Your Health in Mind

Improving the mental health of communities

Royal Australian and New Zealand College of Psychiatrists

2022–2023 Pre-budget submission: Key recommendations

December 2021

Workforce shortages

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:

- Committing to fully fund training and training supervisor posts under the Psychiatry Workforce Program beyond June 2023- $6,475,000 per year, ongoing.
- 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 the development of a program for supervisors to strengthen and support their resilience.
- Developing initiatives to improve the working lives of doctors, including supporting effective and sustainable supply to reduce the pressure on the existing medical workforce.
- Developing the HeaDS UPP Tool as a single source of data for workforce planning that is nationally and locally accepted. The RANZCP advocates for psychiatry to be prioritised.

Acute care for young people 0–25

Action: Develop additional services nationally to meet the acute mental health care needs of the 0–25 age group. Funding to evaluate 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.[1] 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.[2, 3] 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. Rolling out similar programs nationally would 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.[4]

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 welcomes 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. Acknowledging that initial and complex services are better suited to face to face or video, the RANZCP guidance recommends that video is used wherever possible.

Medicare Benefits Schedule (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 House of Representatives 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.[5]

Action: Develop and implement a loading payment to support services in regional, rural and remote areas for both face-to-face and telehealth attendances.

The RANZCP understands that the Government has implemented the MBS Review Taskforce (MBS Taskforce) recommendation to remove the 50% loading for item 288.[6] 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. If removed without the introduction of an alternative loading payment, it may 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. The 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.

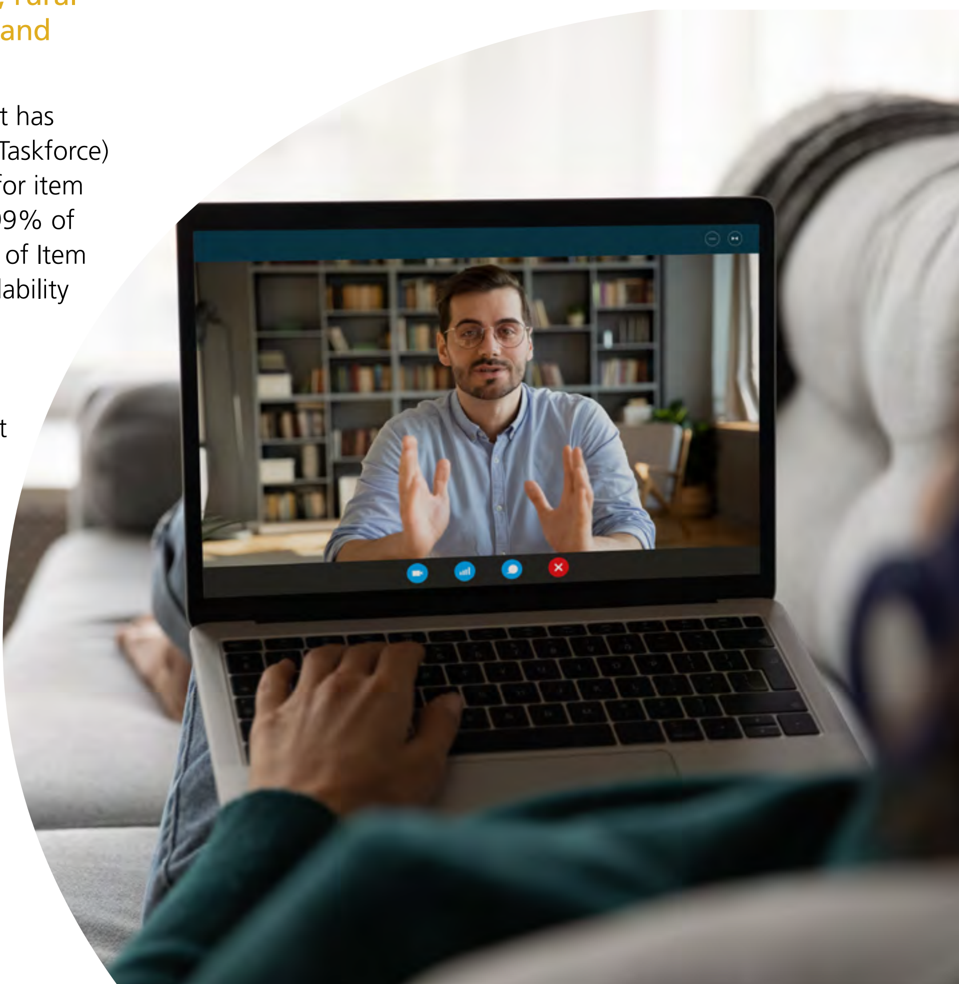
The National Mental Health and Suicide Prevention Agreement

Action: Align governance between levels of government to support integration.

The National Mental Health and Suicide Prevention Agreement (the National 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 that addresses 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.



Accessible, reliable national data

Action: Establish clinical registries for mental health and suicide prevention.

The Australian Institute of Health and Welfare 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.[4] 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.[7]

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'.[5] Collaboration between services and the Government is required to develop clinically appropriate patient outcome measures. Outcome measures should be captured at four weeks, six months and 12 months to provide a comprehensive overview of readmissions and relapses.

Academic psychiatry/research

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.

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

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