1 Data-related issues including but not limited to under-utilisation of data

Making more effective use of data is part of a global movement to improve health outcomes, inform policy development, develop and evaluate interventions and improve intervention exchange. The use of health data has potential to provide significant public health gains by informing evidence-based health care, education, policy, practice, service delivery and reducing the burden of disease [2-7] . Yet, Australia lags behind other developed countries in the collection, storage and use of patient centred health care data[1].

There is an immediate need for the linkage of mental health care data across the tertiary, secondary and primary health care sectors. The linkage of cross sectorial mental health data will: provide a better understanding of the patient journey across the health system; enable the identification of evidence to practice gaps; facilitate the generation of risk stratification models and reduce clinical variation. The linkage of mental health data with social service and demographic data will also enable the monitoring of health and wellbeing in different jurisdictions across time. Currently, routinely collected mental health care data is being under-utilised, and as a result individuals from vulnerable communities are not being adequately monitored. The linkage of mental health data with health service, social, and economic data will enable the identification of vulnerable communities so that individuals at risk of mental illness will have greater access to timely and appropriate mental health care. The nimble analysis of routinely collected data will not only drive improvements in mental health care, it will also enable resources to be directed at communities that do not have equitable access to mental health services such as those located in rural and remote areas.

The use and linkage of data requires agreements between the sectors, the development of data extraction tools and the construction of primary care data repositories. The Department of General Practice has already established a primary care data extraction system which enables the transfer of non-identifiable, record-linkable primary care, hospital and administrative data into independent data repositories. This gives researchers at the Department of General Practice access to an active and functioning data repository, so that new knowledge can be rapidly generated to inform current mental health policies, mental health practices, as well as social and healthcare reforms. This places the Department of General Practice in a good position to contribute to the translation of research evidence into social and economic benefits which include: cost savings; the early detection of people at risk of mental health illness; and improved care and better outcomes for those with mental health illness.

DGP capability

- We use digital technology to extract, analyse and interpret primary care data. Digital technologies used in the department include the use data linkage techniques to link primary care data to hospital, emergency department, MBS and PBS data sets (Grhanite[8]).

- The department warehouses in a digital repository (Patron[8]), a large amount of securely stored Victorian primary care data to provide information for mental health policy and practice initiatives.
- The department also houses a unique repository which contains experiential information provided by 4000 Victorians who reported on mental health symptoms that ranged from sub-syndromal presentations to severe mental illness (Diamond study[9]). This data was collected across a 10 year period, from 2005 to 2015.

DGP recommendations

- The monitoring of mental health care through the analysis of routinely collected data needs to be considered an essential component of mental health care to ensure the impact and gaps in service provision are feed back into the health care system.
- Powerful research tools which incorporate the linkage of de-identified personal medical records will provide opportunities to rapidly generate new knowledge that informs the development of mental health care policy and practice.
- The increased use of prognostic tools and interventions which are supported by digital-human interactions will improve the delivery person centred care in the primary care setting.

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2 Patient perspectives and the need to include these in policy and service/treatment design and evaluation

The vast majority of mental health problems are identified and managed in primary care[1]and around one quarter of Victorian primary care patients meet criteria for probable depression[2]. This necessitates the involvement of consumers and primary care providers across the continuum of development, design and evaluation/research of mental health services, treatments and policy. The incorporation of patient perspectives into all these activities provides an avenue for the patient voice to be integrated into the development process and includes the gathering of perspectives from the inception of the evaluation/research question through to the dissemination of outcomes. Innovative user-centred design and co-production is widely used across all programs in the Department of General Practice. The incorporation of patient perspectives includes the use of peoples lived experience to develop of an evidence-base of methods which can be used to engage carers, consumers and health services in collaboration and partnerships for service re-design[3]. All programs in the department are cognisant of the need for trauma informed care where our research includes the collection of information around the lived experience relating to the exposure to traumatic events[4].

GDP capability

- The Integrated Mental Health Research Program (IMHRP) aims to optimise person-centred mental health that enhances physical and mental well-being. The IMHRP is focused on health system reform based on user-centred, lived-experience approaches, integration between primary care and other sectors, whole person approaches to mental health care, and the integration of innovative interventions into primary mental health care. The IMHRP has established a Living Lab group that is comprised of people with lived experience of mental illness that have participated in research studies run by the team This has multiple benefits as it enables in-person participation and inclusion of the lived experience perspectives of people who have may be in remote or rural areas, or unable to attend in-person for other reasons.
- In the Centre for Research Excellence for Safer Families which is addressing the burden of family violence Professor Kelsey Hegarty and her colleagues have a group of women with lived experience called 'The Weavers' who generate research questions, help shape study interventions and protocols, provide discussion and commentary on panels and papers and are central to the CRE.
- Similarly in the Centre for Research Excellence in Making Adolescent Health Services Work in a Digital Age, Professor Lena Sanci and her colleagues in NSW have established an Adolescent Health Research Commission consisting of young people who are involved in research from generating questions, to commenting on research protocols or co-designing interventions for testing.
- We also have a secure electronic Practice Based Research network (ePBRN) consisting of Victorian practices sending de-identified patient data for the purposes of informing policy and research. This has a governance committee chaired by a consumer and with two other consumer representatives and legal, ethical, research, GP, public health and practice manager representatives to ensure all questions asked of the data are respectful of its prime purpose.
- We understand how to engage general practice in implementation of change, and to evaluate the effects of the translation of research into primary care practice. We have good networks and linkages with general practice (VicReN) and understand the barriers which are related to that part of the health care system

DGP recommendations

- Involvement of expertise from consumers, clinical staff, and academic experts needs to be fully integrated into the policy and service design and evaluation process to improve uptake of policy and practice initiatives and mental health outcomes.

- Health system reform requires user-centred, lived-experience approaches that are integrated between primary care and other sectors. The facilitates whole of person approaches to mental health care and enables the integration of innovative interventions into primary mental health care.
- Relationship building is an integral component of participatory design. This allows for the building of participant trust in the design/evaluation processes and increases the validity of the outcomes.

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3 System integration and related issues

Integrating mental health services into PHC is one of the World health Organisation's (WHO's) most fundamental health care recommendations[1]. Yet in Australia the Commonwealth-funded primary care and state-run public hospital divide remains a significant challenge especially when contemplating approaches for mental health system integration.

In its current form, the mental health system in Victoria is burdened by fragmentation, duplication, lack of coordination and insufficient planning. It is a system full of 'silos', where multiple primary, secondary and tertiary services are delivered in an ad hoc manner. This results in a 'revolving door' situation where patients move from one agency back to another and back again. For example, providers who are based in hospitals and general practice often refer patients to multiple state and community-based services. These services have a variety of funding arrangements, different eligibility criteria and alternate point of entry requirements, yet there is no single point of coordination or case management

process in place to assist patents and their carers to navigate their way around the services. As a result, patients find themselves pulled in a variety of directions, where they have to continually repeat their mental health story to multiple providers. This places an unnecessary burden on the patient and also has the potential to re-traumatises the patient when they have to repeat their mental health experiences(stories) to a multitude of providers across a variety of settings.

Navigation of the Victorian mental health system is difficult, not only for patients but also for their carer's. Care navigation is a particular issue for people who have complex and multifactorial issues (including physical co-morbidities) that underpin their mental health issues. To address this we need to build up the capacity of care brokers/navigators who can facilitate integration and collaboration between a multitude of providers. As general practice is the cornerstone of Australia's health care system where around 85% Australians visiting a general practice at least once in any given year[2], general practitioner and nurse providers are well positioned to take on the broker role to facilitate improved mental health service integration and navigation on behalf of their patients and their patients carer's.

GDP capability

- The Department of General Practice can offer expertise in helping to align federal systems with state systems so that a complete picture of all the available care options can be envisaged. This is already being successfully done in the Vic Gov's Doctors in Secondary School Program (DiSS) (Professor Lena Sanci is the expert advisor) where Primary Health Networks (PHN) coordinate the general practices providing services within school. This program allows school students greater access to the realm of mental health initiatives provided by general practice and the PHN while at the same time enabling students to retain access to services and care via the school to state based systems. Around 40% of presentations are primarily for mental health with the remainder for general health issues. This service is providing access which is otherwise difficult, particularly where doctors are in shorter supply hence relieving pressure on families needing to take time off to access care for their children.
- Our academic staff are also practicing GPs and members of the RACGP and mental health MBS panels (Dr Caroline Johnson) and on boards of the PHN (Professor Jane Gunn) hence we can provide information on federal systems.
- Our work in schools and as GPs in the community also provides first hand witness to the problems arising from lack of system integration within state initiatives or between state and federal initiatives.
- Professor Jane Gunn is leading with Professor Jane Pirkis are large national trial of triaging a patient's risk using digital tools and matching patients with complex needs to a service navigator

(i.e. nurse or social worker) who is trained to assist the person to identify their priorities and link them with appropriate pathways. The service navigators are within the PHN and have a budget to support interventions such as assisting mental health appointments, finding housing, accessing food, or joining social clubs. This model has been shown to provide benefits in the management of patients with chronic conditions. Results for our trial are currently being analysed for its effect on mental health outcomes.

DGP recommendations

- The inclusion of consumer and provider experiences around the challenges relating to care fragmentation and service navigation barriers is an essential component of mental health planning and policy development.
- General practice is often the entry point for pathways toward secondary and tertiary health care service provision. General practitioner and nurse providers should be funded and supported to take on a broker role to coordinate and navigate mental health services for patients and their carers across the sectors.
- Having a GP and nurse as the cornerstone of primary health care based on location at a secondary school is a model worth studying more closely as access to care for students is de-stigmatised and the issues of mind and body can be tackled simultaneously. Adolescents are the lowest attendees of any age group to primary care and manifest risks for later life disorder. This model as core coordinating component can be augmented with the additional mental health workforce to be introduced by the Vic government this year. Evidence from US models do show reduced ED admissions and better educational outcomes associated with schools that have a clinical service combining general health and mental health care.[3]
- A barrier noted is that Child and Adolescent Mental Health Services based in hospitals/regions do not accept children for intervention if under 16 without parents. This can be difficult when parents are difficult to engage in care and hence leaves the child not helped at all. An advantage of headspace centres is that children can be referred allowing for involvement of parents or other guardians over time once trust has been gained. The need for parental involvement in state-based specialist mental health should be re-visited when parents are not able to be engaged in the care initially.

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4. Structural issues in relation to mental ill health

There are multiple structural barriers which impede mental health care seeking behaviour which include stigma, homelessness, associated costs, lack of time, lack of knowledge about available services and negative expectations about mental health care services and their quality[1-4]. Of these, the most common factor is that of stigma. Stigma has both interpersonal and social effects. The interpersonal effects of stigma negatively impact on perceptions of self-worth and self-esteem, and as a consequence have a direct impact on relationships, as well as work and educational outcomes. The social effects of stigma negatively impact on social connectedness, education outcomes, parenting autonomy, work opportunities, housing security and personal safety.

The general depiction of mental illness in society and the media is predominantly negative, these negative associations are both embedded and pervasive[1-4]. These associations not only impact on the person with mental illness, but also impact on the public's perception of psychiatrists and mental health care providers (associative stigma), intra-collegial perceptions across medical disciplines(associative stigma), the care and detection of mental illness in children and the detection and care of physical health issues in patients with co-morbidities (iatrogenic stigma)[4].

Until now the relative neglect of child psychiatry has produced a system where the focus on a child's health has been centered on physical health rather than on mental health problems. Failure to recognize and manage in children the signs of trauma due to adverse childhood experiences (eg from violence, abuse, bullying, parental loss/substance misuse/divorce) has been shown to contribute to poorer mental health and physical health outcomes into later life. This inertia has produced situation where the mental health issues which were expressed in a child are being addressed at later stages in life. This has multiple effects such as treatment resistance, the development of co-morbidities and greater vulnerability to the consequences that result from the structural issues which are described above.

DGP capability

- The Vic Gov's Doctors in Secondary School Program (DiSS) (Professor Sanci) where Primary Health Networks (PHN) are the base for the general practices providing services within school. This program facilitates early intervention in mental health care.

- This care navigation model developed as part of the Link-me trial lead by Professor Jane Gunn and Professor Jane Pirkis as previously mentioned is a trail that aims to investigate the issues around mental, physical, and social multimorbidity's. The clinical- and cost-effectiveness of the Link-me model of care navigation is currently being analysed, however early indications are that this approach to care is highly valued by recipients. This is evidence in the quotations provided by some patients who are involved in the Link me trial (Box 1)
- In response to the issue of physical comorbidities, the IMHRP has commenced a 5-year (2018-2022), NHMRC funded research project led by A/Professor Palmer which aims to improve cardiovascular health in people with severe mental illness through primary care settings. This project is assessing an intervention that is based on a pro-active approach to the identification of cardiovascular risk factors and the persistent engagement with participants to improve these over the research project. The project has utilised a series of Living Labs with people with lived experience to develop key aspects of the study and provide feedback on recruitment and the approach to potential participants.
- The associated stigma, social disconnectedness and structural barriers (such as homelessness, poverty and carer responsibilities) that result from the effects of domestic violence on mental health is a core part of the work that is undertaken in the Centre for Research Excellence for Safer Families which lead by Professor Kelsey Hegarty.

Box 1 Quotations from respondent involved in the DGP Link me trial

Without Link-me and without your help we wouldn't have got anywhere. There's no way I would have been able to get a social worker without [care navigator], I tried and I didn't get anywhere. When you've got contacts in other places, that's sometimes what you need. Now we've got nurses who call [patient] up and come to our house in and someone has taken care of Centrelink and that's taken the pressure off. This program has been invaluable, for patients and their families, and I hope that it continues.

I've actually gained control of my life. I'm in the driver's seat.

Moving was one of the things that we had identified she would help me with…Within an hour of our appointment the nurse had done the groundwork to get me a removalist and identified which one was the best, it just blew me away.

I also have several other medical issues that are going on at the same time…she explained the process of how to get triaged appropriately and [work within] the healthcare system.

DGP recommendations

- Improve mental health literacy at the GP, patient and community interface, and include medical professionals suffering from mental health illness on the committees of peak professional bodies.

- Incorporate co-production into research and medical curriculum design (patients, their family and carers, health professionals and researcher to reduce stigma and the effects of stigma on access to mental health services.
- Avoid diagnostic/medicalised labels (describe symptoms rather than label) and use multi-media population level campaigns to reduce stigma and lever changes in people perception of mental health illness. This will assist to change perceptions of mental illness in children and young people and their parents.
- Reorientate the education system so that it can respond rapidly respond to emerging mental health issues in children and young adults by providing streamlined care pathways.
- Provide more support for the Department of Human Service to help disadvantaged families to cope and stay connected.
- Provide strategies and interventions that meet the basic needs of people with mental health illness such as address homelessness and poverty, so they can fully engage with the services provided as part of the health care system.

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5 Workforce issues/development

Workforce for mental health care comprises psychiatrists, general practitioners, nurse practitioners, practice nurses, mental health nurses and psychologists/social workers. The main issue around workforce relates to the numbers the number of qualified providers not being able to meet demand, the maldistribution of workforce across geographic areas of Australia and the age of the workforce. These issues are particularly evident in rural and remote Australia where not only are barriers to access of

psychiatrics and psychologist, but there is below optimal access to general primary care services in these areas, which do not even meet that basic physical healthcare needs of the community. This results in patients present to emergency departments in tertiary hospitals for crisis or first aid mental health care as a result of not receiving proactive prevent vie care in the primary care setting. Workforce issues not only place patients mental and physical health at risk, but also compromises the wellbeing of their carer's.

In 2016, there were 3,327 psychiatrists employed in Australia, of these 87.5% were located in a major city[1]. This disparity is also evident in general practitioner workforce, where major cities had the highest number of general practitioners per 100,000 population at (421.4 per 100,000) and remote areas had the lowest number of practitioners at 185.8 per 100,000[1]. It is projected the future demand for psychiatrists will exceed supply, where there is a projected workforce shortage of 74 full-time equivalent (FTE) psychiatrists by 2025 and a shortfall of 124 FTE by 2030[1].

Nurse practitioners and trained workforce mental health workforce is not sufficient to fill the current and projected medical practitioner workforce gaps. In 2017, there were only 131 nurse practitioners working in mental health, of all nurse practitioners in the workforce, mental health practitioners reported the highest average number of hours worked each week (40.8 hours)[1].

There were 22,123 registered nurses with a post graduate qualification in mental health nursing in 2017[1]. These mental health nurses were reported as having the second highest average hours worked per week (36.2 hours), just behind nurses who had a managerial role[1]. In 2017, 72.3% of nurses and midwives worked in major cities, 17.8% in inner regional, 7.9% in outer regional and 2.0% in remote locations[1].

Between 2013 and 2016, the rate of psychologists per 100,000 population increased overall from 99.7 to 104.2 per 100,000 population[1]. However, in remote locations the rate of psychologists per 100,000 population decreased by 3.5 per 100,000 from 38.9 to 35.4, and in very remote locations the rate decreased by 3.9 per 100,000 population from 28.2 to 24.3[1].

The average age of the medical workforce in 2016 was 45.9 years and the average age of psychiatrists was 53.1 years, of these psychiatrists 29.7 % were aged 60 or older and 43.4 % Intend to retire by 2026[1]. The average age of the nurse practitioner workforce has increased from 48.4 years in 2014 to 49.4 years in 2017. The proportion of nurse practitioners in the 55 years and over age group has grown from 23.2% in 2014 to 30.5% in 2017 [1].

It is clearly evident that Australians living in rural and remote areas tend to have shorter lives, higher levels of disease, increased reports of injury and poorer access to and use of health services compared to people living in metropolitan areas[2]. Poorer health outcomes in rural and remote areas are considered to be due to a range of factors that include a level of disadvantage related to: (i) education and

employment opportunities, (ii) income and (iii) access to health services[3]. Yet the reported prevalence of mental illness in rural and remote Australia appears similar to that of major cities[2]. However, there is a substantial limitation in access to mental health services in rural areas compared with major cities[2-4]. The evidence also indicates rates of self-harm and suicide increase with remoteness[2].

In 2015-16, there were 382 and 108 encounters per 1,000 people in rural and remote areas respectively, this compares poorly with the 482 MBS funded mental health encounters per 1,000 people in major cities[3]. This overall lower service provision rate may reflect the lesser access to specialised mental health care in rural areas (Table 1). When compared with major cities, per capita Medicare expenditure on mental health services in rural and remote areas in 2015-16 was, respectively, 74 per cent and 21 per cent[2].

Table 1: Prevalence of mental health professionals, by Remoteness, 2015

Clinical FTE per 100,000 populational					
Providers	Major Cities (%)	Inner Regional (%)	Outer Regional (%)	Remote (%)	Very Remote (%)
Psychiatrists	13	5	4	5	2
Mental Health Nurses	83	74	46	53	29
Psychologists	73	46	33	25	18

The above data paints a picture of a diminishing and ageing workforce that is in the main centre around the provision of care in major city areas. For the current workforce who are still working at or over capacity, they are at risk of burn-out, fatigue and disengagement. This is a major problem and has serious consequences the communities, especially in rural and regional Victoria.

DGP capacity

- The Department of General Practice delivers post graduate training in primary care nursing for nurses who are considering specialising in primary care[5]. This places the department in an excellent position to address current and projected medical and nursing workforce deficits by upskilling the nurse workforce so that nursing workforce can build up capacity in mental health care across Victoria, especially in rural and regional areas. The course has been developed in the Department of General Practice.
- The Department of General Practice has a training program for nurses and other care navigators in care coordination and motivational interviewing for patients with a range of metal health care needs[6] and for medical practitioners and nurses who respond to abuse and violence[7]. We also lead

the clinical training and support functions for the GPs and Nurses in the doctors in secondary school program, in collaboration with the Royal Children's Hospital, Orygen centre for excellence in youth mental health, headspace and Family Planning Victoria. This training covers engagement, communication, risk assessment, youth friendly care and responses to common issues – training is ongoing with mental health being a major focus.

DGP recommendations

- Provide on-going and sustainable funding for the development of interdisciplinary and intersectoral teams which are all trained in trauma informed care and in mental health assessments and responses.
- Provide funding to increase remuneration for services/incentivise services for all health care providers who work in outer regional, remote and very remote areas.
- Focus on upskilling the nurse workforce to build up capacity in general practice.
- Streamline general practice training for international medical graduates (IMG) and provide intensive training for IMGs in the area of mental illness detection, focussed psychological strategies and mental health first aid training.
- Provide telepsychiatry for rural areas to increase access to specialist mental health care.

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6. Innovation

DGP Capacity: The Department of General Practice (DGP) which is headed by Professor Lena Sanci, focuses on the evaluation of clinical and health services and the training of medical and health care practitioners. Through the use of clinical data analytics, the DPG explores patient pathways and describes the epidemiology of health and disease in primary care. The department is also developing a range of risk stratification tools for use within primary care. In this field, the focus on primary care innovation provides opportunities to develop, test and implement simple and complex interventions including digital technologies that have an emphasis on co-design and patient centred care. Central to our work in the DGP is to gain an understanding the patient and practitioner experience by involving both patients and practitioners in the design and delivery of interventions. The DGP has successful research areas that investigate Children and Young People's Health; Mental Health; Abuse and Violence, Diabetes and Cardio-Metabolic Conditions and the Prevention of Cancer and has direct relationships with over 600 Victorian general practices for teaching and research.

- Professor Jane Gunn with the TARGET D project is a digitally enabled clinical prediction tool which is to triage and tailor mental health care according to need. The primary aim is to test whether stratifying patients into low, medium and high risk groups will reduce depressive symptoms at 3 months compared to usual care. The secondary aims are to test differences between the intervention and usual care arms within each risk group in terms of physical and social functional impairment, quality of life, health service use and cost-efficacy at 3 and 12 months.
- Professor Lena Sanci with REACHOUT Australia in designing an online mental health care service navigation tool (NEXT STEP) for young people and also a GP tool (Check Up GP) for identifying mental health and risk taking behaviours in young people attending GP
- Professor Kelsey Hegarty with the I-DECIDE project aims to address this issue of women's reluctance to disclose domestic violence by developing and evaluating an online healthy relationship tool and safety decision aid (www.idecide.org.au). Women can assess their relationship, weigh up their priorities, and plan for a safer future. I-DECIDE comprises: self-

reflection exercises, priority-setting exercises, problem-solving tools, safety assessments, and an individualised action planning process tailored to each woman's particular circumstances.

- Associate Professor Victoria Palmer with the Digitally enabled intervention to support safe and appropriate antidepressant cessation in primary care (current NHMRC-funded project [ID1157337], with development work supported by funding from the RACGP). The key components of the intervention were identified through focus groups with antidepressant users and GPs, and members of the Living Lab engaged to help refine early prototypes.