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5 July 2019

Royal Commission into Victoria's Mental Health System
To the Honourable Chair, Ms Penny Armytage and Commissioners Professor Allan Fels AO, Dr Alex Cockram and Professor Bernadette McSherry
Post Office Box 12079
A'Beckett Street
MELBOURNE 8006

Via email: contact@rcvmhs.vic.gov.au

Dear Commissioners

RE: Australian Medical Association (Victoria) Submission to the Royal Commission into Victoria's Mental Health System

AMA Victoria thanks the Royal Commission into Victoria's Mental Health System for the opportunity to provide input into its process.

A broad range of our members have participated in the submission process and attended almost all of the recent community based consultations around Victoria to contribute to the Royal Commission's work. Our members have also worked very hard to prepare a considered and cohesive document, which integrates responses from public and private sector psychiatrists, general practitioners, child psychiatrists and emergency physicians.

AMA Victoria would welcome and value the opportunity to meet with the Royal Commission in the coming months, to contribute further to its program of work.

If you would like to discuss any aspect of our response, please contact Ms Nada Martinovic, Senior Policy Advisor, on [redacted]

Yours sincerely

Julian Rait

Associate Professor Julian Rait OAM
AMA VICTORIA PRESIDENT

AUSTRALIAN MEDICAL ASSOCIATION (VICTORIA) SUBMISSION TO THE ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

5 July 2019

Australian Medical Association (Victoria)

AUSTRALIAN MEDICAL ASSOCIATION (VICTORIA) SUBMISSION TO THE ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

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Adult Public Mental Health Recommendations

Every person living with a mental illness should have ready access to quality mental health care in the public sector that is appropriate to their needs.

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Fund a minimum of 4 new pilot specialist outpatient psychiatry services over the next 3 years** - these pilot sites would be staffed by state-funded psychiatrists, and provide timely and quality access to care for patients who cannot afford private psychiatry services.
- **Fund the development of a public day program for complex or high-risk patients** - either run by, or associated with, public mental health services.
- **Provide a significant number of additional beds in Victoria** - specifically AMA Victoria advocates for 50-60 beds per 100,000 population.
- **Undertake a feasibility study into the establishment of:**
  1. ***Three Centres of Excellence*** - to admit complex patients and support the provision of necessary mental health services within their draining catchment areas. These centres could be distributed across metropolitan Melbourne (for example the north, east and west) to provide a hub and spoke model of care with a centralised service and governance system; and
  2. ***A National Centre for Inpatient Mental Health*** - large state of the art inpatient facility close to the city (within 6-10km) and with strong relationships to key mental health academic institutions which could provide an integrated approach to acute inpatient care, teaching and research.
- **Undertake a comprehensive statistical and population review of all areas of the state, and the current mental health infrastructure in those areas** - with a special but not exclusive focus on areas experiencing rapid growth. This development should be carried out with consideration of the norms provided by the National Mental Health Services Planning Framework, but with necessary adjustments for specific characteristics of different demographic areas, such as social or socio-economic determinants of health.
- **Explore opportunities for state and federal collaboration** - including shared care models, a review of the Fifth National Mental Health Plan and how it can be tailored to Victoria, with involvement and input from AMA Victoria and other peak stakeholders in the mental health space.
- **Review the 2019 VAGO report on Access to Mental Health Services** - with a view to implementing all six recommendations.
- **Develop and strengthen existing mechanisms so that funding provided towards mental health services is protected or ring-fenced –** it is also important that funding is provided on an equitable basis throughout Victoria.
- **Release any reports and inquiries collected by the Victorian Government Department of Health and Human Services in the past five years** - for viewing by the Royal Commission and the public.
- **All of the above recommendations are predicated on appropriate and adequate resourcing of an array of related services** - this particularly includes effective funding of drug and alcohol services, housing for persons with a mental illness and forensic services. Without adequate resourcing of related areas, we anticipate that this will result in fallout from limited resourcing of services onto mental health services, overstretching any existing capacity.

Child Psychiatry Recommendations

The Royal Commission offers an opportunity to rectify the problem of long-standing neglect of children's needs in the community, and to improve the mental health and wellbeing of Victorians over generations.

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Implement the 20 recommendations of the VAGO report on Child and Youth Mental Health (2019).**
- **Review current system design –** recommendations relating to system design to be informed by outcomes of the Royal Commission.
- **Address gaps in accommodation and service coordination** – young patients experience longer than necessary stays in CYMHS facilities as inpatients, as they cannot access family or carer support and/or services such as disability services, accommodation, child protection and out-of-home care.
- **Take action to address service gaps for dual disability** - take action to support CYMHS to provide services to clients with dual disability who have complex needs.
- **Facilitate increased parent participation in child and youth mental health programs** – parents and siblings (where appropriate) should be involved in care planning, ongoing consultations and review of progress.
- **Review the New Orleans (Tulane model) -** and how it can be tailored to Victoria, with involvement and input from AMA Victoria and other peak stakeholders in the mental health space.
- **Fund research and training in assessing parenting capacity –** there is a lack of trained professionals who are able to provide reports to the court regarding parenting capacity and the impact on the child of contact arrangements.

General Practice Recommendations

We know that general practice is the most efficient and cost-effective part of the health system, but requires greater support to continue providing high quality primary health care to the Australian community.

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Commit to supporting the well evidenced, GP-led 'Patient-Centred Medical Home' for those living with mental illness -** this supports accessible, comprehensive, coordinated and continuous care.
- **Explore opportunities for state and federal collaboration** - including shared care models, pooled funding and improved MBS rebates to better support a GP-led, patient-centered medical home, underpinned by adequate remuneration for GPs.
- **Commit to funding dedicated and properly remunerated on-call psychiatrists across all state mental health services –** to facilitate timely secondary referral/advice for GPs and better-coordinated care for patients in the community.
- **Develop new models to facilitate care by psychiatrists, in consultation with AMA Victoria** – these models could include public sector psychiatric outpatient clinics and private psychiatrist linked modified Consultation Liaison Psychiatry to Primary Care (CLIPP) models, to facilitate GP referrals of patients with significant mental illness to psychiatrists.
- **Prioritise reform and investment in significant mental illness to support the most vulnerable populations in our community with serious mental health problems** - including people experiencing homelessness, those in the criminal justice system, parents with children and adolescents.
- **Invest in coordinated efforts with AMA Victoria, Primary Health Networks (PHNs) and area mental health services to develop better integrated models of care** – these models of care must be underpinned by strong clinical governance that includes a single-entry mechanism for non-emergency care for those who cannot access private care by psychiatrists and allied mental health professionals.
- **Provide targeted subsidies for rural mental health** - for the provision of mental health care by GPs to ensure these services are provided in rural and regional areas.
- **Mandate the provision of expert and timely specialist advice from dedicated public hospitals to rural GPs, including in emergency scenarios** – to facilitate improved networking and communication between primary care and other public and tertiary health services.
- **Invest in telehealth for rural GPs** - including video, phone and email communication from dedicated public hospitals to ensure optimal care, timely referral, and assistance in urgent and semi-urgent scenarios.
- **Facilitate streamlined pathways of care** - provide GPs working in rural hospitals with priority access to regional hospital hubs and streamlined pathways of care for emergency advice and transfer.
- **Reduce venue opening hours, cash out in venues and maximum bets –** to decrease the negative effects of gambling on those with mental illness.

Emergency Physicians Recommendations

Patients, families and carers faced with a crisis know that whatever else, the Emergency Department (ED) is always open. The ED provides a safe haven for patients, families and carers 24 hours a day, every day of the year.

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Classifies any patient event involving more than 24-hours in the ED as 'a reportable event' to the Department of Health and Human Services (DHHS)** - every event should require a review to determine the patient specific and system-based factors that prevented the patient from getting to a more appropriate health care setting. The acceptable incidence of 24-hour stays in the ED should be 0%.
- **Develop models of care that emphasise low stimulus, high resource environments that combine acute and mental health care** - models based on short-stay units but with additional high acuity nursing and inclusion of mental health and drug and alcohol staff have been developed and evaluated (the Behavioural Assessment Unit provides a template for such a model).
- **Develop models of care for patients with a clear-cut need for a psychiatric admission but who, due to concurrent medical illness or intoxication, require a period of medical management and stabilisation** - this cohort is not suitable for a Behavioural Assessment Unit due to the high-risk nature of their psychiatric illness; and so this model requires a secure setting, staffed by clinicians with both mental health and critical care training.
- **Develop a framework for the governance of restrictive interventions in acute settings** - this should consider consumer, organisational and staff perspectives, and focus on minimising the rates of restrictive interventions, whilst maintaining a safe environment for patients, staff and visitors.
- **Mandate that the use of restrictive interventions be clearly documented using a standardised template to allow ready documentation and data extraction** - this should record the type of restraint, the reason it was required and the duration (with the move of all healthcare facilities to electronic medical records, consideration should be given to the benefit of common definitions and minimum datasets).
- **Require that a readily accessible registry of restraint be kept at all health care organisations** - this should include physical, mechanical and chemical restraint (or therapeutic sedation), and consideration should be given to the reporting of restraint rates.
- **Facilitate integrated care pathways for patients with mental illness and complex needs** – these pathways should support health, social and financial needs as a whole, not in discrete parts.
- **Review the resourcing available to elderly people with a mental health issue -** this is an especially complex group of patients and is expected to grow as the population ages.
- **Review whether changes should be made to the *Mental Health Act 2014 (Victoria)*** - to allow patients to be treated under the Act, whilst in the justice system.
- **Facilitate better and earlier access for mental health teams from existing health care organisations to patients within the justice system** - to prevent deterioration in their mental health.

Private Psychiatry Recommendations

Private mental health care is one of the only areas mentioned by consumers in the Royal Commission's community consultations, which is described as a positive area of success.

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Adopt the private psychiatry, patient-centred, long-term treatment model instead of the current episodic community mental health service model –** patients living with ongoing and recurrent significant mental illness would greatly benefit from adoption of the proposed model.
- **Include private psychiatrists in the planning stages of mental health policy development** – along with the public sector and primary care sector.
- **Recommend to the Federal Government to increase Medicare rebates -** for patients treated by private psychiatrists and general practitioners.

Workforce Recommendations

Public mental health services are struggling to recruit, retain and develop the mental health workforce. A sustainable mental health workforce is critical to support provision of optimal care for the most significantly mentally ill patients.

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Commit to ongoing collaboration with AMA Victoria to support regional and rural specialist training opportunities –** to ensure quality of care in regional and rural communities, and provide employment for the increasing number of medical graduates.
- **Implement the five measures outlined in the AMA's Position Statement on Rural Workforce Initiatives –**
  - encourage students from rural areas to enrol in medical school, and provide medical students with opportunities for positive and continuing exposure to regional/rural medical training;
  - provide a dedicated and quality training pathway with the right skill mix to ensure doctors are adequately trained to work in rural areas;
  - provide a rewarding and sustainable work environment with adequate facilities, professional support and education, and flexible work arrangements, including locum relief;
  - provide family support that includes spousal opportunities for employment, educational opportunities for children, subsidies for housing/relocation and/or tax relief; and
  - provide financial incentives to ensure competitive remuneration.
- **Implement state-wide core occupational violence training** - across all hospitals.
- **Simplify reporting systems** - to increase reporting of incidents and inform prevention and controls.
- **Undertake state-wide regular audits** - hospitals should commit to regular audits to identify their organisation's vulnerability to violence and inform risk management planning.
- **Implement state-wide leave cover across all hospitals** - trainees (and often their supervisors) are generally not covered when taking leave, other trainees within the service are often expected to pick up the patient workload.
- **Address 'bottlenecks in training'** – by funding an appropriate number of training positions to meet training requirements and workforce projected needs.
- **Create more part-time training positions** – this is absolutely necessary for trainees to be able to create and support their families during training.
- **Create more funded and accredited research positions** - for registrars with sufficient clinical exposure to meet accreditation requirements.
- **Invest in system improvements to reduce the burden of paperwork and excessive administrative tasks** – this has a significant impact on the amount of meaningful clinical time the doctor has to spend with the patient, family and carers.
- **Facilitate access to psychotherapy training and supervision** - to provide a richer training experience but also better patient outcomes.

Other Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Review mandatory reporting laws** – we need to strike a better balance between doctor wellbeing and patient safety. Specifically we need to align Victoria's mandatory reporting laws with Western Australia, where health professionals can see their GP or psychiatrist without fear of reprisal.
- **Remove discriminatory exclusion clauses –** mental health conditions are common and insurers should not impose exclusions that are not justified by a strong evidence-base, and further the statistical data relied upon should be made available to the public.

And further, AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Provide funding to measure and report on indicators of communication with GPs and other medical practitioners** - as per the '10 Minimum Standards for Communication between Health Services and General Practitioners and Other Treating Doctors'.
- **Provide funding for electronic communication** - to ensure all public hospitals are working towards the ability to receive and send secure electronic communication to and from the medical software platforms of referring doctors.
- **Develop agreed principles for contracts around IT provision to health services** - to enforce minimum standards for software providers.

Introduction

About AMA Victoria

The Australian Medical Association (Victoria) is the principal voice advancing the Victorian medical profession and influencing policy makers. We proudly connect and support our members, providing a unified voice to advocate for Victorian doctors and the health of all Victorians.

Consultation to date

AMA Victoria thanks the Royal Commission into Victoria's Mental Health System for the opportunity to provide input into its program of work.

The AMA Victoria submission was produced by a number of highly experienced clinicians with many years of expertise in their specialisation, along with extensive consultation from its membership. This document does not represent the entire views of any specific individual nor the organisations that they are affiliated with.

To inform and support AMA Victoria's response to the Royal Commission, we established an internal advisory taskforce and extend our deepest gratitude to Chair Dr Ajit Selvendra, who was ably supported by Associate Professor Julian Rait OAM, President of AMA Victoria.

We also thank AMA Victoria's Senior Policy Advisor, Ms Nada Martinovic, for supporting the consultation process over many months and for collating and producing the final submission.

Note on this submission

This submission reflects the diverse views of AMA Victoria's broad membership base, which includes general practitioners working in a range of community settings, private and public psychiatrists, psychiatrists working with children and adolescents, emergency department physicians, psychiatrists and other doctors involved in the treatment of alcohol and other drug disorders and geriatric forensic psychiatrists.

This document covers a breadth of key dimensions in mental health and the challenges faced at personal, clinical, organisational and government levels. A range of models, approaches and recommendations have been made to provide optimal care for individuals with a lived experience of mental illness and those who support them.

If you have any questions about this submission, or want to arrange a time to meet with AMA Victoria to discuss, please contact Ms Nada Martinovic, Senior Policy Advisor, [redacted]

Executive Summary

Mental illness

The World Health Organisation (WHO) defines good mental health as:

> *a state of wellbeing in which an individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to their community*.[1]

Almost half of the Australian population will experience a mental illness at some point in their life.[2] The effect of mental illness on individuals, families and carers can be severe and its influence on society as a whole, far reaching. Social problems often associated with mental illnesses include poverty, unemployment or reduced productivity and homelessness. People with lived experience of mental illness may also experience isolation, discrimination and stigma.[3]

Throughout this submission, the terms 'mental illness', 'mental disorder' and 'mental condition' are used interchangeably to describe a wide range of mental health and behavioural disorders which vary in duration and severity.

Equity in access to timely and quality healthcare

Every Victorian in need of mental health care should have timely access to high-quality and targeted care. Continuity of care is also particularly important, especially for patients with complex and chronic problems, the elderly and socially vulnerable groups.

Too often Victorians living with mental illness are disadvantaged by for example, experiencing homelessness, being a low income earner, having complex needs or residing in a regional or rural area.

[1] World Health Organisation (WHO), Mental health: a state of well-being, 2014. Access here: https://webcache.googleusercontent.com/search?q=cache:okX5Oxn98pgJ:https://www.who.int/features/factfiles/mental_health/en/+&cd=1&hl=en&ct=clnk&gl=au
[2] headspace, What is mental health and mental illness? 2018. Access here: https://headspace.org.au/young-people/what-is-mental-health/
[3] The Australian Institute of Health and Welfare (AIHW), Australia's Health 2018, 2018. Access here: https://apo.org.au/system/files/179001/apo-nid179001-872396.pdf

Addressing service gaps in Victoria's mental health system

AMA Victoria has identified significant gaps in the state mental health system which impact on the ability of Victorians living with mental illness to receive the care they need, when they need it:

- there is increasing fragmentation arising from the divide between federal and state-funded mental health services;
- there is a divide between public and private mental health services and a lack of coordination between the two sectors; and
- there is a divide in access to services between metropolitan and regional and rural areas.

The medical profession plays a key role in prevention, diagnosis and management of mental illness. Medical practitioners strongly advocate that it is time to fix our health care system, both for medical practitioners working in a fragmented and poorly resourced sector, and for patients and carers who oftentimes struggle to navigate the complex health system and find appropriate, timely and quality care.

Given the diversity and complexity of mental illnesses, there are different priorities across practitioners and medical sectors, highlighting the breadth of the current problems.

General practitioners (GPs) face challenges caring for patients who present with increasingly complex needs. They rightly advocate for greater funding for prevention and primary care services and greater support for general practice, so that GPs can better care for patients living with mental illness in the community, keep patients well and functioning optimally and decrease the likelihood of hospitalisation.

Psychiatrists working in public sector mental health services emphasise the urgent need for more beds in psychiatric units in hospitals. Private psychiatrists propose a plan to involve the private sector in actively treating 100,000 of the more seriously and significantly mentally ill Australians each year. Private psychiatrists are also heavily involved in the care of many patients who are also treated by state-based services. Greater integration and collaboration is possible. This submission also explores how the private sector can be further involved in actively treating up to an extra 100,000 of the more seriously and significantly mentally ill Australians each year, enhancing collaboration and supporting the workforce.

Physicians working in hospital emergency departments provide a large component of mental health crisis care and are calling for models of care that emphasise low stimulus, high resource environments and combine acute and mental health care.

Piecemeal investments in existing systems and services will not fix Victoria's fragmented mental health system and will offer services that are poorly integrated and fail to deliver quality care.

Funding priorities for the new state mental health system

Positive reform of the mental health system in Victoria will only be achieved through targeted investment. AMA Victoria broadly advocates for three strategic initiatives:

1) evidence-based and cost-effective funding for mental health services;
2) fully funded public mental health services, including access to outpatient care by psychiatrists; and
3) integrated and accessible services and systems for prevention, diagnosis, early intervention and management of mental illness.

AMA Victoria's submission to the Royal Commission into Victoria's Mental Health System reinforces our message of shared purpose. Despite the breadth of current problems and sometimes divergent views of medical practitioners on what needs to be done to fix Victoria's mental health crisis, this submission unequivocally focuses on patients.

AMA Victoria advocates that primary care systems should be strengthened to address multiple health priorities more broadly, as physical, social, economic, and mental health conditions are often inexorably linked.

A key strategy for improving access to quality health care while keeping costs down is to prevent mental health crises, which often result in expensive emergency care. This is best achieved by targeted funding that supports general practice to meet the needs of patients, by investing in the ability of patients to access timely and appropriate care by psychiatrists and other specialist services, and by ensuring the state health system is integrated and easily navigated by patients, carers and health professionals.

Mental illness puts people at higher risk of losing a job or becoming homeless, while many carers are also forced to leave work to care for a loved one living with mental illness. Unless we address issues like homelessness, we are unlikely to achieve optimal health outcomes for patients.

To support patients to receive timely and high quality health care, AMA Victoria recommends that the public psychiatry inpatient and outpatient sector be adequately resourced to provide at least equivalent care to that provided in the private system. This is because the unique assessment and treatment required by some patients can only be provided by the public system.

AMA Victoria advocates for an urgent need to assess the effectiveness of current mental health interventions. We need to look at where money is being spent, who is receiving the benefits and who is missing out. This assessment should

guide the development of coordinated federal and state government efforts in mental health reform and service delivery.

AMA Victoria's submission to the Royal Commission is organised so that interventions in the Victorian public sector that can be funded quickly and easily are discussed first (Q9 and Q10), followed by discussion of early intervention and analysis of what is working well and what could be done better to foster early treatment (Q2). We then discuss what makes it hard for people to experience good mental health and what can be done to improve this (Q4). AMA Victoria has opted to answer all 11 questions.

Responses to the consultation questions

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?

Our response to question 9 is broadly a response to TOR 6.

As part of our response to Q9, we will broadly examine useful interventions that can be funded quickly and be easily implemented to support Victoria's mental health system to effectively deliver treatment, care and support to all Victorians living with mental illness.

Historical context

Victoria has undergone a process of progressive deinstitutionalisation in delivery of mental health care. This particularly gained momentum in the 1990s and was largely complete by the early years of this century.[4] The outcome of this process was the removal of large, stand-alone psychiatric hospitals and instead patients were integrated into small single or double psychiatric wards attached to general hospitals. During this time, community managed mental health rehabilitation services continued to grow. We especially recognise the important role that community organisations play in supporting the mental health of Victorians living in rural and remote areas.

[4] Meadows, G. et al., 'Victoria on the Move': Mental Health Services in a Decade of Transition 1992-2002, *Australasian Psychiatry,* 2003: 11(1); 62-67. Access here: https://www.researchgate.net/publication/229724018_'Victoria_on_the_Move'_Mental_Health_Services_in_a_Decade_of_Transition_1992-2002

In the greater Melbourne area, there are 12[5] public hospitals and 8[6] private hospitals with psychiatric wards.[7] We acknowledge that there are fewer mental health services in regional and rural areas of the state. At question 5 of this submission, we discuss that targeted strategies and funding are needed to improve access and reduce barriers to mental health services for Victorians living in regional and rural areas.

The process of deinstitutionalisation has resulted in some benefits, for example access to mental health care in primary care settings has been substantially improved. However, the last two decades of mental health system reform have also contributed to:

- loss of some of the positive effects, services and resources of prior large psychiatric hospitals; and
- unintended and unforeseen consequences of mainstreaming into general hospitals.

There have also been substantial successive changes in health, social care and support services funding since mental health deinstitutionalisation, as evidenced by:

- the transition and realignment of the psychiatric disability rehabilitation and support services (PDRSS) to Mental Health Community Support Services (MHCSS) in Victoria;
- the development of the NDIS funding streams and benefits;
- lack of affordable housing for patients living with significant mental illness;
- extensive changes to federally-funded programs, with the introduction of case conferences, the Access To Allied Psychological Services (ATAPS) and Better Access programs;
- lack of indexing of Medicare items to the CPI, over 35 years, resulting in greater out-of-pocket gap payments for many consumers of health services; and
- subsequent changes in funding of related services including dual diagnosis, dual disability and forensic psychiatry services.

Changes made at various levels of government have had a significant flow-on effect on the funding of public sector mental health services in Victoria, and the subsequent care and support able to be provided to patients living with mental illness. AMA Victoria notes that from first place in ranking of funding levels among states and territories at the inception of the National Mental Health Strategy in the early 1990s, Victoria has slid down over time to quite

[5] Alfred Health, Austin Hospital, Casey Hospital (Monash Health), Dandenong Hospital (Monash Health), Frankston Hospital (Peninsula Health), Maroondah Hospital (Easter Health), Mercy Health, Moorabbin Hospital (Monash Health), North Western Mental Health at The Royal Melbourne Hospital, Northern Hospital, St Vincent's Hospital and Upton House (Easter Health)
[6] Albert Road Clinic, Beleura Private Hospital, Delmont Private Hospital, Essendon Private Clinic, Ramsey Health Clinic, St. John of God Pine Lodge Clinic, The Melbourne Clinic, The South Eastern Private Hospital
[7] Mental Health Compass, Hospitals with psychiatric wards in the greater Melbourne area, 2019. Access here: http://www.mentalhealthcompass.com.au/hospitals

consistently coming last on that scorecard, with the lowest per capita expenditure on mental health in Australia. Access to services now is at 39 per cent below the national average.[8]

Length of stay in Victorian public hospitals

Patients are referred to the public system when acutely unwell for acute care via crisis teams or admission to hospital.

The average length of stay in Victoria's acute psychiatry public hospital units is just over nine days[9] but it takes two to four weeks for any psychiatric treatment to be effective for severe acute psychiatric illness. Effective treatment includes biological, psychological and social treatment known as the biopsychosocial model. Most psychiatric medications take about three to four weeks to show a strong clinical effect.

There are many patients with both physical illness and psychiatric illness who are in general hospital wards primarily for treatment of their physical illness but who need referral to consultation liaison psychiatrists for their psychiatric treatment.[10]

The consequences of decades of under-funding include public hospital admissions progressively becoming shorter and public hospital services involvement (including subacute and case management care) becoming episodic.

The short length of stay in hospitals is concerning, as many mental health patients rebound and often return to hospital shortly after discharge, or in some cases they suicide. The pressure to discharge patients from hospitals often leads to 'revolving door' admissions.[11]

On occasion, mental health patients might receive outpatient case management for a brief period of time following discharge, but then patients are discharged to primary care. Primary care practitioners, such as GPs, have access to care plans and other resources but lack ongoing specialist support required to maintain wellness, often resulting in a relapse and revolving door presentations to public hospitals.

[8] Mental Health Victoria, Saving lives. Saving money. 2018. Access here: https://www.mhvic.org.au/images/PDF/Policy/FINAL__Saving_Lives_Money_Brochure_HR.pdf
[9] "Southern psychiatrists crying out for acute-care beds", *The Australian*, 25 July 2018. Access here: https://www.theaustralian.com.au/news/southern-psychiatrists-crying-out-for-acutecare-beds/news-story/d6b2c153b4d175e0b38826358ac2ffcf
[10] Ibid
[11] Allison, S. et al., Mental health services reach the tipping point in Australian acute hospitals, *Medical Journal of Australia,* 2015: 203 (11); 432-434. Access here: https://www.mja.com.au/journal/2015/203/11/mental-health-services-reach-tipping-point-australian-acute-hospitals

Consultation Liaison in Primary Care Psychiatry – CLIPP

In the last two decades, Victoria has also witnessed the closure of programs, especially programs that support GPs. Examples include the CLIPP project, (Consultation Liaison in Primary Care Psychiatry), a large GP shared mental health care initiative developed and evaluated in Victoria over the last eight years.[12] The CLIPP project involved firstly facilitating collaboration and consultation between GPs and psychiatrists to support people with a high level of need in the community and ensure that relapse prevention takes place. The second aspect of the project involved the transfer of a selected group of psychiatric clients into shared care, with GPs utilising the channels of communication and collaboration developed as part of the psychiatrist-liaison attachments.

As hinted above, the CLIPP model used the concept of a 'relapse signature', involving recognition of early warning signs of relapse, to simplify clinical monitoring. This model of service delivery provided a supportive mechanism for mental health service clients to be reintegrated into general health care within a seamless service delivery structure.

Primary Mental Health Service Programs

Funding cuts have also resulted in the closure of various primary mental health service programs that involved mental health workers supporting GPs to look after patients living with serious mental illness.

An example is the Mental Health Nurse Incentive Program (MHNIP), a government-funded program in operation since 2007 that facilitated mental health nurses to work in primary care settings, in collaboration with GPs, psychologists and private psychiatrists. The mental health nurses provided co-ordinated care with interventions from the acute phase through to identifying the need for and referring for medical and dental appointments, social services, legal services and NDIS advocacy.

In addition to funding cuts and closure of many highly effective community programs, Federal government Medicare rebates have not kept pace with the Consumer Price Index (CPI), over a period of 35 years, causing a funding gap for the patient, between the appropriate fee charged by many doctors, and the Medicare rebate leaving a gap fee for the consumer to pay for that service. A paper published by the *Medical Journal of Australia (MJA)* warned that the reduction in GP rebate income due to the freeze may force GPs who currently bulk bill to cover their loss by charging non-concessional patients a co-payment. The paper estimated an increase in out-of-pocket costs of $8.43/patient. The

[12] Meadows G., Overcoming barriers to reintegration of patients with schizophrenia: Developing a best practice model for discharge from specialist care, *Medical Journal of Australia*, 2003: 178(9); 53-56. Access here: https://www.mja.com.au/journal/2003/178/9/overcoming-barriers-reintegration-patients-schizophrenia-developing-best

freeze is therefore likely to have a greater impact on practices that serve socioeconomically disadvantaged populations, the paper noted.[13]

Critical areas of reform – models proposed

The solutions proposed by AMA Victoria are targeted to facilitating better coordinated services for patients who fall between the cracks of our fragmented state mental health system. There is a particular focus on the needs of those living with serious or significant mental disorders, who have been particularly neglected by the system so far.

These proposals are formulated to be longer-term and enduring, as they cut across the artificial divides created by different funding streams and programs. The proposed areas of reform are geared towards ensuring that requirements for mental health care services are optimally met at all phases of illness and to foster a seamless transition for patients moving through different parts of the mental health system.

Apart from clinical care, the additional systems proposed by AMA Victoria would provide a focus for communication, education and information sharing so that groups on both sides of a funding stream gap develop a deeper understanding of the needs of the patient and collaborate more effectively with one another.

Proposal 1 – Fund four (4) new pilot specialist outpatient psychiatry services

Reforms to state mental health infrastructure are urgently needed to strengthen the linkages between general practice and public and private sector psychiatry services. Stronger linkages are necessary to manage complex patients that fall through the cracks of our fragmented state mental health system but also to reduce demand on public sector community services by managing patients earlier in the course of illness.

The term 'psychiatric outpatients' was historically used to highlight a clear distinction between the services currently provided by public hospital community mental health services, and services in community health centres and private psychiatry.

A central concern reported by GP members of AMA Victoria is the lack of access to both public and private sector psychiatrists for different reasons. Further, the lack of opportunity to discuss with psychiatrists the ongoing management of patients was identified as a major barrier to facilitating the continuity of care.

Our GP members report that the cohort of patients that most often miss out on receiving a specialised assessment by a psychiatrist are people very impaired by

[13] Harrison, C., et al., The cost of freezing general practice, *The Medical Journal of Australia*, 2015: 202 (6); 313-316. Access here: https://www.mja.com.au/journal/2015/202/6/cost-freezing-general-practice

their illness and consumers that struggle financially to afford private psychiatry services.

What this means, in practice, is that there are few services between the GP and emergency crisis care. As a result, many Victorians living with significant and disabling mental illnesses who would benefit from a comprehensive psychiatric assessment, may be unable to access the care (and diagnosis) they need, because they are on the one hand, not unwell enough to be admitted to hospital, and on the other, too unwell to be treated and managed by a GP alone. These patients represent 'the missing middle'[14], a newly coined term to describe patients whose needs are too complex for primary care responses but who cannot currently access specialist mental health services.

In AMA Victoria's *2019-20 State Budget Submission*, we called on the Victorian Government to fund a minimum of 4 new pilot specialist outpatient psychiatry services over the next 3 years.[15] These pilot sites would be staffed by state-funded psychiatrists, and provide timely and quality access to care for patients who cannot afford to access private psychiatry services. These sites would be set up to provide necessary mental health services for Victorians living with mental illness, including the 'missing middle':

- INITIAL COMPREHENSIVE ASSESSMENTS

Initial comprehensive assessments would be carried out in public psychiatry outpatient clinics by psychiatrists who will perform psychiatric assessments over two sessions, and a subsequent follow-up with the patient's GP. Where necessary, patients will return to the public psychiatry outpatient clinic for further review and treatment in liaison with their GP and their other mental health clinicians. A psychiatric nurse present would be engaged to obtain relevant background information prior to the first session and also to give directions to the patient, their family and carers on how to access and navigate the mental health system effectively. There would also be administration support for this program.

This model would be similar to the current Item 291 on the Medicare Benefits Schedule (MBS) – however this item number is usually for a single session review, and it is not optimal for significantly mentally unwell patients who often attend late, do not attend at all, or need to be followed up assertively. These patients attend without important past documents or reports, have difficulty articulating their story clearly, or have complex histories.

[14] "Mental illness is more ubiquitous than cancer. How can we help the 'missing middle'?" *The Guardian,* 26 April 2019. Access here: https://www.theguardian.com/commentisfree/2019/apr/26/mental-illness-is-more-ubiquitous-than-cancer-how-can-we-help-the-missing-middle

[15] AMA Victoria, 2019-20 State Budget Submission, 2018. Access here: https://amavic.com.au/files/2019-20%20State%20Budget%20Submission%20(AMA%20Victoria).pdf

AMA Victoria's proposed program allows for a nurse to obtain a volume of information prior to the first assessment and also to facilitate contact with relevant agencies and speak to the patient's family and carers. Our proposed program also facilitates a second consultation to review the case if the patient is late, presenting as unwell or neglects to provide important information during the initial assessment.

Additionally, GPs complain that they cannot get a public psychiatrist on the phone to discuss ongoing management of patients under their care and this assessment program facilitates liaison with the patient's treating GP.

- PROVISION OF LONG-TERM SUPPORT TO GPS

This proposed program would also involve the provision of long-term support to GPs treating patients who are discharged from public hospitals but who continue to be treated with antipsychotic medication and do not require case management or allied health support.

These patients would be reviewed every four to six months by a psychiatrist who is familiar with the patient's history and ongoing needs for care, to support the GP and provide early intervention at times of initial deterioration, or to recommend broader care requirements.

This proposal aims to optimise care coordination and reduce the likelihood of relapse. Additionally, if a patient deteriorates between these occasional reviews they can be referred back at an early stage to their treating psychiatrist, who can review the patient more frequently for a brief period of time in the acute phase, and then once stable, could refer the patient back to the GP for ongoing management and review.

This process avoids episodic presentations to GPs and referral to acute public hospital crisis teams. Currently case management is viewed as the defining reason to remain in public hospital mental health facilities, but as noted earlier, some patients do not require case management. However, due to the often longer-term nature of many mental illnesses, these patients do require specialist review.

There already exists a lot of evidence for the benefits of this type of program with the current clozapine shared care clinics.[16,17] In 2017, Sowerby et al carried out a qualitative study and reported that shared-care clozapine clinics supported

[16] Kelly, B., et al., Shared care in mental illness: A rapid review to inform implementation, *International Journal of Mental Health Systems,* 2011: 5(1); 31. Access here: https://www.researchgate.net/publication/51819298_Shared_care_in_mental_illness_A_rapid_review_to_inform_implementation

[17] Filia, S., et al., Transitioning patients taking clozapine from the public to private/GP shared-care setting: Barriers and criteria, *The Australian and New Zealand Journal of Psychiatry,* 2012: 46(3); 225-31. Access here: https://www.researchgate.net/publication/221888933_Transitioning_patients_taking_clozapine_from_the_public_to_privateGP_shared-care_setting_Barriers_and_criteria

clozapine service users to live as independently as possible by facilitating a person-centred focus to care delivery.[18]

Clozapine shared care occurs in the public sector where a patient who has been stabilised on clozapine in the public sector is then referred to their GP. The patient's clozapine medication is managed by their GP but patients present for review to a public sector psychiatrist every 6 months.

Patients remain well for years on the clozapine program, often for over a decade, without significant relapses. If there is notable deterioration in the patient's condition, the GP would contact the clozapine coordinating nurse who would then refer the patient back to see the public sector psychiatrist. AMA Victoria submits that this process should be extended to patients on all antipsychotic and mood stabilising medications, not just those on clozapine.

- PROVISION OF ONGOING CARE TO THE 'MISSING MIDDLE'

There are a broad range of conditions and presentations that require a multidisciplinary treatment team to ensure optimal care. These patients are very impaired, but do not have a significant psychotic illness, or severe risk features, which is often the time when public sector services usually become involved. There are various clinical models that could be trialled in developing programs for these groups of patients, but effective clinical governance and clinical leadership involving psychiatrists is crucial to ensure optimal standards of care, effective use of resources and adequate risk assessment of acutely unwell patients.

Ongoing training and education of the workforce would be a critical component of proposed reforms and effective research and evaluation would further complement the skills and capabilities of the outpatient program.

BENEFITS OF PROPOSAL 1 – FUND FOUR (4) NEW PILOT SPECIALIST OUTPATIENT PSYCHIATRY SERVICES

This proposed program provides access to timely and quality care, ongoing assessment, review and follow up for patients that cannot afford to attend a private psychiatrist. This cohort of patients includes the financially disadvantaged, those who are disabled and struggle to access private sector services, and patients requiring a more comprehensive assessment than could otherwise be provided during an Item 291-type assessment.

[18] Sowerby, C., et al., Cross-sector user and provider perceptions on experiences of shared-care clozapine: a qualitative study, *British Medical Journal, [BMJ Open],* 2017. Access here: https://www.researchgate.net/publication/320130096_Cross-sector_user_and_provider_perceptions_on_experiences_of_shared-care_clozapine_A_qualitative_study

The proposed reforms especially benefit patients who are caught between the federal-state divide in accessing public sector services, and who are reliant on federal government funding of Medicare psychiatric consultations.

The proposed psychiatric outpatient program facilitates continuity of care for patients who are discharged from public sector services to long-term, low intensity support, facilitated in coordination with a psychiatrist and a GP. This is critically important to maintain stability, prevent relapse and optimise care. AMA Victoria advocates that implementing this proposal would be highly cost-effective, as it would limit referrals to acute crisis teams and prevent costly inpatient admissions.

The VAGO report[19] quoted that the audited area mental health services (AMHS) reported that their bed day costs were higher than the price that the Department of Health and Human Services (DHHS) pays, and that they do not receive the necessary funding to meet demand. The DHHS costings of acute mental health inpatient funding found that the price paid by DHHS met only around 62 per cent of full costs of the AMHS, compared to 82 per cent of the price paid for general acute hospital beds. A DHHS commissioned-review advised that the price paid should be 80 to 85 per cent of the full cost. All the audited AMHS advised that, because of the current gap, AMHS cross-subsidise their inpatient mental health services from other areas within the health service, which risks a negative impact on those services.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Fund a minimum of 4 new pilot specialist outpatient psychiatry services over the next 3 years -** these pilot sites would be staffed by state-funded psychiatrists, and provide timely and quality access to care for patients who cannot afford to access private psychiatry services.

Proposal 2 – Public Sector Day Program

We noted earlier that psychiatric disability rehabilitation and support services (PDRSS) transitioned to Mental Health Community Support Services (MHCSS) and this sector continues to evolve. Public sector day programs and activities have been outsourced in Victoria now for the better part of two decades to the PDRSS (now the MHCSS) organisations, which have developed independent programs.

[19] Victorian Auditor General's Office, Access to Mental Health Services, 2019. Access here: http://audit.vic.gov.au/report/access-mental-health-services?section=

Similarly, many initiatives and interventions have now transitioned to the National Disability Insurance Scheme (NDIS). The limitation of NDIS-funded models is that they do not always incorporate an appropriate level of specialisation in clinical mental health, necessary to manage complex patients or high-risk patients. The NDIS model also does not promote effective liaison with public mental health services.

Similarly, there is an important link missing in the MHCSS programs for patients who require long-term, day activities and structured programs but who are too unwell for the MHCSS program or pose significant risks to self or others.

AMA Victoria urges the Royal Commission to recommend to the Victorian Government the development of a day program, either run by, or associated with, mainstream public mental health services.

At a service level, this would be a program that facilitates optimal linkages with public sector mental health services and public sector case managers, but also facilitates closer monitoring of the patient by trained mental health clinicians.

One approach would be to utilise the successful Prevention and Recovery Centre (PARC) model approach to integration of the MHCSS sector and regional area mental health services, but with the development of long-term day programs.

The day programs would be run either by the public hospital mental health program, or in a shared capacity with the MHCSS, and in a geographic location where the given MHCSS provides the broader staffing, and the public mental health service provides the clinical support and related processes. This allows the mental health service to be directly involved in the ongoing daily activities of the proposed day program, to optimise linkages for patients who need the closer integration and support.

BENEFITS OF PROPOSAL 2 - THE PUBLIC SECTOR DAY PROGRAM

For patients with complex needs and others that cannot access mental health care by a private psychiatrist, or support services through the NDIS, this level of outpatient support provides a facility that allows for closer monitoring of the patient (for example during regular attendances) by trained clinicians, and is also a place where public sector case managers can visit the patient regularly as part of the day treatment program. This proposed model also facilitates development of programs tailored specifically to consumers of public sector services, and can be used as a step-up from case management alone, or step-down from an inpatient or PARC-type stay to medium-term care.

Additionally, despite the public mental health services ceasing to be involved in day programs for the past 20 years, private hospitals have continued to provide an extensive range of day programs suited to the needs of their patient groups. Leveraging this expertise could ensure that there is optimal clinical care in any programs that are developed.

The proposed model would incorporate opportunities for training and education of the MHCSS sector in severe mental illness, and secondment opportunities to this treatment facility. Clinical mental health education is an area that is lacking in the rapid transition to NDIS-based care models, resulting in a less consistent standard of care across the current MHCSS sector.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Fund the development of a public day program for complex or high-risk patients** - either run by, or associated with, public mental health services.

Proposal 3 – Review of population demographic changes

AMA Victoria urges the Royal Commission to recommend that the Victorian Government develop robust health infrastructure, aligned with population demographic changes.

Victoria has experienced a rapid population growth over the past 15 years without adequate infrastructure development, especially in public hospital mental health beds. In fact, the Victorian Population Policy Taskforce projected that the state population will reach 10 million by 2050. Melbourne's population is set to almost double to 8 million by 2051 on current trends, which will put a significant strain on health services (including mental health services) in Melbourne, given that 77 per cent of the state population lives in Victoria's capital city. Regional Victoria is projected to grow by about 700,000 people, while its per capita GDP growth is negative.[20]

The Victorian Population Policy Taskforce estimated that the economic situation in regional areas will only worsen, with the closures of the Hazelwood power station and Australian Sustainable Hardwoods in Heyfield.[21] As noted at question 3 of our submission, mass layoffs and the associated duration of unemployment have both been shown to increase the risk and incidence of suicide in local populations affected by the closure of a major factory, or mine site.[22] Rural GPs report that people on government pensions who can no longer find cheaper rental in Melbourne, are moving to rural areas where

[20] Victorian Population Policy Taskforce, Looking Forward 2050, 2017. Access here: http://vicpopulation.com.au/wp-content/uploads/2017-PPT-interim-report-May-2017-web-final_20170619.pdf

[21] Ibid

[22] Classen, T., et al., The effect of job loss and unemployment duration on suicide risk in the United States: a new look using mass-layoffs and unemployment duration, *Health Economics*, 2012: 21(3); 338-350. Access here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3423193/

accommodation is cheaper. These people often suffer a number of chronic illnesses (including mental illness), but the local health resources in these areas are fewer and harder to access compared with Melbourne.

The rapid population growth has caused significant capacity constraints and extensive challenges to a broad range of infrastructure and services. Mental health is no different and services and funding have been particularly slow to respond. It is clear that we need to develop a robust health framework to manage our state's growth.

For example, Wyndham (in the city's south-west) and Casey and Cardinia (in the south-east) are areas experiencing huge population growth.[23] These regions are more extreme examples of a range of metropolitan and outer regions of Melbourne that are struggling with rapid population demographic changes.

AMA Victoria recommends a comprehensive statistical and population review of all areas of the state, with a special but not exclusive focus on areas experiencing rapid growth, and the current mental health infrastructure in those areas. This body of work should include attention to contemporary information on known variation of rates of mental health problems associated with the socio-economic disadvantage of given areas.[24]

As the population has grown, there have been changes in the demographic characteristics of many areas and suburbs. Many inner-city areas such as Footscray have become much more expensive to live in, and socio-economically disadvantaged populations of Australia's major cities are substantially clustered into suburbs now predominantly located in middle and outer metropolitan areas.[25]

AMA Victoria anticipates that additional inpatient and community mental health services are required to keep pace with this rapid growth. We recommend that work currently under way on funding models pay close attention to considerations of known influences of social determinants of mental ill health. AMA Victoria strongly advocates that this work should involve psychiatrists and public health specialists, and that this process moves towards transparency and accountability, for flow of funds to where they are most needed.

In some areas of Victoria, like Ravenhall, there is a need to review the state's forensic mental health capacity, to align with changing population dynamics at

[23] ABC News, 'Population commission' could rein in housing approvals under Victorian Coalition government, 20 September 2018. Access here: https://www.abc.net.au/news/2018-09-20/victorian-coalition-population-commission-to-manage-growth/10284862

[24] Australian Bureau of Statistics, National Health Survey: First Results, 2017-18. Access here: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2017-18~Main%20Features~Psychological%20distress~20

[25] Australian Housing and Urban Research Institute, Addressing concentrations of disadvantage in Urban Australia, 2015. Access here: https://www.ahuri.edu.au/__data/assets/pdf_file/0012/2163/AHURI_Final_Report_No247_Addressing-concentrations-of-disadvantage-in-urban-Australia.pdf

the new prison located in that area. A comprehensive support package is needed for forensic mental health services that also aligns with the criminal justice system. For example, the new Ravenhall Correctional Centre is capacity-built for 300 correctional beds. When remand is completed and patients require mental health care, they are commonly referred to the local public hospital mental health service. As a result, the local health services must be strategically resourced and staffed to cope with the increased new forensic patient load.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Undertake a comprehensive statistical and population review of all areas of the state, and the current mental health infrastructure in those areas** – with a special but not exclusive focus on areas experiencing rapid growth. This development should be carried out with consideration of the norms provided by the National Mental Health Services Planning Framework, but with necessary adjustments for specific characteristics of different demographic areas, such as social or socio-economic determinants of health.

Proposal 4 – Inpatient psychiatric services

The promise of early intervention and effective community treatment reducing or preventing the need for later hospitalisation remains a valuable aspiration. However, AMA Victoria cautions that despite the best efforts of treating practitioners, some patients do require hospitalisation at certain times during their treatment journey.

Admissions are a crucial part of treating very unwell patients and stabilising acute relapses, and sometimes this may require a longer admission to hospital, with community based support following discharge.

Additionally, there is the unfortunate reality that some patients are unwell for lengthy periods of time, despite the best of treatment, and require extended stays in hospital. With a rapidly increasing population, optimal care is particularly important to avoid serious consequences, including greater rates of mortality, homelessness and criminal justice system involvement.

AMA Victoria welcomed the State Government's announcement of 89 new and existing acute inpatient beds.[26] However, the number of beds in the state system has grown by 7 per cent, while the state's population has increased by

[26] Victoria State Government, Budget Paper No. 3 2018-19, 2018. Access here: https://www.dtf.vic.gov.au/state-budget/2018-19-state-budget

15 per cent over 8 years. The availability of beds per 100,000 people has fallen by 9 per cent.[27]

There is a significant shortage of acute hospital services for patients in need of psychiatric care in Victoria.

Victoria has one of the lowest bed bases nationally, including acute beds.[28]

The Victorian Auditor-General's Office reported that a review commissioned by the Department of Health and Human Services (DHHS) stated that the bed base needs to grow by 80 per cent over the next decade.[29] Allison et al (2018) estimated that the bed base should sit between 50-60 beds per 100,000 population.[30] More beds also provide an opportunity for patients to be treated in inpatient units which are separated by age, illness and gender (especially to prevent sexual harassment and assault in psychiatric inpatient units).

AMA Victoria further advocates for safe and therapeutic spaces to de-escalate aggression, so that patients and staff are protected from the threat of occupational violence, especially from patients who have recently used crystal methamphetamine ('ice') on leave, or at the ward. If existing hospital infrastructure, especially a concern in rural and regional hospitals, is not fit for purpose, this leads to higher rates of seclusion, assaults and the need for chemical sedation.

Safe and therapeutic spaces are also critically needed in the aged care sector, where many residents present with delirium and frequently exhibit aggressive behaviour towards patients and staff. GPs working in the aged care sector fear the risk of complaints made against them from patients, their families and carers if chemical restraints are used on patients in aged are facilities. One GP working in the aged care sector recounts the case of an aggressive patient:

> This man was a very aggressive patient to staff and other residents. He was unable to be admitted as an inpatient at an acute medical hospital, as they were reluctant to admit him as a 'psychiatric patient'. Further, the local Aged Psychiatry Assessment and Treatment Team (APATT) would not accept a patient presenting with delirium. There are never any psychiatric beds for these patients in the community. The patient was eventually admitted to the ED, discharged back to our aged care facility and continued with the same aggressive behaviour.

[27] "Southern psychiatrists crying out for acute-care beds", *The Australian*, 25 July 2018. Access here: https://www.theaustralian.com.au/news/southern-psychiatrists-crying-out-for-acutecare-beds/news-story/d6b2c153b4d175e0b38826358ac2ffcf

[28] Victorian Auditor General's Office, Access to Mental Health Services, 2019. Access here: http://audit.vic.gov.au/report/access-mental-health-services?section=

[29] Ibid

[30] Allison S. et al., When should governments increase the supply of psychiatric beds? *Molecular Psychiatry,* 2018: 23; 796-780. Access here: https://www.ncbi.nlm.nih.gov/pubmed/28696434

A reformed service structure would cover various and broad inpatient requirements, including acute beds, long-stay wards (secure, extended care beds), specific inpatient units separated by age, illness and gender and with safe spaces to de-escalate aggression, as well as adequate beds for general in-patient admissions requiring extended stays in hospital.

Rehabilitation beds are needed, as are beds to support dual diagnosis. As well, we need specialist state-wide beds for acute treatment, in addition to the acute emergency department hubs. This development should be carried out with consideration of the norms provided by the National Mental Health Services Planning Framework[31], but with necessary adjustments for specific characteristics of areas as noted earlier.

These services could be provided at a local level in mental health wards attached to general public hospitals, with assessment of local needs and resources to be based on regional population requirements.

Alternatively, to provide specialised expertise in complex cases, and to support the state-wide inpatient infrastructure - a combination of some services provided at a local level, in association with some of the beds provided at a specialised inpatient centre, could foster optimal care, innovation and develop standards that could be implemented across state-wide inpatient settings.

AMA Victoria respectfully suggests that the Royal Commission should recommend to the Victorian Government to undertake a feasibility study of these two proposed options:

1. THREE CENTRES OF EXCELLENCE

These centres could be distributed across metropolitan Melbourne (for example the north, east and west) to provide a hub and spoke model of care with a centralised service and governance system.

These centres would admit patients who are complex to treat and support the provision of necessary mental health services in the draining catchment area.

2. A NATIONAL CENTRE FOR INPATIENT MENTAL HEALTH

The current approach which sees the Victorian Government fund an extra ward or unit in different growth areas does not necessarily provide a comprehensive or considered solution, or optimise our understanding of how best to address the needs of Victorians now and in the future. Following deinstitutionalisation, Australia now has no main centre to carry out research into best-practice

[31] National Mental Health Service Planning Framework, Introduction to the NMHSPF, 2019. Access here: https://nmhspf.org.au/wp-content/uploads/2019/01/Introduction-to-the-National-Mental-Health-Service-Planning-Framework_2019.pdf

inpatient care and Victoria currently has no academic Chair in inpatient psychiatry.

A large state-of-the-art inpatient facility close to the city (within 6-10km) and with strong relationships to key mental health academic institutions (such as the University of Melbourne Department of Psychiatry or Monash University, as well as key institutions for nursing and other mental health disciplines) could provide an integrated approach to acute inpatient care, teaching and research.

The large facility (possibly 200 beds) would provide evidence-based treatment, especially for patients with complex needs draining from the local catchment regions, and remove pressure from regional services.

Australia, unlike many other countries, does not have a National Inpatient Centre and an investment in Melbourne during a period of rapid population growth would provide clinical and research benefits, and ensure that Victoria as a state, aims for the highest standards of inpatient care. Adequately funded, resourced and staffed public facilities would also help Victorian health services to attract and recruit staff from interstate and overseas, in the short and long term.

A large inpatient facility would also provide a central hub of gender specific psychiatric acute and intensive care beds for acutely and severely unwell patients who are not able to be optimally managed in regional services across the state. The centre would also provide secure extended care unit (SECU) beds for patients who live with a more disabling form of illness.

The relationships with key academic institutions would ensure that research is conducted to understand and optimise treatment for these patient groups and to ensure the highest standards of evidence-based treatment is provided for Victorians living with mental illness.

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Provide a significant number of additional beds in Victoria** - specifically AMA Victoria advocates for 50-60 beds per 100,000 population.
- **Undertake a feasibility study into the establishment of**:
  1. ***Three Centres of Excellence*** - to admit complex patients and support the provision of necessary mental health services within their draining catchment areas. These centres could be distributed across metropolitan Melbourne (for example the north, east and west) to provide a hub and spoke model of care with a centralised service and governance system; and
  2. ***A National Centre for Inpatient Mental Health*** - large state of the art inpatient facility close to the city (within 6-10km) and with strong relationships to key mental health academic institutions could provide an integrated approach to acute inpatient care, teaching and research.

Proposal 5 – Review approaches to state and federal collaboration in providing mental health care, including review of the Fifth National Mental Health Plan Strategy

By way of an overarching comment, here and elsewhere in what follows, there is a need for closer and better collaboration between state and federally funded services. This AMA Victoria submission provides a range of approaches and models around the interface of Victorian State Government and federally-funded (MBS and NDIS) services from the perspectives of a range of healthcare providers. These interface approaches need to be explored and effectively invested to provide optimal care.

With federal approaches, a partial template for moving this collaboration forward does exist within the implementation strategy for the Fifth National Mental Health Plan.[32] Collaboration between state and federally-funded services is very complex and requires effective integration and a considered approach.

We suggest that the Royal Commission recommends to the Victorian Government to:

- review how the Fifth National Mental Health Plan can be applicable to Victoria; and
- involves key stakeholders in the public and private mental health sectors.

AMA Victoria would be pleased to engage and participate in the process and has been actively involved in state and federal mental health submissions.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Explore opportunities for state and federal collaboration -** including shared care models, a review of the Fifth National Mental Health Plan and how it can be tailored to Victoria, with involvement and input from AMA Victoria and other peak stakeholders in the mental health space.

[32] Australian Government Department of Health, Achieving integrated regional planning and service delivery, 2018. Access here: https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-health-intergrated-reg-planning

Proposal 6 – VAGO recommendations need to be reviewed with a view to implementation

In 2019, The Victorian Auditor-General's Office (VAGO) released a report, *Access to Mental Health Services*[33] in which it recommended that the Department of Health and Human Services (DHHS):

- complete a thorough system map that documents its capacity, including capital and workforce infrastructure, geographical spread of services, and estimate current and future demand, including current unmet demand;
- use this map to inform a detailed, public, state-wide investment plan that integrates service, capital and workforce planning; setting out deliverables and time frames;
- set relevant access measures with targets, which reflect the intended outcomes of the investment plan, and routinely report on these internally and to the public;
- undertake a price and funding review for mental health services, which includes assessing funding equity across area mental health services, and provide detailed advice to the Minister for Mental Health on the results and use of this information to inform funding reforms;
- resolve the known catchment area issues of misaligned boundaries that prevent people from accessing services; and
- re-establish routine internal governance and reporting against mental health system priorities, activities and performance that ensures senior executive level oversight and accountability.

AMA Victoria recommends that the VAGO recommendations should be reviewed with a view to implementation. Similarly, the State Government and Department of Health and Human Services may have conducted other inquiries into Victoria's mental health system that have not been made available to the broader community. AMA Victoria recommends that all reviews and reports undertaken by the State Government and Department of Health and Human Services be provided to the Royal Commission and made available to the general public.

A vulnerability that could exist in Victoria is that mental health funding has not to date been ring-fenced, with the potential that much needed funding that could be used on mental health patient care could end up being diverted for other needs. AMA Victoria additionally recommends that funding for mental health services is reviewed on a regular basis, to account for demographic and other variations and to ensure that funding is distributed equitably across the state.

[33] Victorian Auditor-General's Office (VAGO), *Access to Mental Health Services*, 2019. Access here: https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Review the 2019 VAGO report on Access to Mental Health Services** - with a view to implementing all six recommendations.
- **Develop and strengthen mechanisms so that funding provided towards mental health services is protected or ring-fenced –** it is also important that funding is provided on an equitable basis throughout Victoria.
- **Release any reports and inquiries collected by the Victorian Government Department of Health and Human Services in the past five years** - for viewing by the Royal Commission and the public.

Proposal 7 – Adequate Resourcing of Related Services

All of the above recommendations are predicated on appropriate and adequate resourcing of an array of related services. This particularly includes effective funding of drug and alcohol services, housing for persons with a mental illness and forensic services. Without adequate resourcing of related areas, we anticipate that this will result in fallout from limited resourcing of services onto mental health services, overstretching any existing capacity.

The Council to Homeless Persons (CHP) has kindly shared some of its messaging with other peak stakeholders, ahead of this Royal Commission. The CHP reports that the private rental market offers very few options for people living in poverty, including many people whose poverty results from mental ill-health. Across all of metropolitan Melbourne there were just 35 rental properties let in the March quarter that would have been affordable to a single person on Newstart, and just 148 across the entire state.[34] This continues a prolonged downward trend of unaffordability.

[34] Victorian Government Department of Health and Human Services, Rental Report March Quarter 2019, 2019. Access here: https://dhhs.vic.gov.au/publications/rental-report

Patients living with mental illness are often admitted to hospital, and more optimal health outcomes would be achieved if the patients could be discharged to the community to reside in safe, secure settings. Even if the patient becomes clinically well enough to be discharged from a public hospital, a lack of accommodation and difficulty transitioning to another part of the health system often results in an extended admission to hospital, or else homelessness[35].

Similarly, persons released from prison are at a heightened risk of homelessness. This is neither optimal for achieving integration of recently released prisoners back into the community or safe for the community at large.

The Conversation quoted in April 2019:[36]

> Like the homeless population, Australia's prison population has increased by 56 per cent in the past decade, from 25,968 to 40,577 people.
>
> Social researchers and policymakers have long been aware of a strong association between incarceration and homelessness. Local and international studies consistently report the homeless are over-represented in prison and ex-prisoners are over-represented among the homeless.
>
> That such a strong association exists should come as no surprise.
>
> Both populations share many similar characteristics – lower education levels, high rates of mental and physical illness and substance misuse, as well as high rates of economic disadvantage.
>
> …We found that homelessness, broadly defined, does not increase the risk of incarceration…[but] the risk of ex-prisoners becoming homeless increases significantly six months after release, and this increased risk persists for nearly another year.

AMA Victoria advocates that there is a need for the State Government to explore policy initiatives and associated funding for extended settlement support programs delivered through a range of supported housing arrangements.

[35] ***Note***: There is no universally agreed definition of homelessness, it could be defined 'literally' to include sleeping on the streets, in squats or staying in emergency or crisis accommodation, or more 'broadly' interpreted to include people couch surfing or people staying in temporary hotel accommodation or living in a caravan park.

[36] "Ex-prisoners are more likely to become homeless but the reverse isn't true", *The Conversation*, 4 April 2019. Access here: https://theconversation.com/ex-prisoners-are-more-likely-to-become-homeless-but-the-reverse-isnt-true-113570

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **All of the above recommendations are predicated on appropriate and adequate resourcing of an array of related services** - this particularly includes effective funding of drug and alcohol services, housing for persons with a mental illness and forensic services. Without adequate resourcing of related areas, we anticipate that this will result in fallout from limited resources of services onto mental health services, overstretching any existing capacity.

Conclusion

Funding gaps between the federal and state mental health systems, rapid population growth and historically low per capita expenditure on state mental health services has led to a fragmented mental health system that is especially difficult to navigate for patients, families and carers. Integration is severely lacking.

AMA Victoria realises that there is no one solution, but rather a series of targeted systemic interventions that are required to ensure our state mental health system genuinely realigns to the needs of patients now and in the future. This would need to be followed by additional interventions tailored at the local level.

There are key interfaces where the system requires substantial strengthening with the provision of associated funding, infrastructure and a skilled workforce to meet those gaps.

AMA Victoria recommends an urgent increase in the number of public inpatient psychiatry beds and 4 new pilot specialist outpatient psychiatry services over the next 3 years. We also call for the urgent establishment of public psychiatry outpatient clinics and public day programs, and the establishment of Mental Health Centres of Excellence to provide a hub and spoke model of care. Further, long term housing support for homeless people with severe psychiatric illness is urgently needed.

There is a need for closer and better collaboration between state and federal funded services. Consideration and implementation of solutions is necessary, including broadening programs currently operating successfully at a local level, discussion with key mental health providers on workforce and strategic

solutions, as well as approaches to collaboration provided within the Fifth National Mental Health Plan[37] are likely to yield valuable benefits.

AMA Victoria recommends a comprehensive statistical and population review of all areas of the state, with a special but not exclusive focus on areas experiencing rapid growth and the current mental health infrastructure in those areas.

The proposals described above have been refined through an extensive process of consultation with AMA Victoria members, as well as discussed with a range of related advocacy organisations along with input from peak consumer groups.

On request, AMA Victoria would be happy to provide further information to support this submission.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

Refer answer to Q9.

We believe that we have set out a number of significant and practicable suggestions for reform of Victoria's mental health system in response to Q9 *(above).* Significant and ongoing funding is needed to implement the reforms which will support lasting improvements to the system. Victoria has slipped to the bottom of the funding levels in Australia and there needs to be a determined effort to lift our state up in line with, or ahead of other states, if our state mental health services are going to meet the criteria for excellence.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

In answering this question, it is necessary to consider how early treatment can best support people to recover from mental illness, early in *life*, early in *illness* and early in *episode* (TOR 1). Given that roughly half of all lifetime mental health disorders start by the mid-teens and three-fourths develop by the mid-20s, the first part of our response to this question will focus specifically on infants, children, adolescents and young adults under 25 years of age. This is the part of our submission focusing on early in *life* and early in *illness* – delineated as the child psychiatry section.

[37] Australian Government Department of Health, Achieving integrated regional planning and service delivery, 2018. Access here: https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-health-intergrated-reg-planning

The second part of our response to this question will focus on primary care and general practice and explore how early treatment can best support people to recover from mental illness early in *episode*. GPs are involved with the treatment of children and young people, and their work also focuses on preventing mental disorders in adults, including geriatric mental health prevention.

The third part is a response to Q2 by emergency physicians, who operate at the junction between community and inpatient systems, and will also focus on best-practice treatment early in *episode*.

Child Psychiatry

Early in life - What is already working well to support early intervention?

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) AND CHILD AND YOUTH MENTAL HEALTH SERVICES (CYMHS)

Broadly, there are two age range cutoffs for child, adolescent and youth mental health services: child and adolescent mental health services (CAMHS), and the more recent child and youth mental health services (CYMHS). This distinction, and the confusion it causes, has been highlighted in the VAGO report.[38]

Different services have different organisational structures based on different cultures, success at tenders and service priorities which is confusing for staff, referrers and families. The four metropolitan-based services - Eastern, Monash, Austin and Alfred Health - cater to people aged 0-25 years. The Royal Children's Hospital provides services to children and adolescents aged 0-15 years. Orygen caters to young people aged 15-25 years. Ballarat and Geelong offer regional teams with infant and child services targeted to the 0-14/15 year age group, and youth 15/16 -25 years, with the other 5 regional CAMHS/CYMHS teams catering for the 0-18 year old demographic.[39]

Some of these services are funded to treat mentally ill mothers or parents aged under 25 years, though most public hospitals offer no perinatal mental health services. Different services offer vastly different models of care, with different intake and discharge criteria. Those which have a range of teams adapted to different subspecialties and staged care work well. They can provide targeted effective care initially and a consistent family case manager over time as the child develops and their needs change. Staff who work across two teams share expertise, whilst retaining a perspective on broader relevant issues. Those families who can access timely care by a compassionate and highly skilled

[38] The Victorian Auditor-General's Office (VAGO), Child and Youth Mental Health, 2019. Access here: https://www.audit.vic.gov.au/report/child-and-youth-mental-health?section=33205--audit-overview
[39] Ibid

multidisciplinary team, which adapts their interventions to the families' needs over time, report that the system works well.

Existing tertiary child and youth mental health services are referred young people who have difficulties which are not resolving with first and second tier services, provide team based interventions early in complex mental disorders and potentially prevent subsequent episodes of mental illness. These services provide consultations to partner agencies and multidisciplinary team based assessments and interventions based on a diagnostic formulation for children and young people. They deal with complex issues like severe eating disorders, school refusal, neurodevelopmental disorders with comorbid disorders/adversity and those with very significant risk issues. They provide a service for people who have recovery needs that will not be adequately addressed in the private system without a child psychiatrist involved with the care team. Interventions that work well do not just focus on risk accountability, psychotropic medication or evidence-based treatment of a child's diagnostic label (symptom cluster). Young people need a safe and therapeutic relational space to process both "what has happened to them," and "what is happening now" in their lives, that overwhelms their abilities to cope effectively.

AMA Victoria members report that given the expansion in the field and loss of staff to other sectors, many CAMHS/CYMHS clinicians are relatively inexperienced, though motivated and compassionate. Services which prioritise a balanced caseload, access to ongoing professional development and reflective supervision have lower levels of staff stress. Much of the child psychiatrists' publically funded time is spent supervising staff regarding how they will prepare to discharge engaged families and suggesting alternative ways of intervening in care teams in the face of rising demand and complexity of referrals. This works well to appropriately triage the families. Families report a higher level of satisfaction when they are confident their child's needs are well understood and often value being directly seen by a child psychiatrist alongside their key worker.

Services available to families who live in certain postcodes are responsive, effective and have high rates of carer and consumer satisfaction. A focus on the therapeutic relationship by meeting people where they are and being solution focused in a step-wise manner is often a key aspect of any intervention that works well. Services which offer outreach appointments to engage young people and their families in familiar environments, with existing workers with whom they feel emotionally safe, generally work well.

"Single session" family therapy interventions work well when key issues are identified and families have a new experience together, and also when the resources to recover from what has happened are available to the family. For some families, this intervention is an impetus to seek ongoing interventions through the private sector or makes it easier for them to seek further timely help if difficulties arise again. The follow-up phone-call helps parents think about what has improved and what else might be needed for their child to recover.

The CAMHS and Schools Early Action (CASEA) program is well received. It provides an intervention for children with disruptive classroom behaviours and improves their regulation within their peer group, classroom and family.

Feedback from families is that they understand their child better, feel more competent and connected as a parent and are ready for the next stage of intervention to promote the child's development. Some families who require additional interventions are identified before the child develops secondary impairments (support from Child First, a neurodevelopmental assessment or case management at CAMHS). CAMHS offers gold standard neurodevelopmental assessments when the diagnosis is unclear in second-tier services. Those services which provide a therapeutic intervention to address comorbid disorders (anxiety/depression/conduct disorders), as well as environmental and relational issues prior to a diagnostic assessment reduce labelling the child unnecessarily with a lifelong disorder. Interventions which improve the quality of interactions improve the child's irritability, social communication and attachment to their caregivers. Those services which offer ongoing team based therapeutic interventions supporting families with highly symptomatic children until the NDIS package has commenced also work well.

Services that work well have resources which more closely reflect local epidemiology and demand, are backed-up by well-resourced local private and non-governmental (NGO) sectors. These services are often in less impoverished areas with less children in out of home care or experiencing ongoing adversity (poverty, parental mental illness or disability, substance misuse and family violence). This means that families have often had interventions prior to requiring a tertiary service, have had a timely crisis response and can re-engage with previous workers after an episode of care for the period of more severe difficulties. It also means that families have a range of follow-up options to meet their ongoing therapeutic needs. Interventions that work well also target developmental transitions such as starting kindergarten, primary and high school in order to prevent entrenched difficulties.

Children and young people from socio-economically disadvantaged families who do not have adequate supports have higher rates of all mental health problems and poorer outcomes across the lifespan. Children living in out-of-home care experience two to five times higher rates of mental health problems and more than double the rate of serious suicide attempts.[40] In the year 2014-2015, out of children receiving Child Protection Services in Victoria, almost 44% commencing intensive family support services were less than five years of age[41], with almost one third less than four years of age. Over the same time period in Victoria, more than 42% of children entering out of home care were less than four years of age. These children have experienced extreme vulnerability due to their family situation and parental characteristics. Parents of these children suffer from multiple challenges, including: mental health problems, substance

[40] Ibid
[41] The Australian Institute of Health and Welfare (AIHW), Child Protection in Australia, 2016. Access here: http://www.aihw.gov.au/child-protection/

use, family violence, homelessness, brain injury, intellectual disability and neglect.

The *Child, Youth and Families Act 2005 (Vic)* has recently been amended to include a time limit of 12 months for parents to stabilise their environment and engage with services before the child is permanently removed from their care. These changes can be seen as a call for services to mobilise around parents with severe mental health illness, to improve their parenting and protective capacity so that families can have the best possible chances of safely providing "good enough" care for their children in a timely manner. In reality, delays in service provision mean that maltreated children do not receive adequate assessments or interventions during this period and are often highly symptomatic. Access notes highlight that parents are unable to read and respond to their dysregulated child's needs during contacts, which can be disruptive to recovery and traumatic for all parties. They are often preoccupied with ongoing stressors and not receiving interventions for perinatal mental disorders or substance misuse problems.

Secondary consultations are a useful adjunct for case planning and are offered to partner agencies supporting high risk families where the children are referred with clinically significant distress and impaired functioning. Reflective practices with other agencies are designed to clarify roles to reduce duplication, increase workers' mental health skills, support therapeutic alliances over time and help workers understand how best to support families with multiple unmet needs and overwhelming difficulties.

The initial priority is environmental safety, maximising effectiveness of current interventions and improving parenting capacity. This approach reduces the need for the family to engage with another service and experience the loss of yet another key worker. In effect, use of this approach means that primary care agencies at the coalface are providing the majority of support for the most high risk families but also that the most symptomatic younger children in our community are not having a therapeutic intervention. Secondary consultations work well when workers feel well-supported, are highly skilled and can access further reflective supervision, care team meetings and direct consultations involving the child and caregivers after periods of further intervention to review what is needed next. Care team meetings are also invaluable when they are continued with partner agencies who remain involved after families have engaged in tertiary therapeutic work and team based assessments.

AMA Victoria members also identified, during various consultation meetings held leading up to the Royal Commission, that these models do not consistently offer outreach services to the at-risk populations including homeless youth, families living in rural and remote areas, low socio-economic regions of the state, culturally and linguistically diverse populations, or Aboriginal and Torres Strait Islander populations. Those services which work well offer outreach as needed with the backup of Intensive Mobile Youth Outreach Services (IMYOS).

Team-based services and safe housing options are essential to support high-risk youth to recover from their complex difficulties which often include family based trauma, sexual assault, substance misuse and emerging personality disorder, or serious mental illness.

Often, our child psychiatrists report that data entry is cumbersome and time consuming. It works well when administration staff have adequate time and role clarity to support the clinical work. On another note, child psychiatrists tell us that certain IT systems work well when they are more intuitive and designed for the types of services offered.

HEADSPACE

Similarly, while *headspace* tries to service any young person aged 12-25 years who presents for care, *headspace* primary clinics often do not have the local resources and expertise to appropriately treat young people with complex mental health issues (the missing middle). At times, this is associated with community dissatisfaction and complaints regarding why children are not receiving a timely, safe and therapeutic response. The current demand from services arising from investment in health promotion is not being met with an adequate, safe and therapeutic systemic response. There are not enough skilled clinicians for young people and families to access effective interventions in a timely way leading to a delay in assessment.

A major study conducted by the University of New South Wales in 2016 revealed that the *headspace* program provided only a 'small' benefit to clients, while the wellbeing of about one in 10 patients significantly deteriorated. The study also found no consistent patterns of improvement in drug and alcohol use, social inclusion or physical health. It also warned that *headspace* was not meeting the needs of culturally and linguistically diverse young people.[42]

There are local differences between *headspace* centres which potentially impact on the effectiveness of service delivery. The model at Alfred Health and Goulburn Valley Health includes clinical governance across *headspace* and CYMHS, with access to child psychiatrists and well supervised psychiatry trainees. When the lead agency for *headspace* has been an area mental health service, it has been found to be more effective due to the clinical governance structures and access to child psychiatrists, multidisciplinary teams and trainee registrars. The open dialogue model, involving consumer and carer consultants, an ethos of "meeting family where they are" (including availability of family therapy) and a focus on partnerships with local services are key factors underpinning the integrated service model.

In many other regions *headspace* primarily functions more as a silo. It seems to offer a first point of call sometimes without adequate transitions for young

[42] "Headspace only provides 'small' benefit for youth mental health, report shows", *ABC News*, 16 December 2016. Access here: https://www.abc.net.au/news/2016-12-16/headspace-only-small-benefit-for-youth-mental-health/8125698

people who need an early, tailored and tertiary team-based response. There is a real risk to young people associated with the expanding availability of *headspace* services which are not integrated with existing expertise and services within CAMHS and CYMHS. This is especially the case if the age range of patients accessing these services is reduced to accommodate very young children, such as five year olds. Young children and older primary school aged children need to be treated, alongside direct therapeutic interventions provided to their families. Investment in workforce training and supervision of systemic interventions is needed to effectively treat young people.

What can be done better to support people to get treatment early in life?

INFANT AND YOUNG CHILD (0-5 YEARS) MENTAL HEALTH SERVICES

Mental illness is the number one health issue facing children and young people worldwide.[43] It is misleading to say that 15-25 years of age is when anxiety and depressive disorders begin (though this is a belief held by some) and to frame early intervention as starting in mid-adolescence. Unfortunately, there is systemic bias with regard to the preponderance of expert advisors, academics and service directors that overlook early mental disorders in infancy and childhood. It is also misleading to confuse community delivered universal preventive approaches or early intervention identification for vulnerable families (enhanced maternal and child health nurse visiting) with infant mental health practitioners providing treatment for very young children with mental disorders (including severe anxiety and depressive illnesses). Mental health disorders in infants aged 0-3 years regularly go unrecognised, despite existing data suggesting that rates of mental illness are similar to older children and adolescents.[44]

In 2013-2014, one in seven Australian children and adolescents aged 4–17 years were assessed as having mental health disorders in the previous 12 months. In that same year, almost one third of all 4–17 year olds reported two or more concurrent mental disorders.[45] More recent parent-reported data, published in 2019, suggests that 50% of Australian children with mental health disorders miss out on care.[46]

[43] The Victorian Auditor-General's Office (VAGO), Child and Youth Mental Health, 2019. Access here: https://www.audit.vic.gov.au/report/child-and-youth-mental-health?section=33205--audit-overview
[44] Lyons-Ruth, K., et al., The Worldwide burden of Infant Mental and Emotional Disorder: Report of the Task Force of the World Association for Infant Mental Health, *Infant Mental Health Journal*, 2017: 38(6); 695-705. Access here: https://www.ncbi.nlm.nih.gov/pubmed/29088514
[45] The Australian Institute of Health and Welfare (AIHW), Mental health services in Australia, 2019. Access here: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary/prevalence-and-policies
[46] Hiscock, H., et al., Use and predictors of health services among Australian children with mental health problems: A national prospective study, *Australian Journal of Psychology,* 2019. Access here: https://onlinelibrary.wiley.com/doi/abs/10.1111/ajpy.12256

For a variety of reasons, children under the age of five years have often been excluded from epidemiological studies, despite this being a critical period of development. They are also excluded from most mental health services. Intake workers are often not adequately trained or experienced to identify which very young children need a tertiary assessment and to advise families as to what alternative interventions are available in other settings. Many public services have focused on expanding their responsiveness and the array of interventions from mid-adolescence onwards and have not prioritised younger children, especially the very young (0-5 years of age).

While accurate data on the prevalence and burden of mental health disorders in infants and young children under five years of age is difficult to come by (poorly reported and poorly identified), global evidence suggests that up to 20% of young children (0-5 years) suffer from mental health disorders, similar rates to that of older children and adolescents.[47] Skovgaard et al (2007)[48] found community prevalence rates of 16-18% in 18 month olds. The lack of widespread recognition of disorders of infancy is particularly concerning due to the unique positioning of infancy as foundational in the developmental process.[49] The 2006 study by Briggs-Gowan found a continuity of problems from infancy through school age.[50]

Without timely access to appropriate mental health services, young children and youth are at risk of ongoing problems that may affect their engagement with education and employment, and lead to greater contact with the health system, human services and the justice system.[51]

CAMHS and CYMHS, like many other youth-specific mental health services such as *headspace*, cannot accommodate every young patient in need of care. Over time the threshold for access to tertiary care has increased substantially. Due to inadequate public mental health services, many patients in need of care who could benefit from child and youth programs are in fact turned away from services like CAMHS/CYMHS. Most of those who do access the service will not be seen directly by a child psychiatrist.

Child psychiatrists tell us that children under 10 years of age often miss out on a team-based model of health care until they get 'big enough' for their aggression

[47] Lyons-Ruth, K., et al., The worldwide burden of infant mental and emotional disorder: report of the Task Force of the World Association for Infant Mental Health, *Infant Mental Health Journal*, 2017: 38 (6); 695 – 705. Access here: https://onlinelibrary.wiley.com/doi/full/10.1002/imhj.21674

[48] Skovgaard, A.M., et al., The prevalence of mental health problems in children 1 ½ years of age – the Copenhagen Child Cohort 2000, *Journal of Child Psychology and Psychiatry*, 2007: 48(1); 67-70. Access here: https://www.ncbi.nlm.nih.gov/pubmed/17244271

[49] Perspectives in Infant Mental Health, Presidential Address: The Worldwide Burden of Infant Mental and Emotional Disorders, 2018. Access here: https://perspectives.waimh.org/2018/02/16/presidential-address-worldwide-burden-infant-mental-emotional-disorders/

[50] Briggs-Gowan MJ., et al, Are infant-toddler social-emotional and behavioural problems transient? *Journal of the American Academy of Child and Adolescent Psychiatry*, 2006: 45(7); 849–858. Access here: https://www.ncbi.nlm.nih.gov/pubmed/16832322

[51] The Victorian Auditor-General's Office (VAGO), Child and Youth Mental Health, 2019. Access here: https://www.audit.vic.gov.au/report/child-and-youth-mental-health?section=33205--audit-overview

to self and others to become obviously dangerous to everyone. The lack of equity in service provision for young children is the most pronounced for infants, toddlers, preschoolers and primary aged children. Although diagnostic criteria (DC0-5[52], ICD-11[53], Zeanah & Gleason 2010[54], Briggs-Gowan Infant-Toddler Social and Emotional Assessment[55], Alarm Distress Baby Scale ADBB 2004 Guedeney[56]) are available to clarify whether an infant has a mental disorder, the criteria are not routinely considered and mental health literacy is naturally poor for children under five years of age.

Several AMA Victoria members have highlighted the need for more public mental health services for infants and children by drawing an analogy with current treatment of serious physical health issues. When patients present to public health services, they are not turned away on the basis of 'not having enough cancer' and advised to return 'when their cancer is more advanced'. Many young people who access a crisis service have previously been referred to tertiary based services in preceding months to years, and their difficulties were triaged as not urgent enough to warrant an assessment. The state mental health system will work better if tertiary services prioritise intervening in childhood for the missing middle and for the most symptomatic children. To truly reform the mental health system and invest in the next few decades of mental health care, we need to intervene much earlier than mid-adolescence.

THE IMPORTANCE OF EARLY INTERVENTION AND EARLY PARENTING SUPPORT

AMA Victoria advocates that early intervention, early in life is critically important. Early intervention early in life starts with building safety, security and nurturance when the parent-infant relationship is distressed, or when the infant has symptoms of a mental disorder. Early intervention continues through to the provision of the appropriate level of mental health services, as needed for symptomatic children and adolescents.[57]

[52] DC:0–5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. Access here: https://www.zerotothree.org/resources/2221-dc-0-5-manual-and-training

[53] World Health Organisation, International Classification of Diseases (11th revision), 2018. Access here: https://www.who.int/classifications/icd/en/

[54] Zeanah CH., et al., Reactive attachment disorder: A review for DSM-5, 2010. Access here: https://www.researchgate.net/profile/Charles_Zeanah/publication/228683818_Reactive_Attachment_Disorder_a_review_for_DSM-V/links/0deec51e86576d1e8c000000/Reactive-Attachment-Disorder-a-review-for-DSM-V.pdf

[55] Briggs-Gowan, M., et al, The Brief Infant-Toddler Social and Emotional Assessment: Screening for Social-Emotional Problems and Delays in Competence, *Journal of Pediatric Psychology (USA publication),* 2004: 29(2); 143-155. Access here: https://academic.oup.com/jpepsy/article/29/2/143/926026

[56] The Alarm Distress Baby Scale. Access here: http://www.adbb.net/gb-intro.html

[57] The Royal Australian and New Zealand College of Psychiatrists (RANZCP), Prevention and Early Intervention of Mental Illness in Infants, Children and Adolescents: Planning strategies for Australia and New Zealand. Access here: https://www.ranzcp.org/files/resources/reports/prevention-and-early-intervention-of-mental-illnes.aspx

In May 2019, the Royal Australasian College of Physicians (RACP) published a *Position Statement on Early Childhood: The Importance of the Early Years*.[58]

In that Position Statement, RACP emphasised that:

- failure to prevent, identify and treat parental mental health problems are felt not only in the current family but are also intergenerational;
- parental stress, anxiety and depression, particularly postpartum depression, has the potential to have a negative impact on the ability of that adult and child to form a healthy attachment; and
- a child's experience of interpersonal violence within the family also has a significant effect on attachment.

Research supports that the environment in which a child grows up is crucial to their lifelong health, functioning in all domains of development and later parenting capacity. The term 'toxic trio' has been used to describe the intersection between domestic violence and abuse within the household, parental mental ill-health (moderate to severe mental disorders), and parental substance misuse (alcohol or drugs), which have been identified as common features of families where serious harm to children and adults has occurred. There is also extensive research and awareness of the importance to health outcomes of adverse childhood events.

The RACP has advocated for adequate, child-focused income support to be provided where there are dependent children of parents who are unemployed or living with a disability which prevents them from working. The RACP also notes that children of parents who have a mental illness, or are dependent on alcohol, drugs and gambling deserve special consideration.

THE IMPORTANCE OF PERINATAL AND ANTENATAL PSYCHIATRY SERVICES

This clearly emphasises the importance of perinatal and antenatal psychiatry services, including infant mental health clinicians supporting the parent-child relationship. Young children's mental health needs are significantly underserviced in Australia, with less than 1% of 0-4 year olds receiving a mental health service.[59] This inequity comes with great cost to our society over the child's lifespan.

It is important to acknowledge that the nature and treatment of mental health problems in pregnancy and the postnatal period is challenging for a number of reasons unique to this specific period of time in a woman's life. Firstly, the

[58] The Royal Australasian College of Physicians (RACP), Position Statement on Early Childhood: The Importance of the Early Years, 2019. Access here: https://www.racp.edu.au/docs/default-source/advocacy-library/early-childhood-importance-of-early-years-position-statement.pdf?sfvrsn=e54191a_4

[59] Segal, L., et al., What is the current level of mental health service delivery and expenditure on infants, children, adolescents, and young people in Australia? *The Australian and New Zealand Journal of Psychiatry*, 2017: 52(2); 163-172. Access here: https://journals.sagepub.com/doi/full/10.1177/0004867417717796

effects of mental health problems at this time require that not only the needs of the mother but also those of the fetus/baby, siblings and other family members are considered. Stigma may prevent women from seeking out medical care during this period that is broadly associated with expectations of happiness. Many women know that they do not feel quite right but feel guilty and ashamed that they are not responding to their baby as they would like. Hence, they also worry that social care and statutory services might become involved and fear the loss of custody of their child if they report mental health problems or difficulty coping.

For women with existing mental health problems, there is an increased risk that they may abruptly stop taking their medication without first consulting a doctor for advice, and there is also a risk of pregnant women with existing disorders (like bipolar disorder) developing an episode during the early postnatal period.[60]

Given that mental disorders are the most common complication of pregnancy, it is unacceptable that best practice interventions are not routinely available. No-one would accept not treating other health complications such as gestational diabetes, premature labour or pre-eclampsia, which are also potentially life-threatening to the mother and baby.

Given the lack of access to public perinatal psychiatrists, women are not uncommonly advised by well-intentioned medical practitioners to cease maintenance of psychotropic medications when planning pregnancy or during antenatal care. This inappropriate advice has profound risks for all including the risk of relapse with attachment difficulties, impaired functioning leading to child protective services involvement, psychiatric admissions and risk to self and others.

Victorian perinatal services have undergone a significant decline over the past decade, despite international recognition of their importance. Many psychiatrists are aware that they will no longer be able to access the team-based supports and parent-infant beds when needed, when they accept a referral of a mother with a major mental illness.

LEARNINGS FROM THE PERRY PRESCHOOL PROJECT

Early parenting support is essential, as demonstrated by the Perry Preschool Project, developed by Nobel Prize winning University of Chicago Economics Professor James Heckman.[61] This landmark study was carried out from 1962 to 1967 and led to a longitudinal study of three and four year old African-American children living in poverty and assessed to be at high risk of school failure.

[60] National Collaborating Centre for Mental Health (UK) and British Psychological Society, Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance: Updated edition, 2014. Access here: https://www.ncbi.nlm.nih.gov/books/NBK338568/

[61] Highscope Educational Research Foundation, Perry Preschool Project, 1962-1967 [website last updated 2019]. Access here: https://highscope.org/perry-preschool-project/

Study participants attended pre-school each morning for 2.5 hours and were taught by certified public school teachers, with an average child-teacher ratio of 6:1. The curriculum was planned, carried out and reviewed by the children and parents together, with teachers offering home visits to mother and child for 1.5 hours each week, to involve mothers in implementing the child preschool curriculum at home.

Professor Heckman's latest research (2019) on the Perry Preschoolers at midlife (age 40) found multi-generational gains for the participants and children of the original participants in the areas of education, health, employment and civic life, including:[62]

- fewer teenage pregnancies;
- greater likelihood of graduating from high school;
- greater likelihood of holding down a job and higher earnings;
- fewer crimes committed; and
- ownership of home and car.

Further, there is a substantive body of international evidence that shows that quality early child care arrangements are advantageous to the development of children from disadvantaged backgrounds, preventing the perpetuation of disadvantage through subsequent generations.[63,64]

In Victoria, the Department of Education and Training has developed the *Access to Early Learning (AEL)*[65] program, a current and evaluated program, targeted to vulnerable young children which has provided limited hours of supported early childcare placement for three year olds. This model places very young children in a stable and positive child care environment, while simultaneously supporting effective health, care and supportive wrap-around services for the child and parents.

With the recent Victorian Government investment in early parenting centres, it makes sense for infant mental health clinicians and perinatal psychiatrists to be core team members who are able to assess the mental health needs of families, where they are already accessing supports.

[62] Professor Heckman, J., et al., The Perry Preschoolers at Late Midlife: A Study in Design-Specific Inference, *The National Bureau of Economic Research,* 2019, Working Paper No. 25888. Access here: https://www.nber.org/papers/w25888

[63] The Carolina Abecedarian Project, The Abecedarian Project, 1972. Access here: https://abc.fpg.unc.edu/design-and-innovative-curriculum

[64] Professor Heckman, J., et al., The Perry Preschoolers at Late Midlife: A Study in Design-Specific Inference, *The National Bureau of Economic Research,* 2019, Working Paper No. 25888. Access here: https://www.nber.org/papers/w25888

[65] Victorian Department of Education and Training, Access to Early Learning Guidelines 2016-17 *[internal document],* 2016. Cited in and accessed at: https://www.education.vic.gov.au/Documents/childhood/professionals/learning/Transition%20to%20School%20Vulnerability%20Project%20Practice%20Review.pdf

Infant mental health clinicians can also be employed in enriched, early education and care-centres to provide group interventions with high-risk families who have had child-first involvement. An example is the early years education program.[66]

Further, mental health clinicians are highly valued in acute paediatric wards and neonatal intensive care units at the Royal Children's Hospital. Consultations should be made routinely available with an NBO (neonatal behavioural observation) to support parental confidence in knowing their infants and identifying those families who need ongoing care after discharge. Funding for infant mental health teams should be made available across the state for consults in special care nurseries. To address inequities, each CYMHS should have a funded multi-disciplinary team from birth to school entry, with access to publically-funded perinatal psychiatric consults for unwell parents.

VICTORIAN AUDITOR-GENERAL'S OFFICE (VAGO) RECOMMENDATIONS

The Victorian Auditor-General's Office recently tabled a report on *Child and Youth Mental Health.*[67] The Auditor-General's report noted that there has never been an independent review of clinical mental health services for children and young people in Victoria, despite significant changes in the service system with the introduction of the National Disability Insurance Scheme (NDIS) and youth-specific community mental health services liked *headspace*.

The 2019 VAGO audit assessed the effectiveness of CYMHS in one regional and four metropolitan health services and found that:

- there is no strategic framework to guide and coordinate the Department of Health and Human Services (DHHS), or health services that are responsible for CYMHS;
- there are a range of issues with the current CYMHS design;
- DHHS's performance monitoring of CYMHS comprises seven separate systems that are conducted in silos and there is poor coordination and information sharing between the different CYMHS services;
- DHHS does not routinely monitor and publicly report on the quality of CYMHS service delivery;
- CYMHS does not enable prioritisation of access for high-risk population groups;
- there is a service gap for young people with dual disability; and
- young people are routinely getting 'stuck' in CYMHS inpatient beds when they should be discharged.

[66] Borland, J., Changing the Trajectories of Australia's Most Vulnerable Children - The Early Years Education Program Randomised Controlled Trial, 2019. Access here: https://medicine.unimelb.edu.au/research-groups/paediatrics-research/paediatric-social-work/changing-the-trajectories-of-australias-most-vulnerable-children-the-early-years-education-program-randomised-controlled-trial

[67] The Victorian Auditor-General's Office (VAGO), Child and Youth Mental Health, 2019. Access here: https://www.audit.vic.gov.au/report/child-and-youth-mental-health?section=33205--audit-overview

The VAGO report made 20 recommendations and DHHS has agreed to accept all recommendations, noting that implementation of the recommendations will be informed by the outcomes of this Royal Commission, particularly recommendations relating to system design.

Given that the resource allocation for CAMHS/CYMHS has not grown with the growth in population,[68] this has led to an inability to meet the growing mental health needs of children and young people living in Victoria. When GPs and primary care clinicians are unable to manage complex mental health issues due to resource and funding limitations, children and young people invariably end up presenting in crises to emergency departments (ED). The CAMHS/CYMHS teams will need to be better resourced to support primary care clinicians like GPs and paediatricans to meet current patient demand for mental health care services.

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Implement the 20 recommendations of the VAGO report on Child and Youth Mental Health (2019).**
- **Review current system design –** recommendations relating to system design to be informed by outcomes of the Royal Commission.
- **Address gaps in accommodation and service coordination** – young patients experience longer than necessary stays in CYMHS facilities as inpatients, as they cannot access family or carer support and/or services such as disability services, accommodation, child protection and out-of-home care.
- **Take action to address service gaps for dual disability** - take action to support CYMHS to provide services to clients with dual disability who have complex needs.
- **Facilitate increased parent participation in child and youth mental health programs** – parents and siblings (where appropriate) should be involved in care planning, ongoing consultations and review of progress.

Early in illness - What is already working well to support early intervention?

Intervention early in *life* is very important but also critically, intervention early in the development of mental *illness* can reduce its impact on health and wellbeing across the lifespan.

Given that roughly half of all lifetime mental health disorders start by the mid-teens and three-fourths develop by the mid-20s, there is especially a need to intervene early in illness where children, adolescents and young adults are

[68] Ibid

concerned. Furthermore, we know that severe disorders are typically preceded by less severe disorders that are seldom brought to clinical attention.[69]

It should be noted that, what is currently working well 'early in illness', is only generally working well for adults or families who are well-resourced and live in a well-resourced area.

These are families who can afford a private psychiatrist can access high-quality therapeutic care over several years, in the context of coordinated team-based interventions for a multitude of mental health conditions, and other associated disorders. However, there are limitations in the private sector with regard to timely autism assessments, psychometric testing, day programs, outreach workers and inpatient beds. Those families who have limited income to afford to pay the out-of-pocket fees associated with these visits, poor support structures or who are homeless experience difficulty accessing much needed health care services including GPs, not to mention specialists.

What can be done better to support people to get treatment early in illness?

WHAT DOES EARLY IDENTIFICATION OF MENTAL ILLNESS LOOK LIKE?

Early identification of mental illness and other disorders occurs when the young person is observed to be distressed and struggling to function at home, or in care or education settings. They might talk to an educator, support worker or consult a health care professional like a GP, paediatrican or a maternal and child health nurse.

The child might then be referred by a parent or clinician for an early psychological assessment (through the Better Access program, a school psychologist or *headspace*), an urgent crisis assessment (emergency department or CAMHS/CYMHS) for a comprehensive tertiary assessment. The GP often provides ongoing support in between sessions with the psychiatrist, or whilst the family waits to be seen. During the common delay in access, the child often has ongoing behavioural problems, which can lead to their distress being medicalised with inappropriate prescribing of psychotropic medications. Paediatricans and GPs often report that they feel pressured to prescribe medication and find themselves responding to parental anxiety and pressure to 'do something'.[70]

Another risk of delaying necessary team-based interventions is the impact on the child of attending the emergency department in crisis, where they are occasionally chemically or mechanically restrained, being transported by

[69] Kessler, R.C., et al., Age of onset of mental disorders: A review of recent literature, *Current Opinion in Psychiatry*, 2007: 20(4); 359-364. Access here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1925038/

[70] "Anti-psychotic medication overprescribed to Australian children, experts say", *ABC News*, 17 November 2014. Access here: https://www.abc.net.au/news/2014-11-16/anti-psychotics-over-prescribed-australian-children-experts-say/5892822

ambulance or having the police called to their home or school. First responders, ED staff and crisis-assessment and treatment teams (CATT) often feel poorly equipped to deal with older primary school aged children with externalising behaviours (including risk to self and others), and new protocols are required.

Child psychiatrists are often referred young people after years of inadequate treatment which might include trials of multiple psychotropics. Often the medication regimen the child is on at the first consultation is outside of what they would usually prescribe (dose, choice and a combination of psychotropic agents), and the parents report grave concerns about possible adverse effects on the child's development and presentation.

BETTER SERVICE INTEGRATION AND COORDINATED CARE IS NEEDED TO SUPPORT INTERVENTION EARLY IN ILLNESS

Children receive care in both clinical and community settings, but this care is rarely coordinated and can result in much stress for the child, their family and carers as they try to navigate a fragmented and complex system of health care.

One AMA Victoria paediatrican member articulated the importance of supporting early intervention for autism-spectrum disorder, which can cause other biopsychosocial disabilities later in life, most commonly an anxiety disorder. The doctor writes:

> *There is a lack of item numbers for diagnosing autism-spectrum disorder. A proper assessment is not just to determine that a child has autism-spectrum disorder (some kids are obvious) but for children whose condition is not obvious, we need a proper Medicare item number for a thorough assessment. This assessment should extend beyond the face to face 2 hours, and incorporate a holistic approach to health care by including preschool and school input and multi-disciplinary case assessment, discussion and review between health professionals.*
>
> *It is too onerous for one paediatrican to do all of this work and there is always the risk of missing attachment disorders or other significant issues.*
>
> *Where there is diagnostic complexity, the assessment is best performed in a CAMHS service, where a paediatric fellow is part of the multi-disciplinary team. Wait lists for these assessments are up to 18 months. Ideally, children access an infant and preschool team to do relationship-based work in the interim, to reduce the severity of the child's disruptive behaviours (including aggression to self and others), to improve social communication and emotional regulation/anxiety.*

The above example illustrates that intervention early in illness often requires presentation to multiple health professionals, as well as coordinated care between community services and the education system. Children may present for treatment and review to a GP to treat core autism symptoms like social and emotional responsiveness and communication problems, but may also need to see other members of the health care team like psychologists, psychiatrists, and neurologists to help the child cope with the associated symptoms of aggressiveness, hyperactivity and irritability. These separate consultations, with different health professionals may be spaced quite far apart, creating a hiatus in treatment and impairing early recovery and optimal health outcomes in the long run.

Families wanting to access disability benefits might then, on top of all these separate clinical and community care appointments, have to navigate the complex and bureaucratic National Disability Insurance Scheme (NDIS) system. Families of children with complex needs often have finite resources, an undiagnosed disability of their own and in addition to having to cope with the added daily burden of their child's additional needs, are often left in doubt as to where to turn for help. Unless the parent is resourceful or fortunate enough to find an advocate, they might feel so overwhelmed and unsure of how to start that they give up applying to the NDIS. Professionals might not recognise the parental limitations arising from an undiagnosed disability (like autism), or be skilled in encouraging them to apply for the NDIS for their own unmet needs which profoundly impact on parenting capacity.

Many children under the age of five years who have been neglected and maltreated have both a disorganised attachment and developmental delays. They often have comorbid mental disorders including depressive disorders, anxiety disorders and conduct difficulties. These children should routinely be assessed by mental health services, but are often overlooked. Sometimes this leads to worst case scenarios, with a Monash University longitudinal study reporting that between 2000 and 2012, one child was killed almost every fortnight by a parent or step-parent, with filicides comprising 18 per cent of domestic homicides during the research period.[71] The risk of filicide and child maltreatment has been relatively overlooked in the family violence sector and service responses, where the focus is predominantly on the safety of the mother from their male partner. The Gilbert et al (2009b) *Lancet* paper on child maltreatment found that the more frequent and severe the early maltreatment, the greater the impact on the child's mental health and likelihood that they will go on to develop PTSD, depression or be responsible for harming others from adolescence onwards.[72]

[71] Brown, T., (Monash University), When parents kill: the reality of filicide in Australia, 2019. Access here: https://lens.monash.edu/@medicine-health/2019/06/12/1375311/when-parents-kill-the-reality-of-filicide-in-australia

[72] Gilbert, R., et al, Child maltreatment 2: recognising and responding to child maltreatment, *The Lancet,* 2009b: 373:167-80. Access here: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(08)61707-9.pdf

Our court system waits for various social services to do assessments of the child's complex needs, many services wait in turn for the court to decide on where the child will live and who will be responsible for decisions relating to the child's health and education. Furthermore, AMA Victoria child psychiatrists describe that there is reluctance within many CAMHS/CYMHS service staff to work directly with children with open statutory involvement and that involved services are usually offered a care team secondary consultation, or a service is refused until the child is in a stable placement. Other CAMHS work with the family without adequate liaison with involved services or the department. There is also a lack of trained professionals who are able to provide reports to the court regarding parenting capacity, the parent-child relationships, the child's mental health and developmental needs and the impact on the child of contact arrangements. Funding is needed to support research and training in this area.

Navigating through a fragmented and complex health system and associated social and justice systems takes time. This is valuable time lost for the child and the gap widens with loss of potential. During this time, the child could disengage from school, sport and peers, and develop increasing anxiety and poor self-esteem. The later onset of a mental health disorder like depression is often preceded by the cumulative stress of secondary impairments from not intervening to support integration of the child with an unrecognised primary diagnosis, like autism-spectrum disorder. This is aggravated by a poorly coordinated health system. Even when a preschool aged child living below the poverty line has been thoroughly assessed and diagnosed with an autism spectrum disorder and intellectual disability, they might wait more than 12-18 months for a planning meeting to apply for funding for early intervention and supports.

We know that many mentally ill patients present to emergency departments seeking care and that some of these hospitalisations could be prevented through a multidisciplinary approach to care, which could be coordinated through general practice. As signposted at the start of our answer to Q2, the role of emergency physicians and GPs in responding to acute episodes of mental illness will be discussed at length later on.

The opportunities of a multi-disciplinary approach to health care is best illustrated by the New Orleans model. In recent years, the New Orleans Health Department (NOHD) in New Orleans, Louisiana, had faced staggering challenges to providing public health services to its residents. Beginning in 2011, the NOHD developed an ambitious new model to address serious population health challenges in the city.

THE NEW ORLEANS MODEL

Dr Charles Zeanah, a world authority on Infant and Early Childhood Mental Health, leads the section of Child and Adolescent Psychiatry, at the Department of Psychiatry and Behavioural Services at the Tulane University School of

Medicine in New Orleans. Over the years, this department has developed several innovative approaches to address the challenges around the mental health needs of children and young people in Louisiana.[73]

Two models that have been very successful are described below. These initiatives are multi-sectorial and multi-agency and the success of these initiatives depends on high-level agreements between these agencies.

The first model will address the challenges of intervening early when children and young people have been exposed to significant cumulative trauma, such that they have to be taken into out-of–home care by protective services. A large number of these children are under the age of five and are at high risk of developing mental health issues.

TULANE PARENT EDUCATION PROGRAM AND FAMILY RESOURCE CENTRE (T-PEP)

The T-PEP team works closely with protective services and the court system. Parents of children aged 0-17 years are eligible for T-PEP parenting services. The ultimate goal of T-PEP, in cooperation with others in the child protection system, is ensuring child well-being and assisting parents to more safely and effectively parent their children.

Providing this "one stop shop" for services enhances efficiency and effectiveness and reduces duplication of efforts. T-PEP provides parent-child relationship assessments and group parenting interventions including the Nurturing Parenting Program, Confident Parenting Program, Triple P Parenting, Circle of Security Parenting Program and Effective Black Parenting Program. They also provide individual/dyadic interventions including Visit Coaching, Family Skill Building, Circle Of Security, Attachment and Bio-behavioural Catch-up, Child-Parent Psychotherapy, Parent Child Interaction Therapy, Cognitive Behavioural Therapy, various psychiatric interventions, and domestic violence groups for men and women.

Furthermore, the Tulane Infant Team is effective at preventing and reducing the incidence of child abuse.

Children most at risk of being abused or neglected are those who have already been abused. The T-PEP Team is one of the few state-supported intervention programs that has proven to be effective. In a four year period from 1995-1999, the T-PEP team demonstrated a:

- 67% reduction in subsequent abuse or neglect in the same child; and
- 64% reduction in risk of the abusing mother committing abuse on another child.

[73] Tulane University, Tulane Early Childhood Collaborative, 2011. Access here: https://medicine.tulane.edu/centers-institutes/tecc

These results were published in the *Journal of the American Academy of Child and Adolescent Psychiatry*.[74] The fact that the Tulane Infant Team changed the type of permanent plans implemented *and* reduced recidivism attests both to direct effects of interventions with families and to indirect effects of providing the court with information to enhance judicial decision making.

This model has been adapted in various states of the United States of America and countries including the United Kingdom. It has also been successfully adapted in South Australia and is known as the Infant Therapeutic Reunification Service.[75]

TULANE EARLY CHILDHOOD COLLABORATIVE

The Tulane Early Childhood Collaborative program provides consultation to paediatric primary care providers to promote optimal mental health in children under six years of age. Their goal is to promote early childhood and family well-being by supporting paediatric primary care providers to identify risk factors early, promote family well-being, and address early mental health problems.

A team of paediatric mental health providers from the Tulane Infant and Early Childhood Mental Health team including child psychiatrists, paediatrician-child psychiatrists and child psychologists provide this service through a mental health consultation at a GP or paediatric clinic or via phone, e-mail, or secure video consultations. A consultation evaluation serves to help clarify the diagnosis or make treatment recommendations.

The Tulane Infant and Early Childhood Mental Health team also offers *in-service trainings/"lunch and learn"* for paediatrician-child psychiatrists about early childhood mental health.

Web-based resources are also available, to hand out to families, to help families learn more about the foundations of early childhood mental health.

This model moves away from the traditional stepped care model of the adult mental health system, where one can access higher levels of care only when they are severely unwell.

In the Tulane model, there is a convergence between various levels of care including GPs, paediatricians and mental health experts such as child psychiatrists and psychologists. This in turn promotes capacity-building of the system of care, as well as providing expert multidisciplinary team based assessment and treatment early on for the child and family. If the problem is of

[74] Drury, S., et al., Thinking Across Generations: Unique Contributions of Maternal Early Life and Prenatal Stress to Infant Physiology, *Journal of the American Academy of Child and Adolescent Psychiatry,* 2017: 56(11); 922-929. Access here: https://www.ncbi.nlm.nih.gov/pubmed/29096774

[75] South Australia Health, Infant Therapeutic Reunification Service, 2016. Access here: https://www.sahealth.sa.gov.au/wps/wcm/connect/5a20418048e1ad80aa81aff25a3eb7d6/WCHN+Infant+Therapeutic+Reunificaton+Service.pdf?MOD=AJPERES

a severe and complex nature, this can quickly be escalated to the CAMHS/CYMHS community service team to provide specialist mental health care.

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Review the New Orleans (Tulane model) -** and how it can be tailored to Victoria, with involvement and input from AMA Victoria and other peak stakeholders in the mental health space.
- **Fund research and training in assessing parenting capacity –** there is a lack of trained professionals who are able to provide reports to the court regarding parenting capacity and the impact on the child of contact arrangements.

General Practice

Early in episode - What is already working well to support early intervention?

General practice is the cornerstone of our health care system. General practice services are utilised by the majority of Australians for a vast array of health conditions, including mental health, and throughout the course of a patient's life. GPs undertake the referral and coordinating role for most health care services.

Approximately 90 per cent of people have a regular general practitioner (GP). A 2018 report of the Royal Australian College of General Practitioners (RACGP) found that over 87.8 per cent of the Australian population visited their GP - more often than they receive prescriptions, have pathology or imaging tests, or see non-GP specialists.[76]

The average person sees their GP between 2 and 3 times per year. People with chronic physical and mental health problems see their GP more often. Children in the first year of life see their GP approximately eight times a year.[77] Over 85 per cent of all encounters with GPs incur no out-of-pocket expenses for the patient.[78] Patient satisfaction with care they receive from their GP is very high.[79]

[76] The Royal Australian College of General Practitioners (RACGP), General Practice – Health of the Nation, 2018. Access here: https://www.racgp.org.au/download/Documents/Publications/Health-of-the-Nation-2018-Report.pdf
[77] Ibid
[78] The Australian Institute of Health and Welfare (AIHW), New report reveals out-of-pocket costs for Medicare services in your local community, 2018. Access here: https://www.aihw.gov.au/news-media/media-releases/2018/august/new-report-reveals-out-of-pocket-costs-for-medicar
[79] The Australian Bureau of Statistics (ABS), Patient Experiences in Australia: Summary of Findings, 2017 -18, 2018. Access here: https://www.abs.gov.au/ausstats/abs@.nsf/mf/4839.0

ABOUT GENERAL PRACTICE

A 2015 report from the National Health Performance Authority (NHPA) showed that general practice is the most efficient and cost-effective part of the health system, but requires greater support to continue providing high quality primary health care to the Australian community.[80]

General practitioners are highly trained medical specialists, trained to care for illness and enhance wellness over the course of a person's life in terms of both their physical and mental wellbeing. GPs care for people with acute and episodic illnesses and those at risk of, or who currently have, chronic conditions. General practices frequently offer a wide array of patient-centred and holistic services for the patients, their families and the local community.

The average general practice employs five GPs[81] and additionally many modern GP practices operate a multi-disciplinary model of care employing allied health staff on site such as practice nurses, psychologists, mental health nurses, physiotherapists and podiatrists. Many GP practices also have visiting specialists, including psychiatrists and paediatricians. GPs work in collaboration with other parts of the health system to facilitate service coordination between primary care and secondary service providers like psychologists and psychiatrists, as well as hospitals.

WHAT GENERAL PRACTITIONERS DO FOR PEOPLE LIVING WITH MENTAL ILLNESS

GPs provide comprehensive, coordinated and longitudinal care in partnership with the patient. One in six Australians has a diagnosed mental health condition including depression (10 per cent) and anxiety (6 per cent).[82] GPs are the first port of call for most people with mental illness and provide the majority of the ongoing care for most people living with high prevalence disorders like depression and anxiety. The RACGP reports in 2017 and 2018 found that psychological issues, including depression, mood disorders and anxiety, remained the most common health issues managed by GPs.[83]

In combination with other mental health care professionals, GPs also care for those with more serious, but low prevalence mental health illnesses such as

[80] The National Health Performance Authority (NHPA), Healthy Communities: Frequent GP attenders and their use of health services in 2012-13, 2015. Access here: https://www.aihw.gov.au/reports/primary-health-care/frequent-gp-attenders-use-health-services-2012-13/contents/summary

[81] National Health Performance Authority, Healthy Communities report: GP care for patients with chronic conditions in 2009–2013, 2014. Access here: https://www.myhealthycommunities.gov.au/our-reports/get-report-file/hc11/publication/NHPA_HC_Report_GP_Care_Report_December_2014

[82] National Health Performance Authority, Healthy Communities report: GP care for patients with chronic conditions in 2009–2013, 2014. Access here: https://www.myhealthycommunities.gov.au/our-reports/get-report-file/hc11/publication/NHPA_HC_Report_GP_Care_Report_December_2014

[83] The Royal Australian College of General Practitioners (RACGP), General Practice – Health of the Nation, 2018. Access here: https://www.racgp.org.au/download/Documents/Publications/Health-of-the-Nation-2018-Report.pdf

schizophrenia, bipolar disorder, personality disorders and eating disorders. GPs do this by:

- diagnosing mental illness;
- providing psychoeducation and counselling;
- working to decrease risk factors and increase protective factors;
- safety-netting and monitoring the risks for suicide prevention;
- prescribing and monitoring medication;
- monitoring and caring for patients on an ongoing basis;
- referring patients to other health professionals and services;
- referring patients to non-health professionals and services (e.g. housing services, drug and alcohol services, gambling support services);
- coordinating care delivery;
- advocating for patients;
- recognising early symptoms of relapse;
- preventing presentations to the emergency department (ED); and
- developing therapeutic alliances through counselling and engagement with the patient, their carers and family.

Of importance, GPs also provide care for physical illness and prevention. This is vitally important for people living with mental illness. Due to the greater burden of physical mortality and morbidity that people living with mental illness have as a result of poorer physical health, we recommend that lower screening rates be adopted for risk factors like smoking, alcohol, substance abuse, poor nutrition and gambling addictions, as well as effective and evidence-based preventative health interventions.

GPs undertake all this in partnership with patients and often their families and carers, and frequently in the context of multidisciplinary care.

The elements of the mental health system that are already working well to prevent mental illness and to support people to get early treatment and support are listed below:

- most people have a regular GP and GPs are highly trained in recognition, early intervention and management of people with high prevalence mental health issues;
- GPs successfully care for many people living with mental illness, either alone, or in combination with other health care professionals;
- GPs provide holistic care for people living with mental illness, including physical health interventions, preventative care and other broader health care needs of patients; and
- PHNs provide ready access to psychologists and mental health nurses for those with limited financial means.

THE PATIENT CENTRED MEDICAL HOME (PCMH) MODEL

Another integrated part of this broader 'healthcare neighbourhood' is the Patient Centred Medical Home (PCMH) model. The general practice patient-centred medical home model with continuity, comprehensiveness and coordination is

well-evidenced to be the best model for accessible, effective and sustainable mental and physical care provision.

Members of the health team can include the patient, their GP, practice nurses, and allied healthcare providers such as physiotherapists, dieticians, diabetes educators and psychologists.

Sometimes a patient requires care from other services, such as community nursing, specialist care or hospital services. Specialist and hospital services strengthen the capacity of community-based services, so that they may adequately support the patient. These services form part of the 'healthcare neighbourhood.' In accordance with the principle of coordinated care, the neighbourhood supports the medical home and remains connected with it.

The PCMH model supports the wellbeing of both patient and carer. All services have a role in delivering patient care, educating for patient self-care, and helping the patient centred medical home perform its role.[84]

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Commit to supporting the well evidenced, GP-led and Patient-Centred Medical Home for those living with mental illness -** this supports accessible, comprehensive, coordinated and continuous care.

PRIMARY HEALTH NETWORKS

Primary Health Networks (PHNs) are Australian government funded mid-scale organisations that operate in a local community or neighbourhood. They work with general practice, allied health and hospitals to develop capacity and capability in primary care, improve pathways of care and commission services to address gaps in health care. There are six PHNs across Victoria. Each of these provides centralised, timely and free access to psychologists and care and case coordination by mental health nurses, for patients referred by GPs who are of limited financial means (e.g. those with health care cards). Access to these same health services for those without health care cards can be problematic and expensive.

Further, access to psychology services through the Medicare Benefits Schedule (MBS) has been a fundamental enhancement to the care of patients in the

[84] Agency for Clinical Innovation (NSW State Government), Navigating the healthcare neighbourhood, 2019. Access here: https://www.aci.health.nsw.gov.au/nhn/patient-centred-medical-home-model/what-is-the-patient-centred-medical-home-model

primary care / general practice setting. This 'Better Access Scheme' has been used extensively and successfully in averting acute admissions to hospital. It is known that patients in some areas cannot access these services and it is necessary to facilitate pathways for accessing these services. As the burden of mental illness grows, there will be an even greater need for these services in future.[85]

What can be done better to support people to get treatment early in episode?

AMA Victoria submits that supporting people living with mental illness to access GPs and supporting the role of GPs in providing the best care for people living with mental illness should be the cornerstone of reforms to the primary care sector.

IMPROVED FUNDING FOR GENERAL PRACTICE

Equity of access to care is especially a concern for populations assessed as at risk of poorer health outcomes, such as patients suffering significant mental illness, patients living in aged care facilities, persons residing in lower socio-economic areas and those living in rural and regional areas of the state, which includes a significant Aboriginal and Torres Strait Islander population.

The RACGP report *General Practice – Health of the Nation 2018* showed that the greater the socio-economic disadvantage, the more frequently a patient presented to their GP. The out-of-pocket costs add up for socially vulnerable patients that access primary health care services more frequently. Similarly in rural and remote areas, GPs remain the most accessible medical specialists.[86]

To facilitate better access to GPs and referral to other subsequent services, suitable funding is required to support GPs to effectively treat the needs of vulnerable and complex patients and optimise health outcomes.[87] Growing out-of-pocket costs represent a barrier to patients accessing their GP for early treatment in an episode of mental health distress. Delayed attendance to primary care means that issues may not be flagged early, or treated in a timely manner to avoid later complications. If mental health problems are not flagged and treated early in episode, the patient's mental health may deteriorate to the extent that the patient requires a period of hospitalisation. In this circumstance, hospitalisation was likely preventable. This simply leads to cost-shifting from

[85] Australian Institute of Health and Welfare (AIHW), Australian Burden of Disease Study 2015: Interactive data on disease burden, 2019. Access here: https://www.aihw.gov.au/reports/burden-of-disease/abds-2015-interactive-data-disease-burden/contents/leading-causes-of-disease-burden

[86] Catherine King MP, Speech to the National Press Club – Labor's Vision for Health Care, 13 February 2019. Access here: https://www.catherineking.com.au/2019/02/13/speech-to-the-national-press-club-labors-vision-for-health-care/

[87] ***Note***: In February 2019, the Shadow Health Minister, Catherine King, blamed the Coalition for the Medicare rebate freeze and argued that this had driven up out-of-pocket costs for both GP and specialist visits, leading to more than 1.3 million people delaying or avoiding medical care.

primary care to the already under-resourced public health sector and our over-burdened state emergency departments.

AMA Victoria recommends that the Royal Commissioners consider recommending to the Victorian Government the funding of cost-effective models of care. These models could include higher rebates for specific patients or problems, especially patients presenting to their GP with multiple complex and co-morbid problems. Another model to explore is bundled payments to support greater time spent with patients and the coordination of their care and provision of wrap-around care by psychiatrists and allied health and support staff.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Explore opportunities for state and federal collaboration** - including shared care models, pooled funding and improved MBS rebates to better support a GP-led, patient-centred medical home, underpinned by adequate remuneration for GPs.

SECONDARY SUPPORT FOR GENERAL PRACTITIONERS

GP members of AMA Victoria repeatedly report that if they could receive timely advice from psychiatrists about the diagnosis or management of a patient, they would be better able to manage patients in the community. GPs tell us that they would be better able to provide care in some cases, and when they did require more complex assistance, better communication would facilitate more effective and expedited referrals to appropriate services. GPs acknowledge that advice from psychiatrists can be received via telephone or email and although these communication pathways are not always timely, they are sometimes the most practicable (and only) way that GPs can communicate with psychiatrists. Moving forward however, our GPs recognise the need for on-call psychiatrists so that diagnosis, especially in complex cases, can be appropriately discussed and the patient's ongoing care managed.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Commit to funding dedicated and properly remunerated on-call psychiatrists across all state mental health services –** to facilitate timely secondary referral/advice for GPs and better-coordinated care for patients in the community.

IMPROVED ACCESS TO PSYCHIATRISTS

GP members of AMA Victoria report that access to psychiatric assessment and care for those with lower financial resources is extremely hard to obtain. This has resulted in a lack of crucial expert assessment and care early in illness, when GPs may be finding it difficult to diagnose or manage a person's mental disorder alone. Very few private psychiatrists routinely 'bulk bill', due to a similar, but more extended Medicare rebate stasis than has applied to GPs. Further, referral to a public psychiatrist cannot occur directly from a GP, which is different to any other specialty such as rheumatology, cardiology or gynaecology, where referrals are made directly from GPs to public hospital outpatient clinics.

A GP member of AMA Victoria writes:

> *I need to be able to access a psychiatrist when my patient needs an urgent review – whether once off, to help with diagnosis or treatment, to continue management or take over the primary care.*
>
> *Urgent reviews are non-existent in the public system, and hard to get in the private system. In any event, most of my patients cannot afford private psychiatry services, due to the prohibitive out-of-pocket expenses. This is completely different to a patient presenting with angina or cancer, where there are publicly available options for urgent concerns.*

In the case of public psychiatry, referral usually occurs through the mental health service. These usually only accept patients living with the most severe mental illness and access and care by psychiatrists appears limited and non-timely.

AMA Victoria recommends that the Royal Commissioners consider recommending to the Victorian Government the development of new and cost-effective models of care. These models could include public sector psychiatric outpatient clinics, aligned with the current system of referrals to psychologists and mental health nurses through PHNs, and a private psychiatrist linked modified Consultation Liaison Psychiatry to Primary Care (CLIPP) model *(please refer to Q9 for a more detailed discussion of the CLIPP model).* To improve access and choice and maximise the available workforce, these models could all operate together.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Develop new models to facilitate care by psychiatrists, in consultation with AMA Victoria** – these models could include public sector psychiatric outpatient clinics and private psychiatrist linked modified Consultation Liaison Psychiatry to Primary Care (CLIPP) models, to facilitate GP referrals of patients with significant mental illness to psychiatrists.

BETTER INTEGRATION AND COORDINATION ACROSS AREA MENTAL HEALTH SERVICES AND PRIMARY HEALTH NETWORKS

As previously noted, GPs are able to refer patients who have higher prevalence but less serious illnesses to PHNs, but only if they hold health care cards. These patients can access timely and free care by psychologists and mental health nurses. For those with more serious mental illnesses who cannot afford private psychiatric care, referrals are often made to area mental health services or the under-resourced public sector.

The following case study (over the page), provided by a GP member of AMA Victoria, illustrates the difficulty of referring patients to timely and appropriate publicly-funded psychiatry services:

I have been a Clozapine prescriber for 30 years and supported many patients with low prevalence mental health issues. Access to publicly funded psychiatry services in a decent time frame is my main problem as a GP.

I treated a long-term patient, residing in a lower socio-economic area on minimal income. The patient was on Clozapine for difficult to control schizophrenia.

The patient was managed as part of a shared care model with X Mental Health. The patient wanted to have children. She was reviewed by the mental health service and we agreed to taper the patient off Clozapine and stop the medication.

The patient conceived 8 months after ceasing Clozapine and delivered a healthy baby at X Health but in the initial 3 months post-partum, she started to feel a recurrence of her mental health issues.

Y Health felt that her condition was out of their scope and suggested reconnecting with X Mental Health. I called, I faxed, sent letters but to no avail. The patient was asked to phone X Mental Health to follow up the written referral – she was unable to get an appointment. She then sought out private psychiatry – most post-partum psychiatrists were uneasy with the past schizophrenia and use of Clozapine and suggested mainstream psychiatry.

The patient was unable to afford to see a private psychiatrist, so the public service was engaged again. In the meantime, I commenced an antipsychotic and up-titrated with minimal impact on her feeling and situation.

Finally, after 2 months of her deteriorating, she managed to get into the public psychiatric service and is on newer atypical antipsychotics and responding well to treatment.

During the intervening time (to get the patient seen by the appropriate service), her family, partner and I were fraught with concern about her condition deteriorating.

This patient, who has had a clearly documented severe mental health issue, was denied ready access to specialist care when needed.

Thankfully, her partner has supported her throughout. Her parents are elderly but very supportive. If not for the support systems around her, the outcomes could have been disastrous.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Invest in coordinated efforts with AMA Victoria, Primary Health Networks (PHNs) and area mental health services to develop better integrated models of care** – these models of care must be underpinned by strong clinical governance that includes a single-entry mechanism for non-emergency care for those who cannot access private care by psychiatrists and allied mental health professionals.

Focus on significant mental illness and vulnerable populations

GP members tell us that the provision of accessible, comprehensive care for the most vulnerable in our community with significant mental health problems is extremely challenging. Such people include the homeless, those with dual diagnosis (both mental health and drug and alcohol addictions), people who have been involved in the justice system, parents with children and adolescents. These groups of people require coordinated case management across health and non-health sectors: including housing, justice, education and training, drug and alcohol services, parenting support facilities and partner violence services.

Yet our current system relies on people coming to health professionals with limited models for comprehensive outreach services linked to a PCMH, and fragmentation across the health care system, as well as poor coordination with other social services. It is vital that we prioritise Victorian Government investment and reforms to address the needs of people with the greatest burden of poor health.

GP members have recurrently told us that it is easier to get care, support and advice for those patients living with high prevalence and less serious mental illnesses than it is for those with more serious mental illnesses. This demonstrates a fundamentally flawed service model for treatment of mental illness.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Prioritise reform and investment in significant mental illness to support the most vulnerable populations in our community with serious mental health problems** – including people experiencing homelessness, those in the criminal justice system, parents with children and adolescents.

Emergency Physicians

Perhaps there is nowhere that demonstrates the current state system failings more than in the emergency departments (EDs) of our hospitals. The state emergency departments are at the junction between community and hospital inpatient systems. They provide a safe haven for patients and carers 24 hours a day, every day of the year. They are the backstop for community services when they feel too unsafe to manage people effectively in the community. The ED is where police and ambulance officers bring patients when they do not know what else to do. Patients and their families faced with a crisis know that whatever else, the ED is always open and available.

Background

A study of Victorian emergency departments showed that whilst the previous 10 years had seen a 53 per cent rise in attendances, which was broadly in keeping with population increases and hospital utilisation, the proportion related to mental health increased 305 per cent over the same interval.

Importantly the acuity of mental health presentations (those classified as Australian Triage Category 1 or 2) went from 10.5 per cent to 18.5 per cent. Over this same period, the proportion of patients with a mental health issue and associated methamphetamine intoxication doubled.[88]

These ED attendances for mental illness represent the highest risk patients in our community. This is the population that the community teams cannot manage, the patients who are in crisis for the first time and do not know where to go, or who to contact. They are the people who the police find on roads and bridges, and acting in a manner that has raised the concern of someone in the community.

When considering this growing, high-risk group, the Royal Commissioners might respectfully consider the following questions:

- Where else should these patients go?
- How can patients know which community services to access?
- What timeframe should patients expect when seeking an urgent community response?
- What happens after-hours: where are the safe havens?

[88] Manchengo PA., et al., Management of mental health patients in Victorian emergency departments: A 10-year follow-up study, *Emergency Medicine Australia,* 2015: 27(6); 529-36. Access here: https://acem.org.au/getmedia/044044f5-542b-4c51-9684-41c5acd32a1b/Manchego-et-al-2015-Management-of-mental-health-patients

Patient perspective

It is known from interviews with patients in the ED that this can be a highly traumatised population.[89] Many are familiar with the mental health system and many are self-medicating. Below is a (de-identified) patient story, provided by an ED physician member of AMA Victoria.

> *I'm rebuilding myself, from the ground up. I'm an addict and an alcoholic of the worst type you could imagine, and I hit my rock bottom 4 or 5 weeks ago when I lost everything.*
>
> *I don't even own a key anymore, not a key, because anything I had a key to went up my arm. And I lost my wife, that's what hurts the most, and that's what's made me hit rock bottom. 17 years of trying to get clean and sober, 17 years.*
>
> *God brought me to my knees, and I thank Him and it's been a privilege, and it finally lets me get well, but I have to want to get well, and that's why I'm here.*
>
> *Yeah I don't enjoy being restrained, in fact I find it very, very disturbing and I always fight it. But I've learnt that if I put my faith into the team, and accept their best intentions for restraining me could be because of their own safety and also for my safety.*
>
> *And I hate it because I was sexually abused as a child, and I was held down by my hands, and I don't like it, but I have to try and deal and grow up from that and learn that it's not the case. I just have to try and relax. And the last couple of times I've been able to relax and let it happen.*
>
> *I know they did it for my best interests and also for the safety, especially because I've been around guns last night, I was trying to get an officer to blow my head off, if you want the truth. That would've been a blessing last night. - Patient A3*

[89] Yap CL., et al., Don't label me: A qualitative study of patients' perceptions and experiences of sedation during behavioural emergencies in the ED, *Academic Emergency Medicine*, 2017: 24(8); 957-67. Access here: https://www.ncbi.nlm.nih.gov/pubmed/28500785

Unfortunately, the increasing use of methamphetamines for the purpose of self-medication is exacerbating chaos in the lives of patients living with mental illness and increasing the chances of physical trauma, interactions with the police and need for hospital admission. Below is a second (de-identified) patient story, provided by an ED physician member of AMA Victoria.

> *You know what, I'm not sure if I want to take up a rehab bed at the moment. No, I'm fighting on my own.*
>
> *I don't know how many days I'm clean. I stopped counting. It doesn't matter. I'm clean today and I survived again. But I need to deal with all sorts of psychiatric issues, especially post-traumatic stress from different things throughout my life.*
>
> *From an accident I had, I suffer post-traumatic stress of that accident, that wasn't to do with drugs or anything, but it was a motorbike accident and caused me a lot of physical injuries, and I suffer from that.*
>
> *The worst is the fear and that I go through, I can't do it anymore, can't. And then set myself on fire, it was a terrible fear, because I don't want to burn to death. I want to die and then get burnt, not burnt and then die. - Patient A7*

The Police, Ambulance, and Community Early Response program (PACER) is an example of a targeted intervention to divert patients with behavioural issues not requiring ED care. Community assessment occurs in tandem by mental health clinicians and police with clinical needs addressed on the spot, including referral to community follow-up or hospital admission. There is currently a limit on how effective these teams can be and this relates to both the complexity of patients in the community, who are requiring a combination of police and community mental health, and the resourcing to ensure that patients can be diverted rather than sent to the ED.

Prolonged ED length of stay

Patients arriving in the ED enter a high stimulus environment and are surrounded by other patients with high acuity illness. This necessarily restricts the individual attention they can receive. Whilst no patient should spend 24 hours on an ED trolley, there are few patients that will benefit less than those with high acuity mental illness. Yet, most 24-hour breaches occurring in Victorian emergency departments are for patients awaiting admission to a mental health bed. Alternatives to this are to increase community resources, increase mental health beds, or find alternative admission pathways.

All patients with a mental illness are seen in the ED by an Emergency Mental Health Clinician. All those who can be managed currently in the community will be. Prolonged stays in the ED are not about lack of community resources but

lack of inpatient resources to allow for the safe, ongoing care of those with mental illness.

The hospital psychiatric wards are at capacity, all the time. The current cost of emergency mental health team personnel resources diverted to searching for inpatient beds is significant. Unless additional inpatient beds are created, the ED will continue to be the overflow for those wards. This is not only a poor outcome for these patients but for all patients who cannot access a bed in the ED because it is continually occupied. The patients with mental illness require dedicated mental health teams and environments. EDs can provide crisis care but cannot be expected to continue complex care, for days at a time, which is what this cohort of patients require.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Classifies any patient event involving more than 24-hours in the ED as 'a reportable event' to the Department of Health and Human Services (DHHS)** - every event should require a review to determine the patient specific and system-based factors that prevented the patient getting to a more appropriate healthcare setting. The acceptable incidence of 24-hour stays in the ED should be 0%.

Behavioural Assessment Units

One innovation that has been introduced into the Australasian system, and occurred first in Victoria, is the Behavioural Assessment Unit.[90] For patients who have a combination of mental illness and medical illness (and often intoxication), a prolonged period of acute management is required that most general medical wards cannot muster.

Medical wards are not well-suited for the containment of patients who are at risk to themselves or others. Thus, the ED has been the most appropriate environment to care for this group until their medical issues abate and the mental health issues can be dealt with.

ED physicians report that their experiences at the Royal Melbourne Hospital have provided a better environment for patients. Patients were seen by a doctor earlier, had a shorter stay in the ED and had a decreased rate of restrictive

[90] Braitberg G., et al., A Behavioural Assessment Unit improves outcomes for patients with complex psychosocial needs, *Emergency Med Australia*, 2018: 30(3); 353-8. Access here: https://webcache.googleusercontent.com/search?q=cache:L8r3_Un9bRwJ:https://acem.org.au/getmedia/74a1fb2c-57a8-49ce-a61d-609f625d4ad7/Braitberg_et_al-2018-Emergency_Medicine_Australasia+&cd=2&hl=en&ct=clnk&gl=au

interventions. Other hospitals across Australia are currently building Behavioural Assessment Units as capital funding becomes available.

The Behavioural Assessment Unit is not an alternative to the longer admission for mental illness that requires stay in a psychiatric bed. However, it is an alternative pathway of one to two days for those who need intensive management but who are then expected to return back to the community.

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Develop models of care that emphasise low stimulus, high resource environments that combine acute and mental health care** - models based on short-stay units but with additional high acuity nursing and inclusion of mental health and drug and alcohol staff have been developed and evaluated (the Behavioural Assessment Unit provides a template for such a model).
- **Develop models of care for patients with a clear-cut need for a psychiatric admission but who, due to concurrent medical illness or intoxication, require a period of medical management and stabilisation** - this cohort is not suitable for a Behavioural Assessment Unit due to the high-risk nature of their psychiatric illness; and so this model requires a secure setting, staffed by clinicians with both mental health and critical care training.

Restraint practices

Victorian EDs all use restrictive interventions to manage the highest risk patients. This includes physical and mechanical restraint, and sedation.

Patients managed under the *Mental Health Act 2014* (Victoria) (the Act) are required to have clear documentation of the restraint used, and the restraint is controlled by the same Act. However, most patients in the ED who require restraint are managed under a duty of care. There is no such governance of these patients. Although various hospitals and health services might have processes to document restraint practices when the patient is not under the Act, no hospital in Victoria provides detailed oversight of this. It is not readily possible to know how often such restraint occurs or what the outcomes are.

A recent study undertaken for the Office of the Chief Mental Health Nurse outlined the rate of restraint in five Victorian EDs but required intensive manual data extraction and linkages.[91] This is not an option for ongoing oversight of an intensive practice of patient care that has clinical, ethical and medical risk. It is likely that the unsuitability of the emergency department environment for patients who require prolonged, multiple assessments and intensive mental health treatment contributes to a number of restraints that may not be necessary and appropriate in the inpatient setting.

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Develop a framework for the governance of restrictive interventions in acute settings** - this should consider consumer, organisational and staff perspectives, and focus on minimising the rates of restrictive interventions, whilst maintaining a safe environment for patients, staff and visitors.
- **Mandate that the use of restrictive interventions be clearly documented using a standardised template to allow ready documentation and data extraction** - this should record the type of restraint, the reason it was required and the duration (with the move of all healthcare facilities to electronic medical records, consideration should be given to the benefit of common definitions and minimum datasets).
- **Require that a readily accessible registry of restraint be kept at all health care organisations** - this should include physical, mechanical and chemical restraint (or therapeutic sedation) and consideration should be given to the reporting of restraint rates.

Discharge of complex patients

For those patients who have been managed entirely in the ED and are to be discharged, there can be significant failings in linking back to community resources. Although the ED mental health teams can usually alert case managers in the community mental health services, there is far less resourcing after-hours for drug and alcohol, social work and housing.

The patients in the ED represent a significantly disadvantaged population. A section of this group of people is going to have enormous difficulty managing multiple appointments with hospital and community appointments, Centrelink

[91] Knott, J., et al., Restrictive Interventions in Victorian Emergency Departments: A Review of Current Clinical Practice, 2017. Access here: https://webcache.googleusercontent.com/search?q=cache:VuwoUeW-NhoJ:https://www2.health.vic.gov.au/Api/downloadmedia/%257B7AF3CB07-AF61-4A9A-9A22-5EB7E3211EFB%257D+&cd=2&hl=en&ct=clnk&gl=au

and housing services. Many are required to balance attending a rehabilitation service or Centrelink. The failure of any one person to coordinate this leads to inefficient operations with many missed appointments and poor outcomes for individuals.

Integrated services where health, social and financial resources are managed by a single, coordinating body has been an effective solution for other high-risk vulnerable populations. Patients who present to the ED have often already "failed" a trial of existing community resources, in that they have been and will continue to be unable to navigate current requirements to make appointments days to weeks, to sometimes months in advance, in business hours only and to receive ongoing mental health and psychiatric treatment for their ongoing and complex issues. Further, discharge is often delayed by a lack of urgent community follow-up available after hours.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Facilitate integrated care pathways for patients with mental illness and complex needs** – these pathways should support health, social and financial needs as a whole, not in discrete parts.

Elderly patients

It is clear from the number of elderly patients with psychiatric illnesses who present to emergency departments that demand for community assessment and psychiatric support for GPs who attend these patients both in the community and in residential facilities greatly exceeds current resources. The ED is a incredibly stressful environment that can increase morbidity for those elderly patients who have already been assessed as requiring further prolonged inpatient assessment and care, but who must present to and remain in the emergency department as beds are unavailable for direct admission.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Review the resourcing available to elderly people with a mental health issue -** this is an especially complex group of patients and is expected to grow as the population ages.

People living with mental illness in the justice system

Many people who require treatment but are too unwell to manage their own care can have management provided in the least restrictive manner under the *Mental Health Act 2014* (Victoria) (the Act). For those patients who are inside Victoria's justice system, the Act does not apply. Those who become unwell in our prison system can refuse care and in those circumstances, care cannot be provided. In what most people would agree is a very challenging and potentially dangerous environment for someone who is mentally unwell, patients deteriorate until their point of release into the community. Only at this point are these people placed under an assessment order and then transferred immediately to an ED.

For healthcare organisations, it is extremely challenging to take over care of people who have had no mental health support for a variable period but who are sufficiently unwell to require an assessment order at the earliest possible opportunity. The lack of forward planning means inpatient care is rarely possible and these people arrive at emergency departments to commence the care previously unavailable to them in prison.

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Review whether changes should be made to the *Mental Health Act 2014 (Victoria)*** - to allow patients to be treated under the Act, whilst in the justice system.
- **Facilitate better and earlier access for mental health teams from existing health care organisations to patients within the justice system** - to prevent deterioration in their mental health.

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.

Private Psychiatry

We respectfully draw the Royal Commission's attention to Q2 of our submission, where we have provided an overview of the barriers to good mental health outcomes for Victorians living with mental illness. In answering this question, we will outline some strategies for delivering the best mental health outcomes for Victorians by improving access to care and facilitating better care

collaboration between private psychiatry services, GPs and other health workers (TOR 2).

Background

Private mental health care is one of the only areas mentioned by consumers in the Royal Commission's community consultations, which is described as a positive area of success.

Patients seen by private psychiatrists are suffering from some of the most significant and serious mental illnesses. A large proportion of these consumers are financially disadvantaged, but treated at discounted rates by private psychiatrists.

Private psychiatrists personally assess or treat 386,268 Australians every year. This is similar to the 420,000 Australians each year contacted[92] by all state and territory funded public mental health services.[93]

The cost of private psychiatrists providing half of the specialist mental health care to Australian consumers is $349 million. When private health fund costs, and the costs of GPs and psychologists who work effectively with private psychiatrists are included, the total cost of private specialist mental health care is estimated as $800 million.[94]

This compares to the state and territory funded public mental health care system, which costs approximately 7 times as much,[95] to care for about the same number of patients (at $5.6 billion per year). This is despite evidence that the acuity of the mental illness and dysfunction is similar.

Outcome measurement, using the Health of the Nation Outcome Score (HoNOS) is on average, 13.8 on admission to Public Mental Health hospitals, and 6.3 on discharge (lower scores representing improvement).[96] Mean HoNOS outcome measurement scores for those admitted to private psychiatric hospitals is 13.1 on admission, and 5.7 on discharge (lower scores indicating improvement)[97]. For five years, private psychiatric hospitals have collected data using a consumer and carer perceptions of

[92] **Note**: The word 'contacted' here is used deliberately. Unlike private services, public services also include contacts only by phone, and do not specifically include the number of patients actually assessed or treated by psychiatrists. As such, comparing like with like, it is likely the public numbers are quite a lot lower.
[93] The Australian Institute of Health and Welfare (AIHW), Australia's Health 2018, 2018. Access here: https://apo.org.au/system/files/179001/apo-nid179001-872396.pdf
[94] Independent Private Psychiatrists Group, Submission to the Productivity Commission into Mental Health, 2019. Access here: https://www.pc.gov.au/__data/assets/pdf_file/0014/241241/sub473-mental-health.pdf
[95] **Note**: Figure arrived at by multiplying $800 million by 7
[96] The Australian Mental Health Outcomes and Classification Network (AMHOCN), Health of the Nation Outcome Scales (HoNOS), 2016. Access here: https://www.amhocn.org/publications/health-nation-outcome-scales-honos
[97] Ibid

care instrument. The patient satisfaction of their private hospital and their private psychiatrist's treatment, is around 90 per cent satisfaction on average.[98]

The private mental health sector is also providing much more care for women suffering significant mental illnesses than the public system, with women comprising 63 per cent of all admissions to private psychiatric hospitals, compared with 20 per cent of all admissions to public psychiatric hospitals.[99] Many of these women are likely to have suffered from complex issues such as sexual assault, domestic violence and trauma.

A false assumption contained in the KPMG review, *Paving the way for mental health: The economics of optimal pathways to care*, prepared for the National Mental Health Commission in November 2014[100] was that private sector patients are well off financially, because they could afford to pay private health insurance premiums. Family, friends and others pay the health fund premiums for some people who are unable to afford these premiums.

A survey of private psychiatrists in 2012 revealed that 20 per cent of their patients were on a government pension, and 45 per cent were not employed.[101] So, the evidence that is available indicates that the private sector is vitally important for treating patients suffering from significant mental illness, including those who are financially disadvantaged.

It is crucial that any new architecture for providing improved mental health care in Australia should not be based on false or prejudicial assumptions about the private mental health system. Any new architecture should include planning which involves active practicing private psychiatrists and GPs, because the private system treats half of all Australians suffering severe and significant mental illnesses; it does so for 13 per cent of the cost of the public system, and these patients suffer severe illness, and are mostly not well off financially.

It is therefore clear that appropriate investment in and development of the private mental health care system is likely to deliver the most cost-effective improvements in mental health care in Australia, for those suffering significant mental illnesses.

The key positive elements of *private practice psychiatry* are:

- Psychiatrist-led treatment and care
- Focus on significant mental illness

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[98] **Note**: Figure provided by the Australian Private Hospitals Association in private email communication to Dr William Pring, AMA Victoria member. Evidence can be produced upon request.

[99] Ibid

[100] KPMG, *Paving the way for mental health: The economics of optimal pathways to care,* 2014. Access here: https://www.mentalhealthcommission.gov.au/media/119874/Paving%20the%20way%20for%20mental%20health%20-%20KPMG.PDF

[101] Private Mental Health Alliance, Quality Improvement Project - Psychiatrist Workload Survey, September 2012, Holding rights: Australian Medical Association, Commonwealth Government of Australia. *[unpublished source]*

- Patient-centred and holistic care
- Long-term ongoing treatment
- Flexible and long-term collaborative multi-disciplinary working model
- Close links to referring GP

Psychiatrist-led treatment and care for those with significant mental illness

Improved mental health planning will occur when the private specialist mental health sector is included in the planning stages of mental health policy development, along with the public sector and primary care sector. Private psychiatrists have not been involved in overall mental health care planning, up to the present time.

Development of policy for any other medical condition would involve consultation with actively practicing medical specialists (in this case, psychiatrists), working directly in the community, in public and private care settings. This has not occurred in mental health.

To remedy that, it is important that active psychiatrist-led treatment of patients living with mental illness is given the highest priority. Over the last two decades, mental health care workers and counsellors have significantly grown in numbers, and we believe that they represent an important part of the mental health workforce. The problem is that during this period of two decades, they have largely operated in silos, with little to no liaison with the consumer's treating psychiatrist. This has led to extreme fragmentation of care, and in many cases, our psychiatrist members observed that this same fragmentation has increased the likelihood of adverse clinical outcomes for patients living with significant mental illness.

The private psychiatrist sector has also been limited in the range of people they can treat because of a lack of adequately trained, collaborating mental health workers in the community. Our psychiatrists report that when a patient is assessed as having reached a stable mental state, and could be referred to a linked, but properly trained GP or mental health worker, there are very few available to the psychiatrist. Our GP colleagues have been limited by being effectively constrained under inadequate Medicare patient rebates, for adequate time-length consultations with consumers. Either GPs see people for longer, and are inadequately remunerated for their time, or they try to make do with the time scale provided to them. Bearing in mind that adequately treating significantly mentally ill consumers in the community is sometimes like doing (physical) intensive care treatment in the community – it requires a lot of skill.

Mental disorders are a broad spectrum, spanning a continuum from largely biological disorders such as the schizophrenias to less predominantly biological disorders.[102] AMA Victoria strongly advocates that the evidence-based medical

[102] Ahn, W.K., et al., Mental Health Clinicians' Beliefs About the Biological, Psychological and Environmental Bases of Mental Disorders, *Cognitive Science,* 2009: 33(2); 147-182. Access here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2857376/

model should be at the forefront of treatment for people living with mental illness. The practice of medicine is a field strongly underpinned by evidence, and while medications may be more effective for more biologically based mental disorders, other interventions like psychotherapy are most effective for the more psychosocially based mental disorders. However, all mental health disorders benefit from the biopsychosocial model of treatment.

Psychiatrists are intensively trained in the biopsychosocial model, and so, practice holistically. Medical doctors, including private psychiatrists, must be at the heart of any reforms to the state's mental health architecture, systems and services.

At some of the public consultations of the Royal Commission, we heard some contributors suggest that the medical model of mental health care should not be used for consumers, or should be eliminated from mental health care. Such comments represent a significant denial of the likely biological contribution to some of the more severe mental disorders, and a lack of recognition of the holistic integrative role of the psychiatrist.

Focus on significant mental illness

In this submission, we have referred to 'significant' mental illness, rather than just 'serious' mental illness. This is because a range of non-psychotic conditions can have serious consequences, including suicide. A prime example is borderline personality disorder. This disorder may not sound as 'serious' as schizophrenia, but research has shown that up to 80 per cent of people with this disorder make at least one suicide attempt in their lifetime, and are more likely to die by suicide, than individuals with any other psychiatric disorder. Between 8-10 per cent of people with borderline personality disorder die by suicide, which is more than 50 times the rate of suicide in the general population.[103]

While people living with schizophrenia or recurrent mood disorder would be considered to suffer from 'serious' mental illnesses, people living with borderline personality disorder, chronic depression or anxiety, also face significantly serious and ongoing consequences, including higher rates of mortality.

[103] Psychology Today, The Destructive Power of Borderline Personality Disorder, 2015. Access here: https://www.psychologytoday.com/au/blog/where-science-meets-the-steps/201512/the-destructive-power-borderline-personality-disorder

In patient cohorts living with physical illnesses, intellectual disability, autism spectrum disorders and drug use disorders, an already moderately concerning disorder (like mild depression) may well develop into a significant and disabling mental disorder (like major depressive disorder). Based on available evidence, we estimate that there are at least 1,200,000 Australians living with significant mental illness, and deserving of psychiatric treatment and care from the public and private sectors within the state mental health architecture.[104]

Over the last twenty years, the public sector has adopted an episodic treatment model for people living with significant mental illnesses. Consumers admitted to public hospitals for acute episodes of mental illness are discharged from the public system at the earliest opportunity, at only the slightest hint of recovery. The evidence supports that pressure to discharge patients from our public hospitals often leads to revolving door admissions.[105]

There is little clinical handover and support to GPs and the funding for people to access the care delivered by GPs and private psychiatrists. Private psychiatrists are becoming reticent to take over treatment of patients coming out of public sector psychiatric hospitals, because they will seldom be able to access the public sector support services that were available in the past, and which are vital for early improvement of consumers who lack private health insurance.

Significant mental illness is often an ongoing or frequently occurring condition. As such, an episode-based treatment model is clearly not fit for purpose in managing significant mental health conditions.

A Collaborative Treatment Model for Victoria (Long-term ongoing treatment)

The high prevalence disorders, like normal emotional reactions to life stressors, mild - moderate anxiety and depression, milder substance use disorders and grief, occur in around 20 per cent of the Australian community at any one time.

These conditions *(mild and moderate illnesses)* are appropriately treated in the primary care setting, under the lead treatment and coordination of the GP (as discussed in greater detail at Q2), with input as needed by mental health nurses, psychologists, social workers and other allied health professionals. It is important to treat these conditions effectively and quickly, because, whilst the level of symptoms and impairment might be low, without treatment these conditions can become more severe. Despite being less severe, these conditions still impact large numbers of people across Australia, and cause significant cost to the community.

[104] KPMG, *Paving the way for mental health: The economics of optimal pathways to care*, 2014. Access here: https://www.mentalhealthcommission.gov.au/media/119874/Paving%20the%20way%20for%20mental%20health%20-%20KPMG.PDF

[105] Allison, S., et al., "Mental health services reach the tipping point in Australian acute hospitals", *Medical Journal of Australia*, 2015: 203(11); 432-434. Access here: https://www.mja.com.au/journal/2015/203/11/mental-health-services-reach-tipping-point-australian-acute-hospitals

Optimal care for *significantly mentally ill* people is best delivered by a psychiatrist-led collaboration of health professionals across the various parts of the health system, with regard to assessment, treatment, support for self-management and follow-up. This model facilitates collaboration with and access to non-health sector services such as housing, justice, employment, education and training.

LONG TERM ONGOING TREATMENT MODEL

One of our key suggestions for improvement in mental health care delivery across Victoria, is the adoption of a long-term ongoing treatment model for people living with significant mental illness. If all sectors adopted this model in full, it would harmonise the mental health care delivery architecture. To improve social and economic participation and assist those living with mental illness to improve their opportunities, we need to ensure they obtain the right care, from the right health practitioners at the right time. Further, keeping people well long-term will ensure that people with lived experience of mental illness are functioning optimally at work and in the community.

AMA Victoria submits that there are a number of significant advantages to this model of treatment, through community-based care. GPs, psychiatrists and other mental health workers that work within such a model develop significant knowledge about the long-term trajectory of a number of different mental illnesses. Those skills can be applied to gradually work with the patient, to develop greater and greater levels of well-being, with a strong primary focus on improvement in symptoms, followed by reduction in disability and ultimately gainful participation in the workforce and community.

In such a model, there must be a clear clinical governance structure, and scope-of-practice rules around the best use of skills mix within the team, and agreed systems and protocols for communication and interaction between team members.

Under this model, the patient's GP would request assessment and treatment from a psychiatrist, for a person suffering significant mental illness, who the GP believes they cannot manage without the psychiatrist's input. Such a referral under Medicare should attract higher Medicare rebates for the patient when they receive consultations from the health care workers in the community team. The psychiatrist involved in the team would lead the complex treatment required and communicate regularly with the patient's GP, and others. At an appropriate stage in the course of treatment, the primary ongoing care for mental health treatment could be handed over to another team member who could be the GP, a mental health nurse, a psychologist, or other allied health worker; but less frequent psychiatrist consultations would still occur, to supervise ongoing patient progress.

Ongoing assessment and review may be necessary, through regular consultations between the different members of the health team. However, once the person has achieved a satisfactory level of stability and well-being, their mental health care would be primarily managed by just one member of the team. AMA Victoria anticipates that members of the health care team would need to meet to improve coordination, but on a less frequent basis than would otherwise be required in facility-based, institutional settings. Those team meetings would have a strong educational component, so that team members can learn from the psychiatrist the best ways of maintaining well-being for the consumer, over the long term.

At times, two or three members of the multidisciplinary team may be actively consulting with the patient, their family, and the patient's carers, as required. These multi-disciplinary teams would be bound together with local ties of trust from working with each other over time, through a mutual understanding of the trajectory of illness and the long-term treatment model, and through regular, but less frequent, patient-focused team meetings. Note that the Federal Government, which is in control of Medicare funding, has the ability to implement this model by working on GP, private psychiatrist and psychologist item and rebate structures.

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Adopt the private psychiatry, patient-centred, long-term treatment model instead of the current episodic community mental health service model –** patients living with ongoing and recurrent significant mental illness would greatly benefit from adoption of the proposed model.
- **Include private psychiatrists in the planning stages of mental health policy development** – along with the public sector and primary care sector.
- **Recommend to the Federal Government to increase Medicare rebates -** for patients treated by private psychiatrists and general practitioners.

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

AMA Victoria will split this question up into three parts and discuss firstly what could be done to *attract* the mental health workforce, followed by strategies for *retaining* staff in the sector and finally suggestions for better supporting the mental health workforce (TOR 2.2).

What could be done to *attract* the mental health workforce?

Firstly, working in the mental health sector is not viewed as an 'attractive' career path, and one psychiatry registrar explains why:

> *There is currently inadequate resources and staffing in public psychiatry to provide our patients and their carers the quality of care they deserve. We try our hardest to fill gaps by working overtime or performing work we are not paid to do but ultimately this is not a long-term solution.*
>
> *Our interns don't enjoy their psychiatry rotations and find them stressful when they are not supported. Our registrar workforce gets exhausted and burnt out. Our consultants similarly so.*
>
> *Our patients and their families ultimately suffer as a result of understaffing leading to prolonged admissions, relapses due to insufficient community management or use of restrictive interventions. Our medical students and interns observe this happening and rationalise that this career path isn't for them.*
>
> *When we are sick or take leave for other purposes, we are not covered. When we are stretched to cover excessive workloads, we do not have the time to teach the medical students. This lack of cover sends a clear message - what you do and the patients you treat aren't worth covering.*

Rural and regional areas

At question five, we explored the drivers behind some communities experiencing poorer mental health outcomes and highlighted the significant workforce shortages in rural and regional areas of Victoria.

AMA Victoria made several recommendations in our answer to question 5, to address the dire shortages of GPs working in regional and rural areas of the state.

Apart from GPs, we know there is a shortage of all types of doctors, especially specialists like psychiatrists in regional and rural areas. People living in rural and regional areas often have to travel long distances to access the mental health care that they need, and rural hospital closures and downgrades are seriously affecting the future delivery of health care in rural areas.[106]

International Medical Graduates (IMGs) have been critical to filling the gaps in our medical workforce. However, the 457 Visas scheme has not properly addressed the maldistribution of doctors. There is still a shortage of doctors in many rural areas especially, while at the same time there is high density numbers in inner-metropolitan areas of Melbourne.[107]

[106] Australian Medical Association (National office), Encouraging more doctors to go rural, 24 January 2018 *[Media release]*. Access here: https://ama.com.au/ausmed/encouraging-more-doctors-go-rural
[107] Australian Medical Association (Victoria), Statement on 457 Visas and medical practitioners, 2016 *[Media release].* Access here: https://amavic.com.au/media/Archived-Media-Releases/2016-media-releases/statement-on-457-visas-and-medical-practitioners

WORKFORCE PLANNING

For some time now, AMA Victoria has been lobbying the Victorian Government to address state-based medical workforce issues. In particular, the urgent need for medical workforce planning, which looks at both demographic areas of need and also the types of doctors / specialties needed.

We believe that it is important to explore the employment patterns and intentions of prevocational doctors. For instance, there is a wealth of data that supports if you grow up in a regional or rural area, you are most likely to stay and work there. However, we recognise also that incentives are needed to encourage doctors (and their families) to relocate to areas of need. There should be opportunities for registrars to undertake rural rotations, especially for psychotherapy.

AMA Victoria psychiatry registrar, Dr Malcolm Forbes, outlines a way forward in his article, *Regional work opportunities for doctors in training (**please refer Appendix**).* In that article, Dr Forbes commends the efforts of the Federal Government in committing to the formation of up to 30 regional training hubs, which will cover vocational training, and also the expansion of the Specialist Training Program to fund 100 additional training places in 2017 and 2018, targeted specifically to rural locations. But more is needed to support regional and rural specialist training opportunities.

There is an urgent need to identify appropriate measures to rectify the maldistribution of Victoria's medical workforce.[108]

AMA Victoria strongly advocates for policy initiatives aimed at attracting registrars to work in regional and rural Victoria, and encouraging junior doctors to complete large portions (if not all of their psychiatry training) in regional centres.

THE AMA'S FIVE-POINT PLAN

The AMA *Position Statement – Rural Workforce Initiatives (2018)*[109] outlines five key areas where Governments and other stakeholders must focus their policy efforts to:

- encourage students from rural areas to enrol in medical school, and provide medical students with opportunities for positive and continuing exposure to regional/rural medical training;
- provide a dedicated and quality training pathway with the right skill mix to ensure doctors are adequately trained to work in rural areas;

[108] Health Workforce Australia, Australia's Future Health Workforce: Doctors, 2014. Access here: https://www.health.gov.au/internet/main/publishing.nsf/Content/F3F2910B39DF55FDCA257D94007862F9/$File/AFHW%20-%20Doctors%20report.pdf

[109] Australian Medical Association (National office), Position Statement – Rural Workforce Initiatives, 2018. Access here: https://ama.com.au/position-statement/rural-workforce-initiatives-2017

- provide a rewarding and sustainable work environment with adequate facilities, professional support and education, and flexible work arrangements, including locum relief;
- provide family support that includes spousal opportunities/employment, educational opportunities for children's education, subsidies for housing/relocation and/or tax relief; and
- provide financial incentives to ensure competitive remuneration.

Maintaining a strong public psychiatry workforce is crucial and clearly it is fundamental to attract, retain and support this workforce. Further to this, AMA Victoria strongly emphasises that doctors need to be actively involved in the design of healthcare systems and health care needs to be clinically informed. For example, we must have an adequate number of beds to fit clinical need (discussed at Q9 of our submission), doctors should not be put in a position where they are forced to prematurely discharge patients due to hospital key performance indicators (KPIs) or bed pressures as patients and their families ultimately suffer as a result.

Psychiatric sub-specialties

CHILD AND PSYCHIATRY REGISTRARS

There are also significant shortages in psychiatric sub-specialties. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) outlined their mental health priorities for the *2019-20 Victorian State Budget*[110] and noted the severe shortage of child and adolescent psychiatrist training positions. RANZCP went on to say that to become a psychiatrist, a trainee needs to complete a six-month placement in child and adolescent psychiatry. However, there are insufficient training places, creating a bottleneck of trainees and restricting the overall number of psychiatrists that are trained in Victoria.

GENERAL PRACTITIONERS

Many GPs practicing in rural and regional areas of the state are 'closing their books' so to speak on mental health patients. There is the problem of adequate remuneration for GPs (discussed at Qs 2, 4 and 5 of this submission), but also a heightened medico-legal risk of something going wrong, if GPs are unable to communicate with the patient's treating psychiatrist, or unable to refer the patient living with mental illness to appropriate public sector psychiatry services. We need to upskill and better support GPs so that they can manage patients presenting with mental illness in primary care.

[110] The Royal Australian and New Zealand College of Psychiatrists (RANZCP), Victorian Branch 2019-20 Pre-Budget Submission, 2018. Access here: https://www.ranzcp.org/about-us/australian-branches/victoria

Psychiatrists also acknowledge the important role of GPs. Forbes et al (2015)[111] writes:

> We need to upskill and better support GPs so that they can manage patients presenting with mental illness in primary care. This is particularly vital in rural locations, where there is a shortage of psychiatrists and psychologists.
>
> Long waiting times and limited access to psychiatrists will continue to impair the care of patients with mental illness, as it is predicted that psychiatry workforce shortages will continue into the future.
>
> Innovative approaches, including enhanced mental health training for GPs and the greater utilisation of telepsychiatry, are needed to ensure Australians in rural areas receive timely diagnosis and excellent care. Adequate recognition and remuneration for GPs who have acquired supplementary mental health training are important incentives.

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Commit to ongoing collaboration with AMA Victoria to support regional and rural specialist training opportunities –** to ensure quality of care in regional and rural communities, and provide employment for the increasing number of medical graduates.
- **Implement the five measures outlined in the AMA's Position Statement on Rural Workforce Initiatives -**
  - encourage students from rural areas to enrol in medical school, and provide medical students with opportunities for positive and continuing exposure to regional/rural medical training;
  - provide a dedicated and quality training pathway with the right skill mix to ensure doctors are adequately trained to work in rural areas;
  - provide a rewarding and sustainable work environment with adequate facilities, professional support and education, and flexible work arrangements, including locum relief;
  - provide family support that includes spousal opportunities for employment, educational opportunities for children, subsidies for housing/relocation and/or tax relief; and
  - provide financial incentives to ensure competitive remuneration.

[111] Forbes, M., et al., The need to upskill rural general practitioners in mental health care *[letter to the Editor], Medical Journal of Australia*, 2015: 203 (5); 211. Access here: https://www.mja.com.au/journal/2015/203/5/need-upskill-rural-general-practitioners-mental-health-care

What could be done to *retain* the mental health workforce?

Our Doctors in Training have told us that to retain the mental health workforce, our workplaces need to be safe – this includes both physical safety (free from violence and aggression) and occupational safety (which incorporates safe working hours, appropriate workspace environments and external oversight).

Work flexibility provides for a healthy and engaged workforce and incentivises doctors and other health workers to continue to work in the highly stressful mental health sector.

Occupational violence

The Victorian Government needs to invest in making hospitals and health services safer to improve workforce retention. In October 2016 a Fairfax media analysis of health services' annual reports showed 8627 reports of occupational violence in Victoria's public hospitals. 1166 of these assaults resulted in staff injury or illness.[112]

Occupational violence remains a major issue for staff in psychiatry units as well as community settings, and more needs to be done to capture data on the incidence of occupational violence and to then devise strategies to address it.

Most notably, there have been some high-profile incidents of occupational violence in Victorian hospitals:

- In April 2017, Dr Patrick Pritzwald-Stegmann was *punched* in the head and knocked unconscious at Box Hill Hospital after asking a patient to extinguish their cigarette[113]
- A nurse at Royal Melbourne Hospital was held hostage at knife point in April 2017[114]
- In October 2016, a patient angry about waiting for care drove his four-wheel-drive through the glass doors of the ED at Sunshine Hospital[115]

[112] "Hospital workers treated like punching bags – one attacked every hour in Victoria", *The Age*, 2016. Access here: https://www.theage.com.au/national/victoria/hospital-workers-treated-like-punching-bags--one-attacked-every-hour-in-victoria-20161029-gsdnja.html

[113] "Man arrested after alleged hospital assault on surgeon", *The Age*, 2017. Access here: https://www.theage.com.au/national/victoria/box-hill-hospital-employee-in-critical-condition-after-serious-assault-20170531-gwgz8g.html

[114] "Nurse taken hostage by knife-wielding patient at Royal Melbourne Hospital", *The Age*, 2016. Access here: https://www.theage.com.au/national/victoria/nurse-taken-hostage-by-knifewielding-patient-at-royal-melbourne-hospital-20170413-gvk0vq.html

[115] "Car 'deliberately' driven into Sunshine Hospital emergency department", *ABC News*, 2016. Access here: https://www.abc.net.au/news/2016-10-22/car-driven-into-sunshine-hospital-emergency-department/7956876

- In 2016, also at Sunshine Hospital, a patient slit their wrists, sprayed blood on staff and punched a nurse in the face repeatedly[116]
- Neurosurgeon Michael Wong was stabbed 30 times in February 2014 at Footscray Hospital as he arrived for work[117]

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Implement state-wide core occupational violence training** - across all hospitals.
- **Simplify reporting systems** - to increase reporting of incidents and inform prevention and controls.
- **Undertake state-wide regular audits** - hospitals should commit to regular audits to identify their organisation's vulnerability to violence and inform risk management planning.

Adequate staffing and flexibility

Poor staffing and high workloads in an already high-stress environment contribute to staff burn-out. While these issues are not unique to psychiatry, our doctors tell us that they are more exacerbated in acute mental health settings due to the historically poor level of investment in services in this area, despite record demand. *The Age* reported in March this year that:
"Decades of underfunding have pushed the state's psychiatric wards far beyond capacity."[118]

Add to this existing burden the fact that there are predicted workforce shortages in the field of psychiatry,[119] and it is easy to understand why many leave this pressure cooker environment.

For many, their first experiences out of medical school working in psychiatry as an intern or resident are stressful, paperwork-ridden environments, filled with pressure to adhere to layers of complex accountability. For example, our members report that trainees have commented that they feel the Mental Health

[116] "Violent patients put into comas to protect staff, emergency doctor says", *The Age,* 2017. Access here: https://www.theage.com.au/national/victoria/violent-patients-put-into-comas-to-protect-staff-emergency-doctor-says-20170413-gvkmu7.html
[117] "Surgeon speaks about being stabbed at Footscray hospital", *The Age,* 2014. Access here: https://www.theage.com.au/national/victoria/surgeon-speaks-about-being-stabbed-at-footscray-hospital-20140711-zt4wn.html
[118] 'Nothing between GP and emergency': Victoria's mental health failure, *The Age*, 26 March 2019. Access here: https://www.theage.com.au/politics/victoria/nothing-between-gp-and-emergency-victoria-s-mental-health-failure-20190227-p510ip.html
[119] The Australian Government Department of Health, Australia's Future Health Workforce – Psychiatry report, 2016. Access here: https://www.health.gov.au/internet/main/publishing.nsf/Content/Australias-future-health-workforce%E2%80%93psychiatry

Tribunal process can often be adversarial and that this has the potential to impact on the therapeutic relationship. Further, the administrative burden of preparing these reports detracts from clinical practice and time spent with patients, their families and carers.

This is made all the more difficult when another staff member takes leave, and (regardless of pre-planning) no cover is provided meaning that everyone else has to cover the work, which further exacerbates the incredible pressure on staff. Further, because of this, patients seldom have the level of face-to-face contact with doctors that they need, and that our doctors want to provide. This is particularly important because in psychiatry face-to-face contact is an even more crucial component of care given the delicate nature of mental health treatment.

Not replacing staff on leave, combined with other shortages of say registered psychiatric nurses and allied health support staff results in increased workload for staff, especially junior medical staff that work in areas that they are sometimes not trained in, covering multiple wards.

Without sufficient staff resources to oversee discharge planning, case management, hospital diversion and clinical review, patient care is compromised, as this case study by a psychiatrist registrar demonstrates:

> *Leave cover is vitally important. I have personally worked on a ward where patients were kept longer than necessary as inpatients because we didn't have the number of staff necessary to make timely discharge plans. I have also worked in a community clinic where, because of a lack of leave cover, patients were not reviewed in a timely manner directly contributing to their relapse and re-admission.*
>
> *The lack of leave cover is for me the most pressing problem for registrars. There is no cover but the workload remains the same. This means the registrar(s) not on leave have to take up the slack. At one point this meant that I was the registrar for 13 patients on an acute inpatient ward when the normal number was 7.*
>
> *It's not possible to maintain a basic standard of care in these circumstances.*

Not to mention the biggest risk of all facing junior doctors of medico-legal accountability. Many junior doctors were deeply perturbed by the sad case of UK paediatric registrar Dr Hadiza Bawa-Garba and the tragic and avoidable death of a child patient in her care. Dr Bawa-Garba was covering 6 wards, spanning 4 floors, her team was dangerously understaffed and she was doing the work of at least one paediatric registrar who was on leave. An investigation by the Leicester National Health Service trust found numerous errors by Dr

Bawa-Garba and nursing staff, but also blamed systemic failures including poor staffing levels and hospital computer malfunction.[120]

Ongoing training and development

It is also critically important to note that public psychiatry depends on registrars for their day to day functioning. The registrar is often the first and last point of medical contact. Public psychiatry is also the forum in which trainees decide whether to move on to private or public work once fellowed.

There needs to be ongoing support and training for registrars who will be managing complex public patients across their care needs and this includes training, supervision and support to enable registrars to provide optimal care in the public sector.

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Implement state-wide leave cover across all hospitals** - trainees (and often their supervisors) are generally not covered when taking leave, other trainees within the service are often expected to pick up the patient workload.
- **Address 'bottlenecks in training'** – by funding an appropriate number of training positions to meet training requirements and workforce projected needs.
- **Create more part-time training positions** – this is absolutely necessary for trainees to be able to create and support their families during training.
- **Create more funded and accredited research positions** - for registrars with sufficient clinical exposure to meet accreditation requirements.
- **Invest in system improvements to reduce the burden of paperwork and excessive administrative tasks** – this has a significant impact on the amount of meaningful clinical time the doctor has to spend with the patient, family and carers.
- **Facilitate access to psychotherapy training and supervision** - to provide a richer training experience but also better patient outcomes.

[120] Isaacs, D., Supporting junior doctors: the sad saga of Dr Bawa-Garba, *The Journal of Paediatrics and Child Health,* 2018: 54(5); 467-468. Access here: https://onlinelibrary.wiley.com/doi/full/10.1111/jpc.13886

What could be done to *better support* the mental health workforce?

Kisley, S. et al (2018)[121] reported in the *Australian and New Zealand Journal of Psychiatry* that funding for mental health services has failed to keep pace with more legitimatised areas of healthcare, such as surgery or intensive care.

The authors go on to say that decades of under-resourcing means that public mental health services cannot recruit, retain and develop a healthcare workforce or have adequate infrastructure to provide comprehensive care for the most severely mentally ill patients.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) prepared a report in 2015 on the Victorian Psychiatry Workforce. The specific focus of that report was on workforce issues in the public sector and also the rural workforce. AMA Victoria suggests that the Royal Commissioners should be guided by the recommendations in that report for actions to address the workforce issues identified.[122]

Everyone with a mental illness should have ready access to quality mental healthcare in the public sector that is appropriate to their needs. AMA Victoria recommends that ongoing investment in the public sector is urgently needed (as per Q9 of our submission, which contains our most comprehensive and pressing recommendations for change).

3. What is already working well and what can be done better to prevent suicide?

AMA Victoria's response to this question will reference TOR 1 and the critical point that we wish to emphasise here is that suicide is not always preventable.

There is much debate about whether suicide can ever be rational. Though most Western nations including Australia place emphasis on patient autonomy, death by suicide is widely held as an undesirable outcome. In recent years, there has been significant pressure on mental health services to improve risk assessment in order to reduce the incidence of suicide, especially in hospitals and other health services.

Angela Onkay Ho (2014) reported that suicidal behaviour in a person cannot be reliably predicted but organisations (like hospitals and health services) have developed standards of care for managing patients exhibiting suicidal behaviour.

[121] Kisley, S., et al., So we beat on, boats against the current, borne back ceaselessly into the past – Continued inaction on public mental health services, *The Australian and New Zealand Journal of Psychiatry,* 2018: 52(9); 824-825. Access here: https://www.ncbi.nlm.nih.gov/pubmed/30091376

[122] The Royal Australian and New Zealand College of Psychiatrists (RANZCP), Victorian Psychiatry Workforce Report, 2015. Access here: https://www.ranzcp.org/files/branches/victoria/ranzcp-vic-psychiatry-workforce-report.aspx

Although the responsibility of preventing suicide is often placed on the treating clinician, Onkay Ho goes on to say that in cases where a person is capable of making treatment decisions – uninfluenced by any mental disorder – there is growing interest in the concept of rational suicide.[123]

AMA Victoria acknowledges that suicide is not a choice in any meaningful sense of the word and we strongly uphold that no one should accept avoidable harm as an inevitable feature of our health system. Regardless of that, AMA Victoria submits that patient death by suicide is not always preventable, though there are some established strategies which have been shown to reduce the risk of suicide.

Studies have demonstrated that restricting access to lethal means, control of analgesics, and addressing hot-spots for suicide by jumping and school-based awareness programs are effective public health measures for reducing suicide. From a therapeutic perspective, effective psychosocial and pharmacological treatment of depression, and ensuring a chain of care for people who have attempted suicide are effective interventions.[124]

AMA Victoria strongly advocates that people presenting to ED following a suicide attempt should be assertively supported and followed-up after discharge. Too often this does not happen, and yet a suicide attempt is one of the most emphatic predictors of future attempts at suicide. Intervention in providing a chain of care has been demonstrated to reduce suicide rates[125]

Keks et al. published a study in *Australasian Psychiatry* in February this year, and the study showed that effective treatment of mood disorders in private hospital settings substantially reduces the risk of suicide. This study demonstrated that it is possible to reduce the *risks* of suicide through effective psychiatric treatment and intervention but not the *incidence* of suicide overall.[126]

A number of innovative prevention strategies are yet to demonstrate effectiveness in controlled trials. Research is urgently needed into the benefits for suicide prevention from education of primary care physicians, screening for suicidality in primary care, Internet and helpline support, media guidelines and public education.

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[123] Onkay Ho, A., Suicide: Rationality and responsibility for life, *The Canadian Journal of Psychiatry,* 2014: 59(3); 141–147. Access here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4079241/

[124] Zalsman G., et al., Suicide prevention strategies revisited: 10-year systematic review, *Lancet Psychiatry,* 2016: 3; 646–59). Access here: https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30030-X/fulltext

[125] Johannessen H., et al., Chain of care for patients who have attempted suicide: a follow-up study from Baerum, Norway, *BMC Public Health*, 2011: 11; 81. Access here: https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-11-81

[126] Keks N., et al., Characteristics, diagnoses, illness course and risk profiles of inpatients admitted for at least 21 days to an Australian private psychiatric hospital, *Australasian Psychiatry*, 2019: 27(1); 25–31. Access here: https://www.researchgate.net/publication/328086509_Characteristics_diagnoses_illness_course_and_risk_profiles_of_inpatients_admitted_for_at_least_21_days_to_an_Australian_private_psychiatric_hospital

Another important point to emphasise is that while suicidality is more common in people with mental disorders, it is not confined solely to this group. A person may experience poor mental health and associated suicidal ideation, but may not meet the diagnostic criteria for a mental disorder.[127] For example, a prime reason for poor mental health may well be a relationship breakdown, which has been linked to a higher risk of suicide in men.[128] Mass layoffs and the associated duration of unemployment have both been shown to increase the risk and incidence of suicide in local populations affected by for example, the closure of a major factory, or mine site.[129]

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

Homeless persons

The Council to Homeless Persons (CHP) has kindly shared some of their messaging with other peak stakeholders, ahead of this Royal Commission. The CHP reports that the private rental market offers very few options for people living in poverty, including many people whose poverty results from mental ill-health. Across all of metropolitan Melbourne there were just 35 rental properties let in the March quarter that would have been affordable to a single person on Newstart, and just 148 across the entire state.[130] This continues a prolonged downward trend of unaffordability.

[127] Australian Institute of Health and Welfare (AIHW), Australia's health, 2018. Access here: https://www.aihw.gov.au/getmedia/1838295a-5588-4747-9515-b826a5ab3d5a/aihw-aus-221-chapter-3-12.pdf.aspx

[128] Scourfield, J., et al., Why might men be more at risk of suicide after a relationship breakdown? Sociological Insights, *The American Journal of Men's Health,* 2014: 380-384. Access here: https://journals.sagepub.com/doi/full/10.1177/1557988314546395#articleCitationDownloadContainer

[129] Classen, T., et al., The effect of job loss and unemployment duration on suicide risk in the United States: a new look using mass-layoffs and unemployment duration, *Health Economics,* 2012: 21(3); 338-350. Access here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3423193/

[130] Victorian Government Department of Health and Human Services, Rental Report March Quarter 2019, 2019. Access here: https://dhhs.vic.gov.au/publications/rental-report

Patients living with mental illness are often admitted to hospital, and more optimal health outcomes would surely be achieved if the patients could be discharged to the community to reside in safe, secure settings. Even if the patient becomes clinically well enough to be discharged from a public hospital, a lack of accommodation and difficulty transitioning to another part of the health system often results in an extended admission to hospital, or else homelessness[131].

Similarly, persons released from prison are at a heightened risk of homelessness. This is neither optimal for achieving integration of recently released prisoners back into the community or safe for the community at large.

The Conversation quoted in April 2019:[132]

> Like the homeless population, Australia's prison population has increased by 56 per cent in the past decade, from 25,968 to 40,577 people.
>
> Social researchers and policymakers have long been aware of a strong association between incarceration and homelessness. Local and international studies consistently report the homeless are over-represented in prison and ex-prisoners are over-represented among the homeless.
>
> That such a strong association exists should come as no surprise.
>
> Both populations share many similar characteristics – lower education levels, high rates of mental and physical illness and substance misuse, as well as high rates of economic disadvantage.
>
> …We found that homelessness, broadly defined, does not increase the risk of incarceration…[but] the risk of ex-prisoners becoming homeless increases significantly six months after release, and this increased risk persists for nearly another year.

AMA Victoria advocates that there is a need for the State Government to explore policy initiatives and associated funding for extended settlement support programs delivered through a range of supported housing arrangements.

[131] ***Note***: There is no universally agreed definition of homelessness, it could be defined 'literally' to include sleeping on the streets, in squats or staying in emergency or crisis accommodation, or more 'broadly' interpreted to include people couch surfing or people staying in temporary hotel accommodation or living in a caravan park.

[132] "Ex-prisoners are more likely to become homeless but the reverse isn't true", *The Conversation,* 4 April 2019. Access here: https://theconversation.com/ex-prisoners-are-more-likely-to-become-homeless-but-the-reverse-isnt-true-113570

Persons living in rural and regional areas

Australia's population is concentrated in the major cities of the south-eastern seaboard states. Close to 80 per cent of the population lives in New South Wales, Victoria or Queensland. AMA Victoria believes that the health, and the mental health of the other 20 per cent of rural and remote Australians, is being neglected.

Health outcomes in rural and regional Victoria are poorer than in metropolitan Melbourne. In rural and regional areas, there is a higher prevalence of mental health and chronic illness but access to resources is more challenging, with health outcomes for the same illnesses often worse.[133]

Around 65 per cent of Aboriginal and Torres Strait Islander people live outside major cities. As a result, they are disproportionately affected by social inequality and poorer health outcomes. The National Rural Health Alliance reported that Aboriginal and Torres Strait Islander people are in particular disproportionately affected by poverty.[134]

The RACP noted that Aboriginal and Torres Strait Islander children and young people have poorer health outcomes than the general population, due in large part to preventable illnesses. We know that the large majority of Aboriginal and Torres Strait Islander people reside in regional and rural areas of the state, and given that RACP data shows poorer health outcomes for Aboriginal and Torres Strait Islander youth, it would appear that health problems affecting this population are intergenerational.[135]

General practice is integral in supporting rural and regional Victorians to be healthy and productive members of society. There are GP shortages in rural Australia[136] and the overall rate of employed medical practitioners (including specialists) is lower (253 per 100,000 population, compared with 409 in major cities).[137]

In regional Victoria, especially the smaller cities and towns, GPs working as Visiting Medical Officers (VMOs) are the backbone of the medical workforce in public hospitals.

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[133] The Australian Institute of Health and Welfare (AIHW), Rural & remote health, 2017. Access here: https://www.aihw.gov.au/reports/rural-health/rural-remote-health/contents/rural-health

[134] The National Rural Health Alliance, Fact Sheet: Poverty in Rural and Remote Australia, 2017. Access here: https://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-povertynov2017.pdf

[135] The Royal Australasian College of Physicians (RACP), Position Statement on Early Childhood: The Importance of the Early Years, 2019. Access here: https://www.racp.edu.au/docs/default-source/advocacy-library/early-childhood-importance-of-early-years-position-statement.pdf?sfvrsn=e54191a_4

[136] Duckett, S. et al., Access all areas: new solutions for GP shortages in rural Australia, 2013.

[137] Australian Institute of Health and Welfare, Rural and remote health: access to health services, 2017.

AMA Victoria is concerned about the challenges of attracting and supporting GPs, as well as other specialist doctors to Victorian regional areas.

AMA Victoria recommends that the Victorian Government invest in supporting GPs as the core part of the provision of health services in rural and regional areas of Victoria. This includes employing, enabling and supporting GPs to provide services and support hospitals in rural and regional areas. This would contribute significantly to strengthening the primary care sector, keeping health services open, enabling care in the community, facilitating better access to health services and improving overall health outcomes for people living with mental illness in Victorian regional and rural communities.

To do this, the Victorian Government needs to ensure that rural-connected metropolitan, and larger regional services are accountable and well-resourced to provide timely, quality and appropriate support, referral, advice and skills maintenance and upskilling for GPs working in regional and rural communities.

Decreases to the scope of services delivered in smaller public rural hospitals have led to some adverse effects on the provision of mental health services to rural communities. This has resulted in many unintended consequences, including:

- rural patients not seeking care for mental health conditions;
- greater financial and non-financial costs of seeking care;
- poorer preventative health; and
- reduced opportunity for doctors and other staff to maintain their skills.

This all leads to poorer health outcomes for patients living with mental illness, as well as those from lower socio-economic backgrounds, refugees living in regional and rural areas and the homeless. Overall, this only exacerbates the inequity of access to health services and impacts on the viability of living in regional and rural communities.

Rural GPs, specialists and hospitals need to be supported to safely maintain and increase their scope of services.

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Provide targeted subsidies for rural mental health** - for the provision of mental health care by GPs to ensure these services are provided in rural and regional areas.
- **Mandate the provision of expert and timely specialist advice from dedicated public hospitals to rural GPs, including in emergency scenarios** – to facilitate improved networking and communication between primary care and other public and tertiary health services.
- **Invest in telehealth for rural GPs** - including video, phone and email advice from dedicated public hospitals to ensure optimal care, timely referral, and assistance in urgent and semi-urgent scenarios.
- **Facilitate streamlined pathways of care** - provide GPs working in rural hospitals with priority access to regional hospital hubs and streamlined pathways of care for emergency advice and transfer.

Gambling and problem gambling and associated harm

It is well established that both frequent gambling is associated with depression and that people who suffer problems with gambling report higher levels of depression.[138] A 2017 study found that the prevalence of having a gambling problem among people who are seeking treatment for a mental health problem is eight times higher than in the general population, and that over 40 per cent of people seeking treatment for mental illness gamble.[139] Shockingly, this study found that 6 per cent of all people seeking treatment for mental illness had a problem with their gambling and lost an average of $440 a month to gambling businesses (eleven times more than the average of people who do not have a gambling problem).

A 2016 literature review found that the rate of suicide attempts has been found to be higher in pathological gamblers than in the general population, and people with a diagnosis of post-traumatic stress disorder (PTSD) were at high risk of becoming gamblers. Additionally, people with both PTSD and gambling had often

[138] Howe P., et al., Gambling and problem gambling in Victoria, *Victorian Responsible Gambling Foundation,* 2018. Access here: https://webcache.googleusercontent.com/search?q=cache:QKLGPvv4aXkJ:https://responsiblegambling.vic.gov.au/documents/393/Gambling-and-problem-gambling-in-Victoria.pdf+&cd=1&hl=en&ct=clnk&gl=au

[139] Lubman D., et al., Problem gambling in people seeking treatment for mental illness, *Victorian Responsible Gambling Foundation*, 2017. Access here: https://responsiblegambling.vic.gov.au/resources/publications/problem-gambling-in-people-seeking-treatment-for-mental-illness-61/

started gambling at an earlier age and had greater lifetime gambling.[140] This review concluded that people with gambling disorders often had associated mental health issues (mostly mood and substance use disorders). Our members tell many heart-wrenching stories of how gambling both exacerbates mental health disorders, and that those with mental health disorders are more likely to become addicted and negatively affected by gambling. This results in loss of finances, loss of stable housing, fractured relationships, decreased adherence to management as a result of loss of money – all of which cause considerable stress and exacerbate feelings of depression and anxiety.

Recommendation

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Reduce venue opening hours, cash out[141] in venues and maximum bets –** to decrease the negative effects of gambling on those with mental illness.

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

Despite public campaigns to improve the community's understanding of mental illness, there is no doubt that people living with mental illnesses continue to experience significant levels of stigma and discrimination.

In fact, many people who would benefit from treatment, do not seek care as a result of their concerns around stigma and discrimination; instead preferring to keep their mental illness hidden.[142]

In regional and rural areas, stigma and discrimination can present an even larger problem. Small communities can provide valuable support for people with mental illnesses but the closeness and highly integrated nature of these communities can also result in the exclusion of some people who are viewed as

[140] Giovanni M., et al., Gambling Disorder and Suicide: An Overview of the Associated Co-Morbidity and Clinical Characteristics, *International Journal of High Risk Behaviour and Addiction,* 2017: 6(3); 2. Access here: http://jhrba.portal.tools/?page=article&article_id=30827

[141] Browne, M., et al., *The social cost of gambling to Victoria*, 2017 [published by the Victorian Responsible Gambling Foundation]. Access here: https://responsiblegambling.vic.gov.au/resources/publications/the-social-cost-of-gambling-to-victoria-121/

[142] Mental Health Foundation Australia, Fight Stigma, 2019. Access here: https://www.mhfa.org.au/CMS/FightStigma

'different', and this can affect a person's willingness to seek help.[143]

Efforts to reduce the stigma associated with mental illness would be welcomed by AMA Victoria. Reducing stigma would help remove a significant barrier for many people who need help but do not seek it out for fear of being stigmatised or discriminated against. AMA Victoria looks forward to hearing the views and idea of other stakeholders in the sector on how this might best be achieved.

6. What are the needs of family members and carers and what can be done better to support them?

AMA Victoria supports the submission made by Mental Health Victoria (MHV) in relation to the needs of family members and carers and what can be done to better support them.
As highlighted in MHV's submission *(and referenced with permission)*, we re-state MHV's recommendations for:

- funding for carer support;
- mandated carer-inclusive practices in all commissioned mental health services; and
- work to be undertaken with the Federal Government, to ensure carer-inclusive practices in the National Disability Insurance Scheme.

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

Please refer to ***Q4 (Private Psychiatry),*** specifically the Long Term Ongoing Treatment Model. AMA Victoria advocates that keeping Victorians well long-term will ensure that people with lived experience of mental illness are functioning optimally at work and in the community.

[143] The Royal Australian and New Zealand College of Psychiatrists (RANZCP), Mental health in rural areas, 2019. Access here: https://www.ranzcp.org/practice-education/rural-psychiatry/mental-health-in-rural-areas

11. Is there anything else you would like to share with the Royal Commission?

Mental health of doctors

In the context of a discussion around mental illness and the Victorian mental health system, it is important to note that mental illness is also experienced by practitioners.

It is therefore critical to examine how the management of mental illness amongst medical practitioners could be improved, and a key direction for change is the reduction of stigma and discrimination associated with mental illness.[144]

As one young doctor describes in his blog:

> "Every fleeting thought, each subtle comment, every little doubt is stigma rearing its ugly head. Yet perhaps the most damaging form of stigma is that directed inwardly by those suffering from mental illness. This is the stigma we rarely see: the irrational shame, the self-doubt, the relentless fear of relapse. As doctors, we are not above such stigma, despite soaring levels of psychological distress in our profession. Doctors continue to take their own lives at alarming rates despite years of awareness campaigns."[145]

Data shows that medical professionals are more likely to die by suicide than the general population. The risk profile is highest for female doctors (2.2 times more likely than the general population to die by suicide), while male doctors are 1.4 times more likely to die by suicide.[146,147] The higher incidence of suicide amongst female doctors is opposite to the situation in the general population, where males have a higher suicide rate compared with females.

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[144] Wallace, J.E., Mental health and stigma in the medical profession, *Health*, 2017: 16 (1); 3-18. Access here: https://journals.sagepub.com/doi/abs/10.1177/1363459310371080

[145] [De-identified to protect privacy], reference available on request

[146] "Why doctors are taking their own lives at alarming rates", *News.com.au,* 30 November 2017. Access here: https://www.news.com.au/finance/work/at-work/obsessed-with-the-fear-of-failure/news-story/d707f7cd8ee0173b17fd289a99889a25

[147] "There are serious problems in our medical industry with an alarming number of doctors taking their own lives", *News.com.au,* 9 November 2018. Access here: https://www.news.com.au/lifestyle/health/mind/there-are-serious-problems-in-our-medical-industry-with-an-alarming-number-of-doctors-taking-their-own-lives/news-story/ce098d0408daaef6cde812389230e2df

Young doctors and female doctors appeared to have higher levels of general and specific mental health problems and report greater work stress.[148]

Female doctors report higher rates than male doctors of current psychological distress (4.1 per cent vs 2.8 per cent), high likelihood of minor psychiatric disorders (33.5 per cent vs. 23.2 per cent), and current diagnoses of specific mental health disorders (8.1 per cent vs. 5.0 per cent for depression; 5.1 per cent vs. 2.9 per cent for anxiety).[149]

The *Medical Journal of Australia* reported that, in recent Australian surveys, one in five medical students reported suicidal ideation in the preceding 12 months, while 50 per cent of junior doctors experience moderate to high levels of distress.[150]

It is also worth mentioning that clinical diagnosis might exacerbate stigma. In fact, several studies support that *diagnostic* labels, despite their obvious benefits, also serve as cues that activate *stigma* and stereotypes.[151,152,153]

In the following case study, we examine the most common barriers to seeking help associated with stigma: the fear that someone would find out the person was receiving treatment, negative career impact and lack of safe and confidential support.

[148] Beyond Blue, National Mental Health Survey of Doctors and Medical Students, 2019. Access here: https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web

[149] Ibid

[150] The Medical Journal of Australia Media Release: Reducing risk of suicide in medical profession, 17 June 2019. Access here: www.mja.com.au/journal/2018/reducing-risk-suicide-medical-profession

[151] Wright A., et al., Labelling of mental disorders and stigma in young people, *Social Science and Medicine*, 2011: 73(4); 498–506. Access here: https://www.ncbi.nlm.nih.gov/pubmed/21794967

[152] Barney L., et al., Stigma about depression and its impact on help-seeking intentions, *Australian and New Zealand Journal of Psychiatry*, 2006: 40; 51–4. Access here: https://journals.sagepub.com/doi/abs/10.1080/j.1440-1614.2006.01741.x?journalCode=anpa

[153] Jorm AF., et al., The public's stigmatizing attitudes towards people with mental disorders: how important are biomedical conceptualizations?, *Acta Psychiatrica Scandinavica,* 2008: 118; 315–21. Access here: https://www.ncbi.nlm.nih.gov/pubmed/18759807

A now widowed general practitioner, worried her husband's life was at risk from depression but says her husband feared the stigma of seeking help. This brave doctor has agreed to share her story (*published with permission*):

Who cares for the carers?

When we talk of the vulnerable, we might think of the homeless, migrants or low income earners. Surely not doctors. They are well-educated and earn very decent money.

But what we do know is that doctors are vulnerable, as is evidenced by their higher rates of suicide compared with the general population. I think it is likely that doctors are more at risk from the very start - medical school. They are perfectionist and high achieving but also have chosen the profession to help others. This desire to help may come from their own traumatic experiences leaving them more vulnerable before they even enter the toxic culture of medicine.

Doctors are pushed hard, hospitals are under-resourced, there is inadequate staff on rotation at wards, and a lot of pressure to do overtime.

My late husband loved his job. He, like many other doctors, had a very strong emotional connection to his job and to the journey of healing patients.

My husband worked as a GP and at the time he became unwell, he visited his GP and was prescribed a variety of anti-depressants and psychological interventions. He was not getting better but feared the stigma of seeking medical help from a psychiatrist (he did eventually see one but only 2 months before his death when he had given up hope of feeling better), or presenting to hospital and he never told anyone at work.

If other doctors suspect that someone, like my husband, is unfit to provide care to patients, mandatory reporting rules require medical colleagues to notify the Medical Board. But mandatory reporting only encourages doctors to hide their problems, and deters doctors from seeking help, for fear of being barred from practicing. There was no anonymous way of connecting with other doctors.

My husband feared no longer being treated the same by colleagues and when I called in sick for my husband, he would only allow me to tell them that he had a back injury.

My husband was silent about his illness and kept 'carrying on' at work, despite me encouraging him to cut down, or even resign.

My husband was at work on Friday, and dead by Monday. It's a story the medical profession knows all too well.

Positive work environments can increase effectiveness and productivity and improve overall staff morale. In healthcare settings this can lead to reduced risk, lower adverse events and better overall patient outcomes.[154]

Specific interventions are needed that target individual stigma (health facility staff), and structural stigma (health facility environment).

AMA Victoria members report that the biggest barrier to doctors accessing mental health services is the fear of mandatory reporting. Hospitals and health services must ensure that their employees are appropriately supported throughout their careers, and have access to safe and confidential support and treatment.

The hierarchical nature of medicine, power imbalances inherent in medical training, and the competitive nature of the field of medicine have engendered a culture of fear and silence that has become pervasive and even institutionalised in many areas of medicine. Hospitals and health services must provide for the safe assignment of work, regular consultation about a doctor's workload, and create procedures that address any health and safety issues arising from hours of work, workload management and other workforce issues like replacement of staff on leave.

Discrimination

Many life insurance and travel insurance policies will not cover a medical practitioner for any claim arising from a mental health condition. This means that even if a doctor does not have a history of mental health problems, but makes a claim in future and wants to take some time off work to recover from a mental health condition, the doctor would not be covered by their insurance policy.

Unfair mental health exclusions create new vulnerabilities. For example, we identified earlier that young doctors are particularly vulnerable and experience higher levels of mental health problems compared with the general population. If a young doctor (say mid- to late-20s) is not able to work, and has few savings, not to mention a significant higher education debt from the many years of study, the doctor's only option is to rely on family or social services to help them access appropriate and quality mental health care. If a doctor does not have adequate family support structures, Centrelink payments are insufficient to cover expensive medical care, especially for complex or chronic mental health conditions. As the young doctor cannot claim on their income protection insurance policy, the young doctor has no option but to rely on the under-resourced public health system.

[154] Künzle, B., et al., Ensuring patient safety through effective leadership behaviour: a literature review, *Safety Science*, 2010: 48(1); 1-17. Access here: https://www.sciencedirect.com/science/article/pii/S0925753509001143

These are the experiences of doctors but many of these same themes occur across the health sector, in other industries and in the broader community.

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

- **Review mandatory reporting laws** – we need to strike a better balance between doctor wellbeing and patient safety. Specifically we need to align Victoria's mandatory reporting laws with Western Australia, where health professionals can see their GP or psychiatrist without fear of reprisal.
- **Remove discriminatory exclusion clauses –** mental health conditions are common and insurers should not impose exclusions that are not justified by a strong evidence-base, and further the statistical data relied upon should be made available to the public.

Improved data collection and research strategies to advance continuity of care and monitor the impact of any reforms (TOR 2.5)

Improved data collection, information sharing and communication between the different parts of the state health system facilitates continuity of care and optimal health outcomes for Victorians living with mental disorders.

A recent systemic review of 22 studies, spanning nine countries in three continents, found strong evidence that continuity of care by GPs, defined as repeated contact between an individual patient and doctor, was associated with decreased patient mortality.[155] Continuity of care has been found to improve medication management.[156] Hambleton[157] reports that there are many potential benefits of improved information flows to patients, between GPs and through the broader health system and with many benefits of an emerging digital health system.

[155] Wright, M. Continuity of care. *Australian Journal of General Practice*, 2018; 47:10. Access here: https://www1.racgp.org.au/ajgp/2018/october/continuity-of-care-is-in-the-eye-of-the-beholder
[156] Stasinopoulos J., et al., Medication management of type 2 diabetes in residential aged care, *Australian Journal of General Practice*, 2018: 47(10); 675–81. Access here: https://www1.racgp.org.au/ajgp/2018/october/medication-management-of-type-2-diabetes
[157] Hambleton S. A glimpse of 21st century care, *Australian Journal of General Practice*, 2018: 47(10); 670–73. Access here: https://www1.racgp.org.au/ajgp/2018/october/a-glimpse-of-21st-century-care

Most notably the benefit of sharing information directly with patients was identified as a key building block to activate patients to be engaged in their care, and to deliver against key Recommendation 3 of the Primary Health Care Advisory Group (PHCAG) report: *Activate patients to be engaged in their care*.[158]

There is fragmentation of care between the different parts of the health system, like the primary care sector and psychiatric workforce.

AMA Victoria psychiatrist members acknowledge that GPs, being the usual gateway to the rest of the health system, need to be acknowledged and supported in their role of providing mental health treatment and support to patients. As such, GPs need to be able to access the help they need from other parts of the mental health system to facilitate better coordinated service provision and ultimately safer and patient-centred care (TOR 2.1).

Victoria's health IT infrastructure is archaic and does not meet the expectations of doctors or patients. Faxes and posted mail are still heavily relied upon by GPs, specialists, hospitals and aged care facilities.

AMA Victoria commends the Victorian Government for their funding commitment in 2018 of $124 million over three years to roll out electronic medical records across three hospitals in the Parkville precinct: the Peter MacCallum Cancer Centre, Melbourne Health and Royal Women's Hospital. AMA strongly advocates for a significant funding investment so that electronic medical record systems can be rolled out across all public hospitals, including in regional and rural areas of the state, to improve patient safety and save lives, with clear expectations that this must include comprehensive cross health sector outcomes.

AMA Victoria GP members are also disappointed that this initiative does not include an ability for GPs to email referrals into hospitals in the near future. Further, government funding needs to support interoperability and interconnectivity of IT systems between health services, like hospitals and general practice. In addition, there is an urgent need for the State Government to provide a secure messaging platform for health workers that does not require proprietary clinical practice software. A large number of psychiatrists and other practitioners in private mental health do not use proprietary clinical practice software, often for legitimate security and confidentiality reasons.

More positively, we commend the State Government on the adoption of real-time prescription monitoring (SafeScript) in Victoria, and anticipate that, after further review, its uptake will ensure greater identification and therefore improved management of those with addiction to medicines and greater

[158] Department of Health, Primary Health Care Advisory Group Final Report: Better outcomes for people with chronic and complex health conditions, 2016. Access here: https://www.health.gov.au/internet/main/publishing.nsf/Content/76B2BDC12AE54540CA257F72001102B9/$File/Primary-Health-Care-Advisory-Group_Final-Report.pdf

medication safety, by enabling medical practitioners to be more aware of medication prescribed and dispensed to patients.[159]

Recommendations

AMA Victoria requests that the Royal Commissioners consider including in their recommendations that the Victorian Government:

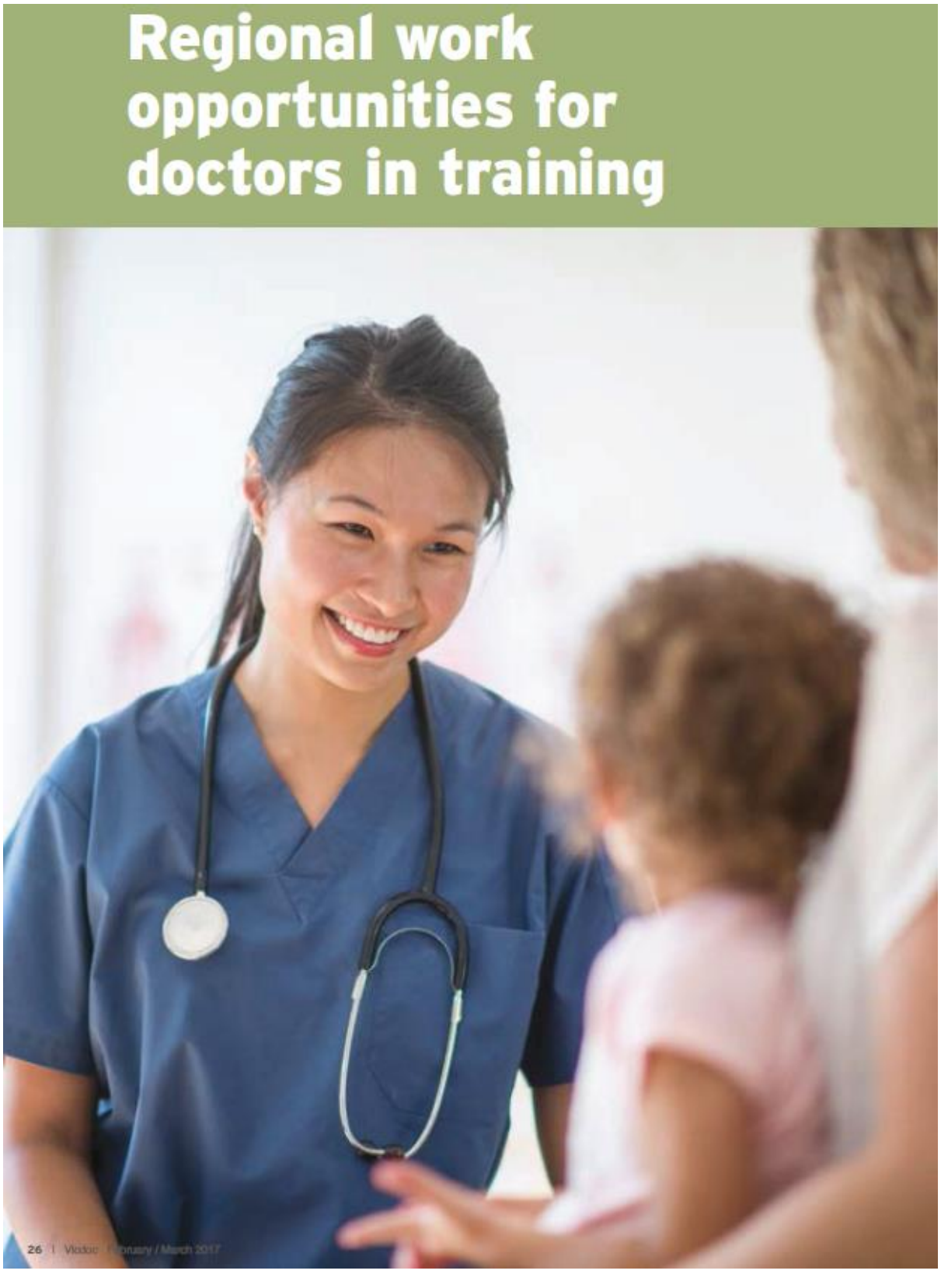
- **Provide funding to measure and report on indicators of communication with GPs and other medical practitioners** - as per the '10 Minimum Standards for Communication between Health Services and General Practitioners and Other Treating Doctors'.[160]
- **Provide funding for electronic communication** - to ensure all public hospitals are working towards the ability to receive and send secure electronic communication to and from the medical software platforms of referring doctors.
- **Develop agreed principles for contracts around IT provision to health services** - to enforce minimum standards for software providers.

[159] "Drug overdose deaths rise in Victoria", *The Age,* 28 March 2017. Access here: https://www.theage.com.au/national/victoria/drug-overdose-deaths-rise-in-victoria-20170328-gv8f6k.html

[160] AMA, 10 Minimum Standards for Communication between Health Services and General Practitioners and Other Treating Doctors, 2017. Access here: https://ama.com.au/article/10-minimum-standards-communication

AMA VICTORIA

Appendix



Australia has a problem with maldistribution of doctors. We have more doctors per capita than New Zealand, Canada, the United Kingdom and the United States but our doctors disproportionately work in the cities. In some areas, we have had to rely on overseas doctors on 457 visas to fill workforce gaps.

Last year the Australian Institute of Health and Welfare found that the gap in the number of GPs per 100,000 people in major cities compared to regional and rural areas had narrowed but for specialists, the city-country divide had worsened.

Victorians in rural areas experience poorer health outcomes compared with their city counterparts. Many rural Victorians must travel long distances and experience significant delays in order to see a specialist. Advances in service delivery through technological innovation (e.g. telemedicine) have gone some way to remedy the situation. However, a specialist offering advice via video-link is not the same as having a specialist on the ground that can provide teaching to registrars, offer collaboration and collegiality, and foster important research and capacity building. Victorians in rural and regional areas need more specialists working in and around their communities.

One of the reasons there are so few specialists in regional and rural areas is that there are so few training opportunities for specialists in training. Either the jobs don't exist, or the jobs are not as attractive as those in big cities.

I have spent the majority of my life living in regional, rural and remote towns. I am acutely aware of the difficulty with accessing specialist services outside of major cities. I would love the opportunity to undertake the majority of my training in a regional area but at present the common perception is that educational, research and clinical opportunities are simply not as good in the bush compared to the cities. Thus I have decided to train in Melbourne where I can undertake research and plan to move to a regional area when I gain my Fellowship.

However, the longer a doctor spends living in an area, the more settled they become. Personal relationships, including those with mentors, life partnerships, work opportunities for partners, financial investments including the purchase of homes, and child care or schooling arrangements become established in urban centres. To uproot all of this and move to the country becomes increasingly unfeasible. If a regional area can attract doctors straight out of medical school and allow them to complete all of their training there, from internship to fellowship, they are more likely to stay permanently.

Since 2000, over a dozen rural clinical schools have been established across Australia and many of these are flourishing. Some medical schools have policies that prioritise selection of students from rural backgrounds, which has shown to be a predictor of later rural practice. However, this will not translate to an increase in specialist numbers if capacity is not developed in these areas to support these doctors during their vocational training.

The Federal Government has listened to the concerns of doctors about this issue and has committed to the formation of up to 30 regional training hubs (which will cover vocational training) and an expansion of the Specialist Training Program to fund 100 additional training places in 2017 and 2018, targeted specifically to rural locations. The first regional training hubs are expected to begin in 2017.

The commitment from Government has been laudable. Dr David Gillespie, the Assistant Minister for Rural Health and a past regional-based gastroenterologist himself, has said, "encouraging GPs, specialists, nurses and allied health professionals to live and work in regional and rural Australia will be one of my greatest challenges."

Ongoing collaboration between Government and AMA Victoria to support regional and rural specialist training opportunities is essential to ensure quality care in regional and rural communities. It will also benefit doctors wishing to serve these communities, and provide employment for the increasing number of doctors graduating from our medical schools.

The Andrews and Turnbull Governments must work with AMA Victoria to ensure Government policy translates into effective action on the ground. Regional training hubs offering comprehensive clinical training, along with educational and research opportunities for specialists in training will result in better health outcomes for Victorians. But what looks good on paper doesn't always work in reality. Over the coming year, I am keen to hear from members working in regional and rural areas to ascertain the situation in their area and work together to optimise specialist training and ensure all Victorians have access to world-class healthcare. Please email me at Malcolm.Forbes@mh.org.au

Dr Malcolm Forbes

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References available from the Editor on request.