Dr Michael Block MBBS FRANZCP
Consultant Psychiatrist specialising in mother-infant psychiatry

Provider number: 036509EY

Consulting hours: Tuesday: 10-6pm
Wednesday: 10-6pm
Thursday: 10-6pm

Commissioners
Royal Commission into Victoria's Mental Health System

Saturday, 25 May 2019

Dear Commissioners

Thank you for providing an opportunity to present my submission.

I am a psychiatrist, working in private practice, in rural north-east Victoria, and mainly in suburban Melbourne. During my 20-year career as a psychiatrist, I have:

- Established a 5 day stay mother-baby unit at Rosebud Hospital in outer Melbourne
- Worked for 12 years on the Parent-Infant Programme at Albert Road Clinic, a private psychiatric hospital based in central Melbourne, during which time I established a hospital-based Day Programme and a Community Outreach Programme. During this period, the Unit won an award for being one of the best private hospital programmes in Australia.
- Worked as visiting psychiatrist to the Masada Hospital Mother-Baby Unit in St.Kilda East.
- Work in private practice delivering individual psychotherapy and medication management, parent-infant play-based therapy, couple therapy specifically focusing on parenting and transition to parenthood issues, and group psychotherapy, including mother-infant play therapy groups as well as therapy groups for new mothers, both in private practice and hospital Day Programmes
- I have a small private practice, based in Wangaratta. This is the focus of the first part of my submission

My experience of an attempted transition from a city-based practice to a rural practice

I have 20 years of experience working in the sub-specialty of **Perinatal Psychiatry**. The focus of my work is working with women or couples from the day they start to plan to begin a family, through issues that arise during conception (natural or assisted), pregnancy, childbirth or loss of pregnancy, early parenting, adaption to parenthood and the impact of this on couples, and parenting issues up until their child is 3 years old. I am not a general psychiatrist and have not worked in this area for 20 years. I do see a range of psychiatric presentations, and prescribe a limited range of medications, suitable for pregnancy and the post-partum period.

Background

Three years ago, my family relocated from inner Melbourne to north-east Victoria. My intention had been to continue working in my sub-speciality 3-4 days a week, based in Wangaratta or Wodonga. I accepted that rural private practice remuneration would not be equivalent to that in inner-Melbourne, however, as a beneficiary of a free university education in the 1970s, I believe that offering a substantial discount to my services for those who cannot afford my regular fee is a part of my repayment to the community for its investment; those patients that can afford a gap fee, cross-subsidise those that cannot. In addition, I contacted the local area mental health service, investigating whether there was any public sector sessional work in my area of expertise. Sessional work in rural

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areas pays the same as urban areas, and it was one way that I could make the transition economically manageable for me.
I was disappointed to discover that there was no sessional work in the public sector in my area of expertise, despite the service offering a small perinatal programme, as there was no funding for a psychiatrist. There was sessional general psychiatry work available, however I have no skills in this area, nor a desire to work outside my area of training and expertise. This situation, that I doubt is unique to me, leaves me with the options of a complete relocation of my practice to rural Victoria and accepting a 50% income reduction, or continuing my private practice in Melbourne. I have understandably, but regretfully, chosen to continue my private practice in Melbourne and only operate a limited private practice in Wangaratta, despite there being sufficient demand for a full-time specialist perinatal practice in the area. There are no other perinatal psychiatrists in the region. I commute to Melbourne where I work three days a week.

Problem

There are no existing programmes that coordinate the relocation of psychiatrists from urban to rural areas unless they are employees of a State based Mental Health Service. This, in part, reflects the difficulty of shared funding responsibility between the Federal Government through Medicare rebates, and State Government full, part-time or sessional employment by an area Mental Health Service. Procedural specialists may be more likely to obtain public hospital sessional access or at least private hospital access and private health funding that maintains income equality after the rural transition. Non-procedural specialists such as psychiatrists are disadvantaged as there are fewer private hospitals, less psychiatric inpatient options, and no specialised rural private psychiatry services. It leaves regional and head office health service planners unaware of any opportunities that may arise with ad hoc relocations of non-procedural specialists, and local mental health services rarely have the budget flexibility to accommodate unanticipated opportunities'

In addition, Medicare pays a supplement to psychiatrists who offer private practice based telepsychiatry to rural based patients, but this means that I can earn more money offering telepsychiatry services to my patients from my Melbourne rooms than I can earn seeing the face-to-face.

Suggested Solutions

Governments like to plan services. This allows for an efficient distribution of resources across the State. Whilst Medicare funding is more ad hoc in that it 'follows the doctor' and it allows me to work anywhere in the country, the reality of rural demographics disincentivises psychiatrists from relocating to rural areas unless they are unable to obtain public sector sessional or part-time employment. This is not possible if local services don't have the budget to offer employment, and the workforce EFT are strictly controlled. There's a tension between the advantages of a coordinated, planned workforce and a flexible response that provides an additional budget to local area mental health services to offer sessional employment to psychiatrists that plan to relocate to rural areas. A central fund that can be used to provide ongoing sessional employment, particularly to psychiatrists that aren't general psychiatrists (i.e. perinatal psychiatrists, psychogeriatric psychiatrists, consultation-liaison psychiatrists) would create treatment options that may otherwise be unavailable for rural citizens at the cost of some addition, and also a less planned service delivery.

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Victorian Perinatal Services

The second item in my submission concerns my experience of working in this area providing services to Victorian citizens for 20 years. I will identify problems and offer some suggestions to remedy these.

Access to Services

There were almost 80,000 births recorded by Births, Deaths and Marriages in Victoria during 2018. Worldwide consensus establishes the rate of significant perinatal mood disturbance at 10-25%, that is, approximately 8,000- 20,000 new cases during that year alone. In addition, 0.01% (1 in 1000 women) will experience a post-partum psychosis, that is around 80 women. The rate of perinatal mood disturbance in men is less researched, however there are strong suggestions that the rate of mood disturbance is similar in men. Understandably, in recent years this has been recognised as a significant problem for Victorian citizens by both State and Federal Governments. There have been a number of welcome initiatives in this area although there it appears to be some difficulty in retaining funding to provide longer term services. Whilst Maternal & Child Health Nurses now offer routine post-natal mood screening, there are no established pathways to care beyond the screening, many women will get no care beyond a suggestion that they see their GP. There is no screening for fathers and presumably even less access to care. There has been no community education regarding the vulnerability for fathers during the perinatal period, and this, in addition to men's general reluctance to ask for help, suggests that there's a significant unrecognised and probably untreated morbidity in new Victorian fathers.
I have a special concern for pregnant women with mental illness. Should they require admission they are often treated in general adult wards during a particularly vulnerable period of their lives and treated by general psychiatric services without routine access to specialised perinatal psychiatry secondary consultation.

Coordination between Adult and CAHMHS

Although most people with perinatal mood disorders are likely treated in the private sector by GPs, psychiatrists and psychologists, in my experience there are difficulties when these families are treated in the public sector. Adult services are good at treating mothers but untrained at assessing and managing mother-infant relationships. CAMHS does a better job at assessing infants but don't have expertise or resources to properly treat adult mental illnesses. The value of a perinatal approach is that it considers both mother and infant, together, and can treat the dyad rather than just treating individuals. The result is that infants and the parent-infant relationship is often neglected if the pathway to care results in a referral to adult services, maternal mental health is often sub-optimally treated of the pathway to care is through CAMHS services, and fathers are routinely under-assessed and untreated.

Suggestion

That specific funding is provided to create specialised perinatal community treatment services, either as a part of adult mental health services, or as a part of CAHMS services. Victoria can also benefit from more specialised Parent & Infant inpatient services and that these should be local, rather than centralised in Melbourne.

Lack of Inpatient & Community Treatment Options, and Poor Coordination

Victoria currently offers routine post-natal mood screening, administered by Maternal & Child Health Nurses. There is no routine screening for pregnant women, and no routine screening offered to fathers.

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There are currently a small number of public Mother & Baby Units in Melbourne teaching hospitals, and 3 units located in large regional cities. There are 2 private MBUs, and several private 'sleep and settling 5 day stay units – these are not MBUs and they are unable to provide appropriate psychiatric care during a brief admission. There are no MBUs in north-east Victoria nor south-west or north-west Victoria. This creates difficulties for families from these areas if inpatient treatment is required, as it must be provided in Melbourne, and it makes it all but impossible to assess and treat the family unit in a holistic way. It creates additional stress on older children in these families, and difficulties for fathers who usually feel like they are needed in two places at the same time.

Compounding this problem though is that there are no specific public perinatal services that provide either day programmes or community-based care, either as an alternative to inpatient care, or as a post-discharge support and recovery. Our experience at the Albert Road Clinic Perinatal Service reflected that of the general literature, that our unplanned re-admission rate dropped from around 25% to nearly 0 after providing both day programme and outreach community-based support for families following discharge. Currently, post discharge care is provided in a completely ad hoc way and is particularly poor for rural citizens who are usually offered little more than medication management or generalised psychology support. The workload for private practice perinatal psychiatrists is difficult as they have no support from public sector day programmes and little specialised community-based service support.

The private sector currently provides little in the way of perinatal inpatient services. At one stage during the 1990s Melbourne was known as 'the Mother-Baby Unit capital of the world', as, at that time, there were more MBUs in Melbourne than in the whole of the UK. The fundamental problem is that, in both public and private sectors, mother and baby units are expensive: lengths of stay are much longer, often around 4-5 weeks is required for the problems to resolve to the level that allows continued community-based care.

Funding models only recognise one of the dyad as 'the patient'. This creates funding stress in both public and private hospitals as a '6 bed' unit effectively has 12 patients, perhaps more if fathers are encouraged to stay, yet, are only funded to provide staffing levels for 6 patients. These two factors make Mother-Bay Units more expensive in the public sector and less profitable in the private sector, yet, the value of these service is undisputed in the literature. The result of this is that, on the whole, the private sector is reluctant to offer these services, the services that are offered are rarely comprehensive, and there are insufficient public sector inpatient and specialised community services. There is certainly no funded capacity that also allows for the admission of fathers in addition to mothers, nor for the care of other children in a way that would keep families together at this difficult time.

Suggestion
That the funding model for inpatient parent infant care is altered so that each member of the family that is treated in an inpatient setting is properly funded.
That community based perinatal care is recognised as a priority, properly funded, and integrated into the health system.

Fathers

As mentioned, fathers are understood to have a similar risk to mothers for perinatal mood disturbance. There is no public mental health response directed towards expecting and new fathers. Whilst, presumably many attend ante-natal birth classes, the focus of these classes is on birth and attendees

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often have poor recollection of parenting issues that may be covered there. Mothers attend MCH nurses, but many fathers are not seen, nor have their mental health assessed at any stage.

Suggestion
That there be some consideration towards a public health awareness response to this problem through community education.
Fathers should be encouraged to attend at least one MCH Nurse appointment, this may be more inclusive of fathers if the service was renamed 'Family & Child Health'.

I'm keen to provide further information to support this submission, and to meet with the Royal Commission if it would be deemed helpful. I note that your web page lists no public hearings in either Wangaratta nor Wodonga.

Yours truly,

Dr. Michael Block