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AMA Submission on the 5th National Mental Health Plan

Overall comments

The AMA appreciates the opportunity to comment on the draft 5th National Mental Health Plan.

The medical profession has a crucial role in responding to the initial presentation of mental illness, making a clinical assessment and then taking responsibility for this and following it through with the patient and with other health professionals and support services.

Doctors, in particular general practitioners and psychiatrists, are well placed to identify the gaps in our current health system in the prevention, treatment and management of mental illness and to articulate the solutions that need to be put in place to improve the system for patients and support the medical profession in the medical and psychiatric care they provide.

For these reasons, the AMA has a direct and significant interest in the development of a robust, well-considered and useful national plan for mental health care.

Australia's national mental health plan should inspire confidence in stakeholders, doctors and other mental healthcare providers, and in people with mental illness and their families and carers, that the challenges facing mental health care are clearly understood and there is a road to better mental health care and better outcomes.

The current draft 5th National Mental Health Plan is not yet that plan. In addition to specific shortcomings, the draft plan overall does not yet inspire the sense of energy, motivation, purpose and cooperation that are needed to deliver better mental health care.

It is clear that the Plan is focused on regional integration through the yet to be proven or reliably demonstrated core architecture of PHNs and LHNs. It seems to be based on an assumption that regional integration will be the solution for improved mental health care, with the addition of action at the national level to establish the 'preconditions for change' and provide generic supports.

This 'fundamental re-conceptualisation' does not obviate the need for the basic supporting components as detailed in this submission, components that are required to make a national plan that is useful and used.

For example, simply stating the Plan "reflects the shared interest of governments in joint regional planning and interests, and setting national directions and priorities" is not sufficient. If national directions and priorities are not actually included in the Plan it becomes merely an intention to develop a future plan.

As a 'plan' that is designed to establish "a national approach for collaborative government effort over the next five years", the 5th National Mental Health Plan fails to articulate, describe, and account for the measures, targets and timeframes needed to deliver a workable and sustainable mental health vision. While it provides some worthwhile commentary on the priority areas, the Plan is lacking in detail and concrete initiatives.

This Plan is not set in the context of previous Mental Health Plans. In some areas it reads as if it were a new, spontaneously generated plan, with no acknowledgment or regard to work of the past 20 years or so.

Workforce

One of the AMA's main concerns with the 5th National Mental Health Plan is that it does not set out deliverable targets and the timelines for delivery. More concerning, there is scant mention of the mental health workforce needed to achieve the Aims and Actions that are broadly described in the Plan. This is clearly a major deficiency. To develop and consider the Plan without discussing and identifying solutions to the major undersupply issues facing medical workforce is negligent.

This Plan does not tell us what the targets are for the next 5 years, when they will be delivered, and which services, specialists, peer workers, GPs, mental health nurses and others will be delivering them.

The 5th National Mental Health Plan does state:

> "The workforce within the system is under pressure, with shortages, distribution issues, high rates of turnover, and challenges in recruiting appropriately skilled and experienced staff. Services within the system are often difficult to navigate, and can be both stigmatising and stigmatised."

Yet, unlike the 4th National Mental Health Plan, the 5th Plan does not address the need to develop and implement a National Mental Health Workforce Strategy that defines standardised workforce competencies and roles in clinical, community and peer support areas. The 4th National Mental Health Plan also addressed the challenges in recruiting, retaining, and supporting a workforce that has appropriate competencies and therefore doesn't compromise the quantity and quality of care available. The Plan must address the need for workforce to deliver both quantity and quality of mental health care.

The Plan should recognise the real value that lies in individual caregivers. These caregivers need specific training, and the Plan should recognise there are major shortages in the various caregiver categories, be they psychiatrists, psychologists, welfare workers, social workers, nurses. Ultimately, effective mental health care requires an individual approach to individual patients.

While this can involve potentially significant expenditure, it is necessary to achieve major improvement in mental health care.

As the previous Plan noted, "Consumers and carers still report that they experience difficulties in accessing the right care at the right time." Access to the right care at the right time is a paramount need. This latest Plan does not satisfactorily provide the necessary structure, models and resourcing that would overcome the problems of accessing the right care at the right time.

The Plan would be much better grounded and 'realistic' if it included or referred to a comprehensive workforce strategy. Not including workforce requirements makes it possible to read much of the 5th National Mental Health Plan as rhetoric, not anchored in the reality of how it is to be delivered.

No health plan, policy or vision can be implemented unless there is an appropriately trained workforce and resources available. Almost every mental health inquiry, report and data have highlighted the workforce shortages in regional, remote, and Indigenous communities. If the sector is to have any confidence in the 5th National Mental Health Plan, it must include a comprehensive and deliverable workforce strategy.

PHNs and integration

While the 5th National Mental Health Plan "recognises that PHNs and LHNs provide the core architecture to support integration at the regional level", the overreliance on PHNs to "provide the infrastructure for implementing integrated planning and service delivery at the regional level" is concerning to the AMA.

The way the Plan reads, the PHNs will be left to coordinate, resource and deliver the Government's mental health actions, and at this stage the AMA believes that not all PHNs are able to achieve this. At this point PHNs are unproven and inexperienced. They are already overloaded with many other strategic priorities.

The disparity in the PHNs means that some are better able to implement, plan and resource mental health services and supports. However, some PHNs, especially those covering regional, remote, and Indigenous communities, may struggle because of a lack of a trusted, continuous workforce; and the number of patients with chronic mental and physical health problems. Some PHNs face major coordination issues and difficulties in overcoming large distances and isolation of various communities in their catchment areas.

The Government seems to regard PHN's as a solution to most challenges in mental health, without realising the limitations of PHNs in the way they function and interact with workers at the coalface. Typically PHNs will identify a service need, apply for funding, call for tenders, and then award the funds to the successful tender. This 'procurement' model is not a very user friendly model for accessing mental health services, particularly in regional areas. Accessing services becomes more complicated, service providers are potentially more changeable with less continuity, and the overheads associated with procurement processes impact on all participants.

Members report that whereas access to services such as Mental Health Nurses was once straightforward, now it is almost impossible.

The AMA understands that PHNs are allowed service provision where there is 'demonstrable market failure'. Therefore successful programs such as Access to Allied Psychological Services (ATAPS) should continue as well as a review of funding to excellent mental health support services by other NGOs, of course ensuring duplication or triplication of services does not occur. AMA members are convinced PHNs won't have the capacity to provide all required mental health services.

PHNs will benefit if there is significant expert psychiatric clinician input at Board governance, risk and quality, and key clinician leadership level. Clinician involvement and input is an assurance that services are developed so that patients receive the care they need, difficulties are addressed early, and evidence based worlds-best practice is routinely followed.

The PHN's are tasked with ensuring that the visions and pathways embodied in national guidelines are followed at a clinician level and services are commissioned optimally. Unless a clear expectation is mandated that key leadership and expert involvement from an early stage is provided by consultant psychiatrists, experienced clinical psychologists and general practitioners who have an experience in mental health in the planning, co-production and development of services, these structures will not develop effectively at a local level.

Clinical input is also essential to counter the natural tendency of regionally-based organisations to work to a population model which identifies percentages of patients regarded as most disabled and patients which are least disabled or in at-risk states. Such approaches assume that it can be accurately assessed who is significantly impaired, and who is in an at-risk state.

However, this assessment is not clear for individual patients. In clinical practice often the most disabled patients are those that superficially present well. The initial mild anxiety may actually be a symptom of significant untreated depression, Asperger's or a psychotic condition in a guarded patient. Without optimal expert assessment of patients by experienced clinicians this will be missed and they will be directed to computer based applications with a support worker. The opportunity for effective treatment of their actual condition is lost. More patients will end up being sidelined due to a simplified pathway chart approach which will appeal to the less clinically experienced staff.
The Plan should be clear about the expectations on PHNs and enable a clear judgement that individual PHNs are, or are not, achieving them.

Equity across geography

A regional focus should not displace overarching concerns for equity in service access and provision across different geographic areas, including for transportability of services, continuity and comparable standards of care for people with mental health needs across different PHN boundaries.

There should also be explicit recognition of the particular challenges faced by PHNs covering large geographic rural and remote areas. For example, on the western coast of Australia there are few if any 'in-patient mental health beds' between Perth and Darwin.

The Plan should also recognise Ministers and government agencies for rural health (where they exist) as direct stakeholders for mental health. In this context some AMA members have suggested responsibility for rural mental health should fall within the portfolio of the rural health minister. It should also recognise that in most rural settings GPs are likely to be the only advocates for improving mental health.

Other organisations and integration

The focus on integration through PHNs must be complemented with inclusion of other key elements of mental health care. The Plan is deficient by giving little or no recognition to the critical roles played by a range of organisations and mental healthcare providers.

For example, AMA psychiatrist members identify ongoing problems with getting the community team to do adequate and appropriate follow-up. It is not sufficient to phone a suicidal person and if they say they are fine to make that the end of the contact.

In relation to Aboriginal and Torres Strait Islander mental health and suicide prevention, the Plan should connect with Aboriginal Medical Services, Aboriginal Controlled Community Health Organisations (ACCHO) and the national body NACCHO, as the major service providers and essential participants/partners in delivery of improved, better integrated mental healthcare.

The Plan should also be very clear on the intersection and interaction between disability services through the NDIS and mental healthcare through PHNs and private mental healthcare providers. This is essential in its own right, but is also specifically required to address emerging concerns of people falling into gaps between NDIS eligibility and services, and mental health care integrated through PHNs.

GPs, psychiatrists and other private sector mental healthcare providers

Potentially the most significant omission from the Plan is recognition of the role of GPs, psychiatrists and other private sector mental healthcare providers.

The Plan should not be a plan *for these providers*, but it must give more recognition to their role (beyond brief passing references in eg integration, physical health and data).

It should cover the scale and nature of the mental health services they provide, how they will be built into integration, and what expectations this involves for the work of PHNs. Without this, the Plan will be partial, incomplete and ineffective. It will certainly not inspire confidence as a blueprint to better mental healthcare.

Mental health and physical health

Recognising and addressing the significant impact of physical health problems on the morbidity and mortality of patients with a mental illness is important. Including this explicitly in the Plan is welcomed and will assist in moving away from the mental health and physical health divide. It facilitates the integration of care, necessitates communication between healthcare practitioners and encourages engagement with patients and their carers.

However, there is a lack of detail in the plan on how this is to be achieved. There have been significant achievements by programs internationally and in Australia regarding proactive and cutting-edge physical care models in integrating general medical treatment. There are also models to address the key cardio-metabolic risks of psychiatric medication. Without recognition of such approaches to physical health care, and the appropriate development of local processes ensuring systemic coverage and expertise, the change in physical health outcomes at the end of this plan will continue to remain limited.

Use of IT and mental health

The Plan gives little coverage or description of how the appropriate use of IT as an adjunct to clinical care can support and enhance mental health care. The use of IT and internet-based applications is applicable to all patients and is a tool available to every clinician as a means of providing for example, information, simple treatments and relaxation strategies.

However, only a relatively few patients have the motivation, skill or persistence to undertake and benefit from internet based computer based training (CBT). Additionally, the therapeutic relationship is a key function in psychiatry and has a core evidence base. Any model that assumes all patients can be pushed into using internet-based mental health applications is not appropriate and would have at best uneven and unsuitable uptake and efficacy.

Other specific comments

The Plan refers a number of times to 'fundamental shortcomings' of the existing mental health system. These shortcomings should be explicitly identified. If they are in fact 'fundamental' they should be a logical starting point and addressed by the actions in the plan.

The Plan's 'achievable and measurable improvements' are not obvious and are insufficiently specified to be measurable. The list of 'what will be different for consumers' under Priority Area 1, for example, is not sufficiently clear to enable objective assessment (a 'journey that is smoother' does not seem readily susceptible to objective measurement).

The Plan should not be 'a plan to produce a plan'. Where matters are identified as needed, but flagged as yet to be developed, they should actually be developed and included in the plan.

It is not acceptable or useful, for example, for a plan to indicate that 'measures to monitor whether making a difference' *will be developed*; they should actually be integral to the Plan.

Including these measures would give a clear message of what the Plan is actually intended to achieve.

Similarly, it could be expected the Plan might actually incorporate national guidelines for coordinated service delivery for people with severe and complex mental illness, not simply foreshadow they will be developed. Suicide prevention also appears to be a marker for an actual plan. A national mental health safety and quality framework is apparently also to be developed (and there is a need to clarify whether action 24 under Priority Area 7 is meant to cover mental health information in general, or refers only to safety and quality?).

The plan would benefit from using more direct and active language – terminology like 'actions setting a direction for change' and 'a foundation for longer term system reform' are relatively indirect and opaque – when boiled down, what actually is going to happen in these areas that makes a tangible difference? Many of the recommendations for action are vague and do not consider their basis in evidence.

The vision statement at p3 is presumably from another document (given that 'vision' statements are more typically articulated at the strategy level)? If the vision statement is to be included, the plan should identify where it has come from, who has developed and shares it etc. Arguably it could usefully include an outcome of a 'better experience etc for people and families of people who look after people with mental illness' (or similar wording).

There is a need to explain how the focus on integration (Priority Area 1) relates to the actual delivery of better care, why does a regional focus mean better mental health care and why should people with mental illness actually care about this as a priority for the Plan.

Integration is not an end in itself, but presumably contributes to better care. The discussion of integration is a very conceptual and abstract discussion which can be seen as being removed from what should be the guiding principle: ie more, better, more timely services (or similar). Integration should be defined in terms of the practical steps to make it happen, and at the different levels that relate to and are useful for those responsible for making it happen.

The 'Setting the Scene' (and other sections of the Plan) would benefit from some perspective on the actual needs of individuals, via mini-case studies, vignettes etc.

Problems identified under the 'Mental health environment' (p14) are referred to as 'areas where the system is not working as well as it should' – are these the same as the 'fundamental problems' referred to elsewhere?

The Plan could directly address these areas/problems, describing what the shortfall or gap is each case and detailing how the Plan will address it in practical, tangible terms. A plan that included some analysis and judgement of these problems, and also of achievements, as the basis for saying what is working and what is needed, would begin to be a more useful document.

There are many models and examples of plans that identify actual problems and opportunities in clear terms with practical, tangible steps to address them. Jurisdictions such as WA have

managed planning processes which are based on and reflect concrete plans, achievable and measurable endpoints.

The section on *Beyond the mental health system* (p16) would benefit from more coverage, given the contribution of factors such housing, employment, income support and education to mental health needs. This should recognise that these factors may be amenable to some incremental improvements, but are unlikely to simply or automatically 'realign' around the needs of people with mental health needs. Beyond naming these factors, the Plan should include actual steps to connect with them and make improvements in the links.

Finally, if the role of the Plan has in fact been reconceptualised as "one that sets an enabling environment for regional action" (p22), this should:

- be explicitly defined at the very top of the Plan, as the current *Summary of priority areas, aims and actions* (p3) gives a different message about setting "out a national approach for collaborative government effort over the next five years", with seven priority areas, only one of which relates to regional planning and service delivery;
- identify what the 'national directions and priorities' actually are, and set expectations for what the regionalised approach to planning and service delivery should actually deliver; and
- include tangible actions, not just lists of generic, conceptual notions such as preconditions for change, facilitating integration, leadership, levers, reforms etc.

In summary, the current draft 5th National Mental Health Plan should be regarded as a beginning, but only a beginning, of a process to develop a robust, well-considered and useful national plan for mental health care.
The current draft does not inspire confidence that the challenges facing mental health care are clearly understood and there is a road to better mental health care and better outcomes.

With further input and development, including to address the AMA's comments, it should be possible to develop a national plan that actually facilitates and enables improved mental health care. The need is clear.

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