THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH COMMITTEE

Submission to the Productivity Commission on Health Workforce, July 2005

The Status and Role of Aboriginal and Torres Strait Islander Mental Health Workers

PURPOSE

The Aboriginal and Torres Strait Islander Mental Health Committee of the Royal Australian and New Zealand College of Psychiatrists wishes to address the current status and future professional development of Aboriginal and Torres Strait Islander Mental Health Workers as part of the Productivity Commission Inquiry on Health Workforce.

INTRODUCTION

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has had a leading role among the Australian Medical Colleges in its interest in and advocacy for Aboriginal and Torres Strait Islander health issues. The RANZCP interest was founded on the recognition of Aboriginal and Torres Strait Islander sovereignty and the right for all Australians to experience good mental health and hence the need to redress the inequality in health and mental health status.

Since 1996, the RANZCP has had an Aboriginal and Torres Strait Islander Mental Health Committee as part of its Board of Professional and Community Relations. The Board is an important organisation within the RANZCP, facilitating the RANZCP's interaction with consumers of mental health services and their carers, as well other professionals involved in the treatment of clients with mental illness. The Board also has a strong association with other organisations involved with consumer and carer issues such as the Mental Health Council of Australia. The Aboriginal and Torres Strait Islander Mental Health Committee is composed of psychiatrists who have a direct experience of Aboriginal and Torres Strait Islander mental health as well as Aboriginal and Torres Strait Islander members who are involved in mental health service provision and policy development. The Committee contributes to Board discussions but may also advise the

RANZCP directly about issues of importance in Aboriginal and Torres Strait Islander mental health.

EXECUTIVE SUMMARY

1. There is high morbidity and mortality associated with Aboriginal and Torres Strait Islander mental health.

2. National Mental Health Policy incorporates the essential role of Aboriginal and Torres Strait Islander Mental Health Workers in dealing with Aboriginal and Torres Strait Islander people who have mental health issues.

3. The current status and career structure of Aboriginal and Torres Strait Islander Mental Health Workers is poorly defined.

4. There needs to be a more effective career structure developed for Aboriginal and Torres Strait Islander Mental Health Workers, and this is probably best achieved through a collaborative interaction between tertiary educational institutions, Aboriginal and Torres Strait Islander community controlled health organisations, state health departments, and Commonwealth and State health regulation organisations, in association with the evaluation of Aboriginal and Torres Strait Islander Health Worker competencies through the VET sector.

5. Registration via Commonwealth or State mechanisms would be an important mechanism for the recognition and status of the Aboriginal and Torres Strait Islander Mental Health Worker profession.

MORBIDITY AND MORTALITY RELATED TO MENTAL ILLNESS IN ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES IN AUSTRALIA

The Committee's interest in the current status and further development of the Aboriginal and Torres Strait Islander Mental Health Worker profession is part of a general recognition of the substantial disadvantage of the health status of Aboriginal and Torres Strait Islander peoples compared to the health status of the rest of the Australian community. A recent publication by the Australian Bureau of Statistics (1) demonstrates this significant inequality in Aboriginal and Torres Strait Islander mental health status. In 1999 to 2001, Aboriginal and Torres Strait Islander mortality in Queensland, South Australia, Western Australia and the Northern Territory was significantly higher relative to the their proportion in the population. Mental and behavioural disorders accounted for 4.1 times as many deaths for Indigenous males and 2.1 times as many deaths for Indigenous females as expected based on total Australian rates in these four states and territories. Aboriginal and Torres Strait Islander populations also appear to be more prone to harmful substance abuse. Aboriginal and Torres Strait Islander males and females appear to have substantially higher rates of admission to hospital as a result of serious mental illness in its own regard or in association with substance abuse. Suicide

rates for Aboriginal and Torres Strait Islander males and females living in the four states and territories also appear to be substantially higher than the non-Aboriginal and Torres Strait Islander population.

The Committee also recognises the severe trauma experienced by the Aboriginal and Torres Strait Islander population who are members of the Stolen Generations. Recent West Australian Aboriginal Child Health Survey data on mental health of children (2) also shows the severe ongoing impact of the Stolen Generations policy on the wellbeing of members of the Stolen Generation and their children. The data showed that members of the Stolen Generation were generally more likely to live in households where there were problems related to alcohol abuse and gambling. They were less likely to have a trusting relationship and more likely to have been arrested for an offence. They were more likely to have been in contact with mental health services. Children of members of the Stolen Generation had a much higher rate of emotional and behavioural difficulties and had high levels of alcohol and other substance abuse compared to Aboriginal children whose parents were not a member of the Stolen Generation.

NATIONAL MENTAL HEALTH POLICY AND THE ROLE OF ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH WORKERS

The Committee recognises the important emphasis placed on Aboriginal and Torres Strait Islander Mental Health in the Third National Mental Health Plan 2003–2008. It also recognises the importance of the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004–2009 in addressing the long standing trauma experienced by the Aboriginal and Torres Strait Islander population of Australia following almost two hundred and thirty years of European settlement. The involvement of Aboriginal and Torres Strait Islander Mental Health Workers in the management of Aboriginal and Torres Strait Islander people with mental health issues is an integral component of the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004 – 2009 and is an important element of its Key Result Areas 8.2 (Building a Skilled and Confident Workforce to provide Social and Emotional Wellbeing Services within Aboriginal Community Controlled Services) and 8.3 (Enhance the Capacity of the Mainstream Mental Health Workforce to deliver services to Aboriginal and Torres Strait Islander People).

CURRENT PROBLEMS WITH THE ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH WORKER PROFESSION

The term "Aboriginal Mental Health Worker" currently covers a wide range of people doing a variety of work under markedly different circumstances. A further factor that influences their situation is whether the Aboriginal Mental Health Worker works in a government-based, or "mainstream", job or has a position in the Aboriginal community-controlled health sector. Various state-based industrial awards and management

structures, as well as the lack of formal registration for Aboriginal Mental Health Workers in every state, further confuse the picture. The term "Aboriginal Mental Health Worker" also covers a range of qualifications and experience. Aboriginal and Torres Strait Islander people possessing Doctorates in Philosophy and professional recognition as social workers, psychologists and nurses have an association with this role. However, the term may also apply to an Aboriginal elder with a significant amount of "life experience" of the Aboriginal and Torres Strait Islander predicament of mental illness who is undertaking the first year of a diploma course in Aboriginal Mental Health Work. The various expectations of the professional skill and "cultural brokerage" issues in respect to a specific Aboriginal and Torres Strait Islander understanding that such a person may bring to their position is also poorly defined.

The current Aboriginal and Torres Strait Islander Mental Health workforce is a particularly dedicated group of people who wish to work for their people and improve the severe mental health problems currently affecting the Aboriginal and Torres Strait Islander population. However, available evidence appears to indicate that they have significant concern about their lack of recognition as a professional, inequality compared to other health professionals, a lack of recognition of the Aboriginal Mental Health Worker role, and differences in pay and differences in qualifications required for appointment between employers (3). This issue was of significant concern to the RANZCP that it produced a statement in support of the status and work of Aboriginal Mental Health Workers (RANZCP Statement #50 Aboriginal and Torres Strait Islander Mental Health Workers – attached). It is hoped that this statement will enhance the recognition of the valuable role of the Aboriginal Mental Health Workers by the psychiatric profession and the community generally. It appears that the statement, along with the development of competency levels for Aboriginal and Torres Strait Islander Mental Health Workers, is helping to develop a career structure for this profession in certain states (4). A particular point of the RANZCP statement is the potential value of older Aboriginal and Torres Strait Islander people with limited formal education as mental health workers. It is hoped that any strategy to develop the Aboriginal and Torres Strait Islander Mental Health Worker profession would include a further recognition of this issue as well as avenues for the further satisfactory training of this workforce.

CURRENT INITIATIVES TO DEVELOP THE ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH WORKER PROFESSION

The Committee supports any further strategies to validate and improve the quality of health care offered by Aboriginal and Torres Strait Islander Mental Health Workers. This support for Aboriginal Mental Health Workers occurs in the context of a number of other important state and national initiatives in respect to Aboriginal and Torres Strait Islander health that may have a flow-on benefit for Aboriginal and Torres Strait Islander mental health in Australia. The Aboriginal Health and Medical Research Council, which is the peak organisation for Aboriginal Community Controlled Health Organisations in New South Wales, and the Health Department of New South Wales recently signed a Health

Partnership Agreement in an attempt to improve health outcomes for Aboriginal and Torres Strait Islander people resident in New South Wales. Charles Sturt University in Wagga and the Federal Office of Aboriginal and Torres Strait Islander Health have worked together to set up a model Djirruwang Aboriginal Mental Health Worker Course that provides an educational progression through basic certificate to Doctor of Philosophy for Aboriginal Mental Health Workers nationwide (5). Other educational institutes such as Bachelor College in the Northern Territory offer courses for Aboriginal and Torres Strait Islander Mental Health Workers. It should also be noted however that a number of local Aboriginal controlled health organisations have set up their own educational courses for Aboriginal Mental Health Workers suited to their local community. There is also an emerging Commonwealth initiative to improve health worker status generally through the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (6). The strategy generally aims to address methods to increase the number of Aboriginal health workers, a clarification of their role, improvement of training, the role of other groups contributing to Aboriginal health worker needs and accountability of government programs in respect to Aboriginal health workers. Strategy 26 of the Strategic Framework states that "*the Commonwealth, States and Territories will consider specific training to develop a quality Aboriginal Mental Health Workforce*." The Australian National Training Authority has also developed a set of guidelines for the vocational education for Aboriginal and Torres Strait Islander Australians that renews and shares an Aboriginal and Torres Strait Islander learning culture in partnership with Australian government and Industry (7,8). This may guide the development of such training in Aboriginal and Torres Strait Islander mental health in association with specific projects to address Aboriginal and Torres Strait Islander Mental Health Worker career development (4).

REGISTRATION OF ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH WORKERS

Aboriginal and Torres Strait health workers in Australia, apart from the Northern Territory, are not formally registered through state health regulatory systems. There does not appear to be any current registration for Aboriginal and Torres Strait Islander Mental Health Workers in Australia. This issue may have significantly impaired the recognition of the profession and the development of a career structure for Aboriginal and Torres Strait Islander Mental Health Workers. It would be hoped that the Productivity Commission may give due regard to the inequalities that this profession faces in this respect and look to a legal framework that would allow the development of such registration.

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THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

Submission to the Productivity Commission on Health Workforce
July 2005

PURPOSE

This submission is made by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to Australian Government's Productivity Commission study on Australia's health workforce.

INTRODUCTION

The RANZCP is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for setting the training program, examining and providing access to Fellowship of the College to medical practitioners. There are currently approximately 2600 Fellows of the RANZCP who account for approximately 85% of all practicing psychiatrists in Australia and over 50% of psychiatrists in New Zealand. There are branches of the RANZCP in each State of Australia, the ACT, and New Zealand.

This submission focuses on issues affecting the psychiatric workforce. To give context to these issues, we present an overview of the Australian mental health system, its funding, and the demand for mental health services; and describe the role of the psychiatrist and current state of the psychiatric workforce. We then consider key issues, including those raised by the Productivity Commission Issues Paper, before providing our recommendations to the Commission.

EXECUTIVE SUMMARY

- Mental illness is the leading cause of disability burden in Australia.
- People with mental illness often face stigma and discrimination.

- Unlike physical illness, there is also a need for significant support and assistance in non-clinical areas such as work, family support, accommodation, access to long term financial support and co-morbid drug and alcohol problems.
- Most mental illness is treatable, as demonstrated by the increasing body of research on evidence-based medicine. The main barrier to the provision of effective treatment to those requiring specialist interventions is their inability to access service responses appropriate to their needs or in a timely manner.
- We currently have services that are significantly under-funded for the needs of the community, with service components that are significantly disintegrated, and has workforce shortages with inadequate strategies to meet workforce needs in terms of both numbers and skills.
- The RANZCP recognises that workforce shortages and difficulties in recruitment are significant and constitute a major challenge to service provision in this field. There is clearly a discrepancy between the available psychiatric workforce and the mental health needs of the population, particularly outside the major cities.
- The key findings arising from the most recent RANZCP workforce survey is that the Australian psychiatric workforce is aging, with the average age of psychiatrists being unchanged since 1999 at 50 years of age with most psychiatrists within the 45–49 age range. More than 20% are aged 60 years or above; only 13% of psychiatrists are younger than 40 years. The rural workforce is ageing more quickly with less than 8% being under 40 years. There is a high rate of imminent retirement; again rates are even higher for rural psychiatrists.
- Recruitment levels are influenced by the marginalisation of the specialty within medicine and by the stigma associated with the profession and mental illness – these are specific issues facing psychiatry as a discipline, which impact on the status and desirability of the profession. Much of this is a direct result of under funding, system dysfunction and chronic workforce shortages, and improvements in the mental health system are necessary to combat psychiatry's unattractiveness as a career.
- The main market mechanism that needs to be addressed by the Productivity Commission is to recommend a range of suitable incentives and improved remuneration to attract and maintain an adequate workforce within the mental health field.
- General practice training has been exposed to market competition and consequently is delivered by a range of external providers, resulting in a clearly unsatisfactory outcome. This should not become a benchmark for the provision of specialist training.
- There is a need to promote specialty training in psychiatry amongst young doctors and to provide a positive experience of clinical psychiatry during medical school and early residency training.
- Overseas-trained psychiatrists must be adequately supported if international recruitment strategies are to be sustainable. A worldwide shortage of psychiatrists means that recruiting from overseas cannot be a sole solution to Australian psychiatric workforce shortages.

- Australia is experiencing a shortage of other mental health workers, notably mental health nurses. Again, stigma and lack of understanding of mental illness, negative attitudes to mental health nursing among other nursing specialties, lack of focus on mental health nursing within nursing education, increased workload and pressure on services are all barriers to recruitment and retention. Workforce shortages must be addressed, as adequate numbers of mental health nurses are critical to the provision of mental health services.

BACKGROUND

The nature of mental illness in Australia

Mental illness is unlike most other illness, in that for a proportion of patients it is chronic, disabling, and affects all aspects of life. According to the Australian Institute of Health and Welfare, mental illness is the leading cause of disability burden in Australia.[1] Although mental illness is common, it is widely misunderstood, and people with mental illness often face stigma and discrimination.

Mental health services funding

Mental disorders account for 27% of all disability costs in Australia but attract only 7% of health funding. Poor mental health was costing Australia more than $13 billion a year in direct and indirect costs. Good mental health is of critical importance to Australia's overall health and productivity and should be supported accordingly.

Total expenditure on mental health care for 2001–02 was $3.1 billion, or 6.4% of total recurrent health care expenditure. Total government recurrent spending on mental health services has increased by 65% between 1992–93 and 2001–02. In the same period, government expenditure on all health services increased by 61%, therefore the proportion of health budget allocated to mental health has remained the same since 1992–93.[2]

Table 1: Health expenditure in Australia, 1992-2003.

	1992-93	2001-02	2002-03
Total health expenditure ($ billion)	$35.1	$66.6	$72.2
Total health expenditure as percentage of GDP	8.2%	9.3%	9.5%
Total recurrent mental health expenditures (excluding dementias, substance misuse disorders and intellectual disability) as a percentage of total health expenditure	6.2%	6.4%	Not yet available

Source: Adapted from Hickie et al.[3]

In 2001–02 the Australian government contributed $1146 million, or 37.1% of total healthcare funding; the states and territories contributed $1798 million or 58.2%, and private health funds contributed $145 million or 4.7%. In 2001–02, per capita spending on mental health services by states and territories ranged from between

$84 to $110. Funding to non-governmental organisations to provide mental health services accounted for 5% of mental health expenditure in 2001–02, compared with 2% in 1993 although there are wide variations in funding and service provision between states and territories.[2]

What psychiatrists do

Psychiatrists are medical practitioners with a recognised specialist qualification in psychiatry. By virtue of their specialist training they bring a comprehensive and integrated biopsychosocial and cultural approach to the diagnosis, assessment, treatment and prevention of mental illness. Psychiatrists are uniquely placed to integrate aspects of biological health and illness, psychological issues and the individual's social context. They provide clinical leadership, with many working in multidisciplinary team settings. Psychiatrists treat patients and work with the patient's general practitioner, other health care providers, families and carers of patients, and the general community.

Effective psychiatric treatment occurs within a biopsychosocial and cultural context requiring coordinated interventions across a range of support systems. A biopsychosocial approach encompasses treatment with medication (the biological component), psychological therapies, and social interventions such as work programs. This multifaceted approach to treating mental illness is analogous to the approach used to treat other common conditions such as heart disease, which is treated with both medication and lifestyle changes.

The psychiatric workforce

Below are the most relevant findings from the 2004 RANZCP Workforce Survey[4] and other published sources.

Number of practising psychiatrists

In 1999, there were approximately 1,960 psychiatrists in active practice in Australia. This has now increased to 2129 practising psychiatrists, an increase of 8.6%.

Distribution

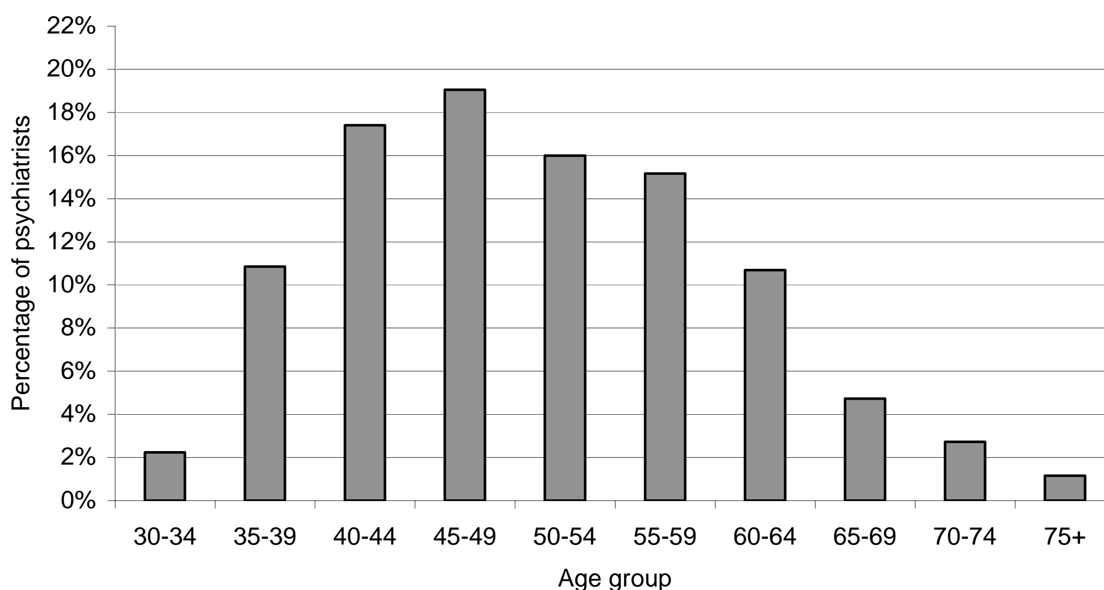
Psychiatrists are distributed unevenly throughout Australia: for 85.3% of psychiatrists, the main place of work is a major city. This urban-skewed distribution is unchanged since 1998. While there has not been any significant change in distribution of psychiatrists there is a notable shift with an increasing numbers of psychiatrists including rural outreach as part of their practice. Of 984 responses to the RANZCP Workforce Survey 2004, there were 71 working in rural areas (7%) and 109 working in both urban and rural areas (11%) – the latter group is mostly outreach providers but includes a small number based in rural areas who also work in the city. For the

figures quoted here, "rural" was defined using the RRMA and ARIA scales, based on residential address.

Age

The average age of psychiatrists has remained unchanged since 1999 at 50 years of age with most psychiatrists within the 45–49 age range. The workforce is ageing with more than 20% being 60 years or above; only 13% of psychiatrists are younger than 40 years. The rural workforce is ageing more quickly with less than 8% being under 40 years.

Figure 1:Psychiatrists by age group



Source: RANZCP Workforce Survey 2004

Gender

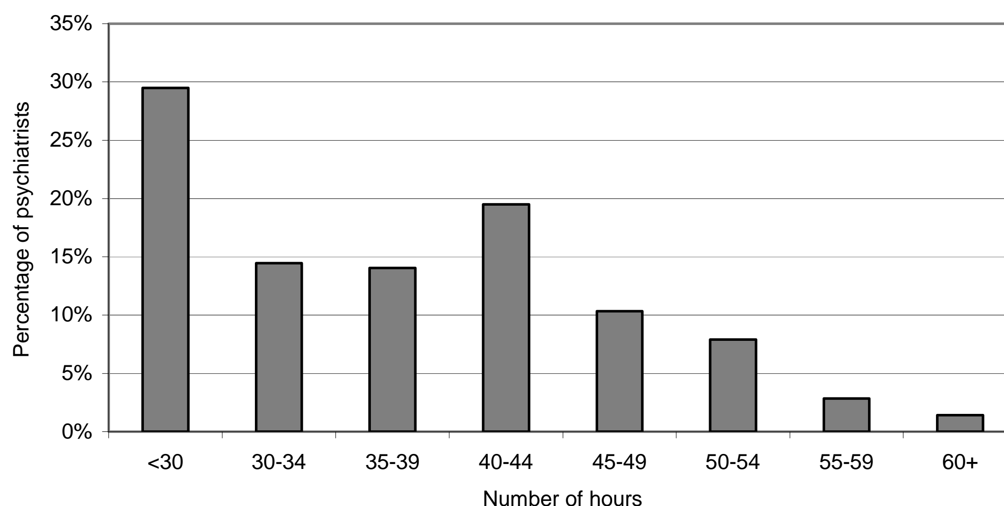
Currently, women make up 32% of psychiatrists, compared with data in 1999 indicating that 27% of the psychiatric workforce was female. Further increases in the numbers of female psychiatrists can be expected, as around 50% of trainee psychiatrists are women.

Hours worked

Previous surveys have found that, on average, psychiatrists work 47 hours per week, with psychiatrists in geographically remote locations working longer hours than psychiatrists in other locations. In the most recent surveys these working hours have decreased to an average of 37 hours per week – see Figure 2. This is supported by HIC data that shows that psychiatric billing is down by over $2 million per year. It appears there are two main reasons for this reduction: reduced working hours to support more family friendly practice, particularly for women, and the increasing

number of hours that are being bought for the provision of medico-legal reports commissioned by a range of private entities such as insurance organisations.

Figure 2: Psychiatrists' working hours



Source: RANZCP Workforce Survey 2004

Work setting

In 1999 the RANZCP/AMWAC survey indicated that 57.1% of RANZCP Fellows worked predominantly in the private sector, 38.3% in the public sector and 4.5% divided their working time equally between the private sector and the public sector. The most recent RANZCP survey showed that the number of Fellows working in private psychiatry is relatively unchanged.

Training arrangements

The RANZCP sets the curriculum for a 5 year training program, which can be undertaken on a part-time basis. Admission to and progress through the program covers two stages following two years post graduation as a medical officer. The training program affords considerable flexibility including the ability to take a break (eg for family reasons) during training and opportunity for people to commence their training at an advanced stage depending on their relevant qualifications and experience. It is estimated that, on average, trainees take in excess of 6 years to complete the program and that less than 40% of trainees complete the training within 5 years.

There were 725 trainees in 2004 compared with 605 in July 1999. Currently just over half of psychiatry trainees are women. There were 115 training places available for commencement in 2005. See the Medical Training Review Panel Report 2004 for further details[5].

Retirement and future plans

Fourteen per cent of psychiatrists plan to retire within the next 5 years increasing to 20% for rural psychiatrists.

DISCUSSION

Psychiatric workforce issues

The RANZCP is of the opinion that it is imperative that quality, safety and legal obligations must be addressed as the basis for determining minimum numbers of specialists within services. The RANZCP, in recognising the current workforce limitations, is committed to developing effective partnerships with the range of mental health professions and examining models of collaborative service provision.

Strengthening the psychiatric workforce involves clarification of the role of the psychiatrist and building on capacities for high-level consultancy, leadership and management, and intervention in complex mental health problems. Effective functioning in these roles requires appropriate training, systemic support for leadership functions and acknowledgment of the psychiatrist as the specialist who integrates biopsychosocial care within an appropriate cultural framework.

To effectively manage workforce issues it is imperative to scope and benchmark the mental health service system and come to agreement on what constitutes an adequate level of care. At present no such benchmarks exist and makes workforce planning an exercise in guesswork.

Recruitment and retention

The RANZCP recognises that workforce shortages and difficulties in recruitment are significant and constitute a major challenge to service provision. There is clearly a discrepancy between the available psychiatric workforce and the mental health needs of the population, particularly outside the major cities.

While issues of poor recruitment into training are not unique to psychiatry and affect all medical specialities, recruitment levels in psychiatry are particularly affected by the marginalisation of the specialty within medicine and by the stigma associated with the profession and mental illness. Much of this is a direct result of under funding, system dysfunction and chronic workforce shortages in the public mental health system, which creates an environment perceived as being continually in crisis mode: highly stressful, unrewarding and unsafe. Improvements in the mental health system are necessary to combat psychiatry’s undesirability as a career. Public sector focus on complex presentations combined with the limited opportunities for broad biopsychological training also contributes to the negative evaluation and perception of the specialty amongst potential trainees.

As noted earlier, the number of female psychiatrists is increasing, which given that women usually bear the primary responsibility for family commitments means an increase in psychiatrists seeking part-time work or taking career breaks. Providing flexible employment arrangements is crucial to retain skilled practitioners.

A worldwide shortage of psychiatrists means that recruiting from overseas cannot be a sole solution to Australian psychiatric workforce shortages, although international recruitment can assist to an extent. Overseas-trained psychiatrists must be adequately supported if international recruitment strategies are to be sustainable. The RANZCP is developing online educational modules to help orientate overseas-trained doctors to the Australian mental health system. In addition, the RANZCP is investigating the provision of a tailored assessment process for overseas-trained psychiatrists, to streamline the examination process for trainees.

Training

Good psychiatric training experiences will not only develop more highly skilled psychiatrists, but also attract more medical graduates into psychiatry. Currently there are concerns that mental health facilities in the public sector provide training mainly in psychotic conditions of low prevalence, with less focus on high prevalence non-psychotic disorders. Trainees should be exposed to a broader range of psychiatric conditions than are currently seen in the majority of the acute mental health services, and should develop skills in psychological interventions in community-based care. Integration of private practice experience from the beginning of training will promote exposure to a broad range of conditions and opportunities to observe experienced clinicians and learn specific skills, and funding mechanisms are required to support this. Public sector services should consider flexible work models for trainees and supported funding for additional clinical medical officer positions to provide cover.

Distribution

For long term development and sustainability of services in outer urban and rural areas, resident psychiatrists must be well supported. Resident psychiatrists working in both public and private practice require practical support to enable them to participate in continuing medical education and peer support activities. The inability to do so, despite "available" leave for conference attendance or time to travel to meetings is a major disincentive to longer term rural practice. Readily available locum relief would enable attendance at conferences and the opportunity for regular holidays and time away from the practice.

In addition, the workforce can be enhanced by visiting services of various types. In rural areas, these include fly-in or fly-out services, telepsychiatry, and outreach teams from larger to smaller centres. The development of formal relationships between large metropolitan and outer urban or metropolitan and rural services is strongly recommended. These relationships could facilitate a variety of models

including rotation (for several weeks/months) of staff between sites and/or regular visiting arrangements.

The development of rural clinical schools offers an opportunity to provide exposure to a range of clinical experiences from an early stage. These include the opportunity to work closely with general practitioners and other primary care providers, to see patients with a wide variety of mental health problems, and to work with indigenous communities. These experiences can also be offered to trainee psychiatrists, with the hope that exposure to these opportunities and the advantages of practice in outer metropolitan and rural areas will attract future psychiatrists to work in these areas.

The rural psychiatric workforce would also benefit from more flexible and integrated practice models. Rural training placements could be linked to general practice settings and be supported by Visiting Medical Officer consultants and supervision. It is seen as extremely important that rural setting training experiences be of sufficient duration (6 months EFT) to allow for the development of appropriate skills and to provide a meaningful exposure to the issues confronting non-metropolitan practitioners. Rural settings may also be more appropriate in providing exposure to issues confronting indigenous communities, an area difficult to address in general training.

Access

The RANZCP strongly supports the role of the psychiatrist as both direct treatment provider and as consultant and coordinator of complex clinical management. Consultation models of working can make more efficient use of the psychiatrist's specialist expertise, and the clinical experience required to work in this capacity is acquired through the role as direct specialist treatment provider. The MBS can be used to facilitate the consultation model. For example, new referred assessment and management MBS items aim to allow GPs to continue to manage psychiatric patients with the advice of a psychiatrist.

Comprehensive assessment and treatment of complex conditions often requires a team approach (with inputs from psychiatrists, psychologists, nurses, social workers and others) and assessment, education and support of the patient's social network. The elements of a clinical team are not easily accessible in the private sector due to out-of-pocket costs beyond the reach of those most in need of such care. Funding models allowing patients of private psychiatrists access to the full range of allied health professionals and mental health nurses are required.

Remuneration

Private psychiatrists have an average annual income of $155,501 with average deductions of $60,357 – the lowest average income of any medical practitioners. Mental health conditions are chronic, but the MBS is set up for episodic, acute or procedural care, rather than the ongoing care those with a mental illness need.

Therefore private psychiatrists may spend a lot of time on necessary activities, other than patient contact, for which they are not reimbursed.

Low levels of remuneration related to the low socio-economic status of many rural and outer urban areas is frequently identified as a disincentive to private practice in these areas. Low socio-economic status has wide ranging effects such as greater need for social/housing and other supports, many of which are not available in these areas. Solutions needed include ways to overcome the income disparity which inevitably develops between practitioners working in outer urban or rural areas and their colleagues. The RANZCP supports the use of incentives such as altered funding arrangements, for example higher MBS reimbursement for those working in rural areas, and perhaps also in selected regional and outer metropolitan areas. In addition, measures will be needed to change the availability of necessary related services if private practice in these areas is to become attractive. Financial assistance to relocate to more distant sites would support workforce redistribution and buffer some of the financial concerns identified.

Roles of the federal and state governments

During the course of the Commission's inquiries we hope that some resources are allocated to the examination of the current anomalies that exist with the existing Federal and State jurisdictional responsibilities. Both of these levels of government have used each other as a foil to avoid investing the necessary resources to address workforce issues that have been brought to their attention over the course of many years.

Concerns are often raised that medical colleges are closed shops interested in maintaining market control by limiting the number of new doctors being trained. It is important to note that while the RANZCP sets the curriculum and administers the examination processes for its trainees, it is the state governments who control the funding for these places. Indeed, as self-funding entities, medical colleges with the goodwill and donation of members' own time, have ensured that the necessary safeguards are in place to meet the standards set by governments to protect the health of the Australian community. The results of a breakdown of this system can be readily seen in the appalling health outcomes on patients of overseas trained doctors who are able to work, with government support, outside these safeguards.

The RANZCP does not believe it is practical to suggest that federal and state funding streams be amalgamated at this point. We propose that the current roles of government be reviewed to address these systemic issues. The following are some suggested strategies for consideration in any such review.

The role of the Commonwealth needs to include:

- Ensuring, via the Medicare Benefits Schedule, that financial incentives are applied in ways that help overcome these structural barriers (for example through the provision of appropriate item numbers for clinical consultation).

- Increasing the Medicare Benefits Schedule rebate for psychiatric consultations to the levels recommended in the Relative Value Study. This would increase the incentive for doctors to enter the speciality and reduce the cost to patients.
- Ensuring, with the states, that the Australian Health Care Agreements support integrated clinical systems rather than encouraging narrow concerns about "cost shifting" between sectors.

The roles of the state departments and services need to include:

- Ensuring a policy environment which, compatible with national policy, promotes state-based systems that respond to a broad range of community needs.
- Ensuring flexible employment conditions for consultant psychiatrists thus promoting a mix of private and public practice.
- Maintaining competitive award conditions for public psychiatrists in order to achieve a proper balance between private and public psychiatry components of the specialist workforce.
- Promoting the development and recurrent funding of innovative and integrated service models.
- Increasing the capacity of state-based services to provide comprehensive treatment for the full range of mental disorders.

Public and private service integration

The best example of poor coordination resulting from lack of agreement between federal and state governments is the delivery of private and public mental health services. Private mental health services are funded through private contribution, Medicare rebates and insurance industry financing. Public mental health services are funded primarily by state governments with contributions from the Australian Government via Australian Health Agreements. Public and private psychiatrists operate largely independently of each another. The division between sectors means that non-medical staff in state services are likely to have limited knowledge of the working environment of private psychiatrists or GPs, and vice versa. Public sector work practices and attitudes may perpetuate these structural divisions.

The impact of these issues is even more exaggerated in outer metropolitan and rural areas where higher community disadvantage and need is exacerbated by lower social capital, fewer alternatives, lower capacity to meet out of pocket costs, poorer public mental health resources and increased public sector vacancies.

However, the Second National Mental Health Plan emphasises partnerships between the two sectors, and, when surveyed, both public and private psychiatrists are in favour of better public–private collaboration and supported the concept of shared care arrangements. The MBS provides little financial incentive or support for collaboration

between the private sector and the public sector or primary care. Flexible employment practices are needed to encourage greater collaboration.

The RANZCP strongly opposes the development of a two-tiered health system in which State administered public services provide care for psychoses and Commonwealth private primary care and specialist services provide treatment for high prevalence disorders such as anxiety and depression. Instead, we propose a layered system with established benchmarks for mental health service delivery.

Private psychiatrists

Private psychiatrists have offered valuable service to the Australian community for decades, treating twice as many Australians as are treated in the public sector, treating a broad range of disorders, and providing that service predominantly within the community, rather than in hospital. Private psychiatrists offer their specialist medical services on a fee-for-service basis, with the Medicare Benefits Scheme paying 85% of the MBS schedule fee for referred patients. To obtain rebates, patients must be referred through their GP. Private psychiatrists mostly provide ambulatory services but around 20% of psychiatric inpatient beds are in the private sector.

State mental health services

Specialist mental health services provided by States have tended to focus on a narrow band of illnesses with a high level of complexity. In many the concept of "serious mental illness" has shifted from its original broader meaning to become equated with psychotic disorders, a difficulty recognised in the second National Mental Heath Plan.

Many non-emergency referrals to state community mental health services are initiated by the patient, family or friends. Therefore public mental health services provide both primary and secondary care. Few other specialist services allow self-referral without a gate keeping or referral function by a primary care provider. In many state services referrals must pass not only through the filter of diagnostic assumptions about "serious mental illness" but also through intake, triage and assessment services provided with limited skills or organisational support.

Primary care

The structural issues within each sector combine to limit the capacity of the two sectors to work together in an integrated way. GPs seeking referral to the private sector draw on limited referral networks and patients may encounter long delays prior to assessment.

Very few mental health services have developed "stepped care" systems linking specialist care to primary care in a systematic way. In such systems GPs and specialists (private or public) develop shared protocols where GPs are supported in the care of simpler clinical problems and more complex or non-responding clinical

problems receive preferential access to specialist assessment or treatment. Such approaches have been implemented in health systems where primary and specialist care sectors operate under one organisational structure. They have been shown to be effective in the care of depression and other disorders.

Subspecialties of psychiatry

The shortage of psychiatrists is particularly acute in some subspecialties, such as child and adolescent, old age and consultation–liaison: this reflects the overall shortage of psychiatrists, and can only be addressed through broader workforce reforms that increase the overall numbers of psychiatrists.

Issues arising from the Productivity Commission Issues Paper

The issues paper provided a good broad overview of a number of major issues related to the Australian health workforce however there a number of specific issues that we believe need to be respond to in relation to psychiatry.

Lack of any mental health focus

One notable omission however is any reference to the specific needs of the mental health workforce. This is surprising considering of the size and diversity of the mental health workforce. The increasing pressure placed on this workforce by rising levels of demand is well documented and the consequent demands placed on people working within these chronically under-funded services is demonstrated by the rising numbers of unfilled vacancies in nursing and psychiatric positions in services across the nation.

Overall, the paper has a specific leaning towards the acute end of the health workforce spectrum. Notwithstanding the complexity the issues within this sector, and consequent demands made on the Commission to find innovative responses, we believe that the issues in relation to mental health workforce require urgent and specific attention.

Previous reports undertaken through AMWAC have raised issues in relation to psychiatry, which we believe have been largely addressed within the constraints of such a significantly under-funded system.

Market friendly mechanism

While we support the relaxing of demarcation lines between some individual health professions we do not see the use of competitive tendering as a suitable mechanism to address medical workforce training. We believe this is a simplistic approach to a complex issue that would result in the loss of goodwill from those within the profession, who give freely of their time in support of their profession and those who work within it.

In the past, competitive tendering of services has worked well for functional aspects of many industries. However as the May 2005 Issues Paper highlights, this process can be fraught with problems and in some cases, can result in the wholesale fragmentation of existing systems and loss of significant intellectual capital and complex supporting networks.

Tendered training programs are not necessarily more efficient, as the experience of practice education and training, which has been exposed to market competition and consequently is delivered by a range of external providers, illustrates. The Royal Australian College of General Practitioners reports that a unitary program costing $25 million per year has become 20 regional training programs at an annual cost of $75 million, and with a failure rate of 70%.

We believe that the main market mechanism that needs to be addressed by the Productivity Commission is to recommend a range of suitable incentives and improved remuneration to attract and maintain an adequate workforce within the mental health field. This is clearly already a significant issue, with the limited number of trainees able to select from a range of more highly remunerated professions that also provide more supportive working conditions.

The introduction of shorter, generic health care degrees.

In order to create more doctors, it is an attractive option to explore the introduction of shorter generic health degrees. The immediate reaction to this proposal is that it is an attempt to dumb-down the profession to which RANZCP would strenuously object if it in anyway compromised patient treatment. However, this may have some application provided that those graduating were under some practice limitations. This raises the issue of credentialing, to which the RANZCP has been historically opposed, and would need to be reviewed on the basis of any future recommendations.

Streamlined options for traditional education training programs.

The RANZCP would have no opposition to the introduction of more streamlined options to existing education and training schedules. However, we would want to ensure that these options delivered effective and efficient outcomes that did not jeopardise patient treatment. We are already in the process of introducing a rapid assessment pilot project to assist overseas-trained specialists to gain Fellowship. We will continue to explore other strategies, in discussion with government, doctors and other stakeholders, that will improve access to specialist advice.

National competition policy

The RANZCP agrees with the Productivity Commission's paper on National Competition Policy that there needs to be an integrated health services reform program within an agreed national framework. However we believe that the nature of any reform program needs to be a negotiated solution rather than one that it

imposed. We support the focus of initial reform on the increasing needs of the ageing population where increasing prevalence of dementia will have significant impact on the service delivery.

Consolidation of professional and registration bodies

We support, where appropriate, the consolidation of professional and registration bodies. The current system of different state based health legislation and regulation reflects the inherent problems previously identified regarding Federal and State jurisdictional issues that creates unnecessary barriers and restricts workforce flexibility.

SUMMARY AND RECOMMENDATIONS

- Mental health services are chronically under-funded. The shortage of psychiatrists must be addressed by rectifying the problems in the mental health system, to make the profession more attractive with improved remuneration and overall mental health system funding.
- The RANZCP believes it is necessary to scope and benchmark the mental health service system and come to agreement on what constitutes an adequate level of care.
- The RANZCP strongly supports the role of the psychiatrist as both direct treatment provider and as consultant and coordinator of complex clinical management. Consultancy models for psychiatrists can be used to broaden access to specialist expertise.
- The RANZCP supports, where appropriate, the consolidation of professional and registration bodies.
- Competitive tendering is not an appropriate way to address medical workforce training. There needs to be an integrated health services reform program within an agreed national framework, which should be a negotiated solution rather than one that is imposed.

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