



13 August 2020

Mr Chris Tallentire MLA  
Chair  
Joint Select Committee on Palliative Care in Western Australia

By email to: [palcare@parliament.wa.gov.au](mailto:palcare@parliament.wa.gov.au)

Dear Mr Tallentire

**Re: Dr Michael Verheggen questions on notice (Inquiry into Palliative Care in Western Australia public hearing 30 July 2020)**

Thank you for the opportunity for the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Western Australia Branch to provide oral evidence at the public hearing into the Inquiry into Palliative Care.

Dr Michael Verheggen was provided with four question on notice from the Committee. Our responses to those questions are outlined below.

*Question One: Economic modelling on the UK National Health Service (NHS) Rapid Assessment Interface and Discharge (RAID) Model*

We have attached to this letter the economic evaluation of the RAID model. It is important for the Committee to note this modelling is a useful comparison but shouldn't be used as benchmarking for purposes in the Western Australian context. Instead the RANZCP WA Branch suggest the Committee consider the Victorian model (further information on this model is also attached).

The RANZCP Victorian model would be preferred in Western Australia for several reasons. Firstly, the Victorian model would require the least structural change to existing services in WA. Adopting the RAID model would require re-integration of consultation-liaison and emergency services. Whereas in the WA context, the most efficient model in terms of patient flow and ease of access would be linking emergency services to acute community services.

Secondly, the RAID model also prefers nursing-led teams and while this may initially sound more cost effective, senior nurses in WA are compensated at comparable rates to registrars. Vitaly, the Victorian model allows for more registrar staffing, easing the bottleneck in our training pipeline. Increasing training opportunities and helping ease the shortage of general and consultation-liaison psychiatrists would be an additional benefit in the WA context.

The RAID model does have the most robust independent economic analysis, demonstrating a minimum of a 4£ return on every 1£ spent. These services provide an excellent return on investment for hospitals, in addition to the obvious benefits for patient care.

*Question Two: Does the Metropolitan Palliative Care Consultancy Service (MPaCCS) employ psychiatrists?*

No, psychiatry is not included as part of services at MPaCCS.

*Question Three: The Committee has received evidence that the enormity of the challenge to provide palliative care with a tiny workforce has created feelings within the palliative care workforce of helplessness, demoralisation and paralysis. Do you have any comments about that? Have you heard that view expressed before?*

The indirect role of consultation-liaison psychiatry services is the support of our healthcare workforce. Dr Verheggen reports having been approached by a variety of healthcare workers concerned about their own mental health in the context of work-related stressors. This definitely includes members of our palliative care workforce who have expressed distress and demoralisation about their inability to provide the level of care they believe should be available to the Western Australian community.

We note this to be particularly true when the palliative care workforce is supporting patients with complex comorbidity, such as mental illness or substance abuse disorders. Palliative care workers can face difficulties when accessing the appropriate specialist services to assist in managing patients with complex comorbidities who require more time spent caring for them. Tasks can end up being left uncompleted due to insufficient resourcing and workforce capacity. This can of course be demoralising.

*The submission notes that early intervention with consultant-liaison psychiatry can significantly reduce suffering and can sometimes facilitate otherwise intolerable life-saving medical treatment.*

*Some other submissions have raised concerns that there is a public and professional perception that palliative care is solely for the elderly and imminently dying, and that a shift in this understanding is needed to ensure early referral of patients to palliative care services. Do you have any additional comments about the importance of early intervention?*

Early intervention is vital for many people with potentially fatal illness, and failure to intervene can mean the difference between curative versus palliative treatment. A recent example was a man with initially treatable throat cancer who planned to undergo radiation therapy with curative intent.

This man was also opiate dependent, and experienced significant opiate withdrawal whenever he was admitted to hospital. This resulted in frequent discharge against medical advice to obtain opiates and, when he was withdrawing, significant agitation and tremors. This agitation and tremor meant that he was physically unable to lay still enough to have radiation therapy. By the time he was referred for a mental health assessment (and access to opioid substitution therapy), his cancer had progressed to the point where curative treatment was no longer viable. Earlier intervention and better access to services could have meant this man's cancer might have been cured.

Even in situations where curative treatment was never a viable goal, early consultation-liaison psychiatry is often incredibly important. When a person is suffering from distressing psychiatric symptoms (whether that be low mood, anxiety, grief, psychosis, etc), these

symptoms can severely impact a person's quality of life and reduce their ability to spend quality time with their family and friends. In palliative care, optimising quality of life is the primary goal. When a person has potentially very little time left, managing these symptoms quickly is vital.

There is an impression within the community that palliative care is solely for the imminently dying. This can lead to people not being referred to palliative care services by their treating healthcare professionals, or people being reluctant to accept seeing a palliative care team. But palliative care teams are the experts in managing complex, difficult to treat symptoms at any stage of illness.

The right time to refer to palliative care is whenever a patient has distressing symptoms that have been difficult to manage. This can ensure that people receive early treatment and have the best control of distressing symptoms for their entire illness journey. At times, this may apply even to people who don't have terminal illness at all.

The RANZCP WA Branch hopes these responses are useful for the purposes of the Committee. We look forward to reading the final report in due course. If you have any further questions related to the content of this letter or our earlier submission please don't hesitate to contact me via Amelia Rhodes, Policy Manager (Branches) at [amelia.rhodes@ranzcp.org](mailto:amelia.rhodes@ranzcp.org) or on (03) 9601 4921.

Sincerely



Professor Megan Galbally  
**Chair, RANZCP WA Branch Committee**