

Australian Department of the Treasury
2023-2024 Pre-budget Submission
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Collaboration to improve access and equity

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 7700 members, including more than 5600 qualified psychiatrists and over 2100 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 its members, including key RANZCP committees comprising of psychiatrists, those in psychiatry training, and people with a lived experience.

Introduction

The RANZCP recognises the Australian Government's renewed focus on accessible and affordable healthcare for all Australians and welcomed the restoration of 50% fee loading for telehealth attendances with psychiatrists treating regional and rural patients through the new Medicare Benefits Schedule (MBS) item 294. The RANZCP acknowledges the ongoing work of the Strengthening Medicare Taskforce to improve primary care and make Medicare fit for purpose, and maintains that a mental health representative on the Taskforce is required. We also note the recent release of the Evaluation of the Better Access Initiative. The RANZCP has long advocated for equitable access to mental health treatment, particularly access to psychiatric care. Informed by a range of our expert committees, we offer our evidence-based guidance on the optimal system design to treat patients from various socioeconomic backgrounds to support delivery of the [recommendations](#).

In 2018-19, the annual cost to the economy of mental ill-health and suicide in Australia was estimated to be up to \$70 billion, this includes an annual cost of lower economic participation and lost productivity of \$39 billion.[1] The 2023-2024 Australian Federal Budget presents an opportunity to make mental healthcare accessible and affordable to all Australians and develop a sustainable mental health workforce. While this submission focuses on the psychiatric workforce, the RANZCP highlights that workforce shortages exist across the health system. Supporting workforce development across the health sector, including the aged care and alcohol and other drug (AOD) workforce, is necessary for the work of psychiatrists to be effective.

While Australia is home to many skilled mental health professionals and excellent services, adequate mental healthcare remains inaccessible for many. This is particularly the case for people with moderate to severe mental health conditions. Investment is required to boost the workforce and improve access to psychiatry and psychiatry subspecialties such as child and adolescent psychiatry.

Now is the time for the Government to invest in the future of the Australian mental health system to ease the burden of disease and develop a workforce with the capacity to care for the next generation of Australians.

Executive summary

1. Workforce

The RANZCP's priority recommendation is to fund additional child and adolescent psychiatry positions, including leadership positions.

The development of a sustainable psychiatry workforce is crucial to addressing existing shortages in the mental health system. Workforce shortages are particularly dire within psychiatry subspecialties such as child and adolescent psychiatry.

2. Affordability

The RANZCP's priority recommendation is to develop bulk-billing incentives for psychiatry consultations for patients experiencing financial disadvantage.

For access to mental healthcare to be equitable, services and treatments must be affordable. More and more Australians are navigating the compounding effects of financial disadvantage and a cost-of-living crisis exacerbated by increasing inflation and global uncertainty. Affordability in healthcare is important to ensure those experiencing financial disadvantage do not need to make difficult decisions between accessing care and other basic necessities.

3. Excellence

The RANZCP's priority recommendation is to establish clinical registries for mental health and suicide prevention.

In the 2021-22 financial year the Australian Government spent \$94.4 billion on health care.[2] Australians expect this money is spent smartly and effectively. Australian Government decision-making should be backed by robust and well-sourced data to understand the need before action is taken. Communication and collaboration among these stakeholders ensure effective policy implementation and delivery on money spent.

4. Equity

The RANZCP's priority recommendation is to develop additional services nationally to recognise the diversity of need across Australia.

Equitable access to quality care in the mental health system is critical to ensure that everyone regardless of location or circumstance is able to access the specialist services they need. Such needs may be diverse among identified priority groups including: children and young people, older people, people with addictions or substance use disorders, people in and being discharged from custody, people who are experiencing or have experienced family violence, veterans, women in the perinatal period, people with disability, and asylum seekers and refugees.

5. Access

The RANZCP's priority recommendation is to lift restrictions on repetitive transcranial magnetic stimulation (rTMS).

The [Select Committee on Mental Health and Suicide Prevention](#) has recommended 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.[3, 4] The RANZCP strongly supports this recommendation to ensure Australians can access healthcare and avoid delaying care and associated costs of delayed care. Current restrictions on rTMS create major limitations on successful use of the treatment, and present an opportunity to improve access to services.

1. Workforce

The delivery of mental healthcare that Australians need cannot be achieved without adequate development of the mental healthcare workforce. The Productivity Commission and the National Skills Commission's national [Skills Priority List](#) have both identified a national shortage of psychiatrists as well as mental health nurses and aged care workers.[1, 5] As Australian, State and Territory Governments at all levels implement plans to increase mental health services, these skill shortages will intensify. Raising the demands on the mental health workforce without increasing it will lead to burnout, high rates of leave and staff exiting the workforce, and compound the problem.[6]

The RANZCP recognises the Government's commitment to funding workforce initiatives including [Specialist Training Program](#) (STP), [Psychiatry Workforce Program](#) and [Military and Veterans' Psychiatry Workforce Training Program](#) and the [Rural Psychiatry Roadmap](#), and would welcome an extension to the programs which continue to boost the psychiatry workforce and strengthen training opportunities. The RANZCP requests the Government's commitment to funding these initiatives on an ongoing basis.

The following recommended actions would support the mental health workforce:

1.1 Psychiatry subspecialist gaps

Action: [Fund additional child and adolescent psychiatry positions, including leadership positions.](#)

Of the approximately 80,000 children with a severe disorder, only 22,000 had seen a psychiatrist (27%) over a 12-month period.[10] Consistent with Action 16.2 of the [Productivity Commission report](#), the [National Mental Health Service Planning Framework](#) (NMHSPF) and [RANZCP's Child and Adolescent Psychiatrist Workforce Discussion Paper](#), the number of child and adolescent psychiatrists in clinical practice must be increased to psychiatrists to 2.5-4.5 FTE per 100,000 total population, in line with UK modelling in order to address this shortfall.[7]

Action: [Increase access to medical care for older people through better availability of funded expertise from old age psychiatrists.](#)

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.[8, 9] At present, aged care services do not meet the mental health needs of older Australians.[9] To meet the growing need for mental health services for older Australians, investment must be made in the old age psychiatry workforce to deliver care for older Australians. Specialist (psychiatrist/geriatrician) MBS items for assessment, providing support following diagnosis, and management of those with dementia/neurocognitive disorders and their behavioural and psychological symptoms. These would support the follow-up of patients and plan reviews, either in-person or through telehealth with care staff.

Action: [Fund costing studies of consultation-liaison \(C-L\) psychiatry to inform appropriate funding of the service.](#)

The RANZCP [submission](#) to the Independent Health and Aged Care Pricing Authority (IHACPA) 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 remain unfunded. The RANZCP urges the IHACPA to fund costing studies of C-L psychiatry to inform appropriate funding for the service. This is a longstanding concern of the RANZCP.

Action: [Fund the development of a program for supervisors to strengthen and support their resilience.](#)

Supervisors report increasing demands on them for service delivery, which increasingly impacts their capacity to provide adequate supervision to meet the accreditation standards of the RANZCP Fellowship program. In the wake of the COVID-19 pandemic, rates of burnout have increased significantly among psychiatrists across the sector.[10] The relationship between burnout and the depletion of the workforce is well established.[11] Fortunately, burnout can be reduced through mental health and on-the-job support to restore a healthy relationship with work demands. The RANZCP supports funding the development of programs for supervisors and psychiatrists to strengthen and support their resilience and mental health.

1.2 Broader mental health workforce

Action: Increase Aboriginal and Torres Strait Islander representation in the mental health workforce and provide training for culturally informed care.

It is 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.[12]

Action: Fund specialist mental health nurse positions.

The projected shortfall of mental health nurses is between 11,500 and 18,500 by 2030.[3] The RANZCP pre-budget submissions for [2021-22](#) and [2022-23](#) 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. Funding mental health nurse positions would bridge critical gaps in psychiatric health care, particularly in community settings, by utilising the clinical skills of nurses and increasing the profession's capacity to treat people with mental health issues.

2. Affordability

Affordability is a key tenet of a strong mental health system. However, the median out-of-pocket payment for a psychiatrist (\$274) is one of the highest across specialties and given this expense, about 18% of adult Australians needing to see a psychiatrist report missing the service due to cost.[23-25]

To ameliorate the financial burden of quality mental health care, the RANZCP recommends the following actions:

2.1 Psychiatry services

Action: Increase the MBS rebate for psychiatry services to 100% of the schedule fee from the current 85% and increase the 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 to meet the costs associated with delivering services, meaning they struggle to provide affordable services to their patients. For Australians experiencing financial disadvantage, the cost of seeing a psychiatrist can mean delaying receiving a diagnosis or care. Increasing the bulk-billing incentive to 100% (that of general practice) will improve the affordability of psychiatry services by increasing the number of bulk-billed patients. Allowing trainees to access item numbers that offer a higher rebate will also improve affordability through lower out-of-pocket fees. Recommendation 9 of the evaluation of the Better Access Initiative supports determining appropriate levels for MBS fees.[13]

2.2 Bulk-billing incentives

Action: Develop bulk-billing incentives for psychiatry consultations for patients experiencing financial disadvantage.

Across both rural and metropolitan Australia, 13.4% of Australians [lived below the poverty line](#) in 2019-20.[14] As such groups are more likely to experience a mental health condition, means-tested bulk billing incentives (50% of the schedule fee as is the case for rural loading) must be prioritised to ensure those in poverty obtain affordable access. Such reform must be supported by continual review of effective measures of financial disadvantage to ensure the long-term efficacy of funding reform and the provision of services to those in need. Recommendation 11 of the evaluation of the Better Access Initiative further demonstrates the need for increasing affordability through bulk-billing incentives.[13]

2.3 MBS telephone items

Action: Reinstate expired MBS telephone items to support those experiencing financial disadvantage.

Multiple MBS Items for telephone-based consultations with a psychiatrist expired on 1 July 2022. With telephone items more commonly used by people facing financial disadvantage, the lack of MBS items deprives those unable to afford full-cost treatment access to a longer consultation with a psychiatrist.[26-28] The RANZCP notes the [Strengthening Medicare Taskforce](#)'s commitment to 'providing universal health care and access for all through health care that is inclusive and reduces disadvantage'. To achieve this inclusivity, telephone items must be reinstated to ensure affordable access to a variety of consultations.

2.4 Medico-legal reports

Action: Create a new MBS item that 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 Australian Government.

2.5 Early developmental checks

Action: Create a new MBS item for early development progress checks for children.

The Productivity Commission recommended the need for early identification of developmental (including social-emotional/behavioural) risk.[1] 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 Hubs (0-12) for support.

2.6 MBS items 348, 350 and 352 - non-patient interviews.

Action: Introduce new time-tiered items and increase the number of services available.

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. This action is supported by recommendation 15 of the evaluation of the Better Access Initiative, which highlights the need for family and carer-inclusive practices.[13]

2.7 Medications

Action: Provide affordable medications through listing on the Pharmaceutical Benefits Scheme (PBS).

- Lamotrigine as an adjunct for bipolar depression or treatment-resistant depression. Bipolar depression and treatment-resistant depression are conditions that must treat but have limited effective medications and treatments available to do so. Accessibility to Lamotrigine for bipolar depression and treatment-resistant depression is important to increase the medications available for the effective treatment of these patients.[15]
- Bupropion, Atomoxetine, Agomelatine and Vortioxetine, in appropriate dosages, for the treatment of ADHD. Affordable access to these medications is important for those with ADHD as co-morbidity with depression or anxiety is common. Access to a broad range of antidepressants is important due to the varied responses experienced by patients as they explore what medications work for them.[16, 17]
- Aripiprazole (doses of 5mg or 2.5mg) for treatment of behavioural and psychological symptoms of dementia. Studies have shown Aripiprazole to be linked to lowering agitation, aggressiveness, anxiety and depression in those with dementia. Its efficacy at lower doses is important for managing risks of adverse effects.[18]
- Lurasidone for treatment of bipolar depression. Bipolar depression is a treatment-resistant mental health condition associated with an increased risk for suicide attempts, a higher switch to mania during antidepressant therapy, and a higher rate of recurrence. Increasing the availability of effective medications such as Lurasidone is necessary to provide affordable and effective treatments for this complex condition.[19]

2.8 Electroconvulsive therapy

Action: Increase the affordability of Electroconvulsive therapy (ECT).

The MBS rebate fee for ECT should be increased to better account for the time and complexity associated with delivering this service. The current fee disincentivises private hospitals from offering affordable ECT to patients, a potentially life-saving treatment. The RANZCP suggests a fee of \$163.05 for a standard treatment.

3. Excellence

Harnessing the expertise of psychiatrists and other stakeholders across specialities and sectors strengthens the mental health system's ability to improve the quality of care and patient outcomes. The research and guidance provided by academic psychiatry are instrumental in enhancing clinical excellence in psychiatric care. The RANZCP will continue to promote and support the work of academic psychiatrists across Australia and New Zealand in 2023.

The following actions support the delivery of quality mental health care:

3.1 Clinical registries

[Action: Establish clinical registries for mental health and suicide prevention.](#)

There is a lack of accessible and reliable national data to inform clinical planning and decisions on policy, programs and funding. For example, there is no regular national data collection or reporting on the mental health of children and adolescents or to comprehensively track outcome data from DBS for OCD.[13] Clinical registries allow for the collection of wider demographic information and key risk factors for suicide. This improves our understanding of quality care, informing and driving change in policy and practice to improve patient outcomes.[14]

3.2 MBS items for multidisciplinary co-operation

[Action: Invest in MBS Item numbers to support psychiatrists engaging in multidisciplinary cooperation, and forge connections between mental health, physical health, and other social services.](#)

As outlined in the National Mental Health and Suicide Prevention Agreement, collaborative models of practice support patients' access to holistic, patient-centred care, by providing clear treatment pathways for people with complex mental health presentations and/or circumstances.[7,33-35] MBS Items numbers are required to support psychiatrists engaging in the processes of cross-agency services:

- case discussions, case conferences and phone advice - geriatricians, paediatricians, psychologists, GPs and family violence support workers.
- report-writing for psychosocial disability for the National Disability Insurance Scheme (NDIS).
- report-writing and providing evidence of psychosocial disability for the Disability Support Pension (DSP).

A similar MBS item should also be created for GPs to discuss clinical questions with a psychiatrist. Such an MBS item would work towards addressing the long waiting lists to see psychiatrists.

3.3 National roadmap for integrated delivery of mental health care to children and young people

[Action: Fund the development of a national roadmap for integrated delivery of mental health care to children and young people.](#)

The RANZCP calls on the Australian Government to fund the development of a national roadmap for the integrated delivery of mental health care to children and young people. The roadmap would focus on developing the child and adolescent workforce, scoping models of care and investigating how best to achieve the integration of the services, disciplines and sectors caring for children and adolescents. Consideration should be made for how best to adapt models and programs to the needs of special population groups such as Aboriginal and Torres Strait Islander children and young people. Development of this roadmap would be led by the RANZCP and done in consultation with other medical specialist colleges, medical professional bodies, private sector organisations, and non-government organisations working in mental health.

4. Equity

The public must have timely access to person-centred and culturally safe specialist services, regardless of their mental health condition, personal circumstances, or socioeconomic background. At-risk populations need access to a mental health system that 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.[20, 21] The [Select Committee on Mental Health and Suicide Prevention](#) recommends that 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'.[3]

The following actions support equitable access to quality care from the mental health system:

4.1 Older people

Action: In the new National Framework for Action on Dementia, specify targets for the availability of psychiatric expertise and outline the specific roles of jurisdictions in the care pathways for the management of severe Behavioural and Psychological Symptoms of Dementia.

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 the total burden of disease and injury (accounting for 7.7% of disability-adjusted life years).[22] While dementia has a biological substrate, the common psychiatric complications of dementia require the involvement of psychiatrists as experts in care, treatment and support.[9]

4.2 Children and young people

Action: Develop additional services nationally to meet the acute mental health care needs of the 0-25 age group. Funding for the 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 its 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 of young people.[23] Several reports have emphasised the mental health of children and families as a priority and a good-value investment, identifying a nationwide pattern of under-resourcing community-based (ambulatory) mental health services, with the greatest gaps including those for children and adolescents.[1, 24] Intake criteria to access the mental health system are 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.

National programs should service the 0-25 age group and work closely with current service providers (e.g. Headspace and Head to Health Kids Hubs) to ensure the entire population group is serviced across a range of needs including 24-hour acute care. 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.[25]

4.3 People with addictions or substance use disorders

Action: Fund substance use treatment services and beds and integrate holistic and person-centred AOD services with mental healthcare.

The RANZCP welcomes the Productivity Commission and the Select Committee on Mental Health and Suicide Prevention's acknowledgements of the underinvestment in specialised AOD services and the significant impacts this has.[1, 3] A report conducted by KPMG and Rethink Addiction has found that AOD addiction costs the Australian community \$35.5 billion in 2021.[26]

While a priority of the [National Drug Strategy](#) is enhancing access to services and supports, more needs to be done.[27] The existing lack of AOD treatment services within the public system means many individuals must 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.[28]

4.4 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 support 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.[29] There is significant evidence that the same issue is present when discharging people from other healthcare, custodial and justice settings.[29]

People in the justice system need support for NDIS applications, and planning needs to occur before their release.[30, 31] The process of securing NDIS funding is challenging, slow, and not available to all people.[29] A 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.[29] These challenges render unacceptably high rates of discharge from hospitals and other settings into homelessness. The RANZCP is supportive of providing NDIS support to those incarcerated to maintain support before, during and after incarceration and ensure adequate disability support is provided in prison.

4.5 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.[32] 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.[33] 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 Australian Government to increase the overall humanitarian refugee intake and to support services and programs to assist asylum seekers and refugees who flee unsafe environments.

4.6 People with disability

Action: Maintain funding for the National Disability Data Asset (NDDA) - \$40,000,000 until 2025

The [Australia's Disability Strategy 2021-2031](#) delivered \$40,000,000 over four years from 2021-22 to extend the NDDA. The NDDA links de-identified data from multiple Commonwealth and state and territory service systems and is essential to the understanding of outcomes for people with psychosocial disability and cognitive disabilities, alongside the impact of services accessed by people with disability. This has improved outcomes for people with disability, and the RANZCP requests that its funding is guaranteed within the budget.

Action: Increase minimum income support payments such as the Disability Support Pension (DSP), Age Pension and Carer's Payment.

People with mental illness are at a significant financial disadvantage compared with the general population.[34] 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.[34] 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 illness have higher than average needs for medication and treatment for both mental and physical health issues, which can result in higher healthcare expenses.[34] This is particularly difficult for people with multiple medications. Discrimination against people with mental illness can also make it more difficult for them to find housing, resulting in higher housing costs.[34] An appropriate minimum income can reduce morbidity and suicide.[14]

4.7 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 the 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.[35] The RANZCP acknowledges the release of the [National Plan to End Violence Against Women and Children](#) (2022-2032) and supports its focus on early intervention and prevention services for families to build and strengthen relationships, develop skills and support parents and children through the Family Support Program. The RANZCP echoes the plan's calls for responsive services and programs for young people.

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.

Action: Fund 100% bulk-billed psychiatry sessions for people who receive a crisis payment.

Escaping FV and recovering from its impacts is difficult for all who experience it but especially for those experiencing financial disadvantage. Patients seeking to access psychiatry services already face significant out-of-pocket costs; those experiencing financial disadvantage are therefore less likely to access necessary psychiatry services during these extremely difficult circumstances. The RANZCP supports the receipt of a crisis payment to make one eligible for 100% bulk-billed psychiatry sessions through the MBS to enable those who experience both financial disadvantage and FV to access high-quality support quickly and without concern for cost.

4.8 Women in the perinatal period

Action: Fund Mother Baby Units (MBUs) in collaboration with State and Territory governments - \$5,000,000 each unit per year/\$90,000,000 over three years.

The RANZCP acknowledges and thanks the Australian government for committing \$26.2 million towards the establishment of 12 perinatal mental health centres across Australia. The RANZCP wishes to emphasise the continued need for MBUs to provide specialist inpatient mental health treatment for those with mental health conditions in late pregnancy and up to 12 months postpartum.

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.[1] Universal access to publicly funded MBUs is best practice for women who require admission for mental health conditions in late pregnancy and up to 12 months postpartum.[1] Women requiring inpatient treatment have improved outcomes if accompanied by their babies and admitting both mother and baby to the hospital is well demonstrated to be effective in treating perinatal illness.[18] Despite this, there are few publicly funded MBUs for inpatient mental health treatment that offers a full inpatient service.[19] The Australian Government must work with State and Territory Governments to provide access to public mental health MBUs in all Australian states and territories, equating to one eight-bedded unit for every 15,000 deliveries at a cost of \$90,000,000 over three years.[20] This is a cost-effective solution considering the \$87,000,000 estimated annual health, economic and wellbeing costs of perinatal mental ill-health.[7]

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.

4.9 Improve veteran access to psychiatry

Action: Revise the Department of Veterans' Affairs (DVA) fee schedule for psychiatrists to align with the Australian Medical Association Fees List.

The RANZCP is advised that most psychiatrists have very high caseloads with long waiting lists and therefore may not be in a position to take on many if any, new patients. The RANZCP supports the [Interim National Commissioner for Defence and Veteran Suicide Prevention's](#) recommendation 6.9, which states that 'the Australian Government should consult the RANZCP on amending the DVA fee schedule for psychiatrists'.^[36] This could include the Australian Government aligning DVA rates for psychiatrists who provide services to veterans with the rates for psychiatrists in the Australian Medical Association (AMA) fees list.^[37] In many states, Worker's Compensation specialist payments have been amended to mirror the AMA-suggested fee structures, successfully creating better access to specialist treatment for injured workers.^[38]

4.10 Pacific Island countries

Action: Fund mental health workforce capacity building initiatives in Pacific Island countries.

Mental and substance use disorders were estimated to be the leading cause of disability in the Oceania region for 2019.^[39] It is estimated that approximately 600 mental health workers will be needed in both outpatient and inpatient services across the region over the period 2010–2050; yet Pacific island countries do not have a mental health workforce which meets current demands.^[40] The RANZCP is committed to supporting the mental health workforce capacity of Pacific island countries and enabling Pacific island countries to meet the needs of their communities. Given the Phase 2 Pacific Clinical Services and Health Workforce Program is not best fit to support mental health/psychiatry, the RANZCP seeks investment in medical education, training and capacity development initiatives in line with national workforce development plans. These programs will strengthen the Pacific mental health workforce to provide higher quality, more equitable, accessible and sustainable health services.

5. Access

The [Select Committee on Mental Health and Suicide Prevention](#) recommended that the concept of timely access should be at the forefront of all policy and funding programs for the mental health and suicide prevention sector.[12] The requirement for further funding to achieve this has also been identified by [the National Medical Workforce Strategy](#) and [Productivity Commission](#). The RANZCP proposes that funding is prioritised for the following actions:

5.1 Access to NDIS support for Attention Deficit Hyperactivity Disorder (ADHD)

Action: Provide funding to list ADHD as an eligible condition for entry to the NDIS.

While many can manage their ADHD through appropriate treatment and medication, for others ADHD can be disabling. The provision of suitable accommodation through the NDIS and the provision of ADHD coaches would make disabling ADHD significantly more manageable. NDIS support would lower the burden of disease for disabling ADHD through the effective provision of support via a clear pathway. The [Australian ADHD Professionals Association Clinical Guideline for ADHD](#) supports the inclusion of ADHD as a condition eligible for entry to the NDIS, and has been endorsed by the RANZCP and the National Health and Medical Research Council.

5.2 Access to ADHD support and services

Action: Fund assessment, monitoring and treatment of ADHD in the public healthcare system to ensure equitable access to healthcare.

A growing number of people are investigating ADHD assessments, and health services across Australia are struggling to meet demand. Deloitte Access Economics has calculated the social and economic cost per person with ADHD to the Australian community as \$25,071.[41] To manage this demand, particularly from people unable to access psychiatric care through the private sector, reform is required to enhance the public sector's capacity to assess and treat patients as they transition across services. Currently there are few ways to access diagnosis or treatment of ADHD through the public system. Delivering assessment and treatment of ADHD through the public system would create access to those for whom ADHD has the most significant impact.

5.3 Deep brain stimulation services

Action: Fund new centres of excellence and introduce MBS item numbers for deep brain stimulation (DBS) to increase access to this treatment.

Obsessive-Compulsive Disorder (OCD) is a psychiatric condition that affects 3.1% of the Australian population.[13] [DBS](#) is a promising therapy for individuals with OCD that does not respond to medical and psychological treatment. At present, there is no state or national level funding available to run a DBS program, and only two expert multidisciplinary teams (Brisbane and Melbourne). New centres of excellence are required, with accompanying funding for treatment provision, to develop more expert teams to run a DBS program and improve access to this treatment. Funding for DBS through the MBS would improve access and affordability for people with severe, treatment-refractory OCD where all other treatment avenues have been exhausted.

5.4 Transcranial magnetic stimulation services

Action: Lift restrictions on rTMS.

There are currently 'lifetime' access restrictions that the Medical Services Advisory Committee (MSAC) has placed on patients for ongoing rTMS treatments.[14] 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.

5.6 Multidisciplinary liaison and collaboration

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 (GPs) 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](#).^[25]

The opportunity to consult between specialists is valuable.^[42, 43] Collaborative models of practice 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.^[44] [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'.^[3, 4]

5.7 Psychiatric group therapy sessions

Action: Fund longer group therapy sessions for psychiatric consultations

As noted by the Productivity Commission, group therapy can ameliorate cost barriers and improve access to therapy by reducing the minimum number of participants.^[1, 7] The RANZCP also supports the recent [changes](#) to the Better Access Initiative to encourage greater uptake of group therapy by allowing allied health professionals to be compensated for their time delivering longer group therapy sessions of at least 90 or 120 minutes. Psychiatrists can only bill for group psychotherapy sessions up to an hour, a length of time deemed insufficient by the Productivity Commission. Changes to encourage greater uptake of group therapy should be extended to psychiatrists to improve affordability for those seeking group psychiatric treatment, particularly in relation to MBS item 342.

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References

1. Productivity Commission. Mental Health, Inquiry Report. Canberra: Productivity Commission; 2020 1617.
2. Australian Institute of Health and Welfare. Health expenditure Australia 2020-21. Canberra: Australian Government; 2022 Available from: <https://www.aihw.gov.au/getmedia/563f467e-9c54-4f46-ab5b-f9a21175965b/Health-expenditure-Australia-2020-21.pdf.aspx?inline=true>.
3. House of Representatives Select Committee on Mental Health and Suicide Prevention. Mental Health and Suicide Prevention - Final Report. Canberra: Australian Parliament House of Representatives; 2021 372. Available from: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/024705/toc_pdf/MentalHealthandSuicidePrevention-FinalReport.pdf;fileType=application%2Fpdf.
4. Prevention HoRSCoMHaS. Mental Health and Suicide Prevention - Final Report. House of Representatives Select Committee on Mental Health and Suicide Prevention; 2021 Available from: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/024705/toc_pdf/MentalHealthandSuicidePrevention-FinalReport.pdf;fileType=application%2Fpdf.
5. National Skills Priority List [Internet]. 2022 [cited 24/11/2022]. Available from: <https://www.nationalskillscommission.gov.au/topics/skills-priority-list>.
6. Johnson J, Hall LH, Berzins K, Baker J, Melling K, Thompson C. Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications, and recommendations for future interventions. *International journal of mental health nursing*;27(1):20-32
7. Faculty of Child and Adolescent Psychiatry. Child and adolescent psychiatry: meeting future workforce needs,. Royal Australian and New Zealand College of Psychiatrists; 2019 June 201917. Available from: <https://www.ranzcp.org/files/resources/reports/fcap-workforce-discussion-paper-board-approved-may.aspx>.
8. Commissioner AD. Safety and Security for Older Women: National Summit on Women's Safety; 2021 [Available from: <https://humanrights.gov.au/about/news/speeches/safety-and-security-older-women>.
9. Royal Commission into Aged Care Quality and Safety. Royal Commission into Aged Care Quality and Safety - Final Report. Royal Commission into Aged Care Quality and Safety; 2021 Available from: <https://agedcare.royalcommission.gov.au/publications/final-report>.
10. Northwood K, Siskind D, Suetani S, McArdle P. An assessment of psychological distress and professional burnout in mental health professionals in Australia during the COVID-19 pandemic. *Australasian Psychiatry*;29(6):628-34. Available from: <https://journals.sagepub.com/doi/abs/10.1177/10398562211038906>.
11. Scanlan JN, Still M. Relationships between burnout, turnover intention, job satisfaction, job demands and job resources for mental health personnel in an Australian mental health service. *BMC health services research*;19(1):62-
12. Aboriginal and Torres Strait Islander Workforce Action Plan. Australian Government Department of Social Services; 2021 Available from: https://www.dss.gov.au/sites/default/files/documents/07_2021/j3797-workforce-strategy-2021-2025-atsiacc-final-version-accessible-version.pdf.
13. Pirkis J, Currier D, Harris M, Mialopoulos C. Evaluation of Better Access Conclusions and Recommendations. Melbourne: University of Melbourne; 2022 13. Available from: <https://www.health.gov.au/sites/default/files/2022-12/conclusions-and-recommendations---evaluation-of-the-better-access-initiative.pdf>.
14. Isaacs AN, Enticott J, Meadows G, Inder B. Lower Income Levels in Australia Are Strongly Associated With Elevated Psychological Distress: Implications for Healthcare and Other Policy Areas. *Front Psychiatry*;9:536
15. Prabhavalkar KS, Poovanpallil NB, Bhatt LK. Management of bipolar depression with lamotrigine: an antiepileptic mood stabilizer. *Frontiers in Pharmacology*2015-October-23;6. Available from: <https://www.frontiersin.org/articles/10.3389/fphar.2015.00242>.
16. ADHD Guideline Development Group. Australian evidence-based clinical practice guideline for Attention Deficit Hyperactivity. Melbourne: Australian ADHD Professionals Association; 2022.

Royal Australian and New Zealand College of Psychiatrists Submission

2023-24 Australian Federal Pre-budget Submission

17. Ostuzzi G, Gastaldon C, Barbato A, D'Avanzo B, Tettamanti M, Monti I, et al. Tolerability and efficacy of vortioxetine versus SSRIs in elderly with major depression. Study protocol of the VESPA study: a pragmatic, multicentre, open-label, parallel-group, superiority, randomized trial. *Trials*2020/08/03;21(1):695. Available from: <https://doi.org/10.1186/s13063-020-04460-6>.
18. Álvarez-Fernández B, Bernal-López MR, Gómez-Huelgas R. Role of aripiprazole in the management of behavioural and psychological symptoms of dementia: a narrative review. *Psychogeriatrics*;22(1):137-44. Available from: <https://onlinelibrary.wiley.com/doi/abs/10.1111/psyg.12787>.
19. Singh MK, Pikalov A, Siu C, Tocco M, Loebel A. Lurasidone in Children and Adolescents with Bipolar Depression Presenting with Mixed (Subsyndromal Hypomanic) Features: Post Hoc Analysis of a Randomized Placebo-Controlled Trial. *Journal of child and adolescent psychopharmacology*;30(10):59-598
20. Consultation response: The Victorian Mental Health and Wellbeing Act 2022. RANZCP; 2021 Available from: <https://www.ranzcp.org/files/resources/submissions/the-victorian-mental-health-and-wellbeing-act-2022.aspx>.
21. Rosen T RA, McGorry P D. 'The human rights of people with severe and persistent mental illness: can conflicts between dominant and non-dominant paradigms be reconciled?' in *Mental Health and Human Rights: Vision, praxis, and Courage*2012.
22. Dementia in Australia. Australian Institute of Health and Welfare; 2020 Available from: <https://www.aihw.gov.au/reports/australias-health/dementia>.
23. Atkinson JA, Skinner, A., Lawson, K., Song, Y. and Hickie, I. Road to recovery: Restoring Australia's mental health.
24. Targeted Review: Chief Psychiatrist's Review into the Treatment of Ms Kate Savage by Child and Adolescent Mental Health Services. Chief Psychiatrist of Western Australia; December 2020 Available from: <https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2021/01/CP-Targeted-Review-Report-KS-Review-081220.pdf>.
25. The National Children's Mental Health and Wellbeing Strategy. Australian Government; 2021 Available from: <https://www.mentalhealthcommission.gov.au/getmedia/e369a330-f8c3-4b9e-ab76-7a428f9ff0e3/national-childrens-mental-health-and-wellbeing-strategy-report-25oct2021>.
26. Rethink Addiction, KPMG. Understanding the Cost of Addiction in Australia. Richmond, Victoria; 2022 Available from: <https://www.rethinkaddiction.org.au/understanding-the-cost-of-addiction-in-australia>.
27. Department of Health. National Drug Strategy 2017-2026. Commonwealth of Australia as represented by the Department of Health; 2017 Available from: <https://www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026.pdf>.
28. Henriksen SM, Dominique. Regulation: The Panacea for Private Rehabilitation Centres. *Flinders Law Journal*;20(2). Available from: <http://classic.austlii.edu.au/au/journals/FlinLawJl/2019/3.html>.
29. Legislative Council Legal and Social Issues Committee. Inquiry into homelessness in Victoria: Final Report. Parliament of Victoria: Legislative Council Legal and Social Issues Committee; 2021 Available from: https://www.parliament.vic.gov.au/images/stories/committees/SCLSI/Inquiry_into_Homelessness_in_Victoria/Report/LCLSIC_59-06_Homelessness_in_Vic_Final_report.pdf.
30. Sotiri M, Russell S. Locked Out: The implementation of the NDIS for people in prison in NSW: 2016-2019. Community Restorative Centre; 2020 Available from: https://www.crcnsw.org.au/wp-content/uploads/2020/09/2020_CRC_NDIS_Report_Royal_Commission_March_2020.pdf.
31. Skatssoon J. Special NDIS support for prisoners, homeless. *Australian Ageing Agenda*. 2018.
32. Royal Australian and New Zealand College of Psychiatrists. Position Statement 46: The provision of mental health services for asylum seekers and refugees. Royal Australian and New Zealand College of Psychiatrists; 2017 Available from: <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/mental-health-services-for-asylum-seekers-refugees>.
33. Victorian Department of Health and Human Services. Refugee and asylum seeker health services: Guidelines for the community health program. State of Victoria Department of Health and Human Services; 2015 Available from: <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/r/refugee-health-services.pdf>.

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34. Royal Australian and New Zealand College of Psychiatrists. Minding the Gaps: Cost barriers to accessing health care for people with mental illness. Royal Australian and New Zealand College of Psychiatrists; 2015 Available from: <https://www.ranzcp.org/files/resources/reports/minding-the-gaps-cost-barriers-to-accessing-health.aspx>.
35. Royal Australian and New Zealand College of Psychiatrists. Position Statement 102: Family violence and mental health. Royal Australian and New Zealand College of Psychiatrists; 2021 Available from: <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/family-violence-and-mental-health>.
36. National Commissioner for Defence and Veteran Suicide Prevention. Preliminary Interim Report Interim National Commissioner for Defence and Veteran Suicide Prevention. Australian Department of Attorney-General; 2021 416. Available from: <https://webarchive.nla.gov.au/awa/20220816132250/https://www.nationalcommissionerdvsp.gov.au/publications/interim-national-commissioner-defence-and-veteran-suicide-preventions-report>.
37. Office of the Royal Commission into Defence and Veteran Suicide. Royal Commission into Defence and Veteran Suicide Interim Report. 2022 Available from: <https://defenceveteransuicide.royalcommission.gov.au/system/files/2022-09/interim-report.PDF>.
38. WORKERS COMPENSATION (MEDICAL PRACTITIONER FEES) ORDER 2022 under the Workers Compensation Act 1987, (2022).
39. GBD Compare [Internet]. Institute for Health Metrics and Evaluation. 2020 [cited 30 August 2021]. Available from: <https://vizhub.healthdata.org/gbd-compare/>.
40. Charlson FJ, Diminic S, Whiteford HA. The Rising Tide of Mental Disorders in the Pacific Region: Forecasts of Disease Burden and Service Requirements from 2010 to 2050. *Asia & the Pacific Policy Studies*;2(2):280-92.Available from: <https://onlinelibrary.wiley.com/doi/abs/10.1002/app5.93>.
41. Deloitte Access Economics. The social and economic costs of ADHD in Australia: Report prepared for the Australian ADHD Professionals Association. Deloitte Access Economics; 2019 Available from: <https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-economics-social-costs-adhd-australia-270819.pdf>.
42. Royal Australian College of General Practitioners. Position Statement: Mental health care in general practice. Royal Australian College of General Practitioners; 2016.
43. Royal Australasian College of Physicians. The role of paediatricians in the provision of mental health services to children and young people. Royal Australasian College of Physicians.; 2016.
44. BestSTART. Mind Link Project: Connecting Experts to Improve Service Delivery.Available from: <https://beststartsws.blogspot.com/p/mindlink-project.html>.