2025 EQUALLYWELL CONFERENCE

Equally Well for all - working together

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Improving Mental Health and Wellbeing

One Team, One Plan: Developing South Australia's Mental Health, GP Shared Care Model of Care

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There is no health without Mental Health, No recovery without Physical Health

Mental Health Foundation UK

We would like to acknowledge this land that we meet on today is the traditional lands of the Kaurna people and that we respect their spiritual relationship with their country.

We also acknowledge the Kaurna people as the custodians of the greater Adelaide region and that their cultural and heritage beliefs are still as important to the living Kaurna people today.

Government of South Australia

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Acknowledgement of Lived Experience

We recognise the strength and resilience of people living with mental health issues and their families.

Their voices are essential to improve the capacity of our services to care and heal.

What are we trying to achieve?

The **SA Mental Health and General Practice Shared Care Model of Care**

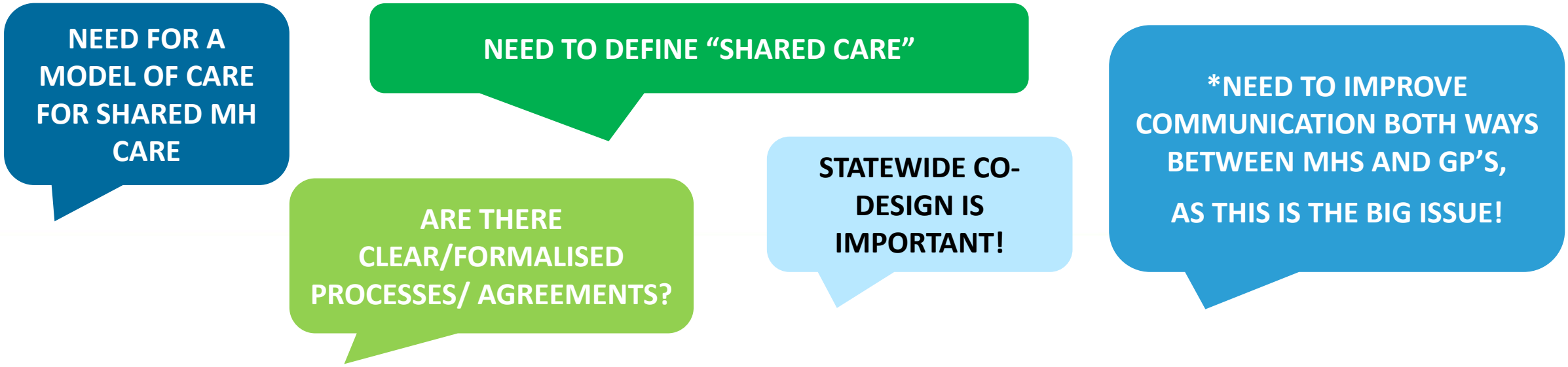
- is developed in a **collaborative process** where we combine the voices of people with lived experience, general practitioners, and mental health services
- aims to support a shared, team-based approach of care by providing a **shared vision**, with all parties being equal partners
- provides **guiding principles** for implementation and **clear expectations** for all parties to work towards

“Shared care” in this context

- Does not require the GP to become part of a specific program managed by a third party and requiring additional training or qualifications (an example of this is the Obstetric Shared Care model)
- Uses the strengths and expertise of the person, their regular GP and Mental Health Services
- Describes **“what good collaboration looks like”**, with clear roles and responsibilities for the person, their regular GP and Mental Health Services

How did we get here?

- **2020: SA Health GP Liaison Group** commenced with the purpose of connecting GP Liaison staff, as well as people and teams across SA Health who had a focus on improving the connection between MH services (MHS) and GPs – in order to connect and share information
- **2021:** The Mental Health GP Shared Care webpage was established as a "one-stop shop" to collate mental health related information.
- **2022:** 4 focus groups with 17 GPs, 16 SA Health MH clinicians and 10 other clinicians across SA were held and all identified similar needs:



Growing the Model of Care through co-design

We are leveraging the expertise of many stakeholders and have relied on joint funding from APHN and the MH Strategy and Planning Branch to support non-SA Health stakeholders to participate in the MOC workshops

Lived experience people

Carers

GPs

MHS Clinicians – Doctors, nurses, Allied health professionals

- **2023:** Planting the seed for the Model of Care (MOC)
  - Collaborative education sessions
- **2024:** Drafting the MOC
  - Collaborative MOC workshop with 2 lived experience people, 16 SA Health MH clinicians and 5 GPs, 2 PHN, and 8 other clinicians from metro and regional SA (Jan 2024)
- **2025:** Consolidating the input and refining the MOC
  - Larger collaborative MOC workshop with 7 lived experience people, 19 SA Health MH clinicians and 10 GPs, and 5 other clinicians from metro and regional SA (May 2025)
  - "Myth busting" joint education forum (Nov 25)

The Principles of the Model of Care

MHGP Shared care Model of Care (MOC) acknowledges, at its foundation, the Equally Well six essential elements,

1. A **holistic, person-centred approach** to physical and mental health and wellbeing
2. **Effective promotion, prevention, and early intervention**
3. **Equity of access** to all services
4. **Improving quality of health care**
5. **Care coordination and regional integration** across health, mental health and other services and sectors which enable a contributing life
6. **Monitoring of progress** towards improved physical health and wellbeing

Aims of the Model of Care?

The MOC aims to:

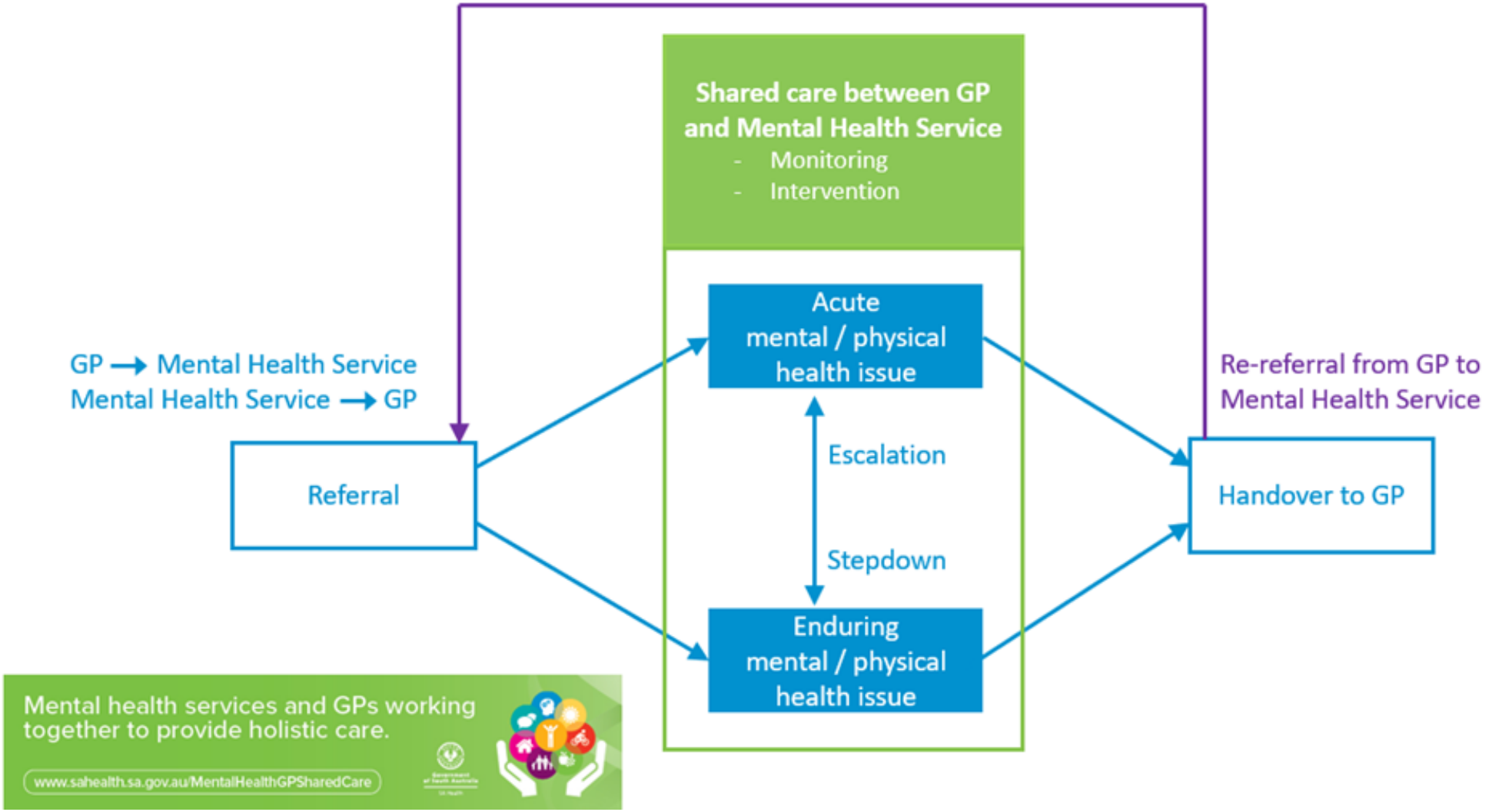
1 - provide high level context for the MOC

2 - describe general guiding principles when a person's care team includes their regular GP and MHS

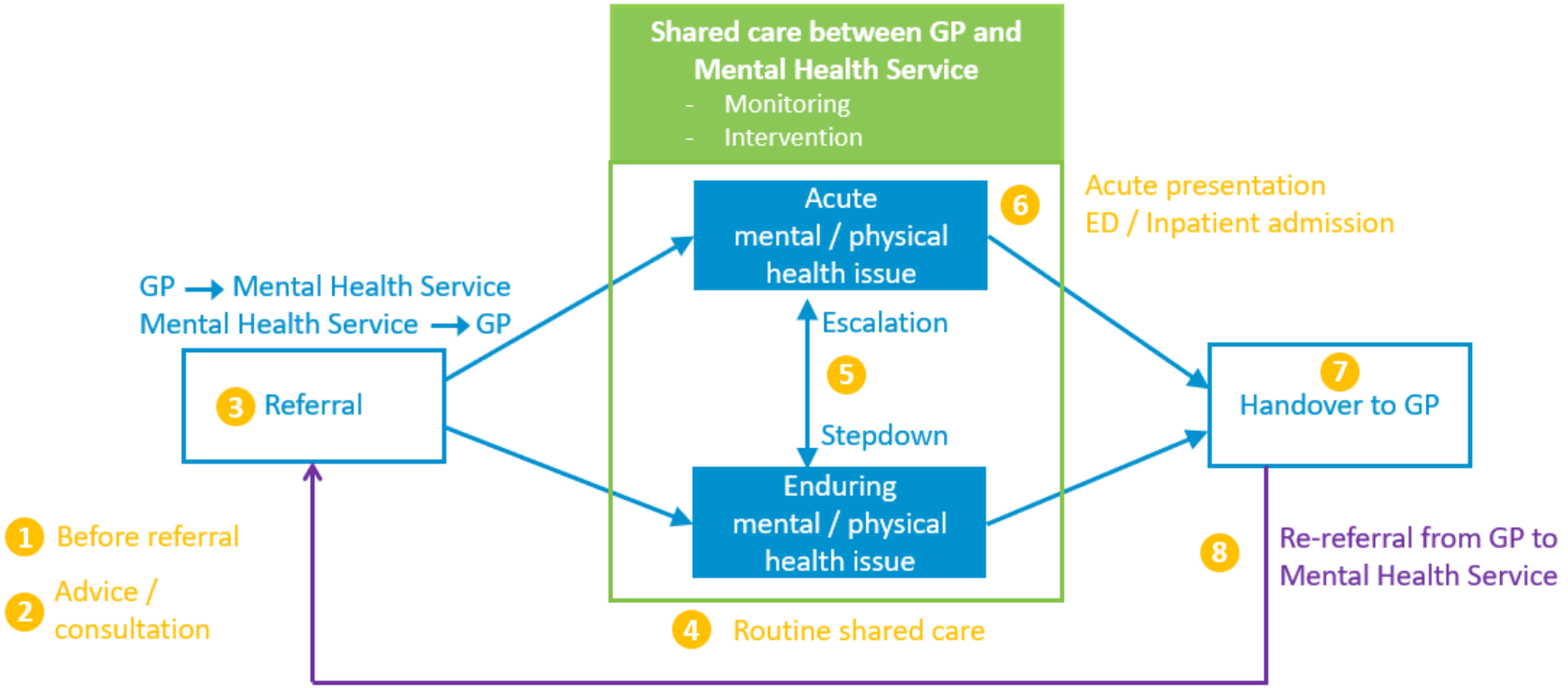
- communication and streamlining information sharing
- combining physical health management and mental health management

3 - include "Step-by-step" guides that show "what good collaboration looks like" at specific touchpoints

- Transition into shared care [Before referral, advice, referral]
- Routine shared care - Sample Annual Cycle of Care [Routine care, escalation]
- ED presentation / Inpatient admission
- Handover to GP care and re-referral


Shared care between GP and Mental Health Service
- Monitoring
- Intervention
GP → Mental Health Service
Mental Health Service → GP
Referral
Acute mental / physical health issue
Escalation
Stepdown
Enduring mental / physical health issue
Re-referral from GP to Mental Health Service
Handover to GP
Mental health services and GPs working together to provide holistic care.
www.sahealth.sa.gov.au/MentalHealthGPSharedCare

Points of Communication



Points of communication

1 2 3 4 5 6 7 8

Example of **General guiding principle** for "communicating on handover to GP from Community MH services"

- Our expectations
- How we go about this
- How we evaluate this
- Long term considerations

9.3.7. Communicating on handover to GP from community MH services	
Our expectations	• There should be joint handover planning between the GP and MHS team. Ideally this would be through an organised case conference at a clinical review. • Where case conferencing is not possible, adequate notification of intent to handover is provided to the GP. Personal communication via phone or through Teams is encouraged. • MHS will send a handover summary, care plans and re-referral criteria • Communication will be timely and succinct

How we go about this	• Shared case conferencing utilising MBS item numbers
	• Handover summary templates including
	  ○ Treatment summary
	  ○ Medication management
	  ○ Relapse prevention strategies
	  ○ Early warning signs
	  ○ Re referral criteria and process
	  ○ Contact number for clarification purposes/guidance.

How we evaluate this	• Audit handover summaries and communication with GP
Long term considerations	• Encourage case conferencing as a standard practice for handover /transfer of care to GPs • Utilise MBS item numbers for regular case conferencing between MHS and GPs through the duration of MHS care.

Routine shared care guiding principles [Routine care, escalation]	
Calendar	**Activity**
GP review **6-monthly** (minimum) requires long appointment **Ideally every 3 months to allow time for all requirements**	**GP (leads physical health care)** ❑ Responsible for physical and mental health review of the person, ❑ Writes physical health medications scripts, ❑ Writes mental health medication scripts (if formally agreed with CMHS psychiatrist), ❑ Orders and reviews blood test results (cc: psychiatrist into any blood pathology requests), ❑ Refers and liaises with other medical and allied health specialties as required, ❑ Notifies any medication changes, who did the change, why, what the old and current dosage is. Utilising Clinical Information Exchange form or letter. Communicating medication changes and plans will assist to prevent medication errors and people taking incorrect prescriptions or deprescribing risks
	❑ Updates physical health assessment form (minimum six-monthly, ideally before face-to-face patient appointment with CMHS psychiatrist) ❑ Discusses physical health care with the person and any carers, family members, kinship groups and support networks of choice
CMHS MDT team-based clinical review **3-monthly** (minimum)	**CMHS Psychiatrist (leads mental health care)** **CMHS care coordinator** Note: person may or may not have care coordinator allocated. If a person does not have a care coordinator, the tasks below will be performed by the allocated worker, being medical officer or medication clinic nurse. ❑ Contacts person prior to clinical review to bring their voice to the clinical review ❑ At least 3-monthly - provides GP with written update after team-based clinical review. CBIS LL40 can be utilised. or CCCME equivalent ❑ Informs person of outcome of clinical review ❑ Informs, as appropriate, carers, family members, kinship groups and support networks of choice ❑
CMHS Medical review **6-monthly** (minimum) **Note- in regional areas medical review as clinically indicated which may be greater than 6 months**	**CMHS Psychiatrist/medical officer (leads mental health care)** ❑ Reviews person and adjusts mental health medication dose ❑ Writes prescriptions for mental health medications (unless formally agreed with GP) ❑ Notifies GP of any medication changes and updates to treatment plan, who did the change, why, what the old and current dosage is. (CBIS Medical support and review letter LL37) or CCCME equivalent Communicating medication changes and plans will assist to prevent medication errors and people taking incorrect prescriptions. ❑ Discusses review outcomes with person and advises about potential side effects of any medication dosage changes and how to action ❑ Advises as appropriate review outcomes with carers, family members, kinship groups and support networks of choice ❑ Is available to discuss concerns with the GP as required, in an agreed format and time, case conference, telephone etc. **CMHS care coordinator** Note: person may or may not have care coordinator allocated. If a person does not have a care coordinator, the tasks below will be performed by the allocated worker, being medical officer or medication clinic nurse or other nominated person in the clinical team.
	❑ Informs GP of dates for the person's face-to-face or Telehealth appointment with CMHS psychiatrist – ideally with 4-8 weeks notice to allow enough time to schedule GP review ❑ Requests the updated physical health assessment from the GP before the person's face-to-face appointment with CMHS psychiatrist ❑ At least 6-monthly contacts the GP and supports the GP in the management of the person
Person **3-monthly** (minimum)	**Person** ❑ **Attends review with GP and / or CMHT** ❑ At least 6-monthly, ideally 3 monthly – attends GP appointment and completes follow up including blood testing as required ❑ At least 3-monthly – attends team-based CMHT clinical review if possible ❑ Medical only clinic - At least 6-monthly – attends face-to-face/videoconference appointment with CMHT ❑ In regional and remote areas face to face/videoconferencing contact may be less frequent due to distance and resourcing ❑ As required - notifies change in GP or contact details ❑ Noting the person may be supported by carers, family members, kinship groups and support networks of choice
Case conferencing **6-monthly** (ideally)	**Person, GP, CMHT Psychiatrist, CMHT Care Coordinator, other relevant stakeholders including where appropriate carers, family members, kinship groups and support networks of choice** ❑ Participate in six-monthly case conferencing as clinically appropriate While it is not currently routine practice the move to incorporate case conferencing as part of an ongoing shared care arrangement is encouraged
All / Escalation of care **As required**	❑ If GP concerned re person's mental state or has any other clinical concerns or updates: GP contacts care coordinator or nominated worker, who will provide support or advice on additional management required in regard to further mental health care requirements ❑ Outside business hours GP contacts MHT or ETLS ❑ If CMHS concerned re person's physical state or has any other clinical concerns or updates: CMHS liaises with GP ❑ If person or their carers, family members, kinship groups and support networks of choice is concerned or has change in circumstances: Notify the GP and/or the CMHS care coordinator or nominated worker. Outside team business hours contact MHT, ETLS

Example of **Step-by-step practical guide** for "Routine Shared Care"

Based on our current state – e.g. separate electronic medical records, faxes etc!

Where to from here?

Consultation and finalisation of the MOC

- Consult more broadly with the Lived Experience Groups, RACGP, ACCRM, RANZCP, PHNs to review language, content and priorities
- Re write…….
- Finalise and publish the model by July 2026 through the SA Health Mental Health Strategy and Planning Branch

Implementation of the MOC

- It is acknowledged that mental health services and general practice have established individual processes around communication with agencies. The challenge is for an agreed communication practice to be fostered through this MOC. While some LHNs have established shared care or GP liaison positions within teams, the practice is not across all LHNs. This should not be an impediment to establishing effective shared care communication and practice strategies.
- Ideally implementation will leverage other statewide programs such as Clinical Prioritisation Criteria

Thank you

- The members of the Mental Health (MH) and General Practice (GP) Shared Care, model of care working group would like to thank all general practitioners, general practice integration officers, local Health Network (LHN) MH services clinicians, people with lived experience, carers and the Adelaide and Country SA Primary Health Networks members for their contributions of time and direct material input into the development of this model of care. Thank you for sharing your time and ideas at focus groups, education sessions and meetings, providing a rich source of knowledge and experience.

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