The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Australian Treasury

2022-2023 Pre-budget submission

January 2022

Improving 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 over 7300 members including more than 5300 qualified psychiatrists and almost 2000 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 this pre-budget submission in consultation with many of its members, including key RANZCP committees comprising psychiatrists, trainees and people in the community who provide their lived experience perspective.

Introduction

The RANZCP recognises 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 of reforms should be on equity, access and affordability of mental health care. We need to ensure that all people in Australia have the appropriate access to the range of services that they require to fulfil their potential and improve their quality of life.

The RANZCP acknowledges the development of the many mental health strategies, initiatives and reports that have been released over the last year or will be released shortly, including the:

- National Children's Mental Health and Wellbeing Strategy.
- Being Equally Well Roadmap.
- Establishment of the National Suicide Prevention Office and National Suicide Prevention Advisers Final Advice to Government.
- Select Committee on Mental Health and Suicide Prevention Final Report.
- National Agreement on Mental Health and Suicide Prevention.
- National Mental Health Workforce Strategy.
- National Roadmap for Improving the Health of people with Intellectual Disability in Australia.
- Royal Commission into Defence and Veteran Suicide.
- The National Mental Health Commission: Vision 2030.
- National Stigma and Discrimination Reduction Strategy.

Now is the time for the Federal Government to act: to bring together all recommendations and develop a coordinated, seamless system of mental health care.

Executive Summary

Equity

Equitable access to quality care in the mental health system is critical. The public must have access to specialist services of the same quality, regardless of location or circumstance.

Key RANZCP recommendations include:

- Providing funding for the provision of specific, person-centred mental healthcare for vulnerable groups to ensure equitable access, including for asylum seekers and refugees, people in and exiting the justice system, people with disabilities, survivors of family violence, veterans and older people.
- Developing a new National Framework for Action on Dementia, guided by psychiatry expertise, and including consideration of the aged care workforce.
- Allocating funds to substance use treatment services and beds, and to integrate holistic and person-centred alcohol and other drug (AOD) services with mental healthcare.

Access

The Select Committee on Mental Health and Suicide Prevention has supported the core concept of access by recommending that the Australian Government ensure the principle of accessibility is at the forefront of all policy and funding programs for the mental health and suicide prevention sector.[1]

Key RANZCP recommendations include:

- Increasing the psychiatry workforce as a priority.
- Committing to long-term funding for training and training supervisor posts under the Psychiatry Workforce Program.
- Investing long-term in the Psychiatry Interest Forum (PIF).
- Changing the National Framework for Medical Internship to ensure that mental health is made an explicit requirement for all prevocational doctors.
- Funding research and academic psychiatry to ensure that psychiatry continues to develop and translate the evidence-base for people's treatment and recovery.
- Developing additional services nationally to meet the acute mental health care needs of the 0-25 age group.
- Enabling liaison with other professionals, services, disciplines, and sectors via a collaborative model of practice to provide better, more holistic care to people with complex presentations.
- Continuing to fund the Rural Psychiatry Roadmap 2021-31 implementation beyond June 2023 to 2031.
- Increasing Aboriginal and Torres Strait Islander representation in the mental health workforce and providing training for culturally informed care.
- Investing in an integrated system, including connections between levels and across portfolios of government.
- Establishing clinical registries for mental health and suicide prevention.
- Funding the development of mental health patient outcome measures.

Affordability

For access to mental healthcare to be equitable, services and treatments must be affordable.

Key RANZCP recommendations include:

- Increasing the Medicare rebate to 100% of the schedule fee for psychiatry services, as is the case for general practice.
- Increasing MBS billing provision for trainees, so that they can bill at 60% of the consultant psychiatrist rate.
- Incentivising practitioners to provide affordable services to people with socio-economic disadvantage.

Equity

At-risk populations

Action: Allocate funding to the provision of specific, person-centred mental healthcare for at-risk populations to ensure equitable access, including for asylum seekers and refugees, people in and exiting the justice system, people with disabilities, survivors of family violence, veterans and older people.
At-risk populations need access to a mental health system which provides the specific types of care required by these groups. There must be support structures in place that regulate system performance issues including barriers to equitable access.[2, 3] The Select Committee on Mental Health and Suicide Prevention recommends to 'ensure the principle of accessibility…with a focus on… frameworks that include consumer co-design and community partnership requirements to ensure equitable access for priority populations'.[1]

1. People living with mental illness

Action: Implement and report on all actions from the Equally Well Consensus Statement.
The RANZCP has long advocated for the physical health needs of people living with mental illness, noting their significantly lower life expectancy as emphasised in the *Being Equally Well Roadmap*, and their increased physical health risks as highlighted in the *National Preventive Health Strategy 2021-2030*.[4, 5] The RANZCP would urge all actions within the *Equally Well Consensus Statement*, which we have endorsed, be implemented and reported on.[6]

2. Older people

Action: Increase access to medical care for older people and fund old age psychiatry positions.
The RANZCP submission to the Royal Commission into Aged Care Quality and Safety (Royal Commission) highlighted that the 65 and over population 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.[7, 8] At present, aged care services do not meet the mental health needs of older Australians.[8, 9] Older people require the same full spectrum of health interventions as other people, including prevention, early intervention and clinical care. We acknowledge the Government's response to the Royal Commission, including the $17.7 billion funding package allocated over five years, which partially addresses the need for increased access to medical care.

While the previous budget funding included announcements to increase the number of nurses and care workers in the aged care workforce, a critical shortfall within old age psychiatry remains.[10] The Royal Commission recommendations cannot be safely implemented without increasing access to psychiatry. Further consideration is needed to ensure that there are sufficient old age psychiatry positions for psychiatrists to train in this area.[8] To implement the Royal Commission recommendations, there is also a need for specialist (psychiatry/geriatrician) MBS items for assessment, providing support following diagnosis, and management of those with dementia/neurocognitive disorders and behavioural and psychological symptoms. These would support the follow-up of patients and plan reviews, either in-person or telehealth with care staff.

Action: Fund the development of a new National Framework for Action on Dementia, guided by psychiatry expertise, and including consideration of the aged care workforce.
Psychiatrists with significant experience in the aged care sector highlight dementia as the single most important contributor to psychiatric symptomatology within residential aged care. 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).[11] While dementia clearly has a biological substrate, the common psychiatric complications of dementia require the involvement of psychiatrists as experts in care, treatment and support.[8]

Action: Invest in the upskilling of the aged care workforce.
There is a need for committed investment to upskill the mental health and aged care workforce through appropriate training. Specifically, the RANZCP recommends funding the delivery of educational modules in relation to the Behavioural and Psychological Symptoms of Dementia (BPSD) and appropriate psychotropic prescribing. In addition to incorporating mental health competencies into training programs, there must be continuing professional development (CPD) measures to ensure the retention of competencies. A comprehensive aged care system can only be delivered by an adequately trained and resourced workforce.[9]

3. People with addictions or substance use disorders

Action: Fund substance use treatment services and beds and integrate holistic and person-centred alcohol and other drug (AOD) services with mental healthcare.
The RANZCP welcomes the Productivity Commission and the Select Committee on Mental Health and Suicide Prevention acknowledgements of the underinvestment in specialised AOD services and the significant impacts this has.[1,12] Substance use disorders are a core concern for psychiatrists considering the complex interrelationship between addictive behaviours and mental health disorders. Substance use is the second most common factor associated with suicide.[13] The consensus of research, evidence and clinical expertise is that psychiatric or addiction-focused treatments alone are insufficient to manage comorbid mental health and addiction issues.[14, 15] Productivity Commission Action 14.2 addresses this concern and needs specific consideration.[12]

While a priority of the *National Drug Strategy* is enhancing access to services and supports, specifically 'outpatient, inpatient and community based treatment services, and post treatment support programs', more needs to be done.[15] There is a chronic shortage of public beds for people with substance use disorders meaning many individuals seek treatment in the private sector. Treatment in the private sector is unaffordable for many, and there are indications that some private AOD residential facilities operate with little medical input and inadequately trained staff.[16]

4. People being discharged from custody or inpatient facilities

Action: Ensure people in and exiting the justice system have access to the same full spectrum of health interventions as other people including prevention, early intervention and clinical care. Fund innovative services to ensure people who are released or discharged do not become homeless.
Ongoing funding is needed for housing services and multidisciplinary psychosocial supports for rapid connection before and upon discharge from custody or inpatient facilities. Recent estimates show that, in Victoria alone, over 500 people each year are being discharged from acute mental healthcare into homelessness.[17] There is significant evidence that the same issue is present when discharging people from other healthcare, custodial and justice settings.[17]

People in the justice system need supports for NDIS applications, and planning needs to occur prior to their release.[18, 19] The process of securing NDIS funding is challenging, slow, and not available to all people.[17] Systemic capacity to provide responsive, person-centred care outside the NDIS is needed. The sector lacks coordination and integration; communication between services is often lacking whether due to under-resourcing or inadequate processes.[17] These challenges render unacceptably high rates of discharge from hospital and other settings into homelessness.

5. Asylum seekers and refugees

Action: Ensure asylum seekers and refugees have access to the same full spectrum of health interventions as other people including prevention, early intervention and clinical care.
The RANZCP is concerned about the inadequate provision of mental health services to asylum seekers and refugees, and calls for change to improve mental health outcomes.[20] The RANZCP highlights the need for increased health service capacity to accommodate asylum seekers and refugees. Dedicated support and information services are required to facilitate refugee access to physical and mental health services.[21] Improved access to primary care services will assist in minimising unnecessary presentations to the ED. The provision of culturally and trauma informed care is key. The RANZCP also encourages the Government to increase the overall humanitarian refugee intake and to support services and programs to assist asylum seekers and refugees to flee unsafe environments.

6. People with disability

Action: Address the needs of people with intellectual and developmental disabilities within all relevant health, mental health and disability frameworks.
There is a significant overlap between the disability, health, and other social service and welfare sectors. Disability services need to be part of an integrated system. There is a need for specialist autism spectrum disorder (autism) mental health services, in both inpatient and community settings.[1] Autistic people are at a

high risk of experiencing a range of physical and mental health conditions.[22, 23] Similarly, specialist inpatient and community services are required for comorbid intellectual disability and mental health conditions.[24]

Action: Invest in education and training which includes a focus on providing care to those with intellectual and developmental disability.
The RANZCP recognises the importance of sufficient training and education for care workers in supporting persons living with a disability. As noted in the Productivity Commission's *NDIS costs review*, the workforce – in the short-term – requires further investment to have the skills to provide services and support to those in need.[25] Support for diagnosis and treatment of intellectual and developmental disabilities such as autism and attention deficit hyperactivity disorder (ADHD) in adults is needed.[25]

In keeping with developments in disability health care, capacity should be built in disability mental health within the health sector. Key areas for investment would be:

- Primary Health Networks - building the capacity of GPs and practice nurses to perform health checks and appropriately manage people with disability and mental health issues.
- Public mental health services - ensuring enhanced funding so that there is disability training and capacity in acute and community mental health teams, and younger persons' mental health services or initiatives.
- Specialised care – for example, funding to set up complex ADHD clinics to manage individuals with ADHD with comorbid conditions that cannot be appropriately managed by the primary health sector; funding to support registrar training focused on ADHD in both private and public facilities. Deloitte Access Economics puts the cost of ADHD in Australia in 2019 at $20.42 billion.[26] A National Centre of Excellence to promote research, training and service provision, or another form of coordinated effort is needed to reduce the impacts that ADHD may have.

7. People who are experiencing or have experienced family violence (FV)

Action: Improve the range of services available to people who are experiencing or have experienced FV, including availability of culturally informed support services especially in outer-metropolitan, rural and regional areas.
Individuals who have experienced FV can suffer from a variety of long-term, chronic conditions such as post-traumatic stress disorder, major depressive illness, eating disorders, problematic substance use, chronic pain, generalised anxiety disorders and panic disorder.[27] The RANZCP submission to the *National Plan to Reduce Family Violence Against Women and Their Children* acknowledges and supports the focus on early intervention and prevention services to families to build and strengthen relationships, and develop skills and support parents and children through the Family Support Program. The RANZCP highlights that there is an opportunity to improve the availability of these services to those living in rural and remote communities. Such services must be culturally safe and trauma-informed. We also suggest enhancing community awareness of FV and working to reduce gender inequality by investing in multi-agency education programs in community services, schools and health services.

8. Women in the perinatal period

Action: Fund Mother Baby Units (MBUs) in collaboration State and Territory governments- $5million each unit per year.
The RANZCP urges the Federal Government to work collaboratively with the relevant states and territories to allocate funding of $5 million for each unit per year for units in New South Wales, and one unit each in the Northern Territory, Australian Capital Territory and Tasmania. 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.[28] Universal access to publicly funded MBUs is best practice when women require admission for mental health conditions in late pregnancy and up to 12 months postpartum.[28] Women requiring inpatient treatment have improved outcomes if accompanied by their babies.[29] Admitting both mother and baby to hospital is well demonstrated to be effective in treating perinatal illness.[29]

Action: Fund locally appropriate and adapted pathways for women following specialist perinatal mental health screenings.

It is an important part of screening that clear, locally appropriate and adapted pathways are in place. A current gap that requires investment is for mental health specialists within maternity services to follow up with women who have screened positive in a mental health assessment. Follow ups cannot be provided from a distance or substituted with online programs.

Access

Psychiatry workforce

Action: Increase the psychiatry workforce as a priority.
The RANZCP commends the Government's efforts to address the psychiatry workforce shortage and welcomes the funding provided in the 2021–22 Budget for additional psychiatry training posts and supervisors. It is recognised that longer-term funding for sustainable training posts and supervisors will help address the immediate workforce shortages while other measures are taking effect. The RANZCP urges the Australian Government to consider a number of psychiatry workforce initiatives in its 2022-23 Budget to increase access to mental health services for the community. Strengthening the psychiatry workforce to meet current and future demand for psychiatry services should include, but not be limited to the following:

1. Attracting new psychiatrists to the specialty

Action: Commit to fully fund training and training supervisor posts under the Psychiatry Workforce Program beyond June 2023- $6,475,000 per year until the end of 2025.
The Australian Government's draft National Mental Health Workforce Strategy noted an existing shortage of psychiatrists, as did the Productivity Commission's findings on Mental Health.[12] The RANZCP recognises and appreciates the Government's initial commitment to fund the Psychiatry Workforce Program. This program is one opportunity to reduce the psychiatry workforce specialisation gaps in the future. There has been a significant number of expressions of interest in additional funded positions from both psychiatrists and health services from a variety of settings.

The Specialist Training Program (STP) has been funded for four years until the end of 2025. The RANZCP recommends that the funding of the Additional Psychiatry Training Posts and Supervisor positions component of the Psychiatry Workforce Program funding is also extended from its current June 2023 end date until the end of 2025. A commitment to long term funding is required for this program to be sustainable.

Action: Invest long-term in the Psychiatry Interest Forum (PIF)- $3,653,960 over 5 years.
Attracting medical students and pre-vocational doctors to become psychiatrists requires high-quality early exposure and experiences in the future career pathways psychiatry offers. The RANZCP's successful PIF program has a proven track record of success in increasing recruitment into psychiatry and has the potential for further growth and expansion. The PIF program is a key strategic element of the RANZCP activities to support Australian Government efforts to address the current and projected shortfall in trained psychiatrists. At present, the PIF program is only funded until June 2023 under the Psychiatry Workforce Package budget measure. A long-term funding commitment is required to meet our future psychiatry workforce needs.

Action: Change the National Framework for Medical Internship to ensure that mental health is made an explicit requirement for all prevocational doctors.
Increasing the requirements for all prevocational doctors to experience psychiatry would equip medical doctors with valuable skills. Changing the *National Framework for Medical Internship* to ensure that mental health is made an explicit requirement for all prevocational doctors so that they all experience psychiatry in the first two postgraduate years. This would ensure that all medical doctors in Australia, regardless of specialty, are better equipped with skills and experience in mental health.

The RANZCP supports clinical placements for interns in a more representative mix of settings, including community mental health services, the private sector, rural placements, and settings other than inpatient units. The RANZCP also welcomes the Flexible Approach to Training in Expanded Settings funding pool which will allow training in an expanded mix of settings. Clinical placements for interns in a more representative mix of settings is essential to creating a more attractive mental health sector.

2. Support for supervisors of those in psychiatry training

Action: Fund the development of a program for supervisors to strengthen and support their resilience.
Adequate supervision and support are vital for strengthening the psychiatry workforce. The COVID-19 pandemic has led to challenges for supervisors of trainees, especially for those in rural and remote areas. Supervisors report increasing demands on them for service delivery which increasingly impacts their capacity to provide appropriate and adequate supervision to meet the accreditation standards of the RANZCP Fellowship program.

3. Psychiatry workforce retention

Action: Develop initiatives to improve the working lives of doctors, including supporting effective and sustainable supply to reduce the pressure on the existing medical workforce.
There are opportunities to improve continuing professional development and workforce retention and planning to improve the proficiency and working lives of doctors. The RANZCP supports the provision of basic psychotherapy and counselling, in addition to group supervision for practical care coordination and self-preservation of all mental health workers. Leadership and management training in addition to mentorship programs should also be considered. The RANZCP further urges the Federal Government to work with the states and territories to address the current inconsistencies in working conditions contributing to gaps in the psychiatry workforce across Australia.

4. Workforce planning

Action: Develop a single-source tool for workforce data collection to underpin workforce planning.
The RANZCP welcomes opportunities to contribute to accurate workforce data. The RANZCP submission to the *National Mental Health Workforce Strategy 2021-2031* highlights the importance of data to underpin workforce planning. We emphasise data-driven initiatives as important but acknowledge the difficulties due to multiple data sources. The development of a tool, such as the HeaDS UPP Tool, could act as a single source of data. The RANZCP advocates for psychiatry data to be prioritised. Additional data for planning is urgently required for the most under-resourced specialities, notably child and adolescent psychiatry.

5. Research and academic psychiatry

Action: Increase funding for research and academic psychiatry to ensure that psychiatry continues to develop and translate the evidence-base for people's treatment and recovery.
The RANZCP submission to the *National Mental Health Workforce Strategy 2021-2031* emphasises that the mental health workforce would benefit from prioritising academic clinical psychiatry. Diminishing academic psychiatry positions ultimately impact patient outcomes. The opportunity to provide additional funding for new academic psychiatry positions for trainees and Fellows benefits both patients and the healthcare system.

The RANZCP recommends the Government consider how academic clinical psychiatry is utilised to address challenges facing Australia's mental health workforce. Training positions in research areas, especially in child and adolescent psychiatry, are needed to stimulate the next generation of psychiatry researchers.

6. Consultation-Liaison Psychiatry

Action: Fund costing studies of consultation-liaison (C-L) psychiatry to inform appropriate funding of the service.
The RANZCP submission to the Independent Hospital Pricing Authority Pricing Framework highlights the challenges in the current funding model for C-L psychiatry. The specific patient therapeutic consultation and development of management plans that are provided by C-L psychiatrists outside of the multidisciplinary team setting remains unfunded. This is a longstanding concern of the RANZCP.

7. Private sector psychiatry

Action: Develop structures to utilise the entire mental health workforce including private practice.
Private practice is a key part of the whole Australian healthcare system and plays a role beyond taking pressure off the public system. The need for adequate funding across the service mix is central to lifting equity in access. Private practice plays a crucial role in our healthcare system and must be a key part of the solution.

8. Child and adolescent psychiatry

Action: Fund additional child and adolescent psychiatry positions, including leadership positions.
There are too few child and adolescent psychiatrists (CAPs) to meet community need. Infants, children and adolescents comprise nearly 25% of the population while CAPs represent only 10% of the psychiatry workforce.[30] The current estimated number of CAPs is 1.6 FTE per 100,000 population.[30] Of the approximately 80,000 children with a severe disorder, only 22,000 had seen a psychiatrist (27%) over a 12 month period, indicating that access to specialist care remains a persistent problem.[31] Substantially more CAPs are required to staff youth, perinatal and infant mental health services.

Action: Develop additional services nationally to meet the acute mental health care needs of the 0-25 age group. Funding for administration and evaluation of pilot programs will also be required.
Our members have consistently provided feedback that child and adolescent mental health needs are not being met. This is demonstrated in the RANZCP *Child and adolescent psychiatry: meeting future workforce needs* discussion paper and infographic. Need is further increased by the COVID-19 pandemic and ongoing impacts. COVID-19 suicide prevention modelling shows expanding community-based specialist mental health services for young people is a key strategy to reducing mental health emergency department (ED) presentations, self-harm hospitalisations and suicide deaths in young people.[32] Several reports have emphasised the mental health of children and families as a priority and a good-value investment, identifying a nation-wide pattern of under-resourcing community based (ambulatory) mental health services, with the greatest gaps including those for children and adolescents.[12, 33] Intake criteria to access the mental health system is escalating due to high demand, resulting in children and adolescents being unable to access the support they require until their condition worsens to the point that they require acute care.

Two examples of existing jurisdictional programs that could be evaluated for national implementation include 'Safeguards' Child and Adolescent Mental Health Response Teams and the Child and Adolescent Virtual Urgent Care Service. Such national programs should service the 0-25 age group and work closely with current service providers (e.g. Headspace and Head to Health Kids Centres) to ensure the entire population group is serviced across a range of needs including acute care, offering 24 hour support. The National Children's Mental Health and Wellbeing Strategy emphasises the importance of employing multicultural workers where culturally diverse population groups are a major demographic component of a local area. Similarly, in Aboriginal and Torres Strait Islander communities, Aboriginal and Torres Strait Islander mental health workers are needed.[34]

Action: Enable liaison with other professionals, services, disciplines, and sectors is enabled via a collaborative model of practice to provide better, more holistic care to people with complex presentations. Psychiatry expertise would be required to lead this.
In child and adolescent mental health services there is significant liaison to support the child, their families and communities. It is acknowledged that the contribution of general psychiatrists, paediatricians and general practitioners in delivering child and adolescent mental health services is invaluable, as is the support of other health workers (such as nurses, psychologists, social workers and occupational therapists). The importance of multi-disciplinary teams is noted in the National Children's Mental Health and Wellbeing Strategy.[34] The KIDS-Connect Integrated care model demonstrates potential for clear care pathways.[35]

The opportunity to consult between specialists is valuable.[36, 37] Collaborative models of practice such as the Mind Link initiative are one opportunity to meet the need for access to support, consultation and advice from psychiatrists in the management of patients with mental health issues.[38] Mind Link is a 'consultation through case discussion and capacity building' initiative.[38] The Select Committee on Mental Health and Suicide Prevention highlighted the need for 'a multidisciplinary team or consultancy function, where other health professionals can quickly access psychiatry expertise.'[1]

9. Rural, remote and regional areas

Action: Continue to fund the Rural Psychiatry Roadmap 2021-31 implementation beyond June 2023 - $450,000 per year until 2031.
Only 14% of Australian psychiatrists work rurally, but 29% of the population (around 7 million people) live in regional, rural and remote areas.[39] A number of factors contribute to the continued inequitable access for rural Australians to psychiatrists and other mental health clinicians, including the predominance of training programs being run in, and supporting mostly, metropolitan locations and services. Aboriginal and Torres Strait Islander

people in particular suffer from a concentration of services in metropolitan areas, as they only represent 1.8% of the population in major cities, but 47% of the population living in very remote areas.[40]

The RANZCP has developed a Rural Psychiatry Roadmap 2021-31 for the development of dedicated and enhanced rural psychiatry training pathways throughout Australia. This work expanded on the efforts already made to increase training rotations and experiences through the STP and Integrated Rural Training Pipeline (IRTP) funding initiatives. It focuses on expanding opportunities for aspiring psychiatrists to live, train and practise rurally, as well as optimising the support available for those who take up these opportunities.

The RANZCP received foundational funding to support the development and implementation of this work. The Roadmap implementation is currently funded until June 2023. The Roadmap is a 10 year plan. Long-term funding is required to further develop this strategic work to improve the distribution of the psychiatry workforce.

Action: Allocate funds to design and deliver rural readiness workshops for trainees and Specialist International Medical Graduates (SIMGs) - $400,000.
Stakeholder consultations highlighted a number of barriers faced by junior doctors who wish to train in psychiatry in rural areas.[17] Trainees reported difficulties finding information about rural training generally and accessing job opportunities, with some having to find their own opportunities, source posts and set things up independently.[17] Funding is needed to design and deliver rural readiness workshops to support trainees.[17]

Similarly, workshops for SIMGs are required for support. Rural communities rely heavily on SIMGs who, having not trained in Australia, may be unfamiliar with the RANZCP Fellowship Program curriculum or regulations, and may not have the professional networks that local training can help build.[39] As a result, SIMGs may be more likely to experience professional and social isolation than their Australian-trained peers.[39] Cultural and language barriers may further increase feelings of isolation.[39]

Action: Increase the number of funded STP positions for those in psychiatry training, and fully funding STP trainees and supervisors.
The 2021-2022 Federal budget allocated $11 million toward boosting the psychiatrist workforce by creating 30 additional training posts by 2023. The RANZCP has the capacity to support further STP training posts, and calls on the Government to appropriately fund further STP psychiatry trainee positions and psychiatry supervisor positions in regional, rural and remote areas, including administration costs and incentives.

The wider workforce

1. Specialist mental health nurses

Action: Increase the number of specialist mental health nurses e.g. by reinstating the former Mental Health Nurse Incentive Program (MHNIP).
The projected shortfall of mental health nurses is between 11,500 and 18,500 by 2030.[1] The RANZCP pre-budget submission 2021-22 called for investment in strategies to increase the number of specialist mental health nurses. Such investment would bridge critical gaps in mental health care, particularly in community settings. The RANZCP recognises that mental health nurses have clinical skills that are complementary to psychiatric care and contribute to a team-based approach in the private sector. The Select Committee on Mental Health and Suicide Prevention also recommends 'increasing support for mental health nurses to provide pre- and post-appointment services'.[1]

2. Grow the Aboriginal and Torres Strait Islander workforce and provide culturally safe care

Action: Increase Aboriginal and Torres Strait Islander representation in the mental health workforce and provide training for culturally informed care.
The RANZCP acknowledges the significant progress made in enhancing entry pathways into medical training for Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander graduates bring both technical excellence, determination, and a unique personal and cultural lens to the workplace. These perspectives not only make them highly effective clinicians, but agents of positive change in their health service environments. The RANZCP pre-budget submission 2021-22 further emphasised the need to ensure coordinated and consistent investment in appropriate staffing for Aboriginal Medical Health Services and for funding to be

allocated to training and retaining Aboriginal Mental Health workers in both mainstream and Aboriginal Medical Health Services.

The RANZCP submission to the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031* supported the stated goals. It was recognised that Aboriginal and Torres Strait Islander peoples are currently underrepresented within Australia's medical workforce and in positions of leadership. Opportunities for Aboriginal and Torres Strait Islander peoples to be placed in senior positions must be increased as a priority. Ensuring that workplaces are culturally safe will also assist in the recruitment and retention of Aboriginal and Torres Strait Islander peoples.[41]

The recommendation to fund cultural safety training for the workforce reflects recommendation 44 of the Select Committee on Mental Health and Suicide Prevention which highlights the need for 'provision of culturally appropriate and sensitive services to Aboriginal and Torres Strait Islander peoples, other culturally and linguistically diverse communities, and LGBTIQ+ and sex and/or gender diverse individuals. Such training should be mandated through Australian Government funding agreements'.[1]

3. Retention and upskilling of the care workforce

Action: Invest in the development of a well-trained, adequately resourced, sufficiently staffed and remunerated care workforce.
The RANZCP submission to the *Care Workforce Labour Market Study* highlighted the opportunity to invest in a care workforce that has the capacity to treat vulnerable groups with specific needs. Training of the frontline health and care workforce is key. This training may include trauma informed practice, family therapy skills, AOD, Dialectical Behavioural Therapy (DBT), human rights facilitation, and distress tolerance skills.

An integrated system

1. Connections between levels of government

Action: Align governance between levels of government to support integration.
The National Mental Health and Suicide Prevention Agreement is yet to be released. The RANZCP believes that patient-focused care should be the primary objective of the National Agreement. Integration with state and territory governments is key, as there is a need to tailor actions in a way that considers jurisdictional variations. Federal funding delivered to states and territories must be based on mutual agreement. The RANZCP supports the co-funding of services by the Federal Government and states and territories, in addition to reform to address complexities in funding, governance, infrastructure, technology and reporting arrangements. A significant brake on the provision of quality mental health care is the well-documented fragmentation within the mental health system. For nationally consistent actions, a clear overarching vision statement and agreed understanding of governance (roles, responsibilities, deliverables) at a national level is needed.

Suggestions to address the lack of integration between state/territory governments and the Federal Government include that all governments:

- Agree collaborative models of care, including for Adult Mental Health Centres, Headspace and Head to Health.
- Integrate funding models and responsibility for mother-baby units.

2. Connections across portfolios of government

Action: Find methods of better commissioning across government portfolios to provide holistic care.
While the National Mental Health and Suicide Prevention Agreement is intended to promote connectedness between the Federal health minister and state/territory counterparts, there remains a need to connect across sectors and government portfolios considering the significant overlaps. The community must have access to integrated, multidisciplinary services.[3, 42, 43] The RANZCP maintains that many complex problems suffered by individuals and impacting on health outcomes cannot be solved by the health system on its own; therefore multidisciplinary, cross-agency service approaches are essential to improve mental health outcomes and avoid fragmented care. Physical health, disability, justice, family violence, employment, education and training, housing and homelessness, and AOD service sectors all play an important factor in societal mental health and

wellbeing, and connections between these sectors must be enabled.[42, 44] Coordination between providers is essential to providing individuals with clear, coordinated care and treatment pathways.[45]

3. Data collection and access

Action: Establish clinical registries for mental health and suicide prevention.
The Australian Institute of Health and Welfare (AIHW) Suicide & self-harm monitoring system has improved the quality, accessibility and timeliness of data, but more is needed. There is a lack of accessible and reliable national data to inform clinical planning and decisions on policy, programs and funding. The RANZCP suggests the Government establish a national data centre in order to collect nationally consistent data on mental health. This will support establishment of clinical registries which enable the collection of wider demographic information and key risk factors for suicide e.g. mental illness and addiction comorbidities. There is also currently no regular national data collection or reporting regarding the overall mental health and wellbeing of children and adolescents.[34] Clinical registries provide the potential to improve understanding of the factors that contribute to quality care – informing and driving change in policy and practice, and improving patient outcomes.[46]

The RANZCP also recommends providing public access to the *National Mental Health Services Planning Framework* (currently restricted and not in the public domain).

Action: Fund the development of mental health patient outcome measures.
The Select Committee on Mental Health and Suicide Prevention recommendation 5 is to 'review available digital technologies to identify and promote best practice options for mental health and suicide prevention professionals to…track outcomes of care to ensure that the right care is being offered'.[1] The RANZCP highlights that collaboration between services and the Government is required to develop clinically appropriate patient outcome measures. These should be captured at four weeks, six months and 12 months to provide a comprehensive overview of readmissions and relapses.

Affordability

Action: Increase income support payments such as the Disability Support Pension (DSP), Age Pension and Carer's Payment.
People with mental illnesses are at a significant financial disadvantage compared with the general population.[47] They have lower than average incomes, largely due to the difficulties of obtaining and keeping a job while managing the symptoms of a mental illness.[47] The overall impact of this financial disadvantage is that people with mental illnesses face a number of cost barriers to establishing and maintaining healthy lifestyles, including the challenges of being able to afford adequate housing, food, health care and medical services. People with mental illnesses have higher than average needs for medication and treatment for both mental and physical health issues, which can result in higher healthcare expenses.[47] This is particularly difficult for people with multiple medications. Discrimination against people with mental illnesses can also make it more difficult for them to find housing, resulting in higher housing costs.[47]

Affordable services

The RANZCP highlights the need to implement the *Medicare Benefits Schedule (MBS) Review Taskforce Report* recommendations, and recommends further reviewing the eating disorders MBS item numbers to confirm they are fit for purpose, with no unintended consequences. The RANZCP has several recommendations which will improve the affordability of mental health services and treatments for the community.

1. Affordable psychiatry

Action: Increase the MBS rebate for psychiatry services to 100% of the schedule fee from the current 85%, as is the case for general practice; and increase MBS billing provision for psychiatry trainees, so that they can bill at 60% of the consultant psychiatrist rate.
Many RANZCP members have raised that MBS rebates for psychiatry services are too low and do not meet the costs associated with delivering services, meaning they are struggling to provide affordable services to their patients. These specific measures will improve access to and affordability of psychiatry services. The RANZCP also recommends consideration of whether there are ways to improve affordability for people with healthcare

concession cards, noting that people in both metropolitan areas and rural areas suffer socio-economic disadvantage. Options to facilitate affordable access to people who need it most, similar to the concession card system that applies under the Pharmaceutical Benefits Scheme (PBS) should also be investigated.

2. Telehealth

Action: Develop and fund telehealth bulk billing incentives for psychiatrists providing care for people with socio-economic disadvantage, in both rural and metropolitan areas.
The RANZCP acknowledges the Government's commitment to permanent telehealth beyond 31 December 2021. The flexibility of telehealth during the pandemic has been of benefit to patients new and existing, and across both metropolitan and rural areas. Psychiatrists have embraced telehealth via video and have developed telehealth guidance.

MBS item 288 provided a 50% loading for all consultations delivered via videoconference to telehealth eligible areas in Australia (RA2–5) which allowed psychiatrists to be able to bulk bill people in these areas. The RANZCP emphasises that socio-economic disadvantage is present in both rural and metropolitan areas and bulk billing incentives would support provision of affordable services. The Select Committee on Mental Health and Suicide Prevention also recommends that 'the Australian Government ensure the next National Digital Health Strategy (2022-27) explicitly addresses barriers to digital access, and includes specific actions for reducing the 'digital divide'' to address socio-economic disadvantage'.[1]

Action: Develop and implement a loading payment to support services in regional and rural areas for both face-to-face and telehealth attendances.
The RANZCP acknowledges that the Government has implemented the MBS Taskforce recommendation to remove the 50% loading for item 288, but without transition arrangements.[48] As psychiatrists bulk bill for more than 99% of services delivered under Item 288, the removal of Item 288 will have significant implications for affordability and access in areas with existing unmet needs. It's removal without the introduction of an alternative loading payment, will result in patients paying a gap fee (or ceasing treatment if they can no longer afford to pay) or fewer psychiatrists providing services in rural areas. Item 288 loading was only available for telehealth consultations, not if practising onsite, which disadvantaged those receiving face-to-face services from regional and rural practitioners. The Government must find new ways to remove barriers to care and incentivise practitioners to support all people in regional and rural areas who face issues of affordable access to treatment.

3. MBS liaison numbers for multidisciplinary care

Action: Fund a new MBS item for psychiatrists to provide advice to GPs or paediatricians over the phone as recommended by the Productivity Commission; and update case conference items allowing multiple professionals within a multidisciplinary team to be involved and bill for the item.
Psychiatrists are well placed to partner with, lead and advise on a range of matters. The RANZCP submission to the MBS Taskforce highlights that enabling psychiatrists to provide advice to other professionals on diagnosis and management issues will assist in streamlining care. Additionally, provision of multidisciplinary care was a core component of the Final Report of the Select Committee on Mental Health and Suicide Prevention; appropriate remuneration is a key enabler.[1]

4. MBS numbers for reporting and providing evidence

Action: Create a new MBS item which remunerates psychiatrists for report-writing for psychosocial disability for the National Disability Insurance Scheme (NDIS).
The creation of MBS items for psychosocial disability reports would create equitable access for people with disability seeking to access the NDIS. Submissions that the Joint Standing Committee on the NDIS received this year were in favour of fully funded consultations with healthcare professionals for the purposes of evidence for access and planning requests.[49] In particular, some called for a new bulk billed MBS item to address equity issues that may enable some participants and prospective participants to afford medical reports while others are unable to do so.[49]

Action: Create a new MBS item which remunerates psychiatrists for report-writing and providing evidence of psychosocial disability for the Disability Support Pension (DSP).

The RANZCP highlights a similar need for remunerating psychiatrists when providing evidence of disability for the DSP. Considering that 35.2% of people accessing the DSP have psychological/psychiatric disability, there is significant time invested in these processes for which psychiatrists are not remunerated.[50]

Action: Create a new MBS item which remunerates psychiatrists for medico-legal report-writing for family or criminal court proceedings.
Most victims of family violence and crime are in a limited position to pay for health services and reports. Medical professionals providing evidence and reports have an important role in court proceedings and should be remunerated by the Government.

5. Universal access to early developmental checks

Action: Create a new MBS item for development progress checks.
The Productivity Commission recommended the need for early identification of developmental (including social-emotional/behavioural) risk.[12] A potential method to de-stigmatise and provide universal access to early developmental checks would be via the MBS, aligning with vaccination visits e.g, 18-month vaccination. Such an MBS item would help engage parents and identify children at developmental/ behavioural risk early and provide early intervention and parenting support. Those identified to be at high risk could potentially be triaged and linked to Head to Health Kids (0-12) hubs for supports.

6. MBS number for family/carers

The RANZCP submission to the MBS Taskforce supports the increased need to consult with people close to patients (usually families) to aid in the assessment and ongoing management. The RANZCP supports the move to introduce new time-tiered items and to increase the number of services available to 15 per year.

Affordable treatments

1. Mental health treatments

Action: Lift restrictions on repetitive transcranial magnetic stimulation (rTMS).
There are currently 'lifetime' access restrictions that the Medical Services Advisory Committee (MSAC) has placed on patients for ongoing rTMS treatments.[51] The recommendation of the MSAC is that a patient with depression will be able to only access a single course of rTMS (35 sessions) and one additional 'half course' (15 sessions) in their entire lifetime. As depression is a recurrent illness, implementation of these recommendations would mean that patients who have done extremely well with their initial therapy will effectively be denied access to funded treatment for the duration of their lives after this. These restrictions have major limitations on successful use. Please see the RANZCP response to the MSAC for further information.

Action: Increase the MBS rebate for Electroconvulsive therapy (ECT) to $163.05.
The fee for ECT needs to be increased to better account for the time and complexity associated with delivering this service. The current low fee is a major disincentive for private hospitals to offer ECT, thereby limiting affordability of, and access to this potentially life-saving treatment. The RANZCP suggests a fee of $163.05 for a standard ECT treatment, incorporating additional components, as outlined in the RANZCP pre-budget submission 2021-22. The last Budget did not include further funding for ECT specifically, but did commit funding to implement the recommendations from the MBS Review Taskforce which supported an increased rebate.

2. Medications

Action: Add long-acting methylphenidate to the PBS for those over 18.
The RANZCP notes that there are affordability and equity issues for medications which require diagnoses to be made at a particular age, as is the case for some ADHD medications. ADHD is becoming increasingly recognised in people over the age of 18.[52] On 1 February 2021 long-acting dexamphetamine became available under the PBS to those diagnosed retrospectively after age 18, but long-acting methylphenidate is still not. Therefore, the price remains a disincentive, particularly for this age group.

Additionally, there are significant issues related to affordability and accessibility of ADHD medications. A review of pharmacological medications is needed to subsidise additional medications including Bupropion, Modafinil, and Atomoxetine. Revision of the maximum doses of medications permitted under the PBS for ADHD treatment in both children and adults is also required, as is a nationwide system that allows prescribers in any jurisdiction to prescribe a comparable level of maximum doses of Schedule 8 for the treatment of ADHD.

Action: Amend the PBS to make 5mg or 2.5mg doses of aripiprazole affordable.

Behavioural and psychological symptoms of dementia (BPSD) have a significant impact on the quality of life for patients and their carers. Over 95% of people with dementia experience such symptoms at some point. Pharmacological approaches are considered where symptoms are severe, disabling, or where a risk of significant harm exists. Aripiprazole is an antipsychotic medication which can be prescribed for patients with BPSD if risperidone is not appropriate. At present, 10mg doses of Aripiprazole are funded in the PBS but these doses may not be suitable for older patients. One study indicated that almost half of those studied were on a dose lower than 10mg.[53]

Action: List lamotrigine on the PBS.

Lamotrigine is a mood stabilising agent used as an adjunct for bipolar depression or treatment resistant depression, which, despite good evidence as to its effectiveness of treating mood disorders, is currently not listed on the PBS. In addition to listing lamotrigine on the PBS, the RANZCP further recommends that consideration be given to licensing bupropion for use in mood disorders, and listing bupropion, agomelatine and vortioxetine in appropriate dosages on the PBS, given evidence of their effectiveness in the treatment of mood disorders. For more information, see the RANZCP clinical practice guidelines for mood disorders.

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