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General Practice
Mental Health
Standards Collaboration

GPMHSC submission to the Productivity Commission Inquiry into Mental Health

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Key recommendations and issues

Structural weakness in mental health care provision

- The current system does not adequately support quality mental health services through the primary care sector
- There is a growing prevalence of mental health diagnosis
- There is insufficient investment in guaranteeing a primary mental health team wherever consumers are based

Specific concerns

- The promotion of e-mental health does not address the needs of those with poor health literacy or more severe mental illness
- The impacts of physical health of the mentally ill is not considered

Health workforce and informal carers

- The current system of providing and billing for Focussed Psychological Strategies (FPS) services is inadequate within the context of clinical practice and acts as a disincentive for GPs in gaining and maintaining their FPS provider eligibility.
- Psychological support for carers is not recognised

Government-funded employment support

- Increased support for those unable to access the National Disability Insurance Scheme (NDIS)

Coordination and integration and funding arrangements

- Duplication of services are sidestepping the important role of the GP in primary mental health care
- Increasing out of pocket costs for consumers

Monitoring and reporting outcomes

- Primary mental health care research is vital to ensuring good evidence based care

Introduction

The GPMHSC welcomes the Productivity Commission's overall objective to consider the role of mental health in supporting economic participation, enhancing productivity and economic growth. The issues around social determinants of health, mental health workforce distribution and remuneration are particularly important to ensure there is provision of training such as Focussed Psychological Strategies (FPS) by GPMHSC-accredited general practitioners (GPs).

GPs are an important source of support and referral for those who experience mental health conditions.[1] Often considered as the first point of contact for people concerned about their mental health, GPs are in a unique position to provide mental health care across the illness spectrum and the lifespan. GPs are central to a patient's care coordination and play a key role in a stepped care model.

According to the Australian Institute of Health and Welfare (2017), approximately 18 million GP encounters in 2015-16 were mental health related. This is an annual increase of 4.7 percent and comparable to the 9 million services provided by State and Territory mental health services in the same period.[2]

The GPMHSC hopes the Commission's recommendations will assist to improve the mental health of the Australian population, a challenge GPs face in their consultation rooms every day.

About the General Practice Mental Health Standards Collaboration

The General Practice Mental Health Standards Collaboration (GPMHSC) is a multi-disciplinary body managed by the Royal Australian College of General Practitioners (RACGP) and is responsible for establishing standards of education and training for the Better Access to Psychiatrists, Psychologists and General Practitioners (Better Access Initiative) under the Medicare Benefits Schedule (MBS). The GPMHSC:

- establishes standards for general practitioner (GP) training in mental health in relation to the Better Access Initiative
- accredits training activities related to general practice mental healthcare. This includes Level 1 Mental health skills training (MHST) and Level 2 Focussed Psychological Strategies (FPS).
- promotes accredited general practice training in mental health that aims to develop GPs' knowledge of and skills in detecting and treating mental illness
- promotes the uptake of MBS mental health items under the Better Access initiative
- develops resources to support GPs to provide mental health services
- regularly updates the general practice sector about current mental health issues and contributes to the development of policy for general practice and mental health.

The GPMHSC committee includes representatives from general practice, psychiatry, psychology and the community. The RACGP chairs the group, and provides Secretariat services. The GPMHSC is funded by the Commonwealth Department of Health.

Committee members are nominated by:

- The Royal Australian College of General Practitioners
- The Australian College of Rural and Remote Medicine
- Mental Health Australia (consumer and carer representatives)
- The Royal Australian and New Zealand College of Psychiatrists
- The Australian Psychological Society

Mental health funding in general practice

It is important to understand the current funding model for mental health in general practice. There are a number of key MBS item numbers that support GPs deliver mental health care, however many GPs will often bill using standard non-mental health specific MBS consultation items due to the inability of the MBS to keep up with appropriate remuneration.

Mental Health Skills Training

GPs who undertake GPMHSC accredited Mental Health Skills Training (MHST) are eligible to claim higher schedule item numbers related to the preparation of General Practice Mental Health Treatment Plans (GPMHTP): 2715, 2717.

The uptake of MHST has been extremely successful with approximately 91.2% of vocationally registered GPs in Australia registered with Medicare as eligible to access the corresponding item numbers. [1]

Focussed Psychological Strategies Skills Training

GPs who complete Focussed Psychological Strategies Skills Training (FPS ST) and undertake Focussed Psychological Strategies Continuing Professional Development (FPS CPD) once every three years are eligible to provide specific evidence-based psychological therapies accessing item numbers 2721, 2723, 2725 and 2727.

Uptake of the FPS ST has not been as successful as MHST uptake. Approximately 3.2% of vocationally registered GPs in Australia are registered with Medicare as GP providers of FPS.[1]

The comparison with the MHST figures show the GP FPS item numbers are clearly under-utilised.

Responses to Terms of Reference and Issues Paper themes relevant to the GPMHSC

Structural weakness in mental health care provision

- **The current system does not adequately support quality mental health services through the primary care sector.**

The mental health sector is complex and fragmented, with multiple providers and siloed funding streams.[3] Variability exists in both state government funded services and the federally funded Better Access program. Mental health care provision in the community is provided by general practice, Primary Health Networks, community health organisations, state hospital care, Headspace, the National Disability Insurance Scheme (NDIS) and aspects of private care, all contributing to fragmentation of the mental health system. Fragmentation results in limited consumer understanding of the services provided by these sources. Consumers and carers experience poor care and unmet needs due to overlaps, insufficiencies, poor planning and lack of coordination of services.

The highest uptake of mental health care in major cities is focussed in affluent urban areas. Socioeconomically deprived areas of metropolitan regions have increased rates of mental illness but lower levels of access to mental health service delivery so people living in such areas can face severe barriers to securing appropriate mental health care.[4]

Inequity in mental health service levels also impacts regional and remote regions of Australia, where the accessibility and quality of mental health services can be significant barriers to care.[5] Consumers, particularly regional and remote patients or those in socio-economically deprived areas are more likely to receive help for mental distress from their GPs. The GP is often a trusted source of advice and health but is also frequently overburdened with such problems.[6,7]

National Mental Services Standards emphasise specialist care. These do not guarantee or mandate levels of mental health care provisions, responsiveness or number of sessions relevant to primary care. As such, there are no primary mental health care standards for consumers that address current needs.

- **There is a growing prevalence of mental health diagnosis**

GPs as community health professionals are well placed to provide holistic individualised care in the context of the patient's physical and social determinants of health. The majority of GPs have completed GPMHSC-accredited MHST and are able to provide mental health assessment for common mental disorders but may lack the supporting elements that would make for a comprehensive response to the level of identified problems.[1]

Approximately 1000 GPs have completed additional GPMHSC-accredited training to deliver FPS such as cognitive behaviour therapy and interpersonal therapy.

However, there has been an increase in mental illness case-finding in the community, which contributes to pressure on services. For example, children with shyness/anxiety and school refusal may increasingly receive a mental health diagnosis, while patients in GP waiting rooms are asked to complete the K10 assessment for depression and anxiety despite not actively seeking mental health care.

The provision of mental health care has been heavily influenced by the view that mental difficulties come as diagnosable disorders that can be treated by specialist practitioners who aim for symptom reduction.[8] However, the high prevalence rates of mental disorder indicate the need for a coherent public mental health approach that addresses the social determinants of health and encompasses the integration of mental, medical, substance use and social care.

- **There is insufficient investment in guaranteeing a primary mental health team wherever consumers are based**

GPs are dealing with rising trauma; evident in suicide rates and the raised expectations for mental health outcomes created by public information campaigns and public investigations e.g. outcomes from the Royal Commission into

Institutional Responses to Child Sexual Abuse, domestic violence, lack of housing and persistent disadvantage despite strong economic growth.[9]

MBS data suggests that during 2007 – 2011, the uptake of GP FPS items in remote and very remote regions was at a rate of 10 and 5 items per 1,000 people respectively.[10] In contrast, major cities have the highest uptake rate of 85 FPS items per 1,000 people.[7] These figures suggest that there is real need for GP FPS services in rural and remote areas. As GPs are often the only mental health provider in these areas, it is crucial that GPs are supported to provide appropriate mental health care in these under serviced areas.

The current two FPS items are for consultation periods of between 30-40 minutes and greater than 40 minutes.[11] Currently, patients with a Mental Health Treatment Plan (MHTP) can access up to 10 consultation sessions in total with a psychologist, a social worker, an occupational therapist or a GP Provider of FPS. However, the limit of 10 sessions per person per calendar year[10] restricts GPs' flexibility in treating patients who present with mental health issues that best meets their needs. This restriction may also affect patients' future referral options as these sessions are not excluded from those provided by psychologists. Consequently, many GPs are avoiding charging under FPS item numbers so as not to disadvantage patients.

Some patients require longer consultation sessions, while others may require more sessions spanning a longer period.[12] Other patients might have their needs best met through more and different interventions from a clinical psychologist or psychiatrist after seeing their GP for initial FPS services. The system lacks flexibility to support different alternatives.

According to the Australian Institute of Health and Welfare (AIHW), there are only 10 Clinical Psychiatrists and 63 Clinical Psychologists per 100,000 population.[13] By allowing up to 10 sessions to be delivered by a GP Provider of FPS, and excluding those sessions from the 10 allowed for psychologists and psychiatrists, coordinated multidisciplinary care can be provided depending on the needs of the patient.

The benefits of these 10 independent sessions would include increased accessibility to mental health services, patient choice by enabling them to see a mental health professional (their GP) they are already familiar with, and the option for referral to a psychologist or psychiatrist if further care is needed. This framework would also support the implementation of the stepped care model by ensuring patients can access the level of service appropriate to their need. A stepped care approach aims to ensure a range of service types, making the best use of available workforce and technology, which are available within the local region to better match individual and population needs.[14]

Specific concerns

- **The promotion of e-mental health does not address the needs of those with poor health literacy or more severe mental illness**

While there are now a wide range of e-mental health interventions, the GPMHSC has particular concerns around what may at times be an excessive and persistent promotion of e-mental health care that is not evidence based as a preferred solution to barriers in treatment.

The GPMHSC has reservations on the required level of patient literacy and mental functioning needed for this therapy to be effective. This is especially concerning in contexts where the effect of social determinants or an active disorder may each impact effective patient literacy at time of help-seeking.

This may perpetuate inequitable provision where people in poorer areas may be offered an online service while better positioned and resourced citizens may receive face to face services with better demonstrated effectiveness due to availability of services. This type of mental health care delivery may be less appropriate for many who are most in need of care.

- **The impacts of physical health of the mentally ill is not considered**

Consideration should be given to the physical health of patients with mental illness; for example, people with schizophrenia often dies decades earlier than they should due to conditions such as diabetes or heart disease.[15]

Health workforce and informal carers

- **The current system of providing and billing for Focussed Psychological Strategies (FPS) services is inadequate within the context of clinical practice and acts as a disincentive for GPs in gaining and maintaining their FPS provider eligibility.**

GPs play a central role as the first and therefore most accessible step in the primary mental health care. Data from the Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity indicated that during 2015-16, around 12.4% of all GP encounters were mental health-related, an increase from 10.8% in 2007–08.[13]

Currently, there are approximately 1000 GPs across Australia registered with Medicare to provide FPS to patients with mental health issues. These GPs provided more than 33,000 charged on FPS item numbers sessions in 2015-16 to patients in need.[13] FPS rebates provided per patient for such consultations do not reflect the challenges and work undertaken when compared to other general practice functions.

GPs who provide higher level mental health care are disadvantaged compared to GPs that do not because of time-based item numbers that penalise longer consultations. According to MBS data, GPs provided 3.2 million Medicare-subsidised mental health-specific services in 2015–16, however just 1% of MBS items claimed for this period[13] was for the provision of FPS. It is widely suspected that most FPS provided by GPs is charged under general time-based consultation item numbers and therefore are not recorded in Medicare statistics.

In addition, day-to-day practice schedules are often not conducive to seeing patients for consultations over 40 minutes. Further evidence of this issue can be found in MBS data supplied by the Department of Health, showing there has been a -3.3% decrease in the use of FPS item numbers by GPs between 2011-2012 to 2015-2016.[13] This is of particular concern to the GPMHSC as there are currently very few GPs registered to provide these services.

In 2016, 300 GPs either nominated to be deregistered or did not meet the CPD requirements to continue as FPS Providers.[3] Feedback from GPs indicates that while an increasing number of patients are presenting with issues requiring psychological treatments, the current MBS funding system is a disincentive for GPs to provide this service and does not allow for the best care for patients in need of these interventions.

Managing patients with complex mental health needs in the general practice environment can be challenging. Providing an appropriate incentive to undertake further training and CPD will attract more GPs to become registered FPS Providers, ensuring better access for patients needing help. A suitably trained GP is thus best placed to provide timely personalised care.

- **Unrecognised psychological support for carers**

The GPMHSC operates on the principle value of the importance of not only consumer contribution, but also carer input in the development of standards for mental health training for GPs. As such these peer workers play an ever increasing role in mental health care for the population. The needs of carers should be supported by Medicare with access to preventive and psychological sessions.

Government-funded employment support

- **Increased support for those unable to access the National Disability Insurance Scheme (NDIS)**

Feedback from GPs has indicated that the introduction of the NDIS has added a level of complexity for mental health consumers and access to assistance. A study from the ACT shows that the new structure has led to a high degree of instability in the system for mental health service providers.[16]

Other reports have indicated a lack of communication to scheme participants from the National Disability Insurance Agency (NDIA), confusion among NDIA staff and time wasted through double-handling.[17]

The GPMHSC supports the key messages set out in Mental Health Australia's report on the NDIS Psychosocial Disability Pathway. This includes the need to provide resources targeted specifically at general practitioners to explain their role in

the NDIS access and planning processes, and provide detailed information about how to support people with psychosocial disability to access the scheme.[18]

Coordination and integration and funding arrangements

- **Duplication of services are sidestepping the important role of the GP in primary mental health care**

The current funding and commissioning arrangements for PHNs and organisations such as Headspace contribute to concern around siloed services that bypass the patient's existing therapeutic relationship with their GP who is best placed for assessment and long term care coordination.

GPMHSC Chair Morton Rawlin was a member of the PHN Advisory Panel on Mental Health convened to provide advice to the Minister for Health about the progress of mental health reform being implemented through PHNs[19]. The GPMHSC supports the report *Reform and System Transformation: A Five Year Horizon for PHN* for improving understanding and implementation of stepped care for primary mental health care.[20]

- **Increasing out of pocket costs for consumers**

The GPMHSC is also concerned with the increasing out-of-pocket costs for consumers with Australia ranking high on this OECD measure.[21] GPs see the pressure placed on consumers despite overall increased spending on mental health care.[22] Programs such as Psychological Support Services (previously ATAPS) for consumers with health care cards – where out of pocket expenditures are not required – are limited in access to a relatively small number of people in the community.

Monitoring and reporting outcomes

- **Primary mental health care research vital to ensuring good evidence based care**

The GPMHSC believes further investment in quality longitudinal research is needed around the consumer journey within primary mental health care. There is a lack of research around primary care mental health episodes, particularly since the bettering the evaluation and care of health (BEACH) survey is no longer conducted. In addition, there are limited statistics in relation to Aboriginal and Torres Strait Islander mental health.

This area is lacking evidence of increased productivity and good outcomes from the range of services available to consumers and has resulted in many expensive short-term solutions of unknown efficacy. Appropriate funding for research in primary mental health care would contribute an evidence-base for addressing the multiple factors of mental ill health.

Conclusion

GPs, being the first contact with the health care system for most patients, are best placed to provide appropriate, personalised, and long term mental health treatment and support. In a stepped care model, the GP should be central to a patient's care coordination, ensuring they do not fall through cracks in service provision. Productivity is limited when large numbers of individuals who need greater care fail to progress beyond the first hurdle.

The current complex, disjointed and siloed system has created numerous barriers and much confusion for those seeking timely help. The absence of agreement on causes, effective treatments and optimal outcomes for mental illness is reflected in the complexity and ad hoc nature of current approaches. It is very difficult to improve productivity when there is no consensus about desired outcomes.

The GPMHSC remains committed in supporting the development of a mental health workforce that is better equipped to respond to needs of patients. For this to happen, the barriers to the accessibility and quality of mental health services in Australia need to be addressed.

References

1. Britt H MG, Henderson J, Bayram C, Harrison C, Valenti L, Wong C, Gordon J, Pollack AJ, Pan Y, Charles J. General practice activity in Australia 2015–16.
2. Australian Institute of Health and Welfare (AIHW). Mental health Services in Australia, 2017.
3. General Practice Mental Health Standards Collaboration. Performance Report 1 July 2017 – 31 December 2017. East Melbourne (AU): The Royal Australian College of General Practitioners; February 2018.
4. Meadows GN, Enticott JC, Inder B, Russell GM, Gurr R. Better access to mental health care and the failure of the Medicare principle of universality. The Medical Journal of Australua. 2015;202(4):1-6. Available from: https://www.mja.com.au/system/files/issues/mea00330.pdf
5. National Mental Health Commission [Internet]. Contributing lives, thriving communities: Report of the national review of mental health programmes and services. Sydney NSW: National Mental Health Commission; 2014 [cited 2018 May 28]. Available from: https://mhfa.com.au/sites/default/files/vol2-review-mh-programmes-services.pdf
6. The Fifth National Mental Health and Suicide Prevention Plan [Internet]. Canberra ACT: Department of Health; 2017 [updated 2017 Oct 17; cited 2018 May 29]. Available from: http://www.health.gov.au/internet/main/publishing.nsf/content/mental-fifth-national-mental-health-plan
7. Kelly BJ, Stain HJ, Coleman C, et al. Mental health and well-being within rural communities: The Australian Rural Mental Health Study. Aust. J. Rural Health. 2010;18(1):16-24. Available from: https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1440-1584.2009.01118.x
8. Van Os J, Guloksuz S, Vijn T W, Hafkenscheid A, Delespaul P. The evidence-based group-level symptom-reduction model as the organizing principal for mental health care: time for change? World Psychiatry 2019;18:88-96.
9. McLachlan, R., Gilfillan, G. and Gordon, J. 2013, Deep and Persistent Disadvantage in Australia, rev., Productivity Commission Staff Working Paper, Canberra. Available from: https://www.pc.gov.au/research/supporting/deep-persistent-disadvantage
10. Potiriadis M, Chondros P, Gilchrist G, et al. How do Australian patients rate their general practitioner? A descriptive study using the General Practice Assessment Questionnaire. The Medical Journal of Australia. 2008;189(4):215-19. Available from: https://www.mja.com.au/journal/2008/189/4/how-do-australian-patients-rate-their-general-practitioner-descriptive-study
11. MBS Online [Internet]. Canberra ACT: Department of Health; 2018 [updated 2018 Apr 11; cited 2018 May 28]. Available from: http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=AN.0.57&qt=noteID&criteria=2721
12. Chien WT, Leung SF, Yeung FKK, et al. Current approaches to treatment for schizophrenia spectrum disorders, part II: psychological interventions and patient-focused perspectives in psychiatric care. Neuropsychiatr Dis Treat [Internet]. 2013 Sep 25 [cited 2018 May 28];9:1463-1481. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3792827/pdf/ndt-9-1463.pdf
13. Australian Institute of Health and Welfare [AIHW]. Mental Health Services in Australia [Internet]. Canberra ACT: AIHW; 2018 [updated 2018 May 3; cited 2018 May 28]. Available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary
14. Department of Health. PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance [Internet]. Canberra ACT: Department of Health; 2017 [updated 2017; cited 2018 June 28]. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools
15. Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Prev Chronic Dis 2006;3(2):1–14.

16. Furst, M A; Salinas-Perez, J A; Salvador-Carulla, L. Organisational impact of the National Disability Insurance Scheme transition on mental health care providers: the experience in the Australian Capital Territory. *Australasian Psychiatry* 2018, Vol 26(6) 590 –594. Available from: https://journals.sagepub.com/doi/full/10.1177/1039856218810151
17. Manthorpe, Michael; Report on the National Disability Insurance Agency's Handling of Reviews. Report No. 3, 2018. Available from: http://www.ombudsman.gov.au/__data/assets/pdf_file/0029/83981/NDIS-NDIA-Final-report-on-administration-of-reviews-under-the-Act.pdf
18. Mental Health Australia. National Disability Insurance Scheme: Psychosocial Disability Pathway. May 2018. Available from: https://mhaustralia.org/sites/default/files/docs/ndis_psychosocial_pathway_consultation_project_-_final_report_-_may_2018.pdf
19. Report of the PHN Advisory Panel on Mental Health. September 2018. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/2126B045A8DA90FDCA257F6500018260/$File/Report-of-the-PHN-Advisory-Panel-on-Mental-Health.pdf
20. PHN Advisory Panel on Mental Health. *Reform and System Transformation: A Five Year Horizon for PHNs.* September 2018. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/2126B045A8DA90FDCA257F6500018260/$File/Reform-and-System-Transformation-A-Five-Year-Horizon-for-PHNs.pdf
21. OECD (2019), Health spending (indicator). doi: 10.1787/8643de7e-en (Accessed on 05 March 2019) Available from: https://data.oecd.org/healthres/health-spending.htm
22. Meadows, G; Enticott, J; Rosenberg, S. Three charts on: why rates of mental illness aren't going down despite higher spending. Available from: https://theconversation.com/three-charts-on-why-rates-of-mental-illness-arent-going-down-despite-higher-spending-97534

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