18 May 2005

Senator Lyn Allison
Chair, Senate Select Committee on Mental Health
Department of the Senate
Parliament House
Canberra ACT 2600

Dear Senator Allison,

Submission to the Senate Select Committee on Mental Health

On behalf of the Board of General Practice Divisions of Victoria (GPDV), I am pleased to provide this submission to the Senate Select Committee on Mental Health. GPDV is the peak body for the Divisions of General Practice in Victoria. The 30 divisions in Victoria are responsible for supporting general practice to improve the quality of primary health care, and for integrating general practice with the acute and community-based parts of the Victorian health system. As such, support to GPs for the delivery of mental health care forms an important part of the overall role of divisions.

This submission supports and reinforces the submission to the Inquiry from the Australian Divisions of General Practice (ADGP) of which GPDV is a member organisation. Also attached, are Recommendations arising from the Primary Mental Health Care Forum, 26 November, 2004, convened by GPDV and the Royal College of General Practitioners (RACGP).

I would like to invite you to attend GPDV's next Victorian Divisions Mental Health Network meeting on Friday 22 July. This is one of our series of quarterly network meetings and will include presentations by both the Commonwealth and Victorian health departments on primary mental health and discussion with divisions' mental health staff. We would be delighted if you were able to attend for direct contact and discussions with these essential support staff for GPs working in mental health.

Yours sincerely

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Mental health care is a key component of general practice. A series of national reports in the 1990s identified the prevalence of depression and anxiety in the Australian population, the debilitating effects of these disorders, and their frequent presentation with other psychiatric or physical co-morbidities in general practice[1]. According to the National Survey of Mental Health and Wellbeing (1997), up to 75% of people suffering mental health problems will first consult a general practitioner[2]. In 2002-03, there were more than 10 million mental health-related general practice consultations, of which one third of problems managed in general practice were for depression[3]. Whilst the range of mental health disorders and problems being diagnosed and treated in general practice is broad, and varies across regions, the three most frequently reported mental health problems managed by GPs in 2003-2004 were depression, anxiety and sleep disorders[4].

In 1997, the Joint Consultative Committee report, *Primary Care Psychiatry: The Last Frontier,* prepared by the Royal Australian College of General Practitioners (RACGP) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP), articulated a set of measures to assist general practice respond to patients with mental health disorders. The report focussed on GP education and training, reform of the MBS to remove financial disincentives for GPs to practise mental health, and recommended stronger support to general practice from psychiatrists and allied health professionals. In 2001, the Australian Government introduced the *Better Outcomes in Mental Health Care* initiative. This initiative is a landmark program in primary mental health care in Australia in that it provides the first systematic attempt to redress structural barriers to mental health care delivered in general practice. *Better Outcomes* provides financial incentives to GPs linked to an episode of mental health care; sets standards for skills-based training; ensures access to time-limited psychological services provided by allied health professionals for low-income patients referred by GPs; and has established a GP/Psychiatrist support service accessible by phone, fax or email. Nationally, approximately 18% of GPs have registered to participate in *Better Outcomes*, and in Victoria, 1 in 5 GPs has registered[5]. This program has been ably delivered and supported by the Divisions of General Practice nationwide.

There are still substantial issues which concern the resourcing and support of general practice to deliver high quality mental health care, particularly in terms of referral and linkage with state-funded specialist mental health services and in engaging private providers, such as psychiatrists. There are particular issues in supporting general practice in rural areas in Victoria where the workforce distribution of private psychiatrists and allied health providers remains consistently low. There are also particular patient groups, such as elderly, depressed patients in supported accommodation, patients suffering chronic and complex conditions, and patients with drug and alcohol dependencies for whom GPs require additional support to manage and to ensure appropriate liaison and referral is available. In addition, the divisions' network, which functions as an excellent infrastructure to support general practice deliver high quality mental health care, needs additional, recurrent funding to sustain its support for general practice in relation to mental health issues.

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.

Primary mental health care has earned a place under the National Mental Health Strategy, and is specifically referred to in the current National Mental Health Plan. Whilst GPDV supports the National Mental Health Strategy and current Plan, there are still further reforms to be achieved to build a strong mental health system in Australia, inclusive of the role of general practice. First, one of the central impediments to the delivery of timely and co-ordinated mental health care is the divided responsibility for mental health policy (Commonwealth) and service delivery (States/Territories). GPs and divisions of general practice are often on the sidelines of state government health service delivery, and this is especially the case in mental health. In Victoria, state-funded services are targeted to patients with psychiatric disorders requiring inpatient admission or community-based treatment, and primary mental health teams are under-resourced to provide any substantial clinical service. GPs regularly experience difficulty in communication with the state mental health service system, in accessing inpatient beds in some areas, and in continuity of care for patients once discharged from specialist mental health services. Whilst some progress is being made in these areas, the difficulties remain substantial and insufficient attention is being given to shared program planning and implementation around mental health services, for both high and low prevalence disorders, by both Commonwealth and State/Territory jurisdictions.

These difficulties are exacerbated by a lack of resources attached to the Third National Mental Health Plan to support its implementation at the state and territory level. Last, there appears to be limited discussion by both levels of Government around a mental health service system that goes beyond jurisdictional borders. This has had negative consequences for patients, and particularly for patient populations who "fall between the cracks", such as young people and patients with disabling disorders which, nonetheless, do not meet the criteria of specialist mental health services.

It is recommended that:

- **the Australian Government, in consultation with the States and Territories, develop a Primary Mental Health Care Policy to:**
  - **articulate the directions of the Third National Mental Health Plan, and**
  - **identify the areas where joint funding, identified patient health outcomes and agreed performance measures can be applied.**
- **joint funding to support the development of Primary Mental Health Care across jurisdictions is quarantined under the Australian Health Care Agreements.**

Terms of Reference (b)
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.

Following from the observations above, in Victoria, the North East Integrated Primary Mental Health Service has successfully brought together three local mental health programs, which comprise funding from both State and Commonwealth Governments, with the local Area Mental Health Service, to deliver an integrated rural primary mental health care service with a good staffing profile and service and patient outcomes.[6] However, both Commonwealth and State Governments are reluctant to trial such an integrated, joint model of primary mental health care service delivery in other locations despite observable benefits for patients and service providers.

It is therefore recommended that:

- **a Primary Mental Health Care Working Group is established under the Australian Health Ministers Advisory Council to oversight the implementation of the Third National Mental Health Plan and to determine the opportunities for the co-ordination and delivery of funding and services;**
- **different models of care to improve co-ordinated mental health services, such as enrolled patient populations across acute and primary care services, are trialled;**
- **Victoria and other States and Territories develop an improved system of discharge planning and shared care arrangements for patients of inpatient units and community mental health services that recognises and supports the role of general practitioners and primary care agencies;**
- **joint Commonwealth and State funding is provided to integrate primary care mental health services, particularly in rural and outer suburban regions, which would benefit from these models;**
- **general practice is represented at all levels of decision-making for mental health service delivery, including within the acute sector.**

Terms of Reference (d)
The appropriate role of the private and non-government sectors

It is only recently that the role of the private and non-government sector contribution to mental health care has been incorporated into national programs, such as *More Allied Health Services (MAHS)* and *Better Outcomes in Mental Health Care,* through the Access to Allied Health projects and through the GP/Psych Support call centre. MAHS offers rural GPs referral pathways to counsellors and local psychologists funded through the divisions. The Access to Allied Health component of *Better Outcomes* similarly funds divisions to purchase free or low-cost psychological services from private providers, for patients referred by GPs registered with *Better Outcomes*. The GP/Psych Support scheme offers all GPs advice from a small number of participating psychiatrists to GP

questions concerning the diagnosis and management of patients with mental health disorders and problems in general practice. Since this scheme commenced, there has been a gradual upward trend in GP usage of the service, and over 726 psychiatrist-GP contacts were recorded in the first six months of operation. [7]These and similar initiatives should be further supported and extended.

In terms of primary mental health care, it is clear that GPs value and rely on the range of private mental health providers and non-government organisations to whom they make referrals, seek advice, assessment and opinion, and maintain ongoing shared care arrangements on behalf of patients with complex and chronic conditions. It is also clear that the State-funded public sector is not sufficiently resourced to meet the demand for mental health care that GPs must respond to in primary care. In addition, the private sector mental health workforce appears unacknowledged as a resource by State Governments, and the role of non-government organisations in the community to which GPs refer or seek support is not well-understood or researched.
More attention to the role of private and non-government organisations in relation to primary care and how relationships can be better established and co-ordinated is required.

Private Psychiatrists and Allied Health
Several reports have found the under-supply and urban-based distribution of private psychiatrists to be impediments to access by patients referred by GPs.[8]This is notably the case in rural areas, but also in some urban settings where vacancies for assessment or treatment may entail long waiting periods. For patients, the major problems which prevent access to private psychiatrists, psychologists, counsellors and other mental health providers include cost, lack of knowledge of available providers, and in rural areas, as noted, the relative absence of private psychiatrists and allied health personnel. For GPs, these difficulties are compounded by professional differences in practice, structural restrictions on general practice which are different in kind to constraints on psychiatrists and mental health providers working in private practice, and an apparent lack of understanding on the part of other mental health professionals of how general practice provides mental health care

It is therefore recommended that:

- **the Commonwealth Government and Royal Australian and New Zealand College of Psychiatrists (RANZCP), in consultation with general practice organisations, continue to explore and resource practical measures to improve communication between GPs and private psychiatrists;**

- **incentives and appropriate measures to redress the workforce distribution barriers to patients' access to psychiatric and allied health assessment and treatment in rural areas are provided;**

- **multidisciplinary team approaches to primary mental health care are expanded (including the Better Outcomes program) which involve private mental health practitioners, and which include appropriately trained practice nurse support at the general practice level.**

Mental Health Care in Supported Residential Services (SRSs)

Little is known and documented about services provided by GPs to residents of Supported Residential Services (SRSs). While SRSs are governed by State regulations, their residents should be entitled to similar Commonwealth benefits available to residents of residential aged care factilities. The 2003 Victorian Census of residents in SRSs found that these facilities offer 7,104 beds statewide, and of these, 20% of residents had psychiatric disabilities and another 12% of residents suffered from dementia.[9] Over 50% of these residents were aged over 80 years and 21% of residents were aged between 70 years and 79 years. It is our observation that the medical care of patients in SRSs is particularly problematic for GPs, as the level of support and quality of services provided by SRSs vary; hence, the mental health care of these patients is predictably more difficult to co-ordinate in an ongoing manner. We also understand that there is little knowledge amongst GPs about the regulations that exist in regard to SRSs, and consequently, advocacy on behalf of this patient group is often impeded.

In 2002 the Victorian Joint State & Commonwealth Advisory Committee on General Practice (VACGP) established a sub-committee to look at the GP/Residential Aged Care interface. The report produced by the committee has provided a comprehensive overview of the issues for GPs and Aged Care Homes in relation to the care provided to residents. However, SRSs were not included in this study and warrant similar investigation.

It is worth noting that the incentives, opportunities and support by divisions of general practice available for GPs in Commonwealth-funded Residential Aged Care facilities (RACFs) are not similarly available to GPs for patients in SRSs. For example, since July 1st 2004, a Comprehensive Medical Assessment item, rebatable under Medicare, has become available in RACFs. This service is available to all new and existing residents of aged care homes regardless of age. However, residents of SRSs are not entitled to access this service from their GP. The Home Health Assessment item is available only to residents who are 75 years and over. In addition, the recently established Commonwealth-funded GP Panels Initiative provides an opportunity for divisions of general practice to undertake developmental work to improve access to medical care for residents of aged care homes; however, the GP Panels Initiative does not includes SRSs.

It is therefore recommended that:

- **the mental health and medical needs of vulnerable patients in SRSs are investigated with a view to identifying Governments' roles and responsibilities and determining appropriate regulations to govern the care of elderly patients in these facilities; and that**
- **performance indicators are established for SRSs for the care of patients with dementia and/or mental health disorders;**
- **GPs receive incentives to ensure co-ordination of care for patients with dementia and/or mental health disorders who reside in SRSs.**

Terms of Reference (h)
The role of primary health care in promotion, prevention, early detection and chronic care management.

General practice has a unique role in mental health care. GPs are well-placed to provide early detection of and intervention for a range of mental health disorders and problems; to offer continuing care for patients who also require specialist mental health services; and to manage the physical health and comorbid mental health of these patients and others. With appropriate support, GPs can provide early intervention for particular patients groups, such as infants, children and young people and for elderly patients with depression and/or dementia.

However, general practice can carry these roles only as long as GPs are adequately supported and resourced to be meet the demands of the varied and complex presentations that may comprise their practice population. The work of the Divisions of General Practice has proved an effective infrastructure over the last decade in supporting local GPs to work better with mental health patients, and particularly since the introduction of the *Better Outcomes in Mental Health* care intiative. Yet more needs to be achieved to fully resource general practice and link it with state-funded mental health agencies and private mental health providers. The development of multidisciplinary mental health teams at the practice level has not been fully researched or supported.

Since the commencement of the *Better Outcomes* initiative, there have been substantial gains in the level of GP education in mental health and number of patients accessing low-cost or no-cost time-limited psychological treatment. Since July 2002, over 4,100 GPs have completed six hours of clinical training to register with the *Better Outcomes* initiative and 841 GPs have completed 20 hours of clinical training to allow them to access new items in the Medicare Benefits Schedule to provide psychological strategies for patients.[10] Of the 121 Divisions of General Practice, 112 have been funded to deliver allied health services. Furthermore, as from December 2004, approximately 2,000 GPs had referred 13,000 patients for approved treatment from private mental health professionals through the Access to Allied Health Services projects.[11] In addition, the national GP Psychaitry support service has been well utililised by many GPs, including GPs not registered for the Better Outcomes iniative. Overall, this level of GP participation supports the arguments for investing in general practice as an important component of the still evolving mental health system in Australia.

It is recommended that the Commonwealth Government:

- **develop a Primary Mental Health Care policy to involve State and Territory participation in primary mental health care and further drive reform of mental health services (see Terms of Reference (a) and (b));**
- **fund the Divisions of General Practice with dedicated mental health funding to continue to support mental health care delivered from general practice, such as GP peer support, ongoing education and training, and service integration and liaison with local agencies;**
- **continue and increase funding to Better Outcomes, to include targeted services to children and young people, and with an emphasis on co-located mental health workers located in general practice.**

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