THE ROYAL
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF PSYCHIATRISTS

Submission to the Inquiry of the Senate Select Committee on Men's Health

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Executive Summary

It is widely recognised that men have a different approach to their health and accessing supports than women. Men have a higher risk of preventable death and this is especially true with respect to mental health concerns. Instead of blaming men for their behaviour, policy initiatives must focus on improving health services for men, for example rather than trying to "re-educate" men who are reluctant to seek help and use health services, the preferred approach is to provide health services that better meet the needs of men and focus on key life-cycle stages.

Although men's health issues are gaining greater awareness and support across the country thanks to campaigns such as "Movember" (primarily promoting prostate cancer awareness), there is limited coverage of how other important men's health issues such as mental health and wellbeing affect the life expectancy and outcomes of males. Issues as highlighted in the Australian Government Department of Health and Ageing *National Men's Health Policy* document key health concerns such as obesity, alcohol and other substance use and abuse, injuries and violence, cancer, sexual and reproductive health, and coronary heart disease for example, all of which have a direct relationship with mental health.

Approximately 23% of the total Australian adult population are affected by one or more mental disorders in any given year (various authors cited in Australian Government National Mental Health Report 2007 page 15). Similarly the Australian Institute of Health and Welfare reported mental disorders to be the third leading cause of overall disease burden, accounting for 13% of total burden and 27% of total years lost due to disability. Mental disorders rank third after heart disease and cancer as the largest causes of illness-related burden in Australia. However, they represent the largest single cause of disability, accounting for nearly 30% of the burden of non-fatal disease (Mathers, Vos and Stevenson cited in the Australian Government's National Mental Health Report 2007 page 16).

This submission highlights the areas the RANZCP believe should be addressed as part of the Senate's Select Committee Inquiry into Men's Health specifically as these key health areas relate to mental health, and the mental health and wellbeing of men in general.

Summary of recommendations

1. Increase the level of mental health funding to be reflective of the mental health burden of disease in all States and Territories across Australia.

2. Develop integrated prevention and intervention mental health strategies that address mental health needs across the life cycle.

3. Continue to rigorously evaluate implemented mental health initiatives in order to inform best practice and maintain the highest standards of mental health care outcomes.

4. Investigate possible gender specific prevention, identification and appropriate treatments of mental illness especially amongst men who have a reluctance to seek help.

5. Provide adequate funding for and mental health support options for men engaged with the family court and criminal justice systems.

6. Integrate mental health care into education and treatment programs for physical disorders common in males, as there are high rates of co-morbid depression, anxiety and substance use as a consequence of physical illness.

7. Develop and implement awareness campaigns regarding the roles of the various mental health practitioners so that consumers can make an informed choice regarding accessing the most appropriate care for their needs.

8. Develop and implement early intervention programs and supports for male children and adolescents in order to decrease the manifestation of mental health problems in adulthood.

9. Urgently support and invest in ensuring access to specialty mental health and dementia care services for those in aged care facilities.

10. Ensure that all mental health professionals have the opportunity to complete Indigenous specific mental health training on a regular and ongoing basis.

11. Increase the availability of tailored mental health services to Aboriginal and Torres Strait Islander men.

12. Develop policies and programs that anticipate and improve the consequences of social changes such as increased unemployment on men's health and mental health.

13. Develop and implement programs that demonstrate a long term investment in the psychiatric and mental health workforce as a whole.

14. Invest in consultancy practice models whereby psychiatrists are funded to provide leadership and management support to other mental health professionals in delivering quality mental health care outcomes.

15. Increase access for clinicians to share their clinical expertise in key community sectors such as the Alcohol & other drug sector especially in non-acute settings (in order to reduce hospitalisation rates).

16. Invest in more specialised dual diagnosis (alcohol/drugs and mental health) beds/services across Australia.

17. Provide greater incentives for mental health practitioners to live and practice in rural areas including access to peer support and continuing professional development

opportunities.

About the RANZCP

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for the training, examining and awarding the qualification of Fellowship to medical practitioners. There are approximately 2900 Fellows of the RANZCP who account for approximately eighty-five per cent of all practicing psychiatrists in Australia and over fifty per cent of psychiatrists in New Zealand. There are branches of the RANZCP in each state of Australia, the ACT and New Zealand.

Through its various structures, the RANZCP accredits training programs and administers the examination process for qualification as a consultant psychiatrist; supports continuing medical education activities at a regional level; holds an annual scientific congress and various sectional conferences throughout the year; publishes a range of journals, statements and other policy documents; and liaises with government, allied professionals and community groups in the interests of psychiatrists, patients and the general community.

About psychiatry and Men's health

The profession of psychiatry has had a long standing interest in men's health and mental health particularly as more men are likely to present with prolonged and untreated mental health concerns. Literature shows that men are less likely to access psychiatric support primarily related to the stigma associated with mental health and accessing psychiatrists; however men represent the greatest cohort of those accessing community mental health services and residential mental health care (NHMRC, 1995).

Projections suggest that the mental health related disease burden will grow markedly as a proportion of overall disease burden (Begg et. al, 2007). This projected increase in mental health disorders, will subsequently increase the risk of males experiencing severe mental health disorders especially, as previously stated, they are less likely to access supports early and often self medicate. This issue places significant pressure on crisis services which are not adequately resourced to deal with disorders at the more severe end of the spectrum.

Although literature demonstrates that there is no significant gender difference in the prevalence of mental health disorders, the pattern of presentation and onset does vary between males and females and there is a marked difference in accessing mental health services depending upon age and social factors (NHMRC, 1995). The most common social factors that affect male mental health are age, employment/unemployment and type of family circumstances.

It's unclear why men have a shorter life span than women, however it is commonly accepted that there are a number of socially approved "male" behaviours that may predispose men to premature death. Statistics show men are more likely to smoke, drink, use illicit drugs, be exposed to violence and engage in risky sexual behaviours than women, all of which can increase their risk of serious diseases. Males, especially young males, are also more likely to behave aggressively, which may partly explain why they have a higher risk of dying from accidents, suicide and homicide. Men of all age groups in Australia are far more likely than women to die

from suicide with men committing suicide four times as often as women do. Depression which is an important risk factor for suicide is under diagnosed in men, partly because men are less likely to seek treatment or identify that they have depressive symptoms and often have different symptomology.

Statistics regarding suicide rates in Australia dispel the widely held belief that suicide is primarily a problem among young men. Findings show that the rise in male suicide has been almost entirely due to an increase in the rates of males aged over the age of 20. Men in the 20-45 year age group now have the highest suicide rate. Moreover, the number of suicides among older age groups can be expected to rise, given that they constitute the fastest growing segment of the population. In fact suicide rates reach a second peak in older men aged over 85 years and may be due to the fact that for the first time in their lives older men are finding themselves physically and economically dependent, or affected by mental and physical health problems. Other treatable factors identified as contributing to suicide in old age include pain, grief, loneliness, alcoholism and carer stress.

The past 10 years has also seen a higher rate of suicide amongst males in rural and remote areas, with the most significant increases in communities with populations of less than 4,000. The effects of social disadvantage on young men influences suicide rates with those with lower levels of education being grossly over represented in suicide rates. Moreover, funding for suicide prevention services has traditionally targeted schools and mental health services. Given that the majority of young men committing suicide were neither in school, nor in a position to or willing to seek medical help, means that prevention efforts were not targeted properly.

Suicide amongst Aboriginal men is also higher for this group. A 1999 study found that suicide has only emerged as an issue among Aboriginal communities in the last decade or two. Aboriginal suicide is seen as having unique social and political contexts, and as a community problem and interventions or prevention campaigns should target supports in a culturally safe manner.

These factors and those illustrated in the National Men's Health Policy document illustrate the broader pressures that currently exist where services with limited capacity and specific service obligations focus on the management of the 'service' they are accountable for rather than the outcomes for the individuals who present, especially where they have more complex needs and a general unwillingness to access support. Providing well integrated services to a population with widely differing and complex needs is inherently difficult and resource intensive. However, the alternative is likely to be a set of interventions that focus on symptomatic rather than causal factors, perpetuates service gaps, cost shifting pressures and ineffective commitment of resources. The call for greater collaboration between all levels of Government, between services at each level of government and with the community sector is welcomed.

Response to the Inquiry

Part 1: Level of Commonwealth, state and other funding addressing men's health, particularly prostate cancer, testicular cancer, and depression.

The additional funding that has been invested by Governments over the last few years has provided a significant boost to the mental health system however we believe that the overall investment in the mental health service system remains inadequate and does not reflect the burden of disease in the community. A significant

increase in funding to the mental health sector is required so that available resources are proportionate to the increasing number of people with mental illness.

The 2006 COAG Better Access initiative significantly increased access to the mental health workforce by the funding of Medicare items that allow patients to be referred to psychologists, social workers and occupational therapists. However as the evaluation is ongoing regarding the quality of care provided through this initiative, it is difficult to comment on whether the funding investment has helped address the burden of disease in the long term, though it has most likely helped in the short term.

It is also important to recognise that depression although important is not the only mental health concern experienced by men and funding needs to also be invested early in alcohol and other drug services, specialist children's services, veterans affairs, and integrated community mental health support services for men that address mental health in the context of homelessness, family situation especially following divorce or separation and, within the context of the criminal justice and employment systems.

Further investment must be made in the prevention, identification and appropriate treatment of mental illness especially amongst men who have a reluctance to seek help. This is also of equal importance within the criminal justice system and the family court system with evidence showing that males who are engaged within these systems are more likely to develop a mental illness, contract HIV and experience trauma.

Recommendations

1. Increase the level of mental health funding to be reflective of the mental health burden of disease in all States and Territories across Australia.

2. Develop integrated prevention and intervention mental health strategies that address mental health needs across the life cycle.

3. Continue to rigorously evaluate implemented initiatives in order to inform best practice and maintain the highest standards of care outcomes.

4. Investigate possible gender specific prevention, identification and appropriate treatments of mental illness especially amongst men who have a reluctance to seek help including more after supports.

5. Provide more adequate funding and mental health support options for men engaged with the family court and criminal justice systems, especially after release from prison.

Part 2: Adequacy of existing education and awareness campaigns regarding men's health for both men and the wider community.

Men's health education and awareness campaigns are primarily focussed on prevention e.g. drink driving, heart health or prostate cancer awareness. Some good campaigns focus on suicide prevention especially for young males however these are rarely supported by meaningful ongoing community supports other than crisis telephone lines. Even though awareness campaigns should continue to focus on prevention, greater community awareness regarding treatment and support options,

including the role of different mental health practitioners would also be beneficial for consumers, carers and their families.

Many people in the community may not realise that mental illness is actually a collection of markedly different disorders. The term covers a wide range of symptoms, conditions and effects on people's lives. In general mental health education and awareness campaigns are not adequate. Stigma and shame associated with asking for help and the fear of associated labels and discrimination mean that many don't access services or supports. There are many misconceptions regarding mental illness, treatments and the role of mental health practitioners. With the introduction of the Medicare items allowing access to psychologists, there has never been greater confusion within the wider community regarding the different practitioner roles and treatment options available to consumers. Psychiatry and psychiatrists in particular have low community awareness and are often associated with archaic perceptions of asylums and forced medication, with little awareness of the varying fields of practice and approaches employed by the profession to obtain the best outcomes for patients.

Research has demonstrated that the media has an important role to play in informing and influencing community attitudes to mental health, mental illness and people affected by mental illness. Further, media accounts of mental illness that instil fear have a greater influence on public opinion than direct contact with people who have mental illness. Mental illness is usually depicted through characters that are physically violent toward self or others or people who are simple, lacking in comprehension and appearing lost, unpredictable, unproductive, untrustworthy, and social outcasts. This is evident in research that indicates that public perceptions equate mental illness to violence (Rosen et. al, 1997; Allan & Narrin, 1997). However this is not an accurate picture of mental illness in the community and promotion campaigns need to focus on the recovery and resilience aspects of mental illness and the more positive outcomes that are achieved every day by people with a mental illness.

Depression awareness and mental health literacy associated with depression has significantly increased thanks to the successful brand of Beyondblue: the national depression initiative; meaning that the community is more aware of the existence of depression, its general symptomology and its treatment. However these mental health literacy improvements do not necessarily equate with better treatment outcomes or the reduction of stigma, fear and discrimination. It is also widely accepted that the understanding of gender specific symptomology of depression is not widely known or understood and could also be promoted in terms of improving men's health.

Age related mental health concerns are also not addressed in awareness campaigns. It is widely accepted that social and emotional issues in childhood, if unresolved will manifest in adulthood and will become more difficult to manage. Teachers and schools are becoming more aware of the social and emotional needs of their students however further training, awareness and prevention campaigns can be implemented to ensure that boys learn more positive coping strategies and that aggressive, externalising coping mechanisms are not reinforced in the home or the community.

As the population ages, the diagnosis of dementia and age related illnesses such as Alzheimer's among men will also increase. Significant investment in the support and education of the community will assist current and future carers and families affected by these disorders. Urgent support and investment is required for those in aged care facilities that are socially excluded and have limited opportunity to access specialty

mental health and dementia care services.

The focus on the health of Aboriginal and Torres Strait Islander men is highlighted in the policy and it is imperative that any policy developed ensures that this area is given priority in order to bridge the gap in health inequalities that Aboriginal and Torres Strait Islander men face. All mental health professionals should undertake regular cultural awareness training in order to develop a better understanding of the social and emotional needs of Aboriginal and Torres Strait Islander men. Further, if services are to be more effective in future, increasing the availability of tailored services to Indigenous Australians and other groups whose needs are not well met by mainstream services is also warranted.

Adequate discharge planning and follow-up of patients should become mandatory for all patients discharged into the community from hospital settings. Acute inpatient units increasingly discharge people with severe illness into crisis accommodation or "no fixed address". In communities that do not have the service structures and operating systems to support people with mental illness to live safely or rehabilitate in the broader community, people with mental illness will not receive adequate follow-up treatment and often end up being readmitted following a worsening of their condition.

The lack of services, particularly in rural communities can mean that people move to locations supports exist but are at considerable distance from the communities where they are known and family or other informal care might best be provided. This can add to social dislocation and exclusion experienced by people with a mental illness and increases the likelihood of people losing access to income support, coming into contact with the police and justice system and a decline in their health as they lose contact with known health care providers.

Recommendations

1. Integrate mental health care into education and treatment programs for physical disorders common in males, as there are high rates of co-morbid depression, anxiety and substance use as a consequence of physical illness.
2. Develop and implement awareness campaigns regarding the roles of the various mental health practitioners so that consumers can make an informed choice regarding accessing the most appropriate care for their needs.

3. Develop and implement early intervention programs and supports for young male children and adolescents in order to decrease the manifestation of mental health problems in adulthood.

4. Urgently support and invest in ensuring access to specialty mental health and dementia care services for those in aged care facilities.

5. Ensure that all mental health professionals have the opportunity to complete Indigenous specific mental health training on a regular and ongoing basis.

6. Increase the availability of tailored mental health services to Aboriginal and Torres Strait Islander men.

Part 3: Prevailing attitudes of men towards their own health and sense of wellbeing and how these are affecting men's health in general.

The prevailing attitudes of men towards their own health is well documented however this could be further enhanced through research into best practice models that have been successful in changing negative attitudes within the community in order to enhance the evidence base of future implementation plans and strategies.

Research conducted for the mental health charity SANE Australia (2005), reveals that one in three people are unsure how a friend or colleague would treat them after hearing they had a mental illness. As employment status is a key social determinant in men's mental health and wellbeing, the early identification of and support for mental health concerns amongst the male population in the context of employment is difficult as it is often equated to job loss, being discriminated against at work and falling out with people they had close business and personal relationships with. This is an important area to focus on especially given the global financial crisis and the projected rise in unemployment in Australia.

This is reinforced by a 2006 *Pfizer Australia Health Report* which reported that approximately 80 per cent of people surveyed believed the general community was not supportive or understanding of those with a mental illness which is further compounded by the problem that most people do not recognise the early signs of mental illness in themselves or others. As stated previously this could be addressed by targeted promotion and awareness campaigns that are supported through improved, integrated service access.

Part 4: The extent, funding and adequacy for treatment services and general support programs for men's health in metropolitan, rural, regional and remote areas.

Currently, there are no standardised service models within the mental health service system within Australia, with levels of care varying significantly across the country. The different governance structures further complicates service delivery issues and would be improved with the development of a single integrated health system, the removal of structural barriers at the State and Australian Government levels, and with substantial reform in both. There is also a need to better coordinate and connect other relevant community supported services needed by patients with severe mental illness and complex needs with their clinical care (e.g. general health care, financial support, housing, substance abuse, rehabilitation etc).

However serious workforce shortages remain across all mental health professional groups and a long term, adequately funded process to address this workforce shortage needs to be implemented. There are a number of short-term initiatives to improve the psychiatric workforce however these need more long term investments if they are to be successful. The College supports consultancy models for psychiatrists to better capitalise on their specialist expertise, as psychiatrists are well placed to provide high-level consultancy, leadership and management support to other mental health professionals in delivering quality mental health care. However, this must not be brought about by reducing the treatment role of psychiatrists for those individuals needing expert care.

The Alcohol and Other Drugs sector is a key area of concern as it is primarily provided by non-government organisations, minimising access to clinical expertise and leadership. Any actions arising from the policy must address workforce needs relating to best clinical practice within the sector and the lack of mental health expertise and clinical leadership currently available. The psychiatry profession should play a major role in reforming this sector with respect to dual diagnosis and co-morbidity, and in ensuring high-quality care for consumers, especially men.

The substantial disadvantage of the health status of Aboriginal and Torres Strait Islander men compared to the health status of the rest of the Australian community also needs to be tackled. The College supports the principle that all governments and services be held accountable for redressing this inequality and promoting better access to services and culturally secure systems of care as a matter of priority.

Currently, only 7% of psychiatrists in Australia are based in rural areas. While another 11% carry out some work in rural areas through visiting services and there are a number of overseas-trained doctors working in rural Australia, this represents a significant workforce shortage. The rural workforce is also ageing faster than its urban counterpart and stands to lose 20% of its number to retirement within the next 5 years, a number unlikely to be balanced by the currently low recruitment rate. This shortage impacts not only upon men's mental health but upon the mental health of entire rural communities.

Recommendations

1. Develop policies and programs that anticipate and improve the consequences of social changes such as increased unemployment or natural disasters on Men's health and mental health.

2. Develop and implement programs that demonstrate a long term investment in the psychiatric and mental health workforce as a whole.

3. Invest in consultancy practice models whereby psychiatrists are funded to provide leadership and management support to other mental health professionals in delivering quality mental health care.

4. Increase access for clinicians to share their clinical expertise in key community sectors such as the Alcohol & other drug sector especially in non-acute settings (in order to reduce hospitalisation rates).

5. Invest in more specialised dual diagnosis (alcohol/drugs and mental health) beds/services across Australia.

6. Provide greater incentives for mental health practitioner to live and practice in rural areas including access to peer support and continuing professional development opportunities.

Conclusion

An effective National Men's Health Policy that adequately addresses the mental health needs of men will allow for flexibility across catchment areas, be able to respond quickly to crisis and changing needs, and address men in an individualised, informal and non-stigmatising manner.

The Royal Australian and New Zealand College of Psychiatrists thank the Senate Select Committee on Men's Health for the opportunity to make a submission to this important enquiry and looks forward to working with the Australian Government in the development and implementation of the adopted policy into practice.

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