General practitioners' response to depression and anxiety in the Australian community: a preliminary analysis

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ABSTRACT

Objectives: To examine the uptake by general practitioners (GPs) of the five key components of the *Better Outcomes in Mental Health Care* (*BOiMHC*) initiative: education and training for GPs; the three-step mental health process; focussed psychological strategies; access to allied health services; and access to psychiatrist support.

Setting: All Australian states and territories during the first 15 months of the initiative (1 July 2002 – 30 September 2003).

Design: Retrospective survey of de-identified registration data held by the General Practice Mental Health Standards Collaboration (training uptake), de-identified Health Insurance Commission (HIC) billing data (provision of the three-step mental health process, focussed psychological strategies and case conferences with psychiatrists), and reports from "access to allied health services" projects to the Australian Department of Health and Ageing (project participation).

Main outcome measures: Number and percentage of Australian GPs certified as eligible to participate in the initiative; provision of the three-step mental health process and focussed psychological strategies by GPs; participation in allied health pilot projects; and access to psychiatrist support.

Results: Within 15 months of the *BOiMHC* initiative commencing, 3046 GPs (about 15% of Australian GPs) had been certified as eligible to participate, including 387 who had registered to provide focussed psychological strategies. GPs had completed 11 377 three-step mental health processes and 6472 sessions of focussed psychological strategies. Sixty-nine "access to allied health services" projects had been funded, with the original 15 pilot projects enabling 346 GPs to refer 1910 consumers to 134 individual allied health professionals and 10 agencies. In contrast, the "access to psychiatrist support" component was less successful, with the HIC billed for 62 case conferences at which a psychiatrist and a GP were present.

Conclusion: The level of uptake of the main components of the *BOiMHC* initiative has expanded the national capacity to respond to the needs of people with common mental disorders, such as depression and anxiety.

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The burden of disease due to mental disorders in Australia is substantial, with depression recognised as the most important single cause of non-fatal disability.[1] Much of this burden may be averted through the provision of an appropriate mix of primary and secondary care services and of evidence-based drug and non-drug treatments.[2] However, consumers and their families have commented on the lack of access to effective non-pharmacological treatments, and on the poor integration of their medical and psychological care.[3,4]

Nationwide, general practitioners (GPs) are the starting point for redressing these deficiencies. Australians rank their GP as the professional they would most likely turn to if they were experiencing depression,[5] and GPs already provide the vast majority of services to people with psychological disorders.[6,7] As community awareness of common mental disorders grows, increased presentations for care are likely to occur in general practice. Although GPs' identification and appropriate management of these conditions has increased substantially,[8] structural, professional and financial barriers to the further enhancement of quality care have been identified.[9,10]

Against this background, the Australian Government introduced a $120 million, 4-year, general-practice-based program in July 2001 (which resulted in new services from July 2002) to improve the quality of primary mental health care. Known as the *Better Outcomes in Mental Health Care (BOiMHC)* initiative, it is ambitious in scope and includes five key, interrelated components (Box 1).

Together, these components are designed to support an expansion in treatment choices in general practice, access to effective forms of psychological therapy, integration of primary and secondary care mental health services, and provision of more evidence-based treatments.[12]

While it is premature to report individual patient outcomes, it is appropriate to consider the early impacts of the *BOiMHC* initiative. We have examined the uptake of its five components. We also describe variability in uptake and propose factors that may have influenced this variability.

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METHODS

Data on uptake of training were drawn from de-identified registration data held by the General Practice Mental Health Standards Collaboration (GPMHSC) for the period 1 July 2002 to 30 September 2003.

Data on GPs' provision of the three-step mental health process and focussed psychological strategies were taken from Health Insurance Commission (HIC) billing data, as were data on psychiatrists' participation in case conferences. All HIC data were downloaded directly from the HIC website in a de-identified form,

1 Components of the *Better Outcomes in Mental Health Care* (*BOiMHC*) initiative (adapted from Reference 11)

Component 1: Education and training for GPs

To participate in the *BOiMHC* initiative, general practitioners must:

- attend *familiarisation training*, designed by the Australian Divisions of General Practice to familiarise them with the initiative and the operation of the "three-step mental health process" (see below); and
- complete *Level 1 training*, which equips them to perform mental health assessments, develop mental health plans and conduct mental health reviews.

Completion of *familiarisation* and *Level 1 training* qualifies GPs to register with the Health Insurance Commission (HIC) to access *service incentive payments* for providing a "three-step mental health process".

GPs can then elect to undertake *Level 2 training*, which equips them to deliver "focussed psychological strategies". Completion of *Level 2 training* enables GPs to access the new federal Medicare Benefits Schedule (MBS) for "focussed psychological strategies".

To qualify for completion of both *Level 1* and *Level 2 training*, GPs must either apply for recognition of prior learning or complete a recognised educational activity. The General Practice Mental Health Standards Collaboration (GPMHSC) sets and administers the education and training standards that govern which previous and current activities satisfy the requirements of *Level 1* and *Level 2 training*.

Component 2: The three-step mental health process

The three-step mental health process provides a framework for the management of mental health problems and mental illness in a primary care setting by encouraging effective and longitudinal care of consumers. Specifically, the process includes:

- an assessment (Step 1);
- preparation of a mental health plan (Step 2); and
- a review of the mental health plan (Step 3).

The process must occur over at least three consultations of more than 20 minutes (at least one for each step), at least two of which must be planned. It must also be documented, and several proformas and a checklist have been developed as resources.

Step 1. The assessment must include:

- a detailed biological, psychological and social history, including the presenting complaint;
- a mental state examination;
- a risk assessment;
- a diagnosis and/or formulation; and
- the administration of an outcome instrument, except where it is clinically inappropriate.

Step 2. The mental health plan should be developed by the GP and the consumer. The development of the plan should include discussion and documentation of:

- the mental health formulation and/or diagnosis;
- treatment options (including appropriate support services);
- the provision of psycho-education;
- a plan for treatment, including a plan for crisis intervention, where appropriate; and
- a plan for relapse prevention, if appropriate at the planning stage.

A written copy of the plan should be provided to the consumer. If the consumer agrees, carers may be involved in the development of the plan and may receive a written copy.

Step 3. The review should include:

- a review of the consumer's progress against the goals outlined in the mental health plan;
- modification of the plan if necessary;
- additional educational input;
- a plan for relapse prevention if not previously provided; and
- readministration of the outcome tool used in the assessment stage, except where considered clinically inappropriate.

The review must take place a minimum of 4 weeks and a maximum of 6 months after completion of the mental health plan.

GPs are remunerated for providing the three-step mental health process via a blended mechanism of payment. When they register with the HIC, they receive a sign-on *service incentive payment* of $150. GPs bill the HIC under normal attendance items (*Level C* or *D*) for the assessment and the mental health plan. They use a specific item number to bill the HIC for the review, and this triggers the payment of a *service incentive payment* ($150 per three-step mental health process per consumer per year), in addition to attracting a Medicare rebate for the consumer.

Component 3: Focussed psychological strategies

The *BOiMHC* initiative emphasises the delivery of evidence-based focussed psychological strategies: psycho-education, cognitive behavioural therapy (including behavioural interventions, cognitive interventions, relaxation strategies and skills training), and interpersonal therapy. These strategies are time-limited, normally being deliverable in up to six planned sessions, each lasting a minimum of 30 minutes. In some instances after review, an additional six planned sessions may be warranted.

Under the *BOiMHC* initiative, MBS rebates were introduced in November 2002 to provide an incentive for GPs to deliver focussed psychological strategies. Only those GPs who are registered with the HIC as participating in the *BOiMHC* initiative and who satisfy the *Level 2 training* requirements set by the GPMHSC are eligible to bill for the delivery of these services.

The *BOiMHC* initiative also provides opportunities for GPs who do not feel confident in the delivery of focussed psychological strategies or who have not undertaken *Level 2 training* to refer consumers on. Consumers may be referred to another GP who has undertaken *Level 2 training* or to an allied health professional under the "access to allied health services" component of the initiative.

Component 4: Access to allied health services

The access to allied health services component enables GPs registered with the HIC to provide the three-step mental health process to access focussed psychological strategies from specified allied health professionals to support consumers. The focussed psychological strategies provided by these allied health professionals are the same as those provided by GPs (see above). These services are deliverable in up to six time-limited sessions, with an option for up to a further six sessions after a mental health review by the referring GP. Divisions of General Practice act as fundholders for this component of the initiative.

Component 5: Access to psychiatrist support

The access to psychiatrist support component of the initiative has two subcomponents, both of which broaden the role of psychiatrists in providing mental health care.

The first subcomponent involves the introduction of MBS rebates which enable psychiatrists to take part in case conferencing on a consumer's behalf. There are three time bands for these case conferences (15–29 minutes; 30–44 minutes; and ⩾45 minutes), which aligns them with the duration of case conferences provided by GPs. Where the psychiatrist organises the case conference, a minimum of four formal care providers from different disciplines must participate. Where the psychiatrist participates in the case conference, the minimum is three. In each case, the psychiatrist is included in the total.

The second subcomponent, which commenced in April 2004, involves the provision of consultancy assistance to GPs by psychiatrists in emergency situations, where "a significant risk of harm to the safety of a patient and/or others exists".

and included the period 1 July 2002 to 30 September 2003 — the 15 months after introduction of the first elements of the program.

Participation in the "access to allied health services" projects was assessed from the reports of the original 15 pilot projects, most of which had been running for nearly 15 months at the time of the study. Between 1 July 2002 and 31 August 2003, all pilot projects had submitted at least three quarterly implementation reports to the Australian Department of Health and Ageing; 12 had submitted a fourth report. Six had made evaluation reports available. The quantitative findings (from routinely collected registration and utilisation data) and qualitative findings (from surveys, interviews and/or focus groups with key informants) in these reports were synthesised for the current analysis.

RESULTS

Component 1: Education and training for GPs

By 30 September 2003, 3046 GPs had been recognised by the GPMHSC as having received *familiarisation training*,[11] being adequately trained at *Level 1*, and having registered to use the new payment systems associated with the three-step mental health process. Of these, 387 had met the requirements for *Level 2 training*, and had registered to provide focussed psychological strategies.

Nationally, this equates to 15% of GPs (3046/20 815) having received *familiarisation* and *Level 1 training* or its equivalent and registered. There is considerable variability across states and territories; the highest uptake was in Western Australia and the lowest in the Australian Capital Territory (Box 2). Within states and territories, there is also considerable variation; for example, certain areas of Perth and Fremantle report that almost all GPs in their Divisions have attained the appropriate level of training to register for the initiative.

There is variability based on rurality/urbanicity (Box 2). Uptake has been particularly rapid in rural and regional areas, reaching up to 39% (446/1148) in small rural centres.

Of the training programs recognised by the GPMHSC, 19 (70%) were provided by individual Divisions of General Practice, four (15%) by Australian universities or other tertiary institutions, two (7%) by private educational providers and two (7%) by pharmaceutical companies. The private educational provider that manages *SPHERE: a national depression project*[14] accounted for 1848 participants receiving *Level 1* approval, of whom 1381 completed training in 2002–2004. Importantly, a further 1411 participants have undertaken SPHERE training since 1996, all of whom would be eligible for *Level 1* approval.

Component 2: The three-step mental health process

As at 30 September 2003, GPs had billed the HIC for 11 377 occasions of service in which they completed the three-step mental health process (ie, the review step). As the Medicare Benefits Schedule (MBS) stipulates that benefits are normally only payable for one three-step mental health process per consumer within a 12-month period, the number of occasions of service equates with the number of individual consumers receiving care. Box 3 shows a breakdown of the provision of the three-step mental health process by state/territory and rurality/urbanicity.

2 Number (%) of general practitioners (GPs) certified for Level 1 and Level 2 registration, by state or territory and rurality/urbanicity*

	Number (%) of GPs certified	
	Level 1	Level 2
State/Territory (*n* = total no. of GPs)		
New South Wales (*n* = 7145)	906 (13%)	118 (2%)
Victoria (*n* = 5275)	841 (16%)	108 (2%)
Queensland (*n* = 3401)	463 (14%)	54 (2%)
South Australia (*n* = 1785)	293 (16%)	35 (2%)
Western Australia (*n* = 1987)	411 (21%)	38 (2%)
Tasmania (*n* = 582)	84 (14%)	15 (3%)
Australian Capital Territory (*n* = 432)	29 (7%)	13 (3%)
Northern Territory (*n* = 209)	19 (9%)	6 (3%)
Rurality/Urbanicity† (*n* = total no. of GPs)		
Capital city (*n* = 13 913)	1836 (13%)	261 (2%)
Other metropolitan area (*n* = 1470)	198 (13%)	26 (2%)
Large rural centre (*n* = 1157)	228 (20%)	22 (2%)
Small rural centre (*n* = 1148)	446 (39%)	41 (4%)
Other rural area (*n* = 1940)	274 (14%)	34 (2%)
Remote centre or other remote area (*n* = 469)	64 (14%)‡	3 (1%)‡
Total (*n* = 20 815)	**3046 (15%)**	**387 (2%)**

*** Source:** General Practice Mental Health Standards Collaboration, unpublished data. GP population (ie, denominator) data are based on December 2000 figures per state,[13] while registration (ie, numerator) data are based on 30 September 2003 figures. These statistics should therefore be considered only as a guide to the relative uptake in different states/territories and areas of differing rurality/urbanicity.
† Rural, Remote and Metropolitan Area classifications in this analysis are based on Australia Post postcodes given in GP mailing addresses, which are not in all cases the same as practice addresses.
‡ Due to very small sample sizes, figures have been collapsed and therefore are indicative only.

Component 3: Focussed psychological strategies

In the first 15 months of the *BOiMHC* initiative, the HIC was billed for 6472 occasions of service at which focussed psychological strategies were provided by GPs (Box 3). The MBS recommends that such care be delivered within six sessions, and that in most cases a given consumer is only able to claim rebates for one set of six sessions within a 12-month period. Data indicate that these occasions of service have been provided to 3187 individuals.

Component 4: Access to allied health services

Sixty-nine "access to allied health services" projects have been funded through Divisions of General Practice. Sixteen pilot projects received Round 1a funding between June and August 2002 (including one which received seeding funding only and is currently inactive), and a further 13 projects received funding between January and March 2003 (Round 1b) (Box 3). Forty-one additional projects received Round 2 funding after July 2003. Initially, there was strong emphasis on supporting projects in rural and regional areas (Box 3).

3 Provision of specific mental health services, by state or territory and by rurality/urbanicity*

	Three-step mental health process ($n = 11\,377$)	Focussed psychological strategies ($n = 6472$)	Allied health services projects ($n = 69$)	
			Round 1a and 1b†	Round 2†
State/Territory				
New South Wales	3677 (33%)	2157 (33%)	6 (9%)	11 (16%)
Victoria	3161 (28%)	2245 (35%)	10 (15%)	9 (13%)
Queensland	1891 (16%)	728 (11%)	5 (7%)	8 (12%)
South Australia	1011 (9%)	484 (7%)	2 (3%)	6 (9%)
Western Australia	1187 (10%)	288 (4%)	3 (4%)	4 (6%)
Tasmania	330 (3%)	–‡	0	3 (4%)
Australian Capital Territory	64 (1%)	–‡	1 (1%)	0
Northern Territory	56 (< 1%)	–‡	1 (1%)	0
Rurality/Urbanicity§				
Capital city	7600 (67%)	4815 (75%)	36 (52%)	
Other metropolitan area	625 (5%)	476 (7%)	5 (7%)	
Large rural centre	884 (8%)	152 (2%)	10 (15%)	
Small rural centre	1220 (11%)	696 (11%)	7 (10%)	
Other rural area	996 (9%)		11 (16%)	
Remote centre	21 (< 1%)¶	333 (5%)**	0	
Other remote area	31 (< 1%)¶		0	

* **Source:** Health Insurance Commission, unpublished data based on 1 July 2002 to 30 September 2003 figures.
† The Australian Government uses the terms *Round 1* and *Round 2* to denote when the funding was provided. Round 1 was split into pilot (1a) and supplementary (1b) projects.
‡ Due to very small numbers in Tasmania, the Australian Capital Territory and the Northern Territory, figures are not currently available for publication.
§ Rural, Remote and Metropolitan Area (RRMA) classifications in this analysis are based on Australia Post postcodes given in GP and Division mailing addresses, which are not in all cases the same as practice addresses.
¶ Due to the small sample size, these are indicative values only.
** Due to very small sample sizes, figures have been collapsed and therefore are indicative only.

The projects are operating through a range of models, with many drawing on elements from several models. The models differ in referral mechanisms (ranging from simple voucher systems to more complicated brokerage models), means of retaining allied health professionals (with most individual allied health professionals and agencies being contracted, but some being directly employed by the Division), and location of allied health professionals (with most providing services in rooms at the GPs' practices, but alternatives including the provision of services at the allied health professionals' own practices, or at another location).

As at 31 August 2003, most of the original 15 pilot projects had been operating for 15 months. According to their implementation and evaluation reports, the projects had recruited 134 individual allied health professionals plus 10 agencies. Of the 134 individual providers, 94 (70%) were psychologists, six (4%) were social workers, five (4%) were occupational therapists, and six (4%) were psychiatric nurses. The professional category of the remaining 23 (17%) was not available.

In total, 346 referring GPs had been associated with the pilot projects at 15 months. This number is likely to increase, as many GPs who are eligible to refer have not yet done so.

According to the relevant reports, the aggregate number of people referred at 15 months was 1910. However, this is likely to be an underestimate, as a number of the project reports did not document individuals until they had completed six sessions.

Component 5: Access to psychiatrist support

Access to psychiatrist support is a relatively small component of the *BOiMHC* initiative. In the first subcomponent, GPs are gradually beginning to take advantage of the opportunity to take part in the new case conferences with psychiatrists. As at 30 September 2003, the HIC had been billed for 62 case conferences at which a psychiatrist and a GP (and at least one other formal care provider) were present. Over half of these (33; 53%) occurred in Victoria, 12 (19%) were in South Australia, and New South Wales and Queensland each accounted for seven (11%).

The second subcomponent, which will provide GPs with access to psychiatrists' support in emergency situations, commenced in April 2004.

DISCUSSION

The initial uptake of the training component of the *BOiMHC* initiative by Australian GPs is remarkable and pleasing. Within 15 months of the initiative commencing, 3046 GPs (around 15% of all Australian GPs) had been recognised as having completed sufficient additional training to participate in the initiative, including 387 who have registered to provide brief but focussed psychological interventions. Further, at least another 1411 GPs have commenced or completed a recognised training program but not yet sought *Level 1* approval. In the initial planning phase, it was envisaged that within the first 3 years of operation (2002–

2005) only 1500 practitioners would participate in the basic service aspects of the initiative, while 300 of these would go on to deliver focussed psychological strategies. Given the high levels of mental health need in rural and regional areas,[15] and the relative lack of specialist services within such regions,[15] the uptake by GPs in rural and regional centres is particularly welcomed.

Registration to participate in the initiative is now being followed by progressive increases in provision of enhanced GP services, and referrals to allied health professionals. According to HIC data, 11 377 three-step mental health processes have been completed, and 6472 sessions of focussed psychological strategies have been provided. Sixty-nine access to allied health services projects have been funded, with the original 15 pilot projects enabling 346 GPs to refer 1910 consumers to 134 individual allied health professionals and 10 agencies.

Anecdotally, these high levels of uptake have been attributed to factors such as strong local leadership, support from state-based offices of general practice, development and liaison officers operating under the National Primary Mental Health Care Initiative, local Divisions of General Practice, academic institutions and state/territory-based specialist mental health services, positive professional attitudes, and good experiences with previous mental health programs. Typical benefits reported from involvement in the *BOiMHC* initiative include ready access to an increased range of care options for consumers who would otherwise be unserved or underserved; increased skills, knowledge and confidence in dealing with mental health issues on the part of GPs; and mutually satisfying collaborations between GPs and allied health professionals.

There have also been anecdotally reported concerns with the main components of the initiative from GPs, Divisions involved in establishing allied health pilot projects, and consumers and carer groups. First, concerning the education and training component, some GPs have been critical of the "superficial" nature of introductory training programs, variability in the quality of delivery of educational programs, and ambiguities about the recognition of past mental health training experiences.

Second, some GPs have also expressed reservations about the three-step mental health process and focussed psychological strategies, including the appropriateness and relevance of assessment, plan and review proformas and the routine use of clinical outcome measures; the limitation imposed by specific requirements (eg, that consultations be conducted within accredited practices and that services be capped); confusion about the processes for claiming reimbursement for different aspects of the process; and the implications of mental-health-specific payment procedures for privacy and subsequent access to life and income protection insurance products. Interestingly, when the Mental Health Council of Australia (the peak body representing the interests of the community and the non-government mental health sector) canvassed consumers, most did not share the GPs' concerns about consumer privacy and insurance eligibility. Given the choice between improved access to evidence-based mental healthcare in general practice and privacy issues, consumers showed a high preference for delivery of better care![3]

Third, preliminary reports from allied health pilot projects indicate some concerns: the time and effort required to establish the infrastructure and personnel for the projects; some difficulties finding appropriately qualified and skilled allied health professionals, particularly in non-metropolitan areas; delays in registration of GPs with the GPMHSC and the HIC, resulting in time-lags in GPs becoming eligible to refer to the projects; the expectation that referrals be made within the context of the three-step mental health process, resulting in a reluctance among some GPs to refer consumers they consider may not complete six sessions and the review step that triggers the service incentive payment; and paperwork demands on GPs.

Finally, the Mental Health Council reports a high level of concern over the lack of accessible community-based information about *BOiMHC*. This lack of information has led to the development of a range of myths about what *BOiMHC* can and cannot offer consumers seeking mental health care through their GPs. Concerns have also been expressed about the impact of declining bulk-billing rates on consumer access to the *BOiMHC* initiative.

Despite these reservations, the high level of uptake of the main components of the *BOiMHC* initiative suggests that general-practice-based care will expand to help reduce the burden of depression and other common mental disorders in the Australian community. Other, more formal and systematic evaluation procedures are planned. These will explore further reported concerns with various aspects of the initiative, and, if necessary, inform recommendations about modifications to the existing components. They will also give priority to whether the experiences of care by consumers and the costs of care are substantially enhanced by these new arrangements. While improved access to non-pharmacological treatments would seem to meet one commonly expressed need, more complex primary and secondary care systems do run the risk of increasing discontinuities in care.[16] This possibility will need to be monitored carefully in the context of ongoing collection of data on the impact of the various components of the initiative on individual patients.

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COMPETING INTERESTS

Ian Hickie was the Co-Chair of the Committee for Incentives for Mental Health, which oversaw the development of the *Better Outcomes in Mental Health Care* (*BOiMHC*) initiative (2001–2005) and is now Chair of the Evaluation Working Group for the *BOiMHC* initiative.

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