Productivity Commission
The role of mental health in supporting economic participation, enhancing productivity and economic growth

April 2019

Improve the mental health of communities

Contents

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, and dvocates for people affected by mental illness and for quality mental healthcare sytems. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

In Australia, the RANZCP has more than 5600 members, including more than 4200 fully qualified psychiatrists and over 1400 associate (trainee) members. The field of psychiatry is extremely broad, spanning across public and private health systems, rural and metropolitan locations, community care and acute hospital environments, intellectual and developmental disability, alcohol and other substance misuse. Psyhiatrists work across the entire life span from perinatal and infant mental health to older Australians' mental health. Psychiatrists are clinical leaders in the provision of mental healthcare and use a range of evidence-based treatments to support a person in their journey of recovery.

In developing this submission the RANZCP consulted widely with members, including key RANZCP committees that comprise psychiatrists, trainees and people in the community who provide their lived experience perspective.

Summary

The RANZCP sees the Productivity Commission ('the Commission') inquiry as a once-in-a-generation opportunity to critically evaluate and influence definitive reform of the mental health sector. This inquiry is a chance to increase focus on prevention and early intervention, while ensuring a rehabilitation and recovery focus within mental health services, with the overall goal of increasing cost-effectiveness alongside improving consumer outcomes. To this end, and appreciating the wide scope of this inquiry, our submission focuses on the following high level priorities for our mental health system:

1. guaranteeing access to affordable and high-quality mental health services
2. targeting services towards at-risk populations
3. ensuring there is adequate and appropriately distributed Commonwealth, State and Territory funding to deliver optimal services
4. building a modern, energised mental health workforce
5. integrating evidence and accountability into standard practice in the mental health sector
6. addressing social determinants of mental health.

The RANZCP submission is focussed on several measures needed to address these key priorities. In this submission, we briefly outline a number of the well-known issues and weaknesses, and then move to a solution-focussed approach, detailing proposed measures to meet these priorities.

Further perspectives

Please note the RANZCP New South Wales (NSW) Branch has provided further detail on a state-specific perspective of the mental health system in the attached Appendix 1.

Introduction

The RANZCP welcomes the opportunity to contribute to the Commission's inquiry into the role of mental health in supporting economic participation, enhancing productivity and economic growth. The aim of this submission is to provide a psychiatric perspective on matters raised by our members as crucial to building a more productive and efficient mental health system.

As mental health specialists, psychiatrists are well-positioned to provide constructive input into improving the delivery of mental health services. This includes identifying gaps, proposing solutions to improve service delivery for individuals and working to build a more effective and efficient mental healthcare system. The recommendations contained in this submission are based on extensive consultation with RANZCP members from a range of geographical locations, psychiatric specialties and expert committees.

The Commission's challenge will be developing a set of real-world recommendations that cut through interest group priorities, and set an agenda that is guided by the basic principles of equity, accessibility, and effectiveness. Whatever comes from the Commission's inquiry, it should aim for recommendations that simplify and support rather than complicate an already chaotic delivery system. The College's view is that this broad-ranging inquiry, to be effective, must address the fundamental weaknesses in the current structures and funding arrangements, and recommend novel and bold solutions.

This is a unique opportunity to recommend true reform, potentially basing system-wide changes on a 'blank slate'. There is no single interest group in the mental healthcare sector with critical pull or influence. All struggle to be heard, and as a result, the mental healthcare landscape has developed chaotically. Whichever interest group manages to call for attention by the government of the time, has a short-term win, gets a brief funding stream, and sustainable models tend not to develop. There has been little political will to systematically address the fundamental structural weaknesses, which have resulted in inequities and ineffectiveness across the mental health system. The growth in the consumer/carer sector is in part a reaction to the appalling state of service structure and functioning. If good, reliable care was comprehensively available, there would be little to agitate about, and much to collaborate with.

Current issues and weaknesses in the mental health system

Mental illness is an area where there is significant opportunity to improve consumer outcomes while also decreasing costs to society, including through lost productivity and ongoing use of government services. The current system, characterised by attempts to integrate mental healthcare into mainstream healthcare, began with the transition from care provided in specialist psychiatric hospitals to community mental health services and mainstream hospital care. While this shift has been unanimously supported, the challenge has always been adequately funding these new structures and braiding together comprehensive service packages to fully meet the needs of people living with mental illness.

Given the many past reviews of the mental health system, the RANZCP notes that many of the key structural weaknesses have already been, for the most part, adequately identified. In particular, the National Mental Health Commission's (NMHC) National Review of Mental Health Programs and Services in 2014 outlined current issues with the mental health system, including persisting stigma, poor experiences of care, unresponsive and fragmented services, poor resource allocation and little prioritisation of people's needs (NMHC, 2014). Research into mental health service use has also emphasised key areas where access to support varies (Parslow, Jorm, 2000). The RANZCP supports the use of these documents as reference points for the broad structural issues and weaknesses in the

mental health system. It is the RANZCP view that chronic underfunding and haphazard allocation of resources have led this system to a point of crisis.

Current structures and resources

The structures that govern and fund the mental health system have changed significantly over the last two decades, and need to be considered by the Commission when recommending system-wide reform. Government agencies have developed planning tools for determining mental healthcare resource requirements for particular populations, however, the benchmarking, targets and assumptions need to be re-examined and widely agreed. National Mental Health Plans have attempted to address specific shortfalls in issues at specific times but delivered little of lasting substance, with no reduction in suicide rates despite it being a specific focus.

States used to provide a greater range of services: inpatient services, outpatient services, and rehabilitation and disability support services. Over the last two decades, the range of state services has declined to become mainly hospital and acute community focused, and some subspecialty services. Nationally, state services have remained static in delivering.

Commonwealth funded services have increased dramatically, starting with the introduction of Better Outcomes in the 1990's, then Better Access, plus the rise in Pharmaceutical Benefits Scheme (PBS) spending on antidepressants, the addition of funding for disability support and other specific programs through Medicare Locals. More recently, services are being delivered and commissioned through Primary health Networks (PHNs), as well as targeted programs such as headspace. Private psychiatry Medical Benefits Scheme (MBS) spending has remained fairly static. The reality of funding is that much of the health funding comes from the Commonwealth through the National Health Reform Agreement (NHRA).

Governance: Clinical and corporate governance frameworks are well-developed in some mental health sectors, however, in many sectors the clinical roles in governance are significantly and progressively lacking.

What we know

The current system of mental health is complex, and a large portion of this is due to our unique governance and funding issues, and other politico-historical accidents. This complexity is unnecessary, and a key focus of the Commission should be simplifying the delivery of services.

Existing service delivery structures and organisations are reasonably well defined, but what they are supposed to be doing, and for whom, i.e. the boundaries of their responsibilities, remain very vaguely defined, if at all. Additionally, the models and pathways of care, including trauma-informed care, require greater consideration, training and supervision resources to empower clinicians and teams.

Notably, the principles of prevention and early intervention are simple, well-studied and irrefutable. Effective treatments and interventions are well-defined and studied. We know the extent of the clinical problems via National Mental Health Surveys: the raw numbers of those affected by mild/moderate/severe disorders and those at risk, by virtue of the population figures for childhood abuse and neglect. The pools of clinicians available to deliver services are also reasonably well-defined.

The College's view is that this broad-ranging inquiry, to be effective, must address the fundamental weaknesses in the current structures and funding arrangements, and recommend novel and bold solutions. Providing a raft of recommendations to better fund the various arms of the current

dysfunctional system, risks propagating dysfunction and inefficiency. It is the RANZCP view that system redesign is critical and sees the inquiry as a potential watershed in mental health service delivery in this country. Only a national focus with depth and breadth will bring about change.

Moving to solutions

In order to meet current and future challenges in mental health, the RANZCP calls for a shift in the design and investment of the mental health system to realise the vision of a recovery-oriented and evidence-based model, grounded in community and regional responsiveness, with sufficient capacity to provide intensive acute services when needed, with the ultimate aim of *leaving no gaps.*

Principles	Failings	Aspirations
Equity	Marked disparities in physical health outcomes for people with mental illness (see Keeping Body and Mind Together, RANZCP 2015a) Concentration of clinicians (psychiatrists/psychologists/mental health clinicians) in inner metro area; outer metropolitan areas of major cities have the same psychiatrist/population ratio to rural and regional areas; remote areas very poorly served; similar distribution issues with allied health and nursing groups; NGOs in regional areas are marginal.	Equity of mental health care with physical health care. Equitable distribution of resources according to population and needs.
Accessibility	Plagued by poorly defined roles for the various players in the sector; influenced by equity, geography, stigma, ethnicity and culture.	Well-distributed, easy to access, timely, responsive and flexible.
Effectiveness/Quality	To be effective, services need to clearly define what they do, and who they do it for; no service can do everything for everybody. Services (and who they serve) need reasonable expectations of them and to be based on simple principles: available biological, psychological and social interventions are easily defined and limited. However, psychosocial care and trauma-informed care need to be 'everybody's business'.	Minimum standards of care defined across disorders and funding and systems designed to deliver them. Free of stigma and discrimination.

1. Access to services

People with mental illness can often face significant barriers to seeking, and receiving, quality mental healthcare. Obstacles to patient journeys are everywhere, well-documented and include lack of resources, lack of clarity about how to access resources if they exist, lack of clarity about what service delivers which intervention, and inevitable duplication. Although the general mental health community subscribes to a 'stepped-care model' what is being delivered more often is a 'step/gap model'. This is where steps do exist, but there is often a chasm between the steps, that many inevitably fall into.

It is vital to acknowledge the magnitude of unmet need when considering access to mental health services; the AIHW has concluded that 54% of people with mental illness do not access any treatment (AIHW, 2014). Governments must also consider future utilisation of psychiatric care and treatment as demand grows. Patients with moderate to severe high-prevalence mental health disorders are the most common diagnoses treated in private psychiatric hospitals. Yet in 2016-17, private psychiatric hospitals treated 39,328 people (unique admissions), just 6.5% of the estimated number of people living with a severe mental disorder (APHA, 2018), which indicates there is still much unmet need. In the absence of private psychiatric hospital treatment, patients suffering these mental health disorders may not have an equivalent public sector treatment alternative when they require hospitalisation.

While we are aware that there will inevitably be limitations to health budget resources, the RANZCP believes that much more needs to be done to redistribute and top-up funding to meet the needs of Australians as early as possible, and to fill the gaps between steps. This reflects the strong economic case for mental health promotion, prevention and early intervention, noting that under-treatment of mental illness can also incur significant economic costs (Knapp, McDaid and Parsonage, 2011).

Acknowledging mental illness as a key factor in suicide, the RANZCP continues to urge for an evidence-based approach to planning suicide prevention programs and interventions, as well as the importance of evaluation.

Care pathways

Under the current system, there is no clear and efficient 'care journey' for individuals with mental illness often accompanied by medical comorbidity and alcohol and substance use disorders to follow. An average of three professional consultations is required prior to first contact with public mental health services (Steel et al., 2006), and within the mental health system there are many complexities for individuals to navigate, including the Better Access scheme and others. This is in contrast for care pathways which exist for individuals with physical health concerns. It is notable also that issues with care pathways are further exacerbated for certain populations who may face other barriers to seeking care, including Aboriginal and Torres Strait Islander peoples (Kilian and Williamson, 2018) and those with a complex trauma history. The 'care journey' and its navigation are affected by several key issues, including governance, funding frameworks, out-of-pocket costs, region and models of care (including the 'step/gap model' discussed above.

A key part of removing barriers and improving access is ensuring there are clear, coordinated care pathways for individuals with mental illness, so that they are able to receive the right care, at the right time, in the right way (Brophy et al., 2014). There must be investment in projects to develop coordinated care pathways, incorporating strategic input as well as practitioner involvement and ownership, and pilot these in various settings. Care pathways for individuals with mental illness also need to be underpinned by improved communication and systems coordination within and between health services (Waterreus and Morgan, 2017). These pathways can also be facilitated by the effective engagement and

participation of people with lived experience, as outlined in a recent report by the National Mental Health Commission 'Sit Beside Me, Not Above Me' (NHMC, 2018).

Recent research has suggested that further evaluation of the Better Access scheme, which provides a pathway to a certain number of psychologist sessions, should be undertaken to ensure value-for-expenditure is being achieved alongside improved outcomes for Australians (Jorm, 2018; Berk, 2019; Mihalopoulos, 2019). Any changes in this area should feed into the MBS Review currently underway within the Federal Department of Health, with the goal of ensuring services are better aligned and cost-effective.

Unfortunately, there is no definitive final answer as to what models will work. Removing barriers requires simplifying systems, and defining clear roles and responsibilities between various funding bodies and their service delivery arms and being willing to fund evaluation and research as an ongoing part of evidence-based good practice. This must also include better integration and coordination between public and private mental health systems, including introducing opportunities to better share work and patients between private and public settings. Notably, there is little point in 'reforming' if there is no definition of what packages of care people should expect when they suffer specific mental disorders. This issue with packages, or pathways, for care is discussed earlier in this submission. It is clear that only with more detailed and coordinated planning can services be appropriately planned for, resourced and evaluated. On this basis, minimum standards of care should be defined across disorders and funding and systems designed to deliver them.

The RANZCP recommends that the Productivity Commission consider:

- incorporating the importance of the private mental health sector in this inquiry and future reforms

- ensuring an evidence-based approach to suicide prevention, and the importance of evaluation

- investigating changes to the mental health governance framework, including options such as the Commonwealth assuming responsibility for funding all ambulatory mental health services, and the design of their delivery systems and their governance arrangements

- examining the impact of the Better Access scheme and other current pathways to care for mental illness

- developing definitions of minimum standards of care.

Patient costs

Due to the complex funding arrangements, and the mix of public and private services within the Australian healthcare system, people with mental illnesses can incur a number of direct and indirect costs of care. These out-of-pocket costs can be a significant barrier to accessing services, particularly for certain vulnerable groups within the population. The Commission must consider both novel and traditional means of making cost a less significant barrier for individuals looking to access mental healthcare.

Revision of the MBS, in particular, is one key area which should be considered by the Commission. This may involve a broad overhaul of the scheme (as is discussed later in this submission), or relatively minor changes to improve the current system. For example, one minor measure which may be beneficial is increasing Medicare rebates for psychiatry services to 100% of the schedule fee. At 1.64% of total expenditure, psychiatry services make up a very small proportion of MBS services, particularly when compared to the mental health needs of the population (RANZCP, 2015b). Re-costing MBS psychiatry item numbers would have a relatively minor impact on total MBS expenditure while providing significant

benefits for the prevention, early intervention and treatment of mental disorder by better accommodating the needs of Australians who are unable to access care in the public sector. However, minor reforms to the existing are not necessarily going to deliver on improved mental health for all. Please see *Section: Funding and Resource Allocation* further submission for discussion of broader reforms.

Currently, certain mechanisms do exist to improve affordability in mental health. These include the various existing safety nets, including the Pharmaceutical Benefits Scheme Safety Net and the Medicare Safety Net. This system of safety nets is difficult to understand and is inconsistently applied, which makes it harder for individuals to know what they are eligible for. In order to better manage the various safety nets available, it may be pertinent to consider the potential implementation of a single safety net for all healthcare costs, including Medicare, PBS and allied health. This topic is explored further in the RANZCP report 'Affordability as a Barrier to Mental Healthcare' (RANZCP, 2014).

The RANZCP recommends that the Productivity Commission consider the following:

- examining re-costing of MBS psychiatry item numbers to reduce out-of-pocket costs
- evaluating the potential implementation of a single safety net for all healthcare costs, including Medicare, PBS and allied health.

Addiction and mental health

Substance-use disorders are a core concern for psychiatrists considering the complex interrelationship between addictive behaviours and other mental disorders. Alcohol-use disorders are highly prevalent in Australia, especially among young adult males. In addition, comorbidity between anxiety and other drug-use disorders is common and remains a significant challenge for the delivery of effective health-care services and treatment (Teesson et al., 2010). Modelling suggests that currently Australian services meet between 26.8% and 56.4% of demand for alcohol and drug treatment (Ritter, Chalmers, Gomez, 2019). This demonstrates the urgent need for expansion of alcohol and other drug services.

Developing a holistic, nationally coordinated and evidence-based response to harmful substance use is an important investment, with significant potential for economic returns. Research shows that every $1 invested in alcohol and other drug services saves Australian communities $7 in flow-on effects (Ettner et al., 2006). The social costs of substance use disorder are estimated to be in excess of $20 billion (Collins, Lapsley, 2008). The RANZCP firmly believes that there must be a greater public health focus on reducing addiction issues, and as part of this government must establish a national quality framework for alcohol and other drug services, including accreditation standards for rehabilitation facilities.

On this basis, the RANZCP recommends the Productivity Commission consider the following:

- examining the benefits of redistributing funding towards public addiction services, including specific services for alcohol use disorder, methamphetamine use disorder and others
- establishing quality frameworks governing the provision of alcohol and other drug services, in particular private rehabilitation facilities.

Providing care in emergency and acute care settings

Emergency departments (ED) and acute services are integral parts of the mental health system in its current form, and appropriate support and reforms are required to ensure people with mental health concerns are receiving optimum care. While there has been a distinct shift towards management of mental illness in community settings, rather than hospitals, high-quality emergency department and

inpatient care is still necessary for some people to ensure safe treatment during episodes of acute psychiatric illness (Allison and Bastiampillai, 2015).

More specifically, emergency departments are in crisis, and getting into hospital when needed is a major issue. By dint of history, emergency departments have become the main entry point to inpatient services, and mental health services, more generally. The performance of emergency departments in managing people with mental health conditions is a true barometer of the health of the mental healthcare system overall. If the emergency department is overwhelmed by mental health presentations, as it is in many parts of Australia, it indicates upstream and/or downstream difficulties. For example, the RANZCP NSW Branch is aware of a situation involving a hospital in a NSW Local Health District in which $4 million in one year was spent on using security to provide one-to-one supervision of mental health patients waiting for beds. The same unit has days where up to 28 admitted patients wait in the emergency department for a psychiatric bed.

Presenting at an ED can be a distressing experience for many people with mental health issues, in particular due to the stressful environment an ED may present. This is discussed in more detail in the Australasian College for Emergency Medicine (ACEM) Report on Mental Health Presentations to Australian Emergency Departments (ACEM, 2018). Recently focus has been placed on the structural and clinical inadequacy of mental healthcare in emergency departments. While work is ongoing towards improving the quality of outcomes and experiences for people seeking help with mental health in emergency departments, the RANZCP believes there are several areas which would benefit from further investigation by the Commission in the interim.

Firstly, it is clear that there is a need for a more attuned focus on patient needs, trauma-informed care[1] and multidisciplinary teams working together through assessments and collaboration with the patient on treatment decisions. This can be achieved through improved training and the exploration of alternative models of care. In refocussing ED care, it is important that cost-effective and evidence-based interventions, including psychotherapeutic interventions, be adequately funded and made accessible for those who present (Abbass et al., 2015).

Secondly, emergency departments require significant structural redesign of specific spaces for mental health, to ensure that individuals with mental illness can seek help in a calm, safe and private environment. In addition to structural and clinical changes in ED, there is an ongoing need to ensure adequate follow-up for individuals who present with deliberate self-harm throughout the mental health system.

Currently, the RANZCP is working with the ACEM to improve care for people in emergency and crisis situations, following a National Summit for Mental Health in the ED and the release of the report mentioned above. It is widely agreed that there are complex problems that require the commitment of all Australian governments to plan and implement effective reform.

The RANZCP recommends that the Productivity Commission consider the following:

- much more focus on prevention and early interventions in the community with service models that provide timely access to expert, early, intensive and multidisciplinary care
- appropriate models of care for the management of mental health presentations in the ED

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[1] Trauma informed care is defined as an evolving concept which highlights the importance of trauma for practice, including its prevalence, impacts and dynamics.

- re-designing emergency department mental health areas to better meet the needs of individuals presenting with mental health concerns, with a focus on better structural design of mental health specific spaces in EDs, including calm, safe and private spaces
- streamlined pathways and increased availability of inpatient services (e.g. acute psychiatric beds)
- exploration of alternative models of care such as after-hours care in the community, including crisis services.

2. Targeted services for at-risk populations

While the RANZCP supports all Australians having access to high-quality, evidence-based mental health services, there is evidence to suggest that specific, targeted services are needed for certain at-risk populations. This may include Aboriginal and Torres Strait Islander peoples; people living in rural and remote communities; people with chronic conditions; people of low socioeconomic status; people affected by homelessness; prisoners; people with culturally and linguistically diverse backgrounds, refugees and asylum seekers; and children and young people. The RANZCP acknowledges that more resources, planning and services are required for many of the vulnerable groups listed above, however, in this submission we address two key groups which were raised in the Productivity Commission Issues Paper and which present significant opportunity for cost-effective reform of specialist mental health service provision. It is expected that further focus on other groups will be raised in submissions from other organisations.

Child and adolescent mental health

Research strongly indicates that the most cost-effective way to prevent the development of mental health problems and promote mental wellbeing is to target childhood and adolescence (Zechmeister et al 2008) including the perinatal period. Subsequent Australian Child and Adolescent Surveys of Mental Health and Wellbeing (2000 and 2015) have shown that the last 15 years of reform are not delivering significant improvements to the mental health of children and adolescents. Notably, in 2016 suicide was the leading cause of death of children between five and 17 years of age (ABS, 2017). Symptoms, disorders and reduced social and academic function usually emerge before the age of 18 and early intervention may therefore substantially reduce the risk of downstream comorbidity, suicide, deliberate self-harm, disease burden, unemployment and costs of medical care and welfare support (McGorry et al., 2007).

Early experiences determine whether a child's developing brain architecture and body regulation provides a strong or weak foundation for all future learning, behaviour, and health (Felitti et al., 1998; Center on the Developing Child, 2007; Moore et al., 2017). Mental health problems during early years can have enduring consequences if left unresolved (Felitti et al., 1998; Raphael, 2000) not only by placing individuals at increased risk of difficulties in adult life, both physically and mentally, but also by placing increased pressure on limited community service resources (Sawyer et al, 2000). Suffering and negative outcomes can also cause intergenerational cycles which become larger problems to address (Austin, 2003). There is robust evidence that the onset of many adult psychological problems have their origins in infancy, childhood and adolescence (Dadds et al, 2000).

It is important to consider that children develop and thrive within the spectrum of their families and communities, and support and prevention for children entails a family and systemic focus. Effective prevention and intervention requires resourcing and training that recognises and ensures collaboration and service integration across health, mental health, including adult mental health, child development and child protection sectors (RANZCP, 2010). On this basis, the RANZCP strongly encourages investing and intervening in early life, from prenatal periods to adulthood.

Specifically, the RANZCP recommends the Productivity Commission consider the following:

- mental health screening within schools and other early-learning organisations, as coordinated by the various education departments, for vulnerable infants, children and adolescents to enable early referral and appropriate intervention

- availability of intervention services in the education sector, as well as throughout the community, suited to children and adolescents

- resourcing and training that recognises and ensures collaboration and service integration across health, mental health, including adult mental health, child development and child protection sectors and then education as age advances

- ensuring specialist early intervention services are available for young people with psychosis, severe mood disorders, depression, eating disorders, somatisation, self-dysregulation and other complex mental illness

- targeted, culturally appropriate and specialised prevention and early intervention programs for young Aboriginal and Torres Strait Islander peoples and children, particularly those in rural and remote communities and those children surviving experiences as refugees or forced immigrants of torture and trauma.

Justice and mental health

Given the high rates of mental health issues among people in contact with the criminal justice system, the RANZCP believes that adequate resourcing for forensic mental healthcare is imperative. This is true in relation to both juvenile and adult justice systems where large numbers of at-risk people may be identified and provided with suitable services to aid them in their recovery and rehabilitation. Unfortunately, these systems all too often provide experiences which compound pre-existing trauma, mental health issues and addiction disorders, rather than alleviate them.

It is important to consider the interrelation of discrimination and the criminal justice system, in particular that Aboriginal and Torres Strait Islander people are overrepresented in the criminal justice system. Aboriginal and Torres Strait Islander people are seven times more likely than non-Indigenous people to be charged with a criminal offence and appear before the courts (Australian Law Reform Commission, 2018). This issue is discussed further in the Australian Law Reform Commission 2018 Report 'Pathways to Justice-Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples'.

The RANZCP affirms the significant benefits of a justice reinvestment approach to criminal justice. This involves measures to decrease rates of incarceration and recidivism by investing funding in prevention and early intervention services in the community. The value of a justice reinvestment approach lies in its potential to direct resources away from prison building and into community building and the building of personal regulation, thereby strengthening and empowering communities and individuals to help people at risk of developing mental health and addiction issues and reduce offending.

With regard to juvenile detection and justice reinvestment in particular, the RANZCP explores a number of related issues in-depth in the submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory The introduction of dedicated adolescent forensic mental health and drug and alcohol services for youth in detention is a key example of an intervention which could result in significant positive health and economic outcomes, as a preventative activity for further serious mental illness and recidivism (Kasinathan, 2015).

The RANZCP recommends that the Productivity Commission consider the following:

- revising the provision of mental health services as they relate to the justice system, in particular considering:
  - the current gaps in the provision of healthcare within the justice system, including ongoing access to dedicated forensic facilities for mental health (including psychotherapy), access

to drug courts, mental health courts and appropriate rehabilitative services in rural and remote regions, access to MBS and PBS in prisons

- o the need for a refocus in the justice system, including organisation processes, staff training and mental health services, on rehabilitation and recovery, with a strong emphasis on trauma-informed care

- reviewing the amount and allocation of funding directed towards mental health in the justice system to determine optimal investment to produce positive outcomes beyond mental health

- implementing cultural competency measures, including relevant training and practice frameworks, for staff throughout the justice system.

3. Funding and resource allocation

The current system of mental health funding in Australia has been identified as fragmented, inadequate and duplicative, and cannot continue. While we are aware that there are limitations to the health budget, the RANZCP believes there is an immediate need to redistribute and enhance funding to meet the needs of Australians. Funding for mental health services should be increased to close the gaps and ensure quality, universal mental health service delivery.

We recommend that the Commission Inquiry focus on several key areas in funding and resource allocation. This should including integrating outcome and function measurement, allocating funding to service integration, and developing a 'blueprint' of what mental health funding arrangements should look like. We urge the Commission to recommend, as a matter of urgency, investment in specific projects (to be trialled and evaluated), of alternative funding models, aimed at improving access, equity, and effectiveness, with the attendant research and evaluation arms to demonstrate these outcomes.

Structural obstacles and solutions

The model of Commonwealth, State and Territory funding, whereby resources are partially distributed through regional Primary Health Networks (PHNs) and allocated to hospitals based on activity rather than outcomes, creates a complex web of resource allocation. Activity-based funding, in particular, creates an incentive to generate activity in order to obtain funding, and provides no incentive to prioritise the removal of gaps, nor to promote rehabilitation and recovery for those severely afflicted.

The RANZCP strongly supports a recovery-focussed and evidence-based model of care throughout the mental health system, and we believe that funding arrangements need to reflect this in practice. The RANZCP considers that one size won't fit all and that different regional areas require different solutions. Options could include coordinated care trials, pooled funding arrangements, the MBS being 'cashed out', so that MBS funding is distributed according to population and prevalence not geographical location of clinicians.

The RANZCP refers the Commission to successful coordinated care and fundholding trials, including those in Aboriginal and Torres Strait Islander Peoples health and in rural psychiatry (Perkins et al, 2016). This could help to prevent the appropriation of mental health funding towards physical health-care, which has been reported as a significant issue in some jurisdictions in Australia. Preventing the appropriation of mental health funding for other purposes will also require further consideration of how the separation of mental health services and physical health services could be adapted to ensure funding is effectively ring-fenced. One such option would be regional fund-holders, contracted to provide all mental health ambulatory care services; consortia would involve operatives with mental health service operational and clinical experience (perhaps comprising groups of clinicians, private sector organisations, public sector mental health services, and community managed organisations).

The RANZCP supports the regionalisation of mental health and suicide prevention services, provided that this is supported by agreed national structures, guidance and measures. The establishment of the PHNs has been ambitious strategy to meet regional needs, but the remit extends far beyond primary care to severe and complex mental illness. The RANZCP has had some involvement in developing guidance materials for the planning and commissioning of mental health and suicide prevention services in PHNs, however, very limited involvement in the clinical governance of individual PHNs that are charged with solving long-standing national problems. RANZCP members have indicated concerns about the current system of commissioning for mental health services, which requires significant expenditure on bureaucratic processes, and requires greater evaluation a model of funding to achieve improved outcomes.

Recently, the RANZCP has participated in the PHN Advisory Panel on Mental Health, established by the Minister for Health, to provide advice on the progress of the role of PHNs against the current mental health reform journey. The Panel identified that 'this reform process is complex and noted that while all PHNs have commenced on the journey towards transforming mental health services in their region, further time and support will be required to ensure that the reform is able to fully deliver the promised results' (PHN Advisory Panel, 2018a). The Panel has provided its recommendations to the Minister via two reports:

- Reform and System Transformation: A Five Year Horizon for PHNs

- The report of the PHN Advisory Panel on Mental Health

<div align="right">(PHN Advisory Panel, 2018a; PHN Advisory Panel, 2018b).</div>

The RANZCP recommends that the Productivity Commission consider the following:

- allocating funding specifically towards integrating the current web of service providers, including mental health professionals, addiction workers, disability workers, non-government organisations, and others; this would require **consolidation** of various provider groups

- investigating novel funding arrangements that integrate outcome and function measurement into funding allocation – this may include more flexible funding pools and partnerships at the regional level

- reviewing the reports and recommendations of the *PHN Advisory Panel on Mental Health*.

4. Mental health workforce

The current mental health workforce is insufficient to meet demand, with more resources needed for planning, recruiting and retaining the required workforce required. This will involve targeted measures to fill current gaps in the workforce, as well as a broad strategy underpinning the growth of the mental health workforce generally.

Planning the workforce

Mental health care is increasingly provided by multidisciplinary teams including peer workers, which help enable greater continuity of care, the capacity to take a comprehensive view of the consumer's networks and problems, the availability of a range of skills, and mutual support and education. The recent commitment of $1 million over two years to develop a National Mental Health Workforce Strategy is a positive development, and must be pursued in a comprehensive and meaningful manner and must incorporate innovative strategies, clude innovative thinking. This Strategy needs to align closely with the National Medical Workforce Strategy and the various workforce strategies underway at State/Territory level. All of these strategies need to be coordinated and should be developed through consultation with peak workforce bodies, subject to implementation and monitoring frameworks, and followed through with concrete actions and investment.

The disparity in the distribution of all mental health professionals between metropolitan and rural areas is of significant concern. Being the peak membership organisation for psychiatrists, the RANZCP is best-placed to discuss the psychiatry workforce, whilst always acknowledging the critical need for a multidisciplinary mental health workforce. With respect to psychiatrists, whilst major cities in Australia have around 13 clinical full-time equivalent (FTE) psychiatrists per 100,000 population, this figure is less than 6 in non-metropolitan areas and 3.3 in very remote areas (Australian Institute of Health and Welfare, 2016). This stark difference demonstrates the need for several specific measures for outer-metropolitan, rural and remote Australia. As part of the workforce strategies, funding for the use of video-conferenced support and other technological service delivery innovations, and related supervision and training needs to be prioritised.

As well as shortages in regional areas, there are also shortages of psychiatrists in certain sub-specialties. One area of particular relevance to the Commission's focus on prevention and early intervention, especially in younger Australians, is child and adolescent psychiatrists (RANZCP, . Currently, there is a shortage of child and adolescent psychiatrists as well as a shortage of child and adolescent psychiatry training posts in Australia to meet infant, child, adolescent and youth mental health needs (Department of Health, 2016; The Werry Centre, 2012). There also remains national disparity of perinatal psychiatry services and mother-infant units, where very early prevention and treatment is being practised. Whilst optimal use of the available workforce and service improvement is essential to improving outcomes for young people (Sawyer et al., 2015), this can only be achieved by accompanying increase in the reach, availability and access to the child and adolescent psychiatry workforce and the adequate training, support and supervision of that workforce.

The RANZCP urges the Commission to investigate the optimal number of full-time equivalent (FTE) psychiatrists in both public and private clinical settings, with the aim to establish benchmarks for clinical roles and for roles that also encompass governance, training, supervision, evaluation and research. This benchmarking exercise could be informed by existing frameworks (i.e. the National Mental Health Services Planning Framework) and should also encompass all key components of the mental health system, such as the minimum number of specialised mental health beds that need to be available in public and private settings in Australia.

The RANZCP recommends the Productivity Commission consider the following:

- investigating and establishing both minimum and optimal benchmarks for:
    - clinical FTE (full-time-equivalent) psychiatrists per 100,000 population (public and private)
    - specialised mental health beds per 100,000 population (public and private)
    - community mental health clinicians with a Community Mental Health Team per 100,000 population.
- providing input into the development of the National Mental Health Workforce Program, including that it address:
    - profession-based workforce targets, based on clinical FTEs, attached to national partnership agreements, and broadly addressing the range of professions needed for integrated care
    - increased funding to ensure medical trainees interested in pursuing psychiatry as a career are supported to do so
    - specific measures to meet the unique needs of rural and regional Australia.

Contribution of carers

It is vital in any discussion of mental health to acknowledge and appropriately value the contribution of carers in the mental health system. In the broader health system, the replacement value for informal care provided by carers would be $60.3 billion (Deloitte Access Economics, 2015). It is logical that a significant portion of this could be attributed to carers of individuals with mental illness, however, further work is required to evaluate the key role of carers in the mental health system and advocate for more effective support to meet their needs. In particular, consideration of the carers in the aged care sector, where the proportion of older people requiring support is increasing rapidly, should be a high priority. This was discussed in detail in the 2011 Productivity Commission report 'Caring for Older Australians', however, a more recent review in this area is warranted (Productivity Commission, 2011). The RANZCP expects this will be addressed in more detail in submissions from carer advocacy organisations. We note the recent introduction of means testing for the Carer Allowance that provided some support for carers supporting a partner or family member with a disability.

In this area, the RANZCP recommends the Productivity Commission consider the following:

- evaluating the key role of carers as unpaid components of the mental health system and other systems such as aged care
- advocating for more effective support systems for carers, including review of the recent changes in this sector
- reviewing the assessment criteria for the Carer Payment and Carer Allowance, to more accurately and appropriately assess what is involved in caring for a person with mental illness.

5. Evidence and accountability

RANZCP members across Australia have suggested that a lack of transparency, accountability and independent evaluation is putting individuals at a significant disadvantage when trying to access quality mental healthcare. The lack of accountability also severely limits the ability of government to evaluate models of care and service delivery, and leaves authorities unable to prioritise individual outcomes when allocating funding and coordinating services.

Outcomes-based monitoring

As identified by the National Mental Health Commission in 2014, and discussed earlier in this submission, there is currently too much focus in the mental health system on generating activity, rather than improving individual and community outcomes. Work is undertaken by various bodies to measure processes and governance, however, with often too little to focus on quality care, evidence-based practice and outcomes.

In order to incentivise better outcomes throughout the sector, there is a need to link the allocation of resources for services, including both funding and staffing, to outcome measures, including quality care, for individuals. However, it is notable that there are a number of areas where little to no data is reported on care and outcomes. While a lack of outcome data does not necessarily indicate that a service or treatment is ineffective, it does limit the ability of government to made evidence-based decisions around funding and resource allocation. Key gaps have been identified in Community Managed Organisations (CMOs) and in the field of private service provision. The Productivity Commission must consider how best to re-engage with certain areas and service providers in the mental health sector, to ensure they are captured in service provision measures.

Funding should be allocated to services which have a relatively strong evidence-base of efficacy and cost-effectiveness. A key example of this is psychotherapy services, which have shown to be financially efficient and clinically effective for a number of mental illnesses (Fonagy et al., 2015; Meuldijk et al., 2017; Stevenson, Measure, D'Angelo, 2005). If this evidence is not available, then pilot programs should be developed prior to significant new funding allocations.

It is important also to consider the most appropriate indicators and outcome data to demonstrate service and program effectiveness. Indicators to monitor mental health improvements could be sourced from epidemiological prevalence of disorders, however the RANZCP would suggest they also include non-medical measures of community involvement. It is possible that the Australian Unity Wellbeing Index may be a valuable resource, however please note this may not be suited to all people.

The RANZCP recommends that the Productivity Commission consider the following:

- developing governing frameworks for measuring and evaluating service outcomes, with a specific requirement for independent and unbiased evaluations

- incorporating a range of determinants, including education, employment, social services, housing and justice, into current measures of service effectiveness and link these to funding allocation

- ensuring effective and evidence-based treatment in mental health, including services such as psychotherapy as a first-line treatment where appropriate.

Evidence-Based Practice

Evidence-based or evidence-informed clinical practice aims to provide the most effective quality care that is available, with the aim of improving person-centred outcomes. Patient individual values and circumstances, clinical expertise and experience, availability of services and treatments all need to be taken into consideration, underpinned by the relevant evidence from robust research. People presenting for mental health care should expect to be provided with the same best-practice care regardless of where they live in Australia, however, this is often not the case (see the Australian Commission on Safety and Quality in Health Care, Third Australian Atlas of Health Care Variation, which reports on unwarranted variation in prescribing).However, bringing together the best research evidence and making it available at the point of care to support effective and quality care is a significant undertaking.

To support psychiatrists and other mental health professionals in the provision of evidence-based care, the RANZCP has developed/updated a number of Clinical Practice Guidelines in key topics. This work is crucial to supporting the delivery of high-quality care, however, it requires significant pro-bono time and resource investment from the members of the RANZCP. In other countries, this work is coordinated and funded by a central agency, whilst ensuring clinician input. For example, in the UK this work is centralised under the National Institute for Health and Care Excellence (NICE).

The RANZCP recommends that the Productivity Commission investigate

- the establishment and funding of centralised processes to prioritise, coordinate and fund the development, implementation and evaluation of resources and programs to support best practice quality mental health care.

Governance

The significant value of clinicians being in roles of leadership, management and clinical governance warrants increased support and re- integration of clinical expertise in service planning, design and implementation. Research in the hospital setting, as well as literature on leadership and management, strongly suggests that clinical leadership is crucial to maximising effective management and delivery of care (Perry, Mason, 2016; Daly et al., 2014). The RANZCP strongly encourages a greater role for mental health clinicians, including psychiatrists, in leadership and decision-making, working in partnership with people with lived experience and carers, to help ensure effectiveness of care and appropriate resource allocation.

The RANZCP recommends that the Productivity Commission consider the following:

- strengthening (and in many cases re-introducing) clinical governance roles in mental health services for planning, decision-making,allocating of budget and resources, and evaluation.

6. Social determinants of mental health

The RANZCP recognises that mental health is informed by the social, economic, psychological and physical environments in which we live. People living with mental illness require access to a range of services to strengthen their community engagement and improve their quality of life. Such services include housing, education, employment and training, disability support, social security, criminal justice, cultural wellbeing, drug and alcohol and other health services. While not addressed in detail in this submission, it is important to consider the disadvantage faced in a number of the sectors addressed above by Aboriginal and Torres Strait Islander peoples (Department of the Prime Minister and Cabinet, 2019). The RANZCP is committed to supporting the entitlement of Aboriginal and Torres Strait Islander people to effective mental healthcare which is appropriate to their culture and needs.

Other countries have also placed focus on the social determinants of health, with a key example being the Marmot Review into health inequalities in England (Institute of Health Equity, 2010). This report draws attention to the evidence that many people in England from lower socioeconomic households spend longer in ill-health than those in high socioeconomic households, and encourages action targeting specific sections of the population along the socioeconomic gradient. The Institute of Health Equity in London has also considered a range of new models of care to reduce health inequalities in a recent report, which may be of relevance to the Productivity Commission (Institute of Health Equity, 2018).

Good mental health service delivery requires a whole-of-government and whole-of-society approach to ensure that the various services required for people living with mental illness are sufficiently coordinated. While acknowledging the importance of addressing social determinants, our submission is limited to where psychiatric expertise is most useful. The RANZCP would encourage the Productivity Commission to further investigate the potential for improvements in homelessness, disability, welfare provision, cultural programs for mental health.

Income support and social services

The RANZCP strongly supports efforts to ensure that people with psychosocial disability can access adequate services and support to improve their wellbeing and participate in the community, both now and in the future. This is particularly important considering that 18.5% of all people with any type of disability have a psychological disability (ABS, 2015). On this basis, the RANZCP supports the principles of the NDIS, and we firmly believe that the NDIS has the potential to improve the lives of many people and encourage person-centred care.
However, there are many people in the community with psychosocial disability who may not have access to the NDIS. The transition to the NDIS, whilst providing for some, has left a significant gap in service provision for many. With the absorption of many community mental health services, and funding being linked to the NDIS, many services are no longer available to individuals who are not eligible for the new scheme. This was acknowledged in the Productivity Commission report on the Review of the National Disability Agreement (January, 2019). Community Mental Health Australia (CMHA) and the University of Sydney further noted that the transfer of programs to the NDIS has led to an increase in the use of more expensive and more reactive clinical services, as opposed to community-based services (CMHA, 2018). Issues around the NDIS are further discussed in the RANZCP submission to the Joint Standing Committee on the National Disability Insurance Scheme (RANZCP, 2018). Since this submission the RANZCP is encouraged to see the development of other support progams announced.

While the RANZCP appreciates that the NDIS is not intended to provide the full range of services required, we are concerned that the reliance on the provision of services via a market-based system leads to fragmented service delivery with a lack of governance, accountability and responsibility for

ensuring the person's needs are met. People with complex needs urgently require an integrated service model. Relying on the continued cooperation between the disability, mental health and justice sectors is also unlikely to provide the kind of holistic support required. Futher consideration is required of how best support for people can be coordinated and delivered.

Notably, a growing proportion of people with mental illness rely on the Disability Support Pension (DSP) for assistance, and it forms an important source of support for people with serious mental illness. Research shows the proportion of working age individuals receiving DSPs for psychiatric conditions increased by 51% between 2001 and 2014 (Harvey et al., 2017). Despite this, it is well known that people with mental illness can face significant barriers to accessing support services like the DSP. The RANZCP believes that more needs to be done to make disability income support more accessible for people with psychosocial disability, and encourages further review of the DSP to ensure it is fit for purpose.

The RANZCP recommends that the Productivity Commission consider:

- Reviewing and addressing services gaps that have resulted from the transition to the NDIS.

- Investigating the accessibility of the disability support pension for psychiatric conditions.

- Ensuring that income support and social services are integrated into an individual's mental health care pathway.

Social participation, inclusion and employment

People with significant and complex mental illness can be among some of the most excluded in society, from community and social engagement as well as participation in the workforce (Huxley, 2003). Evidence suggests that steps towards social re-engagement can lead towards a reduction in symptoms for many people with mental illness (Tew et al., 2011; Burns et al., 2009).

Employment is almost universally ranked among the highest goals of people with serious mental illness yet this population faces the highest unemployment rates of any disability group (Ramsay et al., 2011; Killackey, 2013). Unemployment is particularly high for people with serious mental illness (Waghorn et al., 2012). The costs associated with the unemployment of 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 to the community are also significant. Investing in programs that support people with mental illness to engage in meaningful work has the potential to generate direct savings in addition 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 (IPS) programs have a strong evidence base for enhancing both vocational and non-vocational outcomes (Tsang et al., 2010). Successful IPS programs for people with mental illness should incorporate education to improve awareness and responsiveness to the particularities of psychosocial disability so that employers are supported to make reasonable adjustments when necessary. Programs should also be accompanied by work-related skills training to enable individuals to overcome the educational disadvantage common in those with severe mental illness. Finally, programs should be fully integrated with clinical mental health services and those workers who are delivering the system within educational and vocational frameworks require supervision to manage the practical, attitudinal, emotional, social and systemic challenges encountered.

The RANZCP recommends the Productivity Commission consider practical measures to improve employment prospects for people with mental illness, including:

- programs which support people with mental illness and alcohol, substance use and other addiction disorders to meet their long-term employment and educational goals, specifically including long-term resourcing for Individual Placement Support programs

- developing a Jobs Plan for groups at risk of poor employment outcomes

- raising awareness of the benefits of employing people with mental illness, and the services and supports available to employers

- supporting study as a stepping stone to skills development and employment with adequate funding of the schools, TAFE and higher education sectors

- establishing a participant and leaders' group to develop practical strategies to increase employment of people with mental illness.

Mentally healthy workplaces

Mental health problems, both clinical (e.g. major depression, anxiety disorders) and sub-clinical (e.g., psychological distress), are very common in working populations. They can produce significant costs to employers and the community through lost productivity (higher levels of absenteeism and presenteeism), workplace health and compensation claims, increasing reliance on social welfare systems (LaMontagne et al., 2014). An Australian costing study found the greatest costs of depression amongst working people were borne by employers (far exceeding healthcare costs), with turnover costs figuring more prominently than presenteeism and absenteeism cost (LaMontagne, Sanderson, Cocker 2010).

However, participation in the workforce can give purpose and provide a strong protective factor for mental illness (Modini, 2016). There is a need to identify and address factors in the workplace that can undermine the mental health of employees, while promoting characteristics that can strengthen individual and organisational health (LaMontagne et al., 2014). This should be underpinned by increasing awareness and acceptance of complex mental illness and alcohol, substance use and other addiction disorders in the workplace. Particular consideration should be given to unique workplace structures in Australia, such as fly-in fly-out work or the work of first responders, which can have significant immediate and ongoing impacts on mental health and therefore productivity. FIFO work is explored in more detail by a report prepared for the WA Mental Health Commission on the 'Impact of FIFO work arrangements on the mental health and wellbeing of FIFO workers' (Centre for Transformative Work Design, 2018).

A UK study on return on investment from various mental health and wellbeing programs indicated that programs promoting health and wellbeing in the workplace reduced both presenteeism and absenteeism, and represented a return on investment of more than 9 to 1 (Knapp, McDaid and Parsonage, 2011). Mentally healthy workplaces need flexible, nuanced interventions and support, acknowledging that one size does not fit all (Nielsen et al., 2010). This should include training for managers to develop mental health skills, and interventions which have a strong evidence-base. The range in quality of various Employee Assistance Programs, while they can be beneficial in some cases, was noted as a potential issue (Kirk and Brown, 2003).

On this basis, the RANZCP recommends the Productivity Commission consider the following:

- developing quality frameworks for the independent evaluation of Employee Assistance Programs to ensure quality services are delivered

- developing best practice standards for mental health in the workplace, including for the :
  - implementation of workplace mental health promotion programs
  - delivery of staff training and supervision for key staff, including senior management leadership
  - implementation of workplace interventions to improve the structural workplace environment.

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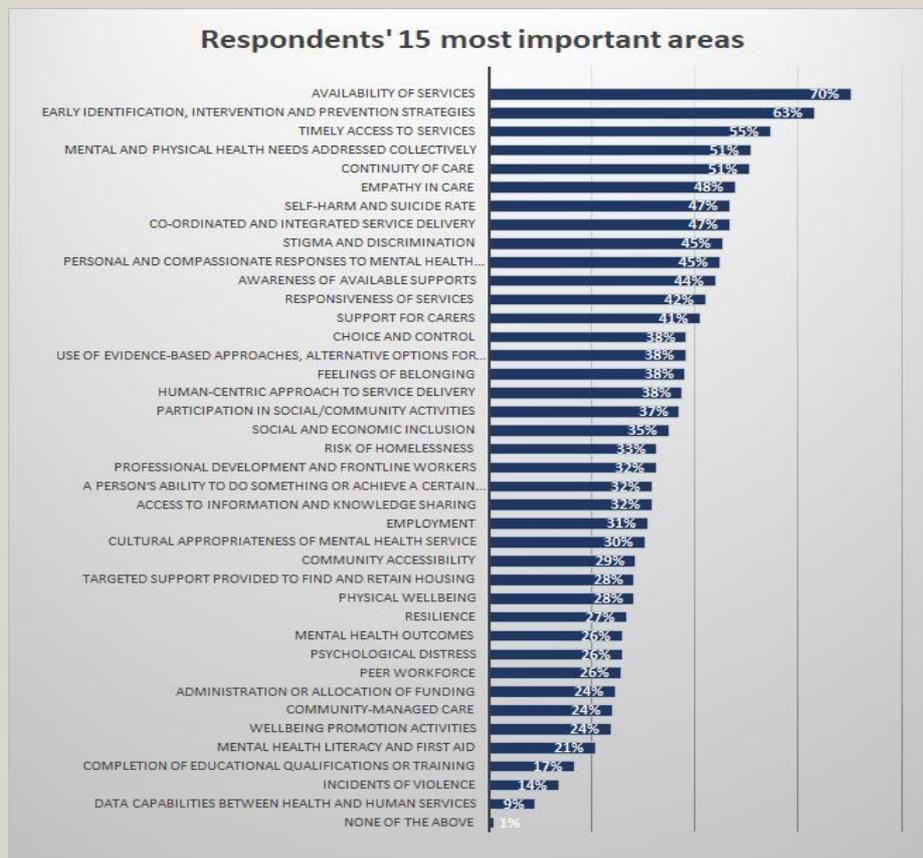## Appendix 1: Additional input from the RANZCP NSW Branch

This appendix provide details and examples of the extent of the crisis, from the NSW Branch's perspective. The NSW Branch is one of the largest branches and provides a compelling snapshot of the failings of the current systems. The NSW Branch has more than 1600 members, including more than 1200 fully qualified psychiatrists and over 400 associate (trainee) members.

We discuss these following issues:

- **What the stakeholders really think**
- **What works**
- **Not enough of anything: proportion of funding needs to increase**

What the NSW stakeholders really think

Before looking at solutions, the NSW Branch draws the attention of the Commission to two recent surveys, which *define the concerns of key players in the sector*. The first was commissioned by the NSW MH Commission to canvass stakeholders about what they regard as headline indicators to monitor mental health reform in NSW. Of the 771 respondents, 662 were those with lived experience of mental health disorder, carers, and mental health clinicians and there was clear concordance between what each group saw as the major issues requiring monitoring. The top 8 considerations were mainly clinical service delivery focussed, as follows:

Respondents' 15 most important areas

Area	%
AVAILABILITY OF SERVICES	70%
EARLY IDENTIFICATION, INTERVENTION AND PREVENTION STRATEGIES	63%
TIMELY ACCESS TO SERVICES	55%
MENTAL AND PHYSICAL HEALTH NEEDS ADDRESSED COLLECTIVELY	51%
CONTINUITY OF CARE	51%
EMPATHY IN CARE	48%
SELF-HARM AND SUICIDE RATE	47%
CO-ORDINATED AND INTEGRATED SERVICE DELIVERY	47%
STIGMA AND DISCRIMINATION	45%
PERSONAL AND COMPASSIONATE RESPONSES TO MENTAL HEALTH...	45%
AWARENESS OF AVAILABLE SUPPORTS	44%
RESPONSIVENESS OF SERVICES	42%
SUPPORT FOR CARERS	41%
CHOICE AND CONTROL	38%
USE OF EVIDENCE-BASED APPROACHES, ALTERNATIVE OPTIONS FOR...	38%
FEELINGS OF BELONGING	38%
HUMAN-CENTRIC APPROACH TO SERVICE DELIVERY	38%
PARTICIPATION IN SOCIAL/COMMUNITY ACTIVITIES	37%
SOCIAL AND ECONOMIC INCLUSION	35%
RISK OF HOMELESSNESS	33%
PROFESSIONAL DEVELOPMENT AND FRONTLINE WORKERS	32%
A PERSON'S ABILITY TO DO SOMETHING OR ACHIEVE A CERTAIN...	32%
ACCESS TO INFORMATION AND KNOWLEDGE SHARING	32%
EMPLOYMENT	31%
CULTURAL APPROPRIATENESS OF MENTAL HEALTH SERVICE	30%
COMMUNITY ACCESSIBILITY	29%
TARGETED SUPPORT PROVIDED TO FIND AND RETAIN HOUSING	28%
PHYSICAL WELLBEING	28%
RESILIENCE	27%
MENTAL HEALTH OUTCOMES	26%
PSYCHOLOGICAL DISTRESS	26%
PEER WORKFORCE	26%
ADMINISTRATION OR ALLOCATION OF FUNDING	24%
COMMUNITY-MANAGED CARE	24%
WELLBEING PROMOTION ACTIVITIES	24%
MENTAL HEALTH LITERACY AND FIRST AID	21%
COMPLETION OF EDUCATIONAL QUALIFICATIONS OR TRAINING	17%
INCIDENTS OF VIOLENCE	14%
DATA CAPABILITIES BETWEEN HEALTH AND HUMAN SERVICES	9%
NONE OF THE ABOVE	1%

The second was the most extensive workforce survey yet of psychiatrists and registrars (public and private sectors) in Australia, from NSW, in October 2018 (yet to be published). In it, psychiatrists were specifically *not asked* about their views of the public sector services, but trends about dissatisfaction (35%) and intentions to leave the public sector within a year (26%) remained fairly consistent with previous surveys. A crisis in confidence in the public system remains.

Negative and positive aspects of working in the public sector were as follows:

Positive elements	% Respondents agreed
The opportunity to work as part of a multidisciplinary team	86%
Working with a diverse range of patients and complexities in clinical care	75%
Opportunity to teach and train new psychiatrists	60%
Opportunities to take leadership roles	37%
Research and academic opportunities	25%

Negatives	% agreed
Increasing general workload	86%
Burnout	82%
Workload related to on-call and ED requirements	79%
Insufficient autonomy	56%
Limited flexibility in employment arrangements	53%

What Works

Having noted the failings of the systems, the NSW Branch acknowledges what works. As will be seen, this list is dominated by State funded and delivered services, where most data is available. These services include but are not limited to:

- State hospital admissions: if you can get into hospital 2/3 will be satisfied or highly satisfied with their treatment (YES results: NSW Health 2018); *this is despite the fact that the lengths of stay are among the shortest in the developed world, are determined more by demand pressures than by any clinical model of optimal length of stay.*

- Supported accommodation: the link between homelessness and mental illness is long-established. According to Homeless NSW, some 75% of people who are homeless have a mental health condition[2] and a quarter of these are aged 12–25 years.[3] Programs, like HASI (Housing and Accommodation Support Initiative), which supports 1000 people in NSW, have been shown to work in preventing homelessness and reducing hospital admissions by up to 24%.

- Community Treatment Orders: research by Harris et al (Australian Psychiatry 2019) shows that hospital re-admission rates are reduced when CTOs are in force.[4]

- Day Patient Programs: private sector insurers realise that day patient services prevent inpatient admissions and reduce length of stay, so these are increasingly developed in that sector.

- Multidisciplinary care: people with complex (and long-term) mental health conditions have a wide range of social and psychological needs and often require support from comprehensive mental health services that are trauma-informed. The benefits of multidisciplinary team working for consumers are well established and the benefits of supporting the multidisciplinary team with training and supervision are being described.[5]

- Early intervention programs: for children, adolescents and youth (see below): Australia has led the world in research in this area, with clear clinical and economic benefits of early intervention.

- Perinatal mental health programs: studies show that up to one in ten women experience depression while pregnant and one in seven women in the year following birth. There is ample evidence showing the importance and effectiveness of early intervention, prevention and targeted interventions for expecting mothers

- Psychotherapy interventions: National Health and Medical Research Council's (NHMRC) Guidelines for the Management of Borderline Personality Disorder (2015) details the effectiveness of a range of psychotherapies.[6] The use of psychotherapy in presentations associated with complex trauma, has

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[2] Homelessness NSW Mental illness and homelessness. Available at https://www.homelessnessnsw.org.au/resources/mental-illness-and-homelessness (accessed 15 March 2019)

[3] Mission Australia (2017) Youth mental illness and homelessness report. Available at file:///C:/Users/bfolino/Downloads/6523_Mental%20Health%20&%20Homelessness%20Report_FINAL_pages.pdf (accessed 15 March 2019)

[4] Harris A et al (2019) Community treatment orders increase community care and delay readmission while in force: Results from a large population-based study *Australian and New Zealand Journal of Psychiatry* vol. 53, no.3, 228-235

[5] Tieman J et al (2007) Integration, Coordination and Multidisciplinary Care: What can these Approaches Offer to Australian Primary Health Care?. *Australian Journal of Primary Health* vol. 13, 56-65. https://doi.org/10.1071/PY07024

[6] National Health and Medical Research Council (2013) Clinical Practice Guideline - Borderline Personality Disorder https://nhmrc.gov.au/about-us/publications/clinical-practice-guideline-borderline-personality-disorder#block-views-block-file-attachments-content-block-1

been well documented.[7] Despite having clear guidelines for treatment of those with high complexity and service utilisation, there is no funding model or stream for such treatment.

Not enough of anything

Inadequate funding of public sector services, upstream and downstream:

- Currently, budget outlays for mental health services are inadequate to meet current levels of need and need to be increased from 7-8%. The public specialist mental health services which provide care for people are at high risk and/or who are suffering from complex and ongoing conditions such as schizophrenia, schizoaffective disorder and bipolar disorder, are not being properly funded. It is the public specialist mental health service system which is the 'safety-net' for the public. They are the only services that operate after-hours and every day of the week. These services are mostly funded by the states and territories. More and more federal funding is being redirected to fund Primary Health Networks, the Community Managed Organisations sector, and early intervention services, it is important that this is accompanied by necessary growth in the public mental health services, which has been the backbone of the service system. The lack of funding of the public system warrants a detailed gap analysis; that is, what is currently being funded for frontline services and the gap between that and international benchmarks for countries comparable to Australia. The largest gaps will be found in the community specialist mental health services which are sorely in need of a very significant investment plan.

Resources for young people

- Mental illness affects a large and growing number of young people. In NSW, it is estimated that one in four people aged 15–24 years is affected by some kind of mental health condition. This equates to around 300,000 people. It is further estimated that around 75% of all lifetime mental health disorders emerge by the age of 24 years. While prevalence of mental illness is high among young people, they are under-represented in visits to mental health services.[8] Tragically, suicide is the leading cause of death amongst this group

Suicide, persons aged 15-24 years NSW 2006 - 2016

— Suicide, persons aged: 15-24 years, NSW 2006 to 2016 Number
— Suicide, persons aged: 15-24 years, NSW 2006 to 2016 Rate/100,000

accounting for one in three deaths. As shown in the adjacent graph 1, these rates have doubled in the period between 2007 and 2016, and based on research in this area, are highest among Aboriginal people, young people living in rural communities, and lesbian, gay, bisexual, transgender and intersex and questioning (LGBTIQ) people. The RANZCP NSW Branch submits that improving the level and quality of child and adolescent psychiatric and mental health services for young people has to be made a priority for government. It is an integral part of early intervention and preventing long-term ill-health.

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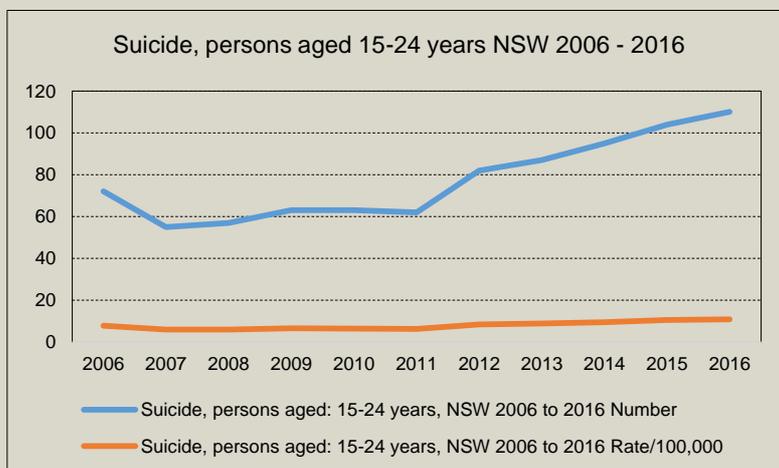
[7] Moloney B et al (2018): Implementing a Trauma-Informed Model of Care in a Community Acute Mental Health Team, *Issues in Mental Health Nursing* vol. 39 no.7 pp. 547-553
[8] Make Mental Health Count (2018) NSW Branch RANZCP Pre Budget Submission 2019/20

- 75% of mental health problems first appear before the age of 25, yet more than 70% of young women and 80% of young men who need help and support don't get it.[9]

Community health

- NSW has the lowest community mental health service provider FTE per 100,000 population (NSW 37.1; Australia 45.2), The greatest disparity is for children and adolescents (NSW: 25.5, AUS:36.6).[10]
- NSW has the highest rate in Australia of non-urgent emergency department presentations (NSW=11.4%, Australia= 6.4%) and the highest rate of planned return visits (NSW=6.9%, Australia=2.5%).

Specific populations

- NSW has escalating rates of young people under 25 years being hospitalised for intentional self-harm. Aboriginal young people are 2.4 times more likely to be hospitalised than non-Aboriginal young people.[11]
- Up to 10% of women experience depression during pregnancy, 15.7% of mothers (48,604 women) and 3.6% of fathers (11,145 men) in Australia across one year.[12]
- If the prevalence of women affected by perinatal depression was reduced by just 5% (15,500 women) in 2013, total costs in the first two years could be reduced by $147M (PWC, 2013).

Accommodation and homelessness:

- It is a well-established fact that people living with mental health conditions are at significant risk of homelessness. According to Homeless NSW, some 75% of people who are homeless have a mental health condition[13] and a quarter of these are aged 12–25 years.33 Almost two thirds of people who are sleeping rough who have a mental health issue also have issues with drug or alcohol abuse.34 People with mental health conditions often experience difficulties in accessing and maintaining affordable, safe and stable housing. Mental health issues can disrupt tenancies and reduce an individual's capacity to live independently. In research commissioned by the NSW Mental Health Coordinating Council, it was revealed that some 5000 supported accommodation beds are needed in NSW to ensure people with mental conditions have a place to live and prevent homelessness.[14]

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[9] Reavley, NJ Cvetkovski, S Jorm, AF & Lubman, DI (2010) Help-seeking for substance use, anxiety and affective disorders among young people: Results from the 2007 Australian National Survey of Mental Health and Wellbeing Australian and New Zealand Journal of Psychiatry, vol. 44, pp. 729–735.

[10] Australian Institute of Health and Welfare *Mental Health Workforce Data 2016 Available* https://www.aihw.gov.au/reports-data/health-welfare-services/mental-health-services/data Accessed 14 March 2019

[11] Australian Institute of Health and Welfare (2016) Mental Health Services Provided in Emergency Departments

[12] PwC 2013 Valuing Perinatal health. The consequences of not treating perinatal depression and anxiety. PricewaterhouseCoopers Australia for Beyondblue

[13] Homelessness NSW (n.d.) Mental illness and homelessness. Available at: https://www.homelessnessnsw.org.au/resources/mental-illness-and-homelessness (accessed 26 March 2019).

[14] This is more commonly known as Housing and Support Accommodation Initiative

- Step up Step down services which help people with mental health conditions transition effectively from acute care arrangements to supported living and re-entry into care when needed were also identified in the research as being needed. Step up Step down facilities, a service that is widely available across Australia, are lacking in NSW. MHCC estimates that some 9,500 would benefit from this kind of service.