School of Public Health

Influences on the Development of a Strategy for a Local Community Based Mental Health Service: A Medical Perspective

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This thesis is presented for the degree of
Master of Science (Public Health)
of
Curtin University of Technology

March 2003

ACKNOWLEDGEMENTS

My deep and sincere thanks to the following:

Dr Alan Brighouse, my friend and colleague since 1950, who inspired me to attempt to write.

Professor Duncan Boldy, my supervisor, whose patience, encouragement and discipline kept the work on track when it might so easily have become sidetracked into overinclusive irrelevance.

Ms Julie Proctor who so kindly undertook the validation of the Categories for GPs.

Ms Marjory Taylor and Ms Robyn Hull at the Psychiatric Services Library who gave me so much help with the references.

All my colleagues who gave so freely of their time for the interviews and helped in so many other ways.

Very special thanks to my wife, Kathy, not only for her help with typing and checking the manuscript, but also for her unfailing understanding, tolerance and support through the many hours that were so tedious for her.

ABSTRACT

The history of the care of the mentally ill in Britain, which has been broadly reflected in Western Australia since 1826, can be conveniently, if simplistically divided into a number of epochs. Each epoch is characterised by a particular focus or paradigm of clinical management, which prevails over a period of time but is then followed by a comparatively short period of rapid change to a new paradigm. Such changes are shaped by a number of forces, but three categories can be readily identified. These are: concepts of mental illness; reactions of administrative systems and the attitudes of medical practitioners.

As the concept of the nature of mental illness has changed, succeeding epochs have evolved to a more humane and enlightened approach to the mentally ill. Nevertheless, each management paradigm has failed to deliver the expected 'cures' and the consequent reduction in the burden of illness. Each has been replaced by a new and radically different paradigm, often at enormous cost, but there has been no progressive evolution towards a system that incorporates measures that have proven value. In recent years 'Community Care', has failed in such a manner that there have been strong arguments that it should be abandoned. At the same time there is evidence that a new paradigm 'Primary Care Psychiatry' is emerging as government policy. The challenge is to preserve the best elements of community care and integrate Primary Care Psychiatry into the broader framework. The best chance of achieving this is to develop a gradual, evolutionary process, built on consensus between psychiatrists, general practitioners and administrators.

The purposes of the present research are threefold: to develop a conceptual model for an optimal community based mental health service. Then by examining the views of general practitioners, psychiatrists and administrators, determine the degree of congruence of these views. This is achieved by a qualitative study comprising extended interviews with 24 GPs, 15 psychiatrists and 11 administrators. This approach is chosen over a more broadly based, structured questionnaire approach for two reasons. Firstly, the views expressed in informal face to face interviews are more likely to be true expressions of opinion, especially when these are critical. Secondly, by using a comparatively unstructured approach, the stakeholders are able to express views on issues that they consider important. Finally, the areas of consensus and disagreement are analysed and recommendations made on strategies to develop a plan for a practical, viable service in a local area.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

' This is perhaps a timely reminder of the need to view in historical perspective, all the currently fashionable plans for the dissolution of the mental hospitals and the development of community care' [Parry – Jones 1984].

1.1: Patterns of Care for the Mentally Ill

A review of the care of the mentally ill in Britain, which has been broadly reflected in Western Australia, can be conveniently, if simplistically, divided into epochs. Each epoch is characterised by a particular focus or paradigm of clinical management that prevails over a period of time but is then followed by a comparatively short period of rapid change to a new paradigm.

As concepts of the nature of mental illness have changed, succeeding epochs have evolved a more enlightened and humane approach to the mentally ill. Nevertheless, each management paradigm has failed to deliver the expected 'cures' and the consequent reduction in the burden of illness. Each has been replaced by a new and different paradigm, often at enormous cost. At no time has there ever been any consideration of the implications, benefits and limitations of a particular paradigm, or how the best elements of it might be blended into those of a new paradigm. As a consequence there has been no progressive evolution towards a system that incorporates the measures that have proven value.

In recent years the ostensible failures of the 'Community Care' paradigm have produced strong argument that it should be abandoned. There is also evidence that 'Primary Care Psychiatry' is emerging as a new paradigm. There are also expectations that this new paradigm will reduce the burden of mental illness, but the historical evidence indicates that that this is an unlikely outcome unless the ramifications of adopting the paradigm are understood and appropriately managed.

It is clear that the concept of 'Community Care' should neither be abandoned nor replaced by 'Primary Care Psychiatry', but that the two should be integrated. An examination of the mistakes of history will point the way to retaining the best elements of community care and integrating them with primary care psychiatry on the one hand and the hospital system on the other. The expectation is that such a service will improve the quality of care for the mentally ill.

1.2: Objectives of the Study

These are to:

1. Identify the key elements of an optimal mental health service and the enabling and constraining forces that have shaped each paradigm of care.
2. Determine the extent to which service providers (general practitioners, administrators and psychiatrists) agree with such a model and how best to implement it.
3. Develop strategies in conjunction with relevant stakeholders, for the implementation of a plan for an optimal service in a local area.

1.2.1 Objective 1

This is met by an extensive literature review, undertaken from an historical perspective. The evolution of concepts of the nature of mental illness and the systemic responses to manage it are traced through a number of epochs. Constraining and enabling forces that shape this evolution are identified.

1.2.2 Objective 2

This is met by a qualitative analysis of the views of general practitioners, psychiatrists and administrators.

These three groups were perceived to be the principal motivators of change in developing improved services. Other mental health professionals and consumers would necessarily be involved in change but were regarded as outside the scope of this investigation. This exclusion is reflected in the title of the investigation.

A qualitative approach was adopted for the following reasons:

- The probability of a poor response rate from GPs to a general survey

In order to study the morbidity managed and treatments provided in rural as compared with metropolitan general practices, 231 GPs were recruited from three states, Queensland, New South Wales and Victoria. Selected practitioners were traced thorough the telephone book and sent letters that were followed up by a telephone call two weeks later. Despite this approach, with all the resources of a University Research Department supported by a grant available, the response rate was 57.5% in rural areas but only 36.5% in metropolitan areas (Britt et al 1993). With the less sophisticated approach available in this study, it was considered unlikely that a sufficiently representative sample could be obtained to make quantitative analysis meaningful.

- The quality of information obtained

With a structured questionnaire the quality of the information collected is a reflection of the questions asked. A loosely structured interview with ample opportunity for the free expression of views not only provides much richer information but also avoids the bias that occurs when the investigator's values and attitudes shape the questions.

1.3: Limitations of the Study

Although similarities between general population studies of psychiatric morbidity are more striking than the differences [Mortensen 1998] mental illness is associated with low socioeconomic status [Elpers & Levin 1996]. Different areas of Perth vary quite considerably in socioeconomic status. For example, Perth City (excluding the Central Business District) may be compared with East Fremantle , which has a similar number of households [ABS 1998]. A few key variables are set out in Table 1.3.1. Apart from the ability of patients with a higher socioeconomic status to access private care, public services differ greatly in their effectiveness and communities in their acceptance [Herrman 1998]. There are also wide discrepancies in the number of GPs per head of population; this issue will be dealt with in more detail later.

Because of these differences in epidemiology and the resources available, it was deemed feasible only to consider the development of a service in a particular locality. For reasons of accessibility, it was decided to focus the study on Perth City. This is an area of low socioeconomic status and would be expected to have a high prevalence of morbidity, which would be likely to present challenges to the development of an optimal service. However, the selective nature of the study means that the results are not necessarily typical or applicable to other areas. Also, the study is essentially qualitative in nature and no attempt is made to assess 'statistical significance'.

Table 1.3.1: Socio-Economic Status - Perth City and East Fremantle

Index of socio-economic status	Perth City	East Fremantle
Total number of households	2414(100%)	2563(100%)
Number of households with families	683 (28.2%)	1547 (60.3%)
Number of lone person households	1225 (50.7%)	775 (30.2%)
Total number of persons employed	2669 (48.3%)	2991 (59.5%)
Mean average income ($ per week)	$434	$659

CHAPTER 2: HISTORICAL REVIEW

This chapter considers the strengths and weaknesses of previous attempts to provide best – practice mental health care. The history of the care of the mentally ill may be divided into six epochs, each with a different paradigm of care:

First Epoch: Biblical times to the 15th Century: Ecclesiastical Care
Second Epoch: 16th and 17th Centuries: The Rise of Secular Care
Third Epoch: 18th Century: Early Medical Care
Fourth Epoch: The 19th Century: The Asylum Paradigm
Fifth Epoch: First half of the 20th Century: The Decline of Asylums and the Development of Informal Methods of Treatment
Sixth Epoch: The second half of the 20th Century: The Community Care Paradigm

Changes in paradigms for the care of the mentally ill are shaped by a number of forces, both enabling and constraining. The forces shaping each paradigm may be conveniently grouped under three headings:

- **Concepts of the nature of mental illness:** This is a highly significant force.
- **Efforts of organisational systems, including governments to establish management strategies and make provision for care:** Such efforts are influenced by public opinion, which is led by reformers and shaped by the media, which tend to focus on the more spectacular failures of the system. Strategies are constrained not only by economic factors, but also by their encapsulation in legislation.
- **Attitudes of the medical profession:** Individual doctors have commonly led the way to reform, but the profession as a whole has often been slow to respond to change, sometimes because of the persistence of outmoded concepts of mental illness.

The modern History of Western Australia may be taken to have begun in 1826 with the formal possession of Albany [Green 1981]. For this reason, the first three epochs will be dealt with very briefly, emphasising the historical roots of contemporary problems, and the last three will be considered in more detail.

2.1: First Epoch: Biblical Times to the 15th Century: Ecclesiastical Care

Prior to 1484, when Pope Innocent VIII issued his infamous Bull, which unleashed the Inquisitors Kramer and Sprenger on a rampage of witch – hunting across Europe

[Robbins 1959], the Church had demonstrated a commitment to the care of the sick. Hospitals, together with hospices and schools functioned as an integral part of the monasteries that built them. During the Crusades, religious orders were founded that had care of the sick as their primary function. Perhaps the most famous of these orders, which built a number of hospitals in the Mediterranean area, were the Knights of St. John of Jerusalem.

Throughout the Middle Ages and even later, such religious groups continued to run hospitals and the best known example in England is the Bethlem Hospital. Simon Fitzmary founded a priory in 1247, which he intended to be a daughter house of the Church of St. Mary of Bethlehem. There is evidence from a document dated 1329 that, by that time, the priory was already being referred to as the Hospital of St. Mary of Bethlehem. Patients were not initially separated into categories and the first evidence that it was being used to house the insane dates from 1403 [Bethlem and Maudsley Hospitals 1999].

2.2: Second Epoch: 16th and 17th Centuries: The Rise of Secular Care

With the Act of Supremacy in 1534, Henry VIII severed the connections between the English and Roman Churches. Two inquests that followed in 1535 revealed that the monasteries had lost their original purposes of spreading piety and learning and Henry lost little time in abolishing 400 of the smaller monasteries in 1536. The remainder were subsequently seized, and their assets transferred to the Crown. The dissolution of the monasteries abolished the only effective system of caring for the poor and it was left to secular administrations to take up the burden. The basic unit of government was the parish and the inhabitants elected their unpaid officials, including the overseers of the poor. These officials were under the supervision and control of the Justice of the Peace. In rural England a Justice was usually a squire, in the corporate towns an alderman and 'in the industrial suburbs of London, a rogue who bought his office and traded justice' [Plumb 1950].

Poorhouses were constructed and it has been estimated that there were between twelve and fifteen thousand separate parishes and townships individually controlling their own institutions. With notable exceptions, however, they failed in their purpose. Apart from inadequate resources, an important factor in their failure was the lack of any classification of the inmates. Able - bodied poor were not separated from the sick or disabled, and no special consideration was given to 'pauper lunatics', who were generally assumed to be responsible for their actions. This assumption sometimes brought them into conflict with the law and incarceration in a prison or 'Bridewell' for punishment instead of treatment. Bridewell and Bethlem Hospital were placed under the joint administration of the Governors of Bridewell in 1557 and this conjoint

administration serves as a metaphor for the lack of separation of the mentally ill, the pauper lunatics, from able bodied criminals. St. Peter's Workhouse in Bristol, which opened in 1696, was the first to treat pauper lunatics as a separate category. This workhouse also established the important principle that they should receive treatment, not punishment.

2.3: Third Epoch: 18th Century: Early Medical Care

During the 18th century the problem of the insane remained submerged because there was still no definition of what constituted insanity. The person who was recognised as insane because his actions constituted a danger to himself or to others had no protection in law. 'He was almost certain to be confined, neglected and intimidated, if not treated with open cruelty.' [Jones 1955]. Those patients who escaped confinement in terms of the Poor Laws, the criminal law or the vagrancy laws might be confined in private madhouses. There is no reliable estimate of the number of madhouses that were operating in the 18th century but they varied in size from those taking two or three patients to those accommodating three or four hundred [Scull 1993]. Conditions were generally appalling. Restraints were thought to be an essential part of the management of the mad and extensive reliance was placed upon chains, manacles and physical coercion. Those confined in Bethlem were unlikely to fare much better as their management consisted largely of bleeding, purging and the induction of vomiting to reduce the patient's capacity for violence, together with physical restraint.

In 1789, the nature of the illness of King George III became public. The question of the King's competence and the appointment of a Regent became burning political issues until, despite the barbaric treatment he received at the hands of Dr. Willis, he recovered. This illness established two important principles: firstly, mental illness could attack anybody, however respectable; secondly, such illnesses could be treated, with a possibility of recovery. The establishment of these two principles seems to have prompted a number of experiments in a much more humane approach to treatment.

St. Luke's hospital, an early example, was founded by public subscription in 1751. Dr. Battie, physician to the hospital, dramatically reduced the use of purges and vomits. He advocated a much more gentle approach with amusements and diversions as adjuncts. Further, medical practitioners and students attended regularly for the serious study of mental disorders. Manchester Infirmary Lunatic Hospital was completed in 1765 and the aim of the trustees was to provide cure for the patients and not merely their confinement. In 1795, the Infirmary Physician, Dr. Ferriar, still relied upon bleeding, purging and drugs such as opium, but also

regarded as important the provision of gardens, small amenities to be given as rewards for increased self - control and remonstration rather than violence to deal with disturbed behaviour.

The Retreat was founded in 1792 by the Society of Friends, possibly influenced by the case of Hannah Mills, who died in the York Asylum after members of the Society of Friends had been refused permission to visit her. The Asylum had been founded in 1777 by public subscription, but apparently operated under conditions of complete secrecy. Thomas Fowler was appointed as visiting physician to the Retreat and, 'After a period of trial and error, he came to believe that 'moral' methods of treatment were preferable to those involving restraint and the use of harsh drugs' [Jones 1955].

2.4: Fourth Epoch: 19th Century: The Asylum Paradigm

2.4.1: The Asylum Paradigm in Britain

At the beginning of the century, England was experiencing the turmoil and ferment not only from the industrial and agrarian revolutions, but also from the aftershocks of the American and French revolutions and the Napoleonic wars (1793 -1815) [Thomson 1950]. These dramatic changes were reflected in a change in attitude towards social problems, such as crime, poverty and social disorder and a number of philanthropists came to the fore. Some attempts had already been made to improve the Poor Laws and, in respect of the mentally ill, Sir George Onesiphorus Paul, High Sheriff of Gloucestershire, set a new initiative in train in 1806. In a letter to the Secretary of State, he gave a graphic description of the appalling conditions of pauper lunatics [Jones 1955].

The situation had been further complicated by the Criminal Lunatics Act of 1800, which provided for the first time for the detention of criminal lunatics 'during His Majesty's pleasure'. Unfortunately the Act was deficient in at least three respects in that it did not specify where they were to be detained, how they were to be financed or how they were to be released. The Under - Secretary of State for the Home Department, Charles Williams - Wynn responded by appointing a Select Committee in 1807. The terms of reference of the committee were to 'inquire into the State of Criminal and Pauper Lunatics in England and the Laws relating thereto.' Significantly, there was no medical representation on the committee, possibly because parliament was thinking of confinement rather than treatment.

The committee recommended that an asylum should be set up in each county to house both criminal and pauper lunatics. A committee of governors, nominated by the local justices, should manage each asylum, and finances should be raised through a county rate. The ensuing Act,

known as 'Wynn's Act' passed through both houses of parliament in 1808. It was permissive rather than peremptory for two reasons: firstly, the committee believed that public opinion was such that the plan would win wide acceptance; secondly, the number of lunatics was unknown. The total number of pauper lunatics in England was given as 1,755, but investigations by Dr. Halliday showed that these figures were wildly inaccurate.

The first asylum to be constructed under the new Act was at Nottingham. It was designed to accommodate 80 patients and was officially opened in 1811. As soon as it opened the accommodation was found to be inadequate because of the lack of discretionary powers in the Act. Parish overseers were bound to give information on all insane persons in the area and the justices were bound to send all who were paupers or criminals to the asylum. These flaws in the Act might have impeded its implementation, for only nine counties erected asylums during the first twenty years of its life. Another flaw in Wynn's Act was that, whilst no directions were given for treatment, harsh fines were imposed on the keepers if a patient escaped. Most asylums were understaffed and, understandably, the staff was most reluctant to take any risk with a patient that might result in escape. Consequently, the use of mechanical restraint was customary. Moreover, the quality of the asylum doctors was very variable and the visiting justices rarely had sufficient knowledge to distinguish the enlightened doctor from the charlatan. The visits by the justices were usually cursory and focussed on whether or not patients were kept quiet, washed and fed. There were, however, notable exceptions, such as Stafford Asylum - opened in 1818 - where the quality of the chief medical officer ensured steady improvement. Between 1815 and 1819, three amending acts were promulgated which allowed the justices to exercise discretion over who was to be admitted, required the parish overseer to provide a 'medical certificate', and provided for the discharge of patients by two justices.

Two events in 1813 provided further impetus for reform. The first was the publication of the 'Description of the Retreat' by Samuel Tuke, which set out the success of 'moral management'. The second was the discovery by Godfrey Higgins of a series of abuses at York asylum, which he communicated to the press. In response to these cases, another Select Committee was appointed and, although the medical profession as such was again unrepresented, the committee did at least contain some members with an interest in medical reform. The Select Committee went on to investigate St. Luke's Hospital and Nottingham County Asylum. St. Luke's, although more humane in its treatment of patients than either Bethlem or York asylum, had not developed as a model for other asylums. Nottingham was found to place comparatively little reliance on restraint, which might possibly be attributed to Dr. Storey, the medical director, having spent time at the Retreat prior to his appointment.

Gilbert's Act of 1782 had been an unsuccessful attempt to disentangle the contemporary Poor Laws. By 1815 the principle of parochial responsibility was no longer adequate and the administration of relief was wasteful and corrupt. By this time, under the impetus given by Gilbert's Act, some 900 parishes had grouped themselves into sixty-seven 'Gilbert incorporations' or unions of blocks of parishes, to set up workhouses. As there were nearly 16,000 parishes in England and Wales, the whole matter was very confused. Existing workhouses were not just poorhouses - they organised work activities such as spinning and weaving - but varied widely in efficiency and reputation [Thomson 1950]. Henry Alexander, a banker, presented evidence to the Select Committee that nine of the forty-seven workhouses he had visited had insane inmates. Only in St. Peter's in Bristol were they reasonably comfortable and, for the rest, he consistently found evidence of 'filth, neglect and unthinking brutality' [Jones 1955].

In 1816, the Select Committee was reappointed to inquire into private madhouses. Various witnesses presented evidence concerning conditions at a number of madhouses. Generally conditions reflected the same abuses as elsewhere. The committee presented the evidence to parliament but drew no conclusions and made no recommendations. Nevertheless, new ideas on the management of the insane began to appear in the print media. Three publications by medical practitioners are noteworthy.

William Ellis, who wrote the first in 1815, recognised that there were different forms of insanity. Patients might exhibit different symptoms, which required different forms of treatment. He also identified a number of factors that impeded reform. These included: some medical practitioners who took up the work because it was lucrative but not arduous; the helplessness of the patients; the insistence of relatives upon secrecy; the indifference to the mode of treatment as long as the patient was confined and the belief that insanity necessarily impairs all faculties [Jones 1955].

The second, the 'General View of Lunatics' was written by Sir Andrew Halliday in 1828, some twenty years after his investigations into the number of pauper lunatics for the Select Committee of 1807. Halliday sought to dispel the fear and secrecy that surrounded the mentally ill. Specifically, he denied that insanity is necessarily hereditary.

The third publication, the ' Commentary on the Causes etc. of Insanity ', was written in 1828 by Dr George Man Burrows (1771 - 1846). Burrows held an MD from St. Andrew's University and kept a private asylum at Clapham, where the highest standards of treatment were maintained.

These three works struck a new note: an interest in insanity not merely from the clinical point of view, but as a social problem [Jones 1955].

On the 13th June 1827, a Select Committee was appointed to consider the state of pauper lunatics in the metropolitan area of London. With remarkable dispatch, the committee reported on 29th June 1827, and made two important recommendations:

- That pauper lunatics would benefit greatly from the construction of a county lunatic asylum;
- That legal provision should be made for more stringent inspection by experienced inspectors.

Both houses of parliament passed the two relevant Bills, the first dealing with madhouses and the second with county asylums, in February 1828. The Madhouse Act covered all private madhouses and subscription hospitals with the exception of Bethlem. The Act removed the power of inspection from the medical profession as represented by the Royal College of Physicians, which had proved itself to be incompetent, and vested it in fifteen commissioners, five of whom were physicians. The Act also required the commissioners to visit each asylum four times annually and to meet quarterly for the granting of licences. They were given powers to recommend to the Secretary of State that any particular licence should be refused or revoked, and to release any patient who, in their opinion, was improperly confined.

No specific provisions were made in respect of medical treatment, but regular medical attention was required. Every establishment with more than one hundred patients was required to have a resident medical practitioner. Restraint was only to be imposed by a medical practitioner and record keeping became mandatory. These measures produced major improvements in the way madhouses were managed, but illegal detentions still occurred occasionally.

The County Asylums Act provided the impetus for a spate of building. Eight asylums were added between 1828 and 1842, including the Middlesex Asylum at Hanwell. This asylum, with accommodation for 1000 patients, was more than twice the size of any other contemporary asylum. Lincoln Asylum was comparatively small with only 130 patients, and Dr. Charlesworth was able to introduce a gradual reduction of restraint between 1829 and 1835. Robert Gardiner Hill, the house surgeon, continued the process. Fortunately, he was able to persuade the justices not only to increase the numbers of staff, but also the remuneration so that he was able to employ better trained staff. As a result, all mechanical restraint was abolished by 1838. In June of that year, Gardiner Hill gave a lecture on 'The total abolition of personal restraint in the

treatment of the insane' to a mixed audience of lay and medical people at the Mechanics Institute in Lincoln. The lecture was subsequently published and aroused such a public furore that Gardiner Hill was forced to resign in order to avoid compromising his principles.

Dr. John Connolly was appointed to the Middlesex Asylum in June 1839, but, before taking up his position, he visited Lincoln to examine their methods and results. After assuming office at Hanwell, on 1st July he required a daily return of all patients under restraint and over the next seven weeks he succeeded in abolishing all mechanical restraint. He realised that this new approach required a high standard of both nursing and administrative staff and a new way of occupying patients. He introduced a system of education for patients, but was compelled to abandon it by the Visiting Committee. He also suggested that both doctors and keepers should receive formal training, but again the Visiting Committee vetoed this initiative. It was left to Sir Alexander Morison to introduce the first lectures for attendants at Surrey Asylum in 1844.

Not all medical superintendents exhibited the same personal integrity and compassion for their patients as Connolly. The Visiting Committee was responsible for the election of the superintendent and frequently chose a member of the landed gentry like themselves. The superintendent was required to live in the asylum, but was provided with everything he needed as well as a substantial salary. Consequently he was often absent, riding to hounds or engaging in other equally agreeable pursuits with the members of the Committee. The matron was often the superintendent's wife, who rarely possessed the qualities necessary to supervise the female side of the asylum. Under such circumstances it is hardly surprising that the attendants often failed to attend to their patients properly.

Driven chiefly by Edwin Chadwick (1800 - 1890) a Commission was set up to examine the problem of dealing with the able bodied poor. The commission reported in 1834 and the Poor Law Amendment Act was promulgated later in the same year. A basic principle of the Report of 1834 was national uniformity in the treatment of each separate class of paupers. There was to be diversity of treatment for each class: so that the able - bodied should no longer be confused with the old and frail, or orphan children with lunatics. This remained the official theory of the new law, but in practice the Commissioners did not fully enforce these principles. The same workhouse was often used indiscriminately as poorhouse, orphanage and asylum [Thomson 1950]. Consequently, the estimated number of lunatics and idiots in workhouses in 1828 was 9000, but by 1845 there were still 4080 [Jones 1955]. The cost of keeping a lunatic in a workhouse was much less than keeping him in an asylum, which was undoubtedly a factor in maintaining this population.

The real point at issue between the Poor Law authorities and the Lunacy authorities was the old one of cure or detention. If the county asylums were looked upon as curative institutions, then their high cost was justified, and they had a legitimate grievance against the Poor Law authorities for refusing to send them pauper lunatics who were susceptible to treatment. If, on the other hand, they were regarded merely as places of detention, the Poor Law authorities could rightly claim that they could do this work more cheaply [Jones 1955]. From 1829 onwards, the Metropolitan Commissioners in Lunacy became increasingly rigorous in the performance of their duties. The Commissioners' report appeared in 1844 and was largely a compilation of facts as a basis for framing recommendations, two of which were very important:

- Each county should be required to build a county asylum for its pauper lunatics (the previous Acts were permissive).
- All asylums and hospitals for the insane should be subject to inspection by the statutory authority.

The workhouses were under the jurisdiction of the Poor Law authorities and therefore not open to the Commissioners, but a number of recommendations were made to clarify the relationships between the workhouses and the asylums. These recommendations can be classified under three headings:

- County asylum authorities should be empowered and encouraged to make separate provision for incurable pauper lunatics in order to make room for those who are curable.
- Pauper lunatics should only be sent to workhouses when they are definitely incurable, and then only to workhouses that can make special provision for them.
- The lunacy authority should be responsible for visiting and reporting on all pauper lunatics, whether the are in asylums or workhouses. [Jones 1955].

The subsequent Lunatics Bill became law on 8th August 1845 and the eleven new Lunacy Commissioners were named. The Commissioners were now required to inspect all hospitals and licensed houses in the country and, significantly, they were also empowered to visit gaols and workhouses. They reported to the Lord Chancellor, who, with the Home Secretary retained the right to order a special visitation in any circumstances in which they saw fit. Even Bethlem was not exempted from this 'special visitation'.

By this time the medical profession was moving towards new standards of professional competence. The asylum doctors organised themselves into a more cohesive group, the 'Association of Medical Officers of Asylums and Hospitals for the Insane', in 1841.The Association became the Medico - Psychological Association in 1865. The Medical Registration Act was passed in 1858, establishing a professional Medical Council with the power to fix an examination standard. The terms doctor, physician and surgeon were defined and the way was opened to further specialisation. Lord Ashley considered the quality of medical and nursing staff to be of prime importance and advocated such specialisation. Sir Alexander Morison, who had begun staff education at Surrey Asylum in 1844, also established a benevolent fund from which grants could be made to patients on discharge. This is the first recorded example of an interest in after - care.

The number of patients known to the Lunacy Commissioners rose from some 20,000 in 1844 to almost 36,000 in 1858. It was also estimated that as many as 7000 of the 126,000 inmates of workhouses were pauper lunatics and mechanical restraint was still in general use. In an attempt to reduce this population, a grant in aid was made to the Boards of Guardians for every patient transferred to an asylum. This led to large numbers of chronic patients being transferred to the asylums, which increased their custodial role and vitiated their therapeutic function.

Notwithstanding a report by Dr Grenville in1877, there was little support for humane treatment from the public, who continued to nurture their twin fears, firstly of the insane and secondly of illegal detention. The legal profession was determined to protect the liberty of the individual and Grenville's arguments that early treatment should be the focus of reform were ignored. The Lunacy Act, which consolidated all previous enactments and provided for limits on detention, was passed in 1890.

2.4.2: The Asylum Paradigm in Western Australia

Captain Charles Fremantle was dispatched in HMAS Challenger to take formal possession of New Holland and found the new Swan River colony in 1828 [De Garis 1981a]. Until 1850, when the first convicts arrived, the mentally ill were too few to pose a significant problem. Male lunatics were confined in the East Perth lock – up and female lunatics in the basement of the colonial hospital.

The convict system worked well at first, but it was not long before numbers of insane prisoners were being transported. By June 1885 there were 2163 convicts in the colony and at least 7 of them were lunatics. A temporary asylum was established in a warehouse and supervised by Dr

Attfield. By February 1858 there were 15 lunatics in a prison population of 1190, a ratio of 13:1000. By the end of May the ratio had risen to 17:1000 and an asylum was obviously needed. A new building, designed to house 45 inmates, was built in Fremantle and was completed in 1865. Control of the facility was passed to a surgeon who was entirely independent of the superintendent of the prison, which was the first time that the criminal and the insane had been separated [Ellis 1984].

The number of patients increased to 75 by 1870 and the asylum was regarded as grossly overcrowded. Rules for admission and safeguards against unlawful detention were laid down in the Lunacy Act of 1871, but the situation continued to deteriorate until in 1883 there were 108 inmates. Until1886 both the British and colonial governments administered the asylum.

Admissions were mainly from the convict establishment and were paid for by the British government. Following a recommendation by a Select Committee, the Establishment, which included the asylum, was transferred from the Imperial to the Colonial Government in 1886. Once this transfer of responsibility had occurred the Legislative Council debated the asylum at great length and emphasised the need for the proper segregation of patients. Dr Barnett, who was appointed superintendent of the asylum in 1872, repeatedly stressed the need to separate the curable from the incurable patients and on 02/04/1888 the West Australian newspaper took up the call for reform.

In 1890 Western Australia became a self governing colony [De Garis 1981b] and the newly elected parliament, guided by Dr Barnett's report for that year and some comments by the authorised visitors, decided that something had to be done. Nevertheless, the government ignored the calls for a new asylum and temporised. In 1895 the old asylum was extended and temporary use was made of The Knowle, a former residence. These measures proved to be short – sighted and by 1896 there were 186 patients.

In 1888, the total population of the colony was only 43,814, but during the 8 years 1890 – 1897 the discovery of several gold strikes attracted 106,862 net immigrants [Appleyard 1981]. Consequently a parliamentary committee was appointed to find a site for a new asylum. In January 1897 the government purchased Whitby Falls, a property of 400 hectares near Jarrahdale. The 30-year-old farmhouse was renovated to house 50 chronic but quiet male patients. Following the death of a female patient at the hands of a fellow patient in 1900, another Select Committee was appointed and engaged Drs Tratman and Davey to give expert evidence. The doctors visited both the Fremantle asylum and Whitby Falls and condemned the

whole system in the strongest possible terms. They insisted that only a new asylum within easy distance of the city would suffice. Dr Montgomery, who had worked at the Nottingham City Asylum, was appointed as the new superintendent in 1901 and, convinced by his arguments, the committee selected a 160 – hectare site in Claremont as the site for the new asylum [Ellis 1984].

2.5: Fifth Epoch: First half of the 20th Century: The Decline of Asylums and the Development of Informal Methods of Treatment

2.5.1: The Decline of Asylums in Britain

Apart from Chancery patients, The Lunacy Act of 1890 prescribed three methods of admission to an asylum, but only the Urgency Order, which was valid for only 7 days, did not require the intervention of a justice. From the patient's perspective, the consequences of this prescriptive legislation were most unfortunate.

'Asylums could only take certified patients, and patients could not be certified until the illness had reached a stage where it was obvious to a lay authority - the Justice of the Peace. This made it impossible for the asylums to deal with early diagnosis and the treatment of most mild or acute cases. Their work became largely custodial.' [Jones 1960].

Many doctors were reluctant to send patients to asylums except as a last resort. Those specialising in psychiatry avoided working in asylums where most of the work was routine. Consequently, the treatment of neurotic disorders developed in consulting rooms and out - patient clinics. The Mental Treatment Act of 1930 eventually allowed the treatment of in - patients without certification, but the standards of treatment in the asylums were already in serious decline. Jones [1960] identified a number of contributory factors:

- **Size:** The first nine county asylums to be constructed comprised an average of 116 beds, but when it became clear that the number of beds required had been grossly underestimated, the asylums rapidly grew in size. In 1870 the average size of an asylum in England and Wales was 542 beds; by 1900 it had risen to 961 and by 1930 to 1221 beds. Lancaster Asylum was built in 1816 with 170 beds, but by 1842 it accommodated 600 patients. In the West Riding of Yorkshire in 1887 there were 2951 patients in two asylums, Wakefield and Wadsley, with another 1060 patients in the workhouses. By 1896 there were 4152 patients in three asylums, Wakefield, Wadsley and Menston, with another 928 in

workhouses. In 1898 the Asylums Committee of the County Council was making preparations to construct an additional asylum to accommodate 2000 patients [Rollin 1998]. Such increases in size produced a loss of the sense of community.

Ten nurses dealing with 100 patients do not have the same quality of relationship as one nurse dealing with 10 patients. Similar arguments apply when there are 5 doctors for 1000 patients as opposed to one doctor for 200 patients. The patient tends to become depersonalised and isolated in a crowd. This process had already been described by JT Arlidge, formerly of St. Luke's Hospital, who wrote in 1859: 'In all cases admitting of recovery, or a material amelioration, a gigantic asylum is a gigantic evil, and, figuratively speaking, a manufactory of chronic insanity' [quoted by Parry - Jones 1984]. Dr. Grenville also noted the same process in his report of 1877. The situation changed very little over the years and as late as 1961 Menston Hospital, by virtue of its size (2350 beds), had been compelled to adopt a largely custodial form of care [Gore and Jones 1961].

- **Architecture:** Many of the asylums built in the late 19th century featured long corridors, large square wards and strong, lockable doors. For example, the Middlesex County Asylum, subsequently called Friern Hospital, was described as "a colossal mistake" with long, narrow, gloomy and oppressive wards [Jones et al. 1991].

- **Shortage of Trained Staff:** At the outbreak of World War I, 42% of asylum medical staff volunteered and were accepted for military service. Their places were taken by those who were physically disabled or retired. Figures for nurses may have been higher. Many of both professions never returned, producing a deficit in trained staff that took decades to replace.

- **Overcrowding:** At the outbreak of war there were about 140,000 patients in 97 borough asylums. London had 10 asylums, of which 8 had more than 2000 beds; Lancashire had 5, all with more than 2000 beds, but in all areas there was overcrowding. During the war years the number of patients declined every year until there were only about 117, 000 by 1919. The respite was only brief and by 1934 the number had risen again to 150,000. No figures are available for the World War II years 1939 - 45 but the number reached its apogee in 1955 when there were 153,000 patients. Respective rates of admission were 63 per 100 beds per annum for psychiatric hospitals as compared with 1802 per 100 beds per annum for general hospitals. Put another way, the mentally ill accounted for only 3% of admissions but occupied 45% of all hospital beds [Royal Commission 1957]. In some hospitals 86% of the patients had been there longer than 2 years.

- **Other factors:** In some cases, public apathy, inadequate funding and the tendency to admit patients with all kinds of social deviance conspired to make the massive institutions therapeutically ineffective [Worley and Lowery 1988].

In 1919, Lloyd George's new "coupon coalition" government faced not only the mountainous financial debts incurred during the war, but also 'the price paid in a debasement of values and a sense of moral bankruptcy' [Thomson1965]. There was thus no pressure for social reform. Nevertheless, the Board of Control produced a report for the government's Reconstruction Committee that made the following recommendations for mental health:

- There should be treatment for limited periods without certification
- General hospitals should develop sections for the early diagnosis and treatment of mental illness for both in - patients and out - patients
- Senior positions in mental hospitals should be restricted to doctors who possessed the Diploma in Psychological Medicine, some times called the Diploma in Mental Diseases. Such diplomas had been awarded by Edinburgh, Durham and London Universities since 1911 and by the Royal College of Physicians since 1918.
- Official encouragement should be given to the establishment of outpatient clinics for mental disorder. Such clinics already existed in Sheffield, Manchester and Birmingham.
- The Board of Control should be empowered to make grants for the continuation of after – care work by voluntary agencies [Jones 1960].

The new Ministry of Health, set up in 1919, took over all the functions of the Local Government Board. This opened the way for the assimilation of the treatment of mental illness into that of physical illness. However, the financial stringency of the 'Geddes Axe' in 1921, together with the lack of any pressure for social reform, meant that there was no improvement in mental health services [Thomson 1965].

In 1922, a book by Dr. Montague Lomax about the conditions in Prestwich Asylum rekindled public interest. The minister responded by appointing a committee to inquire into the administration of public mental hospitals. The committee recommended that future asylums should be limited in size to 1000 beds and should be constructed on a villa system, with separate reception and convalescent wards. They also found a general lack of suitable staff, although the RMPA in 1891 and the General Nursing Council in 1921 had started examinations for nurses. Notwithstanding the work of the Board of Control and the dedication of the more enlightened staff, there was little improvement in conditions in the asylums until two important

outside influences came into play. The first of these was the development of the Maudsley Hospital as a prototype for the treatment of neurotic illness; the second was the growth of the After – care Association.

2.5.2: The Development of Informal Methods of Treatment in Britain

Since the asylums were manifestly incapable of curing established madness, the possibility of preventing its onset by intervening at an earlier stage was canvassed at the beginning of the 20th century. With the advent of psychoanalysis [Freud 1900] and other psychotherapeutic systems came the possibility that the psychodynamic origins of neurotic or even psychotic disorders might be explored and remedied. Because it was untestable and therefore irrefutable, the Freudian system had great merit as a professional ideology [Scull 1993], but it failed to provide cures for any but the affluent minority who could afford the protracted treatment. Nevertheless, it made several important contributions to other forms of psychotherapy [Holmes 1996].

Henry Maudsley, who was the son - in - law of John Connolly, became Medical Superintendent of the Manchester Royal Lunatic Hospital at the age of 23 years. He succeeded Dr. Bucknill as the editor of the Journal of Mental Science and in 1869 became Professor of Medical Jurisprudence at University College Hospital. In 1907 he offered PS 30,000 to the London County Council for a new mental hospital on three conditions:

- It should deal exclusively with early and acute conditions
- There should be an out - patients clinic
- It should provide for teaching and research

The hospital was completed in 1915 at a cost of PS 250,000 and became the benchmark for modern psychiatric hospitals. [Bethlem and Maudsley Hospitals 1999] It was used for the treatment of "shell shock" victims both during the war and afterwards until 1923. In 1924 it became a teaching hospital of the University of London. In 1930 the Mental Treatment Act made provision for the treatment of voluntary patients. Chairs in Psychiatry and the Pathology of Mental Disease were established in 1936. With the advent of the National Health Service in 1948, it was amalgamated with Bethlem as the only postgraduate teaching hospital devoted exclusively to psychiatry. The medical school was then renamed the Institute of Psychiatry and became part of the British Post - graduate Medical Federation.

The Mental After - Care Association was founded in 1879. The Association undertook both personal and residential work and dealt with 41 cases in 1887. This figure increased to 95 in 1900 and 670 in 1918. The personal work was undertaken by a number of 'voluntary associates' who found work and lodgings for the patient who was without friends of family. Residential placement for short periods was offered to former patients in convalescent homes, often run by former staff of the asylums.

Public perceptions that large numbers of sane people were being detained in asylums where widespread cruelty was practised prompted the appointment of a Royal Commission from 1924 to 1926. The Commissioners made the observation that there is no clear line of demarcation between mental and physical illness. It followed that the focus of management should shift away from detention towards prevention and treatment. They believed that legal interventions should be confined to three functions:

- Protecting the patient against neglect or ill – treatment
- Ensuring that any deprivation of liberty lasts only as long as is necessary in the interest of the patient or the public
- Ensuring that the patient receives proper treatment

The Commissioners also noted that: 'The transition from asylum life to the everyday world is a stage of peculiar difficulty for the recovered patient. The home and family life to which he returns may be unsuitable or unsympathetic, employment may be hard to obtain and friends may be unable or unwilling to help' [quoted by Jones 1960]. Accordingly they made the following recommendations:

- The Board of control should remain under the aegis of the Minister of Health
- Voluntary patients should be allowed to enter hospital without certification
- Local authorities should be encouraged to set up out – patient clinics
- Mental hospitals in future should not exceed 1000 beds and should be constructed on the villa system
- Nurses should be graded according to capability
- Social rehabilitation should be undertaken and funding should be given to after – care work

Pursuant to these recommendations, there were gradual improvements in conditions at the asylums. Toiletries were provided, patients were allowed to wear their own clothes and Occupational Therapy Departments were established. The Mental Treatment Act Of 1930,

which was permissive in most of its provisions, achieved four results: Reorganisation of the Board of Control; Provision for voluntary treatment; Official sanction for setting up out – patient clinics; Abolition of outmoded terminology.

The setting up of out – patient clinics in general hospitals stimulated an interest in psychological medicine amongst students and the growth in after – care services prompted an interest in their relationship with social services and social workers. The universities in London, Liverpool and Birmingham ran courses for social workers. The first degree course was established at Manchester in 1937. A specialised course in psychiatric social work was also inaugurated at the London School of Economics. The Association of Occupational Therapists was founded in 1936 and examinations began in 1938.

Dame Ellen Pinsent, who had been a Commissioner on the Board of Control for 30 years, was asked to conduct a survey of Oxford's mental health services in 1939. She made two general criticisms: there were often failures to secure a diagnosis by properly qualified professionals and failures to make referrals to the proper authorities. This latter deficiency may have been aggravated by the fact that the 'proper authorities' were represented by no fewer than six separate committees. Amongst her recommendations was one that each area should employ at least one fully trained psychiatrist for local authority work.

In the late 1930s there were four voluntary organisations concerned with community work. The Mental After Care Committee, founded in 1879, was concerned with patients discharged from hospital. The Central Association for Mental Welfare, founded in 1896, was concerned with the feeble – minded. The National Council for Mental Hygiene, founded in 1918, was concerned with preventive and educational work and the Child Guidance Council was founded in 1927. The Feversham Committee's report in 1939 recommended that the four voluntary organisations should amalgamate into the National Mental Health Association.

During World War II, the expected epidemic of mental breakdowns did not occur; apparently the authorities had learned nothing from WW I when the number of patients in mental hospitals declined significantly. The exigencies of wartime pressed the voluntary hospitals, the municipal hospitals and the public assistance hospitals into an emergency medical service. A Medical Planning Commission, comprising representatives from the BMA and the two Royal Colleges, was set up in 1940. Lord Beveridge published his report on 'Social Insurance and the Allied Services' in 1942, crystallising the concept of the Welfare State. Beveridge stressed that the development of a social insurance scheme that provided for medical care was contingent upon

the reduction of both the frequency and the duration of illness. Discussions between the RMPA, the Psychological Medicine Section of the BMA and the Royal College of Physicians produced a report, 'The Future Organisation of the Psychiatric Services', in 1945. This report recommended full integration of general and mental health services. Local authorities were to be given wide powers in community care but mental hospitals were to be removed from local authority and made the responsibility of joint boards.

Aneurin Bevan, as Minister for Health, was responsible for the controversial National Health Act in 1946. This Act set out to provide free medical treatment for all and took over the responsibility for voluntary hospitals, which were placed under Regional Boards. There was strong opposition from the medical profession, but this ultimately proved to be ineffectual [Thomson 1965]. Mental hospitals were also placed under the authority of Regional Boards, but the Board of Control was retained. Regional Boards set up Hospital Management Committees, each of which administered a small group of hospitals. A typical group might comprise a general hospital, a tuberculosis hospital, a mental hospital and a convalescent hospital. Some mental hospitals were so large as to require management committees of their own; a single committee might manage a small group of mental hospitals, and there were all kinds of admixtures in between.

With regard to the structure of mental health services, Dr. Blacker produced his report on 'Neurosis and the Mental Health Services' in 1946. Noting that GPs retained a deep - seated prejudice against psychiatry, he proposed that there should be closer links between mental and general hospitals. The alternative structure would have been to keep the mental health services separate to improve continuity of care, which would have required an enormous development in mental health services. In the USA there is evidence that some 60% of all mentally ill are treated in primary care [Regier et al. 1978] and adopting the integrated model means that a great deal of energy has to be expended on working at the interface. Ad hoc meetings and cooperation have been perhaps the most effective; certainly Joint Health Consultative Committees have not worked.

2.5.3: The Decline of Asylums in Western Australia

The building of Claremont Hospital was started in 1903 and completed in 1910, providing 700 beds. Lemnos Hospital for ex – servicemen was opened in 1926 and Heathcote Hospital in 1929. Despite the provision of 200 additional beds in these two hospitals, Claremont Hospital soon became dilapidated and overcrowded. There was also a shortage of staff and there were only 4 doctors to care for some 1500 patients overall, a situation that changed little over the next 30 years. Trial leave began to used extensively in 1947, which had the effect of slowing the rate

of increase in the number of patients but the daily average of patients in Claremont climbed inexorably from 1490 in 1956 to 1683 in 1966. Meanwhile the number of admissions increased from 197 to 365 per annum. During the same period the daily average of patients at Heathcote hospital remained fairly constant at 110 – 120, but the number of admissions increased from 592 to 1657 per annum. Examination of the diagnostic mix of patients showed that the two hospitals were serving very different functions with Claremont providing for the long – term patients with mental subnormality and dementia as well as the chronically psychotic. The failure to separate different categories of patients and the overcrowding recapitulated the UK mistakes with the same inevitable results.

Royal Perth Hospital had been involved with the treatment of the insane since it was founded in 1830 but it was Montgomery's strong advocacy for the development of a unit in the general hospital that led to the establishment of the 'Mental Ward' in 1908. A similar ward was also established at Kalgoorlie but closed because of lack of staff 10 years later [Skerritt et al 2001].

2.6:Sixth Epoch: The Second Half of the 20th Century: The Community Care Paradigm

2.6.1: The Drive for Reform in Britain

An early medical pioneer of reform was Dr Ian Skottowe who became Superintendent of the Buckinghamshire County Asylum in 1935. At that time the hospital was understaffed and overcrowded. Tuberculosis and dysentery were endemic, but the Superintendent had only one doctor to assist him with 700 patients [Crammer 1990]. Dr Skottowe immediately set to work to broaden the scope of the mental health care. In July 1936 he was appointed as consultant to the 5 workhouses in the county and in August he persuaded the local Committee to agree that he and other senior doctors could visit urgent or difficult patients in their homes at the request of their general practitioners. A psychiatric clinic was opened at the Royal Buckinghamshire Hospital in September and Dr Skottowe became an honorary consultant to the hospital in January 1937. Eight beds in the medical wards were allowed for the use of psychiatric patients. Finally, in 1947 he was made County Psychiatrist and consultant to all hospitals and homes run by the County Council.

Obviously there was a great need for reform, but unfortunately the profession as a whole did not follow the lead given by Dr Skottowe. The result was that reform not driven from inside by careful appraisal of the defects of the mental hospitals and the development of corresponding remedies. When the medical profession failed to take the lead, reform was driven by pressure

from outside commentators. Foremost amongst these was Erving Goffman [1968] who described the tendency for the big asylums to develop their own social systems in which patients were thrust into subordinate 'sick' roles. Patients living and coping skills became lost and they tended to develop the apathy, lack of initiative and poverty of speech, which was originally termed 'clinical poverty syndrome' [Freudenberg 1976]. Such negative symptoms are now recognised as occurring primarily in a number of disorders, such as schizophrenia, bipolar disorder, major depression or dissociative identity disorder. They may also appear secondarily in response to psychotic symptoms, depression, drug side effects or understimulation. [McPhillips & Barnes 1997]. Goffman took the view that such symptoms should be regarded as an adaptation to the environment.

Thomas Szasz [1974] expressed even more extreme views:
'The belief in mental illness as something other than man's trouble in getting along with his fellow man, is the proper heir to the belief in demonology and witchcraft. Mental illness exists or is 'real' in exactly the same sense in which witches existed or were real'.

These views are idiosyncratic to the point of absurdity. They depend on the 'dichotomy game', in which 'disease' and 'particular forms of personal behaviour' are regarded as mutually exclusive categories [Roth 1976]. Such a dichotomy is at best a perpetuation of mind/body dualism, at worst a form of sophistry. Yet the views exerted some powerful influences, which were later succinctly encapsulated by Kendell [1989]:

'A generation of sociologists convinced themselves that mental illness was a myth and the disabilities of those so labelled were largely a consequence of incarceration and mistreatment. Civil liberties lawyers sought to restrict or abolish compulsory detention and treatment. Health ministers, dismayed by a series of embarrassing hospital scandals, began to see abolition as the only solution; and health service managers, desperate for economies, began to calculate how much they would save by discharging patients to 'community care', closing the hospitals and selling the sites to developers.'

In response to these influences a Royal Commission 'On The Law Relating to Mental Illness and Mental Deficiency' was appointed on 22/10/53. The Commissioners reported in May 1957 and their principal recommendations were:

- The term "mental disorder" was to include mentally ill patients, psychopathic patients and severely subnormal patients.

- The Board of Control to be abolished and its functions as an inspectorate to be taken over by the Ministry of Health; appeals to be dealt with by Mental Health Review Tribunals.
- The wisdom of the decision to integrate the mental health services with the general health and welfare services was endorsed.
- Admission and discharge of patients should be informal as far as possible. Compulsory detention should only be used when necessary treatment is refused.
- The magistrate's order to be abolished and Mental Health Tribunals set up to hear complaints of wrong - doing.

Following the commissioners' recommendations, the Mental Health Bill had its second reading on 26/1/59. The Act was built on two planks [Rollin 1977]:

- New and potent methods of treatment;
- Transfer of the emphasis for the care of patients from the hospital to the community.

Consequent upon this enabling legislation, the then Minister for Health, Enoch Powell, proclaimed his Hospital Plan in 1962. This plan called for:

- The establishment of acute psychiatric units in general hospitals;
- The construction of Day Hospitals and Hostels by Local Authorities;
- The provision of a substantial increase in medical and ancillary staff;
- The gradual run - down of the mental hospitals.

Such were the qualities of emotional appeal and moral compulsion of community care that neither the underlying assumptions nor the implications for patients and their families were ever critically examined [Hawks 1975]. For example, the term 'community care' is ambiguous in several respects [Shepherd 1989]. Firstly, there is no clear definition of the term 'community'. It was widely assumed that all communities are social units occupying defined geographical areas, sharing common lifestyles, relating face to face at comparatively deep emotional levels and possessing both the motivation and the expertise to care for the mentally ill at home. Secondly, the concept of care implies both care in the community and care by the community. This means not only a change in the locus of care but also a change in the methods of delivering and financing care.

Failure to examine the implications of these assumptions led to a number of unhappy consequences, as later commentators indicated. For example:

'To assume that the community is a homogeneous unit or even therapeutic in some way, that it is more than a geographic entity, or that it is necessarily capable of showing concern, skills or tolerance, seems to us to be a naive or potentially dangerous concept' [Khoosal & Jones 1989].

Nevertheless, during the next 30 years the centre of gravity of psychiatric care moved inexorably from the hospital to the community [Rosen1992]. The driving force behind this move was the closure of hospital beds.

2.6.2: The Closure of Hospital Beds in Britain

Tooth and Brooke [1961] predicted a decline in the number of patients in mental hospitals in the UK from 340 per 100,000 population in 1961, to 180 per 100,000 by 1975. The Ministry accepted these figures, which quickly attracted criticism from Gore and Jones [1961]. Quoting the Ministry of Health circular of 28/3/61, these authors observed that no figures had been adduced to support this assumption, on which the future need for beds would be predicated. Kingston [1963] drew attention to errors of calculation in the figures, which presumed a linear decline in the number of patients. In fact the figures indicated an exponential decline and Kingston concluded that by 1975 accommodation would have to be found for between 40,000 and 50,000 patients - at a conservative estimate - for whom no plans had seemingly been made. A subsequent analysis of the Tooth and Brooke prediction [Watt 1986] noted that the long - stay population in psychiatric hospitals in England and Wales declined from 110,000 in 1954 to 78,000 in 1959. One third of the difference of 34,000 was accounted for by discharges, two thirds were accounted for by deaths. In concluding that none of the long - stay patients would still be in residence by 1970, Tooth and Brooke made three assumptions:

- The death rate would remain the same. In fact the death rate declined. An extensive study of the death rates in mental hospitals in Finland between 1920 and 1955 [Ekblom & Frisk 1961] showed that, following a peak during the war years, death rates showed a progressive decline until they reached levels almost comparable with the normal population. Moreover the decline was most marked amongst schizophrenic patients. Subsequently Sturt [1983] found a population - standardised mortality risk of 2.4 for chronic patients in Camberwell. Diseases that are common in the general population caused most of the deaths. This finding was in contrast with deaths amongst acute patients, in which suicide and accidents are important contributors.

More recently, a meta – analysis was undertaken of 152 papers published between 1966 and 1995 reporting on the risk of premature death in mental disorder [Harris & Barraclough1998]. The results showed that for psychiatric in - patients there is an all causes of death risk 2.8 times the expected. The highest risks were associated with substance abuse and eating disorders but for long stay patients the all causes of death risk declined to 1.8 times the expected.

- The discharge rate would remain the same. Discharge rates were widely perceived to be the result of the introduction of the new psychotropic drugs in 1955. In fact it had been demonstrated that the steep rise in both admission and discharge rates over the five - year period was the continuation of a trend that had started in 1952. Two factors driving this trend were readily identified. Firstly, there was a rapid expansion of both staff and amenities during the immediate post - war period. Secondly, the increase in discharges was principally amongst patients suffering from neurotic illnesses, affective disorders and personality disorders who would be expected to have shorter hospital stays. There was little change in the population of schizophrenic patients who would be expected to form the bulk of the long - stay residents.

- There would be no further recruitment to the ranks of the long - stay patients. This assumption also seems to have been founded on the perceived effectiveness of psychotropic medication. Depot phenothiazines reduce the risk of relapse in schizophrenia for up to four years [Johnson 1986] but it never becomes zero and some recruitment to the ranks of the long - stay is inevitable. According to the Tooth and Brooke prediction, the number of long - stay patients should have declined to 50,000 by 1963. In fact the figure was 88,000 or 10,000 higher than it had been in 1959. With ample justification Watt [1986] concluded: 'Thus in 1963 the grounds for believing that mental hospitals could be dispensed with by 1970 were demolished.'

Ignoring the warnings, the Ministry used the Tooth and Brooke figures, not as predictors, but as determinants of policy and pressed ahead with closures. Between 1960 and 1969 the hospitals lost 24,000 beds ["Rootless Wanderers" 1973].

2.6.3: The Drive for Reform in Western Australia

Western Australia lagged behind Britain in developing informal methods of care and it was not until a new Mental Health Act was proclaimed on 01/07/1966 that there was a dramatic change in the pattern of discharges from Claremont Hospital. During 1967 there were 1493 discharges,

including 1168 discharges to after – care or boarding out. Three hundred patients were discharged to the new psychiatric hostels made possible by the legislation. For the first time the number of patients discharged exceeded the number admitted, making it possible to reduce the number of beds from 1500 to 1100 [Buchan 1991]. In September 1972, Claremont was divided into Graylands Hospital with 400 beds for acute patients and Swanbourne Hospital with 500 beds for chronic patients. By 1979 the number of beds had shrunk to 1008 and by 1984 to 723 [Annual Reports 1960 – 1984]. Swanbourne Hospital was subsequently closed and by the beginning of 1990 Graylands Hospital was effectively reduced to 280 beds.

Heathcote Hospital replaced the receiving ward at RPH in 1929. It's original function was as a 'Receiving House', discharging many patients and transferring those who were becoming chronic to Claremont. It later became a regional mental hospital serving the part of the city south of the river and was finally closed in 1994 when 50 beds were established at both Bentley and Fremantle Hospitals. This resulted in a loss of 10 beds from Heathcote together with the loss of the 16-bed ward already in existence at Fremantle. The psychiatric ward at RPH was re – established in 1958 and the unit continues to function with 28 beds.

Further beds have recently been taken from Graylands to establish units at Swan, Armadale, Joondalup and Bunbury. These have not been entirely successful; for example Swan and Bunbury have both had to close for brief periods because of staff shortages and there have been frequent 'Red Alerts' when there are no beds available in the metro area.

Dr Cunningham Dax was appointed to the position of Chairman of the Victorian Mental Hygiene Authority in 1951. Under his leadership there was progress towards the replacement of custodial care with active treatment, rehabilitation and return to the community [Dax 1961]. Dr Ellis was able to introduce these concepts into Western Australia when he became Director of Mental Health Services in 1963 [Ellis 1984]. Havelock Clinic was opened in 1956 and Graylands Day Hospital in 1959.

In November 1964 a small out – patient clinic was opened in a house in Fremantle. Clinics were also established at Bentley in 1975, Armadale in 1976 and Swan in 1977. Out – patient clinics were also established in Geraldton, Port Hedland and Kalgoorlie.

2.6.4: The Opening of Psychiatric Hostels in Western Australia

The release of patients on trial leave was documented as early as 1904, but it was only after the promulgation of the Mental Health Act in 1966 that there were provisions for after – care and the

establishment of privately owned hostels. These provisions facilitated the release of patients to the community and the process accelerated from 1967. From 1969 a subsidy of $1 per day was paid for each patient in a hostel or rest home as defined by the Mental Health Services. At that time there were 18 hostels accommodating 470 patients. By 1985 there were 645 patients in 23 hostels. The Community Psychiatric Division was created in 1974 to review the hostels and the needs of the patients. It had been hoped that the patients in hostels could be rehabilitated sufficiently to live independently in the community, but a decade later these hopes had not been realised. There were a number of reasons for this but two of the more significant were the age of the patients and their length of stay. Some 42% of hostel residents were aged 60 years or more in 1974 and this rose to 45% in 1985. About 12% were in the 75 – 80 years age group and only 1.8% were under the age of 25 years. Moreover, about 56% of patients had been resident in the hostels for more than 3 years, 25% for more than 5 years [Paust 1986]. There is little evidence that such chronic patients can be rehabilitated to a normal level of functioning in the community [Howat & Kontny 1982].

There were other unsatisfactory aspects of hostel care, redolent of the findings in California where Lamb [1979] found that the residents in 'board and care' homes, as a group, were characterised by an overwhelming dependency. It was considered an illusion that these residents were 'in the community' at all and it would be more realistic to regard them as members of a subsociety [Lamb and Goertzel 1971].

The Community Psychiatric Division was closed in 1986 and its functions taken over by the community clinics. Unfortunately the functions of the clinics were not clearly defined, especially with regard to 'emergencies'. There were increasing demands for a rapid response to all kinds of crises, whether or not these were associated with major mental illnesses.

Many were so called 'situational crises' that did not require the expertise and resources of the full multidisciplinary team. The result was that the amount of clinical resources devoted to the 'seriously and enduring mentally ill' (SEMI), for want of a better term, was significantly reduced. Apparently this was also happening in other parts of Australia because, in 1987, there were a number of press reports across the country. There was a claim that community care was not working because of a lack of resources [McDonald 1987], which had led on occasion to patients being unsuitably placed in motels [Thomas 1987] or even in police cells when industrial action blocked admission [Dixon and Donohoe 1987]. Graham Williams [1987] reported:

'Thousands of Australians, seething with psychiatric problems, are being sentenced to the anonymity of dingy boarding houses or crisis refuges. At worst they call lonely inner city streets home.' In WA Perth's refuges for homeless people were being 'flooded by psychiatric patients – and it is not known what to do with them.'

Critics of the move from hospital to community care, amongst them the General Council of the Royal Australian and New Zealand College of Psychiatrists, described the intended closure of hospital beds as precipitous, pointing out the need for in – patient facilities to be integrated with community services [RANZCP 1987].

2.6.5:The National Mental Health Strategy in Australia

The State and Territory governments responded to these and other criticisms by launching a National Mental Health Policy in 1992 [National Mental Health Policy 1992]. The Policy translated into a Strategy covering 12 important areas. In the present context the recommendations in four areas are of particular relevance:

- Relationship between mental health services and the general health sector
- Linking mental health services with other sectors
- Service mix
- Primary care services.

- **Relationship between mental health services and the general health sector:**

Mental health services should be part of the mainstream health system – a full range of mental health services that are integrated within an identifiable mental health programme. In some cases this might involve delivering services in a general hospital setting; in other cases a specific mental health service might operate from a separate location but be managed within the wider health system. An integrated mental health programme would be necessary to ensure continuity of care.

- **Linking mental health services with other sectors:**

Not all the complex needs of the people with mental disorders and mental health problems can be met by specialised mental health services. Access to housing, accommodation support, social support, community and domiciliary care, income security and training and employment are all part of maintaining a person in the community.

- **Service mix:**

An integrated and comprehensive mental health service must cater for both acute episodes and long term needs. For the acutely ill, such a service would need to include acute hospital care, community and home – based acute care, emergency assessment and day treatment. For the more chronic patients the service would need out- patient treatment, social and vocational rehabilitation, varying degrees of residential support and long – term care. There are a small number of patients who are unable to live in the community despite the available support and who will require prolonged admission to a psychiatric hospital.

- **Primary care services:**

The Ministers commented: ' General practitioners are often the initial point of contact for people with mental health problems and mental disorders. It has been estimated that they represent about a quarter of people visiting general practitioners. Primary health care services also have an important role in caring for people with mental disorders and for referring those with serious disorders on to specialised mental health services. Considerable attention needs to be given to increasing the skills, at both undergraduate and graduate level, of primary health care providers to strengthen their capacity for assessment, diagnosis, treatment and referral of people with mental health problems and mental disorders.'

Further impetus was given to these proposed reforms by the publication of the report of the Human Rights and Equal Opportunity Commission often given the eponymous title of the 'Burdekin Report'[1993], after Brian Burdekin, who was Commissioner at the time.

2.6.6: The Burdekin Report

The 'Burdekin Report' collected a vast amount of evidence (1000 pages) and recorded a number of findings that were highly critical of the existing mental health services. Amongst these findings were the following:

- **Chapter 5: Mental health services**

➢ 'The promise of more, and more effective, community – based services following implementation of policies of de-institutionalisation has not been realised.'

➢ ' New policies of 'mainstreaming' mental health services will not work without a substantial increase in resources and greatly improved coordination between all government and non – government service providers.'

➢ 'Specialist public and private mental health services in Australia are inadequate and underfunded; there is a real risk that they will be increasingly marginalised.'

- ' Evidence to the Inquiry indicated that NGOs are now assisting many people virtually discarded as 'untreatable' by the public psychiatric system.'

- **Chapter 6: Health professionals**
- ' The needs of mental health professionals and allied staff in terms of primary and continuing education are not adequately met.'
- ' General practitioners (GPs) have insufficient training in the assessment and treatment of mental illness.'
- ' Many health professionals and allied staff working both in institutions and the community require education and training in the delivery of community based services.'

- **Chapter 8: Inpatient care and treatment**
- ' The lack of crisis teams to assist with psychiatric emergencies sometimes places consumers and their families at serious risk.'
- ' The rights of people with mental illness to inpatient care in a safe, therapeutic environment are not being respected.'
- ' Some form of long – term institutional care must be retained for the small proportion of people whose psychiatric disability is so severe that they will not be able to live in the community.'

- **Chapter 9: Community care and treatment**
- 'The inadequacy of existing community mental health services to treat, care for, and support people with mental illness living in the community is disgraceful. Those services that do exist are grossly underfunded and underdeveloped,'
- ' There has been virtually no systematic retraining of psychiatric hospital staff to work with people in a non – institutional setting in the community.'
- ' There is little coordination between mental health services provided to people in inpatient psychiatric facilities and community mental health services.'
- ' Procedures for discharge planning and for coordination of services for community treatment and care of people with mental illness are generally inadequate and, in many instances, non – existent.

- **Chapters 10, 11 & 18: Accommodation, boarding houses and homelessness**
- ' People affected by mental illness face a critical shortage of appropriate and affordable housing. The absence of suitable supported accommodation is the single biggest obstacle to recovery and effective rehabilitation.'

- ' Government housing programmes for people with disabilities exclude many Australians with mental illness, due to inflexible criteria and poor coordination between departments and agencies.'
- ' Homeless shelters, refuges and boarding houses are now functioning, de facto, as a major component of the 'accommodation' provided by our society for thousands of Australians affected by mental illness. This is completely unacceptable.'

- **Chapter 21: People with dual or multiple disabilities**
- 'Specialist services for the many thousands of Australians affected by mental illness and some other form of disability are almost non – existent.'
- ' Service providers lack the specialist training and have insufficient resources to deal with dual or multiple disability. Misdiagnosis is common and treatment often inappropriate. This can have devastating consequences.'

- **Chapter 27: Prevention and early intervention**
- ' Although the specific causes of serious mental illness have not yet been fully identified, many elements which increase risk are now understood. It may be possible in many instances to lessen risk by mitigating these factors.'
- ' Cultural factors influence perceptions and understanding of unusual behaviour, and patterns of response and care.
  Not only is an understanding of relevant cultural issues essential for the provision of mental health care, but unless care is provided in culturally appropriate ways additional stresses occur, adding to the burden, illness and disability of those affected.'
- ' There is now significant scientific evidence suggesting the effectiveness of early intervention programmes in addressing serious mental illness (eg schizophrenia, bipolar disorder and depression).'

2.6.7: The Ministerial Task Force in Western Australia

In the financial year 1995 – 1996, the Western Australian responded to the National Mental Health Strategy and the Burdekin Report by convening a Ministerial Taskforce to advise the Minister on how to proceed. Seven major Taskforce Committees were established to examine respectively: Psychiatric emergency services; Management structure for mental health; Resources for community service; Resources for hospital services; Training; Rural and remote issues; Child and adolescent services. The principal findings of the Taskforce Committees were as follows [Task Force 1996]:

- **Psychiatric Emergency Services:**

The establishment of the Psychiatric Emergency Team was a very positive step, but it needs to be appropriately resourced to implement its three year business plan 1995/6 – 1997/8. While, in the longer term, psychiatric emergency services should be established at a local level, the central Psychiatric Emergency Team service must be maintained until local services are functioning in all areas to a high standard.

- **Management structure for mental health:**

There was complete agreement amongst the members of the Taskforce that there were major systemic problems in the delivery of mental health services. There had been major and frequent changes in the health system as a whole over the previous ten years.

Each change had been accompanied by alterations in the organisational structure with virtually no consultation with service providers. Various models of health service delivery had been implemented with little time available for assessing their effectiveness before the next change had occurred. This had militated against the development of an effective and efficient mental health service. Since the psychiatric services were incorporated into the general health services in 1984 the system lacked clear leadership and direction. It did not allow clinicians the necessary input into planning and decision making, was not supportive of high quality service and hence had difficulties in retaining well – qualified and experienced staff. Accordingly the Committee recommended the establishment of a Branch/Division as part of the central office of the Health Department. A Chief Psychiatrist should be appointed as a member of the Health Department's Executive to direct the function of the Mental Health Branch. The Committee further proposed that the local organisation of services should be based on catchment area populations of 250,000 to 300,000 people.

- **Resources for community services:**

The Committee recommended benchmarks for resources that were comparable with other quality Australian and international services. They noted that a wide range of services is required to enable people to remain in the community. Such services include housing, employment, income security, respite care, recreational facilities and others. The Committee also believed that to ensure that district based teams could provide and coordinate services to their catchment population they should have responsibility for their mental health budget. The Mental Health Branch/Division would provide support and advice to the district based teams to ensure that their policies were consistent with statewide policies and priorities.

- **Resources for hospital services:**

The Committee believed that inpatient services, including accident and emergency services, should be provided conveniently close to where patients live. Administrative and legislative arrangements should be changed to allow compulsory treatment in all psychiatric inpatient units. Hospital psychiatric services should relate to their hospitals in a similar way to any other department but with the protection of their financial allocation by the office of the Chief Psychiatrist. The Committee also believed that moving resources from a hospital to a community setting would not, by itself, achieve the aim of a quality mental health service. Both the hospital and community components of the service need to be sufficiently resourced to ensure that continuity of care is provided across both settings. The closure of beds without the establishment of proper community services has been the major failing of de-institutionalisation wherever this has taken place. There will be a continuing need for tertiary services to be delivered from settings such as Graylands Hospital.

- **Training:**

The Committee proposed a planned approach to training throughout the mental health service system, linked to workforce recruitment strategies and involving innovative approaches to extend training opportunities beyond the metropolitan area. A key role was seen for the Mental Health Research Unit to extend its structures and objectives and coordinate postgraduate training and continuing education for mental health professionals. Plans for extending the training programme for psychiatrists must be linked to workforce strategies, which will continue to require overseas and interstate recruitment, and also to consultant psychiatrists accredited to supervise trainees. Changes to nursing education were proposed for increased training in the treatment and management of mental disorder in the comprehensive nurse – training programme. Specific proposals were made regarding training for clinical psychologists, and training in mental health settings for social workers and occupational therapists. There was strong support for training programmes for general practitioners.

- **Rural and remote issues:**

The Committee found that the lack of resources was the major issue in rural and remote areas. Where it existed, the rural and remote mental health service had been so understaffed that service providers had been barely able to provide any service. Service providers had been unable to cope with the clinical demands and staff turnover had been high, compromising the service even further.

The Taskforce submitted a comprehensive Report to the Minister in March 1996 and at the same time the Health Department delivered its own Mental Health Plan, 'Making a Commitment' [Smith et al 1996]. This plan mirrored many of the recommendations of the Taskforce but proposed a very different organisational structure of Clinical Directorates. This concept did not find favour, but the proposal of Centres of Excellence was adopted, possibly with the intent of emulating the influence of the Maudsley Hospital locally. Pursuant to the recommendations of the Taskforce, the Mental Health Division was established within the Health Department in November 1995.

The Division assumed responsibility for statewide planning and purchasing services. The Divisional staff provided advice on mental health issues to the Minister, other staff throughout the health system and the community. In conjunction with the Western Australian Association for Mental Health, the Division was responsible for stimulating significant developments in the provision of mental health services through the non – government sector. The Division also provided executive support to the Ministerial Advisory Council on Mental Health, which included broad community representation [HDWA 2000]. In order to improve coordination of services the state was divided into geographical areas. There were 4 metropolitan areas (North, East, South – East and South – West) and 6 rural areas (Midlands, Midwest, North – West, South – West, Goldfields and Great Southern).

The first National Mental Health Report was released in March 1994 and described the situation in each state and territory to provide a baseline for monitoring progress in subsequent reports. Over the period 1992/3 to 1995/6, the gross recurrent expenditure on mental health services in WA increased by $15.5M to $120.2M, making the state the third highest spending jurisdiction in Australia in terms of per capita expenditure (8% above the national average). Per capita spending on psychiatric inpatient services was the highest of all jurisdictions (21% above the national average). Expenditure on community based services increased as a proportion of the total mental health budget from 26% to 35%, but remained below the national average of 41%. Funds allocated to non – government organisations increased by 165% [HDWA 2000].

At the outset of the reform process the state government committed an additional $40M over a three year period to support the process. A further $47M was committed over five years for a building and works programme to support the reforms. The first $6M of the $40 was allocated in 1996/97. Adult services were expanded in 4 metropolitan areas and the 6 rural and regional areas. A further 70 places were allocated by Homeswest, bringing the total to 230 in the state. Twenty NGOs were funded to extend or establish support services. Sixteen psychiatrists were

recruited and the training scheme was expanded by 8 places. Scholarship support was offered to registered nurses undertaking mental health training. The Centre of Excellence for Primary Care was established at Fremantle and the Centre for Clinical Research in Neuropsychiatry at Graylands Hospital. This increase in resources was reflected in the number of people treated in the community, which rose from 15,643 in 1995 to 20,426 in 1999.

This increase in the number of people treated in the community was facilitated by the new Mental Health Act, which was passed by Parliament on 14/11/96 and promulgated on 13/11/97. The Act was particularly important in protecting the rights of involuntary patients but also allows involuntary treatment whilst patients are residing in the community. The mechanism for this involuntary treatment is the Community Treatment Order (CTO). Reservations have been expressed about CTOs, both in terms of ethical issues and clinical efficacy [McIvor 1998], but they have certainly allowed the treatment of some patients in the community who would have otherwise been admitted to hospital. A key element in the administration of CTOs was the creation of a register of Authorised Mental Health Practitioners who are empowered by the Act to compulsorily refer people for examination by a psychiatrist [Mental Health Act 1996].

2.6.8:The Second National Mental Health Plan in Australia

The second National Mental Health Plan was released in 1998 [AHMS 1998]. This strategy continued the reforms of the first strategy and was particularly focussed on: illness prevention and mental health promotion; intersectoral collaboration and service partnerships; quality standards.

In WA a further $6M of the $40M was allocated during 1998/99. Adult community services were expanded in Bunbury, Wellington, the northern Goldfields, Esperance, Great Southern, Midlands, Midwest, Murchison and North – West. The South – West corridor released its report in September 1998 [Tait 1998] and was seen as a good example of an integrated service [MHSB1998 – 1999].

In July 1999 a joint Metropolitan Health Services Board and HDWA project team released its report [Campos 1999]. The report had to be produced in a very short time so, although it produced some interesting ideas it did not have the depth to explain how these might be implemented in practice.

In 1999/2000 the mental health budget was approximately $160M. The Mental Health Program was recognised as one of 10 sub – programmes and it was Health Department policy that the

mental health budget must be transparent, separately identified and quarantined to ensure that all allocated funding continue is directed to mental health. Community mental health services were expanded in rural areas. Construction of new inpatient units was started at Swan and Armadale [HDWA 1999/2000].

The year 2000/2001 was a year of great change in the management of hospitals and health services in metropolitan Perth. Following the state election in February 2001, the incoming Labour Government dissolved the MHSB and the Health Minister accepted the role of the Board within the ministry. The Commissioner for Health assumed the functions and powers of the MHSB to ensure the continuous delivery of metropolitan health services [MHSB 2000/2001]. In April, the Minister established the Health System Administrative Review Committee (HARC) to examine and advise on how the public health system's administrative structure could be reformed following the abolition of the MHSB. The committee reported in June and found that the administrative structure delivering the service needed simplification. The committee recommended the establishment of three metropolitan area health services taking responsibility for the public hospital, community and population health needs of the area, plus a women's and children's health service. The services would report through boards and chief executives to the Minister and the Commissioner of Health. The proposed services were:

- East Metropolitan Area comprising: Royal Perth Hospital, Bentley, Swan and Kalamunda Health Services, and all public health services located in their catchment areas.
- North Metropolitan Area Health Services comprising: Sir Charles Gairdner Hospital, Osborne Park Hospital, North Metropolitan Health service, management of the Joondalup Campus contract, Graylands Selby Lemnos and Special Care Health Services, and all public health services located in their catchment areas.
- South Metropolitan Area Health Service comprising: Fremantle Hospital and Health Service, Rockingham/Kwinana Health Service, Armadale Health Service, management of the Peel Health Service contract and all public health services in their catchment areas.
- Women's and Children's Health Service, comprising King Edward Memorial Hospital, Princess Margaret Hospital for Children and other related services.

Morley Clinic, a satellite of Swan Clinic opened in October 2000.The 25 bed inpatient unit at Swan opened in January 2001, the comparable unit at Armadale shortly afterwards. New buildings were commenced in rural areas [HDWA Report 2000/2001]. A community based forensic psychiatry unit was established and care was provided through contracts with private facilities at Joondalup (365 beds, 295 public & 70 private) Peel (120 beds, 100 public & 20

private) and Bunbury (15 psychiatric beds). Improved support was given to hostels and the training of Authorised Mental Health Practitioners continued.

CHAPTER 3: THE LESSONS OF HISTORY

3.1: Contemporary Problems with Historical Roots

3.1.1: Definitions of Mental Disorder and Criminal Behaviour

Henry's abolition of the monasteries in 1536 precipitated the care of the sufferers from the church to the secular authorities. Unfortunately the confusion between mental disorder and criminal behaviour was reflected in social policy, with the consequent failure of the poorhouses and Bridewells to provide the expected solution. This confusion still persists, partly because of the difficulty in defining 'mental disorder', which is the preferred term in the World Health Organisation's International Classification of Diseases, 10th Edition [ICD10 1992]. The Royal Commission on the Law relating to Mental Illness and Mental Deficiency [1957] used the term 'psychopath' to:

'include any type of aggressive or inadequate personality ..... which is recognised medically as a pathological condition.' ' Our psychopathic group includes all patients classified as feebleminded or moral defectives who need care'.

There is no attempt to define a 'moral defective' but there are implications redolent of the concept of sin. Following the lead of the Royal Commission the 1959 British Mental Health Act defined 'psychopathic disorder' as: 'a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible behaviour'. This definition had many critics. For example, McCrae [1973], quoting Lady Wootton, pointed out that the definition is circular; mental illness is defined on the basis of antisocial behaviour, which is then excused on the grounds of mental illness. Moreover, no definition of 'abnormally aggressive' or 'seriously irresponsible' behaviour is given so that value judgements in terms of cultural and community values were inevitable.

The distinction between mental disorder and criminal behaviour became critical in 1999. The UK government then 'made it clear that it intended to introduce legislation in England and Wales for the compulsory and potentially indefinite detention of people with what it called 'dangerous severe personality disorder' whether or not they had been convicted of a criminal offence' [Kendell 2002]. Part of the difficulty with this legislation lies in the definition of 'disorder'. Some of the difficulties associated with this differentiation have been explored elsewhere [Buchan & Sparling 1985] but Scott [1970] noted:

'Since no one is very clear where mental illness finishes and disturbed or deviant behaviour begins, it is inevitable that there will be doubts whether certain sorts of persons should be in prisons or hospitals. The choice is often arbitrary and many years ago Penrose showed that the utilisation of prisons and asylums varies inversely'.

Kendell [2002] offers four definitions of mental disorder, each based on a different concept of mental disorder. The failure to arrive at some consensus about an operational distinction between the mentally ill person and the criminal has led to doctors becoming drawn into areas where they have no special skills [Ormrod 1975]. Until there is some consensus about the boundaries of psychiatric responsibility, there will inevitably be some spectacular failures.

3.1.2: Failure to Distinguish Different Categories of Mental Disorder

Following the report of the Commissioners in Lunacy in 1844 an attempt was made to separate the curable from the incurable pauper lunatics. The intent of this distinction was to restrict admissions to hospital to the 'curable' pauper lunatics. The 'incurables' were to be sent to workhouses where maintenance was much cheaper. The Lunatics Act of 1845 required the county authorities to build asylums, which, it was believed, would 'cure' large numbers of the insane, thereby reducing the economic burden. Notwithstanding the good intentions of the legislators, asylum care proved to be a costly failure. Three factors have been identified as significant contributors to this failure [Jones et al 1991]. They are:

- Increasing numbers of the incurable insane filling the available beds
- Pressures to economise in the wake of Britain's lack of international competitiveness
- The intent of the medical profession to monopolise the care of the mentally ill

Increasing Numbers: Taking the Buckinghamshire County Asylum, St Johns, as an exemplar of what was happening elsewhere in the country, one factor in particular can be identified as having a major impact on overcrowding [Crammer 1990].

' The magistrates began sending the partially paralysed, the deaf and blind, the physically incapacitated, the old and the young without family to care for them, provided they had some behavioural disturbance as well. The workhouses were discouraged from taking them or glad to get rid of them and charitable and private hospitals were too few and far between to accept them (or too costly).'

Pressures to Economise: In 1890 the Buckinghamshire County Council cut the cost of weekly maintenance from about 9 shillings to 7 shillings per head and most of this saving

was on food [Crammer 1990]. As a consequence the morbidity and mortality of physical illnesses increased until after World War 1 when a more enlightened policy prevailed. Another aspect of economising was that asylums were chronically understaffed. When St Johns was opened in 1853 the total staff for 200 patients was 6 men and a head male nurse, together with 7 women, a needlewoman and a matron. The nurse/patient ratio was about 1:15 and, because of the nature of the patients admitted, there was a good deal of heavy physical nursing. Moreover the training of nurses did not begin officially until 1885.

Attitudes of the Medical Profession: Considerable faith was placed in the medical profession to supervise treatment within the asylum. The local committee was required by law to provide the buildings and the consumables but what went on inside the buildings was a matter for the doctors [Crammer 1990]. This situation provided ample opportunity for the profession to establish a monopoly over the treatment of mental illness. Those practising this line of work acquired 'the status and prerogatives owed to professionals, most notably the autonomous control by the practitioners themselves over the conditions and conduct of their work.' [Scull1993]

Fortunately WA escaped the disaster of the private madhouses, but seemed to learn nothing of the mistakes made in England over the construction of asylums. Initially there was the same failure to separate criminals and lunatics and subsequently the failure to separate the chronic and incurable from the curable. Notwithstanding the efforts of Dr Barnett and the authorised visitors, the asylum was expected to fulfil the functions of both the active treatment of the curable and the confinement of the incurable. Both functions can be accommodated in the same hospital but separate wards are mandatory because the treatment philosophies are quite different. The curable require intensive treatment over a short period of time, with a view to returning them to independent living, whilst the incurable require low key interventions over a long period of time with the aim of giving them some quality of life.

3.1.3: Problems of Community Care

3.1.3.1: Pressures on the Development of Community Care

Founded as it was on unsustainable assumptions and driven by the closure of hospital beds, the development of community care was also subjected to a number of powerful pressures, which have made the progress of its development halting, uneven, erratic and not always beneficial. Two significant groups of pressures can be readily identified:

- **Clinical pressures:** Clinical problems change with time. For example, one of the most difficult contemporary problems is not the fate of patients discharged to the community after many years in hospital, but the largely unforeseen one of the next generation of seriously mentally ill that has grown up since de - institutionalisation. These patients have had only brief admissions to hospital and have not been homogenised into passivity by many years in back wards [Lamb 1993]. It is from their ranks that the homeless mentally ill are drawn. Studies from the UK suggest that as many as 50% of the homeless have a mental illness, which worsens as the homelessness continues [Scott 1993]. Patients with dual diagnoses are also a burgeoning problem. It has been reported from the US that 47% of patients with a lifetime diagnosis of schizophrenia or schizophreniform disorder met criteria for some form of substance abuse or dependence [Hoult 1993].
- **Organisational Pressures:** In order to deliver services to a particular community, an administrative framework is needed and in setting up such frameworks Departments of Health are subjected to a number of competing ideological pressures [Hazelton 1993]:
  - **Managerial Pressures:** Two distinct and opposing orientations towards management structures have emerged. One the one hand, the social reform movement has agitated for the development of a "bottom up" model of management, using slogans such as "community participation", "shared governance", "participating management", etc. On the other hand, the administrative reform movement has favoured the tightening of central control over policy and funding, using slogans such as "efficiency", "effectiveness", and "accountability". This 'top – down' model has been disguised under the rhetoric of regionalisation, decentralisation and devolution, but it is abundantly clear that whilst responsibility for service outcome has been devolved, this does not amount to operational and financial autonomy at the regional level. The frequent reorganisations in WA have all followed this 'top down' model, which stifles innovation at a local level.
  - **Medical Pressures:** Both these administrative models challenge the traditional medical domination of the mental health agenda. Consequently, psychiatrists have defended their positions using slogans such as 'disorder' (violence, crime and delinquency), 'misguidedness' (idealism, impracticality, naivete) and 'progress' (the rapid advance of biological psychiatry) to maintain their authority.
  - **Consumer Pressures:** Consumers also contest the adequacy of the medical approach and want to set different priorities for dealing with mental disorder [Grusky et al 1989]. Using slogans such as 'consumer needs' (sometimes expressed as rights), 'self – reliance', 'empowering', 'sharing' and 'networking' etc, consumers advocate an end to paternalism and a move to cooperative carer – patient relationships, with shared responsibility for decision – making. Consumers' demands may also reflect differences

between communities, such as different levels of resources, social disruptions, cohesiveness, modes of organisation etc.

3.1.3.2: Adverse Consequences:

Shaped by a multiplicity of forces, which were totally unrelated to clinical issues, it is hardly surprising that the development of community care had adverse consequences for both staff and patients.

- **Adverse consequences for staff:**

The proliferation of various models for service delivery was an early source of confusion for staff members who were searching for reliable guidance in how to set up systems. As yet there is still no single model which provides an ideal framework [Wykes et al. 1998]. It may well be that local variations in the problems preclude any overall solution. As Kathleen Jones [1996] has observed:

'Patients live in a variety of settings: in their own homes, in hostels, in private sector Homes, in lodgings. These classifications obscure important differences. 'Own home' may mean a comfortable suburban dwelling, or a council flat in a run down area where petty crime and drug abuse are facts of everyday life, and neighbours may be hostile. It may involve living with a devoted and caring family, or being barely tolerated in a family beset with other problems, or living alone - often in isolation, since people with psychiatric problems tend to have fragile or tenuous social networks.'

Notwithstanding this lack of clarity over the most basic terms, the move to community care proceeded relentlessly. The increasing pace of change and the different skills required to work in a community setting have led to bewilderment among staff [O'Grady 1996]. Specifically, few psychiatrists are trained for the roles they take on in the community, and they have to develop their skills in situ [Muijen 1993]. This author believed that training should be thoroughly revised, at both pre and post - Fellowship levels. Boyce and Tobin [1998] have also critically examined the different roles of the psychiatrist in public service in Australia in order to provide some clarity. They conclude that clinical and management roles each require specific professional skill development, and make recommendations about how this might be undertaken. They draw particular attention to the problems of working in a multidisciplinary team and the effect this may have on career choices.

- **Adverse Consequences for Patients:**

Community care developed in such a way that there were a number of adverse consequences for patients and their carers. Some of these consequences can be easily related to each of the four major provisions of the UK Hospital Plan:

➢ **Acute psychiatric units in district general hospitals:** The superiority of District General Hospital Units was taken as axiomatic but never proven [Kessell 1973] and the following difficulties were soon encountered:

1. The difficulty of treating all kinds of mental disorder - including the violent and the long stay patient - in the same short stay unit had not been fully appreciated. ['Care of the Mentally Sick' 1972]
2. A 'surgical' type of psychiatry tended to develop with heavy emphasis on physical methods of treatment and rapid discharge. There was a consequent devaluation of the time consuming analysis of the patient's problems and family difficulties [Jones and Tuxford 1963].
3. The social characteristics of the patient are often more significant than the diagnosis in determining admission [Dean and Gadd 1990]. Consequently an analysis of the health and economic peculiarities of the family and the burden imposed upon them by the patient may, in fact, make admission unnecessary [Grad and Sainsbury 1963].
4. Many chronic patients have special needs, such as the need for gradual re - introduction into the community, which cannot be adequately met in DGH units [Gath et al. 1973].

   This last difficulty is particularly apparent in WA where there is virtually no hospital accommodation for long – term rehabilitation.

➢ **The Construction of Day Hospitals and Hostels by Local Authorities:**

The National Association for Mental Health in the UK sent out questionnaires to all 173 local authorities in 1971 and 1973 [Early 1974]. The results in 1971 were 'alarming' and the follow - up caused 'grave concern'. By 1984 residential places for the mentally ill were only 40% provided [Social Services Committee 1985]. Much of the accommodation that was provided left much to be desired. Transitional hostels could become replicas of the worst aspects of old institution life at almost twice the cost. It had been noted that many hostel residents had a long list of problems, which any critic would recognise as characteristic of poor mental hospitals [Wing 1973]. Even short stay hostels often had to modify their policy of keeping patients only two years; 40 - 50% of patients stayed longer than two years. High domestic and social standards for the patients could only be achieved at the cost of strong supervision and protection, with consequent loss of autonomy for the patients [Hewett et al

1975]. Similar problems with the hostels in WA have been discussed elsewhere [Buchan1991].

Because of the shortage of sheltered accommodation, many chronically psychotic patients lived at home. A survey of long - term patients in Wales revealed that almost two thirds were suffering from schizophrenia [Pryce at al 1983] and about one third lived with relatives. In general the relatives were very tolerant of the patient's behaviour, but found some aspects distressing; for example: poor social mixing; shouting or screaming at others; talking to self; poor self care; incontinence and lack of conversation. Consequently, families often had different priorities for management but were rarely included in drawing up care plans [Hewitt 1983].

In 1985 Social Services Committee also considered the level of provision of Day Hospital places to be "appallingly inadequate". Again the quality of care left much to be desired, partly because of the haphazard and uncoordinated way such facilities developed. Some mixed patients from the community with in - patients, whilst others became dumping grounds for chronic patients discharged to the community.

Because of this failure to identify and define the functions of day care facilities, the opportunity to create independent units offering a comprehensive range of treatments for both patients and families was lost [Vaughan 1983]. In WA, before the new unit was built at Fremantle, the Day Hospital there cared for SEMI patients, but since then facilities have tended to shift towards the care of difficult neurotic patients or personality disorders.

- **The provision of a substantial increase in medical and ancillary staff:**

  Medical manpower: In 1985 the Social Services Committee commented: 'Psychiatry for both mental illness and mental handicap remains a shortage speciality.' The UK College of Psychiatrists found that although there was an 18% increase in consultants in psychiatry between 1970 and 1980, this compared unfavourably with the 25% increase in all other medical specialities [Royal College of Psychiatrists 1982]. Similar shortages in the US led one author to describe psychiatrists as 'an endangered species' [Hackett 1977]. An idea canvassed by the Committee, which might provide some relief for the manpower shortage, was an increased role for the general practitioner [par188]. In line with this concept, the Committee made two recommendations:

'**85:** We recommend a review by the Department of the training of GPs in psychiatry and mental handicap, with a view to ensuring that GPs are better equipped to provide general medical services to mentally disabled people.'
'**86.** A greater understanding and encouragement of the GPs role in the management of mental illness on the part of hospital psychiatrists would be welcome.'

In Australia, the Joint Committee of the Royal College of General Practitioners and the Royal College of Psychiatrists issued their report 'Primary Care Psychiatry: The last Frontier' in 1997 [Joint Report 1997]. This issue will be explored in more depth at a later stage.

Ancillary Staff: With regard to social workers, the 1973 survey estimated that it would be 1990 before a 75% level of adequate social work staffing would be achieved. This lag in social service provision might be partly attributable to a lack of understanding of the kind of service to be provided, and the DHSS failed to provide any leadership on this issue. There were no accurate figures for the number of Community Mental Health nurses but estimates varied between 2000 and 3500 [Social Services Report 1985]. These estimates were clearly far short of the 10 per 100,000 population recommended by the College of General Practitioners. Goldberg [1986] also drew attention to the disparities in distribution of nurses.

- **The gradual run - down of the mental hospitals:**
  The Social Services Committee [1985] commented [para 30]:

'The pace of removal of hospital facilities for mental illness has far outrun the provision of services to replace them. It is only now that many people are waking up to the legacy of a policy that began over 20 years ago. Many of the horror stories of mentally ill people living on the streets or miserably in board and lodgings are the results of an earlier era.'

There were a number of adverse consequences:

Decline in standards of care: The concentration of resources in DGH units at the expense of mental hospitals led to continual staffing problems. There was a decline in the morale of staff who believed that their hospitals were scheduled for obsolescence ['Staffing our Asylums' 1972]. Standards of care declined and there ensued a series of inquiries into allegations of assault on patients by staff in several hospitals ['Shut Away' 1972].

Inappropriate discharge of the chronically mentally ill: Mann and Cree [1976] surveyed patients in 15 representative hospitals in England and Wales and allocated them to categories according to the length of stay. The categories were: Short stay patients - less than one year (27%); "New" long stay - one to 5 years (21%); Long stay - more than 5 years (52%).

Wing [1986] subsequently showed that short stay and 'new' long stay patients stabilised at roughly 60 and 40 per 100,000 population respectively, but reductions in long stay patients were by death rather than discharge. Leff [1986] demonstrated that 46% of the new long stay patients had been admitted from sheltered accommodation in the community, which indicated that existing community services had proved inadequate for this category of patient. Schizophrenic patients comprise one third of the new long stay, but 74% of the old long stay patients. Even after 10 years in hospital, almost one half had experienced a flare up of florid symptoms during the previous year. Only 16 patients (4%) were considered capable of living in sheltered accommodation without resident staff. Similar findings were reported for 194 long stay schizophrenic patients in Horton Hospital [Curson et al 1988]. These and other similar findings notwithstanding, chronically ill patients continued to be discharged. The consequences of inappropriate discharge may be summarised under the following headings:

a) Recurrent readmissions: The causes of readmission include inadequate maintenance medication [Davis1975], and crisis of life change. Datable events such as moving house, starting or finishing a job etc. occur more often in relation to the relapse of schizophrenic patients than they do at other times during the patients' lives or in a control group without psychiatric illness [Birley and Brown 1970]. This finding offers scope for the identification of vulnerable patients and the implementation of preventive measures.
b) Marginal community adjustment:
   With the loss of the sanctuary of the mental hospital, patients of "no fixed abode", who may account for 30% of admissions, were cast adrift in the community and condemned to a life of rootless wandering.' ['Rootless Wanderers 1973]. Lodge - Patch [1971] spoke of: 'the spectacle of untreated schizophrenics drifting through lodging houses.' By the end of 1965, some 27,000 men and women were resident in 550 lodging houses. In some instances, 59% of the men had lived in this manner for more than 5 years ['Down and Out' 1966] and about 28% of such residents were psychiatrically ill [Scott et al 1966]. The state of affairs in 1973 was succinctly summarised by Sir Keith Joseph in his

Foreword: 'There is a sad, poignant army of people who progress from mental illness hospitals to hostels to lodging houses to prisons to resettlement centres, pursuing a treadmill of a life.' ['Policy for Action' 1973]

The mentally ill were also frequently admitted to prisons or borstals. Between 1971 and 1976 the number of prosecuted offenders referred for a psychiatric report remained fairly steady at about 13,500 per annum, but the proportion admitted to hospital declined from 10 - 12% in 1961 to 7,8% in 1976 ['Inhumanity to Man' 1977].

Jeremy Coid [1994] drew attention to the inadequacy of many studies of the effectiveness of community care, notably that an effective, community based service may require even more inpatient beds when the unmet needs of a catchment area are revealed. An editorial [Tyrer 1998] drew attention to the role of the media:

'Confidence in the policy has faltered, largely because of adverse reports in the media. Scarcely a day goes by without a scandal alleging that it has failed fundamentally.'

A series of reports in the London Telegraph illustrate Tyrer's comments:

Issue 967: 17/01/98: 'Care in the community is scrapped'; by Alice Thomson and Rachel Sylvester:
' The policy of sending mentally ill people out of hospital to be cared for in the community is to be reversed by the government. Frank Dobson said in an interview with The Telegraph yesterday that seriously disturbed psychiatric patients must be kept in secure units to protect the public. This will mean the recall into residential care of some people who are currently living in unsupervised units. A recent report found that one murder is committed every two weeks by mental patients and about 1000 commit suicide each year. The number of beds for psychiatric patients has fallen from 150,000 in 1960 to 37,000.'

Issue 994: 13/02/98: 'Mental Health shake - up'; by Celia Hall.
' A leaked document is said to conclude that Care in the Community for the mentally ill has not worked, that it has failed to respond to people in crisis and does not offer continuity in care. While the report does not propose a return to expensive asylums, it suggests extra crisis beds and 24 – hour specialist emergency teams.'

Issue 1117: 16/06/98: 'Jail killing prompts shake – up of care in the community'; by Philip Johnston:

' An overhaul of mental health services will be announced by the Government within weeks after the shortcomings of care in the community were blamed yesterday for the death of a prisoner killed by a paranoid schizophrenic put in the same cell.' 'The Health Department is preparing to unveil its new strategy amid calls from campaigners for more money to improve the supervision of the mentally ill and provide more hospital beds for them.'

Issue 1290: 06/12/98: 'Dobson announces plan to take mentally ill off streets'; by Jacqui Thornton and Tom Baldwin.

'Frank Dobson, the Health Secretary, will promise this week to reverse the previous government's care in the community programme by taking thousands of mentally ill people off the streets and putting them back in psychiatric hospitals.'

Public disquiet over community care in Australia surfaced in 1987 and reflected much the same concerns as in the UK.

McDonald [1987] claimed that putting the mentally ill back into the community was not working because of lack of resources, which had led on occasion to patients being unsuitably place in motels [Thomas 1987] or even in police cells when industrial action blocked admission [Dixon and Donohoe 1987].

Williams [1987] reported that:

'Thousands of Australians, seething with psychiatric problems, are being sentenced to the anonymity of dingy boarding houses or crisis refuges. At worst they call inner city streets home.' 'In Western Australia, Perth's refuges for homeless people are being "flooded by psychiatric patients – and it is not known what to do with them.'

The reforms in Western Australia that followed the National Mental Health Strategy, the Second National Mental Health Plan, the Burdekin Report, the Task Force Report and 'Making A Commitment', went a long way towards addressing some of the problems. For example, there were responses to the lack of provision of services in rural areas, the lack of affordable accommodation, the lack of preventive measures, the provision of telepsychiatry, and the mainstreaming of acute services.

3.2: Towards a Realistic Solution

3.2.1: The Future of Community Care

Notwithstanding the mistakes that were made and the adverse consequences, Tyrer [1998] concluded: ' *community care* is relevant and effective but still has some rough edges.'

Tessa Richards [1987] went much further in commenting on the report of the Audit Commission (Making a Reality of Community Care): 'What is needed, it concludes, is a radical rethink of our approach to community care and some major changes in policy.' More recently, Leff [2001] has made a considered evaluation of community care and listed some of the reasons why it has been – and possibly is still – perceived as a failure. These include ignorance of the facts; the increase in the number of homeless mentally ill; the public's perception that mental illness is associated with violence and the invisibility of the community based service. Perhaps most significantly he sets out a fundamental criterion by which services should be assessed:

' It is probably fair to say that a comprehensive community psychiatric service catering to all the needs of the catchment area population exists nowhere in the British Isles and will never be achieved. This is because health service provision is always chasing need in an ascending spiral. When basic needs are satisfied, a new level of need becomes apparent. This is another reason why the success of a service cannot be absolute and must be relative.'

He points out that many of the problems associated with community care, such as social isolation, can be solved and goes on to say: 'A new generation of psychiatrists is growing up who not only have never worked in a psychiatric hospital but have never seen one! All of us need to accept the role of 'product champions' for community care and, by our actions, to promote the social and occupational integration of patients, become more visible in our local communities now that the protection of the asylum walls is no more.'

3.2.2: The Components of Community Care

Whilst there is no consensus about the structure and formation of a community based system, perusal of some of the literature from the UK [MIND 1983; Second Report from the Social Services Committee 1985; Sims 1991; Murphy 1991] and the US [Kennedy 1990; Romeo et al 1990; Anthony et al 1990] reveals a number of common themes. In the Australian context, these themes are reflected in documents such as the National Mental Health Strategy, the Second National Mental Health Plan, the Burdekin Report, the Task Force Report, and the Western Australian Health Department Reports. The principal themes can be identified as follows:

- Services should be integrated. In – patient care, out – patient care, day - care, home based care, residential care and primary care should be integrated so that the patient can move from one component to another without becoming lost to the system.
- In order to achieve such a unified concept in the development of services, planning should be a collaborative effort, involving the participation of staff from all agencies involved in the delivery of services. It should reflect the needs of the individual, the family and the community rather than building on existing service descriptions or organisations.
- The plan should be acceptable to the community that it is intended to serve and must operate within community values.
- Planning should begin with a quantitative analysis of the population to be served to determine their needs. Needs can be considered under four headings:
  - Housing: A sufficient stock of low cost, affordable accommodation ranging from hostels through half – way houses with resident staff to group homes and independent units.
  - Support: This might be in the form of domestic help, daily occupation and work, opportunities for leisure activities, personal friendships and education. This aspect of care requires relatively unskilled workers who can be trained on the job. Additional support for the families, who are often the principal care – givers is fundamental.
  - Rehabilitation: Services should be appropriate for each patient's age, functional level and individual needs. Such services might include vocational training, supervised work, occupational therapy and social skills training.
  - Treatment: There needs to be a range of mental health treatment centres, including mental hospitals, acute in – patient units and day – hospitals attached to district general hospitals and community based clinics and services.
  - Resource allocation should be adequate. Community care is not necessarily a cheap alternative and might even be more expensive in the short term ['Community Care' 1985]. Careful option appraisals will be needed to ensure that any changes in resource allocation produce real benefit for the patient. Any savings that accrue should be made available to mental health and not returned to general revenue.
  - Much more accurate information is required on trends in numbers, characteristics, needs etc of the mentally disordered.

With such widespread accord on what needs to be done, it is disconcerting to discover that not only has comparatively little been achieved, but that what has been achieved has failed to reassure the public.

3.2.3: The Development of Community Care

The historical review reveals three important themes that are relevant to the development of an ideal community based mental health service:

- Concepts of the nature of mental illness
- The administrative framework for delivering services
- Attitudes of the medical profession

The first theme is of fundamental importance because both the responses of administrators and the attitudes of doctors to the mentally disordered depend to some extent on how they construe the disorder. Neither administrators nor doctors have fully grasped the complexities and difficulties of moving medical care from the hospitals into the community. Doctors have to understand that the patient's disorder reflects the socio - economic, cultural and personal ecological niche that the patient occupies. This means that the doctor has not only to be aware of these various ecological aspects but also to accept that a multidisciplinary team is essential to deal with these aspects. For many psychiatrists this means that they have to adapt to a new way of working in which the consultant is not necessarily the team leader. Further that because general practitioners are accustomed to working in this environment, they have a wealth of experience and knowledge that those psychiatrists who have not been general practitioners do not have. This means that the general practitioners must have a voice in the debate.

Administrators have yet to understand that local ecological factors often frustrate their efforts to achieve the bureaucratic uniformity that tends to flow from policy. There is a real danger that policy grounded in 'evidence based medicine' might be too restrictive to allow local innovation. Moreover, administrators have often been preoccupied with imposing legal restraints on those doctors who have neglected their duties, or even abused their powers, in their care of the mentally disordered. They have not always understood that some abuses at least have arisen because of the doctors' frustration with a system that sets no limits on their responsibilities, or curbs unrealistic expectations of the public. For the system to function efficiently there has to be some understanding, at least at an operational level, of what conditions are not a medical responsibility. Criminal or other deviant behaviour, or ordinary distress should not be treated as medical problems. Doctors might be asked to advise about management, but this is not the same as accepting clinical responsibility.

To deal with these difficulties a more appropriate conceptual model of mental illness is proposed, which needs to be grasped by both doctors and administrators alike. Then, in Chapter 4, the views of doctors and administrators are sought in order to find practical ways of applying this model to make delivery systems more effective.

3.2.4: The Medical Model

Throughout history, the management of mental disorder has depended on measures derived from linear logic. Mental disorder has been construed as having a single cause, for which a single remedy could be found. With the decline in the belief in witchcraft in England during the 17th century, there came a renaissance of the Hippocratic method in medicine. Thomas Sydenham (1624 – 1689) believed that every kind of illness could be distinguished by its clinical picture and its natural history [Kraupl – Taylor 1966]. Nevertheless, the concept of disease is not necessarily constructed from symptoms and signs alone.

With the rapid progress of morbid anatomy during the 18th century, it was realised that it would be both possible and profitable to base the concept of disease on the pathological changes that could be observed in the affected organs. Foremost among the proponents of this view was Giovanni Morgagni, who was a professor at Padua for 56 years. In 1760, at the age of 79 years, he published the results of his enormous experience in his book: 'The Sites and Causes of Disease'. This classic work carefully records the history of the patient's disease and tries to relate the symptoms to the post – mortem findings [Singer 1944].

Following this line of thinking, Rudolf Virchow (1821 – 1902) relocated the source of disease inside the body, specifically within the cell. From being an attack from something outside the body, disease became a lesion within the body [Singer 1944]. An unfortunate consequence of this concept of 'disease as lesion' has been the tendency for some psychiatrists to believe that all mental illness has an organic substrate, that all mental disease is brain disease. Griesinger (1817 – 1868) was an early proponent of this view and was followed by Reil, who coined the term 'psychiatry' in 1908, and Kraepelin, who published his book in 1883. Although Kraft – Ebbing first used the term 'psychopathology' in 1875, he clearly expected any doctor treating a patient with psychiatric symptoms to search diligently for signs of pathology in the brain [Kraupl – Taylor 1966].

This biological approach to psychiatry postulates that: 'Mental events are but epiphenomena of cerebral processes whose occurrence and features will be, sooner or later, fully accounted for

by the neurosciences ' [Lipowski 1986]. In its simplest form, this view can be encapsulated in the Medical Model, which can be represented as follows,

Aetiology(I) -> Pathology(2) -> Clinical Picture(3) -> Diagnosis -> Treatment -> Course and Outcome.

The Medical Model is a linear model in that it assumes that the steps follow logically and predictably upon one another. Given knowledge of 1, 2 or 3 the other two can be inferred and the diagnosis made. Once the diagnosis has been made, the treatment, course and outcome follow predictably, a sequence that can be summarised as prognosis. Most medical students are still taught this model, with heavy emphasis on inferring aetiology and pathology from the clinical picture, then confirming the inferences by appropriate investigation. Nevertheless, the model is open to criticism on a number of grounds.

Firstly, there are pragmatic objections. Any graduates entering general practice will find this conceptual model limited and inadequate in their day to day work. Many illnesses presenting in primary care do not fit the customary diagnostic categories and, because they are self – limiting, the aetiology often remains obscure. Treatment is therefore symptomatic and the patient recovers before any definitive diagnosis has been made. Consequently, Arthur Koestler [1975] has argued that the Medical Model is just as limited and inadequate in medical practice as the concept of a flat earth is in navigation. The Medical Model has even more limitations for psychiatry and, if used uncritically, may lead to 'flat earth psychiatry', to paraphrase Koestler.

Secondly, there are philosophical objections. The Model is reductionist, and although there are different kinds of reductionism, the most widely held would seem to be causal reductionism, which supposes that mental events are caused by neurobiological events alone. One of the difficulties with this 'disease as lesion' approach is that similar neurobiological effects may produce widely disparate results. For example, it is possible to identify eight disorders with a shared pathological physiology: major depression, bulimia, panic disorder, obsessive disorder, attention deficit disorder, cataplexy, migraine and irritable bowel disorder [Karlsson et al 1995].

Moreover, several studies have shown that it is possible to modify the course of malignant disease or heart disease with psychosocial interventions, suggesting that, contrary to the usual view, psychological events can modify neurobiological events [Andrewes 1992]. It can also be argued that psychodynamic approaches are also essentially reductionist inasmuch as - causal explanations are reduced to only one class of putative aetiological factors [Lipowski 1986]. As a

result, adherents of these two opposing conceptual polarities have engaged in much specious argument over whether a particular condition is either organic or psychological in origin. Beahrs [1986] proposes a more useful approach that involves defining limits fundamental to our subject matter and progressing to a more flexible multiple systems - oriented thinking.

Considering the apparent inadequacies of the Medical Model, its survival over the years is somewhat surprising and it is prudent to examine the reasons. Firstly, the concept of reductionism has a long and venerable history. Although the concept antedates the 14th century, William of Occam, an English philosopher and theologian who studied and taught at Oxford from 1309 to 1319, expressed it succinctly. His name is given to the principle of economy in formal logic stated as 'Entia multiplicanda non sunt praeter necessitatem' (Things are not to be made more complicated than necessary) known as Occam's razor.

In the 18th century, the proposition that 'Every event has a cause' was considered by Kant (1724 - 1804) to be an a priori judgement common to all humans, a kind of filter through which our knowledge of the world is perceived [Hamlyn 1988]. In more modern times, the reductionist view can be seen in the early work of Ludwig Wittgenstein (1889 - 1951). It seems likely that the attitudes, beliefs and values associated with a reductionist philosophy are, as Kant suggested, now deeply ingrained in our culture, just as those associated with spirits and witchcraft were in the culture of the 15th, 16th and 17th centuries.

The retention of the Medical Model may well be part of the inherent conservatism of the medical fraternity in the same way that belief in demons was part of that of the ecclesiastical. Meaning structures are often system – bound, as Press [1982] has observed: 'Physicians as a group tend to share common modes of logic and sets of priorities distinct from those of their patients.'

Although authors such as Tatham [1987] and Koestler [1975], who have criticised the reductionist philosophy have not won general acceptance, the neuroscientists themselves are making new discoveries. These discoveries, far from reinforcing the reductionist philosophy, demand a paradigm shift. For example, the exploration of multilayered neural nets, which can be structurally modified by learning through neuroplasticity and neuromodulation, has given a much better understanding of the genesis of hallucinations and delusions [Spitzer1995].

Moreover, the Medical Model does have some value, especially in a hospital setting. Admitting a patient to hospital removes him from his ecological niche whilst absolving him, at least temporarily, of his responsibilities. Students are then taught how to treat patients in teaching

hospitals where the artificially simplified environment focuses attention on the pathology and makes the Medical Model workable. Unfortunately, of the 18-30% of people in the community with some kind of mental disorder only about 0.2 - 0.5% are admitted to hospital. Primary care physicians treat 40 - 80% of patients with mental disorders, many of whom do not reach the threshold for formal psychiatric diagnosis [Ustun & Gater 1994].

It follows that many of the concepts of conventional psychiatry are based on experience with a very limited, atypical sample of patients. Now psychiatrists have forsaken the citadel of the asylum and moved into the community, they have also moved conceptually much closer to general practice. For the community psychiatrist, the Medical Model displays all the inadequacies that it does for the general practitioner, making cooperation and mutual learning essential.

3.2.5: The Biopsychosocial Model

In 1910, Adolf Meyer proposed a dynamic origin for dementia praecox, which was in direct contradiction to Kraepelin's views. Moreover, Meyer proposed that the proper subject of psychiatry should be the patient as a whole, that is as a mind - body complex interacting with the environment [Lipowski 1986]. Following this lead, George Engel [1980] proposed his Biopsychosocial approach to medical practice, which is based on systems theory.

The systems view looks at the world in terms of relationship and integration. Systems are integrated and organised wholes whose properties cannot be reduced to those of smaller units. Systems theory deals with both animate and inanimate systems such as computer systems or complex chemical systems, but only living systems will be considered here.

Every organism is an integrated whole, a living system whose specific structure arises from the interaction and interdependence of the components [Capra1984]. The structure imposes a series of rules that limit the ways in which the simultaneous mutual interactions between the components are conducted. Systemic properties are destroyed when a system is dissected, either physically or theoretically, into isolated elements. Individual components can be discerned in any system, but the whole is always more than the sum of its parts. For example, a human nervous system is demonstrably composed of neurones, but the function of the brain cannot be conceived in terms of sequences of axonal impulses.

A system is dynamic in nature, which is to say its form depends on flexible, but stable manifestations of underlying processes. This internal plasticity creates a number of characteristic properties, such as:

- **Living systems are 'open' systems**

This means they maintain a continuous exchange of energy, matter and information with the environment in order to thrive in defiance of the second law of thermodynamics. Metabolism allows the system to remain in a state of organised non – equilibrium instead of decaying into disorganisation. Eventually the system dies but the species is preserved through reproduction.

- **Self – organisation**

The order is structure and function of a living system is not imposed by the environment but is established by the system itself. Although there is continuous interaction with the environment, the size of the system, for example, is determined by internal principles of organisation independent of environmental influences. Human beings for example, vary in size through quite a narrow range irrespective of where they live. The two principal and complementary phenomena of self - organisation are:

  - **Self renewal**

    This is the ability to renew and recycle their components whilst maintaining the integrity of the overall structure. For example, white blood cells are replaced about every ten days, most of the protein in the body is recycled within 3 – 4 weeks. It is as if the structure of a house were replaced one brick at a time so that after 3 weeks every brick has been replaced without any discernible change in the overall appearance of the house.

  - **Self - transcendence**

    This is the ability to reach out creatively beyond physical and mental boundaries in the processes of learning adaptation and evolution.

- **Fluctuations play a central role in the dynamics of self – maintenance**

Any living system can be described in terms of interdependent variables, each of which varies over a wide range between an upper and a lower limit. All variables oscillate between these limits, so that the system is in a state of continual fluctuation; such a state is known as homeostasis. Because of these fluctuations, the system has a range of options available for interacting with the environment. Negative feedback may occur to restore the original balance, but positive feedback may play a crucial role in adaptation. These changes may be considered in the short, medium and long term:

- Short Term: Reversible physiological changes which push one or several variables to extreme values; for example heart and respiration rates in climbing a mountain. These changes cause a loss of flexibility, which reflects throughout the whole organism.
- Medium Term: Longer term physiological changes occur to absorb environmental input and restore flexibility; for example adaptation to living at a high altitude.
- Long Term: Adaptation of the species through evolution. This genotypic change is irreversible within the lifetime of the individual.

- **Living organisms are systems which are embedded in complex ecosystems**

Like individual organisms, ecosystems are self – organising and self – regulating systems in which populations of organisms undergo periodic fluctuations .

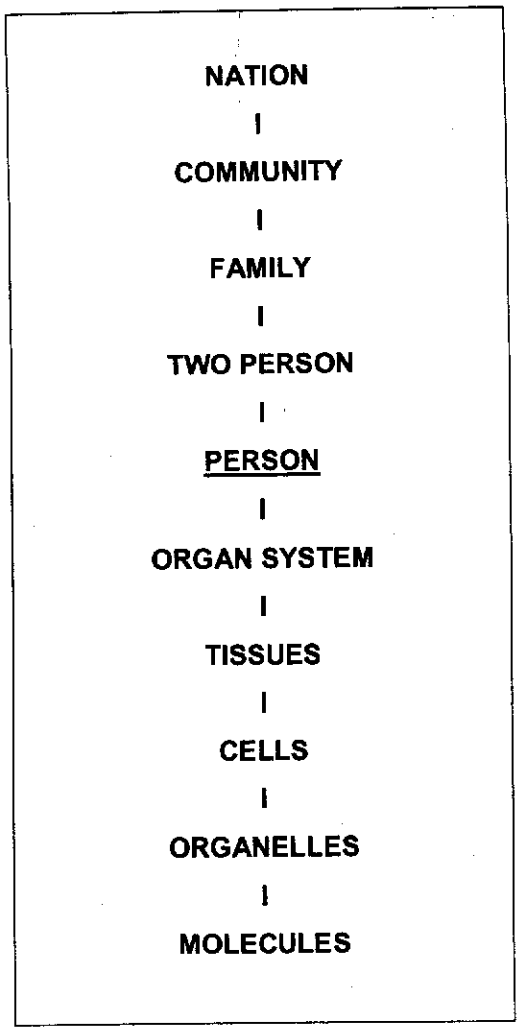
In this way, all living systems can be arranged in a hierarchy. Every organism is a system, which not only has component subsystems but is itself a component subsystem in a higher order system (See Fig.1) Whatever their level in the hierarchy, all systems retain their common features as well as their unique features. It follows that, because of the relationships between systems, disturbances at any level in the hierarchy may produce reflected disturbances up or down the hierarchy.

3.2.6: Disadvantages of the Biopsychosocial Model

Although the model is a significant step forward, it has some disadvantages, not the least of which is that it is not easy to use in clinical practice.

Firstly, although some progress has been made towards understanding the rules which govern the interactions between components of a system at any particular level of the hierarchy, very little is known about the way in which systems at one level influence systems at a different level. Certainly, the rules operating at any particular level are not applicable at another level. This has been stated in terms of 'emergent rationalism'. Higher levels 'emerge ' from lower ones. Emergence has two aspects – higher levels are dependent on lower ones, but are at the same time lawful in their own right. This means that the laws of the higher level are not generally deducible from the laws of the lower one. Higher levels host novel, emergent properties not found at the lower level [Karlsson & Kampinnen 1995].

Figure 3.2.6. The Hierarchy of Systems



Secondly, there is an inadequate explanation of how any particular system exchanges information with a different system. Schwarz & Wiggins [1986] have attempted to deal with this problem by analysing the role of structure in stabilising not only the internal transactions of a particular system, but also the external transactions with other systems. Structure limits by selection both the internal activities of the system as well as the environmental influences that will affect it, thereby reducing complexity. In biological systems this works through organic structures; for example, the retina of the eye selects only certain wavelengths of light as visible. At psychological and social levels, selection is achieved through 'meanings'. Meanings arise because present experiences and actions refer to certain other experiences and actions only, and eliminate reference to others.

By exercising the capacity for self - transcendence inherent in all systems, humans assimilate meanings through individual development and socialisation. There is progressive development

of a view of the world, which eventually becomes capable of appreciating that other people have potentialities for experience and action beyond those of the individual. These potentialities arise because others belong to different systems that provide different meanings. Meaning - structures are therefore, to some extent, system bound and systems at different levels may be involved in their development, for example, family, community, sub - culture, culture. It follows that meaning structures can influence, say, the interactions between the family and the community as well as the experiences and actions of the individual.

Thirdly, the Biopsychosocial Model does not, of itself, adequately account for the unpredictability of human systems. It is necessary to understand that the activities of any system as complex as a person are essentially non – linear or chaotic. The term 'chaos' is used to denote a form of time evolution in which two states that are initially very similar grow exponentially different with time [Firth 1991]. Chaos theory grew from the work of Edward Lorenz, who, in the early 1960's created a computer model for studying weather [Gleick 1991]. Initially the model worked well, but he then discovered, quite serendipitously, that rounding up figures for the variables from six decimal places to three produced a completely different weather pattern.

In other words, a change in initial temperature conditions of 1 /1000th of a degree C produced a weather pattern that became exponentially more different from the original with the passage of time. Given that a weather satellite is at the limit of its capacity to measure surface temperature with that degree of accuracy, it follows that long – range weather forecasting is impossible.

By analogy, it follows that, in any system as complicated as a human being, one can never know all the antecedent variables with sufficient accuracy to make exact prognosis possible. At best one can only make an informed guess, based on experience, empirical knowledge and intuition.

3.2.7: A Clinically Useful Model

With the foregoing considerations in mind, the most useful model for everyday clinical practice would seem to be the Ecological Model. Essentially, this model asks a series of questions that can all be answered according to the meaning - structures of the individual practitioner, allowing a truly eclectic, hermeneutic approach. The questions are:

What kind of patient?

Is confronting

What kind of environment?

With

What kind of consequences?

Requiring

What kind of interventions?

With

What kind of outcomes?

- **What kind of patient?**

This question permits an answer with a DSM IV, Axis II diagnosis, or a broader statement about personality type. Developmental issues can be couched in terms of genetically determined traits, as Eysenck's model [1965], or in terms of family influences such as Attachment Theory [Bowlby 1965] or Erikson's model [1965]. Current coping strategies or defence mechanisms can be listed as can strengths and vulnerabilities. Alternatively, a description can be given in terms of an existentialist framework, derived from philosophers such as Husserl, and favoured by practitioners such as Jaspers or Laing. The advantage of this last approach is that the patient can be seen in the framework of his own meaning structures, including the spiritual. This last is a sadly neglected area at present [Kroll 1995].

An understanding of the relationships between belief in souls, belief in spirits and dreaming [Jung 1960] is essential if we are to make sense of our patients subjective experiences. If mental health services in a multi - cultural society are to become more responsive to 'user' needs then eliciting the 'religious history' with any linked spiritual meanings should be a routine component of a psychiatric assessment, and of preparing a more culturally sensitive 'care plan' [Cox 1994]. Nevertheless, as Sims points out that psychiatry is not valueless. Just as the patient is embedded in the ecology of his own meaning systems, so is the psychiatrist [Sims 1994]. This is a reminder that the psychiatrist must be constantly on guard to avoid imposing a particular world view on a vulnerable patient, a world view that may include preconceptions about the value of autonomy versus the right to care.

- **What kind of environment?**

This may be answered with an Axis IV diagnosis or more broadly in terms of psychosocial stresses, precipitating or perpetuating factors. For workers in the community, a more formal needs assessment may be required [Wing et al 1993] which takes into account the views of the patient [Slade1994]. Appropriate weight can be given to environmental supports, such as- caring family; devoted spouse; housing advantages; occupational advantages; educational advantages etc.

- **What kind of consequences?**

This may be answered firstly in terms of Axis I and Axis III diagnoses. Secondly a more dynamic formulation can be given, linking the developmental issues with current psychopathology. A statement in terms of an Axis V diagnosis is also possible, as are statements concerning levels of disability, which is a considerable advantage in first episode psychoses [McGorry 1995].

- **What kind of Interventions?**

This question can be answered at three levels at least: Pharmacological, Psychological and Psychosocial. Psychological interventions can be framed in terms of different models such as cognitive/behavioural, supportive psychotherapy, dynamic psychotherapy or counselling. Psychosocial interventions may be at a practical level, such as the provision of accommodation or retraining in living skills, or at an interpersonal level, such as couple counselling. In addition, it is vital that the therapist grasps the implication of chaos theory that there are so many variables involved in human behaviour that the impact of any particular treatment modality is essentially unpredictable in the individual case.

- **What kind of outcomes?**

Answers to this question can be given at two levels, the level of patient improvement, both subjective and objective, and the level *of* service delivery. It is the latter that has created so much controversy. The initial assumptions were that that use of services implies 'cure', and the amount of use is related to the severity of the condition. It is now recognised that use is not necessarily 'cure' and that amount of use relates not only to the severity of symptoms and disability, but also to sociodemographic variables and the characteristics of the service [Jenkins 1990]. These difficulties remain unresolved.

3.2.8 Conclusions

A national survey of the mental health of Australians showed that 17.7% of the sample population had suffered from an anxiety, affective or substance abuse disorder in the previous year [Henderson et al 2000]. Only 32% of people with any mental disorder were seen by the health services during the survey year. Of those who sought treatment this was much more often from a general practitioner than a psychiatrist or a clinical psychologist. They also consulted their GPs much more frequently than those people with physical illnesses [Andrews et al 2001].

Socio – demographic variables accounted for much of the variation in consultation rates a change in mental health service delivery is clearly needed. Western Australia seems to be in a phase of 'ambivalent dual provision', when the decreasing numbers of institutional beds is not matched by a full range of 24 hour alternative services [Rosen 2000]. As Rosen says:

' This phase is commonly associated with a narrowing of intervention modalities to illness focussed biological treatments, rather than a repertoire of psychosocial or wellness orientated services.'

Rosen argues cogently for a service in which hospital and community services are integrated rather than balanced and, because most patients consult their general practitioners, it is imperative that primary care psychiatry be developed and integrated into the broader community services. For this integration to be successful, at least two fundamental changes will be required. Firstly, clinicians will have to adopt a broader, systems based concept of mental illness, such as the Ecological Model. Secondly, administrators will have to grasp the complexity of mental health service delivery systems.

This complexity is such that any single intervention may change the functioning of the whole system in unpredictable ways. The corollary to this is that changes should be small, incremental and based on local consensus of the stakeholders.

Attempts to drive change by administrative measures based on a particular ideology will inevitably lead to failure. Apart from the historical examples cited, the failure of Primary Health Care in developing countries is a notable recent example. The Alma – Ata Declaration of 1978 adopted the model of Primary Health Care (PHC), which involved universal, community based preventive and curative services with substantial community involvement. PHC did not achieve its goals, at least in part because experts and politicians in developed countries refused to accept the principle that communities should plan and implement their own health – care services. PHC was replaced by 'Health Care Reform', which was based on market forces and the economic benefits of better health [Hall & Taylor 2003].

Finally there are a number of fundamental problems with historical roots that need to be addressed, at least at an operational level. These include:

- The distinction between mental disorder and criminal behaviour

- The distinction between 'curable' and 'incurable' patients. As a corollary there should be some definition of the level of care that will be available to the incurable patients. There should be the psychiatric equivalent of 'palliative care'.
- The definition of what constitutes an 'emergency' situation and what should be an appropriate response in realistic rather than idealistic terms.

CHAPTER 4: FIELD WORK METHODOLOGY

4.1: Objective 2: The Views of Service Providers

In the previous chapter, the elements of an optimal mental health service were discussed and analysed (Objective 1). In this chapter, the extent to which service providers agree with such a model and how best to implement it, are considered.

In order to achieve this second objective, a number of key stakeholders - 24 GPs, 11 administrators and 15 psychiatrists - were interviewed. Some were interviewed individually, but others preferred to be interviewed in small groups of 2 - 4 persons. This was usually because of the convenience of holding the interview at the time of a scheduled professional meeting. As there was a financial and/or opportunity cost to the participants in granting the interview, every effort was made to suit their convenience. Each interview lasted 30 - 40 minutes and was tape recorded, except in the case of one general practitioner. This GP was very inhibited by the presence of a microphone, but had no objection to notes being taken of his comments. A printed summary of the purposes of the interview was provided to each stakeholder (see Appendix 1). A brief verbal explanation was also given and any questions answered. With the exception of the one GP, all persons approached gave written permission to be recorded (see Appendix 2).

4.1.1: The Selection of Questions

Each stakeholder was given a printed list of six basic questions prior to the interview (see Appendix 3). During the 7 months November 1998 – May 1999 Kathy Bruton, a GP Liaison Officer, and I visited 15 GPs in the Bentley area and 12 in the Armadale area. The meetings were conducted very informally and GPs were encouraged to discuss whatever topics they believed might help them to improve their management of psychiatric patients. The interviews were not formally recorded but brief notes were kept of important topics raised. These topics included:

- Role of the mental health services
- Referral to out – patient clinics and hospital
- Adolescent services and referral
- Crisis management of depressed patients
- Suicidal patients
- Presentations and management of 'difficult' patients
- Management of schizophrenic patients
- Specific disorders: post – traumatic stress disorders; post – natal depression; obsessive – compulsive disorder; dementias; somatisation disorders
- Specific treatments: antipsychotic medication, antidepressant medication.

The six questions were based on these findings and relate principally to Primary Care Psychiatry. The questions were constructed to be open – ended, neutral and non – leading in order to avoid imposing the author's values eg "What do you understand by Primary Care Psychiatry?" In addition it was made clear at the start of each interview that the questions were only intended as prompts and any topic that related to community mental health could be included in the comments.

4.1.2: The Derivation of Categories, Subcategories and Themes

Since the stakeholders were not selected at random and the interviews were comparatively unstructured, the numbers of comments have no particular significance. The interviews were tape recorded and transcribed verbatim apart from minimal editing of non – content phrases such as "Well", "OK" "You know what I mean?" and so forth. The transcripts were then read and when a new concept appeared it was given a category name, which was a subjective assessment of the most appropriate label for the information provided. In this way the major and minor categories were identified and were colour - coded on the transcripts. The major categories comprised comments that were responses to one of the prompt questions. The minor categories were unrelated to the questions but were topics raised during the course of the interviews that reflected specific concerns.

The comments within each colour - coded category were then read again and assigned to subcategories. The subcategories were chosen either on the basis of the number of comments elicited, which was taken to give some indication of the level of concern amongst the stakeholders, or on a subjective judgement of their significance based on the literature and experience. For example, in the category 'Access', the Subcategory "Use of the Private Sector" comprised 15 comments by 12 GPs. The Subcategory "Suicidal Risk", which had been expected to be a major concern for GPs, comprised only 3 comments by 2 GPs.

During the sorting into categories and subcategories some editing of the comments was made to reduce the redundancy and improve the flow, but as much as possible of the original was retained to preserve the meaning and the flavour of the comment. A number of comments were reassigned to different subcategories and some subcategories were renamed or collapsed into others to simplify the analysis. When the stakeholder made more than one comment in a subcategory these were recorded as separate paragraphs under the same identification. The categories and subcategories were then put onto a manual spreadsheet and checked numerically to ensure that no comments had been missed or counted twice. Referring back to the transcripts rectified any discrepancies.

Finally a number of Themes were identified within each subcategory. A theme either reflected the views of several of the stakeholders making comments within that subcategory or were judged to be significant perceptions by a few. Sometimes stakeholders made comments that were not germane to any of the themes identified, and sometimes long comments had more than one theme embedded; this latter situation was particularly true for mental health services staff. For these reasons the number of stakeholders contributing to each theme bears no direct relationship to either the number of stakeholders commenting or the number of comments in a particular subcategory. Tables have the same number as the paragraph they illustrate. Some particularly significant themes are illustrated by quotations of comments. There was some editing to reduce the redundancy and improve the flow, but as much as possible of the original comment was retained to preserve the meaning and flavour of the comment. Comments are enclosed in inverted commas: 'comment'. Words in italics were added to replace pronouns, to indicate that the comment was a response to a direct question or to clarify meaning that was lost by taking the comment out of context. To preserve confidentiality, the names of individual Community Teams, Hospital and Services have been deleted and shown only as (Team), (Hospital) or (Service). The stakeholders are identified by a capital letter with a prefix, **Dr A:** etc for GPs, **Ad A:** etc for administrators and **Psy A:** etc for psychiatrists.

4.2: The Units of Analysis

As anticipated, the stakeholders interviewed in groups made fewer comments than those interviewed individually. There were a number of reasons for this:

- The interviews were all roughly the same length, that is 30 – 40 minutes, which placed some limitations on the time available for each stakeholder to comment.
- Four GPs in the group interviews were called out to see urgent cases before the interviews were concluded. This did not happen with any of the GPs interviewed individually, even in single - handed practices. Neither did any of the administrators or psychiatrists have to leave before the end of the interviews.
- Occasionally when one stakeholder made a comment, the others merely signified agreement and moved on to the next topic.
- Sometimes stakeholders became preoccupied with a particular topic to the exclusion of others. For example, one GP who was interviewed individually, made no comment in the major category 'Primary Care', but made 6 comments in the minor category 'Substance Abuse'.

With the possibility of a group of stakeholders expressing a consensus, consideration was given to using the interview as the unit of analysis. That is to say that if, for example, one of a group of 4 psychiatrists made a particular comment, this should be multiplied by 4 to express a group

consensus. Further investigation revealed that this would imply a much greater degree of consensus than was present in reality. This investigation was in two parts, numerical and qualitative.

4.2.1: Numerical Investigation

The differences between the number of comments made by stakeholders interviewed individually as compared with those interviewed in groups is set out in Table 4.2.1:

With the GPs the larger discrepancy between those interviewed individually and those interviewed in groups was in the minor categories. These discrepancies are dealt with later. As there were only 7 comments in the Minor Categories for administrators and 6 for psychiatrists, these subdivisions have been ignored for these stakeholders in subsequent discussions. The discrepancies in the major categories are comparable with those for GPs.

Table 4.2.1: Stakeholders' Comments: Numerical Investigation

Stakeholders	Interviews	No. of Stakeholders	No. of Comments	Average per Stakeholder	Range	SD
General Practitioners	**Individual Major Cats.**	11	173	15.73	5 – 24	5.9
	Group Major Cats.	13	116	8.92	5 – 18	3.95
	Individual Minor Cats.	11	51	4.64	0 - 8	2.60
	Group Minor Cats.	13	7	0.54	0 – 3	1.05
Administrators	**Individual**	3	62	20.7	16 - 25	3.7
	Group	8	95	11.9	3 - 19	4.3
Psychiatrists	**Individual**	6	101	16.8	10 - 21	4.1
	Group	9	76	8.4	4 - 12	2.5

4.2.2: Qualitative Investigation

Although some stakeholders sometimes nodded assent to a particular point made by a colleague, it was considered that to assume that the whole group had achieved a consensus and weight the comments accordingly would not be justified. For example, there were 5 general practices involved in group interviews. One member of a practice of 3 made 2 comments in the category Primary Care whilst the other 2 made none and it would clearly be a major distortion to use a weighting of 6. Moreover, two GPs from one practice were interviewed individually as well as one from another practice in which three other members were interviewed as a group. There was little evidence of consensus in either of these practices. Accordingly, agreement was only assumed when a specific comment to this effect was made. In summary, there was thought to be sufficient overlap in the

number of comments made by each stakeholder and sufficient spread of comments within categories (details are set out below) to justify using the individual comments as the unit of analysis in what is considered to be essentially a qualitative study.

4.3: The Selection of General Practitioners

Objective 3 of the study is to develop strategies for a plan for the implementation of an optimal service in a local area; the Inner City Mental Health Service was selected for two complementary reasons. Firstly, as an inner city service, it can be expected to have a high level of psychopathology. Secondly it is a comparatively new service that, for a variety of reasons, has not yet achieved a high level of service integration. Specifically it has not achieved a high level of cooperation with GPs. For these reasons the GPs to be interviewed were selected from the Perth Division of General Practice. Twenty – four GPs were purposively selected so that there were 12 'Beacon' and 12 'non – Beacon' GPs. A 'Beacon' GP is defined as one who is participating in the Division's "Healthy Minds" programme; the inference being that these GPs have a particular interest in mental health issues.

Table 4.3: GP Interviews

Practice No.	Individual Interviews	Group Interviews
1	**Dr A(be)**	**Dr N(be);Dr O; Dr P**
2	**Dr B**	
3	**Dr C(be)**	
4	**Dr D(be)**	
5	**Dr E(be)**	
6	**Dr F(be)**	
7	**Dr G**	
8	**Dr H**	
9	**Dr I**	
10	**Dr J; Dr K**	
11		**Dr L; Dr M**
12		**Dr Q; Dr R**
13		**Dr S(be); Dr T(be); Dr U(be)**
14		**Dr V(be); Dr W; Dr X**

Three single - handed practices were excluded. One GP treated only Vietnam War veterans with post - traumatic stress disorder; another treated only cardiac patients with intravenous chelating agents. The third was quite prepared to be interviewed, but had no appointment system so was unable to set aside a particular time for interview. Of the 24 GPs interviewed, 11 were interviewed individually and 13 in two groups of 2 and three groups of 3. Four of the GPs interviewed individually were in single-handed practices but it was a personal preference for the other 7. The GPs are identified by capital letters. Where the GP is a Beacon GP he/she is further identified by the lower case letters **(be)** in parenthesis. Details are set out in Table 4.3. There were 12 "Beacon"

GPs, divided equally between the individually interviewed GPs and those interviewed in groups. Where the comments contained identifiably different content, these were recorded as separate paragraphs in the "Comments" section. On this basis, 347 comments were recorded altogether (Range 3 – 32; Average 14.46; SD 7.98).

4.4: The Selection of Categories and Subcategories for GPs

The categories and subcategories are set out in Table 4.4.

Table 4.4: Categories and Subcategories for GPs

Categories	Subcategories	Symbol
Major		
1. Primary Care	Role of the GP	ROL
	Use of a Community Team	UCT
	Difficulties in General Practice	DIF
	Counselling given by GPs	CON
	Financial Disincentives	DIS
	Care of GPs	CGP
	Use of the Divisional Psychologist	DP
	Doctor Shopping	SHO
2. Access	Use of the Private Sector	UPS
	Use of the Emergency Department	EMD
	Difficulty with Delays	DEL
	Difficulty with Boundaries	BON
	Difficulty with Access (Not Specified)	DAN
	Problems of Responsibility	RES
	Good Services	GSE
	Inadequate Services	INS
	One Off Consultations	OOC
	Failure of Response	FAL
	Suicidal Risk	SUR
3. Communication	Need for Advice	NFA
	Lack of Feedback	LOF
	Problems with Changes in Medication	MED
	Lack of Communication (Not Specified)	LOC
	Problems with Continuity of Care	CON
	Problems with Discharge Summaries	DIS
4. Education	Need for Information about Services	NIS
	Responses to the Need for Education	RNE
	Content of GP Training	CGP
	Adequacy of Undergraduate Training	UGT
	Value of Balint Groups	VBG
Minor		
5. Substance Abuse	Minor Problems with Substance Abuse	MIN
	Major Problems with Substance Abuse	MAJ
6. Problems with Youth	Major Problems with Youth	MPY
	Minor Problems with Youth	NPY
7. Problems with the Elderly	No subcategories	

4.4.1: Category Validation

In order to provide some validation for the categories and ensure that they reflected the substance of the comments, a Clinical Psychologist was asked to read the transcripts blind and derive her own set of categories. The list of categories that she defined, together with the corresponding set of categories and subcategories derived by the author, are shown below in Table 4.4.1. The subcategories are indicated by their symbols in parentheses, for example: Primary Care (ROL).

Table 4.4.1: Comparison of Derived Categories

Psychologist's Categories	Author's Categories
Primary Care Psychiatry Defined	Primary Care
Diagnoses seen by GP	Primary Care
Adolescent patients	Problems with Youth
Elderly Patients	Problems with the Elderly
Substance Abuse patients	Problems with Substance Abuse
Accessibility:	
Regional Boundaries	Access
Waiting times	Access
Shoved around services	Access
Emergency and after hours support	Access
Feedback and Follow - up	Communication
Item for Counselling	Primary Care
Relationship with Mental Health Services	Access
Private system	Access
Education:	
Groups	Education
Education by Divisions	Education
One - off consultations	Access
Shared Care	Primary Care

There is broad agreement between the two sets of categories. Specifically, there are no items in the Psychologist's list that are not matched in the author's list. Accordingly, it was deemed appropriate to proceed with the categories as devised. When the comments had been classified into categories and subcategories, an attempt was made to identify the dominant themes in each subcategory. Again, themes were defined either as the common concerns of several GPs or a judgement was made as to the significance of the concerns of one or two GPs.

4.5: Within Group Differences

4.5.1: Beacon vs. Non – Beacon GPs

There were 12 Beacon and 12 non – Beacon GPs. Since the Beacon GPs appeared to show more interest in the psychological aspects of their work by enrolling in the "Healthy Minds" programme, it

was supposed that they might make more comments than their non – Beacon colleagues. The results are set out in Table 4.5.1.

The Beacon GPs did in fact make more comments than the non – Beacon GPs but the differences were minor. It was not possible to make any assessment of the quality of the comments. Accordingly any differences in Beacon and non – Beacon GP comments have been ignored in further analyses.

Table 4.5.1: Beacon vs. non – Beacon GPs

	Beacon GPs (n = 12)		Non – Beacon GPs (n = 12)	
	Major Categories	**Minor Categories**	**Major Categories**	**Minor Categories**
Total Comments	163	26	126	32
Range	3 – 24	0 – 8	5 – 24	0 – 8
Average	13.58	2.17	10.5	2.67
SD	5.99	2.64	5.56	2.92

4.5.2: Male vs. Female GPs

Anecdotally, lady doctors are more able to relate emotionally to their patients, and for this reason it was thought that they might make more comments than their male colleagues. There were 10 female and 14 male GPs. As there seemed to be little to be gained by analysing major and minor categories separately, the figures were taken for all categories. The results are set out in Table 4.5.2.

Table 4.5.2: Male vs. Female GPs

Figures for all categories	Male GPs (n = 14)	Female GPs (n = 10)
Total Comments	227	120
Range	6-32	3 – 26
Average	16.2	12.0
SD	8.7	6.04

The apparent gender differences are accounted for by 9 males being interviewed individually and 5 in groups; the comparable figures for the females were 2 and 8 respectively. The results are set out in Table 4.5.3.

Table 4.5.3: Individual vs. Group Interviews for GPs

Figures for all Categories	Individual Interviews		Group Interviews	
	Male (n = 9)	**Female (n = 2)**	**Male (n = 5)**	**Female (n = 8)**
Total Comments	181	43	46	77
Range	8 – 32	17 – 26	5 – 18	3 – 15
Average	20.1	21.5	9.2	9.6
SD	7.88	4.5	4.87	3.53

Again it was not possible to evaluate the quality of comments: gender differences have been ignored in subsequent analyses.

4.5.3: Individual vs. Group Interviews: Minor Categories

In the minor categories the 11 GPs interviewed individually made 51 comments (Range 0 – 8; Average 4.64; SD 2.60) whereas the 13 GPs interviewed in groups made only 7 comments (see Table 4.2.1). However, a few GPs at the extremes of the range brought about this apparently significant discrepancy. Comments in the category "Substance Abuse" accounted for 33 of the total of 58 comments made in all three of the minor categories. There were 4 GPs who made 4,4,6 and 6 comments respectively, accounting for 20 of the 33 comments. The two who each made 6 comments seemed to have particular difficulties.

4.6: The Selection of Mental Health Service Staff

Although the 3 psychiatrists and one administrator from the Inner City Service were of particular interest in the context of implementing a service, it was thought that a broader range of opinions was necessary. Specifically, it was considered possible that different types of service delivery might have different approaches to integrating with primary care. Four different types of mental health service delivery were identified:

- Two teaching hospitals with both in - patient and community based services (Royal Perth and Fremantle).
- Two District General Hospitals with both in - patient and community based services (Bentley and Joondalup).
- Three District General Hospitals with associated community based services (Swan, Osborne Park and Armadale).
- Four stand - alone community based clinics (Avro, Mirrabooka, Rockingham/Kwinana and Peel).

Exclusions:

The Senior Psychiatrist at Joondalup advised that no attempt had been made to establish any liaison with GPs. This was because there were only two staff psychiatrists and 450 GPs in the catchment area, which meant that the work involved would be overwhelming. Joondalup was therefore excluded.

No response was received to an approach to Osborne Park Hospital and Armadale was without a full time psychiatrist at that time; no response was received to an approach to Mirrabooka Clinic. Interviews were therefore conducted as set out in Table 4.6.

Amongst the Administrators there were two GP Liaison Officers. Both had nursing backgrounds, but were working predominantly as administrators to improve liaison between GPs and Mental Health Services. Two of the other 9 administrators came from backgrounds in medical administration; two came from backgrounds in nursing, two from social work, two from psychology and one was medically qualified. Six were female and 5 male. There were 10 male and 5 female Psychiatrists

Table 4.6: Mental Health Service Interviews

Service Delivery Site	Psychiatrists	Administrators
Royal Perth Hospital	3	1
Fremantle Hospital	1	2 (joint interview)
Bentley Hospital	3 (joint interview)	2 (joint interview)
Swan District Hospital	4 (joint interview)	1
Avro Clinic	2 (joint Interview)	0
Rockingham/Kwinana Clinic	1	1
Peel Clinic	1	2 (joint interview)
Mental Health Division		2 (joint interview)
Total	**15 (7 interviews)**	**11 (7 interviews)**

4.7: The Selection of Categories and Subcategories for MHS Staff

The comments of the mental health services staff were similarly grouped into categories and subcategories using essentially the same approach as with the GPs. Themes were also identified within each subcategory using the same criteria. There were 7 major categories and one minor category common to both Administrators and Psychiatrists. Psychiatrists had an additional major category "Barriers to Change". Administrators had an additional minor category "Poor relationships with GPs". These are set out in Tables 4.7.1 and 4.7.2.

Table 4.7.1: Categories for Administrators

Categories Major	Number of Subcategories	Number of Comments
Factors in good relationships	6	21
Need to deal with GPs' Problems	4	28
Need for training for MHS staff	5	34
Problems in communication	4	20
Use of the multidisciplinary team	4	21
Variability of response from GPs	3	13
Primary care psychiatry	2	13
Minor		
Referrals from other agencies	2	4
Poor relationships with GPs	0	3
Totals	**30**	**157**

The congruence of the categories was interpreted as an internal validation of them so that further external validation was not considered necessary. The author has worked in all 4 hospitals selected, which might have been a contributory factor.

Table 4.7.2: Categories for Psychiatrists

Categories Major	Number of Subcategories	Number of Comments
Factors in good relationships	4	18
Need to deal with GPs' problems	4	41
Need for training for MHS staff	2	27
Problems in communication	3	17
Use of the multidisciplinary team	3	10
Variability of responses from GPs	3	12
Primary Care psychiatry	3	20
Barriers to change	5	26
Minor		
Referrals from other agencies	2	6
Totals	**29**	**177**

4.8: Within Group Differences

4.8.1: Individual vs. Group Interviews

The figures for Administrators and Psychiatrists from Table 4.2.1 are recapitulated in Table 4.8.1.

Table 4.8.1: Individual vs. Group interviews (MHS Staff)

Stakeholders	Interviews	No. of Stakeholders	No. of Comments	Average per Stakeholder	Range	SD
Administrators	Individual	3	62	20.7	16 - 25	3.7
	Group	8	95	11.9	3 - 19	4.3
Psychiatrists	Individual	6	101	16.8	10 - 21	4.1
	Group	9	76	8.4	4 - 12	2.5

These figures compare with: 173 comments, an average of 15.7 (SD 5.9) for those GPs interviewed individually and 116, an average of 8.92 (SD 3.95) for those interviewed in groups respectively.

However, two trends were noted for Administrators that were quite different from the GP interviews. Firstly, when interviewed in pairs the administrators were much more likely than the GPs to pick up topics from one another. The number of categories in which both partners made comments were 5,5,2 and 1 for each pair respectively. Secondly, the Administrators tended to make much longer comments, which tended to reduce the total number of comments. The Psychiatrists also tended to make longer comments than the GPs but the tendency to pick up

topics from one another was less marked. When the group of 4 was interviewed, there was only one category in which all 4 made comments ("The Need for Training MHS Staff").

4.8.2: Male vs. Female

The figures for male and female MHS staff are set out in Table 4.8.2.

Table 4.8.2: Male vs. Female (MHS Staff)

Figures for all Categories	Male Administrators (n = 5)	Female administrators (n = 6)
Total Comments	71	86
Range	3 – 25	10 – 21
Average	14.2	14.3
SD	7.52	3.59
	Male Psychiatrists (n = 10)	Female Psychiatrists (n = 5)
Total Comments	136	41
Range	7-21	5 – 12
Average	13.6	8.2
SD	5.14	2.99

There are no marked differences between the numbers of comments made by male and female administrators respectively. The apparent differences between male and female psychiatrists are accounted for by Individual vs. Group Interviews, all 5 female psychiatrists being interviewed in groups.

Four male psychiatrists were interviewed in groups. They made a total of 35 comments (Range 7 – 11; Average 8.75; SD 1.48). Again it was not possible to evaluate the quality of comments: gender differences have been ignored in subsequent analyses.

CHAPTER 5: THE VIEWS OF GENERAL PRACTITIONERS

5.1: Major Categories

5.1.1: Primary Care

This category comprised 8 subcategories as set out in Table 5.1.1.

Table 5.1.1: Primary Care: Subcategories

Subcategory	Subcategory Symbol	Number of GPs Commenting	Number of Comments
Role of the GP	ROL	16	35
Use of a Community Team	UCT	9	14
Difficulties in General Practice	DIF	7	13
Counselling given by GPs	CON	8	11
Financial Disincentives	DIS	7	7
Care of GPs	CGP	3	5
Use of the Divisional Psychologist	UDP	5	5
Doctor Shopping	SHO	2	2
Total Comments			**92**

The category "Primary Care" contained comments that were mostly prompted by the first four questions (What do you understand by Primary Care Psychiatry? What do you believe is its relationship to Mental Health Services? What do you believe is your role in the area of Primary Care Psychiatry? and What special skills do you bring to this area?

5.1.2: Access to Mental Health Services

This category comprised 11 subcategories as set out in Table 5.1.2.

Table 5.1.2: Access to Mental Health Services: Subcategories

Subcategory	Subcategory Symbol	Number of GPs Commenting	Number of Comments
Use of the Private Sector	UPS	12	15
Use of the Emergency Department	EMD	15	15
Difficulty with Delays	DEL	11	12
Difficulty with Boundaries	BON	6	9
Difficulty with Access (Not Specified)	DAN	6	8
Problems of Responsibility	RES	6	8
Good Services	GSE	7	7
Inadequate Services	INS	4	7
One - Off Consultations	OOC	5	6
Failure to Respond	FAL	4	5
Suicide Risk	SUR	2	3
Total Comments			**95**

Comments in this category were mostly prompted by Question 6 (How do you think the Mental Health Services might be improved?).

5.1.3: Communication with Mental Health Services

This category comprised 6 subcategories as set out in Table 5.1.3.

Table 5.1.3: Communication with Mental Health Services: Subcategories

Subcategory	Subcategory Symbol	Number of GPs Commenting	Number of Comments
Need for Advice	NFA	16	16
Lack of Feedback	LOF	6	7
Problems with Changes in medication	MED	5	5
Lack of Communication (Not Specified)	LOC	6	6
Problems with Continuity of Care	CON	4	6
Problems with Discharge Summaries	DIS	1	1
Total Comments			**41**

Again, comments in this category were mostly prompted by Question 6 (How do you think the Mental Health Services might be improved?).

5.1.4: Education

This category comprised 5 subcategories as set out in Table 5.1.4:

Table 5.1.4: Education: Subcategories

Subcategory	Subcategory Symbol	Number of GPs Commenting	Number of Comments
Need for Information about Services	NIS	11	19
Responses to the Need for Education	RNE	12	15
Content of GP Training	CGP	8	11
Adequacy of Undergraduate Training	UGT	7	9
Value of Balint Groups	VBG	6	6
Total Comments			**61**

Comments in this category were mostly prompted by Question 5 (What assistance, if any, do you believe you need to enhance your performance in this area?)

5.2: Minor Categories

5.2.1: Substance Abuse

This category comprised 2 subcategories as set out in Table 5.2.1.

Table 5.2.1: Substance Abuse: Subcategories

Subcategory	Subcategory Symbol	Number of GPs Commenting	Number of Comments
Minor Problems with Substance Abuse	MIN	10	19
Major Problems with Substance Abuse	MAJ	5	14
Total Comments			**33**

5.2.2: Problems with Youth

This category comprised 2 subcategories as set out in Table 5.2.2.

Table 5.2.2: Problems with Youth: Subcategories

Subcategory	Subcategory Symbol	Number of GPs Commenting	Number of Comments
Major Problems with Youth	MPY	6	8
Minor Problems with Youth	NPY	3	4
Total Comments			**12**

5.2.3: Problems with the Elderly

There were no subcategories in this category, as shown in Table 5.2.3.

Table 5.2.3: Problems with the Elderly: Category

Subcategory	Subcategory Symbol	Number of GPs Commenting	Number of Comments
Problems with the Elderly	PEP	10	13
Total Comments			**13**

Overall, the three minor categories were mostly concerned with topics that were not prompted by the basic questions but came up in conversation, or were responses to specific questions.

5.3: Themes Identified

5.3.1: Primary Care: Summary and Selected Comments

Table 5.3.1 provides information about identified themes related to primary care.

Table 5.3.1: Primary Care: Themes Identified

Subcategory	Theme	Symbol	Number of GPs Commenting
Role of the GP	Concepts of Primary Care Role of the GP in managing mentally disordered patients	**ROL 1** **ROL 2**	**8** **4**
Use of a Community Team	Satisfaction with the role of the team Dissatisfaction with the role of the team	UCT 1 **UCT 2**	5 **4**
Difficulties in General Practice	Difficulties with diagnosis or management Difficulties in persuading patients to accept treatment	**DIF 1** DIF 2	**5** 2
Counselling given by GPs	The kinds of counselling given by GPs Constraints on giving counselling	CON 1 **CON 2**	5 **5**
Financial Disincentives	Meeting patients' needs regardless Constrained by finances	DIS 1 DIS 2	4 2
Care of GPs	Need for emotional support	CGP 1	3
Use of the Divisional Psychologist	Helpfulness of this service	DP1	5
Doctor Shopping	Problems	SHO 1	2

Selected Comments from Highlighted Themes:

Theme:

- **ROL 1:** Concepts of Primary Care: Illustrative Comment

Dr A(be): 'My understanding of *Primary Care Psychiatry* is psychiatry within the global community treated by the primary care physician and the community mental health services that deliver health care to that primary care psychiatry group that we have in common.'

- **ROL 2:** The Role of the GP in managing mentally disordered patients: Illustrative Comment

Dr P: 'As GPs we have an integral role *in the mental health system.* I think we actually maintain our patients. I think the psychiatrists see the very dramatic episodes of their conditions, but we see them on a weekly or a monthly basis.'

- **UCT 2:** Dissatisfaction with the role of the team: Illustrative Comment

Dr G: 'I've tried the community nurse coming out, but in a lot of those cases a lot of times they don't come out – not immediately. With one I rang the psychiatry registrar and they said they were

going to get a nurse to come out and visit, or at least ring. In a day or two nothing had happened and I was quite upset about that.'

- **DIF 1:** Difficulties with diagnosis or management: Illustrative Comment

Dr E(be): 'Somatisation is a large problem. It's quite easy to pick the chronic somatiser because of the chronicity and the fleeting nature of the symptoms as they move from one system to another. It's picking someone with very focussed symptoms such as chronic myalgia or chronic headache, chronic lethargy.'

- **CON 2:** Constraints on giving counselling: Illustrative Comment

Dr G: 'I couldn't say I do a lot *of my own counselling*. I think we all do a bit you know, but you don't have time to do much. Somebody who needs a prolonged type of psychotherapy – I don't have the time, I send them somewhere else if I can.'

5.3.2: Access: Summary and Selected Comments

Table 5.3.2 provides information about identified themes related to access.

Table 5.3.2: Access: Themes Identified

Subcategory	Theme	Symbol	Number of GPs Commenting
Use of the Private Sector	Private sector as first choice Financial problems for patients Dissatisfaction with private sector	**UPS 1** UPS 2 UPS 3	**7** 2 2
Use of the Emergency Department	Use of the ED as a last resort Satisfactory service from the ED	**EMD 1** EMD 2	**9** 3
Difficulty with Delays	Delays for patients not in crisis Delays for patients in crisis	**DEL 1** DEL 2	**8** 2
Difficulty with Boundaries	Difficulty with catchment areas	**BON 1**	**5**
Difficulty with Access (Not Specified)	Systemic difficulties with access	**DAN 1**	**6**
Problems of Responsibility	Teams being defensive Responsibility of non – psychiatrists Problem of labelling	RES 1 RES 2 RES 3	4 1 1
Good Services	Particular teams provide a satisfactory service	**GSE 1**	**7**
Inadequate Services	Lack of services for high – prevalence disorders	INS 1	4
One Off Consultations	One – off consultations as an appropriate response	**OOC 1**	**5**
Failure of Response	Delays in response to crisis Selectivity in response to crisis	FAL 1 FAL 2	2 2
Suicide Risk	Difficulty of assessing suicidal risk	SR 1	1

Selected Comments from Highlighted Themes:

Theme:

- **UPS 1:** Use of the private sector: Illustrative Comment

Dr. A(be): 'Yes. In psychiatry I use the private sector quite extensively. There are some private psychiatrists who will bulk bill. I am aware of which ones they are. The private sector would be my first choice. Where possible I often use that. I think probably the convenience and the earlier referral; the patient can be seen in the earlier stages.'

- **EMD 1:** Use of the Emergency Department: Illustrative Comment

Dr. M(be): 'No, I haven't *used the Emergency Department,* I haven't needed to. But I would do my best to avoid it – it's such a chaotic place. Sending someone with a psychosis to (Hospital), you just find that they abscond and don't get treated properly, waiting for hours to get sorted out'.

- **DEL 1:** Delays for patients not in crisis: Illustrative Comment

Dr. W: 'The other point I must make is we seem to see a lot of psychiatry in general practice and invariably, in our practice, we don't pass them on for referral unless they are quite difficult. We've had a go ourselves, which usually means by the time we refer them on they are quite urgent. It's quite frustrating to have these long delays - there's a several week delay for a psychiatric opinion.'

- **BON 1:** Difficulty with catchment areas: Illustrative Comment

Dr. D(be): 'The thing about all the rules and things like that - a certain area will draw from certain postcodes. There are so many different things that I suppose it does make things a bit more complicated, but I can understand a system like that would have to be in place. But then there must be a clear definition for those postcodes. Send patients here, so that we don't waste time with inappropriate referrals and the waste of another few weeks.'

- **DAN 1:** Systemic difficulties with access: Illustrative Comment

Dr. J(be): 'From my experience it always seems the difficulty is in access. When I get to the point in managing a patient where I feel I need a bit of help, I can't really go much further or I need expertise to continue, there always seems to be a big gap before that can occur. I guess that's part of the public system.'

- **GSE 1:** Particular teams provide a satisfactory service: Illustrative Comment

Dr. F(be): 'At the moment most of my patients that need help go to (Team) and I actually do find them very good. (Team) I don't find great and I also have one patient who goes to (Team). I've only got one patient but she can never access help when she needs it up there.'

- **OOC 1:** One off consultations as an appropriate response: Illustrative Comment

Dr. I: 'Yes. Often having them seen by a psychiatrist or a psychiatric registrar would be sufficient to reassure the patient that they are being cared for and reinforce their need for medication or for whatever other care is required. Then you will be able to carry on providing that care.'

5.3.3: Communication: Summary and Selected Comments

Table 5.3.3 provides information about identified themes related to communication.

Table 5.3.3: Communication: Themes identified

Subcategory	Theme	Symbol	Number of GPs Commenting
Need for Advice	Value of telephone advice	**NFA 1**	**6**
	Value of verbal advice	**NFA 2**	**4**
	Advice not readily available	NFA 3	4
	Value of personal contact	NFA 4	2
Lack of Feedback	Lack of feedback from GP to psychiatrist	LOF1	1
	Lack of feedback from psychiatrist to GP	**LOF2**	**4**
Problems Changes in Medication	Lack of timely information	MED 1	3
	Changes without discussion with GP	MED 2	1
Lack of Communication (Not Specified)	Lack of discharge planning	**LOC 1**	**4**
	Lack of communication from GP	LOC 2	1
Problems with Continuity of Care	Change of community team	CON 1	1
	Insufficient information for GP to be able to continue care	**CON 2**	**3**
Problems with Discharge Summaries	Delays in posting summaries	DIS 1	1

Selected Comments from Highlighted Themes:

Theme:

- **NFA 1:** Value of telephone advice: Illustrative Comment

Dr A(be): 'I think *the ability to phone a psychiatrist and talk about a case* is always of value, the reassurance. It is always of value and I don't have a problem, both at a teaching hospital or a private level. I've always been able to talk to the psychiatrist or the psychiatric registrar concerned.'

- **NFA 2:** Value of verbal advice: Illustrative Comment

Dr O: 'I realise that *talking to a doctor* may eliminate the need for a psychiatric referral, but I think in most cases if the GP feels that the patient does need a psychiatric assessment it's probably necessary, but obviously discussing the matter with a doctor then, if it can be left a couple of days the patient will feel better knowing it has been brought to the attention of the doctor.'

- **LOF 2:** Lack of feedback from psychiatrist to GP: Illustrative Comment

Dr B: 'Unfortunately, I don't always get enough feedback. Sometimes I send the patient there and I get a letter back and then the patient comes back and there's nothing after that. I can't mention specific cases but I get that problem from time to time'.

- **LOC 1:** Lack of discharge planning: Illustrative Comment

Dr J(be): 'She was discharged from (Hospital) in this case. I guess I've got the usual gripes there. It would be really helpful to know when people are discharged. Perhaps not acute admissions who don't need any follow - up particularly, but especially for people with chronic ongoing problems. First of all that they have been in hospital, because I didn't know she's been in hospital and secondly when she's discharged to know that she's been discharged and that there have been any changes to treatment or medication, what they are, and thirdly what follow - up may have been arranged from me. So I guess it gripes against the hospital specifically. I am not sure but I think it's a common complaint.'

- **CON 2:** Insufficient information for GP to be able to continue care: Illustrative Comment

Dr N(be): 'There have been lots of instances where I have had to call and most of the times the letters are done but not posted. So when you call the letter is available and they fax it, but we don't get it in time. I don't know the reason for that but if you can expedite that before the patient comes so that we know what is going on it is easy for us to continue care.'

5.3.4: Education: Summary and Selected Comments

Table 5.3.4 provides information about identified themes related to education.

Table 5.3.4: Education: Themes Identified

Subcategory	Theme	Symbol	Number of GPs Commenting
Need for Information about Services	Need for information about facilities available	**NIS 1**	**8**
	Need for information about protocols for access	NIS 2	4
Responses to the Need for Education	Impact of personality on patient's illness	RNE 1	1
	Value of Divisional and other programmes	**RNE 2**	**6**
	Value of community team training	RNE 3	1
	Value of postgraduate diploma	RNE 4	1
	Negative responses to need for education	**RNE 5**	**3**
Content of GP Training	Need for training in counselling	**CGP 1**	**6**
	Format of training	CPG 2	2
Adequacy of Undergraduate Training	Inadequacy of undergraduate training	**UGT 1**	**5**
	Adequacy of undergraduate training	UGT 2	2
Value of Balint Groups	Positive view of value of Balint groups	VBG 1	4
	Negative view of value of Balint groups	VBG 2	2

Selected Comments from Highlighted Themes:

Theme:

- **NIS 1:** Need for information about facilities available: Illustrative Comment

Dr. E(be): 'I think the big challenge for general practitioners is in fact knowing what are the services that are out there. There are so many services out there that we don't know about, large numbers of them, and who they specifically service, what they cost, are the services any good? Are the counsellors within them people of great experience, are they relative lay counsellors? We've all had a few nightmares of lay counsellors causing more harm than good and so I think this is an area that probably needs some regulation and accreditation to some degree as well.'

- **RNE 2:** Value of Divisional and other programmes: Illustrative Comment

Dr. N(be): 'It's good to have refresher courses I think. We do the depression programme in the Division and it's very helpful because you go for a little talk and you discuss your patients, that sort of thing. That definitely helps.'

- **RNE 5:** Negative Responses to need for education: Illustrative Comment

Dr G: 'The combination of bookwork and reports and all these things and seeing patients. I'm working 12 hours a day and I just don't want to do any more. It was OK when I was in my twenties but now I am nearly 67 I don't want it. So I am not looking for education much. I don't say that I don't want any education but I am too busy at the moment to be worried about it, and if I get into the semi – retirement situation where I am only working sessions, I'd ponder a bit of education to keep one going. Just right now I'm not interested.'

- **CGP 1:** Need for training in counselling: Illustrative Comment

Dr. E(be): 'The latter part of the morning was devoted to psychotherapeutic interventions and brief intervention type stuff. And how to handle certain difficult patients, that sort of thing. He gave us a framework, which gives us a greater form and structure than GPs perhaps are particularly used to. That in itself was quite an empowering sort of thing because when you get a difficult patient who comes in crisis or just dissolves in front of you, your first thought is where the hell do I start. And if the patient's lost it and the doctor's lost it then you're really in strife. So if GPs can in fact pick the best of some of the tools that are out there plus their often good experience base and combine the two, that would be very useful.'

- **UGT 1:** Adequacy of undergraduate training. Illustrative Comment
- **Dr. S(be):** 'As *an Australian* graduate I had very little training in general practice based stuff. We learned a lot about schizophrenia and a lot about severe depression and stuff that was hospital based but we got absolutely no training really in any sort of skills that would help in a general practice setting.' (The two GPs who considered their undergraduate training to have been adequate were both overseas graduates).

5.3.5: Substance Abuse: Summary and Selected Comments

Table 5.3.5 provides information about identified themes related to substance abuse.

Table 5.3.5: Substance Abuse: Themes Identified

Subcategory	Theme	Symbol	Number of GPs Commenting
Minor problems with Substance Abuse	Non Prescribing practices	**MIN 1**	**4**
	Problems with benzodiazepines	**MIN 2**	**7**
	Problems with amphetamines	**MIN 3**	**3**
	Problems with analgesics	MIN 4	4
Major problems with Substance Abuse	Substance abuse as significant problem	**MAJ 1**	**4**
	Problems with GPs being manipulated or intimidated	MAJ 2	1

Selected Comments from Highlighted Themes:

Theme:

- **MIN 1:** Non prescribing practices: Illustrative Comment

Dr. D(be): 'Seldom. I don't have a lot *of problems* because I give them the message clearly that I don't prescribe. It doesn't happen and the message gets out pretty quickly which doctors do, and which doctors don't and I tend to be a doctor who doesn't.'

- **MIN 2:** Problems with benzodiazepines: Illustrative Comment

Dr. Q: '*We used to have a problem with substance abusers.* We used to have a very large turn out. We seem to have cured it but we still do get it. They ask for benzodiazepines and "Rohypnol", and pain – killers when they are going off the heroin. We seem to get a lot of people like that.'

- **MIN 3:** Problems with amphetamines: Illustrative Comment

Dr. E(be): 'No, *I don't get kids coming in wanting amphetamines.* I think general practices as an entity rapidly establish a reputation for being a soft touch or being "Don't go there you are wasting your time". Most patients know that if they come in here. We have very very few - I can't remember the last time I saw a drug addict in here. I think it's probably the fact that any drug addict who comes in here knows they are going to get short shrift, although I'll embark on a 25 minute consultation with them as to why they should give it away and offer them all sorts of referrals and advice and help and God knows what else, which is exactly what they don't want - they just want the drug. So we don't have much of a problem in that regard and patients are encouraged to go to "Next Step" and if I see even a crack in the door, I'll get on to "Next Step" and organise a referral pro tem.'

- **MAJ 1:** Substance Abuse as significant problem: Illustrative comment

Dr. I: 'I don't think you can improve *the situation* because the individual will never accept responsibility. So it can't be improved. You can provide all the facilities available and it will never get any better. That sounds as if I'm giving up too soon but you can't provide change until they are ready to change. That's how I feel about it.'

5.3.6: Problems with Youth: Summary and Selected Comments

Table 5.3.6 provides information about identified themes related to problems with youth.

Selected Comments from Highlighted Themes:

Theme:

- **MPY 1:** Difficulties in forming therapeutic alliance: Illustrative Comment

Dr E(be): 'My perception of what I can do for the patient might not be the what they actually want from me whatsoever, and teasing out what they want from me and what I feel I can do for them and making sure they are not too far apart is a big challenge in adolescents.'

Table 5.3.6: Problems with Youth: Themes Identified

Subcategory	Theme	Symbol	Number of GPs Commenting
Major Problems with Youth	Difficulties in forming therapeutic alliance	**MPY 1**	**1**
	Drug and alcohol problems	**MPY 2**	**1**
	Lack of resources	MPY 3	1
	Preference to refer on	**MPY 4**	**3**
Minor Problems with Youth	Selection of GPs	**NPY 1**	**3**

- **MPY 2:** Drug and alcohol problems: Illustrative Comment

Dr I: 'Some drug and alcohol problems *with young people* and they are the most difficult to deal with and the least rewarding to deal with. There's never a resolution, there's never an effort, the effort has to be provided by anybody and everybody but they themselves. It's a hopeless situation, very unsatisfying.'

- **MPY 4:** Preference to refer on: Illustrative Comment

Dr G: 'We get a few children with disturbed behaviour, but again I usually send them to a paediatrician or a paediatric psychologist. *I* don't have many. I can't say that I have very many.'

- **NPY 1:** Selection of GPs: Illustrative Comment

Dr F(be): 'I don't really *get many problems with young people* . Personally I have a lot of older patients. There would be quite a significant number of them I'm treating for depression.'

5.3.7: Problems with the Elderly: Summary and Selected Comments

Table 5.3.7 provides information about identified themes related to problems with the elderly.

Table 5.3.7: Problems with the Elderly: Themes Identified

No Subcategories	Theme	Symbol	Number of GPs Commenting
	Good assessment services available	**PE 1**	**5**
	Difficulty in separating physical and psychiatric illnesses in the elderly	**PE 2**	**2**
	Inadequacy of community based support	PE 3	1
	Occurrence of family problems	PE 4	1

Selected Comments from Highlighted Themes:

Theme:

- **PE 1:** Good Assessment Services Available: Illustrative Comment

Dr C(be): 'For the elderly the diagnostic, the assessment type area is well supplied. If you want to get an elderly person assessed then that's easy. There are multiple ways of doing that. It's more the provision of services once you've assessed them and said what they need that's the difficulty. The actual services seem to have been cut down. There's a lot of focus on the assessment but really the focus should be on the provision of services. There's not much point in assessing people and you say they need home help and Silver Chain intervention and these services aren't available.'

- **PE 2:** Difficulty in separating physical and psychiatric illnesses: Illustrative Comment

Dr I: 'Recognising that depression may be a problem *in the elderly* and treating them accordingly. They have got so many other different medical problems that very often the last thing you think about is that depression may also be a problem that's affecting them more significantly. When that's recognised and you treat them along with all their other medication you find that they improve. Some of the ones who have been on long - term tricyclics, you invariably find they are having problems and you have to change to one of the newer ones. I've had that a few times.'

5.4 Summary

Many GPs had difficulty in perceiving primary care psychiatry as extending beyond the boundaries of general practice. Most perceived some limitations in their skills, generally in the area of management rather than diagnosis. Specifically, they identified difficulties in counselling. Most local graduates believed that their undergraduate preparation for general practice psychiatry had been inadequate and several suggestions were made as to how this might be rectified. All identified major difficulties with access to the mental health services. Most identified difficulties in communicating with mental health services. Most difficulties were in obtaining information, but some acknowledged that the information they provided was sometimes inadequate.

CHAPTER 6: THE VIEWS OF ADMINISTRATORS

The 11 administrators made 157 comments, which were grouped into 7 major and 2 minor categories with 30 subcategories, as set out earlier in Table 4.7.1.

6.1: Major Categories

6.1.1: Factors in Good Relationships

This category comprised 6 subcategories as set out in Table 6.1.1.

Table 6.1.1: Factors in Good Relationships: Subcategories

Subcategory	Symbol	Number of Administrators Commenting	Number of Comments
Provision of Support	POS	5	6
Memorandum of Understanding	MOU	4	5
"Front - end" working	FEW	3	4
First contact with Duty Officer	DOC	3	3
Informal Relationships	IIR	2	2
Brief Early Intervention	BEI	1	1
Total Comments			**21**

6.1.2: Need to Deal with GPs' Problems

This category comprised 4 Subcategories as set out in Table 6.1.2.

Table 6.1.2: Need to Deal with GPs' Problems: Subcategories

Subcategory	Symbol	Number of Administrators Commenting	Number of Comments
Consultation/Liaison	CL	7	10
Help without ownership	HWO	4	9
Education of GPs	EGP	5	7
GP Admissions	GPA	1	2
Total Comments			**28**

6.1.3: Need for Training for MHS Staff

This category comprised 5 subcategories as set out in Table 6.1.3.

Table 6.1.3: Need for Training for MHS Staff: Subcategories

Subcategory	Symbol	Number of Administrators Commenting	Number of Comments
Working in community	WIC	6	18
Understanding discharge process	UDP	4	4
Resistance to change	RTC	3	7
Limitations of clinics	LC	2	3
Improved outcomes for patients	IOC	2	2
Total Comments			**34**

6.1.4: Problems in Communication

This category comprised 4 subcategories as set out in Table 6.1.4.

Table 6.1.4: Problems in Communication: Subcategories

Subcategory	Symbol	Number of Administrators Commenting	Number of Comments
GPs' lack of understanding of MHS	LOU	4	7
MHS staff lack of understanding of general practice	UGP	3	5
Lack of feedback	LFB	3	5
Lack of MHS staff skills	LSS	3	3
Total Comments			**20**

6.1.5: Use of the Multidisciplinary Team

This category comprised 4 subcategories as set out in Table 6.1.5.

Table 6.1.5: Use of the Multidisciplinary Team: Subcategories

Subcategory	Symbol	Number of Administrators Commenting	Number of Comments
Relationships with non - medical members	RNM	5	9
Lack of resources	LOR	5	8
By - passing the Duty Officer	BDO	1	2
The GP as a community team member	GPT	1	2
Total Comments			**21**

6.1.6: Variability of Response from GPs

This category comprised 3 subcategories as set out in Table 6.1.6.

Table 6.1.6: Variability of Response from GPs: Subcategories

Subcategory	Symbol	Number of Administrators Commenting	Number of Comments
Importance of working at a local level	LLW	4	5
Lack of time for GP consultations	LOT	3	3
Level of GP interest	LOI	3	5
Total Comments			**13**

6.1.7: Primary Care Psychiatry

This category comprised 2 subcategories as set out in Table 6.1.7.

Table 6.1.7: Primary Care Psychiatry: Subcategories

Subcategory	Symbol	Number of Administrators Commenting	Number of Comments
Patient Population	PP	8	10
Involvement of Non - Government Organisations	NGO	1	3
Total Comments			**13**

6.2: Minor Categories

6.2.1: Referrals from Other Agencies

This category comprised 2 subcategories as set out in Table 6.2.1.

Table 6.2.1: Referrals from Other Agencies: Subcategories

Subcategory	Symbol	No. of Administrators Commenting	Number of Comments
Referrals from other agencies	ROA	1	1
Self - referrals	SR	3	5
Total Comments			**6**

6.2.2: Poor Relationships with GPs

This category had no subcategories, as set out in Table 6.2.2.

Table 6.2.2: Poor Relationships with GPs: Subcategories

Category	No. of Administrators Commenting	Number of Comments
Poor relationships with GPs	3	3
Total Comments		**3**

6.3: Themes Identified

6.3.1: Factors in Good Relationships: Summary and Selected Comments

This category comprised 6 subcategories as set out in Table 6.3.1.

Table 6.3.1: Factors in Good Relationships: Themes Identified

Subcategory	Theme	Symbol	Number of Administrators commenting
Provision of Support	Importance of support for primary care	**POS 1**	**5**
Memorandum of Understanding	Provision of information Local variations in memoranda	**MOU 1** **MOU 2**	**2** **2**
"Front – end" working	Importance of working with individual GPs Importance of working with Divisions of General Practice	FEW 1 FEW 2	1 1
First contact with Duty Officer	Importance of a satisfactory first contact	**DOC 1**	**3**
Informal Relationships	Importance of personal contacts	**IIR 1**	**2**
Brief Early Intervention	Importance of early intervention	BEI 1	1

Selected Comments from Highlighted Themes:

Theme:

- **POS 1:** Importance of support for primary care: Illustrative Comment

Ad K: 'I guess primary care psychiatry is GPs managing people with mental health concerns and mental health problems. I guess we cannot - it's not possible for a mental health service to manage all the people out there with mental health concerns, so if we are really sensible and we have some vision, we can support general practitioners, advise general practitioners, be there for them, have some face to face contact, have some form of education for general practitioners and they may do a better job. They are already doing a good job and it will reduce our work - load as well and I guess the primary outcome would be it helps our patients. It's a much more comprehensive way of managing somebody with better outcomes.'

- **MOU 1:** Provision of information: Illustrative comment

Ad A: 'Yes, an MOU. It's two things; it's information to GPs but it's also the process to very clearly determine what Mental Health Services can and cannot do. And what GPs are able to do. So I think that process is critical in developing good relationships with GPs. The other one that we've found for GPs, given their demand for the practice, is we've also given them information about sedation and the Mental Health Act. But the more important part is the resources that they can use in their local area where a client may have a relationship, a mental health problem, be it alcohol, be it relationship issues, be it adjustment disorder, and what appropriate agency can they refer to. So I think as well as the MOU between our Services, we are trying to give them information about where etc. they can refer clients to. I think there's a number of different mechanisms we can do to improve relationships with primary care. All of them take a degree of time, all of them take a degree of time from the practitioner who's involved but also time to get the relationships very clearly in place and having dividends over a longer period of time'.

- **MOU 2:** Local variations in Memoranda: Illustrative Comment

Ad E: 'No, I mean I think certainly the focus at the moment is the shared care and it's quite broad. You can look at consultation liaison and there's various models about how that might happen. But I guess whatever agreements you develop between the GPs and the Services will be talking about the particular models and what should happen and who should have responsibility, and how referrals should take place and all that sort of thing. And that may vary from place to place, depending on the resources and the particular needs.'

- **DOC 1:** Importance of a satisfactory first contact with a Duty Officer: Illustrative Comment

Ad A: 'I think first up in the Service the pivotal contact for a lot of GPs is the duty officer person who needs to be able to triage and make assessments about how quickly we need to respond. Most of the Services are trying to bring in a model that after three months review, information goes back to the GP. And GPs are saying that can be very brief, it can be by writing, fax or the least preferred model is the telephone contact - unless it's urgent.'

- **IIR 1:** Importance of personal contacts: Illustrative Comment

Ad H: 'I've noticed it more in the city. When I was in the rural areas you'd see the GP and your kid would be playing soccer with his kid or whatever else. But, hey, in the city a lot of our staff they don't live in the area or the GPs don't live in the area and so there needs to be extra work in the city about that interface stuff.'

6.3.2: Need to Deal with GPs' problems: Summary and Selected Comments

This category comprised four subcategories as set out in Table 6.3.2.

Table 6.3.2: Need to Deal with GPs' Problems: Themes Identified

Subcategory	Theme	Symbol	Number of Administrators Commenting
Education of GPs	Need to educate GPs	**EGP 1**	**5**
	Value of continuing education	**EGP 2**	**1**
	Value of GPs working in the mental health services	**EGP 3**	**1**
Help without ownership	Psychiatrists to do more consultative work	**HWO 1**	**4**
GP Admissions	Value of consultation – liaison	GPL 1	1
	GP Liaison Officer	**GPL 2**	**1**
	Value of a broad based approach	GPL 3	1
	Value of case conferences	GPL 4	1
	Value of practice visits	GPL 5	1
GP admissions	GPs admitting to general wards	GPA 1	1

Selected Comments from Highlighted Themes:

Theme:

- **EGP 1:** Need to educate GPs: Illustrative Comment.

Ad G: 'I feel some of the GPs are lacking very basic skills in counselling that they fear, I suppose, what they don't understand. I think because they are frightened of it they don't want to open a can of worms, as a lot of them say. They don't want to talk to the patient too much because they're frightened of what will come out.' (All 5 administrators agreed on the need to educate GPs but there were a number of opinions on whether this should be tackled at an undergraduate or postgraduate level, what topics should be taught and who should be involved).

- **EGP 2:** Value of continuing education: Illustrative Comment

Ad B: '(Name) Division has identified the GPs in their region who have a greater interest in psychiatry than the others, and so that was going to form the basis of our list. And because we are continuing to run the training program, each semester that that runs we add another three or four - however many - who are provided the advanced training. So I think the system that's running out here seems to be very pro-active. The general practitioners, from all accounts, seem to really value the Service highly and it's the sort of model now that (Name) Division are interested in as well, which is fantastic and so we're really looking forward to having the (Name) Service opened. We are already doing a lot of work with the (Suburb) GPs in the (Name) Division but that will just

cement it further because we will actually be in the area.' (Although only one administrator commented, there is evidence that will be discussed later that this is a useful approach to GP education).

- **EGP 3:** Value of GPs working in the mental health services: Illustrative Comment:
- **Ad A:** 'I think that the training can be done on a structured basis over time or even one-off sessions to up-skill general practitioners and I think we've had (Service) recently conduct quite a few seminars from GPs on Mental Health. I think the ones that benefit are the ones where there is some rotation of the GPs through the mental health services, so the relationship to the actual service is developed. I think the relationship between the primary care and mental health services is fairly critical and there needs to be some dialogue and meetings to occur for both parties to raise issues. I believe mental health services have to respond to GPs' demands, particularly in the acute assessment stage. I think most GPs are saying that's an area that they require urgent assistance.' (There is also other evidence that this is a useful way to educate GPs, at least in the way the services function: Buchan & Lowe 1995).

- **HWO 1:** Psychiatrists to do more consultative work: Illustrative Comment

Ad D: 'Well, that's what the Federal Government is trying to push. To gradually position psychiatrists from being therapists into remaining therapists but putting more time into consultative work. You've got to keep in mind that that if you just take an hour a week out of treatment and put it into evaluation, you're actually increasing your valuation by two or three times. Whereas your therapy diminishes almost imperceptibly. There's such a huge weight to treatment and such a small weight to the role of consultation that the slightest move makes a very big difference. (Name) in Victoria did this very successfully and was absolutely amazed by putting a couple more hours into evaluation the service he could give GPs was astounding. He developed a whole bunch of GPs who looked on him as a sort of provider of consultation and advice. It was quite dramatic and took very little time.'

- **GPL 2:** GP Liaison Officer: Illustrative Comment :
- **Ad B:** 'I think one of the things that would be of value with the development of (Clinic) is the trial of a GP liaison position. I think as it currently stands, it's the responsibility of everyone working in the adult service to fulfil that role and some people fulfil that to a higher level than others obviously. Having a designated role to progress that in the (Clinic) area will enable us to compare and contrast. And I guess if that's successful it would be a great way to enhance our service.' (Seven administrators agreed that this was an important concept, but there was no

consensus about how it should be implemented. There is evidence from services that have appointed GP Liaison Officers, which will be discussed later, that this is a useful approach).

6.3.3: Need for Training for MHS Staff: Summary and Selected Comments

This category comprised 6 subcategories as set out in Table 6.3.3.

Table 6.3.3: Need for Training for MHS Staff: Themes Identified

Subcategory	Theme	Symbol	Number of Administrators commenting
Working in the community	Need for changes in medical education	WIC 1	2
	Need for changes in nursing education	**WIC 2**	**3**
	Working in an integrated service	WIC 3	1
Understanding the discharge process	Need for GPs to have good information	**UDP 1**	**3**
	Value of cross barrier working	UDP 2	1
Resistance to change	Barriers between specialists and GPs	**RTC 1**	**1**
	Variable responses from hospital staff	RTC 2	1
	Uncertainties and the 'comfort zone'	RTC 3	1
Limitations of clinics	Need to understand environmental influences	**LC 1**	**2**
Improved outcomes for patients	Consideration for the patient.	**IOC 1**	**2**

Selected Comments from Highlighted Themes:

Theme:

- **WIC 2:** Need for changes in Nursing education: Illustrative Comment

Ad F: 'Secondly, I think that one would have to question the clinical exposure for people under the current program. The new (University) program for nurses is going to provide a lot more clinical time in the field. So to answer your question, there are difficulties putting people out into the Community to gain experience during their preparation and their immediate graduate year.

But until we do that, and whilst we continue to provide that experience in a setting such as a mental health institution or the general hospital, I don't think we are going to make sufficient progress in that area. There's a lot of work that needs to be done.' (Three administrators made comments, which reflected their professional backgrounds).

- **UDP 1:** Need for GPs to have good information: Illustrative Comment:

Ad A: 'And I think also discharge planning. In the past I think Secondary Mental Health Services actually just discharged clients to GPs. As we have gone down the path of supporting primary care, there's more emphasis from the GPs to want to have good discharge preparation before

clients are discharged from our Service. And that includes, both written and telephone contact before they are referred. The other area that I believe - this area has developed is a solid memorandum between both parties, which actually gives information about what each Service will do.'

- **RTC 1:** Barriers between specialists and GPs: Illustrative Comment:

Ad J: 'I can't see a way of that working here, the whole culture isn't set up around that. There seems to be a real barrier between general practitioners and hospitals and the stuff that (Name) is doing to me seems enormously sensible. Yet even within our own service, there is some resistance to that. It's all a bit different or a bit threatening, or a bit "Nothing to do with us. That's the stuff that general practitioners do and we're the specialists working in the 10-15% stuff." I think that's something we have to - I mean I think that's the really tough bit of (Name)'s job and she's only one person - I know she finds it frustrating. But I think it is up to people like (Name) and me to make it very clear that that's a priority for this service, that this is a priority. I don't think there's any disagreement about that.'

- **IOC 1:** Consideration for the patient: Illustrative Comment:

Ad J: ' It's interesting that all of those arguments don't at any point relate to the patient. And I think this is the disappointing thing. Much of it is related to peoples' own personal positions, their own personal prejudices and biases, rather than what's actually best for the patient. I think that has to be the censor check, is what we are doing in terms of GP liaison ultimately better for the patient.'

- **LC 1:** The need to understand environmental influences: Illustrative Comment:

Ad H: 'My experience in adult clinics is that makes you really put your energy behind it, the majority of assessments are going to be in the clinic. So you go from one room to another room. So again it's about how do you shape what community mental health is about. What the GPs are asking for is they don't want a clinic, they want somebody that's going to - my impression is - somebody they can refer to, but also somebody who's going to add something to their knowledge. The GP often knows Mum & Dad and auntie and uncle, and so we need to add to that and not just in terms of the symptoms and the signs and recommended dosage and this that and the other, but perhaps something about how to manage the crises when they arrive.'

6.3.4: Problems in Communication: Summary and Selected Comments

This category comprised 4 subcategories as set out in Table 6.3.4.

Table 6.3.4: Problems in Communication: Themes Identified

Subcategory	Theme	Symbol	Number of Administrators Commenting
GPs' lack of understanding of mental health services	Lack of benefit to mental health services	**LOU 1**	**1**
	GPs to work in mental health services	LOU 2	1
	Lack of information	**LOU 3**	**2**
MHS staff lack of understanding of general practice	MHS staff's misconceptions	**UGP 1**	**1**
	Lack of understanding by registrars	UGP 2	1
	Value of doctor to doctor links	UGP 3	1
Lack of feedback	Need to audit written information to GPs	LFB 1	1
	Bilateral failure to provide feedback	LFB 2	1
	GP as part of the treating team.	**LFB 3**	**1**
Lack of MHS staff skills	Inadequacy of undergraduate training	**LSS 1**	**1**
	Lack of skills in managing the interface	LSS 2	1

Selected Comments from Highlighted Themes:

Theme:

- **LOU 1:** Lack of benefit to mental health services: Illustrative Comment:

Ad C: 'I think a guideline would help. I guess we need to make it clear what our relationship should actually be as well, and what our expectations are. I think *that* now we have met their expectations in terms of providing them funding and allowing them to have a *psychologist's* position there and giving them the funds to do that, that has actually improved their service. I don't think we have benefited from it *in* any way. Maybe we have in the last couple of months. Prior to that I don't think we actually got anything out of this deal. I think it's got to be both ways. So we need to feel we are getting something back whether it be referrals or whatever, just to feel that we have a relationship.'

- **LOU 3:** Lack of information: Illustrative Comment:

Ad F: 'Historically, before mental health came on board here, (Hospital), for decades has been known as a surgical hospital. The surgeons used to operate and the GPs never got patients in, they could hardly ever get patients in. So as a result, you go out there, and even to this day, there'll be a lot of GPs in this area who wouldn't even know (Hospital) exists. And they had a Clinical Association, for example *at* (Hospital), which had its ups and downs, but it was pushed by certain interested parties. That degree of association between the hospital and the GPs does not exist at (Hospital). I think that's part of the problem. That's the difference.'

- **UGP 1:** MHS staff's misconceptions: Illustrative Comment:

Ad B: 'And that's been quite a shift because what *the psychiatrists* initially thought was "This is a great idea because the GPs will know better how to refer" "They'll know how to fill out the referral forms better." Which wasn't quite the emphasis behind the program. Now they're actually engaged with the general practitioners, and we've had quite a few who have been on sessional attachment to the adult service for a long time and are really highly valued members of the team. And I think that has gone a huge way to breaking down any misconceptions that may have existed in terms of the role of the general practitioner.'

- **LFB 3:** GP as part of the treating team: Illustrative Comment:

Ad C: 'And knowing *how the system works,* who they can contact, that's right. I mean obviously it's done that, having GPs into various clinics. I think it would be very beneficial for us to do that in the adult area as well. To actually have clinics for GPs to come in. Yes, *the problem is that you have to pay them for that,* but I think it is a worthwhile venture. I mean, how much money do we spend on things that we don't have any evidence work, and yet we just sort of commit lists of money. Let's use it for something beneficial that actually improves the efficiency of the Service.'

- **LSS 1:** Inadequacy of undergraduate training: Illustrative Comment:

Ad D: 'Well, actually the first part – *that undergraduate training is inadequate* - is true. They get about 400hrs of training in the undergraduate course now and one has to question why that doesn't adequately prepare them. In other words, what's the focus of that training? That's one issue. The issue about *registrars not understanding that their care goes beyond* the hospital walls - I think it isn't as true as it used to be. It is still true.'

6.3.5: Use of the Multidisciplinary Team: Summary and Selected Comments

This category comprised 4 subcategories as set out in Table 6.3.5.

Selected Comments from Highlighted Themes:

Theme:

- **RNM 1:** Attachment of staff to a GP's surgery: Illustrative Comment

Ad A: 'The other work we would like to see happen is the attachment model, where you have a nursing or Allied Health member of staff be the contact person for a GPs surgery. That has not yet been brought in, but in (Service) in particular, it's a model that's being mooted as the model to move into in the next 12 months. It will have our multidisciplinary professionals having GP Surgeries allocated to them and they can contact in there. In the (Service) area, because they are covering such a wide catchment area, there have been already GPs who have got set staff to contact in outlying areas like (Town) and (Town) So I think there's a lot of scope within that. The other one again, some professionals can also be available for joint assessments with GPs at the

start and GPs now have availability of funding if they need a consultant. So you can have meetings with GPs about particular clients. And I also believe particularly discharge planning - our best results tend to be from professionals who have a discharge plan. So I think there's a range of areas where professionals can be involved with general practice and I think also, if they have advice, even for clients GPs want to manage, can come back and get advice about particular disorders.'

Table 6.3.5: Use of the Multidisciplinary Team: Themes Identified

Subcategory	Theme	Symbol	Number of Administrators Commenting
Relationships with non – medical members	Attachment of staff to a GP's surgery	**RNM 1**	**3**
	Professionalism of non – medical staff	RNM 2	1
	Development of trust	**RNM 3**	**3**
Lack of resources	Training GPs with inadequate resources	**LOR 1**	**2**
	Lack of community trained nurses	**LOR 2**	**1**
	Bed closures	**LOR 3**	**1**
By – passing the Duty Officer	GP liaison staff might by – pass the normal intake procedure	BDO 1	1
GP as community team member	GP as a participant in care	GPT 1	1

- **RNM 3:** Development of trust: Illustrative Comment

Ad F: 'This would be part of the education process of the GP through the Division of General Practice and I think you also allow for the fact that they learn to have respect for one another. In other words, if the nurse were a good nurse, I think the time would come when this would be recognised. So it's a question of trust.'

- **LOR 1:** Training GPs with inadequate resources: Illustrative Comment

Ad A: I've seen services that have put some resources into their general practitioner training, even with very inadequate resources, into a good effect. I think we could always argue we need more but I think primary care is one area that regardless of the size of the service, we need to invest in over time with training, with some consultancy, with advice and developing relationship. I think that there is the schema between primary and secondary care, if we don't do that I think mental health services will be inundated of their resource base when it comes to clients who are being referred to them.'

- **LOR 2:** Lack of community – trained nurses: Illustrative Comment

Ad F: 'No, there are not *that many nurses who are trained in working outside institutions.* That can only be rectified by addressing some of the issues I've brought up about lack of funding to provide the opportunities for them to be there. We all know the almighty dollar seems to rule everything. But unless you do, you're not going to get anywhere. As far as training is concerned, we are training enough mental health nurses, it's quite interesting. Our own graduate program here will have 8 or 10 or 12 a year, depending on which year it is, but a goodly number do seem to be sufficiently interested to come back into mental health nursing. But again there's that other problem there. You go off and do a post-basic course, you're up for HECS fees and then you come back and there's no extra remuneration. It's the same with midwifery, the whole issue has to be looked at, that you can continue to be a Registered Nurse or a Comprehensive Nurse and you get good wages, but you go off and do other things and in the short term, and in the medium term, there's no financial remuneration. You'd have to question the whole way things are being done at the moment.'

LOR 3: Bed closures: Illustrative Comment

Ad F: '"How do you think the mental health services might be improved?" That's an interesting one. I can only speak for (Service). One of the things - I'll get back to it again - we are grossly under resourced for what we are doing. The funding, for example, that we get compared to (Service) is very much less. I think that - I get the impression that they are trying to close down on the beds and get people out into the community, but it seems to me they are doing it the wrong way round and they're cutting down the beds first and then putting in the services. Whereas, in fact, they need to seed the community services and then shut down the beds. You only have to look at what happened in the Eastern States to see the number of people out there also couldn't cope and then got themselves into trouble. A number of them ended up being shot by Police, so somewhere along the line someone has got to resource mental health a little better and also to recognise you need your community services before you shut beds.'

6.3.6: Variability of Response from GPs: Summary and Selected Comments

This category comprised 3 subcategories as set out in Table 6.3.6.

Selected Comments from Highlighted Themes:

Theme:

- **LLW 1:** Planning service delivery: Illustrative Comment

Ad B: 'One of the things that's been really valuable for me to understand in the last few months is the difficulties that (Service) faces in terms of the numbers of general practitioners actually available in their region. And that was drawn home to me through getting a copy of this Workforce Audit Report that was done on general practice and the (Service) region is one of the most

disadvantaged regions - certainly in the metro area - whereby what they've done is analyze the population by the number of practising GPs and we are up to one GP per 2,500 people in this region. I suppose what it does do is reaffirm views that we have that hadn't any concrete way of being able to measure just what the demands on GPs were. Certainly getting some data like that is quite important because when you compare that to, say, (Region) which is equally a socio-economically disadvantaged area, that their population ratio to GPs is one in 1300. (Region) is, I think, one in 1100, something like that and obviously the (Region) is much lower. I think the (Region) is one in 900. So when you are looking at those ratios, you think the GPs in this region, given the pressures, it just highlights their commitment even more. But it equally I guess, reaffirms the need for us to be much more understanding than perhaps sometimes we are in terms of the pressures that the GPs are under. Even though there have been all the recent changes in the Medicare Schedule for the GPs to be able to claim extra payment for case conferences and things like that, if they've got truckloads of patients waiting, then the changes to the Medicare Schedule are really of no consequence in some respects. So that's been quite valuable I think.'

Table 6.3.6: Variability of Response from GPs: Themes Identified

Subcategory	Theme	Symbol	Number of Administrators Commenting
Importance of working at local level	Planning service delivery Importance of Memoranda of Understanding	**LLW 1** LLW 2	**2** 1
Lack of time for GP consultations	Inadequate funding Inadequate time available	LOT 1 **LOT 2**	1 **2**
Level of GP interest	Different levels of interest	**LOI 1**	**3**

- **LOT 2:** Inadequate time available for GP consultations: Illustrative Comment

Ad I: 'I think it's more to do with time frames. I think GPs look at mental health clients in respect of time frames. How long they've got to deal with them rather than how they can deal with them. That would be my understanding. I think they tend to get very flooded by the symptoms and the treatment modalities. Generally the biggest feed back we've had from the GPs is the time frame involved with caring even in a GP relationship with someone that has mental illness.'

- **LOI 1:** Different levels of interest: Illustrative Comment

Ad H: 'I think that one of the other things that strikes me is that the GPs are clear that only about 20% of them have got a primary interest in mental health and so we've got to keep that in mind as well – that they are not all the same. So you get those GPs who are happy to say "I know very little" and will refer across very quickly, those with a moderate interest and are keen to have some

kind of learning and the very interested, and I guess just looking for assessment and advice and very happy to manage people. So there is a wide range.'

6.3.7: Primary Care Psychiatry: Summary and Selected Comments

This category comprises two subcategories as set out in Table 6.3.7.

Table 6.3.7: Primary Care Psychiatry: Themes Identified

Subcategory	Theme	Symbol	Number of Administrators Commenting
Patient populations	Wide scope of primary care psychiatry	**PP1**	**2**
	Nature of the target population	**PP 2**	**4**
Involvement of non – government organisations	importance of partnerships	NGO 1	1

Selected Comments from Highlighted Themes:

Theme:

- **PP 1:** Wide scope of primary care psychiatry: Illustrative Comment

Ad F: 'My understanding of primary care psychiatry is the involvement of the professional who really has the first association with the person who is suffering from a condition requiring expert help, out there in the community as opposed to a person who has been diagnosed and then has continuing care. So it's that first contact, whether it be nurses, or be doctors or for that matter any other person who is in a position to provide some assistance or direction. The reason why it's wider than general practice, you go out to the more remote parts of Western Australia and you haven't got those doctors. You have got the nurses there however. In fact, I think over the weekend it was recognised that nurses will take on a greater role in the absence of doctors.'

- **PP 2:** Target population: Illustrative Comment

Ad D: 'First of all I recognise that 70% of all mental health problems present to general practice and are dealt with in general practice. A relatively smaller percentage actually are dealt with by specialist services. And I have in mind a model that's with a fairly clear cut boundary primary care being general practice, community health centres and so on where people present, where they can be assessed by people who have reasonable skills in assessment and where first line treatment can be provided, especially counselling at the cognitive and advice level - not necessarily at the psychotherapeutic level. And of course the provision of antidepressants, tranquillisers and the like. I think then, because the primary care provider either wants more advice

on how to manage or feels unskilled or recognises that the patient has a more severe disorder that needs specialised care, a referral will be made to the consultative services, the specialist services where mental health professionals then undertake formal assessment etc. Now the outcome of that might be hospitalisation, continuation of treatment and so on, or referral back with advice and the opportunity for further consultations along the way. You're either talking about direct care by the primary services, which is probably the majority of cases, shared care which is quite a few and referred care by specialist services, the outcome being continuing care or referral back to *primary care*. That's the model I see.'

6.3.8: Referrals from other Agencies: Summary and Selected Comments

This category comprised two subcategories as set out in Table 6.3.8.

Table 6.3.8: Referrals from Other Agencies: Themes Identified

Subcategory	Theme	Symbol	Number of Administrators Commenting
Referrals from other agencies	Patients without GPs	**ROA 1**	**2**
Self – referrals	Problem with self – referrals	**SR 1**	**1**

Selected Comments from Highlighted Themes:

Theme:

- **ROA 1:** Patients without GPs: Illustrative Comment

Ad H: 'I see it a bit different than (Name), but then I think that's a different demographic profile as well. I've got a particular interest in Youth so I might as well put that on the table - that particular age group between 16 and 25, the majority of those people, males particularly, don't have a GP. And they have not seen a GP, some of them, for a decade. So conceptually, going back to your original question, I see primary care as GPs, as the Youth Sector, but there's also a couple of other significant minority groups that don't access us through GPs, no matter how much we try they are not going to. So Youth, if you want to take that broad approach, cut the cake that way, and other age groups, *(inaudible)* other ways to cut the cake. I see Aboriginals, they just don't go to their GPs and if they do, it could be all over the place. And there's a fairly significant Aboriginal community in both (Town) and (Town) for example. And there is here in (Town) as well and the other group which don't access GPs particularly well; which I'm not talking by race or by age, are people who are heavily into the drug culture. So whether you've got a relationship with Next Step or Palmerston or the Ministry of Justice or whatever, I think we look at each Community and target those most vulnerable groups. Now, this is the old Pareto effect isn't it? Eighty percent are going to come from one source, and that's about right for the GPs, but the other 20% I think, in my mind

conceptually, we need each community to look at there's 20% of people who fall under some other primary care agency.'

SR 1: Problem with self – referrals: Illustrative Comment

Ad C: 'I guess I am of two minds. I think that people should be able to present. If they are not going to come to see Triage, a PAS nurse in Triage, then they are only going to front up to ED. So my feeling is - Yes we should do it. I think there should be some form of assessment though and if we have to do this we should have a direct link to the person's GP, if they have one to be able to get additional information. That GP should be advised and that that relationship should be looked at very closely as to whether we think that person could be managed by the GP. Rather than just saying "Yes, you're a self-referral thank you", if the person has a GP then we should be assessing them because obviously they're fronting up there because they've got a crisis. I have less of a problem with this.'

6.3.9: Poor Relationships with GPs: Summary and Selected Comments

This category contained no subcategories and only one theme. Surprisingly, only 3 administrators made the poor relationships between mental health services and GPs explicit, although most of the others clearly believed that this is the case.

Table 6.3.9: Poor Relationships with GPs: Themes Identified

Theme	Symbol	No. of Administrators Commenting
Poor relationships between MHS Clinics and GPs	PR 1	3

Selected Comments from Highlighted Theme:

Theme:

- **PR 1:** Poor relationships between MHS Clinics and GPs: Illustrative Comment

Ad G: 'Historically we've had a very bad relationship with GPs. The (Clinic) and that kind of thing. They used to say they can't get their patients in and then they can't get them out once they get them in. There are still some who years and years down the track still won't refer to (Clinic), despite what you say to them. I was just going to ask about the age of GPs, because a lot of older GPs, say over the 50 mark, something like that. Would that make a difference in this area?'

6.4: Summary

Most administrators were aware that GPs have problems with the mental health services. They proposed a number of realistic solutions, stressing the importance of working at a local level and establishing informal relationships. They were aware that there are problems of access and proposed that one strategy for improvement is to develop relationships with non – medical members of the multidisciplinary team, as opposed to the conventional doctor-to-doctor contact. They were also aware that members of the multidisciplinary team have not been sufficiently educated in community based work and stressed the difficulties inherent in remedying this situation. Consultation – liaison work was seen as important, with the consultant not necessarily taking clinical responsibility for the patient.

CHAPTER 7: THE VIEWS OF PSYCHIATRISTS

The comments were grouped into 8 major categories and one minor category, with 29 subcategories. Seven of the broad categories were the same as for the administrators and for this reason are set out in the same order as Table 4.7.2. The major category ' Barriers to Change' was not appropriate for the administrators' comments, whilst the minor category 'Poor Relationships with GPs' was not appropriate for the psychiatrists. The minor category 'Referrals from Other Agencies' was included because anecdotal evidence had suggested that this was a cause for considerable concern for psychiatrists. There was no evidence to support this. The degree of congruence between the major categories for administrators and psychiatrists was notable and was probably influenced by their working in the same environments, which facilitated a degree of communication. The similarities became much less marked in the subcategories and the themes identified.

7.1: Major Categories

7.1.1: Factors in Good Relationships

This category comprised 4 subcategories as set out in Table 7.1.1.

Table 7.1.1: Factors in Good Relationships: Subcategories

Subcategory	Symbol	Number of Psychiatrists Commenting	Number of Comments
Skills in managing relationships	SKL	7	10
Provision of support	POS	2	3
Importance of informal relationships	IIR	3	3
GP attachments	GPA	1	2
Totals Comments			**18**

7.1.2: Need to Deal with GPs' Problems

This category comprised 4 subcategories as set out in Table 7.1.2.

Table 7.1.2: Need to Deal with GPs' Problems: Subcategories

Subcategory	Symbol	Number of Psychiatrists Commenting	Number of Comments
Education of GPs	EGP	8	12
Value of different consultations	VDC	7	10
Importance of shared care	ISC	8	14
GP led responses	GPR	4	5
Totals Comments			**41**

7.1.3: Need for Training for MHS Staff

This category comprised 2 subcategories as set out in Table 7.1.3.

Table 7.1.3:Need for Training for MHS Staff: Subcategories

Subcategory	Symbol	Number of Psychiatrists Commenting	Number of Comments
Training of medical staff: Postgraduate	PGT	9	14
Training of medical staff: Undergraduate	UGT	8	13
Totals Comments			**27**

7.1.4: Problems in Communication

This category comprised 3 subcategories as set out in Table 7.1.4.

Table 7.1.4: Problems in Communication: Subcategories

Subcategory	Symbol	Number of Psychiatrists Commenting	Number of Comments
Inadequacy of documentation	IDC	5	7
Lack of understanding	LOU	4	6
Importance of information technology	IIT	3	4
Totals Comments			**17**

7.1.5: Use of the Multidisciplinary Team

This category comprised 3 subcategories as set out in Table 7.1.5.

Table 7.1.5: Use of the Multidisciplinary Team: Subcategories

Subcategory	Symbol	Number of Psychiatrists Commenting	Number of Comments
Involvement of non – medical staff in liaison	NML	6	7
By – passing the duty officer	BDO	1	2
Training for staff	TFS	1	1
Totals Comments			**10**

7.1.6: Variability of Responses from GPs

This category comprised 3 subcategories as set out in Table 7.1.6.

Table 7.1.6: Variability of Responses from GPs: Subcatergories

Subcategory	Symbol	Number of Psychiatrists Commenting	Number of comments
Willingness of GPs to be involved in Mental Health issues	WIL	4	6
Variability of responses	VR	4	4
Specialisation by GPs	SPEC	2	2
Totals Comments			**12**

7.1.7: Primary Care Psychiatry

This category comprised 3 subcategories as set out in Table 7.1.7.

Table 7.1.7: Primary Care Psychiatry: Subcategories

Subcategory	Symbol	Number of Psychiatrists Commenting	Number of Comments
Patient populations	PP	11	17
Dual diagnosis	DD	2	2
Non – government organisations	NGO	1	1
Totals Comments			**20**

7.1.8: Barriers to Change

This category comprised 5 subcategories as set out in Table 7.1.8.

Table 7.1.8: Barriers to Change: Subcategories

Subcategory	Symbol	Number of Psychiatrists Commenting	Number of Comments
Need for adequate resources	NAR	5	8
Lack of a theoretical framework in primary care	LTB	3	7
Problems in Mental Health systems	PMH	3	6
Importance of preventive work	IPW	2	3
Problems in general practice	PGP	2	2
Totals Comments			**26**

7.2: Minor Categories

7.2.1: Referrals from Other Agencies

This category comprised 2 subcategories as set out in Table 2.4.2.1.

Table 7.2.1: Referrals from Other Agencies: Subcategories

Subcategory	Symbol	Number of Psychiatrists Commenting	Number of Comments
Self referrals	SR	3	5
Referrals from other agencies	ROA	1	1
Totals Comments			**6**

7.3: Themes Identified

7.3.1: Factors in Good Relationships: Summary and Selected Comments

This category comprised 4 subcategories as set out in Table 7.3.1.

Table 7.3.1: Factors in Good Relationships: Themes Identified

Subcategory	Theme	Symbol	Number of Psychiatrists Commenting
Need for Skills in Relationships	Skills in relating to GPs. Skills in conducting groups Skills in dealing with mutual misunderstanding	**SKL 1** **SKL 2** SKL 3	**6** **1** 1
Need for Informal Relationships	Need for personal contact	**IIR 1**	**3**
Provision of Support	Need for an attitudinal change from 'the specialist knows best'	**POS 1**	**2**
GP Participation in Attachments	GPs learn how the local MHS system works MHS staff learn to value the GP's role	GPA 1 GPA 2	1 1

Selected Comments from Highlighted Themes:

Theme:

- **SKL 1:** Skills in relating to GPs: Illustrative Comment

Psy B: 'My special skills are exactly that, specialist skills as a psychiatrist, that is actually different from some of the skills that are necessary, because again we know that mental ill health presents differently in general practice. I'm not sure how good I would be at picking up problems at that level. The skill has got more to do with how do you interact with the GP, how do you act as a mentor, supervisor, specialist, colleague, whatever you want to call that relationship. It's developing that skill, that aspect, and do it in a way that doesn't threaten the GP - makes it jointly worthwhile. So I would say, it's not so much what specialist skills do I bring, it's more what else would I need to have, I guess. The biggest problem that we have always - it's two problems actually - one is time and the other is constant staff turnover. I think that it's pointless setting up a

relationship with a GP if you're going to be moved in a matter of months. It's got to be an ongoing relationship and really a lot will depend on that interpersonal interaction between two colleagues.'

- **SKL 2:** Need for skill in conducting groups: Illustrative Comment

Psy F: 'The special skills in the Balint group have to be group skills, and I do have group skills because I have learned them and I've had lots of experience and I think that's important. But how many psychiatrists have group skills? I think it's about managing a small group with structure.'

- **IIR 1:** Need for personal contact: Illustrative Comment

Psy A: 'The hidden agenda is really just building relationships. I think the key to all of this - the first step in the whole exercise of getting GPs more involved and so on - the first issue is building relationships and getting people to know each other and talk to each other. To try and recreate what we all did when we were younger, which, because the numbers were small the *doctors* all knew each other in town. There was more mutual respect. We knew each other because the numbers were smaller. Now because numbers and systems have got so big, we've lost that informality and what we are trying to do is recapture that to some extent.'

- **POS 1:** Need for an attitudinal change from 'the specialist knows best': Illustrative Comment

Psy E: 'Underlying this there is also an attitude that what the GP should do, and that's the GPs should be supporting the mental health services. I guess my position is very much the reverse of that. It's not asking what your country can do for you, you ask what you can do for your country. This situation in mental health services, we should be asking what we could do to be of assistance to the major practitioners of mental health services. So it's turning the focus round so that the GP is much more central in the process, rather than the assumption that we know what is best and going that way. I know from my personal experience in general practice the incredible frustration of seeing a lot of people that I could identify as having mental health problems *who*, one, wouldn't go to see someone if you've identified it and, two, if you did send them along you weren't quite sure what you were going to get at the other end. Whether they would come back better or worse or it would make no difference. Questions of quality at the other end.'

7.3.2: Need to Deal with GPs' Problems: Summary and Selected Comments

This category comprised 4 subcategories as set out in Table 7.3.2 below.

Selected Comments from Highlighted Themes:

Theme:

EGP1: Educating GPs will not reduce the workload for mental health services. Illustrative Comment

Psy B: 'The relationship with community mental health services is an interesting one because it always seems to me that the emphasis foremost by mental health services is: "If we can skill GPs to do all sorts of different things and give them better supervision and so forth, then they can do a lot of the work that we currently do. And that leaves us theoretically free to either do other things or to save money on community mental health services" I think it's absolutely wrong because I would see the relationship with community mental health services ought to be in helping GPs to both recognise and treat those patients that they don't currently pick - up as having mental health problems. So, if anything I see a move to some kind of closer liaison with general practitioners as increasing our workload, not decreasing it overall, but overall giving a much better level of service.' (Although only one psychiatrist commented, it seems to be widely believed that one of the incentives for engaging with GPs will be a reduction of workload. All 9 psychiatrists commented and agreed that educating GPs is essential. There was such a wide variation in the comments on the content and method of teaching that it was difficult to identify any salient themes, but individual psychiatrists raised some very significant difficulties).

Table 7.3.2: Need to Deal with GPs' Problems: Themes Identified

Subcategory	Theme	Symbol	Number of Psychiatrists Commenting
Education of GPs	Educating GPs will not reduce workload for mental health services	**EGP 1**	**1**
	"Saturation effect" of drug companies	EGP 2	1
	Value of a Balint Group	EGP 3	1
	Problems in management	**EGP 4**	**6**
Value of different kinds of consultations	Value of "one off" consultations	**VDC 1**	**2**
	Value of telephone consultations	**VDC 2**	**3**
	Value of the case conference	VDC 3	1
Importance of shared care	"All or nothing" response	ISC 1	1
	Resolution of professional boundary problems	**ISC 2**	**6**
	Accessibility of mental health service staff	ISC 3	1
	Need for standardised interventions	ISC 4	2
GP led responses	Importance of GP recommendations	GPR 1	2
	Importance of innovative approaches	**GPR 2**	**2**

- **EGP 4:** Problems in Management: Illustrative Comment

Psy N: 'In practice it's not the same as in theory, but in theory it should mean that the community team should have the responsibility of helping to educate GPs into modern psychiatry techniques.

And helping with case by case supervision when psychiatric teams aren't necessarily involved and support for GPs with use of part of the Mental Health Services psychiatry team - if they don't need all of it and in joint care. Also better liaison for GPs when they think they are out of their depth.' (The 6 psychiatrists who commented raised a variety of issues, but generally focussed on aspects other than medication).

- **VDC 1:** Value of "one – off" consultations: Illustrative Comment:

Psy C: 'I did a 6 weeks locum at (Name) Clinic before it closed when I was back once, and the Social Work & Psychology Staff there said: "Look - you're only here for 6 weeks. We don't want to take loads of people on board just because you're here, but once you go we'll need a lot of medical psychiatric input and then won't have access to it." So what we agreed was that I would take referrals on the understanding with GPs that this was a consultation only that I'd be passing them back if I thought it appropriate. And when GPs rang up to discuss - to ask for a consultation - whenever I said that, virtually everybody I spoke to was quite happy to do the referral on that understanding. I had no problem to get GPs to keep patients that they were referring.' (Only two psychiatrists commented but both administrators and GPs also aired the topic).

- **VDC 2:** Value of telephone consultation: Illustrative Comment

Psy N: 'I think it would be great *to have a telephone service.* I have friends that's are GPs that use me as that service and always ring me up and I find it quite easy. There's one particular case that I've been involved with and never met for quite a long time. But they give me a question, I give them an answer.'

- **ISC 2:** Resolution of professional boundary problems: Illustrative Comment

Psy C: 'I read it a year ago when I first came into the service – that registrars are not supposed to pass their out – patients on to the next registrar – they are supposed to refer back to the GP. So the whole idea is that we don't have chronic patients, but the truth is we do have chronic patients who will never be fit for referral back to a GP. I think it would be better to say "What's a reasonable percentage of our clientele to say these are the people who are the hard cases and we are going to have to keep managing them over a long period of time." So that we can within the service give ourselves our own expectations. This is what I expect of myself in terms of the patients I refer to a GP, the percentage of patients that I keep to myself in the long term and the percentage of patients that we can do a time – shared care of. In other words they are being managed week to week by the GP, but I'm doing intermittent review and advice. I think we need to do this administratively because then I think we are looking at what's best for the patient.'

- **GPR 2:** Importance of innovative approaches: Illustrative Comment

Psy I: 'I think if we look at the whole area of training or educating GPs, that in itself is a challenge, because once you've worked with GPs who are interested in the area, which I think basically we've done in this Division, maintaining their interest is quite difficult. So apart from the courses we run in the year we have bi – monthly evening meetings but the attendance is variable. So maintaining the interest is quite difficult. One day we'll review the level of interest five years on of the ones who went through the course, whether this will remain the same. But certainly networking and the informal benefits are there. I think we have to look at other ways of maintaining a level of interest. We need some creativity and innovation.'

7.3.3: Need for training for MHS Staff: Summary and Selected Comments

This category comprised 2 subcategories as set out in Table 7.3.3.

Not surprisingly, the psychiatrists confined their comments to medical staff and made no mention of the training of nurses or allied health staff. All of the 8 who commented on the undergraduate training agreed that the teaching is based on an inappropriate patient population.

Table 7.3.3: Need for Training for MHS Staff: Themes Identified

Subcategory	Theme	Symbol	Number of Psychiatrists Commenting
Postgraduate Medical Training	Need to define role of psychiatrists	PGT 1	1
	Institutional base of postgraduate training	**PGT 2**	**7**
	Lack of training in teaching.	PGT 3	1
Undergraduate Medical Training	Progressive specialisation of medical training.	**UGT 1**	**1**
	Need for a community focus	**UGT 2**	**3**
	Differences between general practice and hospital care	UGT 3	3
	Need for appropriate diagnostic categories	**UGT 4**	**2**

Selected Comments from Highlighted Themes

Theme:

- **PGT 2:** Institutional base of postgraduate training: Illustrative Comment

Psy D: 'I think *registrar training* is very "bin" based and therefore not particularly good. It may vary in other places. I think here we've a huge emphasis on a small number of large institutions and they bring their own problems. There should be an increasing amount of training in community psychiatry. The way teams work here is very reasonable and they probably get a good training out of it, but it's only going to be one small portion of their however many years rotation.'

- **UGT 1:** Progressive specialisation of medical training: Illustrative Comment

Psy A: 'Fifty years ago the medical school training was broader, but as time has gone on the hospital population has been sicker and sicker and sicker. Medical students are being taught on an increasingly limited range of cases and at the classic specialist end of all the classification systems. So that's certainly true of medical students, absolutely, they're just seeing a much sicker group. And we in the University Dept. of Psychiatry, I have to say, are trying to respond to that. Recognising it and trying to teach at least at a theoretical level, a broader perspective or trying to have the notion of psychiatry for non - psychiatrists as a more seriously recognised issue. So that teaching time on psychosis is being restricted down and the teaching time on the neuroses and things is being expanded. We are trying to address that. But for our own trainees in psychiatry, *there is* the same issue. Increasingly they are just being trained on a very sick group of people.'

- **UGT 2:** Need for a community focus: Illustrative Comment

Psy F: 'Well, there's a pretty good thing about teaching at the end. It's all about training. It's about changing the focus of the learning out into the community. That would be really good, if we could have medical students, or any sort of students, out in the community, going round with - as part of their training - expected to go out with community nurses. Expected to go along with the registrars and consultants out into the community. It's unusual, you have to make a special effort to get them out there. It would be an expectation that they go out, and as long as it's not they'll quite happily hide in the hospital and drink coffee in the canteen.'

- **UGT 4:** Need for appropriate diagnostic categories: Illustrative Comment

Psy B: 'I wonder if even 26 *categories in ICD 10 for Primary Care* are too many. It was my thought that we could get down the principal diagnoses to probably six or seven that we use most often, the most common that we use. The issue for me is that the only benefit of diagnosis per se is to guide treatment and that would be the same in general practice. That's really all we're about. If we can guide them to the diagnosis and then explain treatment. And if we can connect those treatments together it should make more sense to them. There are probably slightly more than half a dozen because there are a few obvious psychotic ones. And there are a few different anxiety ones, but there are probably only a couple of depressive ones for instance that are of any use. Just bipolar and unipolar depression would probably ignore most of the rest. Maybe an abnormal bereavement reaction or something else, one or two extra ones.'

7.3.4: Category: Problems in Communication: Summary of Themes identified

This category comprised 3 subcategories as set out in Table 7.3.4.

Table 7.3.4: Problems in Communication: Themes Identified

Subcategory	Theme	Symbol	Number of Psychiatrists Commenting
Inadequacy of Documentation	Importance of a common language Inadequacy of information from GPs	**IDC 1** **IDC 2**	**2** **3**
Lack of Understanding	Lack of insight amongst trainees Differences in objectives	LOU 1 **LOU 2**	1 **3**
Importance of Information Technology	Use of faxes and email Importance of compatible IT systems	IIT 1 **IIT 2**	1 **2**

Selected Comments from Highlighted Themes

Theme:

- **IDC 1:** Importance of a common language: Illustrative Comment

Psy F: 'Well that's right. I don't think there is much, but also just the fact that there's a common language that's been developed in the U.K. There are various white papers and green papers and also the way services are structured, so even how people represent service delivery is quite similar. But here, when you talk about service delivery, or even use a simple word like access to services, a simple phrase, it means different things to different people. There isn't a common language - even a common clinical language between clinicians - but certainly in service delivery there's a long way to go. So this is why I'm actually thinking that you can talk about service delivery and interface of services and primary care and secondary care and stuff like this, but these are just words and when you actually get down to it, it's very messy.'

- **IDC 2:** Inadequacy of information from GPs: Illustrative Comment

Psy N: 'I don't know what the problem is with certain GPs but in our intake meetings we are getting a flood of letters with minimal information saying "Patient depressed - please counsel". Which to me indicates that the GP hasn't actually got much information from the patient. Maybe they are just not willing to take on that type of case.'

- **LOU 2:** Differences in objectives: Illustrative Comment

Psy A: 'I think that *primary care and mental health services* are poles apart, and never the twain shall meet. They have different objectives, specialists and generalists have different objectives anyway at a theoretical level. What they do in their daily work is very different. The patient population they deal with is very different and they have very little understanding of each other's expectations and needs. A constant theme running through all this are people with difficult personality disorders that mental health services don't deal with at all well, because they don't really know what to think about it - whether it's mental illness or not. They discharge them and the

GPs struggle with them. So that's another whole domain; that's a group of patients that no one seems to handle. The more conventional psychiatry - it's just very different to the rest and they don't understand each other.'

- **IIT 2:** Importance of compatible IT systems: Illustrative Comment

Psy F: 'I think the U.K. primary care system is pretty reasonable, but we don't have that system here. The Federal Government would very much like to have it and they talk as though we've got something similar, but it's not. Even as an example, in Scotland all the GPs basically use the same electronic systems, computer based system. A friend of mine at a University department of general Practice in (Place), he can actually access data from GPs all over Scotland. There's just not that cohesiveness in primary care here.'

7.3.5: Use of the Multidisciplinary Team: Summary and Selected Comments

This category comprised 3 subcategories as set out in Table 7.3.5.

Table 7.3.5: Use of the Multidisciplinary Team: Themes Identified

Subcategory	Theme	Symbol	Number of Psychiatrists Commenting
Involvement of Non – Medical Staff in Liaison	Importance of funding for case conferences	**NML 1**	**1**
	Value of a GP liaison nurse	**NML 2**	**4**
	Value of a CAT team	NML 3	1
By – passing the Duty Officer	Case – manager should not be the first contact	BDO 1	1
Training for Non – Medical Staff	Providing staff with skills	TFS 1	1

Selected Comments from Highlighted Themes:

Theme:

- **NML 1:** Importance of funding for case conferences: Illustrative Comment

Psy E: 'The big change that is going to come about is the GP funding for case conferences and we are looking at that. That, potentially, will make a huge difference, both in terms of getting them to come to the clinic or even the case manager and someone else going out to the GP's Surgery, sitting down with the GP and doing some joint planning in that setting. That will make a huge difference in terms of quality care. We are looking at getting some of the case managers, as GP liaison workers. Not necessarily in terms of the clinical stuff, but in terms of managing the relationship. So that if you've got say one nurse linking with two or three of the GPs they pop in every so often - "How are things going? Any problems with the referrals stuff back?" If there is a

consistent problem, saying "Well look, we'll get back to the Team and see if we can brainstorm what you need in that area". We've got one of the community nurses who goes down to (Place), because it's so far away, linking with the other community agencies and the GP in terms of a meeting once every two months.'

- **NML 2:** Value of a GP liaison nurse: Illustrative Comment

Psy H: 'At (Centre) there was actually a GP liaison nurse and she had established to my mind, very good relationships with the GPs that facilitated their more active involvement in patient care, and also their entry into the service. So that, I saw as a very positive and beneficial step. And a practical one, because there was a nominated person who was involved with the local Division who was identifiable. She had attended the practices, she was the more positive face of the Clinic, rather than the invisible voice at the other end of the phone. And she also had involvement in other community based groups or agencies to receive referrals, so there was that go-between, the ambassador, or however you might like to think of her role. That sort of initiative I think can be positive as well'.

7.3.6: The Variability of Responses from GPs: Summary and Selected Comments

This category comprised 3 subcategories as set out in Table 7.3.6.

Table 7.3.6: Variability of Responses from GPs: Themes identified

Subcategory	Theme	Symbol	Number of Psychiatrists Commenting
Willingness of GPs to be Involved in Mental Health Issues	GPs not a homogeneous group	**WIL 1**	**4**
	Difficulty with uniformity in service delivery	WIL 2	1
Specialisation by GPs	GP preferences	SPEC1	1
	Patient preferences	SPEC 2	1
Variability of GPs' Responses	Spectrum of perceived need	VR 1	1
	Variability of GPs' sensitivities	**VR 2**	**3**

Selected Comments from Highlighted Themes:

Theme:

- **WIL 1:** GPs not a homogeneous group: Illustrative Comments

Psy G: 'I get the sense that some GPs are a bit reluctant - some are more than others - to necessarily take on the care of some *psychiatric* patients. I mean they can be demanding in terms of time and in terms of the way you prescribe things. For instance, giving a very short supply of medication to people who might be going to overdose or having to titrate doses a lot, which can be quite challenging. So you cannot talk about GPs as a homogenous group. I don't think any more

than you can talk about any group as a homogenous group, but I think a lot more could be done to liase with GPs and find out who is amenable or willing to be involved more with their patients. Maybe a little bit of consciousness raising for the GPs on a potential role for them in this might work. I know the (Division) of GPs have someone looking to suss out what the GPs wanted out of the mental health service and this kind of thing. I think one of the requests was greater liaison. But they also wanted more responsiveness from the service so that when they have a patient they wanted seen that day, they got seen that day and these requests may be a little unrealistic given the constraints that we operate on in the community.'

Psy J: 'You've identified quite a major problem. We have an interest in the delivery of mental health services, so we can strive for some kind of uniformity, equity in access and that kind of thing, but GPs have differing interests in the subject. *That* can affect our work quite significantly and affect our ability to carry out liaison effectively if someone's not interested. You can't devise a policy that will encompass all GPs because they won't sign up to it. And there's tremendous frustration at having to negotiate with each individual GP what they are prepared to do when there are so many practices.'

- **VR 2:** Variability of GP sensitivities: Illustrative Comment

Psy E: 'At the intake meeting, we can call the shots on planning what kind of response. Then if I haven't got time to get back to the GP then the Triage Officer is - depending on who the GP is and the personalities and the sensitivities - get them to contact the GP and say "Look, this is what we are suggesting: Case Manager see them first, registrar will see them in a few weeks. Would you bump up their Sertraline from 50 to 100, then another 50 if it's not working in a few weeks?"'

7.3.7: Primary Care Psychiatry: Summary and Selected Comments

This category comprised 3 subcategories as set out in Table 7.3.7.

Table 7.3.7: Primary Care Psychiatry: Themes Identified

Subcategory	Theme	Symbol	Number of Psychiatrists Commenting
Patient Populations	Patients attending GPs	**POP1**	**6**
	Patients who do not meet diagnostic criteria	**POP 2**	**4**
	Wider definition of primary care psychiatry	**POP 3**	**5**
Significance of personality disorders	Significance of substance abuse	DD 1	1
	Significance of personality disorders	**DD 2**	**1**
Non – government organisations	Importance of hostels	NGO 1	1

Selected comments from Highlighted Themes:

Theme:

- **POP 1:** Patients attending general practitioners: Illustrative Comment
- **Psy A:** 'My view of what it is, which I'm still in the process of formulating after all this time, is that it's a bit like this. (Refers to a diagram of pyramid). This is *a diagram of* Goldberg's filters in the sense that it shows the volume of patients, filtering down from primary to secondary to tertiary care. Only a very small number get referred through to tertiary care. The volume of work done by general practice or primary care is actually much bigger, but the tertiary care, looks after the very sick that need to be hospitalised, or the seriously mentally ill and so on. So my view of what general practice psychiatry is the conventional one - includes the conventional one - which is all of the other diagnoses - affective, anxiety disorders, somatisation, hypochondriasis disorder, substance abuse and so on. In big volume, the mild and moderate and even some of the severe ones, plus bits and pieces of the others, personality disorders. All of those psychiatric conditions which to some extent are defined and have some definitive treatments, whereas secondary psychiatry looks after the more serious ones and does psychotherapy and tertiary psychiatry looks after the most sick and those that need hospitalisation and community mental health continuing care. So my issue firstly then is that general practice, or primary care psychiatry is about looking after this big volume of still moderately severe morbidity. By no means minor, sort of mild in psychiatric classification lingo is not the same as saying mild in terms of morbidity, it's still very significant morbidity for the sufferer.' (There was general agreement amongst all 11 psychiatrists who commented that the population of patients seen in primary care is very different from that seen in hospital practice).

- **POP 2:** Patients who do not meet diagnostic criteria: Illustrative comment

Psy A: 'But the other part of general practice psychiatry is not talked about, which is what I call distress. It includes all the subsyndromal conditions so called in psychiatric lingo, but that doesn't capture what they are really about. I mean the "not otherwise specified" *conditions* in the DSM are actually by far the most common and most important numerically therefore. By distress I mean, coping with chronic symptoms, physical or mental - coping with pain, disability. Coping with adversity of all kinds, social adversity, poverty, and unemployment. Coping with crisis, sudden events, including of course bereavement, domestic violence, relationship issues and parenting issues. All of which are huge sources of distress, none of which qualify until, unless a secondary psychiatric condition emerges, none of them qualifies as the stuff of psychiatry. And yet *they cause* an enormous amount of psychological, emotional morbidity.'

- **POP 3:** Wider definition of primary care psychiatry: Illustrative Comment

Psy O: 'I understand Primary Care Psychiatry to be the first port of call for people with psychiatric problems. Essentially that would be people in the community and the person I would think of first would be a GP, but of course there would be NGOs *(non – government organisations)* and Clinical Psychologists and other people working out there. Certainly I think in the rural areas the mental health teams do provide primary care because of distances and access. In other communities I've worked in they do provide a walk-in service but it's as a primary urgency and there's always the emphasis on moving people back to their GP.'

- **DD 2:** The significance of Personality Disorders: Illustrative Comment

Psy B: 'I think a pure personality disorder without associated – usually a raft of mental health problems is extremely rare. Where that occurs, the person has part of a mental health service requirement. So if he is a psychopath and not depressed, not psychotic and not this and not that, that's an issue for society it's not an issue for us. But I think we know that 50% of our patients, no matter that the diagnosis, have some kind of a personality problem. We know that most people with personality problems have a heap of mental health issues, be it self-harm or depression or whatever. Clearly the mental health part of their problem is a matter for us to deal with. I try and get the registrars not to put down personality disorder as a diagnosis, even under Axis 2. The minute you do that the patient will be labelled and they will be excluded from services. I try to get Registrars to think "What is the mental health problem?" and then that legitimises the role of the mental health services. I don't know how many times I hear Registrars saying "So and so has been admitted with a Borderline Personality Disorder". If that really is all that they had, it is possible to have only that and no mental health consequences, then they shouldn't be in hospital. If they've got mental health consequences, they should be saying this person is in self-harm, depressed at the moment. And if you have to acknowledge the Axis 2, which you probably have to for funding, you simply acknowledge it and don't make a big issue of it.'

7.3.8: Barriers to change: Summary and Selected Comments

This category comprised 5 subcategories as set out in Table 7.3.8.

Selected Comments from Highlighted Themes:

Theme:

- **NAR 1:** Need for financial incentives: Illustrative Comment

Psy B: 'They, Medicare, have just agreed that they will reimburse for case conferences and care plans. So I guess that's a step in the right direction - at least it means that Medicare or HIC are recognising there is a structural failure of the system, because clearly GPs aren't going to do down

this road if there is a financial disincentive. Actually there needs to be an incentive because our patients are not easy.'

Table 7.3.8: Barriers to Change: Themes Identified

Subcategory	Theme	Symbol	Number of Psychiatrists Commenting
Need for adequate resources	Need for financial incentives	**NAR 1**	**4**
	Problems with staff	**NAR 2**	**3**
	Need for gate - keeping	NAR 3	1
Theoretical Problems in Primary Care	Lack of theoretical base	LTB 1	1
	Different methods of working	**LTB 2**	**2**
	Lack of definition	LTB 3	1
Problems in Mental Health Systems	Problems with geographical boundaries.	PMH 1	1
	Bureaucratic frustrations for GPs	PMH 2	1
	Separation of treatments.	PMH 3	1
	Problems with medication.	PMH 4	2
Importance of Preventive Work	Need to define objectives	**IPW 1**	**1**
Problems within General Practice	GPs' lack of knowledge	PGP 1	1

- **NAR 2:** Problems with staff: Illustrative Comment

Psy G: 'One of the problems is that staff are coming and going all the time in the clinic, so what you might establish for one period of time may break down in the next period of time and this kind of thing. I spoke with a GP the other day and he seemed absolutely joyful to hear form me, just to know there was a human being here at (Clinic). He hadn't heard from anyone in such a long while and it really is a disgrace that things had got to that stage. But by the same token there's a lot of a culture of non – contact with the GPs generated by overload just to keep seeing the patients. Up until about a month ago we were in that total overload because of lack of medical manpower. So there are the things we have to deal with sporadically which undermine your habits of functioning in an appropriate way medically.'

- **LTB 2:** Different methods of working: Illustrative Comment

Psy E: 'The other issues that I see in there are things to do with major differences in how psychiatrists and GPs tend to work. GPs tend to have a limited period of time, use time as a diagnostic tool and work more on problems and issues than necessarily on specific diagnoses. I'm a bit rusty on it, but I think a GP comes to a definite diagnosis in about 15% of consultations. So the actual solid diagnosis is fairly rare.'

- **IPW 1:** The need to define objectives: Illustrative comment

Psy B: 'And we don't spend nearly enough on the issues of prevention and promotion and the most important prevention that we could do would actually be in general practice. If we are going to actually prevent mental ill - health, or, not quite prevention, it's early recognition, early appropriate treatment in that area. Most of all we need to do that, but that requires a sea - change in the way that consultants see their role, and for that matter the way our employers see our role.'

7.3.9: Referrals from Other Agencies: Summary and Selected Comments

This category comprised 2 subcategories as set out in Table 7.3.9.

Table 7.3.9: Referrals from Other Agencies: Themes identified

Subcategory	Theme	Symbol	Number of Psychiatrists Commenting
Self – referrals	Obligation to accept "walk – in" admissions	**SR 1**	**2**
	Advocacy role for mental health services staff	**SR 2**	**1**
Referrals from other agencies	Role of Emergency Department	**ROA 1**	**1**

Selected Comments from Highlighted Themes:

Theme:

- **SR 1:** Obligation to accept 'walk – in' admissions: Illustrative Comment

Psy D: 'Again it's difficult if the primary care isn't there and you've got somebody with an established mental illness. Really it *should* all be coordinated through the GPs but to be honest the GPs are so sidelined in a lot of the dealings we have with the patients that they genuinely haven't got a GP. So I just tend to say you've got to get one, you can't expect us to be looking after the other conditions, the physical problems. But given the fact there are a large population who don't seem to have ties with general practice we can't not take walk ins.'

- **SR 2:** Advocacy role for mental health services staff: Illustrative Comment

Psy L: 'I believe that *it means* working with primary care, by which I understand general practitioners in this particular role representing primary care. I believe it's critical for holistic patient care that *we work* together with a GP who understands the patient's physical status, often has lots of history, lots of knowledge. Using that information with the mental health team can be very valuable. It's unfortunate that a lot of our patients don't have GPs, so I think one of our roles needs to be to advocate on behalf of the patient to show them the advantages of having a primary care physician, if you like. So that's a key role.'

- **ROA 1:** Role of the Emergency Department: Illustrative Comment

Psy D: '*In the UK* there's a big push that people who are mentally ill shouldn't be taken to police stations. So they are tending to take them to an A & E department and I think that's fine because they are screened by a casualty officer and then found to be psychiatric. That would be better than setting up an interview room at the psychiatric hospital. It's very difficult because you couldn't get the GP to come out. It would effectively mean that the consultant on call was the first doctor called for anybody the police thought was potentially mad. Here it works better with ED screening first'.

7.4: Summary

The psychiatrists had good insight into the need to deal with GPs problems. They understood the need for interpersonal relationships and that this would mean a change of attitude towards GP colleagues. They also understood the difficulties with access and the problems with communication. Understandably their concerns about education for mental health service staff were confined to doctors, but embraced both undergraduate and postgraduate levels. Like the administrators they identified a number of factors that would impede progress. Significantly, they identified the problems of defining the patient population to be managed in primary care and the difficulties that GPs experience with those patients who do not meet the thresholds for diagnostic categories. They were sanguine about the benefits for psychiatrists in increasing GP involvement and believed that it might well increase rather than reduce their clinical load.

CHAPTER 8: DISCUSSION AND RECOMMENDATIONS

8.1: Preamble

Objective 3: Develop strategies, in conjunction with relevant stakeholders, for the implementation of a plan for an optimal service in a local area.

The attitudes of doctors and administrators have been shown to be significant in shaping delivery systems so it is appropriate to search for congruence in their views. Areas of congruence will facilitate the development of short – term strategies for integrating primary care psychiatry into a broader mental health service without sacrificing the best elements of both hospital and community care. Areas of major difference will at least indicate where there needs to be intensive dialogue to bring the stakeholders' attitudes closer. In exploring areas of congruence, themes common to various stakeholders will be identified by reference to the fieldwork.

Recommendations will be made, which, it is hoped, will lead to the development of an implementation plan.

8.2: Comparison of the views of GPs and MHS Staff

The major categories of GPs' comments were easily identifiable areas of common concern to all three groups of stakeholders:

- Concepts of Primary Care Psychiatry
- Access to specialist services
- Communication
- Education

8.3: Concepts of Primary Care Psychiatry

8.3.1: The Scope of Primary Care

Most GPs defined Primary Care Psychiatry as the care of the mentally ill in general practice [Table 5.3.1ROL1]. This follows the 'traditional model' as set out by the Joint Report [1997].

'The general practitioner assesses, diagnoses treats and manages mental disorders and mental health problems independently unless requiring a second opinion in relation to these processes

or the doctor assesses that the individual's disorder is of such severity/complexity to warrant management by the specialist mental health services. Access to the specialist occurs through a written referral and feed back from the specialist will also occur in written form.'

On the other hand, MHS staff perceived a wider involvement of other agencies, particularly non – government organisations (NGOs) and other personnel, such as psychologists [Tables 6.3.7 PP1; 7.3.7 POP3; 7.3.7 NGO1]. The perceptions of GPs are surprising in that they valued the services of the Divisional Clinical Psychologist [Table 5.3.1 DP1] and some had found community teams helpful [Table 5.3.1 UCT1].

8.3.2: The Content of Primary Care Psychiatry

The GPs reported that the commonest psychiatric disorders that present are depression, anxiety or somatisation; psychotic disorders are comparatively rare [Table 5.3.1 ROL1; DIF1]. This difference between patients seen in general practice and hospital practice was clearly understood by psychiatrists [Table 7.3.7 POP1; POP 2] and administrators alike [Table 6.3.7 PP 2].

Patterns of psychiatric morbidity in general practice in WA are similar to those in the UK [Finlay – Jones & Burvill 1987,1988]. Accordingly it is reasonable to assume that 30 – 40 % of patients who consult a general practitioner will suffer from a psychiatric disorder that is the principal reason for the consultation [Horder 1988]. Anxiety and depression are the most commonly diagnosed disorders [Dunn 1986] but such patients are infrequently referred to psychiatrists in comparison with patients who are suffering from schizophrenia and paranoid disorders [Munk – Jorgensen 1986].

Many GPs have difficulty with issues of diagnosis and management [Table 5.3.1 DIF1], partly because the natural history of mental disorders in general practice are largely unknown [Joint Report 1997] although some studies are beginning to emerge [Furukawa et al 2000]. Consequently they would consider it useful to have an assessment by a psychiatrist but would prefer to undertake the long term treatment themselves [Table 5.3.1 ROL 2]. This was a reflection of an earlier finding in the UK [Horder 1988]. When depressed patients are referred, it is often factors such as suicidal gestures or substance abuse that influence selection [Paykel & Leff 1984]. As a result, psychiatrists in the past have been preoccupied with very small, highly selected samples of patients admitted to hospital [Goldberg & Huxley 1980]. This preoccupation with serious and enduring mental illness (SEMI) has often led to an unfortunate focus on biological psychiatry and its associated medical model thinking, which has already been discussed.

Such thinking leads in turn to the development of systems of classification such as ICD 10 [1992] and DSM IV [1994] and the management strategies that flow from them that have little relevance in general practice [Wilkinson 1985; Hickie 1999]. As one psychiatrist [Table 7.3.8 LTB 1] succinctly put it:

"I don't think psychiatry has actually got its own house in order in the sense that we haven't yet got an acceptable theoretical base from which to tackle distress – symptomatic depression, symptomatic anxiety. Not to mention other responses to somatisation, substance abuse, suicide. Because we still haven't got a good understanding of those things we end up giving up. Some psychiatrists retreat into biological psychiatry, some to psychotherapeutic and developmental models and get criticised for it because it's not scientific."

This dilemma of differentiating between disease and distress has also been discussed in the UK [Paykel & Leff 1984] as has the importance of subthreshold disorders [Pincus et al 1999]. One psychiatrist with a background in general practice also commented on the significance of distress and subsyndromal disorders [Table 7.3.7 POP 2]. Nevertheless, there is no doubt that the GP can and should manage these conditions.

8.3.3: The Involvement of GPs in Mental Health Care

A survey of 53 GPs in South Australia showed that 94% regarded the care of the mentally ill as and integral part of general practice [Buttfield & Murrell 1989]. None of the 16 GPs who commented in this survey disagreed with this view [Table 5.3.1 ROL1].

As long ago as 1966, Shepherd and his colleagues were able to conclude from their researches that:

'.....the cardinal requirement for the management of the mental health services in this country is not a large expansion and proliferation of psychiatric agencies but rather a strengthening of the family doctor in his therapeutic role' [Shepherd et al 1966].

In 1973 this theme was taken up by WHO, which suggested that there are a number of advantages in general practitioners undertaking the management of these disorders [WHO, Oslo 1973]. Not the least of these advantages are the capacity of the GP to deal with the complex relationships between physical illness and psychiatric disorder and the capacity to use their knowledge of the family background to make sense of symptoms that are only understandable in this context. To provide an illustration of psychosocial complexity, I studied

the records of 100 patients referred consecutively to my private practice in Midland between 21/12/92 and 21/07/93 [Buchan 1994]. All the patients were followed up until 21/01/94, that is for a minimum of 6 months. As a diagnostic classification system I used the International Classification of Health Problems in Primary Care (ICHPPC) [Jenkins et al 1988].

This system has the advantage that it provides simplified coding for diagnostic groups (both psychiatric and general medical) together with coding for both social problems and supports. There were 65 female and 35 male patients. About 1/3 (37) were identified as having conjugal problems. Other common problems included: parent/child relationships (20); other family relationships (8); non – familial interpersonal relationships (10); occupational problems (17). Conjugal support was most commonly identified (42), followed by other family support (22) and non – family support (18). Only 5 patients were identified as having no support. These figures probably reflect the comparatively high proportion of married patients (55). More than half the patients were diagnosed as suffering from depression (35) or low mood (17); only 3 were diagnosed as psychotic. More than a third of the patients (38) were physically healthy and the commonest associated physical disorders were those of the musculo – skeletal system, sometimes associated with a pain/depression/pain cycle.

GPs might agree that depression, for example, carries a poor prognosis, not only in terms of suicide, but also in terms of chronic morbidity unless energetically treated [Murphy et al 1986]. The thinking of depressed patients is characterised by the prominence of certain themes, particularly low self – esteem, ideas of deprivation, exaggeration of problems and difficulties, self criticism and wishes to escape or die [Beck 1967]. These cognitive anomalies are amenable to cognitive therapy [Beck et al 1980] but such therapy would benefit from the intervention of an expert in the field, such as a psychologist. Moreover, a degree of social impairment is found in depressed patients as compared with normal people and social factors strongly influence prognosis. Severe marital disharmony, chronic housing problems, lack of family and social support, are likely to lead to the depression becoming chronic. There is evidence that depressed women who have poor relationships with their sexual partners or poor social contacts, benefit from referral to a social worker [Corney 1984].

Depression [Bedi et al 2000] and anxiety [Catalan et al 1984] have been shown to respond well to generic counselling, which may be as effective as prescribing medication but the quality of the counselling might be an important factor. Several of the GPs in the current survey indicated that they provide some counselling for their patients [Table 5.3.1 CON1] but there were clearly constraints. Apart from the constraints of lack of time and financial reward, some GPs were concerned about their lack of special skills [Table 5.3.1 CON 2]. Some administrators also

perceived the GPs as lacking in skills [Table 6.3.2 EGP1] and one psychiatrist that they lacked knowledge [Table 7.3.8 PGP1].

8.3.4: The Involvement of the Multidisciplinary Team with GPs

There is therefore good reason to believe that GPs' management of their psychiatric patients would often benefit from interventions by the multidisciplinary community teams, but this gives rise to at least two problems. On the one hand, multidisciplinary teams should be able to tackle a range of disorders, but this will have implications for resources, not only in terms of staffing levels, but also for the training of staff in 'quality counselling'. Social workers, nurses and other professional groups will have to be trained to be effective counsellors as they may be working in relative isolation [Elpers & Levin 1995]. Such training is not difficult to implement [Buchan & Smith 1989] but has not yet been widely adopted in WA. On the other hand there is a real danger that if the team becomes preoccupied with the high prevalence disorders, there might be neglect of those with SEMI. This dilemma has never been adequately addressed. Part of the problem is that there is no generally agreed definition of SEMI, and despite attempts to derive an operational definition [Ruggieri et al 2000] there is none that is easy to use clinically.

8.3.5 The Dangers of Neglecting Patients with SEMI

Notwithstanding the lack of an adequate definition, the term SEMI continues to be widely used and there is some broad, if vague, understanding of what it means. With this caveat, the following comment is germane:

" Should such services squarely prioritise the most intensively and chronically mentally ill by merely cloning assertive mobile community teams in each location, doing everything for all their clients (the current Program for Assertive Community Treatment Model)? Or should such services evolve and differentiate into separate inter – relating functional compartments allowing for greater diversity of intensity of service requires by different service users?" [Rosen 1992].

In the USA the policy has been for the development of specialist mental health centres, specifically to provide care for discharged long – term patients. Unfortunately the role of the GPs was never clearly delineated [Meadows et al 1997] and the centres moved to caring for a less disabled population to the neglect of patients with SEMI [Thornicroft and Tansella 2002]. Primary care physicians were left to provide a 'de facto' mental health service for this group of patients who were not adequately cared for by the mental health services [Regier et al 1978].

In the UK the move to a National Health Service in 1948 led to a reorganisation of general practice. This reorganisation included financial arrangements that led to the development of

group practices and/or multidisciplinary health services with practice based ancillary staff such as community nurses, social workers and psychologists, followed by a major growth in trained psychiatric staff attachments [Meadows et al 1997]. As a result it has been possible, with careful planning and management of the discharge from hospital of long – stay patients, to avoid any marked increase in vagrancy, crime or mortality, including that from suicide [Dayson 1993].

Nevertheless, there has still been considerable doubt about what Community Mental Health Teams (CHMTs) are expected to do. A survey of 42 CMHTs in Scotland revealed a lack of consensus amongst the teams about a number of operational issues [Mauthner et al 1998]. There were important differences in the size and professional composition of the teams, whether or not they were aligned to a geographical catchment areas or general practices, referral criteria and the range of services delivered. The definition of the target group of patients proved particularly difficult and the authors commented:

' One of the central problems faced by CHMTs concerns 'gatekeeping' and targeting their services towards the severely mentally ill, in the face of the needs of a group of patients often referred to as the 'worried well. Just over half the patients referred to teams were said not to represent severe and long – term mental health problems. None the less, only 10% of these referrals were considered by the respondents to be inappropriate. Thus while the formal remit of the CMHTs may be to provide care for the more severely ill patients, teams are operating de facto within a broader remit.'

Unfortunately, Australia seems to have followed the general pattern and the expansion of the community health programme in the 1970s saw the community mental health centres providing prevention, treatment and rehabilitation services, but without any significant integration between existing primary care and the mental health services [Meadows et al 1997]. The move to a preoccupation with the less disabled followed:

' Community mental health centres have tended to move upmarket and become over – selective or swamped by being overly accessible. Consequently severely psychiatrically disabled individuals have experienced difficulty in competing for care.' [Rosen 1993].

Historically, community care programmes in WA began in 1974, as they did elsewhere, to provide care for the mentally ill discharged from psychiatric hospitals [Paust 1986]. Later there were warnings that WA might be following this path to move 'upmarket'.

Lawrence and colleagues [Lawrence et al 2001] in WA studied suicide in patients who had their first contact with mental health services during the 19 years 1980 – 1998. They found a significantly increased rate of suicide in users of mental health services as compared with the general population (Risk rate ratio 6.66 for males and 7.52 for females). Suicide risk was highest in the first 7 days after discharge from in – patient care and decreased exponentially with time after discharge. The risk also increased over the period of the study. The authors conclude: ' While there is no doubt that community – based mental health services have significant advantages for patients over in – patient services, there may be an increase in suicide risk associated with premature discharge and the reduction in patient supervision. Our data highlight the crucial importance of adequate follow – up services for patients discharged from in – patient care, and the need for adequate resources for the provision of community care.'

More recently our local press [Rose 2002] reported on a study by Access Economics, commissioned by SANE, that indicated that the number of suicides related to mental illness has risen 400% in 40 years. Schizophrenic patients were found to be 12 times more likely to commit suicide than the general population; further 84% of all the schizophrenics who died in 2001 committed suicide.

Similar problems have been described in the UK where 2370 of 10040 suicides (24%) had been in contact with mental health services before death. Of the 2370 suicides, 519 (24%) occurred within 3 months of leaving hospital. The number peaked in the first week after discharge, with the highest number of the first day. In all 187 of the 519 (41%) suicides occurred before the first follow – up appointment [Appleby et al 1999]. Geddes [1999] commented sadly that, because suicide is a comparatively rare event, we do not know how to prevent most of these deaths.

It is clear that in order to provide an effective community based service, there must be much closer cooperation between mental health service providers and general practitioners.

Mauthner and colleagues [1998] commented:

'The relationship with primary care in general and GPs in particular was considered to be critical to the success of CMHTs and the team model.'

This opinion was reflected in the views of those interviewed for this survey [Tables 5.3.1 UCT 2; 7.3.2 ISC 1; 6.3.2 GPL 1-5]. However, a balance needs to be struck between the needs of the general practitioners to have help with the high prevalence disorders and the need for the

mental health service providers to provide adequate care for their SEMI patients. The psychiatrists recognised this as an issue [Table7.3.2 ISC 2]. The Joint Committee Report (1997) listed as one of its strategies:

" Increase opportunities for integration of services provided by general practitioners and the mental health services."

Unfortunately, although the Report makes some suggestions, it gives no clear guidelines about how this integration is to be accomplished. One series of guidelines has come from Canada. The McMaster University in Hamilton, Ontario has provided some useful guiding principles for psychiatrists in collaborating with general practitioners [Kates et al 1987].

- To understand the needs of family physicians and the pressures they face
- To offer relevant clinical services in a variety of locations
- To encourage personal contacts with family physicians
- To utilise a problem orientated approach
- To develop and refine the additional skills required when working with family physicians
- To monitor the interface between psychiatry and family medicine for any problems and resolving them as quickly as possible
- To use clinical contacts as educational opportunities.

Because of the differences between general practitioners and mental health service staff about the levels of priority to be assigned to various patient groups, criteria for referral will have to be negotiated at an early stage. Thornicroft and Tansella [2002] have made some useful suggestions that might form the basis for such negotiations:

"As specialist services are scarce and expensive, they should target their skilled impact upon:

- Undertaking the assessment and diagnosis of complex cases and those requiring an expert second opinion
- Treating people with the most severe symptoms
- Providing care for those with the greatest degree of disability consequent from mental illness
- Making treatment recommendations for those conditions that have proved non – responsive to initial treatment.

8.3.6: The "Shared Care" Approach

Since mental health services began to evolve into 'community care' there has been an extensive exploration of other practice models that link general practice with specialist services. In Australia these efforts have been called 'shared care' which had been defined as " a collaborative approach to coordinating patient care between specialists and primary care providers" [Joint Report 1997]. In the UK at least four different models have been explored as a means of facilitating this collaboration. These are: patient held records; computer – based shared care; standardised record sheets interchanged between providers and consultation/liaison [Warner et al 2000]. It seems likely that there will be no generally acceptable solution and that extensive work will have to be undertaken at a local level to determine the best model or combination of models to suit local conditions.

Meadows and colleagues [1997] have suggested a RANGES model. (Ranges is an acronym for ' Recognising, Assessing and Negotiating GPs Engagements with Secondary services'). Represented as a hierarchy of levels, it draws on a 'filters' model and some concepts from motivational progression. It anticipates that individual mental health services would choose from a menu of interventions according to their own needs and the levels of interest and motivation amongst the GPs with whom they are associated (see Figure 8.3.6).

Figure 8.3.6: The 'RANGES' Model

GP Participation	Level	Area Mental Health Service Participation
GP works part – time in mental health services	5	Paid sessions and defined roles for sessional GPs
GP frequently participates in shared care arrangements	4	More sophisticated consultation – liaison services
GP uses consultation – liaison services and participates in shared care occasionally	3	Psychiatrists supervise GP groups. Basic consultation – liaison services GP liaison Officer attached to MHS
GP consults MHS staff and attends educational sessions occasionally	2	Educational packages. Clinical guidelines for GP/MHS interaction
GP engages in no educational activity	1	Activities to raise GP awareness

The authors conclude:

"It is important to acknowledge general practitioners' massively important role in the management of mental health problems in the community and to regard collaborative models of working with them as a high priority."

The advantage of this model is that it provides a menu of options, each with some description of roles for both GPs and MHS staff, across 5 levels of cooperation that will suit different local conditions. The importance of working at a local level was clearly understood by both administrators and psychiatrists. The psychiatrists are aware that GPs are not a homogeneous group [Table 7.3.6 WIL1]. They show a spectrum of perceived need as well as variability in sensitivity [Table7.3.6 VR1; VR 2]. The administrators also recognised the importance of working with GPs at both an individual and Divisional level [Table 6.3.1 MOU 2; FEW1; FEW 2]. One administrator also mentioned the importance of local demographics.

As an illustration of the diversity in local demographics, the Swan Hills Division of General Practice may be compared with the Perth Division, which is geographically adjacent [Innes & Scarffe 2000]. [Author's note: These two Divisions have now amalgamated]. Details are set out in Table 8.3.6.

Table 8.3.6: Demographic Differences Between Divisions

Demographic Variable	Perth Division	Swan Hills Division
Total Population (ABS 1998)	125,690	149.840
Male/Female Ratio	49.6%: 50.4%	49.5%: 50.5%
Age Group 0 – 14 years	18.7%	24.5%
Age Group 65 + years	12.3%	8.8%
Number of GPs	148	90
Ratio of GP FTE per head of population	1:849	1:1665
Area of Division	90.5 sq. km	2,400 sq. km
Special Characteristics	High population of non – English speaking background. Large numbers of high – dependency mental health patients	About 1/3 of the population employed are in a professional or managerial capacity, 1/3 in clerical and 1/3 in trades or labouring positions

It is clear that not only are the populations of the two Divisions markedly different in several respects, but also that the number of GPs per head is dramatically different. Moreover, it is evident that the CHMTs will have to travel much longer distances in the Swan Division to reach their patients. This will have implications for staffing levels and other resources such as vehicle costs.

8.3.7: The Importance of Personal Relationships

Whatever model is used there will be obstacles to successful negotiations. The psychiatrists were particularly aware of these [Table 7.3.8.], but there were a number of areas of agreement with administrators. The importance of early intervention [Tables 7.3.8 IPW1; 6.3.1BEI 1] will be dealt with under the rubric of 'Access'; the barriers between specialists and GPs [Tables 7.3.8 LTB 2; 6.3.3 RTC 1] under 'Communication' and the GPs' lack of knowledge [Tables 7.3.8 PGP 1; 6.3.2 EGP 1] under 'Education.'

Some difficulties are redolent of those encountered in the UK [Mauthner et al 1998]:

'Difficulties in the relationship between CHMTs and GPs arose from: working with numbers of GPs too great for the establishment of personal relationships; inappropriate referrals; professional rivalries and disagreements over clinical responsibility between GPs and psychiatrists and GPs imposing ways of working on teams.'

The difficulty of establishing personal relationships is notable, and all three groups of stakeholders were agreed on the importance of personal contacts [Tables 5.3.3 NFA 4; 6.3.1 IIR1;7.3.1 IIR 1]. It is clear that a special effort needs to be made in this area.

8.3.8: Recommendations

Negotiations should begin as soon as possible between clinical and administrative representatives from the mental health services (MHS) on the one hand and the local Division of General Practice on the other. The objectives of the negotiations should be to draw up a Memorandum of Understanding (MOU) that will serve as a plan for the implementation of an optimal service. The MOU should cover the following aspects of Primary Care Psychiatry (PCP):

- The scope of PCP, with specific discussions about the roles of non – medical personnel and non – governmental organisations.
- The content of PCP, with specific reference to patient populations and the establishment of clinical boundaries and responsibilities. This is likely to be a contentious area.
- A suitable framework for diagnostic categories, taking subsyndromal disorders into account.
- The involvement of the multidisciplinary team with GPs. This will also require a great deal of work within the MHS to clarify the functions and work practices of the multidisciplinary team so as to enable the team to provide the support that the GPs need to manage the high prevalence disorders without neglecting the SEMI patients. The GPs input will be valuable in focussing the support.

- Various models of 'shared care' should be discussed with specific reference to liaison models, such as case conferences.
- Special efforts need to be made to foster informal personal relationships. It might be helpful for some specialists to become associate members of the local division.

8.4: Access

Most of the GPs had a number of complaints about access to the Mental Health Services, especially after hours. There was very little understanding by either the psychiatrists or the administrators that this is a major problem for GPs, which often inhibits early intervention. Early intervention, preferably in the prodromal stage, is particularly important in early episode psychosis where it may significantly alter outcome:

'Early intervention with its promise of more efficient treatment through an enhanced focus on the early phases of illness, is an additional prevalence and burden reduction strategy, which is now available to be widely tested and, if cost effective, widely implemented.' [McGorry 2002]

There are also major difficulties for patients [Cook et al 2002; SANE Charter 2002]. The difficulties may be considered under a number of subheadings:

8.4.1 Difficulties with the Complexities of the Mental Health System

This difficulty was succinctly encapsulated by one particular GP [Table 5.3.2 FAL 2]:

'One thing I've found with (Team) and the whole psychiatric service is that they've got all these pigeon holes and sometimes the person at the other end of the phone seems almost delighted when they say ' Ah, this person is out of our pigeon hole – you'll have to refer her to another department. It's an adolescent, you have to refer to the adolescent department.' So you speak to the person in the adolescent clinic and you tell them this is really urgent – this person is smashing up the house and threatening his mother. 'But is the patient suicidal?' No she isn't. 'Then it's about three months wait.' It's hard enough banging your head on the wall because one department won't take on the outreach of another. If you can't tick the box for suicidal, well just forget it.'

Most CMHTs are attempting to address the problem by having a single point of entry through a Duty Officer. However, the roles and responsibilities of these officers vary widely from one team to another so there is no consistency of response.

Further, many GPs find it difficult to deal with a person who is unable to make a commitment to providing care but has to pass the message on to the rest of the team. Consequently GPs would prefer to speak directly to a psychiatrist as a person who can accept responsibility for providing clinical care. The situation could be improved by giving the Duty Officer greater flexibility and slightly different responsibilities in their job descriptions.

When a call is received from a GP the present priority is for the Duty Officer to make a decision as to whether the patient meets the criteria for acceptability to the service. Perhaps the priority should be reframed as providing the GP with a solution to the problem. Some administrators understand the pivotal importance of this first contact [Table 6.3.1 DOC1] and some original work has been done by the Peel Mental Health Services [Collier & Fairly 2000]. A Memorandum of Understanding has been negotiated with the Peel Division of General Practice and some of the ideas from this memorandum merit further exploration. For example the concept of providing access to a psychiatrist for telephone advice is perceived as useful by some psychiatrists [Table 7.3.2 VDC 2]. More consistency of responses might be achieved by an agreement between units on the training of Duty Officers. An algorithm for making decisions, such as is used in the Telephone Triage system in WA [Turner et al 2002] would be particularly useful. There is evidence that telephone triage can be safe and effective, but certain specific skills are necessary [Ledek et al 2002].

8.4.2: Difficulties with Geographical Boundaries

Several GPs had difficulties with catchment area boundaries [Table 2.2.3.2 BON1], which were appreciated by some psychiatrists [Table 2.4.3.8 PMH 1]. The Ministerial Task Force on Mental Health [1996] recommended: 'That the organisation of community mental health services be catchment population based.' This has now become Health Department policy. CMHTs all have catchment areas that are defined by post – codes. These have been subject to a number of changes in the past but now seem to be comparatively stable. This means that there should be no difficulty in defining the appropriate team to which a patient from a particular address should be referred, even if the address is temporary. The question of which area the GP belongs to is irrelevant, unless the patient is of no fixed abode. Rigid demarcation of areas has never been intended and there should be a certain permeability of the boundaries in individual cases. The principal remedy for the GPs' difficulties would seem to be to provide better information about the post code boundaries.

An alternative solution might be for a particular service, or a team within a service to be associated with a number of practices, irrespective of where their patients live.

It seems likely that most patients will visit a GP close to home and the number of 'out of area' patients might not be substantially increased.

8.4.3 Difficulties with Delays

Eight GPs referred to difficulties in getting out – patient appointments within a reasonable time frame for patients who were not in crisis [Table 5.3.2 DEL1]. There are two aspects to this problem:

- **Time delays within the mental health system**

  These may be broken down into three components:

  - The time from the date the referral was made until the date it was received by the duty officer. As far as the Inner City Mental Health Service (ICMHS) is concerned there is anecdotal evidence that there may be a delay of several days between the parent hospital receiving a referral and it reaching the ICMHS. Attempts have been made to counter this by suggesting that GPs refer directly to the ICMHS, and by improving internal communications. However, a formal study will be needed to tighten up the whole system.
  - The time from the date the Duty Officer received the referral until the date the CMHTs received it. Locating the Duty Officer geographically close to the CMHTs, the improvement in the stability of the Duty Officer appointments and the growing confidence of the teams in the Duty Officer's ability to prioritise referrals has reduced this delay quite dramatically.
  - The time from the date the CMHT received the referral until the date the team made the first contact. This can be influenced by factors such as the frequency with which a team meets to deal with referrals, the availability of case managers to respond promptly and the availability of transport.

- **Out – patient waiting lists**

  There are two factors that are of major importance in extending waiting lists:

  - The large number of patients who do not attend.

    Figures provided by the Clinical Neurosciences Division at Royal Perth Hospital for the year 01/07/01 to 30/06/02 show that of 5677 appointments booked in the psychiatric out – patients clinic, 4104 attended and 1573 (27.7%) did not. Formerly this figure was inflated at ICMHS by the routine practice of offering the patient another appointment. A recent strategy now put in place requires a doctor to make a decision about the course of action to be taken. The menu of options is: offer the patient another appointment; send the patient a letter requiring him/her to make another appointment within 2 weeks or be discharged; or discharge the patient, preferably after consultation with the GP.

- The large number of patients attending for routine follow – up.

  In the past there has been a tendency for mental health services to adopt an 'all or nothing approach' [Table 2.4.3.2 ISC1]. That is to say, once a patient had been accepted into a mental health service, this was taken to mean that there would be life – long follow – up. There is now a broad perception that other kinds of management strategies and innovative kinds of consultation styles might be more appropriate and would reduce waiting lists. For example:

  a) The one – off consultation

  All 5 GPs who commented were in favour of the one – off consultation [Table 5.3.2 OOC1]. All believed that for many patients an indication from a psychiatrist of an appropriate course of treatment would enable the GP to carry it out. Psychiatrists [Table 7.3.2 VDC1] endorsed this view, which was congruent with my own findings in a study of the patients whom I saw in Kalgoorlie.

  Between January 1990 and December 1992, I made 34 monthly visits to Kalgoorlie where I conducted 306 consultations, 165 first consultations and 141 follow – up. One hundred patients had only one consultation, 74 of whom were discharged back to their GPs whilst 23 were lost to follow up and 3 were admitted. Overall 114 (69.1%) patients were discharged back to their GPs, 44 (26.7%) were lost to follow up and 7 (4.2%) were admitted. There was some evidence that the GPs were satisfied with this strategy inasmuch as 22 out of the 44 who referred patients referred more than one patient [Buchan 1999]. This implies some kind of 'shared care' concept which has been dealt with under the heading of 'Primary Care'.

  b) Telephone consultations

  Five psychiatrists favoured this kind of consultation [Table 7.3.2 VDC 2] as did 10 GPs [Table 5.3.3 NFA1]. This is dealt with in more detail in the category 'Communication'.

  c) Case Conferences

  Administrators were enthusiastic about this approach [Table 6.3.2 GPL4] but only one psychiatrist commented [Table 7.3.2 VDC 3]. GPs have been surprisingly unenthusiastic in view of the recent increase in Medicare rebates for this item. Following the appointment a GP Liaison Doctor to ICMHS, he drew up a simple guide for GPs who were interested in writing joint Care Plans for patients by means of a Case Conference. Largely in response to his initiative, care plans were completed for 15 patients between 19/07/01 and 03/04/02.

These were completed by the GP with the involvement of myself in 14 cases or another consultant in one case, and either the GP liaison doctor or a case manager as the third party. All meetings were conducted in GPs' surgeries. The roles of the various participants were spelled out in the Care Plans.

The outcomes as at 19/07/02 were that treatment had been completed in 4 patients; 6 patients were still under treatment; 2 were referred to other CMHTs after changing address; 2 patients defaulted treatment and were referred back to the GP and one refused treatment. Although there are not enough patients to draw any firm conclusions, there is an impression that patients have better defined outcomes following care plans. For example, patients who persistently fail to engage with Mental Health services can, with the GPs knowledge and consent, be discharged back to the practice with the proviso that that patient can be quickly returned should they present again with a change of heart. Significantly, both patients who defaulted had long - standing problems of alcohol abuse. There is also an impression that patients who have already met the psychiatrist and case manager engage more readily with the multidisciplinary team, which is one of the prime objectives of care planning [Harris 2002].

However, there are some obstacles to involving GPs in Case Conferences that have recently been investigated [Mitchell et al 2002] and the uptake of the MBS item numbers has been slow across Australia. The bureaucratic complexity of the process is certainly a disincentive and one of the solutions proposed by Mitchell and his colleagues is to place the burden of organising the conference on the specialist services. To my mind this defeats the purpose of the case conference, which ought to preserve the GP as the protagonist in the process. Since the GP liaison doctor has not been available for case conferences, we have experienced problems with having case managers available to attend conferences at scheduled times. Their work – loads are so heavy and the urgently needed interventions so unpredictable that they find it very difficult to meet at pre – arranged times. The appointment of a GP Liaison Nurse for several regular sessions would greatly alleviate this problem. In the past I have always opposed this approach on the grounds that all case managers should be involved, but this would seem to be an unrealistic expectation at this time. Experience in other services where I have worked suggest that there is considerable merit in having a dedicated person in this role and administrators with this experience are enthusiastic [Table 6.3.2 GPL 2 – 3].

8.4.4: Use of the private sector

Seven GPs commented that referral to a private psychiatrist would be their first choice [Table 5.3.2 UPS1]. Baily [2000)] interviewed 24 GPs in the Wheat belt and also found that referral to a private psychiatrist was rated the most useful support strategy. There were a number of reasons for this:

- Inadequate services available for patients who become acutely anxious or depressed as a result of a distressing adverse experience. Specifically required are support, help with coping strategies and quality counselling [Table 5.3.2 INS1]. This relates at least in part to the problem of identifying those patients which are the principal responsibility of the mental health services, which has been dealt with under the rubric of 'Primary Care'.
- Long delays for appointments (see above)
- The high turnover of registrars in the public sector [Table 7.3.8 NAR 2]. This precludes the development of any genuine rapport between registrars and GPs, thereby limiting the opportunity the opportunities to match a patient's needs to a therapist with a compatible style. The matching is obviously much easier with a psychiatrist who has an established private practice.
- Problems of responsibility

  One GP was concerned about where the clinical responsibility lies if management decisions are not made by a psychiatrist [Table 5.3.2 RES 2].

  The new Mental Health Act [1996] has created a new category of 'mental health practitioners', who are usually nurses, social workers or other Allied Health professionals. These mental health practitioners have sufficient training and experience to make clinical decisions, such as whether a patient requires involuntary admission, and to carry the responsibility for doing so. This has not given rise to any major problems so far, but it is important that the team functions in a true multidisciplinary sense and that there is adequate psychiatric back – up for difficult cases. Administrators report that GPs relate easily with non – medical staff once they are familiar [Table 2.3.3.5 RNM 2 – 3]. Notwithstanding all the problems with the mental health services 7 GPs reported that they had received good support from particular teams [Table 5.3.2 GSE 1].

8.4.5: Emergency Services

Several GPs complained of delays in response to patients in crisis [Table 5.3.2 FAL1; DEL 2]. The psychiatrists were aware of the need to be available, but only went so far as to suggest that regular 'emergency slots' in out – patient clinics are helpful [Table 7.3.2 ISC 3]. These are useful when crises occur during normal working hours but are of no value after hours.

The Mental Health Division's Emergency Psychiatric Service Policy [Lipton 1998] states:

' Psychiatric emergencies are managed in the community by a wide network of providers including public mental health services, hospital accident and emergency departments, general practitioners, the Police Service, Family and children's services and a range of other community based services.'

' Psychiatric emergencies are distinct from psychosocial crises, although the distinction is not always clear where full information is not available. However, whenever possible psychiatric emergency resources should be directed to the core business of mental health services, which is the treatment of people with serious mental health conditions.'

- **Community based services**

  The Psychiatric Emergency Team (PET) was established in 1989 to provide a seven day per week, 24 hours per day service to the metropolitan area from a central site.

  The policy document goes on to say :

  ' To date the PET has been the main community emergency service provided by the mental health system, with some mental health services providing emergency services during normal working hours, A central service has not been able to adequately meet the needs of rural and remote areas and it becomes increasingly difficult to cover the whole metropolitan area as Perth grows.'

  The policy document provides for the devolution of PET and the development of a number of protocols. The protocols are to be developed: within hospitals between psychiatric services and emergency departments to establish clear roles and procedures; between mental health services, hospitals and other service providers, such as the Police, ambulance services and private sector providers, particularly general practitioners. No details were given as to how these protocols might be negotiated, and the fundamental difficulty of the different perceptions by mental health professionals vis a vis general practitioners as to what constitutes an emergency was not addressed.

  The Task Force [1996] supported the concept of more localised emergency services and recommended that they should be developed as part of district based teams.

Pursuant to this recommendation and the policy statement, a great deal of work was undertaken to define the ways in which locally based services should develop. For example, the South West Corridor produced a detailed report in November 1998 [Hodges et al 1998] and the North Metropolitan Health Service in December 1999 [Sultan et al 1999]. Despite this extensive groundwork, the proposals were not accepted and in July 2000 the Metropolitan Mental Health Service issued the following statement [MMHS 2000]:

' Despite this hard work, there are complex operational circumstances that are likely to cause impediments to the smooth introduction of the changes required by the proposed regional model. These varied circumstances were such that the MMHS could not guarantee regional emergency services in a reasonable time frame across the metropolitan area. Therefore the MMHS has developed an alternative model of psychiatric emergency services that builds upon the present Psychiatric Emergency Team.' 'It is anticipated that the PET organisation will be reconfigured to enable the expansion of functions and to identify key staff with regional mental health service links.'

One of the specific functions of this reconfigured PET was to provide emergency community visits in the Peel Mental Health Services catchment area. This could never be a satisfactory service because the Peel catchment area extended over 2700 sq. km and contained some 50,000 people. The main population centre, Mandurah, is about 75 km from Perth. The PET based strategy for emergency services is still in place and there is still no satisfactory community based strategy for managing emergencies, although most CMHTs do their best to cope with what they can. Experience in Tasmania suggests that there is little to be gained by extending the working hours of the CMHT to 2300 hrs without further development of other services [Habibis et al. 2002].

There could probably be some improvement if GPs could have a better understanding of the limitations of the mental health services and the administrators interviewed were very much in favour of local memoranda of understanding [Table 6.3.1 MOU 1 – 2].

- **Hospital Emergency Departments**

  Nine of the 15 GPs who commented said they would use the Emergency Department, but only as a last resort because they found it unsatisfactory, whilst another 3 said they would not use it at all. Reasons for dissatisfaction included mental health patients being given a low priority resulting in long waiting times, or being sent home because there were no beds for admission [Table 2.2.3.2 EMD 1].

Similar complaints had been raised earlier at Fremantle Hospital so I undertook a study of all psychiatric presentations to the Emergency Department between 01/04/98 and 31/05/98. One hundred and fifty patients accounted for 164 presentations. There were 87 female and 77 male presenters; 57 (34.8%) were aged 15 – 25 years and 75 (45.7%) were aged 26 – 40 years. Sixty – seven presentations (40.8%) were for an overdose with a further 18 (11%) for suicidal ideas/self – harm. Unfortunately times of total attendance were only recorded for 30 presentations, but 25 of these cases were seen and left the ED within 4 hours. There were 2 outliers who spent more than 6 hours in the ED. One, who was seen within 90 minutes, spent 8 hrs 45 mins in ED. She had taken an overdose of benzodiazepines and it seemed likely that she was left to sleep off the effects before being allowed home. The other, who spent 9 hrs 45 mins in ED, had slashed his wrists. He was seen within 5 minutes of Triage so this was presumably a fairly serious injury that required treatment before he was admitted to the Observation Ward.

There was thus no clear evidence of undue delays but the recording of times needed to be improved before any conclusions could be drawn. Forty – seven presenters were admitted to the Observation Ward and 42 were discharged within one day after admission, which was taken to indicate that the Observation Ward was being appropriately used. Forty presenters were admitted to the Alma St Centre, but 15 were discharged within 3 days, suggesting the possibility that some of the admissions might not have been necessary.

The most glaring omission to be exposed by the study was the lack of follow up for patients who were not admitted. In only 2 cases was there any mention of follow – up; one was referred to the University Department of General Practice and the other was given an out – patient appointment. There might have been other informal referrals to the CMHTs or other agencies, but it was clear that a much more systematic approach was required. For example there was no mention of any attempt to engage the 10 presenters who had overdosed on heroin in a methadone programme. Neither was there any mention of referral to a GP for on – going care.

Similar results were reported from the US [Forster & King 1994] where only 10% of patients treated in a hospital – based psychiatric emergency service connected with outpatient care after referral.

The authors conclude:

'Definitive treatment in the psychiatric emergency service is possible in services where patients receive close follow up from case – managers or continuous treatment teams who are affiliated with the service and who provide crisis management and mobile case management.'

Some services are improving the management of psychiatric patients in ED by having a Psychiatric Triage Officer available in ED. This will probably improve cooperation and reduce waiting times but the provision of a management plan to follow discharge needs to be addressed. Particularly important is the need to keep the GP informed.

Notwithstanding the GPs dislike of Emergency Departments, there seems to be little prospect that their use will diminish in the future. The St Thomas' Hospital, London, team, which noted [Cassar et al 2002], succinctly encapsulated the situation:

'Psychiatric presentations to A&E departments serving deprived urban areas are unlikely to diminish in number and dedicated mental health services are urgently required to meet these needs. The strict sectorisation of community mental health services poses a funding problem for mental health work in A&E departments. Funding arrangements for patients coming to A&E who live outside the local area need to be resolved. The advent of primary care led mental health service commissioning threatens to sideline the role of the general hospital in mental health provision for non – local patients even further.' '....A&E departments can make a valuable contribution to 24 – hr access to services, particularly for patients who have deliberately self – harmed, rough sleepers and those not registered with a GP. However the underlying assumption guiding national policy seems to be that A&E departments are not the right environment for mental health assessment out of hours. Telephone help lines, extended hours for CMHTs and domiciliary visits by GPs are often mentioned as alternatives. We would argue that spending on these developments is unlikely to divert patients with mental health problems from A&E departments. Investment in dedicated mental health liaison services could transform the quality of patients' and professionals' experiences of A&E psychiatry and lead to the view that this is a preferred point of access to mental health services, especially after hours.'

As far back as 1952, the Maudsley Hospital established an emergency clinic that offered a 24 hour walk – in service seven days a week, open to all patients including self – referrals, regardless of catchment area. Between 0930 hrs and 1730 hrs every week day, it was staffed by three full – time psychiatrists, nurses, a social worker, a secretary and a receptionist.

After hours it was staffed by one duty psychiatrist from a rota, two nurses and a part time receptionist. Over a 6 month period, there were 1280 presentations; 41.9% were self referrals, 5.6% were of no fixed abode and 62.0% were from outside the Camberwell catchment area. Significantly, 43% made between 2 and 12 visits over the 6 month period and there was no doubt that some were abusing the system [Meng Hooi Lim 1983]. Whatever might have been the benefits of this kind of service, the resources required would be far beyond the funding capacity of the WA mental health services.

8.4.6: Recommendations

A number of working parties should be established involving clinicians from the mental health services, administrative staff including those from the Mental Health Division and GPs from the local Divisions of General Practice with a view to improving GP access to mental health services. Particular aspects to be discussed should include:

- Improved performance and consistency of Duty Officers by agreement on the roles and standardised training in the use of algorithms developed in conjunction with GPs. The 'Access' model [Keller & Sara 2000] might be useful in this context.
- Better information for GPs on geographical boundaries and which Duty Officer to telephone.
- The feasibility of having one team attached to a group of general practices instead of a geographical catchment area.
- Examination of the internal communication systems of mental health services to improve the speed and efficiency of the processes.
- The development of more effective strategies for dealing with non – attenders.
- The development of innovative responses to GP referrals. For example, one – off consultations, telephone consultations and case conferences.
- The development of services for 'quality counselling'. This might involve the training of non – medical members of the multidisciplinary team or the use of computer programmes such as CLIMATE [Andrews & Erskine 2003].
- Examination of the feasibility of dismantling PET and using the resources to improve consultation – liaison services to emergency departments.

Following these discussions, appropriate implementation plans should be developed.

8.5: Communication

8.5.1: Need for Verbal Advice

Ten GPs expressed a need for verbal advice [Table 5.3.3 NFA1; NFA 2]. Three psychiatrists also favoured this kind of consultation [Table 7.3.2 VDC 2] but only one had any established

protocol for making himself available. He asked GPs to fax a brief outline of the problem to him in the morning, then set aside and hour at lunch time to phone back to each GP and discuss the cases. He made detailed comments about the advantages; an edited version is set out below:

Psy E: 'What would happen if I - when a referral came in - gave the GP a ring and, having read through the referral and formulated it - got back to the GP and say "Thank you for your referral. I've read through it and what it seems like is those are the issues. I've got a few questions, this, this, and this, but this is what seems to be going on. Am I on track or am I off?. And the number of referrals I've had from a GP who isn't fairly confident in saying this person has depression and I think they need to be on medication would you review them and give me your opinion? With that information, just ringing them up and saying, "Yes, Yes," deals with it in thirty seconds. The idea I've been running with is work out what the issues are, get back to the GP verbally on the phone, saying "This is what's going on, any other issues?" "Yes, No, whatever". "This is plan A, this is plan B and plan C is that if this isn't working, give us a ring and I'll squeeze them in quickly."

Similar difficulties were found in the UK [King & Pullen 1994]. The authors considered both verbal and written communication. Verbal communication by telephone is probably the most common form of spoken communication between GP and specialist. It is frequently the channel for urgent referral, or for conveying sensitive information that the GP does no want to commit to paper. The authors commented:

'There is much anecdotal evidence that GPs find psychiatric consultants and junior staff difficult to reach by telephone, and mutual understanding may not easily be reached unless GP and psychiatrist have some knowledge of each other.'

Administrators made no specific comments about telephone contacts.

8.5.2 Value of personal contacts

All groups stressed the value of face to face contacts, especially at an informal level. Two GPs emphasised the value of personal contact with a team member [Table 5.3.3 NFA 4] as did 3 administrators [Tables 6.3.1 IIR 1; 6.3.4 UGP 3] and 3 psychiatrists [Table 7.3.1 IIR 1].

There is no doubt that face to face contact is an extremely useful mode of communication and local discussions between the GPs and mental health services might provide the foundation for successful innovative changes by planners [King & Pullen 1994]. Unfortunately there are some difficulties with face to face discussions. Notably there is a culture of non – involvement with

GPs [Table 6.3.3 RTC1] and an attitude of condescension [Table 7.3.1 POS1] in some MHS units. Also there are differences in the way general practice and hospital practice differ, both in objectives [Table 7.3.4 LOU 2] and in methods of working [Table 7.3.3 UGT 3]. Nevertheless, 4 psychiatrists commented on the importance of GP led initiatives [Table 7.3.2 GPR 1 – 2].

8.5.3: Written Communication

' The quality of care which patients receive within the NHS is dependent upon the communication between and specialists and the letter is the most widely used instrument in this process' [Prasher et al 1992].

Four GPs complained specifically about the lack of planning for discharges from the MHS [Table 5.3.3 LOC1] but one mentioned a lack of information from the GP [Table 5.3.3 LOC 2]. Three psychiatrists also complained about the inadequacy of information from GPs [Table 7.3.4 IDC 2]. Three administrators made comments about the importance of understanding the discharge process and the need for the GPs to have adequate information [Table 6.3.3 UDP1]. As a corollary, they saw a need to audit written communication to GPs [Table 6.3.4 LFB1] and there was a perception of a bilateral failure to provide feedback [Table 6.3.4 LFB 2].

Part of the difficulty in communication stems from the difference between the information required by psychiatrists from GPs from that required by GPs from psychiatrists. This discrepancy gives rise to difficulties in at least three types of letter: the referral letter; the discharge summary and the follow – up letter.

- **The Referral Letter:**

  King and Pullen [1994] have listed the following items required by psychiatrists in a referral letter:

  - Medications prescribed so far
  - Family history, especially any sensitive information
  - Main symptoms or problems
  - Reasons for referral
  - Psychiatric history
  - Expectations of outcome.

  If a GP is to receive an appropriate response from the consultation, the psychiatrist needs to know the real reason for the consultation. The GP might have a number of specific questions or outcomes in mind, such as:

- Please confirm my diagnosis
- Please confirm my treatment plan
- Please clarify what is going on
- Please suggest a management plan
- Please assess the suicide risk.

These requests have an underlying assumption that the GP wishes to continue managing the patient. Alternatively, requests that have an underlying assumption that the GP does not want the patient referred straight back might include the following:

- Please share the care of this worrying distressful patient
- Please take over the care of this patient for a while
- Please use your specialist skills to treat this patient
- Please use your specialist facilities to treat this patient.

Mental health services often seem to respond as though all referrals fall into this second category, which might stem from a lack of clarity in the referral letter. Prasher and colleagues [1992] investigated 270 referrals from GPs to out – patients over a two – year period. Of the 270 Patients referred, 112 attended and the letters referring these patients were used in the survey. The presenting complaint was given in all but two of the letters, and the reason for referral was given in 97 (87%). Current medication was given in 76 letters (68%), family history in 39 (35%) and psychiatric history in 58 (52%) letters respectively. The omission of the psychiatric and family histories in so many cases was disappointing because the GP might well have an intimate knowledge of the patient's background. The medical history, which might have an important bearing on the choice of treatment – for example when there is a combination of depression and ischaemic heart disease – was not mentioned in over half the letters.

- **The Discharge Summary:**

  General practitioners require the following information in a discharge summary [King & Pullen 1994]:

  - Diagnosis
  - Treatment
  - Arrangements for follow – up
  - Prognosis
  - A concise explanation (formulation)

- What the patient has been told
- An answer to any specific questions in the referral letter.

Essex and Rosenthal [1991] emphasised the vulnerability of patients discharged from hospital after an admission for an acute psychiatric illness, especially in the first two weeks.

' For these people and their families, the first two weeks is a critical time. This is when problems arise, support is needed, drugs run out and default is most likely.'

The authors surveyed all the psychiatrists caring for patients admitted to the 21 acute units in the South East Thames region. Fifty one of the 72 psychiatrists responded. Surprisingly, 22% of consultants did not send early discharge summaries and many of the responses suggested an inadequate understanding of the role of the GP after discharge. The authors commented:

' For many, it is the general practitioner who will have to provide the long – term care. Yet effective continuity is made very difficult by the lack of essential information about treatment and future management plans. It is essential for the general practitioner to be informed about treatment as soon as possible after discharge. Giving patients the discharge summary to take to their doctor has been shown to be the quickest way to achieve this goal. It is therefore disappointing to discover that only 25% of respondents gave copies to their patients to take to the doctor.'

One of the impediments to providing early discharge summaries is the different requirements of GPs and psychiatrists for the information they provide. Craddock and Craddock [1989] investigated this at Highcroft Hospital in Birmingham, which was staffed by 10 consultant and 13 junior psychiatrists and served as a referral centre for 234 general practitioners. They found that most psychiatrists preferred a longer summary (2¼ pages of A4), which ended with concise, detailed information under 11 headings that conformed to the Institute of Psychiatry guidelines for summaries. Most GPs preferred a one page summary, even though this was comparatively unstructured.

Wattis and Protheroe [1990], who investigated the response of 28 GPs to a brief, computerised summary for patients in old – age psychiatry, confirmed these findings.
They concluded that The GPs preferred a short, standardised format discharge summary. They noted that all the GPs stressed the importance of receiving the summary quickly, preferable on the day of discharge, but certainly within a week. The authors also noted that

the standardised format had an additional advantage in that the summary accumulated data on a computer data base in a way that facilitated analysis.

One of the psychiatrists interviewed also stressed the value of a standardised summary and suggested that the CLIPP (Consultation Liaison in Primary Care Psychiatry) format might be used [Meadows 1998]. Others have emphasised the importance of developing a common language and the need for compatible information technology.

- **Follow – up Letters:**
  After the first report psychiatrists should probably only write letters either when there is a significant change in management or to remind the GP that a patient is still attending when there has been a gap of several months.

8.5.4: Recommendations

- There should be a concerted effort by senior clinicians to change the attitudes of condescension and non – involvement with GPs that still persist in some MHS units.
- There should be discussions between clinicians and GPs about the best strategies for improving personal contacts. These might include protocols for telephone access, informal social meetings and participation by MHS staff in GP Balint groups (these will be discussed further under 'Education'). Because of the rotation of junior staff it is probable that these initiatives will be the province of consultants or medical officers.
- There should also be joint discussions about protocols for the improvement of written communications. Specifically, there should be discussion of the King and Pullen framework that might serve as a basis for protocols to be incorporated into a Memorandum of Understanding.
- There should be regular audit of correspondence. For example, a brief discharge summary should be available on the day the patient is discharged and this is fairly easily monitored. Consideration should also be given to whether the patient should have a copy.

The key stakeholders involved in these discussions should also develop implemenation plans.

8.6: Education

The stakeholders' comments in this section clearly indicate that there is wide agreement on a need for improved education at several levels:

8.6.1: Undergraduate Medical Education

Five GPs [Table 5.3.4 UGT 1], 3 administrators [Tables 6 .3.3 WIC1; 6.3.4 LSS1] and 7 psychiatrists [Table 7.3.3 UGT 1 – 3] agreed that there is a need to improve undergraduate curricula to provide better preparation for general practice psychiatry. They saw current training as being too hospital based, too specialised and too lacking in a community focus to prepare GPs to manage the kind of patients they are likely to encounter in their surgeries. These views are similar to some expressed in the UK.

In 1985 the Social Services Committee in the UK commented:

' It is to a GP that families have always looked in the first instance for medical advice and support. While there will continue to be an important backup task for psychiatrists and community medicine, a relatively unregarded corollary of community care has been the growing burden on GPs.' 'A witness from the RCN *(Royal College of Nursing)* told us that GPs were not always adequately prepared to meet the new needs and that they looked to hospital consultants for expertise.'

'The RCGP *(Royal college of General Practitioners)* themselves confirmed that GP training was inadequate for the job they were expected to do.' 'It is essential that their training reflect that task and that the specialist medical services do more to help GPs in the performance of their duties. We recommend a review by the Department of the training of the GPs in psychiatry and mental handicap, with a view to ensuring that GPs are better equipped to provide general medical services to mentally disabled persons.'

The situation hardly improved over the next decade and in 1996 Goldberg and Gater observed:

'Because of their high prevalence, their relationship to disability, their susceptibility to treatment and the fact that most disorders will continue to be managed entirely within primary care, it is important that training about common mental disorders and their management is emphasised both within medical schools and in vocational training schemes for general practitioners.'

Very similar views have been expressed in Australia. In 1994 the Burdekin Report (p911) stated: 'General practitioners (GPs) have insufficient training in the assessment and treatment of mental illness. This is particularly apparent in specialised areas such as the diagnosis and treatment of psychiatric disorders and mental health problems in the elderly, children and adolescents and other particularly vulnerable groups.'

Burdekin goes on to recommend (p912):

'State education authorities need to provide appropriate undergraduate, graduate and continuing education programmes. In particular, further programmes are needed in community - based service delivery skills.'

The Joint Committee [1997] also made the recommendation:

'That communication and counselling skills, being core skills for best practice, should be reinforced at all stages of the undergraduate and postgraduate medical training course through appropriate supervision, feedback and assessment process.'

Hickie and his colleagues [1999] noted:

'Psychiatric epidemiology now highlights the need to improve markedly the delivery of psychological treatments in primary care. There have been significant defects in the training of practitioners for this role and a lack of support from the mental health services.'

An important first step in training GPs in primary care psychiatry is the method of selecting candidates and some Australian universities have already made a change in the way they select students for medicine. Entry now depends on the candidate being successful in the University Medical Aptitude Test (a test that measures attributes other than academic achievement), the Tertiary Entrance Examination (that measures academic achievement) and an interview.

Dr Capolingua - Host (2000) explains:
'The new system in WA was introduced in an attempt to respond to community needs and the result of years of deliberation and consultation involving faculty committees, most other medical schools, the Australian Council for Education and Research (the premier body in educational assessment in the country), schools' representatives (state, private, Catholic) and the community'

The second important step is to examine closely both the contents of the curricula and the methods of teaching and the Royal College of Psychiatrists held a symposium [Symposium 1983] on the teaching of psychiatry to undergraduates. The emphasis was on innovative approaches and papers were submitted from: Queen's University in Kingston, Ontario (Letemendia and Burra); Michigan State University in the USA (Werner); Universities in Copenhagen, Odense and Aarhus in Denmark (Nystrup and Rafaelson); St George's Hospital

Medical School in London, UK (Crisp); The University of Manchester in the UK (Goldberg et al) and Aberdeen University in Scotland (Blackwood and Alexander).

There were a few themes common to most of the papers, such as:

- Teaching the social and psychological aspects of medicine in the pre - clinical years.
- Emphasis on the teaching of clinical interview skills.
- Preference for small group teaching, use of videotapes and supervised clinical practice instead of didactic lectures.

The paper from Manchester is of particular interest because it describes how the course there is shaped by feedback from the students:

'It is important to emphasise that the students themselves have played a large part in developing a teaching package that we describe. We have regularly asked their views on component parts of our teaching, and have modified the course in the light of them.'

Nevertheless, the first year Social Sciences course and the second year Psychology course remained unpopular. Students complained that the lectures were difficult to understand and that they could not see the importance of the teaching.

Notwithstanding these bold attempts to improve the teaching of psychiatry to undergraduates, little progress was made in the UK during the next 13 years. As Goldberg and Gater [1996] remarked:

'Regrettably, in practice, teaching tends to be confined to those disorders that can easily be found in the specialist service, such as dementia, schizophrenia and bipolar illness. It is an unusual training scheme that provides much instruction on the detection and management of those disorders which have been shown to be the most common, notably states of mixed anxiety/depression either accompanying known physical illness, or other somatic symptoms for which no organic cause can be found.'

Recently, Rajan and colleagues [1999] had some scathing remarks to make:

' Conventional medical courses rely on the teacher centred didactic setting of a lecture theatre to transmit vast quantities of information. The information that a student is required to retain is excessive, of questionable relevance and soon becomes out of date. The assessment procedure requires regurgitation of information in an anxiety provoking setting that does not

encourage more than a superficial understanding. Thus sight of the real purpose of medical education, that is to enable the student to become a competent clinical practitioner and life - long learner, has been lost'

The author goes on to describe an innovative curriculum of problem - based psychiatry that was introduced into Liverpool University in the UK in 1996. There is evidence that such a curriculum results in improved clinical performance, enhanced academic process and greater student and faculty satisfaction in comparison with traditional courses.

An even more daring innovation was introduced into the curriculum at Glasgow University in 1998 when it was recognised that there are educational advantages in including arts and humanities courses in the medical curriculum [Downie & McNaughton 1999]. Ten students chose a module in philosophy, which provided them with an opportunity to spend five weeks studying Plato's 'Republic' in the context of a course of lectures on political philosophy. The rationale for this was as follows:

'One of the major criticisms levelled at recent medical education has been that students, particularly in the preclinical years, are so busy digesting large amounts of information that they do not have the opportunity to think for themselves. Once they start their clinical training, however, they are expected to be able to piece together a case history and come to a logical conclusion on diagnosis. This requires students to sort out and order information about a patient, and construct arguments for or against certain conclusions (diagnosis). Philosophies can assist students with the logic of argument, and with identifying which conclusions can be strongly or weakly argued, valid or invalid. Philosophy also encourages a sceptical attitude to the assertions of others (a valuable attitude to the authoritative structure of much medical education) while simultaneously raising awareness of the reality of alternative points of view. It is good preparation for the skills of medicine.'

Most students felt they were better able to analyse arguments by the end of the course, but the authors accept that: 'healthy scepticism abounds about the value of the humanities in medical education and it is true that not all medical students will benefit from their inclusion.'

Notwithstanding the scepticism [Mattes 2000], psychiatry would seem to be one subject in which the ability to analyse the value of evidence is particularly important.

UWA is also moving towards a problem - solving approach and away from conventional didactic medicine in teaching medical students [Jablensky 2000]. The new undergraduate curriculum will embrace four themes:

- The scientific basis of medicine
- Doctor, Health and Society
- Doctor and Patient
- Personal and Professional Development.

8.6.2: Postgraduate Education Needs for GPs

The Confederation of Postgraduate Medical Education Councils of Australia has considered the introduction of two mandatory years following graduation and prior to registration, together with the introduction of training modules to supplement the clinical experience of junior medical officers. In this context, the Royal Australian and New Zealand College of Psychiatrists has recommended that a rotation in psychiatry should be mandatory during these two years [RANZCP Project Team: Interim Report 2000]. The report states:

' This would benefit all doctors, given the growing psychiatric morbidity of the population as identified in the WHO Study on the Burden of Illness. A mandatory rotation in psychiatry may assist by recruiting some who would not have considered it. Such experience should be considered pre – vocational and not be accredited towards the RANZCP.'

This measure might bring benefits in the future, but for the present there are two complementary areas in which the skills of GPs might be improved:

- **Recognition of Psychiatric Disorders**

  There are a number of problems that impede the general practitioner from recognising psychiatric disorders.

  ➢ Problems with the symptoms presented by the patient.

  A study in Scandinavian countries found that GPs identified only 44% of psychiatric cases as compared with formal Present State Examination assessment and CATEGO diagnosis. On the other hand the GPs identified 14% of patients as psychiatric cases who, according to the PSE assessment were non - cases [Munk - Jorgensen et al 1997].

  However, a study of 91 GPs in Manchester indicated that there was wide variability amongst GPs in their ability to detect psychiatric cases [Goldberg et al 1980]. In this study

'caseness' was determined by a threshold score on the General Health Questionnaire (GHQ 28). Some GPs made assessments that were as accurate as those of research psychiatrists using standardised interviews, but about one third made assessments that were not significantly correlated with the symptom levels of their patients.

One of the findings was that many patients presented with physical symptoms. In a WHO study of mental illness in primary care in developing countries [Harding et al 1980] the majority of patients presented with physical symptoms, such as headaches, dizziness and weakness. Similar results were reported by Munk - Jorgensen and colleagues (1997). They found that only 4% of patients with a PSE diagnosis of mental disorder presented with only psychological symptoms, whereas the remainder presented with either physical symptoms alone or a combination of both physical and psychological symptoms. In Manchester, only 5.3% of patients with mental disorder presented with psychological symptoms [Goldberg and Gater 1996].

The most common complaints were pain, fatigue or poor sleep and other somatic complaints. In Zimbabwe the commonest presenting symptoms of depressed patients were abdominal pain, headache and chest pain [Buchan 1969]. Similar results were reported in Kenya where Ndetei and Muhangi [1979] found that 20% of patients at a walk - in clinic were psychiatrically disabled. The commonest presenting complaints were joint pains, backache, abdominal pain and headache.

One of the reasons why somatic complaints are so common is that there is a complex relationship between physical and psychiatric disorder that may take one of five forms [Rose 1988]:

a) Psychiatric illness may present with symptoms that are suggestive of a physical disease but which have no organic basis (for example, anxiety may mimic thyrotoxicosis or asthma).
b) Psychiatric illness may result from the pathological effects of a physical disease (for example, cerebral tumour).
c) Psychiatric symptoms may be the presenting symptoms of physical disease [Buchan 1972].
d) Psychiatric illness, such as anxiety or depression, may worsen the pain or discomfort of a physical disease.
e) Psychiatric illness may precede the onset of physical illness (for example, depression may precede the onset of myocardial infarction or malignant disease).

An additional factor in developing countries, which was identified in the WHO study, is that: 'It seems that many patients assume that a physical symptom is almost a requirement in order to be seen at a health facility.' 'Our own experience shows that the presenting complaint, once presented, becomes insignificant.'

'The physical symptom may only be the 'admission ticket' to the clinic, although the use of the symptom is not necessarily at a conscious level.' [Buchan et al 1984]:

There is at least anecdotal evidence that similar mechanisms are to be found in developed countries.

➢ Problems presented by diagnostic classifications:
Two psychiatrists stressed the need for appropriate diagnostic categories [Table 7.3.3 UGT 4].

An extended WHO survey of common mental disorders across 14 countries [Ormel et al 1994] showed that there was a consistent relationship between psychopathology and disability. Disability was strongly related to major depression, panic disorder, generalised anxiety and neurasthenia. Non - psychiatric morbidity was an independent, although weaker, contributor.

A major problem is that there is as yet no satisfactory way of distinguishing clearly between patients with normal psychological problems and those who are really sick, except in extreme cases.

'There is a large grey borderline area of patients in distress who may be ill or in the process of becoming ill, but equally may be experiencing normal emotional reactions in difficult circumstances, reactions that are unpleasant but can be coped with.' [Ingham 1982].

Faced with this dilemma, GPs may be understandably reluctant to give a patient who does not meet the DSM IV or ICD10 criteria a psychiatric label because of the stigma involved. In the USA, Regier and his colleagues [1978] found that:

'Routinely reported data on mental disorders in their sector *(primary care)* are generally understated because organic illnesses are more often the presenting problem. This reflects the non - psychiatrist physicians' organic illness orientation and their preference to avoid a mental disorder diagnosis whenever an alternative is available.'

Another reason why mental disorders are understated is that many do not fill all the criteria required for diagnosis by the major diagnostic systems such as DSM IV or ICD 10. For example, the Australian National Survey of Mental Health and Well - Being [Korten and Henderson 2000] showed that considerable disablement was associated with symptom levels indicating distress but not reaching levels for formal diagnosis of anxiety or depression. Four psychiatrists commented on this problem [Table 7.3.7 POP 2].

In an extensive review of the literature [Pincus et al 1999], the authors coin the term 'sub - threshold mental disorders' for these conditions.

They found that whilst sub - threshold depressive disorders do not cause as much disability as major depressive disorders, they are quite comparable with other medical conditions in the level of disability they cause. They have high rates of service utilisation and cost and it might be that some of the false positive identifications reported by Munk - Jorgensen [1997] were the result of GPs classifying patients as psychiatric on the basis of disability rather than diagnostic category. For these reasons, it is highly desirable to have a reliable system for classifying these disorders so that management strategies can be developed.

'Without a commonly accepted diagnostic language, it is impossible to communicate adequately about the patient without misunderstandings to establish reliable standards of care, to evaluate advances in treatment and to plan the development of the relevant health services.' [Jenkins 1992] Two psychiatrists also raised the issue of a common language [Table 7.3.4 IDC 1].

One way out of the dilemma of classifying these disorders has been the use of the category of 'Adjustment Disorders' (Category 309 in DSM IV, F 43.2 in ICD 10). Pincus and his colleagues believe that neither of these diagnostic classifications [DSM IV 1994] [ICD 10 1992], even in a primary care version eg ICD 10 [WHO 1996], captures all the issues that are important in primary care. They attribute this inadequacy, at least in part, to the different perspectives of GPs and psychiatrists:

'There are clearly a number of mental disorders, conditions and other psychosocial factors that primary care physicians think are very important but are not well articulated in the psychiatric nosology and are often not a major consideration of mental health specialists.'

They recommend the elimination of the category of 'Adjustment Disorders' and the substitution of a sub - threshold category within the major phenomenological groups of the

DSM IV and the ICD 10, with permission to subtype in relation to the presence of a stressor. However, they stress the need for collaborative research between GPs and psychiatrists to resolve the difficulty.

➢ Problems related to the GP's performance:

Goldberg [1982] found that some of the variability in the capacity of GPs to detect psychiatric disorder was inherent in the way they approached the problem. Doctors who were rated by an independent observer as empathic; who asked about the patient's home and family and who tended to ask questions that related to the patient's psychological adjustment were better able to make accurate assessments of the patient's emotional health. 'Conservative' doctors, who were inflexible, authoritarian and resistant to change made less accurate assessments. A number of behaviours were identified as important:

Start of the interview:

- Making eye contact with the patient
- Clarifying the presenting complaint
- Use of problem solving questions:
- High proportion of directive questions
- Use of directive questions in relation to physical symptoms
- Focussing on the present rather than the past

- **Management of Identified Psychiatric Disorders**

Even when the GP recognises psychiatric disorder, treatment is not always given. In Goldberg and Grater's study no treatment was prescribed for 18.3% of recognised cases. Regier and colleagues [1978] reported:

'However, it is clear that physicians and other health providers in the sector may not offer any direct mental health treatment to some identified patients for a variety of reasons. In a remarkably comprehensive study of general medical physicians Shepherd at al *(1966)* found that 67% of those with identified mental disorder received some form of treatment from the physician himself, another 5% were referred for specialty mental health care, with 28% receiving no treatment in the year.'

It is also clear that even when treatment is given, it is of variable quality. Goldberg and Gater [1996] reported:

' Across the world, the study has shown that the treatment provided is little different from one diagnosis to another and that benzodiazepines are extensively used (except in

Manchester and Seattle) irrespective of diagnosis. Some centres (eg. Ibadan and Shanghai) do not use antidepressants at all, whereas others (Athens and Rio de Janeiro) use them for fewer than 10% of cases of recognised depression.'

Munk - Jorgensen and colleagues reported:
'Only a small proportion of the patients were given psychoactive medication, sedatives being the most common type. The most prevalent treatment was psychotherapy, which was received by 20% of the patients with a mental disorder.'

A review of the literature [Buszewicz and Mann 1997] concluded:
'Several groups described the enormous variability in the prescribing practice for psychotropic medication by general practitioners.' 'Pharoah and Melzer *(1995)* examining data from 61 practices, found a 13 fold difference in the annual defined daily dose for anxiolytics, an 11 fold difference for antidepressants. There was a wide range of doses prescribed, many regimes being ineffective according to the guidelines set down jointly by the Royal Colleges of General Practice and Psychiatry *(1992)*. Donoghue and Tylee *(1996)* analysed Prescribing and Analysis Cost data for over 80,000 prescriptions for antidepressants over a three - month period in north - west England.

The authors found that less than 12% of prescriptions for tricyclics achieved the recommended dose of 125 mgm per day, whereas the newer antidepressant Lofepramine was prescribed in effective doses 61% of the time and selective serotonin re - uptake inhibitors for 98% of patients.'

- **Training Programs for GPs**

  With the above considerations in mind it should be possible to develop suitable training programs for GPs. Linda Gask has done a considerable amount of work in this field in the UK and has published a summary of her findings [Gask 1994]. She maintains that teaching about psychiatric illness should have four components:

  a) Diagnostic criteria and the skills involved in detection
  b) Factual information about treatment strategies
  c) Skills involved in carrying out treatment
  d) Local resources available for consultation and referral.

a) Diagnostic criteria and the skills involved in detection:

Goldberg and his colleagues [1980] showed that it is possible to improve the accuracy with which family doctors rate psychiatric disturbances by videotaped feedback of their own interviews, aimed at identifying their interview style. Further work with this approach [Goldberg et al 1993] extended the previous findings to show that doctors who use a 'patient - led' style of interview elicit more cues of distress from the patient than doctors who use a 'doctor - led' style. A survey of GPs in New South Wales also showed that many were interested in improving their diagnostic skills [Phongsavan et al 1995].

b) Factual information about treatment strategies:

Gask is of the opinion that formal lectures should be limited in number and should emphasise problems rather than diagnoses. Topics included might be:

Anxiety and depression

Somatisation

Dealing with a new episode of psychotic illness

Chronic psychotic illness and the role of the GP

Common psychiatric disorders in childhood

Confused elderly patients

Alcohol and Drug problems

Sexual and marital problems

Dealing with suicidal behaviour

Personality problems

c) Key management skills:

Those listed by Gask include -

Ventilation of feelings

Negotiation

Making links (eg between physical symptoms and psychosocial problems)

Motivational interviewing (helping patients to change their behaviour)

Problem solving

Special types of interviewing (eg couples and families)

d) Local resources available:

Eight GPs commented on the need for more information about the facilities available [Table 5.3.4 NIS 1].

Two administrators [Tables 6.3.2 EGP 3; 6.3.4 LOU 2] one psychiatrist [Table 7.3.1 GPA 1] and one GP [Table 5.3.4 RNE 3] agreed that this information is probably best learned by an attachment to a local multidisciplinary team on a part - time or sessional basis.

8.6.3: Relevance of Local Findings for GP Training

- **Training Programmes**

Like most Australian GPs [Buttfield & Murrell 1989], many of our local GPs believe that dealing with psychiatric problems is part of their role as general practitioners. Nine of the 12 GPs who commented in the present survey were in favour of on - going education, but there were a number of problems:

Only 5 GPs expressed difficulty with diagnosis or management [Table 5.3.1 DIF 1] and it would seem that there is no general appreciation that skills in these areas need to be improved. This corresponds with the results of the study reported by Buttfield and Murrell in which 60% of GPs believed that their management of psychiatric problems was adequate.

Although 9 GPs made comments about the need for education there was little consensus about what the content should be. As already noted, there were four widely disparate themes [Table 5.3.4 RNE 1 – 4]:

Impact of the personality on the patient's illness
Value of Divisional (or other unspecified programs)
Value of community team training
Value of a postgraduate diploma.

Notwithstanding this lack of consensus about how training should be conducted, there have been a number of attempts in WA to establish programs along the lines suggested by Linda Gask. The first of these, in which I played a leading role, was established as a collaborative venture between Swan Clinic and the Swan Hills Division of General Practice in 1995. The programme rested on information drawn from a number of local surveys, from which four conclusions were drawn:

- The commonest conditions seen by GPs were: depression; anxiety; sleep disorders; relationship difficulties and physical symptoms with a psychological base.
- Depression and anxiety, together with psychoses, were the conditions most commonly referred to psychiatrists.

- The commonest underlying problems were with relationships (conjugal, family and other interpersonal relationships). Occupational problems were less common.
- GPs identified counselling, especially in interpersonal relationships, as the most pressing need in the community. As a strategy for meeting this need they identified more training in counselling and education in mental health issues as primary concerns.

Accordingly the course was designed with two components:

1. Weekly sessions of supervised clinical practice at Swan Clinic.
2. Two semesters of teaching, each comprising 16 weekly sessions of 90 minutes.

The first half of each session was devoted to didactic teaching and the second half to discussion of a case brought by one of the participating GPs. The first semester dealt with depression, anxiety and related topics, the second with "serious mental illness".

In order to secure continued funding the course had to be evaluated at six months [Buchan and Lowe 1995], by which time 8 GPs had completed the first 16 teaching sessions and 3 had completed the clinical attachment.

The objectives of the course were: To improve the GPs ability to:

- Detect psychiatric morbidity in his/her own practice.
- Formulate a multiaxial diagnosis (systems approach).
- Plan management strategies in terms of both the different levels of diagnosis and the framework of the multidisciplinary team.
- Develop counselling and simple cognitive/behavioural psychotherapy skills.
- Manage patients with "serious mental illness".

The evaluation of the clinical sessions showed that the 3 GPs had some understanding of multiaxial diagnosis and had little difficulty managing "serious mental illness". The 8 GPs who completed the teaching sessions were asked to complete a questionnaire but only 6 did so. The questionnaire was designed and evaluated by Phillip Lowe, a Clinical Psychologist.

The effects of the training were assessed in terms of the GPs' knowledge of symptoms, confidence in diagnosis, knowledge of intervention strategies and confidence in managing patients in relation to a range of mental disorders. The numbers are too small for any general conclusions, but there was some effect of training in all areas across the range of disorders. In particular, all GPs improved in areas relating to depression. An improvement was also noted in

relation to anxiety/other neurotic disorders and emotionally driven physical symptoms. There was a decrease in the number of referrals made to the mental health services and an increase in their willingness to take over on - going case management of mental health patients. There was also an increase in the GPs knowledge of the mental health services and increased liaison between Swan Clinic mental health professionals and the GPs.

A second training programme was launched in Fremantle in September 1995. This programme was a collaborative venture between the Directorate of Psychiatry at Fremantle Hospital and the Fremantle Division of General Practice. The programme was arranged in 3 modules. Module A comprised a series of workshops held over the week - end of 23rd and 24th September. Twenty GPs participated in the Saturday programme and 19 returned for the Sunday. In the evaluation of the week - end [Stephenson 1996], 7 GPs responded to the question: "What were the highlights of the week - end for you?" Responses fell into the following categories:

- Psychiatric interview and the following related discussions
- Counselling sessions
- Psychiatrists as teachers and facilitators, especially the opportunity for face to face discussions.
- Presentation by the Health Insurance Commission (dealing with charging for long consultations by GPs)
- Contact with other GPs.

Learning outcomes were identified by 17 GPs as being mainly related to different ways of thinking about psychiatric problems; of now having a structure, a broader and more systematic approach to the assessment and management of psychiatric problems. Three GPs identified improved counselling skills. Thirteen GPs commented on improvements that might be made. In general they saw the week - end as too long and too slow moving with too many refreshment breaks.

Module B comprised 12 weekly 90 minute seminars focussing on specific aspects of general practice psychiatry. A psychiatrist facilitated each session with a GP being made responsible for presenting a case or cases related to the seminar topic. Seventeen GPs participated in the module with an average weekly attendance of 12. The seminars were evaluated by means of feedback sheets, which were collected each week, and a focus group at the end of the module. Suggestions for improvement included GPs taking more responsibility for the sessions, acting as moderators in rotation, with the psychiatrist functioning as a resource person.

Module C provided for the attachment of GPs to one of the multidisciplinary mental health teams at Fremantle for 8 sessions. Four consultants were involved in one to one supervision. Nine GPs completed this module, but only 7 had completed the module at the time of the evaluation, so the findings are based on their comments.

Most were satisfied with the range of clinical experience offered and all agreed that the experience was relevant to general practice. Adverse comments were made about organisational problems, such as sessions not running to schedule, patients not keeping appointments and disruptions caused by staff absences. All GPs reported that their level of confidence in diagnosis had improved, as had their skills in problem identification and management. Three GPs had a strong interest in being involved in the local mental health service through increased liaison with the team, peer consultation and in - reach.

- **Balint Groups:**

  Four GPs [Table 5.3.4 VBG 1] and one psychiatrist [Table 7.3.2 EGP3] commented positively on the value of Balint groups [Balint 1964]. Between November 1998 and May 1999, I conducted 4 similar groups for GPs in the Cannington Division that were favourably received.

  Balint groups examine the process of the consultation between the GP and the patient from two aspects:

  The relationship between the patient and his illness
  The relationship between the doctor and the patient.

Unfortunately, evidence of the effectiveness of Balint training is equivocal. On the one hand, Balint training did not improve the doctor's ability to detect mental disorders [Joukamaa et al 1995], but the authors conceded that the training was more focussed on the management of patients with mental health problems than the diagnosis of mental disorders. On the other hand a study of 5 centres in Scandinavia showed there was a close association between GPs' ratings and PSE ratings of the severity of illness only in Aarhus, where 29% of the GPs had trained in a Balint group for at least three years. The strengths of the Balint system are, firstly, that the GPs are not removed from their daily practices, but are helped to cope better in those situations. Secondly, GPs feel more comfortable and confident in dealing with mental health problems.

'Good groups behave as think - tanks rather than teaching sessions. They identify the nature of the presenting doctor's problem, not only the patient's problem and they aim to offer fresh

perspectives rather than absolute solutions.' 'Members of the group are encouraged to apply empathy rather than sympathy, to rely on greater awareness, until achieving their deep understanding to be brave enough to learn through trial and error, and to respond to patients thoughtfully instead of automatically.' [Norell 1993].

Modifications of the Balint group are possible for those who are not psychoanalytically minded [Pettit 1981].

- **Training in Counselling**

  Six GPs [Table 5.3.4 CGP 1] commented on training in counselling and raised a number of difficulties specifically related to the content, the format and the relevance of the training. The NSW GPs also identified an interest in improving their counselling skills [Phongsavan et al 1995].

  There are significant problems in the GP accepting the role of counsellor [Noon 1992]. In an acute illness the patient expects the GP to exercise his 'Aesculapian Authority' and confer the status of the 'sick role' upon the patient. This role absolves the patient from any responsibility for his illness and, conventionally imposes an obligation upon the doctor to provide a cure. In a psychological illness, non - directive or 'client centred' counselling aims to place the responsibility for change firmly upon the patient being counselled. If the patient has been successfully treated for a number of acute illnesses by his GP wearing his 'medical hat', he may have difficulty relating to his GP when the latter is wearing his 'counselling hat'. Moreover, the GP may find it difficult to change hats.

  Sheldon [1994] expressed similar views:

  'Although counselling skills help the GP in the clinical consultation, the main focus of the doctor's work is often different from that of the counsellor.
  The aim and function of counselling is to encourage the client to help him/her to clarify difficulties and attempt to resolve them. Rather than giving advice, reassurance or medication, the counsellor systematically attempts to avoid long term dependency by putting the responsibility for their lives back into the patients' hands.'Thus the doctor and the patient would need to make a mental shift in the way they see each other before counselling could begin.'

  In its extreme form this view may lead to the conclusion [Farell 1993]:

'That is, if truly taken seriously, the values of counselling and counselling psychology may pose such a serious challenge to the philosophical basis of traditional medical practice, that either they can only be incorporated at the expense of a fundamental change in the way health care is delivered or that true counselling can only take place in the context of an independent and separate profession.'

One solution that has already been commented on by one of the local GPs is that patients choose different doctors for the different roles. In the UK, where this solution is not possible, counsellors have increasingly been recruited to general practice [Tyrer et al 1993] so that one third of practices in England and Wales have a counsellor with no other task within the practice [King 1994]. Counsellors may be drawn from a variety of professions, but Community Psychiatric Nurses and Psychologists predominate. Patients appear to approve of their interventions and there are reductions in attendance rates and the prescribing of psychotropic drugs, but there is no evidence that the outcomes of the illnesses are affected. Nurse counsellors have also proved to be effective in private practice in Australia [Kaplan et al 1999].

Corney [1993] takes an opposing view that counselling skills are fundamental to general practice:

'This is even more important in diagnosis, for a doctor who attends to the patient's concerns, worries and theories about the illness is more likely to find out what is wrong.'
'Patients who feel that medical staff have listened to their concerns and anxieties will be more likely to cooperate in treatment.'
'Psychosocial factors play a major part in the prognosis of mental illness, chronicity being associated with long term social and psychological difficulties.'

Hickie and his colleagues [1999] take a similar stance:

'The cornerstone of any significant improvement in the provision of mental health care will be improvement in the assessment and treatment skills of primary care practitioners. Current evidence suggests that many practitioners have limited psychological interviewing skills, specific pharmacological knowledge and/or experience with modern non - pharmacological treatments.'

These authors make three other very important points:

- Changing the way GPs work will be a slow developmental process

- Success will depend on an extreme commitment at a local level
- The emphasis must be on the GPs owning the education process but this will require extensive support from mental health services.

- **Advanced Courses:**

  Only one GP commented on the value of formal education:

  Dr I: 'You can put on a series of formal lectures for us to attend and that may give us pointers to help us cope, but essentially I would say we would have to go and study and learn it properly, rather than just a series of lectures giving pointers about various topics. The essence of treating properly you would – to do it properly you would have to do a more intensive course. At home there was a Diploma of Psychiatry that you could do if you spent six months to a year working in psychiatric institutions or under the care of a psychiatrist. Some people did that . Because of it's being a more specific, isolated type of medicine it wasn't the most popular.'

  Some consideration has already been given to the establishment of a formal postgraduate Diploma by UWA, but this has not been as successful as the combined Melbourne and Monash Universities programme. This programme offers a Graduate Certificate, which can be upgraded to a Master of General Practice Psychiatry degree by distance education [General Practice Psychiatry Programme; Course Coordinator Grant Blashki]. The courses are designed to meet the academic standard of a postgraduate degree whilst at the same time containing subject matter that is relevant to everyday practice.

  The Graduate Certificate is modelled on the Monash University Graduate Diploma in Family Medicine, which has attracted 400 enrolments in 5 years. The course consists of 7 units conducted part time over a 30 – week period. The Master's degree is a three – year part time professional course work but many GPs will be granted recognition for up to one year for prior learning (eg. Fellow of the Royal Australian College of General Practitioners). The second year of study consists of 6 units, also conducted over a 30 week period.

  There are two weekend workshops each year, which are highly recommended, but not compulsory. Consideration might be given to either a similar local programme or advising aspirants to enrol in the Victorian programme.

8.6.4: Postgraduate Education Needs for Psychiatric Trainees

Seven psychiatrists commented on the institutional base for postgraduate training [Table 7.3.3 PGT 2] and 3 stressed the need for a community focus [Table 7.3.3 UGT 2]. Some of the issues involved have been examined in the UK [Linsley et al 2001]. These authors base their paper on discussions by the Collegiate Trainees Committee of the Royal College of Psychiatrists. Unfortunately, they confine their comments largely to the management of SEMI in the community to the neglect of the broader spectrum of disorders seen in primary care. Nevertheless they make some valuable observations under the rubrics of skills, knowledge and attitudes required.

- Skills:
  - Assess at home someone who has severe mental illness (SMI) and develop rapport not only with the patient but also with the carers.
  - Stabilise an acutely disturbed patient in a community setting.
  - Determine who cannot be managed in the community and should be admitted.
  - Take an abbreviated and focused history and carry out a mental state examination.
  - Manage their own safety and that of carers.

- Knowledge:
  - Understand the functions of innovative service models, particularly their role in preventing admissions, facilitating early discharge and addressing functional improvement.
  - Appreciation of psychosocial might involve a change in mid – set from traditional medical syndromes to an individual symptom approach and a focus on vulnerabilities and environmental stressors as well as symptoms.
  - Awareness of the debate over the inadequacies of new services.
  - Awareness of the roles of community psychiatric nurses, social workers, occupational therapists, psychologists and support workers in the multidisciplinary team.

- Attitudes:
  - As mental health care shifts from hospital to community care, the emphasis shifts from 'cure' to 'care', from symptom treatment to quality of life and from control to collaboration.

These authors do not consider the issue of a separate discipline of 'adult community psychiatry' as they believe that: 'The new skills, knowledge and attitudes required to meet

the challenge of providing both hospital and community – based care are pertinent to all trainees.'

In this context they comment:

' Consideration should be given to psychiatric trainees undertaking general practice attachments, so that mental health issues can be seen from an alternative perspective. General medical confidence is increasingly important now that trainees work in isolated sites and that the evaluation of physical problems is reflected in the MRCPsych examination.'

Some influential Australian commentators [Hughes at al 2002] appeared not to favour such attachments but noted:

'The change from custodial to mainstreaming and integrated hospital and community mental health care has been followed by a paradigm shift towards a population health model and a focus on the management of mental disorder in primary care settings.' ' Working in partnership with primary care providers and/or within multidisciplinary teams requires both leadership skills to supervise and support others and the ability to advocate for and facilitate appropriately coordinated clinical care.'

From 2004, all RANZCP trainees will be required to complete 3 years of basic training and 2 years of advanced training in Child and Adolescent, Old Age or Consultation – Liaison psychiatry or the Psychotherapies [RANZCP Project Team; Final Report 2001]. Adult psychiatry is a 'default option' but Hughes and colleagues argue that it requires the equivalent of subspecialty expertise. This is not a novel idea but was mooted in the UK more than 20 years ago [Royal College of Psychiatrists 1982]. Hughes and colleagues see the 'core competencies' as:

- Skills in the engagement, assessment and management of complex needs and high rates of comorbidity.
- Skills in consultancy to and collaboration with general practitioners and other primary care providers.
- Skills in leadership within multidisciplinary teams. The difficulties of working in multidisciplinary teams have been explored in some detail [Herrman et al 2002; Rosen 2001].

- Specific expertise within a developmental framework that defines the expectations, needs and challenges that people face from late adolescence to early old age.

They propose that 12 months of the 2 years mandatory specialty training will be spent in core training and the remainder in a range of choices that reflect the diversity of interests among practitioners of adult psychiatry. Completion of the Advanced Training programme will be recognised by the award of a Certificate of Advanced Training in Adult Psychiatry. Although the authors do not make any specific recommendation, it would seem possible that, following the suggestion of Linsley and colleagues, at least part of the second year of specialty training could be profitably spent in a general practice attachment. If the whole year were to be spent in general practice, it might be possible for the trainee to complete the Graduate Certificate in Primary Care Psychiatry.

8.6.5: Training Programmes for Case Managers

Three administrators commented on the need for changes in nursing education [Table 6.3.3 WIC 2] but these views probably reflected their professional backgrounds and their comments should be applied to case managers in general.

' Case management was seen as the answer to the haphazard delivery of services and it has been implemented in many countries to help individuals coordinate services and manage the complexities of psychiatric care.' [Rosen and Teesson 2001].

However a major problem in training case managers is that there is no consensus over the most effective model of case management. Quoting Diamond and Kantor, Rosen and Teesson suggest three varieties of case management:

- Travel Agent Model: where the professional just sits behind a desk offering advice.
- Travel Companion Model: where someone goes with you but without any special expertise or training.
- Travel Guide Model: where a person will not only be there and do things with you, rather than doing things to you, but also has the appropriate training, experience and expertise to know the most scenic routes, how to take short cuts without getting lost, how to reliably avoid the pitfalls and to arrive reliably at the desired destination.

Rosen and Teesson continue:

'Australasian mental health case management team draw on all these models, but most have in common with the more assertive clinical, networking and travel guide models, particularly in the higher level of professional training and the more active mobile response to needs requires.' ' While there is no gold standard, and no perfect service meeting all criteria, there is a growing consensus regarding the components of assertive case management (ACT) which consistently result in improved outcomes for users and their families.'

- Assertive Community Treatment teams are generally characterised by:
  - A service provider to service user of about 1:10
  - A 7 day operation
  - Capability for responding to crises of all service users
  - Professionally skilled multi disciplinary staff, adept at psychosocial as well as pharmacological interventions
  - Serving a subpopulation of highly and continuously disabled psychiatric service users.

- The Fremantle team has demonstrated the effectiveness of an Intensive Case Management (ICM) model [Preston & Fazio 2000]. Their criteria for ICM are:
  - A 1:10 staff patient ratio
  - Most services provided in the community, rather than in the office
  - Assignment of patients to a dedicated case manager
  - Time unlimited service
  - Most services provided by the ICM team and not brokered out
  - Provision of a 7 day per week service (The criterion of a 24 hour service was not met)
  - The patients were high service users.

Rosen and Teesson mention 'appropriate training, experience and expertise' and 'the higher level of professional training' required for ACT. Unfortunately discussion of the professional background and training required for case managers, are issues are beyond the remit of their paper.

One approach in the UK [Kingdon 2002] is the creation of 'mental health practitioners' (MHPs). Kingdon argues that these workers could be recruited into mental health work from graduates in social sciences and psychology who, for a variety of reasons, do not normally enter the mental health system. He proposes that training should be for one year and involve placement with inpatient wards and community teams. At the end of their training MHPs should be able to:

- Perform and document a full psychosocial assessment, including a basic assessment of risk.
- Develop a care plan collaboratively with the patient, carer and other team members.
- Participate in implementing that care plan to the extent that he/she is equipped by his/her training.
- Ensure that follow – up occurs and that the relevant information is disseminated to those involved in the plan, including the general practitioner.

Kingdon describes a range of training requirements in both clinical areas, such as cognitive behavioural therapy, and non – clinical areas, such as teamwork and leadership. It is not envisaged that the MHPs would have any duties in terms of the Mental Health Act. This is the converse of the position in WA, where authorised Mental Health Practitioners were introduced in the 1996 Mental Health Act for the express purpose of assessing whether patients should be made involuntary in terms of the Act. To this end, experienced case managers are given limited training in the mental state examination and assessment of risk.

The two papers cited above assert that ACT and ICM are only effective when applied to a subpopulation of chronically psychotic, disabled recurrent users of psychiatric services and that entry criteria should be restricted to these patients. The EPPIC team in Melbourne [EPPIC 2001] has developed a system of case management for early intervention in acute psychosis, but none of these approaches would be suitable for the kind of patients routinely seen in general practice. The work of nurse counsellors, either attached to general practices or working in private practice, would seem to be fundamentally different and might well require a different emphasis in training. The kind of mental health practitioner envisaged by Kingdon would seem to be more appropriate for this role. Different criteria for entry into the service would also be required as would increased resources both for training and service delivery.

8.6.6: Recommendations

- Undergraduate Medical Education
  There might be value in local Divisions of General Practice approaching the University Department of General Practice with a view to having input into the development of the new undergraduate curriculum.

- Postgraduate Education for GPs

- Dialogue would be profitable between the RANZCP and the RACGP to discuss mandatory placements in community mental health teams as preparation for general practice.
- Educational programmes for GPs should be driven by local Divisions but should probably include the following topics:
    - Diagnostic criteria and the skills involved in detection
    - Information about treatment strategies
    - The skills involved in carrying out treatment
    - The local resources available for treatment
- Local programmes will provide information about suitable formats, but most GPs have found placements in mental health services to be helpful.
- Dialogue should be established with the local Divisions about a number of issues, such as:
    - The feasibility of setting up Balint groups
    - The feasibility of providing specific counselling training. Advice would be needed on making the training relevant to extended consultation item numbers.
    - The usefulness of advanced courses.

- Postgraduate Needs for Psychiatric Trainees
    - Dialogue should be established between clinicians, including general practitioners, and the RANZCP concerning the desirability of establishing Community Psychiatry as a recognised sub – specialty for advanced psychiatric training.
    - Attempts should be made to make the training less institutionally based.

- Training Programmes for Case Managers
  A working party should be set up with broad professional representation to define the expected roles of case managers and the core competencies requires for these roles, depending on an operational definition of the model of case management to be adopted.

8.7: Concluding Comments

Evidence from the historical review shows that an optimal mental health service would not be achieved by introducing a new treatment paradigm that supersedes previous paradigms, but by accepting the challenge of integrating the best elements of the old with the new. Accelerating

the rate of change from a medical model concept of mental illness to a workable systems based approach would facilitate this integrative process.

Hospital in – patient care remains a critical component of any mental health service delivery system. As this care is transferred from the old institutions to acute units in general hospitals it will have to be integrated not only with community care but also with the general hospital system. It is not yet clear how the new regional administrative structure will achieve this.

There is a broad consensus about the components of community mental health care, but a number of conditions will have to be met if these components are to be successfully integrated. Perhaps the most important condition is that the process should not be ideologically or politically driven, but should be evolutionary and founded on the consensus views of stakeholders. Consumers are fundamentally important stakeholders, but require consideration beyond the scope of the present study. The fieldwork shows that there is already considerable agreement among service providers about what needs to be done, but a great deal of practical work remains if integration is to become a reality.

Primary care psychiatry is clearly a critical component and work needs to be done to define the scope and content of this area of practice. General practitioners need to have better access to specialist services and better communication with their specialist colleagues, which will require much closer cooperation and communication than has hitherto been the case. There is also a need for mental health services to work more closely with other primary care providers, including other government agencies and non – government organisations. Finally there is an overall need to improve the education and training of all service providers to fit them for their new roles.

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APPENDICES:

APPENDIX 1

The Inner City Mental Health Service

Information Sheet for Study Participants

Collaboration Between GPs and Mental Health Professionals Working with Patients with Mental Disorders and Mental Health problems.

Why is the present study being conducted?

The delivery of mental health services for patients with all types of mental disorders has moved away from institutions into the community. Involvement of general practitioners and the development of "Primary Care Psychiatry" are now government policy.

General practitioners and mental health professionals do not have a history of working together and this study is intended to find ways of fostering co-operation in order to improve both the quality and continuity of care for patients.

What does this study aim to do?

The study will examine the ways in which general practitioners and mental health professionals collaborate successfully at present. A process will then be established to ensure the continued development and enhancement of collaboration after the study is concluded.

Who will be involved?

The study will have its principal focus on the Inner City Mental Health Service catchment area, with some involvement of other GPs who are members of the Perth Central Division of General Practice. Mental Health professionals and Administrators will also be involved.

What can I expect if I participate?

You will be invited to participate in some interviews to discuss the services provided by GPs and mental health professionals. With your consent, a record of the interviews will be kept. You will be asked to sign a Consent Form to indicate that you have agreed to participate and that you understand that you may withdraw from the interviews or the study at any time.

Privacy of participants and confidentiality of material will be preserved. Any identifying information disclosed during the interviews will be coded and the coding key will be destroyed when the study is completed. Results may be published but the publication will not contain any identifying information.

How do I obtain more information?

Terry Buchan at the Inner City Mental Health Service (9224 2244 for RPH), 74 Murray St., Perth WA 6000, or Judith Bancroft at the Perth Central Division will be able to provide more details.

APPENDIX 2

Inner City Mental Health Service

Consent Form for Service Providers Participating in Interviews

Collaboration between General Practitioners and Mental Health Professionals Working with Patients with Mental Disorders and Mental Health Problems.

Investigator: Dr Terry Buchan

Supervisors: Duncan Boldy; Professor and Head of Department
Janice A Lewis; Lecturer

Department of Health Policy and Management
School of Public Health
Curtin university of Technology

This form signifies my consent to participate as a volunteer in the above named project.

The project has been explained to me and I have been given an information sheet.

The investigators have given me an opportunity to ask whatever questions I desire and all questions have been answered to my satisfaction.

I agree to participate in and interview and give permission for the interview to be tape recorded.

I understand that:

- I am free to withdraw my consent and terminate my participation at any time.
- All tapes will be destroyed at the completion of the project.
- Transcribed data from the interview/focus group may be retained but my identity will not be disclosed.
- All information provided is treated as strictly confidential and will not be released by the investigator unless required to do so by law.

I agree that research data gathered during the project may be published provided my name or other identifying data is not revealed.

The project is under the supervision of Curtin University and any complaints about the way the project is being conducted should be submitted through Professor Boldy to the Ethics Committee.

Signed:

Participant; Date:

Investigator: Date:

APPENDIX 3

Inner City Mental Health Service

Basic Questions For Interviews

1. What do you understand by Primary Care Psychiatry?
2. What do you believe is its relationship to Community Mental Health Services?
3. What do you believe is your role in the area of Primary Care Psychiatry?
4. What special skills do you bring to this area?
5. What assistance, if any do you believe you need to enhance your performance in this area?
6. How do you think the Mental Health Services might be improved?