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Invited article

Divided we fall: clinicians and academic psychiatrists need to stand together

1. Stephen Allison – Associate Professor of Psychiatry, Faculty of Medicine, Nursing and Health Sciences, Flinders University, Adelaide, Australia. Discipline of General Practice, School of Medicine, Flinders University, Adelaide, Australia.

2. Tarun Bastiampillai – Executive Director, Mental Health Strategy, Department of Health, South Australia. Professor of Psychiatry, Faculty of Medicine, Nursing and Health Sciences, Flinders University, Adelaide, Australia. Research Fellow, Mind and Brain Theme, South Australian Health and Medical Research Institute, Adelaide, Australia.

3. Malcolm Battersby – Clinical Director, Mental Health Services, Southern Adelaide Local Health Network, Adelaide, Australia. Professor and Head of Psychiatry, Faculty of Medicine, Nursing and Health Sciences, Flinders University, Adelaide, Australia. Flinders Human Behaviour and Health Research Unit, Flinders University, Adelaide, Australia.

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Corresponding author:

A/Prof Stephen Allison
Discipline of Psychiatry, Flinders University
Bedford Park, 5042, South Australia, Australia
Phone: +61 8 82045412 Email: stephen.allison@ flinders.edu.au

Abstract

Objective

Psychiatry faces urgent problems requiring united action. These problems affect academic psychiatrists in the universities, and clinicians in publicly funded mental health services. Academic units are isolated and endangered, finding it difficult to recruit. They could benefit from closer relationships with public mental health services, in terms of recruitment, shared teaching, and clinical research. However, mental health services are preoccupied with their own problems, particularly in relation to acute clinical demand. How can we stand together to improve academic units and clinical psychiatry?

Conclusions

Clinicians and academic psychiatrists can stand together on important matters, but it takes initiatives from local leaders to overcome the structural barriers between health services and the universities. An example is given of united action by clinicians and academic psychiatrists to address a crisis within a state mental health system. Firstly, psychiatrists undertook independent health services research that compared the state system with those in other Australian and international jurisdictions. The comparative data was used to generate solutions, which were presented at every level from ministerial offices through to service managers. Finally, psychiatrists took up joint academic and clinical leadership roles in the university and the mental health system. This united research-led approach turned around the crisis in the state mental health system.

Key words: academic units, tripartite mission, health services research

Clinicians and academic psychiatrists encounter major structural barriers when they seek to cooperate. Traditionally, medicine has successfully combined its clinical and academic aspects within the tripartite mission, which incorporated research, teaching and the pursuit of clinical excellence. The tripartite mission underpinned the major advances in modern medicine during the twentieth century. However, the tripartite mission is now divided between the universities with primary accountability for research and teaching, and health services with primary accountability for patient care. With the division of the tripartite mission, research has become less clinically relevant, and there has been a slowing in the development of new treatments in psychiatry. In the process, academic psychiatry has become isolated from the larger mental health system, and is endangered, mainly due to difficulties with recruitment.[1] As it is extremely unlikely that governments will undertake a radical top-down redesign of their departmental structures to realign the tripartite mission, local academic and clinical leaders need to take the initiative by aligning the tripartite mission within the teaching hospitals and regional mental health services.[2]

Furthermore, psychiatrists find it inherently difficult to unite on major political questions. Our discipline is based on a broad biopsychosocial explanatory model that extends from the molecular level to social networks, cultures and philosophy. Service models have also been changing for fifty years, moving from an institutional model in stand-alone mental hospitals before the introduction of chlorpromazine, through to the contemporary mix of primary mental healthcare, private sector psychiatry, mainstreamed state mental healthcare, and non-government organisations. Psychiatry's broad and changing models create much of the intellectual appeal of the discipline, but they can represent a political weakness. When faced with a challenging decision, the discipline can refer to a wide range of models, leading to very different priorities.

A classic example is the political and ideological debate about community versus hospital services, which has formed the historical backdrop to mental health services for fifty years.

Governments are used to closing psychiatric beds, and using a proportion of the savings for new community programs. Old habits die hard, and mental health policy debates tend to focus on the same old choice of beds versus community. These debates miss the point that services for people with severe mental illness are often underfunded, and achieve poorer outcomes, including much higher rates of premature mortality than the rest of the population.[3] Mental illness has been subjected to long-standing stigma, and government can perceive increased funding for mental health services as politically unpopular. Hence, demand often exceeds supply for underfunded mental health services. In the UK for example, there have been calls to "accept spending in the short term for financial and therapeutic gains later", largely from preventable diseases such as heart disease and diabetes.[3] Australia spends less per capita than the UK on mental health, yet our national debate is still focused on whether we should fund new community programs by making further cuts to the already low levels of acute psychiatric beds.[4]

Each state has its own unique set of challenges with mental health service delivery. In South Australia, there are major systemic changes to the entire health system within the context of broader economic shifts. The state is dealing with a long period of deindustrialisation with the lowering of Australia's tariff wall, and the closure of the car industry following the removal of federal government support. The state is looking for alternatives, and is embracing the universities and medical research. In parallel, the state government is transforming health services with the closure of two older hospitals, and the construction of a large biomedical precinct around a new central teaching hospital.

Additionally, the state's public mental health sector was facing a crisis. While the state had the second highest spending per capita on mental health, problems emerged after acute bed numbers were reduced to fund new community subacute units, based on the recommendations of the *Stepping Up Report*.[4, 5, 6] It was expected that the step-up/step-down functions of the sub-acute units would reduce the pressure on the state's hospitals, but instead ED waits

progressively increased over several years, peaking at an average ED wait time of 33.5 hours for admission to an acute bed during 2014.[4] These extended ED waits exposed patients to the potentially lethal risks of long periods under chemical and physical restraint. When patients could not be admitted due to the bed shortages, there was an increased burden on the unpaid caregivers who supported patients during these exacerbations of severe mental illness when the risks of suicide and violence were higher.

These major systemic problems brought together clinicians at Flinders Medical Centre, and academics at Flinders University to work on health systems research that could identify the causes of the dysfunction. It became apparent that the state had crossed a tipping point by implementing the *Stepping Up Report* recommendation to cut acute beds numbers below the Australian average.[4, 5, 6] To reverse the crisis, the psychiatric bed supply needed to increase above the tipping point.[4, 6] Three Colleges (Psychiatry, Emergency Medicine and Emergency Nursing), the Australian Medical Association (AMA), and the South Australian Salaried Medical Officers Association (SASMOA) lobbied on behalf of the proposed changes.[7] Based on expert advice from local clinical leaders, the state government recognised that the subacute model had not fully substituted for the reduction in acute beds. In response, the government funded more general adult psychiatric beds to take the state back the national average with a changed bed mix to improve patient care, and prevent the boarding of mental health patients in the EDs.[4, 8] In making the announcement, the state health minister generously acknowledged that, "*Detailed modelling and consultation with clinicians has taken place to work out the right mix of short-stay, acute, intermediate care and rehabilitation beds*" (italics added, p.1).[8]

As part of the implementation of the new state mental health policy, an academic psychiatrist was recruited to provide strategic leadership in the state health department, aiming to reunite the tripartite mission of research, teaching and clinical excellence from the department through to the regions. The state health department indicated that clinical directors should

have executive authority for regional mental health services with single-point accountability for "*strategy, clinical services, consumer flows, consumer outcomes and efficiency of the mental health service*".[9] An academic psychiatrist was appointed as the clinical director of the regional mental health service linked with Flinders University, and clinicians returned to leadership roles as heads of individual units associated with Flinders Medical Centre.[10] Daily dashboards were developed to allow for localised bed management by the regional health networks. The increased bed numbers and localised bed management improved patient flow through the mental health system, reduced average lengths of stay, and lowered the average ED wait time from 15.7 hours during 2014 down to 9.6 hours by 2016.[11] To maintain these improvements, ongoing mental health services research is being conducted in the Mind and Brain Theme of the South Australian Health and Medical Research Institute (SAHMRI), one of four Australian translational research centres recognised by the National Health and Medical Research Council (NHMRC).

At present, there are few incentives for clinicians and academic psychiatrists to cooperate in such ways. While Australian governments spend huge amounts on co-locating medical schools and teaching hospitals, there are few pressing reasons for them to actually work together. This limits their ability to use the tripartite mission to solve the major problems confronting mental health services. In these circumstances, clinical research is often an afterthought, rather than being central to health service delivery. Governments are well aware of this deficit, and should give careful consideration to the incentives that could be made available for local academic and clinical leaders who want to cooperate on improving patient care throughout the Australian mental health sector.

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