Submission to the Senate Select Committee on Mental Health

Australian Divisions of General Practice

Promoting the health and wellbeing of the community through primary health care teams

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Executive Summary of Recommendations

The policy thrust of Australia's *National Mental Health Strategy* is generally sound. There have been chronic shortfalls in the rate and pace at which its implementation plans have been implemented.

There are many compelling reasons why mental health reform must be accelerated. The burden of disease and disability is profound and expenditure has consistently remained below 7 percent of GDP[1] and has not kept pace with the growth in overall health spending as a proportion of GDP which was 9.5 percent in 2002-03[2]. Consumers continue to experience barriers to care, recovery support and workforce participation. Health workforce shortages, a crippled public mental health system, and systems of care that are poorly linked and coordinated compound this problem.

What is needed is adequate investment in building linked systems of care, embedding and strengthening some of the policy gains such as the *Better Outcomes in Mental Health Care* Initiative, serious commitments to prevention and early intervention and action to address community stigma and the needs of high need groups such as rural and remote communities, Aboriginal communities and young people.

ADGP is pleased to make this comprehensive submission to the Senate Select Committee on Mental Health. We have considered each term of reference in detail and offer a series of practical, implementatable solutions.

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

- That Health Ministers develop and implement a national primary mental health care policy under the National Mental Health Strategy to drive a consistent approach to primary care-specialist integration and coordination of mental health care nationally

- That Health Ministers support the policy implementation by introducing and funding a cost-matched program with goals and targets, ensuring its funds are quarantined under future Australian Health Care Agreements and monitoring implementation via a high level working group

- That the Australian Government seeks to rationalise and better coordinate the National Mental Health Strategy, National Drug Strategy and National Suicide Prevention Strategy in consultation with the states and territories

Terms of reference 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
Terms of reference c: Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided through the episode of care

- That education, support and other incentives are introduced into general practice for mental health promotion, prevention and early intervention and that a more integrated, responsive system of care that is early intervention oriented is introduced

- That options for GP access to respite care referral options for carers are widened

- That enhanced systems of integration between primary care and the public mental health system (acute and community care), including referral and discharge protocols, shared care arrangements and improved communication flows are developed

- That services are funded and orientated to address needs of the consumer rather than traditional orientation of specialist services

- That targeted and accessible programs are put in place for supported accommodation, rehabilitation, vocational and re-entry into workforce support

- That a system of crisis care for people with urgent and complex mental health problems is introduced to enable rural and provincial GPs and families to timely access an appropriate range of care through a central access coordination point similar to that available in some states for people with urgent complex physical health problems

Terms of reference d: The appropriate role of the private and non-government sectors

- Improve relevant continuing education and post-graduate education criteria in mental health for GPs. In particular, work with the medical training consortia in each state and territory to ensure that GP level 1 *Better Outcomes* training in assessment, management and referral skills in mental health is systematically incorporated into GP registrar training

- Accelerate primary mental health care reforms to expand allied health services available to GPs under relevant programs such as *Better Outcomes*, to implement strategies and incentives to strengthen consultation and liaison support to GPs from private psychiatrists and to fund specific, targeted measures to attract and retain allied health and psychiatry support for GPs in regional, rural and remote settings

- Encourage the inclusion of coverage of primary care psychiatry in training curricula for nurses, allied health professionals and psychiatrists

- Continue and expand multidisciplinary team approaches to the delivery of quality primary mental health care, including extending and expanding the *Better Outcomes* program (see terms of reference h) and other programs to support GPs to deliver quality mental health care, and the involvement of practice nurses in assisting in the care of patients with chronic disease, including mental illness

- Facilitate the involvement of private psychiatrists in primary mental health care through incentives that encourage provision of advice and consultation services

to GPs, shared care and involvement in informal and formal education of GPs and other health personnel in the primary care setting

- All governments to commit to funding and supporting a viable non-government sector to provide mental health promotion, psycho-education, rehabilitation and other support services to mental health consumers and carers as adjuncts to clinical services.

Terms of reference 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 comorbid conditions and drug and alcohol dependence

Infant, child and family mental health

- Develop, fund and implement an infant and early childhood promotion, prevention and early intervention program for primary care under the National Agenda for Early Childhood that includes:

  - a child and adolescent health check item number into the Medicare Benefits Schedule, including a child health check item number for Aboriginal and Torres Strait Islander children

  - access to evidence-based information and skills development regarding prevention, promotion and early intervention strategies specifically as they relate to infants, children, young people and families for GPs and other health providers working in the primary care setting

  - access to on-going networks and support 'post-training' through Division-based peer support initiatives, including promoting an awareness and understanding across primary and specialist sectors of their role and function

  - access to information about the populations of children and young people who have been identified as having a greater risk of developing mental health problems than their peers (eg. children of parents with a mental illness, children under the guardianship of the state, children of refugees and children of problem drug users) for people and services which are a 'first point of contact' for families, children and young people (eg schools, GPs, youth workers, early childhood workers).

  - increased capacity for primary and specialist providers to work in a best practice and collaborative manner through:

    - access to advice from appropriately trained mental health professionals for GPs through expansion of *Better Outcomes* and MAHS allied health service programs to include child and adolescent mental health
    - GPs, and infant, child, adolescent and family mental health services/providers being supported to utilise shared care/case management/enhanced primary care strategies where major mental health issues are identified

- Access to dedicated positions to support multi-agency participation in, and evaluation of, collaborative practice
- Provision of incentives and infrastructure for agencies and individuals to engage in collaborative practice
- Appropriately resourcing existing public mental health services for infants, children and adolescents in each state/territory to collaborate more effectively with general practitioners and others who provide 'first point of contact' for advice regarding mental health promotion, prevention, and early intervention.
- Access to support services for at risk families including home visiting, child nutrition, crisis care, family support, drug and alcohol services, domestic violence services etc
- Investment in strengthening the role of families through national role out of evidence based family intervention eg building on the success of the state wide role out of the Positive Parenting Program

Youth mental health

- Expand *Better Outcomes* to allow enrolled GPs deliver services in youth centres/clinics, to ensure each Division has access to a child and adolescent health services, GPs have access to dedicated education, training and support in child and adolescent mental health and Divisions have capacity to broker shared care and other collaborative arrangements with specialist health and community providers

- Expand the *MindMatters Plus GP* demonstration project currently in 23 Divisions nation-wide to ensure GPs in all Divisions are linked with specialist services, schools, youth centres and other primary care providers for prevention, early intervention, targeted referral and continuity of care for young people with high mental health support needs.

- Introduce a Medicare item for annual health check for adolescents that acknowledges that additional time is required to engage the young person and support preventative health advice – including risk assessment where appropriate

- Introduce specialised early intervention youth mental health services, particularly targeting marginalised young people who do not necessarily access mainstream primary care services

- Policy guidance for services that emphasize service reorientation to meet the complex and often comorbid problems of young people, and investment by governments in more appropriate specialist facilities to meet the needs of young people.

The aged

- Increased training and support for GPs and other aged care workers to identify and assist in the management of depression and other mental health issues in the aged.

- Ongoing utilisation of Divisions in partnership with other agencies to implement self-help and other community-based programs which can assist older people with physical and mental health comorbidities

- Develop resources and a communication strategy to assist families to identify the signs of depression in ageing relatives

- Promotion of 'ageing in place' under a mental health promotion and prevention program to be introduced and implemented under the National Strategy for an Ageing Australia.

Indigenous Australians

- Indigenous cultural awareness training for practitioners rolled out through Divisions

- Education and training for GPs in identification and effective management of Indigenous mental health to be rolled out through divisions in conjunction with local indigenous communities and indigenous health service providers.

- Education and training for indigenous health care workers in improved recognition of the signs and symptoms of mental health problems and disorders

- Support the delivery of culturally appropriate primary mental health care services, including allied health services under *Better Outcomes*

Socially and geographically isolated

- Continue support for and expand the More Allied Health Services (MAHS) program and introduce appropriate and flexible models of allied health service delivery in rural and remote areas through Divisions of General Practice

- Continue to provide schemes to attract and retain GPs, practice nurses and other primary care workers to regional/ rural and remote Australia

- Support Divisions to provide appropriate workforce support and service linkages

- Develop and fund modes of education and training relevant to rural and remote GPs

Complex comorbid conditions

- Ensure that chronic disease and population health initiatives such as the Lifestyle Prescriptions Initiative includes a psychosocial component

- Implement the recommendations of the WA HealthRight committee nationally, particularly:

    - measures to support GPs in the physical care of mental health consumers such as
        - trialling enrolled populations across general practice, community agencies and specialist mental health services for packages of care

  - Medicare incentives such as item numbers for preventive physical health checks and supporting the role of the practice nurse in proactive and preventative care with the consumer
  - adaptation of the 3-step mental health process to incorporate a prompt for an annual check.

- Provide incentives and support for practice nurses to play a greater role in the primary mental health care team providing a proactive service including a role in health promotion and chronic disease management

- Introducing standards to improve the quality of mental health services to include physical health care in the routine care of mental health consumers

- Introducing structural linkages and protocols between general practice and specialist services, particularly at points of service entry and discharge

- Incorporation of mental health promotion strategies in existing and emerging lifestyle risk factor management programs.

Drug and alcohol dependence

- Targeted support for GPs to manage comorbidity issues within the general practice setting

- Introduction of comprehensive training and systems integration for clinicians and relevant social care workers to ensure screening and assessment are mandatory and referral options and clinical support are clear and present

- The development of innovative specialist, integrated services for people with comorbidity (eg at the moment people misusing substances are often considered inappropriate for mental health services, with the flip side being that people with mental illness and substance misuse problems are not acceptable in drug and alcohol services)

Terms of reference h: The role of primary care in promotion, prevention, early detection and chronic care management

- Provide a ten-fold increase in funding to *Better Outcomes*, including a minimum of $150 million per annum for expansion of the allied health services particularly to include co-located practice mental health nurses and psychologists, child and adolescent mental health services and funding to boost the capacity of Divisions to continue to support the program

- Increased remuneration to GPs for time spent on mental health consultations

- The allied health workforce is currently underutilised in primary health care. Introduce strategies to improve access and overcome low incentives for them to work in primary care

- In the immediate term, reallocate underspends on the 3-step mental health process to allied health services and Divisional programs to better meet community need for primary mental health services

- Introduce strategies to support access to education and training particularly for rural GPs including on-line self-directed training courses, options that will facilitate outreach by training providers to deliver training to regional networks of GPs, the provision of capacity to support GPs meet the costs of locum support and capacity for Divisions to offer small group learning opportunities .

- Link rural allied health workforce incentives to participation in Better Outcomes

- Allow for some exception criteria for GPs working outside of accredited practices, particularly those working with high need population groups such as Aboriginal people and youth in settings such as aboriginal community controlled health services and community-based youth health centres, and locally flexible and appropriate solutions to primary mental health care delivery in remote communities who currently cannot comply with allied health services guidelines

- Strategies to improve links and promote service integration between primary care and specialist public mental health services are ad hoc and not occurring systemically or consistently nationally. There is great variability of 'buy-in' by state and territory governments. This needs to be driven by a national primary mental health care policy (see terms of reference a, b, c).

- Support the strategies to boost practice capacity in mental health care such as the integration of psycho-education and resources to promote self-management as adjuncts to clinical practice, and education and training to involve practice nurses in the primary mental health care team

- Support and fund Divisions with dedicated mental health funding to continue to promote and build primary mental health care capacity in general practice, including access to viable ongoing education, training and peer support and local systems of collaborative care and service integration with both private and public service providers.

Terms of reference l: The adequacy of education in de-stigmatising mental illness and disorders in providing support service information to people affected by mental illness and their families and carers.

- Fund and implement a national community awareness campaign complemented by a targeted mental health awareness programs in key settings such as primary health care

- Continue support for *beyondblue: the national depression initiative*

- Ongoing funding for the suite of *MindMatters* initiatives and expansion of *MindMatters* into primary schools

- Ongoing support for meaningful consumer and carer involvement in design, implementation and evaluation of mental health services.

Terms of reference p: The potential for new modes of delivery of mental health care, including e-technology

- Increased IM/IT funding for general practice, and accelerated implementation of broadband into general practice
- Support the availability and accessibility of viable on-line mental health skills training
- Support the integration of evidence based on-line consumer self-help resources, psycho-education and focused psychological strategies into primary mental health care delivery
- Improve availability and systematic access to web-based support systems for GPs and viable telepsychiatry including case conferencing, care planning, diagnosis and assessment.

1 Introduction

The Australian Divisions of General Practice (ADGP) is pleased to make this submission to the Senate Select Committee on Mental Health on behalf of the Divisions of General Practice Network. ADGP is one of Australia's largest representative voices for general practice. The Network is responsible for supporting general practice and integrating general practice with other parts of the health system, both government and non-government, to deliver high quality care to the Australian community.

Good mental health is a community priority. Poor mental health affects individuals, families, relationships, workforce participation and has an enormous impact on quality of life and community economic burden. Yet mental health disorders and problems are common. While many people with mental health problems go without treatment, 75 per cent of those who do seek help see their GP first[3]. High prevalence mental health disorders such as depression and anxiety are commonly seen in general practice. In many cases, these patients have complex, co-occurring conditions such as chronic physical illness or substance misuse problems. In addition, 7 out of 10 consultations in general practice involve care for chronic physical conditions. Up to 50 per cent of people with chronic physical conditions have comorbid mental health conditions such as depression. It is not surprising that increasing evidence confirms that if depression is effectively treated physical health outcomes improve, though at a lower health care cost.

General practice is therefore a critical setting for the delivery of quality mental health care. However, GPs have struggled to meet the level of community need for mental health care without support for many years. It has only been in the last three years that the government has begun to make a serious investment in the delivery of quality primary mental health care through the *Better Outcomes in Mental Health Care* Initiative (Better Outcomes). Community consultations by the Mental Health Council of Australia and others confirm that supporting the increased role for GPs in mental health care remains an underdeveloped national mental health goal[4].

ADGP developed a *Mental Health Policy Statement* in May 2003, available from www.adgp.com.au . Based on feedback from Division staff, general practitioners (GPs) and allied health professionals set out a plan for primary mental health care for the next ten years.

The *Statement* suggests the following imperatives are required for a sustainable and effective primary mental health care system in Australia:

- That primary mental health care must be a **key policy priority** in national mental health policy and planning;
- That quality primary mental health care must be supported by **quarantined funding;**
- That **reform in mental health care must be accelerated** particularly around supporting general practice and in assisting stronger integration of the general practice sector with State and Territory mental health services, both private and public;
- That **the resource base is more adequate;** and
- That the approach in many areas needs to be **more innovative** than it has been to date.

The *Statement* identified the following areas of priority action as crucial to a future primary mental health care agenda for Australia:

- **Investment in capacity and quality** – to strengthen the capacity of the general practice workforce and support key roles by other members of the practice team such as psychologists and practice nurses in order to embed and support quality primary mental health care delivery in the general practice setting
- **Improved service integration and responsiveness** – to optimise and support the role of general practice in mental health care delivery through measures that promote integration, shared care and improved communication and coordination of care between general practice and other providers in both the mental health systems and wider network of relevant community services such as supported accommodation
- **Innovation and best practice** – to ensure delivery of evidence-based care as well as appropriate primary mental health care service delivery to high need population groups such as rural and remote communities, children and young people and Aboriginal and Torres Strait Islander people
- **Services across the lifespan** – to ensure that general practice is supported to deliver preventive and early intervention services to patients at stages in the lifespan where vulnerability to mental health problems is heightened.

These remain relevant and are reflected in the following discussion in relation to the Inquiry's terms of reference.

1.1 The scope of this submission

This submission provides a general commentary against terms of reference (a) regarding the extent to which the *National Mental Health Strategy* has achieved its aims and objectives, and the barriers to progress. It provides a detailed response and specific recommendations under terms of reference (h): the role of primary health care in promotion, prevention, early detection and chronic care management. This is the area where the unique national infrastructure represented by the Divisions of General Practice Network is best placed to offer advice and direction. It also responds to terms of reference concerned with:

- the adequacies of various modes of care for people with mental illness, opportunities for improving coordination and delivery of funding and services, and opportunities for promoting recovery-focussed care (terms of reference b and i)

- opportunities for improving coordination and delivery of funding and services (terms of reference c)

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

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

- the special needs of groups such as young people, the aged and Indigenous Australians, the role of primary health care in promotion (terms of reference f)

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

- the potential for new modes of delivery including e-technology (terms of reference p)

The submission draws on substantial consultation undertaken by ADGP with the Divisions Network and GPs over the last three years, and is presented in four parts.

Part 1 provides an overview of contemporary general practice in Australia and the Divisions of General Practice Network.

Part 2 provides an overview of primary mental health care delivery in Australia and the context for recent primary mental health care developments.

Part 3 responds with discussion and specific recommendations to the terms of reference of most relevance to general practice and Divisions.

Part 4 consolidates the recommendations into four broad domains and provides an overall conclusion.

1.2 Contemporary General Practice in Australia

Well over 80 per cent of the population see their GPs in any one year making general practice an ideal setting for health promotion, opportunistic and managed clinical intervention and delivery of health gain.

The profile of general practice in Australia is changing. This is a result of many factors such as changes in health consumer expectations, structural changes and the pressures experienced by the workforce through workforce shortages. The shift is away from the solo practitioner, episodic opportunistic care, one way referral processes and fee-for-service financing to a greater focus on integration and shared care, prevention and early intervention, structured chronic disease management, multidisciplinary primary care teams, and blended payments that remunerate quality care.

Australian general practice staff and systems were traditionally trained and organised for the diagnosis and treatment of acute conditions. While this remains an important part of medical practice, primary health care must also increasingly deal with the management of chronic disease, as well as play a greater role in preventative health care.

The proportion of patients new to GP practices is increasing, indicative of increased mobility in the Australian population but also carrying implications for continuity of care. Patients are increasingly making appointments for prescriptions, referrals, tests or investigations and less likely to visit GPs with symptoms and complaints, or specific diseases. This may suggest increasing long-term management of chronic diseases. Hypertension is the most frequently managed chronic problem, followed by depression, then diabetes, lipid disorders and osteoarthritis. Together these account for almost half of all chronic problems managed. There is a growing burden of disease associated with common risk factors, and increasing evidence of the link between

mental health and physical health outcomes (see discussion under terms of reference f).

There is good evidence that successful chronic disease care involves a team of health personnel. Although GPs have a key role in such care, non-doctor personnel are also crucial, for example to conduct routine assessments and provide patient education and counselling to support and improve self-management. Team approaches also enhance care in areas such as mental health and palliative care and can assist in health promotion activities.

1.3 The Divisions Network

ADGP is the peak national body representing the Divisions of General Practice Network, which links 95 per cent of GPs across Australia. There are 120 Divisions of General Practice across Australia, supported by eight state-based bodies. The Australian Divisions of General Practice (ADGP) is the national peak body. These three levels of organisation comprise the Divisions Network and are predominantly funded by the Australian government.

As part of ADGP's representation program, grass roots GPs sit on approximately 60 key decision making bodies in the health sector, having direct input to general practice financing, workforce, education and training, clinical practice and practice management and other key issues facing general practice. ADGP also coordinates a number of national programs across a broad range of primary care issues such as immunisation, practice nursing, aged care and mental health.

Divisions are an integral component of the Australian Government's general practice strategy. Divisions assist GPs and other health professionals to work together, improve communication and linkages between GPs, hospitals and other health and community services, and provide educational opportunities for GPs and practice teams. Divisional programs and activities include a focus on preventive health care, managing chronic disease and promoting good practice and providing training in key population health areas such as mental health, aged health care, drug and alcohol and adolescent health.

Divisions play a major part in implementing policy, supporting general practice and managing health programs at a local level right across the country and have been responsible for progressing many of the current developments in Australian general practice. ADGP, through its network of Divisions of General Practice, provides a key local health infrastructure that enables the planning and delivery of primary care services at the local and regional level. In particular, the Divisions network is focused on supporting high quality, evidence based primary care, integrating health services and engaging the local community. At the state level, state-based bodies are instrumental in integrating and linking national initiatives with state systems of care.

Together the contemporary general practice setting and Divisions Network occupies a unique place in the Australian health system. In particular,

- Divisions offer a well established national infrastructure through which a range of health and community initiatives can be introduced, and the state bodies can assist in integrating and linking national initiatives with state systems

- Divisions can introduce and embed national or state-based programs quickly and effectively, adapting programs to suit local conditions and target local needs

- Divisions can bridge the Government's health and social goals by bringing together health and community services on the ground

- Divisions have proven expertise and capability in introducing and managing change in primary health care and driving health system reform

- Structured practice teams and multidisciplinary care achieves better health outcomes. Divisions are the only national infrastructure actively working to build and promote primary care teams and to link Commonwealth, State and local government health services[5]

- Divisions engage with local communities to deliver health programs.

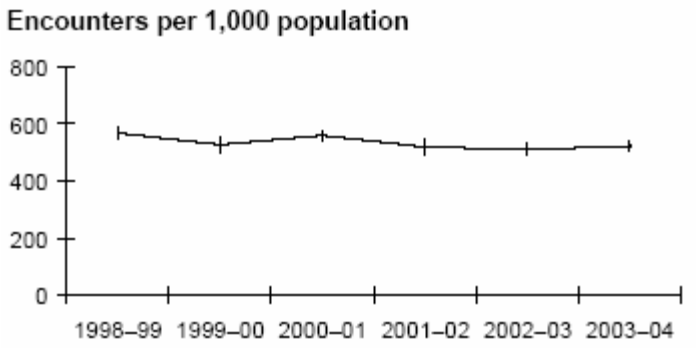
2 Primary Mental Health Care in Australia

2.1 The prevalence and nature of mental health in general practice

The World Health Organisation has described general practice as well placed to deliver primary care of mental illness[6]. One reason for this is that mental health problems seen in general practice are frequently associated with a psychosocial element that facilitates the GP's broader understanding of the patient's bio-psychosocial environment. Further, although a proportion of general practice patients require referral for more specialised management a number of patients that present to GPs with mental health problems can be adequately managed in the general practice setting when suitable GP mental health training has been provided and linkages to multidisciplinary teams / allied health professionals are available[7].

In Australia, GPs are the main providers of care for people dealing with mental health problems. Data from the *Bettering the Evaluation and Care of Health* (BEACH) survey estimate that in 2003–04, there were a total of 10.4 million mental health-related general practice encounters with an estimated 522 mental health-related general practice encounters per 1,000 population with depression accounting for about one-third of mental health problems being managed[8]. These figures have remained relatively stable over recent years (see figure 1 below).

Figure 1: Mental health-related general practice encounters / 1,000 population, 98–99 to 03–04



In addition, seven out of every ten general practice encounters are for chronic conditions and the great majority of these tend to be often ill defined, evolving and involve mental health co-morbidities.

Findings from the 1997 National Survey of Mental Health and Wellbeing indicated that almost one in five of the adult population had a mental health disorder at some time during the 12 months prior to the survey. Of those that seek help for mental health problems, over 75 percent do so from their GPs. With regard to young people, the survey indicates that 14 percent of children and adolescents in Australia have mental health problems, with higher prevalence evident among children living in low income, step/blended and sole parent families and that only one in four receive help [9]. Of those who do seek professional help, family doctors and school-based counsellors are most likely to provide a service[9]. 24 per cent of Aboriginal children are at high risk of developing emotional and behavioural difficulties - a stark figure when we compare it to the equivalent figure in the general population[10].

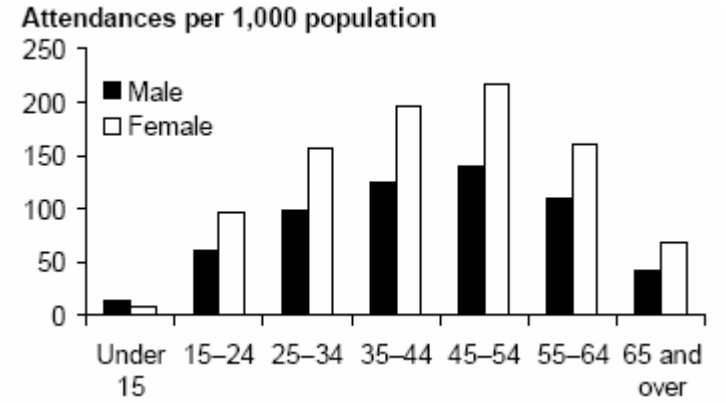
Types of MH problems seen in general practice
In 2003 - 2004, the three most frequently reported mental health related problems for both male and female patients managed by GPs were depression, anxiety and sleep disorders. (A breakdown of mental health-related problems for both sexes managed by general practitioners in 2003 – 2004 is provided in table 1 below). In general, however women are more likely to experience affective and anxiety disorders whereas males are more likely to experience substance use and psychotic disorders[11] [12]

Table 1: Mental health-related problems managed by general practitioners 2003– 2004. (Data is combined across sexes).

Mental health problem	Proportion
Mood (affective) disorders	33%
Neurotic, stress-related and somatoform disorders	23%
Behavioural syndromes from physiological / physical factors	16%
Mental and behavioural disorders from psychoactive substance abuse	10%
Schizophrenia, schizotypal and delusional disorders and	6%
Other	12%

Age / sex patterns of service use
The patterns of general practice and other service use differ by sex as well as by age. Generally, a greater proportion of mental health-related general practice encounters are with female patients. In 2003 – 04, 59.5 per cent of such general practice encounters were with females, compared to 40.5 per cent with males[13]. This higher proportion of female patient GP encounters is seen in all age groups *except* in patients aged less than 15 years (see table 2 below). In contrast, public community-based mental health service contacts in 2002 – 2003 were slightly higher for male (51.0 per cent) than for female patients (49 per cent) overall, although in the 45 year plus age groups, more females than males use this service.

Table 2: Mental health-related general practice encounters by age group and sex of patient, 2003–04



It is also of note that whilst recent evidence indicates little difference in the prevalence of mental health disorders across rural, remote and metropolitan areas, rates of GP encounters for psychological problems for non-metropolitan residents are lower than for metropolitan residents[14].

Despite the relatively high prevalence of mental health disorders in primary health care in Australia and the contribution made by general practice to managing these, it is increasingly apparent that many Australians with mental health problems often

experience sub-optimal care for both their psychological and physical illnesses[15] [16]. Many people with major degrees of disability due to mental disorders do not receive services from *any* health professionals[17]. For this reason, primary mental health care has recently gained greater policy emphasis under the *National Mental Health Strategy*.

2.2 Relevant policy frameworks

Primary mental health care is a relatively recent policy development - significant government investment and policy priority has only occurred in the last 5 years. Prior to the late 1990s, there was nothing that resembled a primary mental health care system in Australia. The *National Mental Health Policy*[18] made some mention of general practice, but the primary focus was on mainstreaming of mental health services and the community mental health service reforms required to accommodate the deinstitutionalisation of people with mental illness.

Coinciding with the *Policy* and implementation of the first five year implementation plan, many Divisions of General Practice were still maturing. Nonetheless, many were developing locally based projects and programs in mental health – prompted by the needs of their member GPs rather than by explicit support from any government policy direction. An important aspect of these projects was better integration and coordination of services for people with mental disorders and mental health problems via partnerships between GPs, their Divisions and mental health services. However, these were often time-limited pilots rolling out without ongoing funding certainty and a national framework for primary mental health care. The primary mental health care landscape was fragmented and lacked sustainability.

1998 saw the introduction of the 2nd National Mental Health Plan under Australia's *National Mental Health Strategy*. The Plan took a broader, population health approach to mental health activity, paying more attention to high prevalence disorders and their impact on individuals, families and communities and was accompanied by the first substantive investment in primary mental health care. Some funding was made available through the *National Primary Mental Health Care Initiative* to further develop skills and roles for GPs in the mental health area. Some funding was also assigned to state and territory health services to develop partnerships with primary care providers (see 2.3 below).

For the first time, primary care, and general practice in particular, was recognised by Health Ministers as a key setting for mental health prevention, early intervention and treatment. Mental health policy and service delivery was no longer considered the exclusive province of specialist mental health services. The National Action Plan National Action Plan for Promotion, Prevention and Early Intervention (PPEI) for Mental Health, a subsidiary plan to the second plan, also identified general practice as a key setting.

This policy shift had three main drivers:

- the results of the 1997 National Survey of Mental Health and Wellbeing (discussed in more detail in Section 2.1) which found that of those people who sought help for a mental health problem or disorder did so from a GP;
- a report by the Joint Consultative Committee on Psychiatry tiled *Primary Care Psychiatry: The Last Frontier* which confirmed that the traditional system of mental health care was failing to meet consumer need and the solution lay in a more collaborative approach to mental health care and increased GP training

and support in the diagnosis and management of mental health problems and disorders[19];
- the potential to extend nationally the early gains made by Divisions of General Practice in primary mental health care.

The 3rd National Mental Health Plan 2003-2008 continued the population health framework of its predecessors and the recognition that the primary care sector was a critical element of the mental health workforce. Federally, the plan was accompanied by investments in measures to improve access to GPs and other primary care providers. It also included federal support for early inroads into improving GP-private psychiatry consultation, liaison and shared care. However, there has been variable investment by state and territory governments in measures that promote linkage and integration between general practice and the public mental health system (see 2.3 below).

Alongside these mental health policy developments, general practice policy was also evolving. A report by the General Practice Consultative Committee, *The Future of General Practice: A Strategy for the Nineties and Beyond*, emphasised the development of collaborative and integrated ways of delivering health care, and the integration of general practice into the broader health system. Divisions of General Practice were funded to enable GPs to work together and to link with the wider health system in order to improve quality and continuity of care, meet local health needs and promote preventive care. Soon after, a suite of Enhanced Primary Care (EPC) items were added to the Medicare Benefits Schedule which, for the first time, remunerated GPs for time spent developing care plans in consultation with other health care professionals.

2.3 Relevant Initiatives

Mental health and general practice reforms over the last ten years have influenced primary mental health care initiatives. At the outset it is important to stress that primary mental health reform in Australia has been general practice driven with Divisions of General Practice leading the way. Between 1991 and 1997, there were 77 projects funded through Divisions that, either in part or wholly, focussed on mental health partnership development. These were implemented prior to *any* major government policy developments in the area of primary care mental health[20].

Building mental health capacity and skills in both general practice and within relevant programs run by Divisions of General Practice such as drug and alcohol, mental health and youth health has been a progressive process – a process of 'evolution not revolution'. Two particular initiatives that are a fusion of general practice and mental health policy have spearheaded primary mental health care developments: the *National Primary Mental Health Care Initiative* and the *Better Outcomes in Mental Health Care Initiative.* Together, these initiatives are the first federal government measures to dedicate funding to promoting change and building capacity in primary mental health care.

National Primary Mental Health Care Initiative

The *National Primary Mental Health Care Initiative* was funded in 1999. Its key components which continued to be funded are:- a network of state-based mental health development and liaison officers supported by a national coordinator at ADGP and a resource centre a Flinders University. The network supports mental health

programs in Divisions of General Practice and promotes, supports and coordinates quality primary mental health care through education and training and other capacity building strategies. The network has provided a vital infrastructure at the national and state levels, previously lacking in the Divisions Network, and represents a body of considerable expertise in primary mental health care. Most notably, the network has been identified as one of the critical success factors in the introduction and uptake of *Better Outcomes* by general practice, to linking relevant federal government programs 'on the ground' (such as suicide prevention, drug and alcohol and youth programs), and it continues to act as change agent driving and supporting primary mental health care innovation and capacity.

Better Outcomes in Mental Health Care Initiative

The *Better Outcomes in Mental Health Care* Initiative, introduced in the 2001-02 Federal Budget, offers the beginnings of a *system* of mental health care, responding to the barriers to mental health care commonly expressed by GPs such as the need for relevant training, access to allied and specialist support and improved remuneration for the time spent on mental health consultations. The 2005-2006 Federal Budget continued this program, and included new funding of $42.6 million over five years to expand it.

The key components of the initiative are:

- education and training for GPs - to familiarise GPs with the initiative and to increase their mental health skills;
- the 3 Step Mental Health Process – remuneration is provided to encourage effective management of mental health problems by GPs through a 3 Step Mental Health Process that includes an assessment, a mental health plan and a review;
- focussed Psychological Strategies - to encourage appropriately trained GPs to provide evidence based focused psychological strategies (FPS) through the provision of Medicare Benefits Schedule (MBS) rebates;
- access to Allied Health Services - to enable GPs to access psychological and other allied health services to support their patients with mental health disorders; and
- access to Psychiatrist Support - to better enable psychiatrists and GPs to participate in case conferencing and for psychiatrists to provide advice to support GPs.

Around 1 in 5 GPs are registered nationally with participation almost as high as 1 in 4 in some states, such as Western Australia and South Australia, and 1 in 3 in some regional areas. Uptake has far exceeded initial predictions of GP interest. The allied health component has been a particular drawcard for GPs who have found that better access to allied health support has resulted in improved clinical outcomes for patients and improved management in the primary care setting. Allied health services under *Better Outcomes* presently involve 105 services covering 112 Divisions of General Practice.

A number of other national programs have been introduced through the Divisions of General Practice Network and integrated with *Better Outcomes* in communities. These include *MindMatters Plus GP* and *Managing the Mix: Your Mental Health and Alcohol*. *MindMatters Plus GP* is developing better referral pathways and networks of care for secondary students with high support needs in the area of mental health and wellbeing. *Managing the Mix* is providing targeted education and training to GPs to assist them to manage mental health and alcohol comorbidity. It also provides funding to 33 Divisions to establish more effective links and systems of shared care for clients

with comorbidity. This is an innovative government-non-government partnership brokered and coordinated by ADGP with funding contributions from the Alcohol Education and Rehabilitation Foundation (AERF) and the Departments of Veterans' Affairs and Health and Ageing. In addition, early steps are being taken to introduce incentives to encourage private psychiatrists to provide consultative advice to GPs. These are demonstration projects at this point but are showing promise as future ongoing programs. They are powerful illustrations of how *Better Outcomes*, with ongoing government support, has the potential to become embedded as an Australian primary mental health care system.

2.4 The role of Divisions of General Practice Network in Mental Health

For the last five years, the Divisions of General Practice Network has played a key role in accelerating the implementation primary mental health care developments with leadership and coordination from the National Primary Mental Health Care Network. This has built on the experience of the many Division-led initiatives described elsewhere in this submission. Divisions continue to be active in mental health working most recently to support the implementation of a number of local and state-funded integration initiatives, as well as federally funded schemes such as *Better Outcomes* and More Allied Health Services (MAHS). While MAHS was not a mental health initiative, a great proportion of the eligible rural Divisions elected to devote it to the establishment of allied psychological services in their community.

The following highlights from the 2002-03 Annual Survey of Divisions indicate the range and breadth of Divisional mental health activity [21]:

- Since 2000-01, the proportion of Divisions involved in mental health programs has increased to 99 percent in 2002-03. Three quarters (77 percent) of Divisions reported their mental health programs were not targeted at any specific group. The remaining quarter targeted a wide range of different populations, children and youth being the most common (26 percent)
- In 2002-03, mental health continued to be the *top ranked* shared care program that Divisions were involved in, and involved 63 Divisions. Rural Divisions tend to have mental health shared care programs more than their urban counterparts, except for WA and Victoria. 52 Divisions (43 percent) reported that they had a formal reciprocal agreement with a mental health service. Excluding the smaller states, WA Divisions were more likely to have a formal reciprocal agreement, and Victorian Divisions tended to have more than one agreement with mental health services, which may reflect service boundaries
- 74 percent of Divisions reported having a dedicated mental health program and dedicated mental health officer
- Over 63 percent reported having a peer support program for GPs dealing with patients' mental health issues, and these usually involve other allied health professionals.

It is noteworthy that this degree of mental health capacity in the network is facing an unprecedented number of pressures. These have serious implications for the ability of the network to embed and sustain the recent gains in primary mental health care. The ramifications of this for community access to care are discussed further under terms of reference h.

3 Response to Terms of Reference

The following provides a commentary of issues relevant to general practice under selected terms of reference. In many cases, specific recommendations are made.

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

ADGP supports the objectives and principles of the *National Mental Health Policy* and the broad areas for action outlined in its most current implementation plan endorsed by Australian Health Ministers, the *National Mental Health Plan 2003-2008*.

An international mid-term review of the *National Mental Health Plan 1998-2003* confirmed that the *National Mental Health Strategy* had provided a framework for national leadership for mental health reform and for quality health care that acknowledges that mental health is fundamental to health. However, the review suggested there was considerable work to be done to fully implement and consolidate elements of the first and second plans[22]. The key areas of need identified included the need to focus on comorbidity between substance abuse and mental health, the contribution of the private psychiatric sector, a continuing lack of coordination between mental health services and other health and social support services, the lack of child and adolescent and aged mental health services and the inadequate knowledge and understanding of the nature and extent of indigenous mental health issues and effective and acceptable interventions.

Many of these areas identified by the mid term review align with the Inquiry's terms of reference. In itself, this is an indication that the rate and focus of implementation has been less than adequate. ADGP therefore concurs with other commentators - Australia's national mental health policy is sound but, given the burden of mental health disorders and problems in the community, the rate of implementation has been inadequate and suffers from variable commitment and investment by all governments.

The *Plan* has the goal of increasing service responsiveness as a priority theme. It identifies the need to improve access to and continuity of care through improved linkages between the specialist mental health sector and the primary care sector, via strategies such as more systemic shared care between GPs and specialists, and improved clinical support to GPs by specialists. Despite this, GPs report a variable level of collaboration with and support from specialist mental health services.

The division of responsibility for various aspects of the health system between federal and state/territory governments is a major barrier to effective early intervention, coordinated care and recovery. While allowing for state variation, there is an urgent need for the National Mental Health Working Group to consider developing and jointly funding a national primary mental health care policy under the auspice of the *National Mental Health Strategy.* Such a policy would provide a framework for the consistent national take-up of a number of strategies to promote more effective relationships and integration between the two services systems.

Under the *First National Mental Health Plan* there was a focus on serious mental illness. An unintended outcome was the rather narrow definition that was applied by specialist mental health services resulting in restriction of services to those with so

called low prevalence, high severity disorders. This inadvertently left a large number of people with severe higher prevalence disorders with little or no access to specialist mental health services and left GPs and families struggling to provide an appropriate range of care. The second plan moved to broaden the focus but inadequate funding levels mean that in reality the barrier remains.

Broadly, it would appear that the federal government provides support for the detection and treatment of high prevalence disorders which form a higher proportion of general practice mental health presentations. In comparison, the states and territories fund a mental health service system focused primarily on low prevalence disorders. Too frequently, the difficulties in moving across the service system are experienced as impediments to high quality and consistent care by all concerned – consumers, carers, and mental health professionals themselves.

There has been some promising federal leadership with the *Better Outcomes in Mental Health Care* Initiative. This initiative has made some inroads by better supporting general practice with access to allied health support. But much more needs to be done to build and support a primary mental health care system in Australia (see terms of reference h for further discussion). The same cannot be said of the public specialist mental health system. Unfortunately this federal investment is yet to be matched by state/territory government initiatives which are necessary to improve the coordination, integration and improved service provision.

Policy emphasis has been given to mental health promotion, prevention and early intervention. However, apart from the *MindMatters* suite of initiatives in secondary schools, there has been a dearth of promotion and prevention programs initiated under the National Mental Health Strategy. Taking a health promotion approach, there is enormous scope to tackle prevention on a much wider scale both in terms of key population groups (see terms of reference f) as well as settings such as primary schools, primary health care and workplaces.

Consolidation is required at both national and state levels to better rationalise and coordinate across drug and alcohol, mental health and suicide prevention policies and programs. At the national level, these policies are often seeking to address similar protective and risk factors, to influence and/or link with the same systems, and take action in similar settings such as schools, general practice and the media. The scope for collaboration and coordination is high. The risk that resources and effort will be duplicated and wasted is also high. There are distinctly separate governance structures of the Ministerial Council on Drug Strategy (MCDS), the AHMAC National Mental Health Working Group (NMHWG) and the National Suicide Prevention Council. There have been some attempts to bring together these spheres of policy, for example, the establishment of the National Comorbidity Taskforce auspiced by MCDS and the NMHWG, but this does not appear to have resulted in any substantial initiatives or systems change. At the state level, policy and program consolidation would eliminate the silos of care, financing and structure thereby assisting to breakdown the barriers between primary care, mental health and substance abuse agencies and services, promote service integration and a seamless system of care for consumers. Equally, we must see better integration across national chronic disease and mental health policies.

<u>Recommendations</u>

- *That Health Ministers develop and implement a national primary mental health care policy under the National Mental Health Strategy to drive a consistent*

approach to primary care-specialist integration and coordination of mental health care nationally

- *That Health Ministers support the policy implementation by introducing and funding a cost-matched program with goals and targets, ensuring it quarantines funds under future Australian Health Care Agreements and monitoring implementation via a high-level working group*

- *That the Australian Government seeks to rationalise and better coordinate the National Mental Health Strategy, National Drug Strategy and National Suicide Prevention Strategy in consultation with the states and territories*

Terms of reference 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
Terms of reference c: Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided through the episode of care

The community and general practice sectors have long held concerns about the adequacy of and access to care for people with mental health problems and disorders. This, in part, has driven policy decisions to build the capacity of general practice to deliver quality mental health care, and to support general practice with enhanced access to allied and specialist support. As a consequence, GPs now have a number of federally funded referral pathways for allied or specialist assistance under present arrangements, including Better Outcomes allied health services, the More Allied Health Services (MAHS) scheme which employs psychologists in many country areas, and Medicare Plus allied health support for chronically ill patients on care plans.

Support and access to public mental health services, including acute and after hours care, is also an important part of the equation. Liaison with local community mental health services by Divisions and the ensuing relationships with and knowledge of local agencies' services, staff and access requirements are valued by GPs and assist continuity of care. 43 per cent of Divisions reported that they had a formal reciprocal agreement with a mental health service in 2002-03. However, there is variability around the extent to which Divisions engage in this type of activity, including variability in the number who regard it as a legitimate part of their mental health program activity. There is also enormous variability in terms of state government engagement.

The divisions of responsibilities for mental health care presents a number of systemic barriers to the co-ordination of care across primary care and specialist care systems. As discussed under terms of reference (a), this is a threshold issue that must be addressed nationally:

> *"There are six contributors to Australia's mental health service – general practitioners, private psychiatrists, private psychologists, private hospitals, state inpatient and community services, and non-government charitable organisations. The work of these contributors is poorly coordinated. It is like a six-horse chariot with six horsemen who seldom coordinate. Coordination of health care is vital……"*
> *Gavin Andrews, The crisis is mental health: the chariot needs one horseman, Medical Journal of Australia, 2005*

States and Territories need to understand the GP sector more closely and to orient their services in ways which recognise the role of the GP. Nationally, there needs to be more joint work and emphasis on continuity of care and linkage between GPs, community mental health agencies and specialist services. There is the potential for Divisions of General Practice, to bridge the interface between Commonwealth and state funded services to deliver truly integrated services. For example, in Victoria primary mental health teams have been developed by the state government to deal with many of the high prevalence mental health disorders through early intervention activities. In North East Victoria this state initiative has merged with a local rural division. This merged team combines federal allied health and mental health funding with state funds from North East Victorian Division of General Practice and North East Health Wangaratta. This model of funds pooling through Australia's national network of divisions of general practice for integrated service delivery could be considered on a national scale.

Access to services for acutely unwell individuals, particularly with comorbid mental health and drug and alcohol problems, remains extremely problematic. This is particularly the case in regional and rural areas. Models exist for more distant GPs to access a range of emergency services for people with complex urgent physical needs, eg GP is able to call one central service that then coordinates evacuation and the range of services needed for their care. Tragically with complex urgent mental health crises it is often extremely difficult for the GP and family to be able to convince a service to accept the unwell person with comorbidities. Families have been known to drive hundreds of miles to a service only to be turned away by a narrow interpretation of service admission criteria.

Recommendations

- *That education, support and other incentives are introduced into general practice for mental health promotion, prevention and early intervention and that a more integrated, responsive system of care that is early intervention oriented is introduced*

- *That options for GP access to respite care referral options for carers are widened*

- *That enhanced systems of integration between primary care and the public mental health system (acute and community care), including referral and discharge protocols, shared care arrangements and improved communication flows are developed, funded and sustained*

- *That services are funded and orientated to address needs of the consumer rather than traditional orientation of specialist services*

- *That targeted and accessible programs are put in place for supported accommodation, rehabilitation, vocational and re-entry into workforce support*

- *That a system of crisis care for people with urgent and complex mental health problems is introduced to enable rural and provincial GPs and families to timely access an appropriate range of care through a central access coordination point similar to that available in some states for people with urgent complex physical health problems*

Terms of reference d: The appropriate role of the private and non-government sectors

With the broadening of mental health policy to include service systems and providers other than public mental health services, the general practice and psychiatry workforces, both of which are principally employed in the private domain, have received greater policy attention in recent years.

General practice has provided leadership in primary care psychiatry over the last decade, seeking linkages to other government and non government sectors to deliver better quality mental health care. Allied health services under MAHS and *Better Outcomes* have made a considerable start to improving access to many mental health specialists in private sector. We need to build on the initial gains and options for doing that are discussed more fully under terms of reference h. General practice has also pushed for incentives that promote changes in the way private psychiatrists work to increase timely access to expert psychiatrist advice for people with more complex mental health illness and problems.

The introduction of *Better Outcomes* was preceded by almost a decade of policy developments and reviews relevant to the primary mental health care arena. Of the reviews, the McKay Report and the work of the Joint Consultative Committee on Psychiatry (the JCC Report) are among the most notable. The McKay Report found Australia had an undersupply and urban-skewed distribution of psychiatrists[23]. A more recent study confirmed these findings and suggested that little change had occurred[24]. Both studies found the majority of psychiatrists are located in urban areas, with a severe shortage of psychiatrists in rural and remote areas. Consumers in urban areas also face difficulties accessing specialist psychiatric care as the majority of psychiatrists are in private practice and have long waiting lists for routine referrals. Using AIHW data the Australian Medical Workforce Advisory Committee (AMWAC) reported that 86 per cent of the specialist psychiatric workforce mostly practiced in capital cities. This is in stark contrast to the 4.9 per cent who practiced in a large rural centre and 3.5 per cent who practiced in 'other' rural or remote locations[25].

Given these ongoing and serious workforce and access issues, the JCC Report concluded that the traditional system was failing to meet consumer demand, and that the solution lay in a more collaborative approach to mental health care and increased training in the diagnosis and management of mental health problems and disorders[26]. Yet more than five years later, commentators were still observing that the medical psychiatric workforce was poorly distributed, largely sited in metropolitan areas, and that majority of psychiatric services were in private practices which plays relatively little part in the consultation to GPs and to rural and remote areas, in liaison with emergency departments, crisis teams or local mental health teams, the conduct of initial (including crisis) assessments, and the training of psychiatrists [22]. Measures to accelerate reform in this area are sorely needed.

The non-medical non-government sector plays a vitally important role in mental health care delivery through the provision of respite care, psycho-rehabilitation, supported accommodation and other support services to consumers and carers; in mental health promotion and building mental health literacy through the activities of organisations such as *beyondblue* and initiatives such as Mental Health First Aid; in after hours and crisis support through vital services such as Lifeline and Kids Helpline and as an adjunct to clinical practice through the provision of psycho-education and other services. It is vital that a robust and mature non-government sector is supported and funded by governments.

Recommendations

- *Improve relevant continuing education and post-graduate education criteria in mental health for GPs. In particular, work with the medical training consortia in each state and territory to ensure that GP level 1 Better Outcomes training in assessment, management and referral skills in mental health is systematically incorporated into GP registrar training.*

- *Accelerate primary mental health care reforms to expand allied health services available to GPs under relevant programs such as Better Outcomes, to implement strategies and incentives to strengthen consultation and liaison support to GPs from private psychiatrists and to fund specific, targeted measures to attract and retain allied health and psychiatry support for GPs in regional, rural and remote settings*

- *Encourage the inclusion of primary care psychiatry in training curricula for nurses, allied health professionals and psychiatrists*

- *Continue and expand multidisciplinary team approaches to the delivery of quality primary mental health care, including extending and expanding the Better Outcomes program (see terms of reference h) and other programs to support GPs to deliver quality mental health care, and the involvement of practice nurses in assisting in the care of patients with chronic disease, including mental illness*

- *Facilitate the involvement of private psychiatrists in primary mental health care through incentives that encourage provision of advice and consultation services to GPs, shared care and involvement in informal and formal education of GPs and other health personnel in the primary care setting*

- *All governments to commit to funding and supporting a viable non-government sector to provide mental health promotion, psycho-education, rehabilitation and other support to mental health consumers and carers as adjuncts to clinical services.*

Terms of reference e: The extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes

Social connectedness, stable accommodation, employment and relationships are well documented factors that protect against the development of mental health problems and disorders[27]. They are also vitally important factors in relapse prevention, recovery and maintaining wellness of consumers in the community. Stigma and negative community attitudes seem to be implicitly accepted in the mental health system in Australia. Gaining access to care remains such a challenge that little focus or investment has been made in the areas of recovery and rehabilitation back to a productive life for people with significant mental illness and disability. This has enormous implications for the individual, their families, our communities as well as poorer social and economic outcomes. This lack of focus also seems at times to pervade the mental health workforce with a sense of impotence with respect to being

able to assist individuals back to a productive role in the community. Investment is desperately needed to assist with recovery, rehabilitation as well as vocational training, and supported return to employment. This needs to be accessible through general practice with streamlined access to an appropriate range of services.

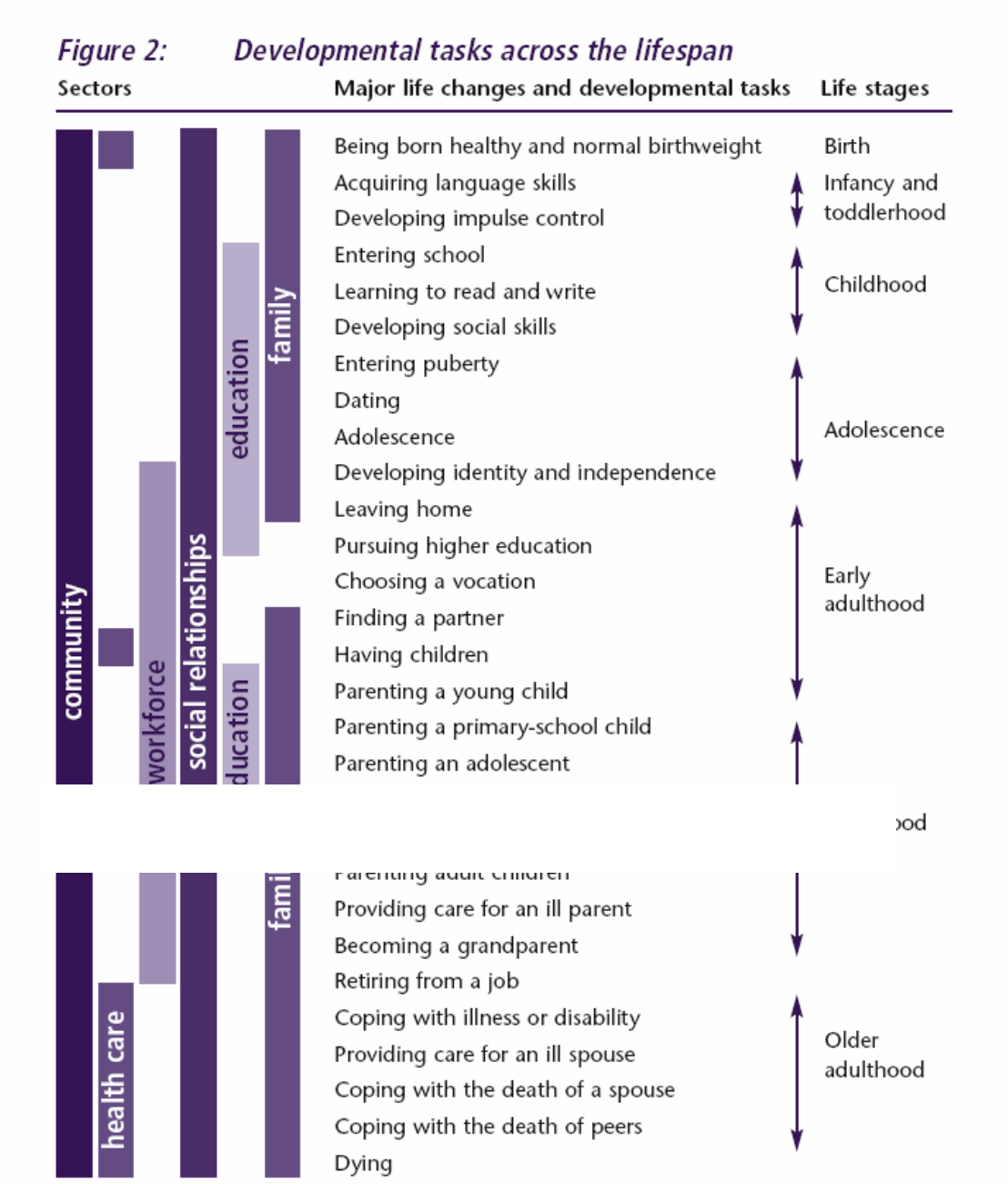
For those individuals not able to be financially independent due to their illness it is an imperative they have ready access to appropriate supported accommodation, health and social services. The number of mentally ill people in our prisons and in homeless services is a sad indictment of the lack of investment in community options following deinstitutionalization. This needs to be urgently addressed, as does greater use of diversionary justice programs to ensure mentally unwell citizens receive appropriate care rather than incarceration.

As with most significant illnesses, an enormous burden of care falls on family members and carers. There is a great paucity of support for them in this often challenging role. Support systems need to be widely accessible to provide education and training to better equip them with their role, as well as an urgent need to provide much needed respite care and support.

Terms of reference 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 comorbid conditions and drug and alcohol dependence

The high need groups in this term of reference warrant discussion in their own right. A whole-of-lifespan approach informs our understanding of the development of mental health problems and mental disorders and thereby informs our understanding of appropriate interventions. The earliest signs and symptoms of a disorder may occur at any time throughout the lifespan, but there are periods when the occurrence of particular mental health problems or mental disorders are more likely such as retirement, school transitions, divorce, and parenthood (see Figure 3). The nature and timing of prevention and early intervention depends not just on the individual's age but on the identified pathways to mental health problems and mental disorders, the risk factors and critical transition points that characterise those pathways.

Figure 3: Developmental tasks across the lifespan
Adapted from Mrazek & Haggerty (1994), which was adapted from Kellam SG, Branch JD, Agrawal KC, Ensminger ME 1975, Mental Health and Going to School, University of Chicago Press, Chicago.



Infant, child and family mental health

The perinatal and early childhood period has an influence on the development of future mental health problems, drug use, criminal behaviour and development of chronic disease. For infants, major influences on their wellbeing that help to prevent mental health problems and disorders include secure attachment between infant and caregiver, adequate nutrition and competent care givers who have access to support services and networks. For children, strategies that improve parenting skills and family functioning, intervene early in conduct and behavioural disorders[28] and address the early signs of internalising disorders such as depression and anxiety can prevent the development of mental health problems.

There is also clear evidence showing the continuity of disorders between childhood, adolescence and into the adult years[29]. For Aboriginal children, the high incidence of emotional distress in Aboriginal children poses a particularly profound risk to the development of chronic disease and more severe mental health problems in adulthood[30].

General practice is a most common first point of professional contact for parents experiencing difficulties with their children. This is particularly the case when they cease attending baby clinics which is usually when the child is six months old. GPs are the health professional most likely to provide services to young people[9] and the place that families at risk often turn to for advice and referral. General practice is therefore well placed to play a key role in prevention and early intervention in childhood behavioural problems and associated familial difficulties, to give children a healthy start to life and to cement a good developmental course by supporting their emotional and social wellbeing. Equally, Divisions of General Practice are well placed in the community to support GPs and primary care teams with education, training and support in this area as well as to integrate general practice with maternity, specialist and community services for children and families, particularly those at risk.

The Australian government has announced a *National Agenda for Early Childhood*. The Agenda calls for promotion and early intervention to promote healthy lifestyles for parents and young children, improved referral mechanisms, improved integration of key services, a skilled and knowledgeable workforce able to provide consistent, up-to-date and practical interventions and advice to parents about child development, health and wellbeing, promotion and prevention, and an integrated system of multidisciplinary care.

Despite this, investment in a systemic, nationally coordinated initiative focusing on building the capacity of general practice to better manage and share care associated with infant and early childhood problems appears never to have been seriously contemplated by the Australian Government. Instead we continue to witness the ad hoc, uncoordinated funding of a series projects by various levels of government. Recent examples include the state-wide implementation of the Triple P (Positive Parenting Program) training for GPs in Queensland using National Primary Mental Health Care Incentive funding, a few local grants to Divisions of General Practice from the Department of Family and Community Services (FACS) for early childhood and family support initiatives, the South Australian Perinatal and Infant Mental Health in the Community (PIMHIC) project, and the Children of Parents with a Mental Illness (COPMI) project. These programs aim to build the capacity of general practice to manage perinatal, infant and early childhood mental health in the community and many have demonstrated extremely encouraging results[31].

The problem is not a lack of evidence, availability of programs, or that these programs lack merit. The issue is quite the opposite. On a national scale, there has been insufficient effort and funding to promote awareness, and coordinated access and uptake of these vital mental health promotion, prevention and early intervention programs.

Recommendations

- *Develop, fund and implement an infant and early childhood promotion, prevention and early intervention program for primary care under the National Agenda for Early Childhood that includes:*

  - *A child and adolescent health check item number into the Medicare Benefits Schedule including a child health check item number for Aboriginal and Torres Strait Islander children*

  - *Access to evidence-based information and skills development regarding prevention, promotion and early intervention strategies specifically as they relate to infants, children, young people and families for GPs and other health providers working in the primary care setting*

  - *Access to on-going networks and support 'post-training' through Division-based peer support initiatives, including promoting an awareness and understanding across primary and specialist sectors of their role and function*

  - *Access to information about the populations of children and young people who are at greater risk of developing mental health problems than their peers (eg. children of parents with a mental illness, children under the guardianship of the state, children of refugees and children of problem drug users) for people and services which are a 'first point of contact' for families, children and young people (eg schools, GPs, youth workers, early childhood workers).*

  - *Increased capacity for primary and specialist providers to work in a best practice and collaborative manner through:*
    - *access to advice from appropriately trained mental health professionals for GPs through expansion of Better Outcomes and MAHS allied health service programs to include child and adolescent mental health*
    - *GPs, and infant, child, adolescent and family mental health services/providers being supported to utilise shared care/case management/enhanced primary care strategies where major mental health issues are identified*
    - *Access to dedicated positions to support multi-agency participation in, and evaluation of, collaborative practice*
    - *Provision of incentives and infrastructure for agencies and individuals to engage in collaborative practice*
    - *Appropriately resourcing existing public mental health services for infants, children and adolescents in each state/territory to collaborate more effectively with general practitioners and others*

who provide 'first point of contact' for advice regarding mental health promotion, prevention, and early intervention.

- *Access to support services for at risk families including home visiting, child nutrition, crisis care, family support, drug and alcohol services, domestic violence services etc*
- *Investment in strengthening the role of families through national role out of evidence based family intervention eg building on the success of the state wide role out of the Positive Parenting Program*

Youth mental health

The top threats to youth development, health and wellbeing are preventable psychosocial issues – depression, substance use and accidents. In fact, many first episodes of mental disorder occur in mid to late adolescence and young adulthood and most mental disorders have their peak period of incidence at this stage of the lifespan[32]. About 50 percent of the burden of disease in adolescents is due to mental health and behavioural disorders[33] and, together with drug and alcohol misuse, these constitute most of the leading causes of disease burden in Australian youth (see Table 3 below). 30 percent of youth deaths are due to suicide with males being at about 5 times more risk than females. More than 400 young people kill themselves each year and it is estimated that at any given time up to 20 per cent of adolescents are suffering from mental ill-health[34].

Table 2: Burden of disease in young people: 10 leading causes (1999)

Males	**Females**
1. Road traffic accidents	1. Depression
2. Alcohol dependence	2. Bipolar affective
3. Suicide	3. Alcohol dependence
4. Bipolar affective	4. Eating disorders
5. Heroin dependence	5. Social phobia
6. Schizophrenia	6. Heroin dependence
7. Depression	7. Asthma
8. Social phobia	8. Road traffic accidents
9. Borderline personality	9. Schizophrenia
10. Gen. anxiety disorder	10. Gen. anxiety disorder

Young people's hospitalisation rates for mental disorders have also risen over recent years with about 43,000 hospitalisations for mental health and behavioural disorders between 2000 and 2001 alone. The most common causes for such hospitalisations are depression, schizophrenia, severe stress and eating disorders. With more structures in place in primary care and the community, it is possible that these hospitalisations could be decreased.

Despite their obvious mental health needs, only a small proportion of children and adolescents with mental health problems attend any professional service. Only one in four young people with mental health problems receive help and even among those with most severe mental health problems, only 50 percent receive professional help. Family doctors, school-based counselors and pediatricians provide the services that are most frequently used by young people with mental health problems[9] but even then young people are under-represented in the number of general practice visits as a percentage of the population. Of greater concern, they are also under-represented in

visits for mental health issues, even though this issue provides the highest morbidity in this age group.[1]

The majority of those receiving help attend services provided by health and education professionals who may only have limited training in the assessment and management of mental health problems. To function effectively, these professionals must have ready access to support from more specialized mental health services. In many areas of Australia, such access is not possible due to a scarcity of child and adolescent mental health services. There is therefore a need to give more formal and informal training in child and adolescent mental health to professionals working in primary health care and school-based services. There is also a need to increase the number of specialized child and adolescent mental health services.

Compounding the problem are the barriers to care reported by young people. For example, 14 percent of adolescents reported being worried about what other people would think of them if they sought help. 38 percent report that they preferred to manage their own problems, and other major barriers include thinking nothing would help (18 percent) and not knowing where to get help (17 percent)[9].

Moreover, adolescents with mental health problems do not have problems that are limited to a single aspect of their lives. There are some striking findings around the relationship between the frequency of emotional and behavioural problems and health-risk behaviour. For example, 50 per cent of adolescents with a high level of problems reported smoking or drinking during the previous few months, and 30 per cent of this group reported at least one episode of binge drinking during the previous month. In addition to the immediate social and economic costs to young people, their families and communities, these effects can have longer-lasting consequences as the health risks and behaviours which accumulate in adolescence often continue into later life where their persistence contributes to the burden of adult disability and mortality, and increased health and disability program costs. There is consequently a need to develop joint policies and strategies across the different programs and services that provide help to young people with mental health and related problems.

As a result, young people are an extremely vulnerable group. They require a different psycho-social approach to meet their health needs which relies on good rapport with general practitioners and other care providers and access to “youth friendly” systems. Marginalised young people and those disconnected from family and school do not necessarily access mainstream services such as general practice. There is a need for specialised services to reach these young people, and for these services to have a strong primary care interface so that discharge for recovery and rehabilitation in primary care can occur. Equally, *Better Outcomes* needs to allow enrolled GPs to deliver mental health care in settings where young people ‘hang out’ such as youth centres and clinics. At present, this is not possible if the centre is not accredited.

Yet practices such as these are often lacking in the current system: establishing rapport can necessitate longer and more frequent consultations with financial disincentives to both client and practitioner, whilst different, youth-friendly settings for care are frequently unavailable. The GP is often the last line of defence for young people. Many young people attempt, or complete suicide, after having seen a GP in the recent past. The GP can also be the lynchpin through which young people can be re-engaged with their family and other social supports, however, they need support in this area. Divisions are ideally placed to bring together the relevant agencies such as GPs, schools, other providers and family/community support groups for better targeted referrals, collaboration and referral pathways.

Recommendations

> *"The main task of developing adolescent and youth health….lies in the development of successful programs in the social settings where young people live and work (schools, families, communities) and in the health care settings where most young people are likely to be seen (primary care)"*
>
> *Professor George Patton, The Scope for Youth Health Development, Centre for Adolescent Health, 1999*

- *Expand* Better Outcomes *to allow enrolled GPs to deliver services in youth centres/clinics, ensure each Division has access to child and adolescent health services, GPs have access to dedicated education, training and support in child and adolescent mental health and Divisions have capacity to broker shared care and other collaborative arrangements with specialist health and community providers*

- *Expand the MindMatters Plus GP demonstration project currently in 23 Divisions nation-wide to ensure GPs in all Divisions are trained in youth mental health and linked with specialist services, schools, youth centres and other primary care providers for prevention, early intervention, targeted referral and continuity of care for young people with high mental health support needs*

- *Introduce a Medicare item for an annual health check for adolescents that acknowledges that additional time is required to engage the young person and support preventative health advice, – including risk assessment where appropriate*

- *Introduce specialised early intervention youth mental health services, particularly targeting marginalised young people who do not necessarily access mainstream primary care services*

- *Develop guidance for services that emphasize service reorientation to meet the complex and often comorbid problems of young people, and investment by governments in more appropriate specialist facilities to meet the needs of young people.*

The aged

Although the overall prevalence of mental disorders declines with age[35], mental health can constitute a considerable health burden for a number of older Australians, either as single conditions, or more commonly, as co-morbidities in association with chronic or other illness[36]. In particular, depression and suicide are significant problems amongst older Australians, especially for residents of aged care homes where depression rates are estimated to be as high as 60.5 percent for residents in high need facilities and are about 47 percent for those in low care facilities[37].

Elderly people are particularly prone to depression because of a range of life events that frequently coincide with ageing such as physical illness, isolation, chronic pain and bereavement[6]. Diagnosing depression in older Australians can, however, be difficult - the risk factors for depression in the elderly are many and varied. Consequently, depression in the elderly can be overlooked. This occurs for several reasons. Firstly depression can be perceived as just a normal consequence of the physical, social and

economic difficulties that can occur with ageing – an attitude which is often shared by both patients and health care professionals themselves[38]. Secondly because symptoms, such as sleep problems and reduced energy levels (which are still good indicators of depression in the elderly) are often attributed purely to age-related change; And thirdly because other symptoms of depression - such as difficulty concentrating, lapses in personal hygiene and memory loss - can also be confused with dementia. As a result, depression in older and elderly Australians is both under diagnosed as well as misdiagnosed[39].

Suicide rates amongst Australians over 65 years continue to be high, (particularly in men, whose suicide rate of around 29 per 100,000 is about four times that of older women) whilst suicide rates for males aged 85 years and over are the highest in the country[40]. Furthermore, despite these rates, there are indications that whilst many elderly male suicide victims are depressed, less than one third are receiving the necessary psychiatric care[41].

Like young people, older Australians are generally mentally healthy, particularly those living in private dwellings whose psychological distress is much lower than overall population rates[42]. However, also like young people, when older people become mentally unwell the impact is often profound and accompanied by a high risk of comorbidity and relapse. For example, the 2003 *Australia's Welfare* report show that in 1998, psychiatric, intellectual and other specific mental health disorders comprised a significant proportion of the conditions affecting older Australians. In addition, it is well established that chronic illnesses, such as arthritis - one of the main disabling conditions of ageing - are also associated with substantial mental health co-morbidity. This means that overall, mental health can constitute a considerable health burden for a number of older Australians, either as single conditions, or, more commonly, as co-morbidities.

Promoting *wellness* in older Australians is equally as important as mental health diagnosis and treatment. Health and social systems need to promote protective factors that guard against mental health problems. Many of these are well known and foremost among them is a sense of connectedness to community, to family and to place. In particular, the current ideal of "ageing in place" which may assist in promoting improved mental health for older Australians, is harder to achieve in rural and remote areas due to the smaller range of care services available. In addition, while rural communities may arguably benefit from an increased sense of community, rurality itself can often increase isolation, so adding to mental health problems[43]. Further, current Australian society with its blended, nuclear or single parent families and the increasing lack of availability of (mainly female) family members to support elderly relatives and parents mean that in practice, older Australians can become a forgotten segment of the population. This makes them vulnerable at a time in their life when they may most need care, especially as they face a decline in physical functioning and the loss of their own peer group for support.

Recommendations

- *Increased training and support for GPs and other aged care workers to identify and assist in the joint management of depression and other mental health issues in the aged*

- *Ongoing utilisation of Divisions in partnership with other agencies to implement self-help and other community-based programs which can assist older people with physical and mental health co-morbidities*

- *Develop resources and a communication strategy to assist families to identify the signs of depression in ageing relatives*

- *Promotion of 'ageing in place' under a mental health promotion and prevention program to be introduced and implemented under the National Strategy for an Ageing Australia .*

Indigenous Australians

The mental health of health of Indigenous Australians continues to be a major concern. The risk that indigenous people will die from external causes including suicide and assault is three times higher than for non-indigenous Australians.[44] Indigenous people also suffer a higher burden of emotional distress and possible mental illness than that experienced by the wider community. Compared with other Australians, Indigenous people are disadvantaged with regard to a range of socio-economic indicators, including education, employment, income and housing, further increasing their risk of mental and physical ill health[45]. They also experience lower levels of access to health services than the general population, are more likely than non-Indigenous people to be hospitalised for most diseases and conditions and are more likely to experience disability and reduced quality of life due to ill health than other Australians[46].

Compared to the general population, Aboriginal people experience a much higher burden associated with the emotional or behavioural difficulties of their children[47]. Some 24 per cent of Aboriginal children are at high risk of clinically significant emotional and behavioural difficulties. This means that about 5,500 Aboriginal children could benefit from treatment or support services for these difficulties[48]. However, there are many structural, geographic, systemic and cultural barriers to the delivery of mental health care to Aboriginal people. Cultural phenomena in indigenous patients can be misinterpreted as mental health problems and the availability and retention of appropriately trained indigenous mental health workers and primary care workers is an ongoing problem.

Recommendations

- *Indigenous cultural awareness training for practitioners rolled out through Divisions*

- *Education and training for GPs in identification and effective management of Indigenous mental health to be rolled out through divisions in conjunction with local indigenous communities and/or indigenous service providers.*

- *Education and training for indigenous health care workers in improved recognition of the signs and symptoms of mental health problems and disorders*

- *Support the delivery of culturally appropriate primary mental health care services, including allied health services under Better Outcomes*

Socially and geographically isolated

Social and geographical isolation are important factors in mental health and it is well established that social isolation can contribute to mental health issues[49]. Social isolation can particularly affect those patients from culturally and linguistically diverse groups, those in rural and remote areas, individuals who are immobilised / bedridden, the unemployed and single parents at home with young children who are removed from other help and support.

Geographical isolation is also of relevance. Although there is little difference in the actual prevalence of mental health disorders across rural, remote and metropolitan areas, mental health specialists are particularly scarce in rural and remote areas. Consequently, there is even greater reliance on GPs for mental health care in these regions. Despite this, rates of GP encounters for psychological problems for non-metropolitan residents are lower than for metropolitan residents [14]. Accessing relevant primary care services is therefore a key barrier to appropriate care for patients with mental health issues in rural and remote Australia. In addition costs involved with service delivery are often higher in remotes areas, eg Kimberley's and relevant models with adequate resourcing are needed to address the needs of remote communities.

Social and geographical isolation can particularly affect older Australians as they become removed from family members who can help to look after their increasing needs. In particular, the current ideal of "ageing in place" which may assist in promoting improved mental health for older Australians, is harder to achieve in geographically isolated areas due to the smaller range of care services available. In addition, while rural communities may arguably benefit from an increased sense of community, rurality itself can often increase geographical isolation, so adding to mental health problems [43] through, for example, decreased access to services. This includes access to GPs, as well as to specialised and allied health services which in turn impacts on access to multidisciplinary care.

Recommendations

- *Continue support for and expand the More Allied Health Services (MAHS) program and introduce appropriate and flexible models of allied health service delivery in rural and remote areas through Divisions of General Practice*

- *Continue to provide schemes to attract and retain GPs, practice nurses and other primary care workers to regional/ rural and remote Australia through Divisions of General Practice*

- *Support Divisions to provide appropriate workforce support and service linkages*

- *Develop, fund and deliver models of education and training relevant to rural and remote GPs through Divisions*

Complex comorbid conditions

There is no doubt there should be greater policy interest in the relationship between physical and mental health. There is increasing evidence that failing to treat people holistically results in poorer health outcomes and quality of life for consumers, and increases the overall costs of service provision. Early intervention in mental health is a frequently overlooked mechanism for cost effective management of both mental health and chronic physical disease such as diabetes. This has implications for consumers,

clinicians, policy makers, service planners and health economists and raises the question as to whether people with mental illness receive an appropriate level of care for their physical health problems.

It has been well documented that mental health problems and disorders are common in the community. What is beginning to be better understood are the wider health implications of having a mental health problem or disorder. These include:

- Mental health disorders operating as an independent risk factor for the development of physical disease. There is now strong and consistent evidence of an independent and causal association between depression, social isolation and lack of quality support and the causes and prognosis of coronary heart disease (CHD). The increased risk is of similar order to the more conventional CHD risk factors such as smoking[50];
- A higher incidence of mental health disorders or illnesses in those with chronic disease. Many studies have demonstrated an increased risk for depression in those with chronic medical conditions. The increased risk varies from double that in the general population to up to 10 times the risk in selected chronic diseases. This means that 10-50 per cent of those with chronic mental health conditions will also have depression. For example, those with diabetes are 3 times more likely to have depression. People who suffer from diabetes and depression are more likely to have both poorer glycaemic control, and a higher incidence of microvascular and macrovascular complications. Conversely, if depression is treated in this population, there is improved glycaemic control and improved quality of life, and
- A higher incidence of physical disease in those with mental health disorders or illnesses. People with mental illness have been shown to have more physical illnesses than the general population, higher rates of illness related to behavioural factors such as smoking and poor diet, and are more likely not to have a physical illness diagnosed[51].

In September 2002, the WA Government established an advisory group to develop a response to this evidence, particularly the last point. The group recommended a number of measures including the need to ensure that attention to the physical health status of mental health consumers is incorporated into routine clinical protocols and is properly documented, to improve the transfer of that information between health sectors, to promote and support the central role of GPs in the care and monitoring of the physical health of mental health consumers and the need for better training of health professionals in the areas of the physical wellbeing of those affected by mental illness.

<u>Recommendations</u>

- *Ensure that chronic disease and population health initiatives such as the Lifestyle Prescriptions Initiative includes a psychsocial component*

- *Implement the recommendations of the WA HealthRight committee nationally, particularly:*

    - *measures to support GPs in the physical care of mental health consumers such as*

        - *trialling enrolled populations across general practice, community agencies and specialist mental health services for packages of care,*

  - *Medicare incentives such as item numbers for preventive physical health check and supporting the role of the practice nurse in proactive and preventative care with the consumer,*
  - *adaptation of the 3-step mental health process to incorporate a prompt for an annual check*.

- *Provide incentives and support for practice nurses to play a greater role in the primary mental health care team providing a proactive service including playing a role in health promotion and other chronic disease management*

- *Introducing standards to improve the quality of mental health services so as to include physical health care in the routine care of mental health consumers*

- *Introducing structural linkages, protocols and other structural linkages between general practice and specialist services, particularly at points of service entry and discharge*

- *Incorporation of mental health promotion strategies in existing and emerging lifestyle risk factor management programs.*

Drug and alcohol dependence

Comorbidity of mental disorders and substance use disorders is common. Furthermore, comorbidity is often associated with poor treatment outcome, an illness course that is more likely to become chronic and disabling, and high service utilisation[52]. The National Survey of Mental Health and Wellbeing showed a considerable degree of comorbidity in substance use disorders and other mental health. About one in four persons with an anxiety, affective or substance use disorder also had at least one other mental disorder[53].

The survey also included a low prevalence study of psychotic disorders. This study demonstrated that drug and alcohol use disorders were highly prevalent in those with psychotic illnesses. Nicotine was the most commonly used drug in this sample with 67 percent using nicotine in the previous 12 months. Lifetime diagnoses of alcohol use disorder were found in 30 percent of the sample and cannabis use disorder in 25 percent.

Comorbidity is of particular concern for young people aged 15-24 years. As discussed earlier, the recent Australian burden of disease and injury study found that nine out of the ten leading causes of burden in young males, and eight out of ten leading causes in young females were substance use disorders or mental disorders. Comorbidity of these disorders is high with over 50 per cent having comorbid disorders[54]. 8Particular barriers to service provision for young people with presenting substance use and mental health problems have been identified including the lack of suitable and appropriate accommodation with suitable primary care outreach, lack of specialist services and lack of appropriate 'youth friendly' models of service provision[55].

The prevalence of comorbidity in the community has profound implications for service delivery. Standard interventions are complicated or even excluded in individuals with comorbid disorders. One the one hand, comorbid substance use disorders can pose difficulties for treatments that are narrowly defined for specific symptoms, or those treatments may have been developed on pure diagnostic groups and therefore of unknown benefit for comorbid individuals. Conversely, anxiety and depression can

complicate the treatment of a substance use disorder. Yet treatment services have to deal with disproportionate numbers of comorbid individuals who are over-represented in treatment settings. Staff are trained within one discipline and rarely have the skills to recognise, let alone deal with, these more complex presentations [52].

GPs frequently encounter people with coexisting mental health problems and substance use. In fact, many people experiencing comorbidity difficulties are never seen by a specialist with GPs being the first and only point of contact for a majority of sufferers. In addition, the spectrum of comorbidity disability seen by GPs is much broader than that seen in specialist services which generally treat only the most severely affected and disabled patients. GPs encounter difficulties similar to those experienced by most health care providers involved in the care of people with mental health and substance use comorbidity. Patients with comorbidity are considered by GPs to be problematic to work with, difficult to evaluate, and even harder to find treatment for These views are exacerbated by low levels of education and training in comorbidity issues and little access to clinical support or supervision for GPs by specialists. A 2001 review of comorbidity management in general practice drew three main conclusions: there needs to be support for primary care/general practice based research into clinical approaches to comorbidity to test which interventions work, shared care programs that have in the past focused on either mental health or substance use need to be enriched to address comorbidity in an integrated manner, and there needs to be support for up-skilling in the mental health and addictions area for GPs[56].

Recommendations

- *Targeted support for GPs to manage co-morbidity issues within the general practice setting*

- *Introduction of comprehensive training and systems integration for clinicians and relevant social care workers to ensure screening and assessment are mandatory and referral options and clinical support are clear and present*

- *The development of innovative specialist, integrated services for people with co-morbidity (eg at the moment people misusing substances are often considered inappropriate for mental health services, with the flip side being that people with severe mental illness and substance misuse problems are not acceptable in drug and alcohol services*

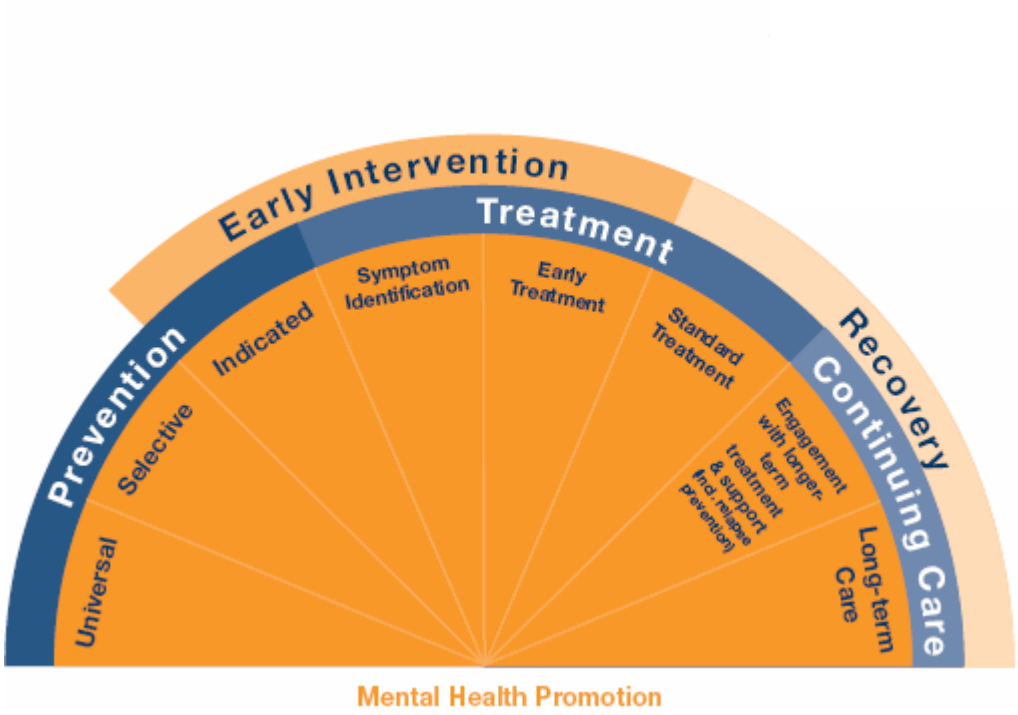
Terms of reference h: The role of primary care in promotion, prevention, early detection and chronic care management

Primary care has a key role to play at many levels of the mental health spectrum of interventions (Figure 4). Mental health services delivered by GPs are range from prevention, early intervention and early treatment ends of the spectrum for some consumers, and across the full range of the spectrum with others. GPs are ideally placed to play an ongoing role in the management of physical health and relapse prevention at the continuing care end of the spectrum in conjunction with specialist treatment providers for those consumers requiring specialist mental health services.

This section principally discusses the role of primary care in the early intervention, treatment and chronic care management of mental health problems and disorders. The role of primary care in promotion and prevention is discussed further under terms

of reference f, particularly with regard to child and youth populations. Our response under terms of reference f also discusses chronic care management with regard to the relationship between physical and mental health.

Figure 4: Spectrum of interventions for mental health.
Source: Adapted from Commonwealth Department of Health and Aged Care 2000 and Mrazek and Haggerty 1994



Policy responses to date which explicitly recognise and support the role of general practice in mental health care service delivery have been the inclusion of general practice as a key setting in the *National Mental Health Plan 1998-2003*, and two federally funded initiatives: the *National Primary Mental Health Care* and *Better Outcomes in Mental Health Care* Initiatives (see Section 2.3 and 2.4).

Better Outcomes is a multi-dimensional program centred around general practice with a focus on providing early and brief intervention. It is based on international evidence which indicates that, to get better mental health outcomes, a whole system is needed that combines primary care with specialist interventions in an integrated way. It recognises that not only are GPs the gatekeeper to other community resources such as specialist psychiatric and acute care, they are also the most accessible source of mental health care in the community. Hence, any attempt to improve mental health on a population-wide basis could not be achieved by the specialist mental health services alone: general practice must be a central plank. The usual system of primary care with specialist referrals isn't as good, and enhancing the skills of GPs without making the rest of the system responsive isn't enough either.

Better Outcomes is designed to achieve an integrated system where allied health is linked to general practice to provide earlier intervention via a short series (up to 12) of

non-pharmacological psychological treatments, where psychiatrists are engaged to be more responsive consultants, and where review and follow-up of patients is a critical part of the process.

Implementation commenced in July 2002 with the rollout of the first round of education and training. It has exceeded both the expectations of the Better Outcomes Implementation Advisory Group and international commentators:

> *"This is a world first for Australia. No other country is doing what you are doing and it seems to have had a tremendous start, this program. The uptake by Australian GPs in learning mental health skills exceeds my most optimistic predictions and I have discerned a very much changed attitude towards collaborative working in mental health"*
> *Professor Sir David Goldberg, UK Institute of Psychiatry, May 2003*

Since July 2002:

- Over 4,200 GPs have completed level 1 training. This figure represents one in five GPs, and is as high as 1 in 3 in some regional areas and states. Almost 900 GPs have completed level 2 training. *Better Outcomes* has also stimulated the increased availability of quality mental health education and training for GPs. In the period 1 January 2002 to 31 December 2004, over 8,600 GPs completed at least one activity accredited as a component of level 1 training, over 10,000 GPs completed other mental health activity, and over 13,000 GPs completed any training relating to mental health[57].
- 105 allied health services covering 112 Divisions of General Practice have been established nation-wide, including in regional and rural areas and 55 Divisions have received (limited) funding to expand service delivery into additional high need areas such as child and adolescent mental health and drug and alcohol comorbidity from mid 2005
- A national psychiatry support service has been established to support GPs with advice within 24 hours on patient's mental management. The service has been widely welcomed by GPs. An average of 50 requests each week is made to the service, with 630 GPs registered to use the email facility[58].

Of all the measures funded by the federal government under recent national mental health plans, *Better Outcomes* has been a relative policy success, a success that has been consistently supported by all national mental health stakeholders as demonstrated by the joint statement issued in the pre-election period last year.

For the period January 2003 to December 2004, over 30,000 3-step mental health plans had been delivered by GPs and over 33,500 focused psychological strategies had been delivered[59]. The uptake of allied health services is high. At December 2004, almost 2,000 GPs had referred almost 13,000 consumers for focused psychological care by allied health professionals. Almost 50,000 sessions of therapy had been received by consumers with an average (mean) of 3.6 sessions per consumer. The number of allied health professionals taking referrals numbered 569[60]. It is noteworthy that this is an under-estimate as not all Divisions have completed data entry to the minimum data set at December 2004.

The services are clearly reaching the consumers that they are intended to target. For example, the majority (62 percent) is on low incomes, most have been diagnosed with depression (76 percent) and/or anxiety disorders by their GPs, and 46 per cent have no previous history of specialist mental health care indicating that access may have been problematic for them. There are good indications that the services are being

delivered in the way in which was envisaged when Better Outcomes was conceived ie. Providing free or low-cost evidence based mental health care to consumers through structured sessions.

Focus group, interview and survey data from the local evaluation reports suggest that participating GPs, allied health professionals and consumers are very satisfied with the services[61]. The following anecdotes are from a series of case studies put together by ADGP:

"This project has made my life so much easier as a GP. It really has. It has enabled me to actually offer something to my patients"
GP, urban Sydney

"I still don't like the amount of paperwork, but I'll be devastated if we lose this project. I don't know how I managed before I was able to refer some of these patients"
GP, outer metropolitan Melbourne

"Because I have the time to do a comprehensive assessment I have been able to discover for the first time significant factors about patients who I have treated for years"
GP, regional NSW

"….I had the good fortune to meet Dr A, who unlike so many others, actually took the time not only to write out a prescription but also to discuss my anxiety disorder and offer me some help in trying to overcome it. And it would all be given free of charge. An appointment was made for me (with the psychologist) and I drove home with tears in my eyes, so thankful that after all these years there may be some way for me to curb this….."
Consumer, Victoria

"The relationship between my GP and counsellor was really effective in my case and I believe has everything to do with getting exactly what I needed at the time"
Consumer, Perth

"It's incredibly satisfying to assist GPs in providing treatment – I am also able to assist in empowering people through provision of education, information and skills training. I enjoy working in the medical practices and believe that co-location has significantly contributed to the success of the program. In particular, the practice is familiar to the patient and there is none of the possible stigma in attending a mental illness facility"
Allied health professional, regional Victoria

In just three years, with the support of the Divisions Network to drive change, *Better Outcomes* has delivered an informed educated and better connected primary care workforce, a national network of allied health practitioners with established links to tertiary and specialists services, new referral pathways including in regional and rural Australia and urgent back-up for GPs for a national psychiatry support service.

The initiative represents an ambitious change to general practice and is, in many respects, a system in development. There are presently a number of limitations to the program in terms of its compatibility with current general practice, and community access. If not addressed these will pose serious impediments to the future viability of the initiative:

- There have been calls to better promote the initiative to the community. However, not all GPs are registered to participate. There is an argument that level 1 training, which essentially centres on the principles and practice of conducting a structured mental health care plan, should be systemically embedded in both the undergraduate medical curricula and GP registrar training. It is at this point that attitudes and patterns of practice are established. Indeed, this was part of the original policy intent behind *Better Outcomes*. This, and the funding limits on the allied health services, is a serious barrier to eligible consumers accessing the program on a universal basis. In addition, the requirement that GPs participating in *Better Outcomes* operate from accredited practices prohibits access to primary mental health care to some of the highest need populations in the community such as young people and Aboriginal people
- The paperwork involved and other changes to practice that GPs have to make is an ongoing barrier for many. This is reflected in the claim rates for the 3-step mental health process. Based on December quarter HIC statistics, the ratio of claims to registered providers nationally was 48 per cent. This clearly indicates that a great number of registered providers are *not claiming at all*, and leaves unanswered how many providers are actively claiming. Reasons given by GPs for non-claiming include difficulty in patient return for the review visit which triggers the item, and the rigidity of the process itself, some which may be overcome by the 1 May MBS changes to the item number. Feedback from GPs indicates that close attention will need to paid to these changes and that further adjustments may need to be made to make access to the item more GP friendly
- Other adjuncts, including additional clinical support to build practice capacity in mental health, have not been explored. Options include the provision of psycho-education in the practice setting and exploring the role of practice nurses in primary mental health care delivery.
- The GPs who are most in need of training are the ones experiencing most difficulty accessing that training in order to participate in the initiative. There is a shortage of GPs in rural and remote areas and, due to the low number of mental health specialists in rural and remote areas, rural GPs have little option of referring patients on for care. This means that rural consumers have little choice in accessing care and it is therefore imperative that rural and remote GPs are adequately trained in the diagnosis and management of mental health issues. However, access to the prerequisite level 1 and 2 training is problematic for them. Similarly, for rural and remote GPs who are registered face the same difficulties accessing the training they require to maintain their continuing professional development (CPD) points in mental health and hence stay as a *Better Outcomes* participant. There are no suitable on-line training courses available. Training providers rarely visit rural and remote centres which means that GPs have to travel to major centres to access training invariably leaving their practices unattended and entire towns/regions without medical care due to a lack of available locum coverage. There is a need for a number of viable options for improving access to training that suit the individual needs of the GP, including ensuring level 1 training becomes embedded in undergraduate medical and/or fellowship training.
- Allied health services are popular with GPs, allied health providers and consumers but demand is far outstripping supply. It is perverse that GPs belonging to Divisions who have worked hard to enrol a large number of GPs in the program are then penalised when the available allied health services are

'rationed' due to capped funds. In terms of service administration, regional and rural Divisions face challenges such as attracting suitably credentialled allied health workers to their communities. This is often due to the availability of relatively short term (annual) employment contracts . Recruitment and retention challenges are compounded by *Better Outcomes'* current status as a lapsing program which means it is difficult for divisions to offer ongoing positions to allied health professionals and facilitate recruiting and retaining them in rural and regional centres.

- Enhanced engagement by the public and private specialist mental sectors will be important to GPs remaining enthusiastic and supported and *Better Outcomes* remaining viable. This was the original policy intent but progress has been slow. There has been some progress with regard to GP and psychiatry liaison with the upcoming item numbers and plans for other supporting activity in this area (see terms of reference d). This along with strategies to improve integration and linkages between primary care and the public mental health system must be accelerated (see comments against terms of reference b, c, i)
- Capacity in Divisions of General Practice has been repeatedly demonstrated as the single most critical enabler to GPs taking up the initiative. Divisions have implemented familiarisation training, level 1 and 2 training, initiated peer support groups, established and administered allied health services, supported the evaluation of the initiative through data entry into the minimum dataset and conduct of local evaluation and, in many areas, have brokered service agreements and other collaborative arrangements with mental health services. However, funding to Divisions has not kept pace with both GP interest in and the pace of implementation required around contemporary primary mental health care developments. Some limited funding was provided by the Department of Health and Ageing (approximately $12,000 per Division) to support the early uptake of *Better Outcomes*. This has since been withdrawn. With the exception of a small administrative overhead, Divisions are now funding mental health out of their 'core' contracts for which they have received no growth funding. It is of grave concern that Divisions are being forced to cut their mental health capacity severely at a time where it is critical to community access that *Better Outcomes* continues to be promoted and GPs supported to participate. Any part of the health system depends on an effective and viable infrastructure. The Divisions Network has provided that function for primary mental health care reform, and it is vital to strengthening primary mental health capacity and linkages with specialist providers that such an infrastructure is seen as worthy of ongoing resourcing.
- While Budget measures to expand the program are welcome, this level of funding will be no where near sufficient to absorb the legitimate demand for primary mental health care services in the community.

Better Outcomes is a 'win-win' for GPs, consumers/carers and allied health professionals. The limitations discussed here are systemic, structural and financial. With political will, they can be overcome and are certainly no reason to discontinue the initiative. Given the Initiative has demonstrated it has the capacity to deliver care to those in the population experiencing whom *have never before received help*, quite the opposite needs to occur.
Investment and effort in addressing these needs to occur in order to build on the gains of *Better Outcomes* and embed it as a system of primary mental health care that all GPs and, most importantly, those in need in the community can access.

Recommendations

- *Provide a ten-fold increase in funding to Better Outcomes including a minimum of $150 million per annum for expansion of the allied health service program particularly to include co-located practice mental health nurses and psychologists , the addition of child and adolescent mental health services, and funding to boost the capacity of Divisions to continue to support the program*

- *Increase remuneration to GPs for time spent on mental health consultations*

- *The allied health workforce is currently underutilised in primary health care. Introduce strategies to improve access and overcome low incentives for them to work in primary care*

- *In the immediate term, reallocate underspends on the 3-step mental health process to allied health services and Divisional programs to better meet community need for primary mental health services*

- *Introduce strategies to support access to education and training particularly for rural GPs including on-line self-directed training courses, options that will facilitate outreach by training providers to deliver training to regional networks of GPs, the provision of capacity to support GPs meet the costs of locum support and capacity for Divisions to offer small group learning opportunities .*

- *Link rural allied health workforce incentives to participation in Better Outcomes*

- *Allow for some exception criteria for GPs working outside of accredited practices, particularly those working with high need population groups such as Aboriginal people and youth in settings such as aboriginal community controlled health services and community-based youth health centres, and locally flexible and appropriate solutions to primary mental health care delivery in remote communities who currently cannot comply with allied health services guidelines*

- *Strategies to improve links and promote service integration between primary care and specialist public mental health services are ad hoc and not occurring systemically or consistently nationally. There is great variability of 'buy-in' by state and territory governments. This needs to be driven by a national primary mental health care policy (see terms of reference a, b,c).*

- *Support the strategies to boost practice capacity in mental health care such as the integration of psycho-education and resources to promote self-management as adjuncts to clinical practice, and education and training to involve practice nurses in the primary mental health care team*

- *Support and fund Divisions with dedicated mental health funding to continue to promote and build primary mental health care capacity in general practice, including access to viable ongoing education, training and peer support and systems of collaborative care and service integration with both private and public service providers.*

Terms of reference I: The adequacy of education in de-stigmatising mental illness and disorders in providing support service information to people affected by mental illness and their families and carers.

Health literacy has been defined as the ability to gain access to, understand, and use information in ways which promote and maintain good health[62]. It is important to health service users recognising risk factors, illness and seeking appropriate help. The term 'mental health literacy' is a relatively new concept but is generally understood to refer to the knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognise specific disorders, knowing how to seek mental health information, knowledge of risk factors and causes, of self-treatments, and of professional help available, and attitudes that promote recognition and appropriate help seeking[63].

A number of studies of adult mental health literacy have been conducted. Foremost among these is a study conducted by the Centre for Mental Health Research (CMHR) which indicated that public views diverge from those of health professionals, particularly mental health specialists. Such differences may lead to unwillingness to accept help from mental health professionals, or to a lack of adherence to advice given. Of greatest importance to mental health policy, the study concluded that if mental health disorders are to be recognised early and appropriate action taken, including appropriate clinical intervention, the level of mental health literacy in the community needs to be raised[64].

The research also indicates that the community rates general practitioners as most likely to be helpful leading researchers to comment that while there has been considerable investment in improving the recognition and management of mental disorders in primary care, this knowledge needs to reach the consumers of services so that they can play a more effective role in the management of their own health.

Despite the comparatively high level of mental health problems in this group, less research has focused on the knowledge of young people. Preliminary results from the CMHR's Adolescent Mental Health Literacy Study indicate that although mental health literacy and attitudes to those with mental health problems among this group are quite good, young people are not seeking the help they need[65].

Increasing the levels of mental health literacy in the community and in particular settings, and decreasing levels of stigma associated experienced by people with mental health problems and mental illness has been a long-standing public health goal of the National Mental Health Policy and the series of five year national plans that have underpinned its implementation to date. Some steps have been taken to achieve this goal. A federally funded National Community Awareness Program implemented in the mid 1990s had some success, but was not sustained. Most recently, *beyondblue: the national depression initiative* has made great inroads to community awareness of depression and received funding for a second five year term to continue this work. In collaboration with *beyondblue*, ADGP produced and disseminated a Community Service Announcement (CSA) promoting the GP as the first port of call for mental health problems. The CSA was taken up by many state and regional commercial television broadcasters, including Imparja. Anecdotal reports from Divisions of General Practice indicated that it stimulated awareness and help-seeking at the local level, and gave Divisions a 'hook' to promote participation in *Better Outcomes* to GPs in order that they may access training and allied health support to meet this community need. The above results indicate that we need to a sophisticated, multi-layered, settings-based approach to promoting mental health literacy.

Recommendations

- *Fund and implement a national community awareness campaign complemented by a targeted mental health awareness programs in key settings such as primary health care*
- *Continued support for beyondblue: the national depression initiative*
- *Ongoing funding for the suite of MindMatters initiatives*
- *Ongoing support for meaningful consumer and carer involvement in design, implementation and evaluation of mental health services.*

Terms of reference p: The potential for new modes of delivery of mental health care, including e-technology

Discussion here centres on the potential offered by e-health to mental health service delivery. Other modes of service delivery such as a role for practice nurses in the primary mental health care team, systems of consultation-liaison between private psychiatry and general practice and shared care, for example, are discussed elsewhere.

Consensus on the precise definition of e-health is yet to be reached, however the Journal of Medical Internet Research has described it as follows:
"*e-health is an emerging field in the intersection of medical informatics, public health and business, referring to health services and information delivered or enhanced through the Internet and related technologies. In a broader sense, the term characterizes not only a technical development, but also a state-of-mind, a way of thinking, an attitude, and a commitment for networked, global thinking, to improve health care locally, regionally, and worldwide by using information and communication technology*[66]*."*

Broadly speaking, e-health can be thought of as those healthcare practices which are supported by electronic processes and communication. It encompasses:

- how consumers interact with health services and information online, eg. tele-psychiatry, accessing consumer health information
- institution to institution transmission of data and information, including on-line training for professionals and electronic transfer of patient information
- within-institution data storage and access eg. general practice software packages such as Medical Director
- consumer to consumer on-line interactions, for example, electronic support groups and "chat rooms"

E-health offers a number of opportunities for new modes of mental health service delivery and workforce development. A number of psycho-education and cognitive behaviour therapy (CBT) programs are available on line and several promising approaches such as CLIMATE, MoodGym, Panic Online are already being implemented in general practice, largely as clinical adjuncts to focussed psychological strategies delivered by allied health professionals under *Better Outcomes* in particular service delivery models.

Although evidence for the effectiveness of CBT in treating a variety of mental health conditions is well established[67], evidence for the effectiveness of CBT on-line is still developing. (Mood gym is currently undergoing a large scale clinical trial with results pending). However, results from several recent studies show promise. For example,

one study investigating the use of web-based interventions in anxiety disorder showed that whilst the use of such interventions may be associated with high attrition rates, significant improvements are gained in those people who continue with the program. This is true even for people who remain with the program for less than 12 weeks[68]. Another study looking at the use of Internet-guided interventions in people with phobic as well as panic disorders has also shown that computer-aided CBT self-help at home via the internet is effective[69].

The use of such interventions provides a valuable mechanism through which to cope with the huge burden that mental health places on the public health system, a system which in Australia often struggles to meet the demand. Most mental health treatment–delivery episodes require a consumer-health practitioner interaction which are costly in terms of human resources and can exacerbate the inequalities in health service delivery based on geographic location. E-health can start to overcome these limitations whilst still providing effective, affordable care which can be accessed at a time and place convenient to the health consumer. Indeed, technology has already enabled GPs, particularly those working in rural and remote areas to provide a better standard of mental health care through the provision of GP training and access to specialist psychiatrist support through telepsychiatry.

GPs delivering primary mental health care identify a wide variety of needs. Some of these may be enhanced by web-based systems and telepsychiatry. Some steps have been taken with regard to web-based supports such as the psych support line funded under *Better Outcomes*, whereby GPs seek advice about a clinical query via secure email. There is, however, considerable scope to take a systematic approach to developing other supports such as decision support systems, on-line education and rapid responses from experts on individual clinical issues[70].

Telepsychiatry is the conduct of psychiatric consultation or case conference through video-teleconferencing where the patient and psychiatrist are in different sites. Education has also been a strong focus for Australian telepsychiatry sites as a means of reducing isolation, and improving knowledge and job satisfaction for health care staff[71]. With regard to clinical services, Australian studies indicate high levels of patient satisfaction, high inter-rater reliability when telepsychiatry and face-to-face consultations were compared, and patient outcomes which were equal to face-to-face consultations[72]. Telepsychiatry is an establishing method providing high user satisfaction and good outcomes[73]. However, since its introduction in 1995 usage has varied between states. To be effective, consumers, GPs and other providers, particularly those in rural and remote communities, need access to appropriate enabling technology such as broadband, the internet and video teleconferencing facilities. In addition, dissemination of the knowledge we have about effective modes of telepsychiatry needs to occur.

<u>Recommendations</u>

- *Increased IM/IT funding for general practice, and accelerated implementation of broadband into general practice*
- *Support the availability and accessibility of viable on-line mental health skills training*
- *Support the integration of evidence based on-line consumer self-help resources, psycho-education and focused psychological strategies into primary mental health care delivery*

- *Improve availability and systematic access to web-based support systems for GPs and viable telepsychiatry including case conferencing, care planning, diagnosis and assessment.*

4 Conclusion

The primary care setting is, in fact, the place where mental health services are most needed"

T Bedirhan Ustun, Division of Mental Health, World Health Organisation, Switzerland, 1998

World Health Organisation predictions[74] and Australian data point to mental health as one of the greatest public health priorities today. The highest burden, highest impact, highest costs disorders are depression, anxiety, and substance use disorders, and there is considerable comorbidity across physical and mental illnesses.

Mental health is not just a matter for health policy. The impact of mental health problems and disorders are felt in the community in poor vocational, educational, social and economic outcomes for consumers and their carers and families. Australia needs robust, meaningful and systematic mental health service delivery reform, driven by a whole-of-government policy commitment at all levels of government through the Council of Australian Governments (COAG). .

General practice the key health setting for the management and coordination of acare of high prevalence disorders and/or coordination of care of these and common comorbidities but cannot act alone. Despite some of the developments outlined in section 2, much more needs to be done*. Out of Hospital, Out of Mind*, a major report of community consultations on the priorities for future mental health policy by the Mental Health Council of Australia, found that primary mental health is among one of the most underdeveloped areas of mental health in Australia.

The recently endorsed *National Mental Health Plan 2003-2008* recognises the importance of continuing to develop systems that enhance the role of GPs and other primary care providers in delivering mental health care and deliver continuity of care through integrated primary care and specialist sectors. This is a solid platform for continued action in the evolution of primary mental health care reform – it just needs action.

The *Better Outcomes in Mental Health Care* initiative has been a policy success. With refinement, expansion to better meet demand and ensure access by high need groups such as young people and Aboriginal Australians, and the injection of more realistic funding levels it could become a workable primary mental health care system for Australia.

But *Better Outcomes,* alone, is not the answer.

In summary, ADGP's recommendations set out in Section 3 can be clustered into the following four key areas. The solution to better quality mental health care lies firmly in serious government action in these areas:

Policy reform

The thrust of Australia's national mental health policy framework is well regarded. Coordination and linkage across relevant policy frameworks is lacking. This is a barrier to service planning and integration and provides little impetus and incentive for better integration between primary and specialist systems of care.

- Secure a Council of Australian Governments commitment to action in mental health
- Rationalise mental health, suicide prevention and drug and alcohol policies and strategies to recognise and better address common risk factors and comorbidities
- Better link mental health and chronic disease policies and strategies to recognise the relationship between physical and mental health
- Develop a national primary mental health care policy under the National Mental Health Strategy to drive state engagement in reform

Primary care-led systems development, including federal-state reform

Better Outcomes is the beginnings of an evidence-based Australian primary mental health care *system*. It needs to be expanded, strengthened by a stronger interface with the specialist sector, with a tenfold increase in per annum funding.

- Better remunerate GPs for the time spent on mental health consultations
- Expand and recurrently fund allied health services to meet demand and ensure access to high need populations and regions
- Introduce a series of measures to ensure GPs can easily access support from private psychiatrists and the public mental health system

Workforce development

The effectiveness of any health care delivery system rests with the quality and availability of its workforce.

- Fund the availability and access of quality mental health education for GPs and primary care psychiatry training for psychiatrists, practice nurses and allied health professionals
- Introduce schemes to put in place primary mental health care *teams* in general practices, including co-location of allied health professionals such as psychologists
- Introduce measures that attract and retain allied and specialist providers in rural and remote Australia

- A primary care-lead system with GPs and multidisciplinary teams as coordinators of care supported by effective and funded integration with specialist systems of care, both public and private and adequate strategies to build and maintain a quality mental health workforce

Other infrastructure development and support

GPs, the private mental health workforce and allied health provides are central to delivery of care. The quality, continuity and availability of care can be optimised when they are supported to keep their skills up-to-date and to work together. Service delivery is also enhanced when the health system is supported with access to community and other support services from a non-government sector that is viable.

- Funded capacity in the national network of Divisions of General Practice to act as change agents for future primary mental health care reform and act as

'systems coordinators'. Divisions are the only existing national infrastructure that can deliver this.

- A robust and well supported non-government sector to provide a mechanism to ensure accountability and expenditure by governments and vital community-based support services to consumers, carers and their families

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