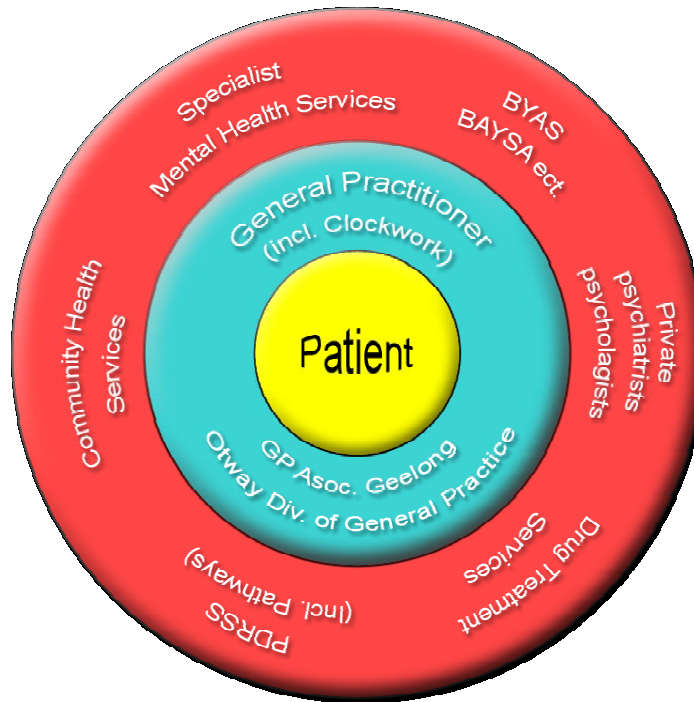


General practice and State mental health services

The challenge of moving to partnership





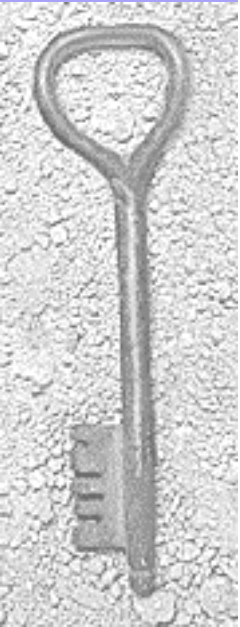
It is clear that in an integrated system of care which hopes to **identify illness at the earliest possible stage** and to offer **ongoing management for what are often chronic illnesses**, it is desirable that the **GP is central to the care team** and is the bridge between the patient and specialist and other services.

Currently - major criticism of our system is that it is public mental health service 'centric'

Conditions have never been better to progress continuity



- ◆ Commonwealth announced in *April* \$1.9bn in funding to MH over 5 years
- ◆ National Action Plan released July 2006
- ◆ MBS – GP mental health care plans, single assessment item for private psychiatrists, psychologists, MH practice nurses



Attempts at Barwon Health



Example: The clozapine program

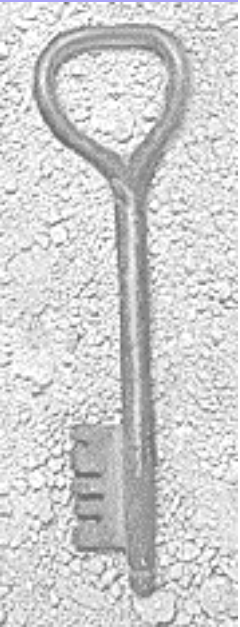
Background

- ◆ Four years ago – Common Care Plan project
 - Based on the realisation that Mental Health, PDRSS and GPs could each be separately preparing a care plan on the same patient
 - Partnership between specialist mental health, GP Association and PDRSS - supported by PCP
 - Paper-based single care plan – if initiated by one party then others contributed
 - Much learned about barriers to coordinating care
 - Limited success – particularly aged care and clozapine program

Clozapine program - history



- ◆ Barwon Health has always been proactive in using Clozapine - started using Clozapine in 1993.
- ◆ Full time Clozapine co-ordinator 2001.
- ◆ Agreement between Commonwealth, GP Association and Barwon Health to establish the G.P.Clozapine program established: 2001.
- ◆ 2001- full time Clozapine co-ordinator
 - policies and protocol developed
- ◆ 2002- role of coordinator
 - attend all AMHT Clozapine clinics
 - enter all blood tests onto websites
 - all issues relating to GP shared care, i.e. use of common care plan



History (contd.)



- ◆ 2004 - Three psychiatrists in public practice agreed to use private practice session to see clozapine patients (bulkbill and use Barwon Health facilities).
- ◆ Clients seen by private psychiatrists every six months in shared care arrangement with GP supported by clozapine program staff
- ◆ Additional staff recruited - current Clozapine program:
 - 2 Clozapine clinicians and part-time receptionist.
 - 7 private psychiatrists

The 'Clozapine problem'

- ◆ Effective anti-psychotic – potential side-effects of Clozapine severe – demand close monitoring (TGA requirement – regular blood tests)
- ◆ S100 – must be managed by a psychiatrist – at least 6 monthly review.
- ◆ 'Labour intensive' to commence and maintain clients on Clozapine and specialist MH teams must case manage client indefinitely unless 'GP care option found'.
- ◆ Above discouraged teams to commence clozapine (when 25% of team case managed clients where on clozapine) – needed 'release valve'

The 'Clozapine problem'



- ◆ From GPs point of view – need support and education. Also need support in establishing shared care plan
- ◆ From private psychiatrist on a view – need someone to ensure bloods tests are monitored, non-attendance are 'chased up'.
- ◆ From systems point of view – need easy re-access to AMHS case management if client becomes ill.
- ◆ Above challenges similar to any Chronic Disease Management programme

Model: a 'care net'



GP (152 trained)

Trained in use of clozapine, reviews client monthly, prescribes medication

Completes 6 monthly Management Plan

Clozapine clinicians (2)

Trains GPs: supports Management Plan completion with GP.

Available to client

Supports GP and psych. attendances

Public mental health AMHTs

Automatic re-access for a period if requested

Private psychiatrist (7)

Bulk bills:

Supported with secretarial, premises: Clozapine clinician

Reviews client 6-monthly

Clozapine



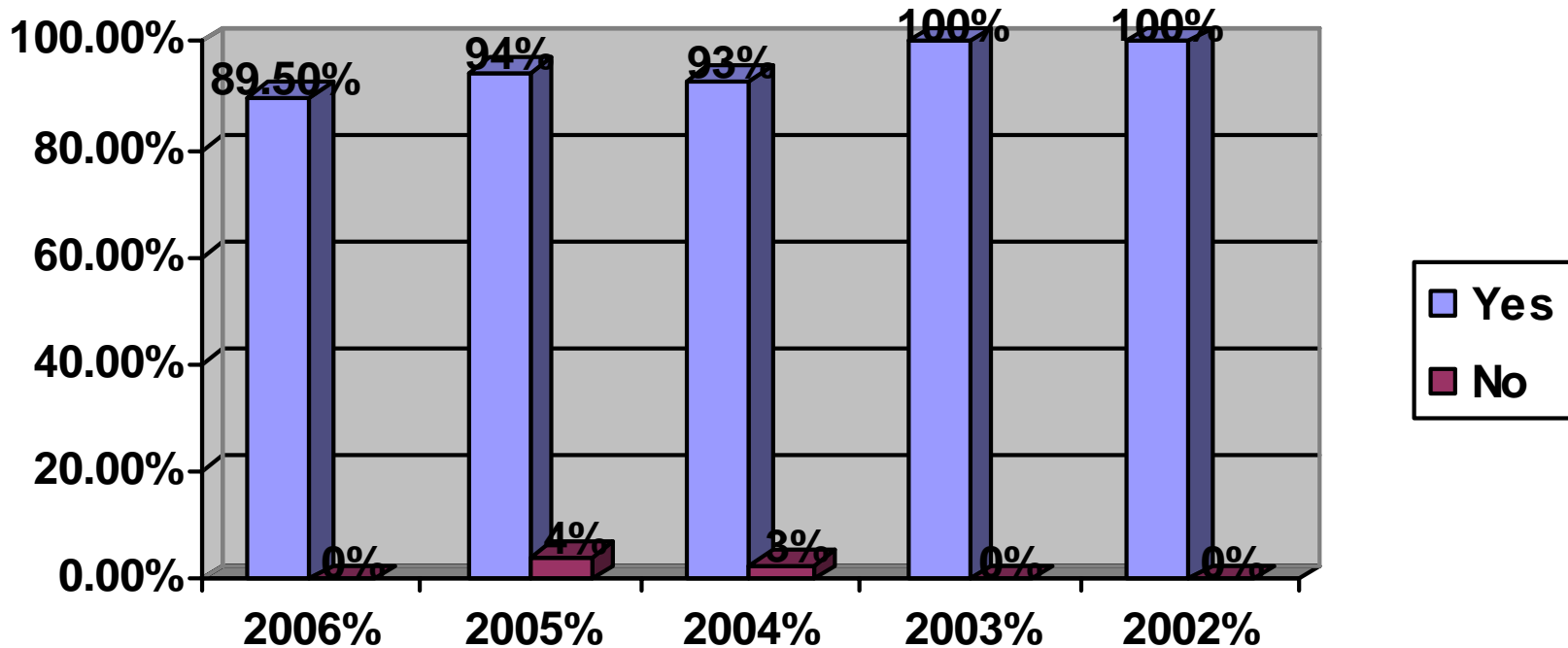
- ◆ Currently, 181 of the 268 Clozapine patients attend their own GP for their monthly review, which includes a routine blood test and obtaining their Clozapine prescription.
- ◆ 140 of this 181 are directly managed by the Clozapine program while the remainder continue to be managed by their AMHT
- ◆ GP completes Management Plan (721) every 6 months with the support of a clozapine clinician who attends the surgery and advises practice manager (GP)
 - In future will complete A GP Mental Health Care Plan (2710) up to 12 monthly, a Review of GP Mental Health Care Plan (2712 after four weeks and then six monthly) and may use the GP Mental Health Care Consultation (2713) more regularly
- ◆ 'Private' psychiatrist reviews client every six months and 'bulkbills'

Role of clozapine clinician

- ◆ After 6 months with specialist MH, a client can now attend their G P.
- ◆ Clozapine Co-ordinator then takes on the educational role and support
- ◆ Resource kit for G P / G P becomes registered.
- ◆ Clozapine Co-ordinator attends the first appointment / client 4 weekly thereafter.
- ◆ Client attend Private Psych every 6/12 for review.
- ◆ Clozapine Co-ordinator reports back to G P after every review.

General Practitioner survey results

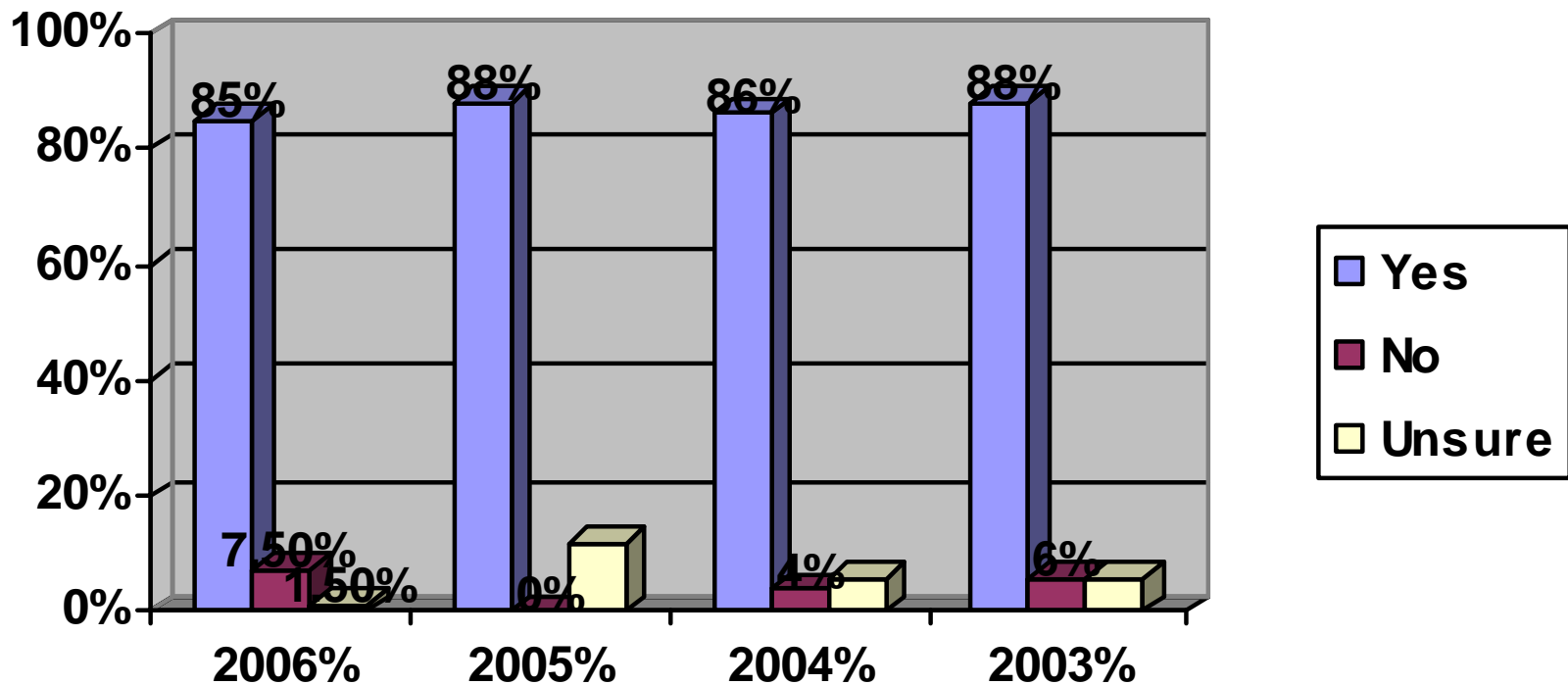
Q Do you feel that the General Practitioner Clozapine Program has been worthwhile program for General Practitioners?



General Practitioner survey results



Q (of GPs): Care Plans have now been incorporated as part of the GP Clozapine program. Do you feel that they are of any benefit?



Summary



- ◆ The Clozapine program demonstrates that GP —public mental health – private psychiatrist linkage can work.
- ◆ More satisfying for clients (attending own GP, same psych. for six-monthly review).
- ◆ ‘Care net’ means better outcomes for clients: fewer relapses, re-admissions
- ◆ COAG initiatives present an enormous opportunity – we must learn how to
 - ‘work outside the square’,
 - become a partner in mental health care rather than ‘take over’
 - utilise Commonwealth funding to extend services to our clients **and** engage with primary care providers – particularly GPs