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WHAT IS THE PLACE OF GENERALISM IN MENTAL HEALTH CARE IN AUSTRALIA: A SYSTEMATIC REVIEW.

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INTRODUCTION

Mental health disorders are a leading cause of the disability burden in Australia (Mathers, 1999). The 1997 and 2007 National Surveys of Mental Health and Wellbeing paint a broadly similar picture of widespread need and patchy use of services (Andrews et al 1999, 2001, ABS 2008). About one in five Australians meet the criteria for a mental health disorder in a 12 month period and almost half (45%) have suffered a mental health disorder at some point in their lives. Of these, 35% accessed services for this disorder during the 12 months and this figure is higher for those with severe and disabling conditions. Sixty per cent of those experiencing a mental disorder in the previous 12 months who did not use services reported an unmet need.

The most common service provider used by people experiencing mental health disorders, both lifetime and in the previous 12 months, was the general practitioner (GP), followed by psychologists and psychiatrists. If mental health needs are to be met in Australia it would seem that generalists are likely to be a big part of the solution. In a stream 6 APHCRI systematic review published in 2007 we addressed the question, what is the place of generalism in mental health care in Australia? (Perkins et al 2007).

In the review the specialist mental health providers were defined as psychiatrists, community mental health teams, clinical psychologists and mental health nurses. These providers are unable to meet the whole of this demand due to workforce shortages and distributional problems, particularly in regional and rural Australia (Productivity Commission, 2006). Generalist providers were defined as GPs, practice and other primary care nurses, non-clinical psychologists, social workers, counsellors and occupational therapists. These generalists are usually based in community settings and may: provide a first point of contact with the health care system; act as a gateway to other parts of the health care system; provide holistic and continuing care to patients and their families across episodes and time; and coordinate patient care received from different providers.

The review addressed the following questions:

1. What elements of care do generalist providers currently provide to adults with mental health problems in Australia and what supports do they have in doing this?

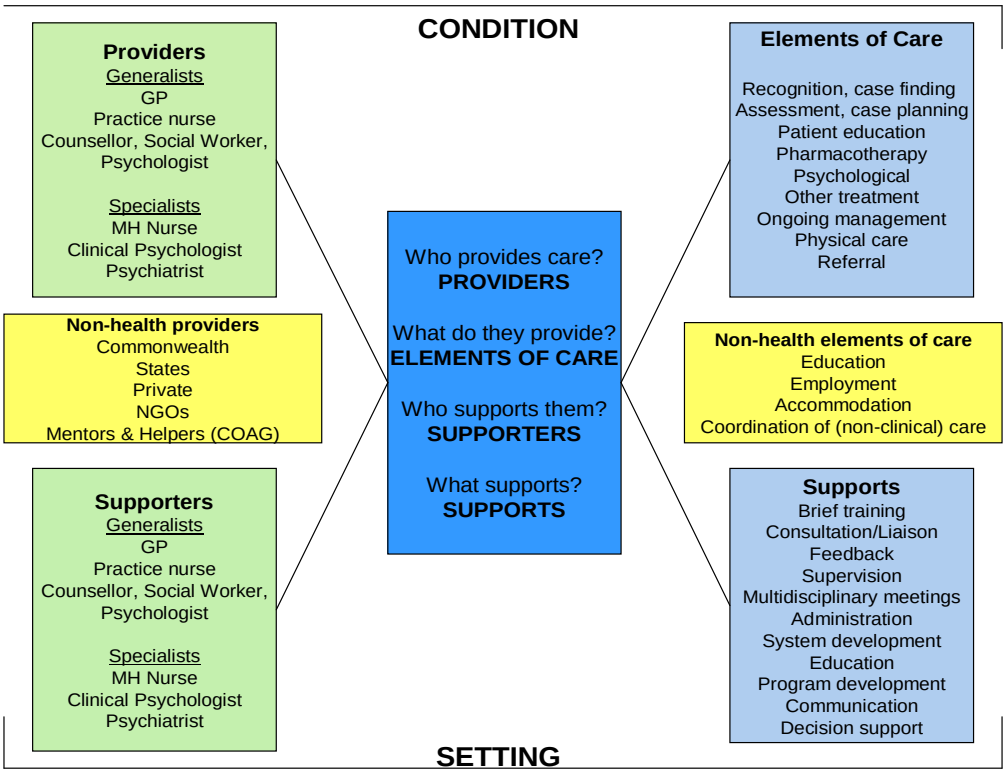
2. What elements of mental health care can be effectively undertaken by generalist primary health care providers taking into account the range of patients, problems and the health service context?

3. What are the implications of effective elements of care for workforce arrangements?

4. How does this relate to current workforce and other primary health care initiatives in Australia?

The review proposed the following framework to map existing and possible relationships between generalist providers, between generalist providers and specialists, to describe the provision of elements and packages of care and supports, such as supervision and feedback, which might assist generalists in providing mental health care.

Table 1: Analytical framework based in the 'configurations of care' (Perkins et al 2007)



KEY FINDINGS OF THE SYSTEMATIC REVIEW

In Australia generalists provide the following elements of care: recognition and case finding; assessment and care planning; patient education; pharmacotherapy; psychological therapies; other therapies; ongoing management; physical care; and referral. GPs provide all elements of care but practice nurses and allied health staff provide a relatively narrow range of elements largely determined by the design of funding programmes (McDonald, 2004).

International evidence suggests that there is scope to increase the range of elements of care provided by non-GP generalists provided appropriate supports are in place. The roles of practice nurses, social workers, and psychologists could be expanded to include assessment and care planning, patient education and ongoing management in collaboration with GPs. Such multidisciplinary teamwork could be supported through team care or other policy and funding arrangements. A stepped care approach would ensure that care is provided using the least intensive and expensive providers rather than more expensive, equally effective providers in the first instance (Andrews, 2006)

GPs could be provided with assistance from other generalists to provide elements of care where they are most effective but encouraged to share or delegate care such as psychological therapies which can be provided effectively by other generalists.
The roles of practice nurses, social workers and psychologists and the associated funding programmes could be expanded to include, assessment and care planning, patient education and ongoing management in collaboration with the GP where they have been shown to be effective as long as appropriate supports are provided.

GPs were more effective in achieving health and service outcomes when they worked closely with other generalists or with specialist mental health workers. Such “teamwork” could be supported through team care arrangements or other mechanisms.

AIMS OF THE TRAVELLING FELLOWSHIP

1. To see how the findings of the systematic review about the effectiveness of the generalist primary healthcare workforce relate to policy and practice in the UK and the Netherlands.
2. To understand how the relationship between policy makers, service providers and researchers contributes to developments in service quality and changes in the roles and effectiveness of generalist staff in primary care settings.
3. To examine more closely evidence about the roles of generalist staff in the care of those with mental disorders with particular focus on the roles of staff, their place in multi-disciplinary teams and supports that are provided to them and needed in their role.
4. To examine how evidence based developments in generalist provided, primary mental health care might apply in Australia and particularly rural in rural settings.
5. To consider how the linkage and exchange model adopted by APHCRI might be further improved.
6. To strengthen collaborative relationships with the Julius Centre and the University of Manchester.

APPROACH TO THE TRAVELLING FELLOWSHIP

The first week of the fellowship was spent in Utrecht in The Netherlands and was organised by Prof Schrijvers, Professor of Public Health and a leading member of the International Network of Integrated Care. The Netherlands is widely recognised as having a progressive primary health system and is undergoing reforms to its funding and governance systems with particular reference to its insurance funding mechanisms.

The remainder of the fellowship consisted of attendance at and presentation of a paper at the Second Future of Primary Health Care Conference at the University of Southampton and a week spent at the National Primary Care Research and Development Centre in Manchester organised by Prof Helen Lester, national leader of the Primary Mental Health Care Research Network (PMHRN). Meetings were held with other key members of the PMHRN in Southampton (Prof Tony Kendrick) and in Bristol (Prof Debbie Sharpe). Staff and graduate seminars were given in Manchester and Bristol as one means of providing expert scrutiny of the findings of the systematic review.

As part of the developing relationship with the Universities of Utrecht and the International Network of Integrated Care, seminars and a conference paper were also given based on a previous APHCRI stream 4 review on the Coordination of Care in Australian Primary Health Care (Powell Davies 2006, 2008).

THE APPROACH TO LINKAGE AND EXCHANGE IN THE SYSTEMATIC REVIEW AND THE FELLOWSHIP

The approach adopted in the systematic review and the traveling fellowship includes:

1. Ensuring that the research questions reflect important policy and service development issues such as those identified in recent government reports, the COAG mental health agenda, as well as reflecting the outcomes of earlier work undertaken by the investigators.
2. Selecting and assessing evidence and relevant material from countries with comparable health systems while noting key contextual differences. This includes consulting with leading Australian policy makers and service providers at key stages including formulation of research questions, developing search strategies, identifying materials, synthesizing data and drafting the report.
3. Collaborating with other groups undertaking similar studies in Australia and overseas including the UK primary mental health research network and others understanding related research in the APHCRI streams program.
4. Working closely with stakeholders during the project including service providers, consumers and relevant professional organisations to inform the review.
5. Actively disseminating findings to stakeholders during the project including service providers, consumers and relevant professional organisations.

The question of the effectiveness of this approach is discussed below in the light of the fellowship and discussions with overseas information.

FINDINGS FROM THE NETHERLANDS

The Netherlands Primary Health system has a form of patient enrollment with GPs and a component of capitation based funding which allows it to adopt a population based approach to primary care and primary mental health care in particular.

Competition between primary care providers and health centres may threaten both the viability of practices and the transparency of the population served but registration does provide a clear definition of the population serviced and is a good starting point for identifying mental health needs.

Primary care psychology has moved from an "extra" to an essential component in insurance company packages of care but only about 30% of GPs are actively interested in mental health care. There is some debate about to what extent GPs should be actively seeking patients with mental health conditions.

The use of agreed clinical protocols

The development and agreement of clinical protocols in the Netherlands is instructive from a number of perspectives. The College of GPs has been successful in negotiating a limited number of evidenced-based care protocols which are increasingly forming the basis of primary health care and primary mental health care. These include protocols for early detection, early intervention, self management and e-programs for depression. The protocols come with linked information packages for patients. These protocols are being agreed across the primary health care disciplines and so becoming the basis for multidisciplinary care. They have been identified by insurance companies as the basis for purchasing packages of health care and they have been identified by patient advocacy groups as a definition of quality care. Informants reported that patients were increasingly asking their primary care providers for protocol based care or for the elements of care that are specified within the protocols.

Informants were clear to point out that 50% of primary mental health care was still not carried out according to protocol but they thought that progress was being made.

This definition and agreement of what constitutes appropriate or quality care has been professionally led and appears to provide a basis for consistent multidisciplinary care by generalists and coordinated care with specialists. The combination of support by funders and demand by informed patients may influence the range and pattern of primary health care services for those with mental disorders.

Primary mental health care

A key benefit of mental health care provided by primary care teams was that these teams understood the context and settings in which their patients lived and could also provide more holistic care. There were some examples of primary care providers attempting to address community problems such as facilities for mothers with pre-school children in severely depressed areas. One respondent commented that generalists were able to address contextual complexity where specialists dealt with technical complexity.

Workplace flexibility and skills development

Any development of the role for generalist staff, particularly allied health staff, in the provision of primary mental health care requires flexibility in the recognition of roles and the possibility of further training. The University Medical Centre in Utrecht provided further training for nurses and allied health staff with four years experience to act as assistants to doctors in the care of patients with chronic conditions.

GP roles and formation

An interesting model of GP formation was described in which GPs spent their first five years establishing their skills as independent practitioners working largely within their practice. The next five or more years might include part time study for a PhD, contributing to vocational GP education or undertaking another teaching role alongside their clinical practice. After this time a small number of GPs would go on to develop a special interest in association with one or more hospital specialists and the University. This development of the GPs role and experience enables the development of a group of GPs with a special interest in mental health disorders which is also taking place in the UK.

Many GPs in the Netherlands work part time and share a full patient list, defined as approximately 2300 patients and 50 hours per week, enabling each partner to take leave and assisting continuity of care. Up to a third of the GP's work may be by telephone consultation.

Findings from the Research and University sector

Longstanding and strong relations between researchers, policy makers and providers underpin linkage and exchange. This is evidenced by policy makers with conjoint academic appointments contributing to research and academic programs, by academics and researchers with roles in policy making and applied research in local and regional health services. Perhaps the issue of continuity is most important in the development of productive relationships between academia, policy makers and health service providers. Good evidence of boundary crossing by all three parties appears to underpin effective linkage and exchange.

One investment in linkage and exchange facilitated by the University was clinical leadership courses for senior clinicians, managers, policy makers and researchers designed to build networks, increase understanding and develop skills (See www.integratedcare.nl). There were also master classes of shorter duration but similar purpose and membership.

The Julius Centre was very keen to improve the value of their research through improving the quality, range and appropriateness of research methods used. One senior staff member within the public health department has a major focus on methodological development within the department as a means of increasing the quality as well as the competitiveness of research.

There was broad agreement that focusing on single research methods whether systematic reviews, controlled trials or program evaluations was unlikely to provide the sort of learning needed to solve the important health policy or delivery problems. This issue also arose in the UK visits discussed below.

FINDINGS FROM THE UK

The context of primary (health) care development

The history of primary care development in the UK and latterly in England is well known. A number of policy, structural and funding developments over at least 30 years including primary care commissioning, practice commissioning and the Quality Outcomes Framework (QOF) have encouraged the development of multi-disciplinary general practice and some movement towards a population health approach to primary health care. Much of the achievement of QOF outcomes has been attributed to the contribution of practice nurses providing protocol based care.

Informants emphasised the importance in policy considerations of the medical home analogy and the need to "consider the patient who is not in front of you". The Quality Outcomes Framework (QOF) supported by a mental health expert advisory committee provides incentives to general practices to actively identify patients with mental health problems

One feature of primary care commissioning is that there is a wide range of service data shared between practices in particular localities which are now aware of how the performance of theirs and neighbouring practices relate to local health needs and targets. Other new developments include the peer reviewing of mental health and other referrals.

GPs with special interests

The NHS in England has seen the development of the role of GPs with special interests (GPSI) being appointed as "mental health leads" for Primary Care Commissioning organisations and working part time in tier 2 referral clinics. These GPSIs are usually supported by psychiatrists. There is currently no accreditation for this role and so there is likely to be some variation in the skills and experience of incumbents.

Policy and the cost of mental disorders

The developing emphasis on mental health services in the NHS, at least until the current recession, can be attributed to major enquiries such as that by Lord Layard which has a strong rationale about the social and economic costs of mental disorder to the community http://cep.lse.ac.uk/textonly/research/mentalhealth/depression_report_layard.pdf (accessed 16 March 2009).

Layard pointed to the huge economic and social costs of depression, which he termed misery, and calculated that it would require 10,000 additional therapists to provide NICE guideline care for those who need it. He argued that the estimated cost of 750 pounds per person was small in comparison to the costs of unemployment benefit or incapacity payments. To address this problem he proposed that 10,000 new therapists made up of 25 teams of 40 therapists covering populations of 200,000 should be created over 7 years. Half of these 10,000 therapists would be clinical psychologists and the other half allied health staff trained in 12-24 month part-time courses to provide CBT treatments.

Improving Access to Psychological Therapies

This proposal is being tested through two pilot services in Newnham and Doncaster known as the (IAPT) project. The centres have recruited and trained so called low intensity high volume therapists who each provide protocol based psychological therapies to as many as 80 patients. A sophisticated evaluation by members of the Primary Mental Health Research Network is underway and expected to report in 2010. This research includes a cohort study, an organisational evaluation, research on patient experience of the service and a benchmarking study.

The Mental Health Worker Initiative

One attempt to meet the need for primary mental care, particularly anxiety and depression, was through the 2004 Mental Health Worker initiative which attempted to recruit 1000 psychology graduates to provide low intensity care. While it seemed an excellent opportunity to make use of available skills and there are still mental health workers in the NHS, the policy appears to have been opportunistic in its development and did not reach its recruitment target. The decision to implement the policy without a formative evaluation seems to have resulted in a disappointing initiative that did not live up to its promise.

The Impact of National Institute for Clinical Excellence

It is perhaps hard to over-estimate the importance of the National Institute for Clinical Excellence (NICE) in the assessment of treatments and the development of clinical guidelines, and particularly its endorsement of Cognitive Behavioural and related therapies (CBT), in the NHS.

A further instance of the importance of the NICE guidelines is a focus on the training received as well as the professional discipline of a therapist. High intensity therapists are increasingly defined by the training they have received such that a clinical psychologist with no CBT training may be unable to provide high intensity therapy which is increasingly defined as CBT.

Providing Primary Mental Health Care to Hard to Reach Populations

New initiatives such as the WISE project in Salford focus on ways of providing primary mental health services to a number of hard to reach groups of patients including the homeless, the unemployed, those with unexplained symptoms, those with advanced cancer, the elderly and those with eating disorders. The initiative is embedded in a network of general practices and will be assessed over five years to allow systematic examination of the research evidence.

Increasing Patient Choice in Primary Mental Health Services

One intention of this growing range of services is that patients should have a range of service choices most of which are subject to the gatekeeping role of GPs.

Findings from the Research and University sector

As in The Netherlands, members of the Primary Mental Health Research Network and the National Primary Care Research and Development Centre reported strong relationships with policymakers and health services providers. With a few exceptions major policy initiatives were accompanied by sophisticated and sometimes extensive research from inception to trial and adoption. The success of initiatives where there was planned roll-out accompanied with formative evaluation or research was compared favourably with those where rapid roll-out was accompanied by implementation problems.

Several informants warned against attempting controlled trials of interventions and developments which were not well understood and advised careful consideration to identify the particular problem an intervention was designed to address. For instance, the rationale of the Layard Report explicitly identifies major savings to incapacity and unemployment benefits from providing evidence-based treatments as well as the benefits to patients. Research should assess whether the full range of benefits are achieved.

Important gaps, such as mental health services for the homeless, were identified and the subject of research involving networks of researchers from different institutions and in a number of cases multi-method, multi-centre research. In this way policy makers, commissioners and providers of health services, and researchers were collaborating to develop and test solutions for important mental health problems.

This critical approach to research methods and quality was also evident in the institutions visited. Complex policy and service problems were often addressed using multiple research strategies including narrative reviews of the literature, qualitative studies of patient experiences, stakeholder and policy consultations and controlled trials of interventions. In several cases this research involved a number of institutions and trial sites in different regions making the most of research networks and the participation policy makers and providers.

A further feature of the primary mental health researchers was the embedding of research in general practices and in networks of practices. A number of informants commented that practices are not standard entities and if primary mental health care is to be effective it is important to understand how it fits into the structure and processes of real practices. This was achieved by skilled health professionals who were researchers in their own and other practices, and by ensuring that practices were properly reimbursed for the costs of research in their practices. Providing part-time academic appointments for health professionals who were skilled researchers was one approach.

WERE THE AIMS OF THE FELLOWSHIP ACHIEVED?

To examine how the findings of the systematic review on the effectiveness of the generalist primary healthcare workforce relate to policy and practice in the UK and The Netherlands.

The findings of the review were presented at formal staff seminars at the Universities of Manchester and Bristol and discussed informally with informants in The Netherlands and with members of the UK Primary Mental Health Care Research Network. The seminars provided a rigorous scrutiny of the review findings by senior and experienced researchers in leading primary mental health research settings.
Participants agreed with the review finding that GPs should not attempt to provide all elements of mental health care and that the roles of other generalists should be expended provided appropriate training and supports are in place. There was strong support for the view in The Netherlands and the UK that GPs cannot be the main providers of psychological therapies for their patients and that referral to appropriate low intensity therapists (generalists) and high intensity therapists (specialists) is a more appropriate option.

It was clear that increasing the role of non-GP generalists requires appropriate training, support and ongoing incentives if generalists are to play a larger part in providing care for those with mental health disorders who reported that they were unable to access care.

There are a number of key developments in the Netherlands and the UK which should be monitored including the development of GPs with a Special Interest in Mental Health Care, the development multi-disciplinary protocols in The Netherlands, the Improving Access to Psychological Therapies Pilots in the UK, and the WISE studies on providing mental health care to hard to reach populations in the UK amongst others. These developments and the associated research will inform the development of primary mental health care services in Australia since they are founded on generalist care models and provided in primary care settings.

To understand how the relationship between policy makers, service providers and researchers contributes to developments in service quality and changes in the roles and effectiveness of generalist staff in primary care settings.

In each of the centres visited there was evidence of strong and longstanding relationships between researchers, policy makers, service providers and clinicians. In the Netherlands policy makers and clinicians held academic appointments and made real contributions to research and teaching, there was a small but significant number of GPs undertaking research training, and a number of practicing GPs with paid academic appointments engaged in clinical work, teaching and research. Researchers were involved in the policy process and in sophisticated multi-method and multi-centre research on addressing important service problems and evaluating major service developments.

The best examples of productive relationships between policy makers, service providers and researchers were found where engagement started at the point of identification of a major policy problem and continued through the cycle until an effective solution was implemented and tested. Whether problems were identified by policy makers, service providers, clinicians or researchers it is the collaborative relationship over an extended period of time that seems to be important.

To examine more closely evidence about the roles of generalist staff in the care of those with mental disorders with particular focus on the roles of staff, their place in multi-disciplinary teams and supports that are provided to them and needed in their role.

The roles of GPs in The Netherlands, UK and Australia had large similarities despite key differences in the funding and incentive systems. GPs were acting as gatekeepers in each system and had varying referral options for patients with mental health disorders.

The importance of patient registration and incentive funding systems was encouraging a population health approach to primary mental health care and a greater use of non-GP generalists in the UK and The Netherlands than is usual in Australia.

The use and agreement of multi-disciplinary protocols in the Netherlands and clinical pathways in the UK provided a clear means of enabling a stronger involvement of non-GP generalists in primary mental health care.

GPs with a Special Interest in mental health were being supported by specialist psychiatrists in developing their skills so that they might in turn become a support for generalists providing mental health care and a further non-specialist referral option.

To examine how evidence based developments in generalist primary mental health care might apply in Australia and particularly in rural settings.

In the UK and The Netherlands primary care has developed in a different fashion with a different mix of capitation and fee for service funding. This has allowed and indeed encouraged a stronger population health based approach than is usual under the current Australian arrangements. However, a number of Australian developments such as the super clinics and other population focused services such as the Headspace initiative for young persons may enable a strong focus on population mental health in primary care settings

The development of GPs with a Special Interest (GPSI) in The Netherlands and the UK may be instructive for Australian rural settings which often operate without good access to specialist clinicians. Such GPSIs, if provided with appropriate training, accreditation and support may provide a new referral option for neighbouring practices and provide a range of supports for GPs and other generalist providers of primary mental health care.

To consider how the linkage and exchange model adopted by APHCRI might be further improved.

The linkage and exchange model adopted by APHCRI has a number of elements including the adoption of the 1.3.25 report format, regular workshops between researchers and Commonwealth bureaucrats, the involvement of stakeholders as appropriate in the design, development and interpretation of research, and the presentation of findings to groups of Commonwealth policy makers.

This model appears to have been particularly successful in developing cooperation and collaboration between the primary care research groups who have been successful in obtaining APHCRI funding. In some cases senior researchers have been able to build on established relationships with policy makers and in others policy makers have been members of the research team.

Many APHCRI projects have been of short duration such as 12 months and so the opportunities for developing ongoing relationships with policy makers have been limited.

Evidence from the Netherlands and the UK shows longstanding relationships particularly between the leading researchers, policy makers and providers. In the UK many developments in primary mental health care commence with studies to address service gaps including reviews of the literature, pilot and qualitative research studies followed by service evaluations and controlled trials to assess effectiveness and efficiency of interventions. Such programs of research are a feature of the funding regimes and the perceived importance of research as part of the policy process.

In the Manchester National Primary Care Research and Development Centre staff are employed to manage and assist with the dissemination of research findings using short common language summaries of reports written by staff with journalistic and other communication skills. They draft short summaries and there is a clear dissemination plan and process for each piece of completed research. Academic and research staff focus on preparing reports and papers and presenting the results of their research directly to policy makers and providers wherever possible.

In the Netherlands there is close connection between policy makers, providers and academics. Policy makers and providers hold academic appointments in Universities and research groups and contribute to research and in some cases teaching. Academics contribute to service development and planning.

Many of these enhancements on the APHCRI linkage and exchange model are dependant on various forms of long term, infrastructure and programme funding. In Australia such funding is often provided to basic and less often to applied research.

To strengthen collaborative relationships with the Julius Centre in Utrecht and the National Primary Care Research and Development Centre, University of Manchester.

The fellowship provided valuable opportunity to speak to academics, policymakers, service providers and clinicians associated with leading research centres in two progressive primary health care services.

This experience provides the basis for ongoing contact with a wide range of primary mental health care experts and an opportunity to monitor the findings from current research, such as the use of low intensity therapists, which is likely to be of considerable value in informing developments in Australian policy and practice.

In summary, the opportunity to meet senior policy makers, managers, clinicians and researchers has been invaluable in developing my understanding of the role of generalists in the provision of primary mental health care, the role of research in supporting service development and the policy process and the value of strong and continuing relationships as the basis of effective linkage and exchange.

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APPENDIX 1: KEY INFORMANTS

Utrecht Medical Centre University of Utrecht, The Netherlands

A J P Schrijvers, Professor of Public Health

J Trappenberg, Research Fellow

H van Stel, A/Professor Health Services Research

R van Damme, Managing Director and Medical Director of five Primary Care Health Centers in Leidsche Rijn, closely related to the Julius Center

Tom Hoogeveen,

H van Steg,

Jo Caris,

N de Wit, Associate Professor of General Practice/ Mental Health

Leo Kliphuis, Deputy Director Population Health, Netherlands Ministry of Health

Erika Manten, International Journal of Integrated Care

Annet Esser,

National Primary Care Research and Development Centre, University of Manchester, The United Kingdom

Martin Roland, Professor and Director

Prof Bonnie Sibbald, Assistant Director, Professor of Health Services Research

Helen Lester, Professor of Primary Care

Anne Rogers, Professor Sociology of Health Care

Linda Gask, Professor of Primary Care Psychiatry

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Nick Goodwin, Senior Fellow

University of Southampton

Tony Kendrick, Professor and Head of Primary Medical Care

University of Bristol

Deborah Sharp, Professor of Primary Health, Care, Head of the Academic Unit of Primary Health Care

APPENDIX 2: KEY THEMES FOR DISCUSSION

- What roles do generalists play in the provision of mental health services in primary health care settings in the Netherlands and the UK?
- What evidence is there about the effectiveness in these roles and their contribution to meeting demand for services?
- How do they work together in teams and other collaborative forms and what supports are needed to ensure their effectiveness?
- What evidence is there about the relative costs of primary mental health care services delivered by generalist providers?
- How useful is the analytical framework developed in the review in explaining the elements of care, supports and relationship to non-health providers in the UK and Netherlands systems?
- How does the relationship between the "extramural services", researchers and policymakers assist in the development of policies and services in the Netherlands?
- What investments over what timescales have been needed to develop the role of generalists in the provision of mental health care?
- What lessons can be learnt about the adequacy of the linkage and exchange theories as explanations of effective processes for building productive collaborations between researchers, policy makers and providers?

APPENDIX 3: SEMINARS AND CONFERENCE PAPERS

Place	Date	Topic
University Medical Centre, University of Utrecht, The Netherlands	9.9.08	Integration in the Australian health care system (building on stream 4 SR)
The Future of Primary Health Care in Europe Conference, Southampton UK	15.9.08	Integration in the Australian health care system
The National Institute for Primary Health Care Research and Development, University of Manchester	23.9.08	What is the place of generalism in mental health care in Australia? (based on stream 6 SR)
University of Bristol, UK	30.9.08	What is the place of generalism in mental health care in Australia?