19 January 2017

Hon Michael McCormack MP
Minister for Small Business
Parliament House
CANBERRA ACT 2600

Dear Minister McCormack

Re: Commonwealth Treasury 2017–18 Pre-Budget submission

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is pleased to provide this submission to the Treasury regarding recommended priorities for the 2017–18 Budget. In developing this submission, the RANZCP consulted closely with its expert committees and individual psychiatrist members across metropolitan, regional and rural Australia to ensure that the priority areas identified reflect clinical experience, community input and mental health expertise.

Mental health disorders are a leading cause of disability burden in Australia. The burden of disease from mental illness could be greatly reduced through improved health promotion, prevention, early intervention, treatment and support. In fact, best practice in health care has the potential to reduce the impact of serious mental illness and comorbidities by almost one third. The RANZCP therefore advocates for the commensurate funding of mental health services to contribute to improved health outcomes overall.

The RANZCP contends that there is a significant public mandate for increased investment in mental health. As public awareness of mental health increases, so too does the demand for mental health services increase. Psychiatrists are often on the frontline of mental health service delivery and are therefore well positioned to attest to increasing community expectations of mental health care.

The RANZCP continues to advocate for a reconceptualisation of mental health-care spending in Australia as a way of improving the efficiency of our economy. We believe that directing Commonwealth funding towards mental health care should be understood as an investment, with the potential to generate high returns.

This submission contains recommendations as to how mental health spending can be used to generate significant long-term benefits, both for the economy and for individuals, families, carers and communities across Australia. We have identified 10 priority areas that will be expanded upon in the submission attached.

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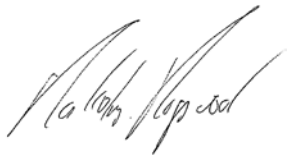
If you would like to discuss any of the issues raised in the submission, please contact Rosie Forster, Senior Department Manager, Practice, Policy and Partnerships via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours sincerely



Professor Malcolm Hopwood
President

Ref: 0589o

The Royal Australian & New Zealand College of Psychiatrists

Commonwealth Treasury

2017–18 Pre-Budget submission

January 2017

advocating for mental health resources commensurate with the burden of disease

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Royal Australian and New Zealand College of Psychiatrists submission

Commonwealth Treasury 2017–18 Budget

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 more than 5500 members including more than 4000 fully qualified psychiatrists and around 1400 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

Introduction

The RANZCP is pleased to provide this submission for the 2017–18 Budget. The RANZP notes the recent release of the draft Fifth National Mental Health Plan which identified seven priority areas for reform of the mental health sector, as well as the 2014 *National Review of Mental Health Programmes and Services* conducted by the National Mental Health Commission (NMHC) which contained 25 recommendations. The RANZCP acknowledges the importance of this work and offers this submission to provide further information regarding our shared priorities, and to identify other areas requiring work.

Mental health and well-being are central to all aspects of health care and the RANZCP therefore advocates for the proportionate funding of mental health services to contribute to improved health outcomes overall. Mental health disorders account for over 13% of Australia's total burden of disease and costs the Australian economy an estimated $20 billion annually (DoHA, 2013). In order to facilitate adequate service delivery, funding for mental health should be reflective of the burden of disease. Yet mental health represents 13% of the burden of disease but only 7% of government funding (NMHC, 2014). Consequently, there is significant unmet need with approximately 60% of Australians with mental illness receiving no mental health care (ABS, 2007). Concurrent to this, community expectation of mental health care is increasing as campaigns raise awareness and expectation of treatment.

The RANZCP therefore advocates for a reconceptualisation of mental health-care spending in Australia. We believe that directing funds towards mental health care should be understood as an investment with the potential to generate high returns. For example, increasing investment in the National Health and Medical Research Council by 3% over the next 10 years would generate $58 billion in health and economic benefits, according to a recent report (Deloitte Access Economics, 2016).

This submission contains 44 recommendations across 10 key priority areas:

- the National Disability Insurance Scheme (NDIS)
- Aboriginal and Torres Strait Islander mental health
- rural workforce distribution
- Medicare
- alcohol and other drug services
- the mental health needs of an ageing population
- the physical health of people living with mental illness
- improved services for people with disorders related to chronic and/or complex trauma
- perinatal, childhood and adolescent mental health services
- vocational support programs for people living with mental illness.

Summary of recommendations

National Disability Insurance Scheme

- Provide alternative funding streams for key health and capacity-building services previously funded by state disability services to ensure that people living with a mental illness who are not eligible for NDIS plans are not left worse off both during and after the transition.
- Support the capacity building of Primary Health Networks and Local Hospital Networks to map service availability, identify and fill service gaps and develop appropriate resources to assist health practitioners and administrators (e.g. specific health pathways, local resources kits and training materials to facilitate service access for people with intellectual and developmental disabilities).
- Review the relationship between the NDIS legislation and the *Aged Care Act 1997* to ensure there is no care gap for consumers over the age of 65 who otherwise meet the eligibility criteria for services under the NDIS but do not meet the requirements of the *Aged Care Act*.
- Ensure that children with autism receive funding under the NDIS to support early intervention therapies of 20 hours per week.
- Ensure NDIS funding for forensic patients, especially during their transition back into the community.

Aboriginal and Torres Strait Islander mental health

- Ensure that Aboriginal and Torres Strait Islander mental health programs respect the principles of self-determination, community governance, reconnection, community life, restoration and resilience.
- Incorporate Aboriginal and Torres Strait Islander mental health workers into mental health initiatives at all levels, and criminal justice systems in particular.
- Consider opportunities for using the Commonwealth's Specialist Training Program to support Aboriginal and Torres Strait Islander doctors to complete their training in psychiatry.

Rural workforce distribution

- Establish enrolment targets and the weighting of enrolment criteria to increase the proportion of regional/rural medical students.
- Increase financial incentives to psychiatrists who reside and practice in rural areas.
- Establish a national locum registry.
- Provide increased support for rural access to continuing professional development opportunities.
- Support health services to develop policies and procedures to assist in finding employment for the partners of medical specialists as well as other support services such as childcare.
- Continue or expand funding of the Specialist Training Program, including:
    - the Integrated Rural Training Pipeline
    - support programs for rural trainees such as mentoring and e-learning
    - the continued indexation of trainee salaries.
- Fund relevant community infrastructure to support flexible models of service provision.

Medicare

- Reverse the Medicare Benefits Schedule indexation freeze.
- Establish a Pharmaceutical Benefits Scheme review taskforce.
- Permit health-care providers to claim Medicare subsidies for the provision of health-care services not currently funded by state and territory governments in custodial settings.

Alcohol and other drug services

- Establish a national quality framework for alcohol and other drug services, valid across both public and private sectors, including accreditation standards for rehabilitation facilities.
- Increase funding for the training of specialists in addiction psychiatry.
- Provide funding to address methamphetamine misuse including:
    - research into ice, its effects and evidence-based treatments
    - support for frontline mental health services to best respond to ice presentations, including managing associated complex and challenging behaviours
    - ice-specific treatment and rehabilitation programs.

The mental health needs of an ageing population

- Develop and implement national principles for providing coordinated care across different services for older Australians with mental illness.
- Fund anti-ageism strategies and increase social inclusion for older Australians.
- Require all aged care providers to make mental health care available to residents.
- Open all MBS mental health items to people living in residential aged care facilities.
- Remove the care exclusions in the *Aged Care Act 1997* that are based on the presence of a mental health condition.
- Commission work to develop guidelines around the mental health care of people living in residential aged care.
- Develop prevention and early intervention initiatives aimed at combatting depression and suicide among older Australians.
- Invest in improving mental health literacy among older Australians.

Physical health of people living with mental illness

- Develop strategies to support health practitioners and services to recognise their role in both the physical and mental health care of people with mental illness and to build stronger partnerships with key stakeholders, including GPs, Aboriginal and Torres Strait Islander medical services and other health-care providers.
- Support the implementation of new models of care that integrate both physical and mental health, including Health Care Homes, and evaluate their effectiveness.
- Increase public awareness of the physical health needs of people with mental illness.
- Develop workforce development initiatives to educate health-care providers about the physical health inequalities among people living with mental illness, including the incorporation of mental health education into the curricula of tertiary courses training allied health professionals.

Improved services for people with disorders related to chronic and/or complex trauma

- Fund improved services for people with disorders related to chronic and/or complex trauma, including training for mental health professionals working in secondary care services and appropriate primary care services.
- Fund parenting programs targeted at parents with borderline personality disorder.

Perinatal, childhood and adolescent mental health services

- Support further research via the Medical Research Future Fund into the effectiveness of prevention and early intervention programs for infants, children and adolescents.
- Work with states and territories to develop a joint and sustainable plan for investment in perinatal mental health services.
- Provide guidance and associated funding for coordinated and integrated care between health and other sectors.
- Work to expand access to mental health services for the 0–11 age group to match investments made for the 12–25 age group.

Vocational support programs for people living with mental illness

- Provide long-term resourcing for Individual Placement Support programs and implement the recommendations made in *Work Wanted: Mental Health and Workforce Participation* (SCEE, 2012) and *A New System for Better Employment and Social Outcomes* (DSS, 2015).
- Fund and evaluate sentinel secondary school pilot programs that enhance supports for students with mental illness.

National Disability Insurance Scheme

The NDIS offers an unprecedented opportunity to improve the lives of people with disability in Australia. The RANZCP commends the Commonwealth Government for its continued commitment to implementing the NDIS at a time when the imperative is to reduce national spending, as well as its consultative approach in doing so. In particular, the RANZCP welcomed the Joint Standing Committee on the NDIS' Inquiry into the provision of services under the NDIS for people with psychosocial disabilities and will be pleased to provide its submission in February 2017.

Much of the feedback from NDIS trial sites indicates that consumers receiving support generally stay well for longer, require inpatient treatment less often and stay in hospital for shorter periods of time. These early reports indicate the potential of the NDIS to reduce reliance on crisis and acute care, enhance the efficient use of resources and contribute to a healthier and more productive society (National Disability Services, 2014).

The RANZCP is concerned, however, that the NDIS may not meet the support needs of many people with a mental illness. In order to be eligible for an individual funding package (IFP), a person with mental illness must have a current diagnosis of a severe and persistent mental illness and associated permanent functional disabilities. However, many people with psychosocial disabilities have needs and impairments that change in their nature and severity over time. People in these circumstances will continue to need support from community-based mental health services which provide critical early intervention and ongoing care.

Furthermore, NDIS funding agreements between the Commonwealth Government and most jurisdictions commit the majority of funding for existing non-clinical support services to the NDIS. As a result, many community mental health support programs are beginning to close in preparation for the NDIS without equivalent programs being offered. This leaves a major gap in services with many people currently supported by existing programs at risk of having no support at all. The NDIS was never designed to cover all disabilities and governments must therefore ensure that the transition to the NDIS does not create service gaps for vulnerable people in need of ongoing psychosocial support. The structure of the NDIS needs to be able to accommodate people with psychosocial disabilities without disadvantaging those who fall outside its scope but who nevertheless rely on existing community programs. Currently, there is a serious risk that people living with mental illness who are not eligible for NDIS services are going to be left with less support than they have now. The RANZCP would also support a more stringent evaluation of the implementation of NDIS, especially with regard to the timeliness of the development of IFPs.

The RANZCP recommends that the Commonwealth Government provide alternative funding streams for key health and capacity-building services previously funded by state disability services to ensure that people living with a mental illness who are not eligible for NDIS plans are not left worse off both during and after the transition.

The RANZCP recommends that the Commonwealth Government support the capacity building of Primary Health Networks and Local Hospital Networks to map service availability, identify and fill service gaps and develop appropriate resources to assist health practitioners and administrators (e.g. specific health pathways, local resources kits and training materials to facilitate service access for people with intellectual and developmental disabilities).

The RANZCP is also alarmed about the potential for a person aged 65 or over not being able to access services under either the NDIS or the *Aged Care Act 1997.* The Act and its associated Principles do not define an age over which people are eligible for services but rather a set of characteristics that a person

must meet in order to be eligible. Current interpretations of the *Aged Care Act 1997* mean that mental illness alone is not enough to qualify for services under this Act. The risk is that an individual who is over the age of 65 and therefore no longer eligible for support through the NDIS, but who does not meet the eligibility requirements under the *Aged Care Act 1997*, will be left without any form of support.

The RANZCP recommends that the Commonwealth Government review the relationship between the NDIS legislation and the *Aged Care Act 1997* to ensure there is no care gap for consumers over the age of 65 who otherwise meet the eligibility criteria for services under the NDIS but do not meet the requirements of the *Aged Care Act*.

The RANZCP is also concerned about the extent to which children with autism will be eligible for IFP, or Tier 3, services under the NDIS. Families of children with autism living in NDIS trial locations report that they will receive funding for early interventions therapies for Tier 3 recipients, but only up to $16,416 per annum, or the approximate equivalent of 6 hours a week – well below the recognised international best practice guideline of 20 hours per week (DSS, 2012). This limitation on funding is a false economy and will not be in the best interests of children with autism who will not fully benefit from less or lower cost therapy.

The RANZCP recommends that the Commonwealth Government ensure that children with autism receive funding under the NDIS to support early intervention therapies of 20 hours per week.

The RANZCP understands that NDIS funding will not be provided to prisoners and young people in detention. This appears to be predicated on the assumption that appropriate services will be provided within custodial settings, funded by state and territory governments. Considering the significant and ongoing underinvestment in prison and youth detention health services, the RANZCP is concerned that individuals whose disabilities render them eligible for NDIS services will lose access to those services while in custody. Furthermore, the RANZCP understands that NDIS funding will only be provided to individuals transitioning back into the community within 3 months of their date of discharge; in reality, the period of transition can often take much longer than this. It is essential that prisoners and young people in detention have their psychosocial needs adequately met, not only to ensure their personal health but to decrease recidivism rates which will have substantial flow-on benefits for the community.

The RANZCP recommends that the Commonwealth Government ensure NDIS funding for forensic patients, especially during their transition back into the community.

Aboriginal and Torres Strait Islander mental health

There have been many positive developments in Aboriginal and Torres Strait Islander health policy in recent times and the RANZCP was pleased to note the draft Fifth National Mental Health Plan included Aboriginal and Torres Strait Islander mental health and suicide prevention as a priority. However, mental health outcomes for these populations continue to be much lower than non-Indigenous populations, and are in some cases getting worse. Rates of intentional self-harm, for example, have increased by 48% over the past decade while up to 12% of the 10-year life expectancy gap is attributable to mental illness with a further 4% to suicide and 6% to substance misuse (Holland et al., 2013).

These statistics indicate that approaches to Aboriginal and Torres Strait Islander health and well-being urgently need to be re-evaluated. Programs must be founded on an evidence base and respect the principles of self-determination, community governance, reconnection, community life, restoration and resilience. Furthermore, effective and efficient investment in Aboriginal and Torres Strait Islander mental health should focus on programs that utilise holistic and interdisciplinary approaches to empower individuals to regain a sense of control. Strategies should be community-led, family-focused, recovery-oriented, culturally responsive and contextualised and should include partnerships with Aboriginal Community Controlled Health Services (ACCHSs) and local communities. In contrast, programs that have been found to be ineffective are those that do not take into account Aboriginal and Torres Strait Islander values and contexts, operate under inadequate timeframes and funding, and/or are delivered without engagement or partnership with the community and ACCHSs (Dudgeon et al., 2014).

The RANZCP recommends that the Commonwealth Government ensure that Aboriginal and Torres Strait Islander mental health programs respect the principles of self-determination, community governance, reconnection, community life, restoration and resilience.

The RANZCP supports the recognition of the role of Aboriginal and Torres Strait Islander mental health workers in all aspects of mental health care including service and policy development, consultation on cultural safety and direct service delivery as well as representation in governance structures and management teams. Aboriginal and Torres Strait Islander mental health workers should be supported to train and apply for appropriate positions and should be remunerated for their work at a level at least commensurate with their non-Indigenous colleagues. Furthermore, where non-Indigenous mental health workers are engaged with Aboriginal and Torres Strait Islander consumers and communities, an essential part of their role should be to engage and consult with Aboriginal and Torres Strait Islander mental health workers (RANZCP, 2012).

The RANZCP recommends that the Commonwealth Government incorporate Aboriginal and Torres Strait Islander mental health workers into mental health initiatives at all levels, and criminal justice systems in particular.

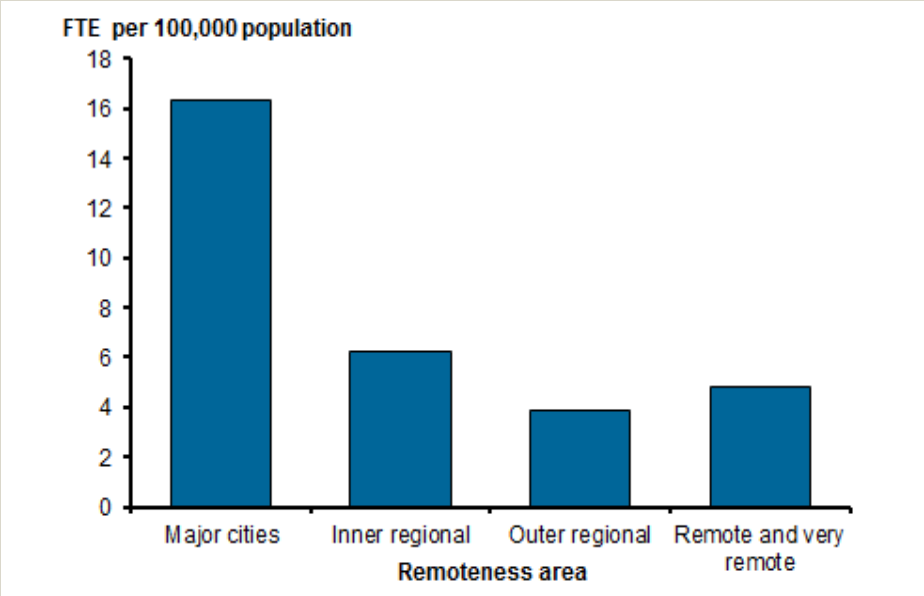
The RANZCP contends that the Specialist Training Program (STP) could be used to support Aboriginal and Torres Strait Islander mental health workers. This approach has the potential to generate multiple benefits including improving the mental health of Aboriginal and Torres Strait Islander communities by providing culturally safe and appropriate mental health care, as well as enhancing the access of this population to education, training and employment opportunities. The RANZCP would welcome the opportunity to discuss this proposal in more detail with the Commonwealth Government and the Department of Health.

The RANZCP recommends that the Commonwealth Government consider opportunities for using the Specialist Training Program to support Aboriginal and Torres Strait Islander doctors to complete their training in psychiatry.

Rural workforce distribution

The significant shortage of psychiatrists working in regional Australia is deeply concerning and the RANZCP therefore welcomed the recent announcement by the Commonwealth Government to undertake a national review of the health services system to address this shortage.

Health Workforce Australia's *Health Workforce 2025* report identified that psychiatry is facing significant shortages both now and into the future. The report found that the more remote the location, the worse the access to psychiatric services (HWA, 2012). Data collected by the Australian Institute of Health and Welfare found that almost nine out of every ten full-time equivalent (FTE) psychiatrists (87.8%) were employed in major cities in 2012. This corresponded with 16.3 FTE psychiatrists per 100,000 people in major cities but only 6.2 per 100,000 in inner regional areas, 3.9 per 100,000 in outer regional areas and 4.8 per 100,000 in remote and very remote areas (AIHW, 2012a). These figures are well below the World Health Organisation's target of one psychiatrist per 10,000 people.



Sourced from: Australian Institute of Health and Welfare, 'Mental health services in Australia', 2012

Furthermore, a RANZCP survey of psychiatry trainees found that only 65% of trainees would consider working in a regional centre and only 37% in a rural or remote area (RANZCP, 2014a). Unfortunately, these figures indicate that the trend of workforce maldistribution is likely to continue into the future without significant intervention to incentivise and support rural practice.

The RANZCP recommends that the Commonwealth Government establish enrolment targets and the weighting of enrolment criteria to increase the proportion of regional/rural medical students.

The RANZCP recommends that the Commonwealth Government increase financial incentives to psychiatrists who reside and practice in rural areas, including via the support of health services to offer competitive salary packages to attract psychiatrists to rural areas.

It is crucial that psychiatrists who are already working in regional and rural areas are better supported – they have a heavy workload and need greater assistance than they are currently receiving. In particular, they require high-quality IT support, time to pursue continuing professional development (which is both more difficult and more costly to access in remote areas), locum services to ensure they are able to take breaks and support services for their families including childcare.

The RANZCP recommends that the Commonwealth Government establish a national locum registry.

The RANZCP recommends that the Commonwealth Government provide increased support for rural access to continuing professional development opportunities.

The RANZCP recommends that the Commonwealth Government support health services to develop policies and procedures to assist in finding employment for the partners of relocating medical specialists as well as other support services such as childcare.

The RANZCP strongly supports continued funding or expansion of the STP which provides vital support for training posts outside of traditional metropolitan teaching hospitals. STP posts in rural areas have proven to be immensely successful in attracting psychiatry trainees to rural locations and the RANZCP particularly welcomed the establishment of the Integrated Rural Training Pipeline which provides additional training posts in rural locations.

However, psychiatry trainees still face a number of disincentives to taking up posts in rural locations including access to education opportunities and the costs of relocation, travel and accommodation. While rural loading is essential to support health services, trainee salaries provided by the STP often do not cover the full costs associated with taking up a post in a rural location. In order to incentivise rural training, it is essential that trainees are not disadvantaged when taking up these posts.

The RANZCP recommends that the Commonwealth continue or expand funding of the Specialist Training Program, including:

- **the Integrated Rural Training Pipeline**
- **support programs for rural trainees such as mentoring and e-learning**
- **the continued indexation of trainee salaries.**

There are a number of ways to supplement the psychiatric workforce in areas of need. For example, rural psychiatrists may provide outreach services in more remote areas and patients may be transferred to larger centres for treatments unavailable in their local region. It is essential that these services have the financial capacity to ensure practical travel arrangements for psychiatrists which minimise fatigue. It is also important that outreach services focus on fitting in with, and upskilling, local services in order to improve their capacity and sustainability. While local settings are likely to have different requirements, the RANZCP believes that the Commonwealth has a responsibility to fund infrastructure according to local needs and preferences, to ensure equity of service access across the country.

Telepsychiatry is another important aspect of rural practice with communication technology being used to connect psychiatrists with patients and their carers from a distance (RANZCP, 2014b). Telepsychiatry has the potential to deliver significant benefits to rural psychiatry, particularly in relation to subspecialist and consultation–liaison services. Telepsychiatry is also a useful tool for training, delivery of clinical services, and supervision opportunities for rural psychiatrists.

The RANZCP recommends that the Commonwealth Government fund relevant community infrastructure to support flexible models of service provision.

Medicare

The RANZCP has consistently advocated for the reversing of the Medicare Benefits Schedule (MBS) indexation freeze. Patient affordability of health-care services is a key concern for the RANZCP, particularly as a vast majority of patients requiring mental health services are socioeconomically disadvantaged. Rebates for psychiatry services under the MBS are notoriously low and many psychiatrists report that they cannot bulk bill patients while meeting the costs of running a practice.

While Medicare rebates remain frozen, the costs of running a practice continue to move up with the Consumer Price Index. These costs are often passed on to patients in the form of higher out-of-pocket costs (gap fees) making seeing a private psychiatrist unaffordable to many Australians. Psychiatrists cannot be expected to reduce their fees to assist patients, nor can patients be expected to simply find the money to pay for increasing gap payments.

Many Australians in need of psychiatric care will have no alternative than to stay with their GP or be referred to an overburdened public system that is better structured for severe mental illness, such as psychotic disorders. Public sector mental services are increasingly delimiting the mental disorders they are willing and able to treat; it is not uncommon for psychiatrists to be advised that patients they wish to refer are unable to be accommodated by public mental health services. As such, many patients with mood and anxiety disorders are unable to access specialist psychiatric care. Those who are able to access psychiatric care are increasingly cutting back on consultations. If people are unable to access appropriate care due to these increases in payments their condition may worsen, leading to more serious mental (and potentially also social) problems.

To illustrate the point, Medicare rebates for electroconvulsive therapy (ECT) is particularly low considering the competencies and skills needed to administer ECT as well as the requirements to fulfil modern compliance standards. Increasingly, the indexation freeze runs the risk of reducing the number of psychiatrists willing to provide ECT in the private sector without the introduction of large gap fees that will render the treatment unavailable to many. Indeed, there are various aspects of the MBS that could be improved. However, the RANZCP is concerned that the level of MBS rebates is simply not keeping pace with the increasing costs of health-care delivery.

The RANZCP recommends that the Commonwealth Government reverse the MBS indexation freeze.

The RANZCP welcomed the establishment of the MBS Review Taskforce and was pleased to provide its submission in November 2015. The RANZCP continues to view the MBS Review as a crucial opportunity to improve and enhance the provision of psychiatry services across the country.

Like the MBS, the Pharmaceutical Benefits Scheme (PBS) is a critical feature of the Australian health system. As the prevalence of mental ill health in Australia continues to increase, the need for new medicines to treat mental illness becomes increasingly pressing, as does the need to review PBS provisions for existing medicines. RANZCP Fellows have expressed a variety of concerns associated with current PBS regulations and processes – for example, medicines may be unnecessarily restricted or allowed medicines may show limited efficacy or not be well-tolerated compared to newer medicines that are not yet PBS-listed. The PBS has a longstanding tradition of supporting Australian consumers to access medication and the RANZCP would welcome the opportunity to provide more detailed feedback on these matters through a substantive review.

The RANZCP recommends that the Commonwealth Government establish a PBS review taskforce.

The RANZCP has consistently highlighted the need to improve mental health services for prisoners and young people in detention. People with mental illness are greatly over-represented in Australian prisons and youth detention facilities. There is also a significant over-representation of Aboriginal and Torres Strait Islanders peoples in Australian prison and youth detention populations with an associated incidence of mental health problems and cognitive disabilities.

Section 19(2) of the *Health Insurance Act 1973* (Cth) precludes provision of services under Medicare or the PBS if these services are already provided by state or territory governments. As mental health services for prisoners and young people in detention are funded via state and territory budgets, they are effectively excluded from Medicare and PBS subsidies.

The RANZCP understands that this law functions to prevent a service from being funded twice through public resources as well as to prevent the transfer of costs associated with state and territory programs to the Commonwealth Government. While the RANZCP agrees with this in principle, it is concerned that the practical realities of health service provision within prisons and youth detention facilities has resulted in significant gaps in service delivery.

Although Australia has committed to the provision of equivalent health care for people in prison and youth detention through various legal instruments, underinvestment in custodial health services by state and territory governments means that many prisoners and young people in detention do not receive adequate mental health care or alcohol and drug treatment. There are many examples of this inequity; perhaps the most readily apparent is that despite an extremely high prevalence of mental illness in prisoners and detained youth, psychological therapies in these settings are almost non-existent. When prisoners can access a psychiatrist, the mainstay of treatment is via the sole prescription of psychotropic medications which deviates from both best practice and community standards which support the augmentation of pharmacological treatment with psychosocial therapies. Depending on the location, there may be services which provide in-reach programs to prisoners and young people in detention but they are severely restricted in the services which they can provide without access to Medicare rebates.

Under the *Health Insurance Act*, the Health Minister has the power to grant an exemption to end prisoners' exclusion from Medicare, paving the way for rebates to be claimed for custody-based health-care services in circumstances where gaps exists in health service delivery. This would allow custodial health systems to retain the existing health service delivery models, enhanced through access to selected Medicare items and PBS subsidies for services providing in-reach care. We believe the costs incurred by Medicare would be minimal.

The RANZCP understands that exemptions have already been granted in cases of clear and demonstrated need. These precedents demonstrate the willingness of the Commonwealth Government to permit access to Medicare if the ability of health services to adequately care for the needs of a community is curtailed by the exclusion; a situation that clearly exists in prisons and youth detention facilities.

The RANZCP recommends that the Commonwealth Government permit health-care providers to claim Medicare subsidies for the provision of health-care services not currently funded by state and territory governments in custodial settings.

Alcohol and other drug services

The RANZCP recognises that alcohol and other drug (AOD) misuse is the cause of significant morbidity and mortality, with associated impairment and other psychosocial consequences for individuals as well as their families and communities. Unfortunately, there continues to be a very significant gap between clinical need and the provision of evidence-based AOD services. Developing a holistic, nationally coordinated and evidence-based response to AOD misuse should therefore be understood as an important investment, with significant potential for return on investment.

Research has consistently demonstrated that well-targeted, evidence-based approaches to reducing AOD-related harm can have significant results. However, to ensure that Australians have access to high-quality, evidence-based programs, the RANZCP believes there is an urgent need to develop a national quality framework that sets standards for AOD services including the development of formal accreditation standards for rehabilitation facilities. In 2015, the National Ice Taskforce made a number of recommendations regarding training and accreditation which the RANZCP supports. However, the RANZCP is concerned that the establishment of a national quality framework may not apply to private AOD services. With public AOD beds in short supply, many individuals in need of treatment must utilise private AOD services. Vulnerable consumers need adequate safeguards to ensure they have access to evidence-based treatments conducted by competent staff in all service settings, both private and public.

The RANZCP recommends that the Commonwealth Government establish a national quality framework for alcohol and other drug services, valid across both public and private sectors, including accreditation standards for rehabilitation facilities.

In 2013, there were only 26 psychiatrists undertaking advanced training in the field of addiction psychiatry. Based on this data, the ratio of advanced trainees in addiction psychiatry to people living with a mental illness and a substance misuse disorder is 1:13,076, indicating a serious shortfall in access to services for people with substance use disorder. The STP has provided welcome investment in a small number of additional training places in psychiatry and this needs to be maintained, with additional funding to develop further training positions.

The RANZCP recommends that the Commonwealth Government increase funding for the training of specialists in addiction psychiatry.

Crystal methamphetamine, or ice, has quickly become one of the most serious issues confronting frontline mental health services and emergency departments. In May 2007, the Commonwealth government committed $150 million in new funding for AOD issues. As this funding has since come to an end, the RANZCP strongly advocates for its reinstatement. Although many approaches common to AOD treatment have been shown to have some success in this area, there are currently no treatments that specifically address the misuse of ice. There is therefore a growing need for a better understanding of ice, its use and effects, and targeted evidence-based interventions. However, it is important that resources are not redirected away from current AOD services which deal with the far more prevalent issue of alcohol misuse.

The RANZCP recommends that the Commonwealth Government provide additional funding to address methamphetamine misuse including:

- **research into ice, its effects and evidence-based treatments**
- **support for frontline mental health services to best respond to ice presentations, including managing associated complex and challenging behaviours**

- **ice-specific treatment and rehabilitation programs.**

Mental health needs of an ageing population

Like many other countries, Australia has an ageing population. Projections suggest that the proportion of people aged 65 years and over will increase from 14% in 2012 to 20% by 2040. The number of people aged 85 years and over is projected to almost triple from 430,000 to 1.2 million by 2040 (ABS, 2013). Furthermore, dementia is the second-leading cause of death in Australia and the prevalence of the condition is projected to triple by 2050 (AIHW, 2015). Dementia is not always recognised as a mental health condition despite the fact that many psychiatrists work with people living with dementia to help them to manage the behavioural and psychological symptoms of the disease. These factors will contribute to significantly increased pressures on psychogeriatric services over the years to come.

Despite this pressing need, Australia is currently unprepared to meet the mental health needs of an ageing population. There is limited access for older people to state community, acute inpatient and non-acute inpatient care as well as supported community residential care (AIHW, 2012b). This is despite older people often being at risk of mental health decline in aged care situations plus the ongoing high rates of suicide in older people (ABS, 2013). Furthermore, access to mental health services by people aged 65 years and older is significantly lower than people aged 33 to 44 years. Older Australians are also at risk of ageism and social isolation, which can be exacerbated by mental illness. The RANZCP considers that greater priority must be given to the mental health care of older Australians, which will in turn provide a significant return on investment for the wider Australian community.

The RANZCP recommends that the Commonwealth Government develop and implement national principles for providing coordinated care across different services for older Australians with mental illness.

The RANZCP recommends that the Commonwealth Government fund anti-ageism strategies and increase social inclusion for older Australians.

A particular correlate of Australia's ageing population is the increasing number of people living in residential aged care facilities where there are already unacceptably high rates of depression (AIHW, 2013) and other mental illness (AIHW, 2012b) with often inadequate treatment (Snowdon et al., 2011). The RANZCP is particularly concerned at consistent reports from psychiatrists and media outlets (Magarey, 2017) that residents of these facilities are not being provided with essential treatments for mental health conditions. This is due to facilities not being legally bound to provide or fund these treatments while the ability for residents to access services via the MBS is further limited due to their current exclusion from certain items under the Better Access Scheme. On this basis, the RANZCP strongly believes that the Government needs to make a commitment to ensure that residential aged care services provide appropriate mental health care and services for older Australians.

The RANZCP recommends that the Commonwealth Government require all aged care providers to make mental health care available to residents.

The RANZCP recommends that the Commonwealth Government open all MBS mental health items to people living in residential aged care facilities.

The *Aged Care Assessment Program Guidelines* (DoH, 2014) state that:

> Aged care services usually do not have the capacity to adequately address the support and associated needs of people with a serious uncontrolled mental illness without the support of and treatment by mental health services. Persons who are a danger to themselves or others m*ay not be suitable for entry to an aged care service*. (emphasis added)

The RANZCP has concerns regarding the assumption that residential aged care should not meet the support needs of older people with mental illness. While recognising that this may pose a significant challenge for residential aged care providers, the introduction of the NDIS, which excludes people aged over 65, means that there will shortly be no alternative providers of this service.

The RANZCP recommends that the Commonwealth Government remove the care exclusions in the *Aged Care Act 1997* that are based on the presence of a mental health condition.

The RANZCP believes that the mental health outcomes of residents in aged care facilities would be greatly improved through the development of guidelines and formal accreditation standards. As an example, the UK National Institute for Health and Care Excellence has a quality standard 'QS50 – Mental wellbeing of older people in care homes' (NICE, 2013) which would provide a useful basis to build an Australian standard to shape the maintenance and improvement of the mental health of people living in residential aged care facilities.

The RANZCP recommends that the Commonwealth Government commission work to develop guidelines around the mental health care of people living in residential aged care.

A particular focus on prevention and early intervention with respect to suicide and depression would also be beneficial for older Australians. The RANZCP is concerned that the media often responds to these issues with calls for better access to physician assisted suicide which reflects an unfortunate lack of public understanding regarding the effectiveness of mental health care for older people with depression.

The RANZCP recommends that the Commonwealth Government develop prevention and early intervention initiatives aimed at combatting depression and suicide among older Australians.

Increased funding should also be provided to improve the mental health literacy of older Australians. The benefits of public knowledge of physical diseases are widely accepted, but knowledge about mental disorders, also known as mental health literacy, has been neglected. This is of particular concern as studies have indicated that the lack of public mental health literacy contributes to slow problem recognition and reduces opportunities for early interventions, which are less costly to the individual and to society as a whole (Thompson et al., 2004).

The RANZCP recommends that the Commonwealth Government invest in improving mental health literacy among older Australians.

Physical health of people living with mental illness

The draft Fifth National Mental Health Plan included the physical health of people living with mental illness as a national priority. There are a significant number of Australians with both physical and mental health issues with 11.7% of Australians aged 16–85 years (1.9 million people) having both a mental disorder and a physical condition (ABS, 2008). The higher rates of chronic disease among people with serious mental illness has a range of consequences including shorter life expectancies, higher levels of ongoing disability, reduced workforce participation and productivity, and greater likelihoods of welfare dependency and poverty. Factors contributing to the physical health issues of people living with mental illness include the side effects of psychotropic medications and lower rates of screening for physical health issues. The link between physical and mental illness is also bidirectional – that is, the mental health of people with physical illness also requires attention. Given the significance of this issue, the RANZCP believes that the relationship between physical and mental health should be a national priority.

The RANZCP recommends that the Commonwealth Government develop strategies to support health practitioners and services to recognise their role in both the physical and mental health care of people with mental illness and to build stronger partnerships with key stakeholders including GPs, Aboriginal and Torres Strait Islander medical services and other health-care providers.

Effective models of care that integrate physical and mental health should be a focus of Primary Health Networks (PHNs). The RANZCP was pleased to note the strong focus of the NMHC on the physical health needs of people with mental illness (NMHC, 2014) as well as the Commonwealth Government's Response (DoH, 2015). The RANZCP is closely monitoring the implementation of the Health Care Homes initiative and hopes that this will prove successful in improving the physical health outcomes of Australians with mental illness.

The RANZCP considers that integrating physical health promotion strategies into mental health services is another effective way of combating chronic disease in people with mental illness. Extensive research documents the clinical benefits and cost effectiveness of such programs (for examples, see Eappen et al., 2012; Shiers and Curtis, 2014). It is the RANZCP's position that screening and lifestyle interventions, based on the best available evidence, should be routinely offered to people living with mental illness in order to treat pre-existing conditions and to prevent avoidable conditions from developing.

The RANZCP recommends that the Commonwealth Government continue to support the implementation of new models of care that integrate both physical and mental health, including Health Care Homes, and to evaluate their effectiveness.

While there has been a very welcome increase in public awareness and discussion of mental illness in recent years, physical health in the mentally ill has received comparatively little attention. One reason for this is the limited information available regarding the increased physical health risks associated with mental illness (Ahire et al., 2012). The RANZCP believes that much more needs to be done to raise awareness about the physical health needs of people living with mental illness.

The RANZCP recommends that the Commonwealth Government increase public awareness of the physical health needs of people with mental illness.

The RANZCP recommends that the Commonwealth Government develop workforce development initiatives to educate health-care providers about the physical health inequalities among people living with mental illness, including the incorporation of mental health education into the curricula of tertiary courses training allied health professionals.

Improved services for people with disorders related to chronic and/or complex trauma

The RANZCP would like to emphasise the inefficiencies in the current mental health system around the treatment and care of people living with disorders related to chronic and/or complex trauma such as borderline personality disorder (BPD). Many of these disorders share similar issues, such as high medical comorbidity and severe impacts on personalities and coping styles, and require integrated assessment and treatment approaches. Psychotherapeutic interventions are particularly important and require appropriate support via Medicare rebates, both for psychiatrists and GPs.

Untreated, disorders like BPD present significant economic and social costs to the Australian community. However, there are effective treatments which have the potential to provide substantial savings associated with reduced service use, reduced instances of suicide and self-harm, fewer family crises and emergency room visits, and improved social and relational functioning.

The Commonwealth Government has recognised the importance of this issue, evidenced by the inclusion of coordinated treatment and supports for people with severe and complex mental illness as the second priority area in the draft Fifth National Mental Health Plan. A number of Australian Parliamentary committees have identified that BPD is under-recognised with most sufferers not offered the most effective treatments; furthermore, due to a lack of appropriate services, people with BPD often present to emergency departments or are admitted to inpatient units (NHMRC, 2013). Past recommendations of these committees have included designated BPD treatment services, a training program for mental health services and community-based organisations, and programs targeting adolescents and young adults as well as providers of primary health care (NHMRC, 2013).

As well as specialist treatment services for people with personality disorders, the RANZCP considers that mental health professionals working in secondary services should be trained to diagnose personality disorders, assess risk and need and provide interventions. Training should also be provided for primary-care health-care professionals who have significant involvement in the recognition, assessment and early treatment of people with disorders related to chronic and/or complex traumas. For instance, GPs often provide the primary support for people with BPD, often over many years (Lawn and McMahon, 2015). In the RANZCP's view, training should be provided by specialist personality disorder teams.

The RANZCP recommends that the Commonwealth Government fund improved services for people with disorders related to chronic and/or complex trauma, including training for mental health professionals working in secondary care services and appropriate primary care services.

A related issue is people with BPD who are also parents. Parenting programs offer an effective method of intervention for both parents and children in these circumstances and can help to enhance the parent–child relationship. It is essential that parenting programs be sensitive to the effects of mental illnesses such as BPD and include practical assistance to help families overcome structural obstacles (RANZCP, 2010). Given the nature of BPD and its disastrous impact on families and relationships, appropriately targeted parenting programs must also be a priority.

The RANZCP recommends that the Commonwealth Government fund parenting programs targeted at parents with BPD.

Perinatal, childhood and adolescent mental health services

Early childhood is the period of greatest vulnerability to stress-related changes to the brain. The majority of neurological development associated with cognitive and emotional functioning are determined in these early years of life. Mental illness in infancy, childhood or adolescence can have enduring consequences if left unresolved. Adverse outcomes include reduced self-esteem and educational and occupational opportunities as well as increased risk of substance abuse, family separation and homelessness. Consequently, the economic, social and personal costs of untreated mental, emotional and behavioural disorders among young people are extremely high (Access Economics, 2009).

Managing mental health and behavioural issues early in life improves long-term health outcomes and can decrease the need for acute or crisis care later in life. Given that 50% of all serious mental health and substance use disorders commence by age 14 (Whiteford et al., 2013), prevention and early intervention services targeted at young people, including infants, and their parents have the potential to generate significant benefits for the community. Evaluations demonstrate that intervention benefits exceed costs – often by substantial amounts (O'Connell et al., 2009). Supporting Australia's young population, as well as mothers and infants, therefore offers substantial, long-term benefits, enhancing the well-being of Australians across their lifetime.

As at June 2012, the total number of children in Australia under 15 years of age was 4.29 million, or 19% of the total population (ABS, 2012). The Commonwealth Department of Health's *Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing* found that high numbers of young people in Australia are experiencing clinically significant mental health issues with almost one in seven 4–17 year olds experiencing psychological distress in the 12 months prior to being surveyed. This is equivalent to 560,000 children (Lawrence et al., 2015). It is essential that funding is proportional to the size of the problem as specialist health initiatives for young people is a cost-effective way of safeguarding Australia's future health, well-being and prosperity.

The RANZCP recommends that the Commonwealth Government support further research via the Medical Research Future Fund into the effectiveness of prevention and early intervention programs for infants, children and adolescents.

Perinatal and infant mental health services support mothers to care for their infants and support their lifelong development. Investing in perinatal and infant mental health services offers multiple and long-term returns on investment as young children who grow up in safe and secure environments have greatly enhanced likelihood of healthy development, positive mental health and well-being throughout their life (Haliburn, 2014).

Perinatal and infant psychiatry (PIP) receives only a small proportion of funding within the mental health budget with many PIP training jobs funded by the STP which operates on a rolling contract. Without secure funding, these services often fit between hospital and community settings, and between obstetric, paediatric, nursing, mental health and social services. As such, funding and service development in this area is subject to considerable risks. Outside of metropolitan areas, PIP services are extremely limited or non-existent.

In 2015, the RANZCP was concerned to learn that federal funding for the National Perinatal Depression Initiative (NPDI) had ceased. While we understand that federal funding for the program was intended to be temporary, we believe that the extent of community concern following the announcement of its cessation strongly illustrates the important contribution this funding was making. In many regions of Australia, services were funded under the NPDI and these were the only perinatal programs available. The planned funding cuts risk leading to the cessation of screening, early intervention and support for

mothers who derived great benefit from NPDI funds. We therefore urge the Commonwealth Government to work with states and territories to develop a joint and sustainable plan for investment in perinatal mental health services.

The RANZCP recommends that the Commonwealth Government work with states and territories to develop a joint and sustainable plan for investment in perinatal mental health services.

The RANZCP supports the recommendations made in the NMHC's *Review of Mental Health Programmes and Services* (NMHC, 2014) which address the mental health needs of children and adolescents. The RANZCP was pleased to note the Commonwealth Government's response included a commitment to improving the connectedness of child and adolescent mental health services, including by consolidating school-based programs and reviewing the provision of services to young people with severe mental illness (DoH, 2015).

The successful design and implementation of the PHNs will be central to achieving these aims. Child and adolescent mental health service (CAMHS) expertise must be fully incorporated into PHNs at all levels including governance, policy design, service delivery and evaluation. The RANZCP would welcome more information on how the government's approach to the design and implementation of the PHNs, and how the expertise of CAMHS, can best support this process.

The RANZCP recommends that the Commonwealth Government provide guidance and associated funding for coordinated and integrated care between health and other sectors.

The RANZCP commends the government for the substantial work done in recent years to develop community-based centres for young people aged 12–25. This excellent work must be expanded so that the 0–11 age group are equally as supported. Unfortunately, many services for the 0–11 age group are barely touching the populations of young people most in need. Treatment rates for major childhood mental and behavioural disorders remain low, despite these being the leading cause of Disability Adjusted Life Years in Australians aged 5–14 years (IHME, 2013). Overall, only a small fraction of 0–11 year-olds with mental health disorders get access to primary mental health care and only a small proportion with the most disabling mental health problems access specialist mental health care. This is especially the case for young people who have experienced trauma and those in out-of-home care. It is essential that services work with families to optimise mental health outcomes for everyone. Children of parents with mental illness also require particular attention. In partnership with the Australian Psychological Society, the RANZCP has prepared a proposal for Kids Life Centres which would cater to this age group, and we would be happy to discuss this proposal further with the Commonwealth Government as required.

The RANZCP recommends that the Commonwealth Government work to expand access to mental health services for the 0–11 age group to match investments made for the 12–25 age group.

Vocational support

Employment is almost universally ranked among the highest goals of people with serious mental illness yet this population faces the highest unemployment rates of any disability group (Ramsay et al., 2011). Unemployment is particularly high for people with serious mental illness. The costs associated with the unemployment of people with mental illness are manifold. On a personal level, unemployment exacerbates isolation and financial strain, creates barriers to accessing health care and other supports, and can impede recovery (Solar, 2014). The economic costs to the community are also significant. Investing in programs that support people with mental illness to engage in meaningful work has the

potential to generate direct savings in addition to indirect savings associated with improving outcomes for people with mental illness, supporting clinical recovery and decreasing reliance on health care and crisis services over time (Solar, 2011).

Individual Placement Support (IPS) programs have a strong evidence base for enhancing both vocational and non-vocational outcomes (Tsang et al., 2010). Successful IPS programs for people with mental illness should incorporate education to improve awareness and responsiveness to the particularities of psychosocial disability so that employers are supported to make reasonable adjustments when necessary. Programs should also be accompanied by work-related skills training to enable individuals to overcome the educational disadvantage common in those with severe mental illness. Finally, programs should be fully integrated with clinical mental health services.

The 2015 report of the Reference Group on Welfare Reform to the Minister for Social Services, *A New System for Better Employment and Social Outcomes*, identified the potential benefits of implementing additional IPS initiatives in Australia. The report recommended that IPS programs be expanded as part of a Jobs Plan for people with mental illness encompassing a holistic package of supports (DSS, 2015). The Commonwealth House of Representatives Standing Committee on Education and Employment's inquiry into mental health and workforce participation made similar recommendations in 2012, including that 'the Commonwealth government explore ways… to support IPS and other service models that integrate employment services and clinical health services' (SCEE, 2012). This approach was reflected in the Commonwealth Government's commitment to implementing specialised employment services aimed at young people using the IPS model (DoH, 2015). While the RANZCP welcomes this development, we would also urge the broader implementation of IPS programs across all age groups.

The RANZCP recommends that the Commonwealth Government provide long-term resourcing for Individual Placement Support programs and implement the recommendations made in *Work Wanted* and *A New System for Better Employment and Social Outcomes*, including:

- **working with educational institutions to enhance supports for students with mental illness**
- **encouraging more peer support programs at universities and TAFE**
- **developing a Jobs Plan for groups at risk of poor employment outcomes**
- **implementing tailored support which integrates employment and mental health services**
- **raising awareness of the benefits of employing people with mental illness, and the services and supports available to employers**
- **establishing a leaders' group to develop practical strategies to increase employment of people with mental illness**
- **setting targets across government for the employment of people with mental illness.**

The RANZCP recommends that the Commonwealth Government fund and evaluate sentinel secondary school pilot programs that enhance supports for students with mental illness.

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