The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Australian Treasury

2021-2022 Pre-budget submission

Improve the mental health of communities

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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, advocates for people affected by mental illness and advises governments on mental health care. 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.

The RANZCP has almost 7000 members including around 5100 qualified psychiatrists and more than 1800 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

The RANZCP has prepared its pre-budget submission in consultation with many of our members, including key RANZCP committees comprising psychiatrists, trainees and people in the community who provide their lived experience perspective.

Executive Summary

The RANZCP acknowledges the Government's focus on mental health is a once-in-generation opportunity to reform Australia's mental health system so that it meets the needs of all people living in Australia. We want to see people living with mental illness having access to a range of services which meet their needs, so that they can fulfill their potential and improve their quality of life.

In recent years, there have been many overlapping processes and inquiries relating to Australia's mental health system, so much so that the Government announced the Select Committee into Mental Health and Suicide Prevention to inquire into the findings. The Productivity Commission Inquiry Report into Mental Health, the Report of the National Suicide Prevention Adviser, the National Mental Health Workforce Strategy, the Aged Care and Disability Royal Commissions, along with other reviews and events relating to the mental health system and the COVID-19 pandemic, all contribute to our understanding of what needs to change in order to protect the wellbeing of people living in Australia. Whilst we commend the Government for committing further energy to the Select Committee inquiry, we urge them to move forward, take assertive action, and commit to funding the processes necessary for sweeping reform.

The Productivity Commission makes a number of recommendations the RANZCP would like to see implemented. Notwithstanding the urgent need for novel and bold solutions to address current major system weaknesses, the RANZCP acknowledges that achieving a fundamental reshaping of our mental health system will require a long-term commitment, strong planning, and co-operation across public, private, government and not-for-profit sectors, and with community members. Further, there must be an adequate workforce to implement these changes.

This submission identifies solutions and opportunities to improve the mental health of the community through strengthening the mental health workforce, improving the accessibility of services, enhancing person-centred care, focusing on suicide prevention, ensuring older adults receive high-quality care and delivering evidence-based care.

Recommendations

1. Workforce

- Provide funding to develop a national initiative to increase the number of psychiatrists, with a focus on addressing maldistribution and in subspecialties with significant shortages.
- Provide funding of $2,000,000 over three years to enable the RANZCP to enhance the Psychiatry Interest Forum (PIF) program (a highly effective recruitment into psychiatry introductory program) to

increase the supply of trained psychiatrists with a dedicated program focus in rural, regional and remote areas as well as those from Aboriginal and Torres Strait Islander backgrounds.
- Provide funding over several years for a project officer and associated operational funds to develop a support program for Specialist International Medical Graduates (SIMGs) undertaking the RANZCP Fellowship program.
- Increase Specialist Training Program (STP) funding and incentives for psychiatry trainee positions and psychiatry supervisor positions in regional, rural and remote areas which can support trainee placements in these areas.
- Provide specific foundational funding for the development of a national dedicated rural and remote psychiatry training pathway and network.
- Provide funding over several years for a project officer and associated operational funds to develop a support program for supervisors which includes training opportunities to improve quality of supervision.
- Assign mental health nursing funding to Primary Health Networks (PHNs) to allow time for other workforce initiatives to be trialled and implemented.
- Commit recurrent funding to implement initiatives to increase the number of specialist mental health nurses.
- Provide funding to develop and deliver a Diploma of Psychiatry to provide specialised training in mental health for generalists, particularly for those working in regional, rural and remote areas.
- Provide funding to develop a program for all members, including the development of eLearning materials and face-to-face workshops, and establish partnerships with local Aboriginal and Torres Strait Islander organisations for the delivery of cultural safety training across each jurisdiction.
- Fund the appointment of an Aboriginal and Torres Strait Islander support liaison officer for psychiatry trainee and Fellow support.

2. Medicare Benefit Schedule (MBS) and telehealth

- Invest in the longer-term expansion of access to psychological therapy and psychiatric treatment by telehealth.
- Allocate funding for videoconferencing technology packages for selected households to ensure equitable access to telehealth.
- Commit to funding an MBS item number for psychiatrists to provide advice to GPs or paediatricians over the phone as recommended by the Productivity Commission.
- Implement strategies to ensure that people in rural and remote areas can continue to access affordable services by application of a loading for psychiatry services, at a rate of at least 50% of the MBS schedule fee, that applies for (a) people living in regional and rural areas who receive services via telehealth or (b) providers residing in regional and rural areas, regardless of whether the service is provided via telehealth or face-to-face.

3. Suicide prevention

- Commit recurrent funding to programs which provide after-care for all people who have presented with suicidal behaviour, accessible to all geographical areas as recommended by the Productivity Commission.
- Commit recurrent funding to crisis mental health care which is accessible 24/7, outside of the hospital emergency department.
- Commit recurrent funding from the Million Minds Mission for the Medical Research Future Fund to psychiatry-led initiatives on research and development of suicide prevention. Funding should cover

research on a range of vulnerable populations and risk factors and explore opportunities for targeted support and intervention prior to a person reaching a crisis point.
- Fund the establishment of clinical registries to improve understandings of the factors that contribute to quality care in line with future national strategies.
- Fund expanded training opportunities for frontline health and community workers, including those in emergency departments, on suicide prevention and screening strategies.

4. Care for older adults

- Invest in the upskilling of the aged care workforce, including local training opportunities in rural and remote areas.
- Fund the development of a new National Framework for Action on Dementia.

5. Electroconvulsive therapy (ECT)

- Increase the ECT schedule fee to $163.05 with provision made for same day consultations for review by the administering ECT psychiatrist, and provision for the more complex procedure of titration.

6. Repetitive transcranial magnetic stimulation (rTMS)

- Fully implement the new MBS item numbers proposed for rTMS for the treatment of depression, as recommended by the Medical Services Advisory Committee.

1. Workforce

A robust and multidisciplinary workforce is essential for ensuring a connected and well-functioning mental health system. Current shortages of mental health professionals are placing significant strain on the capacity of the system to deliver high-quality, accessible care. The disparity in the distribution of the workforce between metropolitan and rural areas and in subspecialties such as child, adolescent and old age psychiatry is of significant concern. A lack of adequate supervision and support for trainees particularly in rural and remote areas is further contributing to the concentration of the workforce in metropolitan areas.

With the shortage of psychiatrists projected to continue for at least the next few years, programs and initiatives which encourage greater accessibility specifically in rural and remote areas, as well as across regional and metropolitan areas are urgently needed.

In addition, greater efforts are required to ensure the mental health workforce delivers culturally safe care. In 2018-19 approximately one-third of Aboriginal and Torres Strait Islander adults reported experiencing high/very high levels of psychological distress, which was more than twice the proportion for non-Indigenous adults. [1] While this is due to a multitude of complex factors, inadequate and inappropriate mental health services continue to contribute to negative outcomes for Aboriginal and Torres Strait Islander peoples. Specifically, the persistence of discrimination and racism within health services and among individual practitioners is creating environments that are culturally unsafe and detrimental to positive health outcomes.

Solutions

Addressing current workforce imbalances and issues will take time and considerable investment from the Australian and State/Territory Governments. As a starting point, workforce planning, including the development of solutions to address the recruitment and retention of psychiatrists and other mental

health professionals, is required to establish the foundations of a strong mental health workforce.

Psychiatry Interest Forum

The Psychiatry Interest Forum (PIF) is a highly effective recruitment into psychiatry introductory program which aims to create and foster the interest of medical students and junior doctors in pursuing psychiatry as their specialty career. PIF is specifically designed to address the current and projected undersupply of trained psychiatrists in the Australian medical workforce. [2]

The PIF program has a strong and proven capacity to increase recruitment into psychiatry in Australia and is a key strategic element of overall RANZCP activities to support Government efforts to address the current and projected shortfall in trained psychiatrists, as identified in the Department of Health National Medical Workforce Strategy: Scoping Framework (July 2019).

- Since its inception in 2014, over 5000 medical students and doctors have joined the PIF Program, and in 2019 and 2020 alone the PIF achieved its highest annual growth in new members joining.
- 909 doctors have since transitioned into the RANZCP psychiatry training program via PIF, and in 2019, 64% of all new psychiatry trainees who commenced the RANZCP training program transitioned from the PIF program.
- In a recent survey of former PIF members who transitioned to the RANZCP training program, 51% indicated that the program influenced their decision to choose psychiatry as their specialisation.

Long-term funding for the PIF program beyond 2021 is one of the most effective ways to address the identified projected shortfall of trained psychiatrists in the Australian medical workforce.

Future expansion of the PIF program will aim to boost the number of rural and regional psychiatry trainees, and to encourage, support and increase the number of Aboriginal and Torres Strait Islander medical students and trainees undertaking the RANZCP Fellowship program.

Support for Specialist International Medical Graduates

The majority of psychiatrists practice in major cities and there is a reliance on Specialist International Medical Graduates (SIMGs) to provide psychiatry services in rural, regional and remote areas. SIMGs are specialist doctors who have completed training outside of Australia or New Zealand. As previously highlighted, regional, rural and remote areas are currently facing a significant shortage of psychiatrists. Further to this, people living in rural and remote locations are at greater risk of self-harm and suicide. [3] It is therefore imperative that SIMGs are supported while undertaking Fellowship training and then to continue practising in regional, rural and remote Australia. SIMGs could be better supported in several areas, including by educating them on the Australian practice context, by providing increased support for the completion of training requirements, and through initiatives which address the challenges, meet the needs of the population and capitalise on the opportunities of life in rural, regional and remote communities.

The RANZCP has previously developed resources as part of the Specialist Training Program (STP) for SIMGs to be inducted into the general Australian context. The resources included workshops which also acted as an important opportunity for SIMGs to network and develop relationships with their peers.

The RANZCP recommends that further funding should be allocated over several years to develop a program for SIMGs undertaking the RANZCP Fellowship program, which includes support to train and continue practising in regional and remote areas.

Regional, rural and remote dedicated training program and network

Despite the increasing need and demand for mental health services in regional Australia, the specialist psychiatric workforce continues to largely remain confined to metropolitan locations. A number of factors contribute to the continued inequitable access for rural Australians in accessing psychiatrists and other mental health clinicians, including the predominance of training programs being run, administered and supporting mostly metropolitan locations and services.

Some success has been achieved in programs dedicated to address the low distribution of psychiatrists and mental health professionals throughout Australia. However, the RANZCP is conducting a scoping project to develop a blueprint for the development of dedicated and enhanced rural psychiatry training pathways throughout Australia. This work will expand on the efforts already made to increase training rotations and experiences through the STP and Integrated Rural Training Pipeline (IRTP) funding initiatives. Foundational funding to support the RANZCP in developing networks and dedicated rural training opportunities, including the administration, provision of training, education and supervision remotely will be required to further develop this strategic work to improve the distribution of the psychiatric workforce into the future.

Support for supervisors of psychiatry trainees

Adequate supervision and support which incentivises trainees to undertake their Fellowships in rural and remote areas is critical to ensuring the workforce is not concentrated in metropolitan areas. The COVID-19 pandemic has led to challenges for supervisors of trainees, with greater challenges for supervisors in rural and remote areas. Supervisors report there are increasing demands on them for service delivery which increasingly impacts on their capacity to provide appropriate and adequate supervision to meet the accreditation standards of the RANZCP Fellowship program. This is having significant flow-on effects on the mental health and resilience of supervisors as well as their capacity to undertake training to enhance their supervision.

Improved supervision skills will bring benefits to other learners as supervisors also educate SIMGs, medical students and other professionals upskilling in mental health skills in addition to psychiatry trainees. The RANZCP recommends funding should be allocated to develop a program for supervisors which will improve the quality of supervision and support the resilience of supervisors. Further, STP funding and incentives for psychiatry trainee positions and psychiatry supervisor positions in regional, rural and remote areas must be increased.

Specialist mental health nurses

Investing in strategies to increase the number of specialist mental health nurses would bridge critical gaps in mental health care, particularly in community settings. The RANZCP recognises that mental health nurses provide broad support for individuals with mental health conditions. Their clinical skills are complementary to psychiatric care and contribute to a team-based approach in the private sector.

Specifically, mental health nurses provide invaluable support to private psychiatrists in assisting with follow-up and review, which is critical given most psychiatrists have high caseloads and limited capacity. The Mental Health Nurse Incentive Program (MHNIP), established in the 2006 COAG Mental Health Package, provided an incentive payment to community-based general medical practices, private psychiatrist services and other appropriate organisations who engage mental health nurses to assist in the delivery of clinical care for people with severe mental health conditions. It was reviewed in a 2010 evaluation commissioned by the National Advisory Council on Mental Health and undertaken by the Australian Healthcare Associates which found that 'overall there was wide acceptance of the program and feedback from all stakeholders was extremely positive'. In 2016-17, MHNIP funding was transitioned to the PHN primary mental health flexible funding pool. Since that funding move, it has been incredibly difficult for private psychiatrists to secure funding from the program to employ a nurse to support them in practice.

In December 2020 the MBS Review Taskforce released the report from the Nurse Practitioner Reference Group, where the introduction of MBS funding for nurse practitioners was not supported. This was disappointing given it could have delivered a clear avenue of funding for mental health nurses within private practice. Whilst the RANZCP notes further work will be undertaken to better define the scope of practice prior to reconsidering MBS funding, there is an immediate need for funding streams to be available which allow private psychiatrists to employ mental health nurses. The RANZCP suggests this be implemented via a 2021-22 Budget measure that ringfences mental health nursing funding to the PHNs to allow time for other workforce initiatives (some of which have already commenced) to be trialled and implemented.

Diploma of psychiatry

The importance of inter-specialty training for medical practitioners has been identified as a medical workforce dilemma and is pertinent in the dialogue around medical workforce planning. Inter-specialty training allows medical practitioners to further broaden their skill set, enhancing patient care and access to health care in under supplied areas.

Diploma level courses are a way for medical practitioners to obtain underpinning knowledge in a specialty that is not their own. Many such short courses and diplomas are already offered by universities, some training organisations and institutes and other Specialist Medical Colleges. However, some of these diplomas do not have a practical component.

Funding a RANZCP Diploma of Psychiatry would work towards ensuring doctors with greater mental health skills can support patients, communities and support the psychiatry workforce. This diploma would contain a practical component, and be embedded in the governance of the RANZCP to enable continual renewal and continued professional development pathways.

Cultural safety

The RANZCP asserts that cultural safety and recognition of culture, Country and community in the healing process should form a key part of improving services for Aboriginal and Torres Strait Islander communities. Health systems and health services should pursue cultural safety and cultural responsiveness as a means of improving the quality and standard of care provided to all consumers and carers. Achieving this requires an increase in the number of Aboriginal and Torres Strait Islander mental health workers and a workforce that is capable of offering culturally safe care.

The RANZCP has made progress with its goal to reach population parity for specialist psychiatrists, but there is still a long way to go. The RANZCP has received Australian Government funding under the STP to provide support to Aboriginal and Torres Strait Islander trainees by holding bi-annual forums to facilitate discussions around how Aboriginal and Torres Strait Islander trainees can be better supported. A mentoring program and exam preparation grants are also offered as part of this funding. In addition, the RANZCP funds a Financial Support Initiative which includes the provision of up $6,000 per year to assist with the costs of specialist training (e.g. RANZCP training fees, assessment fees, attending conferences) and other activities to achieve Fellowship. In the period from 2018-2020 the number of Aboriginal and Torres Strait Islander trainees and Fellows has doubled, highlighting the effectiveness of these initiatives.

The RANZCP recommends funding an Aboriginal and Torres Strait Islander liaison officer to provide further support for Aboriginal and Torres Strait Islander Fellows and trainees.

Greater education for members would further assist in developing psychiatrists' skills in culturally safe care and practice. The RANZCP would like to highlight its Enabling Supported Decision-Making (ESDM) project, commissioned by the Victorian Government in 2017, as a positive example of the co-production of training and resources to support psychiatrists and trainees. The project could be used as a blueprint for the development of cultural safety training and resources.

Recommendations:

- *Provide funding to develop a national initiative to increase the number of psychiatrists, with a focus on addressing maldistribution and in subspecialties with significant shortages.*
- *Provide funding of $2,000,000 over three years to enable the RANZCP to enhance the PIF program and increase the supply of trained psychiatrists with a focus in rural, regional and remote areas as well as those from Aboriginal and Torres Strait Islander backgrounds.*
- *Provide funding over several years for a project officer and associated operational funds to develop a support program for SIMGs undertaking the RANZCP Fellowship program.*
- *Increase Specialist Training Program (STP) funding and incentives for psychiatry trainee positions and psychiatry supervisor positions in regional, rural and remote areas which can support trainee placements in these areas.*
- *Provide specific foundational funding for the development of a national dedicated rural and remote psychiatry training pathway and network.*
- *Provide funding over several years for a project officer and associated operational funds to develop a support program for supervisors which includes training opportunities to improve quality of supervision.*
- *Assign mental health nursing funding to the PHNs to allow time for other workforce initiatives to be trialled and implemented.*
- *Commit recurrent funding to implement initiatives to increase the number of specialist mental health nurses.*
- *Provide funding to develop and deliver a Diploma of Psychiatry to provide specialised training in mental health for generalists, particularly for those working in regional, rural and remote areas. [4]*
- *Provide funding to develop a program for all members, including the development of eLearning materials and face-to-face workshops, and establish partnerships with local Aboriginal and Torres Strait Islander organisations for the delivery of cultural safety training across each jurisdiction.*
- *Fund the appointment of an Aboriginal and Torres Strait Islander support liaison officer for psychiatry trainee and Fellow support.*

2. MBS and telehealth

The temporary expansion of the availability of telehealth in light of the pandemic has been an unexpected but welcome development. Psychiatrists have highlighted a number of advantages of the use of the temporary telehealth item numbers, including increased accessibility for consumers, improved consumer wellbeing and engagement, increased engagement with hard-to-reach consumers and increased service availability. Consumer feedback received by psychiatrists in relation to the use of telehealth for their psychiatry consultations has also been positive.

However, psychiatrists have noted some consumers lack access to the required equipment, poor internet connectivity experienced by consumers, and technology failures as key issues that require attention. It is essential that future use of telehealth in psychiatry be informed by the basic principles of equity, accessibility and effectiveness. People with poor socio-economic status, including many of those in rural and remote areas, are currently the most under-served in terms of access to psychiatry services. [5] Delivery of psychiatry services to rural and remote areas (both face-to-face and via telehealth) is complex and time consuming as psychiatrists spend additional time understanding, liaising, and building relationships with local health services and communities with which they may not be familiar. Historic underfunding of rural psychiatry services has contributed to the extreme disparity in face-to-face service availability, a gap that is partly met by current MBS loading (item 288) which allows telehealth consultations to be bulk-billed, thus improving affordability to access psychiatry services for many.

A key challenge that must also be addressed to improve the mental health system is the fragmentation

of care which is leading to poor consumer outcomes. Psychiatrists play an important role in building the capacity of other health professionals and providing advice so that patients receive continuity of care and evidence-based treatments. The availability of psychiatric advice to other health professionals is particularly critical in light of the shortfall of psychiatrists.

Solutions

Ensuring the longer-term expansion of access to assessment and treatment by telehealth as an adjunct to face-to-face consultations will enhance person-centred care and go some way to compensating the shortfalls in psychiatrists, particularly in rural and remote areas. Flexible access to all types of consultations should be a priority. This will serve to enhance service provision by providing cost-effective delivery of services to people who already have mental health conditions or who have developed them during the pandemic. The continued expansion of telehealth should also complement ongoing initiatives to support access to psychiatric care in rural and remote communities, such as rural workforce development strategies and adequately funded health services.

It is critical that regional and remote populations have affordable access to psychiatry service, both face-to-face and via telehealth. If item 288 is to be removed from the MBS, as documented in the December 2020 MBS Review Taskforce Recommendations report, alternative strategies must be implemented to ensure people in rural and remote areas, as well as other disadvantaged populations, continue to be able to access affordable psychiatric care both face-to-face and via telehealth either within the MBS or outside it.

In addition, providing opportunities for generalists, particularly those working in rural and remote areas, to be further informed in mental health and psychiatry is another means for enhancing the accessibility of mental health services. More support from psychiatrists for GPs and paediatricians facilitated by the introduction of an MBS item would support best-practice and integrated care. However, any new service would have to be affordable whilst avoiding excessive demands on the relatively small psychiatrist workforce.

Recommendations:

- *Invest in the longer-term expansion of access to psychological therapy and psychiatric treatment by telehealth.*
- *Allocate funding for videoconferencing technology packages for selected households to ensure equitable access to telehealth.*
- *Implement strategies to ensure that people in rural and remote areas can continue to access affordable services by application of a loading for psychiatry services, at a rate of at least 50% of the MBS schedule fee, that applies for (a) people living in regional and rural areas who receive services via telehealth or (b) providers residing in regional and rural areas, regardless of whether the service is provided via telehealth or face-to-face.*
- *Commit to funding an MBS item number for psychiatrists to provide advice to GPs or paediatricians over the phone as recommended by the Productivity Commission.*

For further details, please refer to the results of the RANZCP member survey on telehealth in psychiatry in Australia.

3. Suicide prevention

The impacts of suicide are devastating for the individuals affected, their loved ones and the wider community. Estimates suggest that the direct economic costs of mental ill-health and suicide in Australia as between $43 to $70 billion in 2018-19. [6] There were 3,318 deaths due to intentional self-harm

(suicide) in Australia in 2019. Suicide is the leading cause of death among people aged 15-49 in Australia. [7]

Statistics show that suicide deaths occur disproportionately in certain communities, cultures and demographics. Deaths from intentional self-harm occur among males at a rate more than three times greater than that of females. The highest proportion of suicide deaths occur among young and middle-aged people, with the rate spiking again amongst males who are 85 years and older. [7] The rate of suicide deaths per 100,000 increases consistently with remoteness. [8] Mood disorders, including depression, were the most commonly mentioned co-morbidity across all suicide deaths, followed by problems relating to substance use. Although not everybody who dies by suicide has a mental illness, appropriate care of mental illness and response to suicidal crisis are fundamental in efforts to prevent suicide.

Solutions

If implemented in a comprehensive and sustained way, the Government's focus on suicide prevention has the potential to significantly reduce preventable deaths and change the cultural expectations and experiences of suicide in Australia. Whilst suicide is difficult to predict, there are measures which can help prevent suicide and support those in suicidal distress. [9] We welcome the Productivity Commission's recommendation for the establishment of a National Mental Health and Suicide Prevention Agreement to clarify responsibilities for mental health service delivery, funding, monitoring, reporting and evaluation. However, this must be accompanied by funding and an implementation plan to enact change. [6]

A key risk factor for suicide is a history of self-harm. [10] Therefore, an important aspect of comprehensive services is ensuring that they meet the needs of people who have presented with suicidal behaviour. Funding must be directed to evidence-based programs which provide after-care for people who have presented with suicidal behaviour. Interventions of active contact and follow-up have been recommended as an intervention for patients admitted to emergency departments for a suicide attempt. [11] The delivery of universal aftercare and assertive outreach for people leaving a hospital, GP, or community mental health service following a suicide attempt must be prioritised, as per the recommendation in the Productivity Commission Final Report. [6]

We applaud recent budget announcements which focus on evaluating suicide prevention trial activities across the country and expanding postvention and assertive outreach programs. Consideration should be given to ensuring that there is enough funding to provide comprehensive and appropriate aftercare in every part of Australia, and that recurrent funding is committed to sustain these services. However, clinical care is also essential in suicide prevention and we need sufficient community mental health services to provide assessment and ongoing treatment for those in suicidal distress.

Investment into research that investigates how best to proactively support vulnerable people experiencing serious life stressors or transitions, including outside of traditional service environments is required. For example, critical time periods, such as in the six months following job or relationship loss. We are encouraged by the announcement of additional funding for the Black Dog Institute and Everymind to deliver a research program which targets people at greater risk of mental health conditions and suicide.

The RANZCP highlights that there is also a need for rapid, readily accessible data on mental health and suicides and the establishment of clinical registries that would provide the potential to improve our understanding of the factors that contribute to quality care.

Recommendations:

- *Commit recurrent funding to programs which provide after-care for all people who have presented with suicidal behaviour, accessible to all geographical areas.*
- *Commit recurrent funding to crisis mental health care which is accessible 24/7, outside of the hospital emergency department.*
- *Commit recurrent funding from the Million Minds Mission for the Medical Research Future Fund to psychiatry-led initiatives on research and development of suicide prevention. Funding should cover research on a range of vulnerable populations and risk factors and explore opportunities for targeted support and intervention prior to a person reaching a crisis point.*
- *Fund the establishment of clinical registries to improve our understanding of the factors that contribute to quality care in line with future national strategies.*
- *Fund expanded training opportunities for frontline health and community workers, including those in emergency departments, on suicide prevention and screening strategies.*

For further detail, please refer to the RANZCP's Position Statement on Suicide Prevention.

4. Care for older adults

The 65 and over population in Australia is expected to more than double between now and 2057, and it is expected that the number of older Australians with mental illness will grow accordingly. At present, aged care services do not meet the mental health needs of older Australians. There is a clear need to re-evaluate, reform and fully-fund the aged care system in Australia.

Whilst we understand care for older Australians was out of scope for the Productivity Commission Inquiry into Mental Health, the provision of mental health care to our ageing population requires significant improvement. We welcome the announcement of an additional $1 billion of aged care funding, which we understand will focus on home care packages. With the growing proportion of Australians accessing aged care services, the country will face a significant shortfall of appropriately skilled aged care workers. The Productivity Commission has previously estimated the aged care workforce will need to grow by over 900,000 workers. [12] A comprehensive aged care system can only be delivered by adequately trained and appropriately resourced workforce. There is a need for committed investment to increase and enhance the capacity of the mental health and aged care workforce.

Among people aged 65 years and over, dementia was the second leading cause of total burden of disease and injury (accounting for 7.7% of disability adjusted life years). [13] While dementia clearly has a biological substrate, it is important to acknowledge that the common psychiatric complications of dementia require the involvement of psychiatrists as experts in care, treatment and support. [14] The Royal Commission into Aged Care recommended all initial antipsychotic prescribing for people going into residential care is undertaken by a specialist psychiatrist or geriatrician. The RANZCP is concerned the workforce to undertake this task does not exist, and such a recommendation would place considerable pressure on psychiatrists. In turn, this would impact on access to care for older people.

Solutions

Reform of the aged care sector is required to ensure the system is appropriately oriented to meet the needs of older people, including their mental health needs. Funding should be directed to upskilling the aged care workforce, particularly with regard to mental health, and ensuring appropriate services are available for people with the behavioural and psychological symptoms of dementia. The RANZCP believes emphasis should be placed specifically on developing a medical workforce, including general practitioners, psychiatrists and other medical specialists, to meet the complex health needs of the growing group of older people in Australia. The RANZCP is willing to work with relevant stakeholders to determine how we might support the delivery of educational modules in relation to the Behavioural and Psychological Symptoms of Dementia (BPSD), psychotropic prescribing, assisting in the delivery of

specialist input into a modified training curriculum, or the delivery of continuing medical education events. [15]

Psychiatrists with significant experience in the aged care sector have raised specific concerns about dementia as the single most important contributor to psychiatric symptomatology within residential care. The RANZCP believes that, on this basis, psychiatric expertise should be utilised to guide and develop a new National Framework for Action on Dementia.

Please refer to the RANZCP's comprehensive submission to the Royal Commission into Aged Care Quality and Safety for further detail on solutions to resolve ongoing issues with mental health care, treatment and support within the aged care system.

Recommendations:

- *Invest in the upskilling of the aged care workforce, including local training opportunities in rural and remote areas.*
- *Fund the development of a new National Framework for Action on Dementia.*

5. MBS funding for electroconvulsive therapy (ECT)

Recently published studies and reviews have continued to support the efficacy and safety of ECT. [16] Indications for ECT include the treatment of the following mental health conditions:

- Depressive disorders including major depression and major depression with psychotic features, major depression with melancholic features, treatment refractory depression, and major depression with peripartum onset.
- Severe depression where an urgent clinical response is required, due to acute suicide risk, risk due to poor oral intake etc.
- Other psychiatric disorders such as bipolar disorder (manic, mixed and depressed phases), acute and chronic treatment-resistant schizophrenia, schizo-affective disorder, catatonia, acute psychosis, puerperal psychosis and neuroleptic malignant syndrome. [17]

However, the current MBS schedule fee was set prior to multiple developments in ECT practice in the last decade. Advances in knowledge have been accompanied by the publication of guidelines and legislation specifying more detailed standards in the clinical practice of ECT. The procedure has become far more complex, involving 1) knowledge and skills of a greater range of treatment approaches, 2) interpretation of a range of clinical markers in determining the parameters of each treatment.

Specifically, current standards recommend 1) a 'titration' session to empirically establish the threshold for stimulation for each individual patient, so that ECT dosage is customised to the patient and 2) interpretation of seizure quality recordings (EEG), cognitive monitoring and clinical progress to determine the optimal ECT dose at each subsequent ECT treatment. This has resulted in the need for psychiatrists administering ECT to be highly trained and to administer ECT in a far more sophisticated way.

Currently the procedure is substantially underfunded to the extent that it is difficult to attract appropriately trained psychiatrists to administer ECT and reduces the incentive for private hospitals to provide it. This is impacting adversely on future patient access to this potentially life-saving procedure. The problem of the low schedule fee is compounded because ECT psychiatrists are unable to bill same-day concurrent or additional appointments for the assessment of the patient prior to or after the treatment under the MBS. As ECT psychiatrists often also provide expert advice on ECT, this means that the patient needs to attend the hospital on separate days, to receive ECT and to consult the ECT specialist.

Solutions

The current schedule fee for ECT is $72.55. The RANZCP supports that a more accurate fee schedule would be $163.05 for a standard ECT treatment, incorporating the following and additional components:

- Administering ECT treatment: The increased complexities described above increase the time for each treatment. Therefore, a fee of $163.05 would be reasonable to accommodate the increased time required due to the increased complexity of the treatment procedure. This fee would incorporate the required pre-ECT clinical assessment, which is an intrinsic part of the treatment, on the same day as the ECT treatment. This is calculated as comparable to existing ECT item number (14224 = $72.55) plus an MBS Item 322 (=$90.50) for each session (=$163.05).
- Same day post-ECT review: Amend the billing rules to allow the ECT administering psychiatrist to also provide a post-ECT treatment consultation review on the day of the ECT treatment as required. This can be claimed as per the existing time-based consultation fees (e.g. current MBS 2 hospital-based time tiered items 322, 324, 326). Note that the treating psychiatrist can already bill for this item if they are different from the psychiatrist who administered the ECT.
- ECT titration session: Apply a loading for doing a threshold titration session, given this requires more complexity, additional skills and time. The RANZCP suggests a time loading be applied (equivalent to an item 320 = $45.35) be applied to the ECT delivery component (see point 1 above) when undertaking a threshold titration session, making the fee $208.40 for a titration session. This will require the creation of a new ECT 'titration' item that can be used instead of the existing ECT item when appropriate.

The RANZCP has provided further detail in its proposal to the Department of Health to be considered by the MBS Review Taskforce Psychiatry Implementation Group. It is noted that the final report from the MBS Review Psychiatry Clinical Committee indicated that there was scope to review upward funding for ECT, which is strongly supported by the RANZCP.

Recommendation:

- *Increase the ECT schedule fee to $163.05 with provision made for same day consultations for review by the administering ECT psychiatrist, and provision for the more complex procedure of titration.*

6. MBS funding for repetitive transcranial magnetic stimulation (rTMS)

Repetitive transcranial magnetic stimulation (rTMS) is a therapeutic, well-tolerated, and safe medical procedure for the treatment of psychiatric disorders, especially episodes of major depression. There is a good evidence base for the therapeutic efficacy of rTMS in major depressive disorder. Those with treatment resistant depression who respond to rTMS treatment (approximately 50% of patients) will subsequently experience a lower burden of disease. [18] However, at present rTMS is not covered under the MBS, meaning it is expensive for clinicians to deliver it and for those who could benefit from treatment to access it.

An application to seek approval for funding for rTMS for the treatment of depression to be available under the MBS was approved by the Medical Services Advisory Committee (MSAC) in August 2019. [19]

MSAC has recommended the introduction of two new item numbers under the MBS Category 3 Therapeutic Procedures to fund rTMS covering:

- Initial prescription and mapping session (undertaken by a TMS-trained psychiatrist)
- rTMS treatment (performed by a nurse or allied health professional who has been suitably trained)

Solution

Given the significant evidence for rTMS as an effective treatment for depression, and the clearly defined standards for the delivery of rTMS [20], the RANZCP supports that it should be accessible in public and private mental health services in addition to the current spectrum of treatments. It should be affordable and, where appropriate, offered as a therapeutic option for the treatment of major depression. The financial and budgetary implications for the implementation of these rTMS item numbers are outlined in detail in the MSAC public summary document [see table 8]. [19]

Recommendation:

- *Fully implement the new MBS item numbers proposed for rTMS for the treatment of depression, as recommended by MSAC.*

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