7 February 2020

Dr Stephen King
Presiding Commissioner
Productivity Commission
Level 12, 530 Collins Street
Melbourne VIC 3000

By online submission

Dear Commissioner

Re: RANZCP response to Productivity Commission Inquiry into Mental Health Draft Report

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to contribute to the Productivity Commission's inquiry into the role of mental health in supporting economic participation, enhancing productivity and economic growth. The aim of this submission is to provide a psychiatric perspective on matters raised by our members in response to the recently released draft report.

In Australia, the College has around 5900 members, including more than 4300 fully qualified psychiatrists and over 1400 associate (trainee) members. As mental health specialists, psychiatrists are well-positioned to provide constructive input into improving the delivery of mental health services. This includes identifying gaps, proposing solutions to improve service delivery for individuals and working to build a more effective and efficient mental healthcare system. The comments contained in this submission are based on extensive consultation with RANZCP members from a range of geographical locations, psychiatric subspecialties and expert committees.

The RANZCP sees this inquiry as a once-in-a-generation opportunity to critically evaluate and influence definitive reform of the mental health sector. The RANZCP is committed to reform of the mental health system and has presented evidence to the Commission at several hearings in late 2019 and early 2020. The RANZCP is encouraged by the Commission's draft report, which comprehensively identifies the weaknesses and challenges within the current system and provides recommendations to redress some of these issues. The RANZCP sees further opportunity ahead of the final report to consider areas which were not addressed within the draft report and has highlighted these within this response.

Whilst considering the wide-ranging scope of the draft report, the RANZCP submission focuses on the following:

- integrating alcohol and other drug and mental health services and funding
- addressing the physical health of people with a mental illness
- ensuring the needs of older adults are considered when developing services

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- addressing the disparity in workforce, services, and funding between metropolitan and regional, rural and remote areas
- embedding clinical leadership, as well as consumer and carer leadership, within future governance structures
- addressing current and future psychiatry workforce shortages
- addressing governance and funding.

The RANZCP response identifies areas we believe the Commission should more thoroughly address ahead of the final report. This includes proposing solutions to improve service delivery for individuals and build a more effective and efficient healthcare system. The RANZCP's response also provides comments on information requests and recommendations where we have additional feedback from a psychiatric perspective.

On behalf of the RANZCP, I would like to invite Commissioners to meet with RANZCP representatives to discuss how we can work together to develop more detailed recommendations.

We look forward to engaging with the Commission as the Inquiry progresses and would welcome the opportunity to meet to discuss our submission in more detail.

For any queries please contact Rosie Forster, Executive Manager, Practice, Policy and Partnerships at rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours sincerely

Associate Professor John Allan
President

Ref: 1683

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

RANZCP Response to the Productivity Commission
Draft Report Mental Health

February 2020

Improve the mental health of communities

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Royal Australian and New Zealand College of Psychiatrists submission

Productivity Commission Inquiry into Mental Health Draft Report

Contents

Royal Australian and New Zealand College of Psychiatrists submission

Productivity Commission Inquiry into Mental Health Draft Report

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 around 5900 Australian members including around 4400 qualified psychiatrists and more than 1400 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental healthcare in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

Summary

The RANZCP sees the Productivity Commission ("the Commission") as a once-in-a-generation opportunity to critically evaluate and influence reform of the mental health sector. The RANZCP is encouraged by the Commission's Draft Report which is comprehensive in identifying the weaknesses and challenges within the current system and providing recommendations to redress some of these issues. The RANZCP sees further opportunity prior to release of the final report to consider areas which were not addressed within the Draft Report and has highlighted these areas within this response.

The RANZCP supports the Commission's preferred **Rebuild** option. Previous National Mental Health Plans, Mental Health Commissions, recommendations from various State parliamentary and other enquiries, have not delivered the necessary reform mental health services require.

The RANZCP also notes that, although funding and governance issues are dealt with in the latter part of the draft report, the success of every recommendation in every other chapter depends on reform of governance and funding. It is critical to get this right, and, to that end, the RANZCP would welcome piloting of different models to inform the best solutions for mental health reform.

Whilst considering the wide-ranging scope of the Draft Report, the RANZCP submission focuses on the following:

- integrating alcohol and other drug and mental health services and funding
- addressing the physical health of people with a mental illness
- ensuring the needs of older adults are considered when developing services
- addressing the disparity in workforce, services and funding between metropolitan and regional, rural and remote areas
- embedding clinical leadership, as well as consumer and carer leadership, within future governance structures
- addressing current and future psychiatry workforce shortages
- addressing governance and funding.

1. Introduction

The RANZCP welcomes the opportunity to contribute to the Commission's inquiry into the role of mental health in supporting economic participation, enhancing productivity and economic growth. The aim of this submission is to provide a psychiatric perspective on matters raised by our members in response to the Commission's Draft Report.

As mental health specialists, psychiatrists are well-positioned to provide constructive input into improving the delivery of mental health services. This includes identifying gaps, proposing solutions to improve service delivery for individuals, and working to build a more effective and efficient mental healthcare system. The feedback provided in this submission is based on extensive consultation with RANZCP members from a range of geographical locations, psychiatric subspecialties and expert committees.

The Productivity Commission's Draft Report is comprehensive and identifies key areas of reform for Australia's mental health sector, with the focus on addressing workforce shortages welcomed. The RANZCP commends the Commission for its identification of major weaknesses, inconsistencies and fragmentations that characterise service delivery. For too long the number of psychiatrists available in the community has not kept up with increasing need due to clinical trends, and demographic change. Of particular concern are the shortages in regional, rural and remote areas. The RANZCP commends the focus on providing access to specialist, early intensive, and multi-disciplinary care for those currently unable to access appropriate care, such as the 'missing middle' who are too unwell for primary care but not severely unwell enough to meet the high threshold for acute care.

The RANZCP recognises the Commission has a significant task in developing a set of real-world recommendations which will address the fundamental weaknesses in current structures and funding arrangements and recommend novel and bold solutions. The Commission faces a long-standing challenge in balancing cost-effectiveness with consumer outcomes, and the RANZCP expects the final report will be guided by the basic principles of equity, accessibility, and effectiveness. The implementation of these recommendations will require adequate funding arrangements and commensurate government commitment, which we hope to see over the coming years in order to redress current weaknesses and improve the mental health of Australians.

In the section 2 of this response, the RANZCP has identified areas which we believe the Commission should more thoroughly address ahead of the final report. This includes proposing solutions to improve service delivery for individuals and build a more effective and efficient healthcare system. In section 3, the RANZCP has provided comments on information requests and recommendations where we have additional comments to make from a psychiatric perspective.

2. Addressing Current Gaps and Priority Areas in the Final Report

The RANZCP is encouraged by the Commission's identification of current weaknesses in Australia's mental health system, and by recommendations for change. We hope these recommendations will result in true reform of the mental healthcare system to the benefit of consumers, their families and carers, and those working within the system.

The RANZCP has identified several areas within the mental healthcare system which we consider require further exploration by the Commission, ahead of the final report.

2.1. Alcohol and Other Drugs

Substance use disorders are a core concern for psychiatrists considering the complex interrelationship between addictive behaviours and other mental disorders. The overall consensus of research evidence and clinical expertise is that psychiatric or addiction-focused treatments on their own are not sufficient to manage comorbid mental health and addiction (1). This disconnect is regularly identified as an impediment to effective referral and holistic treatment.

The RANZCP is encouraged to see the Productivity Commission recognise the multifarious issues faced by individuals requiring care for comorbid substance misuse and mental health issues, including a lack of integration between mental health, physical health and alcohol and other drug (AOD) services, and unclear, often disjointed, treatment pathways. The RANZCP also acknowledges the marked under-investment in, and neglect of, specific drug treatment services, particularly in light of the ice epidemic (2). The consequences of this, on individuals, families, the broader community, on mental health and Department of Health have been extraordinary.

We agree with the Commission's comment that these wider systemic problems, including fragmentation of care, are leading to poor consumer outcomes. The RANZCP is supportive of a more integrated funding and governance model, which spans health and non-health sectors, and facilitates holistic and person-centred care. However, this funding and governance model will need to consider how mental health, physical health and AOD services, funding and workforce can be better integrated in order to create the holistic system so desired.

The RANZCP is supportive of measures which improve coordination of services for those receiving care from multiple providers. However, as noted in commentary under draft recommendation 10.3, the RANZCP has some reservations regarding the achievability of Single Care Plans. There will be technical requirements to overcome in order to support Single Care Plans. My Health Record is one way in which to achieve this, but it relies on the opt-in of clients, available health service infrastructure, patient-provider continuity of care, and the quality of information provided by treating clinicians. Practitioners will also need the capacity to strengthen health plans, so they are sufficiently clear for other treating practitioners. Where individuals change geographic location, the impact of differing State and Territory systems and legislation will need to be accounted for.

In addition, there is a chronic shortage of public beds for people with substance use disorders, meaning many individuals seek treatment in the private sector. Several issues have emerged in some private AOD residential facilities including inadequately trained staff, exorbitant fees and too little clinical input from medical specialists. The RANZCP recommends a national quality framework for AOD services be developed to ensure both public and private services are providing treatments which meet a minimum standard. In addition, the RANZCP also recommends private rehabilitation services be required to undergo a formal accreditation process.

Whilst we are encouraged by the Commission's recognition of issues relating to comorbid substance use and mental ill health, it is concerning to see that this has not translated as yet into recommendations for how services can be improved for this group of people including investment in evidence-based programs

such as residential treatment programs; diversion programs and Justice Health services to deal with comorbid disorders.

2.2. Physical Health

The RANZCP welcomes the acknowledgement within the Draft Report of the higher rate of physical illness among people with mental health conditions and the serious consequences of this. As noted in the Draft Report, physical health disparities result in substantially reduced life expectancy of people living with mental illness as well as increased personal, social and economic burden of mental illness (3). The RANZCP has long advocated for the physical health needs of people living with mental illness, noting the significantly lower life expectancy for people with mental illness in contrast to their mentally well counterparts. We believe that much more needs to be done, and can be done, to address the gap in physical health and life expectancy between those who live with a mental illness and those who do not.

The RANZCP agrees with the commonly recommended initiatives in Chapter 9 of the Draft Report for addressing physical comorbidities, which include: ensuring that health professionals take responsibility for the physical health of their patients with mental illness; improving coordination and integration of mental and physical health care across all services, providers, professions and settings ; building individuals' capacity to have control over their physical health; addressing stigma and discrimination among healthcare providers; and addressing the difficulties people face in finding and accessing support. However, we are concerned that there is no translation of these into draft recommendations.

In order to achieve parity in physical health outcomes between people with mental illness and people who are mentally well, the RANZCP calls for recommendations that support the above commonly recommended initiatives. In addition, people with serious mental illness must be designated as a health priority group to redirect broader health policy towards better health outcomes. Further research into ways of improving the physical health of people with serious mental illness is also needed (4). Physical healthcare services must also be expanded and enhanced to help close the gap in life-expectancy for people living with mental illness.

The RANZCP urges the Commission to recommend:

- people with serious mental illnesses be designated as a health priority population group by policy makers
- health promotion mechanisms (for example to quit smoking, undertake exercise, mitigate alcohol misuse) be adapted for delivery in all specialist mental health settings and become core elements in the service 'offer' in both inpatient and community settings
- screening and lifestyle interventions, based on the best available evidence, be routinely offered to both people newly diagnosed with a serious mental illness and those with more long-standing illnesses in order to prevent unnecessary chronic conditions from developing (4).

2.3. Older Adults

The RANZCP notes the lack of consideration for the mental health needs of older people within the Commission's Draft Report. Whilst we acknowledge a large part of the report relates to improving the efficiency and cost-effectiveness of the mental health system, the focus on a more productive workforce and associated expansion in national income and living standards tends to exclude older people. Older people are often viewed through this lens as a 'burden to the economy' rather than active contributors. This view of older Australians as 'non-productive' further adds to the stigmatisation of old age. Older people, who will continue to make up a great proportion of Australia's population, cannot simply be ignored in this equation.

The changing demographic of the Australian population requires that policymakers think innovatively about planning and resourcing service delivery. As we are all aware, the 65 years and over population in

Australia is expected to more than double between now and 2057, growing from 3.8 million in 2017 to approximately 8.8 million. By this stage, older people will comprise around 22% of the population, an increase from 15% in 2017 (5). It is expected the number of older Australians with mental illness will grow accordingly, and improvements to mental health services for older people are required to ensure the system is oriented to meet the needs of older people (6). If there are not appropriate services to care for older people, the burden of care falls to the community, including families and carers, which results in a net loss in productivity for the wider population.

Additional age-appropriate services with the capacity to manage both the physical and mental health needs of older people will be needed to accommodate an increase in the older population. This will create additional strain on old age psychiatrists.

In addition, as raised in the RANZCP submission to the Royal Commission into Aged Care Quality and Safety, it is essential services are developed to provide expert mental health interventions to certain groups who may be at increased risk of developing mental health problems as they age (6-8). This includes Aboriginal and Torres Strait Islander peoples; people who live in rural and remote areas; people with substance use disorders; people from low socioeconomic backgrounds; people from different ethnic backgrounds; those who are homeless; and those who are accessing the justice health system. Additionally, services must be able to provide high-quality care for physical comorbidities that exist for people with mental health issues, and the Commission should consider this need in conjunction with the issues raised in Chapter 9.

Dementia also appears to be excluded from consideration in the discussion of mental illness. Whilst the biological substrate of dementia is undeniable, the exclusion of dementia neglects the reality that psychiatrists are frequently involved in the management of psychiatric and psychological complications of dementia. The exclusion of dementia also reflects the lack of clarity across tiers of government about roles, responsibilities and funding that the report references as a driver for poor outcomes for consumers. There is a need to begin development on an updated National Framework for Action on Dementia and develop clear guidelines around behavioural and psychological symptoms of dementia referrals in mental health services for older people.

Good mental health is essential to healthy ageing, and older people require the same full spectrum of mental health interventions as other people, from prevention to early intervention and clinical care. Mental healthcare for older people should not be subsumed into a broader ‘adult mental health’ or ageless services, reflecting the distinct needs of older people who require care from appropriately trained clinicians with specialised skills (9). There is an ongoing need to properly commission residential aged care and older adult community mental health services. These services should be integrated with social care services and must make use of opportunities to address both physical and mental health concerns.

The RANZCP would like to emphasise the role of psychiatrists in successful treatment of older people. The role of the psychiatrist includes caring for patients; managing complex and severe psychiatric conditions; providing clinical leadership; teaching and training; researching mental illness; and advocating for health by challenging stigma and discrimination. The Commission should consider the workforce requirements of providing services to an ageing population and make recommendations for increasing the number of psychiatrists and other experts to ensure this group of people receive adequate care.

2.4. Regional, Rural and Remote Communities

The RANZCP recognises that Australians living in rural and remote areas generally experience poorer health and welfare outcomes than people living in metropolitan areas (10). They have unique factors that impact on their health including reduced access to health services, greater distances to travel for health services, engaging in high-risk occupations such as farming, exposure to hazardous working conditions and environmental adversity such as flood, bushfire and drought (11).

Nearly one million Australians living in rural and remote areas will experience a mental health disorder each year (12). While the prevalence of mental disorders is similar across all geographic locations, some adverse outcomes for mental health, for example, rates of suicide and self-harm, are significantly higher in rural and remote areas, and increase with increasing remoteness (13). Farmers, young men, older people, and Aboriginal and Torres Strait Islander peoples in remote areas are at greatest risk of suicide (13). Access to appropriate mental health services remains one of the largest problems facing rural and remote communities. Yet data relating to the psychiatry workforce, as at 2016, shows that major cities in Australia have approximately 15.1 full-time equivalent (FTE) employed psychiatrists per 100,000 population, while that figure is 5.8 for inner regional areas, 3.4 in outer regional areas, 5.0 in remote areas and only 1.4 in very remote areas (14). Generally, the more remote the location, the worse access is to psychiatric services (15).

Psychiatrists working with rural communities are required to have broad knowledge and specialist skills across a range of areas of expertise, working with people across all age ranges and treating a wider array of issues. This occurs where there are fewer clinical supports and leads to increased responsibilities and requirements for a diverse range of expertise. Challenges of rural practice include professional isolation, social and family factors (including difficulties with spouses obtaining employment), limited career and research opportunities, large size of patient base, burden of travel to outreach services, lack of specialist positions at regional hospitals, and remuneration.

Current strategies, including few dedicated rural training pathways, a reliance on Specialist International Medical Graduates and a tendency for metropolitan based outreach programs such as telehealth, as well as a reliance on a fly-in fly-out workforce, have not served rural and remote communities well. A lack of opportunities, familiarity with local circumstances and resources, continuity of care and coordination of care at a local level are perpetuated by these program models in rural and remote communities. Multiple inquiries have identified these problems in mental health service delivery over many decades.

The RANZCP is calling on the Commission to work with us to identify innovative and sustainable ways of developing a locally integrated mental health workforce, and sustainable models of care for rural and remote communities. This should include equitable and dedicated funding to develop and retain a rural and remote mental health workforce akin to the generalist rural pathway established to enhance access to primary care physicians in communities.

2.5. Role of the Psychiatrist in Leading the Mental Health System

The RANZCP believes the Commission should consider further the need for clinical input from psychiatrists when developing recommendations and strategies, as well as when considering how to redesign the architecture of the mental health system in Australia. Psychiatrists play an important role in building the capacity of other health professionals and providing advice so that patients receive continuity of care and evidence-based treatments.

Exceptional medical leadership is required for health services to provide safe, effective, and efficient care. Exceptional medical leadership is required most when resources are limited. Having consumer, carer, and clinical leaders embedded within health systems is important. Psychiatrists are best-placed to undertake leadership roles (16). Psychiatrists have a breadth of understanding and appreciation of risk in complex clinical scenarios. Reflective skills allow them to understand and analyse complex, interacting systems. This helps consumers, their support networks and the mental health multi-disciplinary team become better integrated, leading to improved consumer outcomes and increased workforce satisfaction. Historically, the most effective services are those that include psychiatric leadership, either in clinical director roles working in close partnership with service managers, or those where the roles are combined. The RANZCP urges the Commission to consider the role of psychiatrists within the stepped care model, as presently there is little mention of their role within the system.

3. Response to Draft Report

3.1. Chapter 3 – What mental ill-health and suicide are costing Australia

The RANZCP notes the Commission has not considered in detail the economic costs of trauma when considering the cost of mental ill-health and suicide. In general, consumers accessing mental health services have higher rates of experiencing trauma in life, particular in the year prior to contact with services (17). As referenced in the Victorian Faculty of Psychotherapy's submission to the Royal Commission into Victoria's Mental Health System, trauma is costly in both human and economic terms. Economic costs can include lost employment, presenteeism (being at work but not functioning well), and reduced productivity, as well as the provision of mental health and other services (18, 19).

Trauma-informed practice is an important practice which emphasises care delivery based on the principle that trauma is a possibility in the lives of all people. The mental health system should maximise the potential for recovery and minimise the risk of retraumatisation. The RANZCP urges the Commission to consider the cost of trauma both within the mental health system, and the wider population, and recommend a service delivery approach which is trauma informed.

3.1.1. Information Request 3.2 – Out-of-pocket costs for mental healthcare

The RANZCP commented on out-of-pocket costs in its initial submission to the Productivity Commission Inquiry, which is repeated below for the convenience of Commissioners.

Due to the complex funding arrangements, and the mix of public and private services within the Australian healthcare system, people with mental illnesses can incur a number of direct and indirect costs of care. These out-of-pocket costs can be a significant barrier to accessing services, particularly for certain vulnerable groups within the population. The Commission must consider both novel and traditional means of making cost a less significant barrier for individuals looking to access mental healthcare.

Revision of the Medicare Benefits Schedule (MBS) is one key area which should be considered by the Commission. This may involve a broad overhaul of the scheme or relatively minor changes to improve the current system. For example, one measure which may be beneficial is increasing Medicare rebates for psychiatry services to 100% of the schedule fee. At 1.64% of total expenditure, psychiatry services make up a very small proportion of MBS services, particularly when compared to the mental health needs of the population (20). Re-costing MBS psychiatry item numbers would have a relatively minor impact on total MBS expenditure while providing significant benefits for the prevention, early intervention and treatment of mental disorder by better accommodating the needs of Australians who are unable to access care in the public sector. However, minor reforms to the existing system are not necessarily going to deliver on improved mental health for all.

Currently, certain mechanisms do exist to improve affordability in mental health. These include the various existing safety nets, including the Pharmaceutical Benefits Scheme (PBS) Safety Net and the Medicare Safety Net. This system of safety nets is difficult to understand and is inconsistently applied, which makes it harder for individuals to know what they are eligible for. In order to better manage the various safety nets available, it may be pertinent to consider the potential implementation of a single safety net for all healthcare costs, including Medicare, PBS and allied health. This topic is explored further in the RANZCP report *Affordability as a Barrier to Mental Healthcare* (21).

The RANZCP recommends that the Productivity Commission consider the following:

- examining re-costing of MBS psychiatry item numbers to reduce out-of-pocket costs
- evaluating the potential implementation of a single safety net for all healthcare costs, including Medicare, PBS and allied health.

3.2. Chapter 5 – Primary mental healthcare

3.2.1. Information Request 5.1 – Low-intensity therapy coaches as an alternative to psychological therapists

The Commission has noted in the Draft Report the benefits of increasing the role of low-intensity cognitive behavioural therapy (LiCBT) are less clear cut (22). However, the Commission has still suggested there is potential for a greater share of therapy to be provided by low-intensity therapy coaches, as this may be more cost-effective. The RANZCP urges the Commission to carefully consider and evaluate provision of any non-evidence-based therapy from a cost-benefit perspective, not only a cost-effective perspective.

3.2.2. Draft Recommendation 5.1 – Psychiatric Advice to GPs

Psychiatrists play an important role in building the capacity of other health professionals and providing advice so that patients receive continuity of care and evidence-based treatments. This is particularly the case in rural and remote areas where there are fewer psychiatrists available. The RANZCP agrees more support from specialists would help General Practitioners (GP) provide best-practice care. However, any new service would have to be affordable and have greater usage, whilst avoiding excessive demands on the relatively small psychiatrist workforce. In our response to the MBS Review Taskforce, the RANZCP supported the introduction of new MBS item for a psychiatrist to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by a GP, as a way of promoting better care coordination (23). The RANZCP supports that item numbers should be available for both the psychiatrist and the GP.

3.2.3. Draft Recommendation 5.4 – MBS-related psychological therapy

The RANZCP supports the recommendation for trials that allow up to 20 sessions of individual or group therapy in total over a year for consumers whose clinical condition requires more than the current 10 sessions. The RANZCP also agrees with the proposal to change the maximum number of MBS-related psychological therapy sessions to per 12-month period, as opposed to per calendar year.

It is essential the psychological sessions which can be provided under current MBS funding are evaluated, and that any expansion is carefully considered in conjunction with current best practice and available evidence for the effectiveness of MBS-rebated psychological therapy. The RANZCP Clinical Practice Guidelines for the treatment of panic disorder, social anxiety disorder and generalised anxiety disorder provide recommendations for treatment based on a review of the evidence base (24). Services provided should reflect the clinical assessment of the specific needs of the person with mental illness, to ensure that people can access the right treatment at the right time from the right professional, and for the right length needed for recovery. Accordingly, the MBS should be non-discriminatory and provide access to services irrespective of diagnosis.

The RANZCP is aware that this matter is currently being considered by the MBS Review Taskforce Mental Health Reference Group.

3.2.4. Draft Recommendation 5.5 – Encourage more group psychological therapy

The RANZCP supports the MBS be amended to allow for group therapy sessions to run for ‘at least 90 minutes’ and ‘at least 120 minutes’. The current time period of an hour is not sufficient, particularly with regard to family therapy.

Whilst this recommendation primarily refers to focused psychological therapies, directed at psychologists, the RANZCP recommends that it should also apply for psychiatrists who also undertake group therapy. The RANZCP also made this recommendation in its response to the MBS Review Taskforce (23).

3.2.5. Draft Recommendation 5.7 – Psychological consultations by videoconference

The RANZCP supports telehealth as an effective method of service delivery, and believes that allowing videoconferencing to be used for psychological consultations for consumers residing in metropolitan areas, regional centres and large rural towns (Monash Modified Model areas 1–3) in addition to those residing in small and medium rural towns, remote and very remote communities (areas 4-7) could bring benefit.

There is, however, a need to ensure that increasing access to telehealth in non-rural areas does not lead to a reduction of services to those already accessing telehealth in rural areas, by drawing services away from these areas.

The RANZCP further supports that the MBS also be amended to allow access to telehealth services for psychiatry by those who require it in major cities and welcomes consideration of this issue by the MBS Review Taskforce and the Productivity Commission (see comments under draft recommendation 7.2).

3.2.6. Draft Recommendation 5.9 – Ensure access to the right level of care

The RANZCP is broadly supportive of this principle and urges the Commission to consult with expert stakeholders, including the RANZCP and carer and consumers, to ensure appropriate services are available at each level of care. For example, inpatient beds are a small aspect of the overall child and adolescent mental health system, albeit representing a group of young people with severe problems. There should be greater emphasis on more comprehensive community-based systems, a tiered system with primary and secondary care levels supported by child and adolescent psychiatrists. In addition, there is a need for well-developed prevention and early intervention in childhood and adolescence.

3.3. Chapter 6 – Supported online treatment

3.3.1. Information Request 6.1 – Supported online treatment for culturally and linguistically diverse people

The RANZCP acknowledges there are many barriers for culturally and linguistically diverse (CALD) people when accessing services, including language barriers. Any expansion of e-mental tools for target populations should also ensure equal access to the infrastructure required for the use of e-mental health tools (e.g., reliable and fast internet connection), especially for those who find it difficult to attend face-to-face appointments.

It is important to note that literature on the effectiveness of online treatment for CALD groups is limited, so it is difficult to comment on this information request in detail. More resources, planning, and services are required for many vulnerable groups, and it is essential that cost-effectiveness is balanced with consumer outcomes. Further research and oversight are needed to ensure e-mental health tools are evaluated and employed based on the best available evidence.

Whilst e-mental health tools and resources have the potential to fill gaps in service provision and reach hard-to-access consumers, quality, supervision and the lack of evidence remain issues to address (25). On this basis, the RANZCP supports e-mental health tools as a complement, rather than a substitute, for face-to-face care, especially in the diagnosis and treatment of severe mental health conditions.

3.3.2. Draft Recommendation 6.1 – Supported online treatment options should be integrated and expanded

Services for people with mental illness need to be evidence-based. Evidence-based or evidence-informed clinical practice aims to provide the most effective quality care that is available, with the goal of improving person-centred outcomes. Patient individual values and circumstances, clinical expertise and experience, availability of services and treatments all need to be taken into consideration, underpinned by the relevant evidence from robust sources (26). The RANZCP strongly supports a

review of supported online treatment as a low-intensity option to ensure that all services delivered are effective and evidence-based.

There is also a need for the Commission to consider gaps in Chapter Six relating to training for mental health staff in e-mental health tools, as well as patient privacy and record keeping. It is essential patient privacy is retained, and this is often a challenge for online treatment and services. This is an issue which remains relatively unaddressed by the Commission in Chapter Six. The protection of patients' information must be properly managed irrespective of the care setting, including virtual settings. This is particularly important for people living with mental illness, who often face social barriers and stigma when seeking help. The RANZCP encourages clarity around mechanisms to ensure the privacy of individuals is a priority of government and those developing e-mental health tools. These issues will need to be monitored carefully by regulators and medical professionals (25).

The RANZCP recommends that the Productivity Commission consider the further measures required to ensure confidentiality and appropriate recordkeeping in the use of supported online treatment.

3.3.3. Draft Recommendation 6.2 – Information campaign to promote supported online treatment

Whilst increasing the knowledge of clinicians regarding online therapy may overcome one key barrier preventing higher uptake of e-mental health tools, it will not necessarily be enough to upskill clinicians to the point where they feel comfortable utilising and recommending e-mental health tools. This has been identified by the RANZCP as a key barrier to e-mental health tools in its Position Statement on the *Benefits of e-mental health treatments and interventions* (25).

The RANZCP recommends that:

- where possible, face-to-face treatment should be utilised as a first preference, however, we recognise that this may not always be feasible
- the Australian Government fund the development of targeted support and resources for psychiatrists to upskill in e-mental health tools, including online therapy
- government funding be dedicated to ensuring that all Australians have equal access to adequate infrastructure for the use of e-mental health tools (e.g. reliable and fast internet connections)
- more research is conducted to distinguish between valuable and ineffective e-mental health resources (25).

3.4. Chapter 7 – Specialist community mental health services

The RANZCP is concerned about the potential misunderstandings which may arise from the way information on psychiatric consultations is presented in the Draft Report. The Draft Report notes that some consumers have 'dozens of consultations' with about 1000 people having had more than 50 consultations. The Draft Report notes this equates to more than '80,000 consultations, or 5% of the total (22)'. The RANZCP notes this seems a small proportion of patients, given that psychiatrists are usually referred patients with complex presentations, and it may be clinically necessary to provide intensive, regular treatment. In addition, providing such intensive treatment ensures that some psychiatrists within the system retain and foster, through ongoing professional development and training, the necessary expertise to treat these complexities.

In addition, by comparing the limited number of MBS-rebated sessions for psychological therapy to the essentially unlimited number of sessions available under the MBS for consultation with a psychiatrist, the Draft Report sets up an implicit message of competition for limited resources. The RANZCP recognises that many psychologists are providing excellent psychological care and require more MBS provisions to facilitate patient access, however, this cannot be placed in opposition to continuity of care and psychological psychiatrist treatment. Consumers should be able to access both psychological treatments from psychologists, psychiatrists, and other trained professionals, according to their needs. Any

movement towards reducing psychiatrists' capacity to offer patients consultations in line with their needs, is not medically or economically sound.

3.4.1. Information Request 7.1 – Freeing up psychiatrists for people who need them most

Private psychiatrists provide care for a significant proportion of Australians suffering severe mental illness in the community. However, there have been few measures to encourage activity by private psychiatrists. At present there may be challenges for private psychiatrists when providing care for potential patients due to inadequate provision of other relevant support services. Only if responsibility for these risks is adequately covered by relevant services or professionals will private psychiatrists be able to provide care for those most needing it. Many RANZCP members have raised that rebates for psychiatry services under the MBS do not meet the costs associated with delivering services. The reversal of the MBS indexation freeze has not addressed these challenges, and many psychiatrists are finding it very difficult to provide affordable services to their patients.

To assist in preventing excess psychiatric hospitalisations, there needs to be an increase in the provision of public sector community-based treatment, which is led and supported by psychiatrists. This will mean consumers who have serious mental health conditions can receive continuous, long-term care. Any measures which incentivise psychiatrists consulting with new patients should not be at the expense of provision of continuous care for pre-existing patients. Mental illnesses are chronic conditions, so when a private psychiatrist takes on a patient, they are often seeing them into the future which limits their ability to take on further new patients. It is more practical for a psychiatrist to see a new patient for one or two sessions in order to give advice back to a GP or other specialist, which is the intended use of MBS Item 291. However, this type of triaging requires further consideration to ensure patients are being directed to the level of care appropriate to their needs. There is also a key role for consultation-liaison psychiatrists in integrating physical and mental healthcare between and within services, as well as providing ongoing care after hospital-based contact.

There is also a need to review the mechanisms by which psychiatrists' expertise can be accessed more effectively for third party patients, such as WorkCover or accident cases. Third party cases may involve complex disputes which use up a psychiatrist's resources, and additional support may be required in order to manage these cases.

RANZCP members have suggested the focus on the supply side risks the unintended consequence described as 'supplier-induced demand', in which increased community mental health services, and increased psychiatric beds, increases demand for psychiatric services and admissions (27, 28).

The primary mechanism by which psychiatrist time can be freed for people most needing expert care requires full investment in the stepped care model, including enhancing leadership capacity and devolvement of significant clinical and social responsibilities to appropriate health professionals and services. An innovative step in this direction is nurse-led management of mental health assessments in emergency departments (29). In its response to the MBS Review Taskforce, the RANZCP has supported a greater role of mental health nurses in providing care in collaboration with psychiatrists, as well as supporting an enhanced role for allied health services. The RANZCP, as suggested above, is also supportive of a consultation-liaison psychiatry-GP model that allows for psychiatrists to provide advice and support to GPs.

At present, there are key gaps in the analysis undertaken by the Commission, including around access to psychiatrists in rural and remote areas. Further consideration on mechanisms to address this maldistribution of psychiatrists is needed. The RANZCP would be supportive of regional service planning to determine the numbers of acute mental health beds in hospitals, specialist mental health community treatment services, and subacute-non-acute mental health bed-based services.

The RANZCP also encourages the Commission to consider an additional recommendation to improve access and affordability of psychiatry services. At present, advanced trainees do not have access to the

same MBS items as consultant psychiatrists. The RANZCP would like to see advanced psychiatry trainees be given access to the same MBS items as consultant psychiatrists, at 65% of the rebate available to consultants. This will improve patient access, and support the provision of accredited training posts in the private sector (23).

3.4.2. Draft Recommendation 7.2 – Psychiatry consultations by videoconference

The RANZCP agrees that a new suite of telehealth items could be implemented to allow for improved monitoring of the use of these items. However, these items would still require MBS loading to cover costs associated with telehealth delivery. This loading should also apply for face-to-face consultations to promote improved service delivery and workforce development in rural areas more generally.

The RANZCP does not support any changes to item 288 without first agreeing clearly defined equivalent alternatives as it risks disrupting services to rural and remote areas. The Bushfire Crisis has brought into critical focus the need for flexible access to urgent psychiatric consultation.

The RANZCP has expressed concerns to the MBS Review Taskforce about the removal of item 288 unless adequate funding replacements are put in place. The suggestion that item 288 may be removed has been a cause of alarm among RANZCP members who provide telehealth services, as well as those who are working or residing in rural areas. Any cut to this currently available funding will severely disrupt services, as many psychiatrists will no longer be able to bulk-bill these services and will therefore stop doing so. The RANZCP considers this to be major threat to the stability of mental health services currently greatly valued by psychiatrists, GPs and rural communities.

The RANZCP agrees with the Productivity Commission draft recommendation 7.2 which recommends that item 291 and 293 take place via telehealth regardless of patient or status location, which could assist in reducing waiting lists in some areas.

In our MBS Review submission, the RANZCP recommends supporting Draft Recommendation 7.2 as below:

'The RANZCP agrees with the Productivity Commission draft recommendation 7.2 which recommends that item 291 and 293 take place via telehealth regardless of patient or status location. The RANZCP strongly supports that… this further Productivity Commission recommendation will improve access for people for whom accessing a psychiatrist face-to-face under item 291 or 293 difficult due to other reasons (e.g. psychiatrist availability, or the need to see a psychiatrist with the same language or culture).

The RANZCP further notes that this initiative could be useful in areas where there are specific workforce shortages for disorders. For example, in South Australia there is a well-documented dearth of psychiatrists who can treat Attention Deficit Hyperactivity Disorder (ADHD) meaning that patients with this disorder are woefully underserviced. It would be beneficial to allow psychiatrists from other states to utilise telehealth to meet this need (23).'

The RANZCP suggests expansion of psychiatry telehealth services for item numbers other than 291 and 293, in line with recommendation 5.7 for psychological services.

3.5. Chapter 8 – Emergency and acute inpatient services

3.5.1. Draft Recommendation 8.1 – Improve emergency mental health service experience

The RANZCP supports the recommendations to improve emergency mental health service experience for people accessing them. The effectiveness of such responses depends, in part, on clinicians having access to patient records.

The RANZCP notes that the increase in mental health presentations to emergency departments in the last 20 years is due to a number of issues, including the lack of direct access to mental health units. As a result of an undersupply of beds, and a lack of investment in community mental health resources,

consumers can no longer present direct to a ward, be appropriately assessed, and admitted if necessary. The emergency department has become the default option for mental health service entry, and few, if any, have been designed for the appropriate assessment and management of those with mental health presentations.

The RANZCP recommends that when planning for significant hospital redevelopments, provision be made for alternative entry points to mental health services (as exist in a range of services across the country).

There is also a need to structurally redesign the physical environment of emergency departments, including creating specific spaces for mental health. The RANZCP is supportive of the proposed recommendation for State and Territory Governments to consider the needs of people with mental illness when designing or building emergency departments. The emergency department is not always the most appropriate place to assess/treat consumers. However, this does not negate the need to make current spaces more appropriate for those attending emergency departments for a mental illness (30). Alternatives to hospital emergency departments are welcomed but will need to be adequately staffed by clinicians with an appropriate level of experience and skill to assess and treat presenting individuals.

The RANZCP further notes a need to address the bed shortages which are resulting in individuals waiting for long periods, often days, in the emergency department. This can be a stressful and chaotic environment. The high occupancy rate for acute mental health beds across Australia means it is often very difficult for clinicians to find a bed for patients presenting in crisis in the emergency department. The RANZCP has previously urged the inquiry to establish, in collaboration with the RANZCP, minimum and optimal benchmarks for specialised mental health beds per 100,000 population. Any measures to reduce bed shortages need to consider jurisdictional variations between the State and Territory mental health systems. It is essential that approaches are developed in coalition with stakeholders at Federal, State and Territory government levels, with consideration of ongoing reforms in certain States and Territories.

3.5.2. Draft Recommendation 8.2 – Child and Adolescent Mental Health Beds

The RANZCP welcomes the Productivity Commission's recommendation that child and adolescent mental health beds should be provided in addition to adult mental health wards. Any new service arrangements and models of care should be designed in a manner which is appropriate for each developmental stage (31). The location of beds needs to be considered in terms of connection with allied health and other services, as well as their proximity to social supports, such as families and carers, as well as school. The variations within States and Territories must be considered when planning provision of child and adolescent mental health beds. Some states, such as South Australia, currently have separate child and adolescent mental health beds. In contrast, in Western Australia the age cut-off of 16 for the state's child and adolescent mental health services causes challenges for young people aged 16-18.

The RANZCP Western Australian branch has also noted that outside of metropolitan areas it is not always possible to provide separate facilities within existing infrastructure (including staffing), and additional resources may be required to implement this recommendation for young people in regional, rural and remote areas. This analysis and recommendation should be included as part of the proposed National Workforce Strategy (Draft Recommendation 11.1).

3.6. Chapter 9 – Physical and substance use comorbidities

The RANZCP has provided a more detailed response regarding alcohol and other drugs earlier in this submission.

3.7. Chapter 10 – Toward integrated: linking consumers and services

3.7.1. Draft Recommendation 10.1 – Consumer Assistance Phone Lines

There is currently a range of phone numbers which consumers can use to access support for mental health issues, suicide and personal crises, and understand services available to them. There have been calls for a single accessible website for someone to go to in order to understand what is available to them in their local area (32). In addition, the Royal Commission into Victoria's Mental Health System (RCVMHS) has identified a high demand for existing helplines, such as Lifeline, Kids Helpline and Beyond Blue and, whilst data is limited, available information suggests many calls to helplines go unanswered. The RCVMHS notes there are obvious inefficiencies in having so many different helplines with overlapping functions (32). The RANZCP is supportive of a comprehensive and integrated Mental Health Access Line in New South Wales – a single number linking consumer, carers, and clinicians to the public sector mental health services in their region, performing triage advice, clinical support and referral functions, with Key Performance Indicators including guaranteed answering within 30 seconds. Such services should be provided nationally.

The RANZCP would also point out that helplines for individuals in crisis need to be available around the clock and provide a timely response in order to be effective. The RANZCP suggests the Head to Health portal be enhanced to act as a first point of contact and resource which can effectively direct consumers to relevant service providers.

3.7.2. Draft Recommendation 10.2 – Online Platforms to support better referral pathways

The availability of identified and agreed pathways of referral is an important measure.

A consistent and readily available online platform will improve diagnostic processes and appropriate referrals. Importantly, any systems are only useful if protocols are in place to ensure information is up to date and relevant to the context of practice.

The referral pathways assessment system should be supported by appropriate training commensurate with the level of clinical judgement exercised by the practitioner.

3.7.3. Draft Recommendation 10.3 – Single Care Plans for some consumers

The RANZCP has some reservations regarding the achievability of single care plans. There will be technical requirements to overcome in order to support Single Care Plans. My Health Record is one way in which to achieve this, but it relies on the opt-in of clients and the quality of information added in by treating clinicians. In particular, the availability and reliability of care plans to all providers in order to facilitate care during an emergency will need to be considered. Practitioners will also require additional time to update health plans, so they are sufficiently clear for other treating practitioners.

Where individuals change geographic location, the impact of differing State and Territory systems and legislation will need to be accounted for.

3.7.4. Draft Recommendation 10.4 – Care Coordination Services

Care coordinators play an important role in assisting those with severe mental illness to navigate services. However, this measure should not be used in isolation and there should be attention to ensuring that carers of people with severe mental illness are provided with enhanced information. Care coordinators need to be connected with clinicians through referral pathways and/or Primary Health Networks (PHNs) to ensure goals of treatment and progress are commonly understood.

The RANZCP recommends that improving the availability of care coordinators be considered an equal priority with improving supports for existing carers.

3.8. Chapter 11 – Mental health workforce

3.8.1. Information Request 11.1 – Aboriginal and Torres Strait Islander Health Workers

The RANZCP is strongly supportive of Aboriginal and Torres Strait Islander mental health workers, who provide insights into communities and customs, actively engaging with Elders and community members

to enhance service delivery. The RANZCP Aboriginal and Torres Strait Islander Mental Health Committee has indicated that there are several obstacles to the recruitment of Aboriginal and Torres Strait Islander mental health workers and to their retention once fully qualified and practicing, including:

- inadequate literacy and study skills at recruitment
- loss of mentorship program for students and graduates throughout their career in mental health services and a lack of experienced/trained mentors (including Aboriginal heritage mentors)
- pressures of work, university study requirements, family issues and sometimes mentees own health issues
- lack of financial support to complete university course, including income and family supports that are reflective of cultural challenges
- insufficient university Aboriginal mental health worker courses and course places nationally
- a need to implement the proposal for an Australian National (Virtual) Institute of Mental Health (ANIMH) nationally standardised mental health workforce training, supervision, mentorship and standardised qualifications initiative, including for peer workers and Aboriginal Mental Health Workers
- assessments being too pathologising, with too much emphasis on clinical questioning and risk rating scales rather than active listening to accounts of severe personal, family and communal trauma rekindled by transgenerational loss and trauma.

The Djirruwang Program at Charles Sturt University (CSU) has been recognised as an excellent University Degree Program to build a qualified Aboriginal Mental Health Workforce. The NSW Ministry of Health provides funding to Local Health Districts to employ entry level workers who attend CSU in blocks and then undertake clinical practice in their workplace. The positions are not traineeships or cadetships, they are full-time positions. The RANZCP is aware of graduates who are now nurses (not mental health specific), social workers, and quite a few are senior managers in Aboriginal health.

In NSW, Aboriginal cadetships are offered for nursing, where HECS (Higher Education Contribution Scheme) is covered, and students are paid a $300 weekly allowance during semesters and employed during the long vacation period. One issue deterring people from applying for cadetships is that people have to leave fulltime employment and a fulltime wage which can be difficult if you have a family. In NSW, the Aboriginal Health College is in the process of re-establishing courses for Aboriginal people employed in Aboriginal Medical Services. The courses are Certificate Three to Diploma levels. Unfortunately, these courses are not self-directed and do not necessarily prepare people for University entry.

Several mentorship programs have been successful, including the Aboriginal Mental Health Worker Mentorship Program in NSW which was successfully run for 10 years by Western NSW Local Health District (LHD) and Far West LHD mental health service but was since defunded despite a five-year evaluation demonstrating its effectiveness. Mentorship was demonstrated to contribute to course retention and completion at degree level. This has been the only university degree program to qualify Aboriginal mental health worker professionals in Australia. It had been envisaged that Edith Cowan University in Western Australia would be the second hub location for this course in the future.

More information on the benefits of Aboriginal and Torres Strait Islander mental health workers can found in our position statement on Aboriginal and Torres Strait Islander mental health workers (33).

3.8.2. Draft Recommendation 11.1 – The National Mental Health Workforce Strategy

Everyone deserves to be able to access expert care at the right time, in the right place. In 2016, the Australian Government's Department of Health Psychiatry Workforce Report (14) confirmed that a national shortfall in psychiatrists is expected nationally by 2030. Most recently in 2019, the National

Medical Workforce Strategy Scoping Framework (34) re-emphasised a current and projected shortage in psychiatry specialists, despite increases in the number of training positions.

The RANZCP is encouraged by the six medical workforce priorities highlighted in the 2019 report, especially the priority to address geographic maldistribution, and welcomes the clearly recognised need to redress the undersupply of psychiatrists.

There is a need for a dedicated strategy to increase the number of psychiatrists, along with other mental health specialists. The RANZCP is supportive of the Commission's recommendation that the updated National Mental Health Workforce Strategy should align health workforce skills, availability, and location with the need for mental health services. The RANZCP would also like to highlight that the workforce strategy should consider the working conditions within the mental health system, as well as how the workforce can be made sustained and retained into the future. Further comments specifically relating to the psychiatry workforce are made below.

3.8.3. Draft Recommendation 11.2 – Increase the number of psychiatrists

The RANZCP welcomes the recommendation for the development of a national workforce plan to address current and pending shortages in psychiatry particularly in regional and rural areas and subspecialties such as child and adolescent psychiatry. We agree such a plan needs to be linked with the development of state-based psychiatry workforce plans to ensure alignment with service delivery and planning structures, remoteness, and specific population groups. However, it cannot go unsaid that state-based planning processes need to be linked to local level planning where workforce issues are more likely to be felt and understood. It needs to be a 'bottom up' process as much as a 'top down' one to ensure all issues are identified and proper strategies developed. The RANZCP would see Regional Commissioning Authorities (RCAs), if established, as having an important role in workforce planning. There needs to be consideration around the current inconsistencies in working conditions between states and territories, and how this is contributing to gaps in the psychiatry workforce in particular parts of Australia.

The RANZCP agrees with the Commission's views that such planning needs to be undertaken in collaboration with the RANZCP to identify and provide advice on trainee numbers and workforce needs, and strategies to ensure trainees are properly supported in their fellowship. The RANZCP looks forward to working together with relevant agencies on this issue. An important point we would like to make in relation to the RANZCP's involvement in workforce planning is that health planning agencies will need to openly share workforce data and information to enable effective planning, such as the National Mental Health Services Planning Framework. Additional planning provides a welcome opportunity for the RANZCP to obtain or gain access to workforce data in order to recommend or provide advice on a course of action.

The RANZCP welcomes the Commission's recommendation for an increase in subspecialty psychiatry training positions, such as child and adolescent psychiatry, but believes other subspecialty training positions also need to be created and funded in order to support implementation of other recommendations made by the Commission in its report(s). For example, there will be a need for more forensic psychiatrists if we are to see better mental health outcomes for the mentally ill in custody and in the community, more perinatal and infant psychiatrists to support the Commission's early childhood recommendations, and more addiction psychiatrists to tackle the growing problem of alcohol and drug addiction.

There are currently too few child and adolescent psychiatrists to meet the direct mental health needs of young people (35). The RANZCP Faculty of Child and Adolescent Psychiatry (FCAP) has produced a discussion paper, which highlights that in Australia, of the approximately 80,000 children with a severe disorder over a 12-month period, only 22,000 had seen a psychiatrist (27%). This indicates that access to specialist care remains a persistent problem (35). Providing services for populations with higher needs will require yet more child and adolescent psychiatrists. Higher need population groups include children

with complex and severe mental health disorders, especially if comorbid with intellectual disability or physical health problems, as well as those involved with child protection or youth justice systems, and children who have experienced abuse or neglect. In addition, the needs of Aboriginal and Torres Strait Islander populations and culturally and linguistically diverse groups must be considered when developing services.

The FCAP recommends that there is a need for an increased number of child and adolescent psychiatrists per 100,000 population to meet basic community child and adolescent psychiatry needs for the population of young people in Australia (35). It is recognised that to achieve this necessary increase, a significant input of resources is needed, and may require regional and jurisdictional variation. Efforts to increase the supply of child and adolescent psychiatrists in regional and rural areas should be in keeping with overall strategies to increase rural workforce, rather than drawing resources away from already underserviced areas.

The RANZCP recommends the Commission, in collaboration with the RANZCP, determine the number of child and adolescent psychiatrists required to service child and adolescent mental health needs, and the training pipeline required to meet this number.

The RANZCP urges the Commission recommend that Federal and State Governments provide incentives and supports to build a critical mass of psychiatrists (including private psychiatrists) in regional and rural areas where access to basic mental health care lags significantly behind urban areas. This should include funding for new psychiatry supervisor positions in rural areas to allow trainees to remain, or choose to work and train in rural and remote areas (36). To that end, there also needs to be an expansion of the Specialist Training Program, so that wherever a novel rural/remote training position is proposed, and meets the requirement for services and is consistent with the regional plan, it is funded. Funding the establishment of dedicated rural and remote postgraduate psychiatry programs, akin to the development of undergraduate rural medical schools, would be an evidence-based approach to overcoming workforce maldistribution. Increasing the number of psychiatrists in metropolitan, rural and remote areas will require both an increase in the number of training positions, and a commensurate increase in the number of supervisors available to appropriately train, supervise and educate a larger cohort.

Additionally, the RANZCP would like to see further consideration of trainee issues, including adequate supervision and support. Trainees are an essential part of the psychiatry workforce, and are often on the frontline of services, as well as the first point of contact for families and carers. There has been increasing concern about trainees being overworked in under-resourced environments, with staff shortages increasing the likelihood of burnout. Many inpatient units are operating with a minimal level of staff, meaning if one staff member takes leave a huge burden is created, leaving remaining staff with a higher clinical load. What suffers under these circumstances is the ability for trainees to receive adequate supervision and support. Overworking and overreliance on trainees impacts negatively on the quality of training, as well as their wellbeing. There is also potential for greater access to psychotherapy positions for registrars, including improved access to psychotherapy teaching, reflective process groups and clinical experiences as part of development of a trauma-informed care and practice model. The RANZCP urges consideration of such training issues in plans to increase the number of psychiatrists.

One area the report appears silent on is the benchmarking of psychiatry numbers (FTE), mental health beds (both public and private settings) and community mental health clinicians per 100,000 population. We believe this is an important exercise that needs to be undertaken to determine the number of clinical and non-clinical roles required to deliver psychiatric care across the mental health system and build clinical capability for current and future psychiatry workforce. We encourage the Commission to examine this in collaboration with the RANZCP, and either undertake this work or recommend that it be undertaken by a relevant organisation.

3.9. Chapter 12 – Psychosocial support

3.9.1. Draft Recommendation 12.2 – Guarantee continuity of psychosocial supports

The RANZCP is supportive of this recommendation. However, the RANZCP recommends that mapping of current services should be undertaken while the National Psychosocial Support Measure is in place to address gaps in services for people who are not accessing the National Disability Insurance Scheme (NDIS).

The RANZCP encourages long-term action in supporting people to access the NDIS and other appropriate services within a system which recognises the episodic nature of mental health in a recovery-oriented framework.

Advocacy is a critical element for individuals accessing the NDIS and associated services. The RANZCP is concerned about the governance and capacity of some NDIS providers. There is awareness of the creation of a fragmented system with multiple provider services, with under-trained staff, assuming considerable responsibility for consumers with high needs. The RANZCP would support consolidation within the system, with a focus on appropriate governance systems.

The RANZCP would like to see advocates for vulnerable people with psychosocial disability funded. Advocates should have appropriate understanding of episodic illness and the recovery model, and be able to work with clinicians to enhance access to the NDIS and supports.

3.10. Chapter 13 – Carers and families

3.10.1. Draft Recommendation 13.3 – Family-focused and carer-inclusive practice

Consumers and carers have experience and expertise that clinicians as well as policymakers must draw upon (37). The RANZCP strongly supports mechanisms to further include carers (family members) in the treatment discussion (within relevant legislative frameworks). Ensuring that carer-inclusion is embedded in consultations on care (within relevant legal frameworks) should be incentivised and adopted as best practice.

The high-value and relative experience of carers in the mental health system makes improvements to their ongoing supports crucial. As part of Head to Health resources for carers, information on support services should be clearly available.

3.11. Chapter 14 – Income and employment support

3.11.1. Information Request 14.1 – Individual Placement and Support expansion options

Everyone working in the mental health sector as well as families, and not least people living with mental illness, are aware of the role employment plays in social and economic inclusion, and the health and wellbeing benefits associated with getting and keeping a suitable job. It is therefore critical that there is a focus on vocational rehabilitation in mental health support service delivery.

Workplaces have become more demanding in recent decades and many roles require a high level of cognitive functioning and communication skills. Many people with a mental illness experience impaired cognitive functioning and struggle with planning, problem-solving, concentrating and using initiative. It is suggested there are benefits to embedding cognitive remediation therapy in vocational rehabilitation.

Individual Placement Support (IPS) programs have a strong evidence base for enhancing both vocational and non-vocational outcomes (38). The RANZCP has previously highlighted to the Commonwealth Treasury that successful IPS programs for people with mental illness should incorporate education to improve awareness and responsiveness to the particularities of psychosocial disability (36). Any employment model should have a focus on appropriate skills development. The RANZCP recommends that IPS programs are fully integrated with clinical mental health services to ensure ease of

access and maximise the likelihood that persons with mental illnesses will be aware of and choose to access those services.

3.11.2. Draft Recommendation 14.3 – Staged rollout of individual placement and support model

IPS models are designed to assist individuals finding employment, which is a positive step towards recovery. Evidence suggests IPS is an effective form of supported employment (39). The RANZCP supports enhancement of pathways between mental health and social services, including the employment sector. The RANZCP also supports trialling and evaluating the IPS program for cost-effectiveness and recommends monitoring how well it delivers outcomes specifically for persons with mental illness. However, adequate funding needs to be allocated to the IPS program should it be expanded.

3.12. Chapter 15 – Housing and homelessness

3.12.1. Draft Recommendation 15.1 – Housing security for people with mental illness

The RANZCP supports this recommendation and suggests this also includes connecting tenants to mental health services to manage and treat mental health conditions faced by those in insecure housing.

3.12.2. Draft Recommendation 15.2 – Support people to find and maintain housing

The RANZCP is supportive of this recommendation and would note that when reviewing the Specialist Disability Accommodation Strategy, there should be a view to encouraging development of long-term supported accommodation for National Disability Insurance Scheme recipients with severe and persistent mental illness.

3.13. Chapter 16 – Justice

3.13.1. Information Request 16.1 – Transition support for those with mental illness released from correctional facilities

Mental health services should be integrated with other social services, such as housing and employment, to ensure that the person is holistically supported. Support for mental health and addiction/substance use disorder should be closely linked to facilitate the best outcomes for individuals accessing those services.

These services should be mobile and flexible in terms of the mode in which they are delivered to ensure that accessibility is maximised.

Although there are several existing transition services, they require more resourcing and better coordination.

3.13.2. *Information Request 16.2 – Appropriate treatment for forensic patients*

Most people who have a mental illness will never commit a crime nor present with violent tendencies. However, those that do whilst mentally ill deserve the right to be treated by an appropriate service. Prisoners are two to three times as likely as those in the general community to have a mental illness and are 10 to 15 times more likely to have a psychotic disorder (40). The RANZCP recognises forensic mental health care facilities do not currently have the capacity to meet demand. There must be enough appropriate facilities to treat people who have been found unfit to be tried or found not guilty by reason of mental impairment. There must be an increase in facilities for therapeutic interventions in hospitals, where the focus is on treatment and recovery, rather than correction facilities – more facilities are needed to do this.

For example, demand for beds at Thomas Embling Hospital in Victoria has grown significantly, with the average wait time for male security patients to be admitted following a recommendation for compulsory treatment being 38.8 days, and the wait time for forensic patients in prison to be admitted following a

recommendation to the court for a custodial supervision order being 319 days (41). The RANZCP Victorian Branch has previously noted this is placing greater strain on the mental health system. The situation is similar in NSW with wait times for admission to the forensic hospital being between 18 and 24 months.

Given forensic consumers often have complex clinical and security needs, mental health services for these individuals tend to be 'high cost, low volume'. However, when designing services there are established ways to ensure cost-effective use of funding. This includes adherence to the evidence base by utilising staff with requisite forensic expertise and providing a stepped care model which can respond to differing levels of risk and security (42) .

The RANZCP is supportive of measures to increase access to forensic mental healthcare and proposes several target populations which could benefit from increased availability of service. We would like to see increased services for persons with intellectual and developmental disabilities, which should be distinct from forensic mental health services so that the needs of this group can be more directly met. In addition, we support having tailored services for young persons in correction facilities, which include specialist adolescent forensic psychiatric services. The RANZCP would also like to see a strengthening of community mental health capacity by establishing local forensic specialist treatment teams which are integrated with community mental health teams. This will enable greater outreach to vulnerable individuals, as well as improved transitions between forensic facilities and the community.

3.13.3. Draft Recommendation 16 – Support for police

The RANZCP is supportive of measures which enable better responses to mental health crisis situations. We broadly endorse the presence of mental health professionals, including psychiatrists, in police communication centres. It may not be necessary for a psychiatrist to be physically present, but rather available over the phone for consultation as necessary. Those who are working within the police communications unit should be aware that a psychiatrist is available and should be trained about when a matter should be referred to the psychiatrist. We also consider it important for police to have basic training in relation to mental health first aid and de-escalation techniques, including specific training in relation to young people and mental health crises.

We would recommend that crisis responses are linked to ongoing mental health treatment and support services pathways. This could include post-contact follow-up, to increase the focus on long-term recovery as well as prevention and early intervention. It will also be essential for first responders to have ample mental health support, and training in mental illness and mental health first aid.

It is also noted that, as a result of their work, police often operate under difficult working conditions and are regularly exposed to potentially traumatic experiences. There is increasing awareness and concern for the possible consequences of prolonged and repeated exposure to trauma. Evidence shows that large numbers of emergency workers experience symptoms of post-traumatic stress disorder (PTSD) and will be at risk for other mental health conditions. It is essential that first responder organisations implement ongoing evidence-based support, reviews and wellbeing checks.

Further information is available in the RANZCP submission on first responders (43).

3.13.4. Draft Recommendation 16.2 – Mental healthcare standards in correctional facilities

The RANZCP supports, in principle, that the standards of mental health facilities in correctional facilities match those available in the wider community. However, careful consideration needs to be given about the governance measures adopted to best facilitate this.

We note that State/Territory health departments manage the accreditation of health services against the National Safety and Quality in Health Care Standards (NSQHS). However, it is not clear whether they have authority to attend correctional facilities to audit the mental health services. There may also be variability state-to-state depending on whether health services in prisons are run by the department of health or corrections. The Commission should further specify in its recommendations whether it is

suggesting mental health services in correctional facilities would seek accreditation against the NSQHS. If so, then consultations should be undertaken with state and territory departments of health to understand the limitations and benefits of this approach, and whether it would be possible jurisdictionally.

The NSQHS are geared towards health service organisations, which have different concerns, contextual issues and legislative/corporate governance frameworks when compared to prisons/correctional facilities. Therefore, we advise that entirely separate standards are desirable.

The correctional context and health concerns are very different to those of the general population. Therefore, it may be appropriate to have separate mental health facility standards which are agreed upon by all the states and then implemented jurisdictionally. If the Australian Commission on Safety and Quality in Health Care (ACSQHC) does adapt the standards, they should have to consult with correctional services and individuals who work in forensic settings (including psychiatrists) in relation to the standards, given that the ACSQHC's business is not usually forensically related. The RANZCP's Faculty of Forensic Psychiatry and Section of Child and Adolescent Forensic Psychiatry are well placed to provide advice in relation to the development of such standards.

The Royal College of Paediatrics and Child Health in the UK published, in consultation with a number of UK specialist medical colleges, including the Royal College of Psychiatrists, the *Healthcare Standards for Children and Young People in Secure Settings* (44). Although specific to children and young people and the UK context, these standards may provide a useful starting point for the development of Australian standards.

3.13.5. Draft Recommendation 16.3 – Mental healthcare in correctional facilities and on release

The RANZCP supports measures which assist in continuity of care for prisoners after release. We recommend that appropriate pathways between correctional mental health facilities and those outside correctional contexts be established to best facilitate this support.

The RANZCP is also supportive of the recommendation that mental health screening and assessment be undertaken in order to recognise and intervene where mental ill health presents and prevent further deterioration of an individual's health. We recommend that this screening include addiction and substance use disorders.

3.14. Chapter 17 – Interventions in early childhood and school education

The RANZCP welcomes the recognition that early identification of risks in children offers potential for improving health, social and economic outcomes. However, the RANZCP urges the Commission to acknowledge children and adolescents throughout all recommendations made with regard to improving the mental health system, given they represent a significant proportion of the population and require commensurate services. There are several sections throughout the draft report where the needs of children and adolescents could be greater emphasised, and RANZCP would direct the Commission to consider this ahead of the final report.

3.14.1. Information Request 17.1 – Funding the employment of wellbeing leaders in schools

The RANZCP Faculty of Child and Adolescent Psychiatrists (FCAP) believes development and implementation of early intervention and prevention strategies for mental illness in infants, children and adolescents is imperative to addressing adverse outcomes and to prevent or reduce mental disorders in adulthood (45). The RANZCP urges the Commission to recommend a comprehensive plan around prevention and early intervention, which integrates policy, strategy and implementation, with a focus on early childhood and extending through the school years.

3.14.2. Draft Recommendation 17.1 – Perinatal mental health

The RANZCP endorses increased perinatal screening as a cost-effective measure to identify and prevent the development of mental health problems. The RANZCP is encouraged by efforts to improve data collection to determine the prevalence of perinatal mental ill-health. We hope these initiatives will also assist in workforce and systems planning.

However, the RANZCP is concerned that the recommendation is for screening alone, without further consideration for the provision of treatment.

The RANZCP recommends the Commission go further in its recommendations and increase dedicated funding for mother-baby units. Internationally, it is estimated that one eight-bedded unit for every 15,000 deliveries is needed to reach the best outcomes for mothers experiencing severe mental health conditions in the perinatal period (46). The RANZCP would like to see universal access to public mental health mother baby unit beds, as exampled in Western Australia. Western Australia is presently the only state which does not fall short of the estimated number of beds required (47).

The RANZCP would also like the Commission to recommend the extensive work undertaken on key screening items in the Perinatal Minimum Dataset (PNMD) is finalised. The RANZCP acknowledges that work is continuing by the Australian Institute of Health and Welfare (AIHW) and other groups to enhance maternity data collection and reporting in Australia. However, we would encourage the prioritisation and addition of several specific mental health data items to the National Perinatal Data Collection; 'depression/anxiety screening conducted', 'additional follow-up indicated due to identification of perinatal mental health risk factors' and 'presence of history of mental health condition'. Such items have yet to be approved by each jurisdictional data custodian. The RANZCP strongly encourages the Commission to recommend the Federal Government invest in the collection and evaluation of these data items.

3.14.3. Draft Recommendation 17.2 – Social and emotional development in preschool children

The RANZCP supports the finding that multiple risk factors lead to an increased risk of mental illness in children and adolescents. A vital service component for optimising social and emotional development is mental health services for this age group (birth to five-year-old's and their parents), including early intervention in the course of a disorder to prevent secondary harm. This need is currently variably met in Australia. A crucial consideration is that the services be developmentally appropriate (31). There is a need for interventions across the spectrum of mild to severe disorders; for early intervention through to the management of chronic illness and across a range of settings. Untreated mental disorders develop rapidly and can impact negatively on future physical health, educational outcomes, ability to form positive relationships, and lead to higher risk of engagement with the justice system. This highlights the need for an efficient system that allows timely access to specialist care by child and adolescent psychiatrists when appropriate, and support for child and adolescent psychiatrists to assess and support the primary care sector in their provision of care.

3.14.4. Draft Recommendation 17.3 – Social and emotional learning programs in the education system

The RANZCP recommends psychiatrists take a leadership role in the development of any national strategic policy projects or guidelines which would influence or impact the emotional learning of young people in the Australian education system. In addition, the RANZCP recommends accreditation guidelines for social and emotional learning programs be contrasted against best practice principles determined in consultation with psychiatrists.

3.15. Chapter 20 – Social participation and inclusion

Draft Recommendation 20.1 – National Stigma Reduction Strategy

The RANZCP is strongly supportive of measures to reduce stigma surrounding mental health. Stigma is a recognised barrier to accessing treatment and support. A significant aspect of this stigma is persistent,

widespread misunderstanding about present day psychiatry, modern mental health care and those who provide it (48). People with mental illnesses, and their carers, also experience substantial stigma. This leads to decreased help seeking, isolation in the community, and discrimination. Furthermore, stigma has led to inadequate resourcing of mental health services.

3.16. Chapter 21 – Suicide prevention

The RANZCP would like to see additional recommendations which focus on societal reforms in acknowledgment of the range of factors which relate to suicide. Presently, the rising suicide rate is often attributed to a failure of the mental health service even when, as the report acknowledges, a large proportion of people with mental ill-health have never been in contact with services. This highlights the futility of a solely service-based approach. The RANZCP would like to see further consideration of how the mental health of communities could be improved as a primary prevention measure.

The recommended interventions for social inclusion appear to focus on those who are already unwell, and do not address why such people have become unwell in the first place. For example, poverty, inadequate housing or relationship breakdowns. This point is particularly valid for Aboriginal and Torres Strait Islander communities who have may have complex histories of intergenerational poverty and trauma.

3.16.1. Draft Recommendation 21.1 – Universal access to aftercare

The specific recommendations on suicide prevention, particularly the prioritisation of aftercare and the improved monitoring and reporting of suicide prevention performance outcomes, are strongly supported. Appropriate support services should be available to anyone in psychological distress, extending beyond diagnosed mental illness, and a rebuilt mental health service system should reflect this. The reforms suggested solely target mental health services, with reforms targeting services likely to have questionable impact on suicide rates without consideration of the societal factors relating to suicide.

Consideration should be given to ensuring that there is enough funding to provide comprehensive and appropriate aftercare in every part of Australia, and that recurrent funding is committed to sustain these services. The RANZCP has previously recommended that governments commit recurrent funding for evidence-based interventions, including programs which provide aftercare for all people who have presented with suicidal behaviour, accessible to all geographic locations. It is recommended that aftercare programs be complemented by:

- broad referral pathways
- additional outreach services to support people in regional and rural areas
- extended service delivery, including outside standard business hours
- dedicated outreach and aftercare services for children and young people who have self-harmed or at risk of suicide.

A key example of assertive aftercare which should be considered by the Commission is the Victorian Government's Hospital Outreach Post-suicidal Engagement (HOPE) initiative. This program in particular focusses on enhanced support and assertive outreach for people leaving an emergency department or medical ward following treatment for an attempted suicide. Acknowledging mental illness as a key factor in suicide, the RANZCP continues to urge for an evidence-based approach to planning suicide prevention programs and interventions, as well as the importance of evaluation.

3.16.2. Draft Recommendation 21.2 – Empower Indigenous communities to prevent suicide

The RANZCP is broadly supportive of Draft Recommendation 21.2. Importantly, the RANZCP Aboriginal and Torres Strait Islander Mental Health Committee has indicated that ensuring a critical mass of Aboriginal service providers are resourced in this area is the basis to improving suicidality outcomes.

Furthermore, Aboriginal Mental Health Professionals should be embedded in both specialty mental health teams and in primary health teams run by Aboriginal Medical Service controlled programs. In addition to this Aboriginal people must be involved through being engaged as staff and on boards running other agencies, including police, corrections, family and housing services, fire and ambulance and so forth (49).

A significant barrier for Aboriginal Medical Services is that funding is usually provided for one worker. It is impossible for one worker to combat suicide in the community alone, and an interprofessional collaboration approach needs to be taken, and funded accordingly. Funding for professional and cultural supervision needs to be included for this team due to the high risk of vicarious trauma for workers.

3.16.3. Draft Recommendation 21.3 – Approach to suicide prevention

The RANZCP is supportive of a whole-of-government approach to suicide prevention and is encouraged by the recommendation for the National Suicide Prevention Implementation Strategy to include strategic direction for non-health government portfolios that have influence over suicide prevention activities. As mentioned above, societal factors implicated in suicide must also be addressed in order to improve the mental health of communities. Reducing suicide cannot be done solely by the healthcare sector.

The Australian Government recently announced funding of $8 million to support research aimed at identifying effective approaches to suicide prevention through the Australian Government's Million Minds Mission. Research could focus on the following areas/factors that the RANZCP has identified as needing more evidence on their associated risk of suicide:

- mental illness, and specifically Borderline Personality Disorder
- alcohol and other drugs
- older people
- broader societal factors, for example, culture, socioeconomics, childhood trauma
- rural and remote communities
- Aboriginal and Torres Strait Islander people
- LGBTQI+ people.

Specific training is available for some disorders, however, there is a lack of access to practitioners providing these services, e.g., for Borderline Personality Disorder, due to only a small proportion of the workforce being trained in these skills. In relation to the elderly, Figure 21.4 in the Draft Report has the potential to mislead as far as older persons and suicide is concerned. The paragraph preceding this figure estimates that for every death by suicide, between 10 to 30 people attempt suicide. In fact, it is suggested death results from around one in four suicide attempts made by older persons (50). For males in 2018, the highest rate (32.9 deaths per 100,000) is for those aged 85 years and older, in part reflecting a smaller underlying population in this age cohort (51). The RANZCP recommends the Commission direct additional attention to this population when considering strategies to reduce suicide.

3.17. Chapter 22 – Governance

3.17.1. Information Request 22.1 – Governance arrangements for NMHC

We agree that the NMHC (National Mental Health Commission) should be an inter-jurisdictional statutory authority. This has the following benefits:

- more formal independence and accountability mechanisms, which may be positive reputationally and allow the public to place more trust in the NMHC, which could increase its influence
- further stability and clarity in relation to the role of the NMHC, rather than relying on the guidance of the governments of the day
- more secure funding as a body established in statute.

The body evaluating government should be independent from government to ensure that the evaluations are apolitical and objective in nature. The NMHC could have statutorily embedded information-sharing powers to enable it to both provide and acquire information relevant to its role (especially with the relevant organisations who are also in this space, as identified by the recommendation). However, careful consideration should be given in relation to what NMHC responsibilities/frameworks do become enshrined in statute and which do not. The relevant statute should not be overly prescriptive. For example, while the obligation to have a three-year schedule of program evaluations may be established in statute, it may not be desirable to set out the details of what is required of those evaluations in statute. This lack of flexibility may prevent the NMHC from drawing on contemporary wisdom, re, evaluations and also moulding the evaluation process to the particular issue.

The operational challenges in setting up an inter-jurisdictional body should be recognised. Care should be taken to ensure that the operational and governance arrangements do not prevent the NMHC from collaborating openly with other organisations. Appropriate lead time and funding should be permitted with a change in governance arrangements/statutory status to ensure that the NMHC is well-equipped and well-prepared to take on this new form and role.

We endorse the NMHC having a skills-based board. Having a board would more specifically separate the role of the board members from those of the Commissioners, who are subject-matter, strategic policy experts. More policy and research support is also needed within the NMHC to ensure that the Commissioners are supported in their work.

3.17.2. Draft Recommendation 22.1 – A National Mental Health and Suicide Prevention Agreement (NMHSPA)

There are already numerous national, state and territory strategy documents in the mental health space. There should be clarity in relation to how those documents interact with each other. The NMHSPA is unlikely to be helpful if it only serves as an added layer. It needs to integrate other documents and work alongside existing frameworks to reduce the fragmentation that is currently occurring within the system.

In terms of specifying responsibilities to ensure maximum separation in responsibilities, it is important to bear in mind the consumer's need for ease of navigation. Maximum separation could provide clarity, but it could also make it more difficult for consumers to navigate the system. This is of particular concern in the mental health space where individuals may be particularly vulnerable, especially those with severe and ongoing mental illness. This is a service division issue and should be carefully considered.

We consider that the new National Mental Health Strategy (NMHS) and the NMHSPA (Draft Recommendation 22.2) should be developed in tandem so that they integrate effectively with each other and maximise the clarity and integration of the system. In addition to reporting and evaluation mechanisms being built into this agreement, we recommend that there be a review mechanism. We recommend that the NMHSPA set out strict timelines for development and implementation.

The RANZCP endorses the co-design process envisioned in the recommendation, emphasising that it is important to involve those with lived experience. Critically, co-designed service provision only works when it is within an evidence-based framework. We recommend that those consulted come from diverse backgrounds, including Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities, as well as persons who live in rural and remote areas. Additionally, it is important to consult with medical professionals who navigate the system with their patients and understand the gaps in relation to funding and governance. We recommend that a draft of the NMHSPA be released for consultation to obtain these varied views.

We also support the agreement covering both mental health and suicide prevention. Suicide prevention is a key area of focus for the RANZCP. As the leading professional organisation for psychiatrists the RANZCP has established the President's Advisory Group on Suicide, which aims to bring strategies to the table that are grounded in evidence and best-practice principles, and ensure the design and implementation of policy, programs, training and services targeting suicidal ideation and behaviour are guided by these principles.

3.17.3. Draft Recommendation 22.2 – A new whole-of-government mental health strategy

A notable gap in this recommendation is that the Commission has not clearly stated who should develop and implement the implementation plan for the National Strategy Framework for Aboriginal and Torres Islander Peoples' Mental Health and Social and Emotional Wellbeing.

The RANZCP recommends that the strategy reference the NMHSPA where appropriate, in order to integrate responsibilities for each government into the new NMHS and to ensure that the new governance structure is recognised and embedded in strategy and program. The RANZCP supports the NMHS being monitored by the new NMHC given it is apolitical and independent (see Information Request 22.1).

The RANZCP endorses an implementation plan being formulated for the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing. The implementation plan should be created in consultation with Aboriginal and Torres Strait Islander peoples and relevant stakeholders. The implementation plan should include target time periods and strong monitoring, reviewing, reporting and evaluation frameworks.

We endorse the co-design process envisioned in the recommendation, emphasising that it is important to involve those with lived experience. Those with lived experience should come from diverse backgrounds, including Aboriginal and Torres Strait Islander and culturally and linguistically diverse backgrounds, and persons who live in rural and remote areas. Additionally, it would also be important to consult with medical professionals who navigate the system with their patients and understand the gaps in relation to funding and governance.

3.21.3. Draft Recommendation 22.3 – Enhancing consumer and carer participation

The RANZCP endorses the move towards more consumer and carer involvement and co-design. Strengthening systemic advocacy is particularly important within the NMHC, given its centrality to the independent review processes envisioned in Draft Recommendation 22.2

We agree that systemic advocacy can assist in consumer and carer collaboration. However, this needs to be coupled with broader consultation and opportunities to contribute to design (such as the opportunity to participate in working and advisory groups). The RANZCP has considerable experience in the co-design process, including development of Enabling Supported Decision-Making resources (52) and actively seeks the input of people with lived experience on its committees.

3.22. Chapter 23 – Federal roles and responsibilities

3.22.3. Information Request 23.1 – Architecture of the future of the mental health system

The RANZCP is generally supportive of the Commission's proposal for a rebuild, rather than a renovate model. However, the RANZCP encourages the rebuild to be strong and move towards one single funding stream which covers all mental health service provision. Existing gaps in the system where service provision is patchy or disjointed must be addressed in whatever new architecture the Commission recommends. This means addressing current weaknesses in the intersections between services, such as the transition between community and acute mental health services, primary and secondary care and the emergency department and mental health services. The Commission needs to consider how new funding arrangements under the rebuild model can streamline patient care. Any approach the Commission recommends should also account for the administrative burden on clinicians and seek to reduce this burden wherever possible. Any consideration of budgetary requirements for the new framework to meet the mental health needs of the nation must include current shortfalls in service provision. This includes, but is not limited to, shortfalls in rural, remote, outer-metropolitan and sub-specialty areas. The budget must be informed by an evidence-based, population-based funding formula.

Consideration should also be given to determining what the RCA will actually deliver, and to whom. The stepped care approach can be useful in forming a framework, but articulating who is responsible for whom is critical in any governance system. There should also be frameworks around what packages of care people can expect, depending upon their conditions and complexities. Funding should be determined by the capacity of the RCA to deliver their areas of responsibility to the population they are responsible for.

A single funding stream should also be aligned to the physical healthcare system, as mental and physical health systems should not operate in isolation. Consumers should expect the system to look after all of their health needs, and not be required to navigate two complex systems in order to receive the care required. The RANZCP would like to see a united mental health system which has clear pathways for consumer care and strengthened partnerships between different levels of care.

A rebuild represents a great opportunity for exploration of how partnerships between public, private and non-government organisations can be formed to create innovative service models. These models could enhance care for consumers, increase the accessibility of care and integrate usually disparate systems. Governance arrangements should create strong links with state-based mental health services, as these generally provide care to the most acutely unwell consumers.

The biggest gaps in service provision, innovation, and workforce development in the mental health system occur in direct proportion to the regionality/rurality of a location. At present, a gap the Commission should consider if it is to implement either the renovate or rebuilt model, is that there is no mechanism likely to effectively address this. The Commission should consider how new structures can address the current trend towards metropolitan areas attracting an overwhelming proportion of funding, workforce, and innovative service. Improvements must be made which bolster and improve relative outcomes for regional, rural and remote populations.

This could include greater access to metropolitan services, such as extending the economies of scale of metropolitan services for infrastructure such as research and training to regional and rural services; or other systemic solutions. For example, the value of the initial introduction of MBS items for telepsychiatry for rural areas has now been proven in low volume, high unmet need rural areas, and it has been recommended that telepsychiatry be extended to some metropolitan patients. An approach which makes support for clinical, organisational, or structural innovations in some way contingent on their extension to the regions could be adopted. A vital part of this approach would be adequate monitoring of the system (per Chapter 25).

In addition, the integration of mental health and alcohol and other drug services must be considered as part of any redesign of Australia's mental health system. It would be useful to undertake a more detailed

evaluation of the current barriers to services and funding integration, as well as how to preserve existing structures in States and Territories which may already be operating efficiently. This integration of AOD and mental health services should also include service provision to people in correctional facilities.

The RANZCP would like to offer the expertise of our members to the Commission and contribute to development of the rebuild model, including discussions on how a strong set of reforms could be implemented.

3.22.4. Draft Recommendation 23.1 – Review proposed activity-based funding classification for mental healthcare

The RANZCP is supportive of activity-based funding but encourages the Commission to make recommendations which ensure monies set aside for mental health activities are appropriately spent on mental health. The RANZCP also urges the Commission to consider additional options to activity-based funding for regional, rural and remote communities where the low-volume means there is not the same economy of scale as in metropolitan areas. There must be weightings for such services, to cover additional costs due to issues of distance and the need for incentivisation.

3.22.5. Draft Recommendation 23.2 – Responsibility for psychosocial and carer support services

The RANZCP urges the Commission to clarify in more detail the practical implications of shifting responsibility for psychosocial and career support services to State and Territory Governments, with a specific focus on addressing the challenges of service continuity under the NDIS. There must be support to ensure gaps between state-based and NDIS services are being addressed as this transition occurs.

3.22.6. Draft Recommendation 23.3 – Structural Reform is necessary

The RANZCP supports measures to clarify roles and responsibilities and incentivise governments to invest in services which best meet the needs of people with mental illness and their carers. The RANZCP is supportive of sensible decentralisation of control and responsibility for mental health funding. However, the RANZCP encourages the centralisation of standards, strategies and frameworks to reduce duplication and ensure more consistency across Australia.

3.23. Chapter 24 – Funding arrangements

3.23.3. Information Request 24.1 – Regional funding pools

The RANZCP supports pooling funds and the notion of RCAs, but there should be consideration of the other major players in the sector (with operational expertise), such as Primary Health Networks, and the private health sector. In addition, even if funds are pooled, the current level of funding is inadequate. Regardless of how services are commissioned, there must be an increase in funding. The RANZCP supports a commitment to piloting different models. Mental health service delivery has become increasingly fragmented and inefficient over time, so it is essential any new funding and governance models are appropriately piloted and evaluated to ensure they are efficient and effective. In addition, there must be increased transparency in the planning and development of funding models. The RANZCP urges the Commission to recommend MBS reform be undertaken in tandem with any changes to funding arrangements in order for better services to be delivered. The RANZCP urges the Commission to evaluate the current fee-for-service model and improve data availability regarding MBS outcomes of both psychiatric and GP services to ensure future governance and funding models can deliver accessible and equitable mental health care. It is noted the Commission makes no comment on the current model where the GP is the gatekeeper to all MBS-funded mental health services.

For regional and rural services, the primary risk relating to regional funding pools would be unintended consequences associated with the relatively low utilisation of MBS services in these regions. Figure 24.1 in the Commission's report suggests that as service delivery increases, the distribution of mental health funding is increasingly dominated by PHN funding, with a decreasing amount of allied mental health MBS funding. The Rebuild model appears to introduce a risk of creating a perverse incentive against

increasing MBS funding outside major cities, as the service would be incurring both an extra salary cost for allied mental health, as well as increased MBS costs due to increased utilisation. The maldistribution of MBS rebated services requires consideration. Consideration should be given to areas of service inequity, as well as supporting access to highly specialised services within a state. The distribution of the population across vast distances, particularly in Western Australia, Northern Territory and Queensland, and the need to close the gap in services for Aboriginal and Torres Strait Islander people should be considered in funding.

Similar to the introduction of MBS items for telepsychiatry outside metropolitan areas, trials and evaluations to guide changes in funding model could be introduced outside major cities first. The benefit of assessing the introduction of new initiatives outside of major cities is that the low volume, high unmet need, and unpredictable response to funding changes make a good laboratory for identifying problems without massive costs. Consideration of telepsychiatry versus the sustainability of a local psychiatry workforce needs to be addressed when analysing funding models.

The linkage of mental health funding with projected MBS rebates for allied mental health care is likely to have greatest impact outside metropolitan areas, but also the greatest potential for inequitable outcomes. It has been suggested the MBS funding pool should be distributed according to need, with clinicians following funding to areas of need, concomitantly solving workforce issues.

3.24. Chapter 25 – A framework for monitoring, evaluation and research

3.24.3. Draft Recommendation 25.1 – A data linkage strategy for mental health data

The greatest barrier to development of mental health services for regional Australia is the lack of basic data about demand, service provision and barriers, such as distance to care. In terms of existing projects which could be prioritised, the HeaDS UPP database (53) for workforce planning has considerable potential, and should be made accessible to wider group of stakeholders. In addition, the Integrated Mental Health Atlas produced by Australian National University has proven useful in conducting analyses of services availability and capacity (54).

In terms of research, the RANZCP encourages the Commission to consider the lack of workforce capacity in the academic mental health sector, particularly considering psychiatrists who are often time poor. It would be timely to review the funding, infrastructure and support for clinical research, especially in mental health, to support dedicated career researchers (55).

3.24.4. Information request 25.3 — Data sharing mechanisms to support monitoring

There must be adequate data collection across states and territories, with appropriate methodologies for jurisdictional data custodians to systematically collect and monitor data. Appropriate data collection will assist in development of an evidence-base to monitor the mental health system and develop improvements or address noted challenges. Data collection methods should not place additional burdens on clinicians and must be efficient and effective.

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