5 February 2016

The Hon Scott Morrison MP  
Treasurer of the Commonwealth of Australia  
Budget Policy Division  
Department of the Treasury  
Langton Crescent  
PARKES ACT, 2600

By email to: prebudgetsubs@treasury.gov.au

Dear Treasurer

Re: Pre-Budget Submission 2016-17

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide a submission to the Department of the Treasury on priority areas for investment in mental health for 2016-17. The RANZCP commends the Commonwealth Government for its engagement with mental health and its support for many important initiatives that promote destigmatisation, improved treatment and better understanding of mental illness. The RANZCP is concerned, however, that vulnerable consumers face growing gaps or barriers to services, a dwindling psychiatric workforce and a Medicare system that does not adequately invest in mental health.

Mental illness will affect every Australian in their lifetime, whether directly, indirectly or both. There is an increasing understanding of the high cost of mental health, on overall health, on the community and on the economy. The RANZCP’s Pre-Budget 2016-17 submission outlines a strategic framework for investing in mental health to promote cost-effectiveness so that the potential for these detrimental impacts can be mitigated into the future and ultimately provide strong returns on mental health dollars invested.

If you would like to discuss any of the issues raised in the submission, please contact Ms Rosie Forster, Senior Manager, Practice, Policy and Projects via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours sincerely

Professor Malcom Hopwood  
President

Ref: 00610
Submission to the Department of the Treasury regarding priorities for the 2016-17 Budget

5 February 2016

advocating for mental health resources commensurate with burden of disease
About the RANZCP

Psychiatrists are medical doctors who are specialists in the treatment of mental illness, substance abuse and addiction. Psychiatrists play a crucial role in the provision of evidence-based mental healthcare in the community using a range of therapies including medication and psychotherapy. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation responsible for training, educating and representing psychiatrists in Australia and New Zealand. Psychiatrists must be accredited by the RANZCP before they can practise.

The RANZCP has over 5,500 members including 4,000 fully qualified psychiatrists and 1,400 members who are training to qualify as psychiatrists. In Australia, approximately 85% of practising psychiatrists are current RANZCP members. The RANZCP is guided on policy issues by a range of expert committees whose membership is made up of preeminent psychiatrists with relevant expertise, as well as consumer, carer and community representatives.

In developing the recommendations for the Department of the Treasury contained in this submission, the RANZCP consulted closely with the relevant committees, to ensure that the priority areas identified reflect clinical experience, community input and mental health expertise. These committees include the RANZCP’s Practice, Policy and Partnerships Committee, the Aboriginal and Torres Strait Islander Mental Health Committee, the Community Collaboration Committee, the Faculty of Child and Adolescent Psychiatry, the Faculty of Old Age Psychiatry, Faculty of Psychotherapy and the Faculty of Consultation-Liaison Psychiatry.

Executive Summary

The impacts of mental ill health in the community are multiple and overlapping, and incur substantial costs on individuals, families, communities and the economy. Overall, the cost of the burden of serious mental illness, including opioid dependence in Australia is estimated at 6% of gross domestic product (GDP), or $98.8 billion. Additionally, the cost of physical health comorbidities associated with premature death in those with serious mental illness is estimated at 2.8% of GDP or $45.4 billion (RANZCP, 2016).

Whilst 60% of the burden of serious mental illness is considered not avertable, it is estimated that current treatment could avert 13% of the burden, optimal treatment at current coverage could avert 20% of the burden and optimal treatment at optimal coverage could avert 28% of the burden. Best practice in healthcare is estimated to have the potential to reduce the impact of serious mental illness and comorbidities by almost one third (RANZCP, 2016). In dollar terms, this means that supporting best practice in mental healthcare, and improved distribution of the workforce, has the potential to generate approximately $48 billion in savings, well over the current budget deficit.

The RANZCP advocates for a reconceptualisation of the discourse around mental healthcare spending in Australia. We believe that directing Commonwealth Government funding towards mental healthcare should be understood as an investment, with the potential to generate high returns. The RANZCP makes recommendations in this submission as to how mental health spending can be used to generate significant long term benefits, both to the economy, and to individuals, families, carers and communities across Australia. We have identified eight key priorities for spending that will be expanded upon further in this submission:

- enhancing employment support and opportunities for people with mental health issues
- addressing the physical health of people with mental illness
- improving the accessibility of evidence-based clinical care for children and adolescents
- making quality mental healthcare available to Australia’s ageing population
• addressing the maldistribution of the mental healthcare via the Specialist Training Program (STP)
• supporting Aboriginal and Torres Strait Islander mental health workers
• establishing ongoing national funding for consultation-liaison psychiatry services
• facilitating effective linkages between the mental health sector and the National Disability Insurance Scheme (NDIS).

Mental healthcare, relative to other parts of the health system, is underfunded – accounting for 7% of government funding, yet 14% of burden of disease, with an estimated 3.6 million Australian adults and 600,000 children and adolescents experiencing mental health issues each year (NMHC, 2014). The RANZCP is committed to advocating for mental health funding at a level commensurate with the prevalence of mental illness in the community.

Further, we emphasise that the full spectrum of mental health needs must be addressed. While we welcome the substantial commitment that the Commonwealth Government has made to establishing effective preventative and early intervention initiatives, this must be accompanied by adequately funded acute, clinical services. In particular, investment in acute psychiatric inpatient care enables the compassionate and appropriate care of consumers when they are most unwell. This is the standard expected in all areas of medicine.

Australia’s psychiatric inpatient bed numbers have fallen steadily, from 313 per 100,000 population in 1960 to 39 per 100,000 in 2010. While these numbers are partly explained by the international movement towards deinstitutionalisation, this is not the full story. Australia’s acute care sector has been reduced far more dramatically than most Organisation for Economic Cooperation and Development (OECD) countries, and is now ranked 26 out of 34 OECD countries for psychiatric care bed numbers (OECD, 2013).

These numbers show that while significant gains have been made in terms of enhancing the quality and reach of mental health services over recent years, more work needs to be done. The RANZCP recognises the commitment of the Commonwealth Government to addressing these important issues. In particular, we welcome and support the National Mental Health Commission’s Review of Mental Health Programmes and Services (NMHC, 2014), the Commonwealth Government’s Response to the Review (DoH, 2015), and the groundwork already underway in the lead up to the development of the Fifth National Mental Health Plan.

The following submission outlines a strategic framework and practical initiatives for investing in mental health that – in the RANZCP’s view – will address some of the discrepancies in mental health service funding and coverage, and foster broad-reaching and long term advantages that will benefit both the health of the Australian population and the economy.

The initiatives proposed by the RANZCP are based on two key principles – namely, that measures to support populations of most need should be cost effective, and that multidisciplinary mental healthcare should incorporate the expertise of psychiatrists to ensure that measures are evidence-based, clinically effective and conducive to long term benefits.

**Key Recommendations**

- That the Commonwealth Government should
  - enable Individual Placement Support (IPS) programs – that are aimed at engaging people with mental illness at work – to be accessible to all age groups, integrated with clinical mental health services and include opportunities for skills development and training
- Ensure that mental health services have policies and strategies in place, including strong partnerships with primary care providers, to ensure that the physical health needs of people with mental illness are identified.

- Provide funding over four years to deliver improved services for those with Borderline Personality Disorder, including training for mental health professionals in secondary care services and appropriate primary care services.

- Ensure that optimal mental health outcomes are achievable for all young Australians by supporting through adequate funding the full spectrum of mental health care from prevention through to acute clinical care for perinatal, infant, children and adolescent mental health services.

- Commit to the development of community and residential aged care services that are inclusive of the needs of people with mental illness, including removal of care exclusions in the Aged Care Act 1997 that are based on the presence of a mental health condition.

- Establish a baseline target of 1.8 EFT per 100 beds for Consultation-Liaison Psychiatry (CLP) services in general hospitals, including an increase in the number of advanced training opportunities for registrars and trainees to work in the area of CLP and the establishment of senior CLP registrar positions in every general hospital. This will help ensure that the provision of adequate mental health services is a core component of general hospital care.

- Commit to ensuring funding for Aboriginal and Torres Strait Islander mental health programs that fully incorporates Aboriginal and Torres Strait Islander mental health workers at all levels of governance, policy and program design, and service delivery.

- Develop clearer and ongoing funding for mechanisms that would enable communication and collaboration between the NDIS and the mental health sector, so as to enhance capacity for collaboration and information sharing, ahead of the nationwide roll out.
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Investing in employment support programs

Employment is almost universally amongst the highest ranked goals of people with serious mental illness; yet this population faces the highest unemployment rates of any disability group (Ramsay et al., 2011; Harvey et al., 2009). For example, Australians with a sensory or speech impairment have a 56.2% labour force participation rate and 7.7% unemployment rate. In comparison, people with psychological disability have a 29.12% labour force participation rate and 20.4% unemployment rate (ABS, 2015).

Unemployment is particularly high for people with serious mental illness such as schizophrenia. At the onset of illness with psychotic symptoms, the unemployment rate for this population is around 50%, however this increases to 70-95% in the chronic stages of the illness (Killackey et al., 2006).

The costs associated with the unemployment rates for people with mental illness are manifold. On a personal level unemployment exacerbates isolation and financial strain, creates barriers to accessing healthcare and other supports, and can impede recovery (Solar, 2014). The economic costs of exclusion of people with mental illness from employment are also significant, illustrated in the fact that the Commonwealth Government spends approximately $5.7 billion, or 60% of mental health expenditure, on income support each year (NMHC, 2014).

Investing in programs that support people with mental illness to engage in meaningful work has very high potential to generate direct savings, in additional to indirect savings associated with improving outcomes for people with mental illness, supporting clinical recovery, and decreasing reliance on healthcare and crisis services over time (Solar, 2011).

Individual Placement Support Programs

Of the range of programs aimed at supporting people with mental illness to enter or re-enter the workforce, Individual Placement Support (IPS) has a strong evidence base for enhancing both vocational and non-vocational outcomes (Tsang et al., 2010). For example, a detailed Cochrane systematic review concluded that those with severe mental illness were significantly more likely to obtain employment with support from an IPS program compared with other, more traditional types of pre-vocational training (Crowther et al., 2001). IPS programs also tend to improve job duration, hours worked per week and wages (Bond et al., 2012).

The 2015 final report of the Reference Group on Welfare Reform to the Minister for Social Services, A New System for Better Employment and Social Outcomes, identified the potential benefits of implementing additional IPS initiatives in Australia. The report recommended that IPS programs be expanded as part of a Jobs Plan for people with mental illness. The Jobs Plan is envisioned as a holistic package of supports including linkages to IPS, Personal Helpers and Mentors (PHaMS), tailored NDIS packages, and other disability employment services (DSS, 2015).

The Commonwealth House of Representatives Standing Committee on Education and Employment’s inquiry into mental health and workforce participation made similar recommendations in 2012, including that ‘the Commonwealth Government explore ways, in partnership with the states and territories through the Council of Australian Government (COAG), to support IPS and other service models that integrate employment services and clinical health services’ (SCEE, 2012).

The report further recommended that the Commonwealth Government should establish a leaders group, composed of representatives from the disability sector, business and government with the objective of developing practical strategies to increase employment of people with mental health conditions. Measures would include promoting good practice in employment, educating employers and workplaces, and investigating incentives to employing people with mental illness.

This approach is also reflected in the Government’s response to the National Mental Health Commission’s (NMHC) Review of Mental Health Programmes and Services, which includes a commitment to implementing specialised employment services using the IPS model. This commitment is
specifically aimed at young people and - while we welcome this development - we would support the broader implementation of specialised employment services, across all age groups.

**IPS and consumers with mental illness**

A contributing factor to the very low employment rates experienced by people with psychological disability is the episodic and unpredictable nature of mental illness, including stable and unstable periods even with treatment or medication, and inter-episode problems also occurring. These experiences can create difficulty in maintaining employment, when there is a lack of employer flexibility and understanding. Successful IPS programs incorporate employer and workplace education to improve awareness and responsiveness to the particularities of psychological disability. Employers need to be supported to make reasonable adjustments and allow for flexibility when necessary.

A further issue for consideration in ensuring the efficacy of IPS for people with mental illness is the importance of accompanying job placement with enhanced education and training opportunities – opportunities that may have been curtailed earlier in life due to illness. The onset of mental illness commonly occurs in adolescence or early adulthood, and this timing can significantly impede educational attainment and transition to the workforce. The impact of this is illustrated in the fact that less than 35% of Australians with a psychotic illness have completed Year 12 (Waghorn et al., 2012). IPS for people with mental illness tends to be most effective when accompanied by work-related social skills training (Tsang et al., 2010).

Finally, people experiencing mental illness are often required to negotiate a complex system of health and support services. IPS programs should be fully integrated with clinical mental health services so as to reduce, rather than add to, the multiple appointments, specialists and services people with mental illness must manage (Orygen Youth Health Research Centre, 2014). To ensure long term success, mental health services and IPS initiatives should have the scope to work collectively towards ensuring there is a good fit between the individual, their mental healthcare provider, disability employment agency and employer (Solar, 2014).

**Recommendations**

- The Commonwealth Government should review the recommendations relating to IPS made in previous reports, including the Standing Committee on Education and Employment’s *Work Wanted: Mental Health and Workforce Participation* and the Reference Group on Welfare Reform’s *A New System for Better Employment and Social Outcomes*.
  - Relevant recommendations from the *Work Wanted: Mental Health and Workforce Participation* supported by the RANZCP include:
    - working with educational institutions to enhance the supports available to students with mental illness
    - encouraging more peer support programs at universities and TAFE
    - undertaking a national education campaign targeting stigma and reducing discrimination of people with mental illness.
  - Relevant recommendations from the *A New System for Better Employment and Social Outcomes* supported by the RANZCP include:
    - developing a Jobs Plan for groups at risk of poor employment outcomes
    - implementing tailored support services integrating employment services with mental health services
    - raising awareness of the benefits of employing people with mental illness, and the services and supports available to employers
• establishing a leaders’ group to bring together key representatives from the disability and health sectors, business and government to develop practical strategies to increase employment of people with mental illness
• ensuring that industry-led awards recognise good employment practice, in particular, the implementation of employment and support strategies for people with mental illness
• setting targets across government for employment of people with mental health conditions across all employment levels (DSS, 2015).

Physical health of people with mental illness

There is extensive evidence to show that people with serious mental illness have higher rates of chronic physical illness than the general population.

People with serious mental illness, are between two and three times more likely to have diabetes, six times more likely to die from cardiovascular disease, more likely to be diagnosed with diabetes, respiratory disease or have a stroke under the age of 55 years, more likely to die from almost all key chronic conditions, and more likely to die within five years of diagnosis (RANZCP, 2015).

There are a significant number of Australians with both physical and mental health issues. Australian Bureau of Statistics (ABS) research has found that 11.7% of Australians aged 16–85 years - 1.9 million people - had both a mental disorder and a physical condition. The most common combination was a chronic physical condition combined with anxiety disorders, affecting an estimated 1.4 million Australians (ABS, 2008).

The higher rates of chronic disease among people with serious mental illness has a range of consequences, including: much shorter life expectancy, higher levels of ongoing disability because of both physical and mental illness, reduced workforce participation and productivity and greater likelihood of welfare dependency and poverty.

Most of this excess mortality is the result of physical diseases including diabetes, respiratory illness, cardiovascular disease and cancer (Robson and Gray, 2007; Fleischhacker et al., 2008).

There are several factors contributing to the high levels of chronic disease among people with serious mental illness. One factor is that anti-psychotic medications, while a powerful tool in managing the debilitating symptoms of mental illness, can cause side effects such as weight gain and changes to blood sugar regulation that often lead to a range of chronic, life shortening illnesses such as diabetes and cardiovascular disease. A delicate balance must be achieved between managing the symptoms of mental illness so they are not debilitating, while still protecting overall physical health by carefully monitoring and managing the side effects of medication. Another factor is that people with severe mental illnesses also receive less screenings for physical health issues as well as less interventions for treatable conditions. This is also a key factor contributing to the premature mortality of these Australians (RANZCP, 2015).

Addressing the physical health of people with mental illness

A range of evidence suggests that that timely and appropriate treatment is effective in improving physical and mental health amongst people with serious mental illness (Knapp et al., 2011). The RANZCP is
currently reviewing this evidence to develop consensus based guidelines for Australia and New Zealand, with anticipated publication in 2016.

In particular, the RANZCP considers that integrating health promotion strategies into mental health services is an effective way of combating chronic disease in people with mental illness. For instance, evidence suggests that one way to improve outcomes is to incorporate healthy lifestyle programs into mental health service delivery (O’Sullivan et al., 2006). A recent evaluation of an Australian lifestyle intervention offered to young people experiencing their first episode of psychosis found that weight gain and its health consequences can be prevented and/or ameliorated when managed appropriately (Curtis et al., 2015). A New Zealand study also found that combining psychoeducation and nutrition and/or exercise counselling may be a cost effective way to help people with first-episode psychosis to manage their weight (Knapp et al., 2011). Clinicians working with young people experiencing their first episode of psychosis have argued that exercise and lifestyle interventions could provide an opportunity to alter the trajectory towards cardiovascular disease and type 2 diabetes, and should be prioritised as a matter of urgency (Eappen et al., 2012, Shiers and Curtis, 2014).

The findings of the benefits of exercise and physical activity are also relevant to adults who may have long-standing mental illness. For instance, healthy lifestyle programs appear to be a cost effective means of managing body mass index in people who have been living with schizophrenia for longer periods of time (Acil et al., 2008; Knapp et al., 2011). Programs that stop the general increase of waist circumference are also important for future preventative treatment (Hjorth et al., 2014).

Improving public awareness of the link between chronic disease and mental illness is another important strategy to help address the current information gap among the general community about the physical health needs of people with mental illness. While there has been a very welcome increase in public awareness and discussion of mental illness in recent years, physical health in the mentally ill has received comparatively little attention. One reason for this is the limited online information available to the public regarding the increased physical health risks associated with mental illness (Ahire et al., 2012).

Programs for enhancing the physical health outcomes for people with mental illness must also involve families and carers, in order to ensure that positive physical health interventions provided by mental health services are reinforced in the home environment. Further, as the families and carers of those with mental illness may themselves face physical health issues, it is important that health practitioners recognise this reality and – in addition to providing treatment for the person with a mental illness – that they provide support and advice to family members and carers so that they know how to maintain their own health and wellbeing. Health practitioners, particularly general practitioners and psychiatrists, can provide advice to families and carers, enabling them to cope with stress and anxiety that may arise as a consequence of their caring role. In addition, families and carers should ensure that they have regular physical and mental health checks and seek medical assistance when they are in difficulty.

Finally, for all age groups – but particularly children, adolescents and young adults – mental health treatment should be a priority for primary health care services.

To this end, the RANZCP was pleased to note the NMHC’s strong focus on the physical health needs of people with mental illness (NMHC, 2015) as well as the Government’s Response where the Commonwealth Government announced that it will be developing innovative funding and delivery models through primary care services to better support and coordinate services for people with complex physical and mental health needs (DoH, 2015).

Optimal treatment should involve psychiatrists at an early stage of mental disorders, particularly if there is a poor response to psychological treatment or if the mental disorder is severe and/or debilitating.

In order to support best practice in this space, the RANZCP is developing a suite of clinical practice guidelines for Australia and New Zealand. These resources will support the application of evidence-
based care for people with mental illness including mood disorders, schizophrenia, self-harm, anxiety disorders and eating disorders, as well as people with comorbid physical and mental health issues. Each of these guidelines will emphasise the management of physical as well as mental health.

**Recommendations**

Given that a significant number of people with mental illness also have physical health problems either contributing to or as a consequence of their illness, the RANZCP considers that the physical health of people with mental illness is a priority issue that needs urgent attention. The RANZCP recommends that:

- Mental health services should have policies and strategies in place, including strong partnerships with primary care providers, to ensure that the physical health needs of people with mental illness are identified and addressed. Where people living with mental illness are not engaged with primary care, mental health services must ensure that physical health needs are addressed as part of a comprehensive package of care.

- There be workforce development initiatives to ensure that psychiatrists and other mental health service providers are aware of the physical health inequalities and risks that impact people living with mental illness. In addition, education regarding mental health conditions should be incorporated into the curricula of tertiary courses training allied health professionals (e.g. physiotherapists, dietitians and exercise physiologists).

- Screening and lifestyle interventions, based on the best available evidence, must be routinely offered to both people newly diagnosed with a serious mental illness and those with longstanding illnesses in order to prevent avoidable chronic conditions from developing.

- Appropriate funding and training should be provided to health practitioners to enable them to recognise and support the physical and mental health needs of families and carers of people with mental illness.

- In addition to health promotion initiatives, increasing public awareness of the physical health needs of people with mental illness is another important, complimentary strategy to promote health literacy in the general public, particularly regarding the link between chronic disease and mental illness.

**Improved services for borderline personality disorder**

The RANZCP would like to emphasise the inefficiencies in the current mental health system around the treatment and care of people living with Borderline Personality Disorder (BPD).

BPD is a common major mental health condition characterised by poor control of emotions and impulses, unstable interpersonal relationships and unstable self-image. The estimated prevalence of BPD in the general population is 1-4%, but among people using psychiatric services the estimated prevalence is 23% for outpatient populations and 43% for inpatient populations. People with BPD experience significant suffering and distress, experience disruption to family and work life and social problems.

BPD patients present with serious comorbidity, which includes drug and alcohol abuse and dependence which fails to respond to normal treatments unless the BPD is treated. It is also associated with high suicide rates. Patients with BPD also have reduced responsiveness to treatment for other conditions including anxiety, depression and drug and alcohol disorders . The symptoms and vulnerabilities start early and can be identified in adolescence and there are interventions in adolescence and early adulthood. Untreated, BPD presents a significant economic and social cost to the Australian community.
A number of Australian Parliamentary Committees have identified that BPD is under recognised, most people with the condition are not offered the most effective treatments and due to a lack of appropriate services people with BPD often present to emergency departments or are admitted to an inpatient unit (NHMRC, 2013). Past recommendations of these Committees have included designated BPD treatment services, a training program for mental health services and community-based organisations in the effective management of people with BPD and programs targeting adolescents and young adults and targeting providers of primary health care (NHMRC, 2013).

The National Institute for Care and Excellence Guideline on Borderline Personality Disorder (NICE, 2009) recommends that services should develop multidisciplinary specialist teams and services for patients with BPD. The National Health and Medical Research Council’s Clinical Practice Guideline for the Management of Borderline Personality Disorder recommends that people with BPD should be provided with structured psychological therapies that are specifically designed for BPD as there is evidence that these therapies for BPD are more effective than the care that is otherwise available (NHMRC, 2013).

As well as specialist Personality Disorder treatment services, the RANZCP considers that mental health professionals working in secondary services should be trained to diagnose personality disorder, assess risk and need and provide interventions. Training should also be provided for primary care healthcare professionals who have significant involvement in the recognition, assessment and early treatment of people with borderline personality disorder. In the RANZCP’s view, training should be provided by specialist personality disorder teams.

There is effective treatment for patients with BPD, providing substantial savings. Outcomes include a reduction in service use, less suicide and self-harm, less family crises and emergency room visits and improved social and relational function.

Of concern is that no treatment for people with BPD can ultimately lead to them experiencing increased physical ill-health and long periods of unemployment – both which may create substantive, long-term social and economic costs for the community.

Further, people with BPD continue to be marginalised and responded to as if their condition is untreatable, including by service providers. The National Health and Medical Research Council has noted that:

A diagnosis of BPD closes the door to already limited mental health services. It leads to social rejection and isolation. Sufferers are blamed for their illness, regarded as ‘attention seekers’ and ‘trouble makers’… Access to services designed for people with BPD is particularly problematic. It is a chronic condition requiring integrated care and specialised services that just do not exist beyond the private sector. Adding to the service access issues is the remarkable situation that service providers and clinicians themselves marginalise and stigmatise people with borderline personality disorder. Some see people with BPD as too problematic, as attention seekers, or as impossible to treat… Accessible, appropriate treatments for those experiencing BPD, and an end to marginalisation of the disorder within the community and the mental health sector, are urgently needed (NHMRC, 2013).

Therefore, the RANZCP considers that there is a clear need for a change in service response within the mental health sector for those experiencing BPD, including the provision of treatments that are appropriate for this disorder.

Given the nature of the illness and its disastrous impact on families and relationships, early intervention must also be a priority.
A related issue is people with BPD who are also parents. Parenting programs offer an effective method of intervention for both parents and children in these circumstances and can help to enhance the parent-child relationship – especially if the program is sensitive to the effects of the mental illness such as BPD in combination with practical assistance to families aimed at overcoming structural obstacles (RANZCP, 2010).

To assist with the development of best practice resources for BPD, the RANZCP has recently published the most recent update of its Mood Disorder Guidelines (Malhi et al., 2015), which are intended to guide the clinical management of bipolar disorders and to advise on diagnosis and treatment strategies.

However the RANZCP considers that much more work needs to be done in this area to support the needs of patients with BPD while, at the same time, reducing the overall costs of BPD to the Australian community.

**Recommendations**

- That the Commonwealth Government commits to providing funding over four years to deliver improved services for those with BPD, including training for mental health professionals working in secondary care services and appropriate primary care services.
- Fund parenting programs targeted at parents with BPD.

**Child and adolescent mental health**

Effective, evidence-based child and adolescent mental healthcare, along the full spectrum from prevention to acute clinical care, is foundational to the overall health of the population. Approximately 50% of all serious mental health disorders, including substance use, commence by age 14 (Whiteford et al., 2013). Therefore, supporting this population, as well as mothers and infants, offers substantial, long term benefits in terms of enhancing the wellbeing of individuals across their lifetime. Managing mental health and behavioural issues early in life improves long term health outcomes, and can decrease the individual’s need for acute or crisis care later in life. This can in turn lead to substantial, long term economic savings.

**Prevalence of mental illness and access to services**

The Commonwealth Department of Health’s Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing found that high numbers of young people in Australia are experiencing clinically significant mental health issues. For example, almost one in seven, or 13.9%, four to 17 year olds experienced psychological distress in the 12 months prior to being surveyed. This is equivalent to 560,000 children (Lawrence et al., 2015).

These statistics reinforce the importance of ensuring all children and adolescents have access to high quality, evidence-based assessment and treatment services. The findings of the Australian Commission on Safety and Quality in Health Care’s Australian Atlas of Healthcare Variation (the Atlas) suggest that this is not currently occurring at an optimal level (ACSQHC, 2015). For example, the Atlas found significant variations in the dispensing of some psychotropic medicines in children and adolescents, including attention deficit hyperactivity disorder (ADHD) medicines and antidepressants. These unwarranted variations indicate that optimal, evidence-based mental health care is not evenly accessible in Australia, and they warrant further inquiry.

In order to begin to address these discrepancies, means of ensuring children and adolescents have access to high quality, evidence-based assessment and treatment services need to be considered. Child and adolescent psychiatrists have an important role here - both in providing services directly to young people experiencing mental health issues, and also in educating, liaising with and providing advice to
other medical professionals more broadly on the proper use of psychotropic medications, and on holistic and evidence-based care in general.

**Government’s Response and Fifth National Mental Health Plan**

The RANZCP supports the recommendations made in the NMHC Commission’s *Review of Mental Health Programmes and Services*, which address the mental health needs of children and adolescents. In particular, frameworks for supporting children exposed to trauma, experiencing behavioural issues and ensuring the availability of supports in infancy are important steps (NMHC, 2014). Further, the RANZCP was pleased to note that this focus was carried across into the Government’s Response to the Review, which included a commitment to improving the connectedness of child and adolescent mental health services, including by consolidating school-based programs and reviewing the approach to the provision of services to young people with severe mental illness (DoH, 2015).

The successful design and implementation of the Primary Health Networks (PHNs) will be central to achieving these aims, and child and adolescent mental health expertise will need to be fully incorporated into the PHNs at all levels, including governance, policy design and services delivery. The RANZCP would welcome more information on how the government’s approach to the design and implementation of the PHNs, and how the expertise of child and adolescent mental health services (CAMHS) can best support this process.

**Perinatal and infant mental health services**

Investing in perinatal and infant mental health services is another area that offers multiple and long term returns on investment. Perinatal and infant depression services are essential not only for mothers, but for the whole family unit. Young children who grow up in safe and secure environments have greatly enhanced likelihood of healthy development, positive mental health and wellbeing throughout their life (Haliburn, 2014). Perinatal and infant mental health services support mothers to care for their infants and support their lifelong development.

In 2015, the RANZCP was concerned to learn that federal funding for the National Perinatal Depression Initiative (NPDI) had ceased. While we understand that the federal funding for the program was intended to be temporary, we believe that the extent of community concern following the announcement of its cessation strongly illustrates the important contribution this funding was making. In many regions of Australia, services funded under the NPDI are the only perinatal programs available, meaning that funding cuts risk leading to the cessation of screening, early intervention and support for mothers. We would support the reinstatement of federal support for the NPDI as a priority.

**Recommendations**

- Perinatal, infant, children and adolescent mental health services should be funded across the full spectrum, from prevention to acute clinical care. Psychiatrists working in these areas have an important role in delivering evidence-based clinical healthcare directly, as well as in providing education, training and liaison with medical professionals more broadly.

- In allocating funding for perinatal, infant, children and adolescent mental health services, care needs to be taken to ensure a balance between prevention and early intervention programs, and acute services.

- Federal funding for the NPDI should be reinstated as a matter of priority.

**Mental health needs of an ageing population**

Australia is currently unprepared to meet the mental health needs of an ageing population. Although significant funding has been allocated in previous budgets for early intervention services, there has been no ongoing funding allocated to improving the lives of older people with mental illness. The RANZCP
considers that greater priority must be given to the mental health care of older Australians, which will in turn provide a significant return on investment for the wider Australian community.

Like many other countries, Australia has an ageing population. Projections suggest that the proportion of people aged 65 years and over will increase from 14% in 2012 to 20% by 2040. The number of people aged 85 years and over is projected to almost triple from 430,000 to 1.2 million by 2040 (ABS, 2013).

Despite this, there is substantial unmet need in terms of mental health services for older Australians. Recent ABS data demonstrate the disparity between rates of mental health Medical Benefit Schedule (MBS) item utilisation and the rates of psychotropic medication prescription, by age.

As illustrated by the graph below, the proportion of the population accessing Pharmaceutical Benefits Scheme (PBS) subsidised mental health related prescription medications increases with age - with more than one third (34%) of all people aged 75 years and over accessing one or more of these drugs in 2011 (ABS, 2014). These data suggest that large numbers of older people are being prescribed psychotropic medications in the absence of appropriate mental health consultations.

![Graph showing PBS and MBS utilisation by age group](image)

(Sourced from ABS, 2014)

The inconsistency of mental healthcare accessed by older people is also reflected in the Australian Commission on Safety and Quality in Health Care’s Atlas, *Australian Atlas of Healthcare Variation*. The Atlas found 6.5 million PBS prescriptions for antidepressants had been dispensed to people over the age of 65 in 2013-14, with significant geographical variation across regions of Australia. Anxiolytic and antipsychotic medicines dispensing in people over the age of 65 were at similarly high rates and levels of geographical variation. This is despite the fact that there is no evidence to suggest that depression increases with age (ACSQHC, 2015).

In the RANZCP’s view, the funding of mental health services for older Australians is substantially inadequate, and this is demonstrated in the variations in the data comparing healthcare across geographical regions and age groups. There is limited access for older people to state community, acute inpatient and non-acute inpatient care as well as supported community residential care (AIHW, 2012a). Another consequence of Australia’s ageing population is that there will be higher numbers of people living in residential aged care facilities, where there are already unacceptably high rates of depression (AIHW, 2013) and other mental illness (AIHW, 2012a) with often inadequate treatment (Snowdon et al., 2011).
On this basis, the RANZCP strongly believes that that the Government needs to make a commitment to invest in providing appropriate mental health care and services for older Australians and, in particular, community and residential aged care services that are inclusive of the needs of older people with mental illness.

Increased funding should also be provided to improve the mental health literacy of older Australians. The benefits of public knowledge of physical diseases are widely accepted, but knowledge about mental disorders, also known as mental health literacy, has been neglected. This is of particular concern as studies have indicated that the lack of public mental health literacy contributes to slow problem recognition and reduces opportunities for early interventions, which are less costly to the individual and to society as a whole (Thompson et al., 2004).

**Recommendations**

- Remove all barriers to older Australians in residential aged care accessing the same mental health services as the rest of the community.
- Develop and implement national principles for providing coordinated care across different services for older Australians with mental illness.
- Commit to the development of community and residential aged care services that are inclusive of the needs of people with mental illness, including removal of care exclusions in the Aged Care Act 1997 that are based on the presence of a mental health condition through:
  - opening all MBS mental health items to people living in residential aged care facilities
  - commissioning work to develop guidelines to shape maintenance and improvement of the mental health of people living in residential aged care consistent with the UK National Institute for Health and Care Excellence (NICE) quality standard ‘QS50 - Mental wellbeing of older people in care homes’
  - the mandating of a formal aged care accreditation standard requiring all aged care providers to make mental health care available to residents.
- Fund anti-ageism strategies and increase social inclusion for older Australians.
- Invest in improving mental health literacy among older Australians.
- Invest additional funding for inpatient and community services for older people with dual diagnoses, including cognitive impairment/dementia and another mental disorder.
- Fund more acute care beds specifically for the elderly with mental illness, separated from general adult mental health facilities and linked in with general hospital and geriatric medicine/rehabilitation services

**Specialist Training Program**

Another key opportunity for reinvestment in mental health is the Specialist Training Program (STP). The RANZCP highly values the support of the Commonwealth Government to deliver the STP, which enables medical specialist trainees to rotate through an expanded range of settings beyond traditional public teaching hospitals.

STP funding is provided to health services, private hospitals and community clinics to employ a doctor who is completing their psychiatry training outside the traditional public hospital system. Through this program, 163 valuable members of the medical workforce currently work in locations as dispersed as Townsville, Ipswich, Albany, Hobart, Geelong, Darwin, Tiwi, Goulburn and Narrabundah as well in major
cities. They work in all areas of psychiatry from supporting children and adolescents to older people, special groups such as Aboriginal and Torres Strait Islander communities and in currently needed research.

However, current funding for the STP will conclude at the end of February 2017 and the RANZCP requests a timely notification of the future direction of this important program to ensure services are not jeopardised. A commitment to the funding for a longer period (at least three years) is also critical to ensure stability in mental health service provision.

STP makes a major contribution to the provision of, and access to, mental health services in Australia in several ways. It boosts access to mental health services in rural areas, as approximately 50% of all RANZCP rural trainees are in STP posts. It also provides strong access to mental health services particularly in Queensland and Victoria as STP currently funds 43 posts in Queensland and 64 posts in Victoria – 60% of the total STP posts.

STP has also been crucial in addressing the current shortfall and projected future shortage of psychiatrists in Australia through efforts to recruit and retain psychiatry trainees. State-based and individual support programs for Specialist International Medical Graduates, webinars and online resources for non-metropolitan trainees, as well as the RANZCP’s Psychiatry Interest Forum for medical students/graduates have been successful in engaging the interest of potential future psychiatrists, and trainees at risk of disengagement. The establishment of a mentoring program and peer support groups for rural trainees has provided another avenue of support for those working in isolated locations.

Going forward, as public and private sectors share responsibilities to provide emergency, acute inpatient and outpatient mental health care, continued investment in STP will also build capacity in the private sector to ensure cost efficiencies in the health system.

For example, there were an estimated 211,139 emergency department (ED) occasions of service with a mental health-related principal diagnosis in 2012–13 - that is, about 3% of all ED occasions of service reported in public hospitals. Over the five years to 2012–13, the rate of mental health-related ED occasions of service rose by an annual average of 5.3%. Just over one in ten of these patients were an Australian Triage Scale category one – patients that should be seen in less than ten minutes (AIHW, 2015). Non-urgent patients could be seen earlier in the community if access to psychiatrists were to be increased. Continued investment in training psychiatrists in private and community settings will work towards increasing this access, alleviating the burden of over-stretched public hospital emergency departments and reducing waiting times.

**Recommendations**

- Continue funding for the Specialist Training Program beyond 2017 to ensure that specialist trainees can work in non-public hospital settings and provide access to crucial mental health services to the community, especially in rural areas and private settings.
- In the current and any future reviews of the Specialist Training Program, ensure funding allocations are aligned to workforce data to ensure its ongoing viability and utility in terms of meeting Australia's current and projected future workforce shortage for psychiatrists.

**Aboriginal and Torres Strait Islander mental health**

There have been many positive developments in Aboriginal and Torres Strait Islander health policy and programs in recent times, including the expansion of Aboriginal Community Controlled Health Organisations (ACCHOs), the implementation of the Closing the Gap Campaign and greater awareness of the need to ensure healthcare is culturally appropriate and holistic. The RANZCP welcomes the NMHC’s focus on Aboriginal and Torres Strait Islander mental health as a national priority in its *Review*
of Mental Health Programmes and Services (NMHC, 2014), as well as in the Government’s Response to the Review (DoH, 2015).

However, despite these developments, and almost a decade of coordinated efforts under the Closing the Gap campaign, Aboriginal and Torres Strait Islander mental health outcomes continue to be much lower than the non-Indigenous populations, and are in some cases getting worse.

Of specific concern to the RANZCP is the continued worsening of several outcomes related to Aboriginal and Torres Strait Islander mental health. Rates of intentional self-harm, for example, have increased by 48% over the past decade. Psychological distress is estimated to be currently experienced at high or very high levels by 30% of the Aboriginal and Torres Strait Islander population, and to be increasing (SCRGSP, 2014). Up to 12% of the ten year life expectancy gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians is attributable to mental illness, a further 4% to suicide and 6% to substance misuse (Holland et al., 2013).

These statistics indicate that approaches to Aboriginal and Torres Strait Islander health and wellbeing need to be re-evaluated. Programs should be founded on an evidence-base, and fully incorporate Aboriginal and Torres Strait Islander community ownership, insight and expertise. Evidently the costs of mental illness in Aboriginal and Torres Strait Islander communities are substantial. Conversely, careful investment in programs that are known to have positive results has the potential to achieve significant improvements in a short period of time (AHRC, 2015).

Aboriginal and Torres Strait Islander mental health programs that are known to work feature the following elements in common: self-determination, community governance, reconnection, community life, restoration and resilience. Effective and efficient investment in Aboriginal and Torres Strait Islander mental health should focus on programs that incorporate the following:

- a holistic approach
- a focus on recovery
- means of empowering people to regain a sense of control
- strategies that are community-led, family-focused, culturally responsive and context specific
- an interdisciplinary approach
- partnerships with the ACCHOs sector and local communities (Dudgeon et al., 2014).

In contrast, programs that have been found to be ineffective are those that do not take into account Aboriginal and Torres Strait Islander values and context, operate under inadequate timeframes and funding, and those that are delivered without engagement or partnership with the community and ACCHOs (Dudgeon et al., 2014).

Aboriginal and Torres Strait Islander mental health workers

Aboriginal and Torres Strait Islander mental health workers have substantial value and skills to bring to mental healthcare. In particular, this group have an important role to play in providing direct, holistic care to consumers and communities. Furthermore, where non-Indigenous mental health workers are engaged with Aboriginal and Torres Strait Islander consumers and communities, an essential part of their role should be to engage and consult with Aboriginal and Torres Strait Islander mental health workers (RANZCP, 2012).

The RANZCP supports the recognition of the role of Aboriginal and Torres Strait Islander mental health workers in all aspects of mental healthcare, including service and policy development, consultation on cultural safety, and direct service delivery. Aboriginal and Torres Strait Islander mental health workers should be supported to train for and apply for appropriate positions, and should be remunerated for their work at a level at least commensurate with non-Indigenous healthcare providers (RANZCP, 2012).
The RANZCP is committed to developing and supporting the Aboriginal and Torres Strait Islander mental health workforce, in consultation with its Aboriginal and Torres Strait Islander Mental Health Committee members. Specifically, the RANZCP has established a working group, with the objective of developing strategies for increasing the uptake of Aboriginal and Torres Strait Islander doctors into psychiatry training. One avenue identified by the working group for supporting this undertaking is via the Commonwealth-funded STP (also discussed above, please refer to the Specialist Training Program section of this submission for more information).

STP would be an efficient mechanism for supporting Aboriginal and Torres Strait Islander mental health workers, given that it is an existing platform, which has already had significant success. The RANZCP recommends that the Commonwealth Government consider how STP could be adapted to the Aboriginal and Torres Strait Islander medical workforce. This approach has the potential to generate multiple benefits, including improving the mental health of Aboriginal and Torres Strait Islander communities by providing culturally safe and appropriate mental healthcare, as well as enhancing the access of this population to education, training and improved employment opportunities. The RANZCP would welcome the opportunity to discuss this proposal in more detail with the Commonwealth Government and the Department of Health.

**Role of psychiatrists**

Psychiatrists have extensive training and clinical experience in mental health, and have an important role in supporting and delivery high quality, evidence-based mental healthcare to Aboriginal and Torres Strait Islander communities. Psychiatrists undergo extensive and multidisciplinary training which incorporates physical and health, as well as population health and the interaction of social, intergenerational and spiritual factors on health and wellbeing. This is essential when it comes to treating mental health in Aboriginal and Torres Strait Islander settings, given the complex layers of historical and present day trauma and dispossession that contribute to experience of mental illness.

Access to psychiatrists is currently very limited for Aboriginal and Torres Strait Islander peoples, especially those living in remote and rural locations due to the maldistribution of the workforce. For example, urban centres have approximately 22 full time equivalent (FTE) employed psychiatrists and psychiatrists-in-training per 100,000 population, whereas inner regional areas have 6 FTE and remote areas have 3 FTE (RANZCP, 2015).

In order to continue to support the mental health workforce servicing rural and remote areas, the RANZCP considers that investment in technological and professional supports is required. This includes investing in teleconferencing and webconferencing technology so that psychiatrists can support consumers across distances, as well as provide supervision and consultation with mental health professionals located in these areas, who would otherwise have very little access to professional supports and who are vulnerable to burnout. Financial assistance and practical travel arrangements should also be available for psychiatrists visiting rural areas via outreach programs in communities where there are unmet needs and an inability to employ a resident psychiatrist (RANZCP, 2015).

Finally, the RANZCP recognises the significant contribution that the Commonwealth Government has made to enhancing psychiatrists’ skills in the area of Aboriginal and Torres Strait Islander mental health. In particular, recent federal funding via the Rural Health Continuing Education (RHCE) Sub-Program has enabled the RANZCP to develop a suite of e-modules on Aboriginal and Torres Strait Islander mental health. These modules are freely available, and have been successful in supporting health professionals to improve their knowledge and understanding of Aboriginal and Torres Strait Islander mental health. Initiatives such as these contribute to improved health outcomes in the long term, as clinicians are enabled to undertake more culturally appropriate and meaningful service delivery.
Constitutional recognition

Exposure to social and structural factors such as inequality, discrimination and racism are linked to poorer physical and mental health outcomes, including incidence of self-harm and suicide (World Health Organization, 2014). Conversely, changes to policy and legislation aimed at creating more inclusiveness and showing broad community support have been linked to improved mental health outcomes (Kealey-Bateman and Pryor, 2015). The RANZCP therefore supports constitutional recognition, due to its potential to enhance mental health outcomes for Aboriginal and Torres Strait Islander peoples (RANZCP, 2015).

We commend the Commonwealth Government for its ongoing support of the movement towards constitutional recognition, including via funding for the important work of the organisation Recognise. As the journey towards a referendum continues, it will be essential that Recognise continues to receive the support it needs in order to sustain and build on the momentum already generated.

Recommendations

- That the Commonwealth Government should:
  - seek to apply an evidence-based approach to Aboriginal and Torres Strait Islander mental health programs, including fostering self-determination, community governance, reconnection, community life, restoration and resilience. Research shows that such programs are the most efficient and effective when these elements are incorporated
  - incorporate Aboriginal and Torres Strait Islander mental health workers into mental health initiatives at all levels. This includes involvement in developing policy, as well as representation in governance structures, management teams, and frontline service delivery teams
  - consider opportunities for using the STP to support Aboriginal and Torres Strait Islander doctors complete their training in psychiatry
  - support the development of technologies such as teleconferencing and webconferencing to enable Aboriginal and Torres Strait Islander peoples in remote and rural locations to access high quality healthcare regardless of workforce distribution
  - fund the creation of Aboriginal and Torres Strait Islander e-learning modules via the RHCE Sub-Program to offer cost effective ways of enhancing the capability of the mental health workforce to respond appropriately to Aboriginal and Torres Strait Islander consumers
  - sustain funding for Recognise at adequate levels.

A national model for consultation liaison psychiatry

Consultation-Liaison Psychiatry (CLP) represents another important initiative that has been shown to provide substantial return on investment.

CL psychiatrists are trained in medicine and psychiatry and operate at the interface between physical and mental health. As indicated in the ‘Physical health of people with mental illness’ section of this submission, it is widely recognised that there is a policy vacuum around the strong connections between physical and mental health systems. This reflects a hangover from the era of ‘split’ mental and physical health systems. This split has been perpetuated in the historic underfunding to CLP and the failure of development of CLP despite the considerable and continuing expansion of the general hospital sector. A direct consequence of this is inadequate and unsafe care, increased length of stay and inefficient management of patients with physical and psychiatric co-morbidity.
CLPs work in multidisciplinary teams of nurses, psychologists and junior medical officers. They provide expert care of medical and surgical patients with mental disorders (including obstetric patients and children) in general and specialist hospitals. They also provide expert care to patients with mental disorders in the Emergency Department, psychological guidance and support of medical ward teams in the care of patients with mental illness and education to hospital staff and students about psychiatric disorders in the medically ill.

Away from the clinical realm, CL psychiatrists undertake research, policy development, service development and improved administration in order to embed best practice and improve holistic care for patients undergoing treatment or rehabilitation. CL psychiatrists also inform government agencies about how to best support patients in their recovery. CLP, which includes psychosomatics (the science of how the mind affects the body) is a sub-specialty of psychiatric practice that serves to integrate medicine and psychiatry (physical health and mental health).

Research shows that CLP services provide a strong return on investment. In 2011, the London School of Economics (LSE) conducted an economic evaluation of a CLP service operating in City Hospital in Birmingham (Parsonage and Fossey, 2011). This service was typical of CLP services also found in Australian hospitals, as outlined above. The evaluation found that the incremental cost of the service was around £0.8 million a year, but that even on conservative assumptions the CLP service generated incremental benefits in terms of reduced bed use valued at £3.55 million a year, implying a benefit: cost ratio of more than 4:1.

The LSE analysis also found that the CLP service offered further potential savings by way of fewer discharges of elderly patients to institutional care rather than their own homes. They concluded that the CLP service was good value for money and that ‘Unlike most health care interventions, CLP services actually save money as well as improving the health and well-being of its patients’ (Parsonage and Fossey, 2011). As a result of these and similar findings (Wood and Wand, 2014; Wand, 2015), the UK National Health Service has published guidelines for commissioners that recommend that all hospitals with emergency departments should have 24 hour CLP services (London Strategic Clinical Networks 2014).

In general hospitals, the rate of mental disorders such as depression, anxiety and delirium is high amongst medical and surgical patients with a range of adverse consequences. These include impacts on the physical health of patients, on the length of hospital stay and costs of care. Psychiatric illness in this population also affects the wellbeing of their families and carers and represent a source of work-based stress for general hospital staff who care for patients who are mentally ill.

Between 1 and 5% of hospital inpatients require specialist mental health assessment and management. The inability to provide this service in a timely manner (less than 24 hours) leads to increased length of stay, delayed transfer to mental health services and inadequate management of high-risk patients. A level of 1.8 EFT per 100 beds is required to provide baseline CLP services in general hospitals, with higher levels required in more specialist settings. Currently, many Australian hospitals fall below this level, representing a systemic gap in mental health care and a structural inefficiency.

Another major service gap is the very limited availability of outpatient CLP clinics. With ‘mainstreaming’ in the 1990s and the establishment of a state-wide system of area mental health services and clinics, many hospital psychiatric outpatient clinics were closed down. These clinics saw and treated many patients whom are now recognised as ‘CL patients’ – patients with complex, co-morbid physical and psychiatric problems. However, the area mental health clinics are ill-equipped and often reluctant to deal with such patients, leaving general practitioners and primary care practitioners struggling to manage. This results in a serious service gap. Without adequate funding for outpatient services CLPs are unable to follow up the patients they have cared for during their acute admissions. In addition to the inadequate service, the current situation provides inadequate training opportunities for trainee physicians and psychiatrists in the increasingly important area of physical-mental co-morbidity.
Despite this, CLP services in the general hospital system are ad hoc, underdeveloped and underfunded. Yet, as illustrated above, CLP services generate strong return on investment – benefiting patients, their families and carers and, ultimately, the wider Australian community. However, there is currently no model of care and model for funding that works effectively across the general and mental health care sectors to provide timely and effective care and efficient patient flow for patients who fall into this chasm by virtue of having physical-mental co-morbidity, perpetuating an arcane and inefficient system. The RANZCP considers that these issues require a national solution.

**Recommendations**

- That the provision of adequate mental health services be a core component of general hospital care.
- That a baseline target of 1.8 EFT per 100 beds be established for general hospital CLP services. This should include an increase in the number of advanced training opportunities for registrars and trainees to work in the area of CLP and the establishment of senior CLP registrar positions in every general hospital.
- That general hospitals are funded to allow adequate CLP outpatient clinics.

**Investing in the implementation of the NDIS**

The National Disability Insurance Scheme (NDIS) offers an unprecedented opportunity to improve the lives of people with disability in Australia. The RANZCP commends the Commonwealth Government for its continued commitment to implementing the NDIS, and its consultative approach in doing so. We recognise that this undertaking requires significant investment at a time when the imperative is to reduce national spending.

The National Disability Insurance Scheme Act 2013 (Cth) states that funded support must represent ‘value for money’, relative to both the benefits achieved and the cost of alternative support. Much of the feedback from NDIS trial sites indicates that these mandates are already being realised. Some RANZCP members have reported that consumers receiving support via an Individually Funded Package (IFP) in general stay well for longer, require inpatient treatment less often and stay in hospital for shorter periods of time. These early reports indicate the potential of the NDIS to reduce reliance on crisis and acute care, enhance the efficient use of resources and contribute to a healthier and more productive society (National Disability Services, 2014).

**Mental health and the NDIS**

The cost savings potential of the NDIS are multiple and significant, however, realising this potential requires careful policy design and implementation. This is particularly the case where the NDIS interacts with the mental health sector, due to the complexity of some of the core NDIS elements such as diagnosis, consumer choice and self-advocacy. The RANZCP has raised these issues in detail in a number of forums, including the following submissions: Review of the NDIS Act (RANZCP, 2015a), NDIS Quality and Safeguarding framework consultation (RANZCP, 2015b) and the NDIS Information Linkages and Capacity Building consultation (RANZCP, 2015c). We also welcome the analysis of this in the NMHC’s Review of Mental Health Programmes and Services, and we fully support the recommendations for what should be prioritised for clarification, and how this could be supported (NMHC, 2014).

Going forward, we welcome increased opportunities for communication between the National Disability Insurance Agency (NDIA) and the mental health sector. 2016-17 will be a significant period for the NDIS, especially with regards to establishing mechanisms for communication and collaboration. The RANZCP welcomes the opportunity to be considered for membership on the NDIA Mental Health Sector Reference Group, and we would further support the establishment of more formalised partnerships at
the service delivery level. The RANZCP is aware that this is already occurring in various NDIS pilot sites on an ad hoc basis, however, we would support a more formalised and consistent approach to this.

Scope of the NDIS

The RANZCP is aware that there are an additional number of issues to do with the scope and eligibility of the NDIS that will require consideration, and potentially investment, to get right. As discussed above, the RANZCP recognises the tension inherent in implementing such an ambitious scheme in the context of a slowing economy, however, we emphasise that establishing comprehensive supports early on for a person with psychosocial disability is an investment that offers manifold returns, including improved overall health, decreased reliance on crisis services and enhanced workforce participation.

In particular, supporting children and adolescents in the early stages of illness offers profound benefits over time. Studies show that the initial onset of mental disorders usually occur in childhood or adolescence, however, diagnosis and treatment typically does not occur until a number of years later (Kessler et al., 2007). The RANZCP is concerned that eligibility for full supports under the NDIS hinges on diagnosis, permanency and severity, which may not yet be clinically established in children and adolescents with mental health issues.

In the period between onset of impairment and formal diagnosis, children and adolescents are at high risk of social isolation, disengagement from education, worsening mental health and missed opportunities for treatment. Conversely, early intervention can offer lifelong benefits (RANZCP, 2010). The NDIS is technically available to anyone between zero and 65 years of age, however, this gap between impairment and diagnosis risks effectively excluding children and adolescents with mental illness by default.

The RANZCP welcomes the trial of early intervention therapy included via the NDIS for children under the age of six with developmental delays, or children under seven with an autism diagnosis. We would support the broadening of this scheme, in consultation with mental health professionals, to ensure that children and adolescents experiencing the early stages of mental ill health are appropriately supported.

The RANZCP also supports the recommendations set out in the NMHC’s Review of Mental Health Programmes and Services for improving the fit between the NDIS and the mental health sector.

Recommendations

- That the Commonwealth Government ensures:
  - the development of more effective mechanisms for communication between the NDIS and the mental health sector, to improve capacity for information sharing and collaboration as the nationwide roll out of the NDIS commences
  - that psychiatric expertise is incorporated into these communications mechanisms, both at the level of direct services delivery, as well as at the policy and strategic level.

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