The Australian Psychological Society Ltd

Preliminary Submission to the

Senate Select Committee on Mental Health

From the Australian Psychological Society

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Senate Select Committee on Mental Health

A Preliminary Submission From The APS

Major Issues

Introduction

Mental health disorders are the leading cause of disability burden in Australia, accounting for an estimated 27% of the total years lost to disability. It is estimated that 18% of adults have experienced a mental health disorder and this is associated with enormous social human and economic costs. These levels represent an increase over recent years in both high and low prevalence disorders. The high prevalence disorders include affective disorders (depression, dysthymia, mania, hypomania and bipolar disorder), anxiety disorders (panic disorder, agoraphobia, social phobia, obsessive – compulsive disorder, generalised anxiety disorder and post-traumatic stress disorder) and substance-use disorders. The low prevalence disorders include schizophrenia and bi-polar disorders and the psychotic disorders are often co-morbid with substance abuse. Despite this growth and increase there seems little evidence of structural change and system readjustment to encompass this and does not seem to be reflected in implementation strategies.

This discussion can easily lead to unconstructive criticism of government or its instrumentalities. This is not our goal. The intention of this is to highlight the fact that policy and strategy development has at least been attempted in documents such as the National Mental Health Plan 2004 (not without its defects) and also reflected in other Commonwealth initiatives such as the Better Outcomes in Mental Health Care Initiative. However, the implementation of such policies and strategies has been very limited. The concerns of the Australian Psychological Society centre around a few crucial issues which are set out below.

1 A lack of evidence that the serious rise in mental health disorders is impacting on government funding of services

These is considerable evidence now that Australia is lagging behind other countries in their expenditure on mental health programs and services. This needs to be seen in the context of some initiatives coming out of the DoHA but even for these, the investment of funds and effort seem inadequate to meet the level of demand and need.

1.1 BOMHC A good example is the primary care initiative, Better Outcomes in Mental Health Care (BOMHC). The involvement of GPs in managing mental health disorders has been significantly enhanced by this initiative and one of its most successful aspects has been the capacity to refer patients to, and receive funding for, allied health (mainly psychology) specialists providing evidenced-based focussed psychological strategies. However, funding for this initiative is capped at a low level – unlike many other medical services - and in addition, access to the program is limited to

GPs who have undergone training for the program. Of the 32,000 GPs in Australia, only 12 percent are currently involved in BOMHC. This means that the communities served by 88 percent of GPs have no access to this government-funded mental health initiative. In addition, the caps on the number of services funded have prompted many GPs to report that they have utilised their annual allocation within a few weeks of the funding year.

1.2 Chronic disease and MedicarePlus Chronic disease items under MedicarePlus were another means – albeit very constrained – of providing publically funded access to non-medical mental health professionals (Allied Health MBS item). However, and despite this being very limited in sessions and rebates, the proposed new chronic disease item for GPs eliminates access to allied health services.

1.3 Mental Health issues and Chronic Disease. Another clear example of the lack of impact on policy and funding of the rising incidence of mental health disorders can be found in the lack of support for psychological services in general medical areas of public hospitals. It is now accepted that mood disorders (especially depression) and relationship factors can be causative in conditions like heart disease as well as commonly associated with the onset and development of those disorders. There is also considerable evidence of the impact of psychological interventions on recovery, treatment adherence and quality of life as well as significant treatment cost reductions for a number of other chronic conditions (cancer, diabetes and respiratory illness). This would suggest the need for the use of psychologists as adjunctive therapists in medical and specialised wards of major public hospitals.

2 A failure not with policy/strategy but with implementation

It is also fair to acknowledge that a number of the State Governments have conducted reviews of mental health services (New South Wales Senate committee review of mental health; the Victorian, Queensland and Western Australian Governments have completed much more focussed reviews). However, repeated reports have indicated low level of funding by states into mental health but more importantly some, or all, of the following issues.

2.1 Underfunding at State Level Repeated reports from APS members working in individual institutions or under specific programs have raised serious concerns regarding the funding of mental health services by the State and local instrumentalities. Although these are clearly anecdotal, they are indicators of a crisis which we feel currently exists in public mental health services.

2.2 A Focus on Crisis Cases One of the consequences of limited resources within mental health services, is that public health facilities within hospitals or related structures are focused on crisis cases. The limited number of beds, which are a function of lack of appropriate staffing and reduction in financial investment in mental health, mean that the facilities can only provide emergency treatment, short stay and

medication-based interventions for the most serious cases. This regularly results in the revolving door pattern of treatment and exposure of clients to premature discharge, inappropriate community placement and high levels of both carer and patient distress.

2.3 Failure to Provide for High Prevalence Disorders in the Public Setting The most worrying aspect of this pattern, described above, is the total absence of in-patient/hospital resources for high prevalence disorders, such as depression and anxiety. It has become almost impossible to find public sector beds for any patient who is not psychotic, suicidal or behaviourally threatening. Cases of depression who are not desperately suicidal or cases of debilitating anxiety cannot find beneficial short-term stay facilities within the public sector. One solution that may not only provide treatment for these consumers but also reduce in-patient demand is the provision of outpatient or ambulatory clinics to assess, treat and manage high prevalence disorders. Many such services have actually been closed down in recent years as part of cost cutting.

2.4 Community resources poorly funded The reforms in mental health care that prompted moves to community-based settings were heralded by many state governments as enlightened and meritorious, but were unfortunately not supported by funding these services which are so vital to the rehabilitation and maintenance of people with chronic mental illness. Not surprisingly, but seriously alarming, there has occurred an over representation of the mental health sufferers in forensic services. This a human rights offence.

2.5 Continuity of care with low and high prevalence disorders. There is a major problem with integration and continuity of care. This is particularly evident through poor discharge planning from acute services and the readmission rate that follows as a consequence. Follow-up of people into the community is essential and a vital part of relapse prevention. This can only be done through better coordination and integration of the many and varied supports that a person who has experienced mental illness might need. There is a need for a clinical case manager role. Furthermore, discharge plans need to be holistic, covering not only medication, but also agreed responses to early warning signs of illness and risk and protective factors for mental health. There should also be goals for rehabilitation and longer-term recovery. Collaborative care approaches need to be prioritised.

For people with complex conditions, there is a great deal of unmet need in Australia for coordination of care. This is generally provided through a case management approach, but often those people in the workforce who are designated as case managers are not optimally effective due to very high case loads and inadequate training. The case management role is vital but needs to employ people with sufficient skills and training to both coordinate and understand intervention options and resources.

3 Crisis in mental health workforce not being constructively addressed

3.1 Declining number of Psychiatrists Whilst the burden of disease for mental health disorders continues to increase over time, there is a decreasing number of psychiatrists in the workforce to meet the demand. Of the 2500 psychiatrists in Australia, most work in private practice, with distribution rates being lower in disadvantaged areas of Australia and much lower in rural and remote areas compared to metropolitan areas. The number of medical graduates entering psychiatry training programs has been declining significantly in recent years.

3.2 An underutilised trained workforce The demand for mental health services in Australia far outweighs that which is currently being provided by psychiatrists and GPs, and the largest specifically trained mental health workforce, psychology, is relatively inaccessible through lack of Government support. It has been shown in the ACE project (Assessing Cost Effectiveness: a joint project between national and State Governments) that psychologists provide effective and cost-efficient psychological treatments and interventions for mental health disorders. In contrast to the number of psychiatrists and GPs involved in mental health service provision, there are 22,000 psychologists in Australia, with 17,500 registered to practice and at least 10,000 of these well qualified to treat mental health disorders. This represents the largest mental health workforce in the country. Seventy percent of these psychologists reside in urban areas, while 30 percent are in rural settings.

3.3 Acute units professionally unattractive One of the additional problems with regard to workforce training and development in mental health flows from one of the issues identified above. The significant reduction in the range of cases and "attractiveness" of working in key public hospitals has become a source of difficulty in persuading medical graduates and fully trained specialists to work in public hospital psychiatry units. Most of these units have become very short term, focused on the more challenging and demanding cases and are understaffed. Not surprisingly, psychiatric and nursing staff are less attracted to working there. Many of the teaching hospitals around Australia report an inability to fill the medical trainee positions in their psychiatric units. Many of them reporting as low as 50% uptake.

3.4 Limitations of overseas recruitment Another aspect that has added to the problem in 3.3 has been the tendency of government to resolve the medical staff shortages by employing overseas trained specialists. The psychiatric milieu, more than any other aspect of medicine, relies very much on the awareness and sensitivity of staff and their capacity to provide socially familiar and culturally appropriate interactions.

3.5 Readily available solutions not sought All of this makes this next point all the more poignant. Present and available in Australia is an

extensive psychology workforce which is highly trained in mental health disorders and treatments and which could extensively support the mental health workforce and provide explicit and specialised expertise to reduce the prevalence of a wide range of mental health disorders. Despite this fact, psychologists are not employed in sufficient numbers in psychiatric units. In many cases where they are employed, they are often confined to case management rather than in positions utilising their training, skills and expertise,

4 Lack of implementation of evidence based practice

It is the contention of the APS that evidence-based practice should be the foundation for mental health treatment programs. Although this is concept and proposition has received considerable support in policy documents, there is little shift in attitudes, recommended strategies or procedural patterns evident in both state and national jurisdictions to direct resources and patient treatment programs towards these interventions.

4.1 As effective as medication There is now overwhelming evidence that psychological interventions (either in combination with medication or alone) are as effective if not more so than drug treatments in the management of high prevalence disorders. These include affective disorders (depression, dysthymia, mania, hypomania and bipolar disorder), anxiety disorders (panic disorder, agoraphobia, social phobia, obsessive –compulsive disorder, generalised anxiety disorder and post-traumatic stress disorder) and substance-use disorders

4.2 More cost efficient There is even more recent evidence that not only supports effectiveness but argues that such psychological interventions are significantly cost efficient, particularly for psychological treatments in high prevalence disorders of anxiety and depression, particularly in the public setting. (See the series of ACE studies referred to above.)

4.3 Still not affecting practice Finally there is also little evidence that the best trained practitioners of these interventions (psychologists) have become the focus of public and private mental health sector staff recruitment.

5 Critical importance of early intervention initiatives

There is now overwhelming evidence that highlights the critical importance of early intervention with people who have been established as clearly at risk of developing more chronic mental health disorders. This is not an issue for which the responsibility rests on acute or public hospital mental health services but in fact really centres on community, educational and primary health care settings. Some of the implications of this proposition are as follows.

- There is a need to fund child and youth services linked with schools and community agencies

- The training of GPs to enable them to more effectively assess risk and refer appropriately to professionals such as psychologists is an important part of early intervention initiatives
- Also needed are specific early intervention programs in schools that fund education and professional support staff in primary care settings to perform risk assessment and provide psycho-educational and skill development programs.

6 The crucial role of primary care

Implied in, and growing from, the points made above and from the well-researched aspects of social policy centres is the need for greater enhancement of the primary care services. There is considerable need to develop a comprehensive approach to primary health care that incorporates a multidisciplinary approach, evidence-based practice and an equitable distribution of resources. Some of the implications of this proposition are as follows.

6.1 Divisions of Primary Care The first step in this process will be to convert the Divisions of General Practice into Divisions of Primary Care that integrate all primary care services in the region (including community health, community mental health, allied health and consumer groups) and are not just based upon GPs.

6.2 Multidiscplinary approaches There is an imperative to develop and resource a multidisciplinary approach to all levels of primary care based upon best practice evidence-based approaches.

6.3 Linkages between services The co-location of primary care practitioners such as psychologists with GPs or in Community Health centers or the creation of formal links between locations should be a prime policy issue

Conclusion

We seem to be faced with a real crisis not just a perceived one. In summary, we have a situation where shrinking public sector services are focused on low prevalence disorders and even then only for the most needy cases and with very limited length and scope of treatment. High prevalence disorders are forced to rely on the private sector in which there is a poor spread of conventional resources and limited access to the evidence-based treatments because of the failure of Governments to fund appropriate services and an available workforce equitably through Medicare or by significantly capping, or otherwise limiting, the only initiatives available to the public. Most alarming is the little evidence of constructive policy/practice change while the problems of workforce shrinkage, poor utilisation and increasing community need continue.

Recommendations

1 There should be increased funding at National and State level as well as resources and clear priorities to reflect seriousness of mental health issues.

2 Governmental committees must set benchmarks for MH funding in Australia and create focussed or tied funding to the States for MH services in public and community settings.

3 All Government instrumentalities to capitalise on, and develop further, good initiatives by lifting capping levels and supporting service delivery eg BOMHC, Allied health access under MedicarePlus, youth initiatives.

4 There should be a national imperative to utilise already trained workforce of psychologists to reduce psychiatric and GP workforce problems and provide appropriate services in public and private sectors.

5 Governmentally auspiced committees should create protocols for programs of treatment that specify best practice (eg CBT, IPT) and endorse a range of recommended extra initiatives (eg ambulatory clinics, primary care, school programs, psychology positions in medical units) for meeting need and demand.

6 There should be a review of the management of relapse prevention and readmissions in the public settings and institute a nation wide program of relapse prevention initiatives.

7 The is a range of initiatives needed in early intervention centred around education and primary care for children and families across the whole healthcare and community spectrum.

8 There needs to be a reform of primary care to become a focus for many of the above initiatives beginning with conversion of DGPs into Divisions of Primary Care based upon all primary care providers and community services.

Explanatory Note

This brief submission was completed at the request of the Committee secretariat. It is not referenced or developed as our final submission will be. It will be followed by a later submission that may contain additional content and will certainly expand on the issues presented in this contribution.