Submission No 64

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Organisation: The Royal Australian College of General Practitioners (RACGP)

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RACGP NSW&ACT

Healthy Profession.
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Committee Chair
Portfolio Committee No. 2
NSW Parliament House
6 Macquarie Street
Sydney NSW 2000

Lodged to submission portal 2973

Dear Dr Amanda Cohn MLC,

The Royal Australian College of General Practitioners (RACGP) NSW&ACT Faculty thanks the Portfolio Committee No. 2 - Health for the opportunity to provide input to the *Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales.*

This submission responds to Terms of Reference (a), (b), (c), (d), (e), (g).

The RACGP is Australia's largest professional general practice organisation, representing over 40,000 members working in or toward a specialty career in general practice, including 4-in-5 rural general practitioners (GPs) who are members of the RACGP. The RACGP sets the standards for general practice, facilitates lifelong learning for GPs, connects the general practice community, and advocates for better health and wellbeing for all Australians.

General practice plays a central role in the delivery of mental health care, with most of the mental health care in Australia being provided in general practice.[1] GPs provide ongoing mental health care in several different ways: through direct care, shared care, and referral to specialist services. Patients under GP care receive comprehensive care encompassing both mental and physical health needs, and assessment and treatment of mental illness is informed by a holistic, whole-of-person approach.

From a general practitioner perspective, access to community mental health services in NSW is extremely poor, with services overstretched, underfunded, and understaffed. There are long waiting lists for patients of moderate severity mental illness and often no accessibility at all for people with mild mental illness. For patients with disability, access to mental health support is challenging and becomes more increasingly so with greater severity of disability. The consequences of this poor access are that services are only provided in extreme or crisis circumstances (e.g., suicidality or threat of harming others) and patients being discharged from services as soon as possible and often too early. In general practice, there is a working assumption that outpatient and community mental health services offer little or usually no support to our patients who need mental health support unless they are in crisis.

There is often no priority given to Aboriginal or Torres Strait Islander patients in public services despite increased need and Aboriginal and Torres Strait Islander people are less likely to be able to access private options in mental health care. Services are not culturally safe for Aboriginal and Torres Strait Islander people. There are good intentions in community outpatient services but there is a lack of time and a lack of appropriately trained health professional to be able to provide wholistic culturally appropriate services. Access to mental health care for Aboriginal children is particularly problematic.

Public mental health services are ineffective in meeting the needs of Attention-deficit/hyperactivity disorder (ADHD) adults seeking diagnosis and appropriate management. There are no existing public services for adult ADHD. Paediatric services are available but are unable to meet present demand; families may wait up to four years for assessment. Those who can afford private psychiatrist fees can be seen and assessed in the private

sector, but those without financial means to do so have virtually no access to care. The effect of this has been the exacerbation of health discrimination through the creation of a two-class health system.

General practitioners, public hospitals and Primary Health Networks are considered the most equitable outpatient mental health services across a system in which equity and access varies substantially between providers.[3] In certain circumstances, a general practice may be the only point of care for people who require mental health services.[4] In rural and remote areas, GPs and their practice teams may manage a high volume of mental health work as a result of geographical barriers and a lack of local mental health practitioners. Furthermore, individuals who might not otherwise have contact with the health care system for various reasons such as people of low socioeconomic status, Aboriginal and Torres Strait Islander people, and people from culturally and linguistically diverse backgrounds, might have contact with a general practice. General practice also bridges the gap between the community and institutions such as hospitals, mental health outpatient services, drug and alcohol rehabilitation facilities, and prisons.

Primary health care is key to building a more integrated and effective health system. Integration ensures the population as a whole has access to the mental healthcare that they need early and gives people the best chance of good health outcomes. The integration of mental health care into primary healthcare is also a cost-effective solution of preventing and managing mental health illnesses in Australia. Primary care-led mental health services will help address issues early and keep patients out of the hospital system at a much lower cost to all levels of government and patients. However, general practices require support to integrate available services. The RACGP advocates for a shift in goals and investments, to better harness and support general practice to deliver sustainable, equitable, high-value healthcare, benefiting patients, providers and funders.

The RACGP champions a GP-led, patient-centred health system in which each member of the care team has specified roles and responsibilities. Timely, respectful and relevant communication between professionals assists patients to navigate a complicated health system and improves their quality of care.[4] Where possible, mental health professionals, including mental health nurses, peer support workers and carers, should be embedded within general practice to encourage strong communication between practitioners, facilitate a 'no-wrong-door' approach to mental health for patients, and allow for more effective use of each practitioner's time and skills. Many GPs also choose to build on their existing skills in mental health as part of their lifelong learning, for example through courses in mental health first aid, focussed psychological strategies skills training, or a postgraduate qualification. Incentive schemes equivalent to those for procedural skills would support GPs to develop or refresh advanced skills in mental health.[4]

The RACGP is supportive of the use of telehealth, including telephone, for mental health services. Technology has the ability to reduce the distance barrier and cost that affect patients, especially those in rural and remote communities. Mental health services provided via telehealth, including telephone, is shown to have the same level of effectiveness as face-to-face consultations in achieving improved health outcomes.[4] Embedding changes to the MBS to enable telehealth consultations between a patient and their regular GP and for GP after hours attendances will help to address gaps in access to community healthcare. The physical health of people living with mental illness requires integration of mental health and physical health care, across the public, private (including general practice) and community sectors and financial support for national, cross-sector coordination is therefore important. The RACGP is a signatory to the Equally Well National Consensus Statement,[6] which puts forward a vision for how this can be achieved.

E-mental health treatment options often relate to online interventions for the prevention and management of mental health illness. While there is evidence to suggest that e-mental health can be used effectively to manage mild to moderate depression and anxiety, consideration must be given to the patient's literacy skills and mental capacity before they are enrolled for e-mental health and other online interventions.[4] The RACGP supports the intention of e-mental health as a complementary activity to face-to-face services, but not as a substitute for all patients. Additionally, support of e-mental health should not be at the expense of adequate funding for other types of interventions, in particular those done face-to-face.

Thank you again for the opportunity to provide input into the inquiry. For any further information on enquires please contact the NSW&ACT State Manager,

Yours sincerely

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Chair RACGP NSW&ACT Faculty

References

1. Australian Institute of Health and Welfare. Mental health services in Australia. Canberra: AIHW; 2021.

2. The Royal Australian College of General Practitioners. RACGP Submission to the Select Committee Inquiry on Mental Health and Suicide Prevention. East Melbourne: RACGP; 2021.

3. The Royal Australian New Zealand College of Psychiatrists. The NSW mental health care system on the brink: Evidence from the frontline. NSW Branch of the Royal Australian College of Psychiatrists; 2023.

4. The Royal Australian College of General Practitioners. RACGP Position Statement on Mental health care in general practice. Melbourne: RACGP; 2021.

5. The Royal Australian College of General Practitioners. RACGP Position Statement on Provision of mental health services in rural Australia. Melbourne: RACGP; 2015.

6. National Mental Health Commission. Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia. Sydney: NMHC; 2016.