

**Senate hearing: 5 September 2011.**

**Questions on notice for Dr Maria Tomasic, President of The Royal Australian and New Zealand College of Psychiatrists, (RANZCP).**

**1. Senator FIERRAVANTI-WELLS: psychologists' training/ two-tiered system**

Senator FIERRAVANTI-WELLS: Regarding the issue of psychologists' training has arisen. Tell us a bit more about how you see that two-tiered system working and whether you think there should be any changes? If you do not have enough time, please take it on notice.

**Response:** *The only thing I want to add to my comments at the hearing is to add that the RANZCP believes that the two-tier system should continue.*

**2. Senator FIERRAVANTI-WELLS: Early childhood**

Senator FIERRAVANTI-WELLS: Has the college done any work specifically in relation to early childhood?

Dr Tomasic: Yes, there has been some work on early childhood, addressing the need for increased services there. Dr Tomasic: I can take that on notice and we can send you that.

**Response:** *The RANZCP has sent this information to the Senator as requested.*

**3. Senator BOYCE: Current MBS numbers for consultations with people with intellectual disability**

Senator BOYCE: Do you have any comments on the current MBS numbers for consultations with people with intellectual disability? I understand they are not being taken up at the rate one would anticipate, partly because of concerns, I gather, of GPs that they will simply become clogged with patients with intellectual disability and that they are not financially viable as they currently are. If that area is improved, does that help feed through to you?

Dr Tomasic: I do not know a lot of details about that and I would have to take that on notice, but that does not help psychiatric treatment of those people.

Senator BOYCE: No.

Dr Tomasic: It may improve access to psychological services within disability services, but I do not know enough about the item.

Senator BOYCE: If you could take that on notice that would be great.

**Response:** *I have discussed this issue with my GP colleagues and there were two common themes in the feedback that I have received. Some GPs are still not aware that these MBS numbers exist. The second issue from the feedback I have received is that some GPs do not feel confident in assessing people with an intellectual disability. The College of General Practitioners would have more details about such issues. I understand that they currently offer extensive online information about the MBS number and training in the assessment and management of people with intellectual disability.*

*We do not have any information that the MBS number is inadequately funded and this question would be better directed to the College of General Practitioners.*

*In terms of the issue of dual disability of those people with intellectual disability also suffering a mental illness this is a more complex area. People with intellectual disability and mental illness often present atypically, have difficulties communicating and are thus more difficult to assess and manage than other people with mental illness even within generalised psychiatric services. Assessment and diagnosis by a psychiatrist is important to develop an appropriate treatment plan. Adequate general practitioner access to people with intellectual disability is essential given their high rates of physical and mental illness but does not detract from the need for improved access to both generalised psychiatric services and specialised disability mental health services.*

#### 4. Senator WRIGHT: Personality disorders

Senator WRIGHT: Can I follow up: is there any data that you are aware of in relation to the prevalence or incidence of that condition—whether it is increasing? Are you aware of any evidence?

Dr Tomasic: I am not aware that it is increasing. It has been fairly static for some time, but the rate is—I should know it.

CHAIR: Just take it on notice if that is okay.

***Response:*** Borderline Personality Disorder (BPD) is prevalent throughout the Australian community with an estimate of between 2% and 5% of Australians having this diagnosis. I am not aware of any statistics that indicate that the rate is increasing. The suicide rate of people with BPD is around 10%, and they have high rates of comorbid depression and anxiety disorders, drug and alcohol abuse, and are over-represented in the criminal justice system.

*The Committee should note that treatment options are scarce and costs to the whole of the system are very high with frequent admission to emergency departments, intensive care units etc.*

*The Senate Select Committee's Report of 2006 highlighted the need for three areas; eating disorders, post natal depression and personality disorders. The first two have received significant government funding; however there has been no funding allocation for personality disorders.*

*There is a need for the provision of coordinated community based state-wide specialist services for people with BPD. Such services could incorporate increased workforce training and education, clinical supervision, research and carer support.*

*The BPD Expert Reference Group was formed within DoHA in late 2010 to explore broad issues associated with BPD including prevention, early intervention, research needs, workforce education and training, and service models; and a Borderline Personality Disorder Clinical Guideline is being developed by NHMRC and a Guideline Development Committee.*

#### 5. Senator MOORE: Referrals.

Senator MOORE: I would really like to know how the referral process has been working, on the basis of people being referred to psychiatrists. I am really interested in your comment about duplicate referral and the one mental health plan. That interests me, and I wish there were some way to find out on how many occasions that happened but I do not think there is. I would like to know about the referrals process.

***Response:*** We have received feedback on this issue from our members but unfortunately do not have statistics available.

*Some people are referred by their GP to a psychiatrist for 'medication', and a psychologist for 'therapy' at the same time. This implies shared care but the decision is not being made by the psychiatrist, often inadequate information is received and specifically no information is available as to what treatment the psychologist is providing.*

*This raises issues of:*

- Poor communication between psychologist and psychiatrist. Some of our members have reported that they have written repeatedly to psychologists requesting information and not received a response.*
- Shared care with no clearly defined roles, in relation to the therapy as psychiatrists always provide some form of psychotherapy and this is sometimes augmented by medication.*
- Concerns by psychiatrists that in such situations it is the psychiatrist who takes on the vast majority of the medico-legal responsibility but is 'forced into' a shared care situation.*

**6. Senator MOORE: How much psychologists and other people who are treating under Better Access work with psychiatrists?**

I would also like to know about the other intent, which was to have a co-operative multidisciplinary team approach to people's needs—a patient centred approach. I am interested to know, from your perspective as a college, how much psychologists and other people who are treating under Better Access work with psychiatrists. I know that would vary, so that is on notice.

**Response:** *In general this doesn't occur. It is more common for psychologists to work with GPs.*

**7. Senator MOORE: Workforce issue**

Is there anything from your college about what the current spread of psychiatrists' services are and whether in fact there has been any discernible reduction in psychiatrist referrals and workload as a result of Better Access.

**Response:**

*The RANZCP has received some feedback from members that there has been a noticeable drop in referrals to psychiatrists, however we do not have any statistics available about this, or if there are variable impacts in the different states.*

*The table below indicates the breakdown of RANZCP members across Australia and New Zealand (as defined by postal address). These Statistics were current as at 31 December 2010. (The College membership includes a further 328 retired Fellow members, who are not included in this count). When looking at the data of the spread of psychiatrists please note that many psychiatrists have one primary practice which would be recorded as their 'location' however many psychiatrists work in many places.*

Member type	NSW	Vic	QLD	NZ	SA	WA	TAS	ACT	NT	Overseas	Total
Fellow*	861	795	482	320	269	237	50	45	13	114	3186
Associate Member (Trainee)	300	212	159	148	53	64	14	16	5	4	975
Affiliate Member	6	10	10	127	2	6	2	0	1	0	164
Total	1167	1017	651	595	324	307	66	61	19	118	4325

*In December 2008 the RANZCP conducted a workforce survey of our members. The following statistics were recorded from that survey and these may also be of interest to the Committee.*

- At least 26% of RANZCP Fellows are over 60 years of age. This needs to be taken into consideration in workforce planning and recruitment of doctors into the specialty of psychiatry.*
- In the RANZCP's most recent workforce survey (2008), 16% of Australian Fellows who responded indicated they spent time practising in rural areas.*
- The 2008 workforce survey also found that a psychiatrist working in both the public and private sectors was common in Australia.*

**8. Senator McKENZIE: 'maldistribution'.**

I wonder whether the college has any suggestions on what can be done or has any recommendations around improving that maldistribution. I am happy for you to take that on notice as well.

**Response:** *Firstly it is important to state that there is an overall shortage of psychiatrists. Rural areas suffer significantly greater shortages, as psychiatrists like most people prefer to live and work in major cities. Trainee psychiatrists also report a clear inclination to practice in capital cities or urban centres.*

*In Australia the distribution of psychiatrists does not reflect the distribution of the population. In Australia, 81% of psychiatrists service 66% of the total population, which leaves 19% of psychiatrists to service 34% of the population, that being the percentage of the population that live in rural Australia. The more remote the location, the worse the access is to psychiatric services.*

*The RANZCP has previously made recommendations on a range of strategies relating to training, workforce, and innovative models of service delivery that are aimed at enabling rural communities to access a full range of mental health services as near to their place of residence as possible.*

**Training:**

*The RANZCP has identified a number of strategies to promote rural, regional and remote psychiatry through training which include:*

- Increasing the numbers of medical students with a rural background in proportion to the population by establishing enrolment targets and weighting of enrolment criteria in favour of regional/rural students.*
- Increasing the availability of longer rural clinical placements for trainees and improving the capability of rural mental health services to accept psychiatry trainees.*
- Improving the support provided to trainees working in rural and remote settings including, information and orientation, internet access, peer support via the internet, good supervision, mentoring, access to CPD and educational material, adequate accommodation, travel assistance, promotion of telepsychiatry training opportunities, increased opportunities for advanced training in rural and remote settings and financial assistance to cover additional costs that are often involved in re-locating.*

**Recruitment and retention:**

*The RANZCP recommends further government funding and grants aimed at improving the recruitment and retention of rural psychiatrists such as:*

- Increasing the level of support to psychiatrists who reside and practice in rural areas, specifically in relation to providing access to continuing professional development and access to locum support. This is particularly relevant to specialist international medical graduates who may require further support in terms of academic requirements and supervision.*
- Increasing financial incentives to psychiatrists who reside and practice in rural areas;*
- Supporting employers to offer competitive salary packages (and relocation costs) to attract psychiatrists to rural areas.*
- Encouragement of health services to develop policies and procedures to assist in finding employment for a psychiatrist's partner. These are to be developed to enable couples to be recruited and once recruited to be retained in rural and remote locations.*

**Continuing Professional Development (CPD):**

*A range of CPD resources and supports for rural psychiatrists is needed to meet mandatory CPD requirements and minimize the risk of professional isolation. It is therefore recommended that extra financial and practical support is required to improve access to all components of CPD for rural practitioners and promote sustainable lifelong learning and clinical practice improvement, including:*

- Regular contact with peers and supervisors is a core component of CPD. Whilst telepsychiatry can improve access, regular face to face contact is also required, particularly for peer review groups, practice visits and supervision.*
- Development of specific ongoing learning resources for rural psychiatrists in generalist mental health and rural and remote mental health practice. This may include online modules and lectures, interactive web based or videoconference workshops, and postgraduate courses*
- Access to locum support to promote attendance at CPD events, postgraduate programs and congress and conferences.*

**Service delivery:**

*Innovative models of service delivery are required to meet the needs of rural communities and provide access to quality mental health care.*

- *In communities without adequate numbers of resident or local psychiatrists, or where sub-specialist services are unavailable, flexible models of psychiatric service provision should be supported to ensure equitable access in all communities. Flexible models may include the use of telepsychiatry and fly-in, fly-out services.*
- *Financial assistance and practical travel arrangements (which minimise fatigue) should be available for psychiatrists visiting rural areas via outreach programs, in communities where there is an unmet need and an inability to employ a resident psychiatrist within the area. Outreach services should focus on fitting in with local services and up-skilling to improve the sustainability of local medical services*
- *Telepsychiatry has the potential to deliver significant benefits to rural psychiatry, particularly in relation to sub-specialist and consultation-liaison services.*

*It is important that the Government work with stakeholders to promote access to relevant community infrastructure. Telepsychiatry is also a useful tool for training, delivery of clinical services to rural areas, as well as supervision opportunities for rural psychiatrists.*

*The RANZCP recognises that the federally funded Medical Specialist Outreach Assistance Program (MSOAP) has been a successful program in funding psychiatrists to work in rural and remote regions and supports its continuation. We are aware the program is currently being evaluated and feedback from clinicians should be used to improve the program.*

**9. Senator McKENZIE: Education and training of psychiatrists**

Senator McKENZIE: I wonder whether you have any comments about the education and training of psychiatrists here in Australia and of their support staff dealing with the particular issues around working with colleagues from other fields and that sort of thing?

**Response:** *Further to the comments I made on this topic at the public hearing the Committee should note that psychiatrists are first trained as doctors who undertake six years of university study, including some teaching and experience in psychiatry, to gain their basic medical qualifications.*

*They then work as interns in a general hospital for a further 12 months to become registered medical practitioners, followed by at least another year as Resident Medical Officers. Throughout this process psychiatrists are working closely with support staff and with colleagues from other fields*

*Further, the College's program for post-graduate training in psychiatry takes a minimum of five years, during which time doctors (as psychiatrists-in-training) work under supervision and within multidisciplinary teams in hospitals and community clinics with children, families, adults and the elderly on a full range of psychiatric problems.*

*Within hospitals they are commonly involved in liaison with other areas of medicine and surgery, for example as consultants to pain clinics.*

*Doctors have extensive training and experience in assessment and diagnosis and in providing written opinions such as case notes, letters and discharge summaries, which are all means of communication between professionals.*

**10. Senator McKENZIE: Comment on the use of online services, please expand particularly in reference to using online services as treatment or complimenting face-to face treatment or primarily as an information/education platform.**

**Response:** *There has been a substantial development of online services, especially over the past five year. Online services have particularly successful in de-stigmatising mental illness for people with mental illness and their families.*

*Australia has been a world leader in online services, and many Australian online services have been recommended for use in other countries for example, MoodGYM, a free, interactive online program, which provides Cognitive Behavioural Therapy (CBT) interventions, has been recommended in the UK. The program includes self-assessment tools and relaxation audio downloads.*

*Another example is the Beyondblue website which lists over 60 links to various online services, targeting the high prevalence disorders. They also offer information for families and supporters.*

*Some programs such as MoodGYM have been evaluated and shown to significantly reduce depressive feelings and unhelpful ways of thinking. They do not replace face to face services but can certainly augment such services with providing further information about disorders and treatment modalities and offering people flexible, private assistance which allows people a greater sense of control and autonomy. They are especially useful to people in rural or remote regions, people who are housebound for various reasons, those hampered from seeking help due to stigma, and younger people who as a group are more comfortable with computer technology.*