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POSITION STATEMENT

Mental health and wellbeing

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Preamble

Many Australians experience a mental illness at some time in their lives, and almost every Australian will experience the effects of mental illness in a family member, friend, or colleague. For mental health consumers and their families, navigating the mental health system and finding the right care at the right time can be fraught and have detrimental socio-economic impacts.

Mental healthcare and psychiatric care are comparatively underfunded when compared to other chronic health conditions for the burden of disease and years of life lost.[1] Mental health must not be stigmatised and cannot be seen in isolation from wider societal influences, known as the social determinants of health. This includes interruption in early childhood development, including child abuse and neglect, social disadvantage, marginalisation, experiences of culturally unsafe environments, homelessness and violence, and unemployment. It is important to note the disparities among those impacted by illness, with women, the LGBTQIASB+ community, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse (CALD) communities, disabled people and people living in rural and remote communities disproportionately experiencing mental disorders.[2,3] The under-resourcing of mental healthcare services often prevents the least able and most vulnerable people from overcoming adverse health determinants and early childhood experiences.

AIHW data indicate that as of December 2022:[4]

- More than 2 in 5 (44 per cent or 8.6 million) Australians aged 16–85 are estimated to have experienced a mental disorder at some time in their life with 1 in 5 (21 per cent or 4.2 million) having experienced a mental disorder in the previous 12 months.
- Anxiety disorders are the most common disorder, affecting 1 in 6 (17 per cent or 3.3 million) Australians, followed by affective disorders (8 per cent), and substance use disorders (3 per cent).
- Almost 1 in 7 (14 per cent) children and adolescents aged 4–17 years are estimated to have experienced a mental disorder in the previous 12 months.
- Five per cent, or 800,000 Australians, are estimated to have a severe mental illness — 500,000 have episodic mental disorder and 300,000 have persistent mental illness.
- Mental disorders and substance use disorders were the second largest contributor (24 per cent) of the non-fatal burden of disease in Australia.

- Mental or behavioural disorders were reported as the main form of disability by almost one-quarter (23 per cent) of people with disability.[5]

All levels of governments, and non-governmental organisations, need to work cooperatively to design a mental healthcare system that is patient centred, and needs based, informed by evidence and research, with adequate investment and sustainable funding. The current fragmentation in the system means people cannot always access the care they need when they need it, increasing mental distress for people in need and placing additional pressure on carers and the health system.

It is vital the key areas of the mental health workforce, including psychiatry and general practice, are adequately resourced and structured to be able to provide the best available care. Greater investment into well-designed, medically governed multi-disciplinary teams is more likely to result in better overall health outcomes. Consumer-led input forms a key part of mental health interventions and healthcare innovation, including the development of multidisciplinary team care, community services and holistic care.

1. The role of general practice

A patient's GP is often the first to be engaged to manage mental illness and act as a gateway for patients to access mental health specialist care. GPs provide intervention and support regarding the mental and physical health of their patients, preventing many patients from further deterioration. Their training equips them to develop comprehensive management plans across the spectrum of illness presentations and severity. When symptoms are more complex, or further expertise is required, GPs are in a strong position to co-ordinate care and draw on appropriate services such as psychiatry, allied health, and psychology.

Mental illness is one of the most prevalent chronic diseases faced by Australians and its complexity should be given the same value as other chronic diseases in terms of item number rebates.

GPs play a central role in diagnosing, monitoring and treating their patients' mental health. It is critical the patient's usual GP is informed about the nature and progress of any mental health treatment provided to a patient.

The AMA affirms a mental healthcare plan must be instigated or assessed by a GP. Ideally this should be the patient's usual GP — or regular general practice — who has an established relationship with the patient, knows their medical history, and is well placed to assess if a mental healthcare plan is appropriate in managing the patient's care.

Where a patient has no usual GP or chooses to access the services of another GP this should be reflected in the medical notes of the GP preparing the plan. This is especially pertinent for those in rural and remote areas, children and adolescents, and those with diverse needs, including LGBTQIASB+, people with disability, and CALD community members.

Mental healthcare plans are living documents and require ongoing review to ensure they still meet the patient's needs.

To reduce fragmentation of care, other treating medical practitioners (including other GPs) and mental health professionals should communicate in a timely manner with a patient's usual GP,

providing the patient consents, about the nature and progress of any mental health treatment they are providing to the patient.

The Commonwealth Government must work to remove real or perceived barriers to claiming mental health items with other GP consultation and service items.
Noting the psychiatry workforce shortages, novel solutions should be developed to ensure patients with severe mental illness can receive best-practice care without barriers. This may include shared consultations with GPs, other medical specialists and psychiatrists, or secondary case consultations with delegation to GP to authorise further allied health treatment.

A streamlined mechanism should also be maintained for authorising access to additional sessions of psychological therapy where clinically indicated in the opinion of the treating doctor for patients with severe or complex mental disorders.

The number of practitioners required for a multidisciplinary case conference for patients with a GP Mental Health Plan should be reduced from three to two. This would support consultation between the referring GP and other treating health practitioners on the appropriate treatment pathway for the patient.

2. Better integration of mental health services

The AMA is supportive of bolstering investments to develop coordinated models of care that are appropriate for the needs of communities and regions. The AMA recommends 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. These wrap-around services have the potential to offer better return on investment and health outcomes rather than investing in siloed service delivery models, particularly in rural, regional, and remote areas.

Private psychiatric care is complementary to public community and hospital psychiatric care and offers patient choice of GP, psychiatrist, and allied healthcare workers, either through outpatient consultation, or when necessary, private psychiatric hospital care and 24-hour non-acute step-up-step-down care. GPs and psychiatrists provide shared care to private patients, working as a team with private psychologists, nurses, and allied health providers.

Data collection, curation and analysis to inform investment

The AMA supports evidence-based medicine and health policy. Current programs need to be rigorously evaluated with significant research funding, so they provide the most effective care in the most efficient way. Those with lived experience must also be included in policy and resource development. Improved data collection and publication is also needed to better inform mental health intervention, patient care policy, care coordination and care funding. This must include the following datasets:

- self-harm hospitalisations
- substance abuse hospitalisations
- suicide deaths
- MBS mental health services accessed
- PBS usage
- mental health-related emergency department presentations
- education and employment outcomes of patients

- income support use by patients
- health and mental health workforce data.

Prevention and early intervention

The AMA recognises the importance of investment in prevention, and early intervention regarding mental health. Significant funding should be provided to research and assess programs that deliver long-term benefits.

Early identification and intervention, particularly for people aged under 25 years, is required to not only prevent, or reduce the development of future mental health problems, but also to promote the best conditions for mental wellbeing. Early intervention and management can also help avoid hospitalisation.

Sustained national community evidence-based awareness campaigns are needed to improve mental health literacy and reduce stigma, misunderstanding and prejudice.

Transition of care

A significant timepoint for clinical and medication errors is at the time of admission, discharge from hospital, or changing location of care. Particular attention must be paid to coordination at those times of transition of care.

Discharge summaries after hospital stays or treatment provided by community mental health teams, must be shared with the patient's usual GP and private psychiatrist as soon as feasible, preferably within 24 hours of discharge. Discharge summaries must include all relevant information on the episode of stay, including any changes in medication and follow-up plan.

Treatment summaries between private psychiatrists and the patient's regular GP are also recommended following any treatment, especially at transition of care touch points.

If the case is severe, complex, or high-risk, resourcing should allow the handover to involve verbal communication from the treating practitioner to the patient's regular medical practitioner.

Severe, complex and chronic conditions

The AMA is concerned by the increasing number of patients with severe, complex, and chronic conditions, where a mental illness may be one of a multitude of conditions. There must be vertical equity for these patients to ensure they receive the appropriate psychosocial support, while being able to navigate and access suitable healthcare to meet their needs.

Many people with serious mental illness are often readmitted to hospital, placing increasing pressure on the acute public and private hospital systems.

MBS items and funding need to be reformed to provide increased rebates for:

- longer GP consultations for patients with mental illness who often have multiple physical and mental health issues
- psychiatric care and treatment provided to patients with complex conditions by psychiatrists in community-managed settings

- GPs and psychiatrists to coordinate care with allied healthcare professionals to ensure patients can continue treatment that keeps them out of hospital and living in the community. Healthcare professionals must be supported to ensure a patient's whole-of-person care is considered, including social prescribing, physical activity, and nutritional advice for patients with mental health conditions

- the Pharmaceutical Benefits Schedule (PBS) must be updated regularly, ensuring approvals and guidelines are decided in a timely manner, so that patients requiring pharmaceutical intervention can access medications they need.

Timely access to acute care in public hospitals is required. It is never appropriate for patients presenting with mental health conditions to spend a prolonged amount of time in hospital emergency departments. Referral and transfer to appropriate care (admitted or community) needs to be expedited and streamlined.

The number and quality of mental health beds in public hospitals must be increased to avoid the logjam that particularly disadvantages mental health patients, in conjunction with the need to increase mental health community service staffing and resources.

Linking and integrating the mental healthcare provided to patients in primary care with the crisis or acute care they receive as hospital inpatients must be a priority in mental health reform, as streamlining of care is imperative to health outcomes.

No patient should be discharged into an unsafe living situation or homelessness.

For severe, complex, and chronic conditions, GPs should be able to seek advice from psychiatrists, psychologists, paediatricians, or other medical specialists when and where needed to initiate therapy, as referrals to these non-GP specialists are associated with delays in management of severe cases.

Specialists must be renumerated for providing guidance to GPs.

3. Mental health workforce

The AMA calls on all governments to commit to improve the function, size and distribution of the Australian mental health workforce. Addressing the current shortfalls requires targeted measures to support and retain an appropriately sized, skilled, and resourced workforce able to deliver high-quality, recovery-focused mental health services in a safe and secure environment. Achieving this aspiration requires targeted funding and policies across community and support services, general practice, psychiatry, allied health, nursing, emergency services, medical training and education pathways.

The mental healthcare system must invest in multidisciplinary mental health teams to support improved mental health outcomes and redress the access and supply issues to services.

There is a specific need for an increased number of child and adolescent psychiatrists to meet basic community needs for the population of young people in Australia. To achieve this necessary increase, significant additional resources are needed, with specific recognition of regional, and jurisdictional variation.

Mental health nurses (or other qualified mental health worker) should be embedded within general practice to support earlier intervention.

Further integration of other relevant community services, such as drug and alcohol and domestic violence support services within GP clinics, would improve accessibility and better provide a care model centred around the patient.
Enhanced GP clinic access to mental health supports will increase the ability of GPs to respond to patient needs within the clinic; in turn relieving pressure on other components of the health system and reducing fragmented service delivery.

Flexible workforce incentive payments (for professions such as nurses, psychologists, and other allied health professionals) would enable GP clinics to determine where the greatest mental health needs are in the community and what additional services would be best placed in their clinic.

There is a critical need for an increased number of GPs and psychiatrists in rural, regional, and remote communities.[6] The provision of mental healthcare services in rural communities is compounded by an ageing workforce, a significant and higher reliance on GPs than in urban areas, a fragmented medical and mental health workforce, and a persistent shortage of psychiatrists to provide specialist care for mental illness. Additional investment is needed to support dedicated, flexible and sustainable regional, rural and remote training pathways for psychiatrists, GPs and other mental healthcare professionals to improve access to mental healthcare for people who live outside urban centres.

4. New technologies

The AMA notes the pattern of federal funding investment towards digital platforms and away from medical workforce and existing mental health service delivery models. This has the potential to create more fragmentation in the system and additional pressures on the existing mental health workforce. The AMA also recognises the changing digital mental healthcare landscape and acknowledges the importance of thorough regulation for digital mental health applications through the Therapeutic Goods Authority (TGA) to ensure digital safety for health professionals and patients.

Telehealth

The AMA supports the ongoing expansion of telehealth, within an appropriate governance model that allows for risk analysis and ongoing outcome evaluation. Telehealth consultations are not always the perfect standard of consultation. However, in many cases for patients it is the only accessible option, and vital to ensuring equity and access to healthcare, especially mental health services.

Digital counselling and support services, with comprehensive information about local referral pathways, must be available to ensure patients are linked to the right service at the right time and provide alternative appropriate access to care for different population needs.

Artificial Intelligence

The AMA supports Artificial Intelligence (AI) in healthcare that is patient-centred and used to benefit patients' health and well-being along with the health of the wider community. The health interests of patients and the wider community should be the primary and guiding focus of all AI applications in mental healthcare.

The AMA upholds that human-delivered medical care, especially mental healthcare, must never be replaced by AI, but AI has the potential to assist in care delivery, reduce inefficiencies in the system, and lead to more appropriate allocation of resources. The AMA calls for the development and

application of AI use in mental healthcare to be accountable and transparent to patients, the medical and healthcare professions, and the wider community.

5. Diverse community needs

The AMA recognises certain groups within our society have additional barriers and needs. These include geographic, cultural, linguistic, physical (disability), age-related or economic barriers to access the mental healthcare 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.

Policy makers must map diverse population needs, including those of Aboriginal and Torres Strait Islander peoples, rural and remote areas, people who identify as LGBTQIASB+, people with disability, and culturally and linguistically diverse groups, to ascertain best models of mental health service design and delivery.

The AMA calls for access to culturally safe healthcare as an essential element to close the unacceptable gap in health outcomes, including in mental health and emotional wellbeing, between Aboriginal and Torres Strait Islander peoples and their non-Indigenous peers. This should be done by building on and facilitating the many culturally specific supports that strengthen mental health in these communities.

The AMA advocates that all efforts to improve mental health literacy must be effectively resourced and informed by the needs of different population groups and designed accordingly, in full collaboration, consultation and co-design with those groups with diverse needs.

See also:

AMA Position Statement on Social Determinants of Health 2020
AMA Position Statement on Cultural Safety 2022
AMA Position Statement on Health Literacy 2021
AMA Position Statement on LGBTQIASB+ Health 2023
AMA Anti-Racism Position Statement 2024
AMA Position Statement on Health and Wellbeing in Custodial Settings 2023
AMA Public Hospital Report Card (Mental Health) Annual Publications
AMA Position Statement on Artificial Intelligence in Healthcare 2023
AMA Position Statement on Data Governance and Patient Privacy 2023
AMA System Interoperability in Healthcare 2022

[1] https://www.ama.com.au/articles/ama-public-hospital-report-card-2023
[2] https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2020-2022
[3] https://www.abs.gov.au/articles/mental-health-findings-lgbtq-australians
[4] :https://www.aihw.gov.au/mental-health/overview/mental-illness
[5] https://www.aihw.gov.au/reports/australias-health/health-of-people-with-disability#Mental%20health
[6] Hayter CM, Allison S, Bastiampillai T, Kisely S, Looi JCL. The changing psychiatry workforce in Australia: Still lacking in rural and remote regions. *Aust J Rural Health*. 2024; 00: 1–11. https://doi.org/10.1111/ajr.13092