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Major issues facing primary care mental health in Australia 2001

Chris Holmwood MBBS MClInEd FRACGP DipRACOG
Primary Mental HealthCare Australian Resource Centre

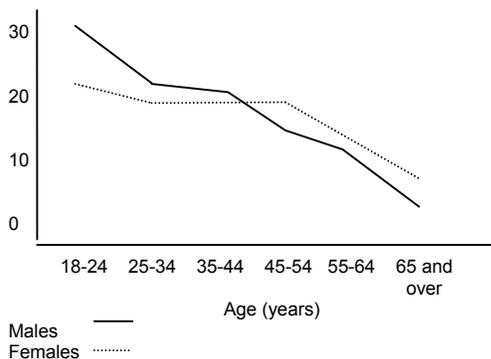
*"We have noted how difficult it is to maintain focus on aims that matter to society – that affect the external customers of our work, like patients and communities. It is sometimes easier to focus on internal reorganisation and improve in ways that are unimportant to outsiders. But it is meeting these external needs that ultimately determines the success or failure of organisations. Reminding people of this and asking relentlessly, "What external needs are we meeting?" is a mark of effective leadership."*¹

Prevalence of mental disorders is high

The Australian Bureau of Statistics National Mental Health and Wellbeing Survey clearly demonstrated the high prevalence of many mental disorders in the Australian community. This data is similar to other cross sectional epidemiological data such as the Epidemiological Catchment Study in the US and the WHO international study^{2,3}.

Age related prevalence data from the NMHWS are represented in table 1

table 1. Males and females, prevalence of mental disorder(a)



(a) Mental disorders from the major groups: anxiety, affective and substance abuse disorders.

With the backdrop of this high prevalence general practitioners are frequently admonished for not detecting more people with mental disorder and treating them.

Logically general practitioners are exhorted to detect and manage more of these people with

mental disorders. Despite our best efforts the highest detection rates are about 60%^{4,5}.

It is usually agreed within the profession that general practitioners have a key role in the management of people with mental disorders in Australia⁶. GPs are generally accessible in a physical and economic sense and there is no stigma associated with attending the local general practitioner for health care.

The main debate centres around just what the key role of the general practitioner is and how to promote it.

As a footnote to the issue of high prevalence we are also encouraged to believe that the prevalence of depression [and in fact all mental disorders] is increasing⁷. There are no data from Australia to support this. The Mental Health and Well-being survey was the first cross sectional study of its type in Australia. There are no longitudinal data to use for comparison to determine trends across time. A recent review of the international data came to the conclusion that there was no strong evidence that mental disorder prevalence is increasing⁸.

“Unmet need” is undetermined but probably high (although not as high as some would argue)

Some argue strongly that there is an immense unmet need out there in the Australian community that needs to be addressed. While this maybe true the exact extent of the unmet need remains to be defined. The prevalence data that we have is based on the Composite International Diagnostic Instrument (CIDI) that was used in the NMHWS. The CIDI is a

diagnostic instrument and has a high level of reliability and addresses both ICD 10 and DSM IV criteria. The issue that arises is that we do not know whether all people detected using a diagnostic instrument as a screening instrument actually require intervention.

Put another way the NMHS tells us that 18% of people in Australia have a diagnosable mental disorder. The Survey also told us that these people suffer significant disability from their condition in terms of days unable to carry out their usual role.

However within that group of people diagnosed as having a mental disorder there is probably a significant number in whom interventions will not change the course of their condition.

What services do these people need?

There are now evidence-based treatments for most of the common mental disorders⁹. These treatments require the provider to be trained but the competencies required are not beyond the capacity of general practitioners and other primary care providers.

The striking thing about the treatments is the sheer magnitude of what is needed on a population level.

Let's take depression and cognitive behavioural therapy as an example.

If the overall prevalence data are correct (5.8%) then with 19 million people there ought to be about 950,000 Australians with depression in any 12 months. If they were all to have say 10 forty-five minute sessions of Cognitive Behavioural Therapy then this would require 7.125 million hours of 1:1 clinician contact time. If there are 15000 full time equivalent GPs in Australia¹⁰ with the required skills then this would require that each devote 475 hours/year or 10 hours per week to CBT for depression. Even if all of these people who had private insurance (say 30%) were referred to clinical psychologists (there are between 400 and 500 in private practice in Australia) this would then mean that all of the clinical psychologists time would be taken up with the management of depression.

If we decide that structured problem solving should be the intervention of choice for depression, then we can do these calculations:

In the study by L M Mynors-Wallis et al¹¹, patients had one 60 minute session followed by five sessions of 30 minutes with a psychiatrist or a trained general practitioner. A total of 3.5 hours per person.

With 950,000 Australians requiring treatment for their depression then the total intervention for this group would be 3.325 million hours per year. This equates to 221 hrs/year or 4.7 hours per week per full time GP. This sounds reasonable until you do the calculations for all the common mental disorders. If we make an assumption that the management of other high prevalence mental disorders take as much time then we need to provide treatments for 18% of the community or 3,250,000 Australians. This would equate to 16 hours per FTE general practitioner per week! Even the most well intentioned GP would cave in under the extra load.

It is not at all obvious that the current general practitioner workforce can meet the "unmet need" that many researchers postulate.

How then can the "unmet need" be met? Other alternatives that we will explore later in this paper are specifically trained nursing staff working within general practices or other primary care facilities or the use of groups and computer-based or book based therapies.

General Practice Workforce issues:

Since the mid 1990's training for general practice has been restricted and directed to contain expenditure and to effect a redistribution of general practitioners into rural and other under-served areas. This has certainly brought about a levelling of GP expenditure but whether it has effected redistribution of GPs is arguable from current data.

There are still significant GP workforce shortfalls in rural areas¹². There is precious little spare capacity amongst GPs in the bush to undertake this kind of additional mental health related work detailed above.

In metropolitan areas the overall number of GPs is static with a slowly increasing population. Latest data suggest a small increase in population per general practitioner in metropolitan areas.

In addition to slow increases in population per Full Time Workload Equivalent GP, the average age of Australia's population is increasing¹³ and this signifies a steady increase in general practitioner workload to support this aging community. For example the number of services for a person aged 75 and over is approximately 20 per year, for the average across all age ranges 10/year¹⁴.

Therefore even without revision of the role of the GP, workload is increasing.

There are also other pressures on general practitioners to expand their role through developments such as the Enhance Primary Care initiative.

There are ample bad news stories about GP discontent in the medical weeklies. They are feeling the pinch although the majority still likes the work that it does.

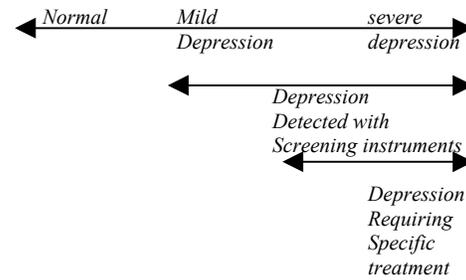
The capacity for general practice to expand its role further without substantial systemic changes that might enable such an expansion is extremely limited.

Various research anomalies that need to be explored

1. Lack of evidence that would support a screening for depression intervention.

Despite several well-constructed trials of screening and management of depression in the general practice setting there is no evidence that it improves patient outcomes¹⁵. There are various explanations for this. One cogent explanation is that what we are detecting with a screening instrument is a fairly broad spectrum of severity[^] and that only some need interventions that will improve their outcomes.

[^] Acknowledging that there is considerable debate on whether mental disorders ought to be regarded as stages on a continuum of severity and disability rather than distinct categories.



The treatment effects for people with the more severe disorders are then diluted by the lack of effect on people with less severe depression who would not measurably improve as a result of treatment.

2. Lack of evidence behind suggested treatments by general practitioners

Most intervention studies have been undertaken in specialist secondary and tertiary settings. Those that have been in primary care have often used health professionals other than GPs to deliver the services. Very few of the studies have been performed in Australia and the generalizability of some overseas studies and findings to the Australian general practice context may be limited.

3. Lack of evidence behind “treatment thresholds” that might guide:

- workforce considerations and
- clinical practice guidelines

As mentioned previously, it is unclear at what level of severity along the continuum of mental disorder, interventions actually make a difference. This is particularly a problem in general practice where people are not usually seen as fitting into a neat diagnostic box. Their illness experience is a dimensional one. At what stage along this dimension does the GP [and the patient?!!] consider that they have a “disorder”?

It is unclear who will benefit from what therapies. Eg who might be appropriately referred for more cost efficient interventions such as group therapy (either consumer based and led or professional-facilitated), computer-based programs and self help books (“bibliotherapy”)?

While there have been some trials with these types of interventions it is unclear

how they should fit into the Australian healthcare system. Trials to clarify these issues ought to be considered in any future plans for primary care mental health.

In contrast to low cost interventions, 1:1 interventions are expensive and offer impressive resource challenges. There is no doubt that many people with disorders that are severely disabling will require interventions of this intensity.

The research challenge is to determine who does best with what and how we might develop a system that fairly allocates resources to people on the basis of needs.

4. Closer partnerships/shared care/integrated care. What does the evidence say about outcomes?

The truth is that most studies into better integration of mental health services and primary care have not looked at patient outcomes. Process outcomes such as services rendered to whom and by whom have been looked at and there are as many models as there are countries.

The Fort Bragg study¹⁶ failed to demonstrate improvement in outcomes for the intervention group who received what would appear to be a well-coordinated stepped care type mental health service based on a strong primary care sector.

Changing the system might meet the needs of various provider groups but the question is whether it meets the needs of the consumers it is purporting to.

What therefore is the role of general practice in all of this? (its obviously part of the solution but not the entire answer)

From the above it is evident that there may not be much spare capacity within general practice to provide the types of specific interventions that are required...at least for some people with mental disorders. This is particularly the case in rural and outer metropolitan areas where GP workforce is particularly stretched.

The role for the GP could still be quite extensive. Initial assessment and negotiation

of management plan with the patient, prescribing, psycho-education, early intervention in alcohol and other drug use, perhaps structured problem solving and some behavioural interventions. Early referral to more specific therapies such as groups, computer based therapies and self help books based on evidence would be the average GP's role as well.

However more intensive 1:1 cognitive behavioural therapy and interpersonal therapy is realistically delivered by other mental health professionals.

As stated above the capacity for further role expansion is limited without major changes to how general practice is structured. In rural areas the current shortfall in specialist services needs to be addressed alongside any other service innovations.

Alternative models.....

We therefore need to consider how specific limited (both in time and cost) interventions can be provided for the people who need them.

Low cost-high volume

There are at least three ways of providing these:

❑ *Groups.*

Group therapy offers economies of scale and has been effective particularly with the anxiety disorders.

❑ *Computer based software*

Using computers for therapy seems to stick in the throats of most mental health professionals and general practitioners.

However there has been considerable interest in computer based programs that lead patients through structured cognitive behavioural therapy¹⁷. Given the high cost of individual therapy and the difficulties particularly in remote areas of getting suitable groups together for group therapy, these options have to be explored.

Some work is being undertaken here in Australia^{18,19} and significant developments in

the UK with *Beating the Blues*²⁰ are promising.

Determining just how such resources might be used in the Australian health setting should be a high priority.

❑ Self-help books with professional assistance.

“Bibliotherapy” has also been examined recently as a low cost option for people with both depressive and anxiety disorders^{21,22}. Bibliotherapy can be effective in selected patients. Its effect can be enhanced with support and re-enforcement by clinicians²³.

Intermediate cost and volume

The above low cost therapeutic options will only suit some patients.

People with high levels of disability, people unable to use computers and those with lower literacy may have difficulty with these modalities. The interplay between personality traits and response to therapy has been explored and will obviously determine who might best benefit from comparatively low cost interventions²⁴.

Using specifically trained nurses within general practices may be a cost and resource effective option, particularly in areas with already extended medical workforces. Nurse therapists have been trained to undertake specific treatments for people with anxiety disorders and training programs have already been established in Australia to train them²⁵. The role of the nurse therapist within the Australian context still needs to be defined. There is evidence that follow up of people with several different mental disorders to ensure treatment adherence, improves outcomes²⁶ and that currently this follow up doesn't occur in any systematic way²⁷. There is great potential for the development of the mental health nurse therapist within the Australian context.

However development of this should involve all relevant stakeholder groups and should be adequately evaluated prior to substantial roll-out.

Medical school and vocational training

Attitudes and patterns of practice are established early on in professional careers. Most

endeavours over recent times have been directed towards skills development with established general practitioners. The earlier attitudes and skills are developed with respect to mental health the more effective the intervention is likely to be.

Medical Schools

The Joint Consultative Committee of the RACGP and the RANZCP report *Primary Care Psychiatry the Last Frontier* recommended that the medical school curricula address the competencies that are required of supervised general medical officers working in hospital settings.

The types of skills that are required at this level would be recognition and initial management of the common mental disorders, basic structured problem solving, grief counselling and skills with breaking bad news, motivational interviewing and brief intervention skills for substance use.

These types of basic level of skills are not taught in a comprehensive manner across all Australian Medical Schools. It is time that this be revisited to ensure that the chance of greatest educational leverage is not missed.

Vocational Training

The RACGP Training Program addresses the mental health competencies required of general practitioners. However how this is implemented and assessed through the Training Program and the College Fellowship examination [and any future consortium based training programs] is not clear.

With the deregulation of general practice vocational training comes some real opportunities for reinforcing the mental health agenda within these new training programs.

Enhanced Primary Care items and mental health

The Enhance Primary Care Items were introduced in November 1999. They included for the first time items that might be rebatable under Medicare that did not necessarily involve face to face contact with the patient. The symbolic nature of this development can not be underestimated.

However with the exception of the Health Assessments for older people there has been low uptake so far of the EPC Items. The only published research into this was from data drawn early in 2000²⁸. It is worthwhile noting that most people with mental disorders do not need complex multi-disciplinary care and therefore do not come under the potential benefits of the EPC items as they now stand. However it would appear that with people with chronic and complex mental disorders, the care planning and case conferencing items might be very relevant.

Case conferencing is difficult to coordinate. Even with the use of the telephone, timing is difficult. When we are trying to communicate with other private providers who would not be able to access some rebate for their time the difficulties multiply. There is some potential for the involvement of GPs [as contributors] in discharge case conferences when people are discharged from in-patient services.

Care planning may be more applicable over time as the contemporaneous input of the different care providers is not required. However as outlined above there may be little spare GP capacity to spend the time to formulate care plans in a pro-active sense when the current workforce is already extended. Even if substantial aspects of the care planning process are devolved to other practice based staff, there is still considerable extra work for the GP.

On a more academic level there is little evidence at the moment that care planning in the Australian context improves patient outcomes. Care planning may represent an intuitively better way to carry out care but improved outcomes have yet to be demonstrated. The recent coordinated care trials have demonstrated that other self-evident ways of managing care such as care coordination for those with complex needs do not always improve outcomes in the Australian context.

Further promotion of the EPC items needs to be driven by the profession, not by Government. Research should be carried out in a rigorous manner to determine whether outcomes are in fact better under care planning.

What's the role of Divisions?

Divisions have been very active in the mental health area over the past decade.

Currently the Primary Mental Health Care Australian Resource Centre (PARC) estimates that there are approximately 70 out of 123 Divisions of General Practice engaged in mental health related activities²⁹. The 1999-2001 Primary Care Mental Health Education Initiative was developed specifically with Divisions as partners.

PARC is currently engaged in a review of mental health shared care/partnerships between general practice and specialised mental health services. There is a broad range of activities within Divisions that have been developed to integrate and coordinate mental health care better.

It is apparent that there is a continuum of level of engagement between general practice and the specialist mental health sector. From preliminary studies based on data that is over 12 months old, the degree of engagement of Divisions with the local mental health services can be tabulated as follows. Of the 70 odd Divisions involved in mental health about 65 are involved in collaborative activities with local mental health services.

Engage-ment level	Types of activity	No. Of Div.s
1	<input type="checkbox"/> Discussions between Divisions and relevant mental health services. Workforce and service planning and recruiting.	20
2	<input type="checkbox"/> Development of tools for communication, better referral processes, better discharge processes. <input type="checkbox"/> Development of protocols for management of psychiatric emergencies. Delineation of roles and responsibilities.	21
3	<input type="checkbox"/> Formal shared care programs. Include service agreements, consultation liaison and liaison MH workers.	24

The movement along the continuum of engagement depends on several different factors.

Harris et al³⁰ describe six factors that are important to sustained collaboration between general practice and other health sectors:

Necessity: *there has to be a need for closer cooperation.*

Opportunity *successful collaborative activities often arise opportunistically as new funding opportunities (eg the Enhanced Primary Care Items) arise, different sectors re-structure, new policies are adopted, etc.*

Capacity *somewhere in each sector there needs to be some space for innovation and experimentation. Change requires effort and risk taking and sectors and health services that are stretched to the extreme often do not have the spare capacity for change.*

Relationships *As Jenny Ouliaris from the North East Valley Division of General Practice stated at a National Shared Care Conference³¹ “No Rocket Science Here- We’re just building relationships!”*

Planned action *The above factors need to be activated through collaborative planning and action. Decision making needs to be inclusive.*

Sustainability *Collaborative activities that owe their initial development to the efforts and zeal of enthusiasts will inevitably falter unless the previous impediments are removed. The “new way of doing things” needs to be at worst just as easy as the old way. At best it should be easier. This may come from the new way being just intrinsically more efficient or from more resources being spent in supporting better collaborative efforts.*

Each of these requirements needs to be addressed on a local level for partnerships to flourish.

The key to successful partnerships over the past decade is that the agendas of all parties are valued and addressed.

So if Divisions are the key to future developments in general practice mental health, then what’s the remaining capacity of Divisions?

Their role has required a fine balance between being membership-oriented bodies and being agents of government driven change. There is a real risk of alienating them from their constituency if pushed too quickly and too far. There are lessons to be learnt from the way in which the RACGP Training Program was used as an instrument of workforce policy in the mid 90’s. A whole generation of young GPs has become alienated from the very body that had their best interests at heart.

Rural Divisions are in a difficult situation because of shortages of both GP members and other mental health professionals. It’s difficult to establish partnerships when there’s no other service with which to collaborate. Resources need to be spent in rural and outer metropolitan areas to ensure that access to specialised services is at least equal to better serviced metropolitan areas.

On a strategic level, the challenge here is ensuring that Divisions maintain their role as agents of change without alienating their constituency.

Access to specialist psychiatric opinion

The fact remains that GPs have a difficult time getting timely advice from psychiatrists. In clinical practice I can get a cardiological opinion within a few days; immediately if necessary and yet specialist psychiatric assistance is not easy to access.

The current Medicare Benefits Schedule currently discriminates against the psychiatrist who has a heavy load of new patients, assesses them and sends them back to their GP or on for specific therapy as required. Some early tinkering with the Medicare schedule for psychiatrists by the current administration stimulated some interesting responses within the profession. An election year is probably not the time to revisit this but the current reimbursement system that actively discourages the exact type of service pattern that GPs and their unserved patients require needs to be re-examined.

Consumer involvement

The quote from Don Berwick at the start of this paper brings us the full circle. What are we

trying to achieve through mental health initiatives in general practice?

We cannot answer this without actually consulting with and involving consumers and carers from the beginning of any service reform or development.

The Mental Health Council of Australia in its publication *Enhancing Relationships between Health Professionals and Consumers and Carers*³² clearly outlines an agenda for adequate consumer involvement in mental health care planning and implementation.

However the unique feature of mental health in the primary care setting is that many consumers do not identify themselves as such. Many have not had a formal diagnosis made and may not agree with the diagnosis if it were made. Treatments given may not constitute a formal psychotherapy but might be quite effective at assisting the person managing their problem or condition. The challenge of the mental health consumer movement in the future is to try to ensure adequate representation from the types of people who end up in their GPs offices with one of the common mental disorders, who may not at first see themselves as mental health service consumers.

Summary

There are many unanswered research questions regarding mental health in the general practice setting. These need to be adequately researched to inform policy and reform.

The great bulk of mental disorders are high prevalence disorders such as depression, anxiety, alcohol related disorders and somatiform disorders. These have evidence based treatments.

Developments in services should not be stalled by the fact that there are still many unanswered questions. There are plenty of opportunities for true innovation in the primary care mental health arena.

The general practice workforce has an important role in managing these disorders but cannot do it alone.

Especially in rural areas extra resources need to be spent in provision of accessible services that are evidence based. This needs to encompass the full range of services from specialist psychiatrist services through to support groups, self help manuals and computer based programs.

Further development though Divisions needs to be done in a measured way and needs to engage Divisions and their members and meet their agendas firstly. The development of three way partnerships between consumers, GPs and specialist services is essential to future success.

Chris Holmwood
Primary Mental Health Care
Australian Resource Centre

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