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SA Divisions of General Practice Inc
Submission to the
Australian Senate Select Committee on Mental Health
Senate Inquiry into Mental Health Issues
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Introduction and Background: the role of Divisions of General Practice in mental health care.

SA Divisions of General Practice Inc (SADI)[1] is the peak organisation for Divisions of General Practice in South Australia. South Australia has fourteen Divisions of General Practice, four urban, eight rural and two mixed urban/rural. SADI and the Divisions form an important link between general practitioners and the State Government and Commonwealth Government, as well as the many other health service providers, consumer and carer organisations, industry groups and lobby groups. We have established networks at both a state level and the local level throughout SA, and are linked nationally to the national divisions network through Australian Divisions of General Practice (ADGP)[2], and our equivalent state/territory based organisations interstate.

Over the past few years, Divisions of General Practice have become increasingly involved in mental health at the primary care level. Divisions are now service providers, employing mental health allied health workers under the Commonwealth Government's Better Outcomes in Mental Health Care program, and in rural areas, under the More Allied Health Services program.

We are in the unique position of having Division Mental Health Project Officers in all areas of the state, urban and rural, putting us in the prime position of being able to enact national or state-based programs quickly and effectively, utilising networks and relationships already established. The Project Officers have intimate knowledge of local mental health needs and conditions and hence are able to adapt and implement programs quickly and effectively. They are experienced in working with general practitioners to develop materials, tools and training methods suitable for engaging GPs in programs.

75% of patients with a mental health condition seek help from their general practitioner first – many of them do not see any other health professional. General Practitioners work across the state, including in rural and remote areas where there are no other health workers and few resources. Strengthening mental health resources and supports at the general practice level is a vital step to improving mental health and care provision across the state. Divisions are in the prime position to be able to make this happen.

Considering the parlous state of mental health service provision in South Australia, and the low level of expenditure on mental health in SA compared to other states[3], SADI is concerned that there is no South Australian representation on the Select Committee for Mental Health.

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[1] www.sadi.org.au
[2] www.adgp.com.au
[3] Mental Health Coalition SA newsletter April 2005 - sourced from relevant state government departments' estimates/budget papers and funding announcements

Responses to Terms of Reference

a) the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress.

The division of responsibility is a real barrier to effective coordinated mental health care and recovery in Australia. It interferes with the ability to share care between public mental health services and private general practitioners, and it makes it difficult to design an effective system which provides clear pathways to care and safety nets. Conversely, the division of responsibility contributes to the gaps in the system, buck-passing and turf-wars, confusion about whose responsibility various areas of service are and confusion for consumers in the system seeking additional care (either step-up or step-down). The lack of any over-arching body that can clearly delineate tasks amongst sectors, professionals and organisations leads to duplication of service in some areas (ie: waste of money and resources) and lack of service in others, as well as inequities in the system for consumers and carers.

The various funding methods for different forms of care is in itself confusing. For instance, currently in rural areas, GPs potentially have access to a number of different referral sources for allied mental health worker assistance. They can refer to allied mental health workers under:

- Better Outcomes in Mental Health Care (BOiMHC), a Commonwealth Government project delivered through Divisions which allows for six consultations, plus a further six if required after further GP review. For this they will need to use the MBS Mental Health 3 step item number.
- More Allied Health Services (MAHS) scheme, also Commonwealth Government funded through Divisions, for a number of consultations that depends on the design of the program (usually three + three) – providing their division chose to use their MAHS money for mental health, which about 95% of them did. For this they will need to find an additional care provider to meet the HIC requirements for doing an Enhanced Primary Care (EPC) Care Plan.
- Enhanced Primary Care Allied Health program, whereby a patient with complex needs can see an allied health worker including HIC registered mental health workers for five visits (although very few HIC registered mental health workers exist in rural areas). These workers are paid by the Commonwealth through MBS item numbers.
- State funded mental health team at their local Community Health Service (if they are not too remote). There are specific referral criteria here as well, and usually long waiting lists. Meanwhile the GPs have several sets of assessment, plan and referral forms of which they need to keep track, and several sets of remarkably similar referral criteria that they need to be able to understand.

Each of these valuable programs, while providing excellent assistance to consumers, carers and GPs, comes with its own referral criteria (which are not mutually exclusive), its own set of paperwork and regulations regarding use. Referrals to specialists, and particularly the new MBS item number for one-off referrals to psychiatrists also have their own paperwork and requirements. We do however welcome the item number as an important step towards supporting general practitioners to manage mental health in the community through enabling access to specialist support.

The Better Outcomes programis a good step towards coordinating the efforts of mental health care in the community but particular effort needs to be made to ensure that other programs link in effectively, preferably using the same paperwork (adapted if necessary). Referral criteria need to

make sense and not overlap, so that the treatment decision can be as clear as possible and hence effective for the patient and cost-effective for the State and Commonwealth health budgets.

Other funding barriers include funding of dementia under aged care thereby excluding patients with dementia from Better Outcomes programs. Many of these patients have comorbid conditions such as anxiety and depression as well as behavioural problems which are best treated with environmental or non-drug programs which can be implemented by mental health workers. This additional support and review will benefit both the patients and their carers. A similar situation exists for the intellectually disabled who may have comorbid behavioural problems.

b) the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care.

Generally, the emphasis has been on the headline-grabbing end of the mental health care spectrum. Adequately funding for crisis intervention services is obviously essential however these services require additional training in the application of specific psychological skills to crisis management. We must also focus on the preventative goal of making crises less frequent by providing good long-term, community-based supportive care. This needs strategic planning to ensure that patients in crisis are not "lost" in the system.

General practice is ideally situated to provide a strong push at the grass roots level for prevention, promotion and early-intervention in the community. Emphasis on long-term social support and integration services, recovery services post acute care and community teams will ensure that people have fewer acute episodes and hence stay well and productive in the community. Mental health has the highest non-fatal burden of disease in Australia[4] and although this statistic does not excite the headlines, it is clear pointer to the area most in need of addressing.

This greater focus on early intervention and illness prevention is needed across the board, in both low prevalence severe mental health disorders such as schizophrenia and other psychoses, and in the high prevalence problems of anxiety and depression. It is needed in all social strata and settings, however particular attention needs to be paid to disadvantaged groups, because they often have difficulty in accessing mental health care and as they cannot afford to see a mental health professional privately, they are often not attended to until their condition is severe enough to be seen by the public mental health services.

Much of the prevention end of mental health service spectrum needs to take into account issues of social inequity – for example poverty, poor education, unemployment, and lack of appropriate housing etc. These all exacerbate predisposition and existing mental health problems. Research done in the UK has shown that the most important factor preventing relapse in people with schizophrenia is stable housing. These social indicators are linked to the whole of health as well as mental health. Governments will need considerable will and a long-term perspective to ensure that prevention receives the focus it requires to ensure the health and well-being of the Australian population. This will involve a systemic and cultural change whereby we value each member of the community and address issues that affect both "the mean and the tail" of the population distribution curve on a number of social spectra. A culture which values *only* self-reliance, user-pays and competitive achievement is not conducive to the health of those who, through genetics, poor parenting, adverse early childhood conditions and accidents of birth, do not start on the same

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[4] Australian Burden of Disease and Injury Study (1996)
http://www.aihw.gov.au/publications/health/bdia/bdia-c04.pdf

competitive playing field as the rest of the community. There are significant cost benefits in terms of human lives and financially to be made through prevention. If we are serious about prevention of mental illness and illness in general then we need as a community, with the leadership and commitment of government, to look after the poorest and most disadvantaged in our community, starting with the perinatal period and early childhood, and before illness can be seen to be present. It is important that this be seen in terms of an investment rather than a cost, and the investment in a fairer and more equitable society will pay off in terms of increased community safety and reduced burden on the criminal justice system and correctional services, as well as improving health outcomes.

The South Australian State Government's moves to highlight the issues of social determinants on health status are to be applauded with the pressing need now to convert theory into tangible outcomes for the community. Ongoing personal care support for long term, chronic conditions and acute phases are required. This requires commitment by Governments to appropriate levels of funding a reliable and accessible system of community based care. Such a system will value the role of the general practice team, the linkages with other health providers and a seamless flow of care between community based care and, when needed, the acute system and specialist support.

Respite care provision has been growing in health generally but has been lagging behind for mental health with very poor access in adult mental health and it is non-existent for children and adolescents. High quality and accessible respite care is an essential component of community based care and can be an effective strategy in both prevention and early intervention, significantly reducing the need for more acute levels of care and the higher associated costs. Carers are a very cost-effective forms of community based care and failure to adequately support carers will inevitably lead to higher demand for other community based care and the acute system.

c) opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care.

We see several opportunities for improving coordination and delivery of services: Firstly, Divisions of General Practice have a history of episodic, short-term project, and pilot funding by government. This is also evident in other parts of the health system, especially for work that seeks to bring about system change. By the time one project nears completion, the funding agenda has moved on and hence the opportunity to capitalise on the learnings and apply them more broadly is lost. SADI recently had the experience of a successful pilot project which aimed to re-align private psychiatrist practice. The project involved 27 private psychiatrists who provided a consultancy role supporting general practice. This project was terminated by the Commonwealth Government Department of Health and Ageing at the completion of the pilot phase with the Commonwealth opting for a national call centre model which did not aim to change clinical practice. The termination occurred before the planned (and paid for) evaluation had been completed or submitted. No evidence was provided as to why this decision was made. It was clearly not based on objective analysis of the comparative evaluation data. Short term episodic funding often makes the whole system worse, as clinicians, consumers and carers become cynical. It is difficult for general practice to change its way of working through becoming part of a pilot, trial or short-term project when continuity of such change is unlikely. Pilot projects need to be a part of an overall strategy, and if they show benefit, need to be rolled out more broadly.

Competitive tendering between the Divisions and other health providers causes inequities of service for consumers and clinicians. Funding one Division to provide service to the exclusion of all others seems neither logical nor equitable unless based on specific local need or social indicators. If the service is required, it should be provided for all consumers, not just those lucky enough to live in a certain geographical area. In particular, the need for general practices to be accredited before individual GPs working in that practice can access the incentives and the allied health support for their patients has led to considerable geographical inequity, as some areas of Australia have low rates of practice accreditation due to factors beyond their control and not directly related to the quality of the clinical services they are providing (eg: remote area practices that cannot get frequent enough garbage collection due to their isolation).

Funding cycles make it difficult for organisations such as Divisions to continue to employ or recruit quality staff and roll out programs. Currently all Division mental health funding finishes 30 June 2005. While we assume that programs such as Better Outcomes will continue to be funded, we are unaware of any changes that may be made. Divisions seeking to maintain their services, experience staff turn-over often to state-funded roles which offer continuity of employment. Divisions which have recently gained additional funding are unable to attract allied health workers because they are unable to offer work beyond the current guaranteed funding period. This is particularly an issue for rural Divisions where they are trying to attract suitably qualified and experienced allied health workers to move to country regions to provide a desperately needed service, but cannot provide a contract for more than a couple of months. A one or two year contract often is not enough to encourage a person to relocate – two months is certainly not. These funding cycle issues also affect project officers and the resultant staff turn-over means a loss of knowledge and experience to divisions, which impacts on service delivery. It can also lead to fragmentation in the relationship between the Division's ever-changing personnel and the general practices it supports, not to mention the difficulty in building an effective therapeutic relationship with consumers when the therapist keeps changing. Currently we do not expect to know anything about funding past 30 June 2005 until May 2005 budget announcements.

Clear delineation of service areas needs to be accompanied by links to ensure coordinated care through such methods as discharge plans, care plans and telephone calls between various service providers. A specific gap in this is the link between non-health services providing support in the community (housing, employment etc) and clinical services. Such services are important for relapse prevention and stability in the community. However, it is currently not in the purview of any of the clinical services to ensure these services if needed are in place.

Other gaps exist within government services. The division of funding and responsibility between adult, adolescent and child mental health services, disability and aged care sectors means that gaps exist, duplications occur, and general confusion prevails about what services are available to which client and through which funding source or service provider. While in theory this could exist as a continuum of care, in reality it is a series of unrelated and uncoordinated services funded for their specific area of care and unable to respond to even obvious lacks or needs. Adult mental health services which are entirely focussed on the adult client are unable to address the issues of carers, family and particularly children. For a General Practitioner within a consultation to be able to decipher the complexities of this system is well nigh impossible.

Joint training does go a small way to addressing some of these problems by creating understanding between various agencies and private providers, including GPs. However, the issue of combining training for salaried employees and self-employed clinical providers is fraught

with timing problems. Salaried employees don't want to spend their evenings or weekends at training, and the self-employed lose money if they attend during consulting time.

d) the appropriate role of the private and non-government sectors

These roles are not currently well defined. There are a lot of players and a lack of role definition. Governments frequently make decisions involving funding and service delivery which rely on the private and non-government providers for implementation without adequate recognition of how this impacts at the grass-roots level. Often Government will approach Divisions in order to get information to GPs, to change the way they work, or to get them to attend CPD sessions without consideration of the volume of such requests or the CPD programs already developed by the Division in response to the needs of its GPs and their community. The Divisions network has provided an infrastructure which serves as a portal to general practice but the effectiveness of any portal is diminished if it fails to manage the volume and nature of information it allows through.

Even after twelve years, the Divisions network still struggles to be recognised as a genuine partner in mental health care by Government. This failure to engage in genuine partnerships is also the experience of non-government service providers. Much work has been done on this at the State level, but more needs to be done at both State and Commonwealth levels.

e) the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes.

Unmet need exists on a number of levels: lack of resourcing, ineffective delivery of services and lack of awareness of available services. As no clear link or responsibility for coordination between non-clinical services and clinical services exists, it is left to the consumer and/or carer to find the services they need, should they be aware that they need them or that services may exist. South Australia has a significant unmet need in community accommodation, and some existing services are inadequate and not consumer-centred.

Social networks and stability in situation (accommodation, employment etc) are an important factor in relapse prevention and maintaining wellness of consumers in the community population. While the move to deinstitutionalise mental health care is to be applauded on a number of levels including stigma reduction, it will only work if community based services are equivalently funded and linked in to other services.

f) the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence.

Children and adolescents have the highest proportion of mental health problems. Adolescence is often the time when mental illnesses first manifest and hence solid prevention and early intervention services should make the most difference. Yet little is available, it is fragmented between child, adolescent and adult services with service gaps, and those services that exist are underfunded, overstretched and inadequate.

In general practice, good quality mental health education that incorporates developmental issues needs to be mainstreamed so that GPs are able to detect early signs and refer on if they are not confident in treating the consumer themselves.

Canada's Professor Fraser Mustard has produced a considerable body of research showing the influence that the perinatal and early childhood period has on future trajectory in terms of mental health, drug use, criminal behaviour and development of chronic disease[5]. His research underlines the importance of supporting parents and early childhood services in terms of ensuring the future health of the community and individuals. Investment in early years would seem to pay off financially in future years by contributing to a healthy well-adjusted community. Childcare centres in particular need to incorporate appropriate developmental stimulation and support for the child and for the parents, promoting attachment and positive child-parent relationships. This key area of prevention and early intervention seems rarely to be considered in a sector largely moving into the realm of private enterprise.

Some excellent programs on parenting and perinatal mental health exist but are not widely known or available. The Perinatal and Infant Mental Health in the Community (PIMHIC) project is a South Australian State Government Innovative Grants funded project with the aim of increasing the skills and knowledge base of General Practitioners and Adult Mental Health workers to manage perinatal and infant mental health issues in the community. As part of the project, an eight hour training package has been developed that is delivered to a range of professionals and agencies including the target professionals listed. Results to date are extremely encouraging with a further trial occurring in Western Australia in August 2005. Progress is underway in the development of a pilot for Aboriginal populations. The project has highlighted the need for training in this area for child protection services, child and youth health services, midwifery services, drug and alcohol services, child and adolescent mental health services and community health services. The project is due for completion in June 2006 unless funding is received to develop the program for roll out to other agencies in SA and in other states. The early childhood agenda needs to pay a great deal more attention to the issue of attachment and infant mental health.

Another successful project is the Triple P parenting program, developed by Dr Matt Sanders in Queensland. This was made available to General Practitioners in Queensland and was very successful and highly regarded by the GPs there, but has not been funded for national application. For school-aged children, Mind Matters and Beyond Blue (still at the trial stage) both have schools based programs, although children excluded from school for any reason will not have access to this, and the programs are not embedded in all schools. Integration into education is vital for both early intervention and stigma reduction – but with clear understanding that the role of teachers does not include either general screening or clinical skills. Services need to be overlaid onto the school setting in such a way that does not interfere with the school core business of education.

Dementia, depression and confusion can be seen by families, carers and the health care system as part of ageing, which leads to acceptance of these problems and not enough attention paid to potential solutions. The prevalence of mental health conditions in the aged is not as well researched as it could be since residents of aged care facilities were not surveyed in the National Mental Health and Well Being Study. The suicide rate in people over 65 years is disproportionately high, and not well addressed. Mental Health for Older Persons coordinates well with other service providers in SA, but it is not a large agency and yet with the changing demographic profile, increasing demand can be expected. The Home and Community Care (HACC) system has had difficulty accepting mental health as a source of disability despite figures demonstrating mental health as the largest cause of non-fatal burden of disease. As with all areas,

[5] www.founders.net

comorbidities with physical illnesses and disabilities impose additional strain on consumers and carers but are not well managed or treated.

Services for Aboriginal Australians continue to be acutely underfunded, struggling to meet basic needs. Breakdown of traditional family structures and the loss of virtually entire generations due to substance abuse means parenting skills have been lost putting Aboriginal children in a situation of crisis. Community resources are reduced, leaving just the old struggling to care for the young as they handle their own ill health and poverty related issues. Mental health programs need to be integrated and integral to the overall health, social and emotional wellbeing programs that need to be funded for Aboriginal people, implemented in a culturally appropriate and socially acceptable manner. One such programs is the Aboriginal Primary Health Care Access Program (APHCAP) which has considerable acceptance within the communities in regional SA and actively engages with Divisions of General Practice, is setting up Aboriginal controlled health centres on a "one-stop" model. Workforce development for Aboriginal health workers in mental health is much needed, as well as these workers being able to easily access specialist support.

Some successes are registered with programs that take services out to the Aboriginal communities – for instance the visiting specialist outreach through the Rural and Remote Mental Health Unit at Glenside Hospital in South Australia. Psychiatrists were also funded to visit the Anangu Pitjanjatjara lands and Ceduna in far western South Australia under the Medical Specialist Outreach Assistance Program (MSOAP) which met an acute need for specialists in remote and rural areas. Unfortunately this funding has been cut back, when in fact the need is expanding. Currently there are two psychiatrists living in rural areas in South Australia – one an overseas trained doctor in Whyalla, and the other in a coastal resort town less than an hour from Adelaide, Victor Harbor. Rural health continues to be out of sight, out of mind and out of funding. Remote Aboriginal communities encounter this doubly.

Another success has been the Riverland Peelies Bus project[6] operating in the Riverland, taking mental health workers out to Aboriginal communities in the area. The Peelies Bus is the result of a partnership between three major organisations, Riverland Division of General Practice Inc (RDGP), Riverland Regional Health Services Inc (RRHSI) and Child, Youth and Family Services (CYFS previously known as FAYS), assisted by minor funding or services from several other partner agencies including the Aboriginal Primary Health Care Assistance Program (APHCAP) and the MAHS project which supports an ATSI counsellor across the Riverland Division. The counsellor's role on this mobile service is to provide mental health services within the scope of the MAHS funding limitations to people of any age of ATSI origin, their extended families (who may not be of ATSI origin) and to see these people either on the Peelies Bus, in their own homes (which may be on the riverbank), outdoor public locations, within hospitals as inpatients or within schools or other institutions that may ask for assistance. The counsellor has close working partnerships with the region's community Mental Health team (RRHSI employees), the Riverland's sole visiting psychiatrist and an excellent rapport with all of the region's GPs, enabling linkages as needed for patients to agencies (like CAMHS or CYFS) or as a conduit to tertiary psychiatric services via Telemed (provided through the Rural and Remote Mental Health Unit).

The Riverland Division of General Practice also provides access to the region's doctors for ATSI people by providing GPs prepared to work at each of the five major town locations funded under APHCAP. The Riverland Regional Health Service Inc provides Aboriginal Health Workers (AHWs) both on the Peelies Bus and also at the Gerard Community Health Centre (which the bus

[6] http://www.riverland.net.au/rivdiv/ (Programs / Indigenous health)

also attends). CYFS provide significant directional and logistical support with the actual vehicle management and servicing and earlier in the project's life provided a well being support worker. Out of a recognised ATSI population in the area of about 900, the Peelies Bus Medical Director software database now has over 450 individual patients listed, demonstrating the reach of this innovative mobile health service.

By recognising and accepting that ATSI people are often unable to access appropriate medication that will enhance the management of their chronic disease including mental health issues, the Peelies Bus has developed a program (funded at present by Anglicare) which allows provision of a pharmaceutical voucher system to cover the gap payment for prescribed medications, supported by all of the area's pharmacies. This has effectively removed one of the major financial barriers to acute and chronic disease management.

The Peelies Bus has seen continued growth of acceptance by the broader ATSI community over the last 18 months. With the addition in the next few months of a much larger purpose built mobile health clinic, this program expects further growth in usage and in the range of the medical services offered. This in turn should see more people referred for secondary (or primary) mental health service provision, often co morbid with other chronic diseases. In the future, the Peelies Bus may explore the expansion of services to include regular maintenance group work involving families and other distinct groups with particular problems pertaining to social dysfunction or disease impingement on Activities of Daily Living (ADLs).

Rural and remote areas remain under-serviced. Even rural specific services are generally run from the larger regional centres and service provision declines as distance from the centre increases. While some of this is going to be difficult to overcome – population based funding will always focus on putting workers where there are more people to see – outreach services need to be specifically funded to reach more isolated populations.

Recent years have seen the addition of two new allied mental health service programs through Divisions of General Practice, More Allied Health Services (MAHS) and BOiMHC Access to Allied Health. Both of these go some way to filling an acute need in rural areas, but attracting the workers to fill these positions remains problematic. The more remote Divisions report considerable difficulty accessing the required training for their GPs to participate in the BOiMHC scheme, and difficulty attracting appropriately qualified and experienced personnel. Training of GPs to do counselling themselves (Level 2 under BOiMHC) is likewise difficult as it requires the GP to do 20 hours of training – not available in the country thereby necessitating the GP to leave their practice unattended for a number of days. With the lack of available locum coverage to backfill, and rural doctors required to provide after-hours emergency care, this may leave entire towns and regions without any medical care. Many doctors do not feel they have the necessary experience to consider doing Level 2 counselling themselves. Nonetheless, these two services are providing some of the services required for rural areas and we would hope that these would attract continued and increased funding to address the waiting lists they have already accumulated. Some requirement or enticement for allied health workers to do some rural service, either as a fly-in model, or for a limited period of time, would also be welcome to address the workforce difficulties.

The prevalence of complex and comorbid conditions, including drug and alcohol is perhaps largely unrecognised. Comorbidities need to be included in training in a wide range of areas including physical- mental comorbidities (a recent study called Identifying Depression as a Comorbid Condition (IDACC) highlighted the high level of comorbidity between cardiac problems and depression, with nearly half of all patients admitted to hospital for cardiac problems

also having depression), comorbidities of mental health conditions and comorbidity with alcohol and/or drug dependence. It is problematic to have mental health services and drug and alcohol services as two separate services. This is an historical accident; there is no clinical or administrative reason for this. Urgent attention to bringing them back together needs to be instigated.

g) the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness.

Patients with a family carer are given a lower priority for services, so extra stresses are placed on them. Being a carer can place considerable strain on family members with little opportunity for respite – except when the consumer becomes acutely unwell and hospitalised. This is not desirable for the consumer, the carer or the hospital system. Just because a consumer is lucky enough to have a carer does not lessen their need for quality services.

Carers frequently bear huge responsibility and yet they do not have the right of access to vital information that would enable them to care for their relative. Services often don't inform carers about discharge, don't involve them in decisions and misuse privacy considerations. Carers report patients being discharged from services because the service is unable to meet all of their needs – but not actually referring them elsewhere to access those services. Rephrasing "discharge" to "transfer of service" may start to address this mindset and it needs to be clear that responsibility does not end at "discharge"; it ends when the consumer's service needs are being met elsewhere or the consumer has no outstanding needs.

MBS item numbers for Enhanced Primary Care Plans and Case Conferences do not count the family carer as a care provider in their minimum of three health providers. While they may be encouraged to attend they do not have the same status as other participants. Carers need to have acknowledgement and respect for the enormous contribution they make to the lives of consumers and to society in general. Acknowledgement of this role in the requirements that need to be met to use the Enhanced Primary Care MBS item numbers would clearly demonstrate the government's recognition of carer's role to the health care of their family members, their assistance to health professionals and to the wider community through undertaking this role.

Carers are unlikely to be provided with extra training, information or support. They may not be aware of clinical or support service options available to them and the consumer. General practitioners are in an ideal situation to funnel information and support not only to the consumer but to their wider support network. This needs to be better highlighted.

Consumer and carer input into service design and delivery is currently often tokenistic. Consideration of the New Zealand model[7] where consumers and carers are more fundamentally integrated into design and implementation would go a long way towards making services more appropriate and accessible. Carers and consumers in these roles need to be appropriately supported and remunerated so that they can feel confident in putting their position and of being heard and understood.

[7] http://www.hdc.org.nz/theact.php

h) the role of primary health care in promotion, prevention, early detection and chronic care management

The nature of general practice places it ideally to play the central role in promotion, prevention and early intervention of mental health care and in chronic care management.

General practice has a central role in primary health care and promotion, prevention and early intervention. GPs work in urban, rural and remote settings, see a large proportion of the community in a regular or semi-regular basis and are the most frequent first contact for consumers seeking help. Specialist services should provide more of a consultancy role to GPs and other primary health care providers who need advice and one-off specialist assistance. Greater coordination of multilevel care between primary health care and specialist intervention is essential.

Health promotion at both population and individual levels utilising primary health care provider organisations eg: Divisions of General Practice is another under-utilised and under-resourced opportunity.

General Practitioners have a strong role in individual health promotion and early detection. Detection and chronic care management requires common formal assessments and documentation. In early detection, screening and the capacity to intervene with appropriate populations the role of the GP is important. GPs are likely to find a high population of depressed people amongst those with physical illnesses with this comorbidity being increasingly recognised in research.

i) opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer operated.

Consumer involvement in mental health programs and services is largely tokenistic, minimal and inadequate. Consumers need to be involved in their own treatment and in remaining well, and in the design of appropriate services and programs. There is currently very little funding and support for consumer driven services and recovery focussed services. New Zealand has legislation regarding consumer involvement and provides a good model for recovery services.

Work undertaken in chronic disease self-management by the Flinders Human Behaviour and Health Research Unit at Flinders Medical Centre (SA) is a good model for consumer self-determination and involvement and could be expanded into mental health services more generally.

j) the over-representation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people

In addition to the criminal justice system and people in custody, this point needs to include people within detention centres such as Baxter. Contracting out of government services does not exonerate government from the responsibility to protect human rights and to deliver adequate and proper services. Government is aware that less control and accountability has the risk of giving rise to systematic abuse in a privatised system. The very nature of the secrecy and seclusion inherent in any form of incarceration, particularly where private companies and corporate secrecy

are involved, breeds a culture of lack of accountability where profit takes priority over human lives. This is not appropriate or acceptable.

l) the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers

Stigma remains a major issue for mental health patients in both acknowledgement and acceptance of illness, seeking of treatment, and recovery and rehabilitation. Barriers exist at all levels, from accommodation, education opportunity, employment opportunity, service provision, the social setting, etc. The barriers extend to family and carers, perhaps particularly to the children of mentally ill consumers. Many health workers still stigmatise mental health consumers, particularly those with personality disorders.

Addressing stigma will require a cultural and social change. It will require major ongoing commitment from a number of different agencies, not just health. Mental illness is highly prevalent in the community and hence the 'us and them' attitudes behind the stigma need to be broken down. Changing the language used to describe mental illnesses, and consumers with mental illness would be a start. Media need to re-educated particularly in news reporting of "escapes" from mental health wards, and reporting of mental illnesses in relation to criminal matters. (SANE organisation has done considerable work in this area[8].) Popular (primarily US) television programs featuring graphic images of violence frequently found to be committed by mentally ill serial killers incite fear of mental illness in the community. This will be difficult to address due to the popularity of the programs involved. Perhaps an education program highlighting how unreal and infrequent these situations are may put the programs back into the realm of fiction, not the fact they purport to be.

A solid ongoing advertising campaign, consistent over a long time, repeated and normalising may start to balance the negative messages currently broadcast, but a grass-roots community education program will be needed to address cultural and social attitudes. Education focussed on early school years and reinforced throughout the school program, integrated into existing health programs and also cross-curriculum, will address stigma and hopefully encourage help-seeking behaviour.

m) the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness.

Agencies should be responsible not only for appropriate service provision (risk assessment , management and referral) but also for the overall safety of the consumer and for their attitude in treating consumers. Consumers have a right to be treated respectfully and this is important to their recovery. Agencies need to be accountable for providing patient-centred recovery and for enabling patients to participate and plan their own services and lives.

The Better Outcomes in Mental Health Care program has begun to improve mental health training in the general practitioner population, improving their ability to diagnose and treat mental health consumers in the primary care setting. Training needs to be ongoing, and at various levels, needs also to be expanded to other agencies such as housing, police, schools, employment agencies, correctional services, detention centres, etc. Provision of respectful and appropriate services can help consumers to remain well and in the community.

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[8] www.sane.org

One major unaddressed accountability is in ensuring appropriate referral and follow-up. Agencies often see their accountability as ending upon discharge. We have heard of cases of consumers being discharged from services because the service was unable to provide for all of their needs. However no referral was initiated, and no follow-up to ensure the consumer was getting the required services. This “falling through the cracks” in the system is a major impediment to consumers remaining well and to the effective and efficient working of the “system”.

In South Australia, the National Suicide Prevention Strategy Strategic Project (NSPS), being run through SADI and several Divisions in SA with Commonwealth and State Governments as key stakeholders and partners is addressing this issue for the assessment and treatment of patients who either self-harm or who are at risk of suicide harm by encouraging health practitioners to conduct a formal risk assessment, intervene and refer appropriately and then provide the follow up assessment and intervention necessary.

Currently many consumers are referred inappropriately to Mental Health Services or Emergency Departments for assessment and treatment that could be better provided locally and less intrusively. Whether these inappropriate referrals are due to lack of time, skills, knowledge or confidence in their ability to intervene, they impact on the ability of all services to provide appropriate, timely treatment and support, and create long waiting lists for these services to deal with the appropriate referrals. There is also a reliance on a pharmaceutical response to problems deriving from social issues and a lack of understanding of the need for long term follow up or a process to facilitate it.

Involvement of the range of service providers needs good planning and communication and a knowledge of the services that can help. In all services the engagement of consumers and significant people in their lives in developing care plans is hampered by attitudes and practitioners’ lack of understanding of legislation relating to privacy and confidentiality. This mapping work being done by NSPS and the closure of the “cracks” needs to be done for mental health, medical and support services across the board. Accountability does not end when the patient walks (or is pushed) out the door.

n) the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated.

Research design frequently focuses on single illness definition, whereas in the community comorbidities in a number of different areas are much more frequent. Resulting “evidence based guidelines” are therefore suitable for only a small population, and the complex high-prevalence conditions remain unresearched, and the evidence-base for treatment very inadequate.

Mental health research needs to focus on patients in all their variety in the real world, to see what treatments and what systems of care are most effective. A multi-pronged approach is needed, in which GPs, nurses and mental health workers receive good quality training, but also the system of care promotes patient self-management and understanding, as well as being able to follow people up and actively re-engage them if they need extra assistance for a period of time. Research needs to be undertaken to test the effectiveness of this approach and then results need to be disseminated so that patients, general practices and mental health services around the country can benefit from this knowledge.

The Primary Mental Health Care Australian Resource Centre (PARC)[9] based in the Department of General Practice at Flinders University is an existing resource centre with an extensive website and a commitment to enhancing the dissemination and use of knowledge in primary mental health care, and they could be utilised as part of a strategy to encourage the uptake of research into practice. Dissemination of research is only part of the answer; even if health providers receive best practice guidelines, this often does not change practice. GPs in particular are inundated with guidelines but without those guidelines being integrated into a system of care they have little impact. For example, telling health providers that they should review their mental health patients is not as effective at promoting regular review than is building an automated recall system into the health records.

o) the adequacy of data collection, outcome measures and quality control for monitoring and evaluating MH services at all levels of government and opportunities to link funding with compliance with national standards

SADI's experience with projects funded through the Division's network is that data collection and evaluation are often based on process and activity rather than any actual better consumer health outcomes. While evaluation of patient outcomes is more difficult, costly and timely, and has issues with privacy legislation, it is important to establish that the programs and therapies being offered through these programs are making a difference. Data collection needs to be integrated with ongoing patient care, not an additional requirement.

The National Standards in Mental Health Care are now quite old and need revision. It is worth noting however that private providers (including GPs) do not have to comply with National Standards. While the Government can mandate procedures, the private sector is not compelled to follow. In practice, if GPs and other private providers can clearly see that a particular procedure will result in better patient health outcomes, they will adopt it. If the procedure seems to be there for a bureaucratic reason, they will resist it.

In an ideal situation, there would be good quality ongoing electronic health records on integrated health systems across private, government and NGO services, enabling quality care for patients no matter where they are in the system and providing de-identified verifiable data collection on health outcomes at all levels.

p) the potential for new modes of delivery of mental health care, including e-technology.

Technology has provided two main areas of benefit for patients and general practitioners in South Australia. Firstly, a number of excellent programs area available for patients to work through either by themselves or in concert with a face-to-face therapy. Examples in use include: CLIMATE (currently being used under the Better Outcomes program in the Adelaide North East Division of General Practice and Riverland Division of General Practice.) and Mood Gym. Panic Online (run from Monash University) assists GPs to better treat panic attacks working in conjunction with the university (GPs are required to be Level 2 trained under Better Outcomes).

It is important to note that while these online options are suitable for some consumers, they are not ideal for all. Technology may add to risk factors such as social isolation. Some consumers are not comfortable with technology, or their conditions may not be appropriate for this method of treatment. While it is a great option for some, it does not take the place of quality individual

[9] http://som.flinders.edu.au/FUSA/PARC/

consumer-centred treatment provided by a general practitioner, specialist or allied health practitioner.

Secondly, technology has enabled GPs in rural and remote areas to provide better mental health care through provision of GP training and access to psychiatric support through telepsychiatry (videoconferencing run from the Rural and Remote Mental Health Unit at Glenside Hospital, SA). Telepsychiatry does have limits; while it may be a great and efficient way for city-based psychiatrists to consult with ongoing patients, it is difficult to establish a therapeutic relationship via videoconference.

A number of mental health training modules have previously been available online which have proved effective and popular for GPs who are on call and unable to leave remote towns for training, and GPs who are time-poor for whatever reason (ie: working long hours or have family at home). Unfortunately one of these, Primed, is currently not offering Level One Better Outcomes training, which has left a significant hole in the range of training available to GPs.

Summary

There are a number of excellent programs addressing a wide range of mental health issues. Largely, the problems in delivering best practice mental health care do not relate to lack of information, lack of treatment options or lack of knowledge. Problems relate to access to programs on a number of levels – geographical distance, referral criteria, bureaucratic hoops, short term nature of project funding.

A number of effective projects addressing specific hard to reach populations or specific high need populations exist and make substantial differences in the lives of the people they serve. An inventory of these programs needs to be drawn up so that their funding can be guaranteed and effective models can be rolled out in other areas of need.

The number of individual programs with separate but distinct criteria is both confusing and confounding. An overall mental health plan is needed showing how these programs link together, rationalising paperwork requirements so that standardised referral forms, risk assessments and health plans. Only by doing this will it become clear where (geographically and in terms of clinical categories of need) there are duplications and where there are gaps.

Prevention and early intervention is a critical area that needs addressing across the community and government spectrum if we are to halt the increasing prevalence of mental illness in our society. This is a large-scale and long-term effort that will need considerable vision and commitment from Governments if it is to be done effectively. The health of the Australian population needs to consider the health of all Australians, not just those able to help themselves or those most able to contribute to the tax revenue. People with mental health problems desperately want to feel part of and make a contribution to society, and if the lack of mental health care prevents them then we are all missing out on their personal, financial, occupational and social contributions to our community.

We are happy to speak to the above submission. Please contact Louise Miller Frost, Primary Mental Health Care Development and Liaison Officer in the first instance, on (08) 8271 8988 or louise.miller.frost@sadi.org.au

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