more likely to be referred to specialist mental health services when compared to anxiety and depressive disorders. Overall analysis of treatment patterns irrespective of disorder and BOMHC registration revealed that 57% of patients were solely assessed and treated solely by the GP. Only 22% of GPs claimed to work together with other mental health services or professionals. Minas et al also found that GPs registered with BOMHC had more positive attitudes to mental health work compared to GPs who had not registered with the initiative ($t = 9.08$, $p = <0.0001$).

In 2005, the RACGP developed a quality framework to systematically analyse the quality of GP practice. The indicators included in this framework were dynamic interactivity, leadership, communication and culture (Booth et al. 2005). Strategies for quality improvements included guidelines, accreditation, ongoing professional development, measurement, standards and risk management (Booth et al. 2005). The Australian General Practice Networks (AGPN) national performance indicators (measurable aspects of care) are now focused on a number of quality improvements which relate to access (making care more accessible); better management of mental health; supporting integration and multidisciplinary care; and governance (a performance improvement culture). Related to this development, Booth et al (2005) identified a range of barriers affecting the uptake of quality frameworks in Australian general practice. These were: (1) the GPs' limited formation of and access to relevant framework knowledge, (2) limited alignment between the financing of general practice and the provision of quality care, (3) a culture of general practice that contains remnants of blame and competitiveness, (4) changing aspirations of the GP workforce (without changing business and delivery systems), (5) limited GP infrastructure, (6) a healthcare delivery system that is fragmented, (7) duplication of services, (8) limited agreement on the recording and measurement of clinical data, and (9) current workforce shortages.

Fletcher (2000) reviewed the current issues and future directions of health care in Australia and found that there is inadequate data on the quality of health care in general practice. Fletcher also identified that current inaccuracies, latent deficiencies in service organisation and delivery of care (latent failures) impaired the quality of health care. A recent study by Makeham et al (2002) categorised errors as process-based (e.g. office administration, investigation, treatment, communication, payment, health care workforce management) or knowledge and skill-based (e.g. execution of clinical task, diagnosis, wrong treatment decision with right diagnosis). According to Fletcher, many errors in health care related to inadequate communication between practitioners in relation to their patients. Poor communication between health professionals accounted for 21% of errors. Accordingly, Fletcher recommended that the implementation of quality initiatives incorporates an assessment of GP communication skills. Additional contributors to practice errors were lack of coordinated care, failures in medical record keeping, illegible prescriptions, and lack of access to resources in rural regions (Fletcher 2000; Makeham et al. 2002; Mott; Kidd and Weller 2000).

These findings endorsed those of the National Expert Advisory Group on Safety and Quality in Australian Health Care in 1999 which found that GPs faced substantial barriers in the provision of quality care, and that GP quality frameworks must be strengthened to encourage a culture of continuous improvement (Department of Health and Family Services, 1998). In response, the General Practice Strategy Group (GPSG) advanced a framework that centred on the training, assessment, certification and continuing education, vocational education and training within general practice as well as the FRACGP, accreditation and the AGPN (Booth et al. 2005). The GPSG recognised multiple participants in general practice: patients, GPs, the practice team, divisions of general practice and funding bodies. The framework identified that:

(1) the practitioner model was insufficient and additional supports were needed

(2) that general practice standards and accreditation were central to quality improvement approaches

(3) that clinical practice guidelines are pivotal for effective care benchmarking

(4) that information management and communication technology are central to improving care provided by GPs (Department of Health and Family Services 1998).

Mental health nursing

Mental health nursing is a specialised field of nursing which focuses on meeting the mental health needs of the client, in partnership with family, significant others and the community in any setting. It is a specialised interpersonal process designed to support clients to optimise their health status in their lives. Registered mental health nurses recognise the need for flexibility, adaptability, responsiveness and sensitivity as they continually shape their practice to the dynamically changing needs of the client, family, significant others and the community (ANZCMHN 1995).

The past ten years have seen unprecedented national and international reform in mental health nursing, service policy and delivery. The Australian Government's National Mental Health Strategies have had a major impact on mental health nurses' clinical practice, service provision and daily care of clients (Cleary, 2003). Mental health nurses now have opportunities to collaborate and shape mental health care service delivery and development through policy (Scott and West 2000). Mental health nurses have also been identified as being responsive in identifying service gaps in their every-day practice (Cleary 2003; Happell 2007). In response to the development of National Standards for the Mental Health Workforce, the Australian College for Mental Health Nurses developed the Standards of Practice for Mental Health Nurses in Australia (ANZCMHN 1995). These standards have been adapted and culturally validated in New Zealand (O'Brien et al. 2003) and are now currently under review in Australia (Neville et al. 2007). It is in the development of standards of practice that the 'professionalisation of mental health nursing is reflected' (O'Brien et al. 2005, p. 66). New and evolving nursing positions include nurses working in consultation-liaison psychiatry in emergency departments and elsewhere within general hospital environments e.g. maternity units (Brinkman et al. 2007; Bryant et al. 2007; Roberts 1997; Wand and White 2007), mental health nurses working with general practitioners in shared care and specialist liaison roles (McCann and Baker 2003), working in private practice and in sole practice (e.g. in rural settings) (Gibb 2003) and employed as mental health nurse practitioners (McBride 2007; Clinton and Hazelton 2000; Fisher 2005; Pearson and Peels 2002).

The role of mental health nurses was most clearly delineated in the era when mental health care was focused on inpatient models. The shift however towards community-based mental health care, has blurred the boundaries of the mental health nurse role relative to other professional groups working in the area (Brown et al. 2000). As well as providing mental health nurses with opportunities to 'reinvent' themselves, for some, the erosion of traditional professional practices causes role confusion, role strain (Brown et al. 2000), high levels of stress and burnout (Hannigan et al. 2001).

Mental health nursing and collaborative mental health care

Multi-professional collaboration, particularly in the form of medical and nursing linkages, has long been seen internationally as the most effective way of delivering primary care (Millward and Jeffries 2001) and the benefits for clients of collaborative processes between nurses and medical doctors (including GPs, psychiatrists and others) are frequently discussed (Gibb 2003; Muir-Cochrane 2001). In Australia, mental health nurses work in complex multidisciplinary organisations (McCann and Baker 2003). In fact, collaboration within and across settings and networks seems the most productive way for nurses to work with others (Jones and Cheek 2003, p. 125). According to Pittaway et al. (2004) the primary benefits of networking for nurses include risk sharing and the pooling of complementary skills. In addition, multidisciplinary community settings have been noted to encourage nurses to challenge the traditional authority of other professions (Brown et al. 2000, p. 426; Mistral and Velleman 1997). Literature exploring the theoretical issues for mental health nurses in collaborative care has identified a number of barriers and enablers.

Barriers to mental health nurse collaboration

The reason for the lack of funding available to support the multidisciplinary care model and the cost of multidisciplinary care is unknown (Department Human Services Victoria 1998).

- The new Medical Benefits Schedule payments revert largely to individual-provider service systems and fee-for-service rebates, rather than providing incentives for co-located services which encourage collaborative care (Hickie and McGorry, 2007)
- Significant workforce issues– Mental health nurses and other team members frequently lack the appropriate amount of time required to attend multidisciplinary meetings. This is particularly the case where remuneration is not provided for attendance at the meeting as part of the professional's role, or it is held outside regular working hours.
- Territorialism or patient 'ownership' (Street et al. 2001).
- Poor Commonwealth/State communication (Makerman 2006).
- In rural settings – Distance (Makerman 2006).
- Lack of medical and psychiatric services and lack of team members (Gibb 2003).

Enablers to mental health nurse collaboration

- Networking between nurses and GPs (Street et al. 2001).
- Meeting GPs in person to discuss collaboration options.
- The availability of mobile phones.
- A shared vision (Glasby and Lester 2004).
- Clarification of the roles and responsibilities of each professional group.
- Appropriate incentives and rewards.
- Ensuring accountability.
- Adequate sustainable funding (Wakerman 2006).
- Specialist assistance available or provided by teleconferencing or videoconferencing as needed.
- Integration of team members across mental health services or regions.
- Commitment of the senior management of the organisations involved (Glasby and Lester 2004). Co-location is an internationally recognised key enabler for the promotion of collaboration (Hickie and McGorry 2007)
- Supportive government policy.
- Inter-professional education.
- Clinical practice guidelines that promote and support multidisciplinary care.
- Interagency agreements on how to prioritise and allocate referrals (Glasby and Lester 2004).

Whilst the role and opportunities for mental health nurses have been subject to considerable literary discussion, little of this has examined the particular outcomes associated with this collaboration. Further research in this area is much needed to delineate the role of the mental health nurse and the impact of this role on some of the continuing concerns about the appropriateness, affordability, and accessibility of quality mental health care (Fisher 2005 p. 222).

Occupational therapy

Occupational therapists are concerned with enabling clients to participate in meaningful occupations in order to meet human needs and restore and maintain health, both physical and mental. Such tasks refer not only to paid employment, but the everyday activities involved in people looking after themselves, connecting with others, participating in recreation, education and contributing to their communities. As such, meaningful occupations enable the use of capacities necessary for maintaining physical, mental and social well-being. OTs are employed within a number of mental health roles and settings and work with clients presenting mental disorders across the spectrum. OTs work with people across the lifespan (children, adolescents, adults and geriatrics) within both public and private settings. Within treatment, OTs may utilise a range of modalities including interpersonal therapy, group therapy, relaxation training, cognitive behavioural therapy, skills based training and family therapy. A key principle of occupational therapy is that of engaging the broader system of a person's life. This may include the primary health care sector, educational settings, employers, social and recreational settings, and family members.

Occupational therapy and collaborative mental health care

There are five new MBS items for occupational therapy services provided on referral by a GP, psychiatrist, or paediatrician. Occupational therapists must meet three eligibility criteria before being able to register to provide FPS. Occupational therapists are committed to participation in interdisciplinary mental health teams, and contributing to the shared knowledge of the impact of occupational role disruption in people's lives. At the time of writing this report, no studies examining the role of collaborative mental health care was available.

Social work

Social work practice is informed by professional education based on an analysis and understanding of human development and behaviour, and of complex social structures and processes. It accepts commitment to working within a stated value position and code of ethics. An integral part of the education of each social worker is the demonstration in practice settings of this analysis, understanding and commitment. Social workers are trained to use a holistic approach in assessing and helping clients with a mental illness and their families. This means understanding how a client's life history, lifestyle and current social and economic circumstances may have contributed to their present mental ill-health. To obtain relevant information, social workers must establish collaborative and trusting relationships with clients and members of their social network who, depending on age and other circumstances, may include parents and other relatives, partners and friends.

The practice of mental health social workers is informed by the ethics and standards of practice as established by the Australian Association of Social Workers (AASW) (AASW Code of Ethics 1999 and Australian Social Worker Benchmarking – current collaborative care arrangements and practices under Better Access Mental Health Competencies 1998, 2004). The focus is on developing relationships with client, carers and other health professionals that facilitate collaborative care (Madsen, 2007).

Social work and collaborative mental health care

Collaborative care, consultation and co-research with clients, carers and mental health workers are developing fields in mental health social work. There is a movement towards inclusion of clients in developing collaborative documentation of therapeutic work for circulation (Madsen 2007). Collaboration between social workers, psychiatrists, clients and other health professionals is being represented in post-graduate level education and in recovery research (Tooth et al. 2003).

AASW is the accrediting body to which experienced social workers may apply to gain accreditation as a mental health social worker. AASW accreditation enables these social workers to apply for registration with Medicare Australia to provide services under Medicare funded programs, such as the Better Access to Mental Health Care initiative. At the time of writing this report, no studies examining the role of collaborative mental health care were available.

Paediatrics

A paediatrician is a doctor who provides specialist medical care to infants, children and adolescents. The Paediatrics and Child Health Division (PCHD) of the Royal Australasian College of Physicians (RACP) is the peak national professional body representing paediatricians in Australia and New Zealand. Paediatricians assess and manage a large number of children and adolescents with mental health problems. These difficulties are often co-morbid to chronic ill-health and developmental concerns. Paediatricians are also involved in the care of children whose parents may have significant mental health concerns.

Paediatrics and collaborative mental health care

Paediatricians work in the private and/or public sector in multidisciplinary teams. Paediatricians now have significant training requirements in mental health and developmental disorders. There are special issues that arise in relation to the transition of adolescents to the adult mental health sector. At the time of writing this report, no studies examining the role of collaborative mental health care were available.

Psychiatry

Specialist psychiatry services are secondary health services accessible through GP referral or acute in-patient admission. A psychiatrist is a qualified medical doctor who has obtained additional qualifications to become a specialist in the diagnosis, treatment and prevention of mental illness and emotional problems. Because of their extensive medical and psychiatric training, psychiatrists are able to view illness in an integrated way by taking into consideration the related aspects of body and mind. Psychiatrists are trained both to recognise and treat the effects of emotional disturbances on the body as a whole, as well as the effects of physical conditions on the mind. This is particularly important, as many emotional disturbances affect various parts of the body and physical illnesses can certainly affect the mind. A psychiatrist's medical and psychiatric training allows both the physical and emotional to be kept in perspective. Psychiatrists are uniquely versed in the clinical conditions that present as mental illness because they are trained in the biological sciences as well as in the social, cultural and interpersonal dimensions of mental illness.

Psychiatry and collaborative mental health care

Health care is increasingly provided by multidisciplinary teams. Psychiatrists are expected to work constructively within teams and to respect the skills and contributions of colleagues. In relation to collaborative practice, the RANZCP acknowledges the following:

- Clinical authority is vested in the psychiatrist by virtue of training and experience and can be enhanced by good teamwork.
- Psychiatrists working in a team remain accountable for their own professional conduct and the care they provide.
- Clinical responsibility, which relates to duty of care and standards of care, rests with every health care professional.
- The psychiatrist is an essential contributor to the multidisciplinary team.
- Collaborative practice assists in promoting better health outcomes for clients experiencing mental illness and their carers.
- Effective mental health care requires collaboration between clients, carers, mental health professionals (including psychiatrists), general practitioners, and non-government and government agencies.
- Psychiatrists understand and value the expertise of the other mental health professionals.
- All mental health professionals need training in the principles and application of teamwork. Training programs need to give trainees a positive experience of collaborative work environments.

- Management of a multidisciplinary team is not necessarily the domain of the psychiatrist.
- Psychiatry trainees are responsible to their supervising psychiatrist.

RANZCP recognises the advantages of collaborative care in maintaining continuity of care, the capacity to take a comprehensive view of the client's networks and problems, the availability of a range of skills, and mutual support and education. A well-functioning team with a shared sense of responsibility may be more than the sum of its parts – the team can produce more and better work than its individual members working as solo practitioners. However, working in clinical teams which are not functioning well can also be a source of professional dissatisfaction for psychiatrists and other mental health professionals, and can contribute to unsatisfactory care for clients and families.

Good communication between psychiatrists and referring general practitioners is part of the basis of good clinical practice. It is clear that collaboration between health care practitioners is essential for an optimal and complete approach to health care. However, communication between practitioners presents two key issues: (1) duty to maintain confidentiality and (2) patient privacy. Consideration of these issues is particularly important in psychiatry as patients may share information with their psychiatrists that they would not share with their other health care practitioners.

In general, psychiatrists should be aware that communication of clinical details with any other health professional requires the patient's implicit or explicit consent. In situations where there is any doubt about that consent, psychiatrists should pursue it explicitly, and ask the patient at the end of the consultation if there are any matters discussed or revealed about which they do not wish the referrer to be informed. Psychiatrists may consider it appropriate to provide the patient with a copy of letters written to the referring practitioner.

Psychology

Psychologists provide a service that complements the physical/medical health care provided by medical and allied health practitioners. Psychologists are experts in cognition and human behaviour and help treat clients with mental illness, as well as those who are mentally healthy to find ways of functioning better (e.g. stress or anger management). Psychologists are trained to provide specialist assessment, differential diagnosis and therapeutic interventions for a variety of physical, neurological and psychological disorders. They assist in the management of a range of cognitive, behavioural and adjustment difficulties, provide education and training to clients, carers and staff, and are involved in health promotion, including the provision of change strategies for health risk behaviours.

Psychologists work throughout the public and private sector. Psychological specialties which focus on mental illness include: clinical neuro-psychologists, clinical, community, counselling, forensic and health psychologists. Each of these specialised types of psychologists' roles will be described briefly.

Psychology specialties

Clinical neuro-psychologists study changes in thinking and behaviour that may arise from brain dysfunction such as head injury, epilepsy, neurological disease and stroke, drug and alcohol disorders, learning disabilities, attention deficit disorders, dementia and psychiatric disorders. They deal with the cognitive, emotional and behavioural problems related to brain dysfunction through assessment, rehabilitation, education and psychological therapy.

Clinical psychologists are specialists in the assessment, diagnosis and treatment of psychological problems and mental illness. They are located in private practice, hospitals, universities, general medical practices, community health centres and mental health services.

Clinical psychologists work with infants, children, adolescents, adults and older adults. They are also involved in designing and implementing a wide range of prevention and mental health promotion programs.

Community psychologists have specific training and experience in understanding and supporting the needs of people in their communities. They focus less on 'problems' and more on the strengths and competencies of community members. They value human differences and are committed to core

principles of flexibility, equity and respect for cultural diversity in meeting the needs of different communities. They work in partnership with people, groups and organisations to achieve the goals and aspirations of their community or social groups and to prevent or reduce individual and community problems.

Counselling psychologists employ a wide range of therapeutic methods. These therapeutic approaches are generally underpinned by a significant emphasis on the quality of the relationship between the client and the psychologist. They assist individuals, families and groups in areas related to personal well-being, interpersonal relationships, work, recreation and health. They are also trained to assist people experiencing both acute and chronic life crises.

Forensic psychologists apply psychological theory and skills to the understanding and functioning of the legal and criminal justice system. They often work in criminal, civil and family legal contexts and provide services for perpetrators (e.g. designing and delivering treatment interventions), victims (e.g. assessment and treatment) and justice personnel (e.g. selecting, training and counselling). Forensic psychology encompasses issues such as: the causes, prevention and treatment of criminal behaviour; the psychology of police, the courts and the correctional system; and the contributions of psychological evidence to legal proceedings.

Health psychologists specialise in understanding the effects of psychological factors related to health and illness. Specifically, health psychologists are engaged in the prevention of illness and the promotion of health-related behaviours. They also work in clinical health and the application of psychology to illness assessment, treatment and rehabilitation.

Psychologists and collaborative mental health care

The Australian Psychological Society has been an active and key member in groups that have developed, participated in and maintained numerous, multidisciplinary, collaborative programs intended to improve client outcomes.

Appendix D Abbreviations and definitions

Abbreviations and definitions

Australian College of Mental Health Nurses (ACMHN)

Australian Psychological Society (APS)

Culturally and Linguistically Different Background (CALD)

General Practitioner (GP)[6]

Focused Psychological Strategies (FPS)

Mental Health Interdisciplinary Networks (MINH)

Mental Health Professionals Association (MHPA)

Occupational therapist (OT)

Registered psychologist (psychologist)

Royal Australian and New Zealand College of Psychiatrists (RANZCP)

Royal Australian College of General Practitioners (RACGP)

Mental Health Nurse Incentive Program (MHNIP)

Definitions

Care planning - the process of deciding what actions and approaches need to be taken and which people can be involved in responding to a client's[7] current difficulties and future wellbeing.

Psycho-education - the provision of education about a mental condition, its effects and possible approaches that may be helpful in its management.

Psychological/counselling therapies - therapeutic conversations and interventions that specifically engage the client in a change process in relation to their mental health.

Coordination of other supports - co-ordination of family/carer and community support structures including income support, housing needs, client group involvement and other social structures significant to the client's mental wellbeing.

Compliance with treatment - providing clients and their carers and /or their families with encouragement and support to help them implement the agreed care plan, eg attend appointments, stick to dietary or exercise regimes, take their medication as prescribed and so on.

Clinical network - is a group of two or more mental health professionals who may possess different skills, who work collaboratively in the provision and coordination of mental health care in a particular clinical case.

[6] In line with common usage references to the 'general practitioner' has been shortened to GP, and 'occupational therapist' has been shortened to OT. Registered psychologists are referred to as psychologists in this report.

[7] People with a mental illness are referred to as 'clients' to enable consistency with the language used in the study survey. This decision of the steering group was made with the awareness that many other terms are routinely used including: patient, a person with a mental illness, and client.