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Personal Submission to Royal Commission into Mental Health Services

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Introduction

This commission is a very heartening and exciting opportunity. Anyone touched by mental illness or working in the field knows how much suffering is missed and even mistreated in Australia. We see the costs and lost opportunities for richer freer lives and of course lives lost that could have been well lived had the right conversations taken place when they were needed. While there are frequent reviews into mental health that are ignored, underwhelming or both, this feels very different. I have contributed to other submissions from the professional bodies I am involved with and this is my personal submission which I hope is just the beginning of my involvement with the commission. I bring multiple personal and professional perspectives to the mental health system and have confidence in my views as representing the balance of many competing demands at many levels.

My professional background, perspectives and experience

I have family members who have had and continue to suffer major mental illness. I am a general, child and adolescent psychiatrist with a fellowship in infant mental health. I have been a consultant psychiatrist for eight years at Geelong CAMHS where my primary roles are for the perinatal and infant mental health program, the paediatric consultation-liaison service child protection liaison and general leadership and supervision of a team of 8 child psychotherapists across disciplines.

I have a been a director of the board of Alfred Health for five years and am the chair of the Primary Care and Population Health Advisory Committee. I also run a private practice seeing children and adults of all ages and am several years into training as psychoanalyst with Freudian school of Melbourne.

I have lived in several states of Australia and Germany and the United Kingdom and have a wide passion for books, film, music, history, philosophy and politics all of which has some bearing on my professional work too.

I have been closely involved in submissions with several groups:

- The Victorian branch of the Royal Australian and New Zealand College of Psychiatrists
- The Victorian branch of the Australian Infant Mental Health Association,
- The Victorian Network of Area Infant Mental Health Services,
- Through discussions with a senior colleague who is the subject matter expert for The AMA Victoria's submission into child and adolescent mental health,
- The submission by Barwon Health – my primary public appointment.
- Alfred Health's submission to the Royal Commission

This submission is mine as an individual; my views are my own and do not reflect those of other institutions. For context and transparency it is important that my involvement in the above is declared.

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Aims
My ambition is to provide background and recommendations that are of interest and of value to the commission. It is impossible to know what the right level of detail is, how persuasive to attempt to be, how indeed to *be* persuasive, particularly without knowing what the questions are in the minds of the commissioners that have emerged following the many hours of consultation and reflection that I am aware have taken place publicly and privately.

If I may be frank, I am hoping to be invited by the commission to provide more focused, detailed and referenced evidence to the commission. By no means do I have all the answers, though I am particularly well placed by virtue of the nature, degree and breadth of my clinical and personal experience to be aware of some of crucial gaps and opportunities in the system. I also work with among the least vocal, the most vulnerable populations who suffer enormously often in silence. I aim to provide insights into the most neglected areas of mental health care and advocate for changes there, specifically perinatal and the 0-12 age group. This is by no means at the expense of those major gaps in service provision that are better recognised and publicised already such as crisis responses, homeless people, forensics, adult inpatient and outpatient care.

There is an extraordinary hidden demand for specialist services that has become apparent to me over the last decade of clinical practice at senior levels that I hope to make the commission more aware of. There are solutions to this that require resources but also an re-emphasis on modes of thinking and treatments that are also widely used within the subspecialist fields but are outside the domain of public mental health services in the main; specifically psychodynamically informed care.

Limits and structure of this submission
This is not my comprehensive plan for mental health nor all I have to say on the matter. I do not cover many important gaps, problems and opportunities within the mental health services, instead I have chosen to focus on those that I feel are most crucial to be emphasised given the breadth and density of the information the commission will be receiving. I have tried to balance the level of detail required to inform and be sufficiently persuasive though with such large and complex material this is difficult. I have also not addressed the determinants of mental health in any detail such as socio-economics, Adverse Childhood Experiences (ACEs) among many others. I know other submissions have and they are crucial too but I have chosen to focus on the actual professional systems of mental health care and treatment to provide some limit to this already lengthy submission. The most important omissions are aspects of care for those with chronic major mental illness, and also elderly and lonely people of all ages, helping them live well, feel safe and be valued in the community.

This document will be in two parts – the first with more over-arching comments on the mental health system and the second part with some focused recommendations informed by my key perspectives, representing the populations I work with. Some of my recommendations apply across the mental health system, though I have sought to discuss the patient groups that need to be brought into far greater prominence.

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PART ONE

Primary themes and recommendations:

1) **Build on Victoria's strong foundations**
    a. Cultivate and grow the great work that is taking place all over the state

2) **Stigma, Culture and lack of services perpetuate the problem**
    a. Mental Health is seen as "other" when it is the most universal thing of all. Doctors refer too late to MHS out of habit, but also because services are so rare
3) **A prominent voice for the most disenfranchised**
    a. The loudest voices and most compelling advocates get the funding in health care. The system must explicitly seek to consider the needs of the most silent groups: infants, young children, pregnant women and partners, the homeless, the disabled and those with severe chronic mental illness

4) **Aim for prevention - Treat early in life and early in the disorder**
    a. Perinatal and 0-12 age groups is where the best value and change takes place

5) **End rationed mental health care**
    a. Demand for access and treatment must drive the funding, not crisis and public disturbance
    b. Each region, metro and regional has specific needs and flexibility in service offering, structure and funding is necessary for locally driven solutions

6) **Provide the service that families and referrers want**
    a. Patients and families, with their doctors guidance, must drive their care and treatment

7) **Aim for parity with physical health care across all ages**
    a. Funding, focus and modes of treatment must be equalised; treatments available in the private sector must be available for low income people too.
    b. Governance needs to be better matched. Consideration should be given for having a general and a child psychiatrist as invited members of each quality committee to assist in carrying out the commission's recommendations.
8) **Small focused investments immediately can make an enormous difference**
    a. Some investments such as capital and improving workforce capacity will take years but there is no need to wait for small targeted, recurring funding to strong teams
    b. An example is the $150k for rural perinatal services – the clinical impact this services make to over 100 families year is extraordinary, and is now a node for increasing expertise and service.
9) **A Royal Commission into the Child Protection System**
    a. It is an open secret that the Child Protection System is not fit for purpose. The neglect, abuse and suffering that goes on under the watch of the state, the social and societal determinants of this are so far beyond what the CP and the courts can remedy. If people affected by family violence and mental heath problems deserve a royal commission to be heard and have solutions, surely neglected and assaulted children do to.
    b. In the mean time, the offices of the (excellent) principal practitioners in CP should be expanded to include child psychiatry and psychotherapy positions to provide clinical work and improve the governance of the thousands of talented and conscientious professionals in the field.

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Build on Victoria's strong foundations
There is a long tradition and an interesting history of good mental health care in Victoria that has ebbed and flowed since the steady waves of psychoanalysts emigrated from England, Europe and South America through the first half of last century and Australian psychiatrists travelled to do fellowships abroad. There is a strong network of highly skilled psychiatrists and psychotherapists across disciplines, many known around the world. A critical mass developed through the 1960s sustaining training and research that has been highly regarded for decades but flies below the radar. But there simply is not enough of them/ us to be able to provide treatment when and where it is needed – the very intellectual and personal attributes that make someone inclined toward becoming a psychotherapist or an analyst are not those that make one a fierce and vocal advocate, administrator or empire builder. Hence the psychotherapies have become less mainstream in recent decades despite their superior effectiveness and rigor to many purportedly evidence-based treatments.

An end to heavily rationed services
Victorians should have access to *evidence informed treatments* that are clinically indicated, that they want and that their treating psychiatrist prescribes, just as we do with medical and surgical services where rationing is more or less not tolerated. In mental health, services are severely rationed such that care is necessarily funnelled into crisis services, with anything subacute or chronic, regardless of how severe the suffering or psychopathology being managed with the few resources that remain.

Whole classes of treatments that are severely rationed – the psychotherapies in particular. For instance if I prescribed risperidone or an antibiotic and the hospital pharmacy was out of stock for a month, this would make the newspapers and be rectified. But let's say I see I single mother with a an aggressive 7 year old and a 4 year old with speech delay who have left a family violence situation and need psychotherapeutic treatment each week (ie perhaps half the cases who present to primary care) essentially the dispensary is almost bare. *Surely its time for rationed mental health care to end.*

Mental health treatment must begin early in life and early in the disorder
Most paediatricians and GPs I talk with have many experiences of very helpful input from private psychiatrists or CAMHS', but they want the process to be simpler and more consistently available so that the countless other families they work with can be helped far more readily. As such we would do well to advocate for a system that provides access when and where families need it, particularly *early in life and early in the disorder's progression*. The way the system is structured, psychiatry is the service of last resort - what we have is akin to an oncology service set up only for metastatic disease.

True prevention of mental illness is probably not possible any more than prevention of all cancer. To be human is to suffer, but some of the worst suffering can be minimised or avoided with:

- Society wide emphasis on improving the determinants of mental health
- A society where people have an equal chance to improve their lives
- A walfare system that supports those in genuine need but doesn't trap others with it
- The right mental health treatment that begins pre-conception (yes this is possible,) with those who are pregnant and with infants and very young children.

The mental health system should approach the problems it is concerned with in a manner similar to cancer services ie: almost limitless resources for public health, primary care and specialist services that aims at prevention where possible and early detection and high level treatments at the right place, right time. There is no delay, no rationing, no piecemeal dosing of radiotherapy as there is for regular psychotherapeutically informed care in mental

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health. Treatment should be based primarily on demand per the clinicians prescription, informed by patients' and families' choices thoughout.

Demographics and hidden demand
Something close to 40% of the caseload of community and developmental paediatrics is emotional and behavioural problems, very few of whom will have access to psychiatry until the risks are high. We could add to this the proportion of children with physical symptoms whose treatment has in part an underlying emotional or relationship component to its resolution.

Children who should have specialist mental health involvement include:
- Very sick babies and children,
- Those born with congenital abnormalities and illness
- Sleep and settling problems
- Feeding problems
- Speech delay
- Intellectual and developmental delay
- Possible autism
- Toileting problems,
- Functional disorders
- Chronic pain
- Conversion-type syndromes
- "Munchausen's-esque" presentations for example.

There is clearly a very large number of children who could benefit from input by a child psychiatrist or psychotherapist but rarely do because of *stigma, culture and lack of services*. The hidden demand for specialist mental health care is perhaps as large as the need that is apparent. *All children with the above could benefit from experienced mental health input, not because they have a mental illness* but because work that is grounded in psychotherapy can help resolve these problems.

Principles for change

It is easy to describe the gaps and problems in the mental health system but surprisingly hard to formulate clear and focused solutions. Two useful questions toward this are:

1) **What should be the role of psychiatry and the mental health service**
2) **What should a mental health services be able to provide?**

1) **Mental health services public and private should be at the centre of care, not the service of last resort**
    a. You don't need a mental illness to benefit from seeing the right mental health clinician.
    b. If a child has a fever, they see a GP and a paediatrician that day if necessary, even though is likely a benign condition that has caused it. By contrast, a child shows signs of emotional disturbance and they are likely to see a child psychiatrist or psychotherapist only after months or years of failed behavioural and medical treatments.

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2) The mental health system should provide:

- **Access: "Right care, right place, right time."** The process of referral should be simple as to any other specialty with the confidence that a meaningful response and reply will take place as urgently as necessary in inpatient and community settings, public and private clinics. This principle underpinned the reform of Alfred Emergency and the general hospital which is now a world leader in efficient systems of care. The same principles can apply to mental health albeit different systems.

- **Improved access to psychiatrists**: A child psychiatrist should be readily available in all the settings of care where doctors and allied health work with sick and suffering children. There is every clinical reason to have a psychiatrist available for specialist outpatient clinics, on the wards, in the vulnerable community settings such as refugee, aboriginal health services and children in out of home care, embedded with maternal child health, the child protection system, juvenile justice and NDIS. The same applies to adult and aged psychiatrists and psychotherapists in the general hospital also.

- **Adequate Inpatient and outpatient consultation-liaison psychiatry services** for adults and children have been steadily whittled over the past 25 years and to reverse this will take time but be a very high value investment even if just calculated in reduced length of medical and surgical stays. There is as imbalance with too much focus has been on inpatient and outpatient mental health wards and services and too little on the enormous demand for patients in the general hospital and their outpatient clinics.

- **Overhaul mental health training in medical undergraduate and post graduate training.** All doctors and most other health professionals graduate with a deeply inadequate understanding of even the very basics of mental health care and treatments. We loosely learn the criteria for some DSM diagnoses, maybe something about a few classes of psychotropic medications, but virtually no skills in taking a meaningful psychiatric history of a patient, on the nature of suffering, of the limits of the diagnostic categories and medical model, of the unconscious and the process of psychotherapy and its origins.

- You can not graduate from medical school unless you can systematically examine the cranial nerves, but there is no requirement to have an approach to understanding a person's mental world. This could begin to be rectified if there were expanded settings of care and longer placements for medical students and specialist registrars. Doctors must complete one - two years of surgery and yet 5 weeks of mental health placements is seen as sufficient. The problems of stigma and culture are reflected in this imbalance and will be redressed by altering it. *Should universities be encouraged to offer a bachelor of medicine bachelor of psychiatry degree?*

- **Adequate inpatient care** The profound shortage of inpatient beds needs little further discussion. There has been almost zero increase in 15 years, despite huge rises in populations and acuity. For comparison medical intensive care unit beds across Victoria have risen per the demand in the past decade. It is striking how the same forces haven't applied in mental health where perinatal, child, adolescent and adult inpatient mental beds have been almost flat for decades.
    - Perinatal beds have grown in 3 rural areas, but reduced in Melbourne Metro
    - Private inpatient care provides an essential service, only available to those on top health cover – there should be parity with physical health where the best care is available in the public system, not private.
- Inpatient beds are very expensive to build and especially to run, they are not the best place for most people for any length of time but they are still necessary. A warning

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though: Intensive outpatient treatment is far more affordable and effective in saving lives and bringing about change in peoples lives. *We need an increase in both inpatient and outpatient resources,* not one at the cost of other just because bed numbers make for more tangible line in a press release.

- Some patients require long term supported institutional care of some sort too. Since de-institutionalisation, many languish in filthy rooming houses or on the streets. Much was lost when the old psychiatric facilities were sold by the state for redevelopment; for many they were places of true asylum.

- **Mental Health Services to be funded based on the need for treatment not just acute risk**: Mental health services are reducing each year, are block funded with no ring-fencing of funds for sub-acute, prevention or early intervention work. Hospitals are not even required to spend the funding they receive for mental health services on mental health. So, as the population grows and acuity rises, resources are inevitably drawn to meet the urgent need leaving an inadequate amount for work that could so often have prevented things reaching crisis point or worse. Some form of activity and demand based funding, protected for levels of acuity and settings of care are the only ways I can conceive of the system being able to grow and properly run all necessary treatment.

- **Medicare Item Numbers for case conferences and work with parents.**
  Private work with even moderately complicated cases require adequate collaboration between GPs, private paediatricians, psychiatrists and others - this time should be reimbursed no differently than if a patient is in front of you. While Medicare is a federal matter, the commission recommending of changes to Medicare will carry some weight.

- **More well-trained, well-supervised clinicians.** A long term workforce plan is required which I explain below.

Workforce issues
An inadequate workforce is a primary barrier to growth. My back of the envelope estimate is that we need three times the number of adequately trained mental health clinicians of all disciplines to meet the needs of the kids, youth, adults and families who struggle and suffer. There is no option for meaningful change that excludes a long-term plan to greatly increase the number of child psychiatrists and psychotherapists to allow for adequate treatment, training and supervision in public, private and the community service sectors. All essential components of this complex machine of care.

The workforce shortage in psychiatry and related mental health disciplines can not be overstated. A meaningful increase in high quality staff will take a generation to achieve, and it will begin with more specialist psychiatry training positions in more settings of care, with more senior clinicians available to train them. In order to have more people wanting to work in mental health, there will need to be a far greater emphasis on mental health in the training across medicine, nursing and allied health and better jobs to go to. Its no one wonder so few people seek a career in mental health given that it usually involves a few weeks hanging around a trauma-inducing inpatient ward or a busy public clinic. Students need to experience the breadth, richness and fascinating process of change that take place all across all sectors of mental health.

A background example of the problem, training positions for child psychiatrists have been whittled away over the past 30 years. For example, where once there were eight full-time two year fellowship positions at the Royal Children's Hospital alone there are now effectively none, aside from a several stand-alone six month rotations for registrars to piece together some of

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their specialist training. Excellent training is provided in these settings (one of which I benefited from enormously) but there are not enough.

The clinical and intellectual foundations of mental health care
Regarding the different clinical orientations, while the medical, psychiatric and psychological model have their utility, their limits and the evidence of the effectiveness in mental health care is much weaker that is stated, even though this is an open secret within the field. *Psychotherapy, psychodynamics and psychoanalysis should resume a more prominent place in the mental health system.* Psychiatry developed as a modern field separate to neurology with the discovery and creation 120 years ago of psychoanalysis and all that this yielded with respect to working the human mind and its workings. Just as physics has progressed from Einstein's discovery of relativity, through quantum theory to computing and nanotechnology, so has psychoanalysis built on Freud's foundations through the work of Klein, Bion, Lacan, Winnicott and dozens of others.

Where once there was a thriving *Department of Psychotherapy at RCH* that produced some of the best thinkers and clinicians in the world (no exaggeration) there is now nothing of the sort. Those who were part of this are doing tremendous work elsewhere but that furnace and culture of ideas and training has been dispersed and diluted. For several years around 2002 the Alfred Hospital had a position of *Consultant Psychoanalyst* but this was cut when the funding went as it was seen as a non-essential service which it technically was, albeit a valuable one nonetheless. These losses are not the fault of any individual or group even (certainly no one presently at the hospital I wish to emphasise) rather it is the inevitable result of three decades of drift, neglect and atrophy. It is also the product of a shift outside the profession of psychiatry and not adequately fought from within that has *seen the role of psychiatry in the public's mind reduced to risk management and medication reviews when that is perhaps 10% of what we do in the majority of cases*. Hospitals need to resume funding more child and other specialist psychiatry positions, to train more child psychiatrists and psychotherapists for public and private practice.

Advocating for the most silent and disenfranchised
Those in most need of mental care are usually the poorest advocates, especially at the time they need it. The depressed, the psychotic, the very young, the very old. Funding in health care is not driven by fairness, it is far more arbitrary and driven by crisis and popular advocacy. Sufferers of mental health care tend to make poor advocates for television and parliament. We need a system where patients and carers have a far stronger voice, and some good inroads have been made. But pregnant women and their partners, infants, young children and those with severe and chronic mental illness have the most need and usually the quietest voices. As a senior clinician I can at least be one advocate for what these people and families need.

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PART TWO

Recommendations from my four key perspectives

1) Perspective of someone with major mental illness in the family

For obvious personal and professional reasons I will omit the details but will give several recommendations that would have made untold differences in my life and those of my family.

- *A family psychotherapist to be available on all teams* who treat people with major mental illness. Family inclusive practice is a very welcome movement in mental health care, but the current staffing and approaches need to be funded comprehensively with the addition of experienced family therapists in addition to the peer and carer workforce. As someone who conducts such therapy as part of my work I know the difference that meaningful, difficult conversations would have made in my personal situation. I can not emphasise the importance and value of such a service even, perhaps *especially* in the most acute settings of mental health care.
- I advocate an approach to care that is grounded in psychoanalytic and psychotherapeutic principles, not only the medical-psychiatric-psychological model of care. This would have made a profound difference to many in my family.

2) Perspective as an infant, child and adolescent psychiatrist

Fundamentally: redress the neglect of children in the 0-12 age group and perinatal cases

The primary gaps and challenges in the mental health system for children vary per the different sub-populations this so I will begin with infants and pre-schoolers. As mentioned, in Geelong, among other roles I am the psychiatrist for the infant and perinatal mental health service, paediatric consultation liaison service and child protection liaison. This means that a great deal of my work in public practice involves children 0-12 and their families, and parents with significant mental health problems in the perinatal period.

If the ambition really is for *intervention early in life and early in the disorder* then clearly starting at 13 - the age of entry into youth services around the state - is far too late. Perinatal mental illness, children in the 0-12 age group and their families have been completely overlooked relative to 13-25yo's for a range of reasons. As such, it is critical they receive specific mention by the commission for recommendations specific to their treatment needs and the complex systems they are in: the family, social services, primary care, paediatrics, maternal-child health care and education settings.

- **On Perinatal Mental Health Services**

There is no provision of specialist outpatient perinatal mental health services at all metro services (I believe,) each regional service has a mere ~1.0 EFT outpatient and most have no inpatient beds. Despite enormous need (the professor of paediatrics in Geelong last week said he could have "work for 50 EFT" for the perinatal psychotherapy services we offer,) there is not the provision of funding nor requirements from the department to provide such a service. If a pregnant woman or her partner have mental health problems that meet criteria for adult psychiatry services these are dealt with in the usual way, but not with the highly specialised perinatal psychotherapeutic input that is necessary for meaningful change, recovery and the development of a healthy relationship between the parents and their baby. Treatment for these women and families falls to the NGO or private sector which does not consistently have the quality and capacity to provide the help that is needed to all. I remain baffled at this gap across the state when compared to how universal the provision of maternity and maternal child health services is, or cardiology and asthma care for that matter.

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Geelong being a regional area received an entire 1.0 EFT to establish our perinatal service and the despite such a small fraction, the difference this makes to the families we treat and the demand this limited workforce has revealed can not be overstated. The private sector has (just) adequate perinatal services in some areas of Melbourne but these are only available for those who can find it and those who can pay.

- **On Infants, pre-schoolers and primary age children:**

Unbeknownst to most people, Melbourne is a world leader for infant mental health services. Just one indication of this is that A. Prof. Campbell Paul from the Royal Children's Hospital is president elect of the World Infant Mental Health Association which he will lead for the next three years as the Biannual congress comes to Brisbane next year. On the ground however, there is a very strong network of infant mental health clinicians across the key sectors of care: CAMHS, MCHN, Primary care and private practice, the NGO/ family services sectors, child protection and elsewhere. These networks are a tremendous base upon which Victoria's mental health system can build if intervention early in life and early in disorder is the genuine goal. Very small investments ie: as little as $100k/ year can make profound differences to the service offerings where there is a good team already in place.

- **On stigma, ignorance and the hidden demand for services for 0-5 yo**

The biggest gap between need and provision of mental health services is for children in the 0-5 age group as their problems are seen primarily as medical ones. There are four primary reasons for this:

- Firstly, the younger a child is, the more their emotional world is expressed only through physical signs in their body. Until a child can speak, their body is almost their only means of communication and expression, how they cry, how they grow, how they feed, their state of restlessness, the flush of their skin and how they engage with the people and faces around them. As such the emotional disturbance of a very young child will be expressed through physical changes such as. As such, the treatment begins and usually remains as a medical one ie: with the GP then to the paediatrician +/- allied health. The better pathway is for referral to an experienced infant mental clinician before or in parallel to the paediatrician.
  - A very large number of preschool children who need mental health services receive only allied health input privately or through NDIS because their problems are seen only through the lens of the physical, not also emotional.
- Secondly, ignorance of the concept of infant mental health amongst all in the community (including health professionals,) except those working and training in the field. For instance, I didn't have any meaningful grasp of infant mental health until well into my child psychiatry training! It is a cultural phenomenon that we see babies as being cute biological machines requiring primarily physical care, not complex individuals who communicate, with a personhood and a mental life in their own right and a capacity for not just physical suffering from the day they are born.
- Thirdly, there is a stigma against the idea of seeing a mental health clinician, least of all taking a baby to one. I often quip that 99% of parents (including doctors) would rather have their child before a judge than a psychiatrist – there is a vicious cycle of ignorance and stigma that means a child will often only see a mental health clinician as the last resort "for medication," when months or years have passed with great struggle and suffering and when it so much harder to intervene than if specialist input were sought at the outset.
  - A very typical CAMHS referral is of a child of 11 or older with significant behavioural disturbance and clear history of having met criteria for specialist mental health input under the age of 5 but no referral ever made.

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- Fourthly, very young children are in many settings of care and need input from infant mental health in those settings in the first instance, not onward referral to yet another service or clinic. These settings are:
    - MCHN
    - Paediatric hopsitals and wards
    - Paediatric outpatient clinics, public and private
    - Day care and preschool setting
    - The child protection system

Key recommendations

- **Funded IMH positions where children are already receiving care**

The remedy to the above patterns and problems is complex, since many of the barriers are cultural, within medicine and society at large. What would help is a combination of far better experience and understanding of infant mental health among the professionals in those settings, combined with much greater availability and access to specialised infant mental health clinicians. Perhaps the most crucial of these is *specialised infant mental health clinicians in the paediatric settings, in-patient and outpatient consultation-liaison services* that can meet the actual clinical demand and not just the tip of of the spear that they do currently. I refer you to the submission from the Victoria Branch of the Australian Infant Mental Health Association to which I was a contributor.

- **Embed infant mental health on health sciences curricula**

It is the best kept secret that almost all infant mental health services in the state are undersubscribed because doctors and other referrers don't know what a case is, when to refer and how to frame the referral with families. Referrals are not made because of the above barriers and also a perception that "you can't get into to CAMHS" which has some but not a total basis in truth, certainly not with infant work. The clinical need for mental health early in life and early in disorder is not reflected in the number of or waiting time for referrals but epidemiological and clinical data exists to support an increase in both clinical services and in the addition of infant mental health to core curricula of all health disciplines.

- **Protected funding specifically for populations not just treatment modalities**

Many other populations in mental health are rightly dealt with through focused programs and protected funding for their specific needs: homeless people, those with dementia, adult inpatients, forensic services so to do these groups who have been overlooked, sidelined and seen as boutique or not serious psychiatry for too long:

- *Women and their partners in the perinatal period*
- *Infants and pre-schoolers*
- *Primary school aged children*

3) My Perspective from adolescent psychiatry

For at least 20 years Alfred CYMHS has been seen as the best such service across the state and beyond for its benchmark level of resources but more importantly the clinical orientations and leadership that have underpinned the work. The current structure of youth mental health at Alfred CYMHS is a great model: improved resources thanks to Headspace under the auspices and governance of the Alfred. The profound difference means that genuinely family inclusive, psychodynamically informed care is the cornerstone of the approach there. This is a model for other regions to emulate.

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Shortfalls in the primary care and private sectors – the "missing middle."
As with younger children, a huge gap in adolescent services is in the private and primary care sector – most GPs say they have far too little training and support in mental health care to feel confident yet can't find specialists to refer to. They do not even have the access to discussions and advice from a psychiatrist as they would say a cardiologist for two reasons:

1) there are too few professional networks in place to contact a private psychiatrist, or to know to contact the local area mental health service for advice. In fairness, the response when they do may not always be helpful.

2) It often takes a considerable amount of time in the clinic for a GP to conduct a thorough mental health appointment not to mention time to speak with a psychiatrist for advice. The MBS schedule does not rebate for the time required to speak with other professionals in a care team, let alone attend care-team meetings. These are crucial elements of good clinical practice and are considerable portion of the work in complex cases especially. Making this time rebatable will be a high value change that will take significant burden off the public system and allow more complex cases to be treated in the more efficient private sector.

"Mental Health Care Plan-itis"
This applies to people of all ages but the mental health care plan system of 10 sessions with a psychologist is something that should be recommended for review by the federal government, and not necessarily to expand the number of sessions. Many people receive good care of course, but I see countless numbers of children, adolescents and adults who have an inadequate dose (ie monthly) of an inadequate treatment (a symptoms and strategies based approach) for months or longer, when much of that time and money should have been spent on individual and family psychotherapeutic care.

The same outpatient psychotherapeutic resource shortfalls apply as with all age groups, and the inpatient bed shortfall I have discussed in Part One above.

4) Perspective as a board member of a large health service
As a clinician on a hospital board for almost 6 years I've become aware in detail of problems and opportunities at four levels of higher governance and systems:

1) The DHHS level
2) The local hospital level
3) The level of primary care, the family services sector and DHHS child protection
4) Structural funding failures

1) Governance at the DHHS level
The Victorian Auditor General released a report very recently and I share all of the criticisms and recommendations it contains – one section is worth quoting:

"DHHS has made little progress closing the significant gap between area mental health services' (AMHS) costs and the price they are paid by DHHS to deliver mental health services....Real progress is unlikely ... unless DHHS accelerates and directs effort towards the fundamentals: funding, workforce and capital infrastructure. Until the system has the capacity to operate in more than just crisis mode, DHHS cannot expect to be able to make meaningful improvements to clinical care models or the mental health of the Victorian population."

There is nothing in this report that anyone working in or being treated for mental health problems was not already aware of, though it is refreshing at last to see it articulated so clearly at such a high level. It has been an open secret for decades that the system is not fit for purpose and operates in spite of the department regulations and funding shortfalls not because of it. Everyone I have had dealings with in the department are good, conscientious people; the individuals are not the problem. Rather as with any bureaucracy, systems have more inertia and power than any individual can override or change in any meaningful way, even the great

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mental health ministers we have had for over a decade now. Change will probably require seconding experienced "at the coal-face" clinicians to simplify and redraw the system at the department level in manner that serves actual clinical need. Authority for treatment and services should rest far more with clinicians as it does in physical health.

2 Governance at the hospital level

Formal governance of mental health services is less detailed than for physical health care. For example the KPIs that are required to be reported capture less than 5% of the activity that goes on in a mental health service. Much finer grain reporting goes on physical health with the concomitant costs and hassles of reporting and the benefits of that scrutiny. An simple contrast can be made with surgery to illustrate: While waiting lists for elective surgery are ruthlessly monitored and acted upon, the equivalent in mental health (such as, say, waiting lists for long term therapy for significant trauma) does not. Generally, waiting lists are actively discouraged from being kept because there are simply not the resources to ever be able to see many of these people. People in desperate need of treatment are routinely "redirected" at triage and told to call back if things get worse. Imagine the outcry if this happened at an emergency department.

The health services I work at genuinely do great work within the profound limits of their resources, but the fact is that 95% of the quality and quantity of activity, and the demand that is met and unmet is not part of the data the board sees. This is not misleading or underhanded, it is just how the system has evolved with other reporting going direct to the department where it seems to sit on a computer. Among various effects, this obscures many of the enduring shortfalls in service quality and quantity. The opportunity for the board and management to lobby government for resources is lost and there are many missed opportunities for growth and change even within the limits of current funding that comes from board scrutiny of other areas of the hospital.

I must emphasise that mental health services are currently already required to spend clinical time reporting clinically meaningless data to DHHS and that any increase in reporting of activity to boards, DHHS or elsewhere should only occur in consultation with clinicians at the services and with additional resources to record and report that data, and only when these data will be used to improve resources and quality.

3) ***Clinical* Governance and supervision at the local level**

Health Services

For historical and technical reasons, clinical governance in child and adolescent psychiatry, psychotherapy and psychoanalysis is very intensive, more so than in general psychiatry. This is a difference more than a criticism, since the rationing of care in general psychiatry is so severe that governance beyond acute safety management and basic medical and team clinical reviews is impossible to provide at current funding levels. As such, given my training in psychoanalysis and child psychiatry I have a high standard for what adequate and ideal clinical governance entails. Just as we aim for world's best practice in physical health care in Australia, so should we aim for gold standard governance and supervision in mental health.

Family Services, NGO and Child Protection

The clinical governance in the family services sector is even more inadequate than at area mental health services. Stating this risks impugning the work of the many talented and conscientious colleagues I work with in these fields but I this general statement is widely recognised as being true by those inside and outside the sectors. For the family services sector to be safe and effective there must be governance approximating those in a well run CAMHS service since they are the very same families we are seeing just in far greater numbers. Adequate clinical reflective supervision and governance can be done in various ways and need not be spelled out in detail here.

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Funding governance
The system of mental health funding is such that hospitals are not actually required to spend the block mental health grants on mental health, and the subgrants within that are not required to be spent on what they are ear-marked for. Under previous leadership at a hospital I have worked for example, $100k of perinatal funding was spent on a consultancy review instead of on clinical services. This kind of misappropriation of funds is scandalous and not uncommon. Funding tied to clinical and related activity is a crucial way of ensuring the work gets done and that funding can grow as does the demand. An important caveat: the most senior person I know in the health system whose views I respect greatly said recently that activity based funding in mental health as he has seen it results in "overfunded inpatient units and badly underfunded outpatient services." Thus, activity based funding will have to be devised and led by the clinicians on the ground and hospital leadership (not DHHS) tailored to each part of the mental health service.

Conclusion

My lengthy submission has hopefully not obscured these five principles. Great things will come if the system can be simplified and guided by them. The needs and choices of patients and their families in discussion with their treating clinicians should drive the care they receive. For this to occur, patients need a voice, and the voice of the most vulnerable amplified by those around them to the level that we can hear and respond to what they need. I look forward to any request to provide further input if it will assist the commission.

Primary themes and recommendations:

1) **Build on Victoria's strong foundations**
   a. Cultivate and grow the great work that is taking place all over the state

2) **Stigma, Culture and lack of services perpetuate the problem**
   a. Mental Health is seen as "other" when it is the most universal thing of all. Doctors refer too late to MHS out of habit, but also because services are so rare
3) **A prominent voice for the most disenfranchised**
   a. The loudest voices and most compelling advocates get the funding in health care. The system must explicitly seek to consider the needs of the most silent groups: infants, young children, pregnant women and partners, the homeless, the disabled and those with severe chronic mental illness

4) **Aim for prevention - Treat early in life and early in the disorder**
   a. Perinatal and 0-12 age groups is where the best value and change takes place

5) **End rationed mental health care**
   a. Demand for access and treatment must drive the funding, not crisis and public disturbance
   b. Each region, metro and regional has specific needs and flexibility in service offering, structure and funding is necessary for locally driven solutions

6) **Provide the service that families and referrers want**
   a. Patients and families, with their doctors guidance, must drive their care and treatment

7) **Aim for parity with physical health care across all ages**
   a. Funding, focus and modes of treatment must be equalised; treatments available in the private sector must be available for low income people too.

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   b. Governance needs to be better matched. Consideration should be given for having a general and a child psychiatrist as invited members of each quality committee to assist in carrying out the commission's recommendations.

8) **Small focused investments immediately can make an enormous difference**
   a. Some investments such as capital and improving workforce capacity will take years but there is no need to wait for small targeted, recurring funding to strong teams
   b. An example is the $150k for rural perinatal services – the clinical impact this services make to over 100 families year is extraordinary, and is now a node for increasing expertise and service.

9) **A Royal Commission into the Child Protection System**
   a. It is an open secret that the Child Protection System is not fit for purpose. The neglect, abuse and suffering that goes on under the watch of the state, the social and societal determinants of this are so far beyond what the CP and the courts can remedy. If people affected by family violence and mental heath problems deserve a royal commission to be heard and have solutions, surely neglected and assaulted children do to.
   b. In the mean time, the offices of the (excellent) principal practitioners in CP should be expanded to include child psychiatry and psychotherapy positions to provide clinical work and improve the governance of the thousands of talented and conscientious professionals in the field.

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