Submission No 80

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Organisation: Australian Medical Association (NSW) Ltd

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The Australian Medical Association of New South Wales (''AMA (NSW)'') provides their submission to NSW Parliament regarding the Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales.

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Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

The Australian Medical Association of New South Wales (''AMA (NSW)'') welcomes the inclusion of outpatient and community mental health care in NSW on the Premier's key priorities for NSW and is grateful for the opportunity to make a submission to the Legislative Council inquiry, chaired by Dr Amanda Cohn.

AMA (NSW) is a medico-political organisation that represents more than 8,000 doctors-in-training, career medical officers, staff specialists, visiting medical officers, specialists, and general practitioners in private practice. Doctors working in the mental health sector are highly trained and care deeply about their patients and improving the system of care available to them.

AMA (NSW) acknowledges that almost all Australians are affected by mental illness – either through lived experienced or a family member, loved one, colleague, friend or neighbour suffering from a mental illness. It is estimated that 1 in 5 Australians aged between 16-85 have experienced a mental illness in the previous 12 months. In NSW, 1.3 million residents will experience a mental illness and 1.8 million are at risk.

Mental illness does not discriminate, it can affect anyone. However, for certain groups the burden is higher. People from culturally and linguistically diverse backgrounds, people in the criminal justice system, people with intellectual disability, people from the LGBTQIA+ community, and Aboriginal and Torres Strait Islander people, experience higher rates of mental illness. Additionally, women in the perinatal period, older people, and people who have experienced trauma are at an increased risk.

Despite the prevalence, mental health and psychiatric care are substantially underfunded compared to physical health. Mental illness is linked to significantly worse levels of morbidity or premature mortality yet receives less than half the funding of the comparable burden of disease funding.

The terms of reference switch between 'outpatient', 'community' and 'outpatient and community' mental health services. For the purpose of AMA (NSWs) submission, we have defined these terms to highlight their differences;

Outpatient mental health service: Outpatient care consists of scheduled appointments that a person attends while they continue to reside in their usual home.

Community mental health service: Community care can occur at a residence such as a residential unit. This includes rehabilitation, treatment, or extended care in a domestic-type environment. This setting helps people move from being inpatient in a clinical setting to living in the community.

Integration

AMA (NSW) recognises that both levels of government are working to improve mental health, but more must be done. The AMA has called for strategic leadership that integrates the National Disability Insurance Scheme, Primary Health Networks, General Practice, National Strategic Framework for Chronic Conditions, Aboriginal and Torres Strait Islander Health Performance Framework and the mental health workforce. Furthermore, AMA (NSW) calls for greater integration with NSW Local Health Districts, Community Managed Organisations, Speciality Health Networks, and other regional providers to alleviate the fragmentation of services and inefficiencies in the system. A well-coordinated, strategic plan must be linked with funding arrangements that are equitably balanced between providers.

AMA (NSW) is fortunate to have a Council including Psychiatrists, General Practitioners, and Emergency Physicians, giving on the ground feedback and recommendations. A common issue raised by AMA (NSW) Council is the fragmented nature of Community Mental Health Teams (CMHTs). Adult CMHTs generally only accept patients with diagnoses of severe mental illnesses (schizophrenia, bipolar affective disorder, severe depression). Patients with complex trauma/personality disorders, patients with co-morbid drug and alcohol problems. Patients with comorbid intellectual disability or neurodevelopmental disorders generally find it hard to access CMHTs. Often patients with personality disorders present to emergency departments and are admitted to mental health wards but can't access CMHTs because they don't meet diagnosis requirements. Mental illness has a strong link to drug and alcohol problems, but often patients are bounced between services, as each thinks the other should take over primary case management. Patients with intellectual disability or neurodevelopmental disorders suffer the same issue. AMA (NSW) is calling on CMHTs to be re-structured and evaluated in order to expand the scope of patients accepted. This would elevate pressure on emergency departments through a reduction in presentations, and ensures patients receive appropriate timely care. Similarly for children and adolescents, those with a chronic and complex condition alongside a mental health condition are often excluded from intake with local child and adolescent community services or have their case managed in silos across paediatricians and mental health physicians. This fragmentation often contributes to prolonged mental health crises, frequent emergency department presentations and caregiver's burnout, all compromising outcomes and stability of care.

Value based healthcare means continually striving to deliver care that improves health outcomes that matter to patients; experiences of receiving care, experiences of providing care, and effectiveness and efficiency of care. This should be driven by patients, clinicians, and the community to ensure the best possible outcomes for patients and the best value for the system. AMA (NSW) believes that despite the model of care chosen, value-based healthcare principles should be the guiding focus in order to achieve the best possible outcome.

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AMA (NSW) acknowledges that public hospital emergency departments are in many cases the only service option available for people experiencing an acute mental health crisis. However, public hospitals are not adequately resourced to address the needs of mental health patients. Patients waiting beyond clinically recommended timeframes to receive treatment, shortages in mental health staff and constraints on admission capacity within hospitals demonstrate the need to strengthen outpatient and community mental health care in NSW. AMA (NSW) is calling for specialised mental health and dual diagnosis spaces or departments to be established as part of public hospital admission processes for psychiatric patients. Referral to appropriate care, whether inpatient, outpatient or community needs to be expedited and streamlined.

Community managed mental health services

Significant investment is needed at all levels of service delivery. Hospital admissions can be reduced by adequately resourcing community-managed mental health services. Community-managed mental health services have not been appropriately structured or resourced, despite the growing reliance on these services. These services need to be properly supported and resourced, to ensure access to these essential services, supported by Aboriginal and Torres Strait Islander mental health care workers, mental health nurses, psychologists, counsellors, and other support staff.

AMA (NSW) suggests transition care services need to be better supported. Step-up and step-down high acuity residential care and resourced coordinated services under appropriate medical oversight are important alternatives to inpatient admission or for earlier hospital discharges. AMA (NSW) is also calling for adequate funding to enable the delivery of coordinated comprehensive mental health services in the community.

Private psychiatric services provide an effective alternative pathway for psychiatric care and play a significant role in coordinating care to ensure patients are able to continue treatment that keeps them out of hospital, However, we note that access to public psychiatric services is limited and comes with extensive waiting lists for those without the financial means to access private care. AMA (NSW) members have reported that direct referrals to public psychiatrists are near impossible, and patients must go through community mental health channels, which can be an obstacle.

Role of General Practice

General practice is often the first point of health care entry for those seeking help with a mental illness. General practitioners provide a variety of mental health care services to those in need and offer referrals to specialised services. Within 2020-21, 3.4 million Australians aged 16-85 years saw a health professional for their mental health, with 13% of people seeing their general practitioner (ABS, 2021). Bettering the Evaluation and Care of Health (BEACH) surveyed general practice activity and noted that the three most common GP managed mental health problems are; depression, anxiety and sleep disturbance. The most common forms of GP management related to prescription, counselling, and referrals. In 2019-20, 30% of Medicare-subsidised services specific to mental health were provided by GPs.

AMA (NSW) is calling on the Government to review the current Medicare remuneration model to better support general practitioners. Managing mental health conditions within GP consults requires extended consultation time, continuity of care and regular review.

An average consultation length has been stuck between 14 to 15 minutes since 2002, despite the growing complexity of patient's needs. The Medicare Benefits Schedule (MBS) needs to accurately capture the time spent caring for individuals, both in person and via telehealth consultation, supporting patients with access evidence-based, cost-effective mental health care. Furthermore, mental illness places individuals at an increased risk of co-morbidities further supporting the need to improve the MBS remuneration for GPs as they manage their patients holistically. During the pandemic, GP Mental Health Treatment Plans increased from 10 to 20 Medicare rebated consultations per calendar year. In 2022, this was reverted to 10 rebated sessions per calendar year. AMA (NSW) is calling for an urgent review of GP Mental Health Care Plans and calling for the number of sessions eligible within a calendar year to be increased. The prevalence of mental health has a significant burden on our society, and access to health services can pose financial burdens and obstacles to treatment. Increasing rebatable sessions through the GP Mental Health Treatment Plan will aid with addressing financial obstacles to seeking help.

Rural, Remote, Regional

People living in rural, remote, or regional areas face a range of unique stressors compared to their metropolitan counterparts, including greater prevalence of chronic conditions, disability, poorer health outcomes and engagement with risk taking behaviours (smoking, drinking), and the ongoing risk of natural disasters. Additionally, there are financial and unemployment issues within these areas, highlighting the exposure and vulnerability of residents. The prevalence of people experiencing mental illness is similar across the nation.

Mental health service provision by all providers is 2.7 times less available in remote areas and 5.6 times less in very remote areas compared to major cities. In regional areas GP MBS primary mental health services reached roughly 135.5 per 1,000, compared to 154.7 in major cities, with remote areas at just 58.05 per 1,000. Rural residents are more likely than metropolitan residents to present to emergency departments with a mental health concern, and remote individuals are more likely to be admitted to hospital due to psychiatry reasons. The lack of alignment with population needs and access to primary health care outside of major cities has resulted in a shift to acute care services as opposed to primary or secondary health care.

AMA NSW is calling on workforce support and incentives to attract clinicians to regional, rural, and remote areas. Potential incentives could include; low-interest loans or scholarships for medical students who pursue primary care in underserved areas, student debt relief or tax-free bonuses for doctors who move to remote communities.

Disadvantaged communities, First Nations People and Culturally and Linguistically Diverse (CALD) people

Disadvantaged individuals are more frequently exposed to risk factors for psychological distress and mental illness, such as violence, crime, social conflict, homelessness, and unemployment. Financial hardship, including a patient’s inability to pay bills and repay debts has a strong association with depression, suicide, and drug dependence. With individuals within this community at an increased risk of experiencing a mental illness, it further supports the notion that we need to improve the MBS. As noted above, seeing a GP is the most common form of service sought when experiencing a mental illness.

AMA (NSW) is calling for improved incentives for GPs to bulk bill disadvantaged individuals when requiring mental health assistance. Furthermore, the time spent during consults needs appropriate financial renumeration. Additionally, AMA (NSW) is calling for reform of the engagement rules of Community Mental Health teams (CMHTs). Currently one of the requirements of CMHTs is having a residential address. This is particularly difficult when patients are homeless or in insecure housing, meaning they are rejected from the service. We would like to see the regulations around CMHTs altered to enable some of the most vulnerable within our community equitable access to mental health care.

Aboriginal and Torres Strait Islander people experience a higher rate of mental health issues than non-Indigenous Australians. Suicide rates are almost twice as high as non-indigenous Australians, hospitalisation for intentional self-harm is three times as high and the rate of psychological distress 2.4 times as high. As many as two thirds of Aboriginal and Torres Strait Islander peoples live in rural, regional, or remote areas. Factors such as discrimination, racism, and intergenerational trauma have been linked to barriers to health care access. With the alarmingly disproportionate rates of mental health inequality that burden First Nations people, it is imperative that new and existing health care workers undertake adequate cultural safety training and support.

Furthermore, AMA (NSW) is concerned at the disproportionate rate of First Nations medical practitioners, with the proportion of total medical practitioners who are Indigenous at 1.4%. AMA (NSW) is calling on further commitment towards making the future of our health system culturally diverse. We encourage the work of the Australian Indigenous Doctors Association (AIDA), whose purpose is to grow ethical and professional Aboriginal and Torres Strait Islander doctors who will lead and drive equitable and just health outcomes for all. AMA as a Federation has always advocated for equity of access to health care and health outcomes for all communities and will continue to do so.

Over a quarter of a million first-generation adult Australians from CALD backgrounds are estimated to experience some form of mental disorder within a 12-month period. Alarmingly, a significant number of people from diverse backgrounds do not or are reluctant to seek help when experiencing a mental health problem. Language and cultural barriers impact on the level of adequate and efficient health services, which are framed through availability (physical location), accessibility (affordability) and acceptability (ethnically and culturally appropriate). The use of community treatment orders (CTO) is divided amongst clinicians. A CTO is a legal order made by the Mental Health Review Tribunal or by a Magistrate. It outlines the terms under which a person must accept medication, therapy, counselling management, rehabilitation and other services while living in the community. Evidence in Australia, which has mirrored UK studies, demonstrates that members of the CALD community are significantly more likely to be the subject of a CTO. AMA (NSW) Council has raised concerns over the use and outcomes of CTOs, particularly due to the disproportionate use within the CALD community. The use of CTOs seems to be as a result of a lack of capacity in the health and social justice system to support people through other means. Additionally, there is strong evidence which demonstrates their ineffectiveness. AMA (NSW) is calling for a review of CTOs, specifically the extent to which they burden the CALD community.

Workforce

It should be noted that there is currently under-subscription to the specialty of psychiatry. This workforce shortage will become more dire as current medical professionals retire, in conjunction with NSW's population growth rate which within the next 10 years is projected to be 14%. AMA (NSW) is calling for an increase in the number of funded psychiatrist trainee positions, along with an increase in investment for workforce training and support. Of particular concern is the maldistribution of psychiatrists, psychologists, and other mental health service providers in regional, rural, and remote areas. Investment in the mental health workforce to support current and future staff is imperative, and incentives should be provided to support rural and regional workforce commitments. Additionally, the profession of general practice is seeing dropping intake numbers, with AMA projecting Australia will face a shortage of more than 10,000 GPs by 2031. These frontline workers must be supported, as GPs play a pivotal role in the care and treatment of mental health within the community. The work of providers in mental health care, from frontline ED staff to GPs and mental health nurses, must be recognised, championed, and supported.

Prevention

As is the case with physical health, prevention can be superior to treatment when it comes to mental health. Mental health education reduces stigma and allows for greater recognition of early symptoms of problems, leading to early intervention. Continual resourcing for online and telehealth support services is crucial, as these have been proven to be effective in assisting children struggling with issues affecting their mental health. Maintaining comprehensive referral pathways is also critical, to ensure patients get linked to the right services at the right time. Funding is needed for specific prevention and early intervention programs to target conditions such as eating disorders, as well as to support the children of patients with a mental illness. Furthermore, we need to improve pathways to embed physical health into mental health care for children and youth with eating disorders, as approximately 2,000 young people die in Australia each year from the effects of an eating disorder.

Conclusion

AMA (NSW) is calling on the State Government to place a greater priority on funding of outpatient and community mental health care, in both the public and private sector.

The balance between funding acute care in public hospitals, primary care, and community-managed mental health needs to be correctly weighted and should be on the basis of need, demand, and disease burden, not a competition between sectors on specific conditions.

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