Dear Commissioner,

I write in the capacity of a General Practitioner with extensive experience treating patients with mental illness. I am a registered medical practitioner. I have specialist qualification and vocational registration in General Practice and am a Fellow of the Royal Australian College of General Practitioners (FRACGP).

Treating mental health comprises about one third of my work. I have worked with patients for over 15 years in the community and have first-hand insight into the practical problems that patients face seeking appropriate treatment.

My comments are primarily about the treatment of *severe* mental illness. I would define this as patients suffering with Schizophrenia, Borderline Personality Disorder, severe Bipolar Affective Disorder or severe Depression.

For people living with uncomplicated anxiety or depressive illness the existing services work quite well, especially if a patient has financial means. There is reasonable access to general practitioners, psychologists and psychiatrists in the private sector.

Mental illness is concealed in society. Because patients who are suffering are not coughing, bleeding, in a wheelchair or collapsing on the street, people do not notice them. They are hidden, often literally, spending hours at home each day distressed, out of sight of the public and the government. Those with severe mental illness invariably have disordered thinking and are not able to organise themselves, let alone advocate effectively for themselves.

It is perhaps not surprising that since the deinstitutionalisation of psychiatric hospitals in Victoria there has been nearly 30 years of underinvestment in mental health care by successive governments, because the problems this produces are not immediately apparent. And now we live in an affluent society but have many patients with severe mental illness who are socially isolated, in poverty and not able to access the standard health care they require.

I will focus on two questions:

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

Fragmented delivery of care in mental health

The delivery of mental health care in Victoria is a hotchpotch of numerous services, poorly co-ordinated and not staffed adequately. There are numerous services provided by the various Area Mental Health services as well as a myriad of Non-Government Organisations providing support roles. The services all have different names, that change from one area to another, the services change frequently and overlap one another. The referral processes are complicated and unclear. There is no or poor defining of roles and responsibilities in the care of an individual patient. There is enormous waste of scarce resources caused by this lack of organisation.

It is important to appreciate the contrast between the way mental health (psychiatric) services are now provided compared to the rest of health care. *In every other part of medicine the approach to services is straightforward*. Patients initially present for care with an undifferentiated problem, usually to a General Practitioner or an Emergency Department. The

problem is diagnosed, treated at that contact and, if necessary, referrals are made to appropriate specialist medical or allied health providers. The system is well established, simple, safe and robust.

For mental health (psychiatric) care, beyond the General Practitioner the services are a mess. If I would like a patient to see a public psychiatrist, or wholly publicly funded psychologist, there is no straightforward process for this. If I want to organise a case manager, or some assistance with peer support, or to find some social activities for a patient to engage with, or special assistance finding suitable accommodation, there are no defined pathways for this.

Instead, I may try to refer to the local Area Mental Health Service but there is no central referral system. Each part of the service has its own separate referral requirements, which change frequently.

To illustrate, in my local area, the local crisis assessment service, aged persons psychiatry service, child and adolescent mental health service and primary mental health service are all run by the same Area Mental Health Service but have their own unique referral processes. This often involves complicated proformas and specific phone calls, just to make a referral. Referrals are often rejected out of hand, and never redirected to an alternate service if the first service does not want to take them on.

My observation is that these ever expanding bureaucratic requirements have evolved to keep patients out of services because there are insufficient staff to provide them. It is a cynical form of rationing. Instead of acknowledging that Area Mental Health services are unable to provide a psychiatrist or psychologist to see a patient, the referral may literally be bounced around for months, giving the appearance that something is being done.

If a patient is seen at all, they are usually seen by a lesser skilled and trained allied health worker, with occasional input from a psychiatrist. Now do not misunderstand my point – these allied health workers have an important role to play, but that role is not providing expert specialist care to these patients. There are times when I specifically want an expert opinion from a specialist psychiatrist that would make a significant difference to treating the patient. A common example would be establishing a diagnosis of Bipolar Affective Diagnosis which is often subtle. I cannot get that in the public health system in Victoria.

In every other division of medicine there as a public outpatient department provided by the local public hospital – from cardiology to gynaecology.

I would not even bother referring a patient with unipolar depression or generalised anxiety for whom I was seeking medication advice. They would never be seen. Meanwhile, if a patient has a mild heart rhythm problem or a chronic cough, they can easily be seen by a specialist cardiologist or respiratory physician at the local hospital outpatient department.

Lack of suitable accommodation

Stable accommodation is fundamental to individual's well being. It is often far more important than any specific psychiatric treatment being provided. Yet there is a gross lack of appropriate accommodation for people suffering with severe mental illness. And there are no straightforward processes for accessing the accommodation that does exist.

Remember, these patients are often poor, unemployed, reliant on social welfare payments and disorganised because of their illness. They may have suboptimal personal hygiene. They have no or a negative rental history or credit rating. They do not have money for a bond and have difficulty organising things like co-ordinating with Centrelink or a bank. These people do badly in the private rental market.

Appropriate accommodation can take many forms depending on the person and the illness. Some private rental, with assistance for making payments, maintaining the house etc. Other forms including public housing, boarding houses, supervised group homes, Supported Residential Services (SRS) and crisis accommodation.

There is a vast shortage of suitable accommodation, especially the supervised group home, that would be the most appropriate for many people with severe mental illness.

Discrimination

There is systematic discrimination against people suffering with mental illness from various government agencies (State and Federal) as well as private organisations, notably insurance companies.

These comments relate to all people suffering with mental illness from mild to severe.

Worker's compensation scheme (Worksafe Victoria).

Claims for psychological injury are routinely disputed by insurers and automatically referred to an "Independent" psychiatric medical examiner paid for by the insurer. Reports from these examinations are frequently withheld from treating doctors. These is completely different to the handling of other types of injury.

If a patient has ever had an episode of mental illness, this is often used automatically to reject a claim on the grounds of a pre-existing illness, with little regard to the new episode of illness.

The use of private investigators, hired by insurance companies to investigate patients, has become common. This is a gross invasion of privacy and these investigators are not qualified to comment on mental health. In my opinion, this practice is disgraceful.

Centrelink

I appreciate that Centrelink is a Commonwealth department however it is inextricably linked to the well-being of Victorian patients suffering with mental illness.

Applications for the Disability Support Pension for mental illness have additional requirements that act as a barrier to access. Usually this involves the input of a clinical psychologist or psychiatrist in addition to the treating doctor's report. General Practitioners are more than qualified and capable to make the appropriate diagnoses and assessment. For many, the cost of a clinical psychologist or psychiatrist is prohibitive. *No other type of illness requires this additional hurdle*. It is pure discrimination.

National Disability Insurance Scheme (NDIS)
Again, I appreciate this is a Federal scheme but it is also inextricably linked to well-being. Some severe mental health diagnoses are not recognised as a disability eg. Borderline Personality Disorder. This is pure discrimination.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

I would ask the commission to focus its recommendations for reform on simplifying and improving the co-ordination of services in mental health care; and to improve the provision and access to appropriate accommodation.

The ideal model of care for a person suffering a severe mental illness would include:
A general practitioner – for regular assessment and management of their overall health; access to a psychiatrist for regular review – frequent at times of crisis; allied health support with psychologists and others as needed; a case manager if warranted – to organise appointments and review; and peer support for engagement in social activities and co-ordinating day to day living. There would be access to stable, appropriate accommodation and there would be access to financial support. There would also be support services for the family and friends of the patients.

Specific recommendations include:

- Create central referral systems for Area Mental Health services – they can then direct them in-house as they see fit.
- Simplify referral systems – a simple letter (electronic) sent to the Area Mental Health service should suffice. This is the same as all other areas of medicine. No complicated and unique proformas. No barriers or extra requirements.
- Mandatory communication from Area Mental Health services to treating general practitioners. These communications should be relevant (not just a print-out of their own consultation notes) and timely.
- Provision of a conventional outpatient psychiatry service. It is fundamental that a general practitioner be able to obtain a specialist psychiatric opinion when required.
- Clear delineation of roles and responsibilities within Area Mental Health services. Reduce overlapping services and wasted resources.
- Clear and uniform naming and definition of roles and services across the State. The current plethora of confusing acronyms and names is a fiasco.
- Reduce the number and types of services. Focus on the most important parts of care as detailed in the paragraph above.
- Explicit acknowledgement that episodes of acute mental illness take a long time to settle. Therefore, provision needs to be made for lengthy hospital admissions (several weeks to a couple of months) and an appropriate number of beds available. This is a distinct difference to other areas of medicine where hospital stays are usually brief.

Yours Sincerely,

Dr Cameron Martin
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