



THE ROYAL
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF PSYCHIATRISTS

Submission to the National Health and Hospitals Reform Commission

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Executive Summary

The College acknowledges the interest and emphasis the Commission has placed on mental health in the National Health and Hospitals Reform Commission (NHHRC) Interim Report (December 2008) and continues to advocate that mental health and well-being is central to all aspects of physical healthcare and that mental illness cannot be approached effectively as a reform issue separate from broader health outcomes.

The College advocates the NHHRC engage closely with major and related reform agendas, notably the Federal government's Social Inclusion and Homelessness agendas as well as the 2008 House of Representatives Inquiry into the needs of carers. A strong interface between these processes aligns with the NHHRC terms of reference and draft principles. The impacts of mental illness are felt across the spectrum of government services at every level.

The reform directions listed in the interim report begin the process of addressing the need for action and reform however there is still a long way to go.

Costs and Consequences

The burden of disease is shifting, driven by, among other factors, structural ageing and lifestyle. Within this, the burden of mental illness is increasing. Furthermore mental illness is expected to continue to have substantial economic and social costs at the individual, family, society, business and economic levels. Mental ill-health constitutes a heavy burden in terms of distress, disability, and mortality and contributes substantially to costs of general health care and social support services. It causes loss of economic productivity due to people being unable to work or being ill or absent from work. It has been estimated that although mental illness causes some 12-14 per cent of the burden of disease in Australia, it only attracts around 9 per cent of health funding and this gap needs to be redressed.

In addition to the burden of disease statistics, it is estimated that some mental disorders are projected to grow substantially in the future, consequently placing a considerable strain on health and social services, and also on family and carers. An important example is dementia, where the number of affected individuals is projected to double over the next 30 years and the cost to economy to treble. Conversely, the future prevalence of many other disorders is much more uncertain and these could evolve and interact in unpredictable ways. For example, common mental disorders such as depression and anxiety are linked to life events (such as bereavement, unemployment etc); lack of social supports; family structures; housing, income, debt, and the workplace environment. Any reform actions need to be flexible enough to adapt to ever changing social determinants.

Research also emphasises that what drives economic growth is not necessarily good for mental health, but mental health is essential for further economic growth. Additionally, although it is difficult to put an economic value on informal care, there is no doubt that the cost for this component of mental

health care is also high with insufficient emphasis being given to the financial burden on the family in current reforms of policy and practice.

Reform directions

Although the NHHRC Interim report focuses on the important age group of adolescents, with proposed dedicated funding and support for identified preventative measures, there are other key groups within the population that are often excluded from society and underrepresented in the reform process. This includes those aged between 16-64 with an existing mental illness and children or youth aged 5-17 that are in out of home care. Couple this with population ageing and the fact that in old age, mental health problems often lead to expensive admissions to nursing homes or hospitals and have a substantial impact on family and carers' mental health. 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 all Australians. The reform direction must focus on mental health across the life span with associated targeted early interventions measures for each relevant group.

Earlier intervention and prevention is the most likely effective solution to reducing the long-term impact of mental illness. Literature shows however that there are existing concerns about whether the premature introduction of medications for some mental disorders could actually reduce resilience and self-reliance, and lead to adverse long-term effects. Further commentary raises concern regarding the difficulty of distinguishing early clinical features from other non life threatening conditions and normal experiences, leading to inappropriate labelling of patients. Again, further research needs to be conducted before considerable investment is made in programs that have limited evidence concerning efficacy.

There has been insufficient research comparing 'stand alone' early intervention services with a tertiary referral base, to well-integrated early intervention teams that are a component of a comprehensive service system. Further, there are obvious problems in trying to adapt the model of 'stand alone' services to rural and remote settings. In addition the identified reform directions are at risk of creating further service disjunction for people with chronic or prolonged mental illness, as their care is repeatedly transferred from one age-specific service to another.

The College supports the establishment and routine monitoring of goals related to health promotion and prevention and recommends that these goals form the basis for the development of an implementation plan that is adequately resourced. Without key action areas and associated resources, there is concern that the excellent work conducted by the reform commission will be lost and have no positive impact on the community.

The College believes that the key first steps to reform requires government and the community to develop a comprehensive awareness of the challenges and the associated health, social and economic benefits of preventing mental illness and promoting mental health across all groups. Considerable effort can also be made amongst employers by improving the recognition of the

advantages of providing flexible and appropriate working environments to maintain individuals in, and return them to, employment, and decrease the reliance on disability pensions. It is important to highlight that as at June 2005, 26.2% of the 706,782 recipients of the Australian Government's Disability Support Pension had a psychiatric/psychological condition, second only to musculoskeletal and connective tissue conditions (33.9%) (DEWR 2006). Considerable savings could be achieved should Government invest more into the treatment of mental health problems through the increased investment in prevention across the life span. It is estimated that every dollar spent on treatment of mental health problems saves 20 to 30 dollars in future costs, especially if interventions are selective or targeted, however considerable investment also needs to be dedicated to universal services in order to be reflective of the burden of disease (McKeith & Scott, 2008).

The RANZCP is committed to working in partnership to develop mental health care in Australia. We would welcome the opportunity to discuss the submission with the commission and provide further information.

Introduction

The Royal Australian and New Zealand College of Psychiatrists (the College) is pleased to provide this submission to the National Health and Hospitals Reform Commission (NHHRC) to assist in designing Australia's future health system.

The College acknowledges the interest and emphasis the Commission has placed on mental health in the Interim Report (December 2008) and continues to advocate that mental health and well-being is central to all aspects of physical healthcare and that mental illness cannot be approached effectively as an issue separate from broader health outcomes.

In this submission, we continue to stress the need for action in the following areas:

- Mental Health workforce needs and issues;
- Improved service integration;
- Increased accountability; and
- Increased research opportunities.

The College welcomes the opportunity to further comment on the reform process and would be pleased to work with the Commission in securing a better basis upon which the health and well-being of the community can be realised.

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.

The College includes a number of expert Faculties, Boards and committees - such as the Faculties for Old Age Psychiatry and Child and Adolescent Psychiatry, Boards of Education, Practice and Partnerships and Committee for Research – all of which are well placed to provide specific, expert advice to relevant aspects of the Commission. Similarly, while psychiatrists all have a central role in integrating the physical, psychological and social aspects of health care and well-being, the RANZCP Section of Consultation-Liaison Psychiatry provides a particular focus and expertise in this aspect of health care.

Overview

Having a mental illness can affect basic abilities to think clearly, engage with others and work through bureaucratic processes. It can interfere with the ability to work through administrative requirements, such as completing forms or attending appointments and the capacity for independent living may fluctuate and be unpredictable. When a person is unwell, they may be heavily reliant on others to navigate their way through the complex mental health system in Australia.

Some of the increasing difficulties facing persons with mental illness should be seen as the effects of poverty and social exclusion. Mental health services have limited influence where people are struggling to maintain basic standards of living. Contributing factors include changes in the availability of low cost housing and public housing, increased banking related costs, increased use of short term credit, increased penetration of gambling, increased public and private transport costs, increased availability of illicit substances, charges such as co-payments for medication and the aggressive marketing of new products, especially through “buy now - pay later” schemes.

The burden of disease is shifting, driven by, among other factors, structural ageing and lifestyle. Within this, the burden of mental illness is increasing and despite positive recent developments in the recognition of mental health, funding and emerging models of collaborative service integration, many people with a mental illness have little or no contact with a health professional, and even fewer with a specialist mental health provider. It has been estimated that mental illness causes some 12-14 per cent of the burden of disease in Australia but attracts around 9 per cent of health funding.

“Within Australia, 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).

“...23% of the total Australian adult population are affected by one or more mental disorders in any given year” and “that about 14% of children and young people (or 500,000 persons) are affected by mental disorders within any six month period” (various authors cited in Australian Government National Mental Health Report 2007 page 15).

Projections also suggest the mental health related disease burden will grow markedly as a proportion of overall disease burden (Begg, 2008). Given the projected increase in mental health disorders, this without question will increase the strain on the existing service system. Serious and enduring mental illnesses such as schizophrenia are life shortening disorders. A series of studies suggest that the mortality rate in patients with mental illness is considerably higher than the general population and especially higher in schizophrenia and related disorders. For example a patient with schizophrenia has, on average, 20 years shorter life expectancy than the general population. This is contributed to by a variety of factors, but especially by the higher prevalence of comorbid medical conditions. These complex care issues and the associated impact on life expectancy invites serious attention to be given to collaborative care models across the health system and an increased investment in the broader health status of people with mental illness.

The high demand for Medicare funded mental health services provided for under the 2006 *Better Access* initiative suggests the extent of previously unmet demand for mental health services in the community. The underpinning causes of mental distress and illness are unlikely to diminish; on the contrary, projections suggest current trends in mental health related disease burden will grow as a proportion of overall disease burden (*Burden of disease and injury in Australia in the new millennium: measuring health loss from diseases, injuries and risk factors*” Begg, Vos, Barker, Lopez Medical Journal of Australia; 188(1): 36-40)). Responsible policy setting should provide for better and earlier detection and treatment to contain the human and financial cost associated with prolonged illness, crisis and trauma. Integrated, patient-centric, collaborative practice will be core to achieving this outcome.

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. Current mental health education and awareness campaigns are not adequate. The College supports the focus toward promotion and prevention, and recommends that mental health is made a priority for any future activities. It is important to maintain health promotion and awareness campaigns that focus on prevention, however greater emphasis needs to be given to building better community awareness regarding treatment and support options available to people with a mental illness and their carers. Specific attention should be targeted towards building better community and professional awareness of the roles different mental health practitioners can play in achieving the best outcomes for patients.

Stigma and shame associated with asking for help and the fear of associated labels and discrimination mean that many do not access services or supports. There are many misconceptions regarding mental illness, treatments and the role of mental health practitioners. In fact, many persons with mental illness face a ‘double stigma’. Not only do they share the burden of stigma associated with mental illness in general, but they are further stigmatised within the ‘mental health community’ as current community awareness campaigns / media coverage have inadvertently driven a wedge between ‘acceptable’ mental health diagnoses such as depression or bipolar, and those that remain feared and misunderstood such as schizophrenia. Recent research supports the notion that individual ‘diagnoses’ have far more in common with each other than difference, and there should be an attempt to include ‘outlier’ diagnoses within the broad spectrum of mental illness awareness campaigns.

Research has demonstrated that the media has an important role to play in informing and influencing community attitudes towards 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; consequently 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.

As the population ages, the diagnosis of dementia and age related illnesses such as Alzheimer's will also increase. The number of older Australians with dementia is projected to increase from 180,700 in 2006 to 452,600 in 2031; an increase of 150% or 271,900 persons. This estimate is based on the projected increase in the number of older people over this period and assumes that prevalence rates for dementia remain stable. (AIHW, 2006) However, prevalence rates may change as a result of changes in prevention, detection, management and treatment of the disease. 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.

Ongoing changes in the population profile and increasing proportion of people from culturally and linguistically diverse (CALD) backgrounds requires an improved emphasis on culturally appropriate services. Enhanced availability of interpreter and other culturally sensitive services at point of service delivery is essential in meeting the emerging need. Recent growth of population arrival from traumatic and war torn parts of the world requires increased investment in health services as their help seeking behaviour is highly complicated by their previous experiences. Early case finding and effective treatment by skilled psychiatrists will assist in reducing the long term morbidity and disability.

The College advocates the NHHRC engage closely with major and related reform agendas, notably the Federal government's current Social Inclusion and Homelessness agendas as well as the 2008 House of Representatives Inquiry into the needs of carers. A strong interface between these processes aligns with the NHHRC terms of reference and draft principles. Appropriate employment, housing and relationships underpin more positive well-being. Conversely, poor outcomes in any of these areas reduce the prospects elsewhere. Consequently, the impacts of the mental health care system are felt across the spectrum of government services at every level. Inadequate, late or ineffective interventions mean higher demand, system stress and/or costs in other areas of health care, employment assistance, housing and crisis accommodation support, drug rehabilitation, justice, foregone productivity and revenue, income support outlays and so on. In addition there are the costs, not only financial, borne by patients, their families, friends and other carers. Taken together, more is spent on non-health specific support services for the mentally ill than in clinical treatment. Better integration and prevention/early intervention will improve overall well-being, contain service demand and improve the prospect of achieving sustainable savings in government outlays overall.

Themes

Taking responsibility

The College supports the establishment and routine monitoring of goals related to health promotion and prevention and recommends that these goals form the basis for the development of an implementation plan that is adequately resourced. Without key action areas and associated resources, there is concern that the excellent work

conducted by the reform commission will be lost and have no positive impact on the community.

There is evidence that health promotion campaigns designed to reach the general public can achieve positive outcomes in terms of mental health literacy, however the programs need to be targeted to specific groups within the population to have an impact on behaviour. More importantly, studies of past promotion programs have found that direct contact with individuals with a mental illness is associated with the development of more positive outcomes. However it is important to recognise that mass media campaigns are expensive, particularly those involving television broadcasts, and it may be that other approaches are more cost-effective and better outcomes will be achieved by investing in specialist service systems. It is important that any health promotion activity implemented involves appropriate resources and methods to evaluate these strategies.

As this theme identifies, there is a need for greater consumer and carer participation in the reform process. The planning and implementation of the reform agenda must have at its centre the needs of consumers and their carers. This necessitates process that empower and encourage them to be full participants, and for their needs to be addressed by service delivery systems. The RANZCP strongly advocates for an ongoing partnership between those who develop policy, clinical service providers and the community as represented through consumer and carer organizations. Consumer and carer participation must move on from 'committee /peak body' representation' (whilst not losing this aspect) to be inculcated into the fibre of every mental health clinician and undergraduate training program, so that it becomes a routine for every patient / carer in every mental healthcare and healthcare setting.

Mental health and wellbeing underlies economic growth and development. A UK report states that days lost from work due to depression exceed all other health disorders. On average, individuals reporting depression are estimated to lose 22 work days per annum compared with 4-6 days for non-depressed individuals, plus impaired performance even when attending work. This loss of productivity is equated to 5-6 million days in total, that are lost in the UK because of depression. Recent economic analyses vividly portray the economic consequences of mental illness. For example, in the US, the total annual cost associated with depression alone was estimated at \$83 billion (in the year 2000), 69% of which was for lost employment and premature mortality (Greenberg et al., 2003). A recent Europe-wide study (Sobocki et al., 2006) demonstrated that depression was the most costly health concern in Europe, accounting for 33% of all health and associated costs. In the UK, the cost of treating depression exceeds the combined cost of treating both hypertension and diabetes (Department of Health, 1996).

However, studies consistently shows that the direct mental healthcare costs are dwarfed by associated costs such as lost productivity and losses in personal and family income and the greater reliance on welfare supports. The longer-term consequences of mental illness are also significant and are the leading cause of long-term disability and early retirement. It is estimated that the economic burden of mental illness on family members and society is considerable, accounting for 60-85% of the total cost of mental illness (Broadhead et al., 1990).

Although constituting 4.4% of all hospitalisations, mental health-related hospitalisations accounted for 12.2% of total patient days. Principal diagnoses of depressive disorders (25.8%), neurotic and stress-related disorders (15.5%), mental and behavioural disorders due to alcohol (11.8%), and schizophrenia (9.6%) accounted for large proportions of mental health-related hospitalisations. Schizophrenia accounted for the largest proportion of such patient days (22.2%). Over the 2005–06 period, there were a further 282,876 hospitalisations with a mental

health-related additional diagnosis and a non-mental health-related principal diagnosis. These accounted for around 2.8 million patient days. The average length of stay in hospital for patients was higher when the patient also had a mental health diagnosis reported (AIHW 2008).

The RANZCP supports the report's focus on treating and supporting Australians with mental health problems back into the workforce. This will require multiple strategies and an upfront investment by government, as returning those with mental health problems to employment will produce major benefits for individuals, families and for the whole community. Recovery and rehabilitation are consistently identified by consumers as areas of key importance.

The RANZCP supports the investment in clinical rehabilitation services however believes that clinical rehabilitation is a complex area that is critical in the prevention of relapse of illnesses and in the reduction of the severity of any future episodes, and needs further clarification and comprehensive action areas. Although an action item is "*increasing housing options and support in accommodation for people with a mental illness*", this also needs to be further articulated, as there is a demonstrated need for both long term and transitional supported accommodation options in the community.

Connecting Care

Interventions identified through the reform process need to focus on the entire lifecycle not just one specific age group. 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.

It is imperative that government policy continues to support a strong private sector primarily because to not do so would place an unfair burden on public mental health services that are already under resourced over stretched. The College advocates increased investment and targeted support to additionally focus on the private sector in order to provide increased opportunities for prevention/promotion or early intervention to the general adult population who are the principal consumers of private mental health care supports. The importance of future investment in the private sector is evidenced through Medicare data that demonstrates the substantial increase in mental health consultations in the private sector (psychiatrists, psychologists and allied health) as a result of the introduction of the 2006 Better Access initiative.

Recent changes to Medicare have enabled access to a broader range of mental health professionals in the private sector, however as it remains 'fee for service' and funds only specific interventions, this funding mechanism cannot alone provide adequate access to mental health care for all Australians.

The College advocates that if the Commission is serious about reducing morbidity rates as a result of mental illness, further investment must be made in reducing the extremely high rates of occupancy of acute mental health in-patient services and investing in more adult beds, specialty services and long term care options. The 2006

Tolkein II report highlighted that acute hospital units are constantly full and many patients who warrant urgent admission have to wait, which is unacceptable given acute services only treat severe conditions. As treatment pathways are different for each mental illness and the affected person, the report proposes that stepped care allows the flexible matching of treatment according to need, thereby increasing the number of people getting appropriate evidence based treatment.

Specifically, the reform process should highlight initiatives that will facilitate the development of a single integrated system of care for people with mental illness and how the close cooperation of State/Territory and Commonwealth governments on all aspects of mental health care will be coordinated. Without such a system, optimum care cannot be provided and people with mental illness slip through the cracks as opportunities for early intervention and effective treatment are lost. 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; create a lot of tension with the geriatric societies if we proposed a 'takeover'
- Inclusion of developmental disability services as an essential component of the service matrix;
- Development of "stepped care" systems linking GPs and state mental health services in the care of common and severe disorders;
- Encouragement of integrated staffing models, with more flexible arrangements for public and private psychiatrists to work together which 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.). A whole of government approach involving health, education, employment, housing and Centrelink like services should be the strategy in achieving better outcome in mental health care.

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. Improved access to care at all stages of the illness and continuity of care and community linkage must be the core model of care delivery system. In such a model the following key performance indicators can drive improvement.

Functions of a layered system should transcend divisions between the public and private sectors and include:

- Acute inpatient beds for all age groups 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 extended care for prolonged episodes of acute illness;
- Long-stay beds for patients needing ongoing care for intensive rehabilitation safety and wellbeing;
- Community mental health teams resourced to enable them to carry a manageable case load, regularly see patients, provide appropriate treatments,

work with other providers such as GPs, and provide a rapid response when there is a crisis so that all people who are acutely unwell have access to ready assessment and appropriate treatment; and

- A recovery focus offering psychosocial and vocational rehabilitation, including supported work programs.

Facing Inequities

Aboriginal and Torres Strait Islander mental health

The RANZCP believes that there is a great need for better access to services and culturally secure systems of care; 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 diverse locations together with the limited opportunity for mental health professionals to participate in regular and region specific cultural awareness training specifically relating to Aboriginal and Torres Strait Islander social and emotional well-being further complicates the provision of and access to appropriate services and the workforce shortage.

Indigenous mental health services are underrepresented in the reform process as mental health and alcohol and drug morbidity are high in this vulnerable population. Enlisting of existing indigenous community health services is an effective way to improve awareness and treatment acceptance.

The RANZCP Fellows are committed to working with Indigenous mental health workers and recommends that further exploration into the Indigenous health workforce shortage also be included as part of the reform process and be considered as a matter of priority.

Rural

Access to mental health services in rural and remote areas also warrants direct and special attention. The lack of services in communities can mean that people move to locations where supports exist but then they 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 increase the likelihood of people losing access to income support, coming into contact with the police and justice system and a decline in their general health as they lose contact with known health care providers.

Enhancement of community mental health services in rural areas should be a high priority. Adequate community acute and assertive outreach and follow up services are the best strategy for providing high quality mental health care, and at the same time relieving pressure on acute health services. To this end, further work would be needed to develop the interface between acute and community-based care, and with Commonwealth-funded primary health care.

In addition to this, the rural workforce is 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. Consultation with College Fellows and trainees identified that traditional factors such as cost of living and cheap housing have been positive incentives for rural practice; however these are no longer the case in some areas, where housing and cost of living equal or exceed metropolitan centers. The needs of the rural mental health workforce are different to their colleagues working in metropolitan centres and need to be addressed. This includes education and professional development as well as economic issues.

Driving quality performance

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

The College supports multidisciplinary models of care and advocates that in the provision of appropriate and relevant mental health care, each mental health professional has an important role to contribute to overall service delivery. Accordingly, initiatives aimed at redressing workforce shortages would benefit from ensuring appropriate representation across all mental health profession groups.

The RANZCP believes that the funding currently going into mental health research is too low and that it is preventing the development and uptake of best practice models of mental health care in the community. The RANZCP believes that to better inform practical policies there should be an emphasis on applied and consumer and carer driven research on interventions and performance measurement of service delivery outcomes. The RANZCP supports an increase in the funding for mental health research from \$15 million to \$50 million a year.

Research is needed into service delivery systems to determine which models of mental health care provide outcomes that are meaningful for patients and their families, as well as clinically effective. Consumer and carer organisations should be empowered to help set the research agenda.

It is imperative that rigorous and ongoing monitoring and evaluation of mental health services across Australia and the impact of the implemented initiatives, which should involve significant consumer and carer consultation is undertaken. This desired independent evaluation needs to be conducted annually to ensure the report objectives are on track and to also allow the flexibility to develop new initiatives to actively address new areas of concern as they arise.

Chapter 10: Supporting people living with mental illness

The College provides in principal support for the reform directions, however wishes to bring to the commission's consideration key concerns related to reform directions 10.1 and 10.2.

Key Concerns

Reform direction 10.1 *We propose that a youth friendly community-based service, which provides information and screening for mental disorders and sexual health, be rolled out nationally for all young Australians. The chosen model should draw on evaluations of current initiatives in this area – both service and internet/telephonic-based models. Those young people requiring more intensive support can be referred to the appropriate primary health care service or to a mental or other specialist health service.*

Reform direction 10.2 *We propose that the early psychosis prevention and intervention Centre model be implemented nationally so that early intervention in psychosis becomes the norm.*

Any new policy direction should be supported by evidence and if the evidence is limited, then investment in research to evaluate outcomes must be a priority.

Throughout the interim report numerous references and focus is placed on whole of life approaches to healthcare reform, however the mental health section of the report primarily focuses on youth. The potential risk of this approach is that those who unfortunately remain ill beyond the youth period, or become unwell outside the specific age group, do not have access to high quality services. Early intervention should be an appropriate paradigm whenever mental health problem arise. The principles of promotion, prevention and early intervention are broadly applicable across all areas and ages of mental health and reform directions should reflect this.

There has been insufficient research comparing 'stand alone' early intervention services with a tertiary referral base, to well-integrated early intervention teams that are a component of a comprehensive service system. Further, there are obvious problems in trying to adapt the model of 'stand alone' services to rural and remote settings.

The College expresses concern regarding investment in age specific community based services that have neither identified transition points nor evidence to support that age specific services provide better outcomes. There is risk of creating service disjunction for people with chronic or prolonged mental illness, as their care is repeatedly transferred from one age-specific service to another. The College supports investment in services that are youth friendly however advocates that youth friendly does not necessarily need to mean youth only service.

Similarly, the College is concerned that investing in one disorder only, psychosis, neglects other more common mental health disorders such as anxiety, depression and older onset disorders that can have a greater impact on the burden of disease and cost to society. For example, estimates show that by 2071 the number of people older than 65 could double and those aged 80 and over could more than treble. This would lead to much more cognitive decline and dementia, and an expenditure time bomb.

Telephone and internet supports are proven to assist those with mental health concerns particularly those in crises; however the College stresses that face to face contact is preferential especially for the screening of mental disorders and this should be encouraged as the first point of contact. In the assessment of any individual for a mental illness, visual cues are of equal importance as verbal ones and this can not be achieved through telephonic based models. Concern also exists regarding

ensuring that assessments/screenings are conducted by appropriately qualified mental health professionals that have the recommended expertise to conduct and interpret an assessment/screening tool and then provide appropriate treatment.

Conclusion

The RANZCP welcomes the attention the report gives to mental health and the prioritising of key reform direction for mental health. The College supports progressive models of change, but highlight that there are no simple solutions to reforming the mental health sector nor will reform directions be able to be uniformly applied.

The critical missing step in the reform process is detailed research into service models that deliver long-term outcomes and enhance the quality of life for people with a mental illness and their families.

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