



# **THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS**

## **Submission to the Senate Select Committee on Mental Health**

### **PURPOSE**

This submission is made by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to address the Terms of Reference of the Australian Government's Senate Select Committee on Mental Health.

### **INTRODUCTION**

The RANZCP is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for setting the training program, examining and providing access to Fellowship of the College to medical practitioners.

There are currently approximately 2600 Fellows of the RANZCP who account for approximately 85% of all practicing psychiatrists in Australia and over 50% of psychiatrists in New Zealand.

There are branches of the RANZCP in each State of Australia, and the ACT and New Zealand.

### **PREAMBLE**

The provision of services for people with mental illness has been through three major periods of development. These are:

- Institutional care – where people were held in congregate care in large isolated communities outside of mainstream society;
- The introduction of psychopharmacology – which enabled the beginning of mainstream services for people with mental illness through hospital based

inpatient and outpatient treatment with no community mental health service delivery

- Community-based treatment – which saw the mainstreaming of mental health services and the increasing movement of services from hospital settings into the community without the necessary resources. This occurred in a context of progressive de-institutionalisation and hospital closures.

Psychiatrists are medical practitioners with a recognised specialist qualification in psychiatry. By virtue of their specialist training they bring a comprehensive and integrated biopsychosocial and cultural approach to the diagnosis, assessment, treatment and prevention of psychiatric disorder and mental health problems. Psychiatrists are uniquely placed to integrate aspects of biological health and illness, psychological issues and the individual's social context. They provide clinical leadership with many working in multidisciplinary team settings. Psychiatrists treat patients and work with the patient's general practitioner, other health care providers, families and carers of patients, and the general community.

Effective psychiatric treatment occurs within a biopsychosocial and cultural context requiring coordinated interventions across a range of support systems. Biopsychosocial approach encompasses treatment with medication (the biological component), psychological therapies, and social interventions such as work programs. This multifaceted approach to treating mental illness is analogous to the approach used to treat other common conditions such as heart disease, which is treated with both medication and lifestyle changes.

Most mental illness is treatable, as demonstrated by the increasing body of research on evidence-based medicine. The main barrier to the provision of effective treatment to those requiring specialist interventions is their inability to access service responses appropriate to their needs or in a timely manner.

As a consequence psychiatrists have a vested interest in the whole mental health system and its impact upon people with mental illness. The RANZCP believes that it would be beyond the scope of such a time limited Inquiry to consider all the issues that are relevant within such a complex system. We have therefore attempted to focus our submission on what we believe to be the key areas that would benefit from Senate support and future recommendations and specific responses to the Committee's Terms of Reference. We look forward to a future opportunity to meet with Senators to further clarify the contents contained herein.

## **EXECUTIVE SUMMARY**

In this submission we will highlight many areas where the system can be improved and provide potential strategies for consideration. Understandably the Senate Committee will be provided with a multitude of submissions on a wide of range of issues. We would therefore like to highlight three main areas of our submission for immediate consideration. These are:

### **Funding**

RANZCP believes that the mental health system in Australia has all the right fundamentals but requires additional recurrent funding. Ideally one billion dollars per year is required to reform existing mental health service systems, ensure a sustainable workforce, address equity issues and ensure the provision of an agreed level of service delivery in all geographic areas

### **Integration**

Development of a single integrated health system requires the removal of structural barriers at the state and Commonwealth levels, and substantial reform in both. RANZCP believes that to begin to achieve this goal a number of strategies need to be considered. These are:

- the re-integration of drug and alcohol and dementia services with mental health services;
- inclusion of developmental disability services as an essential component of the service matrix;
- funding of nursing and allied health professionals in private psychiatric outpatient practices such as More Allied Health Services (MAHS);
- development of "stepped care" systems linking GPs and state mental health services in the care of common and severe disorders, including prioritisation of GP referrals over self-referrals in state services; and
- encouragement of integrated staffing models, with more flexible arrangements for public and private psychiatrists to work together will also strengthen system effectiveness.

Co-ordination of care must extend beyond mental health care to all other relevant services needed by patients (general health care, financial support, housing, substance abuse, rehabilitation etc.).

### **Workforce**

The RANZCP recognises that workforce shortages and difficulties in recruitment are significant and constitute a major challenge to service provision. There is clearly a discrepancy between the available psychiatric workforce and the mental

health needs of the population, particularly outside the major cities, and issues of distribution and work practices of specialists exacerbate this.

The RANZCP is of the opinion that it is imperative that quality, safety and legal obligations must be addressed as the basis for determining minimum numbers of specialists within services. The RANZCP, in recognising the current workforce limitations, is committed to developing effective partnerships with the range of mental health professions and examining models of collaborative service provision.

To effectively manage workforce issues it is imperative to scope and benchmark the mental health service system and come to agreement on what constitutes an adequate level of care. At present no such benchmarks exist and makes workforce planning an exercise in guesswork. We strongly recommend that a project is funded to establish a benchmark for the delivery of mental health services in Australia. This would incorporate specific detail on the number inpatient beds and community mental health services required per 100,000 population with weightings for rural, remote and outer urban populations.

Within this context, RANZCP would also support a re-evaluation of the roles and domain of the psychiatrist and improved collaboration across the mental health and medical disciplines, and with consumers and carers. Responding to the mental health needs of the community involves not only adequate levels of services and staff but also requires a responsive and integrated mental health workforce that delivers quality and sensitive care to consumers, carers and families. Quality improvement and critical reflection on practice are core values of the profession.

### **RANZCP responses to Terms of Reference**

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| a) the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress; | The RANZCP supports the retention of a National Mental Health Plan. However we do not believe that sufficient progress has been made in relation to its primary goals due to inadequate resources and the existing federal and state government structures that do not permit effective integration of funding and service systems.<br><br>We would encourage the Senate to pressure Government to include the mental health portfolio within Cabinet to address some of these issues at a federal level. |
| b) the adequacy of various modes of care for people with a mental illness, in   | Additional recurrent funding, ideally one billion dollars per year, is required to reform existing mental health service systems, ensure a sustainable workforce, address equity issues and ensure the  |

particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

provision of an agreed level of service delivery in all geographic areas.

To enable this to happen in a way that ensures optimal care we recommend that benchmarks for the delivery of mental health services be established consistent with the functions of a layered system (refer to p14). This would incorporate specific detail on the number of inpatient beds and community mental health services required per 100,000 population with weightings for rural, remote and outer urban populations.

c) opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

Co-ordination of care must extend beyond mental health care to all other relevant services needed by patients (general health care, financial support, housing, substance abuse, rehabilitation etc.)

Development of a single integrated health system requires the removal of structural barriers at state and Commonwealth levels, and substantial reform in both sectors.

RANZCP believes that to begin to achieve this goal a number of strategies need to be considered. These are:

- the re-integration of drug and alcohol and dementia services with mental health services;
- inclusion of developmental disability services as an essential component of the service matrix;
- funding of nursing and allied health professionals in private psychiatric outpatient practices such as More Allied Health Services (MAHS);
- development of “stepped care” systems linking GPs and state mental health services in the care of common and severe disorders, including prioritisation of GP referrals over self-referrals in state services; and
- encouragement of integrated staffing models, with more flexible arrangements for public and private psychiatrists to work together will also strengthen system effectiveness.

d) the appropriate role of the private and non-government sectors;

The RANZCP believes that collaborative approaches that integrate service delivery into a seamless system of diagnosis, treatment and community support are urgently required to allow patients to readily move between systems.

e) the extent to which unmet need in

This is a significant deficit in the current system. There is little hope for a speedy and long-term recovery from a period of mental

supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

illness if the person does not have a range of community supports in place. Mental health and illness occur in a social context, where there is a strong interaction between the illness, the disability and the social setting of the individual.

The current system is overly complex with an overt focus on managing demand rather than meeting individual need.

RANZCP recommends the establishment of specialist mental health advocates in each Centrelink office to assist people access appropriate services and supports across mental health services, social security, employment and housing.

We also would encourage the increased resourcing of the Commonwealth Rehabilitation Services to assist people who are managing their mental illness to re-enter the workforce. We believe that this will require workplace environment support.

f) the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

Specific needs group: Indigenous

The RANZCP believes there is a great need to redress inequity and improve Aboriginal and Torres Strait Islander mental health and wellbeing. The RANZCP supports the development and validation of the crucial role of Aboriginal and Torres Strait Islander Mental Health Workers in Australian Indigenous mental health service delivery.

Additionally we would advocate for the establishment of a proactive training program for Mental Health Nurses on indigenous issues and ideally recruit indigenous people into these roles including innovative models such as specifically trained mental health nurse practitioners.

Specific needs populations: Older adults

Psychiatric services for elderly people must be concerned with all mental disorders, both functional and organic, occurring in people in the older age group.

The RANZCP endorses the establishment of dedicated units for frail elderly that would integrate physical and psychiatric care.

Specific needs populations: Children

The RANZCP supports the provision of adequate numbers of child and adolescent inpatient and community based services and the recognition of the special needs of this group within mainstream

service settings. Cross-sectoral collaboration and integration must occur between the mental health and education systems to promote better mental health outcomes for children.

Early intervention is particularly important to reduce the early onset and impact of mental illness on children and young people.

Women with babies who require inpatient psychiatric treatment should be admitted to dedicated mother-and-baby psychiatric units. These should be established in each state.

Specific needs populations: The homeless

The needs of homeless people with mental illness must be addressed by targeted mental health services integrated with housing services, primary care, physical health services, rehabilitation services, employment services, financial support services, substance abuse services and the justice system. The model should allow for flexibility across catchment areas, be able to respond quickly to crisis and changing needs, and address the person in an individualised, informal and non-stigmatising manner.

Drug and Alcohol Dependence

During the past few decades there has been remarkable progress in improving the outcomes for a wide range of physical and mental health conditions including heart disease, injury and depression. Application of the same commitment to independent scientific research and transfer of research findings to policy and practice is likely to produce similar improvements in outcomes for illicit drugs.

The RANZCP endorses the government's development of a national alcohol strategy and action plan for 2005–2009.

g) the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

The RANZCP believes that primary carers require improved and structured support to assist in the treatment, recovery and support of people with mental illness.

Our organisation is well placed to work in collaboration with peak carer groups to inform the development of a training curriculum that would underpin a range of support options. These supports need to also incorporate strategies which ensure the mental health of the carer is maintained during often prolonged periods of illness.

h) the role of primary health care in promotion, prevention, early detection and chronic care management;

The function of primary health care is imperative in identifying the early onset of mental illness and effective management of these disorders when they arise so as to reduce the impact of mental illness. Primary care is at the forefront of medical and non-medical interventions that support those with mental illness, their families and carers.

The RANZCP supports the development of varying models of consultation and supervision with GPs including allocated time for consultation cases. Facilitating psychiatrists' provision of consultation and supervision should be embedded within structural relationships between GP organisations and private psychiatrists.

While psychiatrists can address a range of physical health issues, the overall physical health of people with mental illness must be addressed through improved linkages between general practitioners, state community mental health services, the public health system and private psychiatric services.

i) opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

The RANZCP does not believe there is significant iatrogenesis. Trauma can be associated with mental illness when access to services is limited to treatment of the acute phase of mental illness. Some treatments also have side effects that need to be minimised. Services need to be properly resourced to ensure treatments are compassionate and respectful. We consider that a significant issue in this regard is posed by the negative effects of stigma arising from treatment within hospital and community settings.

The RANZCP supports the Recovery Competencies developed in New Zealand by the Mental Health Commission. This approach utilises not only the resources of mental health services but builds on the individual resources of those people with mental illness, their carers and communities to take an active role in managing their recovery.

j) the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise

Currently conditions for the management of mentally ill persons in prisons are unacceptable. Some detainees may have committed a crime for no reason other than mental illness. Often they have been remanded to prison because there is a shortage of mental health beds. These patients are doubly stigmatised: they are mentally ill and they have a forensic history. Most are



to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

marginalized again because the poor, the uneducated, the indigenous, from Non-English Speaking Background and those with developmental disability are highly over represented in the prison population.

Two main strategies need to be implemented to reduce this trend; the provision of properly resourced court diversion programs, and the establishment of stand alone forensic hospitals that are staffed by appropriately trained mental health practitioners and with correctional security.

k) the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;

The RANZCP supports the development of a national Mental Health Act that includes consistent standards for the use of detention and seclusion. When applied in clinically appropriate ways it is an essential component of managing acute disturbances (arising from mental health problems) to prevent harm to themselves and to others. The removal of detention and seclusion options may result in the increased use of pharmacological interventions that may have more harmful consequences.

l) the adequacy of education in destigmatising mental illness and disorders in providing support service information to people affected by mental illness and their families and careers;

Stigmatisation of people with mental illness is a critical issue. It can affect a person's social, financial, physical and mental health and emotional well-being. It can be a contributing factor that can increase the time it takes to recover and increase the likelihood of a relapse of mental illness. Stigmatisation can lead to discrimination across a range of life domains that will impact negatively on life outcomes.

RANZCP recommends the continuation of the Australian Government's Mind Matters strategy with additional resources allocated to the implementation of a national media strategy focusing on improving the reporting of mental illness and addressing the myths associated with these disorders. This strategy should not be seen as a panacea for the need to appropriately fund treatment.

m) the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health

There is currently little accountability within and across these domains in monitoring the delivery of support to people with mental illness. The RANZCP believes that in order for people with mental illness to get a better deal there needs to be improved

services, in dealing appropriately with people affected by mental illness;

transparency in funding of mental health services and an integrated pathway to inform and access support services that are a prerequisite for their recovery across federal, state and private services.

Our previous proposal to establish a mental health advocate on Centrelink offices under (e) would apply equally well to this issue.

n) the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

Mental health research in Australia is under-funded. Mental illness comprises 23–27% of Australia’s health problems yet only receives 4–10% of health research funding. This has resulted in low levels of grants and fellowships going to mental health relative to the high level of disability existing in the community due to mental health problems. As well as clinical research into new treatments and their effectiveness evaluative research of mental health service delivery and consumer outcomes in the community are required.

The RANZCP would like to see mental health research become a priority for NHMRC specific stream funding.

o) the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and

The RANZCP supports the routine collection of outcome data. However, the results need to be given to services and clinicians in a timely and useful form. This data could be augmented with a comprehensive system of evaluation that focuses on service delivery and effective treatment provision.

It is essential that routine data collection can be done efficiently and that it does not become so excessive that it interferes with essential clinical work.

p) the potential for new modes of delivery of mental health care, including e-technology.

The RANZCP is supportive of new modes of service delivery that will meet the needs of the increasing number of people with mental health problems. We believe it is important that these new systems are designed to focus on consumer need as well as cost effectiveness.

It will vital for the Australian Government to be proactive in reviewing Medicare item numbers to allow specialist advice to be provided by clinicians to patients via these new modes of delivery.

## **DISCUSSION**

The funding problems associated with the Australian mental health system are well documented. While specific figures may vary there is widespread agreement that a significant deficit exists in funding mental health services that needs to be addressed.

### **The nature of mental illness in Australia**

Mental illness is unlike most other illness, in that for a proportion of patients it is chronic, disabling, and affects all aspects of life. According to the Australian Institute of Health and Welfare (AIHW), mental illness is the leading cause of disability burden in Australia<sup>1</sup>. Although mental illness is common, it is widely misunderstood, and people with mental illness often face stigma and discrimination.

People with mental illness also have higher rates of physical illness than the general population, and higher death rates (for all main causes of death). Several reasons for this are likely. People with mental illness have higher rates of drug and alcohol use. A study in Western Australia found that 43% of people with a diagnosable mental illnesses smoke, compared with 24% of the overall population. Mental illness is also associated with obesity, poor diet and lack of exercise. Mental illness is often considered as distinct from physical illness, and even if a person is receiving treatment for their psychiatric illness, their general health may not be addressed. This may explain why with a comparable incidence of cancer between the two populations, people with mental illness are 30% more likely to die from cancer than the general population<sup>2</sup>.

### **Mental health services funding**

Mental disorders account for 27% of all disability costs in Australia but attract only 7% of health funding. Poor mental health was costing Australia more than \$13 billion a year in direct and indirect costs. Good mental health is of critical importance to Australia's overall health and productivity and should be supported accordingly.

Total expenditure on mental health care for 2001–02 was \$3.1 billion, or 6.4% of total recurrent health care expenditure. Total government recurrent spending on mental health services has increased by 65% between 1992–93 and 2001–02. In

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<sup>1</sup> Australian Institute of Health and Welfare (AIHW) (2005) Mental health services in Australia 2002–03. Canberra: AIHW (Mental Health Series no. 6).

<sup>2</sup> Coghlan R., Lawrence D., Holman D., Jablensky A. (2001) Duty to care. Physical illness in people with mental illness. Consumer summary. University of Western Australia

the same period, government expenditure on all health services increased by 61%. Therefore the proportion of health budget allocated to mental health has remained the same since 1992–93. Two thirds of growth in Commonwealth expenditure is due to an increase in pharmaceutical costs, rather than in non-pharmacological or service systems<sup>3</sup>.

In 2001–02 the Australian government contributed \$1146 million, or 37.1% of total healthcare funding; the states and territories contributed \$1798 million or 58.2%, and private health funds contributed \$145 million or 4.7%. In 2001–02, per capita spending on mental health services by states and territories ranged from between \$84 to \$110. Funding to non-governmental organisations to provide mental health services accounted for 5% of mental health expenditure in 2001–02, compared with 2% in 1993 although there are wide variations in funding and service provision between states and territories<sup>4</sup>.

Additional funding is required to improve current service provision to ensure that service delivery is of an appropriate standard, that the workforce is sustainable and that equity issues are addressed so that an agreed level of service delivery is provided in any one geographic area. Ideally, an increase in recurrent funding of a billion dollars is required for mental health. Funding should be provided by both Federal and State governments and include a component to reform existing mental health service systems.

### **Federal and state governments**

Both Federal and State jurisdictions have been involved in reform processes to improve the service delivery to people with mental illness. Inherent in a relationship spanning political and financial boundaries will be the risk of non-agreement. Both these tiers of government have some aligned and non-aligned objectives.

Effective communication between these government bodies is required to enable effective planning, financing and delivery of services that will improve the lives of people with mental illness. To those outside these bureaucracies it is difficult to understand how their lack of integration has been left unaddressed for so long.

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<sup>3</sup> Mental Health Council of Australia (2003) Out of hospital, out of mind. A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003–2008

<sup>4</sup> Department of Health and Ageing (2003) National Mental Health Report 2004: Eighth Report. Summary of changes in Australia's Mental Health Services under the National Mental Health Strategy 1993-2002. Commonwealth of Australia, Canberra.

### ***Roles of the federal and state governments***

The primary responsibility for many necessary changes to improve integration of competing service streams lies with federal and state governments. The RANZCP does not believe it is practical to suggest that federal and state funding streams be amalgamated at this point. We propose that the current roles of government be reviewed to address these systemic issues. The following are some suggested strategies for consideration in any such review.

The role of the Commonwealth needs to include:

- Ensuring a national policy framework that promotes and values the development of an integrated mental health system.
- Ensuring, via the Medicare Benefits Schedule, that financial incentives are applied in ways that help overcome these structural barriers (for example through the provision of appropriate item numbers for clinical consultation).
- Increasing the Medicare Benefits Schedule rebate for psychiatric consultations to the levels recommended in the Relative Value Study. This would increase the incentive for doctors to enter the speciality and reduce the cost to patients.
- Ensuring, with the states, that the Australian Health Care Agreements support integrated clinical systems rather than encouraging narrow concerns about “cost shifting” between sectors.
- Considering support (including funding) for strategies allowing collective action by groups of clinicians to increase access to emergency consultation, assessment and treatment.
- Health Care Agreements must be linked to clinical outcome measurements with funding adequate to reach specific targets. This must not mean an increase in the bureaucracy at the expense of clinical services.
- Encouraging better integration between clinical and non-clinical services (housing, employment, rehabilitation, etc).

The roles of the state departments and services needs to include:

- Ensuring a policy environment which, compatible with national policy, promotes state-based systems that respond to a broad range of community needs.
- Ensuring flexible employment conditions for consultant psychiatrists thus promoting a mix of private and public practice.
- Maintaining competitive award conditions for public psychiatrists in order to achieve a proper balance between private and public psychiatry components of the specialist workforce.
- Increased payments to attract more mental health nurses.

- Increased training opportunities for mental health nurses through universities.
- Ensuring that mental health nurses are not replaced by untrained workers.
- Change the focus of inpatient mental health care to a therapeutic rather than a custodial one.
- Promoting the development and recurrent funding of innovative and integrated service models.
- Promoting effective triage assessment and consultation functions within state mental health services.
- Increasing the capacity of state-based services to provide comprehensive treatment for the full range of mental disorders.
- Encouraging better integration between clinical and non-clinical services (housing, employment, rehabilitation, etc).

### **Public and private service integration**

The best example of poor coordination resulting from lack of agreement between federal and state governments is the delivery of private and public mental health services. Private mental health services are funded through private contribution, Medicare rebates and Insurance industry financing. Public mental health services are funded primarily by state governments with contributions from the Australian Government via Australian Health Agreements.

Public and private psychiatrists operate largely independently of each another. The Second National Mental Health Plan emphasises partnerships between the two sectors. When surveyed, both public and private psychiatrists were in favour of better public–private collaboration and supported the concept of shared care arrangements<sup>5</sup>. The MBS provides little financial incentive or support for collaboration between the private sector and the public sector or primary care. Approximately 36% of psychiatrists work in both public and private practice<sup>6</sup>. Encouraging this through flexible employment practices will lead to greater collaboration.

To assist in integration RANZCP believe that publicly funded outpatient services need to be readily accessible to all people with mental illness as part of the overall system of care. This will include referral from general practitioners and

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<sup>5</sup> Yung A, Gill L, Sommerville E, Dowling B, Simon K, Pirkis J, Livingston J, Schweitzer I, Tanaghow A, Herrman H, Trauer T, Grigg M, Burgess P. (2005) Public and private psychiatry: can they work together and is it worth the effort? *Aust N Z J Psychiatry*. 39:67–73.

<sup>6</sup> RANZCP 2004 workforce survey

private psychiatrists as part of an overall rehabilitation plan for people with mental illness.

RANZCP strongly opposes the development of a two-tiered health system in which State administered “public” services provide care for psychoses and Commonwealth “private” primary care and specialist services provide treatment for “high prevalence” disorders such as anxiety and depression. Instead, we propose a layered system with established benchmarks for mental health service delivery. Functions of a layered system should transcend divisions between the public and private sectors and include:

- Acute inpatient beds to provide care for up to 30 days thereby ensuring patients are not prematurely discharged;
- Ensuring that all patients whose clinical state indicates that they require admission to an acute admission wards, can be admitted in a timely manner (within 12 hours).
- Medium-stay beds for patients needing care beyond 30 days;
- Long-stay beds for patients needing ongoing care for safety and wellbeing;
- Community mental health teams resourced to enable them to carry a manageable load, regularly see patients, provide appropriate treatments, work with other providers such as GPs, and provide Crisis Assessment Treatment response within 2 hours so that all people who are acutely unwell have access to ready assessment and appropriate treatment;
- A recovery focus offering psychosocial and vocational rehabilitation (including supported work programs) and outpatient services in public hospitals.

### ***Private psychiatrists***

Private psychiatrists offer their specialist medical services on a fee for service basis. The Medicare Benefits Scheme pays 85% of the MBS schedule fee for referred patients. To obtain rebates, patients must be referred through their GP. Private psychiatrists mostly provide ambulatory services but around 20% of psychiatric inpatient beds are in the private sector.

RANZCP strongly supports the role of the psychiatrist as both direct treatment provider and as consultant and coordinator of complex clinical management. Comprehensive assessment and treatment of complex conditions often requires a team approach (with inputs from psychiatrists, psychologists, social workers and others) and assessment, education and support of the patient’s social network. The elements of a clinical team are not easily accessible in the private sector due to out of pocket costs beyond the reach of those most in need of such care.

GPs seeking referral to the private sector draw on limited referral networks. Access to urgent phone advice from a specialist is likely to be limited. Long delays prior to assessment may be encountered and there is unlikely to be a collective system in which specialists may collaborate to arrange earlier assessment.

There is currently no organisational structure to guide the development of approaches such as coordinated emergency appointment rosters, development of clinical systems with GPs, provision of access to emergency specialist consultation or phone advice etc. While some psychiatrists have worked to develop such systems their broader application will require additional resources and support.

Funding models allowing patients of private psychiatrists access to the full range of allied health professionals and mental health nurses are required.

### ***State mental health services***

Specialist mental health services provided by States have tended to focus on a narrow band of illnesses with a high level of complexity. In many the concept of “serious mental illness” has shifted from its original broader meaning to become equated with psychotic disorders, a difficulty recognised in the second National Mental Health Plan.

Many non-emergency referrals to state community mental health services are initiated by the patient, family or friends. Therefore public mental health services provide both primary and secondary care. Few other specialist services allow self-referral without a gate keeping or referral function by a primary care provider.

In many state services referrals must pass not only through the filter of diagnostic assumptions about “serious mental illness” but also through intake, triage and assessment services provided with limited skills or organisational support.

Medical workforce shortages (specialist and trainee) may limit the quantity and continuity of medical input in state services. Causes for these shortages are complex. Differential specialist reimbursement between public and private sectors is one contributing factor.

### **Primary care**

#### ***Coordinated access***

The structural issues within each sector combine to limit the capacity of the two sectors to work together in an integrated way. GPs or private psychiatrists



seeking referrals to state services must compete with self-referred patients for specialist assessment and treatment in that service.

Very few mental health services have developed “stepped care” systems linking specialist care to primary care in a systematic way. In such systems GPs and specialists (private or public) develop shared protocols where GPs are supported in the care of simpler clinical problems and more complex or non-responding clinical problems receive preferential access to specialist assessment or treatment. Such approaches have been implemented in health systems where primary and specialist care sectors operate under one organisational structure. They have been shown to be effective in the care of depression and other disorders.

Where a GP, a private psychiatrist and a public mental health service are involved in care of one person, coordination of this care is often unclear.

Work practices within the private fee-for-service environment make it difficult for GPs or private psychiatrists to give priority to non-reimbursed activities such as participation in case conferences or management planning meetings. Recent MBS changes have begun to address this, but they remain administratively complex, and poorly understood by the public sector services that may be in a position to provide the necessary administrative support for their widespread use.

The division between sectors means that non-medical staff in state services are likely to have limited knowledge of the working environment of private psychiatrists or GPs, and vice versa. Public sector work-practices and attitudes may perpetuate these structural divisions.

The impact of these issues is even more exaggerated in outer metropolitan and rural areas where higher community disadvantage and need is exacerbated by lower social capital, fewer alternatives, lower capacity to meet out of pocket costs, poorer public mental health resources and increased public sector vacancies.

### ***Strengthening relationships with general practitioners***

The RANZCP has a key role in working with GPs to improve relationships and to develop work practices which maximise access by GPs and their patients to expert psychiatric consultation and support.

The Australian Government has introduced MBS item numbers that provide reimbursement for case conferences involving GPs, psychiatrists, and other professionals. These item numbers are yet to be fully evaluated but there are a number of potential barriers to their widespread uptake. The RANZCP believes it

may also be appropriate to trial and evaluate additional items focussing on relationships between individual GPs and psychiatrists for the purpose of more in-depth case conferencing and supervision.

The RANZCP also supports the development of varying models of consultation and supervision with GPs including allocated time for consultation cases. Facilitating psychiatrists provision of consultation and supervision should be embedded within structural relationships between GP organisations and private psychiatrists. The RANZCP has a key role in developing and negotiating these strategies with government and GP organisations.

The RANZCP has been working with the Royal Australian College of General Practitioners and the Australian Divisions of General Practice to develop a new MBS GP-referred case consultation report item number to encourage psychiatrists to engage in more assessments for a consultant psychiatric opinion and then provide a management plan back to the GP (and telephone or other verbal discussion if practicable). This will enable GPs to access specialist psychiatric advice, by providing the GP and patient, and his/her carer if appropriate, with a brief report with a summary of treatment recommendations. It is a focussed reward for assessment and good communication of a management plan and will help rebalance the time spent by psychiatrists in assessment as against specialist treatment without jeopardizing the valuable specialist treatment skills in the psychiatric workforce.

Other support mechanisms for GPs could include access to clinical and additional support with public sector mental health services. Examples of this include access to training rounds, case conferencing, journal clubs and Grand Rounds and the development of local information sharing systems to facilitate communication between GPs and psychiatrists. GPs should be appropriately reimbursed for their involvement in these activities.

### **Pathways between services**

Recovery and rehabilitation are consistently identified by consumers as areas of key importance, but these are not readily available. There is a need for both long term and transitional supported accommodation options. Psychosocial and vocational rehabilitation, in addition to improving quality of life for those with a psychiatric disability, may also help to prevent relapse of illnesses or reduce the severity of episodes.

People with mental illness want to find work but are disproportionately unemployed. Furthermore, a report by the Australian Government Department of Family and Community Services shows that people with psychiatric disabilities make up the largest proportion of those using publicly funded disability

employment services but achieve the lowest outcome rates. Supported employment programs, where job-seekers are matched with an appropriate position and provided with ongoing professional support and options to modify aspects of the workplace to accommodate their disability, are the best option for improving employment rates of people with mental illness.

The move to community based services, while positive, has not been matched by attention to stratified and good quality accommodation options for persons with chronic mental illness who rarely can access supervised community accommodation. Disabled and disorganised patients flounder in unsupervised single accommodation, are cast onto the streets, or are involved in "revolving door" admissions to acute units, which are the only "accommodation" facilities remaining for them. A distressingly high number kill themselves.

Some of the increasing difficulty facing persons with mental illness should be seen as the effects of poverty. Mental health services have limited impact where people struggle to maintain basic standards of living. Contributing factors include changes in the availability of cheap housing and public housing, increased banking costs, increased use of short term credit, increased penetration of gambling, increased public and private transport costs, increased availability of illicit substances, new government charges such as co-payments for drugs and the marketing of new products such as mobile phones.

### **Mental health workforce**

In 2002, there were 12.1 psychiatrists per 100,000 population, and 3.0 psychiatrists in training per 100,000. Psychiatrists are distributed unevenly throughout Australia: for 85.3% of psychiatrists, the main place of work is a major city. This urban-skewed distribution is unchanged since 1998. Victoria had the most psychiatrists (15.7 per 100,000 population), and the Northern Territory had the lowest, with 5.9 per 100,000 population.<sup>7</sup>

The RANZCP recognises that workforce shortages and difficulties in recruitment are significant and constitute a major challenge to service provision. There is clearly a discrepancy between the available psychiatric workforce and the mental health needs of the population, particularly outside the major cities, and issues of distribution and work practices of specialists exacerbate this.

It is also clear however, that some of the issues of poor recruitment into training are not unique to psychiatry and affect all medical specialities. The RANZCP has the capacity to support the training of more psychiatrists if there are appropriate

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<sup>7</sup> Australian Institute of Health and Welfare (AIHW) (2005) Mental health services in Australia 2002–03. Canberra: AIHW (Mental Health Series no. 6).

applicants and available consultants to provide clinical supervision and teaching. The RANZCP believes that it is imperative that quality, safety and legal obligations must be addressed as the basis for determining minimum numbers of specialists within services. The RANZCP in recognising the current workforce limitations is committed to developing effective partnerships with the range of mental health professions and examining models of collaborative service provision.

Australia is also experiencing a shortage of mental health nurses. Stigma and lack of understanding of mental illness, negative attitudes to mental health nursing among other nursing specialties, lack of focus on mental health nursing within nursing education, increased workload and pressure on services are all barriers to recruitment and retention. Workforce shortages must be addressed, as adequate numbers of mental health nurses are critical to the provision of mental health services.

To effectively manage workforce issues it is imperative to scope and benchmark the mental health service system and come to agreement on what constitutes adequate levels of care. At present no such benchmarks exist and this makes workforce planning an exercise in guesswork. RANZCP strongly recommends that a project is funded to establish a benchmark for the delivery of mental health services in Australia. This would incorporate specific detail on the number inpatient beds and community mental health services required per 100,000 population with weightings for rural, remote and outer urban populations.

Within this context, RANZCP would also support a re-evaluation of the roles and domain of the psychiatrist and improved collaboration across the mental health and medical disciplines, and with consumers and carers. Responding to the mental health needs of the community involves adequate levels of services and staff but also requires a responsive and integrated mental health workforce that delivers quality and sensitive care to consumers, carers and families. Quality improvement and critical reflection on practice are core values of the profession.

There has been an erosion of the notion of the teaching hospital. Previously, psychiatrists in these settings had a diversity of activities – teaching, research, self-directed learning, community leadership – which were seen as integral to their role. Now clinical pressures have overwhelmed all other roles. In addition, there has been a fragmentation in the overall mission of the teaching hospital. The environment in psychiatric units is no longer conducive to high quality training of future medical practitioners and psychiatrists adding to the difficulty of recruiting new graduates and junior doctors to the specialty of psychiatry.

Strengthening the psychiatric workforce involves clarification of the role of the psychiatrist and building on capacities for high-level consultancy, leadership and management, and intervention in complex mental health problems. Effective

functioning in these roles requires appropriate training, systemic support for leadership functions and acknowledgment of the psychiatrist as the specialist who integrates biopsychosocial care within an appropriate cultural framework.

### **Consumer and carer participation**

Improvements in mental health systems can only be made with the participation of those who use mental health services. Aware of this, the RANZCP invites consumer and carer representatives to sit on its Board of Professional and Community Relations (BPCR). The purpose of the BPCR is to develop and oversee programs and activities in the area of community relations and work together with the community to promote mental health, reduce the impact of mental health disorders, improve care and assure the rights of people with mental health disorders. The BPCR is currently developing a framework of community engagement to inform core areas of the College's work, such as the training of psychiatrists and in the ongoing professional development of RANZCP Fellows. Through engaging the community, the RANZCP hopes to build research partnerships to inform policy development and to advocate for improved and more accessible mental health services and psychiatric care, and strongly supports consulting the community in improving mental health systems.

### **Specific needs groups**

#### ***Indigenous people***

Aboriginal and Torres Strait Islanders have high rates of mental illness, appear to be more prone to harmful substance abuse, have substantially higher rates of admission to hospital as a result of mental illness, and have higher rates of suicide than the general population<sup>8</sup>.

The RANZCP is concerned by the substantial inequality in the mental health status of indigenous peoples in Australia and endorses the important emphasis placed on Aboriginal and Torres Strait Islander mental health in the Third National Mental Health Plan 2003–2008. Since 1994 the RANZCP has required a formal training experience in Aboriginal and Torres Strait Islander and Maori Mental Health for its registrars in Australia and New Zealand. The RANZCP also recognises the significant trauma experienced by the Aboriginal and Torres Strait Islander population who are members of the Stolen Generations, and has issued an apology to Aboriginal and Torres Strait Islander people in this regard<sup>9</sup>.

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<sup>8</sup> Trewin D and Madden R. (2003) The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples Australian Bureau of Statistics ABS 4704.0

<sup>9</sup> RANZCP Statement #42 Stolen Generations.

The RANZCP sees the role of the Aboriginal Mental Health Worker as crucial in the provision of culturally appropriate mental health services for Aboriginal and Torres Strait Islander Australians, and shares their concerns about their lack of recognition as a professional. Guidelines for registration of Aboriginal and Mental Health Workers should be developed. The RANZCP believes that current Aboriginal Mental Health Worker training initiatives should be supported, and further training courses in indigenous health developed.

The RANZCP believes that there is a great need for much better access to services and culturally secure systems of care and believes that all services must accept their responsibility for taking steps to redress inequity and improve Aboriginal and Torres Strait Islander health and wellbeing. Services should include improved support for hospital based consultation–liaison psychiatric services to Aboriginal and Torres Strait Islander peoples, due to the high burden of chronic disease in this population and associated mental health problems. There is an added high relative risk for mental health problems in children of Aboriginal and Torres Strait Islander parents suffering from chronic disease. Improved support for specialist initiatives is required in rural and remote areas as well as child and forensic services for Aboriginal and Torres Strait Islander populations. The RANZCP hopes that the Australian Senate may assist these processes as a result of its enquiry.

### ***The aged: mental disorders in late life***

Despite the increasing concern in the broader community regarding the impact of an ageing population upon our health system, the delivery of services to improve the mental health of older Australians has received very limited resources, and development is hindered by lack of clear responsibility for planning or funding of services. This situation is exacerbated by the reality that older Australians with mental illness and their carers are not as vocal, nor as likely to be in the media, as their younger counterparts. Effective systems for improving the mental health of older people exist but they require adequate resourcing. We believe that the nation has a responsibility to offer equivalent access to mental health care to older Australians as it does to younger Australians. RANZCP does not believe this is currently the situation

By 2001, over 12% of the Australian population were over the age of 65 years. The number of people over the age of 80 years will increase dramatically over the next two decades. In addition to an increase in the prevalence of age-related illness such as dementia, there will be rising numbers of people for whom the psychiatric services provided for younger people may not be appropriate. The RANZCP recommends the provision of dedicated inpatient beds for frail aged people with mental illness. Effective treatment improves the quality of life of

significant numbers of patients. Many, if treated, could be discharged to less costly and more appropriate community facilities or services.

Although general practitioners are the primary providers of health services for elderly people, they appreciate support from specialised area psychiatric services for the elderly. Special expertise is needed in assessing mental disorders in this age group and in understanding the interacting psychological, physiological and social effects of ageing. The presentation is often atypical, and frequently there are coexistent physical conditions that further complicate assessment and management.

Dementia represents a noteworthy case where a specialist psychiatric service for the elderly can fulfil many roles. Many patients with dementia suffer from comorbid psychiatric syndromes during their illness and these often improve with treatment. Specific behavioural problems are common and require specialist assessment and management.

Communication and liaison with the patient's family or carers and other medical and community services is paramount for delivery of effective geriatric psychiatry services.

The RANZCP believes that to assist in communication and improved access to treatment that dementia services and mainstream mental health services be better integrated. Further information on the RANZCP's position regarding mental health services for the elderly can be found in a separate submission by the RANZCP Faculty of Old Age Psychiatry.

### ***Children and young people***

Children experience significant rates of mental illness. Services for children must reflect differing needs between children and adults, and be tailored accordingly. Access to mental health services for children must be improved. Cross-sectoral collaboration and integration must occur between the mental health and education systems to promote better mental health outcomes for children.

Much mental illness occurs in late adolescence and young adulthood, at a time when people are in education or training or beginning careers, and thus its disruptive effects can be profound. Early intervention for first-episode psychosis is important to reduce the impact of illness; resources for this must be balanced within the overall mental health system. Earlier treatment of common mental health problems may also prevent subsequent drug and alcohol problems and suicide.

### *Children of parents with a mental illness*

Children of parents with mental illness are demonstrated to be at increased risk of adverse developmental outcomes and mental health problems. Parents with mental illness may experience disruptions in their relationship with their child, social isolation and disadvantage, and the effects of stigma. A range of mental illnesses can affect parenting capacity. Parental substance abuse considerably increases the risk of poor outcome for the child. Child protection issues must be considered, and the process must be managed sensitively and collaboratively with patients and families.

Provision of services to families affected by mental illness requires integration of child and adolescent, and adult, psychiatric services. Care must include regular review of parental concerns about their children and, when necessary, the provision of parenting assistance and psychosocial support for them. Women with babies who require inpatient psychiatric treatment should be admitted to dedicated mother-and-baby psychiatric units, as general adult psychiatric facilities are not an appropriate environment for infants and do not have the requisite parenting facilities or specialist expertise. Mother-and-baby units should be established in each state.

### *Children in detention*

The RANZCP opposes the routine prolonged detention of child asylum seekers under the policy of mandatory detention. Detention is detrimental to children's development and mental health and has potential to cause long-term damage to physical, social and emotional functioning.

### ***The homeless***

Since the population of homeless people with mental illness fluctuates, it is difficult to quantify. An individual does not become part of this statistical group and remain there; rather there is a constant movement of people with mental health problems into and out of the homeless population. It has been estimated that 100,000 Australians are homeless at any time. The cost of housing and boarding house closures contributes to homelessness among the mentally ill.

Any attempt to address the needs of homeless people with mental illness requires a shift from a "health" model of care to an integrated model that addresses the broad range of psychosocial problems alongside the health problems. The service system is currently chaotic involving federal government agencies, state government agencies, non-government organisations including the charitable sector and volunteer organisations. Targeted mental health services to homeless people must be integrated with housing services, but also need to be linked with primary care, physical health services, rehabilitation services, employment



services, financial support services, substance abuse services and the justice system. As this population have both a very high degree of need for a large number of service types, and a correspondingly low ability to actively seek and engage with services that might provide assistance, it is recommended that a service model be funded that integrates both clinical and non-clinical support. The model should allow for flexibility across catchment areas, be able to respond quickly to crisis and changing needs, and address the person in an individualised, informal and non-stigmatising manner. To facilitate this, Commonwealth and State funds that are provided to clinical and non-clinical services should be pooled and held by one agency (fund-holder) that can integrate all components of care; this may be a clinical or non-clinical service.

### ***Drug and alcohol dependence***

#### *Illicit Drugs*

The RACP and RANZCP Joint Policy Statement on Illicit Drugs – Using Evidence to Get Better Outcomes states that:

*It is undeniable that efforts used to reduce the demand and supply of illicit drugs have had limited effectiveness. Supply reduction measures, though often costly and accompanied by serious unintended negative consequences, are generously funded. In contrast, pharmacological drug treatments and harm reduction interventions that have proved to be relatively inexpensive, effective and safe are relatively poorly funded. For the last three decades, drug policy has been a major political issue during many election campaigns. This has not served the interest of effective policy making.*

*Improved outcomes can be achieved by investing more appropriately in interventions better supported by evidence of effectiveness. This will only happen if politicians are prepared to lead an informed community debate rather than just follow vocal and often unrepresentative media commentators.*

*During the past few decades there has been remarkable progress in improving the outcomes for a wide range of physical and mental health conditions including heart disease, injury and depression. Application of the same commitment to independent scientific research and transfer of research findings to policy and practice is likely to produce similar improvements in outcomes for illicit drugs.*

#### *Alcohol*

Any attempt to treat and rehabilitate those with alcohol-related disorders will always be hindered by the fact that alcohol consumption in Australia and New

Zealand is high when compared with many other Western societies. It is well documented that death, ill health, social disruption and economic loss result from excessive alcohol consumption and that this is in proportion to its relative cost and availability. Not only does alcohol misuse directly cause serious disease in the nervous system, cardiovascular system, liver and pancreas, it contributes to other conditions such as hypertension, endocrine disorder and cancer of the oesophagus. It is a contributory factor in approximately one-third of serious and fatal accidents, in breakdown of the family unit and in unemployment.

RANZCP endorses the government's development of a national alcohol strategy and action plan for 2005–2009.

### ***People with intellectual disability***

People with an intellectual disability have a high risk of developing a concurrent mental illness, but psychiatric diagnoses in this population are often overlooked, particularly if the symptoms of psychiatric illness are incorrectly thought to arise from the intellectual disability. Mental health and disability services are separate, therefore staff in one area often lack the training and confidence to provide services to people with dual diagnosis. Interagency collaboration and training together with joint case management and assessment are required for both services to meet the needs of this population.

### **SUMMARY**

RANZCP would like to thank the Committee for the opportunity to highlight many of the areas in the mental health service system that could be further improved. We reiterate our belief that the areas for immediate consideration by the Committee are the need for increased funding; improved integration of services; and the introduction of strategies to increase mental health workforce participation.

We believe that it is timely for the Committee to critically examine the mental health system and provide recommendations that will support the increasing mental health needs of the Australian community and the overwhelming dedication of those who support them during periods of mental illness.

We look forward to the opportunity to meet with the members of the Committee and provide further information to assist them make informed decisions on these recommendations.