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Royal Australian College of General Practitioners

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Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales – Post Hearing Responses

1) **The CHAIR: We had evidence earlier today from the NSW Nurses and Midwives' Association which, in a beautiful moment of interdisciplinary collaboration in its submission, talks about the need for patients experiencing mental illness to have access to a GP, particularly for physical health needs and for that holistic patient care. One of its suggestions is embedding GPs within community mental health services, or finding another way for patients who don't have a regular GP to actually access a GP for free. What are some ways that the New South Wales Government could actually enable that and make it a service that the GP would want to work in? Either within the community mental health service or some kind of alternate model to provide people with access to a GP for free.**

In the latest Health of the Nation Report, RACGP has identified that 72% of GPs now report psychological issues in their top three reasons for patient presentations, up from 61% in 2017. This rise indicates the need for shared holistic care and demonstrates the value of GPs in identifying and referring patients through shared care pathways. RACGP supports Shared Care Models where there is joint responsibility for planned care that is agreed between healthcare providers, the patient, and any services they would like to engage. When there is an effective communication structure and clearly delineated roles in these multidisciplinary teams, there are proven benefits for the consumer including a reduction in the fragmentation of care and quality outcomes of continuous care and support pathways. Regarding what options there are to increasing access to GP services where that patient does not have a regular GP, employing a GP within a service is one option but this is likely to be on a sessional basis as fee-for-service medicine is unlikely to be financially viable. It would be more attractive if it was paired with training and support to skills GPs interested in upskilling in mental health perhaps through bursaries or training through HETI Higher Education.

The scope of practice would also need to be clear – is the patient to be offered the full scope of general practice including chronic disease management, skin checks, contraception etc? Will that GP be managing that patient's diabetes for the next 10 years or would time be better spent helping that patient establish themselves with a local GP for ongoing care? Importantly, how will the patient maintain good communication and continuity of care across agencies? These are all points that would need to be considered.

Regarding models for community members to access a GP for free, it is important to consider that not one size fits all and these models should be considered in consultation with local services so as not to undermine any existing services or businesses. There have been successful community models in different states that the New South Wales Government may want to consider. Some great examples for young people include:

- **GPs in Schools Pilot program** (Queensland)
    - Provides funding to schools to establish an on-site GP clinic.
    - Includes funding for infrastructure, support services, and remuneration for a GP to attend the campus one day a week.
    - No out-of-pocket expense to the students
    - Caters to a range of health issues including mental health support and referrals.

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  - Pilot has received significant positive feedback States including Victoria have engaged in pilot programs based on this model.

- **Headspace** (National)
  - Work in community-based collaborative models
  - Include multidisciplinary teams of GPs, psychologists, social workers, nurse practitioners and psychiatrists.
  - Scope of this serviceonly caters to young people aged between 12 and 25 years old.

- **Bega Teen Clinic** (New South Wales)
  - Nurse – led clinic working with GPs
  - Provides young people with access to mental health support through General Practice (GP Led)
  - PHN-funded
- **The Wednesday Room** (New South Wales)
  - Operating in Jindabyne
  - Started as a sexual health drop-in clinic that has evolved into also addressing mental health.
  - Service was highly patronised by seasonal workers
  - Discontinued when critical staff moved on.

For consumers who are adults, there are community health services that incorporate multidisciplinary healthcare teams, however, ones that have access to a GP within that model are limited, even in metropolitan areas. Many adult services are community outreach-based models that provide non-clinical advocacy services and engage GPs via referral. Models aimed at adult consumers include:

- **Central and Eastern Sydney have funded GP Mental Health Shared Care Program** (New South Wales)
  - Shared care model
  - Emphasises a care partnership between consumers, mental health services, and GPs to work with consumers living with enduring mental illness,
  - Holistic care approach .
- **Floresco Service Mode**l (Queensland)
  - State-funded service
  - Based on a consortia model of non-government organisations, General Practitioners, and both private and public mental health services
  - Operated as a service hub for adults to provide the residents of the area with an integrated service model that supported patient-centred, multidisciplinary care interventions in one building.
  - Operated from 2014-18.
  - The integration of practitioners, shared client information systems, and inconsistent governance models proved to be challenges that caused fragmentation issues within the model.

To effectively provide these models, collaboration with established healthcare clinics in the area is crucial to ensuring that this care journey is continuous, well communicated, and assists established clinics, rather than undermine them. Communication and collaboration, effective systems for information sharing, and resourcing need to all be seriously considered before implementing community-based healthcare models. Strong communication between practitioners and effective consultation and codesign is the cornerstone to providing effective models that are responsive to the needs of the community. Flexibility in the structures and policies of these models is important to accommodate private practice and other allied health services, allowing for close collaboration and patient-centred care.

2) The Hon. WES FANG: That's the practical aspects of feeling comfortable around the provision of those drugs to a patient, but there's also the impact on the business or the income of the GP. There's also an impact on the psychiatrist's income as well because it is reasonably quick or quicker when you've got somebody who's well known to them being re-prescribed what they have or with a slight alteration. How do you see that being managed? What would be required from the GP standpoint to make it not necessarily a profitable exercise, but certainly not a negative in the way that you conduct your practice? Also, with the training, I imagine that's also going to impact your business or income, and that might also need some assistance. How do you see that working as well?

RACGP supports movement towards a nationally consistent approach to assist adults and children with ADHD, and symptoms of ADHD, to access support via their GP and a coordinated team of health professionals. Facilitating access for patients should be front and centre of our services but care must be taken not to compromise the rigor of diagnosis or the appropriate medication follow-up and titration. We need to avoid setting up a 'tick-and 'flick' model that does not reflect the complexity of the issues. If GPs are to be involved more in the diagnosis and prescribing of conditions such as ADHD, then appropriate training and funded time allocation for assessment and follow-up needs to be structured into any model.

We do have some provision now with longer consults with the new Level E MBS consults that are available to us, which will last longer than 60 minutes. That does assist us in some ways to make the longer and more complex consults more sustainable. Patient-centred care is at the forefront of what we do as GPs and having the appropriate time to engage in thorough care coordination is the best pathway to diagnosis and continuity of care. Better access to diagnostic & prescription services are also imporotant. Appropriate remuneration for practitioners to have time to engage in the rigorous diagnostic testing that is associated with some conditions is so important for an accurate diagnosis. Best models for equity of access and ongoing treatment should not be at the cost to the practitioner. If GPs are involved, they need to be appropriately accredited and remunerated to provide that level of service that gives high quality care that aligns with best practice standards. Advocacy services must also be adequately remunerated for practitioners. These services are crucial particularly for people living in rural and remote areas and are important in a patient not having a fragmented care journey when engaging multidisciplinary teams. Proper remuneration and adequate time for diagnosis is important not only for the job satisfaction of the practitioner but also for medicolegal safety.

For training, RACGP advocates for GPs with an interest in this area to be supported to take on an expanded role in the diagnosis and treatment of ADHD. In addition to evidence-based guidance, there is a need for access to and funding for appropriate education and training for GPs with an interest in this area Regulatory barriers need to be addressed, with consistent rules across all states and territories describing the clinicians that are authorised to diagnose and prescribe stimulant medications for patients. Enabling GPs to initiate and/or continue stimulant medications for attention deficit hyperactivity disorder [ADHD] will greatly improve access for patients, particularly for rural communities where access and financial disadvantage make access to treatment and diagnosis difficult.

There are some services available to support GPs in diagnosis and case management. There is a GP Psychiatry support line. I have not utilised the service personally, but I have had colleagues tell me that they have used the service and it has been a successful example of multidisciplinary healthcare teams working in unison to provide patient-centred care. There is also a Drug and Alcohol Services Information System (DASIS). These are both very valuable resources that already exist but are not widely known in the industry and are underutilised. The New South Wales government may wish to consider extending the promotion of these resources to assist practitioners.

3) **The Hon. SUSAN CARTER: Is there a difference in terms of accessing alcohol services as opposed to drug services? Or are the wait times basically the same?**

This is difficult to determine as the data sets and reports that are publicly available through the Australian government classify alcohol and other drugs together. What we do know, however, is that the burden of alcohol and drug usage increases with remoteness. Accessing treatment services for all substance misuse conditions is difficult and requires extensive travel for people living in remote areas despite people in rural and remote areas patronising these services at a higher rate than people in major cities.

RACGP would welcome additional drug and alcohol services in rural and regional areas to allow people to detox and undergo rehabilitation closer to home.