Communication with General Practitioners to support the employment of people with mental illness

September 2008
This report is based on research conducted by Hunter Institute of Mental Health for the Department of Education, Employment and Workplace Relations, 2008.

Disclaimer:

The views expressed in this report do not necessarily represent the view of the consultant, Hunter Institute of Mental Health, or the Australian Government or any departments thereof.

Interview comments contained in the report are changed so that it is not possible to identify an employer, DEEWR funded employment service or mental health specialist service. Any resemblance to an individual or organisation is therefore coincidental and not intended.
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**Abbreviations**

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<tr>
<td>ACRRM</td>
<td>Australian College of Rural and Remote Medicine</td>
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<td>AGPN</td>
<td>Australian General Practice Network</td>
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<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
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<td>DEEWR</td>
<td>Department of Education, Employment and Workplace Relations</td>
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<td>DoHA</td>
<td>Department of Health and Ageing</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>GPET</td>
<td>General Practice Education and Training</td>
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<td>HIMH</td>
<td>Hunter Institute of Mental Health</td>
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<td>JCA</td>
<td>Job Capacity Assessment</td>
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<td>MHNIP</td>
<td>Mental Health Nurse Incentive Program</td>
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<td>PHAMs</td>
<td>Personal Helpers and Mentors Program</td>
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<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
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<td>TDR</td>
<td>Treating Doctor’s Report</td>
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Executive summary

Employment and work are important for people’s mental health. Statistics indicate that people with mental illness are over-represented in labour non-participation and unemployment groups. The assessment, treatment and care coordination activities that are part of a General Practitioner’s (GP’s) role mean that GPs play an important role in supporting people with mental illness return to, remain in and enter employment. However, to date, it has been unclear as to the degree to which GPs consider employment outcomes as relevant to the care of patients with mental illness. It is also unclear as to the degree GPs are comfortable or confident in completing the activities associated with supporting someone with mental illness to engage or re-engage with employment, or feel that there are other issues that affect their capacity to fully engage in their clinical activities in this area.

As part of the Council of Australian Governments’ (COAG) commitment to supporting people with mental illness to engage in employment, the Hunter Institute of Mental Health (HIMH) was contracted by the Department of Education, Employment and Workplace Relations (DEEWR or the Department) to identify information and tools that GPs might find useful in assisting people with mental illness return to, remain in or enter work, including those that would assist the GP in assessing work capacity and completing the SU415 Medical Certificate (Medical Certificate), and to recommend how such information and tools could be provided to GPs.

As part of this project, eight focus groups comprised of GPs and mental health nurses were held across three Australian states, covering urban, regional and rural areas. The focus groups resulted in a total of 40 research participants (32 GPs and eight mental health nurses). In addition, 11 interviews with representatives of GP membership and professional groups and academic experts were held. This consultation process allowed information to be collected regarding GPs’ information needs in relation to their role in supporting patients with mental illness to engage or re-engage or remain in work, with particular relevance to the GP role in completing the Medical Certificate. The consultation process also scoped participants’ preferences regarding how best to disseminate and deliver this information to GPs.

The information collected through this project has been used to develop a model that captures the most pertinent issues impacting on a GP’s capacity to support a person with mental illness as they engage or re-engage or remain in work (see page 39). The model highlights the importance of not only considering the information needs of the GP, but also the context in which they are working. It emphasises the importance of considering strategies to address the interface between GPs and the employment support system (specifically Centrelink) and the capacity of other groups (including Centrelink, employers and co-workers) to effectively respond to the needs of people with mental illness.
Based on participant reports, the consultation process highlighted that GPs and mental health nurses value the importance of employment for people with mental illness, but that they struggle to capture their judgements about work capacity for people with mental illness on the current Centrelink forms. The participants also indicated that GPs and mental health nurses generally do not understand the employment support service system processes, their role in it or how they should best navigate it.

Based on the consultation process, the following key themes and issues for consideration were identified:

1. The GPs reported that they have a need for information about:
   - the employment support system and the GP role generally, specifically the services available and access pathways for patients
   - who they can contact when they need advice around navigation of the employment support system, or in regards to issues specific to shared clients
   - work capacity assessment for mental illness and how it can best be captured on the required Centrelink forms (i.e. Medical Certificate).

2. The key messages identified as likely to be of most assistance in promoting best practice for GPs and the primary health care team, with regards to their role in supporting people with mental illness to engage or re-engage with employment, were:
   - employment has positive benefits for people with mental illness
   - there are employment support services and programs available to assist people with mental illness to engage or re-engage with employment (available through Centrelink and the Job Capacity Assessment process)
   - information provided by the GP (including that provided through the Medical Certificate) plays an important role in determining the types of employment support services that a patient may be offered
   - completing the Centrelink forms without understanding the possible employment pathways may not result in the optimal referral outcomes for a patient. The key access and eligibility information GPs should be aware of are...
   - if specific problems are experienced in relation to patient care or additional information is required about the employment support system, the contact point is...

3. The research suggests that a variety of information dissemination and resource formats are required in order to get appropriate coverage of GPs and practice support staff. The research suggests that information should be:
   - available through a variety of media (including print, electronic and personal contact)
   - provided in such a way that more information can be sourced if required
   - disseminated in a way that integrates with the completion of existing clinical activities
available in such a way that it can be made locally relevant.

By doing this, the characteristics of GPs and their practice support staff that may influence information dissemination and preferred format will be addressed. These characteristics include factors such as urban versus rural location, technological status of the practice, interest of the GP in mental health or employment, size of the practice or practice structure, attitude and experience in team care, workload and patient load and demographics of the patient load.

The development of a specific information resource was identified as not being required for the different practitioners within the primary health care team, unless there were specific varied roles expected of the different practitioners.

Research participants recommended that any information targeted at GPs should be:

- simple, clear and concise
- a source of decision making support regarding patient care
- interactive, so that the information can be automatically tailored to a specific patient
- accurate and up to date
- locally relevant
- easy to use and easy to access
- available in different formats (to ensure appropriate coverage)
- multi–levelled, such that more information can be accessed if needed
- delivered ‘in context’ and preferably as activities that have networking

5. A variety of information delivery methods and formats may be required to ensure appropriate coverage of GPs and practice support staff. The research suggests that the following would be beneficial:

- a simple and concise hard copy and electronic version of information about work capacity assessment for people with mental illness, the employment support system (including who it assists and when) and the GP role, of which the availability could be promoted through a short information letter directly sent to GPs and face-to-face contacts
- a strategy to investigate the feasibility of introducing an electronic Medical Certificate (including electronic lodgement) which hyperlinks each question to various relevant information regarding assessment, how the information is used, services available and eligibility criteria (for example, some of the content could be taken from the resource above)
- a GP contact and liaison point within the employment support system (preferably Centrelink) who can assist with system navigation
- a feedback and communication process for shared service users for whom GPs have provided information (for example, through completion of a Medical Certificate). This could take the form of a short letter as to the outcome of any assessments, any employment
support service referrals made, and who can be contacted for more information.

6. To encourage uptake, promotion of the above resources and supports would be beneficial. The consultation process indicated that a proactive dissemination strategy would be appropriate and could include:
   - alerting GPs and practice support staff that the information and supports will be available in the future, using existing communication channels (see below)
   - announcing the availability of the information and supports once they 'go live'. Promotion could use existing communication channels, and delivery of prompt resources (for example, magnets, stickers, business cards) with a short letter explaining the available resources and where additional information could be sourced, sent directly to general practices
   - reminders to GPs and practice support staff regarding the availability of the information and supports, using existing communication channels
   - face-to-face promotion of the resources
   - practice visits working with local Divisions of General Practice, and involving local Centrelink or employment support staff to promote the information and supports and develop the relationship and networks between local service providers
   - ‘piggy-backing’ onto existing education and training or networking activities to promote the existence of the resources and supports (for example, 10 minutes during an existing meeting, preferably by a local Centrelink staff member).

7. There is a range of existing communication channels that could be used to disseminate information to GPs. These include newsletters from the Divisions of General Practice and professional representative bodies (for example, Australian Medical Association; Royal Australian College of General Practice); professional magazines (for example Australian Doctor; Medical Observer); and existing education and training events. It may also be of benefit for local Centrelink offices to develop their own databases of, and networks with, local GPs, potentially in collaboration with the local Division of General Practice.

8. The research suggests that a partnership approach between DEEWR, Centrelink and Divisions of General Practice would be beneficial for promotion of any information or resources developed. Such an approach would make use of existing communication networks with GPs and would leverage the existing role that these organisations play in disseminating information to GPs and make use of the expert knowledge the organisations have of the local context.

9. In order for the above strategies to have optimum impact, research participants suggested that strategies be developed to address what is commonly considered an adversarial relationship between GPs and Centrelink, in order to develop a relationship that is more collaborative
and collegiate. This shift would require GPs to experience a change in the way they perceive Centrelink to be responding to the needs of their patients with mental illness. More feedback, communication between the service providers and the development of opportunities for additional face-to-face contacts and networking activities could help develop a more collaborative and collegiate relationship between GPs, Centrelink and employment support service providers.

10. To increase the impact of promotion of any supports or resources developed, the research suggests that there would be benefit in investigating the role of a ‘GP champion’ who would work in partnership with local Centrelink offices and the local Division of General Practice. This strategy may be of particular importance in areas where there are high proportions of people in the target population.

11. In addition to the GP supports described, the consultation process indicated that there was also a need to investigate and promote activities that would enhance the capacity of frontline Centrelink staff and employers to respond appropriately to people with mental illness. Further, the consultation suggested a need to consider the degree to which existing Centrelink professional access points are appropriate and relevant to GPs, and have capacity to provide information regarding the specialist nature of issues associated with mental illness.

The findings of the research indicate that the above strategies may be useful in addressing the information needs of GPs and practice support staff, with regards to GPs’ and practice support staff’s role in supporting people with mental illness engage or re-engage with employment. Further, by addressing the relationship and interface issues between GPs and Centrelink, the research suggests that a more collaborative and collegiate approach could be developed between service providers. This would result in a more integrated and cohesive pathway to support for patients with mental illness. Combined, these strategies would be likely to result in better patient outcomes and more people encouraged and supported to return to, remain in or enter employment.
1. Background and purpose of project

1.1. Introduction

Work has particular value in promoting mental health. Engaging in meaningful activity such as employment provides a structure to the day, offers opportunity for social contact, requires effort and purpose, has the potential for achievement experiences and contributes to a person’s sense of identity and self-concept (Harnois & Gabriel 2000). Employment activities are also one way of indexing social inclusion and engagement, and represent an important feature of daily living (Waghorn & Lloyd 2005).

People with mental illness are over-represented in labour force non-participation and unemployment figures. The workforce participation rate for people with mental illness in Australia in 2003 was 29 per cent, which is low in comparison to the workforce participation rates of people with physical disability (49 per cent) and the general community (74 per cent) (OECD 2003). Further, the workforce non-participation rates are substantial across the spectrum of mental health disorders from depression (57 per cent) and anxiety (47 per cent) through to psychosis and bipolar disorder (75–78 per cent) (Waghorn & Chant 2005; 2007; Waghorn, Chant & Jaeger 2005).

The barriers to employment for people with mental illness are multiple. These barriers, as outlined by Waghorn and Chant (2005), include:

- cognitive symptoms impacting on capacity to effectively complete tasks
- other symptoms (for example, inappropriate behaviour, lack of motivation) impacting on behaviour and capacity to complete work activities
- the episodic nature of mental illness resulting in difficulties in establishing the true support needs of a person to stay in work (for example, overestimated during an episode and underestimated during a stable period), particularly because of the reliance on clinical symptoms to identify support and work capacity needs
- treatment effects presenting indirect barriers (for example, medication side effects affecting energy levels)
- low vocational expectations of health professionals resulting in employment not being placed as a priority in treatment and life goal setting
- community stigma towards mental illness making disclosure (and thus garnering of appropriate support) difficult
- stigma and attitude of helping professionals who may place a low priority on employment goals in treatment planning. This is a result of service providers’ concerns that employment may place too much pressure on a person with mental illness
- workplace stigma, meaning employers may be hesitant to employ someone with mental illness
- co-morbid disorders and presentation of multiple needs making treatment planning and the identification of appropriate employment options difficult
- no standardised ways of classifying disability, assessing work readiness or assessing level of need for vocational
assistance for people with mental illness being available

- government funding structures making it difficult to garner the assistance required to ease transition to employment
- disincentives in the health and income support system meaning that gaining employment may result in financial or other disadvantages for people with mental illness
- population dispersion in Australia meaning that supports and services are not evenly spread or easily accessible, particularly in rural and remote areas
- usual pathways to education and employment being interrupted by episodes of mental illness resulting in career immaturity
- work being experienced as a negative and difficult activity when in a non-supportive employment environment, resulting in exacerbations in clinical symptoms.

Thus, while it is generally recognised that most people with mental illness have the capacity and desire to engage with some form of employment, there may be a need for extra assistance for people with mental illness in order to maintain their work activities, or for specific workplace changes to accommodate their continued participation (Waghorn & Chant 2005). There is also specific risk that disengagement from employment will compound the existing barriers, resulting in greater difficulties when looking to return to work and resulting in a higher risk of longer term labour force non-participation. In a review of an employment support program designed to assist people with personal barriers, Perkins (2005) found that 78 per cent of the people engaged in the program had some type of mood, anxiety or personality disorder, while Butterworth (2003) found that approximately 30 per cent of income support recipients had symptoms indicative of a mental health disorder.

Thus, the importance of supporting people with mental illness to return to, or engage with, employment is clear.

GPs play a key role in the assessment, management and treatment of people with mental health problems and mental illness. Their role is one of health management whereby they work with the patient to address illness and its impact on daily functioning. The GP role involves delivery of treatments for medical conditions, illnesses or symptoms, care coordination and patient education. The health service with which people with mental illness are most likely to have had contact is the GP. Over 80 per cent of people with mental illness visited a GP in the past year, although only a subset of these (approximately one third) contacted their GP specifically in regards to their mental health (Meadows et al. 2001).

GPs also play a key role in supporting people with mental illness to return to, engage with or re-enter employment, and have specific care coordination interface activities with the employment support system. The role of the GP is a result of the evidence that indicates that vocational rehabilitation should be considered part of the recovery process for people with mental illness, but also as a consequence of systemic protocols. An example of a system’s role fulfilled by the GP is with regards to the completion of the Medical Certificate (SU415). This form is required
to be completed by a GP and provided to Centrelink as supporting evidence when a person is seeking income support (and activity requirement exemptions) during a period of illness.

Thus, the provision of Medical Certificates for people with mental illness presents a critical care coordination activity, with specific treatment and employment outcome implications. There is only limited evidence available around GPs’ understanding of the importance of vocational rehabilitation for people with mental illness. Available evidence suggests that GPs may undervalue the role of employment and workforce participation for their patients with mental illness, particularly for those with schizophrenia (Bond et al. 2001). A recent Australian study suggested that GPs were supportive of the benefits that paid employment has for their patients with mental illness, but that their knowledge of available employment support services and direct referrals was low (Crawley, Fitzgerald & Graham 2007).

Surprising findings by Waghorn and Chant (2007), also using an Australian sample, found that patients with anxiety or depression who were being treated (including by a GP) were less likely to be engaged in or looking for work (that is, they had a significantly higher labour non-participation rate) than those who were not being treated. Although there are a number of potential explanations for this finding, it highlights the importance of ensuring that health professionals are aware of and understand the employment support services available to assist their patients with mental illness, and the importance of employment in the recovery process.

1.2. Current project

Within this context, the objective of this project was to:

- conduct qualitative research to identify information and tools that GPs might find useful in assisting patients with mental illness return to, remain in or enter work, including those that would assist the GP in assessing work capacity and completing the SU415 Medical Certificate
- recommend how such information and tools could be provided to GPs.

Specifically, HIMH was contracted by DEEWR to conduct focus groups with at least 30 GPs and five mental health nurses across three states and territories over metropolitan, regional, rural and remote areas, and to conduct interviews with at least 10 subject matter experts. This process provided a means of establishing what information and tools may be of use to GPs in their role of assisting patients with mental illness return to, remain in or enter work, including those that would assist the GP in assessing the work capacity of a patient with mental illness when issuing the Medical Certificate (SU415). The information collected was then used to identify the possible key messages to be communicated to GPs in relation to the objective and to formulate a list of recommendations for DEEWR regarding how the identified information and tools could best be provided, delivered or disseminated to GPs.

It should be noted that this was a qualitative study designed to give insight into the information needs of GPs based on the feedback provided by a
self-selected sample of informants. It was outside the scope of this project to include or invite Centrelink or other employment support service providers’ perspectives. Thus the findings of this report must be considered in this context.

1.3. Current report
This report consists of eight sections:

- executive summary
- background and purpose of the project
- methodology
- results overview, including:
  - sample characteristics
  - overview of survey responses
  - overview of themes and relevant quotes from the focus group discussions and subject matter expert interviews
- conclusions from data collection process
- model developed from analysis
- key findings and issues for consideration
- references.

As a whole, the report includes:

- documentation of the process followed in conducting the focus groups and interviews, including a list of the focus groups and interviews conducted
- a de-identified record of discussion from the focus groups and interviews
- an analysis of the information collected in the focus groups and interviews, with regards to the possible key message to be communicated to GPs to assist them in their role of supporting people with mental illness to return to, re-enter or engage in work
- a list of key findings and issues for consideration about how identified information and tools could best be provided to or disseminated among GPs including:
  - to whom key messages should best be directed (for example, GPs or those who provided support or assistance to them in the general practice setting)
  - whether the recommended audience can be usefully segmented (for example, along geographical lines)
  - whether there are existing channels that can be used to facilitate the provision of information and tools to the intended audience
  - the best communication channels to use, including the best language, format and method of delivery
  - if and how key messages, tone and execution should differ between each audience sub groups
  - other recommendations that could be used as a basis for further development of strategies and key messages.
2. Methodology

2.1. Focus groups
Focus groups were held in five sites across Australia and were selected to provide a mix of metropolitan and regional/remote perspectives. These sites included Newcastle, Orange, Melbourne, Adelaide and Murray Bridge. Local contacts were identified to assist in the recruitment of GPs and mental health nurses for each site.

A list of around 20 local GPs for each site was compiled with the assistance of a Division of General Practice staff member or a local contact point. These GPs were identified on the basis of their previous interest in mental health, the employment support system or participation in similar divisional or research and consultation activities. This list of GPs was submitted and approved by DEEWR as part of the first project deliverable.

The specific process whereby GPs were invited to participate was dependent upon the site. In Newcastle, Melbourne and Orange, GPs were sent a co-signed invitation and information letter (with a Division or GP consultant) and provided with a return registration of interest fax sheet. Divisional representatives for Adelaide and Murray Bridge were also provided with the invitation and information package used in the other sites, and were able to use this at their discretion. Where participant numbers were limited, a follow-up invitation fax was sent a week prior to the event to those GPs who had not responded to the first round of invitations. GPs who had indicated interest in participating were sent a confirmation letter and received a confirmation reminder phone call the day before the scheduled activity. Responsibility for management of the RSVPs was negotiated by site.

The mental health nurses were invited in a similar manner. Melbourne Division of General Practice employs up to five mental health nurses under the Mental Health Nurse Incentive Program and these nurses were invited to participate in the focus group. In Newcastle, a peer support network has been established by the Area Health Service and the local Division of General Practice, which supports mental health nurses working in primary care. This group was provided with information and an invitation to participate and a convenient time to hold a focus group was negotiated.

All participants completed a pre and post focus group questionnaire, to provide additional quantitative information to the qualitative themes discussed within the focus groups.

Focus groups followed a discussion guide and were led by HIMH. A co-chair was nominated for each focus group, and was either a HIMH staff member or the local consultant. Focus groups were recorded and transcribed. Participant comments were recorded in an anonymous fashion. Transcripts were reviewed for themes, relevant quotations and comments. A summary record of discussion has been provided in Section 3. Two GP consultants have also reviewed the transcripts and contributed to the analysis of the transcripts and the translation of the descriptive analysis into key themes.
2.2. Subject matter expert interviews
A list of relevant subject matter experts, including members of GP representative groups, member organisations, registration or accreditation groups and academic experts, were identified by the GP consultants or from review of the literature. From this, DEEWR nominated a list of 11 subject matter experts to be interviewed. The interviews were recorded, transcribed and coded in a similar manner to the focus groups. The interview overviews were reported in a de-identified fashion in order to protect the privacy of the interviewees.

2.3. Terminology
It is important to note that some of the terms used in the focus groups and the subject matter expert interviews have variable meanings for different audiences and the meaning depends on the context of their use.

For the purpose of this report, ‘mental illness’ refers to diagnosable mental health problems across the spectrum (from high to low prevalence disorders). This was clarified in the focus groups and the interviews, as it was recognised that the term ‘mental illness’ was usually interpreted by GPs to refer only to severe and serious mental health disorders (usually low prevalence disorders such as schizophrenia). It was only with clarification that the participants’ scope of reference was widened to include high prevalence disorders (such as depression and anxiety).

Secondly, for the purpose of this report, the term ‘employment support system’ refers to the range of government payments and services designed to support the recruitment and retention of people with mental illness in employment, including Centrelink, the Job Capacity Assessment (JCA) process, and employment services (Vocational Rehabilitation Services, Disability Employment Network and Job Network). The generic application of this term was because this was how GPs viewed and understood the services (that is, as a generic whole system, with little distinguishing between the various agencies and services). When specific reference was made to Centrelink, it has been referenced accordingly.

Finally, the term ‘people with mental illness’ has been used interchangeably with ‘patients with mental illness’ because within this context the target group for assistance are general practice service users, and GPs generally thought of their clientele as ‘patients’.

2.4. Other
It should also be noted that a number of views expressed by the GP and mental health nurse participants were specific to their perception of their relationship with Centrelink. However, the scope of this project did not allow for consultation with Centrelink staff. Thus, it is important to recognise that the conclusions drawn have been based solely on the views expressed by the primary care provider participants, and responses or balancing views have not been sought from Centrelink or other employment support service providers.
3. Results overview

The following section consists of three parts. Firstly, an overview of the sample characteristics are provided. Secondly, an overview of the survey quantitative information is provided, and finally, an overview of themes, quotes and relevant examples from the focus groups and interviews are provided.

3.1. Sample characteristics

Table 1 provides a summary overview of the participant sample by location. In total, eight focus groups were held resulting in a total of 32 General Practitioners and eight mental health nurse participants.

The spread over urban, regional, rural and remote GPs was relatively even, with a slight over-representation of the regional area (13 versus nine or 10 participants). The focus groups were held across three states (New South Wales, Victoria and South Australia).

At least five GPs reported using the Better Access to Psychologists, Psychiatrists and General Practitioners through the Medicare Benefits Schedule initiative, at least five GPs reported having completed the previously required Level I, or Level II, mental health training (to allow access to the Better Outcomes in Mental Health program), and at least five GPs employed or had access to (for example through their Division) a mental health nurse employed under the Mental Health Nurse Incentive Program. The characteristics of the sample indicate that the participants were, as a group, extremely interested and engaged in mental health work.

It should be noted that of the mental health nurse participants, at least five were engaged with and able to be employed under the Mental Health Nurse Incentive Program and the others were working towards the credentialing required to be able to claim under this scheme (that is, were currently completing mental health work but not yet able to claim under the incentive because of the credentialing requirement).

Table 1: Sample size report 1

<table>
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<tr>
<th>Location</th>
<th>General Practitioners</th>
<th>Mental health nurses</th>
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<td>Newcastle</td>
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Eleven interviews with subject matter experts were completed. The key stakeholders and representative bodies who participated included:

- Australian College of Mental Health Nurses (ACMHN)
- Australian College of Rural and Remote Medicine (ACRRM)
- Australian General Practice Network (AGPN)
- Australian Medical Association (AMA)
- Australian Practice Nurses Association (APNA)
- Department of Health and Ageing (DoHA)
- Royal Australian College of General Practitioners (RACGP)
- Rural Doctors Association of Australia (RDAA).
The academic experts who participated included representatives from:

- Primary Care Research Unit, University of Melbourne
- Primary Mental Health Care Research Centre, University of Adelaide
- Queensland Centre for Mental Health Research.

3.2. Focus group survey responses

The GP sample size for the pre and post focus group survey was 32. The mental health nurse sample size for the pre and post focus group survey was eight. Due to the small sample size, specific references to the mental health nurse responses have only been made when they showed a specifically different pattern to the GP responses.

In general, as shown in Table 2, the survey results showed that:

- the majority (82 per cent) of GP participants considered re-entering the workforce as a very important or essential part of recovery for people with mental illness
- half (50 per cent) felt somewhat or extremely comfortable discussing employment and support services with their patients, while another third indicated neutral comfort
- the majority (65 per cent) considered it somewhat or very important to link their patients with employment support services.

With regards to the completion of the SU415 Medical Certificate, as shown in Figure 1 and 2,

- forty one per cent of GP participants reported completing the certificate one to three times per week, and approximately another third reported completing it one to three times per month
- nearly half (44 per cent) reported completing the Medical Certificate for patients with mental illness one to three times per month
- half (50 per cent) reported some understanding of the Centrelink processes that occur after submission of the Medical Certificate, with a further 41 per cent indicating little or no understanding.
Table 2: Pre focus group survey, questions 1, 2 and 3 percentage response

1. Scale of importance of re-entering workforce as part of recovery for people with mental illness
(Where 1 = not at all important and 5 = essential)

<table>
<thead>
<tr>
<th>Profession</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioners</td>
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<td>0.0</td>
<td>28.1</td>
<td>53.1</td>
<td>18.8</td>
</tr>
<tr>
<td>Mental health nurses</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>25.0</td>
<td>75.0</td>
</tr>
</tbody>
</table>

2. Comfort level in discussing employment and support services with patients
(Where 1 = not at all important and 5 = essential)

<table>
<thead>
<tr>
<th>Profession</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioners</td>
<td>3.1</td>
<td>12.5</td>
<td>34.4</td>
<td>15.6</td>
<td>34.4</td>
</tr>
<tr>
<td>Mental health nurses</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>25.0</td>
<td>75.0</td>
</tr>
</tbody>
</table>

3. Importance of role assisting patients to connect with support services
(Where 1 = not at all important and 5 = essential)

<table>
<thead>
<tr>
<th>Profession</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioners</td>
<td>3.1</td>
<td>12.5</td>
<td>34.4</td>
<td>15.6</td>
<td>31.3</td>
</tr>
<tr>
<td>Mental health nurses</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>25.0</td>
<td>62.5</td>
</tr>
</tbody>
</table>

Figure 1: Frequency of completing Centrelink Medical Certificate

Figure 2: Understanding of Centrelink processes surrounding Medical Certificate completion
Similarly, as can be seen in Table 3, the majority (87 to 100 per cent) reported very little to a medium level of awareness of the supports available to people to re-enter the workforce, accessed through local community organisations or self-help groups. There was a similar low level of awareness of employers with flexible work practices for people with mental illness.

From the post focus group survey, the majority of participants (88 per cent) indicated that they had not received any training or information about assisting people with mental illness to enter or re-enter the workforce. Sixty per cent indicated that they had found the information presented in the focus group about the services available somewhat or very useful, with another third indicating a neutral response.

With regard to the specific employment support services and programs, as shown in Figure 3 and 4, the majority (84 to 93 per cent) of participants identified very little to limited understanding of the employment support services available, with only Vocational Rehabilitation Services being identified by a number of participants (50 per cent) as being somewhat understood. Within the focus group discussion, the GPs spoke of having no knowledge of these services or programs and being surprised that they existed or were available.

As seen in Figure 5, 69 per cent indicated that they would find information about research about vocational rehabilitation as relevant to the GP role in fitness for work assessment for people with mental illness somewhat or highly useful, with a similar number (65 per cent) indicating that they would be likely to use this information.
Figure 3: GP understanding of employment support services or programs

Figure 4: Mental health nurse understanding of employment support services or programs
As can be seen in Figure 6, a similar number (71 per cent) indicated that screening tools to help identify those patients with mental illness at risk of long term incapacity for work would be somewhat or very helpful, while a lower proportion (60 per cent) indicated that they would be likely to use these tools.

As shown in Figure 7, more than half (56 per cent) of participants indicated that they would find tools assessing the capacity of people with mental illness to enter the workforce somewhat or very helpful, with a similar proportion (55 per cent) indicating that they would be likely to use these tools.
As can be seen in Figure 8, nearly three quarters (72 per cent) indicated that they would find information regarding the Medical Certificate and how Centrelink determines incapacity exemptions somewhat or very helpful, with a similar proportion (69 per cent) indicating that they would be likely to use this information. Figure 9 shows that the majority (84 per cent) indicated that information regarding free support services and programs would be helpful, and most (75 per cent) indicated that they would be likely to use that information. In general, the majority of participants thought that other GPs would be more likely than not to use this information.
In general terms, the mental health nurse responses were similar, although more mental health nurses appeared to have a better understanding of Centrelink and the employment support system than GPs. In addition, their interest in additional information about employment support services including vocational rehabilitation and related information was similar or greater than the GP interest. The mental health nurses were more likely to indicate that they would use this information. However, it is important to note that the small sample size limits the ability to generalise the information.

As seen in Table 4, there were no clear or consistent patterns for the preferred types of information dissemination (that is, methods for which a clear majority of the sample supported), however the most frequently nominated preferred strategies of information dissemination for this sample were:

1. Hard copy resources and a website (50 per cent; 38 per cent)
2. A website (50 per cent; 75 per cent)
3. Information provided through existing training courses attended by GPs (44 per cent; 63 per cent)
4. Education or information sessions provided to groups of GPs (44 per cent; 50 per cent).

Further, approximately two thirds of the mental health nurse sample identified as a preferred information dissemination strategy a hard copy resource delivered to each practice, while there was little support for just this strategy alone by GPs (16 per cent).

The remaining options all received less than one third of the sample’s support. The least frequently nominated information dissemination strategies included:

5. Electronic resources (for example, CD-ROM) provided to each practice (nine per cent; 13 per cent)
6. Hard copy resources provided to each practice (16 per cent; 63 per cent; mental health nurse differential response noted above).

The free text responses are overviewed in Table 5 and reiterate the suggestions covered in the focus group discussions.

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1 The proportion of GPs who nominated that option and proportion of mental health nurses who nominated that option are reported in the brackets respectively.
### Table 4: Best way to provide information to GPs or those supporting GPs

<table>
<thead>
<tr>
<th>Information type</th>
<th>General Practitioners (%)</th>
<th>Mental health nurses (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hard copy resources provided to each practice</td>
<td>15.6</td>
<td>62.5</td>
</tr>
<tr>
<td>Website</td>
<td>50.0</td>
<td>75.0</td>
</tr>
<tr>
<td>Hard copy resources and a website</td>
<td>50.0</td>
<td>37.5</td>
</tr>
<tr>
<td>Electronic resource (for example, CD ROM) provided to each practice</td>
<td>9.4</td>
<td>12.5</td>
</tr>
<tr>
<td>Electronic resource and a website</td>
<td>31.3</td>
<td>25.0</td>
</tr>
<tr>
<td>Education or information sessions provided to groups of GPs</td>
<td>43.8</td>
<td>50.0</td>
</tr>
<tr>
<td>Education or information sessions plus hard copy resources and website</td>
<td>28.1</td>
<td>50.0</td>
</tr>
<tr>
<td>Education or information sessions plus electronic resources and website</td>
<td>25.0</td>
<td>37.5</td>
</tr>
<tr>
<td>Information provided through an existing training course attended by GPs</td>
<td>43.8</td>
<td>62.5</td>
</tr>
<tr>
<td>Information provided through an existing training course attended by GPs plus hard copy resources and a website</td>
<td>28.1</td>
<td>37.5</td>
</tr>
<tr>
<td>Information provided through an existing training course attended by GPs plus electronic resources and a website</td>
<td>28.1</td>
<td>12.5</td>
</tr>
</tbody>
</table>

### Table 5: Free text survey responses

15. Suggestions for other ways that such information could be provided to GPs or mental health nurses (verbatim comments)

- hyperlink or web address to Medical Director ‘Medical Certificate’
- via the Divisions
- brief presentation, brief information sheet
- management protocols/algorithms, a nominated person with each Division of General Practice
- GP networking in mental health
- through the software company templates
- through practice visits by divisional staff through a high quality, clinically focussed resource
- divisional: laminated sheet, visits, newsletters
- early funded involvement in strategic planning processes would be sensible if we are expected to use the forms and system
- via general practice networks and their staff
- involve us in drawing up a collaborative effort and consensus document of process
- Centrelink representative should visit regions and establish relationship with GPs through one on one plus group meetings with a view to ‘win-win’ solution
- via mental health nurses’ lunchtime info sessions
- Continuing Medical Education (CME) linked activities. Allied health information
- Centrelink liaison officers would be very useful
- dedicated education sessions or specialist Centrelink worker trained in needs of mental health clients/workers
- GP Voice. Practice manager to present at meetings
- GP and Centrelink liaison hotline.
3.3. Focus group discussion record

The record of discussion for the focus groups has been summarised along the common themes and with regards to the relevant information needed to address the project objective. The discussions from the focus groups were coded by the project coordinator, with a secondary confirmatory coding by the GP consultants.

The themes from the focus groups have been segmented under:

- GPs’ role in assisting patients with mental illness to enter or re-enter employment or engage with the employment support system
- Systemic issues relevant to the GP role
- Work capacity assessment for people presenting with mental illness
- GP understanding of the role of the SU415 Medical Certificate
- Current ‘solutions’ around the challenges
- Information, tools or supports identified that would assist GPs to support people with mental illness engage in employment or with the employment support system
- Preferred style of information, tools or support
- Barriers to the use of relevant information, tools or support
- Potential dissemination strategies
- Mental health nurse role.

3.3.1. GPs’ role in assisting patients with mental illness to enter or re-enter employment or engage with the employment support system

‘We have a role of support and early intervention to try and get people to stay in employment and not give it away.’

The focus group participants generally considered work and employment a fundamental part of mental illness recovery and thus recognised the importance of the GP in supporting patients to enter or re-enter employment or engage with employment or the employment support system. They identified that the key components of their role in this area was around care coordination and liaison (getting patients to the services they needed), advocacy (ensuring their patients got ‘a fair go’) and advice to patients around what was appropriate with regards to their work capacity (for example, the impact of symptoms on work capacity). Thus, this role requires GPs to be able to navigate the employment support system, understand the impact of mental illness on work capacity and understand the administrative procedures required to enable a patient to access appropriate programs.

‘I think a very important part of our role would be that often we are advocates for people who have a disability.’

The participants also emphasised the importance of the longitudinal relationship in enabling them to accurately understand and assess a person’s work capacity. They also felt that their long term relationship with patients was particularly important for people who were very isolated (which they
reported their patients with mental illness frequently were). This meant that their support role for these patients was even more important. Thus, the participants generally considered that GPs did have a role in assisting people with mental illness to enter or re-enter employment and engage with the employment support system, because of the importance of work in the recovery process and because of their role as patient advocate.

3.3.2. Systemic issues relevant to the GP role

A number of system issues were identified which have relevance to the GP’s role in assisting people with mental illness to return to employment or engage with the employment support system (particularly Centrelink). These issues have specific implications for GP information needs and dissemination options.

‘I’ve had patients who are sick enough that they really shouldn’t be in there or cannot be in there for one reason or another and they really don’t have a system around that.’

‘That is the problem with mental illness; they are the least well-equipped people in the community for finding their way through the intimidation and the maze of Centrelink.’

‘Why? When the character of mental illness is disorganised…They cannot provide what Centrelink is requesting them to do.’

The first issue was the participants’ perception that Centrelink frequently places unrealistic demands on people with mental illness and does not have the capacity to respond with flexibility. The requirements of, and interactions with, the employment support system frequently result in an exacerbation of symptoms. Many of the GPs queried the degree to which Centrelink staff understood mental illness or had training in dealing with the issues presented by mental illness. The exacerbation of patients’ symptoms resulting from the difficulties of engaging with the system appeared linked to the GPs’ feeling there was an increased need for them to advocate on behalf of their patients. Many of the participants gave examples where the generic employment support and Centrelink rules had resulted in inappropriate decisions and expectations for, and of, their patients.

‘I’m not aware of any feedback from Centrelink to say “we can help this person, how about you give us some more information and we can recommend you refer them this way or that.”’

‘It’s very hard to contact any person at Centrelink. It is impossible. They can contact us, but we can never contact them, so that’s a real problem.’

The second frequently identified systems issue was the lack of communication from Centrelink and the employment support services to GPs about assessment decisions or referrals made. This resulted in the GPs feeling they were providing information into a ‘black hole’ where it was unclear to them how the information was used or what patient pathways it would trigger (thus making the advocate’s and care coordination role more difficult). The lack of a systems feedback loop means that GPs generally only get information about the system functionality from their patients—and this is usually only when the system has not been seen to be helpful. Thus, the understanding of GPs about the
employment support system remains low and their relationship with the system is generally based on negative experiences or reports (particularly of the Medical Certificate being 'rejected'). This issue has specific implications for possible information dissemination strategies, because of the generally negative opinion and relationship that GPs appear to have with Centrelink.

‘Getting someone back to work as soon as possible is good, but that assumes that the work environment is flexible…I can’t think of any area where I could say that I was comfortable sending someone back with either a physical or mental disorder where the workplace is supportive. They don’t exist.’

The third frequently mentioned system issue was the difficulty in identifying mental illness friendly and flexible workplaces. The lack of appropriate workplaces was commonly reported by the participants to be a barrier faced and influencing assessment decisions when they were looking to support someone with a mental illness return to, or engage, in employment.

3.3.3. Work capacity assessment for people presenting with mental illness

‘The trouble with mental illness is that it fluctuates. There will be some days where they can’t get out of bed, they stay at home and become withdrawn and some days they feel they can get out there and work. The dilemma when you’re filling out any work fitness form, how do you say ‘you might get two good weeks out of four?’ You need to document how many hours a week…I suppose it’s the dilemma of mental illness, you have good months and bad months.’

The GPs identified a number of issues specific to assessing work capacity for people presenting with mental illness as compared to physical illness. They noted that in general, work assessment for mental illness was much more difficult because of a number of variables. These include the fluctuating nature of mental illness, the difficulties in prognosis and the reliance on patient report (that is, no ‘objective’ way to identify the likely impact of psychiatric symptoms on work capacity).

The participants spoke many times of these issues not being appropriately captured by the current forms (that is, ‘they don’t fit the boxes’ on the Medical Certificate or Treating Doctor’s Report).

‘Another issue in terms of the ability to get back to work is being able to understand or anticipate what it is about the workplace that is going to be difficult for a person with a mental illness...knowing how to judge what stresses the workplace is going to place on that person and it’s really difficult to know.’

The GPs also spoke of the importance of the work context on a person’s work capacity, in that a specific work environment could be one of the stressors impacting on a person’s mental health. GPs recognised that patients were usually capable of some work in the right environment, but they indicated that they felt that this was difficult to indicate on the current forms. It was clear that the GPs considered work capacity on a sliding scale (number of hours) versus able to work or not. However, GPs reported that the fluctuating nature of mental illness usually meant that they erred on the side of caution rather than risk exacerbating a person’s illness episode. All of these
issues result in the work capacity assessment process being a lengthy and difficult one.

‘You can’t test it. You have to go by what the patient says and use your clinical judgement.’

A few GPs reported using some mental health outcome measures to support their assessment of mental health status. However, none were aware of, or used, other screening tools. In general, most GPs reported completing the assessment using their clinical judgement, based on their knowledge of the patient, their history, the local context and their overall treatment plan for the patient.

3.3.4. GP understanding of the role of SU415 Medical Certificate

Participants generally understood that the Medical Certificate was needed for patients to continue to receive benefits and most appeared to understand that it was usually associated with activity requirement exemptions. However, the participants showed little to no understanding of the JCA process, the Medical Certificate’s role in this, or the supports or programs available to assist those with mental illness. This lack of knowledge appeared to contribute to the negative attitude many of the participants held towards the employment support system (which was generally seen as unresponsive to the needs of people with mental illness). This was exacerbated by the increasingly frequent experience reported by GPs where the outcome of the JCA was not consistent with their clinical opinion (as indicated on the Medical Certificate). Similarly, currently the feedback loop around the JCA or Medical Certificate ‘acceptance’ (or not) has been via the patient. This may contribute to the GPs’ reported feelings that their clinical opinion was not being respected.

‘The certificate is the passport of not going back to work rather than starting to go back to work.’

‘All of us have been writing certificates for years and none of us have seemed to have any formal education about the system.’

This issue is particularly emphasised when considered in terms of the usual medical system of care, which is that when a doctor provides information for a patient for another service, they usually receive feedback about the outcome, particularly if the conclusion is different to that of the treating doctor. Thus, in some ways, the Medical Certificate process represents the interface between the medical model and the employment support system and the difficulties that emerge may be seen as being a result of the different approach and protocols used in those sectors.

‘The only feedback that I have ever received is that I’ve been told that “I’ve got knocked back” [by the patient]…They will come back and say that “I didn’t get enough points” or whatever.’

It should also be noted that in all focus groups at least one person identified an ‘inside’ or ‘backdoor’ Centrelink contact who could be contacted with specific queries or problems. This was invariably regarded positively by all those who had the contact.

‘What we find out about Centrelink is very little. You are very lucky if you find someone who gives you some inside
Thus, the participants were particularly interested in understanding the patient pathways to services and how the information provided by the GP would open or shut the referral processes. It is important to recognise that the GP’s desire to know the ‘magic words’ on forms was not motivated by a desire to manipulate the system, but to ensure they could facilitate their patients’ access to the services they needed. At the same time, this information allows GPs to advocate more strongly on behalf of their patient. It is possible that until GPs and Centrelink develop a stronger collaborative relationship, increasing GP knowledge about the employment support system may increase the adversarial relationship between the two service providers rather than address it.

The only tools mentioned by participants as being currently used (although only by a few) were mental health symptom questionnaires (for example, K10; Depression, Anxiety and Stress Scale). These had not been used to consider the impact of symptoms on work capacity and no GPs reported being aware of any tools that did so. Some GPs identified awareness of some tools to identify those at risk of long-term incapacity to work but these were specific to physical illness (particularly back pain) and not mental illness.

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The information, tools and supports that the GPs identified as being of interest fit well with their identified role as care coordinator, liaison point and patient advocate. This information was perceived as being information that would assist them in providing a service that would promote the best outcomes for their patients.

3.3.5. Information, tools and supports identified that would assist GPs to support people with mental illness engage in employment or with the employment support system

Thus, the information, tools or supports identified as being useful to GPs in their role of assisting people with mental illness return to, or engage with, employment (or the employment support system) were:

- information about employment support services (available through Centrelink) that were locally relevant and available for their patients
- information about the employment support system in general, as relevant to the GP role (including pathways to services and Centrelink processes)
- information about program requirements, eligibility criteria and entry pathways, and how the GP could facilitate that access
- ways to ensure that the same ‘language’ was being used between sectors (for example, ‘when I say depression, is that understood in the same way by Centrelink staff?’)
- to a lesser degree, objective tools and information to assist the assessment of work capacity of people with mental illness.
that having service information and a clear idea of system pathways would mean they could provide the same appropriate information to their patients, in order to assist their patients to navigate the system themselves.

‘What we put on the Medical Certificate and where that’s actually leading our patients, because sometimes you get people come in and say they need you to do this, that and the other…and you have no idea about what they mean…and you’re thinking “I don’t know if this is a good or a bad thing—what does it mean?”’

‘If we were aware of the criteria for different things we would be able to say “well yes, this patient definitely meets that” it would make life much easier.’

‘It would be nice to know what services are out there’.

### 3.3.6. Preferred style of information, tools and support

All participants indicated that there were three key features that increased usefulness of information. These were that the information collated should be:

- simple
- clear
- concise.

Participants also noted that the immediately obvious usefulness of information would increase uptake (and use). Usefulness appeared to be driven largely by the degree to which the information was relevant to patient care (and more particularly, relevant to specific patients—that is, those who were sitting in front of them at that moment), and by the degree to which the provided information could be translated into suitable treatment actions. That is, GPs indicated that information for the sake of information was not helpful (and would not be used), but that which could be applied in a practical (and immediate) way would drive interest and uptake.

The participants also identified that information needed to be locally relevant for it to be identified as useful. It also needed to be easy to find and use.

Finally, participants in each focus group highlighted the importance of having a respected organisation or service develop the materials. Such an organisation would be seen as having the appropriate level of expertise, an understanding of the GP’s role and the patient’s best interests at heart. This was identified as a way of increasing interest in the material and reassuring users of the validity of the information provided.

A number of participants also identified the importance of considering the relevance of information across the spectrum of mental illness and phases.

### 3.3.7. Barriers to use of relevant information, tools and support

The identified barriers to use of information largely dovetailed with the aspects that determined the usefulness (and hence the preferred style) of information. The most frequently identified issues were GPs’ lack of time to digest, seek or evaluate information. Participants indicated that this issue usually resulted in only a subset of the information reaching GPs actually being processed. This means that a GP’s interest in a content area will usually determine even their initial pick-up of specific information or resources.
Information that was identified as not being user friendly, with regards to lack of local relevance, inaccuracies (particularly in light of program changes over time), too great an amount of information, or difficulties associated in finding relevant information, was identified as going ‘straight in the bin’.

‘As long as it doesn’t add to your paperwork, another form…’

‘Not the 10 page document you get with everything else that you’re going to throw straight in the bin.’

3.3.8. Potential dissemination strategies

Participants identified a variety of potential dissemination options. In general, participants were only partially supportive of a ‘mass send out from Canberra’, because of the perceived lack of local relevance. A variety of other strategies were popular, a number of which dovetail with the system issues identified earlier. However, the specific relevance of the identified dissemination strategies will depend on the type of information to be disseminated and the outcomes desired.

- Use of the Divisions: The Divisions of General Practice were identified as generally being respected bodies that applied appropriate filtering to the type of information which they forwarded to GPs. Thus, information received through the Divisions is perhaps more likely to be considered by GPs. Similarly, Divisions have established communication with GPs (usually a weekly email) which could be used to promote certain issues.

‘The most rapid contact would be through the Divisions of General Practice. Most GPs are in touch with the Divisions…we receive a weekly email.’

- Hyperlinking relevant information (around assessment, definitions and programs) on an electronic Medical Certificate. This would allow GPs to follow up on information if they were interested, would ensure that the information is easy to find and patient relevant, and is tied to an activity which GPs complete anyway (albeit, usually not electronically).

‘We could get a pro forma on Medical Director…where you type in the patient details, it spits the form out then the second form follows with all the information the patient needs including where to go, where you’re needing to go. I think if these forms were already on computers, if you had a link so you didn’t have to go looking…it would be good.’

- Feedback mechanisms: By linking dissemination of information about programs to specific patients, GP interest in the information is automatically assumed and education about the system becomes an automatic secondary outcome. This option also has the possibility of improving the perception and relationship of the employment support system with GPs, as it works within a care coordination and health management model. Many options for feedback were suggested.

‘It would help if they just communicated.’

‘Like a GP liaison officer…’

‘And the other thing is that Centrelink make themselves available for case conferencing with the community and ourselves so that we actually have direct input into the decision making.’
Communication with general practitioners to support the employment of people with mental illness

The information provided is patient specific, relevant and meaningful. It is of interest to note that for those GPs with a ‘backdoor’ Centrelink contact, they were all extremely positive around this support. Furthermore, one of the subject matter experts indicated that GP liaison workers were already identified within Centrelink sites, but this was not promoted to the community or well known at the frontline Centrelink site level.

a. a letter template advising the outcome of JCA or when a patient has been referred to a specific employment support program (provided for people for whom a GP has supplied assessment information, for example, through the Medical Certificate) or when activity requirement exemptions have not been awarded. This feedback mechanism could explain the outcome or reasons behind a decision and could include a phone number or website where a GP could obtain more information on programs a patient was referred to, to be followed up if they desired more information.

b. the use of case conferencing or the capacity to book times to discuss specific patient issues with a Centrelink or employment support system mental health or disability specialist. This would overcome the ‘telephone tag’ situation or GPs having to be put ‘on hold’ for an inappropriate amount of time. As above, the systems orientation and information becomes an automatic secondary outcome of the treatment planning as referral options are identified. This strategy is in some ways similar to the usual protocols for WorkCover patients.

c. a GP liaison hotline. Many GPs were attracted to the idea of having a specific contact within Centrelink with mental health expertise or knowledge who could be contacted as needed with specific questions or as problems arose. This option particularly meets the preferred style characteristics—it assumes that Centrelink is the specialist in the area of the employment support system. It also means that GPs only need to remember one number, and can be used when needed (meaning

d. a central contact point. Similar to the idea of a GP liaison hotline was the suggestion of having one direct point to which GPs could direct queries, seek patient-related feedback or directly access or refer patients to for employment support programs. This was considered relevant not just to people with mental illness, but also for GPs’ other patients who interface with the Centrelink system or require other forms of support to engage with employment.

These feedback mechanisms also have the capacity to address some of the relationship issues identified earlier by developing personal and individual relationships between workers (versus GPs trying to navigate a faceless and bureaucratic system they do not understand), and would promote the idea that GPs and the employment support system are all part of the ‘treating team’.

- Website: A website with relevant information about services, programs and relevant assessment information was also identified as being a potential information dissemination strategy, particularly for when GPs were seeking particular information. It is of interest that the vast majority (78 per cent to 82 per cent) identified very little to little
understanding of the JobAccess site, although the target audience for JobAccess does not include GPs. Those who had used it reported that they found it difficult to navigate. As per the identified barriers, its usefulness may be hampered in that it requires the GPs to seek the information out rather than it being flagged with them and the generic description of the programs may make it difficult for GPs to identify which programs relate to local services. ‘A website…that would be easy, that gives you some tips about what you can access, how or what you need to do.’

- Training and education: It was generally identified that training and education could be an appropriate way to disseminate information; however it would only reach a subset of GPs. The training and education strategies were also seen as an effective way of developing a working relationship between GPs and Centrelink and other employment support service providers, particularly if trainers came from local offices. A variety of training and education options were identified:
  - face-to-face Continuing Medical Education registered activities or events
  - presentations in existing GP network meetings (for example, hospital meetings)
  - content added to existing mental health training or education packages (for example Teams of Two, Better Access orientation)
  - practice visits to surgeries by Centrelink or employment support staff to promote and explain systems and local programs or services available or provision of information to Division or other liaison staff (for example, shared care clinicians, mental health nurses) to distribute in their routine practice visits, although this would require specific training and support for the dissemination staff
  - e-learning packages.

‘It might be good to have a seminar, education around what is available.’

‘The most useful thing that isn’t being used would be for someone to come around, do their 10 to 15 minute: here is the information, and then it’s done.’

‘Arrange with people who are running those (mental health) courses to have this sort of information as part of their training programs.’

- Reimbursement: By introducing a Medical Benefits Scheme (MBS) item number for completing a back to work assessment requiring specific assessment treatment plans which would include liaison with relevant employment support service providers, GPs indicated that this strategy would be likely to improve the quality of assessments and GPs’ understanding of the system.

‘Maybe what they should have is some specific (MBS) item number that’s a return to work Medical Certificate assessment…it could be a return to work plan where you could sit down and spend time.’

- Marketing: The participants identified that alerts or short articles in professional magazines would be an effective way of promoting information. The most frequently identified
professional titles were Australian Doctor, Medical Observer and the Division or Colleges newsletters.

‘(Professional magazines) are useful. If it was a simple article about how to help doctors it would get a lot of attention!’

3.3.9 Stand-out products
A few stand-out products were identified. The majority of these were mental health awareness or treatment GP training products. A couple were examples of local service details or pathways. The information developed by drug companies about products was identified as usually being presented in a way that was useful, user friendly and effective.

3.3.10. Mental health nurse role
The usual activities of the mental health nurse were identified as pertaining generally to mental health assessment, service coordination and patient support. Thus, it was felt that the activities required to support people with mental illness to return to work were within scope. It was highlighted that the mental health nurse plays an important role in flagging with the GP potential patient support options, and thus any information dissemination or support should also target mental health nurses.

It was identified, however, that because the employment support system area is likely to be new to mental health nurses, it is important that the mental health nurses are appropriately supported with information, training or access to expertise. Further, because of limited uptake of mental health nurses into general practice, the importance of considering the role of other practice support staff (for example practice nurses, practice managers) was highlighted.

It was generally felt that information did not need to be developed specifically to target mental health nurses and that the best way of disseminating information to mental health nurses would still be to target GPs or general practices directly, as relevant information would usually be passed on automatically to the practice support staff.

‘We have a mental health nurse. She doesn’t fill in the forms, but if I’ve got someone that I want to try and get back into working, she plays a huge role and she really gets on the phone and tracks down the right way.’

3.4. Subject matter expert interview discussion record
Eleven subject matter expert interviews were completed. In general, the subject matter experts came to the same conclusions as the GP and mental health nurse participants in the focus groups, with regards to their suggestions around the best way to deliver information or support to GPs that would assist them in their role of supporting people with mental illness to return to work and interface with the employment support system.

Overall, the most frequent and important themes were that:

- a multi-modal approach to information development and dissemination was needed
- any information resource or support developed needed to be obviously patient relevant, and preferably interactive and tied to the management of specific patients (for example, information provided based on recording specific patient needs; responses to specific queries accessed easily)
The potential dissemination strategies identified were similar to those identified in the focus groups and included:

- linking service information and eligibility criteria to the electronic software that is used for medical records (for example, allowing the GP to record patient needs and see how it relates to the referral pathway)
- promote the availability of the local Centrelink GP liaison worker
- develop information that provides an overview of local services and the care pathway and disseminate directly to practices, ensuring local relevance, accuracy and preferably accompany this with face-to-face contact of some sort
- work through the local Divisions of General Practice to disseminate any specific important information
- ‘piggy back’ onto or integrate information into other mental health relevant (and existing) information, training or network meetings, preferably with use of local Centrelink or employment support staff
- develop a feedback letter that is delivered after the JCA process and which informs the GP about the outcome of the JCA and any employment support services to which the patient has been referred.

- information and supports developed need to be simple, with options to seek more information if needed.
- information dissemination about the support and systems available should be tied to other strategies. For example, providing feedback about the outcome of a JCA for a patient for whom a GP has provided information will result in an automatic secondary outcome of increased service knowledge.
- there is a need to consider the whole system of care and the role of all available mental health and practice support workers in supporting people with mental illness to engage with employment.
- there is a need to promote information and support available as being resources that will help doctors deliver better patient care and reduce their work load burden.
- do not develop a large information pack ‘stamped by Canberra’ and delivered straight to GPs, particularly without orientation or context.
- information and resource development will be ineffective without strategies to develop a more positive relationship with Centrelink, which requires personal and local relationship building.
Further, a range of existing communication strategies were identified (for example: Royal Australian College of General Practitioners (RACGP) 'Friday Fax'; Divisions of General Practice newsletters; Australian Medical Association (AMA) newsletters; Rural Doctors Association of Australia (RDAA) newsletters; and Australian College of Rural and Remote Medicine (ACRRM) weekly update).

A number of successful information strategies and products were also identified of which the success factors lay in that they:

- addressed a GP-identified need for information or service
- were simple and straightforward
- were easily accessible
- were easily and frequently required or appropriate for a number of patients (soon after dissemination).

Finally, the information and dissemination needs of rural and remote GPs were generally not identified as being different to urban GPs’, although the importance of ensuring that the service system description was applicable to ‘the bush’ was highlighted. Similarly, the subject matter experts identified: the importance of recognising the varying technological capabilities of practices; the range of interest or motivation that GPs may have in mental health or the employment support system; and creating information dissemination strategies that would engage GPs across the spectrum.
4. Conclusions from the consultation process

The final analysis and issues for consideration are provided in chapters five and six. However, the three strategies of information collection (survey responses, focus group discussion and subject matter expert interviews) in general (noting the small sample and qualitative nature of the consultation) are consistent in indicating the following:

- GPs and mental health nurses value the importance of employment and work for their patients with mental illness.

- GPs report specific difficulties in assessing work capacity for people with mental illness. This is not well captured by the current system and increases the reliance on clinical judgement as a fundamental assessment strategy.

- GPs and, to a lesser degree, mental health nurses, report a low understanding of the Centrelink process and their role, or the employment supports or programs available to their patients. However, they recognise that having a better understanding would assist them in their role and they are generally interested in becoming more aware.

- While GPs and mental health nurses identify specific information needs in this area, they appear more strongly interested in the availability of a local Centrelink worker in a GP liaison role. This person could assist the GPs in their role of helping people with mental illness to return to, or engage with, employment.

- There is limited support (up to 50 per cent of the sample) for a variety of typical information dissemination strategies, with the most popular being the development of a website and hard copy resources, and education or information sessions provided to groups of GPs.

- The information that GPs want is simple, clear, concise, patient relevant, preferably interactive (relevant to the patient sitting in front of them), easily accessible and locally relevant.

- A multi-modal approach to resource and support development and dissemination is needed to increase the likelihood of reaching and promoting uptake of information by as many GPs as possible.

- There is a variety of existing communication channels that could be used to transmit information to GPs.

- There is a variety of alternative means of supporting GPs in their role of assisting people with mental illness to return to work, which use the patient contact (between the GP and Centrelink or other employment support services) as the target for activity. These strategies may result in increased GP knowledge about vocational rehabilitation and the employment support system and are primarily based on introducing some form of feedback or interactive mechanism to promote communication between the employment support system and GPs.

- Currently, GPs and mental health nurses find themselves in the role of advocate with the employment support system, and they generally have a negative perception of the employment
support system. This research suggests that there is a need to develop strong relationships directly between GPs and local Centrelink and employment support staff if any information or support is to be effective in enabling GPs and mental health nurses to better support their patients with mental illness to return to work or engage with the employment support system.
5. Analysis overview

Figure 10 represents a model developed to capture the information provided through the focus groups and the subject matter expert interviews (as described in previous chapters). It describes the issues that impact on a GP’s capacity to support a patient with mental illness to return to employment or engage with the employment support system. The model highlights four key areas (expanded upon below) including:

- Centrelink’s role in supporting people with mental illness to engage or re-engage with employment (as the gateway to income support and employment support services), and the perceived lack of capacity for the system to respond flexibly to the needs of people with mental illness.
- The GP’s role as advocate and patient care coordinator and their self-identified lack of knowledge about: Centrelink processes; available employment support services; how the information they provide is used in determining people’s eligibility for support or services; the best ways to capture this information on the required forms; and a person’s work capacity when they are presenting with mental illness.
- The perceived lack of available and appropriate employers and workplaces for people with mental illness.
- The sometimes adversarial relationship between GPs and Centrelink as a result of the above issues, and the degree to which this is exacerbated by: the lack of a feedback loop between the two service providers; the mismatch of philosophical cultures and associated professional behaviours; and lack of a common language.

This model is important in that it captures the highly relevant information in regard to GPs’ information and support needs in assisting people with mental illness to return to work or to engage with the employment support system, while also providing a framework in which the key themes can be considered.

The model highlights the need to consider not only the information and knowledge needs of the major, relevant service providers, but also the way in which this information and understanding is, or can be, utilised in practice. It also highlights the degree to which system change, relationship building and attitude change may determine the effectiveness of strategies that aim to better prepare GPs in their role of supporting people with mental illness to engage or re-engage with employment.
Figure 10: Model of GP and employment support service system relationship as relevant to supporting people with mental illness to engage or re-engage with employment

- **Centrelink**
  - gateway to income support and employment support services
  - little systemic flexibility to be able to respond appropriately to problems associated with mental illness
  - limited staff understanding of mental illness
  - business culture (for example, working hours, outcome focus) versus health management culture
  - complicated system of support available

- **Employment support services and programs**

- **JCA**

- **Patient/Customer/Employee**

- **GPs**
  - primary role as patient care coordinator and advocate
  - variable priority placed on employment for patients with mental illness, often patient initiated
  - specific assessment challenges in assessing work capacity for people with mental illness, but patient load for this issue relatively small
  - little understanding of Centrelink or available employment support services (particularly for people with mental illness)
  - GPs only want to be given the essential information, when it is needed and as it’s relevant to the patient pathway
  - have a longitudinal relationship with the patient; in rural areas, specific locally relevant context knowledge
  - have an advocacy and licensing role in the system
  - heterogeneous population with regards to demographics, interest, practice structure and style, workload, technological engagement, etc.

- **Employers and Workplaces**
  - limited employers and workplaces available with appropriate supports and attitudes for employment of people with mental illness

- **Practice Support Staff**
  - eg mental health nurses

**Key**

- Movement of information
- Movement of person

Communication with general practitioners to support the employment of people with mental illness
5.1. The Centrelink system: mental illness friendly?

Centrelink was identified by GPs as being the gateway to income support and employment support services and programs. However, in general, GPs reported a lack of system flexibility with regards to how it enabled access to support for people with mental illness. The main concerns raised by GPs with regards to how Centrelink manages or responds to the issues presented by people with mental illness were:

- the minimum activities or processes required to access income support or employment support services usually exceed what would reasonably be expected from someone when they are actively unwell, in terms of organisational, emotional or coping capacity. For example: needing to wait in long queues when paranoid; waiting in a crowded room when agoraphobic; or needing to collect a variety of information or attend multiple appointments when struggling just to 'get out of bed'. In addition, it was perceived that there were few fallback options if someone was unable to meet the requirements, and those which were available required strong advocacy to organise

- perceived inflexible or idiosyncratic application of rules and regulations resulting in support being awarded or denied to people with mental illness in a manner that was inconsistent or did not make sense to the GP. For example, the employment support system being extremely complicated and requiring a specialist to navigate it, and the perception that there is little understanding by frontline Centrelink staff of mental illness, how it could present or how it should be managed in day-to-day operations

- difficulties in capturing, on the required current forms (for example, the Medical Certificate), the fluid nature of work capacity of people with mental illness, particularly for the high prevalence disorders (for example, depression and anxiety).

Thus, in general, GPs did not perceive Centrelink (or the gateway to employment support services) as being easy to access or supportive of people with mental illness. This has specific implications for the GP’s role in assisting people with mental illness to engage or re-engage with employment.

5.2. GP advocacy role and the system information gap

GPs identified their primary role as being a patient care coordinator, and their overriding objective as ensuring that a patient’s best interests are served. However, the current employment support system places a licensing role on GPs with regards to the completion of the Medical Certificate, because the Medical Certificate is a piece of evidence required to process the income support and activity requirement exemptions that a person may be awarded during a period of illness. Because of these issues, GPs often reported finding themselves in the role of the patient advocate, fighting bureaucracy to ensure that a patient was able to access available, appropriate support. Thus, Centrelink, as the gateway to income support and employment support services, was often seen as being a system to be ‘fought’ with and through, rather than being available to assist people with mental illness access the support they need.
At the same time, GPs reported having little knowledge about Centrelink processes, the available employment support services or how the information they provide to Centrelink and employment support services is used. Thus, this research suggests that the GP advocacy role is limited by the fact that they have very little knowledge of the system, and the knowledge they do have has usually been gained through previous experience with the system or from patient report. While the GP may be clear on what a patient needs to be able to return to work, participants appeared generally unaware of the available service system or how it could be accessed by their patient (or what they, as the patient care coordinator, needed to do to facilitate that access). The GP and mental health nurse participants also appeared to be unaware of the best way to convey their views of their patient's needs.

5.4. The service provider relationship: a treating team?

The above suggests that both GPs and Centrelink have information, knowledge and systems gaps with regards to providing a clear pathway and consistent approach to supporting people with mental illness to engage or re-engage with employment. GPs identify limited knowledge about employment support services and how their information is used, while Centrelink is perceived as having limited capacity to respond appropriately to the needs of people with mental illness. Combined, these factors result in a confused and non-integrated approach to helping people with mental illness to engage or re-engage with employment. Further, there is a reported lack of a feedback loop or communication process between GPs and Centrelink, even when they have shared service users. This is seen to result in few opportunities for the development of a collaborative or collegiate working relationship. It may also represent a barrier to working towards the development of a shared agenda between employers and workplaces

A number of concerns were raised throughout the focus groups with regards to the availability of supportive and flexible employers and workplaces in local areas. GPs also raised the difficulties of translating the symptoms and presenting difficulties of people with mental illness into appropriate employment arrangements and of what advice to give employers. These issues are of specific relevance to the project for two reasons.

Firstly, if a GP feels that there are no appropriate employment options for a patient presenting with mental illness they may be more willing to provide a Medical Certificate or a Treating Doctor’s Report. They also may not include employment as a priority outcome in the treatment plan, even when a patient may be able to work in a supportive environment. The clinical decisions are then being made by GPs with little knowledge of the available supports and this may result in counter-intuitive outcomes for the patient.

Secondly, these issues emphasise the importance of developing and continuing to disseminate programs that promote employers’ understanding of mental illness, and appropriate employment arrangements to support the employment of people with mental illness.
service providers, for common service users. The lack of a feedback loop also means that there are few routine liaison opportunities that would assist GPs in becoming more familiar with the employment support services, as a secondary outcome of engaging in their regular clinical care activities.

In addition, feedback from research participants suggests that that GPs and Centrelink have different philosophical cultures (for example, health management versus business cultures) with different expectations of partners and different work activity structures. As a result, GPs report that they often do not find Centrelink’s work practices ‘GP friendly’. For example, having to wait on hold for longer than 10 minutes to speak with a representative; representatives not being available after 5pm; difficulties associated with ‘telephone tag’; and different priority of issues.

Combined, these issues appear to exacerbate the already adversarial relationship between GPs and Centrelink that was identified by many research participants. This leads to the conclusion that if strategies are being considered to support GPs to assist people with mental illness to engage or re-engage with employment, they must also address the communication and relationship interface between these key service providers.

5.5. Exceptions
As noted in earlier chapters, some GPs spoke positively of the benefits of having had access to ‘inside knowledge’ (for example, someone within Centrelink with whom they could directly communicate). These GPs highlighted that they did not want to be employment support specialists, but having direct access to someone who understood and could navigate the system for them resulted in better, less stressful and less time consuming patient care.

5.6. Conclusions
Thus, the model in Figure 10 captures the information presented in earlier chapters. It has been used in conjunction with the data collected regarding GPs’ information and support preferences and dissemination and delivery options, and used to help frame the targets of suggested strategies and issues for consideration in responding to these issues. As noted earlier, it is also important to remember that the development of this model did not include scoping of Centrelink or employment support staff perspectives.
6. Key findings and issues for consideration

This section is based on an analysis and collation of the information described in previous chapters. It outlines:

- the information and tools that may be of use to GPs as they assist patients with mental illness to return to, remain in, or enter work. This includes tools and information that would assist the GP in assessing work capacity for a patient with mental illness when issuing the Medical Certificate
- the key messages which may be communicated to GPs in relation to the objective
- issues for consideration regarding how the identified information and tools could best be provided to, or disseminated among, GPs including:
  - whether key messages are best directed to the GP or those who provide support or assistance to them in the general practice setting
  - whether the audience can be usefully segmented
  - whether there are existing channels that can be used to facilitate the provision of information and/or tools to the intended audience
  - the best communication channels to use, including notes about language use, format and method of delivery
  - if and how key messages, tone and execution should differ between the audience sub-group (if applicable),
  - other information that could be used as a basis for further development of strategies and key messages.

6.1. Communication principles

There were a number of key themes that were repeated throughout the consultation process. These need to be taken into consideration with regard to information dissemination to GPs around this topic. These principles were that communication strategies need to be:

- multi-modal, using a variety of methods, formats and strategies to ensure appropriate coverage of the GP and primary care team population
- specifically relevant to patient care and the patient pathway to services
- interactive in that information should be able to be tailored to specific patients, which usually requires GP input of information and would result in an employment support system generated response of some sort
- ‘GP friendly’ (simple, easy to access and use)
- Multi-levelled, so that more information can be accessed if needed
- delivered ‘in context’ and preferably as activities that have networking and relationship building opportunities
- delivered within an environment where there is supporting systemic change regarding how Centrelink manages the issues presented by mental illness and relates to GPs.

These principles are expanded below.

6.2. Information needs and tools

As is clear from the model described earlier, this research suggests there is no one tool or information resource that could address all the factors that impact on a
GP’s capacity to support a person with mental illness to engage or re-engage with employment. Rather, a multiplicity of strategies may be required on a variety of levels, such that an information and communication system could be developed to support GPs to access the information they need, when they need it (usually this will be when a patient is sitting in front of them).

To adequately address all issues raised, it may be beneficial to consider the development of specific information resources and tools as well as the introduction of specific systems communication, liaison and feedback processes.

According to the research, the specific information needs of participating GPs are:

- information about employment support services, what they are, what they do, how a patient can access them, and who is exempt
- information about the best way for GPs to express their views about a patient’s work capacity (the ‘magic words’) that would lead to the best outcomes for their patient
- information about who are appropriate employment support service system experts and how they can be contacted when GPs have specific queries or problems related to Centrelink or the other employment support services
- information about how work capacity should be assessed for people with mental illness, including how this translates to appropriate workplace and employment modifications
- information about how to capture the complexities of work capacity for people with mental illness on the existing systems forms (for example, Medical Certificates).

The research also suggests that supports designed to address these information needs be formatted in such a way that they provide GPs with a decision making support tool which is relevant to the navigation of the employment support system and their role in assessment, treatment, advocacy and care coordination. No other specific tools were identified as being a high priority.

In addition, the consultation process identified other information needs, including:

- the information needs of Centrelink staff about mental illness, including consideration of how the symptoms and issues may impact on a person’s capacity to complete usual requirements, and how their system could most appropriately respond to these issues
- the information needs of employers about mental illness and how they can provide supportive and productive employment conditions for people with mental illness.

These issues have been highlighted because they contribute to an understanding of the context influencing GP activities associated with supporting people with mental illness to engage or re-engage with employment. However, for the purposes of this report, the focus is on addressing the information needs of the GP population, based on the feedback provided by the research participants and these issues have not been explored further.
It should be noted that, as previously discussed, it is important that increasing GP information and awareness about the employment support system be paired with changes in the way GPs and Centrelink (or the employment support services) work together. If this does not occur then there is potential for an increase in the perceived adversarial relationship between GPs and Centrelink. This may occur if GPs are perceived as manipulating the system as opposed to advocating and working with their patients and other service providers to ensure patients are able to access the support they need.

6.3. Key messages

Based on this research, five key messages were identified as relevant to enable GPs and practice support staff to more effectively assist patients with mental illness to engage or re-engage with employment, and their role in completing the Medical Certificate. These key messages are:

- Employment has positive benefits for people with mental illness.
- There are employment support services and programs available to assist people with mental illness to engage or re-engage with employment (available through Centrelink and the Job Capacity Assessment process).
- Information provided by the GP (including that provided through the Medical Certificate) plays an important role in determining the types of employment support services that a patient may be offered.
- Completing the Centrelink forms without understanding the possible employment pathways may not result in the optimal referral outcomes for a patient. The key access and eligibility information GPs should be aware of are...
- If specific problems are experienced in relation to patient care or additional information is required about the employment support system, the contact point is...

These key messages would address the GP information needs identified through this project and could be promoted through a variety of formats, as described below.

6.4. Target audience

The findings of this research suggest that key messages and information dissemination strategies should be targeted at the primary care team, which includes GPs and practice support staff (for example, mental health nurses, practice nurses and practice managers). The key messages and information dissemination strategies for each member of the team do not need to differ in content, unless there are specifically different roles expected of the practice support staff.

In general, the research suggests that information dissemination should target general practices directly and use existing general practice communication networks (for example, Divisions of General Practice). Additional strategies using the communication networks of the various professional representative bodies could also be used (discussed below).

With regards to audience segmentation, GPs and primary health care teams vary along a range of co-occurring characteristics. These characteristics influence information dissemination and format preferences but may also interact...
with one another. This means that no single strategy is likely to provide full coverage of any specific subgroups, but rather that a variety of strategies and different formats of information delivery should be used to ensure that coverage is as comprehensive and appropriate as possible for all the various subgroups.

Table 6 identifies a range of characteristics of general practices and the information dissemination or format preference implications, as reported by research participants.

Table 6: Audience segmentation

<table>
<thead>
<tr>
<th>General practice characteristic</th>
<th>Implication</th>
<th>Conclusion</th>
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<tbody>
<tr>
<td>Urban versus rural areas</td>
<td>Urban and rural areas were identified as having similar information needs, but feedback from rural areas highlighted the importance of ensuring that generic information is applicable to the rural area (as often service collation at a central level is found to be not relevant to a rural area because of service unavailability, inaccessibility or due to limited clinical relevance).</td>
<td>Information resources need to have the capacity to be made locally accurate and relevant. This usually requires collation of information at a local level, translating generic program information into local service names, contact details and checking availability and accessibility details.</td>
</tr>
<tr>
<td>Technological status of the general practice</td>
<td>General practices range from being fully paper based to being completely paperless. The primary form of record keeping appears to largely determine the preference for how information should be accessed (for example, hard copy, website, within electronic forms).</td>
<td>Information resources must be available in a range of formats and accessible through a variety of media, including printed copies, electronic copies (for example, on the internet), websites, and a contact person.</td>
</tr>
<tr>
<td>Interest of the GPs in mental health or employment</td>
<td>The degree to which GPs have a specific interest in either mental health or vocational rehabilitation and employment is likely to determine the degree to which they will pick up or seek out information relevant to these areas, or include this in their treatment planning. Supporting people with mental illness to get back to work is a very specialised area.</td>
<td>Embed the information or support in a more general context (for example, mental illness treatment or services; employment) where appropriate. Embed the information into existing clinical activities (for example, completing the Medical Certificate). Use a range of strategies to pique GPs’ interest in the topic, by indicating how it will be useful to them to find out or use more. Promote work as being an important part of mental health care planning.</td>
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Table 6: Audience segmentation cont

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<tbody>
<tr>
<td>Size of practice and/or practice structure</td>
<td>GPs range from working in solo practices through to multidisciplinary teams, with different roles for each staff member and a greater level of staff specialisation in larger practices.</td>
<td>Be clear in what the specific roles of the GP and other practice support staff are in this area in all information dissemination.</td>
</tr>
<tr>
<td>Attitude and experience in team care</td>
<td>As above, however, the degree to which a GP is used to working with other groups, and their experience of this, will affect their attitude towards external treating partners, and the degree to which they have capacity to foster these relationships.</td>
<td>Be clear in what the primary care health team can expect from Centrelink and employment support services and how they should interact with, or seek further advice from, these service providers.</td>
</tr>
<tr>
<td>Workload and patient load</td>
<td>GPs work across a range of employment conditions (for example, part-time, full-time, after hours, etc.) and will have varying patient loads within the target group.</td>
<td>Basic relevant information and an outline of how more information can be accessed should be provided through a variety of forums. Embed information into existing clinical activities so that information seeking is not time demanding, and is relevant to all GPs.</td>
</tr>
<tr>
<td>Demographics of the locality of the general practice</td>
<td>Certain areas are likely to have higher patient loads in the target group (for example socio-economic status and practice billing may influence the number of patients seen in the target group).</td>
<td>Consider targeting specific information and communication strategies in these areas.</td>
</tr>
</tbody>
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6.5. Information style preference

As identified in previous chapters, the consultation process clearly identified that the style of information that was of interest to GPs was that which was:
- simple, clear and concise
- provided decision-making support regarding patient care
- interactive, so that the information could be automatically tailored to a specific patient
- accurate and up to date
- locally relevant
- easy to use and easy to access
- available in different formats (to ensure appropriate coverage).

Research suggests the content of resources should focus on the patient pathway to employment support services (relevant to the GP role). GPs can seek more information about the system and guidelines around work capacity assessment for people with mental illness. This information should be presented in a manner that has the above characteristics. Suggested methods of delivery of this type of information are provided below.
6.6. Methods of delivery and format
As previously identified, a variety of delivery methods and formats are needed to ensure appropriate coverage and promote uptake. Suggested methods of delivery and format of the target information include:

- a simple and concise hard copy and electronic version of information about work capacity assessment for people with mental illness, the employment support system and the GP role. The availability of this information could be promoted through a short information letter directly sent to GPs, face-to-face contacts and existing communication networks.

- investigation of the feasibility of introducing an electronic Medical Certificate (including electronic lodgement) which hyperlinks each question to various relevant information regarding assessment, how the information is used, services available and eligibility criteria (for example, some of the content could be taken from the resource above).

- a GP contact and liaison point within Centrelink who can assist with system navigation.

- a feedback and communication process for shared service users (whom GPs have provided information about, for example through completion of a Medical Certificate), which informs GPs through a short letter as to the outcome of any assessments, any referrals made, and who can be contacted for more information.

The existence of these resources and supports could be promoted using a variety of strategies including:

- alerting GPs and practice support staff that the information and supports will be available in the future, using existing communication channels (see below).

- announcing the availability of the information and supports once they go live. The promotion could use existing communication channels, and involve the delivery of prompt resources (for example, magnets, stickers and business cards) with a short letter explaining the availability of resources and indicating where additional information could be sourced, sent directly to general practices.

- reminders to GPs and practice support staff regarding the availability of the information and supports, using existing communication channels and face-to-face promotion of the resources.

- practice visits working with local Divisions of General Practice, and involving local Centrelink or employment support staff to promote the information and support and to develop the relationship and networks between local service providers.

- ‘piggy-backing’ onto existing education and training or networking activities to promote the existence of the resources and supports (for example, 10 minutes during an existing meeting, preferably by a local Centrelink or employment support service staffer).

6.6.1 Existing communication channels
As outlined in Table 7, there is a number of existing communication channels that could be used to disseminate information to GPs. The relevance of the different communication channels will be dependent on the type of information to be disseminated. As per previous comments, using a variety of the existing communication channels to disseminate information would ensure best coverage.
Table 7: Existing communication channels

<table>
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<tr>
<th>General practice characteristic</th>
<th>Implication</th>
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<tbody>
<tr>
<td>Divisions of General Practice</td>
<td>Newsletters: usually weekly, developed locally by the individual Divisions. Websites: often provide a key general practice resource interface. Practice visits: Division staff regularly visit general practices in their area. Education and training events: see below.</td>
<td>Divisions are recognised as having the most comprehensive networks of communication and coverage of GPs across Australia. Divisions usually develop or pick up specific topics or issues to promote, based on their catchment area and individual interests. 119 Divisions across Australia + state and territory bodies + national body.</td>
</tr>
<tr>
<td>Professional representative organisations</td>
<td>Including: AMA RACGP ACRRM RDAA All have newsletters or update strategies.</td>
<td>Particularly important if specific local Divisions are not interested in promoting a specific topic or issue. Also more able to capture or target GPs with specific interests and characteristics.</td>
</tr>
<tr>
<td>Professional magazines</td>
<td>Including: Australian Doctor Medical Observer Australian Family Physician.</td>
<td>An effective way of promoting information is via an article (that is, allows more information than that which can be provided in newsletters) or through advertisements.</td>
</tr>
<tr>
<td>Education and training</td>
<td>Existing education and training packages particularly focused on mental health, usually run through the Divisions. Including: Teams of Two, Better Access orientation, RACGP currently proposing an inter-disciplinary training module plus local Division initiated events.</td>
<td>Effective way of promoting information and developing relationships (that is, increases likelihood of uptake of information), however only a small subset of the GP and primary health care population attend these events.</td>
</tr>
<tr>
<td>Local Centrelink offices</td>
<td>GPs already recognise Centrelink, but local networks have not yet been developed.</td>
<td>Local networks between GPs and Centrelink offices could be developed, and would provide an effective way of developing the relationship between local service providers. This could be done in conjunction with Divisions of General Practice.</td>
</tr>
<tr>
<td>All have newsletters or update strategies.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6.7. Other comments

6.7.1. Partnership between DEEWR, Centrelink and Divisions of General Practice

This research suggests that, in light of the existing communication networks, the Department’s role in disseminating information to GPs, and their knowledge of the local context, a partnership approach with the Divisions of General Practice would be beneficial for the promotion of the available information, support and issues. This partnership would provide specific opportunities to ensure the information developed was relevant to the local community and could provide additional opportunities to ‘piggy-back’ onto existing mental health or employment focused activities. Active involvement of local Centrelink or employment support staff in these activities would also be of benefit in addressing the reported lack of a collaborative and collegiate relationship between service providers and would provide each Centrelink (or employment support service) office with a range of useful primary care contacts in their local area. While key to the dissemination of information and support to GPs, this research suggests that such an approach should not be the only dissemination strategy used.

6.7.2. Proactive approach to developing the relationship between GPs and Centrelink

As already described, the development and provision of information and system supports targeted at GPs will only be effective in influencing practice to the degree to which the reported adversarial relationship between GPs and Centrelink can be moved to one of collaboration and collegiality. While the development of specific information supports targeted at GPs will mean that GPs will be able to make more informed decisions about their clinical practice, the degree to which these information supports will be used, or used in a way that leads to better patient outcomes, is likely to be influenced by the attitude that the GP has towards Centrelink and employment support services.

Thus, in addition to the discussed information and key messages to be targeted to GPs, there appears to be a need to also promote that Centrelink:

- has the patient’s best interests at heart
- is available to help people get the assistance they need
- employment support services should be considered part of the ‘treating team’.

These messages will not be effectively addressed through dissemination of information. Rather they require GPs to perceive and experience a change in the way Centrelink manages and responds to their patients with mental illness. The experience of changed behaviour will lead to changed perception and a more collegiate relationship over time.

Dissemination strategies that rely on personal contact (for example, Centrelink GP liaison contact; practice visits by Centrelink or employment support staff to GPs; briefings at local meetings) and the introduction of feedback processes are likely to begin to promote these messages. It is important to note that it would appear that until there is change in the level of cynicism from GPs about the intent of Centrelink and the employment support system, availability of more information (however useful) is likely to have little impact on GP clinical practices.
Thus, it is suggested that additional strategies that would serve to proactively address the relationship between GPs and Centrelink be considered. These could include:

- local Centrelink staff working with Divisions of General Practice to identify networking opportunities, or ways to address particular issues in their area
- promotion, through the existing communication channels, of the message that DEEWR is proactively working on this issue
- working with Centrelink staff to help them to develop ‘GP friendly’ communication practices and clarity the role of the GP and what should be expected from GPs.

6.8. Other relevant information

Additional information relevant to the project is provided below.

6.8.1. Definitional issues

It is important in the development of any information resources regarding this topic that definitional issues are explicitly considered. For example, ‘mental illness’ tends to be understood by GPs as referring to severe and serious mental illness (for example, schizophrenia, bipolar), whereas the scope of the information is likely to be relevant across the spectrum of mental illness (for example, mild to moderate depression or anxiety). To cover the spectrum, it may be more appropriate for information resources to refer to ‘mental health problems’, or specifically to ‘mental health symptoms’ versus ‘mental illness’ per se. It is suggested that any information or promotional products arising as a result of this research are appropriately market tested with members of the target audience.

6.8.2. GP feedback

It is likely that feedback and communication between GPs and Centrelink or employment support services would increase as a result of the above strategy. Negative interactions may increase once GPs become aware of referrals as they were previously unaware and do not agree with the referrals.

It is important then for feedback to GPs to be clear about the reasons why a decision has been made and the steps taken to ensure that a person is being supported
appropriately. Further, feedback should be clear as to who a GP can contact for further discussion of the issues (for example: [Staff name and position] is available for discussion on [phone number] between [time period]).

Similarly, it is important that Centrelink and employment support services have clear procedures for managing and responding to GP contact, and protocols regarding when, and how, escalation to management should occur if needed.

Overall, feedback to GPs should be short (for example, letters no longer than one page), explicit in the decision-making processes and consistent (over time and across patients or service users).

In interactions with GPs, it should be remembered that generally the prime concern for the GP is to ensure that the patient will be served in their best interest. Therefore, showing how a decision supports the best interests of the patient will help establish the shared agenda between service providers.

6.8.3. The central contact point for GPs
This report has largely focused on Centrelink being the most appropriate central contact point for GPs, regarding issues around supporting a person with a mental illness to engage or re-engage with employment. However, it is possible that one of the other employment support service providers may be more appropriate given the specialised nature of mental illness. The focus on Centrelink has been largely driven by two factors:

- Centrelink appears to be understood by GPs and primary care practitioners generally as representing the gateway to income and employment support programs. Thus, it is universally known and GPs have relatively regular interfaces with this service provider (for example, through completing Medical Certificates and other forms). In contrast, other employment support service providers are less well known or understood.

Providing a contact point within Centrelink with whom GPs could discuss issues or seek advice regarding system interface issues adds a logical layer to the existing interface between GPs and Centrelink. However, it should be noted that it would be difficult (and potentially ill advised) to attempt to limit liaison activities specific to the issues associated with supporting people with mental illness to engage or re-engage with employment, as GPs are likely to welcome and use a Centrelink liaison point for assistance with patient issues with the employment support system in general (not just as it applies to their patients with mental illness).

The risk of having a different employment support service provider contact is that the task for information dissemination and engagement from GPs is greater. There will be a need to educate GPs about the service's core business, as well as overcoming the perception that the program will finish or cease relatively soon after introduction (for example 12–24 months). In contrast, these issues are less likely to need to be addressed if Centrelink is the identified contact point. Similarly, it is likely that the nature of the queries to the contact point would be likely to be relatively general, requiring a response from a group with generic system
knowledge versus knowledge specific to one service. Thus, the identified contact point would need to have a strong knowledge of the employment support system as a whole, as it relates to supporting people with mental illness.

- Having a ‘GP friendly’ contact point specifically within Centrelink may also assist in beginning to address the adversarial relationship described by the GPs (which focused on Centrelink). This is because a Centrelink contact point creates opportunities for the development of local working relationships, establishes a ‘face’ (or at least a ‘voice’) to a bureaucratic system, and makes available someone with whom GPs can liaise to ensure the system is working for their shared service users. It is unclear then as to the degree to which attitude change would be generalised to Centrelink if another employment support service provider were to provide the contact point. Thus, while the issues regarding GP feedback and communication are of relevance to all the employment support service providers who have regular interfacing with GPs, the service with which GPs have most contact and which they see as being a gateway to the other employment support service providers is Centrelink. Consequently, it would seem that Centrelink would be the most appropriate group with whom responsibility for promoting feedback and communication with GPs should lie.

### 6.8.4. Other relevant reports

A targeted literature search was conducted to establish the degree to which the published evidence base supported the nature and pattern of the findings of this consultation. Overall, there was a very high degree of consensus, in that this consultation process indicated similar GP information needs and dissemination preferences that were consistent with what has been reported in previous studies. This is outlined in more detail below.

**GP role in assessing work capacity for people with mental illness**

Consistent with this sample’s reports, previous research suggests that training about work capacity assessment has been minimal for primary care practitioners and that GPs struggle to assess functional capacity (particularly for mental illness) in the time poor primary care setting (Krohne & Brage 2007). Further, the complexity of assessing work capacity is increased by the issues presented by mental illness and the lack of ‘objective’ measures whereby to guide work capacity assessment, which leads to a reliance on ‘gut feeling’ in GP clinical decision making in this area (Krohne & Brage; Lofgren et al 2007; Wahlstrom & Alexanderson 2004). Similarly, the sample in this research reported a significant lack of knowledge and understanding about the vocational rehabilitation system, which is consistent with the findings from another Australian study on GPs’ engagement with the vocational rehabilitation system with regards to their patients with mental illness (Crawley, Fitzgerald & Graham 2007). Also consistent with other studies, this consultation process found that GPs indentified that a significant barrier for their
patients with mental illness who were wanting to return to work was the lack of appropriate work environments available to provide ‘light duties’. The research also found that a lack of communication between sectors was leading to fragmented and uncoordinated care for people with mental illness wishing to engage or re-engage with employment (Crawley et. al; Hussey et al 2003; Krohne & Brage 2007; Pransky, Katz & Himme 2002).

Two studies highlight points of specific relevance to the current report. Firstly, Krohne and Brage (2007) did an investigation into the GP role in the ‘sick certification’ process in Norway and found that GPs identified a significant lack of knowledge and confidence in expressing work capacity and functional assessment on the required income support system forms. Through a reflection on the impacting factors, the authors recommended that if stakeholders wished to change GP clinical behaviour in this area, strategies would need to recognise and integrate GPs’ existing clinical practices. The authors also highlighted that a consensus needed to be reached and promoted regarding the best ways for GPs and the employment support system to: conduct work capacity assessments in the time poor primary care environment; address patient confidentiality issues; and promote appropriate and effective communication and information-sharing processes between GPs and the employment and income support system.

Secondly, a New Zealand study has explored the use and experience of GPs in using information about psychosocial factors that indicate high risk of long term work impairment for people with back pain (Crawford, Ryan & Shipton 2007). Interestingly, this qualitative study identified similar issues to the current consultation process. This study found that GPs identified that their therapeutic relationships with patients were the key strength that allowed them to discuss the impact of psychosocial features on patients’ capacity to return to work. However, the complexity and nature of the psychosocial issues often exceeded or challenged the time available in appointments in the primary care setting, as well as the GP’s generalist knowledge.

Further, the information dissemination process of the ‘yellow flags’ guideline (outlining the psychosocial risk factors and how to take them into account in patient care) was via a mail out and clinician ‘road show’ and the authors concluded that the resource did not appear to have met GPs’ needs. The information was perceived by participants as being mechanistic, prescriptive and having little relevance to the daily context of their work activities. Further, the issue of GPs being overloaded by information but unable to find it when needed had not been adequately addressed in this information dissemination process. The study concluded that the information dissemination needed to be reoriented to take account of the GP environment, to better effect change in the organisational and behavioural mechanisms.

Overall, these studies indicate that despite the qualitative nature of the current consultation process, the issues raised by this sample with regards to GPs’ capacity and engagement in activities associated with assessing work capacity for people with mental illness and the issues that
Impact on information uptake, were typical of the information needs and GP experiences described by other groups.

**Information dissemination and delivery**

There is a substantial evidence base that has investigated information dissemination and uptake of clinical practice guidelines by GPs. There are also some publications that have investigated GPs' preferred style and methods of information dissemination for specific topics. Overall, the information dissemination style and preferences reported in these studies are consistent with the identified preferences of this sample and the evidence base around success factors associated with uptake of information by GPs support the outlined strategies.

Specifically, the characteristics of preferred information style common across studies with GP samples (Austin et al. 2005; Kanouse, Kallich & Kahan 1995; Moorjani & Fornum 2004; Prosser et al. 2003; Puecher et al. 1998; Rubin et al. 2000; Ryan et al. 2004; Watkins et al. 1999) were that the information should:

- emphasise how it would improve patient care
- be developed and auspiced by a respected and legitimate change agent
- be precise and brief
- be provided in a way that is convenient and accessible
- be clear in its implications for clinical practice (for example, delegation of responsibility)
- when provided directly to GPs, make it clear how further information can be accessed and be provided in a way that it represents a ‘memory jogger’
- make use of GPs' typical existing professional development activities, which are most typically through academic journals or newspapers or (preferably) through face-to-face activities
- address the barriers to uptake of information, including lack of time, competing priorities (with regards to topic areas), and lack of access to appropriate information dissemination methods.

There were also a number of publications that conducted systematic reviews of the literature regarding the effectiveness of different information dissemination methods for GPs. See Rubin et al. (2000) for an overview. In summary, these reviews indicated that:

- a multi-faceted approach to information dissemination is likely to be more effective than a single strategy (Blashki, Joll, Piterman & Gunn 2003; Gilbody, Whitty, Grimshaw & Thomas 2003; Grimshaw et al. 2001; Moulding, Silagy & Weller 1999; Rubin, Frommer, Vincent, Phillips & Leeder 2000; Wensing, Van der Weijden & Grol 1999)
- information transfer alone (for example, reading materials, group education) is generally ineffective and unlikely to result in behaviour change (Grimshaw et al. 2001; Wensing et al. 1998)
- when information transfer is paired with face-to-face and/or interactive activities (including educational meetings and educational outreach or academic ‘detailing’ or practice visits), it is more likely to result in behaviour change
- decision-support systems (manual or automated) that integrate information
into the system of care by prompting health care providers to consider specific information or activities at key clinical decision making points have evidence of being consistently effective in changing clinical behaviour (Moulding et al. 1999; Rubin et al. 2000), particularly when they are patient specific versus generic reminders or feedback (Wensing et al. 1998).

These reviews also highlighted the importance of considering the many factors that may impact on a GP’s willingness to accept or use information provided to them and change their clinical practice. A few key points made by the publications were:

- Information uptake will be determined by the perceived compatibility, complexity and relative advantage of the information disseminated. In other words, the degree to which the information can be easily translated and complements existing practice and will result in valued benefits will influence whether the information is used (King, Hawe & Wise 1998).
- ‘Boutique’ guidelines (or information relevant to a small subset of the patient population) will be more difficult to promote than information with wider relevance (Penrose-Wall 2000a; 2000b).
- GPs respect their peers. Thus, ‘opinion leaders’ will tend to be perceived as identifying with the concerns of clinicians rather than the outside agency, and information being endorsed by a peer will often be considered more acceptable than information being promoted by an outside group (Moulding et al. 1999).
- In summary, the published literature suggests that the nature of this study’s findings regarding GP interface with the employment support system and their information dissemination preferences is consistent with the findings of other studies. Further, the information dissemination strategies outlined are supported by an evidence base that indicates that they are the most effective ways of disseminating information to GPs, in order to influence and promote best practice.

6.9. Conclusion

This research and consultation process suggests that GPs would benefit from information about the employment support system, their role in it and patient access and entry points or requirements, as well as guidelines regarding assessment of work capacity for people with mental illness. This information is likely to be well received if it is made available in a variety of formats and preferably tied to specific patient care and the clinical activities in which GPs are already engaged. The dissemination of any information could be paired with networking and relationship building opportunities between GPs and Centrelink or employment support service staff and may be enhanced if it is done in the context of consideration around how Centrelink and the employment support system manage the issues presented by people with mental illness. There is a variety of existing communication channels that may be useful in the promotion of any information or support made available.

By addressing GP information needs and improving the interface between GPs and the employment support system, a more integrated and effective approach can be taken to supporting people with mental
illness return to, remain in and enter work. This is likely to improve patient care, the pathway to employment support services and result in better outcomes for people with mental illness.
Table 8: Key findings overview

<table>
<thead>
<tr>
<th>Key principles</th>
<th>Key messages</th>
<th>Information style</th>
</tr>
</thead>
<tbody>
<tr>
<td>The information resource should be:</td>
<td>- Employment has positive benefits for people with mental illness.</td>
<td>The information provided should be:</td>
</tr>
<tr>
<td>- multi format (for example, hard copy, electronic, etc.), delivered through a variety of means (for example, within existing clinical activities; as a specific website; through a GP liaison contact point, etc.) and promoted through a variety of strategies</td>
<td>- There are employment support services and programs available to assist people with a mental illness to engage or re-engage with employment (available through Centrelink and the Job Capacity Assessment process).</td>
<td>- simple, clear and concise</td>
</tr>
<tr>
<td>- relevant to patient care, the patient pathway to services and should promote how it will assist GPs in their role</td>
<td>- Information provided by the GP (including that provided through the Medical Certificate) plays an important role in determining the types of employment support services that a patient may be offered.</td>
<td>- provide decision making support regarding patient care</td>
</tr>
<tr>
<td>- interactive and able to be tailored to individual patient care</td>
<td>- Completing the Centrelink forms without understanding the pathways may not result in the optimal referral pathway for a patient. The key eligibility information GPs should be aware of are…</td>
<td>- clear in what is expected of the GP and practice support staff and what can be expected from Centrelink and employment support services</td>
</tr>
<tr>
<td>- ‘GP friendly’: simple, easy to access and use; not time demanding</td>
<td>- If specific problems are experienced in relation to patient care, or additional information is required about the employment support system, the contact point is…</td>
<td>- value adding to existing required clinical activities</td>
</tr>
<tr>
<td>- delivered ‘in context’ and preferably with activities which have networking and relationship building opportunities</td>
<td></td>
<td>- interactive, so that the information could be automatically tailored to a specific patient</td>
</tr>
<tr>
<td>- delivered within an environment where there is supporting systemic change regarding how Centrelink manages the issues presented by mental illness and how it relates to GPs.</td>
<td></td>
<td>- multi levelled, so that more information can be accessed if needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- accurate and locally relevant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- easy to use and access</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- available in different formats (to ensure appropriate coverage).</td>
</tr>
</tbody>
</table>
### Information delivery and format

A variety of information delivery strategies are required, including:

- A simple and concise hard copy and electronic version of information about work capacity assessment for people with mental illness, the employment support system and the GP role, which can be promoted through a short information letter sent directly to GPs and face-to-face contacts.

- Investigation of the feasibility of introducing an electronic Medical Certificate, which hyperlinks to relevant information (as per above).

- A GP contact and liaison point within Centrelink who can assist with system navigation.

- A feedback and communication process for shared service users about the outcome of assessments for which they have provided information. For example, through a simple feedback letter outlining which employment support services a patient has been referred to and who can be contacted for more information.

### Dissemination strategies

A proactive dissemination process is required including:

- Alerting GPs and practice support staff that the information and supports will be available.

- Announcing the availability of the information and supports once they ‘go live’, and delivery of ‘prompt’ resources (for example, magnets, stickers, business cards) with a short background letter delivered directly to general practices.

- Reminders to GPs and practice support staff regarding the availability of the information and supports. Further, face-to-face contacts should be provided, including:
  - Practice visits with local Divisions of General Practice, by local Centrelink staff to promote the information and supports and develop the relationship and networks between local service providers.
  - ‘Piggy-backing’ onto existing education and training or networking activities to promote the existence of the resources and supports (for example, 10 minutes during an existing meeting preferably by a local Centrelink staff member).

### Existing communication channels that could be utilised in promotion

The following groups have regular newsletters or updates and education or training activities for their GP membership:

- Divisions of General Practice
- Australian Medical Association
- Royal Australian College of General Practice
- Australian College of Rural and Remote Medicine
- Rural Doctors Association.

In addition, the Divisions of General Practice do regular practice visits. Professional magazines are also an effective way of reaching GPs and practice support staff, including:

- Australian Doctor
- Medical Observer
- Australian Family Physician.

Information dissemination should be negotiated with the various organisations on an individual basis and the type of information to be disseminated will determine the relevance of the specific method. Multiple communication channels should be used.

### Other issues for consideration

- A partnership approach between DEEWR, Centrelink and the Divisions of General Practice could be taken for the roll out of information.

- A proactive approach could be taken to strengthen the relationship between GPs and Centrelink, including creating networking and relationship building opportunities by organising face-to-face contact between local Centrelink staff and GPs. This could be tied to the dissemination of the information.

- The information needs of Centrelink staff with regards to mental illness and working with GPs may need to be considered and addressed.

- A salaried ‘GP champion’ to facilitate information and relationship promotion could enhance information uptake and could be particularly valuable in areas where there are many patients within the target group.
References


Penrose-Wall, J & Harris, M 2000a, From Woe to Go. Mental Health Clinical Practice Guidelines and General Practice - Positioning Dissemination Programs, Centre for General Practice Integration Studies, Sydney.

Penrose-Wall, J 2000b, To Their Full Potential. Evidence based guideline uptake in primary mental health care, Centre for General Practice Integration Studies, Sydney.


