# Better outcomes

## *A case study*

**Julie McCormack,** BA, DipEd, is National Manager, QA&CPD Program, The Royal Australian College of General Practitioners, Victoria, and Project Manager, General Practice Mental Health Standards Collaboration.

**Julian Thomas,** BA, BSc, is Professional Development Officer – Mental Health, General Practice Mental Health Standards Collaboration.

It is estimated that mental health problems will affect more than 20% of the Australian adult population in their lifetime.[1] The 2001 Australian Commonwealth budget provided $120.4 million over 4 years to improve the quality of care provided through general practice to Australians with a mental health illness. The Better Outcomes in Mental Health Care (BOMHC) initiative – which forms part of the National Mental Health Strategy – began in 2001 and aimed to improve the quality of care provided through general practice to patients with a mental health problem. This article reviews the uptake of education and training initiatives of the BOMHC initiative and good uptake by general practitioners across Australia. Well over 3600 GPs have completed the first 'level' of training associated with the initiative, representing 16.5% of the GP population. Access by consumers to mental health trained and registered GPs also significantly improved, with one in four practices employing a GP registered with the BOMHC initiative.

General practitioners are at the forefront of primary mental health care. In recognition of this, the Better Outcomes in Mental Health Care (BOMHC) initiative aims to support GPs in improving the quality of care provided through general practice to patients with a mental health illness by providing mental health education and training for GPs, and providing more support from allied health professionals and psychiatrists.

## Standards for training

The General Practice Mental Health Standards Collaboration (GPMHSC) was established in 2002 to set, maintain and review the standards for the education and training component of the BOMHC initiative. Central to its success in developing accepted 'standards' was the inclusion of all stakeholders in the collaborative standard setting process; recognising professional skills and territories.

Two 'levels' of training standards and requirements were designed. Level one training focusses on the three step mental health process and clinical knowledge and skills associated with:

- conducting a mental health assessment
- developing a mental health plan, and
- undertaking a mental health review

for patients with common mental health disorders. Complex cases are referred to other mental health professionals with specific skills in delivering appropriate interventions.

Level two training is designed to give GPs increased skills in the delivery of focussed psychological strategies (eg. cognitive behaviour therapy or interpersonal therapy) to consumers. Importantly, level one GPs are able to refer cases to level two trained GPs, facilitating inter practice specialisation.

The standards underpinning the training have recently been revised and come into effect from 1 January 2005. The complete standards are available from the GPMHSC website at: www.racgp.org.au/mentalhealth.

## Mental health registrations

By mid August 2004, the number of GPs who had taken up training far exceeded initial expectations; 16.5% (n=3624) of the GP workforce having registered at level one, with nearly one in five level one GPs undertaking extended training to register for level two. There is significant variance between states in terms of uptake (*Table 1*).

### Rurality

In rural areas, the uptake has been particularly good. In metropolitan areas (RRMA 1–2), 14.7% of GPs are registered, whereas over 22% (n=1071) of GPs in areas classified as rural (RRMA 3–7) have registered. In remote areas (RRMA 6–7), the figure rises to 17.6% (n=78). The significant uptake in rural areas is thought to be partly in response to the lack of support services (eg. psychiatrists, psychologists and other mental health services) available to GPs outside capital cities.

### Gender

Women GPs are over represented among registered GPs at level one, and the trend is even more pronounced at level two. The

**Table 1. Registrations for the BOHMC initiative**

| State | Level one registered | | Level two registered | | All registered | Proportion of GP population* |
|---|---|---|---|---|---|---|
| | Men | Women | Men | Women | | |
| ACT | 8 | 13 | 3 | 10 | 34 | 8.6% |
| NSW | 448 | 378 | 99 | 107 | 1032 | 13.7% |
| NT | 3 | 9 | 1 | 9 | 22 | 9.4% |
| Qld | 255 | 238 | 42 | 46 | 581 | 14.6% |
| SA | 165 | 148 | 27 | 43 | 383 | 20.7% |
| Tas | 33 | 46 | 10 | 12 | 101 | 16.8% |
| Vic | 452 | 361 | 81 | 85 | 979 | 18.5% |
| WA | 189 | 180 | 49 | 57 | 475 | 22.8% |
| Not known/overseas* | – | – | – | – | 17 | – |
| National | 1553 | 1373 | 312 | 369 | 3624 | 16.5% |

* GP population estimates based on RACGP figures ** No valid address known, or overseas address listed

Royal Australian College of General Practitioners (RACGP) data indicate that of those GPs for whom a gender is recorded, 37.2% are women (n=8084); but make up 48.4% of level one registered GPs (n=1753). At level two, 54.1% of registered GPs are women (n=369). Women GPs are estimated to work a mean of 33.0 hours per week compared with 46.8 hours for their male counterparts.[2] Taking these figures into account, an estimated 39.8% of all service hours delivered by GPs registered with the BOMHC initiative are delivered by women GPs. It should be noted that this figure does not account for possible differences in case load/mix between male and female GPs, and does not distinguish between 'general' service delivery and 'mental health' service delivery.

### Consumer access: practices

A view of registrations which gives a better picture of consumer access to registered GPs involves estimating the number of general practices with at least one mental health trained and registered GP – and therefore meeting a key objective of the initiative. These figures are derived from an analysis of practice addresses (n=6371) held within RACGP records for QA&CPD Program participants, and show that nationally, 27.7% (n=1765) of practices have at least one QA &CPD Program participant who is also a mental health registered GP, rising to 36.75% (n=460) when limited to 'rural' practices in RRMA 3–5. Nationally, 7.0% (n=444) of practices have a level two registered GP (*Table 2*).

It is important to note that these figures are likely to be underestimated due to limitations imposed by the data set that allow only one practice to be associated with each GP. Instances where GPs have given different addresses for the same practice (eg. PO box rather than street address) will artificially inflate the total number of 'practices' listed. Non-QA&CPD Program participants may also register with the BOMHC initiative, but are not accounted for in this analysis.

**Table 2. Practices with registered GPs**

| RRMA band | Practices in sample** | At least one L1 registered GP** | At least one L2 registered GP** |
|---|---|---|---|
| RRMA 1–2 (metro) | 4906 | 25.5% (n=1252) | 6.8% (n=333) |
| RRMA 3–5 (rural) | 1252 | 36.7% (n=460) | 7.7% (n=97) |
| RRMA 6–7 (remote) | 154 | 26.6% (n=41) | 6.5% (n=10) |
| RRMA unknown* | 58 | 20.7% (n=12) | 6.9% (n=4) |
| All areas | 6370 | 27.7% (n=1765) | 7.0% (n=444) |

* No RRMA match made to practice postcode
** Sample limited to practices with at least one QA&CPD Program participant GP

## Mental health CPD – all training

The BOMHC initiative has heightened awareness among GPs about the prevalence of mental health presentations in their practices and generated a desire to undertake mental health training whether individuals decide to formally register for the initiative or not.

The following data are based on all mental health CPD activities, and are not limited to GPMHSC recognised level one and level two training.

General practitioner training in mental health CPD proceeded fairly consistently over the triennium, with the average participant in the QA&CPD Program having completed just under 6 hours of formalised mental health education activities to 30 June 2004, and having accrued just over 20 CPD points. This indicates that across the GP spectrum, an interest in updating mental health skills has been demonstrated through

participation in mental health QA&CPD.

QA&CPD program data indicates that 57.1% (n=10 247) of participants have completed at least one instance of mental health training since 1 January 2002, and in general, the penetration of mental health training has been very good outside metropolitan areas.

## Conclusion

The roll out of training associated with the BOMHC initiative appears to have achieved good coverage in most areas of Australia, including remote Australia, although barriers to participation still exist. However, it appears that despite barriers to training including substantial cost and extended time out of practice, rural and remote GPs are keeping up with – and are in fact exceeding – their city based counterparts in their participation in the initiative through training and registration.

As a model for workforce re-skilling, the BOMHC initiative has been highly successful in its penetration to rural and remote areas, and has achieved this through voluntary participation by GPs. Formal studies of the impact of mental health training for GPs on clinical outcomes will enhance analysis of the effectiveness of the initiative for consumers, but it is fair to say that consumers now have significantly better access to GPs specifically trained in delivery of the 'three step mental health process' (level one) and 'focussed psychological strategies' (level two).

Conflict of interest: none declared.

### References

1. Andrews G, et al. The mental health of Australians. Canberra: Mental Health Branch, Commonwealth Department of Aged Care, 1999.
2. Australian Institute of Health and Welfare. Medical labour force 2001. Canberra: Australian Institute of Health and Welfare, 2001.

AFP

**Correspondence**
Email: julie.mccormack@racgp.org.au