Australian Treasury  
**2020-2021 Pre-budget submission**December 2019

# Executive Summary

# 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 is accredited by the Australian Medical Council to deliver specialist medical education and training, and professional development programs.

The RANZCP has over 6,700 members, including more than 5,000 qualified psychiatrists and approximately 1600 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.

**Introduction**

The RANZCP acknowledges the Australian Government’s focus on mental health is a once-in-a-generation opportunity to critically evaluate and influence definitive reform of the mental health sector. The focus should be on ensuring that people living with mental illness have the appropriate access to the range of services that they require to fulfil their potential and improve their quality of life.

The RANZCP welcomes the development of the National Medical Workforce Strategy Scoping Framework as well as the Productivity Commission Inquiry into Mental Health Draft Report (1, 2). These documents highlight the importance of mental health to Australians and are an opportunity to examine the role of prevention and intervention, and to ensure an evidence-based approach is taken in designing and implementing services and programs.

Both of these documents align with the RANZCP’s position in recognising that the current mental health workforce is insufficient to meet demand, with more resources needed for planning, recruitment and retention. The disparity in the distribution of mental health professionals between metropolitan and rural areas is of significant concern.

The RANZCP’s submission to the Australian Government identifies solutions and opportunities to improve the mental health of the community through strengthening the psychiatry workforce, improving equity of access to services and delivering more evidence-based, co-designed programs for Australians. Specifically the RANZCP’s submission addresses:

1. **Workforce**

People living in regional, rural and remote areas do not have the same access to mental health services as those residing in metropolitan areas which negatively impacts their health. Workforce maldistribution between metropolitan and other areas of Australia contributes to this access inequity. With a shortage of psychiatrists anticipated within the next few years, funding into programs and initiatives which support growth in this specialist medical profession is important in addressing the access gaps in rural and remote areas especially, as well as metropolitan areas. It is important the Government continues developing and supporting strategies, including telehealth and digital health, which work towards addressing the maldistribution of the mental health workforce.

**Recommendations:**

1. *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 (1).*
2. *Increase the funding for project support for the STP and the Integrated Rural Training Pipeline for Medicine initiative by $500,000 over three years.*
3. *Provide funding to deliver five years of the military and veteran training program to 10-20 posts to increase the capacity of the psychiatry workforce to care for the mental health needs of the military and veteran community ($9,387,730 - $18,453,850 total over 5 years, depending on number of positions).*
4. *Provide funding of $2,000,000 over three years to enable the RANZCP to enhance the Psychiatry Interest Forum (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.*
5. *Provide funding to develop and deliver a Diploma of Psychiatry to provide specialised training in mental health, particularly for those working in regional, rural and remote areas (3).*
6. *Commit to no funding cuts to any psychiatry services that are currently provided to rural communities via telehealth.*
7. *Increase funding to accelerate the development and implementation of the* [National Safety and Quality Standards for Digital Mental Health Services](https://www.safetyandquality.gov.au/our-work/e-health-safety/national-safety-and-quality-standards-digital-mental-health-services) *by the Australian Commission on Safety and Quality in Healthcare.*
8. *Provide funding to support programs which upskill psychiatrists and other health professionals in the use of e-health resources as adjuncts to assessment, management and treatment monitoring.*
9. *Provide funding to develop* *a Regional Psychiatric Workforce Translation Group addressing the maldistribution of medical professionals across Australia using local knowledge and expertise.*
10. **Appropriate and Equitable Access to Services**

***Mother and Baby Units***

Women are at greater risk of developing a mental illness following childbirth than at any other time, and the effects of post-natal mental illness can be devastating for the mother, baby, families and the surrounding community (4-6). Mother and baby units (MBUs) play a vital role in supporting mothers who are facing complex mental health conditions while allowing them to continue to bond with their baby. It is important that all states and territories have MBUs available to support mothers and their babies.

Appropriate levels of MBUs in Australia will reduce the potential short and long term impacts for both mothers and children, including babies who are required to stay in out of home care where the risk of prolonged separation impacting the health, attachment and wellbeing of mother and child.

***Repetitive Transcranial Magnetic Stimulation***

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. Given the significant evidence for rTMS as an effective treatment for depression, and the clearly defined standards for the delivery of rTMS (21), it should be accessible in public and private mental health services and affordable through the Medicare Benefits Scheme.

**Recommendations**:

1. *For the Australian government to work collaboratively with state and territory governments to allocate funding for new MBUs in Queensland, New South Wales and Tasmania and develop arrangements for people in the Northern Territory and Australian Capital Territory to have access to support where a MBU is not viable.*
2. *That the new MBS item numbers proposed for rTMS for the treatment of depression, as recommended by Medical Services Advisory Committee, be implemented in full by the Australian Government.*
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 $51 billion in 2018-19. Funding must be directed to evidence-based programs, including after-care for people who have presented with suicidal behaviour. 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.

**Recommendations:**

1. *Commit recurrent funding for evidence-based interventions, including programs that provide after-care for all people who have presented with suicidal behaviour, accessible to all geographical areas. Aftercare programs should be complemented by:*
2. *broad referral pathways*
3. *additional outreach services to support people in regional and rural areas*
4. *extended service delivery, including outside standard business hours*
5. *dedicated outreach and after-care services for children and young people who have self-harmed or are at risk of suicide.*
6. *Commit recurrent funding from the* [Million Minds Mission for the Medical Research Future Fund](https://www.health.gov.au/sites/default/files/the-million-minds-mission-roadmap.pdf) *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.*
7. *Invest in research to identify professions with the highest incidence of suicide and the effectiveness of any existing organisational-level interventions. Fund pilot projects of organisational-level interventions for high risk professions.*
8. *Fund training to frontline health and community workers, including those in emergency departments, on suicide prevention and screening strategies.*
9. *Improve coordination of care for people in psychological distress across service providers, beyond health, to include, for example, schools, public housing tenancy managers, maternal and child health nurses and Centrelink social workers.*
10. **Mental Health of Aboriginal and Torres Strait Islander Peoples**

The RANZCP recognises the importance of implementing best practice suicide prevention initiatives as agreed to by the National Aboriginal and Torres Strait Islander Leadership in Mental Health and the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention. The RANZCP also supports the development of cultural safety training for specialists through the Australian Indigenous Doctors Association (AIDA) and multidisciplinary health teams in Aboriginal Community Controlled Health Organisations (ACCHOs) and mainstream services. Through funding best practice initiatives in suicide prevention, training and workforce development the government can ensure that Aboriginal and Torres Strait Islander people are able to access the mental healthcare they require in environments that are culturally secure.

**Recommendations:**

1. *Commit to funding best practice suicide prevention initiatives as agreed to by the National Aboriginal and Torres Strait Islander Leadership in Mental Health and the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention.*
2. *Provide funding to the Australian Indigenous Doctors Association (AIDA) to support the development and delivery of cultural safety training for the specialist medical workforce.*
3. *Increase funding for mental health services within existing multidisciplinary health teams, which are embedded in both Aboriginal Community Controlled Health Organisations (ACCHOs) and mainstream services.*
4. *Increase funding for the recruitment and placement of Aboriginal and Torres Strait Islander mental health workers in public health services, which includes necessary support mechanisms, e.g. mentoring, debriefing and supervision.*
5. **National Disability Insurance Scheme**

The RANZCP recognises that the National Disability Insurance Agency (NDIA) is seeking ways to better support people with psychosocial conditions through the National Disability Insurance Scheme (NDIS). Investment and education is required to improve the interaction between the NDIS and mental health sector. This could include including incorporating elements of recovery and consideration of the episodic nature of psychosocial conditions into the NDIS, which would help support people with psychosocial conditions more effectively and deliver more holistic care.

**Recommendations:**

1. *Fund the development of avenues for better sharing of information, coordination of support and dispute management between health professionals, the NDIA and service providers, which includes a central point for medical professionals to engage with NDIA staff in relation to NDIA eligibility processes and requirements for medical professionals seeking information on how best to support a patient access the NDIS.*
2. *Provide flexible funding options, including rollover of funding, for participants on the psychosocial stream of the NDIS which are responsive to the episodic nature of psychosocial conditions to ensure access is available when it is needed.*
3. *Fund advocates for vulnerable people with psychosocial disability, who have with appropriate understanding of episodic illness and the recovery model, to ensure NDIS participants are better able to access the NDIS and supports.*
4. **Aged Care**

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. 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.

**Recommendations:**

1. *Invest in the upskilling of the aged care workforce, including local training opportunities in rural and remote areas.*
2. *Fund a national, consistent regulatory framework around minimum staffing and skills in aged care, including for community aged care and residential aged care facilities.*
3. *Fund the development of a* National Framework for Action on Dementia 2020-2024*.*
4. *Invest in appropriate stepped care services to provide improved care for people with moderate to severe behavioural and psychological symptoms of dementia.*

For further details, please see the attached submission.

### RANZCP Pre-Budget Submission for 2020-2021

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Both of these documents align with the RANZCP’s position in recognising that the current mental health workforce is insufficient to meet demand, with more resources needed for planning, recruitment and retention. The disparity in the distribution of mental health professionals between metropolitan and rural areas is of significant concern.

The RANZCP’s submission to the Australian Government identifies solutions and opportunities to improve the mental health of the community through strengthening the psychiatry workforce, improving equity of access to services and delivering more evidence-based, co-designed programs for Australians.

1. **Workforce**

Everyone deserves to be able to access expert psychiatric care at the right time, and solutions are required to better service our communities with an appropriately skilled workforce.

The Australian Government’s Department of Health conducted a psychiatry workforce review in 2016 which concluded that a shortfall of psychiatrists was expected nationally by 2030. The 2019 National Medical Workforce Strategy Scoping Framework also highlights that a projected shortage in psychiatry specialists persists, despite increases in the number of training positions. Australia has a lower number of psychiatrists per million people than the Organisation for Economic Co-operation and Development average.

The RANZCP is delivering a number of successful programs, including increasing the number of training positions, to respond to the undersupply of the psychiatry workforce.

The National Medical Workforce Strategy Scoping Framework priorities for developing the medical workforce provide opportunities to respond to the psychiatry workforce issues, including:

* geographical maldistribution (including rural and remote workforce)
* speciality undersupply
* Indigenous and culturally safe workforce
* doctor work-readiness and
* changing models of care.

The RANZCP’s submission has considered these priorities, and identifies the following opportunities for investment by the Australian Government:

***Rural Workforce***

Approximately seven million people live in rural or remote areas in Australia (7). Almost one million Australians living in rural and remote areas will experience a mental health condition each year (8). However, they will not have the same access to mental health services as those residing in metropolitan areas which will significantly impact their health (7). Stigma around mental health and isolation combined with poor availability of mental health services and health staff shortages in rural and remote communities exacerbates these issues (3). This lack of mental health support can have detrimental impacts on rural and remote communities.

Rates of suicide in regional, rural and remote areas are higher than in metropolitan areas, particularly among Aboriginal and Torres Strait Islander people. Despite this, Aboriginal and Torres Strait Islander people are only half as likely to receive help for mental health concerns (9).

The RANZCP is committed to ensuring those living in rural and remote Australia have equitable access to healthcare. However, there is a severe shortage of consultant psychiatrists in rural and remote Australia (10). The trend of workforce maldistribution is likely to continue into the future without significant intervention to incentivise and support rural practice. In the context of current metropolitan based training programs, most trainee psychiatrists also report a continuing inclination to practice in urban centres (11).

The release of the National Medical Workforce Strategy Scoping Framework has the potential to influence the geographical disparity in the medical workforce between metropolitan and rural and remote areas including the lack of accredited speciality training positions in non-metropolitan settings (1).

Funding for new psychiatry supervisor positions in rural areas would assist in creating positions for trainees to remain, or choose, to train and work in rural and remote areas, encouraging greater dispersion of psychiatrists across geographical locations.

***Training Programs and Recruitment into Psychiatry Initiatives***

Specialist Training Program

The Specialist Training Program (STP) supports specialist medical training outside the traditional public teaching hospital setting, including in rural areas. Incentivising and supporting trainees to train in rural and remote areas is critical to ensuring the workforce is more evenly distributed and not concentrated in metropolitan areas.

Funding for new psychiatry supervisor positions in regional, rural and remote areas, similar to the Training More Specialist Doctors in Tasmania (TMSD) ‘Tasmanian Project’ would be a step towards increasing not only current workforce capacity in non-metropolitan area, but would also be an investment in the future workforce as trainee positions may also be increased or added to these areas.

Currently many trainees must reside in metropolitan areas to undertake specialist training. Further investment in STP would provide opportunities for those residing in non-metropolitan areas to remain in their communities.

Providing additional funding for supervisory positions in regional, rural and remote areas (particularly the Northern Territory) would be a positive step in correcting the maldistribution of psychiatrists.

The Scoping Framework for the National Medical Workforce Strategy identifies that there is an opportunity to ‘capitalise on current stakeholder support for a nationally coordinated approach to medical workforce planning’ and the RANZCP highlights that this should be a priority for all jurisdictions’ (1).

To optimise the success of the STP, the RANZCP acknowledges that the provision of the program is not only dependent on the provision of supervisors but also requires the associated increases in state and territory mental health services.

The RANZCP welcomes the Australian Government’s prioritisation of the proposed Medical Workforce Strategy to develop solutions to workforce issues and their contributing factors.

The RANZCP recognises the unique occupational risks associated with military roles and the mental health challenges that may be faced by Australian veterans and is committed to improving military and veterans’ access to specialist mental health care. In 2020, the RANZCP will deliver a 1-year training pilot with funding for five clinical posts in hospitals or other healthcare settings where trainees will be exposed to military and/or veteran psychiatric patients.

The RANZCP submitted a proposal to expand military and veteran psychiatry training to the Minister for Veterans and Defence Personnel the Hon Darren Chester MP in October 2019. The Minister welcomed the proposal and has asked his department to consider opportunities to support it. Providing funding to expand military and veteran psychiatry training will increase the capacity of the future psychiatry workforce by providing trainees with exposure to military and veteran psychiatry.

The Psychiatry Interest Forum (PIF) is a highly effective *recruitment into psychiatry introductory program* 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 (1).

The PIF program has a proven track record of successfully increasing the number of medical students and medical postgraduates into the RANZCP psychiatry training program:

* Since 2014, 4,042 medical students and doctors have joined the PIF Program, with 661 of those members choosing to enter the RANZCP psychiatry training 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.
* In 2018, 79% of all new psychiatry trainees who commenced the RANZCP training program transitioned from the PIF program.

Long-term funding for the PIF program beyond 2020 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 and increase the number of Aboriginal and Torres Strait Islander medical students and graduates into the psychiatry fellowship training program.

Funding of a Psychiatry Diploma

Generalists play a primary role in delivering healthcare particularly in rural and remote areas. The creation of a diploma in psychiatry would provide the opportunity for generalists, particularly those working in rural and remote areas, to seek further training in mental health and psychiatry.

With the funding announcement in 2019-20 by the Australian Government for the National Rural Generalist Pathway over four years, specialist training in mental health remains an option for those wishing to provide more support for mental health conditions (3). Incentives to undertake training in mental health could also be utilised to encourage generalists working in rural and remote areas to undertake a Diploma of Psychiatry particularly as mental health is a leading cause for seeking medical advice (3).

As reported by the Productivity Commission (2019) the benefits of creating a diploma in psychiatry to upskill Generalists in providing mental health care would assist in providing further training in mental health across the health system(3)(2)(6). As medical staff have significant exposure to people presenting with complex and acute mental health conditions, providing funding for a diploma in psychiatry would be highly beneficial to professionals, patients and the community.

Regional Psychiatric Workforce Translation Group (RPWTG)

The RANZCP believes that policy initiatives which rely on the development and implementation of innovative models of care with collaboration across state-wide and national networks, must be driven by the knowledge and experience of regional psychiatric clinical and training directors, academic psychiatrists with regional workforce and training expertise, and training and policy representatives from the RANZCP. These individuals could work in collaboration with the Medical Workforce Reform Advisory Committee, particularly around data access and analysis.

The RANZCP proposes the development of a group to address these shortages, acknowledging that a coordinated effort with those who have experience in working in mental health in regional, rural and remote areas would help provide a clear understanding of the issues at all levels. The RPTWG would coordinate and drive the implementation of the many possible strategies already gathered within policy documents including establishing a strategic map comparing workforce, training resources and service demands, identifying high priority workforce development sites and implementing pilot interventions at priority sites across regional, rural and remote Australia.

The development of the RPWTG would also align with the Australian Government’s Long Term National Health Plan (12), addressing the maldistribution of medical professionals across Australia using local knowledge and expertise.

***Models of care including telehealth***

The RANZCP supports the ongoing provision of telehealth for the wellbeing of rural Australians. Telehealth enables psychiatrists to be able to reach individuals who are otherwise isolated and without psychiatrist support in their areas.

Telehealth services in psychiatry under the MBS provide patient assessments, management plans and ongoing support for patients, families, multidisciplinary teams and General Practitioners (GPs). This provides much needed support for GPs and the local community. In addition, ongoing support of patients through both regular psychotherapy and medical management makes a real difference in the life of many rural Australians who have accessed telepsychiatry services.

Teleheath services can be complex and time consuming as psychiatrists will spend additional time understanding and liaising with local health services and communities with which they are not familiar. The provision of additional funding via MBS item 288 allows psychiatrists to partially meet these additional costs. Furthermore many people living in rural areas are severely socio-economically disadvantaged. The additional funding helps ensure that, in the vast majority of cases, psychiatrists are able to bulk-bill patients for these services [Department of Human Services, unpublished data].

The RANZCP is aware that the draft report from the MBS Review Taskforce Psychiatry Clinical Committee, currently open for consultation, suggests potential phasing out of MBS item number 288, or replacement with alternative incentives. The RANZCP is concerned that withdrawing this support, without clearly defined equivalent alternatives, will severely disrupt services in rural communities as many psychiatrists may choose not to offer these services. The RANZCP is in the process of developing its response to the MBS Review Taskforce draft report from the Psychiatry Clinical Committee, which aligns with this submission.

Given the severe and significant disadvantage that rural communities face in regard to the availability and accessibility of psychiatry services, the RANZCP strongly supports measure that promote the delivery of psychiatry services to these areas.

***Digital mental health***

The Australian National Survey of Mental Health and Well-being in 2007 found that only 35% of people with a mental illness had used a health service within the survey period (13). By providing another means of early access to services, e-mental health allows for reduced duration of untreated illness, and potential for less intensive treatment and faster recovery.

Digital services can be particularly effective at meeting the needs of groups and individuals that face unique barriers to accessing services and who may not currently seek help from current service providers.

E-mental health services can offer creative and cost-effective ways to meet some of the mental health needs of the community. E-mental health refers to the broad range of digital resources, services or programs, delivered via online, mobile or phone-based platforms, which offer support to people affected by mental health issues, including consumers, families, carers and communities.

E-mental health may also offer benefits for certain groups in Australia, such as young people, rural and remote communities, and those who do not access traditional services. Studies have shown that young people feel favourably towards the use of mobile phone applications and online resources for mental health care (14, 15).

The changes brought to mental health care by the development of e-mental health tools are substantial and ongoing. New technology and approaches bring benefits, but also challenges and risks. It must be considered that e-mental health tools need oversight to ensure quality and safety.

The RANZCP acknowledges that there are efforts around Australia to develop and enhance e-mental health services, including the Australian Commission on Safety and Quality in Healthcare project on developing National Safety and Quality Standards for Digital Mental Health Services. Ensuring that all e-mental health services are evidence-based and high quality should be a priority for government, and on this basis the RANZCP strongly recommends that funding be dedicated to accelerating the development and implementation of the National Safety and Quality Standards for Digital Mental Health Services.

The growing introduction of e-mental health tools alongside face-to-face services requires an appropriately trained workforce. It is important that all mental health professionals are equipped to utilise e-mental health tools in the workplace, including psychiatrists.

In order to ensure this, the RANZCP recommends that the Australian Government dedicate funding to support programs which upskill psychiatrists and other mental health professionals in the use of e-mental health tools. This is essential to the safe and widespread uptake of e-mental health tools, and to realising the benefits these tools can bring to mental health across Australia.

**Recommendations:**

1. *Increase 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 (1).*
2. *Increase the funding for project support for the Specialist Training Program and the Integrated Rural Training Pipeline for Medicine initiative by $500,000 over three years.*
3. *Provide funding to deliver five years of the military and veteran training program to 10-20 posts to increase the capacity of the psychiatry workforce to care for the mental health needs of the military and veteran community ($9,387,730 - $18,453,850 total over 5 years, depending on number of positions).*
4. *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.*
5. *Provide funding to develop and deliver a Diploma of Psychiatry to provide specialised training in mental health, particularly for those working in regional, rural and remote areas (3).*
6. *Commit to no funding cuts to any psychiatry services that are currently provided to rural communities via telehealth.*
7. *Increase funding to accelerate the development and implementation of the* [National Safety and Quality Standards for Digital Mental Health Services](https://www.safetyandquality.gov.au/our-work/e-health-safety/national-safety-and-quality-standards-digital-mental-health-services) *by the Australian Commission on Safety and Quality in Healthcare.*
8. *Provide funding to support programs which upskill psychiatrists and other health professionals in the use of e-health resources as adjuncts to assessment, management and treatment monitoring.*
9. *Provide funding to develop* *a Regional Psychiatric Workforce Translation Group addressing the maldistribution of medical professionals across Australia using local knowledge and expertise.*
10. **Appropriate and Equitable Access to Services**

***Mother and Baby Mental Health Units***

Women are at greater risk of developing a mental health condition following childbirth than at any other time, and the effects of post-natal mental illness can be devastating on mothers, babies and the surrounding community (4-6).

The Australian National Perinatal Mental Health Guidelines state that universal access to publically funded Mother Baby Units (MBUs) is best practice when women require admission for mental health conditions in late pregnancy and up to 12 months postpartum (16). Women requiring inpatient treatment have improved outcomes if accompanied by their babies (17, 18). Admitting both the mother and baby to hospital circumvents the possibility of women refusing inpatient treatment in order to avoid being separated from their children and is well demonstrated to be effective in treating perinatal illness.

While guidelines and government policy in Australia have clearly identified the need to screen pregnant women and new mothers, this has not been undertaken consistently in many areas with estimates of screening rates for perinatal mental health conditions between 50 to 75 per cent (9). The establishment of MBUs across all states and territories could increase rates of screening by better ensuring a referral pathway for pregnant women and new mothers experiencing a serious mental health condition (9).

In order to provide the best possible care, mothers in Australia should have access to dedicated 24-hour MBUs, to provide inpatient treatment of mental health conditions for antenatal and postnatal women as well as supervision and support for the care of the baby as clinically indicated.

Internationally, it is estimated that one eight-bedded unit for every 15,000 deliveries is needed to reach the best outcomes for mothers experiencing severe mental health conditions in the perinatal period (19). However, currently there are limited publically funded MBUs in Australia for inpatient mental health treatment that offer a full inpatient service (24-hour care, 7 days a week). These are located in Victoria, Western Australia, South Australia and Queensland. This leaves women in New South Wales, Northern Territory, Australian Capital Territory and Tasmania without access to mother baby inpatient mental health services. While the RANZCP acknowledges the New South Wales State government has committed to introduce MBUs, it is crucial that this commitment be followed through.

**Table 1- MBU beds required**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **State** | **No. Birth (ABS, 2017)** | **Current MBU Beds** | **Estimated Number MBU beds** | **Additional beds required** |
| Victoria\* | 66,835 | 22 | 36 | 14 |
| South Australia | 16,755 | 6 | 9 | 3 |
| Queensland | 51,552 | 4 | 24 | 20 |
| Western Australia | 30,389 | 16 | 16 | 0 |
| New South Wales | 76,562 | 0 | 40 | 40 |
| Tasmania | 5,259 | 0 | 3 | 3 |
| Northern Territory | 3,505 | 0 | 1 | 1 |
| Australian Capital Territory | 4,804 | 0 | 2 | 2 |

\* Victoria has an additional 8 regional public MBU beds however these are only operational from Monday to Friday, not on a continual basis.

As evidenced in Table 1, Australia currently falls short of the estimated number of beds required in most states and territories except Western Australia.

The formula to calculate the required number of MBUs has been developed to account for the number of women delivering babies, the estimated prevalence of severe mental health conditions during this period and the known elevated relapse rate for schizophrenia, psychotic disorders and bipolar disorder in the early postpartum. This formula does not take into account likely differences for Australia from the United Kingdom such as the coverage of larger geographical areas (e.g. in Western Australia and Queensland) and the more limited community specialist perinatal mental health services for follow up after an admission. This would suggest that these estimates would reflect the minimum number of beds required in Australia.

The RANZCP urges the Australian government to work collaboratively with state and territory governments to allocate funding for:

* two additional eight-bed units in Queensland
* four new eight-bed units in New South Wales
* one new four-bed unit in Tasmania
* arrangements for people in the Northern Territory and Australian Capital Territory to have access to support where an MBU is not viable.

***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 (20).

An application to seek approval for funding for rTMS for the treatment of depression to be available under the Medicare Benefits Schedule (MBS) was approved by the Medical Services Advisory Committee (MSAC) in August 2019 (21).

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

1. Initial prescription and mapping session (undertaken by a TMS-trained psychiatrist)

2. rTMS treatment (performed by a nurse or allied health professional who has been suitably trained)

Given the significant evidence for rTMS as an effective treatment for depression, and the clearly defined standards for the delivery of rTMS (22), 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 (21). Table 8 of this document includes estimated costs over five years of implementing these rTMS MBS item numbers (see below).

**Table 8: Respecified net financial implications to the MBS (21)**

|  | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** |
| --- | --- | --- | --- | --- | --- |
| Population with TRD (less prior patients) | 112,488 | 103,015 | 86,779 | 66,902 | 47,027 |
| Uptake rate of rTMS | 10.00% | 17.50% | 25.00% | 32.50% | 40.00% |
| Patients starting rTMS | 11,249 | 18,028 | 21,695 | 21,743 | 18,811 |
| **Resubmission base net to the MBS** | **$42,836,116** | **$66,409,818** | **$76,783,842** | **$72,646,671** | **$57,149,161** |
| 1. Estimating MBS costs as a proportion of ECT cost offsets a | $44,706,939 | $71,278,874 | $85,261,024 | $84,740,015 | $72,370,968 |
| 1. Assuming cost offsets apply for three years (as per the model time horizon) | $42,836,116 | $66,409,818 | $76,783,842 | $74,887,178 | $62,980,366 |
| **Respecified net implications to the MBS (i.e. multivariate analysis #1 and #2)** | **$44,706,939** | **$71,278,874** | **$85,261,024** | **$85,109,698** | **$73,333,116** |
| Assuming maximum uptake of 60%b | $44,706,939 | $91,749,890 | $112,416,162 | $101,895,560 | $71,359,525 |
| Assuming all prescription rTMS items are claimed with item 306 | $46,489,199 | $74,135,171 | $88,698,344 | $88,554,671 | $76,313,479 |

Source: compiled from Table 12 of Critique and SBA Critique Table 5

Note: These have not corrected for the minor errors as identified in Table 12.

a In the economic model, ECT treatment was comprised of 10 sessions at $907 (based on AR-DRG U40Z). MBS items associated with ECT are item 14224 ($70.35) and item 20104 ($79.20). Thus the component of ECT therapy costs attributed to the MBS is approximately 16.5%.

b While the proportion that uptake increases from Years 1 to 5, the pool of patients eligible for rTMS decreases as the number of patients eligible who had not previously received rTMS decreases. Thus the implications to the MBS are observed to peak in Year 3.

**Recommendations**:

1. *For the Australian government to work collaboratively with state and territory governments to allocate funding for new MBUs in Queensland, New South Wales and Tasmania and develop arrangements for people in the Northern Territory and Australian Capital Territory to have access to support where a MBU is not viable.*
2. *That the new MBS item numbers proposed for rTMS for the treatment of depression, as recommended by MSAC, be implemented in full by the Australian Government.*
3. **Suicide Prevention**

There were 3,046 deaths due to intentional self-harm (suicide) in Australia in 2018 (23). Suicide is the leading cause of death among people aged 15-44 in Australia. Death rates recorded over the five years from 2014 to 2018 have been between 11.9 (2016) and 12.9 (2015) deaths per 100,000 people. Mood disorders, including depression, were the most commonly mentioned co-morbidity across all suicide deaths. This was followed by problems related to substance use, which includes abuse of alcohol and drugs (like heroin and methamphetamine), but also intoxication due to excessive use of a given substance at the time of death. Problems related to substance use were present in over one quarter of suicide deaths (29.4%).

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, while the proportion decreases in progressively older age cohorts. However, the suicide rate spikes again among males who are 85 years and older (23). The rate of suicide deaths per 100,000 increases consistently with greater remoteness.

While the RANZCP welcomed the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) (24), and relevant funding towards suicide prevention from the Australian government, more is needed to prevent the suicide rate from continuing to increase. The complexities associated with suicide mean that no one intervention can be expected to prevent suicide and, as such, suicide prevention strategies must be comprehensive not only in longevity but also in their breadth.

A key risk factor for suicide is a past suicide attempt. 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 are recommended to reduce the risk of a repeat suicide attempt at 12 months in patients admitted to emergency departments with a suicide attempt (25). 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.

Additionally, suicide prevention strategies must be supported by ongoing research and development. The RANZCP welcomes the recently announced $8 million funding to support research aimed at identifying effective approaches to suicide prevention through the Australian Government’s Million Minds Mission (26). The RANZCP recommends funding be allocated to psychiatry-led initiatives around research and development.

The RANZCP has identified that more evidence is needed on the associations between the following areas and risk of suicide:

* mental illness, and specifically borderline personality disorder
* alcohol and other drugs
* older people
* broader societal factors, for example, culture, socioeconomics, childhood trauma
* rural and remote communities
* Aboriginal and Torres Strait Islander people
* LGBTQI people
* doctors and medical students (27)
* supports and services that can identify and help people prior to a first suicide attempt.

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 6 months following job or relationship loss.

Mechanisms could be explored to offer more follow-up, screening or support to individuals in psychological distress. For example, the Draft Report of the Productivity Commission Inquiry into Mental Health (2) has recommended that online navigation platforms be used to support mental health pathways by both health practitioners and other psychosocial service providers such as schools and Centrelink social workers. Such a system could help to coordinate care for people during psychological distress, as well as those experiencing mental illness.

**Recommendations:**

1. *Commit recurrent funding of evidence-based interventions, including programs that provide after-care for all people who have presented with suicidal behaviour, accessible to all geographical areas. Aftercare programs should be complemented by:*
   1. *broad referral pathways*
   2. *additional outreach services to support people in regional and rural areas*
   3. *extended service delivery, including outside standard business hours*
   4. *dedicated outreach and aftercare services for children and young people who have self-harmed or at risk of suicide.*
2. *Commit recurrent funding from the* [Million Minds Mission for the Medical Research Future Fund](https://www.health.gov.au/initiatives-and-programs/million-minds-mental-health-research-mission) *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.*
3. *Invest in research to identify professions with the highest incidence of suicide and the effectiveness of any existing organisational-level interventions. Fund pilot projects of organisational-level interventions for high risk professions.*
4. *The provision of training to frontline health and community workers, including those in emergency departments, on suicide prevention and screening strategies.*
5. *Improve coordination of care for people in psychological distress across service providers, beyond health, to include, for example, schools, public housing tenancy managers, maternal and child health nurses and Centrelink social workers.*
6. **Mental Health of Aboriginal and Torres Strait Islander peoples**

The RANZCP commends the Government for announcing funding for additional Aboriginal and Torres Strait Islander social and emotional wellbeing programs, mental health supports and suicide prevention initiatives in the 2019-20 budget (28). This investment provides a foundation for further action to address the disproportionate levels of psychological distress present in Aboriginal and Torres Strait Islander communities across Australia (29). As a result of complex intergenerational trauma, historic discrimination and ongoing marginalisation, Aboriginal and Torres Strait Islander peoples face significant mental health challenges (30). Ensuring that the health system is free of racism and safe to access for Aboriginal and Torres Strait Islander peoples requires an increase in the available and appropriately skilled workforce, as well as improvements to access pathways.

***Suicide Prevention***

The current levels of suicide within Aboriginal and Torres Strait Islander communities is a national crisis. The loss of cultural identity, history of trauma and grief, together with barriers to accessing culturally appropriate mental health services are contributing factors to the epidemic of suicides in Aboriginal and Torres Strait Islander communities. The social risk factors associated with poverty, isolation, relationship breakdown and marginalisation exacerbate the challenges for providing the required mental health care (31). The RANZCP calls on the government to fully fund the outcome of current initiatives that are underway to develop a best practice approach for preventing Aboriginal and Torres Strait Islander suicide as recommended by National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) and Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP).

***Aboriginal and Torres Strait Islander specialists***

The RANZCP is committed to increasing the Aboriginal and Torres Strait Islander psychiatrist workforce, with eight Fellows and seventeen Trainees currently identifying as either Aboriginal and/or Torres Strait Islander. Recruiting and retaining Aboriginal and Torres Strait Islander people into the medical specialities, in particular psychiatry, is essential to improving cultural safety across the health system and to enhancing services to communities. Ensuring that these practitioners and the people they care for are able to work in a culturally safe and supportive environment is a central priority for the RANZCP. In order to improve the cultural safety of medical specialists and to create a culturally safe environment in health services, the provision of cultural safety training is crucial. The RANZCP recommends continuing funding be provided for the Australian Indigenous Doctors Association (AIDA) to deliver cultural safety training to ensure a culturally safe specialist mental health workforce.

***Mental Health Funding within ACCHOs***

The use of multidisciplinary teams, which are structured around the promotion of social and emotional wellbeing and a broad range of mental services, is the preferred model of care for Aboriginal and Torres Strait Islander peoples in both Aboriginal Community Controlled Health Organisations (ACCHOs) and mainstream services (32). The RANZCP asks the government to ensure that mental health is adequately funded as an embedded part of these teams, including provision of specialist psychiatric services, which are critical to ensuring full coverage of mental health needs within communities. Adequate funding for multidisciplinary teams in rural and remote areas is crucial to improving the ability for Aboriginal and Torres Strait Islander peoples to access a full range of timely and culturally safe mental health services.

***Aboriginal and Torres Strait Islander mental health workers***

Aboriginal and Torres Strait Islander mental health workers provide insights into communities and customs, actively engaging with Elders and community members to enhance the provision of care. Psychiatrists engage with Aboriginal and Torres Strait Islander mental health workers in a variety of care settings, including ACCHOs, where the collaborative relationship is essential to the provision of advice on cultural safety and security to multidisciplinary teams. The RANZCP contends that Aboriginal and Torres Strait Islander mental health workers should be supported to train and apply for appropriate positions. More information on the benefits of Aboriginal and Torres Strait Islander mental health workers can found in our [Position Statement 50: Aboriginal and Torres Strait Islander mental health workers](https://www.ranzcp.org/News-policy/Policy-submissions-reports/Document-library/Aboriginal-and-Torres-Strait-Islander-mental-healt) (33).

**Recommendations:**

1. *Commit to funding best practice suicide prevention initiatives as agreed to by the NATSILMH and CBPATSISP.*
2. *Provide funding to the Australian Indigenous Doctors Association (AIDA) and to support the development and delivery of cultural safety training for the specialist medical workforce.*
3. *Increase funding for mental health services within existing multidisciplinary health teams, which are embedded in both Aboriginal Community Controlled Health Organisations (ACCHOs) and mainstream services.*
4. *Increase funding for the recruitment and placement of Aboriginal and Torres Strait Islander mental health workers in public health services, which includes necessary support mechanisms, e.g. mentoring, debriefing and supervision.*
5. **National Disability Insurance Scheme (NDIS)**

The NDIS was implemented in Australia to help people with disabilities live their life to its full potential. The NDIS is based on a person-centred model, which focuses on supporting people with disability who require assistance with day-to-day activities.

The RANZCP has welcomed the addition of the psychosocial stream to the NDIS to include those with severe or persistent mental health conditions and notes the rise of people with a primary psychosocial disability accessing the NDIS since 2016/17 (5.4 to 8.8 per cent) (3). However, these numbers remain lower than anticipated. Only 21,700 people accessed the NDIS with a primary psychosocial disability in June 2019, in lieu of the expected number of 64,000 (3).

Psychiatrists have a key role in assisting people with psychosocial disabilities access the NDIS through the provision of evidence to the NDIA. Medical professionals, including psychiatrists, report some ongoing confusion about their role including the absence of information resources. There is an opportunity to increase medical professionals’ knowledge of the assessment process to better patients to access the NDIS.

While the RANZCP appreciates that the NDIS is individual-centred to best meet the needs of participants, this can impact the sharing of information between the NDIS, service providers and medical professionals, particularly as the model does not necessarily encourage cooperation between service providers (3). Medical professionals are often unaware of details of patient plans, and subsequently, of service provider supports under the NDIS, which can have an impact on patient health care and planning. This is also a missed opportunity to ensure participants are provided with holistic care and support in achieving their identified goals.

The RANZCP suggests there is a need for the Australian government to direct funding towards information and coordination improvements to ensure clinicians can better support people accessing the NDIS. The NDIS access figures above indicate that significant challenges remain for people with psychosocial disability in engaging with the NDIS. Previous reports relating to the psychosocial disability pathway that health professionals report confusion of eligibility due to inconsistent information received from NDIA staff (34). While acknowledging that the NDIS is a large-scale reform with many elements, the RANZCP would welcome increasing the communication and information access points between mental health professionals and the NDIA.

Evidence to date, including the NDIS Act Review and NDIS Participant Service Guarantee (Tune Review) (35), has illustrated that the episodic and transitory nature of mental illness makes implementation of the psychosocial stream challenging. The RANZCP recognises the NDIA’s continual efforts in this space, especially training of NDIA staff to better support people with psychosocial disability (36).

As stated in the National Framework for Recovery-oriented mental health services, recovery is a core component of many mental health services (37). However, the eligibility criteria for the NDIS involves permanency which directly contradicts the recovery model utilised in mental health. The recovery model as used by the mental health sector should be embedded within the NDIS. Like the person-centred model used by the NDIA, it also focuses on self-determination and respect of the knowledge held by those with lived experience of their own needs for recovery (37, 38).

The use of the term ‘episodic’ by the NDIS also requires further investigation so that the NDIA may adapt processes to better assist those with mental health conditions. The nature of mental health conditions require a flexible system which easily adapts to an individual’s circumstances. A mental health crisis can require a quick response, which the current process renders difficult. People who experience long periods of recovery and wellbeing should also be able to have flexible funding which is available when needed. The NDIS should be able to transition between providing adequate and appropriate support and ensuring people remain hopeful of recovery and be as independent as possible to help people to experience good outcomes in all areas of life. On this basis, the RANZCP recommends the introduction of improved flexible funding to account for the episodic nature of mental health.

Advocacy is a critical element for accessing the NDIS and associated services. There are many vulnerable groups, including people with mental illness, who may not have people to advocate on their behalf. The creation of professional coach or advocate roles are necessary to fill this gap. Such roles would assist vulnerable people with disability to better ensure they are able to access the NDIS and needed supports.

The recent underspend of NDIS funding should provide an opportunity to fund tangible solutions to issues within the NDIS.

**Recommendations:**

1. *Fund the development of avenues for better sharing of information, coordination of support and dispute management between health professionals, the NDIA and service providers, which includes a central point for medical professionals to engage with NDIA staff with clinical experience to further explain NDIA eligibility processes and requirements to medical professionals seeking information on how best to support a patient access the NDIS.*
2. *Provide flexible funding options, including rollover of funding, for participants on the psychosocial stream of the NDIS which are responsive to the episodic nature of psychosocial conditions to ensure access is available when it is needed.*
3. *Fund advocates for vulnerable people with psychosocial disability, with appropriate understanding of episodic illness and the recovery model, to ensure they are better able to access the NDIS and supports.*
4. **Aged Care and Mental Health**

The 65 and over population in Australia is expected to more than double between now and 2057, growing from 3.8 million in 2017 to approximately 8.8 million. By this time, older people will comprise around 22% of the population, an increase from 15% in 2017. It is expected that the number of older Australians with mental illness will grow accordingly, and therefore reform of the aged care sector is required to ensure the system is appropriately oriented to meet the needs of older people.

The RANZCP acknowledges the ongoing Royal Commission into Aged Care Quality and Safety, however, action is needed to ensure older people can access the care they need as soon as possible. Particular focus is needed on upskilling the aged care workforce and ensuring appropriate services are available for people with dementia.

The RANZCP recognises the valuable role that the current aged care workforce plays in providing treatment, care and support to older people. The contribution of this workforce to the health and wellbeing of older Australians is well acknowledged in the Interim Report released by the Royal Commission and by many users of aged care services (39).

To ensure safe and high-quality care is delivered to all individuals, there needs to be more education and training for staff working in aged care, particularly residential aged care. The aged care workforce requires appropriate training to manage mental health symptoms and presentations, including the behavioural and psychological symptoms of dementia. To this end, training for individuals who work in the aged care sector, including personal care workers, must incorporate specific, measurable competencies regarding mental health symptoms. In addition to incorporating mental health competencies into training programs, there must be continuing professional development measures to ensure people retain their competency in managing mental health symptoms in aged care.

It is also vital that the National Medical Workforce Strategy, the Department of Health and governments consider the current psychiatry of old age workforce shortages and outcomes of this Interim Report when considering supply and demand forecasting for medical workforce planning.

Among people aged 65 and over, dementia was the second leading cause of total burden of disease in 2011 (accounting for 7.8% of years of life lost due to illness or death) and the leading cause of non-fatal burden (accounting for 10% of years of life lost due to living with the disease) (40). 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 (41). RANZCP members 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 for 2020-24.

The RANZCP acknowledges the announcement and implementation of Specialist Dementia Care Units (SDCUs) to support people who experience very severe BPSD. Individuals with BPSD require a comprehensive care pathway which encapsulates a range of stepped care options, each providing for a defined range of individuals with differing levels of BPSD. Well-resourced services must be available to ensure appropriate and graduated levels of care, particularly for individuals with the most severe versions of BPSD (behavioural and psychological symptoms of dementia). The RANZCP believes that, with appropriate support and resources, the SDCUs can provide a valuable service, within the stepped care model, for those with BPSD. However, the RANZCP feels that the current projected number of SDCUs is insufficient to meet demand, and further resourcing should be allocated to the program to ensure the needs of individuals with BPSD are met. Any additional resourcing must not lead to reduced State funding.

The RANZCP submission to the Royal Commission focusses on solutions to resolve ongoing issues with mental health care, treatment and support within the aged care system. For more information, this submission is available on the [RANZCP website](https://www.ranzcp.org/files/resources/submissions/ranzcp-submission-to-royal-commission-on-aged-care.aspx).

**Recommendations:**

1. *Invest in the upskilling of the aged care workforce, including local training opportunities in rural and remote areas.*
2. *Fund a national, consistent regulatory framework around minimum staffing and skills in aged care, including for community aged care and residential aged care facilities.*
3. *Fund the development of a National Framework for Action on Dementia 2020-2024.*
4. *Invest in appropriate stepped care services to provide improved care for people with moderate to severe behavioural and psychological symptoms of dementia.*

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