AMA Victoria's submission to the Discussion Paper on "*Victoria's next 10-year mental health strategy*"

16 September 2015

The Australian Medical Association (Victoria)

AMA Victoria welcomes the opportunity to provide input into the Discussion Paper on "Victoria's next 10-year mental health strategy".

We first wish to make the point that the timeframe for this response was unsatisfactory. If the Government wishes to receive thorough and thoughtful contributions from industry bodies then more than four weeks' notice is required. Given the scope of this Discussion Paper, a one-month consultation period is insufficient to ensure proper and meaningful feedback from the sector.

Mental illness affects all sectors of the community, irrespective of one's age, socio-economic background or physical health. The current system in Victoria is under immense pressure with constantly increasing demand. It is largely crisis driven and not able to adequately respond to the long-term care or management needs of people with mental illness.

The themes and priorities outlined in the Discussion Paper are, in general, very worthy. However, they are highly aspirational and must be accompanied by sufficient funding and outcome measures if they are to be successful.

While Victoria only has direct responsibility for a small part of the mental health system, it is vital that a planned and coordinated approach is taken across all care settings. Communication, coordination and partnership between state and commonwealth agencies, across state departments and health service providers will be a key factor in achieving meaningful system reform.

Funding to the mental health sector must increase. While there are opportunities for innovations and efficiencies to be implemented, the system will not achieve real and lasting outcomes for patients until funding is increased to meet continually rising and increasingly complex demand.

In addition to increased funding, greater transparency around the use of mental health funds is required. Currently health services are funded to provide mental health services but it is not possible to ascertain exactly where, or how, this money has been used. Without clear information on how current funding is being utilised and the outcomes it is producing it is not possible to review the efficiency or effectiveness of these funding strategies.

Given the current fiscal constraints at both state and national levels, it would be appropriate to undertake trials of new funding or service models so they can be properly evaluated for cost-effectiveness and outcomes before being implemented on a broader scale.

The state must also consider how actions at the federal level will impact on patients in Victoria. For example, the new Single Medicare Safety Net, due to start on 1 January 2016, will significantly increase the out-of-pocket costs for some patients. If out-of-pocket costs are increased then access to care will be constricted and patients will fall back on the public system to manage when they reach crisis point.

The mental health system can no longer be seen as separate to the health system. It must be a fully integrated, coordinated service across Victoria.

Mental and physical health and wellbeing are intertwined. People with mental health problems are more likely to have risk factors for other health problems (e.g. smoking, overweight, physical inactivity, higher stress), drug and alcohol problems, poor screening rates and poorer management of their non-mental health problems (e.g. cardiovascular disease, diabetes). Overall people with mental have higher mortality from their non-mental health problems than their mental health problems and have higher rates of

morbidity and mortality than those without mental health problems for similar conditions[1].

A key omission from the Discussion Paper is the impacts of the new *Mental Health Act 2014 (Vic)* on the service system. The requirements under the new Act have significantly increased the amount of paperwork that must be undertaken; this increased administrative workload detracts from the time a doctor can spend with the patient and may also be discouraging people from entering the profession.

For Victoria's next mental health plan to be successful it must shift away from the current system of crisis response and towards a system that is planned, coordinated and focused on prevention, management and rehabilitation.

[1] DE HERT M, CORRELL CU, BOBES J, et al. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*. 2011;10(1):52-77.

Mental health care in the private sector

Private sector mental health services are delivered by psychiatrists and GPs in private practice, private hospitals and psychiatric beds (hospitals) and other allied health professionals.

The state-run public health sector does not generally provide long-term mental health care in the community, this role is taken up by private psychiatrists and general practitioners.

Private sector mental health services account for 80% of all people seen by the Australian specialist mental health sector. [2]

To build an effective mental health system it is important that the roles of GPs providing mental health care, private sector psychiatrists providing mental health care and psychiatrist input in general are all recognised as part of a comprehensive, integrated mental health system that supports and is supported by effective primary care.

General Practice plays a vital role in the ongoing management and care of people with a mental illness and are best placed to provide holistic care where the mental and physical health needs of the patient are met.

GPs work with the whole person to develop goals and care plans for the long-term management of mental health conditions. This work is often done in multidisciplinary teams and includes prevention, health promotion, supporting self-management, management and monitoring.

For high prevalence disorders of depression and anxiety, 80% are managed by GPs in primary care.[3] It is often only the severe and persistent conditions that require a specialist service as part of the patient's core mental health response.

The use of inappropriate mental health settings for patients can lead to increased stigma, reduced access, fragmentation of care, less holistic care and greater costs. All of this reduces the quality of care that is provided to patients and will ultimately affect their long-term outcomes.

Communication, support and referral pathways are vital. The links between general practitioners and private psychiatrists must be strengthened. Good communication practices between care settings improves overall outcomes for patients and ensures a holistic approach to care.

Referral pathways for patients must be developed to ensure that general practitioners are supported when caring for patients with mental illness and able to access additional support and services when they needed.

Substantially more investment is required in community-based psychosocial, primary and community mental health services. This has been recognised by the *National Review of Mental Health Programmes and Services(Dec 2014)* which recommends a major shift of funding priorities from hospitals and income support into more community-based psychosocial, primary and community mental health services.

[2] Department of Health, National Mental Health Report 2013. Tracking progress of mental health reform in Australia 1993-2011

[3] Timonen M, Liukkonen T; Management of depression in adults. BMJ. 2008 Feb 23;336(7641):435-9.

Mental health sector resourcing

The Discussion Paper suggests that the capacity of services to provide treatment and support to children and their families could be increased by "gradually readjusting the balance of investment in specialist mental health services" and the paper as a whole, disappointingly takes a 'no new investment' approach.

The AMA strongly disagrees with any approach to review existing policy or set new policy for mental health care that is restricted only to considering current funding.

The policy review process should include a comprehensive assessment of needs and identify what is required to meet them.

In circumstances where all types of mental health care are currently significantly under-resourced it is critical that any proposal to shift resources is supported by a detailed and convincing case. Such as case must explain how current and anticipated needs for acute, specialist care will continue to be met to at least current levels.

National Disability Insurance Scheme (NDIS)

The National Disability Insurance Scheme (NDIS) has the potential to improve care for many people living with disabilities and mental health issues across Australia. However, AMA Victoria would caution against placing too high an expectation on the ability of the NDIS to relieve the pressure on the public mental health system and to provide the coordinated care that is required.

The roll-out of the NDIS is not due to commence until mid-2016 in a staged manner so it may be many years before the Scheme is fully operational. In addition, the NDIS, currently in its trial phase, has already experienced significant increases to the annualised cost of care packages and greater enrolment from higher-needs patients. If this trend continues it may affect the availability of packages once full roll-out commences.

It is also possible that, particularly in the early stages of implementation, the majority of packages will be provided to people living with severe physical or intellectual disability and that mental health will continue to experience a second tier status.

The effects of the full implementation of the NDIS on patients with severe mental illness should be carefully monitored by the state government to ensure that all the person's needs are met and the system is 'joined up'. It should not be viewed as a way to shift the responsibility of care to another agency.

Prevention and Early Intervention

Early intervention is an important and promising concept but it needs to be based on evidence from proven, effective interventions conducted in the correct way by properly trained staff and provided at the correct time of the illness.

Prevention and early intervention should focus on programs to target key disorders at all ages. Conditions such as conduct disorders, anxiety disorders and depressive disorders, self-harm or risk of suicide and children of parents with mental illness are important to review.

The early intervention process should involve comprehensive assessment in a biopsychosocial framework to ensure intervention is optimally tailored.

Evidence-based school programs are needed to help identify high-risk children and facilitate early referral to mental health professionals.

Funding should be increased to support programs to enhance youth access to primary care advice and support. There needs to be a focus on developing and promoting comprehensive local referral pathways to ensure that patients get linked to the right service at the right time.

The private sector, both general practitioners and private psychiatrists plays a key role in prevention and early intervention activities but the state needs to recognise the need for

- more support for the role of general practice in identifying and preventing potential mental health problems before they require downstream specialised services;
- more recognition that successful ongoing treatment for patients under psychiatric clinical care is key to the prevention of acute and crisis episodes (including suicide);
- structured opportunities through health assessments; and
- better shared care arrangements for adolescents who require clinical care, for referral to GPs and to psychiatrists, and encouragement to have a regular GP.

In mental health there is also potential for substantial gains from spending that delivers improved levels of recovery and/or the ability to cope more effectively. Improving recovery and coping ability can provide long terms gains increasing a person's ability to manage their own condition and to participate more wholly in society.

It is also important to recognise that a number of conditions, despite the most optimal evidence-based early intervention, do have ongoing morbidity and functional impairment. The increased focus on prevention and early intervention is a positive aim, but cannot be adopted at the expense of other treatment approaches.

Suicide prevention and crisis intervention

Increased investment in crisis intervention services is required, particularly for those with severe mental illness and/or those at risk of suicide.

Every public sector acute mental health service should have a rapid-response outreach team. In-patient and intensive intervention services must have the capacity to provide care for as long as the patient requires, not until the bed is needed for a new patient. Sufficient support services must be available in the community to ensure that a patient is not released from intensive intervention and left to manage alone.

Suicide prevention programs must also recognise the importance of adequate and timely biological treatment for the severely mentally ill by clinicians, which can prevent many suicides directly. This recognition should be built into policy and planning.

The current system for people with mental illness

There is clear unmet and urgent need to fund more acute mental health care as well as ongoing care in settings other than hospitals for people with severe and enduring mental health problems.

Access to appropriate care for those with psychosis and severe disease varies and is inequitable. Ready access to quality mental health care based on a person's particular needs requires a significant expansion of services, intervention and support for people with mental illness across the whole continuum of care.

Whole of system enablers that need to be in place include an appropriately sized and skilled workforce, better coordination across health care and support services, and significant additional overall investment in mental health services.

The current system of crisis driven care, where patients are left to manage as best they can until they reach crisis point and then are often discharged too early, needs to end.

The social model of care

The social model of mental health does not necessarily provide optimal treatment of illness. Best-practice in mental health care involves a comprehensive holistic treatment of the complete person. This model is best known as the biopsychosocial model.

The biopsychosocial model of care is an approach stating that health is best understood in terms of a combination of biological, psychological (which entails thoughts, emotions, and behaviors), and social (socio-economical, socio-environmental, and cultural) factors which all play a significant role in human functioning in the context of disease or illness.

This model of care tailors interventions to the specific needs of the individual ensuring that all the supports required, such as social, environmental, housing or assertive biological treatment are available when needed.

The use of medication to treat mental illness

The approach of using psychologically based treatments are often very effective and have a strong evidence base in treatment of many types of conditions such as anxiety and depressive disorders and psychosis.

These conditions are often captured by the private sector psychiatry and psychology services in association with general practitioners.

The adult public sector mental health services currently treat a range of disorders, but a significant number, if not the majority, are psychotic disorders. Social and psychological approaches are very important as part of complete treatment and are provided or supported through a case management approach in service-based care for psychotic conditions.

Medication treatments are an essential feature of treatment of psychosis.

To discount this and the evidence for effective medication intervention with a belief that substitution of other approaches on their own would not only be concerning but also result in serious consequences from their ineffectiveness.

Sub-acute care

More capital and recurrent funding is required to increase the number of sub-acute beds for long-stay patients and for residential rehabilitation. This will need to be supported by reporting and transparency arrangements to monitor the establishment of new beds and recurrent funding for sufficient episodes of care.

Step-up and step-down residential care should be made available as an alternative to inpatient admission or for a period of transition after hospital discharge.

To ensure continuity of care clinical services should be provided to residents by, or in conjunction with, local clinical service providers through coordinated community-based services including psychiatrists and general practitioners.

In addition to long-term and step-up and step-down care more, respite care for people with mental illness and their families is urgently required. Respite care provides family carers with the ability to take a much needed break to ensure that their own health and wellbeing is maintained. Carers provide a valuable service to society, significantly relieving the burden on the health system yet they often neglect their own health and wellbeing, devoting all their time and effort to the person under their charge. When carers become run-down or ill it falls back onto the health system to manage. Providing sufficient respite services will relieve pressure on the public system.

Acute care

More access to acute care in public hospitals is required. These services must be able to provide care for as long as the patient needs.

Increased capital and recurrent funding is required and this will need to be supported by reporting and transparency arrangements to monitor the establishment of new beds and recurrent funding for sufficient episodes of care.

In addition, increased access is required to speciliased public outpatient services providing diagnosis and ongoing treatment and psychiatric care for people with mental illness and dual diagnoses.

Increasingly, emergency departments in major hospitals are performing a significant role in providing care to patients with mental health issues. The emergency department is often the initial point of contact, entry and treatment for patients with acute mental illness.[4] In 2002 the Victorian Department of Human Services Emergency Demand Coordination Group found that there had been a 13.2% increase in mental health presentations to Victorian emergency departments from 26,902 to 30,985 over the years 2000 and 2002 respectively.[5]

The Victorian Health Services Performance report shows that in the April – June quarter of 2015, on average, only 66% of patients were transferred from the emergency department to a mental health bed within 8 hours, well below the state's target of 80%.[6]

Most emergency departments are not secure environments for such patients who are at risk of self-harm or harm to others.[7]

[4] Management of mental health patients attending Victorian emergency departments, Knott J C, Pleban A, Taylor D, Castle D, 2007 Australian and New Zealand Journal of Psychiatry 41:9, 759.
[5] Gardner D. Analysis of VEMD mental health emergency department presentations in 2000/01. Melbourne: Emergency Demand Coordination Group, Department of Human Services (Victoria), 2002.
[6] Victorian Health Services Performance, Emergency department patients transferred to a mental health bed within 8 hours adult report, April – June 2015
[7] Knott JC, Bennet D, Rawet J, Taylor DM. 'Epidemiology of unarmed threats in the emergency department' (2005) 1. Emergency Medicine Australas351-358

Crisis response services must also be boosted to ensure that the right people are responding to crisis events.

Emergency departments also commonly provide a management setting for patients with mental issues concomitantly affected by drugs.[8] The impact of co-morbid substance use, in particular the Ice (crystal methamphetamine) epidemic, can dramatically worsen the severity and presentation of mental illnesses. This should be addressed with appropriate and relevant resourcing for the acute sector and through the "dual diagnosis" of patients.

A 2012 study by Monash University and Victoria Police no CAT response was available in one out of six requests by police for support.[9] The same study also found that once every two hours, someone who is having a mental health crisis is apprehended by police and transported to hospital meaning than an increasing number of psychiatric patients are forced to attend over-stretched emergency departments to receive treatment. Specialised mental health and dual diagnoses spaces, or departments, must be established as part of public hospital emergency departments.

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

Coordination of care and services

Without a coordinated approach to care the mental health system becomes fragmented and fails to provide patients with continuity of care.

A key barrier to coordinated care is the failure of hospitals to pass on patient information in a timely fashion. Often patients are discharged with little or no information. Proper funding is needed to ensure that the GP and psychiatrist is able to support these patients by developing a care plan and connecting with additional services to reduce the chance of readmission and enable them to manage the condition long-term. This will require investment by the state in health IT.

People with mental health disorders would benefit from coordinated care which shapes the system around the needs of the person to address their specific needs. The medical home is a good model of care to ensure holistic, coordinated care of the patient. This model ensures that a patient's care is coordinated by a central doctor, their general practitioner. It addresses the whole person's needs, preventative and rehabilitative care, supports self-management and engages their family, carer and other support networks.

Care by a medial home means also addressing the needs of children, partners and carers to ensure ongoing, coordinated support.

This model of care needs to be supported by appropriate funding models, eHealth communication between sectors, referral pathways and secondary support. The importance of a shared and real time health record across sectors is crucial for assessment, care, care planning, safety and efficiency and the long-term outcomes for the patient.

Specific funding is required for mental health coordinators working with patients in the community and assisting with transition in and out of acute care.

[8] Knott JC, Bennet D, Rawet J, Taylor DM 'Epidemiology of unarmed threats in the emergency department' (2005) 17 Emergency Medicine Australas 351-358, p. 765.
[9] Shorta, T . et.al "The nature of police involvement in mental health transfers", *Police Practice and Research: An International Journal*, October 2012.

Better support for medical practitioners, particularly general practitioners and private psychiatrists is required to ensure that referral pathways are clear and that they can access the right services at the right time to ensure the best patient outcomes.

The Department of Health is intending to trial a coordinated care program in 2016, named *Health Links*, which will pool funds for people with chronic and complex conditions and wrap services around the patient's need. This program will be aimed at reducing hospital admissions and assisting patients to manage their conditions in the long term. This model could also provide significant gains for people with mental illness.

Primary Health Networks (PHNs) may play a role in improving coordination and reducing service gaps and design and support appropriate referral pathways at the local level.

Specifically they may be able to work to improve:

- links between the public and private sector;
- links between hospital based services and community-based and sub-acute services;
- discharge planning arrangements and community follow-up;
- integration between child, adolescent and adult services to ensure smooth transition for patients over time; and
- links between education, child protection, family court, corrections, social supports, allied health practitioners and community-based health services

Patient choice

The Discussion Paper's proposal to move away from a catchment area model is interesting and useful to review but will require careful planning and proper resourcing to ensure that patients are able to access care.

Patient choice is an important part of ensuring good care. Where possible patients should be able to access medical professionals that they feel comfortable with and in a location of their choice, however with choice of service there is also the danger of significant risks and logistical challenges at crisis periods.

For instance, if a service in one part of Melbourne routinely treats a patient living on the other side of Melbourne this may be quite effective at stable non-crisis periods of care. However at crisis times the need to liaise from a longstanding treatment service based in one part of the city, to crisis teams in another part where the patient regularly lives, with related communication, resourcing, expectations and patterns of care differences, may result in patients slipping between the gaps without staff knowledge. This could lead to potentially damaging outcomes including an increased risk of self-harm or actual suicide due to a lack of effective coordination that a single unitary localised service more naturally provides.

Any alternative approach will require a strong communications framework and protocol to encourage and promote participation with a service to develop a longer term positive therapeutic interaction rather than regularly moving between services and "service shopping" akin to doctor shopping. To ensure effective communications between care settings and professionals will require a substantial investment by the state in health information technology.

Mental health and aged care

Support is also required for better linkage between aged care and mental health services. Especially in light of our ageing population, we must ensure that the elderly with mental illness, who live in residential aged care and in the community, have access to

specialised mental health assessment and care, and dementia care services in the public and private settings.

Currently in Victoria there are almost 81,000 people living with dementia; this figure is forecast to reach almost a quarter of a million people by 2050.[10] The individuals living with this condition deserve improved advocacy on their behalf.

The Government needs to work to empower consumers, provide better quality dementia care, increase awareness and aid for dementia patients, and identify effective strategies for preventing and delaying the progress of the disorder.

[10] Alzheimers Australia.

Mental health of prisoners

Proactive steps should be taken to address the poor mental health of people living in incarceration.

Rates of mental illness in prison are higher than in the general community, with 37% of prisoners reported as having a mental health disorder at some time and 18% reported as currently taking medication for a mental health related condition. A history of self-harm was reported by 18% of prison entrants. A history of mental health problems was more common among female prisoners, at 57% compared to 35% of male prisoners.[11] The prevalence of schizophrenia and bipolar disorder among them is almost 10 times greater than the general community.[12]

In the 2011 Investigation into prisoner access to healthcare, the Ombudsman found that the level of mental health services available in Victorian prisons was 'grossly inadequate'. This must be reversed. Mental health issues have been shown to increase the likelihood of prisoners reoffending and, if not addressed, can adversely impact on the community upon the prisoners' release.

More mental health beds are needed in the prison system to provide necessary care and to reduce waiting times in accessing that care. In some prisons, there is up to a three month waiting period to access treatment in psychiatric wards and the Ombudsman has reported that the male prison system supplies only one bed for every 88 prisoners. [13]

As a matter of urgency, increased funding must also be allocated to improve the level of forensic mental health services in Victoria. The government must ensure that there are sufficient forensic mental health facilities in this state which are adequately resourced and funded in a manner which guarantees the safety of both staff and patients.

Access to proper mental health care while in the justice system can reduce recidivism rates and improve a person's reintegration into the community following release[14]. Support systems must be put in place to ensure that prisoners receiving mental health care are able to access continued support once they are released and are not left to try to navigate to mental health system on their own.

11 Ombudsman Victoria, Investigation into prisoner access to healthcare, August 2011

12 Department of Justice, Justice Mental Health Strategy, 2010.

13 Ombudsman Victoria, Investigation into prisoner access to healthcare, August 2011

14 Bureau of Justice Assistance, US Department of Justice, August 2011

Workforce

An appropriately sized and skilled workforce must be developed in order for mental health care to be delivered to patients when and where it is needed. A critical element of the new strategy should be for the workforce to provide continuity of care to patients with mental health conditions.

The current mental health workforce is already stretched and under increasing pressure from the growing Victorian population.

The definition of terms in the Discussion Paper such as "moderate to severe" mental illness could incorporate a range of disorders and presentations. Some of these conditions have a current skill shortage or no management framework within the public sector at present.

If the workforce is already under challenge from the current and growing Victorian population for the treatment of current presentations and disorders, a focus on a broader range of conditions, at the expense of investing more in key areas, would further dilute the workforce.

In the public system, continuity of care is very limited for patients. Often patients must start afresh with each admission and there is inadequate provision of long term review. Mental health workforce development strategies should address these shortcomings.

Rural areas are significantly under-resourced in terms of mental health workers and services. For the mental health workforce to be able to adequately meet community needs in rural and remote areas, it must be adequately resourced to do so.

International Medical Graduates are increasingly being relied on in rural areas to supply communities with mental health care. These doctors must be given greater support to adjust and live in rural and remote areas; they need access to high quality education and comprehensive training, along with adequate ongoing supervision.

The medical profession has a key role in responding to the initial presentation of illness, making a clinical assessment and following it through with other health professionals and support services.

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

We recognise the benefits of multidisciplinary team care arrangements and would recommend that collaboration could be better achieved with the implementation of additional measures that improve communication and coordination between care settings to allow for the ongoing, uninterrupted care of patients.

General practice is not well linked into mental health services, despite most people with mental health issues first approaching their GP. The implementation of GP liaison officers in each mental health area would ensure better links between general practice and mental health services. GP liaison officers have been successful in hospitals, and this success should be replicated in mental health.

Improving communication and coordination across care settings and introducing GP liaison officers would also assist in creating referral pathways and promote access to existing and new services.

AMA Victoria supports allocation of specific funding for mental health coordinators working with patients in the community and assisting with transition in and out of acute, subacute care, and residential care.

Increased numbers of mental health workers, especially mental health nurses, are required to ensure access to care into the future.

An increased number of funded psychiatrist trainee places with appropriate trainee experience and scope of training must be provided, including through more training in private sector. Education programs should incorporate training as to telemedicine, e-health and related technology.

More continuing professional development and competency training opportunities for the primary health care workforce who choose to access it is very important, including for medical practitioners and practice nurses, at undergraduate and post graduate levels and through online mental health courses and training and peer review groups as part of continuing professional development.

Support services for doctors and other mental health workers are vital to workforce retention. Health care professionals are often forced to accept conditions in their workplaces that would be unacceptable elsewhere. People working in mental health are often exposed to distressing, violent or abusive situations. Unless health care workers are properly supported to deal with sometimes difficult situations or patients the mental health workforce will continue to experience high turn-over and fail to attract new workers.