AMA

SUBMISSION TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

AUSTRALIAN MEDICAL ASSOCIATION

CANBERRA

APRIL 2005

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EXECUTIVE SUMMARY

Mental health and indigenous health are the two weakest links in the Australian health care system. Both areas suffer from under-funding and under-manning. The health outcomes in both areas are very poor. There is ample scope for Australia to lift its game.

In this summary of the AMA's position, we identify the top seven problems affecting mental health delivery and the top eight opportunities to "get it right".

The "top seven" problems affecting mental health delivery

- **Mental health services get low funding priority:** In Australia, the provision of mental health services receives an inappropriately low priority having regard to the large number of people affected, the high burden of disability, the untoward impact on service-deprived sub-groups within the community and the missed potential for the cost-effective achievement of better health outcomes. International comparisons of mental health spending are dated (circa 1993) but suggest a spending shortfall in Australia compared to Canada, the US and the Netherlands.
- **Workforce shortages** in mental health are increasingly apparent and are producing sub optimal outcomes for patients. Current and prospective workforce shortages **must** be addressed concurrently with funding issues.
- **Policy directions** were not all appropriate. The **National Mental Health Strategy** was a worthwhile initiative but it is now becoming clear that some of the directions set early in the piece were quite inappropriate. The AMA applauds the steps that have been taken to improve policy directions and urges more. The main challenge now is to address the **failures in the implementation** of the policy. A decade or so after the de-institutionalisation of mental health, it is now obvious that governments did not ensure enough resources for the new community-based care structures to operate effectively.
- **Access and equity** has not yet been achieved for sub-groups within the community with special needs or facing barriers to access: A key failure of policy is the failure to address access and equity issues for people living in rural and remote areas, Aboriginal peoples and Torres Strait Islanders, children and adolescents;
- **Stigma and discrimination** remain as major obstacles to improving outcomes for those who suffer from mental health conditions.
- **Existing resources are not being used as well as they could or should:** Governments decry and undervalue the large contribution of the private psychiatric sector. The separation of some services results in significant inefficiency eg between mental health, drug and alcohol services, and there is scope to improve patient outcomes by integrating these services. Existing funding mechanisms favour defined episodes of care. However the mental health conditions that generate the highest burden of disease are chronic conditions and they require longitudinal care. The Commonwealth/State funding arrangements are dysfunctional, funds are wasted in duplication of administration and policy formulation while a silo mentality detracts from the continuum of care.
- **Access to hospital services is increasingly problematical** for public mental health patients. The AMA does not believe that there is consistency between the National Mental Health Strategy and the resources applied to mental health in the public hospital sector.

The "top eight" opportunities to "get it right"

- **An appreciation of the need for new money is critically important**. There is a joint obligation on governments and private providers to ensure that existing funds are spent smarter to improve outcomes for patients. Even so, a cost-neutral constraint is a

recipe for continuing failure. There is no more fundamental starting point than ensuring that mental health gets appropriate priority.

- **Funding and workforce initiatives** belong together. Steps to secure an appropriate workforce will reduce the risk of new funding being ineffective;
- **A proper analysis of need is an essential foundation for policy**. Governments issue lengthy reports giving the data on past spending and service provision but the analysis of demand and unmet need is very seriously lacking. Existing and new spending will be more effective if there is rigorous analysis of the main shortfalls in service provision and involvement of clinicians in that analysis. Mental health spending priorities can be much better informed than they are now. Understanding and meeting the needs of special interest groups is a large part of this task.
- **We must address the dysfunction**. There are recipes to address each element of dysfunction in the mental health financing and delivery systems. We know what has to be done. Governments are running out of excuses. The claim that we cannot afford to take the necessary steps is bogus. Australia cannot afford **not** to take the necessary steps. This submission contains many practical recommendations on steps that can be taken to reduce or eliminate the dysfunction that is now apparent as a result of the failures of policy and implementation including the inappropriate focus on episodic care, the Federal/State imbroglio, the barriers between services which impair the continuum of care, the over-specialisation of services and so forth.
- **We must build on the strengths of the current system**. It is important to understand what is not working but it is just as important to understand what is now working. Australia's system of primary care has been one of the strengths of the system. Equipping GPs and supporting their efforts to deal more effectively with mental health problems ought to be a priority. The **Better Outcomes in Mental Health** is a successful initiative, the rationing of funds notwithstanding. This program now deserves to be expanded and has potential to be further improved. The data collection in the private sector is another success story, one which should be emulated in the public sector.
- **The Government must ensure there is a well trained and highly motivated psychiatrist workforce** and needs to address such issues as unfilled Registrar training positions, unattractive working environments, poor remuneration etc. Psychiatrists are among the poorest paid of all medical specialties and it is not attracting sufficient new entrants which will show up in serious workforce shortages in later years.
- **The ongoing neglect of mental health prevention must cease**. There is just as much potential to improve patient outcomes through health prevention, early intervention and population health initiatives in the area of mental health care as there is in other areas of health care. The realignment of priorities in favour of mental health services should not neglect those activities nor should it absorb funding needed to provide ongoing mental health care services.
- Governments need to more effectively **engage the Australian community** in regard to mental health care by: **specifying what patients can expect in terms of access to services and health outcomes** (noting that potential health outcomes will differ depending upon the condition); and being properly **accountable** for the way that public funds are spent and the patient outcomes that are achieved or not achieved as a result.

1 INTRODUCTION

The Australian Medical Association (AMA) is pleased to have the opportunity to make this submission to the Senate Select Committee on Mental Health.

On any comparison with similar first world countries, Australia has an excellent health system. Health outcomes compare very favourably. Most Australians have access to high quality health services and a large number of services are delivered for a relatively modest total cost to the community. Our health professionals are well trained and health facilities are, for the most part, high quality.

We are doing well but we could be doing better. Our health system does have some material failings. In the judgment of the AMA, the two weakest links in the Australian health care system are **mental health** and **Indigenous health**. Both areas suffer from under-funding and under-manning and the health outcomes that are achieved fall well short of those that could be achieved and well short of the outcomes that the people should expect.

There is ample scope for Australia to lift its game in mental health.

1.1 Responding to the terms of reference

The terms of reference identify sixteen particular issues for the inquiry to examine. Some of these are first order issues while others are lower order issues. In responding to the terms of reference, the AMA has focussed on what it sees as the first order issues and has concentrated its effort in areas where the medical profession is best able to contribute expertise and experience. Brief comments are offered on the remaining terms of reference.

1.2 Structure of this report

Part 2 provides a snapshot of mental health in Australia.

Part 3 identifies key areas of policy failure.

Part 4 addresses the inadequacy of financial and human resources for public mental health services (including public hospitals), responding in particular to terms of reference items (a) and (b).

Part 5 addresses the role of the private psychiatric sector, responding in particular to terms of reference item (d) and the role of General Practitioners (GPs) in mental health, responding in particular to terms of reference item (h).

Part 6 addresses the issue of accountability, responding in particular to terms of reference item (o).

Part 7 addresses the remaining issues.

Part 8 draws together the AMA's recommendations as to the actions that the Federal, State and Territory governments can take to improve Australia's performance on mental health.

2 MENTAL HEALTH OVERVIEW

2.1 Defining mental health

It is important in any inquiry of this nature to properly stake out the ground, to understand the full range and importance of the conditions that come within the broad mantle of "mental health".

The following table lists the main categories of mental health diseases as per the World Health Organisation's International Classification of Diseases (ICD) system, the latest iteration of which is known as ICD-10. The ICD is the best-known and most widely used disease classification system.

Table 1: Mental and Behavioural Disorders as per ICD-10

Category	Description
Organic disorders	The best known/most recognised of these is **dementia**, with **Alzheimer's Disease** having a high prevalence among the various types of dementia.
Schizophrenia, schizotypal and delusional disorders	**Schizophrenia** is the most important member of this group of disorders.
Mood [affective] disorders	**Depression** and **bipolar disorder** are the two best known affective disorders.
Neurotic, stress-related and somatoform disorders	Well-known conditions included in this group are **anxiety** disorders and **post-traumatic stress disorder**.
Behavioural syndromes associated with physiological disturbances and physical factors	Well-known conditions included in this group are **eating disorders**, **non-organic sleep** and **sexual dysfunction disorders**.
Disorders of adult personality and behaviour	This group covers a range of **personality disorders**, **habit and impulse disorders**, **gender identity disorders** and **disorders of sexual preference**.
Mental retardation	Various degrees of **mental retardation** (from mild through to profound) are classified in this group.
Disorders of psychological development	Well-known conditions included in this group are various **learning disorders** and **autism**.
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	Well-known conditions in this group include **hyperkinetic disorders**, **conduct disorders** and **anxiety disorders** associated with childhood and adolescence.

Source: World Health Organisation, ICD-10 Online, http://www3.who.int/icd/vol1htm2003/fr-icd.htm.

In some other disease classification systems, dementia is classed as a nervous system disorder rather than a mental illness. That said, the aetiology of many mental illnesses is not well understood.

There are a number of different 'views' by which we might seek to understand the relative importance of these groups of diseases in the wider context and in relation to each other. They vary in their impact in aggregate and on the lives of individual patients. The various 'views' include the burden of disease, the prevalence of the conditions, the health system costs, the impact on primary care and the utilisation of hospital services.

Depression makes a large call on primary care, psychotic illnesses have their major impact in an acute care setting (hospital stays can be long) while the biggest impact of anxiety disorders is the need for specialist care and pharmaceuticals. Note that, due to the high prevalence, depression has a significant impact on the use of pharmaceuticals in aggregate. Since the prevalence of depression is significant among older people, it also contributes to aged care costs.

2.2 The burden of disease

Drawing upon methodology developed by the World Health Organisation, AIHW has estimated the burden of disease in Australia. These measures assess the impact of disease via a non-monetary measure, the DALY (disability adjusted life year) which has two components:

- the years of life lost (**YLL**) due to premature death—the **mortality burden**; and
- the years of healthy life lost due to disability (**YLD**)—the **morbidity burden**.

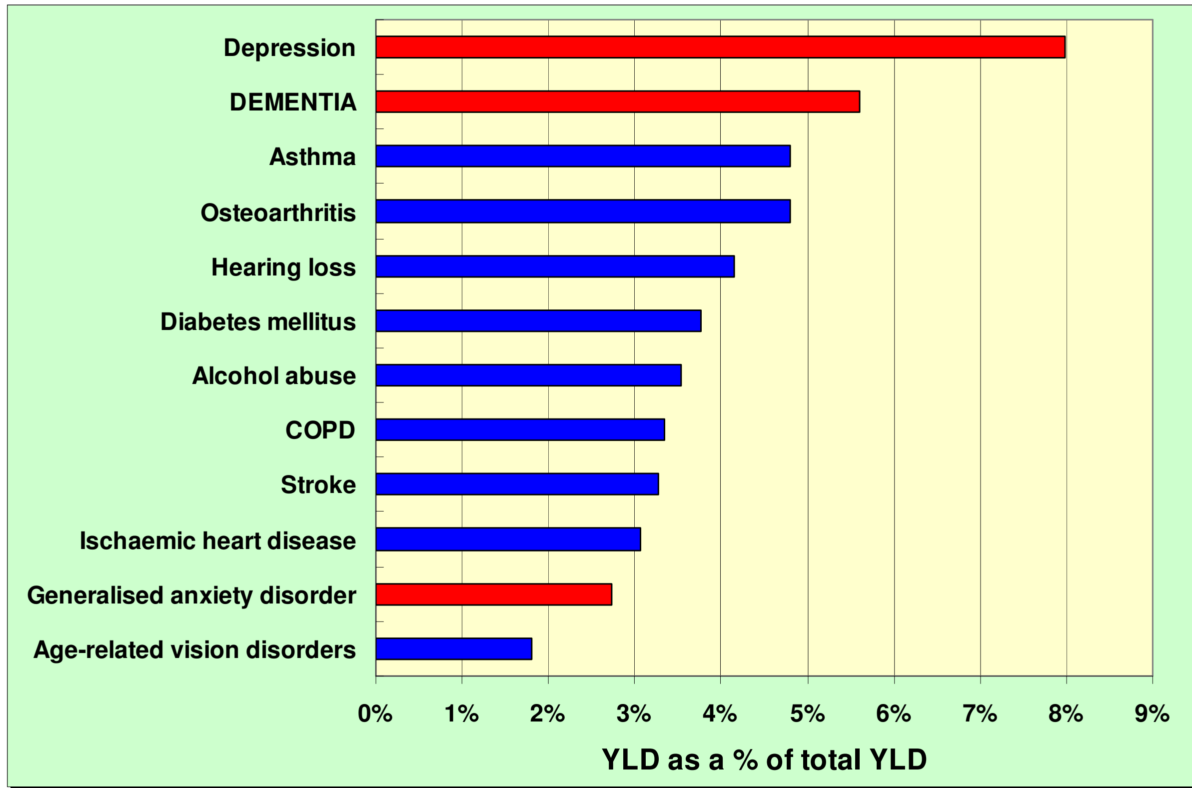
AIHW published the first Australian burden of disease study in 1999. The study showed that:

- The burden of mental disorders in Australia is dominated by affective disorders, substance use disorders and anxiety disorders.
- Substance use disorders are the leading cause of mental disorder for males, accounting for 33% of their mental health DALYs. In turn, alcohol abuse accounts for 59% of male substance use disorder DALYs.
- The major cause of mental disorder for women is affective disorders, accounting for 39% of women's mental health DALYs. This is almost entirely depression (87%).
- In 1996, mental illness was responsible for 13% of the burden of disease. Compared with other broad disease categories, mental illness is not a major cause of death (less than 1% of deaths). **However, mental illness is a major cause of chronic disability. In 1996, it was estimated to account for 27% of the burden of disability (YLD), more than any other major disease group**.

The 1999 report showed that the areas of mental health with the highest burden of disease (YLL and YLD) were affective disorders (dominated by depression), substance abuse disorders and anxiety disorders.

In terms of the burden of disability (the area where mental illnesses have a particularly heavy burden), the mental health conditions with the greatest impact are depression and dementia (see Chart 1).

Chart 1: Diseases generating the highest burden of disability



Source: Mathers, Vos & Stephenson (1999).

2.3 Prevalence of mental health conditions

It is difficult to get consistent and contemporary measures of the prevalence of various types of disease. One source is the National Health Survey (NHS), a household survey conducted by the Australian Bureau of Statistics. This is a self-reporting survey. Due to the stigma attaching to mental illness, self-reporting does not produce reliable measures of prevalence. In addition, due to sampling errors, the NHS is not a reliable source of estimates where the prevalence of a disease is low.

The 1999 AIHW burden of disease study included prevalence estimates for 1996 compiled from many secondary sources. These are reproduced in Table 2.

Table 2: Prevalence of mental illnesses, 1996

Disease category	Number	Per cent of population
Dementia	**124,290**	**0.7%**
Substance use disorders		
a. Alcohol dependence/harmful use	727,820	4.0%
b. Heroin or polydrug dependence and harmful use	41,790	0.2%
c. Sedative dependence/abuse	19,230	0.1%
d. Cannabis dependence/abuse	170,960	0.9%
e. Other drug dependence/abuse	38,130	0.2%
Schizophrenia	**64,800**	**0.4%**
Affective disorders		
a. Depression	538,050	2.9%
b. Bipolar affective disorder	133,360	0.7%
Anxiety disorders		
a. Panic disorder	128,740	0.7%
b. Agoraphobia	71,390	0.4%
c. Social phobia	291,070	1.6%
d. Generalised anxiety disorder	285,560	1.6%
e. Obsessive-compulsive disorder	29,090	0.2%
f. Post-traumatic stress disorder	88,360	0.5%
g. Separation anxiety disorder	102,480	0.6%
Borderline personality disorder	**61,900**	**0.3%**
Eating disorders	**42,940**	**0.2%**
Childhood conditions		
a. Attention-deficit disorder	173,250	0.9%
b. Autism and Asperger's syndrome	29,730	0.2%
Mental retardation	**21,840**	**0.1%**

Source: Mathers, Vos & Stephenson (1999).

While the estimates have the advantage of having been done at a single point in time, they do refer back almost a decade. Also, it might be noted that not all stakeholders agreed with the AIHW authors in their interpretation of the various studies and data sources. Other studies undertaken in the intervening period may give a more up-to-date account. That said, the need for more and better quality epidemiological data is widely accepted.

The following brief notes give an indication of how the ground has moved since 1996:

- The 1997 ABS Survey of Mental Health and Wellbeing (SMHWB) put the prevalence of affective disorders at 5.8% of Australian adults, substance abuse disorders at 7.7% and anxiety disorders at 9.7%.
- Mitchell, Slade and Andrews estimated 12-month prevalence of bipolar disorder at 0.5%. This extrapolates to 100,000 Australians as at 2003.
- As at 2002, Access Economics estimates the prevalence of dementia at 0.8% of the population, or 162,000. In 2005, this will reach 1% of the population and pass the 200,000 mark. These estimates cover those diagnosed. It is a well-recognised issue with many health conditions that there is under-diagnosis.

Taking into account comorbidity, it would seem that at least one in five Australians has a mental health condition of one sort or another.

2.4 Health system costs

As at 1993-94, nearly 80% of estimated health system costs for mental health were encountered in five areas:

- Dementia (24% of the total);
- Affective disorders (21% of the total);
- Schizophrenia (15% of the total);
- Substance abuse disorders (12% of the total); and
- Anxiety disorders (8% of the total).

Further details are given in Table 3.

Table 3: Health System costs by mental illness by sector, Australia, 1993-94

	Hospital (a)	Medical (b)	Pharma-ceuticals	Other health services (c)	Other (d)	All sectors	Per cent of total
Dementia	110	11	2	9	582	714	23.6%
Substance abuse disorders	136	46	12	18	136	348	11.5%
Schizophrenia	275	26	8	106	40	454	15.0%
Other non-drug psychosis	63	5	1	6	53	128	4.2%
Affective disorders	217	141	68	70	148	644	21.3%
Anxiety disorders	24	102	51	25	37	239	7.9%
Personality disorders	24	7	1	12	9	53	1.8%
Stress and adjustment disorders	28	27	7	31	19	112	3.7%
Mental retardation	16	1	0	3	5	26	0.9%
Disorders of psychological development	2	2	0	3	10	16	0.5%
Eating disorders	14	3	0	1	4	22	0.7%
Disorders of childhood and adolescence	10	9	1	19	16	55	1.8%
Behavioural syndromes and other mental disorders	17	53	45	9	50	174	5.8%
Unspecified mental disorders, prevention and screening	5	6	2	23	1	37	1.2%
Total	**941**	**438**	**199**	**334**	**1,110**	**3,022**	**100.0%**

Notes:
(a) Public and private acute hospitals, repatriation hospitals and psychiatric hospitals. Excludes public hospital non-admitted services.
(b) Medical services for private patients in hospitals are included under Hospitals.
(c) Includes hospital non-inpatient services, specialised community mental health services, residential and non-residential treatment services run by non-government organisations and allied health services.
(d) Includes National Drug Strategy funding for prevention, research expenditure and other institutional, non-institutional and administration expenditure. Does not include expenditure for other public health services, non-specialised community health services, ambulances, or medical aids and appliances.
Source: Australian Institute of Health and Welfare (AIHW) analysis of health expenditure data. http://www.aihw.gov.au.

AIHW has provided more up-to-date estimates (for the year 2000-01) but at a much higher level of aggregation (Table 4). While the later data do not provide any new insight into the relative importance of the various mental illnesses, they do show where mental health sits in the wider picture.

In 2000-01, mental health spending accounted for only 6.0% of national health spending. However, in that analysis dementia is classified as a nervous system disorder[1]. **When dementia is included together with other mental health conditions as per the ICD-10 classification system, the total increases to 10.5% of national health spending.**

[1] Consistent with the earlier AIHW work by Mathers, Vos and Stephenson (1999).

In comparing the 1993-94 and 2000-01 estimates, there is an apparent trebling in spending on dementia in money terms (from $714m in 1993-94 to $2,209m in 2000-01). We are not able to offer an informed view as to whether some of this increase may be explained by better knowledge/more accurate diagnosis of dementia.

Table 4: Health Spending by Disease, 2000-01 ($m)

	Hospital	Medical services	Pharma-ceuticals	Other profess-ional services	Aged care homes	Other	Total health spending	% of total
Infectious & parasitic	478	366	209	27	8	139	1,226	2.5%
Respiratory	1,437	840	1,189	64	88	35	3,654	7.4%
Maternal conditions	1,178	107	9	10	0	11	1,315	2.7%
Neonatal causes	334	12	1	0	0	11	358	0.7%
Neoplasms	1,988	258	183	24	37	215	2,705	5.5%
Diabetes mellitus	289	183	234	36	38	35	814	1.7%
Endocrine, nutritional & metabolic	396	340	714	64	14	68	1,594	3.2%
Mental disorders	1,196	499	616	144	366	109	2,929	6.0%
Nervous system disorders	1,115	573	408	410	2,168	204	4,878	9.9%
Alzheimer's and other dementias	160	18	27	9	1,902	94	2,209	4.5%
Other nervous system	955	555	381	401	267	110	2,669	5.4%
Cardiovascular	2,533	782	1,411	78	526	153	5,484	11.2%
Digestive system	1,571	347	637	204	34	31	2,825	5.7%
Genitourinary	1,317	469	233	31	14	13	2,078	4.2%
Skin diseases	562	341	344	103	13	13	1,376	2.8%
Musculoskeletal	1,828	879	680	760	482	55	4,684	9.5%
Congenital anomalies	158	19	2	1	6	37	221	0.5%
Oral health	189	15	34	26	0	3,111	3,374	6.9%
Injuries	2,830	622	184	284	105	6	4,031	8.2%
Signs, symptoms, ill-defined conditions and other contact with health system	2,633	1,802	996	174	0	21	5,626	11.4%
Total	**22,030**	**8,454**	**8,085**	**2,440**	**3,899**	**4,266**	**49,174**	**100.0%**

Source: Australian Institute of Health and Welfare (AIHW) analysis of health expenditure data. http://www.aihw.gov.au.

2.5 Provision of primary care services

General Practitioners (GPs) are the most accessible medical resource in the community and are the gatekeepers to other community resources such as specialist psychiatric care and acute care. Australians see their GP on average just less than 5 times per year. GPs provide close to 100 million consultations per annum to Australians and in any one year approximately 82% of the population will see a GP.[2]

GPs play a vital role in the provision of mental health care. Data from the National Profile of Mental Health and Well-Being study indicated that approximately 20% (1 in 5) of the Australian population over the age of 18 years met the criteria for a mental health problem or disorder. The data showed that only 38% of these people sought help and of those who did seek help, approximately 75% did so in the first instance from a GP.[3]

There is concern from these and previously cited statistics, that there is an under-recognition and less than optimal management of common mental illnesses at the primary care level.[2] A

[2] Harrison, C. and Britt H. (2004).
[3] McLennan, W. (1998).

range of factors contribute to this phenomenon. Patient factors include co-morbidity, presentation as somatic complaint, stigma and embarrassment. GP factors may include inadequate skills, time and resources. Other practice and business demands are immense, and factors such as inadequate consultation time and insufficient access to specialized mental health resources also play a part.[4]

GPs are valued by the community as important providers of mental health care and have an important role in early detection of mental health disorders and disease management, particularly of high prevalence disorders.[5]

The BEACH study has collected data from 1,000 GPs per annum since 1998. It analyses the morbidity aspects of mental health ("psychological") conditions using the *International Classification of Primary Care*—Version 2 (ICPC2). Whereas the World Health Organisation's ICD-10 is a system of classifying diseases, ICPC2 is a classification system for primary care covering symptoms, diagnostic screening/prevention, treatment procedures/medication, test results, administration, other and diagnosis/disease.

Between April 2000 and March 2002, psychological problems were managed at a rate of 11.5/100 encounters in GP. Problems most commonly managed were mood disorders, stress-related disorders, behavioural syndromes and disorders due to psychoactive substances.[2] Overall, depression, anxiety and sleep disturbance were the most common psychological conditions treated. GPs also often manage schizophrenia, dementia and child-related psychological disorders.[2]

Of all the chronic health problems managed by GPs, depressive disorder was the second most common, representing 7.1% of all chronic problems managed. Hypertension (non gestational) was top-ranked at 18.1% of all chronic problems managed. Furthermore, the prevalence of major depression among patients in primary medical practice is about twice that found in the general community.[4]

"*The GP is the key to treatment for most people with mental disorders*"[6]. In short, GPs play a significant role in the recognition and management of psychosocial disorders in the primary care setting. Patients with mental health problems consume significant GP resources and time. Moreover, there are increasing barriers to GPs providing these services in a timely and effective manner.

While the prevalence of mental health problems in the Australian population has increased over time, the number of mental health related GP encounters per 1000 population has fallen slightly, and in 2003-04 stood at 522 GP encounters per 1000 population. Private psychiatric attendances per 1000 population have declined steadily also. This would reflect the GP workforce shortage Australia is currently experiencing, the availability of other non-medical options for care and a shortfall in service provision.

The other concern in relation to workforce supply and distribution is that there are less financial incentives for GPs to treat patients with mental illnesses, as they generally require more time than patients with physical illnesses to manage.[5] The GP consultation item structure encourages shorter consultations and discourages longer consultations. The rate of bulk billing is steadily declining, which may provide a further barrier for patients with mental illness to access general practice. The percentage of bulk billed services has declined from 80.6% in June 1997 to 72.4% in December 2004.

[4] Richards, J.C., et al. (2004).
[5] Groom, G., Hickie I.B., and Davenport T. (2003).
[6] Andrews, G., Henderson S., and Hall W. (2001).

Recent steps by the Government to establish separate MBS item numbers to encourage a greater GP contribution to the management of mental health patients, despite initial high rates of uptake and registration, have not proved popular in practice. GPs report increased paperwork and bureaucratic processes required to access these items.[5]

The Government will be introducing new MBS item numbers from 1 May 2005, which will encourage a psychiatrist to make an initial assessment of a patient, prepare a management plan and then refer the patient back to a GP for ongoing management. Anecdotal feedback from psychiatrists predicts a low uptake of this initiative as the Government did not accept the profession's advice regarding the level of MBS fee necessary to change practice. In addition it will require a significant change in management process to implement effectively.

2.6 Hospital separations

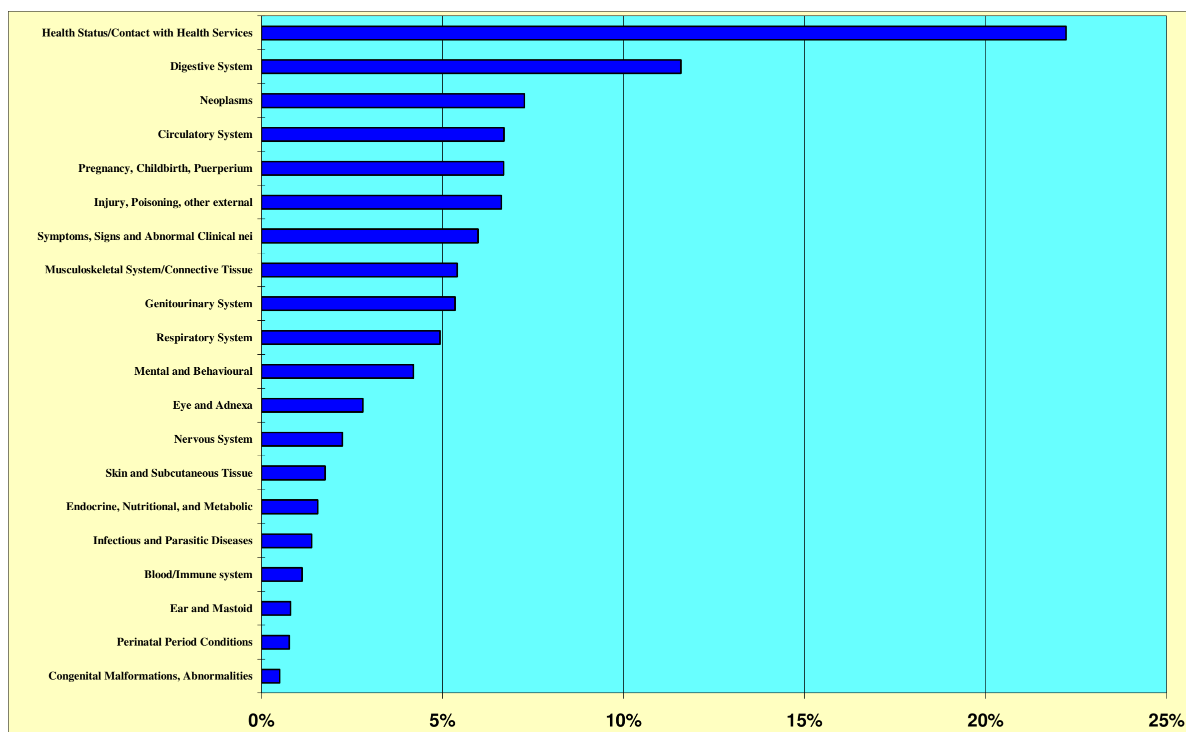
Mental and behavioural illnesses accounted for just over 4% of Australian hospital separations in 2002-03. This percentage has changed very little over the last five years, ranging from 4.13% in 2001-02 to 4.20% in 2002-03 (Chart 2 depicts the 2002-03 data).

Part 3 addresses the problems in accessing hospital services, particularly public hospital services. It would be a fundamental error to assume that the mental health share of hospital services is proportional to the need for hospital services. Hospital utilisation data tell us nothing about unmet needs.

The various illness groups within the area of mental and behavioural illnesses are by no means uniform in the demand they generate for hospital services (see Table 5). In 2002-03, mood (affective) disorders explained over one third of hospital separations due to mental and behavioural illnesses and 1.5% of total hospital separations. Schizophrenia and neurotic conditions each explained nearly 50,000 separations (one sixth of mental and behavioural and 0.7% to 0.8% of total separations). Disorder due to psychoactive substance abuse explained a further 44,000 separations (16% of mental and behavioural and 0.7% of total separations). These four mental illness categories account for almost 90% of mental and behavioural separations, approaching 3.7% of total separations.

It is important to note that these figures are based on separations where mental and behavioural illnesses are the principal diagnosis. Secondary diagnosis of mental illness (comorbidity) is significant so these data necessarily understate the impact of mental illness on hospital utilisation.

Chart 2: Australian Hospital separations by broad disease group (% total, 2002-03)



Source: Australian Institute of Health and Welfare (AIHW) National Hospital Morbidity Data Cubes http://www.aihw.gov.au/hospitals/datacubes/index.cfm.

Table 5: Australian hospital separations for mental disorders, 2002-03

	Number	% of total separations
Organic, including symptomatic, mental disorders	11,287	0.17%
Mental and behavioural disorders due to psychoactive substance use	44,159	0.66%
Schizophrenia, schizotypal and delusional disorders	48,266	0.73%
Mood [affective] disorders	99,590	1.50%
Neurotic, stress-related and somatoform disorders	50,727	0.76%
Behavioural syndromes associated with physiological disturbances and physical factors	9,023	0.14%
Disorders of adult personality and behaviour	9,286	0.14%
Mental retardation	356	0.01%
Disorders of psychological development	1,179	0.02%
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	4,579	0.07%
Unspecified mental disorder	377	0.01%
All Mental Disorders	**278,829**	**4.20%**

Source: Australian Institute of Health and Welfare (AIHW) National Hospital Morbidity Data Cubes http://www.aihw.gov.au/hospitals/datacubes/index.cfm.

2.7 International comparisons of mental health spending

There is a widely held belief that Australia underspends on mental health disorders relative to other health spending, when compared with other similar countries.

In 2003, AIHW issued a report comparing spending on mental health disorders by four countries—the Netherlands, the USA, Canada and Australia[7]. The report concluded that,

[7] Australian Institute of Health and Welfare (AIHW 2003).

given the uncertainties of the data (including differences in the classification of mental disorders, differences in institutional arrangements and differences in methods for allocating cost by disease), there was no evidence that any of the four countries were under-spending or over-spending on mental health disorders relative to each other.

One of the data issues is the boundary between health and welfare spending. AIHW notes, for example, that residential care facilities for people with intellectual and developmental disabilities might be classified as health spending in one jurisdiction and as welfare spending in another.

Other factors which are said to mitigate against any easy comparison of spending on health disorders include the differences in:

- population demographics (the age/sex structure); and
- the geographic dispersal of the population and the implications this has for the cost of service delivery (Australia's relatively small population base is spread over a large geographic area).

The data in the AIHW report is up to a dozen years old:

Australia	1993-94
Canada	1993
Netherlands	1994
USA	1996

The Australian data suggests that spending on dementia had tripled in money (not real) terms between 1993-94 and 2000-01. We cannot assess whether there was a similar surge in the comparator countries.

In short, we have no contemporary and consistent international comparison to draw upon. The bits and pieces of information we have been able to track down would suggest that Australia's spending on mental health is at the low end of the range. For example, in a major audit of the NHS under the Labour Government, the King's Fund has noted that England allocated over 13% of its total health budget to mental health in (2004). This is certainly higher than Australia and higher than most European countries.

Chart 3 summarises the data in the AIHW study. Note that the raw data for the Netherlands puts spending on mental health at 15% of total expenditure on diseases. AIHW adjusts that data to remove "non-health" spending.

As Chart 3 shows, Australia was the lowest spender among the four countries compared at the time the comparison was made albeit not by any large margin. The Netherlands is a geographically compact country and does not face Australia's challenges of service delivery in remote communities. The USA health system offers less equity in access compared with most other first world countries and would undoubtedly be spending a lot more on mental health if all US citizens had access to services.

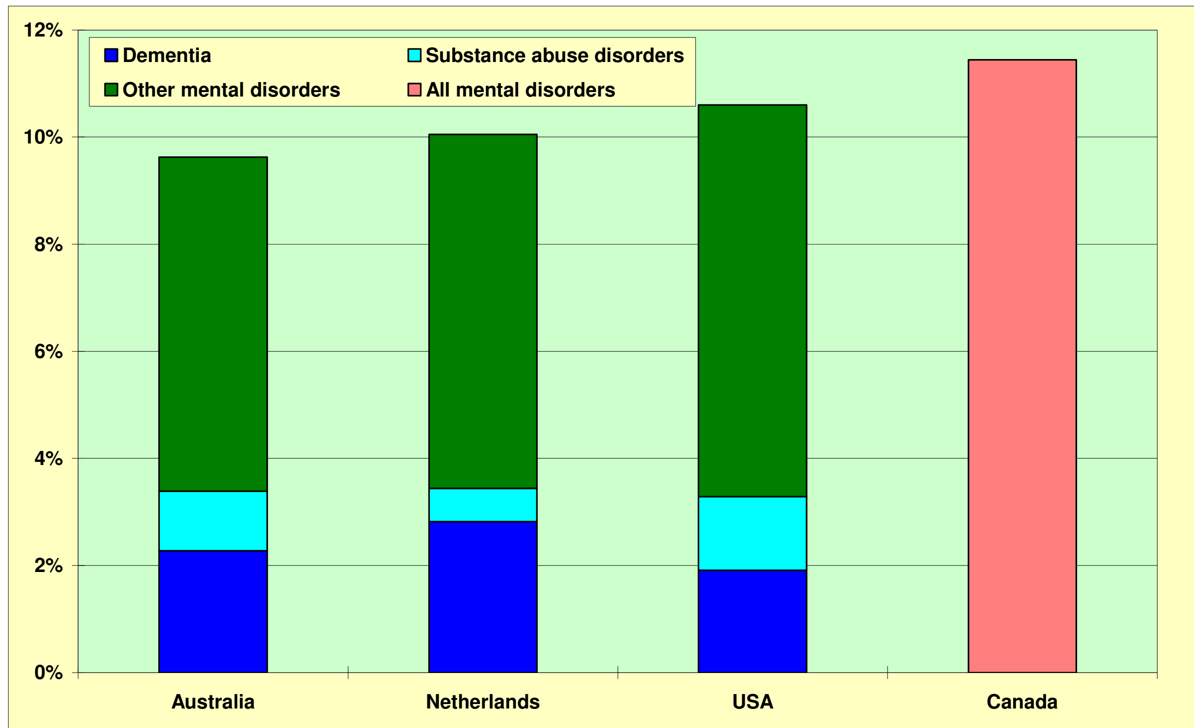
Of the four countries, Australian and Canada are most alike on any number of measures, having similar:

- federal systems of government;
- health financing systems;
- population demographics;

- prevalence of mental illness; and
- geographic dispersal and remote/rural service delivery challenges.

The fact that Canada spends proportionately more on mental health does not mean that they are spending enough. A 2002 report on mental health in Canada pointed to the high burden of disease and the need to raise awareness of and reduce the stigma attached to mental illness[8]. These same issues apply to Australia.

Chart 3: International comparison of spending on mental health (% of total)



Source: Australian Institute of Health and Welfare (AIHW 2003).

The AIHW report notes that:

> "*As there are differences in the definitions and methods used in the disease costing processes, it is not possible to say with any confidence that these countries differ in the proportion of health expenditure that they allocated to mental disorders*."

It goes on to conclude that:

> "*Given the uncertainties with this data, there is no evidence from this disease costs information that any of these four countries are under-spending or over-spending on mental disorders relative to each other*."

While the AMA can appreciate why the AIHW would wish to be cautious, if Australia had been spending 11.4% of all health spending on mental disorders (as per Canada) it would have been spending nearly 20% more. In summary, we appear to have been at the low end of the scale in a context where the World Health Organisation has referred to wide scale underspending on mental health.

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[8] Health Canada (2002).

2.8 The Crystal Ball

In responding to the terms of reference for this inquiry, we do have a concern at the back-looking nature they imply. It is very important to look ahead, as well as looking back.

Australia's population is ageing. This has important implications for the health system both in terms of the overall costs of the system (costs which fall to the community, whether as taxpayers or individuals) and the way heath services are organised and delivered.

The ageing of the population points very clearly to the need for greater efforts in dealing with chronic illnesses and degenerative diseases. In the area of mental health, two areas which will be very much affected by the ageing of the population are organic conditions (dementia) and mood [affective] disorders (depression).

Although the prevalence of depression among the elderly is lower than for younger age groups (eg adolescents), depression is still a significant problem for elderly people. Often, depression among elderly people is associated with the overall deterioration in their health status. The importance of holistic care cannot be over-emphasised. If we treat the arthritis or the cardiac problems but not the depression they cause, then we are not treating the patient appropriately.

Due to the ageing of the population and, save for any major breakthroughs in medications and other treatments, the number of people with dementia is forecast to increase to over 730,000 by the year 2050 (2.8% of the projected population cf. 0.8% currently)[9]. The number of people expected to be diagnosed with dementia ***every year*** (175,000) is not far short of ***the total number of people*** estimated to be suffering from dementia in 2004 (185,000). In short, Australia is facing a dementia epidemic. **A treatment breakthrough which, for example, deferred the onset of dementia on average by 5 years is forecast to reduce the total number of cases by 35% by the year 2020 and 50% by the year 2050**. The obvious conclusion is that investment in research which produces a breakthrough could generate a very large return in terms of patients' quality of life and health system costs saved.

Bipolar disorder may not have as high a prevalence as some other mental disorders but it is a condition with a very high burden of disease (greater than for ovarian cancer, rheumatoid arthritis or HIV/AIDs and similar to schizophrenia and melanoma) and a high rate of suicide. But it attracts relatively low priority, with a very modest level of health spending per patient. The prevalence of bipolar disorder is forecast to increase by 6%, to over 100,000 people, by 2013.[10]

The prevalence of schizophrenia is lower again, estimated at 37,233 people in 2001 but forecast to increase by 10.7%, to over 41,000 people, by 2011.[11]

All told, we are seeing a rising incidence of mental health disorders in Australia and this in turn is lifting prevalence.

In looking to the future, it is important that we not only focus on an ageing population but also take due account of the burden of mental conditions on children and adolescents.

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9 Access Economics (2005)
10 Access Economics (2003b)
11 Access Economics (2002)

We now have a clear choice, that of burying our heads in the sand or taking timely action to train the workforce of health professionals who will be needed to care for those with mental illness in future.

3 WHERE PUBLIC POLICY HAS FAILED

Mental health is a weak link in the Australian health care system but not because the problems are too hard, nor because the financial costs of satisfactory outcomes are more than the community can afford. Australia is a wealthy nation and we can afford to give all members of the community access to quality health care. When we fail to do so, it is not because the solution is beyond our means. Rather, it reflects the choices we have made as a community.

Due to policy and systemic failures, we have not achieved all we could with the resources that are currently available. Furthermore, mental health has not been given appropriate priority. The stigmatisation of mentally ill people is only partly to blame. An honest and open assessment of policy and systemic failures is a necessary prerequisite to improving the quality of mental health care in Australia. If the failures are denied or ignored, then it is highly likely that they will be repeated.

It does need to be said at the outset that the AMA supports the concept of the National Mental Health Strategy. There have been some concerns with the Strategy itself but far greater concerns with its implementation.

This part addresses six significant public policy failures that have not been corrected over recent years. In each case, the AMA considers that solutions are feasible and affordable.

3.1 Inappropriate focus on so-called 'serious' mental illness

The first National Mental Health Strategy in 1992 sought to focus public mental health services onto people who were suffering from so-called 'serious' mental illnesses. It seemed a good idea to many mental health policy makers at the time and was only opposed by a small minority of mental health professionals.

While that policy has been watered down in recent national mental health policies and plans, there has been no overt admission that the original policy was very misguided and, as a result, there has been no proper remedy to the problem caused by the original policy and plan. The legacy of that policy is that most public mental health services have been designed to cater for people with schizophrenia and paranoid psychoses. They do not cater for very many other groups of people with mental illness at all.

Such a policy:

- ignores the importance of early detection of clinical symptoms and early intervention;
- does not recognise the considerable burden to the community caused by so-called non-serious mental illnesses, such as anxiety disorders and depression;
- tends to have an acute focus dealing with episodes of severe disorder; and
- does not have a holistic long term follow-up strategy.

Solution: Public mental health services should be empowered to treat all mental health problems and mental illnesses and to become expert at long-term management of people with such mental health problems.

3.2 Naive belief that community care would be cheaper

The deinstitutionalisation of mental health care was the right policy but the full implications were not understood at the time the decision was made. The provision of community based

specialist mental health services had the potential to provide better outcomes for patients but were not cheaper to provide than asylum care.

Our politicians have long since sold off the land that the asylums were sited upon and have made significant capital returns to the States without regard for the ongoing and very significant need for recurrent funds to provide mental health services in the community.

There is also a need for a significant capital injection to provide facilities spread throughout the community to provide special mental health needs to particular populations.

One of the ways that administrators of mental health services seek to keep the cost of care lower is to limit care to specific treatment episodes. The result of this is that care is not being provided in a long term more holistic manner in most environments within Australia.

Solutions: Address the under-funding of mental health services both in the community and in the institutional sector. Increase acute care/sub-acute beds for mental health by 10 to 20 per cent so that people are not discharged only partially well for their long-suffering carers to manage as best they can. Facilitate the phasing in of transition beds to permit appropriate new and cost-effective modes of care and strive for an appropriate balance of acute and transition beds.

Address the need for specialist acute care beds throughout the community for conditions such as combined drug and alcohol problems, combined physical illness and mental illness problems, mood disorder units, eating disorder units and mother and baby units.

Provide step-down beds in the community to ensure an appropriate transition from hospital to home.

Provide more respite accommodation or supervised beds so that carers may obtain respite from time to time.

Increase the provision of supported housing in the community where people can live within the community but also have some degree of safety and security in the place within which they live.

Strengthen rehabilitation services in mental health, equip them to utilise modern scientific mental illness treatment paradigms and reverse the trend of de-professionalisation of these services.

Target public mental health services at disadvantaged Australians, including those who are financially disadvantaged.

3.3 Failure of generic management paradigms

Generic management paradigms have failed abysmally. Whilst a large part of the increased cost of mental health services has been related to the increase in administrative officers, there has been a concurrent decrease in cost effectiveness of service delivery because these managers do not have a proper understanding of clinical management issues. It is now becoming difficult to attract doctors and nurses into training positions in public mental health facilities partly because of the management structures used in mental health services.

Solution: Reconsider the management paradigms within mental health. Doctors and nurses should, in a coordinated way, have overall management leadership of

all mental health services and the management administrators should be at the service of those clinical directors. It will be difficult to attract doctors and nurses into true clinical director roles unless there is sufficient funding for those clinicians to provide high-quality services to their consumers.

3.4 Failure in accountability

The fourth major policy failure has been in accountability. Whilst there have been eight National mental health reports since 1994, there is still no accounting in them for the number of people that are actually seen and treated in mental health services and whether they are seen face-to-face, or merely by telephone contact. This contrasts with very specific details of the number of Australians treated and even the number of hours spent treating consumers by private psychiatrists in the private mental health sector.

In 2004, the Chief Psychiatrist in Victoria released a ground-breaking report[12] which documents the critical incidents and suicides of people treated in the mental health system in Victoria. A similar report has been issued in NSW[13]. The AMA suggests that both approaches by the two big States be incorporated as part of a basic requirement for accountability by mental health services.

While the private mental health sector has been collecting outcome measures of consumers treated in private psychiatric hospitals over the last three years, the public mental health system is only just starting to approach such a project. There are also rumblings from public sector clinicians that unless there is a very significant increase in funding for such data collection, the outcome measurement process is likely to further undermine the management of consumers in the public mental health system.

Solutions: Mandate reporting by State and Territory jurisdictions of the number of people treated and whether those people are treated face-to-face or by telephone.

Significantly increase the resources for outcome measurement in the public mental health system.

3.5 Failure through separation of mental health

The fifth major policy failure has resulted from the separation of mental health from general health services. This is a failure in the conceptualisation of mainstreaming. Whilst it seemed reasonable for mental health to be split off from the general health sector in order to preserve and quarantine funds for mental health, the consequence is that mental health services provided in general health facilities have been degraded enormously. General health services are now poorly equipped to meet the needs of patients who have comorbid physical and mental conditions.

Recent research shows that mental health services provided adjacent to general health facilities are often the most cost-effective and outcome efficient method of providing mental health services. Such specialised mental health services—which have a deep knowledge of physical and mental illnesses and the interaction between the mind and body—have in the past been called consultation liaison psychiatry services. Funding to such services is almost nonexistent because neither the mental health sector nor the general health sector wants to pay for such services. Support for GPs providing mental health care in the community needs to be part of the solution also.

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[12] Office of the Chief Psychiatrist (Victoria, 2004).
[13] NSW Mental Health Sentinel Events Review Committee (2003)

A related issue is that some of the more highly specialised services in the community are delivering services which lack a strong evidence base. It is not suggested that the "medical model" is the answer in every case but it is foolish to ignore the evidence of what works and what does not work. It may be that the pendulum has swung too far in excluding appropriate clinical involvement.

Solution: Provide specific funding within the general health sector for consultation liaison psychiatry services which are also then provided into community general health facilities and not just general hospitals.

3.6 Failure in the Federal system

The sixth major policy failure has been the inability to deal with the dysfunction in the Federal system. This affects many areas of the health system. It has a particularly adverse impact on patients at the interface between the institutional and community health care sectors. In terms of mental health, the multiplicity of programs accentuates the barriers. The worst outcomes from this are for patients with comorbid and serious physical and mental health conditions. In Section 7, we address the issue of substance abuse.

Governments are wasting money through unnecessary duplication of administration and policy formulation. These funds need to be redirected to the care of patients.

The AMA restates that the concept of the mental health strategy is a good one and the involvement of both levels of government has been essential. There have been some mistakes made in the directions set early in the piece but at least some of these are now being corrected through the refinement of the strategy.

The implementation of the strategy has not, however, been as pretty. We have noted that mental health has received an inappropriately low priority, that the funds earmarked for mental health could have been better spent and that there has not been enough accountability by State and Territory administrations.

A key issue is that mental health patients are often poorly placed to negotiate the health care system, with carers given the added burden of seeking to advocate on their behalf.

The dysfunction of Federal systems is one of the most obvious stumbling blocks to spending the money more effectively on service delivery. The AMA does not believe that the solution lies in adding a third tier, the proposed "Australian Health Commission" on top of the tiers that already exist.

Solutions: Serious endeavours by the Commonwealth and State/Territory governments to place the needs of the patients ahead of their turf wars.

4 PUBLIC MENTAL HEALTH SERVICES

4.1 Key Points

- Public mental health services in Australia are not delivering the standard of care which the public has a right to expect.
- Public mental health care services are dysfunctional because insufficient resources have been made available. Widely based reports and complaints from consumers, carers, paramedical health professionals and medical staff working in mental health attest to the above.
- A very serious outcome from the under-funding of public mental health services is the destructive impact on morale and the disincentive for health professionals to train for and work in the area.
- There is not enough access to public hospital beds for mentally ill patients. This means that such patients are “warehoused” in hospital emergency departments which is highly inappropriate to their special needs, as well as the needs of other patients. The shortage of acute beds misappropriates the time of private psychiatrists who currently expend considerable time trying to arrange hospital access for patients when they need it.

4.2 Discussion

Because the public mental health system has been run down over many years and is now seriously dysfunctional, the expected number of young doctors entering training to ultimately become psychiatrists is decreasing. Many psychiatric registrar training positions across the country are not filled by trainees. We have a clear choice now—to act now to redress the looming workforce shortages—or to wear the larger burden of disease that will attend a shortage of psychiatrists over the next ten years.

Similarly, nurses are not being attracted to work in psychiatry because the system is dysfunctional and because of security problems. It is a common theme across the nation that nurses and doctors attending severely disturbed patients are being assaulted at a rate which is causing concern and public discussion amongst these groups.

The public system has to assume an extra responsibility for some special needs groups within the community, groups who would otherwise have difficulty accessing appropriate care due to the particular nature of their needs or their lack of income to afford privately provided services. As to one area, the mental health of veterans, the AMA acknowledges the considerable efforts made by the Department of Veterans Affairs (DVA) to identify and meet their special needs. The mental health of veterans is not further addressed in this submission as we feel that the Committee will be able to access ample information from DVA and the special interest groups representing veterans.

An example of the dysfunction in the system is the problem that occurs in many emergency departments at major hospitals in Australia. There are not enough acute units to manage the many disturbed individuals presenting to emergency rooms and there are not enough “places of safety” (pre-acute beds). This leads to safety and security problems in emergency departments for patients, their families and staff, inappropriate use of emergency room facilities, inefficiency in the overall operation of emergency facilities and dissatisfaction of staff attempting to work in such a situation.

In some country areas the problem is even worse as, for example, a GP or a country hospital doctor may find it extremely difficult to organise an acute admission for an acutely disturbed

individual into an appropriate facility. Many GPs report extreme concerns in attempting to manage such patients due to the dysfunction in the public system.

Historically, over twenty years ago a move began to close down many of the long-term psychiatric hospitals and to move more towards a community based mental health care system. What was promised at that time by governments was that in parallel with the closing down of the chronic psychiatric beds, the community facilities would be developed at an appropriate pace. However, what has happened is that the long-term hospitals were closed down but the community facilities were not developed at a rate which would enable provision of services to keep pace with needs.

Many of the patients with chronic psychiatric disorders were then left more or less to fend for themselves on the street. This has led to many of these individuals becoming involved with the law and ending up in gaols. Gaols are not an appropriate facility to treat individuals suffering from serious mental disorders. Whilst there has been a move to establish acute care psychiatric beds in inpatient facilities attached to major public hospitals, once again there has been a reduction in the number of beds available to the point that there is no elasticity in the system. Despite what State health departments say, there is widespread concern in the medical community that there are not enough beds in the system to accommodate patients who require acute psychiatric admissions. This is an unacceptable situation in a country with ample resources.

Funding and workforce issues are inextricably linked. They must be addressed as two sides of one coin. Funding initiatives without complementary workforce measures risk wasting money. Workforce initiatives without complementary funding measures risk wasting people. If we do not plan complementary funding and workforce initiatives, then we are planning for more failure.

4.3 Recommendations

The compendium of recommendations (Part 8) contains a number of recommendations which are directly relevant to the public mental health sector. The recurrent themes are:

- The need for policy makers to understand that a key ingredient in the solution to workforce issues is to build public mental health services of high quality and high regard so that people will want to work in them;
- The urgent need for additional funding, to reflect the higher priority which should attach to mental health, in particular to deliver more acute care beds, sub acute beds, transition beds, step down beds, respite accommodation, supported housing and better rehabilitation services;
- The need for policy makers to understand that it is highly inappropriate to “warehouse” mentally ill patients in emergency departments and that this has adverse outcomes for all emergency patients and for the efficacy of resource use in emergency departments;
- Likewise, it is highly inappropriate to “warehouse” mentally ill patients in gaols and remand centres;
- The need for consultation liaison psychiatry services to emergency departments to assist in the management of people suffering comorbid mental and physical illnesses, including drug related illnesses;
- The case for targeting public mental health services to ensure equity of access for disadvantaged Australians, including those who are financially disadvantaged; and
- The need for management and treatment paradigm reforms that will ensure that funds are spent more efficiently.

5 ROLE OF THE PRIVATE SECTOR INCLUDING GPs

5.1 Key Points

- Private mental health is a success story in mental health.
- The myth of private psychiatrists treating only the worried well is simply not borne out by the facts. Private psychiatrists and private psychiatric hospitals treat many of the very disturbed and seriously unwell psychiatric patients in Australia. The contribution of the private psychiatric sector needs to be properly understood and recognised in terms of the overall functioning of the mental health delivery system.
- The private system should be better incorporated into mental health service delivery and planning.
- The **Better Outcomes in Mental Health** initiative in general practice is one area of relative policy success notwithstanding the excessive rationing of access to some of the services and the limited number of GPs participating.
- That initiative is not, however, sufficient to help GPs meet all the challenges they face, particularly those thrown up by the failures in other parts of the mental health care system. More needs to be done to support GPs.
- There is an increasing requirement for closer cooperation between psychiatrists, GPs and other treating doctors in the management of patients. Whilst the government has moved somewhat to facilitate this, there needs to be further government policy moves in this direction to enhance the quality of psychiatric care delivered to Australian patients.

5.2 Discussion

In the 2002 National Mental Health Report, the Health Department estimated that private psychiatrists in Australia are treating about 60 per cent of the patients with psychiatric disorders. There has been an increasing tendency in Australia for psychiatrists to either work for the public system or in private practice but not both. The considerable experience of psychiatrists in private practice needs to be tapped in order for those experienced psychiatrists to provide valuable input into the public system to assist psychiatrists working in the public system. In other words, there has to be a better integration between the public and private systems to deliver mental health care. It is in no one's interests, particularly the patient, to have a type of divide between the two systems. Whilst some moves in this direction are occurring, this needs to become the uniform policy across Australia.

It is not commonly recognised that the private mental health sector in fact sees approximately twice as many individual Australian citizens each year as are seen by the public mental health sector. It sees those Australians for 1/3 of the cost to the community of public mental health services across Australia, even though the public mental health services see only half the number of Australians that are seen by the private mental health sector. Private mental health services are also unique in providing excellent long-term follow-up mechanisms for people with mental illnesses. Those services are not provided only to those with private health insurance but are also provided to people without private health insurance on a significant scale within the community. Private mental health services are not just for rich people. The level of bulk billing by private psychiatrists is very close to the level of bulk billing provided by GPs and may even be higher.

Private psychiatrists treat many people with chronic illnesses in the long term, recognise when their patients are struggling financially and discount the true cost of delivering those services so that their patients won't be deprived of treatment.

Instead of valuing the private mental health sector and perhaps directing targeted funds to try to increase the value that sector can provide to the Australian community, Commonwealth mental health policy over the last ten years has tended to be hostile towards the private mental health sector and has, at times, tried to make that sector the scapegoat for government policy failures.

There has been a failure to adequately recognise the private mental health sector's important organisational strengths. That sector has formed a voluntary alliance of the key players, including consumers and carers, hospitals, health insurance funds and private psychiatrists. That alliance is called the **Strategic Planning Group for Private Psychiatric Services** (SPGPPS) and it is recognised as a member of the **National Mental Health Working Group**.

Commonwealth mental health policy in relation to private psychiatrists has produced the unenviable result that there has in fact been a decrease in the number of services provided by private psychiatrists in recent years, rather than any increase in order to meet the unmet demand in the community. It is largely because of direct Commonwealth government policy which does not encourage entry into the specialty of psychiatry. Commonwealth mental health administrators have expressed pride in the fact that their policies have:

- produced a decrease in the cost of the Commonwealth medical benefits in mental health; and
- led to a decrease in some services.

This seems incredible when there is an increasing burden of mental illness in the community.

One area of relative policy success has been the **Better Outcomes in Mental Health (BOiMH)** initiative funded by the Commonwealth government over the past four years. This strategy is designed as a suite of evidence-based quality initiatives aimed at assisting GPs to improve their identification and management of persons with high prevalence mental illnesses. As well as education designed to improve the assessment, management plan development and review processes, there are incentive payments and specific item numbers for undertaking evidence-based focused psychological strategies (FPS) for those GPs who fulfill certain minimum criteria. The initiative also aims to increase GP access to urgent advice from psychiatrists and management support from allied health professionals.

Significant weaknesses of that policy are apparent.

Despite the apparent high registration rate of GPs with the HIC for the service incentive payments, (SIPs) the claim rate for that pool of money is vastly under-spent. Anecdotally, this is due to a combination of factors from the GP perspective including bureaucratic red tape processes and the fact that a wide variety of conditions are included in the 'mental health' item number, which stigmatises a patient with a mental illness.

Bureaucratic processes also inhibit utilization of these processes, particularly regarding the fact that only GPs who work in accredited practices can register for the initiative—this excluded many Aboriginal Medical Services and Youth-specific services, just as examples.

Access to 'Level 2' training for participation in the FPS is difficult, with only a limited number of (minimum 20 hour) programs certified by the Standards Collaboration. Most of these training programs are held in metropolitan or large regional centres which make access difficult for doctors in rural and remote locations.

The lack of proper integration of that initiative with private practice psychiatry is a matter of concern and of direct relevance to the Senate inquiry. As mentioned previously, a new

Medicare item number for GPs to refer for assessment and development of a management plan will be implemented from May. The AMA is concerned that the Government's moves are not sufficiently bold to provide the necessary encouragement for either the psychiatrists to asses and refer back, or the GP to undertake ongoing management of these patients.

A popular component of **BOiMH** has been the access to allied health. Psychological and counselling services that are financially accessible to persons with mental illness are extremely restricted throughout Australia. These BOiMH projects are Division of General Practice based, although not all Divisions run these services. This counselling component is subject to capped funding and GPs are very limited in the numbers of services that they may refer patients to, some Divisions reporting that they can only refer 5 patients per annum.

Unfortunately the Government has not released the full evaluation report for this program. This is of grave concern, when even the members of the Better Outcome Implementation Advisory Group are not privy to the details of the evaluation. The initiative has, however, been funded to continue and expand its scope for another four years.

Finally, there is little evidence that increased psychological training of GPs actually improves outcomes for persons with mental illnesses. At best, it appears to improve GPs' confidence, detection and possibly management effectiveness.[4] As a result, the **BOiMH** initiative has not been able to achieve the full measure of success that could have been achieved.

Despite the positive aspects, the **BOiMH** initiative is not a panacea that can solve all the challenges that GPs face in the area of mental health. GPs tell us that they are being left to look after people that no one else is able to manage due to resource constraints. They note that the financially disadvantaged in the community suffering from mental illness are still not being looked after adequately by the public mental health services. Some of those people are being managed by the private mental health sector but that sector is limited because of policies that have caused it to contract. GPs are being asked to pick up the pieces when other services fail to meet the needs. GPs report a continued lack of collaboration with, and support from, specialist mental health care services.[5]

GPs say they desperately need services in the community that can provide long-term follow-up to those people with mental illness, particularly those that are disadvantaged socio-economically or in other important ways. The general practice sector is not able to manage all those people without support and require further assistance from private psychiatrists and public mental health services.

GPs are in the front line of service provision and more than 70% of mental health illness care is provided by General Practitioners so it is important that we get it right and that referral to fully trained Psychiatrists is available as a back up for GPs where there are difficult cases.

5.3 Recommendations

The compendium of recommendations (Part 8) contains a number of recommendations which are directly relevant to the public mental health sector. The recurrent themes are:

- The BOiMH program shows promise and very good arguments can be made for building it up and further improving it.
- The Federal and State Governments need to acknowledge the key role of private Psychiatrists and General Practitioners in the provision of services to the mentally ill and work with the relevant representatives to encourage the provision of those services to Australians.

- An intensive and ongoing re-education program be provided to Commonwealth and State mental health administrations in order to assist them in being able to recognise the benefits of a collaborative approach with the private mental health sector.
- Innovative funding should be provided for key targeted strategies in the private mental health sector. Such strategies may include early intervention and prevention approaches in conjunction with general practice. They may also include statistical collection and outcome measurement in private psychiatry office-based practice and targeted funding for psychiatric nurses and psychologists to be able to work under supervision of private psychiatrists in private psychiatric practices, linked closely to the current referral system from GPs to private psychiatrists. This will facilitate the provision of integrated community treatment in the longer term to people who have long-lasting mental illnesses.
- The need to address the considerable disincentives for workforce participation in all arenas including: the dysfunction in the management of public health institutions and the poor working conditions which deter younger doctors from seeking a career in mental health care; the low rates of pay compared with other medical specialties; the inappropriate rebates and remuneration structures which discourage GPS from providing high quality longitudinal care and the inappropriately low rebates for psychiatric services.

6 ACCOUNTABILITY

Terms of reference (a) and (o)

6.1 Key Points

- The greatest failure in accounting for the outcomes of the mental health strategy is the failure to assess needs. This is utterly basic to the whole analysis. Without a needs assessment, it is impossible to rate progress in achieving the aims of the strategy.
- There should be much more open accountability for the actual spending of mental health allocated funds from Federal and State Government sources, looking at the actual application of these funds to the delivery of mental health services. We are continually informed that allocated funds may not reliably end up in mental health services but may end up in some other part of the health system.

6.2 Discussion

The National Mental Health Report for 2004 (the 8th report in the series) comprises 120 pages of detailed reporting of expenditure, staffing and utilisation measures (eg, private psychiatric services, inpatient bed days). It is typical of so many reports from the health bureaucracy in that it limits its focus to the formal health delivery system—the costs of that system and the outputs from it—and ignores all the indirect costs of disease, the burdens on families and carers and so forth. It is, at best, a very partial assessment of the matters which ought to be taken into account in the assessment of any health strategy.

The report states, very lamely, that:

> "*It is not known how much spending on mental health services is required to meet the priority needs of the Australian population. However, surveys conducted of the extent of mental illness in the community have highlighted a high level of unmet need. Similar findings have been reported in other countries.*"

Later it concedes that:

> "*Finally, changes in the resourcing of mental health services need to be considered in the light of the findings from the National Survey of Mental Health and Wellbeing and increasing international evidence that highlight the substantial level of unmet need for mental health care. An implication is that current funding levels in all states and territories may not be enough to meet priority community needs.*"

These two quotes from the report contain the only references in it to unmet need. How then can we assess progress in achieving the aims of the National Mental Health Strategy? The third and current version of the strategy declares:

> "*The framework also stresses the importance of monitoring mental health and mental illness within populations – both at single points in time and longitudinally – in order to describe the epidemiology of given mental illnesses and to provide information to match the level and type of interventions to population needs.*"

If we don't know what the needs are, how can we match interventions to needs? A proper needs assessment is essential if governments are to comply with the first principle of the National Health Strategy.

> "*All people in need of mental health care should have access to timely and effective services, irrespective of where they live.*"

As addressed in Part 3.4, there has been a major failure in accountability in relation to the mental health strategy. There is no accounting in the reports for the number of people that

are actually seen and treated in mental health services and whether they are seen face-to-face, or merely by telephone contact. We reported in that Part that the Chief Psychiatrist for Victoria has documented the critical incidents and suicides of people treated in the mental health system in Victoria. This is one example of the sort of reporting which should be a standard for all jurisdictions in Australia.

There is also scope to improve the tools for assessing quality in mental health. An OECD technical paper[14] canvasses twelve indicators in four areas, as follows:

Area	**Indicator Name**
Continuity of Care	Timely ambulatory follow-up after mental health hospitalisation
	Continuity of visits after hospitalisation for dual psychiatric/ substance related conditions
	Racial/ethnic disparities in mental health follow-up rates
	Continuity of visits after mental health-related hospitalisation
Coordination of Care	Case management for severe psychiatric disorders
Treatment	Visits during acute phase treatment of depression
	Hospital readmissions for psychiatric patients
	Length of treatment for substance-related disorders
	Use of anti-cholinergic anti-depressant drugs among elderly patients
	Continuous anti-depressant medication treatment in acute phase
	Continuous anti-depressant medication treatment in continuation phase
Patient Outcomes	Mortality for persons with severe psychiatric disorders

6.3 Recommendations

The compendium of recommendations (Part 8) contains a number of recommendations which are directly relevant to the issue of accountability. The recurrent themes are:

- The importance of a proper econometric analysis of the need, including the unmet need, for mental health services in Australia with this analysis incorporated into future National Mental Health reports.
- The desirability of mandatory reporting by State and Territory jurisdictions of the number of people treated and whether those people are treated face-to-face or by telephone.
- The need for a significant increase in the resources for outcome measurement in the public mental health system.

[14] Hermann R et al (2004)

7 OTHER ISSUES

7.1 Substance abuse

Term of reference (a)

Substance abuse is having a significant and increasing impact on morbidity and mortality of Australia's younger generations. Alcohol related problems are also significant, particularly for younger females.

Individuals with substance related problems increasingly present to doctors or emergency departments with what initially appear to be psychiatric symptoms.

These trends present significant challenges for the National Mental Health Strategy. While the strategy itself presents mental health issues in terms of motherhood statements, there is a clear and ever present need for reassessment of the nature and extent of the problems so that resources can be directed to the areas of greatest need.

There has for many years been a distinction between alcohol and drug related services and psychiatric services in Australia and New Zealand. The separation of drug and mental health services produces poor outcomes for patients. We note that:

- 80% of mental health patients smoke. Nicotine withdrawal is a significant problem aggravating acute admissions for psychosis. These issues are often not recognised and not addressed;
- More than 50% of detained patients have problems of Alcohol and other drugs (AOD) abuse and or dependence. These are poorly treated and the two systems lead to patients going from pillar to post;
- Advanced training for Fellowship of the Australasian Chapter of Addictive Medicine (FAChAM) has no or very few training posts in medicine and none in psychiatry;
- Patients with mental health and AOD comorbidities fall between the cracks are badly treated and relapse. Suicide, marriage breakdown and prison are not at all uncommon consequences for these people with psychosis and AOD problems.

Because of comorbidity problems there needs to be a national policy to integrate services for psychiatry in general, substance related problems and general medicine.

There are many policy problems with the National Drug Strategy. It has been dominated by the public health approach and psychology. There is room to improve the clinical management of people with AOD by GPs, general physicians and surgeons or in teaching hospitals as evidenced by the following:

- it is estimated that 15% of admissions to a general and teaching hospital are a direct consequence of AOD problems;
- in another 20% of admissions AOD problems are a secondary finding;
- alcohol consumption is implicated in many types of cancer;
- smoking cessation programs are absent from hospitals;
- there are no AOD services in most teaching hospitals in Australia. This results in poor training of students and young doctors, who do not see anyone addressing these problems as a part of what should be basic care;
- 83% of all patients see GPs each year; 5% of these patients have alcohol dependence; 10% of these patients have other AOD problems. GPs don't intervene because there is no policy that supports doctors to intervene. For example the Asthma 1,2,3 Special Incentive Payment should be there also for alcohol; and

- home detox for alcohol should have a SIP payment.

Much of the AOD clinical funding has gone to NGOs. Whilst those AA based supportive services are important, there is a range of excellent, evidence based clinical interventions that GPs and physicians and psychiatrists can undertake including: good brief intervention; care planning; home detox; acamprosate; naltrexone; smoking cessation; methadone maintenance; and, buprenorphine maintenance. Separation of AOD services and psychiatry occurs only in Australia and New Zealand. It is an accident of history.

Placing individuals with serious mental health problems in gaols under the legal system is not an acceptable way to manage such problems. This has led to a large increase in gaol populations of people with psychiatric disorders. The forensic psychiatric services in the gaols simply cannot cope with the extent of this problem.

What can be done to improve outcomes? Following are some practical suggestions:

- Appropriate care for people with psychiatric disorders in a place of safety (not gaol) where they can receive appropriate treatment;
- The provision of AOD services by teaching hospitals should be a requirement for their accreditation and the Australian Council of Health Care Standards should be asked to develop the criteria. Accreditation should be only provisional and for 12 months if they are found wanting. This would be the case in all except one SA teaching hospital, many in WA, NT, and Victoria;
- Bringing together MH and AOD and making them both a part of the National chronic disease strategy and initiatives; and
- Most people with chronic health problems and psychiatric comorbidity are also very poorly served by current mental health policies. CL psychiatry which picks up much of the overt AOD problems in hospitals also recognises a great lack of care for many patients with depression, anxiety, somatisation disorder, chronic pain, chronic fatigue states, COPD, heart disease and diabetes etc.

7.2 Co-ordination through an episode of care — Term of reference (c)

We have a problem with the concept of episode of care in relation to many people suffering from mental illness. The nature of many mental illnesses is that they can be ongoing or chronic and may be associated as well with chronic physical illnesses. An episodic model of care is therefore intrinsically most inadequate. Concepts associated with ongoing tracking of people with chronic illness, as described in chronic physical illness strategies, are often much more appropriate for consideration with people who suffer from ongoing mental illnesses.

Better integration of the treatment provided to people who suffer from chronic co-morbid physical and mental illness would be of great benefit.

7.3 Accommodation, employment, social support — Term of reference (e)

There is no doubt that for full and adequate recovery from mental illnesses it is important that the areas of accommodation, employment and social support are addressed adequately. It has been the experience of people with mental illness that the services in these areas are even less well provided for people with mental illness than are treatment services.

There is an urgent need for the provision of much greater supported accommodation options with professional and other supervision. Likewise, there is an unmet need for employment training and adjustment options as well as the provision of places in employment situations for people that may not be able to work to full capacity. Social support services are

sometimes provided by non-government organisations but the full range of options for people with different types of mental illnesses has not really been provided in our communities.

7.4 Special needs of Indigenous Australians

Term of reference (f)

The healthcare available to Australia's Aboriginal peoples and Torres Strait islanders is completely inadequate having regard to their health status. This undoubtedly contributes to the poorer health outcomes they experience.

This also applies in the mental health area where there is ample evidence of Indigenous people being seriously affected by:

- disproportionately high rates of suicide;
- disproportionately high rates in gaol contributing to mental health problems;
- substance abuse (alcohol, drugs, petrol sniffing);
- social and cultural dislocation;
- child abuse; and
- serious comorbidity issues.

A number of initiatives for the mental health of Aboriginal and Torres Strait communities will be more effective if a culturally empowering approach is pursued, including actions to improve the community spirit and confidence in those communities.

That said, there are a number of mental illnesses that can strike in any community and occur at a similar incidence in most communities and which require specialised mental health interventions. It is important that such illnesses can be readily identified and quickly and that adequate culturally sensitive mental health specialist resources can be applied to assist those people comprehensively.

On the evidence available to us, such mental health resources are not readily available to many Aboriginal and Torres Strait communities.

7.5 Special needs of children

Term of reference (f)

The AMA agrees with the Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) that the Australian Government should convene a National Mental Health Summit on Infant, Child, Adolescent and Family Mental Health including key stakeholders in order to develop a dedicated Infant Child and Adolescent Mental Health Plan to complement the National Mental Health Plan 2003-2008.

The AICAFMHA position paper cites recent evidence compiled by the World Health Organization (WHO) which indicates that by the year 2020, childhood neuropsychiatric disorders will rise by over 50 percent internationally to become one of the five most common causes of morbidity, mortality, and disability among children.

In Australia surveys indicate that between 14 – 18% of children and young people aged 4-16 years experience mental health problems of clinical significance (which equates to more than 500,000 individuals nationally). These findings are comparable with findings internationally.

It is also well-documented that young people can encounter special problems in accessing health services that are appropriate to their needs.

The prevalence of mental health problems and disorders in children and young people in Australia is significant and represents a large public health problem. This clearly requires a greater investment in infants, children and adolescents within a developmental model which addresses their unique needs and helps them develop the life skills which will equip them to deal adequately with whatever life throws at them. The clear objective is to reduce the number needing acute support services in the future.

There is a need for a structured support system for children with mental health problems including behavioural issues such as Attention Deficit Hyperactivity Disorder (ADHD). There is a need for better evidence in matters such as the effectiveness of drugs. Funding for research in these areas should be a priority.

7.6 Special needs of older people **Term of reference (f)**

Older Australians frequently have multiple, chronic and complex health care problems that impact upon not only their medical health but also their physical, psychological and social functioning.

The quality and availability of medical care, including for mental illness, for older people at home, in hospital and in residential aged care facilities should be compatible with the highest standards of care. Standards of care should not be compromised through discrimination on the basis of age, restriction of resources or economic rationalisation. Health care and social services, including comprehensive assessment and effective rehabilitation, should be directed towards the restoration and maintenance of each person's optimal level of independence.

With the increasing proportion of older people in the population, health care services for older people should be expanded within the community setting, in hospitals and in residential care. The effectiveness of these services must be regularly evaluated to ensure that older peoples' needs are being met.

Dementia is a very significant health issue confronting aged Australians and the health system. Its prevalence is expected to rise dramatically as previously indicated. Whether it is regarded as a mental illness or a neurodegenerative illness is not important from the point of view of the impact on people and the health system. This is why the Government has declared dementia an effective national health priority area. This is appropriate and will help to keep a focus on dementia care and research.

Psychogeriatric care for both mental illness and dementia requires specialised staff and facilities to complement geriatric services. The staff and facilities should be able to provide appropriate assessment and management whether the older person is at home, in hospital or in residential care. Adequate staff must be available to provide quality care.

Partnerships must be built and maintained between GPs, primary health care providers, specialists, carers, service providers, patients and their family carers, through consultation, regular communication, and education. Collaborative, multidisciplinary approaches to treatment and care work best in terms of both patient and social outcomes.

7.7 Special needs of Australians in rural areas **Term of reference (f)**

There are some clear differences in the availability and delivery of services to people with mental health conditions in rural areas. There are also different patterns of mental illness in rural Australia. For example, there is an increased risk of suicide particularly for young males compared to their metropolitan counterparts. This is coupled with poor access to psychiatrists and General Practitioners for the treatment of mental illness. Although there

has been much effort expended on attracting medical practitioners to rural settings, it is still the case that the doctor/population ratios are much worse for rural Australia which exacerbates the greater underlying reluctance of many rural Australians to seek medical care particularly in relation to mental illness.

There is even poorer access to Non Government services such as Church based counselling services and private sector psychologists and therapists.

From the medical practitioner's point of view, there are fewer options for care available for patients presenting to a GP surgery with sometimes severe mental illness. Also, there is a reduced capacity in small hospital emergency departments to deal with psychiatric emergencies. Medical Practitioners have much more difficulty in finding inpatient beds and there is greater difficulty in transporting psychiatric patients to a bed in another rural environment or in a metropolitan area.

7.8 Support of Primary Carers

Term of reference (g)

The Government and the health professions are duty bound to seize all the opportunities for cost-effective ways to achieve better quality health outcomes for patients. The evidence suggests that health outcomes will be enhanced where the primary carers of those suffering from mental illness receive support, education and training as well as being involved in the overall treatment management of their loved ones.

Strategies to involve primary carers in the overall treatment management of their loved ones are subject to one important qualification. The patient must consent to it. Patients should be encouraged to involve their primary carers in their overall treatment planning in some way but this should never be coerced.

7.9 Reducing Iatrogenesis

Term of reference (i)

Our organisation was puzzled by the use of the term "iatrogenesis" in the context of mental health. The main cause of continuing suffering in the mental health area is the lack of adequate access to adequate and professional mental health services. Therefore, the main cause of suffering in mental illness is not due to doctor produced illness but to a lack of medical management of their mental health conditions.

We believe that the use of this term "iatrogenesis" in the Terms of Reference indicates a carryover of stigma, into the formulation of ideas for this Inquiry. It is a common stigma that mental illness can be treated by almost anyone because it is just commonsense dressed up; and so, does not require doctors for treatment provision. Conversely, a stigmatised view holds that doctors involved in mental health care are causing much of the disturbance in their patients.

The people that provide services to those with mental illness are often stigmatised alongside of those people suffering from mental illness. To some extent, psychiatrists in particular, are willing to wear that stigma, because they therefore share in the stigma that their patients suffer from. Psychiatrists are then able to work together with their patients in a genuine way, to try to decrease such stigma within the community.

We would like to highlight the fact that rather than iatrogenesis being a major systemic problem in relation to mental illness, the most serious systemic problem causing people to NOT obtain adequate treatment for mental illness, is actually stigma within the Australian community. Stigmatised attitudes cause people to avoid approaching mental health services for assistance and stigmatised attitudes lead people to seek help from alternative sources of mental health care that may be far from adequate. We would note the large number of

internet sites and other counselling-type services that actually have destructive effects rather than helpful effects for those people suffering from mental illnesses. The fact that the community does not consider such poor information sources as a major problem for people with mental illness, reflects either stigma, or a lack of concern about this whole area.

The final comment in this reference term concerning the need for greater consumer participation is agreed by our organisation. The AMA has been at the forefront of the development of innovative partnerships between consumers, consumer organisations and our profession. We have been instrumental in assisting the formation of national consumer participation groups in mental health.

7.10 Mental Health in Detention

Term of reference (j)

Mental health is a major issue for people in detention, whether those in the prison system or asylum seekers in immigration detention. There are important differences between these two groups of detainees particularly in relation to how they arrive in detention ie through the court system or through immigration processes.

There is evidence of severe and chronic post-traumatic stress disorder among asylum seekers during and after detention, some of which may relate to the situations they faced before seeking asylum in Australia as well as the experience of detention itself.

The system of detention for asylum seekers has a particularly corrosive impact on children held in detention. The AMA calls for the release of all children held in immigration detention. The Australian Government has a duty of care to all asylum seekers held in immigration detention including a duty to give them access to independent, transparent, appropriate and timely mental health care. Asylum seekers must also have access to translation services so that their health care can be effective.

The relocation of immigration detention centres much closer to major population centres and capital cities in particular, would make it much easier to provide adequate mental health service resources and also interpreting resources for providing adequate investigation of both physical and mental health needs of these people. There is a requirement for a very large increase in resourcing to provision of mental health and interpreting services to immigration detainees, until the time that such detention centres can be relocated to facilities adjacent to major population centres.

In terms of prison detainees there is overwhelming evidence of the poor state of mental health of those people detained under the criminal justice system and, more recently, in the immigration detention system. Such evidence for poor mental health has been available for many years and through a number of scientific studies. The recent case of Cornelia Rau has drawn the public's attention to the problems in identifying and adequately managing cases of mental illness, including pre-existing mental illness, within both the criminal justice system and the immigration detention system. The case also raises the possibility of people with mental illness being inappropriately detained in prison. We would certainly advocate for better resourcing for mental health services to people in detention including better forensic services.

The AMA calls for greater use of diversionary programmes, especially for young offenders and first time offenders. We would also advocate for appropriate addressing of psychosocial difficulties of young offenders and first time offenders, in order to try to prevent further offending behaviour.

7.11 Detention and Seclusion

Term of reference (k)

For some deeply disturbed individuals, the appropriate treatment paradigm will include a sanctuary, or place of safety. We understand that detention and seclusion on an involuntary basis within mental health facilities is presently complying with human rights instruments, after a review of all jurisdictions' detention and seclusion activities in relation to human rights requirements. We also applaud the process of safety and quality policy, which is specifically looking at the issues of seclusion and detention under that framework. We believe that most facilities in Australia where people are involuntarily detained or under seclusion, do in fact comply with international human rights requirements.

We have become aware of a problem related to the difficulties in maintaining involuntary treatment status for people in the community. On a number of occasions, doctors have become aware that a person who has previously suffered a mental illness is becoming ill once again and the doctor has been approached by family members of the patient who also are aware of the impending descent into severe mental illness that is about to occur. Both family carers and doctors in those situations feel very powerless to be able to do anything about the situation. That is because the person's illness has not deteriorated to the point where they are a danger to themselves or other people and the patient cannot be required to undertake involuntary treatment unless there is a clear danger to life.

Nevertheless, the high probability that the patient is likely to deteriorate into that state is clearly apparent to both doctors and family carers. Neither group of people can do anything about that situation until there is an actual risk to life.

We wonder whether it is possible to examine this issue, with involvement from both professional and consumer and carer groups, to see if there is any way of being able to ensure involuntary treatment to people who have a history of significant mental illness and threat to life in the past and who appear to be deteriorating in the eyes of both professionals and family carers. Would it be possible to institute a legal mechanism, perhaps accessed through magistrates' courts, which might allow earlier involuntary detention where health professionals, carers and an advocate for the patient are in agreement? There are issues of judgment here. Nobody would wish to see a patient's human rights violated in a situation of involuntary detention. Equally, it can be argued that those rights are violated when appropriate care is not provided.

7.12 Education and De-stigmatisation

Term of reference (l)

Educational information for consumers, carers and community can always be improved with greater resourcing. High quality information is important as part of the total process towards de-stigmatisation. Poor quality or inaccurate or misleading information has a very negative impact on the process of de-stigmatisation and often reinforces stigmas associated with mental illness and its treatment. It is important when considering such educational material to involve consumer and carer groups as well as professional groups in assessing the information and its likely impacts.

7.13 Mental Health Research

Term of reference (n)

We believe that mental health research is vital in strengthening the evidence base to mental health services in Australia. There is a cross-fertilisation of the research community with the practising community in our country and a strong research community is vital for that positive cross-fertilisation to continue occurring. We would also note that this is a time of burgeoning new knowledge in neuroscience. We would suggest that it would be prudent for Government to invest increased resources into mental health research, because there may actually be

financial pay-offs to Australian society through mental health research that makes breakthroughs in the understanding and treatment of mental illnesses.

There is only one note of caution regarding all types of health research. We commonly refer to “evidence-based medicine” to mean clinical practices based on the results of research. Evidenced-based medicine has its limitations, particularly when it is based on limited data and used simplistically. While it is a potentially useful tool to improve the quality of treatment, we also need to mindful of the risks when it is not done well. There are particular risks in seeking to use evidence-based medicine as a fiscal managerial tool. Recent examples of the problems that can arise with a simplistic use of evidence-based medicine concern the effectiveness of antidepressant medicine and problems associated with a lack of adequate evidence concerning the safety of use of modern antidepressant medication in young people and adolescents. These incidences should serve as a warning.

We believe there is a need for more applied research, with research monies specifically directed to research about the treatments that are already being applied by experienced clinicians and the outcomes achieved. Then there can be a matching up between such applied research and purer randomised control trial research.

7.14 New modes, e-technology

Term of reference (p)

It is always worth looking towards new modes of service delivery, which might lead to greater productivity and better outcomes. Clinicians working in the area of mental health and the consumers with whom they interact, are working together to look at new modes of delivery that might achieve those aims. Doctors would be willing to consider extending their ability to provide long term treatment of mentally ill people in the community, through supervision of other health professionals. This could include extension of the better mental health outcomes initiative, by specific inclusion of private psychiatrists in such supervision modules and linked to general practitioners.

E-technology has been specifically mentioned in your reference term, indicating an expectation that electronic communications and computers may be one of the new delivery modes of interest. Mental health has been quite active in looking at this new area and that is interesting because mental health care by and large is not highly technological; meaning that it does not involve many machines or non-human technologies. Australia has been a leader in the development of telehealth or telepsychiatry and it is depressing that the area of tele-mental health has not developed more, largely because of a lack of governmental interest, despite the high demonstrated needs of rural and remote populations.

E-health records are often touted as a new way forward for communication between clinicians. We think it is very important that the hype for what can be achieved with electronic communication is not overblown. In the mental health sphere, e-health records offer quite a number of opportunities for better communication but also provide a number of problems in terms of privacy and confidentiality. The concerns of the sector about such matters are not improved by frequent revelations in the media of other supposedly secure databases being accessed by unauthorised individuals. Seemingly repeated inappropriate access to the Victoria Police “secure” database is a disturbing case of this. Even more disturbing has been the lethargy of politicians and police in correcting those problems. It was even alleged that a politician accessed the database inappropriately. Little sanction has been applied to the offenders. Consumers and doctors will remain wary of “secure” e-health databases until our community leaders wake up to their responsibilities.

8 COMPENDIUM OF RECOMMENDATIONS

Reference (a): Relating to Effectiveness of National Mental Health Strategy

- Retain the concept of the National Mental Health Strategy.
- Correct the glaring deficiencies in the funding of the Strategy—acknowledge that there are both funding deficiencies and a workforce shortfall.
- Focus funding initiatives to deliver more places of safety, acute care beds, transition beds, step down beds, respite accommodation, supported housing and better rehabilitation services.
- Increase mental health's "slice of the pie" of government funding for public health services in a staged program consistent with progress in training more health professionals to work in the area.
- Reconsider the management paradigms within mental health to give doctors and nurses overall management leadership of all mental health services.
- Empower public health services to treat all mental health problems and mental illnesses and to become expert at long-term management of people with such mental health problems.
- Undertake a proper econometric analysis of the need, including the unmet need, for mental health services in Australia and incorporate this analysis into future National Mental Health reports.
- Mandate reporting by State and Territory jurisdictions of the number of people treated and type of treatment provided, including whether those people are treated face-to-face or by telephone.
- Be more forward-looking in planning for future mental health requirements in the context of an ageing Australia.
- Acknowledge that a key ingredient in the solution to workforce issues is to build public mental health services of high quality and high regard so that people will want to work in them.
- Acknowledge that mental health has suffered from the dysfunction in Commonwealth/ State health administration and find ways to 'cut through' the inertia to streamline administrative processes and bring a stronger focus on national mental health goals.
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Reference (b): Adequacy of Modes of Care

- Take immediate action to correct the inadequacies of acute and very basic community care services in the public sector implying, inter alia, a greater provision of services by psychologists and counsellors.
- Address the highly unsatisfactory outcomes that arise from "warehousing" mentally ill patients in emergency departments, gaols and remand centres.
- Provide specific funding within the general health sector for consultation liaison psychiatry services which are also then provided into community general health facilities and not just general hospitals.
- Look for effective (evidence-based) programs involving prevention and early intervention and apply the incentives for the provision of these programs in all sectors (public and private). Expand the capacity of community by sponsoring mental health first aid courses.

- Widen the focus of prevention and early intervention programs to maintain the integrity of families affected by mental illness and help minimise the adverse consequences of people suffering from mental illness on general family life.
- Strengthen rehabilitation services in mental health, equip them to utilise modern scientific mental illness treatment paradigms and reverse the trend of de-professionalisation of these services.
- Redress the great unmet need for respite care to relieve the pressures on the carers of people suffering from mental illness.
- Focus publicly provided mental health care onto populations of disadvantage, including populations of financial disadvantage.

Reference (c): Funding Co-ordination throughout an Episode of Care
Reference (n): Mental Health Research
Reference (o): Data Collection and Outcome Measurement

These three elements of the terms of reference are addressed co-jointly because they are inextricably interlinked.

- Acknowledge that the chronic nature of many mental illnesses and, in some cases, their associated chronic physical illnesses render completely inappropriate the concept of an 'episode of care'. Whether care is ongoing or episodic, the need for better co-ordination is the same.
- In addition, build programs around an understanding of the need for better integration of treatment provided to people who suffer from chronic mental illness with particular attention to those with co-morbid physical and mental illness.
- Increase the priority given to mental health research in Australia from the now inappropriately low priority having regard to the burden of disease. Epidemiological studies are often based on old and hopelessly inadequate data.
- Facilitate wider circulation of the clinical practice guidelines prepared by *The Royal Australian and New Zealand College of Psychiatrists*.
- Explicitly fund data collection in the public sector (especially the public community sector) to allow outcome measurement to occur (without sacrificing good clinical practice in service units that are very hard pressed trying to meet the needs of patients as things stand) and so that it can catch up to the private sector.
- De-identify all data to combat stigmatism and discrimination.
- Recognise that even the rudimentary outcome measures (at this juncture) are changing the culture of mental health service delivery in a positive way and encourage further development of these measures.
- Tie the funding for service provision to patient services rendered, not to compliance with national standards of data collection or outcome measurement.

Reference (d): Role of Private and Non-Government Sectors

- Acknowledge the key role of Psychiatrists and General Practitioners in private practice in the provision of services to the mentally ill and work with the relevant representatives to encourage the provision of those services to Australians. This will encompass solutions to the considerable disincentives for workforce participation in all arenas including the dysfunction in the management of public health institutions and the poor working conditions which deter younger doctors from seeking a career in mental health care, the low rates of pay compared with other medical specialties, the inappropriate

rebates and remuneration structures which discourage GPS from providing high quality longitudinal care and the inappropriately low rebates for psychiatric services.

- Provide an intensive and ongoing re-education program to Commonwealth and State mental health administrations in order to assist them in being able to recognise the benefits of a collaborative approach with the private mental health sector.
- Provide innovative funding for key targeted strategies in the private mental health sector to facilitate the provision of integrated community treatment in the longer term to people who have long-lasting mental illnesses. Such strategies may include:
  - early intervention and prevention approaches in conjunction with general practice;
  - statistical collection and outcome measurement in private psychiatry office-based practice; and
  - targeted funding for psychiatric nurses and psychologists to be able to work under supervision of private psychiatrists in private psychiatric practices, linked closely to the current referral system from GPs to private psychiatrists.
- Non-government providers of rehabilitation services should be involved in appropriately clinically determined and monitored management plans for selected patients, with the same levels of accountability as government providers of rehabilitation services.

Reference (e): Accommodation, Employment and Social Support

- Acknowledge that full and adequate recovery from mental illnesses requires proper attention to the areas of accommodation, employment and social support.
- Work with State and Territory administrations to meet the urgent need for the provision of much greater supported accommodation options.
- Supplement that where required with support from professional and other supervision for employment training and adjustment options.
- Encourage the provision of places in employment situations for people that may not be able to work to full capacity.
- Provide a wider range of social support services for people with different types of mental illnesses to support those provided by non-government organisations.

Reference (f): Special Needs Groups

The lame efforts to assess the need for mental health care means a lack of clarity around the adequacy of services provided to many special needs groups. There is much that can, and should, be done.

Aboriginal Peoples and Torres Strait Islanders:

- recognise that Indigenous Australians experience much worse general health and mental health outcomes than other Australians, accept the need for more generous funding and ensure that it is delivered in a way that is culturally appropriate and empowers communities.

Infant, child, adolescent and family:

- convene a National Mental Health Summit on Infant, Child, Adolescent and Family Mental Health including key stakeholders in order to develop a dedicated Infant Child and Adolescent Mental Health Plan (including a structured support system for children with mental health problems) to complement the National Mental Health Plan 2003-2008.

- fund preventative mental health programs to help individuals, particularly young people, develop life skills which will help them to deal adequately with whatever life throws at them with the aim of reducing the number needing acute support services in the future.

The elderly:

- ensure that the right mix of medical services is available to treat mental illness in all aged care settings and that the current shortages and lack of incentives and facilities to treat aged Australians are overcome.
- Recognise the need for specialised staff and facilities to complement geriatric services to meet the needs for psychogeriatric care for both mental illness and dementia.

Australians living in rural and remote areas:

- develop mechanisms such as telemedicine, specialist outreach etc to make a higher level of mental health medical services available to rural Australians. Provide greater training to the existing medical workforce in the treatment of mental illness and ensure that the special needs of the mentally ill are considered when acute care services in rural areas are being reviewed.

Alcohol and Other Drug (AOD) services:

- Provide appropriate care for people with psychiatric disorders in a place of safety (not gaol) where they can receive appropriate treatment.
- The provision of AOD services by teaching hospitals should be a requirement for their accreditation and the Australian Council of Health Care Standards should be asked to develop the criteria. Accreditation should be only provisional and for 12 months if they are found wanting.
- Bringing together mental health and AOD and making them both a part of the national chronic disease strategy and initiatives.
- Support consultation liaison psychiatry which will pick up much of the overt AOD problems in hospitals and redress the great lack of care for many patients with depression, anxiety, somatoform disorder, chronic pain, chronic fatigue states, COPD, heart disease and diabetes etc.

And more generally:

- Recognise that services have become too highly specialised around treating one issue and that this renders them poorly equipped to deal with mental illnesses co-morbidity with substance abuse problems (AOD) or mental illness comorbidity with significant physical illnesses services.
- Recognise that over-specialised services are not the best way to provide appropriate patient-focused health care for special needs groups or for the general population of people with a mental condition.
- Recognise that the provision of mental health services at the same time as, or very adjacent to, general medical or surgical services, leads to much better outcomes and a significant improvement in the cost effectiveness of the health system.
- Provide significant funding for mental health services in general hospital facilities, including out-patient general medical and surgical health services, attached to general health funding rather than mental health funding.

Reference (g): Support of Primary Carers

- Provide primary carers, children of patients and other family members with support, education and training. Provide further opportunities for primary carers to be involved in the overall treatment management of their loved ones.
- Encourage carer involvement in care plans while recognising that it is necessarily subject to patient consent (which should never be coerced).

Reference (h): Primary Health Care

- Expand the **Better Outcomes in Mental Health** initiative, engaging all GPs and without a link to a Service Incentive payment so as to improve the availability of psychiatric support services to all GPs.
- Recognise the very important role that GPs play in primary mental health care (especially in the areas of depression, anxiety and sleep disturbance together with the management of people with multiple co-morbid chronic conditions) and, in that context, understand that the current MBS fee structure discourages long GP consultations and works against quality primary care.
- Recognise that GPs will not be able to 'pick up the pieces' when other mental health services, public specialist mental health services in particular, are not able to provide sufficient services to their consumers, particularly those with supposedly less serious mental illnesses and those in extreme disadvantage, including financial disadvantage.
- Support innovative funding initiatives to help GPs lift the quality and quantity of mental health services they provide with emphasis on early intervention and prevention as well as improving support of GPs by psychiatrists in private practice.

Reference (i): Reducing Iatrogenesis

- Recognise that doctor produced illness is not a material problem in mental health, rather the main cause of continuing suffering in the mental health area is the lack of adequate access to adequate and professional mental health services for proper medical management of mental health conditions.
- Recognise that the use of this term "iatrogenesis" in the Terms of Reference indicates a carryover of stigma, into the formulation of ideas for this Inquiry. Two common stigmas are (1) that mental illness can be treated by almost anyone because it is just commonsense dressed up; and so, does not require doctors for treatment provision and (2) conversely, that doctors involved in mental health care are causing much of the disturbance in their patients.
- Support greater consumer participation (the AMA has been at the forefront of the development of innovative partnerships between consumers, consumer organisations and the medical profession and has been instrumental in assisting the formation of national consumer participation groups in mental health).

Reference (j): Mental Health in Detention

- Take immediate steps to end the practice of holding children in immigration detention centres.
- Recognise the special problems of asylum seekers while in and following immigration detention (such as the very high level of post traumatic stress disorder) and ensure that these special needs are met (including the need for translation services). Assess the scope for relocating immigration detention centres closer to major centres so that appropriate mental health care can be more easily provided.

- Recognise the overwhelming evidence of the poor state of mental health of those people that end up being detained under the criminal justice system and support better resourcing for mental health services to people in detention including forensic services.
- Support much greater use of diversionary programmes, especially for young offenders and first time offenders as well as addressing psychosocial difficulties of young offenders and first time offenders in order to try to prevent further offending behaviour.

Reference (k): Detention and Seclusion within Mental Health Facilities

- Recognise that, in a framework where the objective is to provide appropriate high quality mental health care, detention and seclusion of the patient within a mental health facility can be the most appropriate form of treatment.
- Ensure that where detention and seclusion occurs on an involuntary basis within mental health facilities, there is full compliance with human rights instruments.
- Recognise also that employers have moral and legal responsibilities to maintain safe workplaces in the interests of other patients and staff.

Reference (l): Adequacy of Education and De-stigmatisation

- Recognise that high quality educational information (for consumers, carers and the community) is an important part of the total process towards de-stigmatisation (poor quality or inaccurate or misleading information often reinforces stigmas associated with mental illness and its treatment).
- Ensure that consumer and carer groups, as well as professional groups, are fully engaged in the preparation and review of such educational material.

Reference (m): Proficiency and Accountability of Other Community Agencies

- Recognise the ongoing need for significant effort to educate community agencies (such as housing, employment, law enforcement and even general health services) to reduce the incidence of these agencies dealing with people suffering from mental illness in a stigmatising way.
- Recognise the critical importance of such programs securing the strong support and “buy-in” of leaders within those agencies, both administrative leaders and leaders within the professional groups involved.
- Recognise that the effectiveness of educational material depends not only on strong priority in early training but also in follow up with ongoing re-education and revision programs at a later time.

Reference (p): New Modes of Delivery, including E-technology

- Recognise that, in a framework where the objective is to provide appropriate high quality mental health care, clinicians will always be prepared to investigate new modes of service delivery which might lead to greater productivity and better outcomes. The key role for government is to ensure that new modes are investigated in a way that does not compromise patient safety.
- Recognise that Australia has been a leader in the development of telehealth or telepsychiatry but that tele-mental health has not developed more, largely because of a lack of governmental interest, despite the high demonstrated needs of rural and remote populations where such technologies would appear to have potential.
- Beware of overblown hype around the issue of e-health records as a new way forward for communication between clinicians. In the mental health sphere, e-health records offer quite a number of opportunities for better communication but also provide a

number of problems in terms of privacy and confidentiality. Consumers and doctors will remain wary of “secure” e-health databases until our community leaders wake up to their responsibilities.

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APPENDIX A: SPGPPS

The **Strategic Planning Group for Private Psychiatric Services** (SPGPPS) is the peak mental health alliance that brings together diverse stakeholders to identify and agree on issues directed at improving mental health services in the Australian private sector. This alliance is a strong partnership between the following stakeholders.

1. Australian Medical Association (AMA);
2. Royal Australian and New Zealand College of Psychiatrists (RANZCP);
3. Royal Australian College of General Practitioners (RACGP);
4. Australian Private Hospitals Association Limited (APHA);
5. Australian Health Insurance Association (AHIA);
6. Australia Government Department of Health and Ageing (DoHA);
7. Australian Government Department of Veterans' Affairs (DVA); and
8. Mental health consumers and their carers.

The alliance seeks to not only better inform each stakeholder's own policy processes, but also to reach agreement on actions that will improve practice and better integrate mental health care across the private and public sectors. The SPGPPS and its Working Groups meet regularly to work toward achieving these goals, particularly in relation to the following key areas that are critical to the provision of high quality private sector mental health services:

- Participation of private sector consumers and carers;
- The funding and uptake of innovative models of service delivery that have been shown to be effective and feasible;
- Flexibility of funding arrangements so that the implementation of appropriate models of care is not inhibited;
- Strong linkages, co-ordination, and continuity of care between GPs, Psychiatrists and private hospitals; and
- The quality, availability and utilisation of information regarding private sector mental health services.

Centralised Data Management Service

In 2001, the SPGPPS established a **Centralised Data Management Service** (CDMS) to improve the quality, availability and utilisation of information regarding private sector mental health services through the implementation of a **National Model for the Collection and Analysis of a Minimum Data Set with Outcome Measures for Private, Hospital-based, Psychiatric Services**. Participation in the National Model by 43 of the 46 Australian private hospitals with psychiatric beds (hospitals) enables those hospitals and payers to evaluate and monitor the quality and effectiveness of the care provided by those participating hospitals.

National Network of Private Psychiatric Sector Consumers and Carers

In 2003, the **AMA**, **RANZCP**, **APHA**, **AHIA** and **beyondblue** financially supported the establishment of the **National Network of Private Psychiatric Sector Consumers and Carers**, to improve the participation of mental health consumers and their carers in private sector mental health services. The National Network is working to better involve consumers

and their carers in policy decisions around the design, delivery and evaluation of private sector mental health services, and to be an effective advocate of their rights and responsibilities.

The work of the SPGPPS, its CDMS, and National Network is supported through the SPGPPS Secretariat, located at the offices of the Federal AMA in Canberra. The SPGPPS website is located at: www.spgpps.com.au.

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