Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF PROFESSOR EMERITUS BRUCE SINGH AM

I, Professor Emeritus Bruce Singh AM, say as follows:

1 I make this statement on the basis of my own knowledge, except where otherwise stated. Where I make statements based on information provided by others, I believe that information to be true.

2 I am giving evidence to the Royal Commission in my personal capacity and not on behalf of my employers or organisations of which I am a member.

Background

Qualifications and experience

3 After completing my studies in Medicine at the University of Sydney in 1968, I completed my Residency at the Royal Prince Alfred Hospital, where I continued as a Medical Registrar and Psychiatric Registrar until 1975.

4 I then became a National Health and Medical Research Council (**NHMRC**) Travelling Fellow in the Clinical Sciences and, from 1975 to 1978, I was based at the University of Rochester, New York, the Institute of Psychiatry and Maudsley Hospital in London, and at the University of Sydney.

5 In 1978, I was appointed Senior Lecturer in Psychiatry at the University of Newcastle, playing a role in the development of the new medical curriculum.

6 In 1984, I became the Foundation Chair of Psychological Medicine at Monash University and the Royal Park and Alfred Hospitals in Melbourne. In subsequent years, I worked as Co-Director of the Master of Psychological Medicine program at Monash University.

7 In 1991, I became the second Cato Professor of Psychiatry at the University of Melbourne. In this role, and as Head of the Department of Psychiatry, I have expanded the academic activities of the Department, which extend across three Clinical Schools and ORYGEN Youth Health, with a strong emphasis on links with the public psychiatric service system.

8 I have developed Professorial positions at both the major private psychiatric hospitals in Melbourne, the Melbourne Clinic and the Albert Road Clinic, and additional Professorial appointments at Barwon Health and the Australian Centre for Posttraumatic Mental Health. These appointments have supported important research in areas such as post-traumatic health, neuropsychiatry, old age psychiatry and women's mental health.

9 I served as Director of Psychiatric Services at the Royal Melbourne Hospital until 1995, when I was appointed as Clinical Director of the Royal Melbourne Hospital Psychiatry Clinical Business Unit.

10 In 1996, I became Clinical Director of North Western Mental Health, comprising Adult, Aged and Adolescent Mental Health Programs, which serve a population of approximately one million people in the northwest of Melbourne.

11 From 1997 to 2000, I served as Assistant Dean, faculty of Medicine, Dentistry and Health Sciences, at the University of Melbourne and was responsible for relations with the North Western Health Care Network.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

12 I have played an active role in the promotion of psychiatry in the Asia-Pacific region. From 2001 to 2004, I was President of the Pacific Rim College of Psychiatrists.

13 In 2003, I was awarded the Centenary of Federation Medal, and in 2007 a membership of the Order of Australia, for my services to medicine and psychiatry.

14 Throughout my career, I have worked as a consultant for both Commonwealth and state governments. These consulting roles include:

(a) Consultant to the Commonwealth Department of Health for Evaluation of New Drugs from 1982 to 1990;

(b) Chief Policy Adviser for the Office of Psychiatric Services in the Health Department of Victoria from 1988 to 1992 (including an active role in developing the first National Mental Health Policy);

(c) Member of the Grants Committee of the NHMRC from 1991 to 1996;

(d) serving on the Community and Research Committees of the Victorian Health Promotion Foundation from its inception in 1990 until 2000;

(e) Senior Medical Adviser to the Mental Health Branch of the Department of Human Services in Victoria from 2001 to 2004;

(f) Chair of Beyond Blue Research Grant Committee for 5 years; and

(g) Foundation Chair Victoria Gambling Foundation from 2012 to 2016.

15 The main focus of my research has been in the area of schizophrenia: together with Professor David Copolov, Director of the Mental Health Research Institute of Victoria, I established the NHMRC Schizophrenia Research Unit, which I co-directed from 1988 to 1996. Other areas of research I have worked in include early onset psychosis, psychiatric rehabilitation, psychiatric aspects of disasters, rehabilitation in physical illness, and care-giving in the community.

16 I have been extensively involved with the Royal College of Psychiatrists as the Chief Censor from 1980 to 1994 and have been awarded the College Citation of Honours and Medal of Honour.

17 I have also written extensively on psychiatry, having published more than 120 papers and co-edited five books. I am currently working on a history of psychiatry in Victoria in collaboration with historian Dr Ann Westmore.

18 I am currently the Clinical Director, Mental Health Services, at South West Healthcare, Warrnambool since 2017. I also work several days a week at Melbourne Health, at the Royal Melbourne Hospital, where I teach Registrars from years one to five. I consult in private practice 5 sessions per week at the Melbourne Clinic.

19 Attached to this statement and marked 'Attachment BS-1' is a copy of my CV.

Current role and responsibilities at the University of Melbourne.

20 Following multiple roles with the Faculty of Melbourne Dentistry and Health Science University of Melbourne, including Deputy Dean, Associate Dean (International) and finally Assistant Vice Chancellor, I retired from the University in 2014 when I was awarded an Honorary Doctorate II of Medical Science and Emeritus Status. I continue to teach in the postgraduate program of the faculty.

Introductory observations on the mental health system

21 I have been working in the field of mental health for the majority of 48 years. In making this statement, I make the following initial observations.

22 First, dealing with mental health patients is difficult. The difficulty lies in the fact that the organ on which one relies in assisting mental health patients (the brain) is the very organ that is damaged in those patients. This means it takes much longer to enlist the support of mental health patients in the management and treatment of their own mental illness. This also explains why insight is never fully complete, even when patients are in remission. Insight is the quality of mind which is fully aware of one's own illness and the need to treat it. It is often impaired in severe mental illness and remains partially impaired when patients are in remission or recovered.

23 Second, providing mental health care and treatment to patients is a labour-intensive and emotionally charged endeavour. Providing adequate care and treatment demands a considerable amount of time, energy and face-to-face effort by mental health staff. People want and expect to be seen and to have human contact when they seek help or are in distress.

24 Third, there are two essential requirements for making meaningful changes to the existing mental health system: one is increasing the system's capacity, which in Victoria has fallen behind in terms of bed numbers and staff numbers; the other is identifying new and more efficient ways of delivering mental health services (discussed further in the section below). As mental health continues to be de-stigmatised, thanks in part to the fine work of Beyond Blue and the Black Dog Institute, more people will expect their mental health needs to be met, which will cause demand to continue to grow. Given the limited capacity of mental health services, we need to harness and develop new technologies in order to meet this growing demand and reduce the strain on the capacity of the existing system.

Contemporary considerations – COVID-19

Emerging changes in health service delivery, including mental health service delivery, as a consequence of COVID-19

25 The COVID-19 pandemic has demonstrated the need to change the way in which mental health services are delivered. The traditional service delivery methods, such as visiting people in their homes or bringing them into clinics, cannot continue to be exclusively relied upon, and are labour intensive, inefficient and expensive.

Longer term opportunities for new approaches to service delivery

26 The development of new technologies will provide opportunities to identify different approaches to service delivery. Technologies such as telehealth and digital services can provide smarter and more efficient ways of delivering mental health services. However, our use of such technologies has so far been limited; they need to be utilised in a more systematic way in order to grow the capacity of the mental health system. To do this, we will be heavily reliant on the current generation of young people, both patients and staff, who have grown up with various forms of technology, including social media. The next generation of the mental health workforce will need to be completely conversant in the use of such technologies, building on the skills of those who are more familiar.

Historic perspectives – the evolution of mental health policy and care in Victoria

Major influences on mental health services and policy in Victoria in the post deinstitutionalisation period

27 In the 1980s, when the transition from the asylum system to a community-based system was made, I was one of the main protagonists for changing the system, having seen the asylums in operation. I supported the growth of community-based mental health practices. However, there have since been several developments in community mental health which we did not anticipate. For example, mental illness has become much more resistant and difficult to treat. This has been compounded by the increased co-morbidity with the epidemic of drug and alcohol abuse, particularly drugs that make serious mental illnesses more resistant and difficult to treat (such as ICE), in addition to increasing patient

non-compliance. This has put a huge strain on the community mental health system, which was not designed to meet these challenges when it first emerged in the 1980s.[1]

28 As noted above, the gradual de-stigmatisation of mental health has changed social expectations of the mental health system; so that more and more people expect the system to meet their mental health needs. However, the process of de-stigmatisation has not occurred in a uniform way; it has primarily occurred in relation to what are known as "high prevalence" illnesses, such as anxiety and depression. De-stigmatisation has been less influential in relation to more serious mental illnesses, such as psychosis and schizophrenia, where patients with these disorders continue to be stigmatised and discriminated against this is particularly a problem in the justice system and in EDs.

29 The continued growth in demand for mental health services has meant that neither patients nor clinicians are content with the status quo; patients feel they are not getting the help and support they need, while clinicians feel they are not able to provide adequate treatment and support. This has resulted in an impasse between what patients and families want and expect, and what the mental health system is able to provide. Rationing of mental health services is now the normal and there is no current approval to the impasse solution.

30 Having worked in rural parts of the country, these problems of supply and demand are only exacerbated by the tyranny of distance. It is because consumers have to travel greater distances to reach their local service, staff recruitment and retention is more difficult, and economies of scale are harder to achieve.

31 The steady growth in demand for mental health services may also be attributed to a number of other influences, including the relative breakdown of family structures, which has in turn put more pressure on people with mental illness (particularly where their families are not accepting of their mental illness), and homelessness to name just a few of modern life.

<u>The need to shift community expectations about mental health services</u>

32 Clearly, the identification of more efficient means of service delivery must be balanced against the well-established community expectations of human connection with those who are mentally ill. As noted above, people expect face-to-face contact when they seek mental health care and treatment. However, expectations have begun to shift in the general health system; for example, people do not always expect to see a doctor in person. In my view, there needs to be a similar shift in community expectations in relation to mental health services. The system simply does not have the capacity to meet the growing demand through traditional means of service delivery alone.

33 In my view, we should be training the next generation of the mental health workforce with this in mind; the community will have to come to accept that face-to-face interaction, while still possible, is not the norm, it will have to be rationed. Face-to-face consultations may still occur, but they should be complemented by other forms of service delivery, such as telephone services and digital applications. Shifting the balance in how we deliver mental health services will increase the capacity of the system.

My observations on how the practice of psychiatry has changed in Victoria, in particular the profile of the workforce, its leadership, the relationship with academia, and its relationship to other professions

34 I was involved in the forging of links between academia and public psychiatry. Although I consider that those links have served us well, they have been diluted by the progressive

[1] In 2007, I wrote a paper with David Castle on this topic, titled 'Why are community psychiatry services in Australia doing it so hard?' Med J Aust 2007; 187 (7): 410-412, published online 1 October 2007 <https://www.mja.com.au/journal/2007/187/7/why-are-community-psychiatry-services-australia-doing-it-so-hard> [accessed 25 June 2020].

withdrawal of funding support. Those links were created in order to aid in the development and establishment of workforce standards and recruitment. We continue to face major problems with recruitment; for example, NorthWestern Mental Health is regularly forced to employ international medical graduates due to the domestic shortage of trained doctors.

35 Another issue I have observed is the lack of clinical psychiatrists who are in positions of leadership. Clinical psychiatrists are often relegated to the role of clinical director, rather than serving as an executive director. As clinical director they have limited ability to lead in clinical governance and standards. They have no control of budget or authority over staff and often feel unimportant.

36 One further challenge faced by medical practitioners (including psychiatrists), identified in an online article published by The Sydney Morning Herald featuring Professor Gordon Parker AO and Scientia Professor Henry Brodaty AO, is that the proliferation of electronic medical records (EMRs) has resulted in practitioners spending more time on administrative tasks, including note keeping, and less face-to-face time with patients.[2]

Key learnings from this evolution in relation to how the workforce can be supported in the future

37 In my view, the mental health workforce would be better supported through the establishment of larger networks, such as NorthWestern Mental Health, which would serve to better coordinate the various forms of specialised mental health services. Larger networks also have the advantage of achieving economies of scale. They are better equipped to recruit staff and resources to provide education, research and evaluation.

Leadership and reform

Ways in which leadership at both a service and system level is important to the successful implementation of transformational and enduring reform to Victoria's mental health system

38 Having been a leader in mental health in Australia at the turn of the last century, Victoria is now lagging behind other states and territories. For example, bed numbers in Victoria have declined in proportion to the population and in comparison to bed numbers in other states. In my view, this decline was primarily due to the lack of leadership in mental health.

39 My experience with mental health so far has been that the collective interest in securing reform waxes and wanes over time; it has never been sustained. Professor George Lipton, Clinical Professor at the University of Western Australia, Department of Psychiatry, wrote a paper in which he made the point that different forms of mental health care (asylum, hospital and community) have been cycled through over time, without necessarily achieving lasting and sustainable improvements and reforms.[3]

Capabilities and skills required for leaders to drive and oversee reform

40 Leaders must be willing to strongly advocate for challenging reforms. I observed this when I worked with John Rimmer and Tim Daly at the Mental Health Branch of what was then the Department of Human Services in the late 1980s. They were visionary but also understood how change had to be driven and implemented and they never dropped the ball, unlike others who fall into a "business as usual" mentality.

41 The strong leadership shown by John Patterson and Jennifer Williams AM in driving mainstreaming and integrating, the twin keys to implementing the first mental health policy

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[2] The Sydney Morning Herald, 'Overburdened psychiatrists abandon 'broken' public system', published 29 May 2019, available at <https://www.smh.com.au/healthcare/overburdened-psychiatrists-abandon-broken-public-system-20190528-p51s3j.html> [accessed 23 July 2020].

[3] George Lipton, 'Politics of mental health: circles or spirals', Aust N Z J Psychiatry. 1983; 17(1): 50-56.

and plan in the early 1990s, was inspirational and pragmatic. Deputy Prime Minister Brian Howe found ways to release funding for the changes, from asylums to a community based mode of delivery.

Structures and mechanisms required to support the ongoing development of leaders who are equipped to drive and oversee transformational change

42 As noted above, leadership (at both a bureaucratic and clinical level) is critical to driving change. In my view, the existing management structures (where mental health forms a part of the wider health sector governance structure) do not facilitate or promote leadership in the domain of mental health.

43 Mental health services should be managed and led by individuals who have an interest in and commitment to mental health. Both NorthWestern Mental Health and Monash Mental Health are good examples of this. However, in general, I do not consider that the current governance structure supports and includes such individuals, for example, as reflected in the board composition of our major hospitals. We need dedicated mental health governance structures, in a form akin to the United Kingdom's mental health trusts. Here a geographic group of mental health services are governed together by a trust with a Board and a CEO. The equivalent in Melbourne would be 3 or 4 such trusts.

44 I do not consider that there is any shortage of people with an interest in mental health. I run a leadership and management program at Melbourne Health for psychiatrist trainees, who show a lot of interest in the area. One of their main concerns however, is that they are not being properly supported and encouraged (at a trainee level) to strive to take on key clinical and administrative roles later in their career.

Structures and mechanisms required to overcome these barriers on an enduring basis

45 There must be clear and tangible career and leadership pathways for those wishing to pursue a career in mental health administration. For example, additional funding should be provided for fellowships in mental health leadership positions – this should be extended not just to psychiatrists, but also aspiring leaders in other mental health professions. These fellowships should be flexible, giving professionals the option to complete them part time while continuing their own work or other training.

46 In my view, psychiatrists should be nominated for clinical governance roles to ensure that more psychiatrists pursue a long term career in the public sector. At present, many well trained psychiatrists complete one or two years of work in the public sector before transitioning to the private sector because they do not see any clear career progression for themselves in the public sector.

Service design and development

Examples in the current health system where better pathways for patients have been created between primary care and other services

47 Shared care models can be an effective means of increasing capacity, particularly in rural or remote areas. For example, at South West Healthcare in Warrnambool, GPs are more heavily involved in the care of the seriously mentally ill. This is an informal arrangement that has arisen simply by virtue of the rural location of the practice. People in country towns know each other and are willing to look after each other. They also know the limitations of the mental health system and are willing to contribute in order to make the system work as best it can.

48 This informal approach to shared care is not confined to the role of GPs; there is cooperation between psychologists who work with headspace, Aboriginal organisations and various other community organisations. Again, this form of cooperation is organic and stems from the common understanding that the capacity of the mental health system is limited (particularly in rural areas like Warrnambool).

Strengths and weaknesses of the current integrated approach where health services are responsible for the delivery of both bed-based and community based mental health services

49 Service integration was one of the foundations of the de-institutionalisation of the mental health system. It is essential that community and bed based services are linked and coordinated in a single network and that this network facilitates the seamless transition from one service to another. It is also important that staff get practical exposure to both community and bed based services, so that they are familiar with both parts of the system.

Ways of determining the optimal service profile for mental health care, treatment and support delivered in rural and regional areas

50 Determining the optimal service profile for mental health care and treatment delivered in a given rural or regional area requires consideration of both generic and specific factors. Specific factors are those that are unique to a particular area or region. Generic factors include the tyranny of distance (mentioned above) and the difficulty in recruiting and retaining staff. These are common themes that are raised at meetings of psychiatrists based in rural and regional areas, such as The Chief Psychiatrist's Authorised Psychiatrists Meeting, whenever I attend.

51 As noted above, the best approach going forward would be to identify new, innovative and more efficient ways of providing services, such as through the use of telehealth services. This is particularly crucial for rural and regional areas, where resources are typically very limited. For example, at South West Healthcare in Warrnambool, we have four clinics each located about 80 to 100 kilometres from Warrnambool, 150 staff, 20 beds and no reliable access to secured extended beds.

52 One way of promoting innovation and information sharing would be to organise regional forums dedicated to sharing and disseminating ideas and information among regional mental health workers.

Catchments

Advantages and disadvantages of catchments

53 Catchments are essentially a mechanism for the rationing of mental health services. They are designed to leverage economies of scale: if a service wants to serve a significant population, it needs to be allocated capacity that is proportionate to that population.

Alternatives to catchments

54 It is difficult to see how the complex and multi-faceted needs of mental health patients could be met using any alternative approach. I have observed that certain European mental health systems, Germany for example, are not based on catchments. But Germany has a heavily institutionalised system with most of its asylum still functioning albeit modernised.

55 Mental health care, unlike general health care, requires multiple forms of professional expertise spanning the five main disciplines: medicine, nursing, occupational therapy, social work and psychology. I cannot envisage how any one institution could properly meet the needs of mental health patients across the entirety of Victoria. If the capacity of services were not calibrated based on the population they serve, it is difficult to see how the mental health system could function efficiently.

Risks of abolishing catchments for mental health services

56 In addition to the inefficiencies that may arise if catchments were abolished, mental health services would be unable to meet the needs of those patients who need help the most: the approximately 2.5% of the population with severe enduring or episodic mental illness.

57 The abolition of catchments would also complicate the coordination and linkage of services. If mental health patients were able to present at a service, regardless of their place of residence, the services would not necessarily have control over the other facilities (such as community care units, secured extended care units and supported accommodation) that may be required to provide the patient with the appropriate care and treatment, leading to constant conflict to access these beds.

The optimal configuration of catchments

58 The optimal distribution of catchments would be three to four catchments covering Melbourne, with additional catchments covering regional Victoria. Each regional catchment could be linked to one of the Melbourne-based catchments. The size of these catchments would be roughly equivalent to the areas covered by NorthWestern Mental Health and Monash Mental Health. Each should be semi-autonomous and governed by a CEO and a Board with heavy psychiatric and community input into these boards.

59 In my view, catchments that are configured appropriately (and cover a sufficiently large geographical area) can still provide a significant degree of flexibility to consumers in each catchment. If services (such as area mental health services) were properly linked across each catchment, they could serve anyone residing within a given catchment.

Service excellence

Structures and mechanisms required to ensure mental health is consistently and fairly prioritised by health service boards and senior management relative to other services operated by these health services

60 Although I initially supported the move to incorporate the mental health system into the general health system, I do not think that structure does justice to the complexities raised by mental health. At the executive or board level, there is a risk that mental health issues will be devalued or diluted if executives or boards are focussed on other issues concerning the wider health system. I have seen this many times.

61 A better approach would be to introduce an independent mental health governance structure, akin to the approach which has been adopted in the United Kingdom through the establishment of mental health trusts. If this were implemented, the mental health and general health management levels could each report separately to the executive or board level, or they could alternatively report separately to two different boards that are each responsible for a particular stream (mental health or general health) – the trust model mentioned above.

62 In my view, the mental health system also requires a dedicated reform committee or body of some kind that is tasked with researching, planning and advocating for reform. This body should be entirely independent from the Mental Health Branch, which is, in my view, better suited to dealing with "business as usual" matters, rather than dealing with system reform. While I have seen the Mental Health Branch be very active in reform, for most of the time it is "business as usual".

63 Whichever governance structure is in place, the prioritisation of mental health is ultimately a political issue; the Minister is responsible for budgeting how much money is allocated to mental health. More specifically, the Minister must also decide how much of the budget devoted to mental health is to be allocated to "business as usual" expenses, and how much is put towards research, evaluation and reform. From what I've seen, mental health

ministers, whilst well intentioned, do not have the power to advocate successfully for mental health services.

Structures, mechanisms or approaches required to ensure high quality and safe delivery of services

64 The mental health system requires both adequate system capacity and adequate strategies and techniques available to meet the mental health needs of people.

65 As noted above however, the capacity of the existing mental health system is limited. Not only do we need to grow the existing capacity, we also need to identify new and innovative ways of delivering mental health services. This may involve a greater use of digital technologies, telehealth services, identifying opportunities to better utilise those parts of the workforce that are less skilled or qualified, and promoting the greater use of psychological rehabilitation by consumers.

66 Capacity can also be built through the creation of joint arrangements or partnerships. An example of this is our Prevention and Recovery Care ("PARC") service, a joint collaboration between South West Healthcare Mental Health Services and an NGO. This allowed the provision of psychiatric rehabilitation services to be delivered by a more rehabilitation orientated workforce.

Ways in which data collection, analysis, synthesis and dissemination can inform the development of mental health policy, practice and research

67 Data collection is central to research and evaluation. This is partly why I have been such a strong advocate for academic roles within the mental health system; to assist in the data collection process and to utilise the expertise of academics in relation to how data is collected from each area mental health service and how that data is used and evaluated.

68 One issue with the current data collection process is that it has largely been in service of what I call the "quality industry". That is, data is collected primarily for the purpose of presenting the data for review by executives or boards with little interest in what this data actually means for quality of service.

69 In my view, there are many opportunities to find innovative ways of collecting and using data that could inform new and more efficient applications of new technologies. We should examine the work done by Professor Ian Hickie, the Co-Director, Health and Policy at Brain and Mind Centre at the University of Sydney, and Professor Patrick McGorry AO, the Executive Director of Orygen, in order to explore how mental health services can be delivered more effectively and efficiently.

Research and evaluation

Ways in which the system can best enable and incentivise the development and implementation of new and innovative service models that meet consumer needs

70 Academic positions should be properly funded, supported, embedded and entrenched within the mental health system. Proper research and evaluation cannot be conducted using a "top down" approach; it needs to be structurally integrated into the health system. For example, in the United Kingdom, research and evaluation units form part of every large mental health trust.

71 In my experience, research and evaluation roles are more effective when they form part of a service; services tend to be more cooperative with internal staff than with people external to the service (such as researchers based at a university).

72 There have been effective structures put in place for this purpose in the past. For example, there was the Mental Health Research Institute (before it merged with the Florey Institute). There are also some notable individuals who have been successful in the field

of research, such as Professor Jayashri Kulkarni, who directs a large psychiatric research group, the Monash Alfred Psychiatry Research Centre and of course Professor McGorry. Note that these and many other successful academics in Melbourne were drawn to their roles by approval of the academic post (eg, Professor Carol Harvey, Professor Christos Pantelis and Professor Suresh Sundram) I established with the Department of Health and Human Services.

73 In my view, there should be centres of excellence associated with each of the three or four major trusts (if the UK model were adopted, as described above in paragraph 43), which would serve to further deepen and develop expertise.

74 To properly entrench these structures, there must be a recognition that funding and supporting academic and research positions should not be perceived as a financial burden on the health system; rather, these roles are essential to achieving system reform.

Mechanisms to facilitate the continuous improvement of service delivery

75 Meaningful and ongoing evaluation is essential to facilitating the continuous improvement of service delivery. This cyclical process should involve translating the findings of evaluation processes into modifications, which must then be implemented in the system, with continuous evaluation of the implementation of those modifications.

76 Digital technologies will certainly play a role here; however, we are still in the process of investigating how they are best applied in a mental health context.

Ways to embed innovation cultures and 'cycles of learning' into service structures and environments

77 Workforce training will be key to achieving this. Both the current and future workforce should be trained in the use of new technologies such as telehealth services and digital services. In my view, this undertaking could be a five year project; however, workforce training is essential if the mental health system is to cope with the steadily growing demand for mental health services.

Opportunities from digital technology

Opportunities for digital technologies in the mental health system and the major challenges to implementation

78 First, we need to identify which digital technologies are best suited to mental health. This is still a work in progress. We then need to decide on an appropriate means of implementing those technologies and train the workforce in the use of such technologies.

79 In my experience, the older generation of the current workforce are more resistant to change; it is the next generation of mental health workers that should be our focus. We now have a good opportunity to train the next generation of the mental health workforce to ensure it is conversant in the use of digital technologies. As noted above however, this will be a big project.

Preparing the mental health sector for the changes necessitated by the adoption of digital services

80 Information sharing and dissemination can play a key role in creating a more receptive environment for the implementation and integration of digital services. This will prepare people for thinking about how they can work in different ways and will also make clear that the system cannot continue to function in the same way if the current growth in demand continues.

Workforce change readiness

Future implications of workforce reform for the size, composition and distribution of the workforce

81 In terms of the composition of the five main professional disciplines, being medicine, nursing, occupational therapy, social work and psychology, I think the relative number of workers among each discipline is about right.

82 In relation to the next generation of the mental health workforce, the training offered by universities will need to account for the different ways in which the mental health workforce will be expected to work. These changes will affect both the public and private sectors, so the next generation of the mental health workforce must be properly equipped to embrace these new ways of working.

Challenges facing the rapid growth and diversification of the workforce

83 A key challenge will be growing the size of the workforce in a sustainable way. Currently, there is a shortage of doctors and nurses; each year, NorthWestern Mental Health has to recruit around 30 English and Irish nurses, as well as 10 to 12 international medical graduates, because of the shortage in Australia each year.

84 One reason for this shortage is that many medical students choose to pursue other careers rather than training in psychiatry, which in my view has become a less attractive profession. Another reason is that the mental health system itself does not have a particularly strong reputation; there are dissatisfied consumers, families and workers who share their negative views and experiences of the system. It is my hope that, if the system were improved, streamlined and made more efficient, this could improve the profile of the mental health system and make it a more appealing career choice for young professionals.

Measures to prepare and support workforces to take part in significant reform

85 It is essential that the leaders of the various stakeholder professions each understand the direction of the planned reforms to the mental health system. Ensuring this common understanding would be the role of the dedicated reform committee or body discussed above.

sign here ► B. Singh

print name Bruce Singh

date 23-7-20

Royal Commission into
Victoria's Mental Health System

ATTACHMENT BS-1

This is the attachment marked 'BS-1' referred to in the witness statement of Bruce Singh dated 23 July 2020.

PROFESSOR BRUCE S SINGH AM – MBBS (Hons), PhD, FRACP, FRANZCP, IntF (APA) FRCPsy(Hon), D. Med Sci (Hon)
EMERITUS PROFESSOR OF PSYCHIATRY,
UNIVERSITY OF MELBOURNE

Bruce Singh was born in Sydney, Australia in 1946 but spent the early years of his life in Fiji prior to moving to Australia in 1959. He obtained the degrees of M.B.B.S. (Hon.II) from the University of Sydney in 1968 (winning the Glaxo prize in Surgery), a PhD from the University of Newcastle in 1982, a D. MedSci (Hon) from University of Melbourne in 2014 and Fellowships of the Royal Australasian College of Physicians (1975) and the Royal Australian and New Zealand College of Psychiatrists (1979).

Professor Singh's original appointments were at the Royal Prince Alfred Hospital, Sydney, where he trained in internal medicine and psychiatry (1969 - 1975). He was then a NH&MRC Traveling Fellow in the Clinical Sciences (1975-1978), during which time he was based at the University of Rochester, Rochester, New York and the Institute of Psychiatry and Maudsley Hospital in London. He was then appointed Senior Lecturer in Psychiatry (1978-1983) at the University of Newcastle where he was involved in implementation of the first problem-based learning (PBL) curriculum in Medicine in Australia. He moved to Melbourne in 1984 to take up the Foundation Chair of Psychological Medicine, Monash University, at Royal Park and Alfred Hospitals. In 1991 he succeeded Professor Brian Davies as the second Cato Professor of Psychiatry at the University of Melbourne. In that role he was Head of the University of Melbourne's, Department of Psychiatry, and expanded considerably the academic activities of the Department which extends across three Clinical Schools, i.e. Melbourne Health, Austin Health and St Vincent's Health and ORYGEN Youth Health an integrated clinical and research facility, with a strong emphasis on links with the public psychiatric service system. He has developed 3 Professorial positions at several major private psychiatric hospitals in Melbourne and 8 additional Professorial appointments including in Geelong, at the Australian Centre for Posttraumatic Health, and Chairs of Neuropsychiatry, Old Age Psychiatry and Women's Mental Health.

Professor Singh's educational experience in addition to his role in the development of the new medical curriculum at Newcastle University included Chief Examiner Final Year Examinations in 1987/88, coordinator psychiatric hospital attachments, and Co-Director of the Master of Psychological Medicine program at Monash University. In his previous position as the Cato Professor and Head of Psychiatry he served on a number of Committees in the Faculty of Medicine, Dentistry and Health Sciences, e.g. Faculty Executive, Faculty Planning and Budgets Committee, Faculty Research Sub-Committee, Curriculum Review Committee etc. and the University of Melbourne Selection Procedures Committee and Committee for Public Academic Programs. He directed the Master of Psychiatry Program and the Graduate Diploma of Mental Health Sciences, offered in a number of specialty areas of psychiatry. He was chair of the Human Mind and Behaviour stream of the new undergraduate curriculum. From 1996 - 2005 Professor Singh was appointed as Associate Dean (International), responsible for international matters in the Faculty of Medicine, Dentistry and Health Sciences, including the establishment of the Australian International Health Institute (AIHI) and subsequently the Nossal Institute of Global Health (NIGH) of the University of Melbourne. In 2005 Professor Singh was appointed Associate Dean (Major Projects). He also served from 1997-2000 as Assistant Dean responsible for University links with North Western Health Care Network. In July 2006 he was appointed Deputy Dean Faculty of Medicine, Dentistry & Health Sciences (FMDHS) and took up this position full-time in 2008 to 2010, when he stood down as Head of Department after 17 years. He was appointed Assistant Vice-Chancellor (MDHS Major Projects) in 2011 and retired from the university at the end of 2013.

The main thrust of Professor Singh's research activities has been in the area of schizophrenia, and his major achievement, together with Professor D Copolov, past Director of the Mental Health Research Institute of Victoria, was the establishment of the NH&MRC Schizophrenia Research Unit, which he co-directed from 1988 - 1996. This unit created the foundation for ORGYEN Research Centre and Melbourne Neuropsychiatry Centre of the University of Melbourne. Other areas of research include psychiatric rehabilitation, psychiatric aspects of disasters, rehabilitation in physical illness, and care giving in the community.

He has received numerous grants in support of his research, the largest of which has been for the Schizophrenia Unit Grant from the NH&MRC ($1m/year), and jointly with Professor Helen Herrman for the Caregivers Program from the Victorian Health Promotion Foundation.

He has published more than 150 papers in the psychiatric literature and has co-edited five books, i.e. The Foundations of Clinical Psychiatry Textbook (1994) extensively revised for its 2nd and 3rd Edition in 2001 and 2007 and Understanding Troubled Minds (1997), all published by Melbourne University Press; Family

Caregivers (1998) by Allan and Unwin; and Mental Health in Australia (2001, 2007 & 2012) by Oxford University Press).

Professor Singh has consulted for both the State and Commonwealth Governments and has held the following positions: Consultant to Commonwealth Department of Health, Canberra, for Evaluation of New Drugs from 1982 - 1990; Chief Policy Adviser, Office of Psychiatric Services, Health Department of Victoria from 1988 to 1992 in which role he was actively involved in developing an academic strategy for public psychiatry in Victoria and the 1st National Mental Health Policy. He was reappointed from 2002 to 2004. Professor Singh was a Member of the Grants Committee of NH&MRC from 1991-1996 and has been a member of and Chairman of Regional Grants Interviewing Committees on many occasions from 1984-1998. Professor Singh was also an active member of the Royal Australian and New Zealand College of Psychiatrists and was a Councilor for NSW (1978 – 1980), Censor from 1980-1988 and Chairman of the Fellowships Board and Committee for Examinations in which role he was a member of the College Executive and Council from 1988 to 1994. He has served on the Community and Research Committees of the Victorian Health Promotion Foundation from its inception in 1990 to 2000 and Professor Singh was Deputy Chair of the Victorian Ministerial Advisory Committee on Mental Health from 2004-2007. He chaired the Beyondblue Victorian Centre of Excellence in Depression and Related Disorders Committee from 2005-2013 and was Foundation Chair of the Victorian Responsible Gambling Foundation for the Victorian Government from 2012-2016.

Professor Singh was appointed as Director of Psychiatric Services at the Royal Melbourne Hospital from 1991 until 1995, then Clinical Director of the Royal Melbourne Hospital Psychiatry Clinical Business Unit, which incorporated the Royal Park Psychiatric Hospital. From 1996-2007 Professor Singh became the Clinical Director of North Western Mental Health, an Adult, Child and Adolescent Mental Health Program which serviced a population of 1 million people in the North and West of Melbourne. He is currently Coordinator of Postgraduate Training for that service and also teaches trainees from Year 1-5. He has also taught psychiatric trainees at Eastern Health from 2014-2017.

Professor Singh has in these multiple roles organised numerous local, national and international conferences most recently the 2004, 2005 and 2007 International Mental Health Conferences in Melbourne and Sydney. In 2007 this meeting was held in conjunction with WPA international conference in Melbourne for which he was a member of the organising committee and chaired the Asian Advisory Sub-Committee. He has been extensively involved with scientific advisory committees for many conferences including in 2007, the International Women's Mental Health Conference in Melbourne and the WPA World Congress meeting in Prague in 2008.

Professor Singh has had a longstanding commitment and interest in psychiatric services, particularly their move into the General Health System. He is also active in promoting psychiatry in the Asia Pacific Region and he is a Past President of the Pacific Rim College of Psychiatrists (2001-2004). He was instrumental in developing the MHLP/Mental Health Leadership Program for Asian Psychiatrists run by the University of Melbourne. He was Foundation President of the Indo Australasian Psychiatry Association (IAPA) from 2004-2007. Professor Singh was the World Psychiatric Association (WPA) Zonal representative for Zone 18, the Australasian zone from 2005-2008. He also established Asia Australia Mental Health, a unique coalition between St Vincent's Health and the University of Melbourne's Department of Psychiatry & Asia Link, advancing psychiatry in the Asia-Pacific region. Professor Singh was awarded the Centenary Medal of Federation by the Australian Government in 2003 for his service to medicine, the 25th anniversary medal of the Federation of Ethnic Communities Council of Australia (FECCA) for his services to multiculturalism and the premier award of IAPA for his contributions to psychiatry in Australia and the region in 2004. He was also made Distinguished International Fellow of the APA in 2005 and Honorary Fellow of the Royal College of Psychiatrists in 2007 in which year he was honoured by the Australian Government with the award of Membership of the Order of Australia (AM). He was also awarded the Meriotious Service Award of the Victorian Branch of the RANZCP and the Chairman Award for Excellence at Melbourne Health. Professor Singh received the inaugural Victoria Minister's Award for Outstanding Achievement in Mental Health in the 2008 Victorian Public Healthcare Awards. In 2014, he received an Honorary Doctorate of Medical Science from the University of Melbourne and the title of Emeritus Professor in recognition of his contribution to the discipline of Psychiatry and the advancement of mental health care in Australia and the region. In 2018 Professor Singh was awarded the College Citation Certificate from Royal Australasian College of Psychiatrists and the Medal of Honour of the College in 2020.

Professor Singh has been in part time private practice since 1977 and currently does five sessions per week at the Melbourne Clinic. He also consults regularly for APHRA.