



Primary Care Practitioners Mental Health Services Survey 2023 Report

Qualitative Analysis

The survey requested free text responses to a number of questions, and some participants shared additional material. There was an overarching theme that GPs expected “kindness and competence” with clear communication, shared decision making between the whole team (including the GPs, patients and carers) and safe handover.

While participants valued some mental health services, they saw the services as patchy, and dependent on the skills and commitment of individuals, rather than the capability of the system as a whole. Some participants described pockets of excellence.

[Perinatal mental health has] clear communication with patient and GP about next steps and plans going forward e referral are helpful and triaged very well

OPMHT had excellent communication from clinicians directly to me the patients GP including phone calls and handover of care verbally! as well as in paperwork.

The GPs particularly valued clear communication, and collaboration, particularly where there was continuity of care with the same clinicians.

[MHS] Easy to communicate with, prompt regular correspondence, continuity of care, excellent psychiatrists, friendly supportive experience for patient, good handover of care, whole person care, good MH nursing.

having a case manager, seeing the same clinician each visit

However, the GPs also recognised that there were significant roadblocks in seeking care that were frustrating, expensive (for the practice and the patient), and frequently dangerous.

Access is critically limited. Unless a person is actively suicidal, there is no timely support.

One participant described a patient who needed depot medication on a PTO (an involuntary treatment order, meaning assertive administration of medication). Like many GPs in this survey, they felt their expertise, knowledge of the patient and their context, and assessment of patient need was not considered by the team who needed to administer this form of care.

It is clear that Access MH, HAART and CMH do not sufficiently take into account the collateral information provided by the treating clinicians (presumably family members experience the same thing). This is also the case when clients are on a PTO. Our experience has been the same with PTOs. Even when Directions is providing shared care/primary health services and know the person very well, our recommendations are often ignored, sadly with significant deterioration in the person's mental health. This has resulted in clients relapsing into acute psychosis on numerous occasions. Also decisions regarding oral and depot medication should include the treating primary health clinicians...we need to better clarify and document the respective roles and responsibilities for people referred to Directions under shared care arrangements and for ongoing care, and how additional step-up support can be provided in a streamlined way when needed.

This patient was at risk of amputation, because his psychosis led to paracytosis (a delusion regarding insects under the skin) which caused continued scratching and subsequent wounds on the legs. He also disengaged from all services, including the GP, because he felt no-one was taking the “bugs” seriously. The GP wrote to the service:

[patient] is adamant that he does not want admission for wound dressings. In the past, vacuum dressings have helped a lot. Could you please assess his capacity for medical decision making and his ability to decline hospital admission for wound dressings?

This request was not actioned, and the patient deteriorated.

[He became] very unwell, violent with suicidal plans and referred with urgent concerns. HAART team attended, no advice to referrer if /what treatment provided. Still no contact at time of writing over 2 weeks later.

The GP wrote again to try to organise review:

[patient] is floridly psychotic. Since his depot was ceased earlier this year, he has become increasingly unwell. His paracytosis is no longer confined to his legs - he feels there are bugs on his head, arms, everywhere. He now has sores and scabs on his head.

He is very distressed that no one can see the bugs and very irritable and doesn't want to engage with us anymore as we can't see the bugs.

This is the worst state I've ever seen him. He is not taking any medications at all. Please reconsider your decision to stop his depot medication as his is not well at all. He is at high risk of lower limb loss (amputation) and his scalp is at high risk of infection.

GPs painted a picture of services that provided erratic, episodic care for many of their patients, and gave some insight into their own helplessness and distress at being willing but unable to care for the most vulnerable patients in the system. One GP described

Daily battles to have referrals accepted, closures reversed, poor clarity in referral pathways so the majority of patients seem to fall through the cracks. I am left struggling to manage difficult psychosocial problems with no solutions without any support.

Overall, there were several major themes that emerged from their feedback, which will be described below.

1. Difficulty resolving fundamental disagreements around competency, capacity and severity

GPs expressed frustration that their assessments and referrals did not appear to be taken seriously. They recognised that patients with complexity were less likely to be seen through the mental health system, and felt there was insufficient recognition of the limitations of General Practice in managing their complex needs.

ACT mental health staff have not taken my referrals seriously through Emergency Departments when I am recommending an inpatient admission for serious mental health issues. Patients are discharged in the same amount of distress and represent in following days. No support organised by mental health doctors other than to see me again. If I could help- I would have!

I have never successfully referred a patient to OPMH. Either the patient is too complex for their service (which is hard to believe that a patient that is too complex for a mental health service is okay to continue care with their GP!) or the patient is so unwell that they lack insight and decline an appointment, or again, the patient doesn't answer their phone so the referral is closed.

GPs felt that they were providing equal care for their patients, and therefore they should have equal influence over decisions around management. In particular, they found it difficult to reconcile the way patients were sent to them, but not accepted back when their needs escalated.

MHS are able to refer directly to Directions primary health services, particularly PAT, for shared care or ongoing care, but this courtesy is not reciprocated when the person requires a step up to specialist MHS care.

The lack of professional "courtesy" seems to focus on poor communication, with GPs frequently left without critical information to manage their patients. Worse, they often found the service assumed they had accepted duty of care, when in fact they had no idea the patient had been discharged.

2. Lack of communication, co-ordination and collaboration

GPs valued good communication, and co-ordination of care. However, unlike other services where it was possible to talk directly to a non-GP specialist for advice and support, they felt there was little opportunity to get assistance through the mental health services.

I think twice before calling MHS. it is not always helpful, nor does it offer you as the clinician the support you are needing to help with these tricky MH presentations.

They described situations where patients were unable to access care, because they were too unwell to arrange attendance at a consultation. These GPs describes a need for “assertive outreach” when the patient is too unwell to access services independently.

Assertive outreach [means the service will] notify GPs, consider protocols to record and up triage any GP concerns, increase case management capacity and broaden supports to include more outreach and transport support, home visits if phone not answered.

Consistently there are road blocks when accessing MH services. Either client is too acute or not able to be contacted so closed or not able to be helped at time of need

There was concern that critical information was not shared, and GPs had to “chase” information themselves. Lengthy waiting times means GPs were left managing patients well beyond the time they felt able to provide care.

Often have to call to get information from the MH assessment but when they come are very useful. Patients describe long waits when distressed

GPs were more concerned when despite long waits, the patients were discharged with no active management, and no communication to the GP. Similarly, there were GPs concerned about intent to die being over-emphasised in suicide assessment. Despite their concern about significant risks to patient well-being, patients were discharged into GP care with no communication and no management.

Patients seen after long waits just want to go home and this is agreed with no management of their condition done

3. Lack of clarity around who is holding duty of care

There were multiple instances described where GPs were unsure who was responsible for duty of care. They described feeling forced to accept patients when they did not feel able to provide safe care.

A patient who had multiple admissions suicidal attempts plus possible bipolar was then discharged back to me because she turned 18. She would have benefited from better handover to adult services rather than immediate discharge on her birthday. She then represented quite unwell. working out how best to transition between services when someone is v unwell is worth review

Many GPs described their patients being or feeling “rejected” because they had accessed a private resource or needed social care. Some patients disengaged because they felt their concerns were not taken seriously. This created problems when they needed support with future exacerbations.

Public services [are] not engaging with patients who have private psychologists + GP - BUT lack of understanding of patients who need more support than they can afford (especially if needing >1 psychologist appt/mth, even more so if on limited income)

Needing access to other more social supports beyond what I can offer in general practice, and no clear mechanisms to access services that can help with getting patients back on their feet when depression/anxiety are limiting their function or have limited their function, and the mountain to climb to functional feels too big

These barriers meant patients were “stuck” in General Practice, despite the fact that GPs felt unable to meet their needs. GPs described deep frustration around having to manage patients who were clearly unsuitable to their service, without negotiation or even notification that duty of care had been transferred to them.

4. The illusion of “choice”

The rhetoric of patient-centred care and choice has become increasingly problematic for the GPs in this study. GPs gave multiple examples where “books were closed” despite the patient clearly needing care. In particular, GPs were concerned that lack of contact by patients was interpreted as a “choice” to disengage, when in fact it reflected a lack of capacity

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One GP described the situation as being similar to placing a respiratory clinic at the top of several flights of stairs.

There are many instances of letters to me about patients being difficult to contact and therefore the service assumes care has been refused. Being difficult to contact is often PART of their mental health issues eg anxiety/distrust/depression/sleep cycle disruption means patients may not answer calls. Many lose their phones or do not have them. Expecting patients with mental health disorders to be organised is like expecting patients with COPD to walk up 3 flights of stairs to their appointment!!

Participants were particularly concerned when patients lacked insight, describing patients with psychosis.

The “Choice” model a serious barrier to care. Person doesn't want depot antipsychotic so MH Team stops that and is reluctant to resume it despite deterioration in clinical state / wellness of the person because it is the person's choice.

Unfortunately, the current MH system is focussed on the human rights of people to refuse treatment, rather than equal consideration of their human right to receive treatment when they do not have capacity to make that decision for themselves and are at risk, which is what mental health acts are designed to facilitate. This serves as a barrier to care and results in unnecessary harms to clients who continue to deteriorate.

Some of the GPs felt that “choice” was used as a form of demand management, which they felt was deeply inappropriate.

Many of my patients do not have a stable phone/phone number. Thus relying on a phone based intake service excludes many people from accessing care. Many of my patients were significant mental health issues have no insight into their poor health, and thus decline contact from mental health services. While I respect patient autonomy, if a patient is lacking the insight and making poor decisions that pose a risk to themselves or others, I feel there needs to be an alternative pathway to accessing care in the community

5. The lack of respect for GP’s time, competence, capacity and structural limitations

GPs were deeply grateful for meaningful engagement from other specialists, including psychiatrists

Psychiatrist called me to discuss inpatient care and discharge plan. This was great and very helpful

However, they felt that their input, context and skills were not acknowledged or respected. This is another example of deep professional discourtesy. Despite the emphasis on the importance of multi-disciplinary teams, and respectful interprofessional engagement, some GPs indicated that they were excluded from this expectation.

All of my patients have been discharged from ED without admission or communication

ACT mental health staff have not taken my referrals seriously through Emergency Departments when I am recommending an inpatient admission for serious mental health issues. Patients are discharged in the same amount of distress and represent in following days. No support organised by mental health doctors other than to see me again. If I could help- I would have!

Time was a particular concern. There was a lack of recognition that GP time in coordinating care is unpaid and unrecognised. Expecting voluntary donations of administrative time indicated a lack of professional respect.

Access MH number is crazy; why can't we have a clinician line?

The PACER team is a great initiative and the overall response from patients using the service is positive. However, referral to the PACER team is a time consuming, challenging process.

One GP gave a very clear example of the waste of resources expected in General Practice to compensate for resource limitations in tertiary care.

Message to phone HAART team about a patient: phoned the GP number (the number provided), went to Access MH, on THE line in queue for 7 minutes 2nd in queue, 38 minutes 1st in queue, total 45 minutes. In this case, the combined staff time, including GP, nurse and CEO, attempting to get an appropriate response to C1 was in excess of 10 hours. This was an opportunity cost for other people who are not able to receive care as a consequence.

Issue: the wait for telephone support response is much too long for people also busy in clinical work.

GPs found themselves in the unpleasant position of receiving mixed messages. On the one hand, their clinical assessments were not valued or respected, but at the same time, they were expected to assume the care of the most complex patients in the system.

My clinical assessment of eg psychosis was disregarded based on brief phone calls with the mental health worker.

Called community mental health about my patient with increasing risk taking and selfharming with BPD. History of complex trauma. Spoke with case manager. I wanted to speak with her psychiatrist, they obstructed this request and had negative cognitions expressed about this patient and they weren't showing an interest and concern in what I was saying about the patient's condition. It appeared to me that they underestimated my concern due to their knowledge of the patient. Difficult conversation with them. I never spoke with the patient's psychiatrist when I wanted to discuss their situation as a care team member clinician to clinician. Quite disrespectful behaviour from Mental health workers who are not clinicians.

I wanted to discuss my patient with a child and adolescent psychiatrist and was given an appointment in three week's time.

There was a deep sense of helplessness with competent and capable GPs watching patients deteriorate, but being unable to help.

[My patient] has chronic schizophrenia. He is usually quite stable on a depot anti-psychotic but several times in the past when he is transferred to PO medications he generally does not take his tablets and then relapses into psychosis. His history is complicated by polysubstance abuse, particularly alcohol with secondary cirrhosis. A few months ago Community Mental Health stopped his depot again as he wanted to transfer to oral medications and they felt he was stable enough to do so. This decision concerned us as there is a clear pattern of his deterioration when he invariably ceases oral meds. He remained stable for a few weeks but then failed to present to see us and then failed to present to collect his medications from the pharmacy. We then found out he had a 9 day admission to AMHU after being found by police agitated and confused with a gunshot wound to his calf.

6. The damaging impact of moral distress on the GPs doing the majority of the mental health work

The sense in the qualitative responses was helplessness and exhaustion as they tried to manage patients who are unsuitable for private GP care. GPs described a frustrating sequence of "co-ordination, chasing, coaxing, calling and concern".

We are the ones who will grieve when bad outcomes happen to our patients, but we can't fulfil all these multiple roles to provide the MH care they need.

I was concerned for his safety and contacted Access MH who put me through to HAART who after much begging visited him but not until the next day, interrupting his latest suicide attempt. After the subsequent involuntary admission and stay at Step Up Step Down, he was referred to a Community MH team. Concerned for his safety again I contacted Access who directed me to the Community Team who directed me back to Access MH because they had not yet seen patient. Several times his psychiatric appointment was rescheduled when he was in this vulnerable space. Eventually he had ongoing Community MH case management but there was no correspondence from them to me, despite my calling twice to request updates. Meantime he was finally seen by Next Step psychology following on from a referral the inpatient Psych unit had recommended I make after a much earlier discharge, only to be deemed too unwell and suicidal for psychotherapy. During this time he was also at Step Up Step Down accommodation several times but without any notification to his GP on admission or discharge.

There was a sense of the GPs feeling under siege, without the tools to manage any of the complexity, and without useful communication and collaboration.

There are daily battles to have referrals accepted, closures reversed, poor clarity in referral pathways so the majority of patients seem to fall through the cracks. I am left struggling to manage difficult psychosocial problems with no solutions without any support.

7. Therapeutic chaos, and the delivery of “homeopathic doses” of care due to inadequate resourcing of services

GPs recognised that the team were doing their best, but the system was “woefully underserved”.

I feel the team in the TCH do their best, but they need more resources

I despair for our community. Canberra is woefully underserved. Patients report feeling disempowered by the frequent changes in the health care providers they see. I have had patients refused community psychiatric support if they have seen a psychologist privately. There is no apparent care or understanding about how hard it is for people in the community to find and afford support.

They felt patients were given “homeopathic” doses of care, the equivalent of “a mg of Panadol and they’re on their way”. Others described healthcare waste with patients being “ping ponged around” without useful management strategies. This seems to be a particular problem for patients with co-morbidity.

[They have] homelessness, alcoholism, unemployment, completely vulnerable and broken. Plus when I referred them to adult mental health services they said they wouldn’t see them due to their alcohol and to see drug and alcohol service who will only see them if they self refer. This means detox and the patient has been in and out of detox and rehab multiple times. Underlying mental health issues not assessed and managed effectively. I suspect ADHD. But community mental health not helpful in doing this. No money for private practice if you can find a psychiatrist interested in seeing someone for suspected ADHD in the ACT. The system is broken!

Inequity and injustice

The participants described deep structural impediments to care, including Unconscious demand management using privilege as a barrier. They described care as a “closed shop” which required considerable resources to navigate.

Having a rigid telephone based entry system does not work for many vulnerable people with complex mental health issues as they do not own a phone (or lose/change numbers frequently). I have never successfully referred a patient to OPMH. Either the patient is too complex for their service (which is hard to believe that a patient that is too complex for a mental health service is okay to continue care with their GP!) or the patient is so unwell that they lack insight and decline an appointment, or again, the patient doesn’t answer their phone so the referral is closed.

Certain patients had particular barriers to entry, including

having both mental health AND drug/alcohol issues and refusal of service to see pts unless certain things were done eg an ECG for pts with possible ADD, certain bloods for eating disorders. Older Persons Mental Health seem reluctant to see ANY patients I refer

Indigenous patients not having referral persistently followed up followed up until contact made

Homelessness, addiction, social isolation, stigma, previous poor experiences with the service, language barriers, disability

The GPs were frustrated that the system seemed to conflate patients who “choose” to disengage, and patients who are unable to engage. Their responses implied that the system excluded certain patients who live with disadvantage due to structural inequity, and also implied that these structural barriers acted as unconscious management strategies for increasing demand.

Finally, GPs and their patients were struggling with a fundamental question around mental health care. How does a patient and their GP survive a system that consistently invalidates their pain?