

17 September 2014

Mr Stephen Palethrope
Committee Secretary
Select Committee on Health
PO Box 6100
Parliament House
CANBERRA ACT 2600

By email to: health.sen@aph.gov.au

Dear Mr Palethrope

Re: Senate Select Committee on Health – consultation request

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback on the Senate Select Committee on Health *Inquiry into health policy, administration and expenditure's* terms of reference.

While the RANZCP supports the Commonwealth Government's increased investment and focus on mental health in recent years, we remain concerned that insufficient resources are being devoted to mental health and the particular needs of people affected by mental illness from key population groups, including children and adolescents, older people, people living in rural areas of Australia and Aboriginal and Torres Strait Islander peoples. In the RANZCP's view, there should also be substantially increased investment in mental health workforce development and training given current and projected future workforce shortages and an increased focus on mental health research and the link between mental and physical illness.

If you would like to discuss any of the issues raised in the submission, please contact Dr Anne Ellison, General Manager Practice, Policy and Projects, via anne.ellison@ranzcp.org or by phone on (03) 9601 4918.

Yours sincerely



Dr Murray Patton
President

Ref: 3731

RANZCP Submission

Senate Select Committee on Health - Inquiry into Health Policy, Administration and Expenditure

September 2014



Introduction

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback to the Senate Select Committee on Health's *Inquiry into Health Policy, Administration and Expenditure* (the Inquiry).

While the RANZCP supports the Commonwealth Government's increased investment and focus on mental health in recent years, we note that mental illness in Australia remains a significant burden on the community. Mental illness accounts for up to 13.1% of Australia's total burden of disease and costs the Australian economy an estimated \$20 billion annually.¹

The RANZCP remains concerned that insufficient resources and services are being devoted to mental health and the particular needs of people affected by mental illness from key population groups.

The RANZCP has outlined its concerns in response to each of the Inquiry's eight terms of reference (a) through (h) as set out below.

Term of reference (a): the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting

In recent years, Australian governments have significantly deinstitutionalised mental health care and services, moving away from hospital based settings to community based settings. One result of this has been reduced Commonwealth funding for state and territory governments for hospital and other health services for people who are mentally ill.

Nonetheless, there remains a strong, ongoing need for appropriately resourced hospital based care for mental health patients. While it would be beneficial for patients to be admitted early because this equates to a shorter hospital stay, it is currently very difficult to try and obtain an inpatient bed for people with a mental illness.

What frequently occurs is that people who require admittance to hospital mental health beds must wait for extended periods of time - often in the emergency department - because the demand for mental health beds exceeds the resources available.

This situation commonly arises in all Australian states and territories and it is a particular problem in rural and regional areas where alternative mental health resources may be hundreds of kilometres away. For example, in Cairns, recent figures show that only 8% of patients were able to access a bed within eight hours of arrival and patients often spent days in the emergency department before being admitted to the mental health ward.²

Given that there can be extensive waiting times for mental health beds in hospitals, the current number available is clearly inadequate to meet current demand and each round of Commonwealth funding cuts to state and territory hospitals only further exacerbates this problem.

On this basis, the RANZCP submits that the Commonwealth Government must make an immediate capital investment to increase funding for mental health beds in state and territory public hospitals. There should be funding for the adequate provision of acute and sub-acute beds as well as an increased number of forensic beds, long stay beds and residential facilities. This investment should also focus on funding beds for key population groups such as older people and children and adolescents given that there is already a chronic shortage of mental health beds for these groups and also boost the overall number of beds in remote parts of Australia. The RANZCP also supports the establishment of specialised mental health and dual diagnosis spaces in public hospital emergency departments to prevent mentally ill patients from spending too long in these areas, freeing up clinician time and relieving pressure on already over-burdened state and territory public hospitals.

The RANZCP considers that the Commonwealth Government should also increase funding for “other health services” provided by state and territory governments, including community services such as those provided by community based mental health teams.

Finally, the RANZCP believes that simply increasing funding for mental health beds and other health services in state and territory public hospitals is not going to be sufficient to address the mental health needs of Australians. What is ultimately needed is greater investment by the Commonwealth Government in preventative health measures to help avert people from entering a state of mental health crisis and requiring admission to a hospital bed or health services in the first place. However, the RANZCP notes that the Commonwealth Government is also cutting funding for preventative mental health initiatives. The RANZCP’s concerns about this are outlined further at term of reference (c).

Term of reference (b): the impact of additional costs on access to affordable healthcare and the sustainability of Medicare

The RANZCP believes that the Commonwealth Government should reinstate Medicare incentives payments for Telehealth or video / telephone psychiatry consultations because it will have a significant impact on access to affordable mental healthcare for people in rural and regional areas.

In 2011, the Commonwealth Government introduced the Telehealth Financial Incentives Program (TFIP) to support the introduction of MBS items for online video consultations with specialists, including consultant psychiatrists. However, TFIP recently ceased as of 30 June 2014.

The RANZCP believes that Telehealth is crucial to increase access to psychiatrists for people living in remote and regional areas of Australia where services are often very limited. Research illustrates that people living in rural and regional areas have poorer mental health outcomes and a higher prevalence of long-term health conditions.³ People living outside a major city are also 16% more likely to report mental and behavioural problems than their city counterparts.⁴

Telepsychiatry provides an effective means of improving rural and remote community access to specialist psychiatric resources.⁵ Research has shown that technological developments such as telehealth could lead to an increase of medical practitioner productivity by 50% or more over the next ten to twenty years.⁶ [The RANZCP Telehealth Project](#) also found that waiting times to access a telehealth consultation is shorter compared to that of a face-to-face consultation.

Now that the TFIP has come to an end, the cost of Telehealth will increase, meaning practitioners will be less likely to use Telehealth services. The RANZCP believes that this will detrimentally affect the ability of people with mental illnesses who are located in rural and remote parts of Australia to access psychiatrists. The RANZCP, therefore, considers that TFIP should be reinstated as a matter of priority.

Term of reference (c): the impact of reduced Commonwealth funding for health promotion, prevention and early intervention

The RANZCP is concerned about the impact that recent Commonwealth funding cuts will have on the health promotion, prevention and early intervention of mental health initiatives.

National Partnership Agreement on Preventative Health

In the 2014-15 Budget, the Commonwealth Government decided to cut funding from the National Partnership Agreement on Preventative Health (the National Partnership Agreement) on the basis that it was an “ineffective or duplicative Commonwealth payment to the States”.⁷ While the Commonwealth Government had previously committed to funding the National Partnership Agreement until 2018, this Budget announcement meant that Commonwealth Government funding ended as of 30 June 2014.

The RANZCP is concerned about the impact that the Commonwealth Government’s unilateral funding cut will have on preventative health programs across Australia, including for mental health programs funded through the National Partnership Agreement.

An example is [Healthy Together Victoria](#) (HTV). HTV involves a co-operative partnership between the Victorian State and local governments and is focused on addressing the rising costs of chronic disease and promoting the physical and mental health and wellbeing of Victorians. One HTV initiative is the [Achievement Program](#), which – in settings such as workplaces and schools - aims to promote positive mental health and wellbeing through a location’s physical environment and organisational culture. HTV was jointly funded by the Victorian Government and the Commonwealth Government under the National Partnership Agreement.

The full impact that the Commonwealth Government’s funding cut will have on programs that promote positive mental health outcomes across Australia such as HTV is currently unclear but the RANZCP is concerned for their ongoing viability and effectiveness. The RANZCP notes that investment in settings based mental health promotion and especially workplace health promotion helps improve people’s mental wellbeing and reduces the individual and economic burden associated with poor mental health and job stress.

The 2014-15 Budget indicated that the Commonwealth Government would invest the money saved from ceasing the National Partnership Agreement in the proposed Medical Research Future Fund. However, there is currently no information about whether or how much monies from the Fund might be directed towards preventative health purposes, including mental health.

Preventative mental health for children and adolescents

Preventative mental health is particularly important for Australia’s young people as 14% of children and adolescents experience mental health problems.⁸ Mental illness in infancy, childhood or adolescence can have enduring consequences if left unresolved. Adverse outcomes include reduced self-esteem and educational and occupational opportunities as well as increased risk of substance abuse, family breakdown and homelessness. Consequently, the economic, social and personal costs of mental, emotional and behavioural disorders among young people are extremely high.⁹

Research shows the cost effectiveness of investing in prevention and early intervention strategies for infants, children and adolescents. Evaluations of interventions generally demonstrate that intervention benefits exceed costs – often by substantial amounts.¹⁰ Studies have also shown that even with best practice treatment applied to 100% of the population with mental illness, this approach would still only avert 40% of the burden of disease.¹¹ This underscores the importance of prevention and early intervention – given that 50% of all serious mental health and substance use disorders commence by age 14.¹² Therefore, prevention and early intervention

orientated strategies targeted at young people have the potential to generate greater personal health, social and economic benefits than interventions at any other time of the lifespan.

Yet, despite the clear benefits of investing in prevention and early intervention services, the RANZCP believes that current Commonwealth Government funding in child and adolescent mental health is inadequate. For instance, a key underserved group in mental health services is the 5-14 year old age group. Treatment rates for major childhood mental disorders and behaviour disorders are low despite mental and behavioural disorders being the leading cause of Disability Adjusted Life Years in Australians aged 5-14 years.¹³ Evidence based methods for improving health systems suggest that increasing coverage where the burden of disease is high is essential. Consequently, improving service coverage for these disorders – and especially in this age group - is vital given that early intervention can reduce the burden presented by these disorders both in childhood and later in adulthood.¹⁴

The RANZCP also notes that current Commonwealth Government investment in child and adolescent mental health does not reflect the percentage of the Australian population that are under the age of 15. At June 2012, the total number of children under 15 years of age was 4.29 million or 19% of the total population.¹⁵ In the RANZCP's view, it is essential that the Commonwealth Government provide greater funding for preventative health initiatives in child and adolescent mental health to ensure the current and future welfare of this vulnerable population group.

To assist with this process, the RANZCP has prepared a [Position Statement](#) and a [Report on the prevention and early intervention of mental illness in infants, children and adolescents](#), which sets out key recommendations and strategies to prevent the development of mental illness in infants, children and adolescents. We refer the Inquiry to this material.

Term of reference (d): the interaction between elements of the health system, including between aged care and health care

The RANZCP believes that Australia is unprepared to meet the mental health needs of an aging population and that greater priority must be given to the mental health care of older Australians, including those in aged care situations.

The RANZCP submits that the funding of mental health services for older Australians is currently substantially inadequate. There is limited access for older people to state community, acute inpatient and non-acute inpatient care as well as supported community residential care.¹⁶ This is despite older people often being at risk of mental health decline in aged care situations plus the ongoing issue of high rates of suicide in older people - both men and women.¹⁷

We also note that this problem will only increase with Australia's aging population. Higher numbers of people will live in residential aged care facilities, where there are unacceptably high rates of depression¹⁸ and other mental illness¹⁹ with often inadequate treatment.²⁰

The RANZCP considers that there needs to be more specific services for elderly people who have mental health issues and are living in residential aged care and that the connection between the aged care and health care systems needs to be enhanced through:

- improved linkages between aged-care psychiatric services in the public and private sectors and general practitioners to improve shared care arrangements
- 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
- the mandating of a formal aged care accreditation standard requiring all aged care providers to make mental health care available to residents.

Term of reference (e): improvements in the provision of health services, including indigenous health and rural health

Mental health of Aboriginal and Torres Strait Islander peoples

The RANZCP is committed to supporting the entitlement of Aboriginal and Torres Strait Islander peoples to effective mental health care, which is appropriate to their culture and needs. Aboriginal and Torres Strait Islander peoples suffer levels of mortality, morbidity and compromised wellbeing far in excess of other Australians.

For instance, Australian government data shows that Aboriginal and Torres Strait Islander peoples are twice as likely as non-Aboriginal and Torres Strait Islander peoples to report high or very high levels of psychological distress. In 2009, the rate of hospitalisations of Aboriginal and Torres Strait Islander peoples for mental health problems and disorders was double that of other Australians.²¹

One way the RANZCP believes that the provision of mental health services to Aboriginal and Torres Strait Islander peoples can be enhanced is to improve the professional standing of Aboriginal and Torres Strait Islander mental health workers who perform a vital role in the holistic care of Aboriginal and Torres Strait Islander peoples with mental illness. The RANZCP has written a [Position Statement](#) on this issue. Strategies to achieve this outcome include:

- appropriate recognition of the role of Aboriginal and Torres Strait Islander mental health workers as part of a multi-disciplinary team
- engaging with Aboriginal and Torres Strait Islander mental health workers in a culturally appropriate manner
- giving Aboriginal and Torres Strait Islander mental health workers appropriate pay, training and resources to enable them to do their work effectively.

The RANZCP also believes that recruiting greater numbers of Aboriginal and Torres Strait Islander medical students into psychiatry could help improve access to mental health services within Aboriginal and Torres Strait Islander communities. We suggest that all government programs relevant for health workforce recruitment should commit to supporting Aboriginal and Torres Strait Islander graduates into Fellowship within the medical college of their choice.

Rural mental health

As noted at term of reference (b), there is a significant incidence of mental health issues in rural and remote locations and difficulties in securing the appropriate care needed by those with mental health problems located in these areas.

Recruiting medical professionals and mental health specialists to work in rural and remote areas and subsequently retaining them also continue to be ongoing challenges. The RANZCP considers that greater investment is needed to support trainees in rural and regional areas to ensure a positive training experience, which has a flow-on impact onto their likelihood to remain in that area. We also think that it is important to make more concerted efforts to retain practitioners once they are qualified, including through the consideration of financial incentives and forms of family support for professionals to work in these areas.

As identified in term of reference (g), there are already severe psychiatrist shortages around Australia – especially in rural and remote areas - and these shortages are projected to get worse over time.

To help overcome these issues, the RANZCP has prepared a [Position Statement on Rural Psychiatry](#), which outlines strategies to help increase the provision of psychiatry services in rural

and regional areas of Australia and so increase access to these crucial healthcare services. We refer the Inquiry to this Position Statement.

The RANZCP also notes that training and service models do exist in rural areas that have been shown to attract and retain specialists such as psychiatrists. Such an example is the Hunter New England Training in Psychiatry program, which is a well-resourced rural specialist training program that delivers care to a region of around 850,000. The RANZCP proposes that models of specialist training such as this should be replicated in other regional centres to help ensure the future supply of psychiatrists.

To increase access to psychiatric services in remote locations, many rurally based RANZCP members now provide psychiatric services predominantly through Telehealth rather than through face-to-face services. However, informal feedback from some RANZCP members suggests that the combination of the recent cessation of financial incentives for Telehealth along with the freeze of MBS indexation is leading them to reduce their working hours and, consequently, the amount of psychiatric services they can provide to rurally based patients through both face-to-face and Telehealth services.

Therefore, as indicated at term of reference (b), the RANZCP submits that the reintroduction of MBS financial incentives for Telehealth will help increase access to mental health services for people living in remote areas of Australia.

Given the 'market failure' of the Medicare funded mental health enhancements in terms of reaching rural areas, the RANZCP also believes that the Commonwealth should work with NGOs and states to develop mechanisms to increase access to this level of care where Medicare funding has failed to achieve this.

Term of reference (f): The better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services

The current, fragmented nature of Australia's mental health system and provision of relevant Medicare services is an acute and ongoing issue and has a particularly detrimental impact on people with severe and persistent mental illness. Conversely, the integration of mental health systems and processes is one of the most effective ways to promote better mental health outcomes for people with mental illness.

A particular area of concern for the RANZCP is service gaps for consumers who transition from the public to the private sector in a shared care service model, involving psychiatrists, general practitioners (GPs) and psychologists.

One of the most effective yet difficult ways to promote mental health service integration is to ensure mutual respect and understanding of roles with streamlined communication between all the services involved in the care and support of people with a mental illness.²²

Applying this idea to the shared care service model, the RANZCP believes that ensuring continuity of services and communication between psychiatrists, GPs and psychologists will help improve the delivery and integration of mental health services and, in turn, enhance outcomes for people with a mental illness.

To facilitate this process, the RANZCP has produced Professional Practice Guidelines: [Best practice referral, communication and shared care arrangements between psychiatrists, general practitioners and psychologists](#) (the Guidelines), which were published in 2014.

The Guidelines outline best practice steps in referral, communications and shared care arrangements between GPs, psychologists and psychiatrists who are the main providers of

community mental health care. They aim to assist communication flow, clarification of patient management and patient care and safety between all practitioners involved in the shared cared service model. For instance, the Guidelines state that it is important to ensure that:

- all clinicians treating the same patient:
 - communicate with each other about the patient's clinical management to facilitate collaborative multidisciplinary care
 - agree that a shared care agreement suits the patient
 - understand the modalities of intervention that other health professionals can provide to ensure the best patient care possible
- clinicians know that good communication can prevent delayed referrals, which can lead to sub-optimal patient care
- team-based mental health care does not lead to the fragmentation of the types of mental health services provided to the patient.

On this basis, the RANZCP proposes that one way in which to better integrate and coordinate the delivery of mental health services under Medicare is to develop strategies that build on current initiatives such as those set out in the Guidelines. This will have the benefit of improving communications between health professionals involved in shared care arrangements as well as improving the integration and coordination of Medicare mental health services across Australia.

Term of reference (g): health workforce planning

The RANZCP considers that mental health services in Australia should be provided by a skilled, multi-disciplinary workforce, which is supported by continuing education. However, poor workforce planning has meant that there are insufficient numbers of adequately skilled people in the mental health workforce to meet the huge need for these services.

There is current extensive unmet demand for psychiatric services. For instance, there are fewer psychiatrists and mental health nurses currently working in Western Australia's public health system now than there were two years ago when a review by Professor Bryant Stokes called for the mental health workforce to be doubled.²³

There is also a lack of relevantly skilled clinicians to provide mental health services to elderly people yet psychiatrists are the only mental health professional group with either expected competencies in providing mental health care to older people or mandatory training involving older people. This factor also appears to be part of the reason for the very low access of older people to Medicare funded mental health services and low referral rates by general practitioners.

The RANZCP is also concerned about future psychiatry workforce shortages. Health Workforce Australia's *Health Workforce 2025* indicates that psychiatry is one of the few medical specialties that relies on international medical graduates to cover more than half of the current psychiatric workforce shortage and estimates that the projected undersupply will only worsen over time – especially in the areas of child and adolescent psychiatry and psychogeriatrics. Without targeted initiatives, the psychiatry workforce will be suffering severe shortages by 2025.²⁴

The RANZCP submits that potential solutions to this workforce shortage could include:

- funding of psychiatry internships to better promote and encourage psychiatry as an attractive career option
- initiatives to increase psychiatry training opportunities in private, rural and addiction settings through, for instance, continuation of the [Specialist Training Program](#)
- ideas to enhance the psychiatry workforce in rural areas. Commonwealth funded programs such as the Medical Specialist Outreach Assistance Program have sought to improve access to specialist services in rural and remote locations and the program has enabled psychiatrists to provide their expertise and services to these areas.

Other relevant strategies are referred to at term of reference (e).

Investment in mental health workforce development and training

In the RANZCP's view, more investment is needed in mental health workforce development and training. In particular, this involves investment in training in psychotherapy and expanding the existing psychiatric workforce rather than attempting to meet service gaps by providing less-skilled health professionals with the scope to treat patients who would be better suited to treatment from a psychiatrist.

For instance, there is a need for ongoing support to develop skilled recruits into mental health nurses - a profession where numbers are also projected to decline rapidly over the next decade. Additionally, as indicated in term of reference (e), the RANZCP believes that significant investment is needed in the training and resourcing of Aboriginal and Torres Strait Islander mental health workers to improve their professional profile and enable them to be resourced to do their work more effectively.

More broadly, the RANZCP has apprehensions regarding the direction of workforce development and training in both the mental health system and general health system as proposed by Health Workforce Australia. The shift towards expanding the scope of practice for less-skilled health professionals to take on roles once occupied by medical practitioners, for example, is an issue of concern. The RANZCP believes that what matters most is in regards to the prescribing and treatment by medical or non-medical health professionals outside their scope of practice is public safety. Therefore, we argue that people living with mental illness, whether mild or severe, should be treated by medical practitioners with the appropriate training in these complex areas when and where needed. In the case of people with severe mental illness, the central decision makers concerning treatment are the psychiatrist, in conjunction with the person and their carer or family and in collaboration with the person's general practitioner.

Term of reference (h): any other related matters

Prioritisation of mental health research

The RANZCP has long advocated for a significant increase in funding for mental health research to a level that accurately reflects mental health's impact on the community in terms of burden of disease. We believe that at least 14% of both health and research budgets should go towards mental health.

Every dollar invested in health and medical research returns on average \$2.17 in health benefits.²⁵ Therefore, a substantial increase in money invested in mental health research would help develop a rigorous evidence base for, and benefits in, the areas of mental health promotion, prevention and treatment.

The RANZCP submits that mental health research activity should be prioritised to increase emphasis on research that:

- identifies factors that would increase the quality, efficiency, effectiveness and the economic benefits of mental health
- examines preventative mental health interventions as well as the effectiveness of existing early intervention programs
- investigates the causes of mental illness and its distribution in the community
- reviews effective treatments and therapies and the metabolic effects of psychotropic drugs.²⁶

The RANZCP also considers that the establishment of an Australian Institute of Mental Health to promote and coordinate research and to develop interventions and mental health service modelling would be a valuable step forward for mental health research.

Mental and physical health

The RANZCP considers that the link between physical and mental illness is often overlooked and that much more needs to be done to raise awareness about the physical effects of mental illness.

People living with a mental illness have an overall death rate of 2.5 times greater than the general population, much higher rates of heart related problems, diabetes and obesity and a 30% greater chance of dying from cancer. Further, antipsychotic medications that are prescribed to manage mental illnesses are directly associated with the risk of severe physical illnesses such as asthma, heart disease and diabetes. This situation compounds the difficulties of people who need to take antipsychotic medication – they are already suffering from a mental illness but will also subsequently experience a decline in their physical health and ultimately quality of life.²⁷

The link between physical and mental illness is a particular issue for older Australians. It is important to recognise that the majority of older people have neither a mental illness nor dementia. However, if older Australians do have a mental illness, they are also likely to have substantial physical health problems because there are frequent coexistent physical conditions that complicate assessment and management of these mental health conditions.²⁸ Even mild mental illness can have a significant impact on an older person's health, function,²⁹ quality of life,³⁰ use of health services³¹ and outcomes of health interventions.³²

Mental illness in elderly people may also often be unrecognised by individuals, family and health care professionals, who may wrongly attribute symptoms of treatable mental illness to the irreversible effects of ageing or to physical or environmental changes. There is a tendency to refer relatively few older people with mental illness for specialised psychiatric treatment.³³ Yet, while early old age is associated with lower mental health related costs, treatment costs for mental illness increase substantially with age in the population over 75 years old.³⁴

Australia's aging population will only exacerbate this problem, leading to increasing numbers of older people with mental illness with associated rising healthcare costs. For instance, people with long standing mental illnesses will be joined by those with mental illness that develops in later life.³⁵ Such illnesses include depression, anxiety disorders, schizophrenia and bipolar disorder.

Given that a significant number of people with mental illness will also have physical problems, either contributing to their illness or as a consequence of their mental illness, the RANZCP believes that the Commonwealth Government must make the relationship between physical and mental health a priority area and that governments at all levels must set targets and work together to ensure the improved physical health of people with mental illness.

Mental health services also need to have policies and strategies in place and strong partnerships with primary care providers to ensure that the physical health needs of mentally ill people are identified and addressed. This includes equipping mental health services to:

- recognise their role in the physical health care of people with mental illness, including advocacy
- clarify appropriate linkages with other health care providers
- build stronger partnerships with key stakeholders, including GPs, people with mental illness, their families and carers
- establish minimum expectations for the physical health care of consumers, together with a program to improve standards.

To further promote the importance of the link between people's physical and mental health, the RANZCP also believes that effective models of care that integrate physical and mental health and aim to improve outcomes in both areas should be a focus of funding reform and the Primary Health Care Networks.

References

- ¹ Commonwealth Department of Health and Ageing (2013) 2013-14 Health and Ageing Portfolio Budget Statements – Mental Health. Available at: [www.health.gov.au/internet/budget/publishing.nsf/Content/2013-2014_Health_PBS_sup2/\\$File/2013-14_DoHA_PBS_2.11_Outcome_11.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/Content/2013-2014_Health_PBS_sup2/$File/2013-14_DoHA_PBS_2.11_Outcome_11.pdf) (accessed 2 September 2014).
- ² Miles, J (2013) Patients wait days for mental health bed *Cairns Post*.
- ³ Australian Bureau of Statistics (2008) National survey of mental health and wellbeing: summary of results 2007. Available at: www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0 (accessed 29 August 2014).
- ⁴ Smith A, Croll J, Gray L (2012) A review of Medicare expenditure in Australia for psychiatric consultations delivered in person and via videoconference. *Journal of Telemedicine and Telecare* (18): 169-171.
- ⁵ Lessing K (2001) Mental Health Telemedicine Programmes in Australia. *Journal of Telemedicine and Telecare*: 317-323.
- ⁶ Duckett, S (2005) Health workforce design for the 21st century. *Australian Health Review* 29(2): 9.
- ⁷ Commonwealth Government (2014) Budget Strategy and Outlook Budget Paper No. 1 2014-15: 1-11. Available at: www.budget.gov.au/2014-15/content/bp1/html/index.htm (accessed 29 August 2014).
- ⁸ Sawyer M, Arney F, Baghurst P, Clark J, Graetz B, Kosky R, Nurcombe B, Patton G, Prior M, Raphael B, Rey J, Whaites L, Zubrick S (2000) *The mental health of young people in Australia: The child and adolescent component of the national survey of mental health and wellbeing*. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Ageing.
- ⁹ Access Economics (2009) The economic impact of youth mental illness and the cost effectiveness of early intervention. Available at: oyh.org.au/sites/oyh.org.au/files/CostYMH_Dec2009.pdf (accessed 2 September 2014).
- ¹⁰ O'Connell M, Boat T, Warner K (2009). *Preventing Mental Emotional, and Behavioural Disorders Among Young People: Progress and Possibilities*. Washington, DC: Board on Children Youth and Families, Institute of Medicine.
- ¹¹ Access Economics (2009) The economic impact of youth mental illness and the cost effectiveness of early intervention. Available at: oyh.org.au/sites/oyh.org.au/files/CostYMH_Dec2009.pdf (accessed 2 September 2014).
- ¹² Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry* 62: 593-602.
- ¹³ Institute for Health Metrics and Evaluation (2013) GBD Compare. Available at: vizhub.healthdata.org/gbd-compare (accessed 12 September 2014).
- ¹⁴ Whiteford H, Harris M and Dimic, S. (2013) Mental health service system improvement: Translating evidence into policy. *Australian and New Zealand Journal of Psychiatry* 47: 703-706.
- ¹⁵ Australian Bureau of Statistics (2012) 3235.0 - Population by Age and Sex, Regions of Australia Available at: www.abs.gov.au/ausstats/abs@.nsf/Products/3235.0~2012~Main+Features~Main+Features?OpenDocument#PARALINK4 (accessed 2 September 2014).
- ¹⁶ Australian Institute of Health and Welfare (2012) Mental health services in Australia. Available at: mhsa.aihw.gov.au/resources/workforce/psychiatric-workforce (accessed 2 September 2014).
- ¹⁷ Australian Bureau of Statistics (2014) Causes of Death, Australia. Available at: www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2012~Main%20Features~Age~10010 (accessed 2 September 2014).
- ¹⁸ Australian Institute of Health and Welfare (2013) Depression in residential aged care 2008-2012. Available at: www.aihw.gov.au/publication-detail/?id=60129544869 (accessed 2 September 2014).
- ¹⁹ Australian Institute of Health and Welfare (2012) Residential aged care and aged care packages in the community 2011–12. Available at: www.aihw.gov.au/aged-care/residential-and-community-2011-12 (accessed 3 September 2014).
- ²⁰ Snowdon J, Rosengren D, Daniel F and Suyasa M (2011) Australia's use of the Cornell scale to screen for depression in nursing homes. *Australasian Journal on Ageing* 30(1): 33-36.
- ²¹ Australian Institute of Health and Welfare (2011) *The health and welfare of Australia's Aboriginal and Torres Strait Islander people: an overview*. Canberra: AIHW.
- ²² Whiteford H, McKeon G, Harris M, Diminic S, Siskind D and Scheurer R (2014) System-level intersectoral linkages between the mental health and non-clinical support sectors: a qualitative systematic review. *Australian and New Zealand Journal of Psychiatry* 7: 1-12.
- ²³ Pownall, A and O'Leary, C (8 September 2014) Too few staff in mental health care *The West Australian*.
- ²⁴ Health Workforce Australia (2012) Health Workforce 2025 – Volume 3 – Medical Specialities. Available at: www.hwa.gov.au/sites/uploads/HW2025_V3_FinalReport20121109.pdf.

-
- ²⁵ Deloitte Access Economics (2011) Returns on NHMRC Funded Research and Development. Available at: www.asmr.org.au/NHMRCReturns.pdf (accessed 2 September 2014).
- ²⁶ RANZCP (2012) *Submission to the Strategic Review of Health and Medical Research in Australia*. Available at: www.ranzcp.org/Files/Publications/2652-President-re-McKeon-Review-2-Nov-12.aspx (accessed 2 September 2014).
- ²⁷ National Mental Health Commission (2012) *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*. Sydney: NMHC.
- ²⁸ Australian Bureau of Statistics (2013) 3222.0 – *Population Projections, Australia, 2012 (base) to 2101*. Available at: www.abs.gov.au/Ausstats/abs@.nsf/mf/3222.0.
- ²⁹ Da Silva S A, Scazufca M and Menezes P (2013) Population impact of depression on functional disability in elderly: results from “São Paulo Ageing & Health Study”. *European archives of psychiatry and clinical neuroscience* 263(2): 153-158.
- ³⁰ Sarma, S & Byrne, G J (2013) Relationship between anxiety and quality of life in older mental health patients. *Australasian Journal on Ageing* 33(3): 201-204 and Shmueli Y, Baumgarten M, Rovner B, Berlin J (2001) Predictors of improvement in health related quality of life among elderly patients with depression. *International Psychogeriatrics* 13: 63-73.
- ³¹ Prina A M, Huisman M, Yeap B B, Hankey G J, Flicker L, Brayne C, & Almeida O P (2014) Hospital costs associated with depression in a cohort of older men living in Western Australia. *General Hospital Psychiatry* 36(1): 33-37.
- ³² Prina A M, Huisman M, Yeap B B, Hankey, G J, Flicker L, Brayne C, & Almeida, O P (2013) Association between depression and hospital outcomes among older men. *Canadian Medical Association Journal* 185(2): 117-123.
- ³³ McKay, R G and Draper, B M (2012) Is it too late to prevent a decline in mental health care for older Australians? *Medical Journal of Australia* 197(2): 87-88.
- ³⁴ McCrone P, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S (2008) *Paying the Price: The cost of mental health care in England to 2026*. Kings Fund.
- ³⁵ Büchtemann, D, Luppá, M, Bramesfeld, A and Riedel-Heller S (2012) *Incidence of late-life depression: A systematic review*. *Journal of Affective Disorders* 142(1): 172-179.