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## **AMA Submission to Productivity Commission - Inquiry into Mental Health**

**Mental Health Inquiry  
Productivity Commission  
GPO Box 1428  
Canberra City ACT 2601**

### **Scope of the Inquiry**

The Commission should consider the role of mental health in supporting economic participation, enhancing productivity and economic growth. It should make recommendations, as necessary, to improve population mental health, so as to realise economic and social participation and productivity benefits over the long term.

Without limiting related matters on which the Commission may report, the Commission should:

- examine the effect of supporting mental health on economic and social participation, productivity and the Australian economy;
- examine how sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity;
- examine the effectiveness of current programs and initiatives across all jurisdictions to improve mental health, suicide prevention and participation, including by governments, employers and professional groups;
- assess whether the current investment in mental health is delivering value for money and the best outcomes for individuals, their families, society and the economy;
- draw on domestic and international policies and experience, where appropriate; and
- develop a framework to measure and report the outcomes of mental health policies and investment on participation, productivity and economic growth over the long term.

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The Commission should have regard to recent and current reviews, including the 2014 Review of National Mental Health Programmes and Services undertaken by the National Mental Health Commission and the Commission's reviews into disability services and the National Disability Insurance Scheme.

## **1.0 AMA General Comments and Positions**

As the peak professional organisation representing medical practitioners in Australia, the Australian Medical Association (AMA) welcomes the opportunity to make a submission to the Productivity Commission (PC) inquiry into the role of mental health in supporting economic participation, enhancing productivity and economic growth.

The AMA represents tens of thousands of medical practitioners who interact with the mental health system in myriad ways. This submission attempts to capture the general views of the AMA; however, we acknowledge that there are other valid views from AMA members that may not have been included in one submission.

The AMA will try to address issues germane to this inquiry, such as the inconsistencies in responsibilities for mental health services. Despite previous attempts, overlap, duplication and gaps are experienced at a Commonwealth-State/Territory level, between public and private, acute and community-managed and regional-metropolitan.

These structural and financial divides and divisions are historic and require a massive overhaul of how mental health services are understood, planned, funded and delivered. A national Royal Commission, which is similar to that currently underway in Victoria, may deliver systemic changes.

This inquiry will differ from past reviews by considering how reforms outside of healthcare – such as in workplaces, education, justice systems, housing and social services – can improve mental health, and hence social and economic participation. The social context underpinning mental health is very important; that is, housing, employment, education, finance, locations and access to services, race and ethnicity, language skills and other ‘determinants’ of health.

The failure of governments to collaborate in reducing gaps and delivering effective services is an ongoing frustration to the AMA. Multi-disciplinary, multi-agency team approaches to mental health care operate in some jurisdictions and overseas, and the PC should examine how these operate and their outcomes. A major obstacle is the way government portfolios operate in silos. The PC faces an enormous challenge here. There must be an understanding that even though mental illness is an individual condition, collaborations by different agencies and disciplines (housing, employment, relationships, domestic violence, disability, drug and alcohol, migrant/CALD and Aboriginal and Torres Strait Islander) are vital to reduce duplication in services and ‘fill the gaps’.

This inquiry should start by examining whether the current Australian payment and funding system is adequate and adaptable to treat and manage episodic mental illness. AMA members have a range of views on this, with some concerned that fee-for-service may not be suitable for all patients, particularly those with severe mental illness. The AMA believes that the current appropriations and allocation of funding for mental health services, treatments and workforce, by both the Commonwealth and State/Territory governments, need to be overhauled and realigned.

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Funding is not properly weighted between community-based mental health services, acute care and advocacy requirements, and there appears to be no effective and evidence-based approach to the overall mental health architecture.

Current funding mechanisms stifle the sector and inhibit proper mental health care. At the community-based end, block, flexible and/or innovative funding is essential to maintain and build services and supports. Block and/or flexible funding ensures a more stable workforce and allows for long-term planning and delivery.

The under-resourcing of acute care has been well-documented. It has been the practice of successive federal and state governments to fund 'attractive' components of the mental health system, such as awareness-raising campaigns, at the expense of frontline treatment and care. The AMA Psychiatrists Group (AMAPG), a committee of psychiatrists within the AMA, believes that funding for psychological care and non-medical providers has been at the expense of acute mental health services for more severe illnesses, clinically appropriate and humane physical infrastructure, and community-based psychiatric mental health programs and services. Consequently, many psychiatric mental health service providers struggle to provide a continuous, stable service, retain qualified staff with corporate knowledge, and provide proper outreach services. The consequence has been a loss of senior psychiatrists and psychiatric leadership from many publicly funded psychiatric mental health services and a fragmentation of the public psychiatric workforce.

Others have called for a more multi-disciplinary team approach to provide coordinated care based on national standards implemented with regional mechanisms. Mental health for many patients is best delivered in a coordinated manner, with agencies working together to meet individual and community needs.

There is ample data available to the Commission indicating that the commonest cause of premature death for people with mental illness is physical illness. The life span of a person with mental illness is shortened by at least a decade. Physical health is too often ignored in these patients.

### **1.1 Accountability in the mental health system**

Any analysis of the mental health sector aimed at increasing economic and social participation and productivity should start with an assessment of how and where mental health dollars are allocated, and the accountability measures in place to assess whether these are the best 'spends'.

Evidence-based targets that can be measured and prioritised should be the basis for funding. Overseas we see targets such as reducing preventable hospital admissions, or reduction in suicide rates. The PC should look at mental health/health strategies like those initiated in Canadian provinces (e.g. British Columbia) and Scotland, as examples of what can be achieved.<sup>1</sup>

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<sup>1</sup> See <https://www.health.gov.bc.ca/library/publications/year/2017/mental-health-substance-use-strategy.pdf> and <https://www.gov.scot/publications/mental-health-strategy-2017-2027/>

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In Australia, millions of dollars are expended on awareness raising, primary care case identification, promoting mental health in the public consciousness, and addressing stigma.

The PC should undertake a comprehensive description of what ‘mental illnesses’ are, who is best placed to diagnose, triage and treat different types of mental illness, and what tools or accountability measures operate to deliver optimum outcomes for the patient and the wider community.

The language of mental health is very important to get right, and the PC should seek the views of medical practitioners to ensure terms like ‘severe mental illness’ and expressions such as ‘moderate’ and ‘severe’ are used appropriately.

Understanding the profile of mental disorders that have been identified by quality research will enable the PC to examine the roles of mental health professionals in the health system and provide recommendations on the best way to make those who fund and deliver services accountable. Setting targets establishes an accountability framework. It creates a system that prioritises outcomes and leads to investment in what works; and not funding what is ineffective or not producing the evidence-based outcomes. Federal, State and Territory funded mental health programmes need careful evaluation to determine the evidence-base of the treatments provided, and the clinical governance system utilised in these programmes. Some Federal programmes seem to lack a good evidence-base and work outside appropriate clinical governance structures.

The AMA recommends that the PC look at the situation of how State and Territory funded patients are treated (this should include Primary Health Networks (PHN) funding on mental health and national programmes such as *headspace*), and what conditions they are treated for. In many cases, an individual must present as acutely psychotic or have acted on suicidal ideation before they are treated in the public system. Clearly, a system that operates in this way is inhumane and dysfunctional, and the impact on the patient’s health, as well as productivity, participation and well-being is profound. The cost to the community is enormous.

## **1.2 Failure to act on previous enquiries**

While the AMA welcomes the PC inquiry, we also note that many other inquiries, reports, forums, summits and commissions into mental health have been undertaken with little or no action on their recommendations. For this reason, we briefly reference previous inquiries to highlight the lack of follow-up to recommendations based on expert input and knowledge.

Despite the large number of inquiries, reports and data, there is a need to better coordinate and evaluate data. Data collection is not the problem, it is coordinating this data to produce the evidence that influences funding, workforce (salaries, distribution, responsibilities) and accountability.

In 2008, the Senate Standing Committee on Community Affairs released *Towards Recovery, Mental Health Services in Australia*. This report produced 26 recommendations, calling for “a clear vision of the services required in a community-based recovery-focused mental health system in Australia.” It argued that this should not be limited to mental health services by including “accommodation, education, training, employment and other community support services for people with mental illness.” The Senate report wanted “funding and consumer benchmarks in each of” the areas identified. Again, few of the recommendations have been

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implemented. The specific recommendations regarding funding of services and accountability have either been ignored or only partially acted on in the decade since the Senate undertook this inquiry.

In June 2009, the National Health and Hospitals Reform Commission (NHHRC), established under the Rudd Government, developed a long-term reform plan for Australia. Titled *A Healthier Future For All Australians*. This Commission noted that a “priority for improving access and equity is better care for people with mental illness”. They listed (as their second priority) improving access and equity for people with serious mental illness. The NHHRC recommend an expansion of sub-acute services in the community and proposed that all acute mental health services adopt a ‘rapid response outreach team’, available 24 hours a day, which would provide intensive community treatment and support, as an alternative to hospital-based treatment. The report recommended a number of other ways to ensure treatment and support services across the spectrum of care, including expanding sub-acute services in the community. The NHHRC made 12 specific recommendations on mental health reform, of which only a few have been partially implemented. Recommendations about housing, increasing social support services, vocational rehabilitation, have not be implemented in full.

The PC should revisit the NHHRC report as its recommendations are still valid and would, if implemented, result in the type of increased participation and economic benefits being sought.

In June 2010, the Senate Community Affairs References Committee released *The Hidden Toll: Suicide in Australia*. This report highlighted the enormous personal, social and financial cost of suicide and made 42 very important recommendations to reduce suicide in Australia. It recommended the PC be tasked with producing “a detailed independent economic assessment of the cost of suicide and attempted suicide in Australia.” We understand some of the recommendations on data collection and collation, more standardised reporting, and awareness raising, have been acted on, however many of the 42 recommendations remain either partially delivered, or are ad-hoc and inconsistent.

The Australian Mental Health Commission releases a National Report Card on Mental Health and Suicide Prevention, and we now have the Fifth National Mental Health and Suicide Prevention Plan. A decade on from these landmark reports and inquiries – and with a Victorian Royal Commission into mental health commencing in 2019 – we have never had more knowledge, data, inquiries, report cards and expertise on how to ‘fix’ mental health in Australia.

If increased productivity and participation is the goal of this PC inquiry, then we urge consideration of the reports and inquiries mentioned above, as well as documents such as *Saving Lives, Saving Money. The Case for Economic Investment in Victoria* (Mental Health Victoria, 2018) and *Investing to Save*, the KPMG and Mental Health Australia (MHA) report (May 2018). In the latter report, MHA outline the economic rationale for investment, pointing out that a large body of reviews, reports and inquiries over the past 30 years have made the case for greater investment in mental health. This detailed report highlights the ‘win-win’ for governments – an upfront investment leads to many positive economic and social returns: avoidable emergency department (ED) admissions and presentations, reduced demand on public hospital beds, reduction in homelessness, less absenteeism, and improved economic productivity and greater workforce participation.

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The AMA hopes that the recommendations of the PC report are implemented, and that Commonwealth and State governments collaborate on a funded, coordinated strategy, including timeframes, accountability tools and measures, and a roadmap outlining when and how reforms will be initiated and the outcomes they will achieve.

### **1.3 Social contexts of mental health**

Previous inquiries and reports into mental health recognise that social contexts of health (often called ‘determinants’) are inextricably linked to recovery and resilience.

Housing and employment are critical issues. To this, we add poverty, disadvantage, racism, illiteracy, and in Australia’s unique geographical circumstances, access to services (which includes transport and accommodation). The social contexts of health are relevant to all health care.

People experiencing mental illness may be particularly susceptible to “downward social drift”. This means that the presence of a mental illness causes the individual’s socio-economic circumstances to decline. Evidence continues to show that social factors can be significant risk factors to the development of many mental disorders (particularly depressive and anxiety disorders) and may also contribute to downward or social drift. Thus, addressing social contexts of ill-health is particularly relevant for those Australians living with mental illness.

We do not need to detail all the issues here; the PC is aware of Australia’s housing problems and the shortage of affordable rental accommodation. Unstable, unsafe and insecure housing impacts on mental health, and those under treatment or experiencing mental health problems will likely have worse outcomes and/or be harder to treat successfully if they are not in safe, stable and appropriate accommodation. Deferring housing as a state/territory issue is one of the political ‘silo’ barriers that must be addressed as part of mental health services, not an adjunct or allied issue.

Likewise, without stable accommodation, employment is much harder to achieve. Onerous job seeker requirements for the unemployed do not consider mental health problems and the episodic or chronic nature of some mental illnesses. It is frustrating to see governments talk about improving mental health on one hand, and then introduce harsh penalties for vulnerable people on welfare, without seeming to recognise the barriers to employment for many with mental health problems. Cashless welfare cards, robo-debt policies and harsh measures against welfare recipients are likely to impact most specifically on those experiencing mental illness.

Poverty and inability to pay for medical services, including private treatment, is a serious problem. Poverty and mental illness are connected, and financial supports are needed so that patients can access the mental health care professional services they need. Australia’s Universal Healthcare System (Medicare) has been neglected; government inaction in increasing Medicare rebates in line with CPI means the government sponsored health care is no longer universal, especially for those living with mental illness.

Local areas of severe economic disadvantage have been identified in Australia. These areas require specific focus of social, health and mental health resources, to try to reduce the promulgation of social disadvantage in families and neighbourhoods. Often the solutions are not

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particularly health related, but may include social, economic and educational solutions, and intensive family interventions, similar to those provided to the population of Glasgow, in the UK.

Harm reduction is another social context impacting on mental health. Harm reduction is a cornerstone of national drug policies. The AMA is committed to the principles of harm reduction. These principles will improve productivity and participation. There has been a significant demand for the newly opened Victoria Safe Injecting Facility, based on the Sydney Safe Injecting Facility. There is still ideological resistance to Harm Reduction, evidenced by barriers to ideas such as pill testing, however the AMA urges the Commission to consider how Harm Reduction policies and changes to the way people with addiction and substance abuse problems can be managed as a benefit that will deliver improved economic and social outcomes.

Specific measures are needed to address mental illness among identified cohorts: refugees and migrants, LGBTIQ populations, Aboriginal and Torres Strait Islander people, prisoners and those in custodial settings, people with substance dependencies, people suffering physical illnesses together with mental illnesses, people with intellectual disabilities and autism, and mental health services in regional, rural and remote areas. These areas must also be addressed with additional specific policies and resources, including for training for clinicians to ensure appropriate engagement with these communities. There cannot be a 'one-size-fits-all' policy.

Social contexts are especially significant in regional and rural areas, and among Indigenous communities where historic disadvantage has contributed to the high rate of mental illness and other health inequities.

## **2.0 The Current Mental Health Treatment System**

The AMA is providing the PC with some general and brief comments about the current system, outlining some of our concerns and issues. Addressing these will impact on recovery and productivity, produce efficiencies and lead to a better funded and coordinated system.

### **2.1 Overview and Background**

#### *2.1.1. Overview of Mental Conditions*

Despite the fact that almost half of all Australian adults have met the diagnostic criteria for an anxiety, mood or substance abuse disorder at some point in their lives, and around 20% will meet the criteria in any given year (ABS 2008), mental health illness in Australia is misunderstood. Education and awareness campaigns can help to reduce stigma and normalize mental illness but more need to be done with understanding the nature of mental illness.

Mental conditions affecting Australians can range from normal emotional reactions to life's stresses, through to the conditions that have more serious symptoms and impairments, which are generally those conditions considered by psychiatrists to be caused by brain disorders of a physical, genetic, biochemical or physiological nature. These include conditions such as schizophrenia, recurrent mood disorders, many substance use disorders, attention deficit conditions, intellectual disability, the autism spectrum disorders, eating disorders and traumatic brain injuries. It is generally these latter conditions that have the greatest economic consequences for our community – both direct in terms of treatment, but also indirect in terms of various supports, and through impairment of work ability. The proportion of our population suffering these serious disorders is around 6%.

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Overall, it is the serious end of the mental illness spectrum which accounts for the largest economic burden to the community, as they suffer the greatest degree of functional disability for the longest periods of time, especially those with chronic illness rather than episodic self-limited patterns of acute high prevalence disorder. The aim should primarily be the alleviation of suffering for these people who in most cases can be treated sufficiently to have fulsome lives (sometimes called “recovery”).

Separate from serious disorders, so-called ‘high prevalence’ disorders are largely comprised of normal reactions to stressors, milder anxiety conditions, mild to moderate depressions, milder substance use disorders and grief. At any one time these conditions occur in around 20% of Australians. These conditions can be for the most part treated adequately in primary care, under the lead coordination of the GP, but with input from psychologists, mental health nurses, social workers, and other allied health professionals. It is important to treat these conditions quickly and adequately. Whilst the level of symptoms and impairment might be lower, the large number of people involved, with less severe but short-lasting significant symptoms, can have a large adverse economic effect if they are not treated expertly. The GP needs to be in a strong position to coordinate care and involve appropriate professionals. GPs should have the remunerated time to adequately assess and treat these people, and we must have a system where GPs can call on allied health professionals to assist them. When the GP believes that the patient needs psychiatric assistance, despite the initial milder appearance of the person’s condition, they should be able to readily access psychiatric assessment and conjoint treatment.

Over the last ten years, more policy effort has been applied to the treatment of the high prevalence disorders. From 2006, the Federal Government directed significant resources to the introduction of psychologists to the Medicare Benefits Schedule (MBS) Medicare system, as well as some benefits for encouraging GPs to coordinate with psychologists and mental health nurses. That strategy made a significant difference to the level of stigma associated with mental illness, as it was also combined with media communication strategies concerning decreased stigma. Yet the community (and policy makers) remain puzzled as to why there are still significant complaints about the mental health system given the large contribution of resources to the sector. The AMA warned the Federal Government in 2006 that if it went ahead with this initiative but did not combine it with a strategy for better resourcing psychiatric services, then there would be more serious cases identified by GPs and psychologists, but there would be insufficient resources available to adequately treat them. We now are seeing increased serious mental illness case identification without available resources to treat them. Hence, the complaints multiply, from the community of those affected by significant mental illnesses.

### *2.1.2 Who Treats Mental Conditions?*

Psychiatrists generally treat the significant or serious end of the mental illness spectrum. Because of the lack of resourcing for psychiatric treatment (due to the factors already alluded to) we now face a crisis of treatment for the most significant mental illnesses. The lack of resourcing, leading to unacceptable compromises forced on psychiatrists in the care of their patients, has led to psychiatry not being a popular medical specialty to enter. Consequently, there are workforce issues with inadequate numbers of psychiatrists available for the needs of the population. At the community-based end, workforce shortages and issues such as a low pay and poor working conditions impacts on the ability for providers to deliver continuity of care through a stable workforce that has on-going relationships with consumers and clients.

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Even if these workforce problems are corrected, psychiatrists (and psychologists) on their own will not be able to adequately treat the significant end of the mental illness spectrum. GPs are the professionals in the middle – identifying people with significant mental illnesses that are too complex for them to treat without psychiatrist assistance, and demanding access to psychiatrists. Mental health specialists will need to work with adequately trained GPs, who are also remunerated appropriately for longer consultations with mentally ill patients. Psychiatrists will also need to be able to access mental health nurses, psychologists and disability employment providers in the community. Other health professionals will be needed, especially mental health nurses (also in short supply) and social workers, and at times other allied health practitioners.

The AMA also recognises that for the many Australians experiencing low to moderate severity mental illnesses, psychologists, GPs, social workers, occupational therapists, speech pathologists and trained peer workers play a vital role in helping people manage their day to day living, including finding and maintaining work.

High prevalence disorders such as anxiety and depression are usually initially identified and often adequately treated by GPs. One concern is that changes in consumer behaviour and GP practices means that some patients do not see one GP consistently. Once seen with a high prevalence disorder, however, most GPs can provide the necessary counselling and advice to deal with what are usually short-term conditions. We see no reason why these patients are not employed at the same rate as the societal average. The question for the PC is whether the current Industrial Relations system and employment practices are sufficiently flexible to accommodate employees who may experience episodic mental illness.

If patients need more counselling than a GP can provide, the GP will often refer the patient to a psychologist. Some patients will seek help from a psychologist without an initial GP consultation. The Federal Government initiative that included psychologists on the MBS Medicare system was intended to provide subsidies for psychological services, and perhaps allow some people who were financially disadvantaged, to obtain such services.

More significant or serious mental illnesses typically have an ongoing or recurrent pattern of illness, and are associated with higher levels of disability, and with higher risk of suicide. The symptoms and disabilities these people suffer commonly lead to an unemployed state and associated financial disadvantage. Once again, GPs are the frontline health professionals with enough knowledge to identify these more severe disorders. If the GP does not have the expertise to treat these people, they may need a psychiatrist to work with them, or to take over most of the care. Psychiatrists' expertise lies in the treatment of more significant or complex mental illness using biological treatments, or more highly targeted psychotherapy. Many GPs have complained that it is becoming more difficult for them to access the services of psychiatrists after they have identified significantly mentally ill patients. There are two main paths to obtaining psychiatric services: through the public mental health system (the State and Territory funded services) or through assessment by a private psychiatrist.

While the Commission is focused on issues related to productivity and increased participation, it is important to consider the roles, fees and workforce issues in the public and private sectors. This is particularly important when considering treatments for episodic and long-term mental illnesses. The AMA can provide more details to the Commission about the roles of private and public psychiatric services, the costs to the government and community and the impact of rebate freezes on the delivery of proper mental health care if required.

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## 2.2 Funding

The AMA's position statement (*Mental Health – 2018*) notes the urgent need to address the gap in per capita spending on mental health, with significant investment at the Commonwealth and State level to reduce the deficits in care, fragmentation, poor coordination and access to effective care. It is generally acknowledged that there are significant deficits in mental health funding. In 2014-15, mental health received around 5.25% of the overall health budget while representing 12% of the total burden of disease. Once-off allocations of funds to specific programmes in isolation from the rest of the mental health system has not redressed this imbalance. It is essential that properly funded, community-based mental health and active treatment services are in place for people with mental illness and disability, as this will reduce the need for hospital admissions and re-admissions. It will also diminish the severity of illness and its consequences over time and will have significant economic benefits.

It has become clear that the current crisis in mental health care is being experienced throughout the Australian community. The whole community-based mental health treatment delivery system is under strain. This includes General Practice, State and Territory funded community mental health centres, psychiatrists, psychologists, mental health nurses, social workers, occupational therapists, speech pathologists, trained peer workers, patient carers and others involved in community-based sectors.

When deinstitutionalisation of mental health services was undertaken from the late 1960s through to the early 1990s, a catch cry of governments at the time was that the dollars for mental health care would follow the patient into the community. Unfortunately, as evidenced by the gap between the burden of mental illness and actual mental health care funding, the dollars did not follow the patients adequately. Preventing hospital admissions is best achieved through building up flexibly integrated community-based mental health services under a multidisciplinary model in both the private and public sector (including psychiatrists, GPs, psychologists, psycho-geriatricians, mental health nurses, social workers, paediatricians, drug, alcohol and gambling support staff, and consumer and carer representatives).

The bulk of health funding is provided by the Commonwealth and the State and Territory governments. The Commonwealth contributes around \$3 billion per year to mental health funding, while State and Territory governments contribute \$5.7 billion. The amount spent per capita by different States and Territories can vary enormously. No level of government exercises complete control or responsibility for health care. This is problematic due to the shifting of responsibility from one level of government to another for the care provided in the community. At times, there has been outright cost shifting between the tiers of government. These problems can be worked through via the Council of Australian Governments (COAG) processes to clarify roles and responsibilities, funding and accountability.

There is wide agreement that greater funding is needed in mental health, in particular targeted evidence-based funding on measures and initiatives that reduce hospital admissions. However, all levels of government need to consider carefully how extra funding will be allocated. Funding for evidence-based services should be prioritised above social media and awareness raising. Investment in independent evaluations of mental health services, including private practice and other allied health services, is also critical.

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## **2.3 Private Health Insurance Funds**

Private Health Insurance (PHI) funds help to finance hospitalisations and some day-patient programmes run by private psychiatric hospitals. Around 40% of the Australian population currently have private health insurance. Rates of insured people in our population have been declining recently due to the very high premiums that must be paid. Approximately 7% of private psychiatrist services are provided in hospital, reflecting the predominant community focus of these psychiatrists.

Mental Health service provision is a relatively small part of private mental health insurers' expenditure, but over the years PHIs have focused very strongly on this sector to decrease their expenditure. For many years the expenditure of PHIs was around \$200 million dollars per year on mental health service provision. That figure has risen in the last five years particularly, to around \$500 million dollars a year. A good part of that increase in expenditure is related to a cost shifting exercise by State and Territory governments.

## **3.0: The Medical Sector and Mental Health**

The AMA wishes to highlight aspects of the mental health system as it relates to this Inquiry.

### **3.1 The Roles and Experiences of General Practitioners**

The PC has previously reported that GPs are providing high-quality, cost-effective care for their patients. The Commission's Report on Government Services found that in 2017-18 almost 37,000 GPs provided around 160.3 million Medicare services to patients around Australia. It also found an extremely high satisfaction rate with GP services, with more than 90% of patients reporting that their GP listened closely to them, showed them respect, and spent enough time with them. These figures have increased steadily over the previous five years, demonstrating that GPs are responding to the growing demand for health services in the community, with an ageing population and rising rates of chronic diseases and complex conditions.

The PC report found that only 4% of the population reported delaying or not visiting a GP in the previous 12 months due to cost, and around three-quarters of patients could get a GP appointment within 24 hours. GPs are working harder but are feeling the squeeze from underinvestment in Medicare rebates for patients and general practice across the board.

GPs require quick access to reliable crisis intervention services when patients present in a more acute mental illness state. Such clinical states might include patients being acutely suicidal, acutely psychotic, or in a general social crisis, or can involve domestic violence and drug and alcohol problems.

GPs also require backup psychiatric advice and review in the longer term from a consultant psychiatrist, who will preferably follow the patient's progress over time in order to know and understand the patient. The GP can then contact the psychiatrist for informal advice between consultations with the psychiatrist. There should be a close working relationship between the GP and the psychiatrist over the longer term.

With patients who have been treated in the public sector, there is a need for ongoing and effective case management from that sector, so that patients who may require re-admission can have it facilitated by the case manager of the relevant public mental health service.

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GPs recognise the need for much more effective communication between the group of people looking after a patient in the community. Achieving this will require increased financial resourcing, as well as an appropriately upheld clinical governance hierarchy. This will ensure that when an unwell patient sees a member of the community-based team, it is quite clear who that mental health professional should contact next, how quickly it can be done, and how readily a consultation can be obtained.

### **3.2 Emergency Physicians in Mental Health**

Emergency Physicians working in Emergency Departments (EDs) have for many years been often the frontline for assessment of the acutely unwell or neglected mental health consumer. As Australians living with mental illness have increasingly been unable to pay the out-of-pocket costs, and because the public sector has poor capacity and fragmentation of services, it is not coping with the severely ill population. More and more Australians end up seeking help from EDs, as a first 'port-of-call'.

Some ED Physicians have suggested properly staffed Emergency Crisis Hubs, where mentally ill patients can be assessed immediately and managed in a safe and appropriate environment. There is also a need for increased funding and resourcing of community acute mental health care teams (e.g. CMHT, CAT and PACER), after hours crisis resources, case workers and options for semi-urgent outpatient review. Currently, often the only option for ED Physicians/acute psychiatry is to refer patients who are discharged to a GP or for delayed clinic assessments. Unfortunately, many of these patients find it difficult to book and keep GP/clinic appointments. Often, they have been sent in by their GPs who recognise they need co-management with Mental Health Teams beyond ongoing GP management. Often when a GP phones the acute care/CAT team, they are advised to send the patient to ED. The ED then refers to the community Mental Health team, but after the patient has already been managed in a clinically adverse environment and may not be feeling engaged. This cycle continues at considerable psychological/economic cost to the patient and their families, financial cost to the community, and the frustration of all clinicians involved.

There is a major need for a significant increase in Dual Diagnosis (those with mental illness also suffering alcohol and drug use disorders) assessment and management, education, training and staffing. The artificial separation of mental health and drug and alcohol services is one of the most frustrating aspects of emergency management of mental health patients. A massive increase in alcohol and drug rehabilitation facilities and programs is required. Currently the wait for dual disability intervention is often well over a month or even unavailable for those with severe dual diagnosis.

More acute psychiatric inpatient beds, or high acuity step down community beds, are required. The most unwell mentally ill patients stay in ED the longest (frequently for over 24 hours in some systems) as they are too unwell for lower acuity units such as short stay psychiatry or behavioural assessment units. Even if they could use these units they are often not used because this would "stop the admission clock" and take the pressure off the need to find an inpatient bed. More importantly, the short stay units are important for borderline admission patients who may avoid prolonged admissions, need time to settle and have plans put in place for community management and follow up. Filling these important resources, which allow flexibility and reduce inappropriate admissions, with patients always destined for longer stays is inefficient and counterproductive. Prolonged ED stays are a travesty for these most unwell patients, who often

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end up sedated or restrained, and create major stressors for the staff, other patients and visitors, and are a significant contributor to burn out in all staff.

Other innovations that would help Emergency Physicians would include increased public outpatient psychiatry services (where the Emergency Physician/acute psychiatry team could urgently refer to a psychiatrist who had seen the patient), and better emergency access to private psychiatry for inpatients and outpatients.

### **3.3 Workforce**

Improvements in mental health services and subsequent economic and social benefits will not be reached unless there are nationally led workforce strategies.

In the community-based sector, poor pay, short-term contracts and job insecurity affects the ability of service providers to fill and maintain a viable workforce. This includes the alcohol and other drug (AOD) sector, the National Disability Insurance Scheme (NDIS), and properly qualified personnel to assist and manage day to day living in the community. At the clinical end, retention of staff and innovative programmes to deal with maldistribution are serious and long-term problems that require redress.

In particular, addiction medicine and addiction psychiatry need to be supported to provide medical governance and expertise for the Australian opiate use problem. Currently, there are Medicare item numbers for addiction medicine, but these have not attracted sufficient physician trainees to the specialty to replace those retiring from addiction medicine. Certainty that Medicare items and their rebates are adequate to ensure that private billing is viable will ensure that addiction medicine remains a viable sector career path.

The concept of up-skilling the mental health workforce has not been very successful due to lack of long-term strategic planning and investment. From our research, it may be appropriate for the PC to look at other jurisdictions, such as Canada, Portugal and Finland where workforce planning appears to be better managed. We also suggest the answer is better Addiction Medicine capacity, with more Addiction Medicine Physicians and Psychiatrists. Having a small hospital ward that acts as a subacute ward within a general hospital increases the capacity to manage complexity, including psychiatric complexity, in AOD patients.

### **4.0 Addressing specific needs**

There are many priority areas in mental health, including migrant/CALD, aged care and mental health, however we want to address two specific areas of concern to the AMA.

#### **4.1 Aboriginal and Torres Strait Islander Mental Illness**

Aboriginal and Torres Strait Islander mental health is an ongoing major concern. The most recent report by the Australian Institute of Health and Welfare (AIHW) in 2017 indicated that Indigenous Australians were 1.3 times more likely to consult primary care providers in respect to mental health conditions and had twice the rate of hospitalisation for mental conditions compared to the general Australian population. The suicide rate for Indigenous Australians was also twice the rate of other Australians, according to 2017 AIHW data. The recent report by the PC into Primary and Community Health showed a significant reduction in Indigenous populations in the

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NT accessing GPs. These individuals also suffered twice the rate of preventable hospitalisation compared to other Territorians.

The recent AMA NT submission to the PC inquiry into Horizontal Fiscal Equalisation also showed the very high cost to the N T Government of managing health conditions in remote communities, with the lack of GPs compared to other States and Territories. Mental health conditions are likely a significant component of this excessive cost of care, along with contributing to the high load of preventable hospitalisations reported. Experts on Australian Indigenous mental health, such as Professor Ernest Hunter, have also pointed to a significant association between chronic mental illness and intellectual disability in Indigenous Australians from remote and rural areas in North Queensland. On the positive side, a recent project being undertaken by the Central Australian Aboriginal Congress has shown some early promise in improving the physical and mental health of mothers and their infants. The COAG NIRA (National Indigenous Reform Agreement) in 2008 was also a strategy to address the social determinants underlying many mental health conditions in Indigenous Australians. It is hard to find evaluations showing whether these measures are leading to substantive improvements in Aboriginal and Torres Strait Islander mental health.

## **4.2 Rural Mental Health**

Around 80% of all community-based mental health care in Australia is provided by GPs. In rural areas this number rises to 95%. Psychiatrists are the only medical group that have more mental health expertise than GPs, and rural GPs urgently require more support from them.

It is not hyperbolic to suggest that rural mental health service provision is about to enter a catastrophic phase. The AMA believes that this is due to several factors. For many years, there has been a strong presence of GPs living and working in rural areas. Many of those GPs who have been the cornerstone of adequate general health care in rural areas are now approaching retirement. Unfortunately, younger medical practitioners have not entered rural general practice at a sufficient rate to replace their more senior colleagues.

In the last 20 years, our rural general practice system has been supported by the employment of international medical graduates (IMGs) as GPs in rural areas, with IMGs having to serve a conscripted ten-year period in a country area before they can work in metropolitan areas. The direction of IMGs into rural areas is now declining. Most IMGs seek to move to metropolitan areas after serving time in rural practice. Many rural areas have suffered economic decline over the last 20 years, and as a result services that were available for doctors and their families to access in rural areas have also declined. The combination of these factors means that we are likely to see deterioration of the rural GP workforce. There appears to be no planning to cope with this imminent catastrophe.

However, few psychiatrists provide services to rural patients or have skills in managing mental health patients in the rural communities. On the whole, it is primarily rural GPs that have access to rural mental health patients, the skills to assess them, and the will to do so. Rural GPs are experiencing what they call severe problems in rural community mental health treatment.

The ability of general practice to provide necessary care to mentally ill patients was given a great boost when the Better Outcomes in Mental Health Care policy was released (July 2001). This programme was developed over a period of twelve months and involved the cooperation of all

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relevant medical groups (AMA, RACGP, APS, RANZCP, ADGP, RDA, Government). The AMA can provide more detail about the problems with this programme.

While many International Medical Graduates (IMGs) have excellent skills, these skills do not always translate neatly into the provision of mental health care in rural areas, especially in the initial stages of placements. Diagnosing and managing mental health issues can be a culturally sensitive process, and different cultural perspectives can make it more difficult. It can take several years of supervision and training for IMGs to reach an acceptable level of competence in the delivery of mental health care to patients, and specifically to rural patients. The current system does not support this level of dedication from a financial perspective.

There has been a chronic shortage of doctors in rural areas for many years. There have been many poorly thought out and underfunded schemes to resolve this issue, but none of these attempts have provided anything but low-level returns.

## **5.0 : Recommendations for Improved Mental Health Treatment and Care**

The AMA believes that the following key principles are vital to the recovery-based and productivity-enhancing architecture required to change mental health treatment delivery:

- Overall mental health funding will need to be increased to account for the burden of disease of the significant mental illnesses treated in our community.
- There is currently a marked lack of capacity at all levels of mental health care which must be addressed by all levels of government.
- The new mental health system should be a strongly evidence-based system. Clinicians should work by evidence-based principles based on high-quality scientific evidence, and evidence-based guidelines determined by medical colleges.
- Mental health policy and system design should initially be guided by sound mental health system research and enhanced by input from practicing clinicians and from consumers and carers.
- A sound mental health system requires a clear clinical governance hierarchy, which guides appropriate and necessary treatment and ensures patient safety.
- Improved coordination of data to be used in ongoing evaluation against set targets and future service planning. For example, a reduction in suicide rates, and reduction in preventable ED admissions.
- The clinical outcome measurements that are collected in public and private mental health facilities and other locations where people access mental health services should continue to be collected, but there must be better coordination of data.
- GPs and psychiatrists will not be able to meet the demand from consumers suffering significant mental illnesses by themselves. Capacity can be dramatically improved by facilitating collaboration with nurses, psychologists and other allied health professionals.

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- State and Territory Government-funded public mental health care can be gradually improved through a widening of the range of conditions that the public sector is able to treat. Currently, only relatively brief episodes of care for people with psychosis or for extreme suicidal depression are commonly provided by the public sector. Providing ongoing care to mental health patients who require public sector care, and who suffer significant ongoing or recurrent illnesses is one key method to improve this.
  - Mental health care must move from a system based on episodic treatment to one based on longer treatment duration, accurately reflecting the courses and patterns of individual illness.
  - There is significant waste and poor coordination occurring in the mental health system because of different policies pursued by the two levels of government. This needs to be acknowledged and confronted by COAG. Processes should be undertaken to harmonise the two systems, which will ensure seamless access to services for those suffering from the more significant mental illnesses. Governments must agree that public mental health services should be readily available to a much broader range of people suffering significant mental illnesses. Such care should not be confined to those who are actively psychotic, or immediately suicidal. This will require significant work from COAG.
  - COAG work will also be needed to ensure public sector services take a long-term treatment and management approach for ongoing or recurrent mental illnesses. This should especially be the case for patients without private health insurance, and those who cannot be safely or effectively managed by private psychiatric practices due to disorganisation, poverty, or complex illness. In addition, improved ongoing coordination with GPs and private psychiatrists will be needed under this initiative, as the current public system does not facilitate shared care between public and private sectors.
  - The PC has previously inquired into aspects of the NDIS, a scheme that is yet to deliver equity of access for people with psychosocial disability. The removal of the GP or psychiatrist from the centre of the mental health patient's care and putting clerks in the role of making healthcare resource allocation decisions will prove to be as disastrous a development as US-style managed care has been in the US. These problems must be addressed and reformed.
  - The AMA has called for multidisciplinary, multifaceted strategies to improve access and care to Australians with mental health needs. These should encompass:
    - improved service delivery;
    - significantly increased funding to targeted collaborative treatment;
    - improved coordination;
    - robust workforce and infrastructure solutions;
    - prevention, education and research; and
    - e-health/ telemedicine solutions.
  - Additional and more timely access to acute care in public hospitals is required. It is never appropriate for patients presenting with significant mental health conditions to spend
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prolonged (>4-6 hours) in hospital EDs. Co-localised or proximally-located purpose-designed, built and governed specialised mental health and dual diagnosis assessment areas or departments should be established as part of public hospitals admitting patients with acute mental illness.

- Access to MBS rebates for clinical care and treatment provided by GPs and psychiatrists must continue to be available on a universal basis for clinical need. This access should not be capped, bundled or rationed. This access is already clinically governed, and this governance structure is built into the Medicare system.
- Private health insurers must not be permitted to go down the erroneous path of managed care where they dictate the ingredients of the care being provided by medical practitioners or specialist-led multidisciplinary teams.
- MBS items/funding need to be reformed. We recognize the MBS Review may address some of these issues. Australians need increased rebates for longer GP consultations for patients with significant mental illness, who often have complex and multiple physical and mental health issues. Increased rebates should be provided for patients treated by private psychiatrists in community managed care and identified as having complex mental health needs by their GP. Appropriate rebates should also be available for GP-psychiatrist-nurse-allied health clinician coordination, to help ensure patients are able to obtain the most effective and efficient treatment packages that reduce their symptoms, minimise their suffering (and that of their families), optimise their level of function, keep them out of hospital and keep them living independently in the community.
- Community Practice Mental Health Nursing programs should be rejuvenated to enable all interested psychiatrists to access mental health nurses for their practices. It is a gross underutilization of the substantive private psychiatric workforce to encourage the majority to work as ‘one-man-bands’, in isolated practices and without nursing support that has traditionally proved to be highly complementary to psychiatric treatment.
- More access to general and sub-specialty mental health assessment facilities for public patients is required, including through more and better-resourced mobile outreach teams operating extended hours for high risk patients.
- Step-up and step-down high acuity residential care, and resourced coordinated services under appropriate medical oversight, are an essential part of transition care and are an alternative to inpatient admission or for earlier hospital discharges.
- Expanded specific services are also required for perinatal psychiatry and adolescent mental health issues. Rather than separating these services from GP and general private psychiatry, they need to be built on or at least co-located with existing services.
- Early psychiatric intervention should be available for people of all ages, recognising that early treatments often lead to better outcomes and reduced morbidity.
- Access to respite care is necessary for many people with mental illness and their families, who bear the largest burden of caring for those with mental illness.

