Submission to

The National Mental Health Commission

2014 Review of Mental Health Services and Programs

Australian Medical Association

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The AMA believes that all Australians with a mental illness deserve to have ready access to quality mental health care based on their particular needs. This requires improvements in services, intervention and support for people with mental illness across the whole continuum of care. The following summarises the key respects in which the AMA believes that services need to be improved. These measures will have the long term effect of creating efficiencies and removing inefficiencies in the mental health service arrangements.

A. *Gaps remaining in the transition from institutional to community-based care*

Well-coordinated and seamlessly provided community-based services reduce the need for hospital admissions and re-admissions and have the capacity to diminish the severity of illness over time. However, community-based service provision has not been appropriately structured or funded since the Burdekin reforms that moved much of the care and treatment of people with a mental illness out of institutions into the community. The following relate to some of the major gaps that remain.

1. General practitioners are at the front line of mental health services, as is evidenced by the significant increase in utilisation of GP mental health MBS items after 2006, when the Better Access initiative was introduced. Private psychiatrist based in the community also play a significant role in treatment. Greater access to care provided by general practitioners and private psychiatrists should be supported through:

    a. increased MBS rebates for longer GP consultations for patients with mental illness who also have multiple complex physical co-morbidities (including substance use and dual-diagnosis), and for prolonged attendance for patients in crisis situations. This will provide an incentive for more extended and targeted care where it is needed;

    b. simplifying the red-tape administrative burden associated with the GP Mental Health Treatment Plan and providing more opportunity for GPs to spend time face to face with patients. This can be achieved through implementing the remaining recommendations from the 2003 Productivity Commission Review of General Practice Administration and Compliance Costs, and the Regulation Taskforce's 2006 review relating to general practice;

    c. better management of the 'handover' process of in-patients transitioning back to the community, where general practitioners are usually relied on for ongoing care once back in the community;

    d. the development of an MBS item for GP telehealth consultations conducted directly with patients;

    e. improved MBS arrangements to recognise and reimburse for non-direct patient care, including time spent finding suitable services for patients with a mental illness and talking to families;

    f. facilitating increased use of mental health nurses in general practice by reviewing and streamlining existing programs. Funding on the Mental Health Nurse Incentive Program (MHNIP) is capped at 2011-2012 service levels.

Demand currently exceeds the service capacity, and this cap should be removed and reviewed. The MHNIP guidelines should also be reviewed to clarify issues around the target groups for the program and the responsibilities of eligible organisations and the mental health nurses;

g. increased MBS funding for psychiatric care and treatment provided to patients with complex conditions by psychiatrists in community-based settings. This will provide an incentive for more extended and targeted care where it is needed;

h. improved patient access to private psychiatrists through sessional and visiting arrangements in community-based facilities;

i. the resourcing of a rapid-response outreach team for every acute mental health service.

2. Specific services are required to enhance early identification and intervention for people under 25 years of age to prevent or delay the future onset of mental illness. These should include:

    a. increased resourcing for specific child and adolescent services and the development of a rigorously evaluated prevention and early intervention program, which involves screening to identify early symptoms of mental ill health, and early referral;

    b. the creation of a national network of Early Psychosis Prevention and Intervention (EPPIC) centres to improve early intervention in psychosis;

    c. greater provision of parenting and parent support programs, particularly for at-risk groups;

    d. strengthening of online and telephone counselling and support services, with comprehensive information about local referral pathways so that people are linked with the right services at the right time.

3. Specific services for elderly people with mental health problems who are living in residential aged care or in the community need to be enhanced through:

    a. improved linkages between aged-care psychiatric services in the public and private sectors and general practitioners to enhance shared care arrangements;

    b. more acute care beds specifically for the elderly with mental illness, separated from general adult mental health facilities, and linked in with the general hospital and geriatric medicine/rehabilitation services;

    c. the mandating of a formal aged care accreditation standard requiring all aged care providers to make mental health care available to residents.

4. The service system should improve the experiences of patients with mental health problems, including by:

    a. ensuring the safety and security of patients, particularly those from vulnerable groups who are at risk of violence including sexual assault;

b. greater awareness of, and more services for, new mothers who are at risk of post-partum depression, including greater provision of mother and baby units in hospitals;

c. improving access to life and other insurance policies for individuals who are experiencing or have experienced a mental illness.

B. *Sustained support for Acute Care settings*

1. Even though mental health care has been significantly de-institutionalised from hospital based settings into community-based settings, there is still ongoing need for appropriately resourced acute care, which requires:

   a. greater access to acute care beds, with funding for episodes of care;

   b. increased access to specialised public outpatient services providing diagnosis and ongoing treatment of people with mental illness and dual diagnosis;

   c. the establishment of specialised mental health and dual diagnosis spaces in public hospital emergency departments;

   d. additional capacity in public hospitals so that patients have the option of being treated in single-sex mental health wards.

C. *Improved mental health support for medical professionals and the emerging generation of doctors*

In order to be in the best position to provide ongoing medical care to their patients, medical professionals (including medical students and junior doctors) need to be appropriately supported to maintain their own health, including their own mental health and wellbeing. To facilitate this, all stakeholders including medical students, medical colleges and employers, must work together to develop and implement programs that ensure appropriate support mechanisms are in place. These programs should:

1. provide resilience training to medical students and junior doctors;
2. destigmatise mental health problems amongst fellow junior and more senior colleagues;
3. target health promotion, a change in doctor culture, and encourage doctors to access support services;
4. provide a consolidated national support program that is promoted to all doctors, and junior doctors in particular, who are least likely to seek help from doctors' health programs;
5. provide a proper reporting mechanism to address bullying in the workplace;
6. establish 'no-judgement' confidential processes and referral pathways for doctors and medical students to seek high quality assistance with mental health issues;
7. implement fatigue management and safe rostering practices.

D. *Addressing mental health needs in rural and remote areas*

There is a significant incidence of mental health and wellbeing issues in rural and remote locations, and well-known difficulties in securing the appropriate mental health care needed by those with mental health problems in these areas. The rate of usage of MBS items for specialised mental health services in rural areas was reported at 40-90 per cent of that in major cities, and in remote areas it was 10-30 per cent of the rate in major cities. A significant proportion of those who are likely to experience mental health problems in rural and remote areas will also not seek professional help. Some of the major barriers to access can be removed through the following measures:

1. The Access to Allied Psychological Services (ATAPS) program, which enables GPs to refer patients with a mental disorder to an allied health professional for psychological services, can be improved through:
    a. minimising the red-tape and simplifying the bureaucratic processes required to access ATAPS services;
    b. ceasing to require that GPs provide mental health treatment plans to Medicare Locals, but only to health practitioners who are bound by ethical standards regarding patient confidentiality;
    c. increasing the number of referrals the GP can make under ATAPS;
    d. reducing the waiting times for access to referrals – which is up to 6 months in some cases;
    e. repairing fragmentations of care, for example, in cases where the existing psychologist is not part of the Medicare Local providers.
2. Recruiting medical professionals and mental health specialists to work in rural and remote areas, and retaining them, continue to be challenges. More concerted efforts need to be made to meet this challenge, including through the consideration of financial incentives and forms of family support for professionals to work in these areas.
3. The barriers presented by distance and limited health workforce can be ameliorated through improved access to telehealth options for doctors, patients and allied health professionals. This will require the establishment of necessary infrastructure and development of an MBS item for telehealth consultations directly with patients.

E. *Guaranteeing the mental health and social and emotional well-being of Aboriginal and Torres Strait Islander peoples*

Aboriginal and Torres Strait Islander peoples are among the most disadvantaged groups in Australia and experience high levels of mental ill health and low levels of social and emotional wellbeing. The sources of this ill health are bound up with the social, economic and cultural circumstances of Aboriginal peoples' and Torres Strait Islanders' history and current lives. Suicide rates are high, including among young Aboriginal people and Torres Strait Islanders, and there are significant levels of substance use, violence and insecurity in many communities. The solutions to these problems need to be multifactorial, and need to include a recognition of the importance of strong cultural identity as a key lever for healing.

The AMA believes that the COAG Close the Gap partnership agreements must be renewed to include a greater focus on mental health and harmful alcohol and substance use. The following measures should be reflected in those agreements, in order to strengthen the service provision available to improve the mental and emotional health of Aboriginal people.

1. Aboriginal people benefit most from health care provided by Aboriginal people. This will particularly be the case in relation to their mental and social and emotional health. The AMA believes, and research shows, that Aboriginal community controlled health services have a strong capacity to provide comprehensive care that can address drivers of poor mental health. The following measures can enhance that capacity:

    a. core funding for the Aboriginal Community Controlled health sector should be set at a rate which allows existing ACCHS to attract GPs, health and mental health professionals through appropriate salaries, and to have the infrastructure to accommodate them, particularly in remote locations;

    b. a capacity-building plan should be developed by the government, in partnership with the National Aboriginal Community-Controlled Health Organisation, for the establishment of further ACCHSs in areas of need;

    c. more services dedicated to mental health and emotional and social wellbeing should be developed according to the ACCHSs model.

2. Mental health must be tackled in an integrated and strategic way for Aboriginal people and Torres Strait Islanders. This requires that:

    a. the *National Aboriginal and Torres Strait Islander Suicide Prevention Plan* must be implemented as soon as possible, with appropriate resourcing;

    b. the *Social and Emotional Wellbeing Framework* must be implemented as soon as possible;

    c. an alcohol and other drugs strategy must be developed.

3. Imprisonment can exacerbate mental health and substance use issues. One in four people in prison today is an Aboriginal person or Torres Strait Islander. Rates of incarceration of Aboriginal people and Torres Strait Islanders must be significantly decreased, particularly young offenders. Those in prison should have ready access to culturally appropriate mental health and substance use treatment.

F. *Provision of adequate mental health care in the criminal justice system*

Mental illness is prevalent among prisoners and detainees, and those who come into contact with the police and criminal justice system. It has been identified as a central factor contributing to offending and recidivism. The rate of co-occurring substance use and mental health is also disproportionately high among prisoners, particularly women prisoners. The AMA recommends that:

1. police should be provided appropriate training, education and support in order to appropriately determine whether an individual who comes to their attention should be directed to the criminal justice system or more appropriately referred to mental health services. There should also be appropriate pathways and mental health facilities for such referrals;

2. medical practitioners with suitable qualifications in psychiatry should be involved in day-to-day management of prisoners with psychiatric disorders. These practitioners should also be represented at the policy and decision-making level in the administration of correctional health services;
3. individuals must not be remanded in a correctional facility solely for psychiatric assessment;
4. mental health services in prisons should be adequately resourced t provide appropriate screening, assessment and therapeutic procedures, including for co-occurring mental health and substance use disorders.

G. *The mental health of asylum seekers in detention*

Long-term indefinite detention has profound effects on the mental health of asylum seeker detainees, especially children. The AMA recommends that:

1. all detainees have ready access to medical professionals with expertise in mental health, and children in detention have access to professionals with expertise in children's developmental health and mental health;
2. specialist treatment for mental health problems should be readily available for detainees, including those in off-shore facilities;
3. an independent panel of medical professionals should be established with the power to monitor the health condition of detainees, the provision of health care in detention facilities (including mental health), and to make recommendations to government regarding ongoing needs.