Submission to Victorian Royal Commission into mental health.

We, the undersigned, a group of senior Victorian psychiatrists with decades of combined clinical expertise and a sound knowledge of the local mental health system, from public, private practice and academic perspectives, write in response to the Victorian Mental Health Royal Commission. A number of us have written about key points raised in this letter, and provide these publications for your reference and for source references. We restrict ourselves largely to public sector service provision for people with so-called 'severe' mental illnesses such as schizophrenia and related disorders and severe mood disorders, but stress the importance of linkages between public and private mental health service providers.

KEY POINTS:

- The **funding envelope** for mental health should be ring-fenced
- **Funding should be expanded** relevant to disability
- A **transparent process of decision-making** regarding mental health service reform is required
- **State and Commonwealth planning** regarding mental health services **need to be aligned**
- **Alignment of mental health and drug and alcohol services** is imperative.
- **Coherent longitudinal care** needs to be the prevailing ethos
- Current **system silos** should be **dismantled** as far as possible
- Linkages between **community and inpatient services** should be strengthened
- The current **under-provision of psychiatric inpatient beds** requires urgent and active redress
- The **physical health care** of the mentally ill must be prioritised
- **Linkages** between mental health services and other relevant services need concerted attention
- **Research** into and evaluation of clinical services should be prioritised, along with **world-leading clinical research hubs**

De-hospitalisation (often referred to as 'deinstitutionalisation') shifted the focus of care of people with severe mental illnesses into the community, with increasing complexity of service provision arrangements. There have been no major pharmacological breakthroughs for people with severe mental illness for decades, and prevention and early intervention programmes have not reduced the burden in any meaningful way. In this context, a major issue for mental health service providers lies in the sheer intensity of requirement for face-to-face work with patients and families, to ensure excellent mental health care. In addition, there is a need to liaise with other service providers, including those in primary care, specialist medical care, education and rehabilitation.

Closing the asylums and old style psychiatric hospitals and shifting care to the community has had some significant benefits, but it has unfortunately also resulted in a policy direction that accepted both a very significant loss of mental health beds and with it the capacity to provide adequate levels of high acuity care. It has also been a way for governments to save money, and this has been to the detriment of many patients.

In Victoria, it is regrettable that successive state governments have failed to ensure mental health funding has kept pace with patient needs and population growth, and our state is now the lowest in the nation in terms of per capita spend on mental health.

Much of the new monies in mental health have been directed at early intervention and prevention services, but the fact is that too many Victorians with mental illnesses have ongoing symptoms of mental illness as well as suffering from poor physical health and social exclusion. Their families are inevitably drawn into this vortex. People with enduring mental illness need concerted and ongoing care, not restricted to youth or to the first few years of illness. Mental health services can and should provide such ongoing, recovery-focussed care, but services need to be properly funded and configured to ensure this happens.

Where monies have been allocated to state-based services to try to meet some of the needs of people with enduring illnesses, health services often 'top slice' or 'tax' these allocations such that only a proportion reaches the coal face to enhance service delivery. This has been compounded by Commonwealth monies being expended on mental health in a manner that is not integrated with extant state-funded services: this leads to major problems in terms of dislocated care, complex care systems and lack of knowing who has responsibility for what.

Another major pressure on the public mental health system is the increasing rate of use of drugs of abuse, with consequent escalations in emergency department attendances and acute inpatient admissions and high rates of aggression to staff and other patients. In this context, the ongoing division of mental health and drug and alcohol services remains a major barrier to integrated care and precludes proper planning and coherent service delivery.

The advent of the National Disability Insurance Scheme (NDIS) has been hugely disruptive to services which traditionally offered psychosocial support to people with a mental illness. In Victoria more than in other Australian states, funding was withdrawn from many psychosocial support programs in the wake of the NDIS. The NDIS scheme itself is clearly not meeting the needs of many people with an enduring mental illness and indeed is predicated on 'disability' whilst people with a mental illness seek 'recovery'.

Fundamental reform is required regarding:

1) The **funding envelope** for mental health being ring-fenced such that it is expended where it is intended
2) An **expansion of funding** such that compatibility is reached with the spend on other areas of health, relevant to disability
3) A **transparent process of decision-making** regarding mental health service reform, rather than the current reliance on lobbying and one or two prominent voices holding sway: governments at both state and Commonwealth levels need to set up a properly inclusive advisory system, with transparency regarding how decisions are made and how service initiatives are evaluated; we advocate strongly for psychiatrists being front and centre in this
4) **State and Commonwealth planning regarding mental health services need to be aligned** and made coherent and consistent
5) **Alignment of mental health and drug and alcohol services** is imperative.

A number of key other points need to be made.

1) Coherent **longitudinal care needs to be the prevailing ethos,** such that people with a mental illness can be supported appropriately by a consistent care team
2) Current **system silos**, such as those with age cut-offs or those with community vs. inpatient barriers and divisions should be **dismantled** as far as possible, and services should be designed such that 'care follows the patient'
3) Any attempt to disaggregate governance between **community and inpatient services** should be strongly resisted, as this merely feeds silo mentalities and undermines continuity of care
4) The current **under-provision of psychiatric inpatient beds** in the public sector requires urgent and active redress: Victoria is way below OECD and national benchmarks in this regard, with upstream pressures being felt daily in emergency departments and downstream by staff and families dealing with acutely unwell patients discharged too soon and with ongoing risk issues, including suicidality; the bed provision should encompass acute as well as a range of longer-term options
5) The importance of **psychiatrists as specialist mental health experts** needs to be reinforced and efforts made to enhance attraction and retention to public sector mental health services; this will also ensure excellence of training for junior staff
6) People with a mental illness should have an expectation of a level of **physical health care** compatible with that provided to other members of the community, and proactive action is required to help them address particular needs including smoking cessation and reduction in cardiovascular risk in particular
7) **Linkages** between mental health services and other services relevant to the lives of people with mental health problems need concerted attention: these include NDIS, Centrelink, and non-clinical service providers.

Finally, support for **research** into and evaluation of clinical services should be prioritised, along with **world-leading clinical research hubs** addressing specific areas of need. These should be seen as additional to a fully functional integrated public health system, and should work in collaboration with such core services but offer special care to specific need groups, such as people with treatment-resistant psychotic disorders; severe obsessive-compulsive and other anxiety disorders; complex attention deficit disorder; and people with complex mental health and drug and alcohol comorbidities, to name just a few. The Melbourne Neuropsychiatry Centre could be seen as a model, as it encompasses academic rigour with clinical excellence in a tertiary setting. A further virtue of establishing such clinical research hubs is the ability to enhance and build the next generation of clinician researchers: we currently have no such 'pipeline'.

In conclusion, we do not support a dismantling of the current system. We need to build on current service structures but enhance them, with attention to the issues raised above. Transparent, collaborative and informed decision-making is required and robust structures built to ensure mental health care becomes more than a political football.

Sincerely

Bruce Singh (FRANZCP 1978),
David Castle (FRANZCP 1999),
David Horgan (FRANZCP 1981),
Bruce Batagol (FRANZCP 1975),
David Copolov (FRANZCP 1982),
Peter Adams (FRANZCP 1988),
Christos Pantelis (FRANZCP 1999),
Christine Simons (RANZCP Affiliate 1975),
Amit Zutshi (FRANZCP 2005),
Samir Ibrahim (FRANZCP 1997),
Esta Papier (FRANZCP 1983),
Michael Piperoglou (FRANZCP 1986),
Tony Miach (FRCPC 1975),
David Tofler (FRANZCP 1982),
Rosemary Schwartz (FRANZCP 1978),
Barbara Matheson (FRANZCP 1990),
Sheryl Lawson (FRANZCP 1985),
Rebecca Adams (Dip American Board Psychiatry & Neurology 1998),
Jaya Reddy FRANZCP 2002),
Abe Zelwer (FRANZCP 1978),
Manjula O'Connor (FRANZCP 1980)

ATTACHMENTS