



EVALUATION OF THE PRIMARY MENTAL HEALTH AND EARLY INTERVENTION INITIATIVE

Volume II

**Follow up of Case Studies
and Interviews with all Area Mental Health
Service Managers**

**Rosalind Hurworth
Bradley Shrimpton**

Centre for Program Evaluation
University of Melbourne

July 2005

Commissioned by:

Mental Health Branch
Department of Human Services

EXECUTIVE SUMMARY	1
1 INTRODUCTION TO THIS REPORT	1
1.1 The Primary Mental Health and Early Intervention Initiative: a brief description	1
1.2 Basis of the second report	2
1.2.1 Sources of information and questions posed	2
1.3 Staff changes	3
1.4 Perceived state of development	4
1.5 Activities involving primary care providers over the past 18 months	5
1.5.1 Coverage by the PMHT	5
1.5.2 Services provided for General Practitioners	6
1.5.3 Coverage of non-GP primary care providers	7
1.5.4 Services for other primary care providers	7
1.5.5 Early intervention activities	9
1.5.6 Other service activities	10
1.6 Facilitators that have assisted Primary Mental Health Teams to work well with primary care providers	11
1.7 Barriers to Primary Mental Health Teams working optimally	13
1.8 Other programs with which the Primary Mental Health Teams were involved	17
1.8.1 Other activities which integrate services	18
1.8.2 The impact of other programs on the PMHEII	18
1.9 Impact of the Primary Mental Health Teams	19
1.9.1 Difficulties ascertaining impact	19
1.9.2 Examples of Impact on General Practitioners	20
1.9.3 Perceived Impact – other primary care providers	21
1.10 Area Mental Health Services and the Primary Mental Health Teams	23
1.10.1 Impact on AMHSs	23
1.10.2 Impact of PMHT on referrals to the AMHSs	25
1.10.3 Integration of the PMHT within AMHS	26
1.10.4 Training for AMHSs	27
1.11 Strengths and achievements of the Primary Mental Health Teams	29
1.11.1 Strengths cited by Primary Mental Health Team Managers	29
1.11.2 Strengths nominated by the Area Mental Health Services	30
1.11.3 Strengths put forward by other Primary Care Providers and representative agencies ...	31
1.12 Overall level of satisfaction	33
1.13 Limitations of the Primary Mental Health and Early Intervention Initiative	33
1.14 Future directions	35
1.14.1 Activities already planned for the next 12 months	35
1.14.2 Activities desired by Primary Care Providers for the next 12 months	37
1.14.3 Should the PMHEII continue?	38
1.14.4 Messages for improving the Initiative	39
1.15 Future Directions for the Primary Mental Health and Early Intervention Initiative	41

Abbreviations

AMHS	Area Mental Health Service
CAMHS	Child and Adolescent Mental Health Service
CATT	Crisis Assessment and Treatment Team
CBT	Cognitive Behavioural Therapy
CHC	Community Health Centre
CHS	Community Health Services
DGP	Division of General Practice
DHS	Department of Human Services
EFT	Equivalent Full-time
EI	Early Intervention
GP	General Practitioner
MHB	Mental Health Branch of Department of Human Services
PCP	Primary Care Partnership
PCProv	Primary Care Provider
PDRSS	Psychiatric Disability Rehabilitation and Support Services
PMHEII	Primary Mental Health and Early Intervention Initiative
PMHT	Primary Mental Health Team

Executive Summary

Introduction

The Primary Mental Health and Early Intervention Initiative (PMHEII) constitutes a significant State-wide reform in Victoria aimed at improving health of people with high prevalence illnesses such as depression and anxiety. The Initiative, overseen by the Mental Health Branch of the Department of Human Services, commenced in 2002. An interim evaluation was completed in 2004, and this focused on six selected Primary Mental Health Teams. This document revisits the six cases to ascertain changes and impacts that have occurred over the past 18 months (2004-2005).

For this final phase of the evaluation interviews were carried out with each Manager of the six case study Teams, as well as the six associated Area Mental Health Service (AMHS) Managers, staff from Divisions of General Practice (DGP) and from local Community Health Services. In addition, to gain a view across the whole state telephone interviews were held with all remaining Area Mental Health Service Managers. Topics for all parties included strengths and weaknesses of the Teams, perceived impacts, activities to be conducted over the next 12 months and suggestions about how the Initiative might be improved.

It should be noted that in the past 18 months there have been considerable changes in staffing among the cases. This has affected the data collected in some instances.

Perceived state of development

With one exception, all Teams reported that their operations are largely settled. However, a number were consolidating or refining their way of working.

Activities involving Primary Care Providers

Primary Mental Health Teams have been providing a range of services that are in accordance with their brief. In the main, most Team energy has been directed towards providing services for General Practitioners. This have involved:

- Primary consultation
- Secondary consultation
- Education and training.

Typical activities have included: conducting patient assessments; carrying out short-term treatment; discussing patients informally; telephone consultations; holding education sessions and running workshops.

Services for other primary care providers have been similar to those for GPs. However, the delivery and amount of services has varied due to differing needs, contexts, and Team 'roll-out' strategies.

Early Intervention activities

Models for the Early Intervention (EI) aspect varied, including:

- Not running EI services at all
- Shared responsibility for EI services
- Dedicated EI position(s).

Reports of EI activities were positive. However, a number of AMHS Managers were forthright in declaring:

- Teams are stretched and have little capacity to provide effective and sustainable EI services
- The funding for the EI component is insufficient and ‘tokenistic’
- Staff time provided for EI activities in rural areas fails to take into account the size of the geographic area
- The EI component appears ‘thrown in’ and doesn’t fit with the PMHT brief.

Other service activities

Other activities undertaken by Teams have included (but have not been limited to):

- Linking a wide range of agencies and their clients to appropriate services
- Assisting with discharge planning of AMHS patients
- Mental health promotion and community forums
- Helping to establish other mental health programs (e.g. Access to Allied Health Services)
- Providing advice and input for other agencies wishing to set up training and mental health promotion activities
- Committee work and attending various reference groups.

Integrated services

Some PMHTs are working to integrate services with primary care providers. For example this has been through:

- Co-delivery of education and training modules
- Running joint group therapy sessions with local community health services
- Sitting on committees of local providers and chairing working parties to monitor local needs.

Facilitators that have assisted PMHTs to work well with primary care providers

Factors that have assisted Teams to work successfully with primary care providers appear to be the:

- Possession of a strong (and stable) Team that can address local needs
- Establishment of effective relationships
- Use of appropriate forms of engagement.

Engaging providers has also been achieved through:

- Making introductions through the right channels
- Having influential stakeholders as part of the Steering Committee
- Being persistent and innovative

- Being contactable/accessible.

Other facilitators include:

- The PMHT undertaking additional training to enhance their own skills
- Receiving support from the AMHS.

Barriers to PMHTs working optimally

PMHTs have been faced with a number of issues. For example, Teams have had to contend with:

Limited resources, such as:

- Insufficient money, and therefore staff, to fulfil the brief (this was noted by all Teams)
- Funding levels limiting the provision of services for some primary care providers
- Resources provided for rural Teams failing to take into account issues associated with the size of catchment areas (e.g. travelling time).

Barriers when attempting to engage GPs. These have included:

- Pressure of time for the GP, e.g. having limited time to sit in on assessments
- A GP preference for the PMHT to take over responsibility for mental health patients
- Difficulties engaging GPs in formal education and training
- A lack of interest in mental health care by a proportion of GPs
- Lack of interest from GPs who work in high socio-economic status areas, i.e. patients can be referred to private providers.

Some GPs also reported that they:

- Have few patients with mental health issues
- Have no work space for the PMHT
- Need a quicker response than the PMHT are able to provide.

An additional issue for most Teams has been that other mental health programs (such as Commonwealth-funded programs) have been offered to GPs simultaneously.

Barriers when attempting to engage other primary care providers. These have comprised:

- Competing demands on many Community Health Centres
- Perceptions that the PMHEII may lead to an increase in agency workload
- The PMHT being perceived as a possible threat in connection to funding and territory
- Some providers feeling patronized or that their experience goes unrecognized
- Changes in personnel amongst primary care providers
- Issues with defining service limitations, i.e. what the Team can and cannot do
- Professional and philosophical differences regarding treatment methods.

Coverage of GPs

All of the case study Teams, except one, have reported extensive engagement with primary care providers – particularly GPs. However, there are a number of issues constraining the Team's ability to attract or support more GPs than occurs at present. The major issues are similar to those associated with engaging GPs, that is not having the capacity or resources to support more GPs and matters of geography and demography. An additional issue has been the inability to attract qualified Team members to rural or 'less attractive' areas.

Coverage of non-GP primary care providers

Having made inroads with GPs, a number of Teams are increasingly turning their attention to working with Community Health Services and agencies. Agencies and workers for whom Teams are providing services include (but are not limited to):

- Local community health centres
- Psychiatric disability rehabilitation and support services
- Drug and alcohol programs
- Youth and family support agencies
- Sexual assault centres
- Home and community care workers
- Maternal and child nurses
- The Royal District Nursing Service.

Issues regarding breadth of coverage for other primary care providers

Again, the availability of resources was identified as the major factor restricting the number and range of primary care providers that Teams could support. Additional issues have been:

- The management structures of Community Health Centres
- Agencies perceiving that their work focus is not on clients with high prevalence disorders
- Anxieties associated with working collaboratively with the PMHT
- Concerns regarding training community workers who are unskilled clinically.

Impact of the PMHTs

Difficulties ascertaining impact

Assessing the exact impact of PMHTs has been difficult to determine because:

- Capacity building takes considerable time
- Disentangling specific outcomes attributable solely to the PMHT as opposed to other mental health programs has not been possible
- Referrals by GPs to the PMHT could mean either that the PMHT has been a success in terms of demonstrating GP engagement – or that Teams have failed to make GPs self sufficient in managing patients with high prevalence disorders

- The PMHEII has focused on primary care providers and so there has been no indication of outcomes for patients.

Nevertheless, from the data collected for this evaluation it appears that the PMHEII has led to:

Impacts on General Practitioners

For General Practitioners -

- Systemic improvements (i.e. new layer of service provision)
- Enhanced skills and improved mental health literacy
- Changes in practice (e.g. working with patients that previously would have been referred)
- Greater confidence (and feeling less stressed) when managing patients with mental health issues
- Improved patient outcomes.

Impacts on non-GP primary care providers

Non-GP primary care providers attributed the following outcomes and impacts to the PMHEII:

- Improvements through secondary consultations
- Enhanced capacity, through formal and informal training, to manage clients with high prevalence disorders
- Better coordinated and more clearly understood referral pathways
- Improved understanding of specialist mental health services.

Other outcomes attributed to the PMHEII include:

For clients:

- Increased access to services
- Care located in community settings
- Access to a wider range of treatment methods.

For counsellors:

- Access to up-to-date knowledge
- Professional supervision
- Insights into clinical aspects of service provision.

For agencies:

- Opportunities for networking with other services
- Better coordination of services.

Impact on Area Mental Health Services

Overall, the impact on the AMHSs was said to be relatively low. Nevertheless, the PMHTs have acted as a:

- Way to reduce inappropriate referrals
- Catalyst for improving pathways, both in and out of the AMHS

- Negotiator/mediator between the AMHS and local primary care providers
- Facilitator of improved relationships with primary care providers
- Provider of training and supervision within the AMHS
- Means to maintain mental health patients in the community.

Additionally, a number of AMHS Managers have said that the service model and collaborative approach of PMHTs will be used to inform the future shape of other AMHS services.

Integration of the PMHT within AMHS

Where co-location has occurred it has worked well and led to good communication and sharing of administrative resources. Indeed, most AMHS Managers appear to favor co-location. Despite the site, all Teams were, in the main, said to be well integrated.

Training for AMHS

Training provided by PMHTs directly for the AMHS was variable and ranged from none at all to a considerable amount. Where training occurred it dealt with:

- Early psychosis
- Eating disorders
- Cognitive Behavioural Therapy (CBT)
- Assessment and treatment of high prevalence disorders

In some instances this training (and training for primary care providers) was provided jointly with AMHS staff.

Overall level of satisfaction

Those who participated in the PMHEII appeared to be very satisfied. However, some providers could be satisfied with the caliber of help they received while at the same time not being satisfied in terms of the amount of service provided.

Strengths of the PMHEII

The five strengths most frequently mentioned by providers were that:

- The PMHT fills a gap in the system
- Services are provided ‘on-site’ and jointly with providers
- PMHTs are accessible, approachable and responsive
- Team members possess expert knowledge
- PMHTs are assisting to build the capacity of primary care providers.

The top five strengths nominated by AMHS Managers were that:

- A neglected group of patients is now serviced
- The AMHS is able to concentrate on severe/low prevalence disorders
- There is skill development and capacity building of primary care providers
- Stronger relationships are being established between AMHSs and GPs
- There are experienced and well-qualified staff in the PMHT.

Indeed, a clear majority of AMHS Managers and primary care providers felt that it was important for the PMHEII to continue.

Limitations of the PMHEII

There were very few criticisms regarding PMHT staff or the work they do. When limitations were identified they were nearly always associated with the issue of resources (linked to both staffing and funding). Other issues raised included that:

- PMHT do not provide enough primary consultations
- The PMHEII brief does not allow longer-term care of patients
- The needs of CALD communities and Indigenous communities are not being catered for
- Servicing huge regions (with limited resources) is difficult
- There are low levels of awareness of the PMHT among some GPs and community agencies.

Future directions

Most case study Teams have begun to consider what the Team is do over the next 12 months. Major activities which have been considered comprise:

- Expanding training and services, including further training for providers and AMHS staff
- Instigating structural changes, through recruiting new staff
- Consolidating existing activities, such as shared care arrangements with providers
- Investigating the overall impact of PMHT services.

Additionally, if there were more resources, some Teams would like to:

- Work with primary care providers, agencies and schools that have not been reached so far.

Activities desired by Primary Care Providers

Meanwhile, primary care providers expressed a clear desire for additional services, including more:

- Primary consultations
- Secondary consultations
- Education and training sessions
- Longer-term care options
- Coordination and/or co-delivery of mental health programs.

Messages for improving the Initiative

Lastly, AMHS and PMHT Managers provided a long list of changes they felt would help improve the Primary Mental Health and Early Intervention Initiative. The major suggestions were to:

- Increase funding
- Provide clear directions regarding the roles, services and activities of PMHTs
- Ascertain the effectiveness of the Early Intervention Initiative Service
- Improve communication and support from Mental Health Branch
- Explore the possibility of different PMHT configurations
- Implement more appropriate reporting and evaluation practices
- Coordinate State and Commonwealth initiatives.

Future Directions for the PMHEII

There was an overwhelming demand for the PMHEII to continue. Eight other major suggestions for future action have been put forward. These include the need to: increase funding; optimize Team efficiency; reconsider the EI component; and for Mental Health Branch of DHS to maintain regular contact with Primary Mental Health Teams.

Evaluation of the Primary Mental Health and Early Intervention Initiative

Volume II

Part A: Follow up of Case Studies and Interviews with all Area Mental Health Service Managers

1 Introduction to this report

1.1 The Primary Mental Health and Early Intervention Initiative: a brief description

The Primary Mental Health and Early Intervention Initiative (PMHEII) constitutes a significant reform of the procedures for the delivery of mental health services through Primary Care. It was developed in response to Victorian Government priorities in Mental Health including to:

- support the Second National Mental Health Plan
- improve access to mental health services, and
- develop a more inclusive and responsive mental health service system.

The ultimate purpose of the intervention is to improve health for people with mental illness through the enhancement of services delivered at primary level. The target conditions are high prevalence illnesses such as depression and anxiety¹. There is also a heavy emphasis on prompt diagnosis and early intervention at onset of mental illness, particularly among young people.

There are many different mechanisms designed to produce the above intended outcomes. Consequently, key local stakeholders, with interests in mental health and primary health care, were encouraged to form community-level partnership arrangements. These were then seed-funded to develop a Service Proposal, in line with a Memorandum of Understanding agreed upon with the Department of Human Services, Mental Health Branch. The Service Proposal presented an outline of key activities for local implementation of the PMHEI Initiative. These activities included the:

- development of a Primary Mental Health Team
- development of a specialist Early Intervention Initiative targeted at young people.

After negotiation and approval by the Mental Health Branch, funding was provided for each Steering Group with the local Area Mental Health Service as fund holder. Initial activities were to obtain premises, recruit staff and commence working on the program, in accordance with the Service Proposal. Subsequently, the core services

¹ More detailed information about the PMHEI Initiative is available in *Primary mental health and early intervention services*. (Department of Human Services 2000)

and activities to be delivered by operational Primary Mental Health Teams (PMHTs) were to include:

- Primary and Secondary consultation for General Practitioners and Primary Care Providers
- Education and Training for General Practitioners and Primary Care Providers
- Early Intervention services.

The Primary Mental Health and Early Intervention Initiative has now been operating for more than three years.

1.2 Basis of the second report

After providing a report about the initial implementation and early operations of the Primary Mental Health and Early Intervention Initiative (Day *et al* 2004), this document returns to the six case studies studied in Round One to examine the current situation in mid 2005. For this final phase of the evaluation it was determined to focus on: perceived impacts; level of service provision; successes; shortcomings; current barriers to service; activities to be conducted for the next 12 months; and suggestions about how the Initiative might be improved.

1.2.1 Sources of information and questions posed

The evaluation is based on information supplied from a variety of sources in order to obtain an overall picture of the Initiative from both provider and recipients' points of view.

Firstly, in-depth interviews were conducted with each Manager of the six case study Teams. This allowed detail to be acquired related to each Team's activities and to provide perceptions of the Team's impact on their local Area Mental Health Service (AMHS), as well as on primary care providers and their clients, over the past 18 months.

Next, shorter interviews were carried out with the six AMHS Managers where changes in referral patterns that might be attributed to PMHTs and the extent to which integration of services has taken place, were discussed.

Then, we talked to associated staff from the Divisions of General Practice and Community Health Services in each of the six case study areas. These providers were able to ascertain the levels of impact of the Initiative on their members or staff.

In addition, all interviewees were asked to: discuss the strengths and weaknesses of the Teams; consider activities for the next 12 months; and propose how the Initiative might be improved.

A third of these interviews were carried out face-to-face with the remainder conducted by telephone. In all, 40 interviews were conducted. All interviews were audio recorded, transcribed, and then subjected to detailed coding and analysis.

Lastly, telephone interviews were held with all remaining Area Mental Health Service Managers (or nominated representatives) (x13). This was undertaken in order to confirm the findings from the six case study Teams and to report on the perceived

impact of the Primary Mental Health Teams on Area Mental Health Services across the State.

1.3 Staff changes

Before reporting on the findings of this second round of data collection, it is important to acknowledge that there has been significant turnover of staff not only in a number of the case study Teams but also among associated primary care providers, Area Mental Health Services and representative agencies such as the Divisions of General Practice. This has meant that in some instances the evaluators have found it difficult, and even impossible, to find people who were in a position to report in detail on the activities of Teams over the past 18 months.

However, some staff changes have resulted in positive outcomes for the evaluation. For example, one AMHS Manager had only been in her current position for a few months but had worked with another Team previously. This meant she was able to give a useful comparative view of Teams. Similarly, in another instance, the representative of a Division of General Practice had formerly been a PMHEI Team Manager.

Issues with PMHT staffing

In regards to the Teams themselves, some staff changes have been for the positive with one reporting they had:

...a chance to broaden the Team and we're pleased with that. We now have senior Clinicians who are psychologists, a consultant psychiatrist, a GP position and we've had an OT start with us. So we are entering a phase of broadening our scope (TM 5)².

In contrast, one case study Team had experienced ongoing difficulties with recruitment, and, in fact, at the time of data collection, the majority of Team positions were vacant. As a result, the Manager reported she was having to 'rebuild completely and start the Team from scratch' (TM 1).

There were additional staffing issues for other Teams. For instance, after one Manager left, recruitment of another Manager has proved difficult. Even after extensive advertising it has been impossible to fill the position with an appropriate person because few people seem to possess the right mix of skills, i.e. clinical and managerial. This has meant there has been an acting Manager in the role for over a year.

Several Teams also described ongoing difficulties coping with administrative tasks. Some Teams explained that when resources could be allocated for administrative support it was often insufficient. This resulted in clinicians having to take responsibility for administrative duties which detracted from optimal Team efficiency. In one case there was no administrative support for the Team at all.

² Audit trail: T = Team; TM = PMHT Manager; AM = AMHS Manager; DGP = Division of General Practice; OP = non-GP primary care provider agency; Number = indicates number attached to each case study site; Number and letter = letters follow case study site numbers (e.g. DGP 6a) to distinguish between like agencies interviewed within case study areas.

An issue for all Teams has been their size. There was a general feeling that small numbers in Teams left them vulnerable or limited the functioning of the Team. Consequently, the loss of only one or two staff led to implications for coverage, continuity and the smooth running of the Team. As one Team Manager explained:

As soon as you have a gap in your Team you have little to play with. If someone moves and you have to re-employ you could have a general practice not getting a service for maybe two months. That's a challenge because we are so big on relationship building and rely on the same person going out to a clinic. We also don't have the potential for backfill or for seconding someone from another Team. One move we have had has been a maternal leave position. Things like that make a big impact because you are a small Team. (TM 3)

1.4 Perceived state of development

Perhaps the most useful way to portray the current state of development for the majority of case study Teams is through a collective view provided by Team Managers, each of whom were asked to describe the current state of play of their particular PMHT:

I think it has in the main settled...I would say that we are well and truly through the consolidation of our activities (TM 2)...We are up and running...We're very clearly past that 18 months to 2 years establishment phase. We've done a lot of the promotion, building and orientation (TM 5)...We're not needing to be out there so vigorously profiling ourselves or encouraging people to see us as advantageous. A lot of that is out there now and people are asking for us instead of us having to go out and sell ourselves. We have built up relationships and there is a lot of trust now. They recognize our expertise and they avail themselves of us (TM 4)...So, for some people we have moved beyond consolidation and are now recognized as a worthwhile Team. (TM 2)

Others added more about being settled:

The other thing that has settled quite well has been our external stakeholders. So things like fund holding, who administers the Teams, and steering groups are well and truly settled. (TM 3)

I now think we are doing every task that we were meant to be doing...I would describe ourselves as a well-established Team (TM 6).

Meanwhile, a number of Teams were refining and evolving their way of working:

We are very much into the phase of delivering a service...So we're into a refining and developing phase. We're now evaluating what we are doing and seeing how we could do things better. (TM 5)

What is still evolving, though, are things like the education component. We were really concentrating on direct service delivery in the first instance. But education and training programs are going full steam ahead. (TM 3)

Just one Team had a quite different experience. After a range of difficulties and having determined a change of direction, the Team is now having to refocus and “*go back out there to primary care providers and repromote the Primary Mental Health Team and all the services we can offer.*” (TM 1)

1.5 Activities involving primary care providers over the past 18 months

1.5.1 Coverage by the PMHT

All of the case study Teams, except one, have reported extensive engagement with primary care providers – and particularly GPs. Teams were able to give an approximate indication of the number of GPs or GP practices to whom they were providing services. Details are given below for each of the six case study Teams:

Rural Team – Case Study 2

We’ve got roughly 100 clinics in our area. We provide services to about 80-85% of these. But keep in mind that not all GPs in a clinic will refer. I can think of one clinic where six out of ten do.

Urban Team – Case Study 3

We’ve got thirty practices currently and there are on average 5 GPs per practice. We feel we have exhausted two of our three Divisions. So GPs have been invited and we’ve made approaches and they have decided to take us up or not. I think it has been an intensive cover that has been given to 70-80% of GPs, but some of them have had to wait.

Urban Team – Case Study 4

We’re working with about 80...The coverage is not too bad. I think we see more than the number that are registered for the Better Outcomes in Mental Health. So the PMHT is more widely used.

Urban Team – Case Study 5

I’d say we cover about 100 GPs. We provided a regular and full service to a third of GPs in our area. Given the limitations of our resources I think that is doing very well.

Urban Team – Case Study 6

We are receiving requests from 45 GPs. This is going to be an evolutionary process because we have over 200 in our catchment area.

A rural PMHT was the only case study Team not providing many services to GPs. This was attributed to staff turn over, difficulties recruiting a consultant psychiatrist and the Team’s initial service focus on providing education and training. Describing this PMHT as “*having to rebuild and re-engage providers*”, the new Manager of the Team hoped to attract GPs by offering direct clinical services in the near future. (TM 1)

1.5.2 Services provided for General Practitioners

Primary Mental Health Teams have been providing a range of services that are in accordance with their brief, with a significant proportion of Team energy directed towards providing these services for General Practitioners. This has involved:

Primary Consultation

- Taking referrals
- Conducting patient assessments
- Undertaking medication reviews (by the consultant psychiatrist or registrar)
- Carrying out short-term treatment.

For example:

We have a 10% workload working with cases, taking them on for brief intervention and treatment. We usually pick them up as an assessment with the GP. But it has to be a person who is going to benefit from a brief intervention. It also means that our clinicians can keep their skills alive. At any one time we like clinicians to have about three patients on their books. It's always short-term for about six weeks or at review we might give them another six weeks. (TM 3)

We tend to offer treatment to about 54% of the people we assess. We average about 4.5 sessions per client taken on for treatment. (TM 6)

- Care planning (note: this is also undertaken as secondary consultation)

Secondary consultation

- Taking part in formal consultation
- Carrying out informal secondary consultations
- Discussing patients through telephone consultations.

As one Team Manager described:

Many of the secondary consultations continue to be informal tea room or hallway conversations. However, some GPs will also pick up the phone and talk to us if they are scratching their head. (TM 2)

Education and training

- Running education sessions (e.g. GP education nights)
- Holding education sessions jointly organized by the PMHT and local Division of General Practice (DGP)
- Facilitating small group learning modules
- Discussing cases in groups

One Team gave details about such a mixture of training approaches:

We provide education and training usually in partnership with the Division of General Practice. For example, we can carry out formal training, such as Level 1 training for mental health. It was a training module packaged by the

GP Division. It upskills the GPs in terms of basic psychiatry, history taking and management. So we were the deliverer of that package. We've also, during the last year, delivered a mental health program with a special interest group through the Division. It covered specific things such as therapy techniques. Recently, we started two new initiatives that we are thrilled about. They are small learning groups for GPs. We thought we would start one, but there was so much interest we were able to start two. Attendance has been great and feedback has been good. (TM 5)

Other activities with GPs:

- Being a screening point for referrals to other programs
- Providing general information regarding referral pathways (e.g. production of a guide outlining referral options)
- Attending local DGP steering groups for the Access to Allied Health Project.

1.5.3 Coverage of non-GP primary care providers

Having made inroads with providing services for GPs, a number of Teams are increasingly turning their attention to working with Community Health Services and agencies. Agencies and workers for whom Teams are providing services included (but are not limited to):

- Local community health centres (T 1, T 2, T 3, T 4, T 5, T 6)
- Psychiatric disability rehabilitation and support services (T 3)
- Drug and alcohol programs (T 2, T 4)
- Youth and family support agencies (T 2, T 4)
- Sexual assault centres (T 2, T 6)
- Home and community care workers (T 4)
- Maternal and child nurses (T 2, T 6)
- The Royal District Nursing Service (T 3)

1.5.4 Services for other primary care providers

Most Teams reported that a similar range of services was being provided for non-GP primary care providers as those for GPs. However, the delivery and amount of services varied due to differing needs, contexts, and Team 'roll-out' strategies. It should be noted that delivery was often uneven in relation to outlying providers due to catchment boundary issues or difficulty manning geographically remote areas. Several Teams also explained that while primary consultations could be accessed by non-GP primary care providers, this was not promoted. As one Team Manager admitted:

We tend not to market primary consultation in any concerted way to non-GPs simply because we couldn't manage the demand. So we tend to highlight secondary consultation and training opportunities to the non-GP primary care providers. We would not knock back a request for primary consultation but we know, first and foremost, that clients in this population group go to their GPs. (TM 2)

Examples of services provided for non-GP primary care providers included:

- Joint assessments
- One-to-one consultations

- Ongoing secondary consultation with difficult clients
- Group secondary consultations.

So, in one instance it was reported that:

The two CHCs are going well. We go out to them. One we go to twice a week and one we go to once a week for primary or secondary consultations. (TM 3)

- Case discussion meetings with a wide variety of allied health workers where:

We do case discussion meetings and we sometimes get quite a high turnout of counsellors and drug and alcohol workers and social workers and psychologists – people who are employed at CHCs as well as some of the non-profit counseling services. (TM 4)

We run clinical review type groups. For instance, in one health service we're holding a monthly meeting with a group of allied health who haven't got a background in mental health really. They might be physiotherapists or community nurses, speech therapists or OTs. Some work with the aged population. The sessions are clinically driven and so they are encouraged to bring cases for review. (TM 3)

- Telephone secondary consultations
- Group supervision:

We also run supervision groups for various disciplines. So there's a nursing supervision group run by the social worker where they're reflecting on their practice. (TM 3)

- Education and training, such as:

At the request of the regional coordinator of maternal and child health nurses we did some sessions: one on accessing psych services; and one on mental states and risk assessment. That gave them some mental health literacy in terms of identifying and communicating levels of risk. (TM 3)

For Pysch Disability Support Services we provide a monthly education session that goes for about three hours. We cover different topics such as mental state assessments or how to identify depression. The topics are based on a needs analysis driven by them. (TM 3)

We've been involved with the MAP (Mental Health Attributes and Practice) training and that's brought the Team into contact with a lot of primary care providers (AM 4).

- Providing general support and information.

To give some indication of the wide range of providers supported and diverse activities than can be undertaken by a single PMHT, here is a summary made by one Team Manager:

We serve the community health counselor and the drug and alcohol counselors here (in a CHC) and at the other CHC. Then we work with places like CAMCARE (an independent family support agency), Eastern Drug and Alcohol Service, and there is the social work service and psychology service in the local area. We go out and run case discussion meetings every month and have ongoing phone calls back and forth. I've also seen some clients with them. But what I think they really appreciate is being able to present a case to get some feedback about it. (TM 4)

1.5.5 Early intervention activities

Unlike the services described above, the Early Intervention (EI) aspect was quite different across cases. Models included:

Not running EI services at all

This was so for two Teams that were located within the service boundaries of Orygen Youth Health and so were not required to provide EI services. These Teams were only involved in EI work in the sense of keeping primary care providers aware of detecting cases.

Shared responsibility for EI services

Sharing EI work was reported by a rural PMHT who felt all Team members should take responsibility for EI activities. Previously, the EI component had been the responsibility of a sole worker but there had been problems. As a result the Team Manager now:

...would like to see all staff in the Team have an understanding and responsibility for that component of our work. It has been really problematic having one person with sole responsibility for EI in a region of this size – and for them to travel so much. (TM 1)

In another instance, a Team that had shared the EI component formerly, scaled back these activities after the opening of a specialist Early Psychosis Clinic in the region. The Team still fulfils its role though of early identification and helping primary care providers to manage those cases, where possible, in the community.

Dedicated EI position(s)

Two Teams had a dedicated person to manage the EI component. The types of activities these workers have undertaken involved:

- Primary and secondary consultations in schools (e.g. concerning young people exhibiting prodromal symptoms of psychosis)
- Training sessions (e.g. on self harming, adolescence)
- Workshops and education packages (e.g. identification and assessment of first episode psychosis, basic assessment and counselling skills for Student Welfare Coordinators)
- Providing information for School Psychologists and School Welfare Officers (e.g. referral pathways)
- Establishing early psychosis guidelines with local hospitals

- Working on community committees that deal with youth, youth services and networks
- Participating in AMHS early psychosis committees
- Making presentations to the above groups about what the PMHT can offer.

Early Intervention Initiative- opinions from AMHS Managers across Victoria³

While the overall tone of discussions regarding specific PMHT early intervention activities was most positive from the majority of cases, a number of AMHS Managers were forthright in declaring:

- Teams are stretched and have little capacity to provide effective and sustainable EI services
- The funding for the EI component is insufficient and 'tokenistic'
- EFT provided for the EI activities in rural areas fails to take into account the size of the geographic area (i.e. travel time involved)
- The EI component appears 'thrown in' and doesn't fit with the PMHT brief.

Furthermore, one AMHS Manager reported that:

We've taken our EI worker out of the PMHT and attached that position to our early psychosis service.

As a result of these concerns and developments there were suggestions to consider:

- Providing more funding for the Early Intervention Initiative
- Removing service provision for First Episode Psychosis from the PMHT brief
- Linking the EI component with AMHS Early Episode Psychosis Programs
- Sharing and expanding EI work within the broader AMHS.

1.5.6 Other service activities

Other activities undertaken by Teams include:

- Linking a wide range of agencies and their clients to appropriate services (TM 3, TM 1). For instance:

Eating disorders are not within our brief but we see it as a need out there – in identifying them and linking them to an appropriate service. It was one of those things we didn't expect but we found people struggling with these types of clients. (TM 3)

We've produced a referrer pack. It's very comprehensive and gives GPs (and others) a clearer sense of which agency can help the client they are trying to refer best. For the first time they can see services that are offered across the age spectrum, geographical boundaries and what the contact points are. The feedback has been enormously positive. (AM 6)

- Assisting with discharge planning of AMHS patients (TM 3)

³ From now on at certain points in the report, in addition to material from the six case studies, comments from AMHS Managers (or nominated representatives) from all other catchment areas will be presented in a separate box.

- Mental health promotion and community forums (TM 1, TM2, TM 6)
- Helping to establish other mental health programs (e.g. Commonwealth funded programs) (TM 2, TM 6). For instance:

The PMHT have been very much involved in the Access to Allied Health project. Two of the senior clinicians have been very active in helping to establish the model and helping to screen possible providers. The PMHT have been very influential and the programs they have been involved with have been very successful. (DGP 6)

- Providing advice and input for other agencies wishing to set up training and mental health promotion activities (TM 2, DGP 6)
- Committee work and attending various reference groups. (TM 6)

1.6 Facilitators that have assisted Primary Mental Health Teams to work well with primary care providers

A number of factors appear to have assisted Teams to engage and work successfully with primary care providers. These include the:

Possession of a strong Team that can address needs

This has involved:

- Having a skilled and experienced Team (TM 2, TM 4, TM 5, TM6)
- Strengthening the Team with people who have particular areas of expertise (TM 5)
- Fulfilling community and provider needs (e.g. training in depression, assessment support for GPs) (TM 3)
- Being able to deliver requested services (e.g. assessment, consultation, treatment, information, education) (TM 6, TM 2)
- Providing services in GP/community settings. (TM 2)

Establishment of effective relationships

- Developing ‘quality’ and trusting relationships with GP and non-GP primary care providers (TM 2, TM 3). As two Team Managers emphasised:

There was clearly a need to spend time and energy developing that relationship - to learn what they wanted and then to reflect back to them that we could provide those services. One of the main concerns that primary care providers had, especially the GPs, was that we wouldn't be around for the long haul. So when they realized that we would be around – that consolidated the relationship. (TM 2)

It's explaining to them that we want to up-skill them so that they can continue to do their work more efficiently...that takes a little while. That means you have to develop trust. When they have understood what our purpose is, then they let us in. (TM 3)

- Building up of a strong positive relationship with the Division of General Practice (TM 5):

We have a very strong partnership with the Division of General Practice and an easy collegial working relationship and lots of day-to-day contact with them. So we work well with them as a Team. That's made the biggest difference because when we want to do something they have advertised it. (TM 5)

Use of appropriate forms of engagement

Teams have managed to engage providers by:

- Making introductions through the right channels (TM 3):

We try to go in at the right level. We do the courtesy of speaking to management first and working out if we can talk to the next level. No one has knocked us back. (TM 3)

- Having influential stakeholders as part of the Steering Committee (TM 3):

Having the external stakeholders on the Steering Group was a plus because they had an investment to make it work – and we did have the ‘big guns’ in – the CEOs from the two health services and the CEO from the Psychiatric Disability Rehabilitation and Support Services (PDRSS). Having them there encouraged their Managers to take us on board. (TM 3)

- Being persistent (TM 3)
- Being contactable/accessible. (TM 2, TM 4)

Other factors included:

Being innovative by:

- Members of the PMHT undertaking additional training for themselves (TM 3):

A couple of us have been out and done the Certificate IV in Workplace Assessment and Training. So the way we deliver our education and training has changed. It's been wonderful and the feedback has been astonishing! We get people saying “When can we come?” and “When are you running the next session?” (TM 3)

- Having a flexible program brief (TM 2, TM 4):

Another factor that has assisted us has been the flexibility in our brief. We have been able to think outside the box and generate projects and programs that are quite attentive to the needs of our clients. We can think outside the box in a way that adult services or CAMHS are not able to do. (TM 2)

Receiving support from the AMHS

A final facilitating factor “*has been the support of the AMHS. We’ve had support from the executive level to exist and to be true to the brief.*” (TM 3)

1.7 Barriers to Primary Mental Health Teams working optimally

While the majority of Teams reported that they have worked hard to implement the Initiative and worked well with primary care providers, they have, simultaneously, been faced with a number of issues. For example, they have had to contend with:

Limited resources, including that:

- There is insufficient money (and therefore staff) to fulfil the brief, i.e. to provide the breadth of activities expected (this was noted by all Teams). Not surprisingly Teams felt that:

There is a lot more we could do if we had two to three times as many people on the ground. We are limited often by that. That’s why we had to stagger the introduction of training. We might have done that two years ago but we had to hold off and make it our focus this year because we just didn’t have enough people to do community development activities, provide a direct service to GPs as well as provide education and training. (TM 3)

We could do a lot more for Community Health Services. But again that is about capacity. We would need more time, money and clinicians. (TM 5)

- Funding levels limit the provision of services for some non-GP primary care providers (TM 2) so that:

Again I would say that limited resources means you can’t get to everyone. There is a plethora of agencies out there wanting a piece of the pie and we just can’t get to everyone. (TM 2)

- Resources provided for rural Teams fail to take into account issues associated with the size of these catchment areas (TM 1, TM 2). Thus one Team Manager was frustrated because:

We’re in a region covering 26,000 square kilometers, and there are some remote communities that we are just not getting access to. (TM 2)... *I can’t believe how much time I spend on the road driving. It’s amazing how much time is wasted in travelling. Trying to cover the entire region is just ridiculous.* (TM 1)

The inability to attract qualified Team members

In other cases the inability to staff rural or ‘less attractive’ areas has prevented, or limited, a Team’s ability to cover and support GPs and other providers. Consequently, several Team members reported that there have been difficulties in attracting

professional mental health workers to more remote areas. As one Team Manager in a regional centre explained:

Services for GPs out there are limited because there isn't the manpower available to deliver them. Unless we get additional EFT I wouldn't attempt to offer GPs something that I can't deliver." (TM 2)

Barriers engaging GPs

Issues associated with engaging GPs have included:

- Pressure of time for the GP, e.g. having limited time to sit in on assessments (TM 4, TM 6) with the result that:

In the high growth corridors of Melbourne, the GP to population ratio is absurd. So their capacity, when they have overfilled waiting rooms, is compromised very much. (TM 6)

- A GP preference for the PMHT to take over responsibility for mental health patients rather than the GP and PMHT working together (TM 3, TM 4):

So there have been times when we have explained how we work jointly and, therefore, need them to be at the assessment, even if it is only for ten minutes. But some of them (GPs) have said 'Oh no! I just want this person to go and get some counselling'. They want us to see their patients separately from them. (TM 3)

- Not providing services desired by GPs:

From what I can gather GPs have not embraced us in this region and that is because the Team was promoting itself as an education and training service - and that's not what they wanted. They wanted direct clinical work. (TM 1)

- A preference only to consult with the Team psychiatrist rather than Team members with allied health backgrounds. Consequently, it was reported that:

With the general practices, one of the things that often came up was that they wanted medicos. They say they want the consultant or the Registrar and, of course, we can't make them available to everyone. But we were quite firm in saying that we are a Team of experts in the area and we all have our strengths. (TM 3)

- Difficulties engaging GPs in formal education and training. Some Managers remarked:

We have not been able to engage the GP in any formal educative process. We still deliver education to GPs through the consultation that we offer and when they are sitting in with you. But pulling a group of GPs together for a formal presentation - well we've not been not been successful in doing that. (TM 2)

The problem is they are bombarded with requirements for training. GPs are expected to be experts in everything. (TM 6)

- Clashes between PMHT and DGP training session times (TM 4, DGP 4a):

One local Division of General Practice (DGP) used to do their training quite independently of us and although we advertised our training through them, there was a period when we would advertise a session and it would then turn out they had also for the same time and the two training sessions would clash. (TM 4)

- Other mental health programs being offered to GPs simultaneously (DGP 2, DGP 4b, DGP 6):

One major issue for several Teams has been the problem of co-existing mental health programs. Because there are other programs, such as the Commonwealth funded 'Access to Allied Health Services Project', there has sometimes been the perception that the PMHT could constitute a form of competition. As part of the problem, too, there has been some confusion about which of the services on offer GPs should choose:

When we first started the Access to Allied Health there were some problems because Better Outcomes, MAHS (More Allied Health Service program) and the PMHT were all picking up pretty much the same patients. That created a fair bit of confusion and concern for some GPs. (DGP 2)

- A lack of interest in mental health care by a proportion of GPs.

Many Teams reported that they were unlikely to attract some GPs no matter what was offered:

There is a rule of thirds in general practice. A third are quite interested, a third are ambivalent and a final third are keenly disinterested. The last group are the sort who would use whatever it takes not to deal with the issue – whether it be humiliating the patient or telling them that it's all in the mind. (DGP 5a)

- Lack of interest from GPs in high socio-economic status (SES) areas. As a member of one Division of General Practice pointed out:

This is a well-to-do area and GPs would be very low users of the PMHT. We are well-serviced by the private sector and many GPs would be referring to people in the private sector where they have the capacity to pay by self-insurance - many indeed would be covered by 'extras' insurance. (DGP 4a)

Other things preventing Teams from engaging GPs included being faced with GPs who:

- Say they have few patients with mental health issues
- Feel they are well-versed in mental health already
- Have no work space for the PMHT
- Say they need a quicker response than the PMHT are able to provide.

Barriers engaging other primary care providers

Again, the availability of resources was identified as the major factor restricting the number and range of primary care providers that Teams can support. However, for some primary care providers the PMHT has been perceived as a possible threat in connection to funding and a possible encroachment on territory. For others there was a sense of being patronized and a sense of having their (often extensive) experience belittled. This was recognized by both Team Managers and those who receive PMHT services (TM 4, OP 6b):

There are some who view us (the PMHT) with a threatening eye and are very wary of using us. They know that our role is to enhance skills and that could sound as if we have come to tell them what to do. Maybe they thought: 'What does the DHS think they are doing? – sending others along to tell us how to do our jobs!' (TM 4)

I'm almost 60 and most of us at this Centre have been doing our jobs for a long time. There is a bit of "Don't teach your grandmother to suck eggs." (OP 6b)

Other barriers comprised:

- The high demands placed on many Community Health Centres:

There are waiting lists at all our Community Health Centres from two months to indefinite. It's really bad and because they're in such demand, attempting to free up time for them to think about what they are doing is a real challenge for them. (TM 6)

- Perceptions that the PMHEII may increase the workload of community agencies (OP 5, OP 6b):

Mental health has decided they have limited funds so what they do is introduce consultants or train us to deal with their problems. Now we simply can't do that. We are feeling swamped. So people (CHC workers) perceive the training as 'Oh, God! Here we go again'. So feelings of resentment against mental health are not just about the PMHT, they're around the whole shift happening in mental health. (OP 6b)

- Changes in personnel amongst primary care providers

For instance:

In both Community Health Centres there have been changes in personnel. So there are changes all round – it's in flux at the moment. (TM 5)

- The management structures of Community Health Centres

Our level of engagement with some centres is variable. These services have a Manager and then a very flat team structure. So if the Manager is not around, nothing happens. (TM 6)

- Agencies perceiving that their work focus is not on clients with high prevalence disorders (TM 4)
- Concerns regarding training workers who are unskilled clinically

... we backtracked quite fast as soon as we realized that some workers were not clinically skilled as that raised a question or two about Duty of Care. We didn't want to have clinical consults because it was like clinical supervision with people who were not clinically trained at all! (TM 3)

- Issues with defining service limitations, i.e. what the Team can and can't do (TM 4)
- Professional and philosophical differences regarding treatment methods (OP 6b):

Some of the workers are really against a Cognitive Behavioural Therapy framework. They see the work of the PMHT as extremely medically based, very much a medical model. So there is a philosophical difference. (OP 6b)

1.8 Other programs with which the Primary Mental Health Teams were involved

The Primary Mental Health Teams were involved in a wide range of programs. In some cases these projects had been instigated by the PMHT, while at other times the PMHT either joined other agencies to deliver a program or coordinated Team activities with the work of other agencies. Examples of programs with which the Primary Mental Health Teams were engaged have included:

- CLIPP (Consultation and Liaison in Primary Care Psychiatry) (TM 5)

This Melbourne-based program was established prior to the commencement of the PMHEII and operates with a broadly similar model and shared care philosophy. While PMHTs tend to work with high prevalence disorders in the short term, CLIPP offers ongoing support to GPs and the psychiatric review of clients, which can include patients with long-term low-prevalence conditions.

- The Clozapine Program (TM 5)

This program exists to provide regulated monitoring and coordination of care for clients who are receiving Clozapine medication as part of their treatment. The AMHS employs a coordinator who monitors the regular blood results and supports clients, carers and GPs in a shared care relationship.

- Eating Disorders Programs (TM 1, TM 5)

Eating disorder projects included:

A program rolled out and managed by The Victorian Centre for Excellence in Eating Disorders (CEED). It's a demonstration project. They employ a specialist worker who spends 6 to 12 months in an area implementing a

project with the aim of capacity building in managing eating disorders. (TM 5)

- The Better Outcomes in Mental Health Initiative including ‘Education and Training for General Practitioners’ and ‘Access to Allied Health Services’ (TM 5)

The Better Outcomes in Mental Health Care Initiative is a Commonwealth-funded initiative which aims to support GPs in improving the quality of care provided for patients with mental health disorders.

- Post-Natal Depression Projects (TM 2)

Post-natal depression (PND) projects include the provision of training, information and support aimed at improving the identification, assessment and quality of care of women at risk of, or experiencing, PND. In one case, a post natal depression project had been funded by a regional office for 18 months and then having been found to be beneficial, was extended by another year. It meant that:

...(in our region) every hospital has introduced screening during the antenatal period as a direct result of the projects. The project has also created a module that will be routinely included in the six-week antenatal classes across the region. We’re also providing training to midwifery care, maternal and child health. This has seen enhanced assessment and identification and in some cases treatment of women. (TM 2)

1.8.1 Other activities which integrate services

Primary Mental Health Teams are also engaged in a range of other integrated activities. These involve:

- Co-delivery of education and training modules with local programs, DGPs and primary care provider agencies (TM 5, TM 2, DGP 2, DGP 6)
- Running joint group therapy sessions with local community health services, e.g.:

There is a group being run at the moment which is a joint venture between the Community Health Service and our Team. It was a project set up as an experiment to see if running a group for six sessions, as a collaborative project, is something that would be useful. It’s a mixed group of adults of all ages who have depression. (TM 4)

- Sitting on committees of local DGPs and community health centres, such as the health promotion committees, service coordination committees and mental health committees (TM 3, DGP 6)
- Chairing a working party to monitor needs in the area. (TM 3)

1.8.2 The impact of other programs on the PMHEII

As previously noted, there was widespread acknowledgment that some GPs have been confused by the co-occurrence of the PMHEII and Access to Allied Health program. However, most Teams and Divisions felt the two Initiatives could co-exist successfully. For example, one Team Manager reported that:

We just took the approach with all the practices and Divisions that we wanted to complement services. So often we are called in for assessment and the second opinion and then we may recommend they go and see someone associated with the Allied Health Project. So that tension has dissipated. (TM 3)

This sentiment was shared by a DGP representative who explained:

We've taken the view that these programs can exist in parallel - and I have promoted both. I have a very strong relationship with the PMHT Manager whose professionalism I admire greatly. I can say the relationship has assisted us and we've provided a lot of support for the PMHT. (DGP 4a)

Indeed, PMHT Managers and DGP representatives noted there appeared to be sufficient demand to keep both programs busy, with one Manager exclaiming “*There are certainly enough patients out there for all of us!*” (TM 2). Several Division representatives also reported that with access to two programs, many GPs were “*feeling much better supported now*” (DGP 2).

1.9 Impact of the Primary Mental Health Teams

1.9.1 Difficulties ascertaining impact

The evaluators have found the assessment of the exact impact to be difficult to determine. This has been for a number of reasons including that:

- The program is not completely settled yet. The focus of the program is on capacity building within the primary care sector. Types of activity, such as knowledge transfer and application of training, take considerable time
- There have been co-existing mental health programs operating at local, regional and Commonwealth levels. Consequently, it is difficult to disentangle specific outcomes that can be attributed solely to the PMEHI as opposed to those arising from other programs
- The nature of the Initiative makes outcomes hard to determine or measure. For instance, if a GP fails to contact the PMHT does this mean that the Team has worked successfully so that the GP is now self sufficient? - or does it mean that they were not satisfied with the service? Similarly, are consistent referrals from GPs a sign of successful engagement and of meeting needs or does this indicate a failure to build the capacity of GPs?
- The evaluation has concentrated on primary care providers and so there is no indication of the eventual outcomes for patients.

Local, small-scale evaluations

While there have been few sophisticated large-scale data collection exercises to determine the impact made by PMHTs, a number of Teams have attempted small-scale evaluation activities. Even so, sometimes this proved difficult to carry out. For instance, one Team was not able to survey as many people as they would have liked. They had tried a telephone survey of local GPs but became frustrated when phone calls were not returned or GPs were unavailable.

Consequently, precise evidence was minimal but there was considerable evidence to suggest that the PMHEII is working successfully with GPs. For example:

We have surveyed the GPs annually and they report that although the service “is a drop in the bucket” they’d like more of it. The majority reported improved ease of recognition and comfort with the management of these conditions. So, while both years the flavour of the survey results has been that the service was great, there wasn’t enough of it. (TM 5)

We have done a GP satisfaction survey. There it was: “Yes we very much want your service to continue” and “It’s helped us with our skills development because of accessibility”. (TM 3)

In addition to direct surveys, there were also signs of impact through unobtrusive measures. Interestingly, in one case, a Team Manager explained how evidence of changed practice had been found through conducting a key word search of Medical Director progress notes. This has been undertaken to assess change. He reported that:

What we have all noticed is that their progress notes have changed over time from little mention about mental health to significant mention of mental health issues. They are now considering other options in addition to just pharmacological options. It’s quite refreshing to read their progress notes about quite detailed examination of the mental state and consideration of different treatment options. The latter might include a stress management course or referral to the PMHT or a referral to a psychologist. So those notes have illustrated the change in their thinking and practice. (TM 2)

Given that difficulties in ascertaining levels of impact were noted in both this and first volume of the PMHEII evaluation, there appears to be an urgent need for the Mental Health Branch of DHS to play a leadership role in assisting Teams to collect appropriate information about impact. This would need to ensure that data collected reflects the full range of activities undertaken by PMHTs.

1.9.2 Examples of Impact on General Practitioners

From all the interview material, it appears that the PMHEII has led to:

Increased knowledge, e.g.:

- Improved mental health literacy (TM 2, DGP 5a, DGP 6)
- Enhanced skills (DGP 5a, TM 2)
- Better identification of mental health issues among patients (TM 2, TM 5)
- Increased awareness of referral pathways (DGP 5a)
- Improved understanding of AMHS eligibility criteria. (TM 2)

Changes in practice, e.g.:

- More confidence when assessing and treating mental health patients (TM 3, DGP 4a, DGP 6)
- Working with patients that previously would have been referred (TM 2)
- Changes in treatment and management practices (TM 2, TM 5)
- Acting independently with treatment strategies and pharmacological approaches (TM 3)

- Referring more appropriately to the PMHT, AMHS and other services. (TM 2, TM 6).

An impact on the GP him/herself, i.e.:

- Decreased stress levels and a greater sense of support for the GP because of the availability of the PMHT (TM 3, TM 6, DGP 6):

They feel supported better in terms of actually dealing with people with mental health problems. So, if you feel less isolated and more supported in terms of treating someone, you are going to feel a good deal more comfortable about trying something...Because you know that if you get into strife you can always ask for help. I think that is one of the things GPs really value. (TM 6)

Systemic improvements, e.g.:

- A new intermediary layer of service provision previously unavailable to GPs and their patients (DGP 5a, DGP 6) so that:

They've filled a gap in the system that the AMHS haven't been able to provide. The AMHS has not been responsive to GPs and are not good at getting back to them. GPs want to make a phone call and have someone answer it straightaway. I think GPs feel that there is something in between them and the AMHS whereas there was quite a gap previously. (DGP 6)

- Access to consultant psychiatrists with up-to-date knowledge:

Each Team has a consultant psychiatrist and so GPs have been up-skilled in evidence-based pharmacotherapy...and there were previously some pretty questionable practices out there to be honest. There were some very outdated ones. (DGP 5a)

Better Outcomes for Patients

- Direct services and support resulting in improved patient outcomes (DGP 5a, DGP 6):

Sometimes the mental state of a patient is at such a level that GPs just don't have either the time or the skills to help them. So while secondary consultation can be important, having the PMHT provide direct care to get a patient and the GP over that mountain to enable the GP to continue care with the patient has been very valuable. (DGP 6)

1.9.3 Perceived Impact – other primary care providers

In comparison with the work undertaken with GPs, the amount of work carried out with other primary care providers has been considerably less. Nevertheless, most case studies reported positive impacts that have occurred as a result of the work of PMHTs. As one Team Manager explained:

For those who we have engaged, I think the impacts have been good. Lots of positive things come back to use along the lines of "You're accessible, you're

approachable and we don't know how we managed before" kind of comments.
(TM 3)

From their perspective non-GP primary care providers attributed the following outcomes and impacts to the PMHEII:

- Improvements through secondary consultations:

It's given us direction with our clients and helped make assessment and treatment strategies clearer. (OP6c)

Our counsellors now feel more confident managing those disorders within our service. (OP 2c)

- Enhanced capacity, through formal and informal training, to manage clients with high prevalence disorders with the result that:

Our staff now understand the vulnerabilities and symptoms around these disorders. (OP 2c)

In the last 12 months the change has been that our workers feel more confident when responding to clients and providing interventions and ongoing treatments. (OP 6a)

The counsellors at our service seem to be seeing those people for shorter periods of time and with better results. (OP 6a)

- Better coordinated and more clearly understood referral pathways so that non-GP providers stated that:

The workers here say they feel a lot more confident in terms of their ability to know where to refer to. (OP 2c)

There is better communication and understanding of what each other does and the referring systems are better because of that. There are better pathways and more efficient ones have developed. (OP 2b)

- Improved understanding of specialist mental health services whereby:

The PMHT give (counsellors) the language they need to be able to talk with the AMHS. So they are feeling more confident dealing with that system as well. (OP 2b)

Workers are less frustrated because they now understand which clients need to go to AMHS versus ones that can be managed in the community. (OP 2c)

- More assistance with identifying and referring patients with low prevalence disorders:

There has been a significant impact around the low prevalence disorders. We struggled with the low prevalence disorders and the PMHT's involvement

resulted in us being able to assess these conditions and refer people on better.
(OP 6a)

Other positive outcomes attributed to the PMHEII include:

For clients:

- Increased access to services (OP 5)
- Care located in community settings (OP 2c)
- Access to a wider range of treatment methods (Op 2b)
- Improvements in mental health. (OP 2b, OP 6b)

For counsellors:

- Access to up-to-date knowledge and “*new ideas, new techniques and new theories on mental health issues*” (OP 2a, OP 6c)
- Professional supervision (OP 6c)
- Insights into clinical aspects of service provision (OP 2b, OP 6c)
- Strengthened practice (OP 6c)

For agencies:

- Opportunities for networking with other services (OP 2b)
- Better coordination of services. (OP 2c)

1.10 Area Mental Health Services and the Primary Mental Health Teams

1.10.1 Impact on AMHSs

Up until now, the focus of Primary Mental Health Teams’ work has been largely concentrated on primary care providers and their patients rather than on Area Mental Health Services directly. Consequently, the perception from Managers was that overall the direct impact on AMHSs has been fairly low. Even so, the PMHTs have acted as a:

- Way to reduce inappropriate referrals (TM2, AM 2):

The AMHS is satisfied with the reduced number of inappropriate or non-accepted cases to them. So there has been a tangible effect for them as they are doing less assessments or the assessments they are doing are more targeted to people they will then take on for case management. This is particularly so for the CAMHS and adult Team. (TM 2)

We’ve (the AMHS) been getting less referrals from GPs. I think it is because of the work of the PMHT. So we are getting less inappropriate referrals. The referrals we are now getting from GPs are spot on. So I think there has been a noticeable impact. (AM 2)

- Catalyst for improving pathways, both in and out of the AMHS (TM 3)
- Negotiator/mediator between the AMHS and local primary care providers, e.g.:

We had a health service come to us and express a lot of concern about referrals that were coming to them from the AMHS and that they had to take those patients on without expertise or without the continued involvement of the AMHS. So they felt a bit dumped on. What our PMHT did was to bring all the parties to the table and started developing a protocol concerning referral criteria. The protocol is now in place. (TM 3)

- Facilitator of improved relationships with primary care providers. So, Managers from both a AMHS and PMHT (TM 2, AM 3) thought that:

The Area Mental Health Service would note the improved relationship between themselves and primary care providers. They (AMHS) see us as an advocate on their behalf whenever they have difficult GPs. For example, some GPs might send inappropriate or poorly targeted referrals. The AMHS can request that we help the GP to understand the service's referral criteria better. We then work with the GP and the AMHS is able to notice the difference. (TM 2)

There's a much better understanding between the two sectors of the pressures that each are under – so it's a much more positive relationship than a few years ago when there wasn't regular contact. I don't think the power of that can be underestimated – even though it may not turn up in terms of numbers of referrals. (AM 3)

- Provider of training and supervision within the AMHS (TM 2, TM 5):

I think we've have had some impact through the awareness training that we've done. And I hope the eating disorders training will also have an impact. (TM 5)

The AMH service has requested supervision of some of their staff by our staff - this is for more junior staff. But we feel it's a good recognition of our abilities that they would turn to us for supervision. (TM 2)

- Means to maintain mental health patients in the community (through the help of the PMHT in combination with primary care providers) so that these patients do not need to access the AMHS.

Impact of PMHTs on AMHSs - opinions from AMHS Managers across Victoria

Closely reflecting the main impacts identified by Managers in the six case studies, AMHS Managers from across Victoria nominated:

- increased awareness of GP concerns and complaints (x6)
- better service provision for a previously poorly supported group (x5)
- improved relations and communication with primary care providers (x4), and
- reduced strain on AMHS resources (x4)

as the most significant impacts of the PMHEII on their Area Mental Health Service.

Additionally, five interviewees described a unique and important impact that was not spoken about in the case studies. These AMHS Managers discussed how the service model and collaborative approach of PMHTs were being used to inform the future shape of AMHS service delivery. The following comments from two Managers provide a composite description of these plans:

There's been a lot of debate in our AMHS that the whole service should change to a PMHT model...We are aiming to add resources to other parts of the program so that we have the capacity to provide primary and secondary consultation for GPs for low prevalence as well as high prevalence disorders...for example we'll provide support for GPs managing patients with schizophrenia in the same way the PMHT are currently doing for anxiety and depression...we would never have dreamt of doing that a couple of years ago.

1.10.2 Impact of PMHT on referrals to the AMHSs

While some AMHS Managers have reported increases in referrals from GPs, others have felt that numbers have remained steady and one said that numbers had decreased. However, all reported improvements in the appropriateness of referrals:

I can tell you that referrals are clearer. We are getting more targeted and appropriate clients into our services. It's more focused. There were a number before that were inappropriate and were referred back to our stakeholders. They are now far more targeted to the criteria of the services that we provide (AM 5)...The patients who are being referred now are more complex. So with depression and straightforward anxiety disorders GPs know how to manage them well now. It's patients who also have a substance abuse issue or other social issue that come to us. They are more complex in their presentations and have an unclear diagnosis. The GP needs advice about that as they find those kind of patients harder to manage (AM 4).

Sometimes this improvement in referral patterns could be attributed directly to the work of the PMHT. For instance, one AMHS Manager revealed that:

We are getting some people referred who are borderline in terms of the threshold for entering the service earlier and more appropriately. And that would be due to the work of the PMHT who have done very good work in terms of secondary consultation with primary care providers. So if GPs were a bit 'iffy' about it, they would engage the PMHT for a secondary consultation and the PMHT would steer them in the most appropriate clinical direction. (TM 6)

However, the majority of AMHS Managers felt that it was extremely difficult to link these changes solely to the work of the PMHT. The problem, as outlined earlier, lay in the fact that several other complementary programs supporting GPs' involvement in mental health care had been introduced during the same period. It was described how:

Although there are more referrals coming to us, it is difficult to isolate any one service component to be responsible for that...because there are a number of parallel initiatives. The PMHT is one. Separate from them, there are a number of projects that are targeting GPs in particular, so I can't say that the increase was just through the PMHT. (TM 3)

Furthermore, in some areas the AMHS had initiated their own activities aimed at improving appropriateness of referral. For instance, two AMHS services (AM 3, AM 6) had introduced a 24hr, 1300 telephone triage number. Another mentioned efforts directed at enhancing connections with local agencies:

We've been doing some relationship building with other agencies and that often results in new referrals. This has included developing protocols with other agencies and we also have a new community advisory committee. We've been talking to people about our criteria and I think it has made it clearer for people. (TM 2)

In addition, AMHS Managers were asked whether there was evidence of changes in the quality of supporting letters or clinical language used by GPs when making referrals. A majority of Managers felt that this had improved. While the PMHT was said to have influenced the quality, the Managers believed that it was difficult to attribute the improvement solely to the work of the PMHT. Nevertheless, in one instance, a Manager said: *“there has been an increase in the information received in the referral forms and that's definitely a result of the PMHTs”*. However, this was the result of all parties being involved in the development of a pad of forms sent out to GPs for the referral of patients to the AMHS.

Finally, an urban AMHS Manager felt that there were clearly detectable improvements in the quality of supporting materials provided by GPs working with the PMHT. However, the Manager then went on to note that, with few resources, the reach of the Team was limited to working with only a third of the total GPs in the catchment area (AM 3).

Impact on referrals - opinions from AMHS Managers across Victoria

Approximately half the AMHS Managers (or representatives) spoken to by the evaluators felt that there were encouraging signs that the number of inappropriate referrals to the AMHS, particularly from GPs, were decreasing. AMHS Managers also indicated that GPs were demonstrating an improved understanding of how to navigate Area Mental Health Services and were displaying a better use of psychiatric terminology. A small number of AMHS Managers attributed these changes exclusively to PMHTs. However, most said these changes were more likely to be associated with the efforts of the PMHT in combination with other activities, such as:

- Projects initiated by the AMHS to improve relations with GPs
- Changes to AMHS triage procedures (e.g. employing additional triage staff)
- Closer ties with GPs through shared care programs
- Long running projects such as the CLIPP program
- The work of the Clozapine coordinator
- Information nights hosted by local Divisions of General Practice
- Other mental health programs.

1.10.3 Integration of the PMHT within AMHS

Physical location

At the time of data collection several Teams were located in the same building as the local AMHS, three case studies had their own premises, and one shared an office with

a local community health centre. Co-location was thought to be beneficial. One AMHS Manager described the perceived advantage in some detail:

We do a lot together and I think it is because of the co-location. I didn't have that at a previous AMHS where I worked. It wasn't as well integrated there. Here we are just twenty feet away. When the Teams were set up there was some discussion about the division of roles. But by co-locating it clarified that quickly. We supported each other and amalgamated which was good. It has also been an educative process where we learn from one another. You get an outcome, a response and clarity immediately without having to ring up. (AM 5)

In regards to another Team, the AMHS were looking forward to a similar type of arrangement:

At the moment the Team are physically located away from the rest of the AMHS. But that is about to change as we are to move into one location. I see this to be very positive in terms of the direct links the PMHT will have with the Crisis Assessment and Treatment Teams (CATT) and Continuing Care Team staff. I think we will have training facilities there too. This means that GPs and primary care providers coming in for training with the PMHT can mix more directly with AMHS staff. (AM 6)

Such co-location was the envy of another AMHS Manager who stated “One problem is that the PMHT are physically located in another building. I would love us all to be in the one building. It would make such a difference if we were”. (AM 2)

Integration of the services

Regardless of location all case study Primary Mental Health Teams and Area Mental Health Services were, in the main, said to be well integrated:

We have shared committees, we have shared initiatives, we have shared partnerships. We also have some shared training. We're also creating some research projects and writing some submissions together and so the PMHT is involved there too. Therefore, the PMHT is now very much part of the AMHS, even though they concentrate on high prevalence and the GP area. But, they're very much involved in many of our initiatives and this has been a springboard for improved communications and referral rates. (AM 5)...The PMHT are integrated the same as any other Team or service. So, if there is a report from a particular Team they are on the list. They are integrated in a structural way. (AM 2)

1.10.4 Training for AMHSs

Training provided by PMHTs directly for the AMHS was variable across cases. The provision of training ranged from;

- None at all:

Not specifically, there hasn't been anything directly for the AMHS at this stage (AM 4)

We don't offer any training to them because we're working more with anxiety and depression which isn't their focus. They wouldn't be seeking training in those areas (TM 4)

to

- A little:

They have run one-off sessions for us on particular issues of primary care. But they haven't done a lot in skilling up our staff (AM 3)

to

- A considerable amount

The Team has provided training for the acute in-patient unit about CBT and its role in the treatment of depression. There has also been a lot of training in relation to eating disorder assessment for triage, the CATT and some staff in the Emergency Department. (AM 6)

Specific examples of training provided for the AMHS include:

- Early psychosis workshops (AM 2, TM 3):

The training that we have provided involved a swag of workshops and education sessions on early psychosis. So we took several early psychosis topics out to the consumer or CAT Teams or in-patient units. (TM 3)

- Eating disorders (TM 1, TM 5, TM 6)

Our Director of Clinical Services and Executive Director have said that they see eating disorders becoming core AMHS business. So they are embracing the training we will be providing for the AMHS on those disorders. (TM 1)

- Cognitive Behavioural Therapy (AM 6)
- Assessment and treatment of high prevalence disorders (TM 5).

Co-delivery and sharing of training with the AMHS

Two case studies reported that the PMHT and the AMHS have run combined training sessions, both internally and externally (TM 5, TM 2). One Team Manager described how:

The AMHS have sponsored two staff members to work with our Team to roll out a program in this catchment. The program is being delivered both internally and externally... We have also run a six-week stress management course across the whole region and we have been able to entice AMHS staff to join us and co-present that material. (TM 2)

In two instances, the PMHT and AMHS workers had continued to provide training for GPs:

Some of our staff have been involved in co-facilitating GP education with the PMHT. We ran some sessions together about physical and mental health consumers at the end of last year. (AM 4)

In yet another form of collaboration, one Team has developed education models that they realized would be useful for other components of the AMHS and so have not kept them just for PMHT use. “*So there is a sort of train-the-trainer access to those modules.*” (AM 5)

Training for AMHS – opinions from AMHS Managers across Victoria

25% of Victorian AMHS Managers reported that a significant level of training had been provided by PMHTs for AMHS staff. Approximately 45% indicated that the PMHT had offered a small amount of training and the remaining 30% said that no training had been provided by PMHTs at all. Interestingly, responses varied considerably for these last two groups, with comments ranging from:

We (the AMHS) already have a learning and development arm with people paid to train our staff (and so do not require the PMHT to provide these services).

to,

What would they train our staff about? Anxiety and depression in the high prevalence area isn't something that our staff focus on anyway.

Where education and training had been provided by PMHTs this included:

- training programs in Cognitive Behavioural Therapy
- workshops on first episode psychosis
- lunch time sessions on techniques for managing patients with co-morbid conditions
- in-services on eating disorders, and
- training for Registrars on treating patients with high prevalence disorders.

Several Managers also noted that AMHS staff were frequently invited by the PMHT to attend education and training programs run for primary care providers.

1.11 Strengths and achievements of the Primary Mental Health Teams

Almost all those spoken to by the evaluators were able to nominate strengths associated with Primary Mental Health Teams. These strengths are now presented by the specific groups interviewed.

1.11.1 Strengths cited by Primary Mental Health Team Managers

PMHT Managers thought that there were strengths associated with:

a) Particular qualities of PMHTs, such as:

- Services are provided by experienced clinicians (TM 3, TM 6)

- Clinicians have developed expertise in carrying out assessments efficiently (TM 3)
- Collaboration and collegiality exists within the Team (TM 6)
- The Team is responsive to requests for assistance (TM 4)
- The Team is accessible (TM 4)
- Good relations have been built up with the local Division of General Practice. (TM 4, TM 5)

b) Efficient management of the Team, so that:

- Resources have been dedicated to employing high quality staff (TM 5)
- Service provision boundaries have been maintained (TM 4)
- The service model is well adapted to local circumstances (TM 5)
- A balance has been achieved between providing training and direct care (TM2, TM 5)
- Core elements of the PMHEII brief have been addressed. (TM 2)

c) Successful outcomes. PMHT Managers believe that their Team's work has led to:

- Gaps in services for high prevalence disorders being addressed (TM 2, TM 3, TM 5)
- A more coordinated response to the provision of mental health promotion and care (TM 2)
- The creation of strong networks in the community (TM 4)
- The development of procedures and protocols between services (TM 3)
- Improved relationships between primary care providers and specialist mental health services (TM 2, TM 3, TM 5)
- Improved mental health literacy among primary care providers (TM 1, TM 2, TM 3)
- An increased capacity by primary care providers to assess and treat patients (TM 2, TM 3, TM 5)
- Better understanding of referral pathways (TM 6)
- Strong support for GPs (TM 4)
- Satisfaction among providers for the services provided by the Team (TM 2)
- Earlier and more accurate diagnosis of conditions (TM 3)
- Better outcomes for patients (TM 3)
- Supported entry into the AMHS for patients. (TM 3)

1.11.2 Strengths nominated by the Area Mental Health Services

Strengths perceived by **all** AMHS Managers⁴ (or representatives) included:

a) Personal qualities, for example:

- Experienced and well qualified staff in the Team (x5)
- Team members work extremely hard (x2)
- The PMHT has a complementary mix of staff background and skills (x3).

b) Team qualities, for instance Team members were perceived to:

⁴ This includes case study AMHS Managers and other Victorian AMHS Managers (or nominated representatives)

- Be innovative (x2)
- Operate independently (x3)
- Be accessible and responsive (x3)
- Have a strong clinical focus (x2)
- Appear credible to skeptics (x3)
- Possess knowledge of the local area, local resources and referral pathways (x2)
- Have strong knowledge of the whole health system (x1)
- Work separately and independently from other specialist mental health services (x2).

c) Efficient management of the Team, because they possess:

- A capable Manager (x2)
- A Manager who has a vision for the Team and the drive to move things forward (x1).

d) High functioning of the Team, so that the Team is:

- Well integrated (x3)
- Stable (x4).

e) The ability to build relationships, which has resulted in:

- The generation of strong links and improved referral pathways between specialist mental health services and the primary care sector (x4)
- New connections being forged between AMHS, youth services and schools (x1)
- Positive feedback from GPs and other providers (x4)
- Stronger relationships between AMHS and GPs (x5).

f) Positive work outcomes, where:

- A neglected group of patients is now serviced (x9)
- Patients receive care in community settings (x1)
- The AMHS is able to concentrate now on severe mental illness or low prevalence disorders (x6)
- There is skill development and capacity building of primary care providers (x9)
- Sound education and training activities are provided (x5).

1.11.3 Strengths put forward by other Primary Care Providers and representative agencies

Primary care providers and representative agencies also reported many strengths associated with the Teams. These included that PMHTs:

a) Provide additional services, because they:

- Add a new service option to the system (OP 2b, OP 6c)
- Service a gap in the system. (DGP 5a, DGP 6)

b) Provide appropriate services to GPs, through:

- Well-targeted services (DGP 6)
- Understanding the GP environment (DGP 6)
- Working directly with GPs (DGP 6)
- Providing services actually in the practice (DGP 2, DGP 5a)
- Providing an intermediary step between GPs and the AMHS. (DGP 6)

c) Deliver services efficiently, by making:

- Prompt responses to requests. (DGP 6, OP 2a, OP 2c, OP 6b)

d) Enhance confidence and knowledge of non-GP providers when dealing with mental health clients, resulting in:

- Improved confidence when managing patients with mental health issues (DGP 2, OP 6a, OP 2c)
- Greater confidence from knowing services are available (DGP 2, OP 2c)
- Increased confidence dealing with specialists mental health services (e.g. mentored about appropriate language to use) (OP 2c)
- Increased confidence by affirming work practices. (OP 6a)

e) Possess particular strengths

i) The PMHT possess expert knowledge, such as:

- Up-to-date knowledge of mental health issues (OP 2a, OP 5)
- Current knowledge on medication (OP 6b)
- A good understanding of how community health centres and counsellors work (OP 2a)
- Specific expertise. (OP 2b, DGP 5a)

ii) The Team has the ability to work with others, so that they:

- Treat other health professions with respect (OP 2c, OP 6c)
- Are approachable (OP 6b)
- Are accessible (OP 2a, OP 2b, OP 5, OP 6a, OP 6c)
- Are prepared to put in the time to develop strong relationships (OP 2c)
- Establish beneficial collaborative arrangements. (OP 2a, DGP 5a)

Fulfil useful functions and tasks, by:

- Offering access to evidence-based psychotherapy (DGP 5a)
- Giving a second opinion (OP 6c)
- Acting as a sounding board for counsellors in the assessment and treatment of clients (OP 2b, OP 6c)
- Providing insights into clinical aspects of service provision (OP 6c)
- Providing language needed to communicate with AMHS (OP 2c)
- Facilitating connections with other mental health programs (OP 6c)

- Supporting the work of counsellors (OP 6a, OP 6c)
- Offering supervision for counselling staff (OP 6c)
- Being a valuable source of information (OP 6b)
- Providing practical and applied information. (OP 6c)

- Contributing to program development (DGP 4a, DGP 6)
- Providing support for DGP staff (DGP 4a, DGP 6)

1.12 Overall level of satisfaction

There were mixed reactions from primary care providers to a question asking about the overall level of satisfaction. Those who participated in the program appeared to be very satisfied. One indicator came from surveys where GPs reported for instance that training had been “relevant to very relevant” and “good to very good” (TM 5) and “*Could we have more?*” (TM 3)

Then, although there was no hard evidence, many of those interviewed felt that workers and GPs were “*absolutely satisfied*”. (OP 2c)

Others were more circumspect or expressed outright disappointment. The latter group either felt that their skills did not need to be improved or did not wish to participate in the Initiative because they felt the PMHT should have been funded to take sole responsibility for patient care. As one Team Manager summarized:

Sometimes we have very enthusiastic people and others who ask questions about why they have to work with us and why they have to be in a session. It's difficult. Because primary care is not asking for this type of service they tend to say; “Why can't you just assess my patient?” (TM 4, also OP 6b)

In an extreme instance it was not surprising that one area's GPs were not at all satisfied with the PMHT, as very few services had been provided. (DGP 1a, DGP 1b)

What should be noted, however, is that there could be two levels of satisfaction whereby providers were not satisfied in terms of the amount of service provided but were satisfied with the caliber of help they had received. (TM 3)

1.13 Limitations of the Primary Mental Health and Early Intervention Initiative

Taken as a whole, there were very few criticisms of the PMHTs themselves or the work that they carry out. **When limitations were identified they were nearly always bound up with the issue of resources linked to both staffing and funding. This cannot be ignored and, as we have seen, pervades the whole of the evaluation findings.** The following quotes are typical:

It's just the EFT. If we had more money we could do so much more (AM 2)... There's a limit to what a few clinicians can pull off in a year (TM 5)...The incidence of high prevalence is just that – that's why it's called high prevalence. So the demands on the PMHT are huge. Now the Team has created expectations with GPs and the community and explained what they can do...they can't meet the new demands. (AM 2)

There are not enough of them! The problem is to maintain a balancing act between direct care, consultation to GPs and other services and providing education. So it's having enough resource and time and not getting bogged down in any one of those areas. Having to do all three components in the job and making sure one does them effectively, is a daily challenge for the Team. (AM 5)

Our Team has done a tremendous job. You pull a Team together for a period of time and take three steps forward - but you only need one person to leave with Teams of this size and that has a profound impact upon what you are able to do. (AM 3)

This is also reflected in views expressed by recipients of services (i.e. the primary care providers) who made comments such as:

- *They're only in this region two days a week (OP 2a)*
- *The youth person is only .5 (OP 2c)*
- *They're not always available (OP 6c)*
- *The Team is so small which makes it very difficult for them. (OP 1a)*

PMHT limitations - opinions from AMHS Managers across Victoria

The matter of insufficient resources was also singled out by all AMHS Managers across Victoria as the major limitation of the PMHEII. Then a significant proportion of other comments were concerned with the small size of PMHTs. For instance, there were remarks that:

The number of staff engaged is just too small. There are only three EFT for this whole region. They're spread too thinly and they're covering a huge catchment.

You just need one person to leave and it cripples the Team. All of the activities grind to a halt and because it is a specialist Team you can't just slot someone in to do the work.

Other comments focused on the limited service capacity of PMHTs:

The problem is not having enough bodies to go around to provide the service. It's meant we have been limited in how many GPs we can actively promote services to.

We have reached our capacity. We have set up community expectations and worry that our relationships with GPs will be affected when we can't provide services.

In summary:

If there is a difficulty, you will find that, at the end of the day, it's not the skill of the workers - it will be their capacity to provide the service.

Other issues raised included that:

- The PMHT should undertake more primary consultations (OP 5, OP 6b, DGP 1a, DGP 6)

- The brief does not allow longer-term care of patients (TM 4, AM 4, DGP 6)
- Resources limit the services that can be provided to child or aged client groups
- The needs of CALD communities (TM 6, DGP 4b) and Indigenous communities are not being catered for (TM 2)
- PMHTs need to carry out more work on enhancing protocols between specialist services and primary care (DGP 5a)
- Training is not tailored to the needs of individual agencies (OP 6b)
- PMHT staff need to be trained as trainers (OP 6b)
- PMHTs have difficulties attracting suitable staff in rural areas (OP 1a, TM 1).
For example:

We have recruitment issues. The job description for a PMHT worker asks for someone who is a public speaker, who is a current educator and trainer, and who can also be a senior mental health clinicians with loads of experience...it's finding all that in this region. (TM 1)

- The range of skills possible in a Team is constrained by the Team's size (AM 3)
- Servicing huge geographic regions (with such limited resources) is difficult for Teams (AM 1, AM 6, DGP 1, OP 5)
- There are low levels of awareness of the PMHT among some GPs (DGP 1a, DGP 1b, DGP 4a, DGP 6) and some community agencies (OP 1b)
- Some primary care workers are unsure of the roles and services associated with PMHTs. (OP 6c)

Finally, several participants discussed the limitations imposed by being unable to coordinate State and Commonwealth funding. One representative of a Division of General Practice explained:

I guess the constraint for us, both the DGP and the PMHT, is the issue of Commonwealth and State funding. So our ability to work together is affected by funding structures. These structures keep us in these silos and it's artificial. We are basically getting the same patients but ideally it would be better to coordinate them. If we were to try that, the risk is that the Commonwealth would think that we are double dipping and they would pull the funding. So that affects the ability of both parties to work in a really coordinated way. (DGP 2)

1.14 Future directions

Some PMHTs have not made any plans at all for the next 12 months and could only provide a wish list (TM 3). Others have been more proactive and had a range of activities planned. Yet others had carried out a needs assessment (TM 4) in order to discover how to progress.

1.14.1 Activities already planned for the next 12 months

Two thirds of the case studies had already considered what the Team would do over the next 12 months. For instance, some PMHTs intended to:

Expand training and services, including:

- Further training sessions for primary care providers (TM 4)
- More GP education in conjunction with the local DGP (TM 4)
- More training for AMHS staff (e.g. CBT) (AM 6)
- Broadening the reach of training (TM 5)
- Implementing better targeted training programs (TM 2)
- Addressing expanding needs in growth corridors (e.g. providing services to new clinics). (AM 5)

Instigate structural changes, through:

- Recruiting a new Manager and/or recruiting new staff (AM 4, AM 1, TM 1)
- Relaunching the Team. (TM 1)

Integrate, in order to:

- Align the EI component more closely with the work of the AMHS. (AM 4)

Consolidate existing activities, such as:

- Consolidating shared care arrangements (AM 5)
- Consolidating relationships with GPs and other providers. (TM 6)

Scale back services, to encourage:

- Primary care providers to use skills and not be reliant on the PMHT. (AM 2)

Evaluate, to investigate:

- The effectiveness of education and training (TM 2, AM 2)
- The overall impact of PMHT services (TM 2, AM 2)
- How to allocate limited resources to achieve greatest impact. (TM 2)

One Team also intended to:

- Distribute a referral guide (TM 6)
- Improve interface issues between primary care and specialists mental health services. (TM 6)

If there were more resources, some Teams would like to:

- Work with primary care sectors that have not been reached so far, e.g. with secondary schools, school counsellors, other non-government agencies, women's welfare agencies, homeless youth, teenage mothers. They would also like to link of agencies further (TM 3), and carry out more work with community health centres and GPs. (TM 5, AM 3)

PMHTs in the next 12 months- opinions from AMHS Managers across Victoria

In the main, AMHS Managers nominated similar future activities as those proposed by PMHT and AMHS Managers in the case studies. However, six AMHS Managers added that a pressing matter for PMHTs would be to find a successful balance between providing direct care services and attending to other aspects of the PMHEII brief.

The AMHS Managers explained that activities such as education and training and community development work appeared to be taking a back seat as PMHTs have been increasingly consumed by primary consultation work. Several participants noted this was occurring particularly at the expense of services for non-GP primary care providers, with one AMHS Manager warning that Teams risked “falling into a trap of just being another referral source for GPs”.

Other suggestions put forward by individuals were for PMHTs to:

- Improve access to services for disadvantaged and CALD groups
- Address the Early Intervention component of the Initiative
- Set up eating disorder and post natal depression programs
- Promote the Team and its services further to non-GP primary care providers.

1.14.2 Activities desired by Primary Care Providers for the next 12 months

When primary care providers were asked what they believed Teams should attend to in the next 12 months a few wished only for the PMHT to “*continue to provide what is currently being offered*” (OP 6c). However, most expressed a clear desire for additional services including more:

Primary consultation work, such as:

- Direct service delivery in general practices (DGP 6) and Community Health Centres (OP 1b, OP 2a, OP 5, OP 6b) e.g:

I would like it if we could just have someone a day a week or who could come out and provide direct service - a hands on approach. That would be the ideal situation. (OP 6b)

- Joint counselling sessions with counsellors and clients (OP 6a, OP 6c)
- Counselling sessions with groups of clients. (OP 2b)

Secondary consultations, for instance:

- Secondary consultations with non-GP primary care providers (OP 1b, OP 5)
- GP case conferencing with the PMHT psychiatrist (DGP 1)
- Regular case discussions in Community Health Centres (OP 5, OP 6c)
- Informal discussions between counsellors and Team members. (OP 6c)

Education and training sessions, involving:

- Training for new GPs (e.g. how to navigate available services) (DGP 2)
- Training targeted to the specific needs of community-based agencies (OP 5, OP 6a, OP6c)
- Education and training for providers in remote areas (OP 2a)
- Community-based mental health workshops. (OP 2c)
- Information sessions on psycho-therapeutic medications (OP 2a)

Teams should also:

- Improve their training abilities (OP 6b)

Care options for patients, particularly:

- Longer-term interventions for patients (DGP 6):

If the PMHT was able to give more than six sessions and keep the patient on for longer that would be a great next step in terms of being able to provide quality care for patients. (DGP 6)

Coordination and/or co-delivery of mental health programs, for example:

- Co-delivery of programs with community health centres (OP 6b)
- Establishing collaborative arrangements with DGP-run programs (DGP 2, DGP 3)
- Coordinating PMHT services with Commonwealth-funded programs. (DGP 1)

Other miscellaneous requests for services and activities included:

- Promoting and marketing the PMHEII (OP 1b, DGP 4a)
- Providing access to a full time worker in remote areas (OP 2a)
- Forging links between community health centres, AMHS and DGPs (OP 5)
- Playing an advocacy role to increase and improve the quality of AMHS services (OP 2b)
- Undertaking a needs assessment for the region (OP 5)
- Providing services for CALD communities (DGP 4a)
- Revitalising PMHT reference groups. (DGP 4a)

1.14.3 Should the PMHEII continue?

A final question posed in interviews with primary care providers and DGP representatives asked whether or not the PMHEII should continue. Reflecting responses to a similar question reported in Volume 1 of the PMHEII evaluation - a clear majority of participants replied with an enthusiastic “Yes!”. Consequently, typical comments conveying this view included:

- People strongly believe it should continue (OP 1a)
- It should be strengthened rather than be taken away (DGP 6)
- GPs using the PMHT would jump up and down if they were withdrawn (DGP 2)
- GPs need to be able to access people with knowledge of these conditions (DGP 3)

- If our PMHT ceased it would leave a large gap in terms of service delivery and meeting client needs (OP 2c).
- I wouldn't like to see anything that lessens resources in mental health (DGP 4)
- It's a terrific service. We're glad they are there and it can only get better. (OP 2c)

As might be expected, DGP representatives located in the case study area where few or no services had been provided for local general practitioners felt that money for the Initiative should be allocated elsewhere (DGP 1a, DGP 1b). As one DGP representative explained:

.... anything that puts additional mental health resources and particularly mental health resources in this region is welcome. So they would like to see it happen. But there is a concern that there has been all this money and so far we haven't seen anything happen. So if they can't get it off the ground for goodness sake give the money to someone else to get it happening. (DGP 1b)

1.14.4 Messages for improving the Initiative

At the conclusion of interviews, case study PMHT Managers and **all** AMHS Managers were asked to consider what decisions they would take in order to improve the Initiative. They suggested to:

Increase funding (x 15)

(At the moment) It's like throwing a thimble of water on a big fire. PMHTs would need at least eight EFT to be able to fulfil the brief they've been given...It's a good initiative but it's tokenistic.

The overwhelming message was that to improve the Initiative much more funding is needed. This affects all aspects of Teams' functioning and their ability to meet the aims and objectives of the PMHEII. Across the State this issue affects the range and amount of services that can be provided by PMHTs. As we have seen, this is particularly apparent with regards to issues of service coverage, geography and demography. For example:

- The current level of funding, and small size of PMHTs, has restricted the numbers of GPs Teams can support and has also meant that in some cases Teams have, as yet, not provided direct services for non-GP primary care providers.
- Rural areas have a particular problem with resource allocation. Current funding has failed to take into account factors such as the huge distances that must be travelled to provide services. An additional issue for such areas has been attracting well-qualified and experienced personnel.
- For metropolitan areas similar problems arise with supporting outlying providers. Some have expressed concern that with resources already stretched they are likely to be constrained in their ability to service more distant agencies and growth corridors:

Provide clear directions regarding the roles of PMHTs (x 12)

It was suggested there was a need to:

- Define 'Direct Care' and associated services
- Define 'Early Intervention' and acceptable EI activities
- Explain the role of PMHTs in community health promotion
- Provide examples of acceptable service models
- Articulate how, with limited funds, PMHTs can offer a 'whole-of-life' service
- Restate what the PMHEII is intended to achieve
- Outline how the PMEHII will progress over time.

Implement reporting and evaluation practices (x7), including to:

- Standardise data collection and reporting
- Establish benchmarks and best practice
- Ensure data collection reflects PMHT activities accurately.

Ascertain the effectiveness of the Early Intervention Initiative Service (x5)

- Determine if the current allocation of EFT can fulfil community needs
- Investigate if the EI component would be better located with other services.

Improve communication and support from Department of Human Services, Mental Health Branch (x5).

Specific suggestions were for MHB to:

- Play a more active role in the PMHEII
- Improve current levels of communication with PMHTs
- Support knowledge transfer and collegiality among PMHTs
- Assist rural Teams to overcome chronic staffing issues
- Investigate problems associated with high turnover and staff burnout
- Provide leadership where required.

Coordinate State and Commonwealth initiatives (x4)

- Bring together Commonwealth and State resources.

Explore the possibility of different PMHT configurations (x2)

Suggestions were to:

- Merge PMHTs to form larger Teams in order to achieve economies-of-scale
- Amalgamate PMHTs with other Teams within the AMHS.

Ensure that the PMHEII keeps abreast of changes in the system (x2), e.g. changes to Medicare.

1.15 Future Directions for the Primary Mental Health and Early Intervention Initiative

1. THE PMHTEII SHOULD CONTINUE

THEN, IF THE INITIATIVE IS TO CONTINUE:

2. FUNDING NEEDS TO BE INCREASED in order to:

- increase Team capacity to fulfil the brief
- deal with the issues associated with rural and outlying areas
- allow greater reach, impact and sustainability.

IN RELATION TO THE PMHTs THEMSELVES:

3. TEAMS NEED TO BE RATIONALIZED/INCREASED IN SIZE FOR OPTIMAL EFFICIENCY AND EFFECTIVENESS

In some areas fewer and larger Teams would achieve economies-of-scale e.g. in regards to administration and infrastructure. Larger Teams would also assist with continuity of relationships with primary care providers and to the creation of fewer problems when staff are ill or on leave.

4. TEAMS SHOULD BE CO-LOCATED WITH THE LOCAL AMHS (WHERE POSSIBLE/APPROPRIATE) TO ENCOURAGE FURTHER INTEGRATION OF SERVICES

5. TEAMS SHOULD BE ENCOURAGED TO WORK MORE WITH DIFFICULT TO REACH POPULATIONS SUCH AS RURAL, INDIGENOUS AND CALD GROUPS

IN RELATION TO COMMUNICATION BETWEEN MENTAL HEALTH BRANCH, DHS AND TEAMS

6. (FOR ANY NEW TEAMS SET UP) MHB SHOULD PROVIDE CLEAR COMMUNICATION ABOUT POTENTIAL MODELS OF SERVICE DELIVERY

7. MHB NEEDS TO BE IN CONTACT WITH ALL TEAMS REGULARLY

OTHER ROLES FOR MHB

8. MHB SHOULD RECONSIDER THE EARLY INTERVENTION COMPONENT OF THE INITIATIVE

9. MHB SHOULD ASSIST TEAMS TO ESTABLISH AND IMPLEMENT DATA COLLECTION, RECORD KEEPING, EVALUATION AND REPORTING PROCESSES

10. MHB NEEDS TO INVESTIGATE THE COORDINATION OF STATE AND COMMONWEALTH INITIATIVES

MHB needs to clarify the relationship between the PMHTEII and other current mental health programs, This needs to occur in order to make optimal use of limited resources, as well as to avoid duplication and confusion for providers.