



The Royal
Australian &
New Zealand
College of
Psychiatrists



Victorian Branch

Formal submission

Royal Commission into Victoria's Mental Health System

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Executive summary

The Victorian Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP Victorian Branch) appreciates the opportunity to provide a formal submission to the Royal Commission into Victoria's Mental Health System (Royal Commission).

The RANZCP Victorian Branch believes that Victoria's public mental health system requires a clear vision statement which describes what will be delivered, how it will be delivered and who is responsible for delivery. Funding needs to be appropriate to the defined roles and responsibilities, and the public needs to be given a clear understanding on what mental health care is available and how to access it.

In forming this vision, the following principles of effective and appropriate mental health care should be adhered to:

- I. Funding is commensurate to the level of activity required to fulfil the obligations and vision of the mental health system.
- II. Funding is appropriate to deliver the services required to meet demand.
- III. Effective accountability and commissioning structures are in place to ensure that the mental health system delivers on its vision.
- IV. Equitable access to services, including specialist services where necessary, are available.
- V. Consumers and carers are able to access quality mental health care, regardless of their location or circumstances.
- VI. Services are designed and delivered with trauma-informed care and supported decision-making at the heart of the system.
- VII. Services are co-produced and governed by experts in mental health – consumers, carers and clinicians working in equal partnership.
- VIII. Effective evidence-based treatments are provided at every service.
- IX. Psycho-therapeutic understandings of mental health are embedded in service delivery.
- X. Recovery-oriented practice is embedded in service delivery.
- XI. There is genuine continuity of care between different aspects of the mental health service and other service providers.
- XII. A stepped-care model, with clear treatment pathways, is available where a person presenting to a mental health service is matched to the intervention level which suits their needs.
- XIII. The mental health workforce has the right capacity and skills.

Recommendations:

The following recommendations are proposed to enact and embed these principles in Victoria's public mental health system:

Governance, accountability and funding: building a sustainable system

1. Funding mechanisms are put in place to ensure:
 - Funding allocated to mental health is spent on mental health
 - Mental health receives parity of funding with physical health
 - Funding is commensurate with current need and reactive to increased needs
 - Increased funding equates to improved consumer outcomes
 - Funding is linked to workforce strategies.
2. Psychiatrists and people with lived experience are embedded as leaders throughout mental health services to ensure structures and systems create safe, high-quality care for consumers and continuous improvement activities are undertaken.
3. Appropriate training opportunities are available to psychiatrists to increase their leadership skills.
4. A body – either within DHHS or as a stand-alone organisation – is tasked with governing the mental health system. It should have responsibility for:
 - Setting targets and indicators which are therapeutic and outcomes focussed
 - Monitoring mental health services against these targets and indicators
 - Ensuring services are held to account by defunding and decommissioning services which are not meeting requirements.
5. All evaluation and planning reports that are conducted on the mental health system are released.
6. Data is gathered regularly to determine mental illness prevalence rates.

Psychotherapeutic approaches, trauma-informed care and supported decision-making

7. Trauma-informed care and the principles of supported decision-making are at the heart of the structure of service delivery.
8. Minimum service delivery periods for psychotherapy are prescribed in Area Mental Health Services.

Mental health care in the Emergency Department

9. A maximum 12 hour length of stay in the ED for consumers presenting with mental illness, with mandatory notification and review of all cases embedded in the key performance indicators of public hospitals and CEOs.
10. Hospitals are made accountable to ensure they implement the principles of care for people with a mental illness in the ED.

Services in the community

11. The PARC model is expanded, and includes extended PARC units that allow longer rehabilitation/recovery oriented admissions.
12. Community mental health services have defined treatment pathways to increase consistency and accountability among services.
13. Treatment pathways with community mental health services include systematic delivery of evidence-based care, psychoeducation on medication adherence and self-management, carer support, physical health strategies, and coping strategies.

14. There are clear pathways between primary and secondary services to Area Mental Health Services and linkages with community mental health care providers.

Inpatient units

15. Increase the bed base, so there are 50 beds available per 100,000 population. There should be a range of beds available, including acute beds, intensive care beds and beds in secure extended care units.
16. Gender specific wards are available at every inpatient unit to ensure people are provided a choice upon admission.

Integrated addiction and mental health services

17. Mental health services have enhanced capability to provide treatment for people with comorbid addiction and mental illness.

Outpatient clinics

18. Outpatient clinics are re-established in Victoria to provide psychiatric treatment to the 'missing middle'.

Specialist services

19. Specialist services with treatment capabilities (including inpatient management) are established, or further extended where they currently exist, for people with presentations including neuropsychiatric disorders, comorbid neurodevelopmental disorders (including intellectual disability and Autism Spectrum Disorders), and comorbid alcohol and drug dependence disorders.
20. Increase the state-wide secure inpatient bed base, including using a regionalised approach and according to a 'stepped' model across a spectrum of security levels (low, medium and high secure). The principle of access based on risk and need, rather than simply legal status, should underpin any service model restructure.
21. Strengthen community mental health capacity by establishing local forensic specialist treatment teams that are integrated with community mental health teams.

Long-term rehabilitation and housing options

22. A dedicated mental health, housing and homelessness strategy is developed and implemented.
23. Investigate options and fund long-term and medium-term residential rehabilitative options for people with mental illness who require a supported living environment.

Integration of private and public mental health

24. Link PHNs and AMHSs to ensure shared care between GPs and mental health practitioners. Shared care arrangements should focus on clear, open and transparent communication between providers.

A skilled workforce with capacity

25. As a short term measure, undertake a gap analysis to provide a clear picture of the numbers and types of staff needed, and where and when they are needed.
26. To meet future needs, a dedicated psychiatry workforce strategy should be developed to address current and future psychiatry workforce shortages.

- 27.** In the long-term, scope and determine appropriate workforce benchmarking to fill future gaps.

Prevention and early intervention

- 28.** Improved screening for at-risk groups, including women and children and enhanced services for these groups.

Services for particular population groups

- 29.** The Uluru Statement from the Heart recommendations are enacted.
- 30.** Aboriginal and Torres Strait Islander mental health workers are employed as part of any multidisciplinary team caring for Aboriginal and Torres Strait Islander consumers and communities.
- 31.** All mental health providers are required to provide safe services for LGBTQI+ people through an accreditation program.
- 32.** Screening and lifestyle interventions, based on the best available evidence, must be routinely offered to both people newly diagnosed with a serious mental illness and those with more long-standing illnesses in order to minimise the development of chronic physical health conditions, such as metabolic syndromes, that are currently more prevalent in those with mental illness, and add to the burden of disease and earlier death.
- 33.** Health promotion mechanisms (for example to quit smoking, undertake exercise, or mitigate alcohol abuse) should be adapted for delivery in all specialist mental health settings and become core elements in the service 'offer' in both inpatient and community settings.
- 34.** Consider bolstering the Individual Placement Support program by expanding it to adults.

Suicide prevention

- 35.** The HOPE trials are evaluated as a matter of priority and outcomes from the evaluation are used as evidence to continue funding post-discharge follow-up initiatives.

Families and carers

- 36.** Mandating protected time for clinicians to work with families and carers to provide psychoeducation which enables families and carers to support their loved one.

Access and navigation

- 37.** Easy-to-understand guides and services maps are developed in the short-term which outline what a consumer, carer and family member can expect from mental health services. These should be made available online and in mental health services.
- 38.** A concierge service is available within each AMHS to assist people to navigate the system and provide a central point of contact to ensure their needs are being met.

Message from the Chair

The Royal Commission is seen by our members as a once-in-a-generation opportunity to design a mental health system which meets the needs of people with mental illness, their carers and family members and the workforce which supports them.

The intensity of feedback and interest from our members has been overwhelming, with many telling us that this is their last hope that something will change for the better. That mental health will finally receive the attention and political will necessary to deliver positive outcomes.

While there are positive parts of the current system, the sector has been marred by a lack of funding, planning, accountability and transparency. It could be said that the current system parallels the stigma which exists in the community in regard to mental health.

Consumers, families, carers and mental health workers have been failed by a system which is unable to deliver meaningful outcomes – where admissions are made on the basis of risk, rather than by need. Where consumers are discharged from hospital – sometimes into homelessness – when they are still unwell to make way for more unwell people. Where the treatment available to consumers depends on the location in which they live, or whether they can afford private health insurance. Where consumer and staff safety is being put at risk and people are being further traumatised.

We have also seen that psychiatrists are leaving the public mental health system because they simply can't get up and face another day of providing insufficient care to some of the State's most vulnerable people. The desperation felt by psychiatrists and trainees is becoming uncontainable.

This Royal Commission provides the opportunity to change this, for both now and the future. Strong, purposive recommendations are expected to be provided by the Royal Commission. To live up to these expectations, radical reform is necessary.

In consultation with our members, both Fellow Psychiatrists and psychiatrists-in-training, and consumers and carers who are a part of the RANZCP, we have proposed a number of recommendations to address these challenges. While they are not exhaustive, we believe that this provides the starting point of where we believe the Commissioners should direct their attention.

We would welcome the opportunity to speak to Commissioners further about this submission.

Professor Richard Newton, RANZCP Victorian Branch Chair

About the 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 healthcare. 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 has approximately 6600 members bi-nationally including more than 4700 qualified psychiatrists and over 1600 members who are training to qualify as psychiatrists. The RANZCP Victorian Branch represents over 1500 members including over 1100 qualified psychiatrists and approximately 400 members who are training to qualify as psychiatrists.

RANZCP Fellows can choose to be a member of a Faculty or Section, which are governed by Bi-national Committees and Victorian sub-committees in some instances. They represent subspecialties and interest areas of psychiatric practice.

Faculties are internationally recognised specialties of psychiatry with College accredited training. Accredited membership is available for members of the College who have completed the relevant Certificate of Advanced Training, or have equivalent experience in the field. Sections are internationally recognised academic or clinical interest areas of psychiatry.

The RANZCP partners with people with lived experience, through the Community Collaboration Committee and our community member on the RANZCP Victorian Branch Committee. Carer and consumer representation is woven into the fabric of the RANZCP and helps to ensure the RANZCP considers the needs, values and views of the community throughout its work.

How this submission was developed

The RANZCP Victorian Branch has undertaken a comprehensive consultation process to provide the recommendations contained in this submission.

RANZCP Faculty and Sections have had opportunity to contribute, and the Victorian Branch surveyed all Victorian Branch members via an online questionnaire, as well as inviting feedback through the monthly Victorian Branch newsletter. A member forum was also held in May, where RANZCP Victorian Branch members were provided the opportunity to have input into this submission.

In addition to these consultations, the RANZCP Victorian Branch has also sought input from consumers and carers on the RANZCP Community Collaboration Committee, our community representative on the Victorian Branch Committee, members of the RANZCP Aboriginal and Torres Strait Islander Committee and members from other States and Territories.

Further perspectives

Please note the RANZCP Victorian Faculty of Psychotherapy Subcommittee, the RANZCP Victorian Faculty of Forensic Psychotherapy Subcommittee, and the RANZCP Victorian Faculty of Child and Adolescent Psychiatry Subcommittee have provided further detail on their subspecialties attached in Appendix 1, 2 and 3 respectively.

Notes about this submission

1. Throughout the submission, reference has been made to 'Victoria's Mental Health System' for consistency and alignment with the Royal Commission. However, the RANZCP Victorian Branch wishes to emphasise that the most significant problem with the provision of mental health services in Victoria is that there is no 'system' – instead there are fragmented, segregated services providing care and treatment to segments of society.
2. The submission particularly focuses on the public mental health system whilst also identifying the importance of the private system and the need for a more structured and comprehensive approach to an effective interface between the two.
3. In providing this submission, the RANZCP Victorian Branch wishes to reinforce the recommendations of the Victorian Auditor General's Office reports released this year; Access to Mental Health Services and Child and Youth Mental Health Services. These reports show that consumers, carers, families and the mental health workforce have been let down by a lack of system-level planning, strategic direction, investment and monitoring over many years. The Royal Commission has the opportunity to change this.
4. The State Government is commended for agreeing to accept all recommendations from the Royal Commission. Psychiatrists provide care to people with severe and complex mental illness. As such, recommendations in this submission are largely focussed on improving outcomes for this population group.
5. The RANZCP Victorian Branch acknowledges that language, and the way we use it, can affect how people think about different issues. We acknowledge the need to give due consideration to the words we choose when communication with and about people with a lived experience of mental illness. We recognise there are a variety of terms people prefer to use, such as "client", "consumer", "patient", "peer", and "expert by experience."

Throughout this document we have used the term consumer to mean a person who has lived experience, whether or current or past, of mental illness irrespective of whether they have received treatment within the mental health system.

The term carer has been used throughout this document to refer to a family member, friend or another person, who is or has played an active caring and supporting role to an individual who has or has had experience of mental illness.

Glossary

AMHS	Area Mental Health Service
AOD	Alcohol and Other Drugs
CAMHS	Child and Adolescent Mental Health
CBT	Cognitive Behavioural Therapy
CMHS	Community Mental Health Service
DHHS	Department of Health and Human Services Victoria
ED	Emergency Department
FTE	Full-time Equivalent
GP	General Practitioner
HOPE	Hospital Outreach Post-suicidal Engagement program
LGBTIQ+	Lesbian, gay, bisexual, transgender/gender diverse, intersex and queer
NDIS	National Disability Insurance Scheme
OECD	Organisation for Economic Cooperation and Development
NMHC	National Mental Health Commission
PARC	Prevention and Recovery Centre
PHNs	Primary Health Networks
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SDM	Supported Decision-Making
SECU	Secure Extended Care Unit
TIC	Trauma-informed care
VAGO	Victorian Auditor-General's Office

Introduction

The Royal Commission into Victoria's Mental Health System represents an unprecedented opportunity to investigate and redesign Victoria's mental health system and move towards a model of care and an integrated system which meets the needs of Victorians. We hope Commissioner's will recognise the voice of Victoria's psychiatrists, as represented in this submission, when putting forward recommendations to Government.

The reasons underlying the need for a Royal Commission into mental health are well-known: a chronically underfunded, fragmented system which is not servicing the needs of Victorians. We know almost half of all Victorians (45%) will experience a mental illness in their lifetime, and 3% have a severe and complex mental illness.¹ Yet in 2016-17, the proportion of the population in Victoria receiving clinical mental health care was 1.1%.²

Psychiatrists have often reported that these funding deficits are having an effect on the care they are able to deliver. As one member concluded at the RANZCP Victorian Branch Royal Commission member forum:

There is a limit to human cognition and sometimes psychiatrists have no time to actually think. That slow, deeper thought and reflection to work out complex patients, there isn't time or headspace to do it.

The RANZCP Victorian Branch urges the Commission to focus the conduct of its inquiry on redesigning the architecture of the mental health system, including its governance, infrastructure and models of care, so that it can provide mental health care to people of all ages and stages of mental illness which improves outcomes for those who use it. There is also a need for funding commensurate to the level of current and predicted demand. To do all of this, an appropriately skilled workforce with capacity to do their job is essential.

The RANZCP Victorian Branch envisions a system which is integrated with other services, provides step-up and step-down care, and is safe and therapeutic for all – consumers, carers, families and the people who work in the system.

Overall, the system needs to focus on providing good outcomes for people with mental illness.

¹ Victorian Government (2015) *Victoria's 10-year mental health plan*. Available at: <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorias-10-year-mental-health-plan> (accessed 25 June 2019)

² Australian Institute of Health and Welfare (2019) Table KPI 8.1: Proportion of population receiving clinical mental health care in 2016-17. Available at: <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia> (accessed 25 June 2019)

Redesigning our mental health system

To meet the current and future needs of people with mental illness, a radical shift in priority and political will must be attained.

The RANZCP Victorian Branch sees that there are fundamentals which will make this a reality:

- Mental health has a seat at the table of the Premier's Cabinet;
- Mental health is a priority of Treasury; and
- Health Service Boards have mental health skills.

It is only then that mental health will no longer be seen as the poor cousin of physical health.

In addition and to ensure changes are sustainable in the long-term, exceptional leadership, robust governance, and adequate funding are required across the system.

Governance, accountability and funding: building a sustainable system

“Radical change in the governance of mental health is needed in order for changes to be sustainable in the long term”

Strong leadership on behalf of the mental health sector is needed to ensure funding is commensurate with need and governance arrangements hold services to account to ensure good quality mental health care is delivered.

To achieve this, governance structures need to be implemented that hold services accountable and have the power to defund services that are not achieving good consumer outcomes.

Funding for mental health services comes from diverse sources, including Commonwealth and State Governments, which contributes to the fragmentation of care provided as consumers navigate the system.

Consumers, carers, families and those who work in the mental health system have been failed by successive governments' inaction to fund the sector sufficiently. Victoria's per capita recurrent expenditure is the lowest in the country and has lagged behind the national average for the past 10 years.³ While the State Government has recently recognised this by making significant funding announcements in the past two budgets, this will merely go some way to propping up existing gaps, and is unlikely to increase services to meet demand.

The DHHS funds Area Mental Health Service's on an input or block funding model which is not sensitive to unmet demand, the needs and complexity of the local client cohort.⁴ The quantum of funding has not kept pace with population data or demographic data. This funding is indexed at a lower rate than actual CPI (for example 1.6% per annum, when it is

³ Australian Institute of Health and Welfare (2018) *Table EXP.4: Recurrent expenditure per capita (\$) on state and territory specialised mental health services, constant prices, states and territories, 1992–93 to 2016–17*. Available at: <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services> (accessed 31 May 2019).

⁴ Victorian Auditor General's Office (2019) *Access to Mental Health Services*. Melbourne, Australia: Victorian Auditor General's Office.

estimated that costs actually increase by about 3% in real terms) to encourage ‘productivity efficiencies’. As AMHSs have no ability to increase funding through increased activity and many of the costs are fixed through industrial agreements, this forces AMHSs to find extra savings by cutting back on staffing, reducing amenity such as vehicle availability or delaying the implementation of growth and new initiatives.

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. The price should be about 80 to 85% of the full cost.⁵ This is just one example of the system-level stigma which mirrors the stigma in the community.

The RANZCP Victorian Branch supports a combination of block and outcome or activity funding. Funding paid to AMHSs should also recognise the costs of compliance, as well as the direct clinical cost and non-direct costs of providing a service. It should also be commensurate with current and future needs. For example, Victoria’s population has aged over recent years, and is not likely to change in the coming years. The number of Victorians aged 65 and above is set to treble by 2058.⁶ The ageing population will result in increased demand for mental health services for older people, as those with long standing mental illness are joined by others with mental illness that develops for the first time in later life.

Consultation Liaison Psychiatry (CLP) funding through the Victorian Department of Health and Human Services’ mental health branch has remained stagnant over the past 20 years despite major growth in acute health services. In July 2016, the RANZCP Victorian Branch published a report; [Service Model for Consultation-Liaison Psychiatry in Victoria](#) which contained specific recommendations to address these funding issues. Since this time, only a small increase in funding has been allocated to consultation-liaison psychiatry.

The RANZCP Victorian Branch recommends:

1. Funding mechanisms are put in place to ensure:
 - Funding allocated to mental health is spent on mental health
 - Mental health receives parity of funding with physical health
 - Funding is commensurate with current need and reactive to increased needs
 - Increased funding equates to improved consumer outcomes
 - Funding is linked to workforce strategies

Exceptional leadership

“You can’t operate a safe, therapeutic environment without the right level of expertise” - psychiatrist

Subject matter experts need to be embedded within the highest levels of governance structures (at both a governmental and local level).

Experts should be either clinical leaders and/or those with lived experience leadership expertise. This means psychiatrists, as often the most senior clinician, must be included in conversations at high levels within mental health services to help determine how safe and high-quality services can be provided. Decisions about resourcing shouldn’t be made in the

⁵ Victorian Auditor General’s Office (2019) *Access to Mental Health Services*. Melbourne, Australia: Victorian Auditor General’s Office.

⁶ Victorian Government (2019) Ageing. Available at: <https://dhhs.vic.gov.au/ageing> (accessed 31 May 2019)

vacuum of a boardroom and conversely clinical decisions should not be made without consideration of resourcing.

Exceptional medical leadership is required most when resources are limited. 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.⁷ Psychiatrists have a breadth of psychiatric training (at least 11 years of training), a deep learnt understanding and appreciation of risk in complex clinical scenarios, as well as an ethical framework as a foundation to evaluate the best decision when competing demands are present.

Psychiatrists are often the senior clinician and have the greatest opportunity as leaders to set the clinical agenda and influence the culture of teams within which they work.⁸

Furthermore, psychiatrists' reflective skills allow them to understand and analyse complex interacting systems. This helps consumers, their support networks and the mental health multi-disciplinary team become better integrated, leading to improved consumer outcomes and increased workforce satisfaction.

In the spirit of co-production, which the RANZCP Victorian Branch strongly supports, it is also essential that consumers and carers are included in the process of determining the structures and systems which will be used to assure safety and quality within mental health services.

The RANZCP Victorian Branch recommends:

2. Psychiatrists and people with lived experience are embedded as leaders throughout mental health services to ensure structures and systems create safe, high-quality care for consumers and continuous improvement activities are undertaken.
3. Appropriate training opportunities are available to psychiatrists to increase their leadership skills.

Robust governance

The RANZCP Victorian Branch believes that the structure of mental health services need to be redesigned so changes are sustainable in the long-term.

The mental health system needs strong governance to produce structures and systems which assure the safety and quality of mental health services and focus on continual improvement.⁹ For quality improvement to occur, outcomes against governance structures and systems must also be monitored at both the health service level and higher up in the mental health system within the Department of Health and Human Services (DHHS).

The mental health system in Victoria lacks specific targets and outcomes, therefore making it impossible for Government and health services themselves to be held accountable. The VAGO report has already recommended DHHS re-establish routine internal governance and reporting against mental health system priorities, activities and performance that ensures

⁷ Perry J, Mason FL (2016) The value of psychiatrists in leadership and management. *BJPsych Advances* 22: 263–268.

⁸ O'Connor N, Paton M (2008) 'Governance of' and 'Governance by': implementing a clinical governance framework in an area mental health service. *Australasian Psychiatry* 16(2).

⁹ Callaly T, Arya D, Minas H (2005) Quality, risk management and governance in mental health: an overview. *Australasian Psychiatry* 13(1).

senior executive level oversight and accountability.¹⁰ Auditing is an essential tool for quality improvement. Auditing should be conducted regularly at the system level and at a clinical level to monitor outcomes and make improvements where necessary. This means adequate data collection must take place and this data must contribute to decisions on how to improve services.

Psychiatrists also report that the key performance indicators they are working toward in the mental health sector are non-therapeutic and feature layers of compliance, with little regard to outcomes for the consumer. The current system for recording contact with consumers perverts the therapeutic alliance between consumer and practitioner and creates tension between management and clinicians, particularly where group sessions only record one contact, despite a multidisciplinary team being present. Unregistered contacts do not get recorded, which are the main contacts for consultation-liaison psychiatrists.

To ensure funding is adequate to meet both current and future service needs and there is system-level accountability, the governance structures of the mental health system need to be redesigned.

There are a number of ways this can be achieved, including establishing a Mental Health Commission with 'teeth' or restructuring the DHHS to ensure it is adequately equipped to set targets and outcome measures and hold services to account to meet those. Any organisation established would need to have power to deliver sanctions, including defunding services which are not producing positive consumer outcomes.

Furthermore, in the interests of transparency and accountability, the RANZCP Victorian Branch recommends that the Royal Commission directs the DHHS to publically release all evaluation reports, which have been undertaken in the past five years. Reports such as the Reform of Victoria's specialist clinical mental health services: Advice to the Secretary, Department of Health and Human Services and the final report of the Design, Service and Infrastructure Plan for Victoria's Clinical Mental Health System.

The RANZCP Victorian Branch also believes that having a clearer picture of prevalence estimates for mental disorders would be of benefit to the Victorian Government for future planning purposes. The last National Health and Wellbeing Survey was completed in 2007, meaning that we are still working from old data. The Victorian Government should lobby the Federal Government to have this survey distributed again within the next year.

The RANZCP Victorian Branch recommends:

4. A body – either within DHHS or as a stand-alone organisation – is tasked with governing the mental health system. It should have responsibility for:
 - Setting targets and indicators which are therapeutic and outcomes focussed
 - Monitoring mental health services against these targets and indicators
 - Ensuring services are held to account by defunding and decommissioning services which are not meeting requirements
5. All evaluation and planning reports that are conducted on the mental health system are released
6. Data is gathered regularly to determine prevalence rates

¹⁰ Victorian Auditor-General's Office (2019) *Access to Mental Health Services*. Available at: <https://www.audit.vic.gov.au/sites/default/files/2019-03/20190321-Mental-Health-Access.pdf> (accessed 7 June 2019).

The infrastructure of a redesigned system

“The current system looks to apply too much uniformity instead of allowing degree of variability...We want some differences, flexibility and choice for patients and families to help the system evolve” - psychiatrist

A continuum of care must be a reality – with services being offered in the community as a priority, with options for acute and specialist care when required, long-term rehabilitation options and step-down services available upon discharge.

The RANZCP Victorian Branch recommends improvements to the current public mental health system, to expand services that are working well, as well as substantial structural changes to address significant gaps.

To enable a continuum of care, there needs to be:

- Well-resourced emergency departments free from harm
- Community services which deliver consistent evidence-based care
- Inpatient units that are safe and therapeutic
- Integration of addiction and mental health services
- Outpatient clinics that provide services to the missing middle
- Specialist services for people with complex mental illness and comorbidity

When enacting these changes, there are three overarching considerations which need to be addressed at every stage of mental health services delivery; trauma-informed care, supported decision-making and psychotherapy being a key component of every psychiatric treatment.

Psychotherapeutic approaches, trauma-informed care and supported decision-making

Both trauma-informed care (TIC) and the principles of supported decision-making (SDM) should be at the heart of the structure of service delivery. It is clear that there is a need for a more attuned focus on consumer needs and multidisciplinary teams working together through assessments and collaboration with the consumer on treatment decisions.

Consumers accessing mental health services have higher rates of experiencing trauma in life and it is especially pronounced in the year prior to their contact with services.¹¹ Particular population groups are more likely to have experienced trauma, such as Aboriginal people, LGBTIQ+ and women with mental illness and intellectual disability.¹²

¹¹ Kesler R, McLaughlin K, Green J et al (2010) Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *British Journal of Psychiatry* 197: 378-85 and Mauritz M, Goossens P, Draijer N et al (2013) Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology* 4

¹² Mental Health Complaints Commissioner (2018) *The right to be safe. Ensuring sexual safety in acute mental health inpatient units*. Melbourne Victoria: Victorian Government.

Their experiences shape their responses to service providers, and can influence the response of providers to the person. Integration of TIC principles into mental health services is therefore essential as the failure to provide TIC is likely to exacerbate mental and physical health issues for consumers and mental health providers. Staff must be trained and enabled to provide TIC.

TIC also encompasses consideration of health service infrastructure, including the formality, layout and approachability of buildings and settings where healthcare is provided. It is important that buildings are made culturally safe and approachable, to ensure people are empowered to seek help wherever possible.

SDM acknowledges that every person has the right and capacity to make informed choices and autonomous decisions.¹³ Supported decision-making is a means of enabling consumers to understand their choices in relation to their treatment and is different from shared decision-making in that it is a collaborative approach to support an individual in their decision-making. The RANZCP Victorian Branch has produced a position paper to educate and inform its members, consumers and their families, and other clinicians about the principles of SDM.¹⁴ The RANZCP Victorian Branch encourages the consistent application of these principles as part of routine clinical practice by all mental health clinicians in the hope this will lead to less coercive practice and involuntary treatment.

To ensure equity and quality of care, clinicians must have the capacity to deliver evidence-based treatments as part of routine clinical practice. Due to system constraints, there is currently limited access to psychotherapy within the public mental health system. It should be a key component of every psychiatric treatment as it is the first-line evidence-based treatment for many psychiatric presentations, especially trauma-related symptoms and personality disorders.

Psychotherapy is the healing of a consumer by establishing a therapeutic relationship with a clinician who can guide them through understanding patterns of behaviour in their lives leading to helpful changes in thoughts, feelings attitudes, behaviours, and relationships of personality.¹⁵

Inadequate mental health sector funding has created a situation where prioritisation is given to containment of risk and acute stabilisation; leaving little time or resources for psychotherapy. Where psychotherapy is available in the public system, it is often patchy in terms of its availability and essentially only various forms of brief therapies. While these are effective treatments, a wide range of different therapies are required, to meet different consumer needs, and there are some presentations for which long term psychotherapy is the most effective treatment (and generally not available).

Psychiatrists who have specialised in psychotherapeutic practice bring together their expertise as medical doctors, psychiatrists and specialised psychotherapists, enabling psychotherapeutic treatments to be provided to consumers who typically have complex symptoms. Psychotherapists also have a key role in providing supervision and training to other psychiatrists and non-medically trained therapists in working psychotherapeutically

¹³ Royal Australian and New Zealand College of Psychiatrists (2018) *Enabling Supported Decision-Making*. Melbourne: Australia: Royal Australian and New Zealand College of Psychiatrists. Available at: <https://www.ranzcp.org/files/branches/victoria/enabling-supported-decision-making-vic-branch-posi.aspx> (Accessed 19 June 2019).

¹⁴ Ibid

¹⁵ Harari E (2014) Ghost Busting: re-introducing psychotherapy for the psychiatrist. *Australasian Psychiatry* 22:433-436.

with people with complex presentations. There is good evidence that appropriately targeted psychotherapy can lead to both personal recovery, and decreased use of costly inpatient admissions.

Ideally, a cost effective and evidenced based approach to psychotherapy provides a range of stepped options, starting with brief and evidenced based treatments, which are both cost effective and efficacious. Where these treatments are either ineffective or not appropriate for particular conditions, a stepped availability of more intensive treatments should be available, including time limited long term therapy.

While these therapies can be delivered by various disciplines, there is a key role for psychiatrist psychotherapists in the assessment of people, decisions around modes of treatment, review of poor progress and reformulation, and ultimately in the delivery of psychotherapy treatments. Psychiatrists psychotherapists also play a role in supervising psychiatry trainees delivering these treatments, so that they are suitably qualified in psychological treatments at the end of their training.

To ensure access to appropriate psychotherapy in public services, and to teach trainees both psychotherapeutically-informed skills, such as reflective process and understanding of psychodynamics, as well as skills in assessment for and provision of psychotherapy treatments, services must set aside guaranteed minimum service delivery periods across the psychiatry system and fund them appropriately to do so. Please refer to APPENDIX 1 for more information.

The Victorian Branch recommends:

7. Trauma-informed care and the principles of supported decision-making are at the heart of the structure of service delivery
8. Minimum service period delivery for psychotherapy is prescribed in Area Mental Health Services

Mental health care in the Emergency Department

There are a number of points a person with mental illness may enter the mental health system, whether it is through a referral from a GP or another primary care provider. But for many individuals, the Emergency Department (ED) is the access point to specialist services. This is especially true after-hours, where the availability of GPs and general mental health services is limited. Of concern, the number of children and young people presenting to emergency departments in Victoria for mental health problems, including self-harm, depression and behavioural disorders has increased by 6.5% between 2008-09 and 2014-15.¹⁶ The poorly integrated and chronically underfunded mental health system is seeing more and more people turn to the ED for care.¹⁷ For many people experiencing a mental health crisis, the ED as a noisy, chaotic environment which is not helpful for recovery and

¹⁶ Hiscock H, Neely R J, Lei S, Freed, G (2018) Paediatric mental and physical health presentations to emergency departments, Victoria 2008-15. *The Medical Journal of Australia* 208(8): 343–348.

¹⁷ [Signed by RANZCP] Australasian College for Emergency Medicine (2019) *Mental Health in the Emergency Department: Consensus Statement*. Available at: <https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Mental-Health-in-the-Emergency-Department/Mental-Health-in-the-Emergency-Department-Consensus> (Accessed 5 June 2019)

can even be harmful. People experiencing a mental health crisis should not have to wait for hours in the ED or face being secluded, sedated or restrained due to a lack of available care.

The ED should be a safe and supportive environment for all distressed and traumatised people and care should be available in a timely and streamlined manner.¹⁸ It is clear that there are strong principles to which ED's are supposed to adhere,¹⁹ but it is not happening in practice. Again, governance and accountability is letting down people with mental illness.

The RANZCP Victorian Branch supports the recommendations contained in the *Mental Health in the Emergency Department* consensus statement signed by RANZCP and the Australasian College for Emergency Medicine recommendations. In particular, we recommend that there should be a maximum 12 hour length of stay in the ED for consumers presenting with mental illness, with mandatory notification and review of all cases embedded in the key performance indicators of public hospitals and CEOs.

The Victorian Government's 2018 commitment to roll-out emergency department crisis hubs for people needing urgent mental health treatment has merit.²⁰ We understand these hubs are to be staffed by a multidisciplinary team, including psychiatrists and psychiatric trainees and are supportive of them in-principle. We look forward to seeing their progress and subsequent evaluation. However, the establishment of these hubs does not negate the need for appropriate development of a full range of community mental health services. Whilst we support access to appropriate mental healthcare within the emergency department, unless robust services are available within the community, more and more people will attend acute crisis services as a default.

The Victorian Branch recommends:

9. A maximum 12 hour length of stay in the ED for consumers presenting with mental illness, with mandatory notification and review of all cases embedded in the key performance indicators of public hospitals and CEOs.
10. Hospitals are made accountable to ensure they implement the principles of care for people with a mental illness in the ED.

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

Community mental health services (CMHS) should provide stepped, evidence based care based on both needs and outcomes. For many people care may be episodic, but for a proportion of people with severe mental illness, chronic symptoms and repeated episodes of relapse, ongoing care and a long-term therapeutic relationship may be essential to maximise

¹⁸ [Signed by RANZCP] Australasian College for Emergency Medicine (2019) *Mental Health in the Emergency Department: Consensus Statement*. Available at: <https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Mental-Health-in-the-Emergency-Department/Mental-Health-in-the-Emergency-Department-Consensus> (Accessed 5 June 2019)

¹⁹ Victorian Government (2018) Emergency departments and mental health care. Available at: <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/service-quality/emergency-departments-and-mental-health-care> (accessed 26 June 2019)

²⁰ Victorian Government (2018) New Mental Health Hubs to Treat More Victorians Sooner. Available at: <https://www.premier.vic.gov.au/new-mental-health-hubs-to-treat-more-victorians-sooner/> (accessed 5 June 2019).

personal recovery, and minimise future risks including; suicide, homelessness, isolation, and repeated use of costly inpatient resources.

The current model of generic case management that is prevalent across CMHS is outdated, not fit to purpose, and does not have a strong evidence base. Ideally, services should be more targeted to the level of need of an individual, and provide more capacity for brief, evidence based interventions. For example, rather than receiving 'case management' for a severe depressive disorder, there may be greater utility and effectiveness from receiving social work input where appropriate, and a psychological treatment such as CBT (which may be best delivered in a group program for some people). In this setting, some consumers may still require a case manager to coordinate complex care, or long term care, where greater levels of support and an ongoing therapeutic relationship becomes more significant. For other people, the role of identifying which aspects of care are needed may be better managed through the reviews with the psychiatry trainee or consultant.

Care in the community needs to be available across a range of settings, and at different degrees of intensity and assertiveness. Community services should also have close links with the NDIS.

Prevention and Recovery Care (PARC) services have been an excellent initiative, with psychiatrists reporting positive outcomes for consumers receiving care at these services. The RANZCP Victorian Branch welcomes the 2019-20 State Budget announcement to provide further more intensive services at three PARC facilities.

The Victorian Branch recommends:

- 11.** The PARC model is expanded, and includes extended PARC units that allow longer rehabilitation/recovery oriented admissions.
- 12.** Community mental health services have defined treatment pathways to increase consistency and accountability among the services
- 13.** Treatment pathways with community mental health services include systematic delivery of evidence-based care, psychoeducation on medication adherence and self-management, carer support, physical health strategies, and coping strategies.
- 14.** There are clear pathways between primary and secondary services to Area Mental Health Services and linkages with community mental health care providers

Inpatient units

“We want a safe, welcoming environment and to have capacity to care for patients” – psychiatrist

Acute admissions are essential for people with severe mental illness who present with complex needs. While community services are the first-line treatment for many people, they cannot completely replace inpatient care. Certain minimum numbers of acute admissions are essential for people with severe mental illness who present with combinations of high risk (to

self or others), severe dysfunction, physical health problems, unsatisfactory living circumstances, and treatment-resistance requiring expert diagnostic reassessment.²¹

RANZCP Victorian Branch members have described inpatient units as unsafe and unwelcoming places for both consumers and people who work in the system. The physical environment of medical hospitals are not conducive to conducting sensitive conversations with patients. There is a lack of private space and extremely limited secure spaces for people who exhibit behavioural disturbances.

Inpatient units require a redesign to provide safe, welcoming environments to consumers.

All major acute psychiatric units continually operate at or above 95 per cent capacity, well above desirable levels of 80-85 per cent.²² These capacity constraints mean that psychiatrists currently have no choice as to which unit they admit consumers to. Consumers of different ages, genders and symptoms are currently being admitted together, creating an unsafe environment for both consumers and staff.

Australia falls below the average for OECD (Organisation for Economic Cooperation and Development) countries in terms of the number of beds available per 100,000 population.²³ It is also well-known and well-reported that Victoria has one of the lowest bed bases nationally, including acute beds.²⁴

Patients are being discharged while still unwell and not yet psychiatrically stabilised to make room for other patients with more acute symptoms. The average length of stay in an adult Victorian inpatient unit is only 9.2 days.²⁵ This is not long enough for many pharmacological and psychotherapeutic interventions to take effect.²⁶

The Victorian Auditor-Generals Office reports that a review commissioned by DHHS states that the bed base needs to grow by 80 per cent over the next decade (see below table).²⁷ Further, estimates suggest that adverse effects worsen should the bed base fall below 50-60 beds per 100,000 population.²⁸

²¹ Allison S, Bastiampillai T, Licinio J, Fuller DA, Bidargaddi N, Sharfstein SS (2017) When should governments increase the supply of psychiatric beds? *Molecular Psychiatry* 00: 1–5.

²² Victorian Auditor General's Office (2019) *Access to Mental Health Services*. Melbourne, Australia: Victorian Auditor General's Office.

²³ Organisation for Economic Cooperation and Development (2018) Hospital beds. Available at: <https://data.oecd.org/healthqt/hospital-beds.htm> (accessed 1 July 2019)

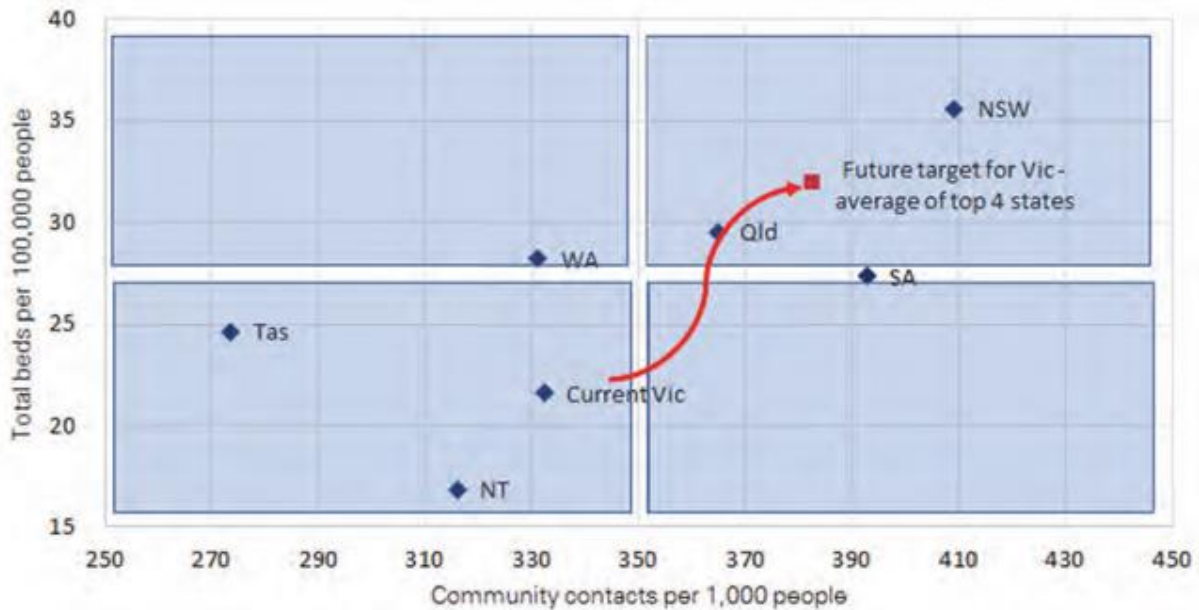
²⁴ Ibid

²⁵ Victorian Government (2018) Adult Mental Health Performance Indicator Report 2018-19 – Quarter 1. Available at: https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports/-/link.aspx?_id=77B00BC70BF244569A6CDA93A732155C&_z=z (accessed 10 January 2019).

²⁶ Galletly C, Castle D, Dark F, et al (2016) Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. *Australian and New Zealand Journal of Psychiatry* 50: 1-117 and Andrews G, Bell C, Boyce P, et al. (2018) Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of panic disorder, social anxiety disorder and generalised anxiety disorder. *Australian and New Zealand Journal of Psychiatry* 52: 1109-1172. Available at: <https://www.ranzcp.org/publications/guidelines-and-resources-for-practice/anxiety-disorders-cpg-and-associated-resources>.

²⁷ Victorian Auditor General's Office (2019) *Access to Mental Health Services*. Melbourne, Australia: Victorian Auditor General's Office.

²⁸ Allison S, Bastiampillai T, Licinio J, Fuller DA, Bidargaddi N, Sharfstein SS (2017) When should governments increase the supply of psychiatric beds? *Molecular Psychiatry* 00: 1–5.



Note: Excludes forensic mental health beds.

*Source: AIHW's *Mental health services in Australia 2013-14*, cited in the Victorian Auditor-General's Office Report *Access to Mental Health Service*, pg.50

The RANZCP Victorian Branch notes that the State Government has recognised the need for more acute beds by funding 53 new acute adult beds in 2018-19. It is reported that 21 are now open and a further 34 are in planning, with 24 sub-acute beds also in planning and 10 mother and baby unit beds to operate seven, rather five days a week.²⁹ The recent 2019-20 budget has also outlined a further 28 beds will be funded. However, as widely reported, this is unlikely to meet current, let alone future demand.

Consumers also have the right to feel safe when receiving treatment and their families and carers should have the confidence in the public mental health system to keep their loved ones safe. Ensuring people's sexual safety is a fundamental prerequisite to achieving the objectives and meeting the principles of the *Victorian Mental Health Act 2014*, while upholding fundamental human rights. Reviews, surveys, advocacy reports and the 2018 Mental Health Complaints Commissioner's (MHCC) report have consistently identified that many people do not feel, or are not, sexually safe when accessing acute mental health treatment in inpatient units.³⁰

As leaders in mental healthcare, Victorian psychiatrists believe that sexual assault in inpatient units, and other healthcare facilities, is completely unacceptable. There is clear evidence that experiences of sexual violence have significant and long-lasting effects on mental health. Being sexually assaulted while accessing acute mental health treatment could lead to more significant and enduring harm and distress for people with mental illness.³¹

Key recommendations from the report include making infrastructure and design changes, including providing gender-specific wards. The RANZCP Victorian Branch believes this

²⁹ Victorian Auditor General's Office (2019) *Access to Mental Health Services*. Melbourne, Australia: Victorian Auditor General's Office.

³⁰ Mental Health Complaints Commissioner (2018) *The right to be safe. Ensuring sexual safety in acute mental health inpatient units*. Melbourne Victoria: Victorian Government.

³¹ Ibid.

should be part of any new hospital build and existing buildings should be modified to offer gender segregated corridors and wards, as well as mixed wards available to offer choice to the consumer.

There is also opportunity for consumers to be treated in inpatient units which are separated by age and illness. Subspecialty units should be available, whether that is within the current catchment system, or where different catchments are able to be joined together to create speciality units.

The Victorian Branch recommends:

- 15.** Increase the bed base, so there are 50 beds available per 100,000 population. There should be a range of beds available, including acute beds, intensive care beds and beds in secure extended care units.
- 16.** Gender specific wards are available at every inpatient unit to ensure people are provided a choice upon admission

Integrated addiction and mental health services

Substance-use disorders are a core concern for psychiatrists considering the complex interrelationship between addictive behaviours and other mental disorders. The levels of comorbidity of people with mental illness and substance use disorder is high.³² Comorbidity between anxiety and other drug use disorders is common and remains a significant challenge for the delivery of effective health-care services and treatment.³³ Modelling suggests that currently Australian services only meet between 26.8% and 56.4% of demand for alcohol and drug treatment.³⁴ This demonstrates the urgent need for expansion of addiction services.

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.³⁵ The disconnect between addiction and mental health services is regularly identified as an impediment to effective referral and holistic treatment.

Mental health services in Victoria currently have limited capability to care for people with mental illness and addiction.

The RANZCP Victorian Branch recommends:

- 17.** Mental health services have enhanced capability to provide treatment for people with comorbid addiction and mental illness.

³² Kingston R, Marel C, Mills K (2017) A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia. *Drug Alcohol Rev.* 36(4):527-539

³³ Teesson M, Hall W, Slade T, Mills K, Grove R, Mewton L, Baillie A, Haber P (2010) *Prevalence and correlates of DSM-IV alcohol abuse and dependence in Australia: findings of the 2007 National Survey of Mental Health and Wellbeing.* *Addiction* 105(12): 2085-2094.

³⁴ Ritter A, Chalmers J, Gomez M (2019) *Measuring unmet demand for alcohol and other drug treatment: The application of an Australian population-based planning model.* *Journal of Studies on Alcohol and Drugs Supplement* 18: 42-50.

³⁵ Deady M, Barrett E, Mills K, Kay-Lambkin F, Haber P, Shand F, Baker A, Baillie A, Christensen H, Manns L, Teesson M (2015) *Comorbid mental illness and illicit substance use: An Evidence Check.* Sydney, Australia: Sax Institute for the NSW Mental Health and Drug and Alcohol Office.

Outpatient clinics

The RANZCP Victorian Branch believes public outpatient psychiatric clinics (also referred to in Appendix 1 as community clinics) should be re-introduced in Victoria to provide clinical psychiatric assessment, advice to GPs and ongoing management, to consumers who do not currently meet criteria for episodic or ongoing care through the current Community Mental Health Centre (CMHC) model. Presently, services exist for those who are acutely unwell, and those with high prevalence disorders, but relatively little in the way of services for the 'missing middle'. Unless someone has the means to access the private system there is little in the way of specialist input available for a large number of people with moderate severity illnesses.

More specifically, these clinics would provide an opportunity for GPs, psychologists, or other medical professionals to refer consumers whose needs are beyond the capacity of primary care practitioners, but do not meet criteria for current public mental health services. This is what would occur with other medical specialists; eg a public cardiology clinic at the local public hospital. These clinics could also provide ongoing low grade input to people who have previously been managed in the CMHCs and discharged to GPs, but still require ongoing specialist input to support their GPs.

There are multiple different models that the above principles could apply to. These range from placing these clinics within the current CMHCs, placing them within hospital outpatient clinics alongside other specialities, placing them in community health centres, or as part of a mental health hub model.

With regards to funding, this may also be an opportunity to look at innovative models for accessing both state and federal funding (ie the capacity to bulk bill patients) as currently occur in other 'privatised' medical outpatient clinics in other medical specialities.

This model could potentially allow for different modalities of psychotherapy delivered by psychiatrist psychotherapists to be offered at outpatient clinics, as well as pharmacological treatments. These include short-term individual and group psychotherapies, as well as medium and time-limited longer-term psychotherapy.

Ideally these clinics should be linked with researchers and academics to ensure cutting edge, evidence-based treatments are being delivered, and to provide the opportunities for ongoing research and quality improvement. These principles would also encompass the capacity to set up subspecialty public outpatient clinics (eg a mood disorder clinic) that could provide a tertiary referral centre on a state-wide basis for complex presentations.

The Victorian Branch recommends:

- 18.** Outpatient clinics are re-established in Victoria to provide psychiatric treatment to the 'missing middle'.

Specialist services

For a small percentage of the population, who live with complex mental illnesses and comorbidity, the services available within the traditional structures are not able to meet their needs. Some individuals require resource-intensive, multi-axial treatment for co-existing illnesses and/or specialised treatment which is not available within area mental health services or is difficult to access due to high demand. The RANZCP Victorian Branch

recognises the need for specialist services is dependent upon the level of need of particular groups, as well as the existing and unmet demand for certain services. However, across Victoria a number of gaps have been identified as of particular concern.

The RANZCP Victorian Branch believes that specialist treatment services should be available to these people. These specialist services should provide resources and support to area mental health services, as well as providing stand-alone services where needed. In some cases, there is a need to bolster existing services to cater for increased demand, whilst in others it is necessary to establish new services.

Across area mental health services, the demand for alcohol and other drug services is high and there is a need to expand these services across Victoria in order to service this population. As mentioned above, there is a need for increased capability within area mental health services to respond to consumers with comorbid mental health and substance misuse needs. In addition, a specialist service is required for those who need ongoing, specialised care.

There is also a need for dual-disability and dual-diagnosis services which can provide coordinated care for individuals who present with complex mental health needs and other co-occurring problems which require treatment, including physical, psychosocial disability and substance misuse problems. This includes individuals with neurodevelopmental disorders (defined here as those with intellectual disability and/or autism spectrum disorder) and comorbid mental health problems, whose needs are currently not met by mainstream mental health services.

In addition, patients with neuropsychiatric disorders, who often have significant impairments, require ongoing, specialised treatment which is currently limited in Victoria. Eating disorder services also need to be bolstered so that consumers with eating disorders can receive specialised and coordinated care to meet both their physical and mental health needs.

The RANZCP Victorian Branch recommends:

- 19.** Specialist services with treatment capabilities (including inpatient management) are established, or further extended where they currently exist, for people with presentations including neuropsychiatric disorders, comorbid neurodevelopmental disorders (including intellectual disability and Autism Spectrum Disorders), and comorbid alcohol and drug dependence disorders.

The Victorian forensic system is also woefully inadequate to treat people with mental illness who come into contact with the criminal justice system. By underfunding therapeutic forensic services, we are failing the people who need treatment and jeopardising the safety of the public. The focus of government must be on therapeutic interventions which enable prisoners with severe and complex mental disorders to be diverted for treatment in a hospital (where the focus is on treatment and recovery), rather than in correctional facilities.

There is a significant shortfall in the number and type of beds needed to meet the demand for forensic services. There is also disparity in access to care close to home, given Thomas Embling is the only forensic psychiatric hospital in Victoria. Nearly all long-term patients at Thomas Embling are subject to a Custodial Supervision Order after a court finding of 'Not Guilty by Reason of Mental Impairment' or 'Unfitness to be Tried' under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997. Resource constraints have led to the state-wide forensic beds being available only to prisoners on Secure Treatment Orders and those

consumers with a disposition under the Act. Other consumers with forensic needs, including those at high risk of offending, offenders with severe mental illness at high risk in the community and those on post sentence dispositions, currently have no access to these beds.

To rectify these problems, the principle of access based on need rather than legal status should underpin a restructure of the forensic mental health system. Specialist forensic services should also have a 'stepped' model of care with low, medium and high levels of security. An increase in the state-wide secure inpatient bed base is also needed to meet demand. This inpatient provision should interface with community services, as part of an integrated care pathway.

The RANZCP Victorian Branch recommends:

- 20.** Increase the state-wide secure inpatient bed base, including using a regionalised approach and according to a 'stepped' model across a spectrum of security levels (low, medium and high secure). The principle of access based on risk and need, rather than simply legal status, should underpin any service model restructure.
- 21.** Strengthen community mental health capacity by establishing local forensic specialist treatment teams that are integrated with community mental health teams.

The RANZCP Victorian Branch recognises the abovementioned specialist services do not constitute an exhaustive list of what is needed in Victoria. Further details on the specialist services mentioned above are outlined in Appendix 4.

Long-term rehabilitation and housing options

"Access to appropriate accommodation options within the system will reduce pressure overall" - psychiatrist

There is a great need for long-term rehabilitation options for people with severe, enduring mental illness to be able to live in a supported environment if required.

There is a complex relationship between housing, homelessness and mental health. A lack of appropriate housing can exacerbate or result in mental illness, and those with mental illness are more at risk of homelessness.³⁶ The Victorian Government has several strategies and policies relating to housing and homelessness, as well as mental health. However, there is little integration across strategies and policies meaning there is no clear, interconnected action to resolve issues relating to housing, homelessness and mental health.

In Victoria, 15.3% of clients seeking assistance from a specialist homelessness service cited mental health issues as their reason for seeking assistance in 2017-18.³⁷ Research and anecdotal evidence suggests that individuals are being discharged from mental health services into homelessness or inadequate housing. In Victoria, 14% of those discharged

³⁶ Brackertz N, Wilkinson A, Davison J (2018) *Housing, homelessness and mental health: towards systems change*, AHURI Research Paper. Australian Housing and Urban Research Institute Limited, Melbourne. Available at: <https://www.ahuri.edu.au/research/research-papers/housing-homelessness-and-mental-health-towards-systems-change> (accessed 10 May 2019)

³⁷ Australian Institute of Health and Welfare (2018). *VIC CLIENTS. 13: Clients, by reasons for seeking assistance, 2017-18*. Available at: <https://www.aihw.gov.au/reports-data/health-welfare-services/homelessness-services/data> (accessed 10 May 2019)

from inpatient care are readmitted less than 28 days after discharge.³⁸ If people do not have a safe, secure and stable home to return to, there is little opportunity for them to continue to recover and they are likely to be readmitted to mental health services or face significant challenges to their recovery in the community.

It is also concerning that where individuals have no fixed address, they are likely to face further barriers to care given access to Victoria's mental health system is determined by residential location.

Stable, secure and safe housing should be seen as a preventative measure and part of a suite of psychosocial supports necessary for an individual's mental health and wellbeing. Furthermore, given the period after discharge is most fraught with risk of suicide³⁹ it is essential individuals are being discharged into an environment that is conducive to recovery.

There are even limited options for people who require long-term accommodation with support for those who need additional help to live independently. The Haven model has proven successful,⁴⁰ and should be investigated further as a model which provides a long-term independent living option for those experiencing mental illness. The Doorway Program also has proven to produce good outcomes.⁴¹

The RANZCP Victorian Branch recommends:

- 22.** A dedicated mental health, housing and homelessness strategy is developed and implemented.
- 23.** Investigate options and fund long-term and medium-term rehabilitative options for people with mental illness who require a supported living environment.

Integration of private and public mental health

There is a need to strengthen the integration between private and public mental health services in Victoria, including introducing opportunities to better share work and consumers between private and public settings. This has been recognised in Victoria's 10-year mental health plan which has strengthening partnerships and information sharing between providers as one of its actions⁴² yet, is still an outstanding concern. Shared-care arrangements and communication between public and private mental health services have been identified as areas of concern in Victoria⁴³ and require improvements to ensure consumers are not falling

³⁸ Victorian Government. (2019). *Adult Mental Health Performance Indicator Report 2018-19 – Quarter 3*. Available at: <https://www2.health.vic.gov.au/mental-health/research-and-reporting/mental-health-performance-reports/-/link.aspx?id=425F98F88996412386E3E7853F907CE8&z=z> (accessed 26 June 2019)

³⁹ Large M, Sharma S, Cannon E, Ryan C, & Neilssen O (2011) Risk factors for suicide within a year of discharge from psychiatric hospital: a systematic meta-analysis. *Australian and New Zealand Journal of Psychiatry*, 45: 619-628

⁴⁰ Lee S, Giling J, Kulur B, & Duff C (2013) *Exploring the impact of housing security on recovery in people with severe mental illness: Summary report*. Available at: https://www.mindaustralia.org.au/sites/default/files/Exploring_the_impact_summary_report.pdf

⁴¹ Wellways (2019) Doorway. Available at: <https://www.wellways.org/our-services/doorway> (accessed 26 June 2019)

⁴² Victorian Government (2015) *Victoria's 10-year mental health plan*. Available at: <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorias-10-year-mental-health-plan> (accessed 20 June 2019)

⁴³ Coroner's Court of Victoria (2015) *Finding into death without inquest (COR 2015 5061) Peter Graham Chaucer*. Available at: https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/petergrahamchaucer_506115.pdf (accessed 20 June 2019)

between the gaps. Minimum standards of care should be defined across disorders and funding, and systems designed to deliver them.⁴⁴

Because Primary Health Networks (PHNs) are funded by the Federal Government and Area Mental Health Services are state-funded, a chasm is created. Better integration between these two programs are required. Resource distribution through PHNs creates a complex web of resource allocation and restricts the focus to funding rather than working towards better outcomes for consumers.

The RANZCP Victorian Branch recommends:

- 24.** Link PHNs and AMHSs to ensure shared care between GPs and mental health practitioners. Shared care arrangements should focus on clear, open and transparent communication between providers.

⁴⁴ Royal Australian and New Zealand College of Psychiatrists (2019) *RANZCP submission to Productivity Commission Inquiry into Mental Health*. Available at: <https://www.ranzcp.org/files/resources/submissions/1421-president-to-commissioners-re-productivity-co.aspx> (accessed 20 June 2019)

A skilled workforce with capacity

“Psychiatrists want the capacity to deliver evidence-based treatments, as opposed to just surface biological treatments and risk-management.”

The RANZCP Victorian Branch submits its profound concern about the future of Victoria’s public mental health system, due to the significant challenges facing the recruitment and retention of psychiatrists. Without a strategy to address this, any recommendations from the Royal Commission about increasing service capacity will be unable to be met. Whilst we are concerned at the state of the whole mental health workforce, as the representative body for psychiatrists we are best-placed to provide advice about the psychiatric workforce.

Psychiatrists are clinical leaders in the provision of mental healthcare in the community and use a range of evidence-based treatments to support a person in their journey of recovery. They are specially trained to assess a person’s state of mind, diagnose illness, management treatment and provide a range of therapies for complex and serious mental illness. Psychiatrists use a “biopsychosocial” model of understanding, which integrates a person’s thoughts, feelings, behaviours and surrounding environment, as well as physical health to see and treat the person as a whole. Psychiatrists play a vital leadership role within multidisciplinary teams. Psychiatrists’ holistic understanding of the physical, mental, social and behavioural aspects of mental health allows them to recognise and treat both the physical and emotional effects of mental disorders. This means they are uniquely placed to manage complexities and coordinate input from a range of other health professionals involved in a person’s care, such as GPs, nurses, psychologists, occupational therapists and/or social workers.

Psychiatrists are an essential part of the mental health workforce and play a key leadership role within services, both in terms of coordinating consumer care, as well as providing high-quality assessment and treatment of mental disorders. In the current system, psychiatrists are seen as largely responsible for managing volume and risk within services. Psychiatrists should be able to discharge their skills as therapists, diagnosticians and managers of teams. The RANZCP Victorian Branch believes it is essential psychiatrists have leadership roles within mental health services and are afforded adequate time to provide high-quality care.

Consumers, carers and those working in the mental health system, including psychiatrists, are being traumatised by an under-resourced system. Psychiatrists and other mental health workers, are facing moral distress: a desire and knowledge to do the right thing, but system constraints make it impossible to do so.⁴⁵

The RANZCP Victorian Branch has repeatedly called for urgent measures to address psychiatry workforce challenges, yet there has been only minor funding allocations to try and address them.

In 2015, the Department of Health and Human Services commissioned the RANZCP to prepare a report on the Victorian Psychiatry Workforce. The report was to focus in particular on workforce issues in the public sector and rural workforces, and provide recommendations for actions to address workforce issues identified. The report was finalised and presented to DHHS in 2017.

⁴⁵ Oliver D (2018) Moral Distress in Hospital doctors. *British Medical Journal* 360

The findings of the Psychiatry Attraction, Recruitment and Retention Needs Analysis Project report revealed that challenges besetting Victoria's psychiatry workforce are multifaceted and stem from a range of issues.⁴⁶ A number of recommendations were proposed to address them and we recommend the Commissioners familiarise themselves with this report, located at: www.ranzcp.org/files/branches/victoria/ranzcp-vic-psychiatry-workforce-report.aspx.

Since that time, the RANZCP has continued to raise these significant concerns, both in public statements, and through regular meetings with DHHS. This advocacy has led to recent announcements in the 2019-20 State Budget which will ease psychiatry workforce strains, including post-graduate leadership scholarships for 40 psychiatrists over the next two years, and establishing additional Director of Training positions. Yet, we are still unaware of a dedicated psychiatry workforce strategy which will address all the concerns raised.

The Victorian Psychiatry Workforce Report shows that psychiatrists are leaving the public sector to work in private at alarming rates. Between 2011 and 2014, the proportion of psychiatrists who worked in both the public and private sectors declined from 43% to 31%. It appears that a number of psychiatrists who were once working in both sectors, are now working solely in private practice. Between 2011 and 2014, the proportion of psychiatrists working solely in private practice increased from 34% to 45%.⁴⁷ Anecdotal reports from psychiatrists suggest this trend is continuing.

The reasons for psychiatrists leaving the public sector are multifactorial, yet can also simply be attributed to the excessive demands being placed on them in an under-resourced sector.

Within metropolitan AMHS, the shortages are acutely felt in inpatient units and EDs, particularly during on-call periods (afterhours and weekends). The greater acuity of consumers has led to an increase in aggression and violence. Management of aggressive consumers requires the presence of an adequate, skilled, and well-supported workforce, including other consultant psychiatrists, trainees, mental health nurses, and allied health. Despite this need, it is during the on-call periods that the psychiatry workforce is minimally-staffed and allied health staff are not available to provide support. Resolving weekend workforce shortages is an imperative for retaining psychiatrists in the public sector. To address this, workforce models should meet acute clinical demand 7 days per week for metropolitan AMHS.

Furthermore, Victoria's public mental health system has an inequitable junior medical workforce structure compared to other medical specialities, with few medical teams that include intern and resident positions. Yet people with serious mental illness are recognised as particularly vulnerable to physical health concerns,⁴⁸ with lower life expectancy and high physical co-morbidities. This results in an inherent tension in the delivery of both optimal mental and physical health care to consumers, in the setting of increasing workplace administrative demands, such as the Mental Health Act reporting. In addition to workplace dissatisfaction and strain, there is lack of access to leave cover by HMO (Hospital Medical Officer) staff which is available in specialities other than psychiatry in public health systems.

⁴⁶ The Royal Australian and New Zealand College of Psychiatrists (2017) *Victorian Psychiatry Attraction, Recruitment, and Retention Needs Analysis Project Report*. Melbourne, Victoria: The Royal Australian and New Zealand College of Psychiatrists. Available at: <https://www.ranzcp.org/files/branches/victoria/ranzcp-vic-psychiatry-workforce-report.aspx>

⁴⁷ Ibid

⁴⁸ Victorian Government (2019) *Equally well in Victoria: Physical health framework for specialist mental health services*. Available at: <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/equally-well-in-victoria-physical-health-framework-for-specialist-mental-health-services> (accessed 2 July 2019)

Additional opportunities for capacity building in our junior medical workforce in mental health care, and recruitment into the speciality of psychiatry are lost.

Regional psychiatry shortage

The shortages which are felt across the psychiatry sector are exacerbated in regional areas. Regional Victoria suffers from a severe shortage of psychiatrists. People living in these areas should expect the same availability and options for care, as those living in metropolitan areas. In inner regional areas such as Ballarat and Bendigo, there are 5.1 psychiatrists per 100,000 population. In outer regional areas, this falls to 1.2 psychiatrists per 100,000 population. In stark contrast, there are 16.9 psychiatrists per 100,000 population in Melbourne.⁴⁹ While it is acknowledged that these statistics are now six years old, anecdotal reports suggest that these figures have not improved with time.

Rural services face a number of challenges, both in recruitment and retention. This issue is not unique to psychiatry though and requires a solution that encompasses family, social and economic needs, not just vocational.

Creating greater linkages between metropolitan and rural services to enable access to specialist services would assist regional areas to fill recruitment gaps. Simple technological improvements would also assist. Improvements to technology to enable greater use of telepsychiatry, enabling teaching and training via videolink are simple measures which should be implemented as a matter of urgency. The Victorian Government may consider expanding technological services which have been set up for other means, such as Mental Health Tribunal, to meet these needs.

Trainee issues

Trainees are an important part of the psychiatry workforce, they are often on the front-line of services and first point of contact for families and carers. There has been increasing concern about trainees being overworked in under-resourced environments. Burnout is more likely to occur when there are staff shortages. Inpatient units have a minimal number of staff already, so if just one staff member takes leave, a huge burden is created because the workload becomes distributed amongst the remaining staff who then have to carry an even greater clinical load. What suffers under these circumstances is the ability for trainees to receive adequate supervision and support. To keep up with the clinical load, trainees end up doing a large amount of unpaid overtime and are often rendered unable to attend scheduled teaching sessions. The heavy workload culminates in the need for sick leave, which further exacerbates staff shortages and low morale. Leave cover should be implemented as a matter of urgency, as well as greater employment flexibility.

Shortages in subspecialties

The psychiatry workforce suffers from shortages across the whole sector, but there are some subspecialties which face acute shortages which are well-known and should be addressed as a matter of urgency.

⁴⁹ Department of Health (2016) Australia's Future Health Workforce – Psychiatry. Canberra, Australia: Commonwealth of Australia. Available at: [https://www.health.gov.au/internet/main/publishing.nsf/Content/597F2D320AF16FDBCA257F7C0080667F/\\$File/AFHW%20Psychiatry%20Report.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/597F2D320AF16FDBCA257F7C0080667F/$File/AFHW%20Psychiatry%20Report.pdf)

Addiction psychiatrists

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.

Child and adolescent psychiatrists

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.⁵⁰

There is also a severe shortage of child and adolescent psychiatrist training positions. To become a psychiatrist, a trainee needs to complete a 6-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.

Psychotherapists

As mentioned earlier in this submission, there is a lack of psychotherapy being delivered in the public mental health sector. Funding more psychotherapists to deliver psychotherapy and provide support to trainees would go some way to address this gap.

The RANZCP Victorian Branch recommends:

- 25.** As a short term measure, undertake a gap analysis to provide a clear picture of the numbers and types of staff needed, and where and when they are needed.
- 26.** To meet future needs, a dedicated psychiatry workforce strategy should be developed to address current and future psychiatry workforce shortages.
- 27.** In the long-term, scope and determine appropriate workforce benchmarking to fill future gaps.

⁵⁰ Royal Australian and New Zealand College of Psychiatrists (2019) *Child and adolescent psychiatry: meeting future workforce needs*. Melbourne, Australia: Royal Australian and New Zealand College of Psychiatrists. Available at: <https://www.ranzcp.org/news-policy/policy-submissions-reports> (accessed 25 June 2019).

Prevention and early intervention

The RANZCP Victorian Branch supports all Victorians having access to high-quality, evidence-based mental health services and recommends specific targeted services are required for certain at-risk populations. This may include Aboriginal and Torres Strait Islander peoples, people living in regional areas, people with chronic conditions, first responders to emergencies, people of low socioeconomic status, people affected by homelessness, prisoners, people with culturally and linguistically diverse backgrounds, refugee and asylum seekers, older people, children and young people, and the LGBTIQ+ community. The RANZCP Victorian Branch acknowledges that more resources, planning and services are required for many of the vulnerable groups, however, we lend our clinical expertise to the following information.

Currently there is no known evidence of primary prevention mechanisms to prevent the onset of psychosis. We therefore emphasise the points raised above that there must be secondary and tertiary care available based on need. There is some evidence to suggest that adverse experiences are a risk-factor for developing certain mental disorders, and so certain groups may benefit from activities which aim to prevent these experiences. The RANZCP Victorian Branch therefore recommends that there are two groups which would specifically benefit from increased prevention, early treatment and support; children and women.

It is estimated that 23% of Australian children live in families with a parent with mental illness.⁵¹ Children of parents with mental illness have an increased risk of adverse developmental outcomes and mental health problems. Developmentally and psychologically-informed assessment intervention, prevention and treatment programs can reduce the risk of mental health problems in children, including those with a mental illness.⁵²

When an adult presents at a mental health service with a mental illness, assessment should include screening for dependent children. If the consumer does have children in their care, assessment should include determining the current circumstances and safety of the child, the capacity of the parent to provide physical and emotional care, the parent access to appropriate supports and services, the effect of the parent's mental illness on the child and the availability of alternative care. If, during assessment of an adult with mental illness, their child or children appear to have significant difficulties, there should be consultation with and/or referral to CAMHS or other appropriate health services. Trust based relational interventions have been shown to be effective in variety of settings.⁵³

It is well documented that the sequelae of psychological distress and mental illness in young people are considerable and include poor mental health into adulthood, low school engagement and performance, high welfare dependency and involvement with the child protection system, criminal activity, insecure housing, drug and alcohol dependency, premature death⁵⁴ and transgenerational transmission of trauma. Failure to address early

⁵¹ Maybery D, Reupert A, Patrick K, Goodyear M, Crase L (2009) Prevalence of parental mental illness in Australian families. *Psychiatric Bulletin* 33: 22-6.

⁵² Royal Australian and New Zealand College of Psychiatrists (2016) Position Statement 56 Children of parents with a mental illness. Melbourne, Victoria: The Royal Australian and New Zealand College of Psychiatrists. Available at: www.ranzcp.org/news-policy/policy-submissions-reports/document-library/children-of-parents-with-mental-illness

⁵³ Purvis K, Cross D, Dansereau D, Parris S (2013) Trust-Based Relational Intervention (TBRI): A Systemic Approach to Complex Developmental Trauma. *Child and Youth Services* 34:360-386

⁵⁴ Segal L, Guy S, Leach M, Groves A, Turnbull C, Furber G (2018) A needs-based workforce model to deliver tertiary-level community mental health care for distressed infants, children, and adolescents in South Australia: a mixed-methods study. *The Lancet Public Health* 3: 296-303.

mental illness effectively could have implications across multiple sectors, highlighting the importance of investing in the mental health of young people. The evidence base for providing psychosocial interventions (such as psychotherapy, school-based programs) has grown, as well as greater awareness and understanding of the effects of family violence and childhood trauma, yet the provision of psychosocial interventions has not increased in tandem. This can lead to excessive use of psychotropic medications that are both ineffective and place children at risk of adverse effects of medication. Psychotherapeutic and psychosocial interventions, as outlined in the evidence-base, must be available as a baseline standard.

Women are at the greatest risk of developing a mental illness following childbirth than at any other time.⁵⁵ Australian Government guidelines on pregnancy care recommend routine antenatal screening for depression, anxiety, psychosocial risk factors and family violence⁵⁶. The National Perinatal Depression Initiative, funded until June 2013, provided routine and universal screening for depression for women during the perinatal period once after birth and, again, four-to-six weeks after birth.⁵⁷ Routine antenatal screening for risk factors associated with postnatal depression and serious mental illness should continue as part of the base-level services offered to pregnant women, and should be conducted at regular intervals, not just immediately following birth. For further information on the health and well-being of mothers and babies during the perinatal period, Commissioners are directed to the [Victorian Branch's 2017 response to the Parliament of Victoria's inquiry into the current situation relating to the health, care and well-being of mothers and babies in Victoria during the perinatal period](#).

Overall rates of mental health conditions are almost identical for men and women but there are striking differences in the patterns of mental illness. Depression, predicted to be the record leading cause of global disability burden by 2020, is twice as common in women compared to men.⁵⁸

The high prevalence of sexual and physical violence to which women are exposed renders women to be the largest single group of people affected by Post-Traumatic Stress Disorder (PTSD).⁵⁹ Women are more likely than men to experience anxiety disorders, as well as Eating Disorders.⁶⁰ Even in younger population, the burden of probable serious mental illness is borne more heavily by young females than young males.⁶¹

Women with children are a particularly vulnerable group, especially if they are already struggling with a mental illness. It is estimated that approximately 60% of women with

⁵⁵ Royal Australian and New Zealand College of Psychiatrists (2015) Position Statement 57 Mothers, babies and psychiatric inpatient treatment. Melbourne, Victoria: The Royal Australian and New Zealand College of Psychiatrists. Available at: <https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/mothers-babies-and-psychiatric-inpatient-treatment>

⁵⁶ Australian Government Department of Health (2018) *Pregnancy Care Guidelines*. Available at: <https://beta.health.gov.au/resources/publications/pregnancy-care-guidelines> (Accessed 18 June 2019)

⁵⁷ Australian Government Department of Health (2013) *National Perinatal Depression Initiative*. Available at: <https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-perinat> (Accessed 18 June 2019)

⁵⁸ World Health Organization (2019) Gender and women's mental health. Available at: https://www.who.int/mental_health/prevention/genderwomen/en/ (accessed 27 June 2019).

⁵⁹ Ibid

⁶⁰ The National Eating Disorders Collaboration (2010) *Eating disorders: The way forward. An Australian national framework*. Sydney, Australia: The National Eating Disorders Collaboration

⁶¹ Mission Australia (2017) *Youth mental health report*. Available at: https://blackdoginstitute.org.au/docs/default-source/research/evidence-and-policy-section/2017-youth-mental-health-report_mission-australia-and-black-dog-institute.pdf?sfvrsn=6 (accessed 27 June 2019)

enduring mental health issues have dependent children.⁶² They also have to contend with multiple other challenges, including lack of social support, inadequate housing, trauma, limited employment opportunities, poor access to childcare services and difficulties in accessing parenting information and unremitting responsibility for the care of others.

The impact on both the mother and child can be devastating. The impact of intergenerational transmission of trauma is well-researched⁶³ but there are limited opportunities for accessing support or therapy work. There are gaps in psychotherapeutic services for women exposed to domestic violence where focus is usually on crisis management.

The RANZCP Victorian Branch advocates for enhanced services for women with mental health issues. This is particularly needed for women with children in their care.

The RANZCP Victorian Branch recommends:

- 28.** Improved screening for at-risk groups, including women and children and enhanced services for these groups

⁶² Reder P, McClure M, Jolley A (2000) *Family Matters: Interfaces Between Child and Adult Mental Health*. London, UK: Routledge

⁶³ Portney C (2003) Intergenerational Transmission of Trauma: An Introduction for the Clinician. *Psychiatric Times* 20.

Services for particular population groups

Certain populations within society have a greater prevalence of mental illness and there are also gaps in services which mean the mental health needs of particular groups are not being met. Victoria's mental health system must be equipped to compassionately and sensitively manage the needs of diverse groups. This means having strategies which broaden the diversity of the mental health workforce, so that it is empowered to deliver the best outcomes for those accessing the system. We have addressed the drivers and needs of some particularly at-risk groups below, though it should be noted this list is not exhaustive and there are other groups within the Victorian community whose needs should also be addressed by forthcoming recommendations.

Aboriginal and Torres Strait Islander peoples

There is an inequality in mental health between Aboriginal and Torres Strait Islander peoples and the general population. Studies suggest Aboriginal and Torres Strait Islander Australians adults have a higher prevalence of psychological distress than the general population.⁶⁴ Reasons for this greater prevalence have been explained in relation to the "disruption to Aboriginal and Torres Strait Islander society and... a strong context of social and emotional deprivation."⁶⁵ The compounding impact of social disadvantages faced by Aboriginal and Torres Strait Islander Australians peoples should also be considered. In reference to an NMHC report, a recent Closing the Gap paper notes the provision of mental health services for Indigenous people is "both inadequate and inappropriate" and recommends changes be implemented as a matter of urgency.⁶⁶

The RANZCP supports the Uluru Statement from the Heart.^{67 68} The RANZCP supports this as self-determination and supportive societal structures can be a protective factor against negative mental health outcomes.^{69 70}

The RANZCP Victorian Branch believes more appropriate management of mental illness within Aboriginal and Torres Strait Islander Australians communities requires an emphasis on cultural safety, as well as recognition of culture and community in the healing process, and well as inclusion of the family.⁷¹ The social and emotional wellbeing and mental health

⁶⁴ Jorm A F, Burchier S J, Cvetkovski S, Stewart G (2012) Mental health of Indigenous Australians: a review of findings from community surveys. *Medical Journal of Australia* 196(2): 118-121.

⁶⁵ Parker R, Milroy H (2014) Chapter 7: Mental Illness in Aboriginal and Torres Strait Islander Peoples. In: Dudgeon P, Milroy H, Walker R (eds) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Available at: <https://www.telethonkids.org.au/our-research/early-environment/developmental-origins-of-child-health/aboriginal-maternal-health-and-child-development/working-together-second-edition/> (accessed 31 May 2019).

⁶⁶ Dudgeon P, Walker R, Scrine C, Shepherd C, Calma T, Ring I (2014) Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people. *Issue Paper no. 12: Closing the Gap Clearinghouse*. Available at: <https://www.aihw.gov.au/getmedia/6d50a4d2-d4da-4c53-8aeb-9ec22b856dc5/ctgc-ip12-4nov2014.pdf.aspx?inline=true> (accessed 31 May 2019).

⁶⁷ Royal Australian and New Zealand College of Psychiatrists (2018) *Position Statement 68: Recognition of Aboriginal and Torres Strait Islander peoples in the Australian Constitution*. Melbourne, Victoria: The Royal Australian and New Zealand College of Psychiatrists. Available at: <https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/recognition-of-aboriginal-and-torres-strait-island> (Accessed 19 June 2019)

⁶⁸ First Nations National Constitutional Convention (2017) Uluru Statement from the Heart. Available at: https://www.referendumcouncil.org.au/sites/default/files/2017-05/Uluru_Statement_From_The_Heart_0.pdf (Accessed 19 June 2019)

⁶⁹ Silove D, Steel M, Psychol M (2006) Understanding community psychosocial needs after disasters: Implications for mental health services. *Symposium* 52(2): 121–25. Yunupingu G (2016) Rom Watangu: The law of the land. *The Monthly*. Available at: <https://www.themonthly.com.au/issue/2016/july/1467295200/galarrwuy-yunupingu/rom-watangu> (accessed 8 August 2018)

⁷⁰ Chandler M, Lalonde C (1998) Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry* 35(2): 191–219.

⁷¹ Parker R, Milroy H (2014) Chapter 7: Mental Illness in Aboriginal and Torres Strait Islander Peoples. In: Dudgeon P, Milroy H, Walker R (eds) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and*

needs of Aboriginal and Torres Strait Islander peoples in Victoria must be met by culturally responsive services.

The RANZCP Victorian Branch recognises that Aboriginal and Torres Strait Islander mental health workers bring valuable skills and knowledge to the practice of psychiatry and should be an integral part of any multidisciplinary team caring for Aboriginal and Torres Strait Islander consumers and communities.⁷²

The RANZCP Victorian Branch recommends:

29. The Uluru Statement from the Heart recommendations are enacted
30. Aboriginal and Torres Strait Islander mental health workers are employed as part of any multidisciplinary team caring for Aboriginal and Torres Strait Islander consumers and communities.

LGBTIQ+

Evidence shows that discrimination and marginalisation experienced by the LGBTIQ+ population increases their risk of developing mental health issues, and also creates barriers to accessing services.⁷³ Compared to the general population, LGBTIQ+ people are more likely to experience mental health issues.⁷⁴ It has been suggested these negative health outcomes are a result of experiences of institutionalised and interpersonal discrimination and marginalisation which increases vulnerability to mental illness and psychological distress.⁷⁵

The mental health of LGBTIQ+ individuals should be supported by including ensuring training programs and services are culturally sensitive to LGBTIQ+ people. Services should make reasonable steps to accommodate the needs and ensure the cultural safety of LGBTIQ+ people.⁷⁶

The RANZCP Victorian Branch recommends:

31. All mental health providers are required to provide safe services for LGBTIQ+ people through an accreditation program.

Practice. Available at: <https://www.telethonkids.org.au/our-research/early-environment/developmental-origins-of-child-health/aboriginal-maternal-health-and-child-development/working-together-second-edition/> (accessed 31 May 2019).

⁷² Royal Australian and New Zealand College of Psychiatrists (2016) *Aboriginal and Torres Strait Islander mental health workers*. Melbourne: Australia: Royal Australian and New Zealand College of Psychiatrists. Available at: <https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/aboriginal-and-torres-strait-islander-mental-health> (accessed 25 June 2019).

⁷³ Royal Australian and New Zealand College of Psychiatrists (2019) *Position Statement 83: Recognising and addressing the mental health needs of the LGBTIQ+ population*. Melbourne: Australia: Royal Australian and New Zealand College of Psychiatrists. Available at: <https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/recognising-and-addressing-the-mental-health-needs>

⁷⁴ Pitts M, Smith A, Mitchell A, Patel S (2006) *Private Lives: A Report on the health and wellbeing of GLBTI Australians*. Gay and Lesbian Health Victoria, Australian Research Centre in Sex, Health & Society.

⁷⁵ Royal Australian and New Zealand College of Psychiatrists (2019) *Position Statement 83: Recognising and addressing the mental health needs of the LGBTIQ+ population*. Melbourne: Australia: Royal Australian and New Zealand College of Psychiatrists. Available at: <https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/recognising-and-addressing-the-mental-health-needs>

⁷⁶ *Ibid*.

People with comorbid physical and mental health problems

People living with a serious mental illness have significantly higher rates of major physical illness than the general population.⁷⁷ A bidirectional relationship exists between mental and physical health, with those with a serious mental illness experiencing physical illness and those experiencing chronic illnesses also likely to develop a mental illness. The gap in life expectancy between those who live with a mental illness and the general population is stark, and needs to be addressed. Reasons for the burden of disease being high amongst people with a serious mental illness are numerous and include greater exposure to other risk factors for chronic illness, such as smoking, alcohol and drug use, insecure housing, unemployment and poverty.⁷⁸ The side effects of some medications for mental illness can also affect consumers' physical health, meaning a delicate balance must be achieved between managing the mental and physical illness.

It is essential that individuals with a serious mental illness are able to access treatments for their physical health, such as smoking cessation programs, sexual health care, dental care, and exercise or weight loss programs. More collaborative care within the system and with other services, as well as routine screening and monitoring of the physical health of people with severe mental illness will also contribute to improvements.

The RANZCP Victorian Branch recommends:

- 32.** Screening and lifestyle interventions, based on the best available evidence, must be routinely offered to both people newly diagnosed with a serious mental illness and those with more long-standing illnesses in order to minimise the development of chronic physical health conditions, such as metabolic syndromes, that are currently more prevalent in those with mental illness, and add to the burden of disease and earlier death
- 33.** Health promotion mechanisms (for example to quit smoking, undertake exercise, or mitigate alcohol abuse) should be adapted for delivery in all specialist mental health settings and become core elements in the service 'offer' in both inpatient and community settings.

Employment programs

Employment is almost universally ranked among the highest goals of people with a severe mental illness, yet only 22% of people with severe mental illness have been shown to be employed on a full or part-time basis.^{79 80}

Individual placement supports have a strong evidence base for enhancing both vocational and non-vocational outcomes.⁸¹

⁷⁷ Royal Australian and New Zealand College of Psychiatrists (2015). *Keeping Body and Mind Together: Improving the physical health and life expectancy of people with serious mental illness*. Melbourne: Australia: Royal Australian and New Zealand College of Psychiatrists. Available at: <https://www.ranzcp.org/files/resources/reports/keeping-body-and-mind-together.aspx>

⁷⁸ Ibid.

⁷⁹ Ramsay C, Broussard B, Goulding S, Hall D, Kaslow N, Likkackey E, Penn D, Compton M (2011) Life and treatment goals of individuals hospitalized for first-episode nonaffective psychosis. *Psychiatry Research* 189: 344–348.

⁸⁰ Waghorn G, Saha S, Harvey C, Morgan V A, Waterreus A, Bush R, Castle D, Galletly C, Stain H J, Neil A L, McGorry P, McGrath J J (2012) 'Earning and learning' in those with psychotic disorders: The second Australian national survey of psychosis. *Australian and New Zealand Journal of Psychiatry* 46(8): 774-85

⁸¹ Bond, GR, Drake, RE, Becker, DR (2008) An update on randomized controlled trials of evidence-based supported employment. *Psychiatric Rehabilitation Journal* 31: 280–290 and Killackey E, Allott K (2013) Utilising Individual Placement and Support to address unemployment and low education rates among individuals with psychotic disorders. *Australian and New Zealand Journal of Psychiatry* 47: 521-3

Currently, the Commonwealth Department of Social Services is trialling a model which integrates employment and vocational services with clinical mental health and non-vocational support, and focuses on the individual needs of people with mental illness who are seeking to enter, or remain in, education and/or employment.⁸² The aim of the trial is to improve educational and employment outcomes for people aged up to 25 with mental illness.

Individual placement supports have been shown to be effective for adults as well as youth, and the Victorian Government should consider bolstering this program by expanding it to this cohort.

The RANZCP Victorian Branch recommends:

- 34.** Consider bolstering the Individual Placement Support program by expanding it to adults.

⁸² Australian Government (2018) Individual Placement and Support (IPS) Trial. Available at: <https://www.dss.gov.au/mental-health-programs-services/individual-placement-and-support-ips-trial> (accessed 26 June 2019)

Suicide prevention

The RANZCP Victorian Branch recognises that there is benefit in providing dedicated suicide prevention strategies which focus on at-risk groups and those who have attempted suicide or have engaged in intentional self-harm. Timely, effective treatment for people with depression and other mental health diagnoses – including psychotherapy and medication – will act as a measure to help prevent suicide at all stages of suicidal behaviour. Older men, aged 85 and over, currently have the highest age-specific rate of suicide in Australia.⁸³ This should be acknowledged within conversations on suicide prevention. A targeted focus on populations at higher risk, including people with mental illness or substance abuse disorders, Aboriginal and Torres Strait Islander peoples, LGBTIQ+ people, older people, families and friends of people who have taken their own lives, and other groups. Community prevention efforts should also focus on individuals not presently in contact with services, as we know a proportion of individuals who suicide are not in contact with mental health services.

The RANZCP Victorian Branch notes and supports the Victorian Government’s commitment to suicide prevention by establishing two dedicated suicide prevention strategies; the place-based initiative and the Hospital Outreach Post-suicidal Engagement (HOPE) initiative.⁸⁴ The latter program in particular has a strong evidence-base, which focusses on enhanced support and assertive outreach for people leaving an emergency department or medical ward following treatment for an attempted suicide. In fact, post-discharge follow-up should be implemented as a matter of course, and shouldn’t require a dedicated program to prompt this to happen. However, we are of the understanding that this program has not yet been evaluated

The reasons people suicide are determined by a number of factors, and the RANZCP Victorian Branch acknowledges that suicide prevention is not just within the purview of the mental health system. However, as the presence of a mental illness is one of the strongest risk factors for suicide⁸⁵ the availability of and accessibility to clinical mental health services is therefore critical to prevent suicide.

We wish to echo and reinforce the Victorian Auditor General’s Office’s statement: “While effort has been directed to worthy activities such as new frameworks for suicide prevention and Aboriginal mental health and planning for forensic mental health services neither these initiatives, nor core services, can succeed while the system is overwhelmed.”⁸⁶

The RANZCP Victorian Branch recommends:

- 35.** The HOPE trials are evaluated as a matter of priority and outcomes from the evaluation are used as evidence to continue funding post-discharge follow-up initiatives.

⁸³ Australian Bureau of Statistics (2016) Age-Specific death rates for Intentional self-harm, by sex, 2015 (a)(b)(c) in *Suicide in Australia*. Available at: <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2015~Main%20Features~Intentional%20self-harm:%20key%20characteristics~8> (Accessed 19 June 2019)

⁸⁴ Victorian Government (2018) Suicide Prevention in Victoria. Available at: www2.health.vic.gov.au/mental-health/prevention-and-promotion/suicide-prevention-in-victoria (accessed 30 May 2019).

⁸⁵ Harris E, Barraclough B (1997) Suicide as an outcome for mental disorders. A meta-analysis. *British Journal of Psychiatry* 170: 205-228

⁸⁶ Victorian Auditor General’s Office (2019) *Access to Mental Health Services*. Melbourne, Australia: Victorian Auditor General’s Office.

Families and carers

“The carer doesn’t need to know everything but we need to feel part of it” – carer

The RANZCP Victorian Branch has consulted the RANZCP Community Collaboration Committee (CCC), a committee made up of consumers, carers and psychiatrists from Australia and New Zealand.⁸⁷ We have also worked with our community representative on the Victorian Branch Committee to develop these recommendations. The RANZCP Victorian Branch strongly believes that consumers and carers themselves are best-placed to respond to this question. The RANZCP believes consumers, carers and families should be included in the coproduction of service design and provision, as well as mental health services planning and research.

Family members and carers report that they are often left out of the decision-making process and are not kept informed of the treatment and progress of their loved ones. Family members and carers need more information and education on how to assist the person they are caring for. Discharge planning also requires conversations with family members and carers – at the very least they want to know when, where and the supports put in place for their loved prior to being discharged.

The RANZCP Victorian Branch supports and is committed to implementing the Chief Psychiatrists Guideline *Working together with families and carers* which sets out the responsibilities of mental health services to work collaboratively with families and carers.⁸⁸ Despite clear guidelines that involving consumers and carers is best practice, the challenge is with implementation.

The guidelines details that mental health services have a responsibility to identify and involve families and carers in assessment, treatment, care and recovery. RANZCP Fellows and Trainees have communicated that there is a strong desire to work with families and carers and a deep understanding of why it is necessary for a consumer’s recovery. However, they have cited time as the main constraint to making this happen in practice.

Members have explained that in an under-resourced environment, they simply feel they don’t have the time to work with families and carers, let alone check-in on their mental health and wellbeing. The RANZCP Victorian Branch submits that resourcing the sector appropriate to its needs will address a key barrier to working with families and carers. In addition, the Royal Commission should consider mandating protected time to work with families and carers as part of the core business of quality healthcare provision.

The RANZCP Victorian Branch recommends:

- 36.** Mandating protected time for clinicians to work with families and carers to provide psychoeducation which enables families are carers to support their loved one.

⁸⁷ The Royal Australian and New Zealand College of Psychiatrists (2018) Community Collaboration Committee. Melbourne: Australia: Royal Australian and New Zealand College of Psychiatrists. Available at: <https://www.ranzcp.org/about-us/governance/committees/community-collaboration-committee> (accessed 31 May 2019).

⁸⁸ Office of the Chief Psychiatrist (2018) Working together with families and carers. Melbourne, Australia: Department of Health and Human Services.

Access and navigation

The RANZCP Victorian Branch believes that strong governance, forward-planning and accountability will greatly improve access, navigation and integration. However, it is acknowledged that embedding governance changes across the system will take time.

In the short-term, the RANZCP Victorian Branch suggests that there are simple communication initiatives the Victorian Government can introduce to help people navigate the fragmented mental health system. There is a plethora of information about mental health and it can be confusing to navigate the many websites and factsheets. Rationalisation of existing information should be encouraged, so there is a simple way to assess which information is accurate and trustworthy. Simple consumer-facing, publically-accessible and up-to-date diagrams, flowcharts and/or matrixes provide a cost-effective, quick option to improve knowledge of services available while structural changes are awaited. These 'guides' should include information about how to get referrals, what specialised services are available to treat specific mental illness, the non-government organisations providing mental health treatment and when psychiatrists are involved in treatment.

The RANZCP Victorian Branch recommends:

- 37.** Easy-to-understand guides and services maps are developed in the short-term which outline what a consumer, carer and family member can expect from mental health services. These should be made available online and in mental health services.
- 38.** A concierge service is available within each AMHS to assist people to navigate the system and provide a central point of contact to ensure their needs are being met.

Conclusion

The need for change is clear. Consumers, carers and families, as well as those working in the system should expect a mental health system which contributes to improving the outcomes of those experiencing poor mental health. One where people exit the system better than when they entered it, and where staff have the capacity to deliver high-quality, evidence-based care which really makes a difference in people's lives. We know change won't happen overnight, and that changing an entire system will not be easy. However, the Royal Commission provides a once-in-a-lifetime opportunity to redesign the mental health system and make purposeful changes and we must ensure this opportunity is not lost.

We expect that with a clear vision, improved governance structures, suitable infrastructure and appropriately resourced and funded services with the right expertise, Victoria's public mental health system will once again be at the forefront of high-quality mental health care and treatment.

The RANZCP Victorian Branch looks to the Royal Commission to listen to the voices of those who have experience of the mental health sector, and provide purposeful recommendations for reforms which will meet the needs of Victorians both now and into the future.