Supporting GPs to manage comorbidity in the community

Written by
Dr. Adam Winstock
Dr. Jill Molan
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Acknowledgements

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Written by Dr. Adam Winstock and Dr. Jill Molan 2.
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<th>Description</th>
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<tbody>
<tr>
<td>ADIS</td>
<td>Alcohol and Drug Information Service</td>
</tr>
<tr>
<td>AGPN</td>
<td>Australian General Practice Network (formerly ADGP)</td>
</tr>
<tr>
<td>ASSIST</td>
<td>Alcohol, Smoking and Substitute Involvement Screening Test</td>
</tr>
<tr>
<td>AUDIT</td>
<td>Alcohol Use Disorders Identification Test</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood-borne Viruses</td>
</tr>
<tr>
<td>BDI</td>
<td>Beck Depression Inventory</td>
</tr>
<tr>
<td>CDM</td>
<td>Chronic Disease Management</td>
</tr>
<tr>
<td>DASAS</td>
<td>NSW Drug and Alcohol Specialist Advisory Service</td>
</tr>
<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>DMMR</td>
<td>Domiciliary Medication Management Review</td>
</tr>
<tr>
<td>EPC</td>
<td>Enhanced Primary Care</td>
</tr>
<tr>
<td>FPS</td>
<td>Focused Psychological Strategies</td>
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<tr>
<td>GPMHCP</td>
<td>GP Mental Health Care Plan</td>
</tr>
<tr>
<td>GPMP</td>
<td>GP Management Plan</td>
</tr>
<tr>
<td>HMR</td>
<td>Home Medicines Review</td>
</tr>
<tr>
<td>K10</td>
<td>Kessler Psychological Distress Scale</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<tr>
<td>MMP</td>
<td>Medication Management Plan</td>
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<tr>
<td>MSE</td>
<td>Mental State Examination</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>PG</td>
<td>The Pharmacy Guild of Australia</td>
</tr>
<tr>
<td>PPC</td>
<td>Patient’s Priorities for Care</td>
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<tr>
<td>PSB</td>
<td>Pharmaceutical Services Branch, NSW Health</td>
</tr>
<tr>
<td>PSIS</td>
<td>Prescription Shopping Information Service</td>
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<tr>
<td>SF12</td>
<td>Medical Outcomes Study Short Form 12</td>
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<tr>
<td>SWAT</td>
<td>State-Wide Advisory Team</td>
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<tr>
<td>TCA</td>
<td>Team Care Arrangement</td>
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<tr>
<td>UDS</td>
<td>Urine Drug Screen</td>
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</table>
Introduction

What is the Kit for?
The Patient Journey Kit 2 will support general practitioners (GPs) working with other professionals and with patients who have comorbid mental health and substance use problems to develop combined care and business plans. These will optimise both the quality of care delivered to patients and the financial remuneration obtained.

It is also suitable for use by other community providers, such as allied health professionals and people receiving treatment.

In addition, this Kit identifies that it is the responsibility of all involved to ensure that the patient has a pivotal role in the treatment provided. Patient consent is necessary for the delivery of high quality care but also for the informed sharing of information between professionals. The Kit provides patients with a genuine opportunity to be an active partner in treatment.

What if I don’t usually bulk bill?
In some areas access to GPs who bulk bill is difficult. For those patients with both mental health and substance use problems, finances and financial management may be a real challenge. In such cases financial difficulties may represent an additional barrier to engaging this vulnerable group in treatment. Wherever possible it would be helpful if GPs could consider bulk billing as a viable alternative for a small proportion of their patients with these difficulties.

The SWAT project suggests that where possible and optimal use of the care plans within a bulk billing framework could have a truly significant public health impact and are worth adopting:

- GP Mental Health Care Plan Item 2710 100% Medicare Australia Rebate $150.00
- GP Management Plan Item 721 100% Medicare Australia Rebate $124.95
- Team care Arrangements Item 723 100% Medicare Australia Rebate $98.95 (we suggest Team Care Arrangements with a dispensing pharmacist and local drug & alcohol worker would meet these requirements)
- Home Medicines Review Item 900 100% Medicare Australia Rebate $134.10

The additional remuneration obtained by utilising these care plans, Home Medicines Review and other related item numbers will offset to some degree any loss incurred through bulk billing, as well as improving care and health outcomes in this population and their families.

Adapted from work provided to SWAT by Dr Vince Roche, GP.
Who can use Kit 2 and why?

**Background**

Rates of substance use are far higher among those with mental illness than in the general population and as such, the co-existence of the disorders occurs in between 30-80% of clients in community and institutional treatment settings. In addition those with mental illness are much more vulnerable to the adverse effects of substance use and those with both disorders have universally poorer outcomes. Although many of this group will present to hospital based services, a large proportion will inevitably be seen within a primary care setting at some point during their illness.

The introduction of a range of new Medicare item numbers in November 2006 under the Better Access to Mental Health Care initiative provides enhanced opportunities for GPs to become pivotal providers of care to patients with comorbid mental health and substance use problems. The new item numbers allow patients better access to care through new Patient Pathways which can be used in the management of mental health (including substance use) problems. The Better Access item numbers allow mental health care to be provided by GPs, psychiatrists, psychologists and other allied health professionals through the Medicare Benefits Schedule (see GP Fees and Patient Rebates).

Although the core objective of the State Wide Advisory Team (SWAT) project was to increase the capacity of public and community services to provide care to those with opioid dependence, it was recognised that some of the approaches adopted with opioid users could usefully be adapted to the development of a Kit addressing the GP management of those with comorbidity. The approach taken in Kit 2 is consistent with and supportive of the Teams of Two and Can Do initiatives of the Australian General Practice Network (AGPN).

**Who can use Kit 2 and why?**

*General Practitioners* | Go to Steps 1-5

Kit 2 will guide GPs in how to sequence assessment, treatment and referral for those with both mental health and substance use problems in order to deliver the best outcomes for patients as well as to maximise remuneration through the use of appropriate Medicare item numbers. It addresses the most effective utilisation of the Better Access item numbers (through use of the GP Mental Health Care Plan), the Chronic Disease Management item numbers (through use of the GP Management Plan, Team Care Arrangement and Case Conference) and the pharmacy Home Medicines Review (HMR). It acknowledges that GPs vary in both their level of skill and interest in these areas and have widely differing access to local public and private specialist services.

*Pharmacists* | Go to Step 5

Kit 2 will encourage community pharmacists to increase their level of involvement in the care delivered to patients with both mental health and substance use problems. Kit 2 will raise pharmacists’ awareness of the important role they have in identifying risky drug prescriptions, particularly of opioids and benzodiazepines, by GPs (especially where the patient may be consulting more than one doctor). It will also improve patients’ understanding of treatment and the role of the pharmacist in enhancing medication compliance and reducing medication misuse when facilitated by a doctor’s prescription. Specifically Kit 2 will provide details on how the HMR can be utilised and appropriately integrated into GP care plans for those with multiple disorders. It is through the HMR that pharmacists can provide additional monitoring and support to both patient and GP. A secondary outcome of Kit 2 may be an increase in the level of involvement of community pharmacists in the supervised delivery of psychotropic medication such as antipsychotics, antidepressants and benzodiazepines.

*Consumers* | Go to Steps 1-5

Kit 2 informs patients of the nature of information to be exchanged between professionals involved in their care and it highlights how they can be actively engaged by their health care providers to contribute to their own care plan.

*Allied health professionals* | Go to Step 3

Kit 2 provides information and guidance to a range of other health care workers, such as psychologists, social workers, occupational therapists, mental health nurses and Aboriginal Health Workers who may be involved in the care of a patient with comorbid problems. Processes supporting optimal referral from GPs to allied health workers are identified in the Kit.

*Other health professionals (nurses, Aboriginal Health Workers)*

The GP may be assisted by their practice nurse, Aboriginal Health Worker or other health professional in the GP’s medical practice or health service (see Medicare item 721, point A.28.44). The service must include a personal attendance by the GP with the patient, as part of the item being claimed.

The Better Access initiative also makes provision for mental health nurses and Aboriginal Health Workers to participate as providers. At the time of writing this Kit, details of provider numbers were under development.

In addition, from July 2007, the Mental Health Nurses Incentive Program will be available to eligible GP practices who wish to employ a mental health nurse.
# How to use this Kit

**PART 1 contains:**
A summary of steps in the care of a patient with comorbid mental health and substance use problems.
If you are familiar with mental health care plans then Part 1 is most appropriate.

**PART 2 contains:**
Details of each step summarised in Part 1.
If you are less familiar with this clinical area or how to use care plans then Part 2 may be more useful.

## PART 1

**Summary steps in planning care for a patient with comorbid mental health and substance use problems**

<table>
<thead>
<tr>
<th>Step</th>
<th>Process</th>
<th>Documentation and information exchange</th>
<th>Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>ASSESSMENT</td>
<td>GP undertakes assessment with patient consent and documents in patient’s file. Refer to ‘Can Do’ website. GP may offer the patient the Patient’s Priorities for Care (PPC) prompt list to assist the patient.</td>
<td>Paper based or Electronic</td>
</tr>
</tbody>
</table>

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The Patient Journey
<table>
<thead>
<tr>
<th>Step</th>
<th>Process</th>
<th>Documentation and information exchange</th>
<th>Forms:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Paper based or Electronic</td>
</tr>
<tr>
<td>Step 2</td>
<td>CARE PLANNING</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Step 2.1 PLAN 1—GPMHCP**

Approximately one week later GP reviews patient (including drug/alcohol use diary if available), identifies a range of treatment options and determines what treatment approach is most acceptable to patient, then:

- completes care plan and
- instigates treatment appropriate to this e.g.
  - outpatient detox;
  - referral to a D&A specialist for assessment;
  - commencement of a psychiatric medication e.g. antidepressant.

GP considers need for compliance enhancement processes (supervised dispensing) and involvement of significant others or allied health professionals, with patient consent.

With patient consent, GP completes GPMHCP and provides a copy to patient.

**Forms:**
- GP Mental Health Care Plan (GPMHCP) Item 2710
- Further details added when any referral information comes back in.

**Step 2.2 PLAN 2—GPMP**

Patient attends GP for assessment of chronic diseases identified as requiring an additional plan (e.g. liver disease, diabetes, hypertension).

With patient consent, GP completes GPMP and provides a copy to patient.

**Forms:**
- GP Management Plan (GPMP) Item 721

**Step 2.3 PLAN 3—TCA**

GP decides whether a Team Care Arrangement with other professionals is appropriate, discusses with patient and arranges if agreed.

With patient consent, GP completes TCA and provides a copy to patient and to other professionals.

**Forms:**
- TCA Item 723
### Step 3: REFERRALS

#### Step 3.1: REFERRALS under GPMHCP

With patient consent, GP makes referrals as appropriate to:

- Drug and Alcohol specialist
- Psychiatrist for assessment and management plan for the GP to implement
- Psychiatrist for management of patient
- Allied health professionals as required for Focussed Psychological Strategies (FPS) or Psychological Therapy services (PTS)
- Eligible GP with training in FPS
- GP receives feedback from D&A and/or psychiatrist referrals.
- Discusses these with patient

**Documentation and information exchange:**

- Standard GP referral processes to other doctors, to psychologists, other allied health, or specialist GP.
- GP makes any necessary changes to GPMHCP.
- Gives a copy of final care plan to patient.

**Forms:**

- Paper based or
- Electronic

**Referral letters**

- Various Item Numbers

#### Step 3.2: REFERRALS under GPMP

With patient consent, GP refers to allied health professionals as required e.g. physiotherapist, dentist.

**Documentation and information exchange:**

- Standard GP referral processes.

**Forms:**

- Various Item Numbers

### Step 4: APPOINTMENT SCHEDULE

Regular review schedule is discussed with patient. Some of these may be as GP Mental Health Consultation, some as Level B or C consultations.

Review schedule determined as indicated by patient needs and feedback from referrals.

With patient consent, Enhanced Primary Care (EPC) Case Conference may be initiated if required with other professionals and carer (if applicable).

**Item 2713 Mental Health Consultation**

OR

**Level B or Level C Consultation**

**Case Conference Items (under EPC Item numbers 740, 742, 744, 759, 762, 765)**
### Step 5: GP requests HMR

At any appointment, the GP may refer the patient for a Home Medicines Review (HMR) if appropriate. With the agreement of the patient, the GP requests HMR from an approved pharmacy.

**Documentation and information exchange**
- GP obtains consent for HMR from patient.
- HMR referral form sent to pharmacy.

**Forms:**
- HMR Referral Item 900

**Pharmacist conducts HMR at location of patient’s choice and provides feedback to GP.**

**Pharmacist HMR information provided back to GP.**

**Pharmacy HMR Report (local format)**

**Step 6: REVIEW of GPMHCP or GPMP or TCA**


**Documentation and information exchange**
- Six monthly (or more often if indicated).
- GPMHCP Review Item 2712
- GPMP Review Item 725
- TCA Review Item 727

**Forms:**
- Complete HMR Medication Management Plan.
PART 2
Detailed steps in planning care for a patient with comorbid mental health and substance use problems

Step 1 First assessment by GP of patient who may have comorbid disorders
(adapted with permission from the AGPN Can Do initiative: Managing Mental Health and Substance Use in General Practice)

Process
The processes in this Kit begin at the point at which a GP considers that he or she may be caring for a patient with comorbid mental health and substance use problems. The patient may be presenting to this GP for the first time, or may be an existing patient with whom the GP has a well established therapeutic relationship. When the patient is already known to the GP, many of the details described in the early sections of this Kit will already have been attended to by the GP. The Kit is designed to cover all the necessary steps in the event that this is a patient who is new to this GP.

Assessment, regardless of the prior presence of a therapeutic relationship, must be a process of information exchange. Sensitive issues are more likely to be disclosed when confidentiality is assured. The aim of an initial assessment is to engage the patient in treatment. Failure to secure the confidence and interest of the patient at this point, particularly with a new patient, makes subsequent contact less likely. Gaining the confidence of the patient is complicated by the presence of mental health or substance use problems. In addition, those individuals with mental health problems are more vulnerable to the harmful effects of psychoactive substances. Even low levels of substance use may be associated with negative outcomes in those with mental health problems, though such individuals will often be unaware or confused about the consequences of their substance use upon their overall well being.

Although it may not be possible at the end of an initial assessment to determine a complete care plan, there should be some attempt at giving feedback to the patient about what the GP has identified and at providing a range of potential interventions for the patient to consider. The GP should make sure to describe the relative merits and problems associated with the suggested interventions.

Acute risk identification (such as high suicide risk or high risk injecting practice) and the provision of immediate harm reduction information should be considered an essential component of any assessment process. For identified risks that are not acute, a brief intervention is appropriate.

Risk identification is assisted by the use of a screening tool such as the AUDIT (for alcohol) or the ASSIST (for alcohol and other drugs) (see below for links to these tools). For low risk (as identified in the ASSIST), offer information; for moderate risk, offer a brief intervention; for high risk, offer intensive intervention.

Brief Intervention
If the patient is not dependent or at risk of withdrawal (in which case more intensive interventions would be required), a brief intervention may be appropriate and effective. Brief interventions are opportunistic feedback processes that may occur in any consultation where the clinician has obtained information about a range of risk behaviours.

One approach to conducting a brief intervention is known by the acronym FRAMES, which stands for:

| Feedback | You (the practitioner) provide objective information to the patient regarding their current consumption or pattern of substance use and associated health risks; |
| Responsibility | You ensure the patient recognises that you (the practitioner) are not responsible for implementing changes in their behaviour. You are simply drawing attention to it and offering assistance—the responsibility for change lies with the patient; |
| Advice | You provide advice on potential consequences including health risks and the benefits of adopting positive behavioural change; |
| Menus | You provide the patient with a menu (range) of options which they may adopt to reduce risk or substance intake; |
| Empathy | You understand how hard it can be to change; |
| Self efficacy | You (the patient) can do it (you have maybe done a bit of it before). |

Further information about Brief Interventions can be found at Drug Info Clearinghouse.
Choice of care plans

In caring for a patient with comorbid health problems, the GP has two main choices:

1. the GP Mental Health Care Plan (GPMHCP) and
2. the GP Management Plan (GPMP).

The GPMHCP is the preferred choice for the management of patients with comorbid mental health and substance use problems. The GPMP may also be used in addition for patients who have chronic physical problems requiring attention. When a GPMP is in place, a Team Care Arrangement (TCA) may also be used.

GP Mental Health Care Plan (GPMHCP)

Since November 2006, GPs have been able to address the clinical problem of comorbid mental health and substance use problems through the Better Access to Mental Health Care initiative which supports the development of a GP Mental Health Care Plan (GPMHCP) for those patients with Alcohol Use Disorder or Drug Use Disorders (for further details refer to GP Mental Health Care Plan, Review and Consultation).

GP Mental Health Care Plan preparation includes assessment and care planning stages. In order to claim the new Medicare Better Access item numbers, the GP must meet specific requirements which are detailed in this and the next section.

The following points must be present in order for the GP to claim Item 2710, the GPMHCP:

- Verbal consent to prepare the GP Mental Health Care Plan
- Taking relevant history (biological, psychological, social) including the presenting complaint
- Conducting a mental state examination
- Assessing associated risk and any comorbidity
- Making a diagnosis and / or formulation
- Treatments and services likely to be needed (must be documented)
- Arrangements for these services made
- Agreed management goals
- Actions to be taken by patient (specifically identified)
- A plan for crisis intervention if required and relapse prevention
- GP Mental Health Care Plan documented with copy prepared for patient
- Setting a review date for the GP Mental Health Care Plan
- Administration of the outcome measurement tool if indicated

Assessment as part of a GPMHCP

Further clinical information about assessment can be found at ‘Can Do Assessment and History taking’.

The next table outlines the most important points of assessment and treatment planning for a patient with comorbid problems. Each step is detailed in the following text, within the relevant sections required by Medicare.
Outline of clinical assessment process used to develop a care plan for a patient with comorbid mental health and substance use disorders

<table>
<thead>
<tr>
<th>Step</th>
<th>Process</th>
<th>Examination/investigations/care plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td>• Explain what assessment will cover, purpose of questions, identify why the patient has presented today and what they would like to get from the review and any immediate concerns.</td>
<td>• Appearance, behaviour, speech, cooperation, mood, weight, height, demeanour, complexion etc.</td>
</tr>
<tr>
<td><strong>Step 1.1</strong></td>
<td>• Assess current substance use—amounts, patterns, duration of use.</td>
<td>• Full physical examination.</td>
</tr>
<tr>
<td></td>
<td>• Assess for dependence, route and behaviour related risks.</td>
<td>• Look for signs of liver disease, injecting drug use, endocarditis etc.</td>
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<tr>
<td></td>
<td>• Assess need for detoxification/maintenance/harm reduction.</td>
<td>• Routine hepatitis screening and vaccination and where appropriate STI screening.</td>
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<td></td>
<td>• Assess history of use and age of first onset in relation to mental health symptoms.</td>
<td>• Urine drug screens.</td>
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<tr>
<td></td>
<td>• Assess past treatment responses.</td>
<td>• Routine blood tests.</td>
</tr>
<tr>
<td></td>
<td>• Assess patient motivations, goals and barriers to potential successful engagement.</td>
<td></td>
</tr>
<tr>
<td><strong>Step 1.2</strong></td>
<td>• Assess mental health status including acute risk.</td>
<td>• Discuss use and implementation of outcome measures. Baseline administration of a standardised mood assessment scale such as the BDI can be useful in tracking symptomatology over time—for example assessing the impact of either abstinence or antidepressants upon a patient’s depression.</td>
</tr>
<tr>
<td></td>
<td>• Assess for past history of overdose or suicide attempts.</td>
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<tr>
<td></td>
<td>• Past psychiatric history including temporal relationship between drug use and mental health problems—attempt to identify primary disorder.</td>
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<tr>
<td></td>
<td>• Assess impact of current use upon mental state and risk.</td>
<td></td>
</tr>
<tr>
<td><strong>Step 1.3</strong></td>
<td>• Assess comorbidity.</td>
<td>• Initial treatment plan.</td>
</tr>
<tr>
<td></td>
<td>• Make provisional diagnosis of substance use disorder/other medical or psychiatric illness (see diagnostic algorithm on page 16).</td>
<td>• Discuss formulation with patient.</td>
</tr>
<tr>
<td></td>
<td>• Identify gaps in assessment—information that needs to be obtained by serial review or access to past notes/carers.</td>
<td>• Feedback risks and harm reduction information.</td>
</tr>
<tr>
<td></td>
<td>• Feedback to the patient your assessment of current possible problems and risks including overdose, BBVs, incarceration, family problems etc.</td>
<td>• Psychoeducation.</td>
</tr>
<tr>
<td></td>
<td>• Offer a menu of possible treatment options (including referrals) and providers to patient including information on advantages and disadvantages of different medications or treatment modalities.</td>
<td></td>
</tr>
<tr>
<td><strong>Step 1.4</strong></td>
<td>• Encourage patient involvement in treatment plan.</td>
<td>• GPMHCP/GPMP.</td>
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<tr>
<td></td>
<td>• Ask patient to consider their treatment priorities and request feedback on acceptability and utility of the options offered (use PPC).</td>
<td>• Discuss patient goals and treatment options.</td>
</tr>
<tr>
<td></td>
<td>• Consider use of family members or carers to become involved in treatment if patient agrees.</td>
<td>• Discuss possible referral to allied health care providers/other health care providers.</td>
</tr>
<tr>
<td></td>
<td>• Develop initial care plan with review date and immediate goal of retention in treatment.</td>
<td>• Copy to patient.</td>
</tr>
</tbody>
</table>
Patient’s agreement

The patient’s agreement is required for the service, as for all treatment and information exchange. The GP must document this in the patient’s file. The GP may wish to offer the patient the Patient’s Priorities for Care (PPC) prompt list to assist the patient to present their issues to the GP.

Relevant history & examination

**Step 1.1 Substance use history**

It is important to obtain a good drug use history first (i.e. before the mental health history), because identifying the temporal relationship between the onset of substance use, other life events, and symptoms of mental illness is critical to making an accurate diagnosis of the underlying or primary diagnosis. In addition, it is often easier for people to remember the age at which they first starting using substances or alcohol than it is to determine the onset of mood symptoms.

It is suggested that the initial approach in the management of co-existing disorders is to optimise the management of the primary (underlying) condition, with the view that this will consequently reduce the symptomatic expression of the secondary disorder. For example a depressed drinker who has primary (underlying) alcohol dependence, if able to maintain abstinence, will see a significant reduction in depressive symptomatology.

An assessment of current drug use includes

- Which drug(s) is the patient using?
- What is the frequency of use?
- Binge use and poly drug use patterns
- What is the pattern of a typical drug-using day or week?
- What is the route of use (e.g. oral, smoked, snorted, injected)?
- What effect is the patient seeking when using the drug?
- Is there evidence of the physical or psychological features of dependence on the drug(s)? (Use AUDIT or ASSIST)
- Maintaining factors for substance use in the individual’s psychosocial environment should be assessed
- Past risk and treatment responses
- Intoxication and withdrawal related risk

**Step 1.2 Mental health history**

The mental health assessment will include the mental health history, the current symptoms (particularly depression) and any treatment history. Note that a Mental State Examination is required in order to claim the GPMHCP item.

**Mental State Examination (MSE)**

An MSE is conducted as for any patient but note the difficulties of assessing a mental state while a patient is intoxicated or in withdrawal (see *Can Do* initiative: Managing Mental Health and Substance Use in General Practice on the AGPN website).


A variety of tools are available for use by GPs to assess substance use history, for example:

**Screening for alcohol use: AUDIT**

Alcohol Use Disorders Identification Test (AUDIT). This is 10 item self complete screening questionnaire that identifies both hazardous and dependent drinking. It is very well suited to use within primary care. To see how a brief intervention can be conducted in four minutes using the AUDIT, go to www.ciwa-ar.com, Tab 4, Quantifying an alcohol history.

**Screening for all drugs: ASSIST**

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

For a copy of the current version of the ASSIST, go to ASSIST version 3.

**Identify substance use issue:** Alcohol Use Disorder F10 or Drug Use Disorders F11
Assess risk & comorbidity

The best predictor of risk to self or others is past history. Substance use and intoxication significantly increase the risk. Identifying past risk behaviour in the context of intoxication or untreated mental illness is of particular importance. A past psychiatric history (especially when it comes with a reliable diagnosis), past treatment response and ideally, contact details of relevant health care professionals who are familiar with the patient, are important. The clinician should ensure that previous risk behaviours, especially harm towards others, is documented in the notes and made available to other carers, particularly on transfer.

Driving Clinicians should consider the impact of any substances, prescribed medications or mental or physical illness on the patient’s ability to drive. The issue of driving is of concern to both individuals and to communities. Loss of a licence to drive has the potential to dramatically affect an individual’s living standards. Where there is concern about fitness to drive, the clinician should advise the patient of their concerns and request that they notify their local driving authority. In cases where the clinician is concerned by the risks that the patient poses to themselves and to others, should they continue to hold a driving licence, consideration should be given to the patient’s doctor directly notifying the driving authority in their State. For further information please go www.austroads.com.au.

Suicide risk assessment is mandatory in this group of patients who are at high risk. Asking about self harm or suicidal thought does not increase the risk of the patient doing something. The risk of self harm exists on a spectrum, from fleeting thoughts of not wishing to be here with no consideration of a plan or intent, to persistent, intrusive ruminations replete with a clear plan and intent. In anyone whom you suspect of having suicidal thoughts, mandatory questions must include whether or not there is a plan (the more violent the method the greater the risk) and whether there is intent. Although suicidal behaviours may occur impulsively with little warning the majority of those attempting suicide will do so on a background of depression and/or substance use (and often a past history).

Other clues that a patient may be at risk include those identified by screening for depressive symptoms. Things to look for include evident distress or psychomotor retardation (patient may appear unreactive to usual conversational cues, make few body movements, frown and avoid eye contact). The depressed person may not communicate their distress and this is evident in the poverty of speech and reduced initiation of conversation in interview. They may speak slowly and quietly in a monotone voice. There may be preoccupation with negative thoughts (hopeless, helpless, worthless), tearfulness, social or occupational decline, impaired physical health (weight loss, poor self hygiene), evidence of past or recent self harm (e.g. cuts on wrists or arms).

In those at immediate risk of harm to self (or others) consideration should be given to the use of the Schedule 2 form of the Mental Health Act. In cases where the patient is at risk of self-harm or violence toward others or where the patient is uncooperative with assessment, the Ambulance Service may request a police escort when transporting the patient to an Admissions Centre.

The patient may be taken first to a general hospital emergency department for a medical clearance if they are intoxicated and / or have any associated medical conditions (such as cardiac disease).

Violence risk assessment. Violence among those with mental illness is strongly associated with substance use, non-compliance with prescribed medication, poor insight, a sense of victimisation and, most significantly, a past history of violent episodes. These acute risk factors should be assessed within the context of past history, situational factors and expressed hostility. The risk is highest when there is a named or identified person who is the object of such violent thoughts. Access to weapons needs to be specifically enquired about.

Failure to document and share information about violent risk behaviours places the patient, clinician and community at risk.

Diagnosis

Arriving at a reliable diagnosis is an important step in deciding on the best management for this patient group.

Step 1.3 Combining information to determine aetiology and primacy of diagnosis

The information obtained so far should now be reviewed, with subsequent assessment to refine:

- the temporal relationship between substance use and mental health status and which of the disorders appears to have begun first;
- the presence of early childhood trauma or pre-morbid mood or anxiety disorders, which are important in understanding the aetiology of substance use;
- a family history and any past psychiatric history outside the context of intoxication, which will tend to suggest an underlying primary mental illness;
- the temporal relationship between acute episodes of substance use and any exacerbation of illness or risk;
- the level and range of risk that presents because of comorbid disorders, such as violence and intoxication or withdrawal experiences.

Making an accurate diagnosis of a mental health disorder can be difficult in the context of ongoing drug use, especially where associated with cycling intoxication and withdrawal. With first presentations of comorbid mental health problems and where there is little available information or prior history of psychiatric disorder it is recommended that diagnosis of a psychiatric disorder be deferred until 2-4 weeks of abstinence where this is attainable. Corroborative information from carers or access to old notes should be sought with patient consent. Precipitant diagnosis and prescription may result in both the absence of clear diagnoses and an uncertain and often poor treatment response.

Where sudden cessation of substance use (particularly alcohol and benzodiazepines) may place the patient at increased risk of acute physical or psychological harm, the patient should be advised against abrupt cessation and should be supported with a supervised gradual reduction.
The following algorithm demonstrates the decisions pathways typically required to differentiate between mental health and substance use disorders and can be used as a guide to treatment in this group. This example relates to comorbid alcohol use and depression, however it may be applied to any co-occurring mental health and substance use disorders.

**Decision Pathways**

First presentation or uncertainty over primary diagnosis

Motivate patient to achieve abstinence—detoxification support if required

Monitor mood symptoms for 2-4 weeks following cessation of drinking

**Depression resolves**

Support continued abstinence, feedback mood improvement in relation to abstinence.

In case of relapse consider alcohol specific pharmacotherapy.

**Depression continues**

Commence antidepressant treatment. Compliance therapy/support.

Monitor response and document treatment progression in notes for future reference.

Adapted from the *Can Do* initiative on the AGPN website, Unit 1 Alcohol

**Example of diagnostic algorithm for comorbid depression and alcohol use**

In cases where there is good evidence of a pre-existing mental health diagnosis, psychiatric medication may be commenced once acute withdrawal has subsided. Untreated mental health problems may be a risk factor for relapse into substance use.
Outcome Measures

Drug or alcohol use
There are no commonly used outcome tools that are in routine use within a primary care setting to monitor the progress of drug related problems. For alcohol, serial monitoring of LFTs may be useful, while for drugs random urine drug screens may be used.

Mental health
Psychiatric screening instruments may be used as appropriate, such as the Beck Depression Inventory (BDI) or Kessler Psychological Distress Scale (K10). For general information on the K10, see GP care.

Finally
If either condition requires urgent treatment, such as hospitalisation, the GP institutes it. If treatment is not urgent, the GP assesses risk and may ask the patient to keep a diary of drug or alcohol use, mood and symptoms for one week and return with it for finalisation of the treatment plan.

Step 2 Development of care plan/s

Process
It may be that the assessment and plan can be completed at the first appointment, but commonly the GP may wish to review the patient again before completing the management plan. This will also have given the patient time to think about issues they wish to raise with their doctor (for example, by using the Patient’s Priorities for Care prompt list), and to have kept some diary entries about substance use and symptoms.

Documentation
Existing GP templates for the GP Mental Health Care Plan (GPMHCP), the GP Management Plan (GPMP) and the Team Care Arrangement (TCA) are available and may be adapted.

Step 2.1 GP Mental Health Care Plan (GPMHCP)
Following the assessment, the care plan document must be completed.

Feedback to the patient on the assessment
The GP discusses the assessment with the patient, including the mental health and substance use formulations and diagnoses.

Step 1.4 Feedback
In relation to the feedback provided, the doctor should offer a range of interventions aimed at reducing substance consumption and related harm and improving health.

Regardless of aetiology, substance use predicts very poor outcomes in those with mental health problems. The key to facilitating positive behavioural change and reduction of substance use among this group is to get their attribution right. The challenge is to get the patient and carer to acknowledge the highly problematic nature of the relationship between their substance use and the symptoms of mental illness. This may assist engagement and compliance with efforts aimed towards reducing use and optimising treatment for the underlying condition.
**Actions to achieve set goals**

- Advise the patient how to get the most out of treatment.
- Focus on engaging and addressing other goals of the patient.
- Identify optimal dose and type of medication, if any, for the patient.
- Address side effects and concerns over medication.
- Regular reviews.
- Referral to specialist providers for treatment including community nursing or allied health professionals.

**Psychoeducation about treatment and diagnosis**

The GP must provide some psychoeducation relating to the patient’s diagnoses. See GP care, go to ‘Psychological Interventions’, then go to ‘Psychoeducation’.

**Crisis intervention and/or relapse plan**

**Crisis**

Patients should all be provided with information on what to do in the event of a crisis related to their drug or alcohol use. Should the patient be in need of urgent advice, they should be directed to either phone the GP surgery or to go to Emergency Department and request any discharge information be copied to the GP.

In addition, all patients must be given the Alcohol and Drug Information Service (ADIS) telephone number for out-of-hours support (02 9361 8000 or 1800 422 599 for callers outside Sydney).

Patients should also be aware that doctors and nurses across NSW can access 24 hour drug and alcohol specialist support through contacting the NSW Drug and Alcohol Specialist Advisory Service (DASAS) line (02 9361 8006). Patients may advise clinicians unaware of this service of its existence.

**Relapse prevention**

Patients who have successfully completed a planned detoxification should be offered relapse prevention counselling. This should focus on the identification of triggers and high risk situations and explore coping strategies to manage ‘craving-rich situations’ (people, places and things) and techniques to ‘surf the craving’ (cravings come and go like a wave, use distraction until it passes, have a list of distractions ready).

Referral to specialist drug and alcohol services may be helpful in such cases.

**Referrals**

See below under Step 3 for details of referral choices.

**Treatment, appropriate support services**

Because symptoms of withdrawal and intoxication can overlap with many psychiatric symptoms, GPs should wherever possible defer diagnosis and especially the commencement of psychiatric medications until after a period of withdrawal / intoxication has finished. This usually means waiting for 2-4 weeks after last use (unless there is excellent evidence and confidence in the accuracy of a pre-existing psychiatric diagnosis, such as a documented past history) before commencing treatment with medications. Prescribing to current drug users is often associated with poor outcomes because of:

- poor compliance,
- risk of adverse interactions,
- interference with medication efficacy by continued drug or alcohol use,
- uncertainty over diagnostic accuracy,
- potentially inaccurate and unhelpful attribution about any improvement in mood / well being that follows simultaneous cessation of drug use and commencement of psychiatric medications.

**Review and follow up**

A date should be set for the formal review and recorded in the patient’s file.

Offer a copy of the care plan to the patient

**Documentation**

The GPMHC can be modified as required. Appropriate documentation may be developed by the GP for their own use, or may involve the use of existing materials such as RACGP templates or the use of software programs such as Medical Director or Best Practice. Specific clinical issues related to the management of those on specific treatments can be added to the plan. All should be based on current Medicare requirements.
**Step 2.2 GP Management Plan (GPMP)**

While it is preferable that the patient has only one care plan, under the Medicare Chronic Disease Management (CDM) items the GP may in addition to a GPMHCP complete a GP Management Plan (GPMP) in specific circumstances. These circumstances include concurrent complex physical health needs which also require treatment, such as liver disease, asthma or diabetes.

The following points must be present in order for the GP to claim Item 721, the GPMP:

- assessing the patient to identify and / or confirm their health care needs, problems and relevant conditions;
- agreeing management goals with the patient for the changes to be achieved by the treatment and services identified in the plan;
- identifying any actions to be taken by the patient;
- identifying treatment and services that the patient is likely to need, and making arrangements for provision of these services and ongoing management; and
- documenting the patient’s needs, goals, patient actions, treatment or services and a review date i.e. completing the GPMP document.

**Step 2.3 Team Care Arrangement (TCA)**

Medicare allows for a Team Care Arrangement (TCA) to be put into place under a GPMP, for patients with complex health care needs who require ongoing care from a multidisciplinary team of at least three health care providers including the GP. Depending on the referrals required, the GP may consider it appropriate to develop a TCA using the information provided by, for example, an allied health provider (see Step 3) and an HMR report (see Step 5) to complete a TCA.

One or more of the following points must be present in order for the GP to claim Item 723, the TCA:

- A need to see other providers on regular, frequent and ongoing basis to manage the chronic condition;
- An unstable or deteriorating condition;
- Increasing frailty and dependence;
- Increasing incidence and complexity of health problems;
- Significant change in social circumstances;
- Two or more hospital admissions for their chronic condition in the past six months;
- Inability to comply with required treatment without ongoing management and coordination;
- Management goals agreed;
- Actions to be taken identified;
- Treatments and services likely to be needed documented;
- Arrangements for these services made;
- Consent to share information with other care providers;
- Collaboration with other care providers;
- Goals of care documented;
- Review dates documented.
Step 3 Referrals to allied health

Step 3.1 Referrals under a GPMHCP

Process

Under the GPMHCP, the GP may refer patients for a range of services provided by other professionals. Referral routes and services are set out at the Patient Pathways site and include referral to a clinical psychologist for psychological therapy services or referral to a registered GP, a psychologist, social worker or occupational therapist for focused psychological strategies (FPS). These services will in future also be provided by mental health nurses and Aboriginal Health Workers with appropriate qualifications and experience. These health care workers must be registered with Medicare to be eligible to claim for the available rebates. For contact details of registered professionals, refer to Finding a Mental Health Allied Health Professional.

In addition to these services, the GP may refer the patient directly to a psychiatrist for initial consultation (item 296); assessment and development of a management plan (item 291); review of a management plan (item 293). For further information on fees and rebates, refer to Better Access Medicare items.

Patients may receive up to 12 individual and/or group mental health allied health services per calendar year. After the first six sessions, the allied health professional is required to report back to the referring GP. If indicated by a review of the patient’s needs, the GP may refer for a further six sessions. In exceptional circumstances an additional third set of six services is available per patient per calendar year.

To make a referral to an allied health allied health professional under the Better Access initiative, the GP follows these steps:

1. Locate an allied health professional registered with Medicare: Find a Mental Health Psychologist; Find a Mental Health Social Worker; Find a Mental Health Occupational Therapist

2. Ensure that the practitioner has a practice orientation that caters to adults with drug and alcohol problems. Some practitioners may specialise in child and family services, for example, and not adults with drug and alcohol problems. Psychologists practice orientation is available for some professionals, however it may be useful for the GP to establish an ongoing understanding with some local professionals for the purpose of referring patients with drug and alcohol problems.

3. Check that the professional has the current capacity to see the patient in an appropriate timeframe (depending on the patient’s needs).

In addition, GPs will find information for consumers about psychologists at Consumer information.

Patients should be made aware prior to attending the first appointment with an allied health professional that some will bulk bill, while others will not and the payment will need to be made at the time of the consultation and claimed by the patient. There may be a gap which the patient must pay themselves. It is essential that the professional indicates what the cost will be when the patient makes the first appointment. Professionals who do not bulk bill may be reluctant to take on some patients, believing that attendance at appointments may be erratic or that payment is not guaranteed.

Documentation

While referrals to allied health do not require a special form, in order for the professional to be paid by Medicare, the referral must include (in addition to relevant patient details), the name of the referring doctor, the provider number, the date, and a request for psychological treatment.

Step 3.2 Referrals under a GPMP and TCA

Process and Documentation

Under the GPMP and TCA, the GP may refer to a range of eligible allied health professionals (including physiotherapists, dieticians, podiatrists and others) for up to a total of 5 sessions per calendar year.

In addition, dental referrals may be made for a limited range of conditions when a dental problem is impacting on other chronic health problems. A Dental Care Factsheet is available which details these conditions. Current Referral form for Dental Care is available for use with the GPMP and TCA.

NOTE: New Dental Care items will become available through Medicare on November 1st 2007
Step 4  Appointment Schedule

**Process and Documentation**

Over the first few weeks the GP and patient should agree on the approximate frequency of visits. If this is a new patient, or one who has recently been discharged from hospital, or there is evidence of deterioration, more frequent appointments may be appropriate.

These appointments are routine reviews (such as Level B or C consultations) and not a full review of the care plan, however they can on occasions qualify for a routine Mental Health Care Consultation (Item 2713) when part of the GPMHCP. A Mental Health Care Consultation (Item 2713) must include

- taking a relevant history and identifying the patient’s presenting problems (if not previously documented),
- providing treatment advice and / or referral for other services or treatment,
- documenting the outcomes of the consultation in the patient’s medical records.

If the GP is using a GPMP, the GP may decide to organise a Team Care Arrangement (TCA) at any point where collaboration with other health professionals would support the patient.

In addition, under the Enhanced Primary Care item numbers, a Community Case Conference may be organised if indicated with either GPMHCP or GPMP. The GP may either participate in (Items 740,742,744) or be the organiser of (Items 759,762,765) a Community Case Conference.

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**Step 5  GP requests Home Medicines Review (HMR) for patient (optional) and GP receives feedback**

HMR is also known as Domiciliary Medication Management Review (DMMR)

**Process**

Most GPs will be familiar with the use of Home Medicines Review (HMR) for a range of medication related issues. HMR may be appropriate for patients with comorbid mental health and substance use problems, depending on the medications they are prescribed and the substances being used. If appropriate, an HMR can be undertaken once per patient per year or more often if medications or other factors change significantly (see Medicare item 900). Full guidelines for the use of the HMR service can be found on the DoHA website at HMR Guidelines.

The information exchange that occurs through the HMR is a potentially powerful source of support for GPs in working with their patient to develop a treatment plan, whether a GP Mental Health Care Plan, a GP Management Plan or a Team Care Arrangement.

**Step 5.1 Starting the HMR**

- Patient can be identified by the GP, practice staff or any care provider
- GP obtains informed consent from the patient for the HMR service

The HMR is an optional component of care, and patient consent is required, and must be recorded. In these discussions with the patient, the GP may use the Patient Information Sheet and Consumer brochures (and Translations) available on the DoHA website.

The HMR may be an opportunity for the pharmacist to enquire as to the level of monitoring and support that the patient receives from health care staff. This may be especially important when patients have been commenced upon a psychiatric medication during a period of withdrawal or intoxication. Their substance use pattern may change, without a review by the prescriber. In such cases many patients may remain compliant with repeat prescriptions without ever seeking a review from the clinician who commenced these medications. For example in some cases it may be that the cessation of substance use has had a profound effect on the patient’s mental health symptoms and may even alter the original diagnosis. Pharmacies should take the chances offered within a HMR review to encourage patients to seek reviews from their prescribers where there is uncertainty as to the context within which the original diagnosis was made.

In addition, the benefit of an HMR to the patient is that it provides an opportunity to have a period of uninterrupted time with a pharmacist to address a range of health care and medication related needs and concerns. An HMR can also provide information on the optimal management of side effects (for both prescription and non-prescription medication) and other issues such as compliance and storage.

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<table>
<thead>
<tr>
<th>Name of item</th>
<th>Item No</th>
<th>Rebate $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Medicines Review</td>
<td>Item 900 for GPs</td>
<td>$134.10</td>
</tr>
<tr>
<td>Pharmacies (claim form, no item number)</td>
<td></td>
<td>$183.60</td>
</tr>
</tbody>
</table>
Other potential benefits include the detection of health care conditions for which the patient is not currently being treated and the experience of having a health care provider focus on issues other than drug use or depression. It may be an opportunity for a patient to establish a relationship with a local pharmacist. In some cases, where controlled dispensing of medication such as benzodiazepines or antipsychotics would be helpful to the patient, it is useful to have such a relationship in place.

**Step 5.2 GP initiates HMR referral to a community pharmacy**

The pharmacy should be of the patient’s choice unless they do not already have a preferred pharmacy. The Pharmacy Guild of Australia provides a list of HMR pharmacies, organised according to the Division of General Practice they occur in. With the patient's agreement, the HMR referral should include the following information: presenting problems; diagnosis; medications; current pathology; medical and surgical history; and clinical monitoring. The better the information on referral, the better the pharmacist’s report. A referral form is available if the GP wishes to use it (see 'Documentation' below).

**Step 5.3 Pharmacist conducts an interview with the patient**

The GP or pharmacist should determine the most appropriate location to conduct the HMR in discussion with the patient. It is not mandatory that the interview be done in the patient’s home, as long as it is in a location in which the patient and the pharmacist are both comfortable, and the patient’s privacy is protected. In part, a suitable location will be determined by factors such as convenience and patient preference. In cases where the pharmacist is considering conducting such a review in the patient’s home, a risk assessment should be undertaken by the pharmacist regarding such factors as the presence in the home of persons with a history of violence, and pets, particularly dogs, in the home. Also, any child protection issues that arise must be appropriately addressed.

**Step 5.4 Pharmacist writes a report to the GP**

The HMR report contains ‘findings’ or what the pharmacist found at the interview; and ‘recommendations’ as a result of those findings. The pharmacy HMR report provided back to the GP will address a range of issues relevant to patient management such as: dose adequacy; other medications taken (including over-the-counter (OTC) and herbal); compliance; side effects; safe storage; interactions; contraindications; potential for misuse and prescription shopping.

**Step 5.5 Patient agreement to Medication Management Plan**

At the next appointment, and in collaboration with the patient, the GP will incorporate the pharmacy HMR report into a Medication Management Plan. The Medication Management Plan contributes to the development of the patient’s overall treatment plan, and this discussion ensures that the patient is consulted about how this feedback is used.

Copies of the plan are provided to the patient and to the pharmacy.

**Step 5.6 GP submits item 900 claim**

**Documentation and Forms**

Information exchange between the patient, the referring GP and the pharmacy can be conducted using existing documents. The DoHA website includes links to a GP Fact Sheet and Process Chart, an HMR Referral Form, and a Medication Management Plan Form. In addition, The Pharmacy Guild of Australia provides a page of detailed information at Home Medicines Review, including links to software templates for GPs.

The GP must provide a copy of the Medication Management Plan to the pharmacy as part of the requirements of Medicare item 900. This facilitates the support that the pharmacy can offer the patient.

GPs should also provide a copy of the Medication Management Plan to the patient to ensure the patient has ongoing access to the plan and to help motivate the patient to comply with the goals agreed with the GP.
**Step 6  Review of GPMHCP or GPMP or TCA**

**Process and Documentation**
Review conducted 4 weeks to 6 months after initial plan

At six months, unless indicated earlier, the GP may conduct a Review of the GPMHCP (Item 2712) and / or GPMP (Item 725) and / or TCA (Item 727). Formal review of the GPMHCP, GPMP and TCA is recommended six monthly, but it may be done more frequently if indicated by a change in the patient’s level of stability. The review date should be set at the time of plan preparation. It is suggested that these reviews be staggered (refer to Example of Medicare Items and Rebates first 12 months).

The review should cover each aspect of the original plan, so that each item can be ticked off. The requirements of the review include the patient’s agreement and a record of progress against goals, with modification of the plan if required. A further review date is to be set at the conclusion of each review.

**A review of the GPMHCP must include the following to be claimable:**

- recording the patient’s agreement for this service;
- a review of patient’s progress against the goals outlined in the GPMHCP;
- modification of the documented GPMHCP if required;
- checking, reinforcing and expanding education;
- crisis intervention and / or for relapse prevention plan if appropriate and if not previously provided;
- re-administration of the outcome measurement tool (unless clinically inappropriate).

**The steps in reviewing a GPMP must include:**

- reviewing the patient’s needs and goals, patient actions and treatment/services;
- making relevant changes to the documented GPMP; and
- adding a new review date.

**The steps in coordinating a review of TCA must include:**

- discussing or confirming with the patient which treatment/service providers should be asked to collaborate with the GP in the review and gaining agreement to share relevant information with them;
- collaborating with the participating providers to establish the patient’s progress against the previously nominated goals, and agreeing on any necessary changes and on the specific treatment or services to be provided by each member of the team;
- making necessary changes to the documented TCA; and
- providing the relevant parts of the revised TCA (if any) to the collaborating providers and to any other persons who, under the revised TCA, will give the patient treatment/services mentioned in the TCA.
Attachments

The Patient’s Priorities for Care

<table>
<thead>
<tr>
<th>Patient Name &amp; Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is my use of drugs or alcohol causing me worry, problems or putting me or others at risk?</td>
<td></td>
</tr>
<tr>
<td>Am I taking any over the counter or prescribed medications that I need to tell my doctor about?</td>
<td></td>
</tr>
<tr>
<td>Any side effects of medication I want to talk about?</td>
<td>e.g. headache, constipation, sweating, sexual problems, nausea, sedation</td>
</tr>
<tr>
<td>What if I want to stop taking medication? How do I do it and what are the risks?</td>
<td></td>
</tr>
<tr>
<td>Am I seeing any other doctors, health care workers, or support people from Child Protection, Probation and Parole, Centrelink?</td>
<td></td>
</tr>
<tr>
<td>Do I have any health concerns I’d like to address over the next few months?</td>
<td></td>
</tr>
<tr>
<td>Would I like somebody close to me to be involved in my care as a support person?</td>
<td></td>
</tr>
<tr>
<td>Is there anything I ever wanted to know about treatment but was afraid to ask?</td>
<td></td>
</tr>
<tr>
<td>Do I want a copy of my care plan?</td>
<td></td>
</tr>
<tr>
<td>Where do I want to be in six months time? Twelve months time? Five years time?</td>
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</tr>
</tbody>
</table>

Prescription Shopping Program

Medicare Australia provides a service which assists doctors to identify patients who are getting Pharmaceutical Benefits Scheme (PBS) medicines in excess of medical need. For more information, go to the Medicare Prescription Shopping Program website.

Usually, patient consent is obtained before a GP accesses this service, however Medicare Australia has the authority to disclose without consent, specific and limited PBS information to a doctor about their patients who may be getting PBS medicine in excess of medical need. The specific details of the circumstances under which this may occur are detailed by the federal Office of the Privacy Commissioner in Information Sheet 19-2007 The Prescription Shopping Information Service (PSIS) and The Privacy Act.

First, the doctor needs to register, that is, complete and sign the Registration Form and fax it to (02) 6124 7820. Medicare Australia will provide confirmation of registration by fax within 2 business days or by mail if a fax number is not provided. Once registered, a doctor can call the Information Service 24 hours a day, seven days a week on 1800 631 181.

Medicare Australia can also contact a prescriber if their patient is identified under the Prescription Shopping Program.
Time Frames for Care Planning and Reviews


The Medicare Benefits Schedule book contains all the requirements of a GPMP, TCA and GPMHCP and it is essential you check these details yourself before billing these items.

1. GPMHCP & review

<table>
<thead>
<tr>
<th>Name of Better Access item</th>
<th>Item No</th>
<th>Rebate $</th>
<th>Recommended frequency</th>
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<td>Preparation of a GPMHCP</td>
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<td>2 yearly</td>
<td>12 months*</td>
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<tr>
<td>Mental health care consultation</td>
<td>2713</td>
<td>66.00</td>
<td>3 monthly</td>
<td>12 months*</td>
</tr>
<tr>
<td>Review of a GPMHCP</td>
<td>2712</td>
<td>100.00</td>
<td>6 monthly</td>
<td>3 months*</td>
</tr>
</tbody>
</table>

2. GPMP, Review, TCA, Review

<table>
<thead>
<tr>
<th>Name of Chronic Disease Management item</th>
<th>Item No</th>
<th>Rebate $</th>
<th>Recommended frequency</th>
<th>Minimum Claiming Period*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation of a GP Management Plan</td>
<td>721</td>
<td>124.95</td>
<td>2 yearly</td>
<td>12 months*</td>
</tr>
<tr>
<td>Preparation of Team Care Arrangements</td>
<td>723</td>
<td>98.95</td>
<td>2 yearly</td>
<td>12 months*</td>
</tr>
<tr>
<td>Review of a GP Management Plan</td>
<td>725</td>
<td>62.50</td>
<td>6 monthly</td>
<td>3 months*</td>
</tr>
<tr>
<td>Coordination of Review of Team Care Arrangements</td>
<td>727</td>
<td>62.50</td>
<td>6 monthly</td>
<td>3 months*</td>
</tr>
<tr>
<td>Contribution to a multidisciplinary care plan or Team Care Arrangements</td>
<td>729</td>
<td>43.40</td>
<td>6 monthly</td>
<td>3 months*</td>
</tr>
</tbody>
</table>

3. Other

<table>
<thead>
<tr>
<th>Name of item</th>
<th>Item No</th>
<th>Rebate $</th>
<th>Recommended frequency</th>
<th>Minimum Claiming Period*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health Check</td>
<td>704-710</td>
<td>167.45–236.85</td>
<td>Annually for under 15 and over 55; once every 18 months for others</td>
<td>12 months or 18 months</td>
</tr>
<tr>
<td>45 Year Old Health Check</td>
<td>717</td>
<td>100.00</td>
<td>Once between ages 45-49</td>
<td>Once only</td>
</tr>
</tbody>
</table>

*These services can also be provided more frequently in 'exceptional circumstances' where there has been a significant change in the patient’s clinical condition or care circumstances (such as development of comorbidities or complications, deteriorating condition, illness / death of carer etc), that require a new GPMHCP or review, a new GPMP, TCA or review service.
**An Example of Medicare Items and Rebates first 12 months**


The Medicare Benefits Schedule book contains all the requirements of a GPMP, TCA and GPMHCP and it is essential you check these details yourself before billing these items.

### Patient flow – first six weeks…

| 1st Cons Admission; Needs assessment | GP Mental Health Care Consultation | Item 2713 +/- 23, 10990 | $66.00 +/- $37.40 |
| 2nd Cons GPMHCP | GP Mental Health Care Plan | Item 2710 +/- 23, 10990 | $150.00 +/- $37.40 |
| 3rd Cons GPMP | GP Management Plan | Item 721 +/- 23, 10990 | $124.95 +/- $37.40 |
| 4th Cons TCA | Team Care Arrangement | Item 723 +/- 23, 10990 | $98.95 +/- $37.40 |
| 5th Cons Continuing care | Level B | Item 23 | $32.10 +/- $5.30 |
| 6th Consultation Possible HMR | HMR | Item 900 +/- 23, 10990 | $134.10 +/- $37.40 |
| **Totals** | | | **$509.40—$657.25** |

### Patient flow - the next three months …

| 7th Cons Wk 8 Ongoing Care | Level B | Item 23 | $32.10 +/- $5.30 |
| 8th Cons Wk 10 Ongoing Care | Level B | Item 23 | $32.10 +/- $5.30 |
| 9th Cons Wk 12 Case Conference | Case Conference 15-30 minutes | Item 740 +/- 23, 10990 | $83.75 +/- $37.40 |
| 10th Cons Wk 14 GP Plan Review | GP Mental Health Care Plan Review | Item 2712 +/- 23, 10990 | $100.00 +/- $37.40 |
| 11th Cons Wk 16 GP Management Plan Review | GP Management Plan Review | Item 725 +/- 23, 10990 | $62.50 +/- $37.40 |
| 12th Cons Wk 18 TCA Review Ongoing Care | TCA Review | Item 727 +/- 23, 10990 | $62.50 +/- $37.40 |
| **Totals** | | | **$372.95—$554.35** |

### Patient flow - Ongoing yearly cashflow

| Week 0—6 | | $509.40—$ 657.25 |
| Week 7—18 | | $372.95—$554.35 |
| Week 19—30 | | $372.95—$554.35 |
| Week 30—52 | | $372.95—$554.35 |
| **Total** | | **$1628.25—$2320.30** |
Links to Resources

Driving
http://www.austroads.com.au

Support Services
For patients (NSW)
Alcohol and Drug Information Service (ADIS) Sydney 02 9361 8000 or for callers outside Sydney 1800 422 599

For health professionals
NSW Drug and Alcohol Specialist Advisory Service (DASAS) Sydney 02 9361 8006 or for callers outside Sydney 1800 023 687

For GPs
GP Psych Support provides GPs with patient management advice from psychiatrists within 24 hours http://www.psychsupport.com.au

Diagnostic and treatment related information
GP Care
http://www.gpcare.org
Alcohol Use Disorder
http://www.gpcare.org/diagnosis/diagnosisindex.html
Drug Use Disorders
http://www.gpcare.org/diagnosis/diagnosisindex.html

http://www.gpcare.org/diagnosis/diagnosisindex.html

Drug Info Clearinghouse

CIWA
http://www.ciwa-ar.com

Screening Tools
AUDIT
ASSIST
http://www.who.int/substance_abuse/activities/assist_v3_english.pdf

Australian General Practice Network (AGPN)

Patient Pathways

Three components of the Better Access initiative

GP Fees and Patient Rebates

Finding a Mental Health Allied Health Professional

Teams of Two: Drug and Alcohol and Mental Health Comorbidity

Can Do initiative: Managing Mental Health and Substance Use in General Practice

Chronic Disease Management (CDM)

Mental Health Nurses Incentive Program

Department of Health and Ageing
GP Mental Health Care Plan (GPMHCP) information

GPMHCP Referrals to Allied Health Mental Health

GP Management Plan (GPMP) and Team Care Arrangement (TCA) information

GPMHCP Referrals to Allied Health and Dental Health (not Mental Health)

45 Year Old Health Check

Aboriginal Health Check

Medicare Australia
Search the Medicare Benefits Schedule

Prescription Shopping Program

Privacy information related to Prescription Shopping Program

Pharmaceutical Benefits Scheme

Home Medicines Review (HMR) Information
Medicare

Department of Health and Ageing

The Pharmacy Guild
http://www.guild.org.au/nsw/content.asp?id=1082 (NSW Branch)
Links to Resources

FORMS

Sample GPMHCP (scroll down page)
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-
gp-mental-health-care-medicare

Sample GPMP and TCA (scroll down page)
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-
programs-epc-chronicdisease-forms

Referral Form GPMP Allied Health (not Mental Health)
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-
medicare-health_pro-gp-pdf-epcahs-cnt.htm

Referral Form GPMP Dental Health
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-
medicare-health_pro-gp-pdf-epcdc-cnt.htm

HMR Referral Form
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-epc-
dmmr.htm/$FILE/dmmrreferral.pdf

Medication Management Plan Form
A09CA256F19001D0364/$File/medmngtform.pdf