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Productivity Commission Inquiry into Mental Health
AMA response to final Productivity Commission Inquiry Report (released 16 November 2020)

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Introduction

The AMA considers the Department's call for submissions in relation into the above Report as opportunity to tangibly reflect on the critical need for systemic reform in the provision of mental health services and rethink how we as a nation tackle mental ill-health at the community, funding and systemic levels.

The AMA welcomes the economic evaluation components of the Report and the evidence base this has provided for ongoing policy and reform considerations. It is important to acknowledge that mental health is underfunded at all levels, with current allocations across sectors and between public and private service delivery falling short in responding to community need, demand and disease burden.

We believe that economic expertise of the Productivity Commission could have also been extended to consider the underlying major economic vulnerabilities of the health and mental health systems in this Inquiry. These include:

- Increasing gap payments under Medicare due to inadequate indexation and the recent extended freeze on Medicare Benefits - opening up a large irreparable gap;
- The current vulnerabilities of the private health insurance system if private insurers continue to pursue a managed care agenda;
- The cost and problems associated with the National Disability Insurance System including the loss of state-based public health services since the commencement of the NDIS and the introduction of corporate professional negotiators to negotiate on behalf of applicants; and
- The problematic allocation of mental health funding to Primary Health Networks which has led to a lack of expertise in developing mental health care services, policies and programs and a lack of overall consultation with the Psychiatry profession.

These systemic issues do not sit independently from the mental health service, system and delivery issues identified in the Report.

The AMA regards the following three aspects of personalised mental health care as critical to this inquiry and we encourage further consideration of these areas as this Report continues to be implemented:

- Importance and value of actual medical treatment for ongoing long term and recurrent mental illnesses;
- The value of longitudinal treatment and care of such longer-term cases; and
- The value of a diverse mental health system available in all regions for such cases, which includes private (GPs and Private Psychiatrists, mental health nurses and psychologists) and public systems.

We support the inclusion of social determinants as we know that housing, employment, education, finance, ethnicity and geographic location are some of the things that can impact on a person's mental health as well as their ability to access and afford the services they need. The AMA agrees that social determinants of health are important, and we support this approach being a key objective of the Report. The AMA also acknowledges that biological and psychological determinants are substantial contributors to mental ill-health.

1. Overview of AMA position

1. The Report proposes the abolition of GP Mental Health Treatment Planning (GPMHP) items under Medicare, replacing them with an online tool (Action 10.4). While the intent of this may be that the tool is used by GPs in collaboration with their patients, the AMA is concerned that patients using this tool may also bypass their GP altogether. We are of the strong opinion that General Practitioners should be able to use their extensive training and professional clinical skills to engage with their patients in the most appropriate way. Online tools may provide a supplement to discussions but should not be seen as a replacement to individualised patient-centred care. The GPMHP items also provide funding for GPs to engage in discussions with patients and developed a structured plan for their mental health care needs. These items should be retained.

2. The Report infers that prescribing of antidepressants, primarily by GPs, is too high based on data showing Australians were the third most frequent users of antidepressants among OECD countries. The Report recommends additional requirements should be added for GPs and psychiatrists to prescribe them, such as prescriptions requiring a statement saying that "clinicians have discussed possible side effects and evidence-based alternatives to medication." (Action 10.2) The AMA does not support this recommendation as it is outside the expertise of the Productivity Commission. We respectfully note that discussion of rationale, expected risks and benefits including side effects and comparison with other interventions is the standard expectation of care when providing any medicine or other medical interventions.

   We also do not support the additional administrative burden selecting out one specific intervention places on medical practitioners. In fact, it could be detrimental selecting out one type of physical treatment for special administrative requirements as this would send a negative message to patients considering their treatment options that this type

of treatment is culturally undesirable. In other words, it would be discriminatory and perpetuate the stigma of people taking psychotropic medications. The AMA notes that comparison with other countries is not scientific evidence, as health systems and recording vary enormously.

3. The AMA supports the recommendation that a Medicare item is introduced for GPs to get advice from a psychiatrist about a patient under their care (Action 10.3). While this policy recognises the expertise of psychiatrists and encourages collaboration, it falls short of what is needed to give GPs the support they need in times when the burden of mental illness is growing, due to the unnecessary restriction that the consultation must be for patients that have not consulted a psychiatrist.

4. The AMA supports the ongoing expansion of telehealth. However, we oppose the recommendation (Action 12.2) which specifies that telehealth for psychiatrists be restricted to 12 sessions per patient per year on the basis that the analogous face-to-face consultation limit is of 50 sessions with a step-down of rebate (Item 319). The current flexible use of telehealth for psychiatric care, since the COVID-19 pandemic is fundamentally different from the pre-existing rural telehealth items and will continue to be useful on an ongoing basis based on patient preference.[1]

5. The AMA does not support Action 10.4 as we are concerned this also extends beyond the specific expertise and remit of the Productivity Commission. There is no evidence provided that the proposed mental health assessment and referral tool is either effective or necessary. It seems contrary to the Report's acknowledgement of the critical roles played by GPs in Australia's mental health system. This recommendation would remove one the few Medicare items that enable GPs to provide longer, more intensive appointments for patients with mental health concerns.[2]

6. The AMA does not support Action 16.3 which we believe extends beyond the specific expertise and remit of the Productivity Commission. There is little to no evidence base for social prescribing as alternatives to clinical interventions and similarly little to no evidence base for de-prescribing initiatives.[3]

7. Action 13.3 recommends addressing current shortfalls in sub-acute and non-acute mental health bed-based services. However, no mention is made of the more pressing concern of similar shortfalls in acute beds. The Report perpetuates the view that community-based and residential services can replace acute and non-acute bed-based services, when, bed-based and community-based services are complementary.[4]

[1] Looi JCL, Kisley S, Allison S, Bastiampillai T, Pring W, *In Press* 'The Productivity Commission Report on Mental Health: recommendations with negative consequences for clinical care in public and private sectors, *Australian and New Zealand Journal of Psychiatry*

[2] *ibid.*

[3] *ibid.*

[4] Looi JCL et al *In Press* and Allison S, Bastiampillai, T, Looi JCL, Judkins S and Perera IM (2020), 'Emergency department-focused mental health policies for people with severe mental illness', *Australia and New Zealand Journal of Psychiatry*, 1-3

8. The AMA is not supportive of the emphasis in the Report on regional commissioning authorities, i.e., Actions 23.4-23.6, p.64-65, as similar purchaser-provider arrangements have been abandoned in the UK by Scotland and Wales on devolution.[5] We are further concerned about the potential impacts of the 'The Rebuild' funding model proposed in the Report on not only public but also private mental health service provision.[6]

2. A patient-centred system

The Report emphasises the need to create a patient-centred mental health system and the AMA acknowledges this is essential to ensure that people experiencing mental ill-health can access quality care based on their specific needs. We also acknowledge that achieving this in practice requires a concerted effort and awareness at all systemic levels of the patient journey. Chapter 10 of the Report notes that a genuinely patient-centred mental health service must be accessible, affordable, empower people to make informed choices about their own care and have connections to a range of appropriate care options. The AMA is supportive of a patient-centred approach. However, the AMA provides the following clinically-informed advice to enhance the real-world effectiveness of the mental health system.

Increased investment into mental health services and infrastructure

The AMA notes that investment in well-designed, medically governed multi-disciplinary teams is more likely to result in better overall health outcomes. Stronger coordination of essential services such as older persons mental health, mental health nurses, psychologists, paediatricians, counsellors and drug, alcohol and gambling support staff are key aspects to a patient-centred mental health system. Chapter 15.4 of the Report acknowledges that a patient-centred model of care requires a 'substantial cultural shift' away from siloed service delivery models. We believe it will require more than 'cultural shift' and that appropriate funding, remuneration and Medicare enhancement models will be required to achieve improved care. The AMA can assist with guiding the development of new community models of multi-disciplinary teams.

We are supportive of bolstering efforts to develop coordinated models of care at that are appropriate for the needs of communities and regions. The AMA recommends that specific investment in developing capacity in mental health support services within GP and Private Psychiatrist practices such as embedding accredited mental health nurses and social workers would be beneficial. These 'wrap-around' services have the potential to offer better return on investment and health outcomes than investing in siloed service delivery models, particularly in rural, regional and remote areas. Similar investment in psychiatry services including private psychiatry through Medicare enhancement to embed mental health nurses and social workers in psychiatric practices will improve complementary (to public mental health service) capacity.

[5] Kisely S and Looi JCL (2020), 'The Productivity Commission's Draft report illustrates the benefits and risks of economic perspectives on mental healthcare', *Australia and New Zealand Journal of Psychiatry*, Vol. 54(11) 1072-1077

[6] Looi JCL et al *In Press*

The AMA would have liked to have seen recommendations that supported the broader inclusion of mental health care professionals within general practice under a medical home model of care. A patient centred medical home model is important because it ensures that GPs can continue to manage other health issues. As stated in the report, comorbid diseases are responsible for much of the average 10–15-year mortality gap between people with severe mental illness and the general population. A medical home model would also facilitate the coordination and continuity of care which is identified as a key action in the report.

Psychiatric service delivery across public, private and non-government sectors

It is important that the most seriously or complexly ill mental health consumers, especially those with less social or financial resources are provided with the highest standard of psychiatric care – this should be the foundational purpose of the public sector. Adequate funds will need to be devoted to the new models of care to ensure that the foundational consumer base is well treated. Action to address acute, subacute and non-acute/rehabilitation mental health bed shortages, complementary to community-based services are across jurisdictions must also be an essential part of this process.[7]

Private psychiatrists lead the private sector mental health treatment services and the sector is broadly well integrated with GPs through the referral arrangements overseen by Medicare. As stated above (Actions 23.4-23.6), the AMA does not support the notion of pooling various funding streams within regional commissioning authorities. Rather, we would support focused examination of where the current system would most benefit from an increase in funding – whatever the source may be.[8] The Report has included MBS funded psychiatry within the calculations for allocating the funding pool, in addition to GPs and allied health.[9] This is a significant deviation from the original draft that went out for consultation. The AMA is concerned of the potential impact this regional fundholding could have on consumers by rationing of and thus diminishing the use of psychiatry services in Australia.

The role of GPs

A patient's GP is often their first point of call when experiencing symptoms of mental illness. GPs are often able to provide brief intervention themselves for mild illness. Their training equips them to develop comprehensive management plans across the spectrum of illness presentations and severity. When symptoms are more complex or external expertise is required, GPs are in a strong position to coordinate care and draw on appropriate services such as psychiatry, allied health and psychology.

We are pleased to see the overall positive experience that patients report having with their GP in the Report (ch 10.2) and we re-emphasise that developing a collaborative Mental Health Treatment Plan is a critical role the GP plays in mental health patient consultations. We do not support the proposal to review these plans or replace them with an online tool in the Report

[7] Allison S, Bastiampillai T, Looi JCL, Copolov, D (2020), 'Australia's National Mental Health Service Planning Framework: Are opinion-based algorithms driving mental health policy?', *Australia and New Zealand Journal of Psychiatry,* Vol. 54(12) 1149-1151 and Allison S et al (2020) – per ref 4.

[8] Looi JCL et al *In Press*

[9] *ibid.*

per our comments above, as we believe this has the potential to compromise the integrity of treatment options that can be discussed under GP-led consultations.[10]

The AMA is particularly concerned that although validated mental health screening tools can be a useful adjunct to clinical assessment, they should not be a replacement for same, nor a barrier to accessing care. Furthermore, the lack of detail provided in the report suggests there may be a decision-making tool put in place devoid of clinical evidence. This was not a purpose for which these screening tools were developed.[11]

Overall, the AMA wants to see implementation of some key recommendations from the Report resulting in an adaptive and flexible system which exhibits greater continuity of care; improved timeliness of access to care; and heightened health literacy to support informed decision making.

3. Expanding the capability of the mental health workforce

The AMA has previously stated that Australia must have an appropriately sized, skilled and resourced workforce able to deliver high quality, recovery-focused mental health services in a safe and secure environment.[12] We acknowledge that achieving this aspiration requires targeted funding and policies across community, general practice, allied health, nursing and medical training and education pathways. Chapter 16 of the Report notes the forthcoming National Mental Workforce Strategy will further examine mental health workforce planning, service delivery gaps, maldistribution and needs-based workforce modelling. To this end the AMA will respond specifically to key recommendations within the Report that pertain to the medical profession.

Action 16.2 Increase the number of Psychiatrists

Current inconsistencies in working conditions between states and territories, and how this is contributing to gaps in the psychiatry workforce in particular parts of Australia are key considerations to workforce planning. The AMA supports the suggestion that such planning needs to be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists to identify and provide advice on trainee numbers and workforce needs, as well as strategies to ensure trainees are adequately supported in their fellowship.

There must be an enacted plan to increase the number of psychiatrists, particularly in regional, rural and remote areas, and in sub-specialities including child, adolescent, consultation-liaison and old age psychiatry (Action 16.2), as well as to promote mental health as a career option (Action 16.7).

The AMA emphasises that health planning agencies will need to openly share workforce data and information to enable effective planning, such as the National Mental Health Services Planning Framework. This will include an open disclosure of the National Mental Health Service

[10] *ibid.*
[11] *ibid.*
[12] Australian Medical Association (2018), Position Statement: Mental Health

Planning Tool, together with the scientific evidence behind it, and the necessary assumptions that are the foundation of this algorithm.[13]

The AMA sees a role for Federal, State and Territory governments to provide incentives and supports to build a critical mass of psychiatrists (including private psychiatrists) in regional and rural areas, where access to basic mental health care lags significantly behind urban areas. There must also be further consideration of rural trainee issues, including adequate supervision and support. Increasing the psychiatrist workforce should occur as part of the broader National Mental Health Workforce Strategy (Action 16.1). There should be funding to expand the number of workers with specialised skills, such as Aboriginal Health workers

We further recommend that there is a specific need for an increased number of child and adolescent psychiatrists per 100,000 population to meet basic community needs for the population of young people in Australia. It is recognised that to achieve this necessary increase, significant additional resources are needed with recognition of regional and jurisdictional variation. Efforts to increase the supply of child and adolescent psychiatrists in regional and rural areas should be in keeping with overall strategies to increase rural workforce, rather than drawing resources away from already underserviced areas.

The Report identified the use of telehealth to complement face-to-face consultations as an additional means to address workforce shortages. It is therefore a disappointing inconsistency that the Report also recommends the abolition of the Item 288 psychiatrist incentive for rural telehealth. The AMA is concerned this will lead to an immediate mental health rural crisis when it is implemented. Psychiatrists have identified that consumer access to the required equipment, poor internet connectivity experienced by consumers, and technology failures are key drivers of the use a telephone consultation, over a video consultation. Additional funding should be allocated for videoconferencing technology packages for selected households to ensure equitable access to telehealth. Consumer and carer views and preferences should inform the future of telehealth in Australia.

Action 16.3 Improved mental health training for medical practitioners

The AMA acknowledges that medical practitioners already receive substantive training. Rather, there are issues with the funding of time with patients. People with significant mental health needs often need the most time and are least able to pay for it.

Complex mental health consultations not only require more time but can also have effects on the clinician. The AMA suggests that the government may wish to consider options around a formalised process of voluntary clinical supervision to allow debriefing and support for doctors working in mental health.

Further to this, the AMA recommends:

- Greater GP rebates for longer consultations and management of complex medical conditions;

[13] Allison S et al (2020) per ref 7

- Investment in evidence-based nursing programs, integrated in General Practice, and funded increased support by psychiatrists, and mental health nurses;
- Improved rebates and continuation of telehealth for psychiatrists, especially with increased remuneration for private psychiatrists involved in shared care with GPs, of complex patients;
- Greater linkages between mental health concerns and physical health and wellbeing through GP integration; and
- Improved access to psychiatrists, through an examination of Medicare enhanced item descriptors.

4. Reducing the pressure arising from acute mental health presentations in Emergency Departments

In our 2019 submission to the initial consultation for the PC Inquiry into Mental Health, the AMA highlighted the systemic issues that have led to increased pressure on Emergency Departments to respond to acute episodes of mental illness. We suggested that the public sector was underfunded and fragmented, coupled with higher private psychiatrist Medicare out-of-pocket costs for consumers, leading to Emergency Departments being a first 'port-of-call' for some people. The AMA recommended that increased outpatient psychiatry services and better emergency access to private psychiatry for inpatients and outpatients would go some someway to mitigate this pressure.

It is important to address the structural foundations of the pressure of acute mental health presentations in emergency departments through a comprehensive, systemic approach. This needs to encompass the entirety of the patient's care pathway including acute, inpatient, subacute, rehabilitation as well as community services, in conjunction with enhanced social and economic support via the NDIS and Centrelink unemployment and other support programs. Focusing solely on the emergency department National Emergency Access Target (NEAT) and length of stay will simply shift pressure to another part of the mental health system without improving the patient care pathways.[14] Accordingly, the implementation of the systemic reforms recommended above by the AMA are necessary to address this problem effectively.

Recommendation 13 – Improve the experience of mental healthcare for people in crisis (p582)

The AMA supports measures to reduce unnecessary presentations to emergency departments, thus removing pressure on hospitals and staff, while also providing more appropriate care for people experiencing acute mental ill-health.

We offer the following additional recommendations:

- Including active deployment of hospital in the home options and improved Medicare rebates for people suffering mental illness;
- Community mental health services expanded and commensurately staffed to provide comprehensive care, including an immediate focus on the impact of COVID-19; and

[14] Allison S et al (2020) per ref 4

- Continuation of existing Medicare private psychiatry incentives (Item 288 additional 50% payment) for rural telehealth, and rapid development of metropolitan and rural outreach telehealth resources (videoconferencing) and administrative support specifically for mental health consultations.

5. Higher needs groups

The AMA recognises that certain groups within our society have additional barriers, such as geographic, cultural, linguistic, physical (disability) or economic barriers to access the mental health care they need. These additional barriers to equity and access can compound mental health problems and diminish the patient-centred model of care we collectively aspire to achieve.

Rural, regional and remote communities

The challenges to growing an adequate, appropriate and responsive medical workforce in rural communities are well-known by policy makers, medical practitioners and communities alike. The provision of mental health care services in rural communities is compounded by an ageing workforce, significant and higher reliance on GPs than urban areas, a fragmented medical workforce staffed by locums and international medical graduates and a persistent shortage of psychiatrists to provide specialist care for mental illness.

As we stated in our submission to the original consultation, around 80% of all community-based mental heath care in Australia is provided by GPs. In rural areas, this number rises to 95%. The only medical group that have more mental health expertise than GPs are psychiatrists, and there is a critical need for an increase in these services in rural, regional and remote communities. Per our comments above, the AMA is concerned that the recommendation (12.2) contained in the Report to eliminate Medicare Item 288 tele-psychiatry extra rebate is counter-productive to the objective of improving rural psychiatric service delivery.

Aboriginal and Torres Strait Islander peoples

Due significantly to the ongoing impacts of colonisation and dispossession, and other identified factors, Aboriginal and Torres Strait Islander peoples continue to experience a burden of disease more than double (2.3 times) that experienced by non-Indigenous Australians.[15] In 2015-2017, the gap in life expectancy for Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians was 8.6 years for males and 7.8 years for females.[16] The AMA recognises that access to culturally safe health care is an essential element to close this unacceptable gap in health outcomes between Aboriginal and Torres Strait Islander peoples and their non-Indigenous peers.

Mental ill-health prevalence and suicide rates for Aboriginal and Torres Strait Islander peoples tell a similar story of sustained disadvantage and systemic failures. Substance use disorders

[15] Australian Institute for Health and Welfare (AIHW), *Health Performance Framework Summary Report* (2020) (p23)
[16] *ibid.* (p21)

including alcohol and drug use disorders, anxiety disorders and depressive disorders are the leading cause of disease burden for Aboriginal and Torres Strait Islander peoples. In the years 2014-2018, the age-standardised suicide rate among Aboriginal and Torres Strait Islander Australians was 1.9 times the rate among non-Indigenous Australians.[17]

Responses led by Aboriginal and Torres Strait Islander peoples to improve the health and wellbeing of communities are the optimal way to reform the health system to be more culturally responsive to the diverse health needs of Aboriginal and Torres Strait Islander Australians. The AMA acknowledges the Report notes this under Recommendation 9 – Action 9.2 in calling for Indigenous organisations to lead on policy development and service provision for suicide prevention for Aboriginal and Torres Strait Islander peoples. Per our comments above, investment in a sustainable and culturally safe mental health workforce is fundamental to improving health outcomes.

The AMA supports Action 23.6 in the Report, acknowledging that commissioning service bodies should engage Aboriginal and Torres Strait Islander Community Controlled Health Organisations as preferred providers of mental health services to Indigenous communities.

We support these statements regarding empowering Aboriginal and Torres Strait Islander communities to take charge of their own metal health services and note with caution that substantial long-term funding and implementation at all government and regional levels is required to realise this objective.

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[17] *ibid.* (p29)