GP PERSPECTIVE TO THE PC REPORT ON MENTAL HEALTH
By Dr Vicki McCartney - FACRRM
Principal GP & working in Nowra NSW for the last 33 years.

Conflicts of interest:
Director Coordinare SE NSW PHN
Chair Illawarra Shoalhaven Clinical Council.

The views presented are my own & are not necessarily reflecting the views of Coordinare
I agree with much of the report.

- **Even earlier care**: If we look at the work commencing by NSW Health re: "First 2000 days of life" we are missing an opportunity to have even earlier identification of families whose children will be at high risk of MH issues. If we focus on the adolescents we have already missed the early interventions. Placing a variety of health workers in preschools & primary schools including clinicians (GPs, Paediatricians, Specialised nurses, Psychologists & Social works) this is far more likely to start a multidisciplinary approach to whole of family interventions. The relevant Colleges should be approached to find if it is possible that part of the training of some of these clinicians could include such experience.
  Placing clinicians in the community could be a valuable trial.
- GPs should have better processes that allow them to **refer whole families** to services that will improve their social determinants of health such as housing, family counselling, education & vocational support. This could be a similar model to "Connecting care teams" who manage complex chronic disease. In the Illawarra Shoalhaven, where I work, these services are co-commissioned by the LHD & PHN.
- I am concerned that the Health Minister appears to think the solution is stand alone buildings that provide services that are similar to headspace for adults. This seems to be creating yet another silo & is not sensitive to communities, nor does it address access to the majority of communities. I am fearful this is just a political legacy rather than a proven effective solution.
- **Psychiatrist's advice to GPs** – very much supported though such program is already available in a selection of PHN areas (funded by the PHNs). One of the difficulties & a very significant issue for GPs, their time is NOT financially compensated & they are unlikely to be able to have these conversations or even online discussion with a patient present. With the recognition by Government that patients over a certain age should trigger a payment to the GP on an annual basis, a similar payment to GPs for MH patients, to allow them to discuss cases with Psychiatrists or arrange care coordination more effectively would be an important incentive. If this was tied to accredited & specific training for GPs wanting to be more fully involved in such a program could increase quality.
- I am familiar with the **Stepped care model of care**. The difficulty is when, as the GP, early identification of a progressively severe problem can be hard to refer – too early for the acute services & it is often difficult to find options & there is a sense we need to wait "till the wheels fall off'.
  Also, as already mentioned, it is very difficult & time consuming to try & link such people with non-health supports. I am probably referring to the "missing middle".

- **Self-help group**: I feel the huge number of online / apps requires navigation & I believe GPs are in a good position to direct people to the best (evidence-based) sites, however they need these resources to be defined using the existing "Health Pathways". This fits well into the GPs role of providing opportunistic advice as early as possible. **Personal access**: it seems more likely to be effective if the ability to navigate this for an individual was also via a user-friendly online directory as I believe many people & especially adolescents & young adults are less likely to use a telephone service.
- **Better Access program**: I agree this is poorly targeted. If mental health care plans are done well they deserve the higher rebate as they are far more complex than a level C (36) item. At the present time, there is a lack of a true multidisciplinary approach for these patients with only a **small proportion of Psychologist** actually communicating adequately with the GP. Personally, I am often having to chase the Psychologist for a letter to up-date the patient's progress so I can formally review & decide if further sessions are required.
  Similar to comments made before – GPs as well as Psychologist do vary quite considerably in the quality of care. PHNs could be responsible for increased & recurring training demanding a higher level of expertise.
  The other alternative is for a similar model to the change for eating disorders where a single management plan can allow both Psychological intervention but perhaps other avenues of treatment such as exercise physiologist to arrange an appropriate exercise program, drug & alcohol services or even referral to vocational or educational services. This then means one document for the patient. **Note this means a lower rebate for the GP.

    - I do believe that on one hand you are identifying how complex some of these consumers are, but on the other hand, you are suggesting GPs should be paid less to manage them. This seems both short sighted but also lacking a true understanding of how demanding the management & support can be. I accept that not all GPs may provide the same standard of management & care but I would suggest that this variation will occur with any group of practitioners, including the Psychologists.
    - ***I do not have any data about OUT OF POCKET COSTS for patients seeing a GP for a MH care plan versus the OOP Costs for Psychological services but I believe this is a factor that should be investigated.*** Rather than make it even less likely the GP can provide high quality care by reducing payments, encourage some increased upskilling & reward that group who are prepared to commit significantly more time to the care of this complex & challenging group of patients.
- ***INFORMATION REQUEST 5.2 — MENTAL HEALTH TREATMENT PLANS***

- **The Invisible MH patients:** I would like to suggest that GPs are seeing many patients & managing them under standard items (23,36 & 44) with mild MH problems. We are using online services such as Mood Gym, This Way Up & other resources & hence these consultations do not get captured by Medicare data. (Which is a blunt instrument)

- Some GPs share de-identified data with their PHN. (Our practice does this with Coordinare, SE NSW PHN). There could be value in mining this sort of data to achieve a more accurate snapshot of GP consultations.
- It is unfortunate that GPs appear to be the only group that you seem to be focused on as not proficient in their management of mental health patients, apparent poor understanding of consequences of psychotropic medication as well as being too costly. I disagree that this is the majority.
- Note, you also point out the complexity of many mental health patients & hence the generalist remains a critical provider for these clients.
- ***Your conclusions are disheartening which, I believe, is a lack of insight of true General Practice especially in rural areas. You do not even appear to discriminate city/urban from rural GPs who have a significantly greater challenge of care.***

MHTP & REVIEWS:
The Medicare rules at present are that a patient needs only an initial 2715/17 which is the treatment plan. Then a review after 6 initial visits or a further 4 within the year or 6 if a new year has begun. My personal approach is that a patient with moderate mental health condition would be managed with the initial plan then reviews. (This is cheaper for everyone involved, but often less cost effective for the GP)

If there is then a significant break in treatment regardless of the reason, I would do another full MHTP – review the diagnosis & reset goals & plans with the patient. Most commonly this is a 2715 but usually is more than 35 minutes duration but less than 40 mins. Hence the rebate is: $92.50 & anyone on a low income or pension card would be bulk billed. However, it would not be feasible for me to only charge Item 36 with a rebate of $73.95 & hence the risk would be those patients would have an out of pocket cost.

Again, it appears that it is not clear to the PC that good GPs spend considerable time looking beyond just the specific treatment plan when reviewing these patients & look at overall well-being as well as other family & social issues that may be impacting.

11.2 INCREASE THE NUMBER OF PSYCHIATRISTS

As with many of the training schemes, Psychiatry is extremely long & arduous & perhaps for some "generalist psychiatrists" the training could be shortened. Should there be an initiative to retrain experienced GPs & allow them a streamlined pathway to consultant status & Fellowship?

Many GPs (I am not one) have undertaken the level 2 MH training & are committed to treatment of a variety of MH patients now. Incentives, particularly for those wanting to work in rural areas with these high-level skills could be supported by both the GP colleges (Rural Generalist program) as well as the Psychiatry College, who must look at ways to increase the numbers coming through their College.

I believe it is very relevant that there are some excellent GPs who work in city areas & provide psychological management as their sole contribution to that patient's care. This is a business model that is viable. It is unlikely to be viable in a rural setting so increased funding to support such a model should be considered.

DRAFT RECOMMENDATION 5.1 — PSYCHIATRIC ADVICE TO GPS
If you believe that Psychiatrists should get paid for consulting by phone, I cannot accept that you believe the GP should do this "for free".

In conclusion: An excellent report that does start the conversation about connecting the services relating to the social determinants of health with clinical services.
Further review requested:
Some services are provided by agencies (LHDs) whose clinicians/managers are paid regardless of whether there is a patient in front of them or not.
Psychologists mainly work on a fee for service basis but have defined sessions & a single focus. Please review the truth in the statement that "**most GP MHTP's are of no value to the Psychologist"** as I believe Psychologists have a **conflict of interest** as they believe they could be the craft group developing this treatment plan. If this was the case it would be very difficult for the GP to be fully informed & contribute effectively to the patient's care.
The GP – Works on a fee for service basis. The rebates for many of the services are inadequate for GPs to spend adequate time. As previously stated, to simply think using standard item numbers will be a solution, I believe, is reflecting a failure to understand the crisis in General Practice especially in rural areas.
There are many studies validating the effectiveness of a robust primary health component to a country's health service in reducing costs & increasing quality care. Please work with us to improve & value this, don't add another nail to the GP coffin.
It is important to keep the GP as a central clinician in the patient's care as their Generalist approach is critical when looking at holistic care for that person as well as their family & carer.

Thank you for this opportunity to comment.

Dr Vicki McCartney