# Mental health workforce needs in General Practice

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## Slide 1

Hello everyone! I’m Michael Tam – a specialist GP and am the representative of the Royal Australian College of GPs. As general practice is commonly misunderstood, this presentation will cover first the context – why GPs are a vital component of the mental health care workforce. And secondly, some of the challenges and needs, and possible strategies and solutions.

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And a high level synthesis. First the “why”? We are expert generalists. Pulling all health issues together so that the care is fundamentally person-focussed rather than body system or organ specific. GP care is local and relationship-based – person, family, community. And importantly, GPs provide a huge volume of clinical mental health care.

Secondly, the solutions. If we want effective system outcomes, we need to build capacity in primary care strategically. Invest in GP mental health leadership and skills and structurally support this scope of practice. Better integrate mental health care into primary care using a patient-centred medical home model.

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It’s always important to remember the ecology of health care – how and where care is provided at a whole of system perspective. It can be easy to become blinkered in silos. This is old data but it is still indicative. If we imagine 1000 adults at risk of any illness, including mental illness in a population, around 1 in 4 will have roughly sought care in primary care – in general practice in Australia. Only around 1 in 100 will have attended an ED, and 1 in 1000 be admitted to a tertiary hospital. Now, this diagram is only about clinician care or medical care. The vast majority of care, of course, is self-care by people for themselves, and the care provided by carers.

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This is the case with mental health care delivered in Australia. If we look at Medicare-subsided mental health-specific services, the vast majority of these are delivered by GPs. And it’s important to understand that the mental health-specific item numbers are a huge underestimate of the mental health work undertaken by GPs. Much of it is integrated into routine consultations.

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Indeed when surveyed, GPs identify that their patients talk to them about mental health more than any other health issue. So the first important concept to understand about the “why”, is that GPs already undertake a large proportion of all mental health work by volume as their core business, integrated within overall primary health care of their patients.

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The philosophic core values of the specialty of general practice, or family medicine, is not disease-centric. This is a screenshot from the College website on the page, “What is general practice”? General practice is person-focussed. It is relationship-based care. It is comprehensive. Expert generalism isn’t about just being a “jack of all trades”. It is about pulling all the parts together coherently to provide whole person care. People obviously are not the summation of their diseases.

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And together, it’s important to remember the impacts. The Black Dog Institute published this document for Primary Health Networks – “An evidence-based systems approach to suicide prevention: guidance on planning commissioning, and monitoring”. The strategy that has the largest estimated reduction in suicide deaths is GP capacity building and support.

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So “why general practice”? Volume. Values. Impact. GPs are expert medical generalists, who provide care that is person-focussed, local, and relationship-based, who provide the majority of clinician-delivered mental health care.

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Challenges and solutions. We need to strengthen team-based mental health care and optimally, within a patient-centred medical home model. Many of you will be familiar with the GP mental health standards collaboration. This with initially “Better Outcomes” and later, “Better Access” initiatives, helped to build capacity in general practice through provision of upskilling. There has been very high uptake of Level 1 training, and this is in fact part of the curriculum for GP registrars. I understand that there are around 2700 GPs who have undertaken Level 2 training – and these are potentially providers of “focussed psychological strategies”.

However, systems often don’t support GPs to work at their level of training and constrains their scope of practice. For instance, there are often minimal levels of integration between the specialised mental health sector and GPs. GP assessment, and often their extensive knowledge about their patients is routinely ignored and excluded in referral processes.

Patient-centred medical home models of care are widely acknowledged to strengthen and support high functioning primary care systems. The College’s “vision for general practice” uses this model. Presently, there are some clinicians such as primary care nurses and physiotherapists, and the rare mental health nurses who work within a team based environment in primary care, despite some structural and financial barriers. If we want mental health care to be local, then mental health professionals – peer workers, mental health nurses, social workers, psychologists, allied health practitioners, psychiatrists – should optimally be embedded in GP settings. Further advantages include making good the promise of integrated care, a context for interprofessional learning, and the opportunity for supervision for providers of mental health care.

Lastly, there may be a role for a smaller number of GPs to be accredited to providing general practice mental health care at a level higher than L2. I know that the GPMHSC has been exploring this at some depth. The analogy here is GP anaesthetics and GP obstetrics – training pathways with scopes of practice that have been promoted particularly with the rural generalist program. Rural and remote areas have benefited particularly from developing a workforce of GP proceduralists. This is probably a translatable model into developing and supporting an upskilled GP mental health workforce.

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There are funding anomalies with mental health care in general practice, but they all tend to go in one direction. As a gross example, standard GP consultation over at least 20 minutes – Medicare provides the patient a rebate of this amount at present. This might be someone who comes to see me where we have a consultation where their cardiovascular health is managed. GP consultation for a mental disorder of at least 20 minutes – perhaps someone living with major depressive disorder. Incredibly, the patient rebate is **LESS** for the person living with a mental disorder. Other issues include the low remuneration of longer consultations. To support GP workforce in mental health, we cannot systematically de-incentivise this work from a funding perspective. In a very real way, GPs who do a lot of mental health care work, often seeing the most disadvantaged people with lived experience, must cross-subsidise the delivery of their care from other remunerated work to keep the business running.

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The following are Bodenheimer’s 10 building blocks of high performing primary care. The foundation, and first building block, is engaged leadership. A challenge is that GPs are often not involved in decision making about service design. When invited, they are often the only person around the table who is not employed to be there. A strategic approach to the GP mental health workforce is to nurture and invest in early career GPs who have a passion in mental health care. I myself would probably not be here if not for the interest in the care of people living with a history of trauma that my GP supervisors had while I was in training, and later, the availability of a scholarship from NSW Health for GPs to undertake a masters degree in mental health at the NSW Institute of Psychiatry.

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So, together, the high level strategic approaches to supporting the GP workforce in mental health care. Move towards a patient-centred medical home model of primary care. Funding equity of mental health care in general practice. And invest in GP mental health leadership, expertise, and advanced skills.

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The “why”, and the “challenges and solutions”. Thank you.