Australian Salaried Medical Officers' Federation

ASMOF Submission to Productivity Commission: *The Social and Economic Benefits of Improving Mental Health*

The Australian Salaried Medical Officers' Federation (ASMOF) is the Doctors' Union, representing over 12,000 Registered Medical Practitioners. ASMOF would like to thank the Productivity Commission for the opportunity to respond to this Issues Paper.

ASMOF's response will address the Terms of Reference and questions raised within the Issues Paper with a focus on:

- Reform of the mental health workforce including our rural and regional workforce;
- reducing mental health staff turnover;
- doctors' mental health and wellbeing in the workplace;
- better integration of clinical and non-clinical services; and
- the bigger picture of mental health reform needed to improve population health.

In order to inform our response to this Inquiry we surveyed ASMOF members working in Psychiatry and Emergency Medicine in the NSW public sector. These two groups of specialists have unique expertise and insights into what reform is needed to promote better mental health in our communities, and realise the social and economic benefits of healthy communities.

The most consistent theme throughout the responses ASMOF received was that mental health was significantly under-resourced by governments. The current investment in mental health is clearly not delivering the best outcomes for individuals, their families, society and the economy, and is not allowing psychiatrists and our broader mental health workforce to deliver optimal care. Doctors' already face challenges to their mental health and wellbeing due to challenging working conditions, and this under-investment further amplifies the stress experienced by doctors employed in mental health services. Our response will therefore highlight where resources can be targeted to gain the best improvements in the mental health of all Australians.

Thank you for considering our response to this Inquiry. If you would like any further information on anything raised within this submission, please contact Carolina Simpson, Policy Officer, by phone on (02) 9212 6900

Yours sincerely,

Professor Geoff Dobb
President, ASMOF

1. Mental health workforce

Of the 86 staff specialists ASMOF surveyed, 91% agreed that the configuration and capabilities of the mental health workforce need to change.

When we asked specialists what they think needed to change, a consistent theme within responses was that the 'workforce is not matched to the workload'. Doctors reported treating greater complexity in patient presentations, frequent comorbidities such as drug use, and compounding psychosocial issues. Doctors responses clearly indicate that public mental health services are under-resourced in both community *and* acute care settings, and capacity needs to be increased across the board. The Issues Paper has noted that mental health reform is already underway, but under-resourcing of existing services must be urgently addressed to genuinely improve outcomes and increase participation for people experiencing mental ill-health.

Doctors say:

'Redesigning the whole system risks a waste of time and money. I would support a thoughtful consideration of how current services can be supported to review and increase their delivery in key areas.'

'We need psychiatrically trained doctors available in the community in the public health system. At present there are significant numbers of people who need access to psychiatrists who cannot afford the private system'

'The basic community mental health teams should remain in place and be enhanced and properly resourced. They are the foundation for providing care to people with complex, enduring, recurring mental illness and those who are acute and at high risk...However, there does need to be a re-configuration of pathways of care for the general population that incorporates a stepped care model as articulated by the NMHC. It is essential to understand that this is not an "either/or".'

'Community mental health teams provide less service than they did when I started in Emergency Medicine almost 30 years ago. This is the area of medicine that has gone backwards in service delivery in my experience. On top of this there are too few mental health inpatient beds for the demand.'

'There needs to be more resourcing in terms of staff and money of public sector community based mental health services. There is also a chronic shortage of mental health beds in both the public and private sectors that would not be tolerated in other areas of health.'

Psychiatrists were keen to see that the mental health workforce was available as early as possible, accessible when and where it is needed, and better matched to the needs of people experiencing mental ill-health (person-centred). Psychiatrists also drew attention to the need to change the configuration of the workforce to better deliver support to families and communities, not just individual patients. Our members also spoke of the need for multi-disciplinary input to deliver holistic care.

Doctors say:

'A much greater focus on providing a broader spectrum of services at a community, rather than inpatient, level is required. We hear constantly about "person-centred care" but there is very little political/senior medical/ administrative will to restructure service delivery to meet the needs of consumers in practical ways. '

'More locally based care, delivered early, free of charge and with multidisciplinary team input'

'There is a dire shortage of diversional therapists (e.g. one DT for a hospital of hundreds of psychiatric patients) exercise physiologists, and dieticians. Lifestyle issues (inadequate exercise and unhealthy diet) are, over all, some of the most powerful (but under-recognised) causes and perpetuators of serious mental disorders and illnesses. These services are crucial at all stages of prevention.'

'more focus on whole of family care including perinatal services'

'Increase 24 /7 inpatient and extended hours outpatient senior medical support'

'Being able to include family members in sessions, and to seek collaboration in mental health care, is essential to the successful provision of care.'

'Reformulating scopes of practice from hospital vs community paradigms to more person-centred or community-oriented paradigms would represent a more person-centred approach which values psychological continuity in terms of the person's experience of the service. Extending scopes of practice to roles that engage with communities (not just individuals) might also be worth exploring.'

Doctors also emphasised the value of clinical knowledge, and the importance of ensuring that the mental health workforce (including case workers) had the appropriate clinical skills required to provide the best care. Doctors also expressed concern around broad mental health worker roles, and drew attention to the benefit of clinical skills for improving outcomes for patients.

Doctors say:

'Some NDIS funded roles are supportive but sub-clinical and not a substitute for clinical support'

'Loading teams with generic 'mental health workers' also diminishes and downgrades allied/ mental health professionals' specific skills and roles, disadvantages patients who could benefit from truly specialised expertise.'

'I would like to see increasing upskilling of the workforce to include evidence based treatments such as cbt [Cognitive Behaviour Therapy] and dbt [Dialectical Behaviour Therapy] widely available'

'Case Managers are often grossly under-used. They need upskilling in therapy'

'More training in the psychological impact of trauma of all sorts and of the impact of psychological impacts of illnesses'

'I would suggest more use of specific clinical skills rather than a generic Mental Health Worker role'

Rural and regional workforce

Geographical maldistribution is an ongoing issue and concerns around this have been well ventilated. In order to attract specialists to these positions, there needs to be adequate incentives, better conditions and active efforts to prevent doctors from being isolated.

Doctors say:

'Need to make the jobs more attractive in a multidimensional way - get pay and conditions right, get the culture right'

'Financial incentives. When corporations need staff to relocate to remote areas they offer huge financial incentives, even defence employees get good incentives. Health doesn't offer anywhere near this and wonders why they don't have staff'

'I work in a regional area. The answer in this area is not technology, but incentives for psychiatrists to work outside the metro areas'

'Mental health care is hard to do as an isolated practitioner so often people are employed and burn out quickly.'

'In my experience the supervision and support for many young professionals who go to the bush is non-existent.'

'need to have extra benefits when compared to the workers work in metropolitan areas; as the workers work in regional areas are having less community facilities (i.e. schools for kids, leisure options , issues with transportation etc....)'

Many of our members acknowledge the important role of telehealth and quality systems in improving access to mental health care, however doctors do not consider telehealth substitute for face to face care. Doctors had particular concerns about access for vulnerable groups:

Doctors say:

'I have 10 years experience with telepsychiatry and it can be useful but is not a substitute for face to face, more a useful adjunct for an expert opinion'

'Establishment of rapport is so important with these types of consults and it is uncertain whether this can be achieved with the existing technology'

'Most patients I see are not tech savvy and live in poverty. Our service is currently bleeding money employing many locums, most of whom are medical staff.'

'I am aware of some rural areas where the use of videoconferencing has significantly improved clinical support in rural areas'

'Telehealth and online chat options are still in their infancy but could be developed to be acceptable and appropriate - providing it is tested at both patient and clinician ends for cultural appropriateness, not just IT effectiveness.'

'beware of ending up like Centrelink, and requiring vulnerable patients to have access to mobile phones, good internet and considerable tech literacy, if they want to access services'

2. Mental health staff turnover

The under-resourcing which has been detailed in this submission leads to doctors are working in systems in which they are not able to deliver the care they want to, and these system failures impact doctor's morale and satisfaction in their role. The psychiatry workforce is facing a future undersupply, and working conditions are a key factor in this. When we asked members what could be done to reduce stress and turnover in the mental health workforce, the majority of members said that turnover would be improved by having more staff.

Doctors say:

'The obvious answer is for increased staffing and resources in general.'

'More bodies. Workloads in my service have increased by 50% in the last 10 years with no increase in staff at the front line.'

'Recruit to all vacant positions as soon as it is clear that a vacancy will arise, including maternity leave. ...All too often, vacant positions have been used to "balance the budget", at the cost of service delivery to consumers.'

'Better staffing levels would help a lot. That would mean better training, pay and conditions for some professions.'

Specialists working in public mental health services are more likely to be taking on patients experiencing extreme mental distress, and they are frequently working through crises. This workload does not provide balance for clinicians and can put our mental health workforce at greater risk of burnout. ASMOF asserts that all staff specialists should be able to have access to non-clinical time to benefit from professional development, teaching and research opportunities. Meaningful non-clinical time must be factored into the normal duties of our psychiatry workforce and articulated in formal agreements.

Doctors say:

'I work as a psychiatrist in a general hospital and a number of other specialities get "non clinical" periods as part of their job. This is never considered for us despite the high intensity nature of the clinical work that we do. It would be good to see this being acknowledged.'

'There needs to be reform of the professional awards to make working in the public mental health services more attractive and to better support professional development, reflective practice and the application of improvement science to patient outcomes. The issues that need to be addressed include: leave relief, non-clinical time to allow professional development, supervision and quality improvement, extending normal hours of operation beyond 9-5 Mon- Fri'

'More continuing professional development (seminars, conferences etc.) for a variety of disciplines (accessible for little or no cost) would stimulate, inspire, motivate, refresh and educate professionals. Reduced patient loads allows greater opportunities for pursuing research which should broaden the field further beyond elite, well-staffed professorial units.'

'More robust supports for recruitment and retention of clinicians especially in the public sector - e.g. links to career mentoring, clinically applied research partnerships, conjoint university positions'

Our members frequently reported being overburdened with administrative processes which can be a drain on their time. Although administrative support may be stipulated in industrial agreements across Australia, it is often unavailable. Decreasing the administrative burden on our workforce will

improve workplace satisfaction and allow doctors to focus on meaningful work.

Doctors say:

'I have worked in my current role without any Admin support for almost 8 years, just because some boffin decided that Administrative support is not a 'front-line clinical service'. Instead, I am the most overpaid useless secretary in the State, having to use a significant proportion of my clinical time on routine Admin tasks.'

'support with admin and clerical tasks is woeful we are asked to collect all these statistics but and when very clinically busy it just goes by the wayside which paradoxically means that resources aren't allocated because you look much less busy than in fact you are'

'There are increased requirements for adherence to mandatory paperwork, greater accountability and transparency and this requires more time than previously was needed.'

'less administrative tasks, or more administrative support'

'Some record keeping is meaningless and has definitely become excessive and takes away from time being spent with patients'

3. Doctors' health and wellbeing

A review of doctors' mental health undertaken last year noted that whilst the physical health of medical practitioners is better than average, they are at significantly higher risk of mental illness and suicide than the general population.[i] The review identified that the risk factors for depression and suicide in medical practitioners are work stress and burnout, which are common in the medical profession.[ii] Young doctors, Aboriginal and Torres Strait Islander doctors, and female doctors may be particularly at risk, and report the highest rates of stress and burnout.[iii]

Working conditions

Unsafe workplace conditions which see doctors working extreme hours and experiencing high levels of fatigue are of significant concern to ASMOF. A 2016 study conducted by the Australian Medical Association (AMA) found that the average doctor's work week was 78 hours with the average shift lasting 18 hours.[iv]

A recent survey conducted ASMOF and the AMA in NSW - the Hospital Health Check- provides further, clear evidence that doctors-in-training are working too many unsafe hours. The Hospital Health Check found that of the 1351 doctors-in-training who responded, 65% were worried their fatigue could lead to clinical error.[v]

The Australian and international evidence about the damaging effects of excessive hours of work is undisputed. Unsafe working hours and practices are a significant risk factor in the health and wellbeing of doctors. The risks of these onerous hours represent not only a risk to the health of

doctors but their patients as well. The evidence shows that reducing excessive work hours, increasing available resources and exploring new rostering initiatives are essential prevention solutions.

A National Framework that addresses doctors' mental health is currently being developed by Everymind in partnership with the AMA, the Australian Medical Students Association (AMSA), Doctors Health Service, Orygen, The National Centre of Excellence in Youth Mental Health, the Black Dog Institute, Standby Support After Suicide and a number of doctors and doctors-in-training. It was funded by the Australian Government as part of the Prevention Hub (co-led by the Black Dog Institute and Everymind) and specific project funding for Tackling Mental Ill-Health in Doctors and Medical Students.

The draft framework notes that internationally there has been a shift away from targeting individual risk factors in the workplace to a broader approach which identifies the key characteristics of a 'mentally healthy workplace'. The first area of identified reform within this draft framework is therefore primary prevention and improving the training and work environment to reduce risk. The framework calls for a review of workplace entitlements across Australia to incorporate best practice clauses including but not limited to:

- Access to leave
- Overtime (un-rostered)
- Overpayment recovery
- Protected teaching /training time
- Professional development leave (exam and conference)
- Roster design and management
- Safe hours
- Fatigue management
- Family friendly arrangements

ASMOF is strongly supportive of this recommendation and we call for doctors work to be covered by Awards and Agreements that are up to date and fit for purpose. ASMOF recommend that these fundamental working conditions must be improved to enhance the wellbeing of our mental health workforce, and to ensure that they are able to deliver safe, quality care to their patients.

Mandatory Reporting

Another immediate priority articulated in the Draft Framework is the need to amend the mandatory reporting legislation across Australia to remove structural barriers to doctors and medical students seeking support from other doctors. Existing mandatory reporting regimes provide a disincentive for doctors from accessing treatment for mental health issues on the basis that seeking treatment for any such condition would require the treating practitioner to notify the Australian Health Practitioner Regulation Agency, potentially resulting in the doctor having conditions imposed on their practice, or even being suspended from practice with profound effects on their career. Any reluctance to seek assistance has a direct impact on the health and wellbeing of the doctor, his/her patients, colleagues and family.

ASMOF calls for reform in this area to ensure that there are confidential and effective pathways overcome barriers to seeking help across the medical profession. Currently Western Australia is the

only jurisdiction which exempts treating doctors from reporting their doctor patients, and we recommend amendments to the legislation across other states and territories to match the WA model.

> **Doctors say:**
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> 'I think we really need to look at the Mental Health of Health care workers across all sectors (especially emergency and critical care, as well as Psychological services) - if we are not mentally healthy ourselves, we cannot offer the best services.'

4. Integration of clinical and non-clinical services

The concept of integrated care has been promoted across health services. However doctors often find that non-clinical services are difficult to navigate, in a constant state of change, may be inaccessible due to inadequate capacity or referral criteria, or are under-resourced. Their comments on integration also draw attention to inefficiencies in the delivery of mental health services by multiple providers.

> **Doctors say:**
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> 'Non-clinical staff turnover is too high. NGOs change, their staff change etc. It causes therapeutic challenges.'
>
> 'Incredibly time consuming and laborious to access non-clinical mental health services.'
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> 'Understanding how and what support is available would be great. In my sector the NDIS has us baffled. The system changes and it can be very hard to learn how to navigate the new system and I don't have a mental health issue to make it harder.'
>
> 'I think that there are too many organisations doing similar things such as Headspace, Early intervention, CAMHS [Child and Adolescent Mental Health Services] and many more. Each organisation has a hierarchy and it costs a lot of money to employ the governing bodies....As a clinician working in an acute inpatient unit for adolescents it is often frustrating when struggling with organising the follow-up after hospital admission as many services are under-resourced (CAMHS) and the ones that have a lot of resources (Headspace) only take cases that are not severe, avoiding any complications (catering for the "wealthy well").

Whilst there are often networks set up to support integration between these services, they tend to be informal. Participation in these networks also requires time away from clinical care, which may not be feasible in over-stretched environments. Suggestions from specialists as to how this could be

improved include restructuring to prevent silos, more formal co-ordination, co-location, and investment to insure integration does not come at the expense of clinical care.

Doctors say:

'Rather than outsource everything to NGOs and then having fragments of services I think having more integrated service that provides this and can see everyone. NGOs tend to see the simpler cases and then leave the very complex cases to the public service. They also don't continue serving when their funding runs out. This makes for a very disjointed and ineffective system.'

'more resources so we have more time to liaise with these services directly.'

'We try to coordinate but end up spending a lot of time in case conferences which takes time from clinical care. Perhaps co locate services to make this easier?'

'It would be much more practical to have one public organisation that gets all the funding and then caters to the need of the local population. In this way there would be one door for all needs and there would be no overlapping/competing services.'

'There needs to be cross-agency / multi-agency coordination for patients using MH services - many have housing and other welfare needs (outside of Health) which cannot be managed alone by MH or acute services (such as EDs). Currently, there is little formal work addressing this, and few formal networks which are capable of coordinating this care in the community, as well as managing crisis care. The formal framework must be set up to allow this cross-agency work, and be led by case workers in the community who could coordinate input from various agencies (health, housing, social welfare, police, ambulance for example).'

5. Big picture reform

In order to inform our response to this Inquiry, ASMOF asked doctors what they believe is the most essential reform to improve population health. The views of our members draw attention the bigger picture of mental health reform, particularly in terms of intervening as early as possible, ensuring basic standards of living are met (including proper housing and adequate income), addressing inequities and building social capital and cohesion. Their responses point to the importance of the Productivity Commission examining how sectors far beyond health contribute to improving mental health. Although often working in crisis mode, doctors' recognise that broader interventions are required to support mental health. ASMOF strongly encourages the Commission to address the bigger picture of reform and consider how inequities can be reduced in order to facilitate the social

and economic participation of all Australians.

Doctors say:

'An economic analysis of what macroeconomic reform could do to improve population mental health has been lacking in Australia, unlike work done in Canada and the UK. Arguably greater investment in supporting early childhood education and heath (0-5 years) and parents would have a greater impact on the future mental health of the nation and its economic development. Such an exercise was done in Ontario 20 years ago and led to substantial government and private investment in services and programs to support infants, parents and young children in an effort to prevent future mental illness and improve cognitive and social development of those children.'

'Whatever social miracle it would take to reduce child sexual and physical assault and neglect. Massive inputs to ensure decent housing available for disadvantaged groups. Some system that provided early childhood interventions and parenting programs.'

'Make society more equitable, improve employment conditions across the board, create some social cohesion and engagement, better urban design to encourage physical exercise and social connection.'

'Early education to improve resilience, increase access to service, decrease stigma, increase inclusion, reduce risk factors to mental illness such as homelessness, low level education, domestic violence, drugs and alcohol. That government and policy makers include those with experience in forming their directives.'

'What ultimately needs to occur is proper recognition of the social and political underpinnings of poverty, disadvantage and therefore mental illness in Australia. For example, the signing of a Treaty with Aboriginal people nationally, statewide and within local areas - based on the Uluru Statement from the Heart - will provide the only significant shift that can alter the current entrenched pattern of genocide of Aboriginal and Torres Strait Islander peoples.'

'Social capital. It is a huge problem. Our society is becoming increasingly disparate and divided. As people become poorer and crowded, they become anxious or angry, isolated and vulnerable. We need a vision for the holistic health and wellbeing of all Australia that government will actually use to guide decision making across many areas of policy. It's not just about money.'

'We need to rebuild social capital and foster social connectedness at every level. The economy needs to serve the society, rather than the society serving the economic masters.'

 'More evidence-informed early intervention programs with families of infants and toddlers and regarding perinatal anxiety and depression for parents. Supporting adequately resourced and longitudinally tested mental health programs (this needs clinical/research partnerships). Tackling especially externalising problems like inattention, aggression and learning problems in boys. Combating racism and promoting social inclusion, intercultural understanding, acceptance/belonging and social diversity in primary and secondary schools. Understanding the influences of social media on (especially child and youth) mental health and more effectively avoiding adverse social impacts by educating about preferred and alternative models - including in schools and mental health services Funding for initiatives to beat depression and anxiety using integrated community and health approaches as in Europe (EAAD program [European Alliance against Depression]). Targeting poverty by increasing Newstart payments and campaigning for a basic wage.'

'Affordable housing… Followed by a rise in the basic minimum wage and a way of offering an unconditional living allowance across the board to low income folk.'

 'Improve access to affordable, safe housing.'

[i] Bailey, E., Robinson, J., & McGorry, P. (2018). Depression and suicide among medical practitioners in Australia. Internal Medicine Journal, 48(3), 254-258. doi: 10.1111/imj.13717

[ii] *ibid.*

[iii] *ibid.*

[iv] Australian Medical Association (2017), *Managing the Risks of Fatigue in the Medical Workforce: 2016 AMA Safe Hours Audit*, accessed at https://ama.com.au/system/tdf/documents/v1%202016%20AMA%20Safe%20Hours%20Audit%20Report.pdf?file=1&type=node&id=46763

[v] The Alliance, ASMOF (NSW) and AMA (NSW) (2018), 2018 Hospital Health Check Results, accessed at http://www.alliancensw.com.au/hospital-health-check-2018/