To improve the mental health of Victorians, more needs to be done now.
About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP Victorian Branch has around 1500 members including more than 1100 qualified psychiatrists and around 400 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

Executive Summary

The RANZCP Victorian Branch appreciates the opportunity to provide the Victorian Department of Treasury and Finance with recommendations of where investment should be made to improve the lives of people living with mental illness, their families and carers, and the workforce which supports them.

While the RANZCP Victorian Branch welcomes the Royal Commission into Mental Health, the Victorian Branch also recognises the mental health of Victorians cannot wait for recommendations of the Commission to be delivered and enacted. The urgency of the situation means investment is needed right now, to address underfunding, under-resourcing and undervaluing of the Victoria’s mental health system.

On this basis, the RANZCP Victorian Branch urges the Victorian Government to:

1. Address the psychiatry workforce shortage and improve the training pipeline
2. Fund more inpatient beds to meet demand
3. Establish outpatient centres for mental health
4. Provide increased services in the Community
5. Integrate Alcohol and Other Drug and Mental Health Services to provide better continuity of care
6. Increase services to address demographic change.

How this submission was developed

The RANZCP Victorian Branch recommendations focus on the most chronic needs of the system, they are in addition to those made in our submission to the Royal Commission. The recommendations are based on extensive consultation with Victorian psychiatrists and community members, with a breadth of expertise in academia, clinical settings, service delivery and lived-experience.

Improving the mental health of Australians requires investment beyond the mental health sector, to ensure all Australians have equal opportunity for good mental health, regardless of their individual circumstances. This submission has been developed by psychiatrists who provide care to people with severe and complex mental illness, and as such, the recommendations are focussed on improving care for those consumers.
What is needed

The RANZCP Victorian Branch have outlined below the key areas which require immediate action and reform to ensure that the Victorian mental health system can meet current and future demand.

The RANZCP Victorian Branch recommends:

I. The Victorian Government mandate at least 70 per cent of doctors complete a 10-week psychiatry internship block during Postgraduate Year One.

II. The Victorian Government commit to undertaking a mapping and gapping exercise to provide a clear picture of the numbers and types of staff needed, and where and when they are needed.

III. The Victorian Government commit to recurrently funding additional trainee and psychiatrist positions in several specialty areas.

IV. DHHS mandate that capital and workforce infrastructure planning for hospital and community services consider and respond to the mental health needs of the catchment area, including sexual safety concerns.

V. DHHS increase funding allocation to meet 100 per cent of the actual cost of providing an inpatient mental health bed.

VI. Funding must be set aside of approximately $200 million to establish at least 100 beds across the State and more than $44.5 million in recurrent funding. It should be noted that funding in addition to this amount will be required to support these extra beds.

VII. The Victorian Government fund and re-establish one Outpatient Centre in each mental health service area to provide psychiatric treatment to the ‘missing middle.’

VIII. The PARC model is expanded, and includes extended PARC units that allow longer rehabilitation/recovery oriented admissions.

IX. Funding for Alcohol and Other Drug Services and Mental Health Services should be integrated, so that AOD services form a fundamental part of every mental health service.

X. The Victorian Government should develop mental health plans for older people, which take into account future demand and resources necessary to address this, as well as identify service delivery priorities.

XI. The needs of Culturally and Linguistically Diverse communities should be taken into account when services are established, and areas of additional need should receive a commensurate increase in funding.

The justification and evidence supporting these recommendations are discussed further in the submission below.
1. Address workforce shortages and improve training pipeline

Problem:

The RANZCP Victorian Branch has previously flagged its deep concerns about the future of Victoria’s public mental health system and once again calls on the Government to address the significant challenges facing the psychiatric workforce. As the representative body for psychiatrists we believe we are best-placed to make recommendations to address the current psychiatric workforce crisis.

There has been no systematic or concerted effort to address many of the issues in the mental health workforce for some time. [1] The reasons for psychiatrists exiting the public sector at alarming rates are complex, yet can also be attributed to the excessive demands being placed on them in an under-resourced sector. [2, 3] Consumers, carers and those working in the mental health system, including psychiatrists, are being traumatised by an under-resourced system.

Psychiatrists are clinical leaders in the provision of mental healthcare and use a biopsychosocial model of understanding, which sees and treats a person as a whole.

The shortages in the psychiatric workforce are exacerbated in regional areas, where the challenges of recruitment and retention are greater. An additional challenge is the shortage in subspecialties which need to be addressed as a matter of urgency. These shortages are particularly evident in Addiction Psychiatry and Child and Adolescent Psychiatry, as well as Psychotherapy.

There is also a great need for additional Addiction Psychiatry positions in Victoria. Whilst there have been improvements in the number of trainee Addiction Psychiatrists, our members report that trainees are leaving Victoria once their training is complete due to the lack of public Addiction Psychiatry positions available. Across both metropolitan and regional Victoria, there is a shortage of addiction psychiatrists, with only 3 – 4 publicly funded FTE positions across the whole state. Addiction psychiatrists are essential contributors to the care of people with addictions, as they are uniquely trained to focus on both the psychological and physical health of the consumer, as well as to understand the social context and public health approaches.

There are too few child and adolescent psychiatrists to meet the direct mental health needs of young people. Commissioners are directed to the recently published Child and adolescent psychiatry: meeting future workforce needs discussion paper for further information about the gaps in child and adolescent psychiatry. [4] There is also a severe shortage of child and adolescent psychiatrist training positions. To become a psychiatrist, a trainee needs to complete a six-month placement in child and adolescent psychiatry. However, there aren’t enough child and adolescent psychiatry training places, creating a bottleneck of trainees and restricting the overall number of psychiatrists that are trained in Victoria.

Psychotherapy is an evidence-based first-line treatment which is effective for many mental health disorders, and which is currently seen as a luxury provided only for the private sector. There is a lack of availability, accessibility and integration of evidence-based psychotherapeutic or psychotherapy treatments within the Victorian public mental health system. Psychiatrists are leaving the public sector due to the lack of capacity to learn and practice psychotherapeutic skills. Psychiatrist psychotherapists are specifically skilled in understanding and managing complex presentations and can provide clinical, supervisory, teaching and management functions across a range of clinical and non-clinical settings. [5]

Response Required:

There is a need for a dedicated psychiatry workforce strategy to address current and future workforce shortages, as well as factors causing psychiatrists to exit the public sector. This strategy should include actions to make the public sector more attractive to psychiatrists. There is a need to attract psychiatrists
to the public sector, fund additional positions and improve the pipeline so that future demand for psychiatry services can be met. In order to do this, it is also necessary for psychiatrists to be included in conversations at high levels within mental health services to help determine how safe and high-quality services can be provided. Having medical leaders at a consumer, team, and organisational level is associated with better consumer outcomes, and psychiatrists are well-suited to undertake these roles. [6]

In addition, the first few years after achieving RANZCP Fellowship are a critical time for a psychiatrist's development, with new consultants expected to develop skills as a team manager, supervisor, and in quality improvement, as well as providing medical expertise as a clinician. The perceived lack of support from employers or opportunities for development in the public sector are affecting retention of new consultants. Any future workforce planning exercise should take into account the needs of early year psychiatrists.

There is also a need to attract more trainees into psychiatry, so that the future workforce is sustainable. In the interim, there is a desperate need for psychiatrists in particular specialty areas which are currently facing a crisis in resourcing.

A Broad-Based Training programme was launched in the UK in 2013 and allowed trainees to undertake six-month placements in core medical training, general practice, paediatrics and psychiatry, before deciding on which of the four specialties to enter for further training. A 2017 review of the Broad-Based Training programme by the Academy of Medical Royal Colleges in the United Kingdom found almost one in five trainees on the program exited into a Psychiatry specialty in 2014. [7] This suggests that exposure to psychiatry through a mandatory internship year results in an increase in the number of trainees choosing to specialise in psychiatry. There is also great value in having more doctors exposed to psychiatry as an intern, as they will develop greater skills in understanding and managing mental illness which they can deploy throughout their medical careers to the benefit of the community.

The Australian Medical Council is currently reviewing the National Framework for Medical Internship, including mandatory term requirements [8]. In this context, the Postgraduate Medical Council of Victoria should be approached regarding a psychiatry internship block, as they currently govern internships in Victoria. As not all health services in Victoria have services where a psychiatry internship block could be undertaken, we would suggest that at least 70 per cent of interns rotate through a 10-week psychiatry block.

Solution Needed:

I. The Victorian Government mandate at least 70 per cent of doctors complete a 10-week psychiatry internship block during Postgraduate Year One.

II. The Victorian Government commit to undertaking a mapping and gapping exercise to provide a clear picture of the numbers and types of staff needed, and where and when they are needed.

III. The Victorian Government commit to recurrently funding:

   a. 30 additional trainee psychiatry positions at a cost of approximately $6.12 million per year.

   b. One psychiatrist psychotherapist at each Approved Mental Health Service at a cost of $11.8 million per year.

   c. 29 addiction psychiatrists and 29 trainee addiction psychiatrists across Victoria at a cost of $17.7 million per year.

   d. 12 Child and Adolescent Psychiatry trainee positions at a cost of $2.4 million per year.
2. Inpatient Beds

Problem:

Acute admissions are essential for people with severe mental illness who present with complex needs. Whilst a great majority of individuals will not require inpatient admission, those who need it must be able to access it and be able to stay long enough for pharmacological and psychotherapeutic treatments to be effective.

A review commissioned by DHHS advised Victoria’s bed base needs to grow by 80 per cent over the next decade to reach levels of service provision of other Australian jurisdictions. [9] Victoria has one of the lowest bed bases nationally with only 22 public sector specialist mental health hospital beds per 100,000 population. The national total in Australia is 29.4 beds per 100,000. [10] The average for Organisation for Economic Development (OECD) countries is 50 beds per 100,000 [11] and the literature suggests that adverse effects worsen where bed bases fall below 50-60 beds per 100,000 population. [12]

RANZCP members have described inpatient units as unsafe and unwelcoming places for both consumers and those working within the system. Inpatient units should provide safe, welcoming environments to consumers. Most major acute psychiatric units in Victoria are continually operating well above the desirable rate of 80-85 per cent. [9] [13]. This is preventing psychiatrists from being able to flexibly respond to the needs of consumers, with different ages, genders and symptoms, currently being admitted together. This creates an unsafe environment for both consumers and staff, and an environment which is not conducive to recovery. Staff working on the psychiatric wards in Victoria’s underfunded health system are pressured to discharge patients early, creating a disrupted environment [14] and increasing proportions of involuntary patients and disrupted environments. At present, the average length of stay is only 9.2 days in a Victorian adult inpatient unit. [13]

Response Required:

In our submission to the Royal Commission into Victoria’s Mental Health System, we recommend the bed base be increased so there are 50 beds available per 100,000 population, with a mix and spectrum of beds available. Funds must also be allocated to ensure a sustainable approach to eliminating sexual safety breaches in acute inpatient units in light of the Mental Health Complaints Commissioner’s 2019 report.

While we await the outcomes from the Royal Commission, Victoria needs an injection of beds, with commensurate staffing to meet current demand. Furthermore, as reported in the VAGO report, and confirmed by RANZCP Victorian Branch members, bed day costs are higher than the price DHHS pays. DHHS meets only around 62% of full costs compared to 82% of the price paid for general acute hospital beds. [9] The price paid by DHHS should be 100 per cent of the actual cost of providing an inpatient mental health bed to show the same dedication to Victorians’ mental health as their physical health.

Solution Needed:

IV. DHHS mandate that capital and workforce infrastructure planning for hospital and community services consider and respond to the mental health needs of the catchment area, including sexual safety concerns.

V. DHHS increase funding allocation to meet 100 per cent of the actual cost of providing an inpatient mental health bed.
VI. Funding must be set aside of approximately $200 million to establish at least 100 beds across the State and more than $44.5 million in recurrent funding. It should be noted that funding in addition to this amount will be required to support these extra beds.

3. Outpatient Centres

**Problem:**

As identified in the RANZCP Victorian Branch’s Submission to the Royal Commission into Victoria’s Mental Health System, there is a need to re-establish outpatient clinics. In Victoria, the ‘missing middle’ who are not acutely unwell enough to be admitted to an inpatient unit are not receiving services. They are falling through the gaps, as they do not meet criteria for episodic or ongoing care through the Community Mental Health Centre Model. Unless consumers with moderate-severity illnesses have the means to access the private system, there is effectively no service available for them at present. Summative findings from a number of studies across Europe and the United States suggest lower suicide rates are associated with a number of factors, including the availability of outpatient mental health care and multifaceted community-based services [15, 16].

In the 2019-20 Federal Budget, the Commonwealth Government allocated $115M to trial eight adult mental health centres. There is support across the mental health sector in Victoria for some similar form of service which provides an additional level of intervention, and is integrated with acute and community services to provide continuous care [17-19]. Presently there is little available between acute and community services. Whilst recommendations from stakeholders within the sector may differ slightly, the goal of improved provision of care to the benefit of the community is the same. There is an agreed need for a model which can manage and support people in the community, as well as provide a much needed point of service within a stepped care model.

Outpatient centres would provide GPs, psychologists and other professionals the opportunity to refer consumers who do not meet the threshold for public mental health services. This is not a new model, and currently occurs in other medical specialties, such as public cardiology clinics. Ideally, these outpatient centres should be linked with researchers and academics to ensure cutting edge, evidence-based treatments are being delivered and to provide opportunities for ongoing research and quality improvement. If innovative models which access both state and federal funding are investigated these clinics could potentially allow for different modalities of psychotherapy to be delivered by psychiatrist psychotherapists and psychotherapeutically-trained members of the multidisciplinary team.

**Response Required:**

Investment is needed to establish infrastructure within existing hospital services or, where relevant, standalone outpatient centres, which are integrated with existing acute and community services. There would need to be at least one outpatient centre per Mental Health Service Area to facilitate a bridge between General Practice, Community, Subacute and Acute Inpatient Services, and Consultation-Liaison Psychiatry services of general hospitals. There is also a key role for Consultation-Liaison Psychiatrists in outpatient services, providing an essential role in integrating physical and mental health care between and within services, and providing ongoing care after hospital-based contact.

**Solution Needed:**

VII. The Victorian Government fund and re-establish one Outpatient Centre in each mental health service area to provide psychiatric treatment to the ‘missing middle.’

4. Services in the Community
If we had an adequate community system of skilled workforce, delivering interventions and not just assessing and monitoring risk, then that flows into what is going on in inpatient units" - psychiatrist

Problem:

There is a need to balance delivery of Community Mental Health Services (CMHS) and acute inpatient care, so that individuals across the spectrum of need can access appropriate, adequate care. Care in the community needs to be available across a range of settings, and at different degrees of intensity and assertiveness. CMHS’s should have the capacity to maintain long-term therapeutic relationships with consumers to maximise personal recovery and minimise the risk of suicide, homelessness, isolation, and repeated use of costly inpatient resources. Patients with acceptable risk, and who require intensive care, should be able to step down into an adequately resourced subacute service, such as a PARC, to receive treatment.

Response Required:

RANZCP members endorse the use of Prevention and Recovery Care (PARC) units which have been reported as having positive outcomes for consumers. The RANZCP Victorian Branch welcomes the 2019-20 State Budget announcement to provide further intensive services at three PARC facilities and would like to see this model expanded to allow for longer admissions.

Solution Needed:

VIII. The PARC model is expanded, and includes extended PARC units that allow longer rehabilitation/recovery oriented admissions.

5. Integration of AOD and Mental Health Services

Problem:

The 2007 National Survey of Mental Health and Wellbeing estimates high rates of comorbidity between substance use disorders and affective and anxiety disorders. One in five individuals with a substance abuse disorder also met a criteria for an affective disorder, with one in three meeting criteria for an anxiety disorder. [20] A lack of integration between alcohol and other drug (AOD) and mental health services in Victoria is leaving individuals to navigate the complex system themselves. [21, 22] This not only makes it difficult for clients to move between different providers and types of treatment, but makes it difficult for services to offer individualised treatment [21] and improve outcomes for people with mental illness and addiction.

The overall consensus of research evidence and clinical expertise is that psychiatric or addiction-focused treatments on their own are not sufficient to manage comorbid mental health and addiction [23]. The disconnect between addiction and mental health services is regularly identified as an impediment to effective referral and holistic treatment.

To further compound the issue, funding for AOD and mental health services in Victoria is separate and leads services to operate in parallel rather than as coordinated, connected systems. In terms of integration between AOD and mental health services in Victoria, there is a need for improved coordination between AOD and mental health services to ensure multiple needs are met between the systems, and patients experience greater continuity of care which facilitates recovery. [22] In addition, the current requirement for patients with a dual-diagnosis of comorbid mental health and substance misuse disorders to seek treatment from different services is creating a gap for individuals to fall through.

Response Required:
There is a need for improved opportunities to exchange client information, develop share treatment plans, as well as routine implementation of comorbidity screening and education regarding dual-diagnosis. [24] In their review of collaboration models, Lee at al (2012) highlight the need for government, organisational and clinical leadership to promote and reward collaboration and incentivise integrated care. [24]

If services compete for funding, they are less likely to collaborate than if they received block funding, and if they receive funding by discrete episodes of care there is less of an emphasis on complex needs. [22, 25] Different approaches to providing care, such as abstinence compared with harm-minimisation, to dual-diagnosis patients can also create a barrier to integrated care. [24] In order for AOD services to form a fundamental part of every mental health service, funding needs to be integrated.

**Solution Needed:**

IX. Funding for Alcohol and Other Drug Services and Mental Health Services should be integrated, so that AOD services form a fundamental part of every mental health service.

6. Increasing services to address demographic changes

**Problem:**

The number of Victorians aged 65 and over is set to treble by 2058. [26] The ageing population will result in increased demand for services for older people, as those with long-standing mental illness are joined by others with mental illness which develops for the first time later in life.

In addition to this, Victoria’s population is growing at pace, with an increase of 2.1% over the past year which equates to over 130,000 additional residents. [27] Out of all States and Territories, Victoria is projected to experience the largest and fastest increase in population, increasing by between 60 to 130 per cent by 2027. [28] According to the latest figures, Victoria also recorded the largest increase in migrant arrivals [29], with over 3500 of these being individuals on special eligibility and humanitarian visas. [30] Of all migrant groups, asylum seekers and refugees are the most vulnerable to mental and physical ill health, with common mental health disorders twice as high in refugee populations in comparison with economic migrants. [31, 32] In addition, the majority of migrants to Australia speak a language other than English, with a significant proportion reporting they speak English not well or not at all. [33] International students, older people who are first generation migrants and women who, due to language or cultural barriers, may be dependent on others to access services, have been highlighted by members of the Victorian Branch as particularly vulnerable groups in Victoria.

The mental health system must be able to respond sensitively to histories of trauma and cultural and linguistic diversity, to ensure migrants to Australia are not being systematically disadvantaged. Culturally appropriate treatment and care must be made available to Victoria’s migrant community, especially as it is projected to grow into the future. [34]

**Response Required:**

We need adequate workforce to address the increase in demand. There needs to be an increase in age-appropriate services with the capacity to manage both the physical and mental health needs of older people, including acute beds for those who need it. This will require an increase in funding to ensure adequate resources are delivered to Victoria’s mental health services into the future.

As stated in Victoria’s 10-year Mental Health Plan, services must address language and cultural barriers, as these can hinder effective treatment and support. Migrants of all status, as well as those from culturally and linguistically diverse backgrounds who are already settled in Australia, should be able to access culturally appropriate services in a language they can understand. Those working in public
mental health services must be able to access ancillary services to enhance their interactions with culturally and linguistically diverse consumers. There should be increased coordination between services in order to respond to culturally and linguistically diverse consumers accessing Victoria's public mental health system. [35]

It is recognised the Victorian Government has taken steps to provide more support to the mental health of culturally and linguistically diverse communities by funding a grants program which is coordinated by Tandem and the Victorian Mental Illness Awareness Council.[36]

**Solution Needed:**

X. The Victorian Government should develop mental health plans for older people, which take into account future demand and resources necessary to address this, as well as identify service delivery priorities.

XI. The needs of Culturally and Linguistically Diverse communities should be taken into account when services are established, and areas of additional need should receive a commensurate increase in funding.
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