

Acknowledgements

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We acknowledge the traditional owners of the land on which we live and work and the role of Indigenous doctors as critical to the health of all Australians.

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The working group that actively guided the development of this framework included Dr Benjamin Veness (Psychiatry Registrar), Dr Jessica Dean (Intensive Care Registrar), Alex Farrell (President

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Other members of the Leadership Group for *Tackling Mental Ill-Health in Doctors and Medical Students* who contributed to the framework include: Prof. Helen Christensen, Assoc. Prof. Sam Harvey and Nicole Cockayne (Black Dog Institute), Prof. Patrick McGorry (Orygen, the National Centre of Excellence in Youth Mental Health), Dr Janette Randall, (Chair, AMA Doctors' Health Services Board) and Dr Margaret Kay (Queensland Doctors' Health Programme).

The framework also benefited from the input of representatives across the medical profession including colleges, societies, associations, training organisations, employers, regulators, organisations supporting the wellbeing of doctors, as well as individual doctors and medical students.



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The framework at a glance

The time is right to set a reform agenda in Australia that positions the mental health and wellbeing of the medical profession as a national priority, requiring coordinated action across all settings and all stages of career.

Improving the wellbeing of doctors and medical students is a key enabler of quality patient care and healthier communities. This framework is based on available evidence and advice from doctors, doctors-in-training, medical students, mental health and suicide prevention experts and other key stakeholders. All jurisdictions, settings, services and stakeholders must be involved to ensure immediate, sustained and coordinated action.

The Vision: A medical profession that works and studies in environments that support wellbeing and enable quality patient care.

The Goal: Coordinated action to prevent mental ill-health and suicidal behaviour and support good mental health for all doctors and medical students.

The guiding principles:

The wellbeing of the medical profession is a national priority, requiring a coordinated and resourced approach.

- Environments that value, develop and support the medical profession are conducive to good patient care.
- Targeting the structural and environmental risk factors impacting on the medical profession is an immediate priority.
- Medical professionals who experience mental ill-health and suicidal behaviour can and do provide quality patient care.
- Support from all key stakeholders is required to ensure implementation and evaluation of evidence-based interventions across all settings.

Stakeholders

Governments and health ministers (state and federal); medical colleges and training providers; health departments, community health services, hospitals (public and private) and primary care; government regulatory agencies; universities; professional associations; specialist health services for medical professionals; national mental health and suicide prevention agencies.

Endorsing agencies

Australian Government Department of Health, Australian Medical Association, Australian Medical Association Council of Doctors in Training, Australian Medical Students' Association, Avant Mutual, Council of Presidents of Medical Colleges, Doctors' Health Services Pty Ltd, Medical Deans Australia and New Zealand Inc.

Pillars for coordinated action and key targets

/01

PRIMARY PREVENTION

Improve training and work environments to reduce risk

- 1.1 Systems change to prevent job strain, fatigue and burnout across the medical profession.
- 1.2 Safe and inclusive training and work environments, where bullying and discrimination are not tolerated.

/03

TERTIARY PREVENTION

Improve response to doctors and medical students impacted by mental ill-health and suicidal behaviour

- 3.1 Recovery-at-work practices are implemented across all settings where medical professionals work, study and train.
- 3.2 An effective postvention response system is built to support doctors and medical students following suicidal behaviour.

/02

SECONDARY PREVENTION

Improve capacity to recognise and respond to those needing support

- 2.1 Mandatory reporting legislation exempts treating doctors from reporting their doctor or medical student patients.
- 2.2 The medical profession is empowered to better identify and respond to mental ill-health and suicidal behaviour.
- 2.3 Doctors and medical students at increased risk of mental ill-health and suicide are supported across settings.
- 2.4 Effective pathways to evidence-based care are available to the medical profession.

/04

MENTAL HEALTH PROMOTION

Improve the culture of the medical profession to enable wellbeing

- 4.1 Strategies to improve the health and wellbeing of the medical profession are implemented.
- 4.2 Leaders and supervisors are developed to support the wellbeing of doctors and medical students.

/05

LEADERSHIP

Improve coordinated action and accountability

- 5.1 A national leadership group is resourced to oversee the implementation and monitoring of the framework.
- 5.2 Mechanisms for effective communication about policy, practice and research are established.
- 5.3 An adequately resourced research and evaluation strategy is developed and implemented.

About the framework

Supporting the health and wellbeing of doctors is vital to ensuring a strong, effective medical profession. Doctors are a critical part of health services and are crucial to the health of individuals and communities. Until recently, however, the mental health of the medical profession, including building mentally healthy environments for doctors and medical students, has received little attention in policy, despite research clearly indicating the need for intervention.

This framework brings together the best available evidence on what works to prevent and respond to mental ill-health and suicide and applies it to the medical profession. The framework:

- Encourages a strategic and integrated approach to improving mental health and wellbeing and reducing risks associated with mental ill-health and suicide;

- Offers an evidence-informed framework with priority actions that are relevant to the medical profession and the environments in which doctors and medical students work, study and train;
- Builds on the capacity of leaders in the medical profession to create environments and systems that support mental health and wellbeing.

The framework was developed under the guidance of a national working group and draws on a review of the evidence, consultations with doctors, doctors-in-training, medical students and other key stakeholders in the medical profession, and best practice in policy and programs nationally and internationally.

Commitment from a range of stakeholders is key to the success of this framework and will ensure a comprehensive and coordinated approach.

Stakeholders	Role
Doctors and medical students	<ul style="list-style-type: none"> – Be empowered to take action on their own mental health and support colleagues.
Governments and health ministers (federal and state)	<ul style="list-style-type: none"> – Endorse this framework and support relevant actions through national mechanisms.** – Provide national and state funding to support implementation and evaluation of this framework.
Key medical stakeholders such as: medical schools; medical colleges and training providers; health services and hospitals (public and private) and primary care; regulatory agencies (AMC, AHPRA, MBA); professional and support services, and advocacy groups	<ul style="list-style-type: none"> – Support national action by signing up to the vision and pillars for coordinated action outlined in this framework. – Develop, implement and report yearly on an action plan aligned to this framework. – Allocate resources to support implementation of this framework.
Doctors' Health Services	<ul style="list-style-type: none"> – Deliver health advisory and referral service for doctors and medical students across Australia.
National mental health and suicide prevention organisations	<ul style="list-style-type: none"> – Consider the medical profession in the development and delivery of mental health and suicide prevention policy, programs and research. – Support implementation and evaluation of the framework.

**National mechanisms include: Council of Australian Governments (COAG) Health Council, Australian Health Ministers' Advisory Council, and the Mental Health Principal Committee overseeing the Fifth National Mental Health and Suicide Prevention Plan.

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Evidence informing the framework

The evidence for creating mentally healthy workplaces

Evidence suggests that work and study environments can either enhance or detract from a person's mental health and have been identified in national and state policies as important settings for programs focussed on mental health and suicide prevention (1,2). Evidence also suggests that creating, building and maintaining a mentally healthy workplace can maximise staff wellbeing, increase productivity and improve patient care (3).

A general review by the Black Dog Institute evaluated evidence-based strategies for creating a mentally healthy workplace (4). This review identified a number of protective factors that may contribute to improvements in mental health as well as risks for mental ill-health in the workplace. These include the design of the job, team factors, organisational factors, home conflict and individual biopsychosocial factors (4).

The evidence for a focus on doctors and medical students

Landmark research conducted by Beyond Blue in 2013 (6) provided the first national data on the mental health of doctors and medical students and highlighted significant issues related to the mental health of the medical profession.

Evidence in Australia indicates that doctors and medical students experience above average outcomes for physical health, but they are at higher risk for mental ill-health and suicide compared to the general population (7). Internationally, there have been a range of different measures used to assess rates of mental ill-health in doctors and medical students. The research consistently demonstrates that the medical profession has an increased risk of depression and anxiety compared to the general public (6,8-12). Data also indicates that there is variable risk for mental ill-health depending upon medical specialty, age, gender and cultural background (6,7,13-17). For example:

- Young doctors have been shown to exhibit higher rates of distress and burnout compared to older doctors with more experience (6);
- Indigenous doctors and medical students report higher levels of psychological distress than their non-Indigenous peers (6);

- Relative to their male counterparts, female doctors report higher rates of depression, anxiety and current psychological distress (6,13,15).

In regards to suicide there exists some discrepancy in the reported level of risk experienced by doctors and medical students. There is research to suggest that female doctors have a higher risk of suicide compared to females in the general population (7,13,15), and some findings indicate that medical professionals have an elevated risk more broadly (9). It is important to note however, that multiple studies recognise that there is inconsistency in reported suicide rates for doctors and medical students throughout the literature and it is difficult to point to one representative figure for the entire medical profession (7,14). Despite this variance in prevalence rates, it is consistently reported that the use of drugs or poisoning is the most common method, which has been attributable in the literature to access and knowledge of use (7,14).

The evidence for individual and organisational approaches

Therapeutic-based programs are the most widely utilised interventions across health services in Australia, which principally focus on building the capacity of individual doctors and medical students to manage their own mental health and wellbeing. Mindfulness-based programs are the most common form of preventative and therapeutic intervention on offer (22,23), but the implementation of these is dependent upon the approach of the institution, and evaluation approaches vary significantly across the range of programs currently operating.

Only a limited number of coordinated organisational-based interventions have been documented that address the way in which training and professional systems interact with the mental health and wellbeing of doctors and medical students (19,20,21). The lack of system-wide approaches, or approaches that target the work and training environments of medical professionals, is a limitation. This has been recognised by some health services and regulatory bodies who have developed structurally-focused interventions in an attempt to move the profession forward (24).

As an example, the *AMA National Code of Practice - Hours of Work, Shift Work and Rostering for Hospital Doctors* (25) was issued in 1999 in response to ongoing concerns about working hours and safe

practice. It acknowledges the special characteristics of the hospital sector as well as the need to manage risks associated with shift work and extended hours for hospital doctors and doctors-in-training. Although the code has been instrumental in shifting workplace practice and changing attitudes (25,26), extremes in hospital doctor working hours persist and many hospital doctors continue to work rosters that place them in higher risk categories. While there have

been some other interventions across a range of medical settings, these tend to operate as silos in each specialty or institution, with limitations to their scope (24). Furthermore, there is a notable gap in the literature that assesses the efficacy of available programs, with variable degrees of evaluation and ongoing review (20). This needs to be addressed.

Evidence from consultations with the medical profession

A series of in-depth interviews and focus groups were conducted to gain rich qualitative data from doctors, doctors-in-training, medical students and other key stakeholders. Interviews and focus groups were conducted with doctors and representatives from hospitals,

universities and colleges. Many of the themes that emerged align with existing evidence and reinforce views from other national consultations and forums in Australia (10). A full summary of consultation themes is presented as Appendix 2 and summarised below.

Themes related to Primary Prevention	<ul style="list-style-type: none"> - Fatigue is a key concern. - A lack of control over work and study conditions. - A “get on with it” culture where the duty of care is to the patients only. - Hierarchical culture where people don’t feel they can ‘speak up’.
Themes related to Secondary Prevention	<ul style="list-style-type: none"> - There are substantial barriers to medical professionals seeking help. - There is a need for tailored support that is suitable for doctors. - Information and training on how to support colleagues would be valued.
Themes related to Tertiary Prevention or Postvention	<ul style="list-style-type: none"> - Mental ill-health and suicidal behaviour is stigmatised in the medical profession. - There is a need for effective responses following a suicide.
Themes related to Mental Health Promotion	<ul style="list-style-type: none"> - Many doctors and medical students experience isolation. - Competition and private practice reduce opportunities for peer support.



Plenty of other jobs, you know, as soon as you get past 13 hours or whatever, or 12 hours, you start getting overtime, no questions asked. Whereas in medicine, there’s like this weird culture that sort of prevents us from being like other industries, and this weird hierarchy that prevents the industry from changing as well.

FOCUS GROUP PARTICIPANT



A framework for action

This framework describes the five pillars for coordinated action and a range of suggested actions to be prioritised across settings to achieve the desired vision and goal. This framework should serve as a guide for a national implementation plan.

This framework is underpinned by the following GUIDING PRINCIPLES:

1. The wellbeing of the medical profession is a national priority, requiring a coordinated and resourced approach.
2. Environments that value, develop and support the medical profession are conducive to good patient care.
3. Targeting the structural and environmental risk factors impacting on the medical profession is an immediate priority.
4. Medical professionals who experience mental ill-health and suicidal behaviour can and do provide quality patient care.
5. Support from all key stakeholders is required to ensure implementation and evaluation of evidence-based interventions across all settings.



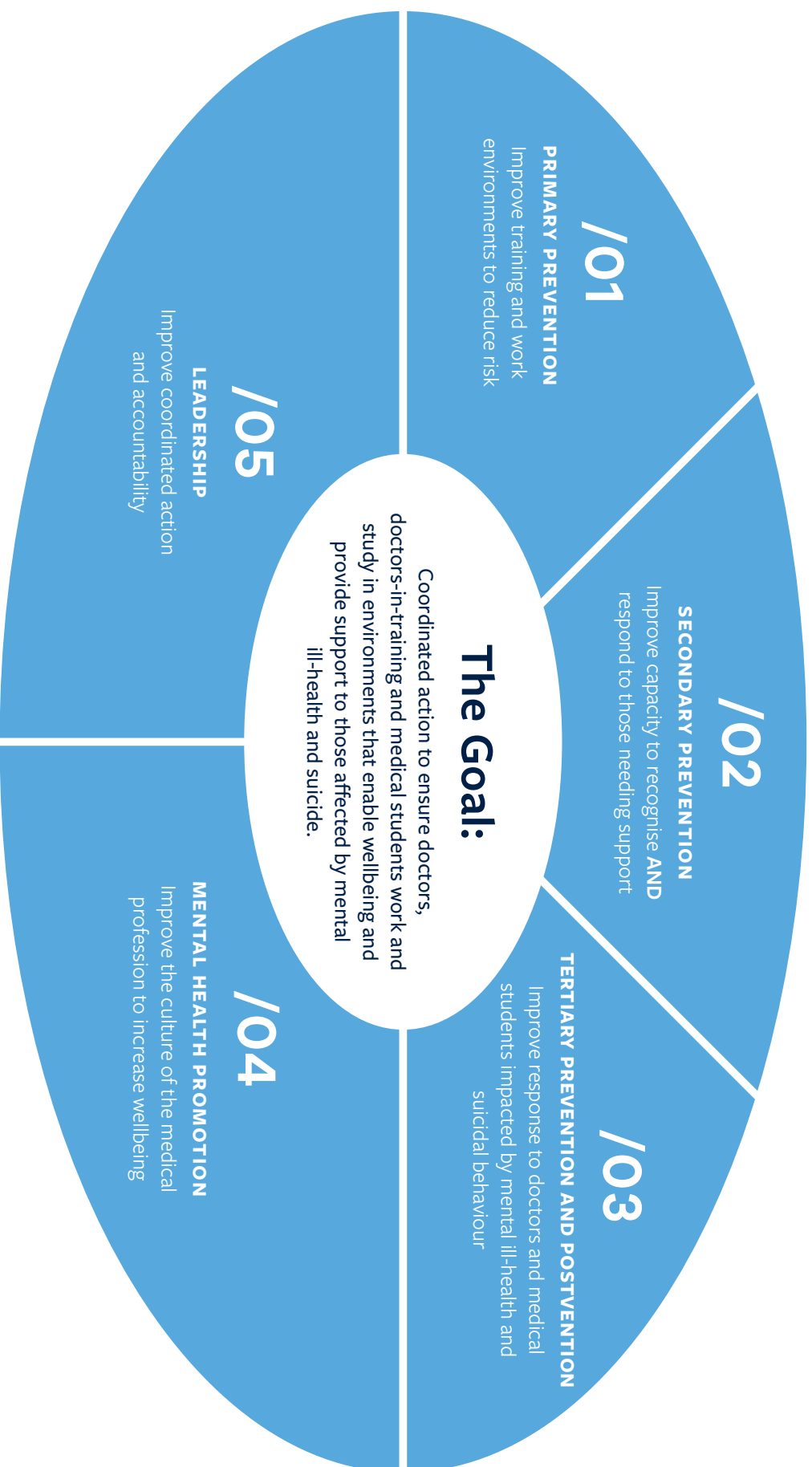
I would say resilience is important but it's not the most important factor... it's very easy to talk about positive work, like work on resilience and so it gets a lot of attention, especially when you've got hospitals or area health networks promoting programmes that they've got focussed on resilience. But the problem is much, much bigger than this and if we're talking about a national framework resilience is a very small part of it.

FOCUS GROUP PARTICIPANT



Vision: A medical profession that works and studies in environments that support wellbeing and enable quality patient care.

PILLARS FOR ACTION:



Medical Student

Prevocational

Career Medical Officer

Vocational

Specialist

Pillar 01 / Primary prevention

Improve training and work environments to reduce risk

Target 1.1	Systems change in both public and private practice to prevent job strain, fatigue and burnout across the medical profession.
Target 1.2	Safe and inclusive training and work environments, where bullying, harassment and discrimination are not tolerated.

Why has this been prioritised?

- Doctors and medical students report an occupation that is stressful and demanding, with long working hours and sleep deprivation (1a).
- Evidence for building mentally healthy workplaces suggests that strategies to manage job strain, organisational culture and reduce environmental risks are important (4).
- High rates of psychological distress and burnout within the medical profession may also jeopardise patient care and safety (32).
- A major concern raised by doctors and medical students who participated in the consultations was the need to ensure good job design, including a review of rosters and individual workloads, and addressing unpaid and unrostered overtime to reduce risks of fatigue and burnout.
- In addition to fatigue and burnout, doctors reported experiencing bullying and harassment from early in their studies and often felt unable to report misconduct or bullying.



Particular rotations are so excessively stressful and rather than adjusting the actual role and adjusting the job itself, instead they're just putting in people who aren't known to yet have a mental health issue and hoping they'll survive and power through...

FOCUS GROUP PARTICIPANT



Taking action on Pillar / 01

	Governments and health ministers	Medical schools	Medical colleges and training providers	Regulatory agencies	Professional services and assoc.	Health services	Employers	Doctors' health services	Mental health organisations
Target 1.1: Systems change in both public and private practice to prevent job strain, fatigue and burnout across the medical profession.									
IMMEDIATE PRIORITY									
Review rostering practices to identify unsafe working hours and implement evidence-based safe working hours' policies and practices for all doctors.	●			●		●	●		
Review rostering practices and staffing levels and provide sufficient cover to ensure doctors can take the leave to which they are entitled, including annual leave, sick leave, professional development and study leave entitlements.						●	●		
Review curricula design and assessment processes for doctors and medical students and implement changes to maintain quality while reducing harm to individuals.		●	●						
Report on changes to work practices, rosters, training expectations and staff resourcing to support accountability for the implementation of these new policies.	●		●	●		●	●		
Review workplace entitlements across all environments where the medical profession is trained and employed, and incorporate best practice clauses including but not limited to: <ul style="list-style-type: none"> - Access to leave - Domestic violence leave - Family friendly arrangements - Fatigue management - Overpayment recovery - Overtime (unrostered) - Professional development leave (exam and conference) - Protected teaching/training time - Roster design and management - Safe hours 	●		●	●		●	●		
Review accreditation standards for training placements to ensure fatigue management policies and programs and safe hours' measures are addressed.				●		●	●		
Review and implement effective orientation processes before new placements or new roles – outlining leave entitlements, rostering options and any issue that may impact on fatigue and burnout.		●	●	●		●	●		

	Governments and health ministers	Medical schools	Medical colleges and training providers	Regulatory agencies	Professional services and assoc.	Health services	Employers	Doctors' health services	Mental health organisations
Implement policy and practice to facilitate flexible work arrangements to allow those with family responsibilities, physical health conditions or mental health conditions to participate actively without placing their health at risk.		•	•			•	•		
Establish processes to regularly review workloads and consult with doctors and medical students through regular team meetings, surveys, formal consultative processes, and focus groups to identify and assess risks and develop solutions.		•	•			•	•		
Conduct workforce planning to meet rostering needs and reduce staff shortages.	•		•			•	•		
Target 1.2: Safe and inclusive training and work environments, where bullying, harrassment and discrimination are not tolerated.									
Review and implement policies and practices that stamp out bullying, harrassment and discrimination in the profession, setting a zero-tolerance approach. This requires senior leadership support across all settings.		•	•	•		•	•		
Educate all employees to create greater awareness of bullying and unacceptable behaviours and how to manage and report them to break the cultural expectations that bullying is commonplace and acceptable, especially in training situations.			•	•		•	•		
Develop and promote a clear, timely and confidential complaints management process, including for bullying and harassment, with regular monitoring and reporting in all settings where doctors and medical students work, study and train.		•	•			•	•		
Provide training to ensure managers and supervisors have appropriate skills to address workplace bullying, including modelling appropriate behaviour, identifying risks related to bullying in the workplace, performance management, feedback, conflict management techniques and unconscious bias.		•	•			•	•		
Develop strategies to ensure that recruitment is carried out in a fair and transparent manner and that discriminatory questions and practices are eradicated from recruitment and selection processes.			•	•	•	•	•		

Pillar 02 / Secondary prevention

Improve the capacity to recognise and respond to those needing support

Target 2.1	Mandatory reporting legislation is amended in all states to mirror the Western Australian model, which exempts treating doctors from reporting their patients who are registered with AHPRA.
Target 2.2	The medical profession is empowered to better identify and respond to mental ill-health and suicidal behaviour in doctors and medical students.
Target 2.3	Doctors and medical students at increased risk of mental ill-health and suicide are supported across settings.
Target 2.4	Effective pathways to evidence-based care are available to the medical profession.

Why has this been prioritised?

- Research suggests that doctors do not adequately diagnose depression in themselves or their colleagues and often miss the warning signs of suicidal ideation (9).
- When mental ill-health is recognised, doctors and medical students are reluctant to seek help as a result of strong social and self-stigma, including fears of appearing unhealthy or weak, licensure restrictions and exposing themselves to litigation (3).
- Many of those consulted in the development of the framework have argued that mandatory reporting legislation should be amended in all states to mirror the Western Australian model, which exempts treating doctors from reporting their patients who are registered with AHPRA.
- Consultations with doctors and medical students revealed a need to improve access to information and training about mental ill-health, suicide and how to respond.
- The consultation process highlighted the need for confidential and effective pathways to care in order to overcome substantial barriers to seeking help across the medical profession.



I feel that a massive barrier for doctors speaking up and saying that they're struggling is the fact that this could implicate their future careers, i.e. if they want to be a surgeon or a certain high demanding specialty training.

FOCUS GROUP PARTICIPANT



Taking action on Pillar / 02

	Governments and health ministers	Medical schools	Medical colleges and training providers	Regulatory agencies	Professional services and assoc.	Health services	Employers	Doctors' health services	Mental health organisations
Target 2.1: Mandatory reporting legislation is amended in all states to mirror the Western Australian model, which exempts treating doctors from reporting their patients who are registered with AHPRA.									
IMMEDIATE PRIORITY Advocate for amendments to the mandatory reporting legislation to remove structural barriers to doctors and medical students seeking support from other doctors, a major priority to ensure non-judgemental access to treatment and support.	•								
Develop a comprehensive program to raise awareness of the proposed new mandatory reporting regime, and reduce unnecessary reporting and stigma.	•			•					
Target 2.2: The medical profession is empowered to better identify and respond to mental ill-health and suicidal behaviour.									
Educate doctors and medical students about signs, symptoms and appropriate responses to mental ill-health by integrating it into the medical curriculum, training program, professional development plans and orientations in all settings where doctors and medical students work and train, and evaluate outcomes.		•	•	•		•	•		•
Develop and implement evidence-based training in suicide prevention for all doctors and medical students, and evaluate outcomes. This training should form part of induction as well as regular refresher courses.		•	•			•	•		•
Develop and promote specific resources for doctors and medical students to support increased literacy around mental ill-health and suicide and how to respond to a colleague in distress.		•	•					•	•
Implement specific training across all settings for supervisors, managers and mentors in suicide prevention and intervention so they can identify and respond to those who need additional support. This includes training in the organisation's policies, protocols and organisational supports available.		•	•	•		•	•		
Conduct a communication and education campaign to increase the awareness and utilisation of existing support services and programs.	•					•	•	•	
Review and implement strategies to better support doctors, doctors-in-training and medical students who are experiencing periods of high stress. This includes ensuring access to a range of support options such as Doctors' Health Advisory Service, peer support, chaplains or mental health professionals, and that help-seeking does not result in punitive employment and career consequences.		•	•		•	•	•	•	

	Governments and health ministers	Medical schools	Medical colleges and training providers	Regulatory agencies	Professional services and assoc.	Health services	Employers	Doctors' health services	Mental health organisations
Develop, implement and monitor proactive and trauma-informed strategies to support doctors and/or medical students exposed to an adverse event. This may include providing formal/informal opportunities for clinical and incident debriefing.		•	•		•	•	•	•	
Review organisational crisis response and/or critical incident strategy to ensure it incorporates a focus on mental health.		•	•	•	•	•	•	•	•
Dedicate resources to implement support strategies for doctors and medical students identified as having greater risk of mental ill-health and/or suicide, including doctors-in -training, young doctors, female doctors, Indigenous doctors and medical students, geographically isolated doctors, and doctors in specialties defined as at high risk.		•	•	•		•	•	•	
Reduce access to means of suicide, including access to drugs, by educating all doctors on safe handling of drugs and reviewing policies and practices to minimise access.					•	•	•		
Develop national guidance to end the practice of doctors self-prescribing medications.	•								
Target 2.3: Doctors and medical students at increased risk of mental ill-health and suicide are supported across the settings.									
Provide sufficient funding to Doctors' Health Advisory Service to allow them to play a leading role in the mental health and wellbeing of the medical profession, with expanded services and advice available to support those at increased risk of suicide.	•						•	•	•
Explore and integrate evidence-based confidential digital programs into the referral and treatment pathways for doctors and medical students – considering integration into existing sites and/or the development of a new site for doctors.		•	•	•	•	•	•		•

Government and health ministers	Medical schools	Medical colleges and training providers	Regulatory agencies	Professional services and assoc.	Health services	Employers	Doctors' health services	Mental health organisations
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Target 2.4: Effective pathways to evidence-based care are available to the medical profession.

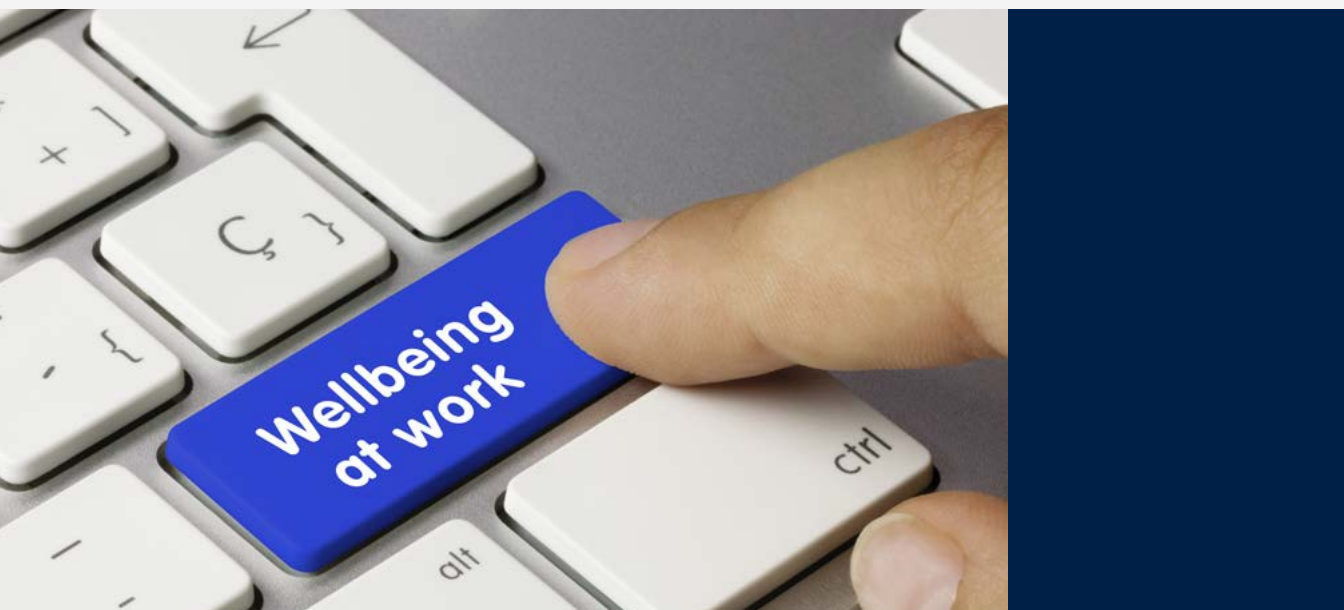
IMMEDIATE PRIORITY

Review the use and effectiveness of funded and available services for doctors and medical students (e.g. support lines, helplines for colleges, EAP) and provide access to confidential, trusted services to meet the needs of doctors and medical students. Such services must provide qualified and experienced mental health professionals with specific medical professional expertise.

Promote GPs for doctors and provide training for doctors who treat other doctors as patients, especially for GPs and psychiatrists as a priority.

Map and promote effective and evidence-based pathways to respond to the specific issues faces by doctors and medical students, with a preference for doctor-led approaches.

•		•		•		•	•	•
•	•	•		•	•		•	•
	•	•	•	•	•	•		•



Pillar 03 / Tertiary prevention

Improve the support provided to doctors and medical students impacted by mental ill-health and suicidal behaviour

Target 3.1	Recovery-at-work practices are implemented across all settings where medical professionals work, study and train.
Target 3.2	An effective postvention response system is built to support doctors and medical students following suicidal behaviour.

Why has this been prioritised?

- The literature and those consulted support the important role that medical professionals with lived experience of mental ill-health or suicide can play in reducing stigma and assisting in recovery (3c). While advocates with lived experience, and campaigns like #CrazySocks4Docs have gained momentum in Australia, doctors and medical students report that mental ill-health and suicide continues to be stigmatised across the profession.
- Tailored stay-at-work and return-to-work plans, including reasonable adjustments, are required to ensure the health and retention of doctors and medical students (3a). However many believe these are either lacking or not applied in an evidence-based way, with barriers across hospital settings and private practice (3b).
- While there are national resources and agencies available to respond to the impacts of a suicide death in the community and in schools, there is no coordinated response for supporting the medical profession, despite the reported rates of suicidal behaviour and the impact on the community when a doctor dies.
- Throughout the consultations, doctors and medical students spoke of the impacts that losing a colleague to suicide can have and noted the response is poorly handled in the medical profession. This has been backed by calls from AMSA and the Doctors' Health Advisory Service to ensure a proactive and evidence-based response.



There's a lot of fear within the profession about being open with your mental health because of perceived impacts on registration and considerations of whether someone has the capacity to continue their job.

FOCUS GROUP PARTICIPANT



Taking action on Pillar / 03

	Governments and health ministers	Medical schools	Medical colleges and training providers	Regulatory agencies	Professional services and assoc.	Health services	Employers	Doctors' health services	Mental health organisations
Target 3.1: Recovery-at-work practices are implemented across all settings where medical professionals work, study and train.									
Implement a nationally consistent and clear framework to support doctors and medical students returning to work or training following an episode of mental ill-health or suicide attempt.	●	●	●	●	●	●	●		●
Investigate, report on and develop an action plan to address the insurance, regulatory and supervisory barriers to doctors returning to work in private and solo practice.			●		●	●	●		
Review and implement evidence-based recovery-at-work practices for doctors and medical students, including specialty-specific 'stay-at-work' and 'return-to-work' protocols. These should include options for alternative duties, reasonable adjustments in the study and work environment, access to leave to attend appointments and supervisor training to support return-to-work plans. Services should temporarily replace the staff member while they are away from work or working fewer hours, to minimise the impact of their absence on patients and colleagues.		●			●	●	●		
Update, implement and monitor protocols and policies for doctors and medical students recovering from mental ill-health or suicidal behaviour. These should include options for reasonable adjustments in the study and training environment, including training for supervisors and other key personnel and support for transitions.	●	●	●	●	●	●	●		●
Develop strategies and a communication plan to address the stigma associated with mental ill-health across the medical profession. This may include: <ul style="list-style-type: none"> – Developing resources to support events, campaigns and work with the media. – Partnering with mental health and suicide prevention agencies to develop resources and structures to support doctors and medical students with lived experience to share their experiences to address stigma. – Support campaigns driven by lived experience such as #CrazySocks4Docs and campaigns for medical students led by AMSA. 		●	●	●	●	●	●	●	

Government and health ministers	Medical schools	Medical colleges and training providers	Regulatory agencies	Professional services and assoc.	Health services	Employers	Doctors' health services	Mental health organisations
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Target 3.2: An effective postvention response system is built to support doctors and medical students following suicidal behaviour.

IMMEDIATE PRIORITY	Government and health ministers	Medical schools	Medical colleges and training providers	Regulatory agencies	Professional services and assoc.	Health services	Employers	Doctors' health services	Mental health organisations
Develop a national best practice postvention protocol and tool kit for the medical profession, with clear information about process, leadership, communication and support options across settings.		•	•	•	•	•	•		•
Build and fund a nationally available postvention response service to ensure that suicide counselling is available if a death in the workforce occurs and that doctor-led and evidence-based support is provided to all doctors and medical students impacted by the suicide death of a peer.	•	•							•
Connect national (and local) surveillance data for suicide deaths to the postvention response service for medical professionals, to ensure timely and accurate responses.	•								•
Collect and report consistent data on suicide deaths in the medical profession, with a mechanism to track and report them centrally.	•								•



[Doctors] are often quite busy but very isolated people who are away from their cultural supports, their religious supports, their family, their friends. They have a busy life, everyone's working different rosters and shifts trying to make a life for themselves... they may have played music, they may have played guitar or piano or done art or played in a sports team, so those things are gone.

FOCUS GROUP PARTICIPANT



Pillar 04 /

Mental health promotion

Improve the culture of the medical profession to increase wellbeing

Target 4.1	Strategies to improve the health and wellbeing of the medical profession are implemented.
Target 4.2	Leaders and supervisors are provided with professional development to support the wellbeing of doctors and medical students.

Why has this been prioritised?

- Doctors are a critical part of health services. Ensuring doctors and medical students are healthy and well is vital.
- Doctors and medical students reported a perceived lack of information about self-care and improving wellbeing across the training and work environment.
- The vast majority of doctors and medical students are exposed to situations that threaten their physical and mental wellbeing at some stage, such as shift work, geographical displacement, exposure to violence, long hours, exposure to traumatic events.
- One of the most prevalent themes that emerged from consultations with doctors and medical students was the experience of isolation - this included geographic isolation, professional isolation from peers, and isolation from family and friends because of workload and hours.
- Competition for training and employment opportunities between doctors and doctors-in-training was highlighted as a challenge, because it reduces the capacity for peer support and connection with others who are experiencing similar stressors and challenges.



Taking action on Pillar / 04

	Government and health ministers	Medical schools	Medical colleges and training providers	Regulatory agencies	Professional services and assoc.	Health services	Employers	Doctors' health services	Mental health organisations
Target 4.1: Strategies to improve the health and wellbeing of the medical profession are implemented.									
Promote work-life balance and ensure doctors and medical students are able to make use of leave entitlements.	•	•	•	•	•	•	•	•	•
Invite people (ideally doctors and medical students) with a personal experience of recovery and management of self-harm/suicide to share their stories in the workplace, ensuring appropriate supports for the speaker and audience are in place.		•				•	•	•	
Encourage and promote doctors, doctor-in-training and medical students to have their own GP - starting at university and reinforced throughout a doctor's training and career.		•	•	•	•	•	•	•	
Develop strategies to promote awareness of GPs, psychiatrists and other medical practitioners who have been trained to work with doctors and medical students.	•	•	•	•	•	•	•	•	
Integrate evidence-based information targeted at healthy lifestyle and self-care into the medical curriculum and employer programs and evaluate for outcomes.		•	•	•					
Increase access to programs and digital platforms and programs that can be used to support wellbeing.		•	•	•	•	•	•		
Develop and promote a single online portal for doctor wellbeing resources and information.								•	
Develop strategies that provide doctors and medical students with opportunities to connect socially within and outside of medicine.		•	•			•	•		
Promote strategies aimed at career planning, financial independence and retirement readiness to ensure a smooth transition between various career stages, including out of medical practice and into retirement.		•	•			•	•		
Provide additional support to medical professionals who work in private practice and as small businesses to ensure they have access to appropriate support for business stress as well as stress associated with the practice of medicine.			•	•				•	

Pillar 05 / Leadership

Improve accountability, coordinated action and monitoring to ensure success

Target 5.1	A national leadership group is resourced to oversee the implementation and monitoring of the framework.
Target 5.2	Mechanisms for effective communication about policy, practice and research are established.
Target 5.3	A research and evaluation strategy is developed and implemented.

Why has this been prioritised?

- National leadership from within the profession and a sector-wide response is essential for any change to succeed in the medical workplace (6,25).
- Consultations with doctors and medical students identified the need for change across the profession and across the settings in which doctors work, study and train.
- Limited research has been conducted in Australia on the mental health and wellbeing of doctors and medical students, particularly those who are at risk of suicide or have taken their own lives (6,21).
- Further research is needed, including data on the incidence of suicide in the medical profession, regular monitoring of the mental health and wellbeing of doctors and medical students, and the evaluation of mental health related policies, promotion activities and services (6,21,25).



There is no single factor that will address the complex and intertwining issues that affect our JMOs, and indeed, our whole medical workforce. What is needed is a multi-pronged approach, with initiatives that are evidence-based, and that address the most serious issues as quickly as possible.

**MINISTER FOR HEALTH AND MINISTER FOR MENTAL HEALTH
NSW, JMO WELLBEING PLAN, 2017**



Taking action on Pillar / 05

	Governments and health ministers	Medical schools	Medical colleges and training providers	Regulatory agencies	Professional services and assoc.	Health services	Employers	Doctors' health services	Mental health organisations
Target 5.1: A national leadership group is resourced to oversee the implementation and monitoring of the framework.									
IMMEDIATE PRIORITY									
Identify, establish and fund a national leadership group within the medical profession to oversee the implementation and evaluation of the framework, including the identification of barriers and ongoing priorities for action.	●		●						
Allocate funding to implement the framework across jurisdictions nationally, with identified targets and roles.	●	●	●		●	●	●		
All stakeholders involved in the employment, training, regulation or support of the medical profession should: <ul style="list-style-type: none"> – Sign up to the framework and the principles underpinning the framework; – Develop a local action plan to implement the framework; – Report yearly on progress, outlining actions that are progressed, planned or inactive. 	●	●	●	●	●	●	●	●	●
Primary Health Networks and the GP colleges work together to develop a plan to implement framework recommendations with GPs, considering the specific nature of stressors for isolated practices operating as small businesses, and report yearly on progress.			●						

	Governments and health ministers	Medical schools	Medical colleges and training providers	Regulatory agencies	Professional services and assoc.	Health services	Employers	Doctors' health services	Mental health organisations
Target 5.2: Mechanisms for effective communication about policy, practice and research are established.									
Provide funding to establish a central online hub (or an enhanced website) to track and report on actions under the framework and on yearly monitoring of progress.	●								
Conduct a mapping exercise to identify programs and research in progress that deliver positive outcomes in respect of doctors' mental health, conducted and connected to the online hub to support communication and collaboration across settings.	●								●
Communicate progress on the framework at state and national forums.	●	●	●	●	●	●	●	●	●
Target 5.3: A research and evaluation strategy is developed and implemented.									
Develop and fund an evaluation and monitoring plan to support implementation of the framework.	●			●					
Develop a research leadership group, including researchers in both the medical profession and the mental health and suicide prevention sectors, to develop an aligned research agenda focussed on the wellbeing of the medical profession. This should include identification of current research, gaps and funding opportunities to progress the research plan.	●	●			●	●	●		●
Implement ongoing research to better understand the extent of mental ill-health and suicide risk among the medical profession and factors associated across settings. This may include a second national survey of doctors and medical students (or similar).	●	●			●	●	●		●
Pilot prevention, intervention and postvention initiatives among the medical workforce, and evaluate potential for roll out more widely in the longer term.	●					●	●		
Fund the establishment of a research, epidemiological database of doctors and medical students at risk of suicide and completed suicide, including systematic research on coronial and other reports of completed suicides of doctors and medical students to ensure system failures are identified and rectified.	●								●

Implementing the framework



NEXT STEPS

The establishment of a national leadership group within the medical profession is the first step towards overseeing the implementation and evaluation of the framework, including the identification of barriers and ongoing priorities for action.

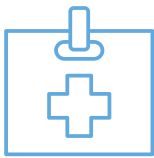
As part of the commitment to improve the mental health of doctors and medical students, each identified stakeholder is asked to:

- Sign up to the framework vision, guiding principles and pillars for coordinated action.
- Develop an action plan to improve the mental health and wellbeing of the medical profession that is appropriate to the role of your organisation or service.
- Report yearly on progress, using a traffic light report outlining actions that are progressed, planned or inactive.

It is recommended that all identified stakeholders:

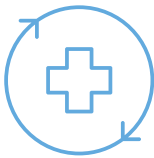
- Set up a leadership team that is accountable for the development and reporting on the plan.
- Involve different levels of the medical profession in the process.
- Map current activity and gaps and use data to inform the action plan – building on strengths and working to address gaps.
- Allocate resources for implementation and evaluation.
- Set up mechanisms to monitor and review the plan.

What will success look like?



For the medical profession

- Reduction in risks associated with stress, burnout and mental ill-health.
- Improved access to treatment and support, free from judgement.
- Reduced stigma and better supports for those who experience mental ill-health.
- Immediate and ongoing support provided to those impacted by suicide.
- Improved health and wellbeing, now and into the future.



For the health system

- Improved morale and retention of medical professionals.
- A supported and high functioning workforce.
- A compassionate workforce who care for colleagues as well as patients.
- Improved culture.
- A reduction in bullying and harassment claims.
- Increase in productivity and efficiency.
- Earlier help-seeking for challenges.



For patients and carers

- Improved quality and safety of care.
- Improved experience of care.

Appendix 1: Glossary

Advocacy groups	Represent member interests.
Career medical officer	A registered medical practitioner employed by a hospital or health service, who does not practice at a specialist or consultant level.
Doctor	A person holding provisional, general or specialist registration with the Medical Board of Australia.
Doctor-in-training/Junior medical officer (JMO)	A doctor yet to apply for or be accepted into a training programme. Includes job titles such as intern, resident, hospital medical officer (HMO), unaccredited registrar, unaccredited trainee, service registrar, registrar, trainee and fellow.
Federal government	Defines policy settings, funds and supports primary care, manages/funds Medicare, and distributes funds to states and territories, universities and colleges.
Hospitals (public and private) and primary care	Deliver and support health care.
Medical colleges and training providers	Set standards, curricula and assessments for specialist practice, select trainees and accredit training positions.
Medical schools	Select and train students to Australian Medical Council standards.
Medical student	A student in a medical school who intends to become a doctor.
Mental health promotion	Interventions that focus on increasing healthy behaviours for individuals where they work, study and train.
Prevocational trainee	A doctor-in-training who is yet to apply for or yet to be accepted into a training programme. Typically includes job titles such as intern, resident, hospital medical officer (HMO), unaccredited registrar and unaccredited trainee. <i>Note: These job titles may vary slightly across states and territories.</i>
Primary prevention	Proactive interventions that aim to prevent the onset of mental ill-health by reducing individual and environmental (or workplace) risk factors and changing practices and behaviours that contribute to injury or illness.
Professional and support services, e.g. medical defence organisations, primary care health networks	Provide services and support to medical practitioners.
Regulatory agencies, e.g. Australian Medical Council, Australian Health Practitioner Agency, and Medical Board of Australia	Set and apply standards for medical education and medical registration to ensure patient safety.

Table continued onto next page.

Secondary prevention	Interventions targeted at those who may have higher exposure to risks in the work or study environment, or individuals showing early signs of mental ill-health, including early identification of mental health problems and appropriate pathways to support.
Specialist	A doctor who has completed specialist medical training and holds fellowship of a specialist medical college. This may include general practitioners who hold specialist registration.
State and territory governments	Fund and support delivery of public hospitals and community services, and employ doctors and doctors-in-training.
Tertiary prevention	Minimising the impact of mental ill-health (or psychological injury) through recovery and return-to-work practices, stigma reduction and postvention responses to support those impacted by suicide.
Vocational trainee	A doctor-in-training who is enrolled in specialist medical training with a specialist medical college.

Appendix 2:

Consultation themes

A series of in-depth interviews and focus groups were conducted to gain rich qualitative data from doctors, medical students and other key stakeholders. Interviews and focus groups were conducted with 98 doctors and representatives from hospitals, universities and colleges (60% female). The data was analysed through systematic coding and analysis using the qualitative software program NVIVO. Many of the themes that emerged align with existing evidence and reinforce views from other national consultations and forums in Australia (10). A full summary of consultation themes is presented below.

Themes related to Primary Prevention

Fatigue as a key concern.

A major concern raised by doctors and medical students was the fatigue they experienced, regardless of where they were in their careers. The need to ensure good job design for the medical profession was a key theme, including a review of rosters and individual workloads and access to leave in order to reduce risks.

A lack of control over work and study conditions.

Doctors, especially doctors-in-training, reported that they did not have a sense of control over the work or their working conditions and often felt pressured to ignore the conditions laid out in enterprise agreements. They also shared concerns about a lack of flexibility with rosters, feeling unsupported when they need to take sick leave, and many reported that they feel like they cannot take annual leave or use study leave entitlements.

A “get on with it” culture where the duty of care is to the patients only.

Consultations revealed a range of structural and cultural issues within medicine that impact on wellbeing, including a collective “get on with it” attitude among doctors and medical students who often perceive their duty of care is only to patients, and not to colleagues or themselves.

Hierarchical culture where people don’t feel they can “speak up”.

Participants spoke of a hierarchical culture where doctors, especially doctors-in-training, feel they cannot speak up without fear of punishment. Instead, they are taught early in their career to just “power through” and “put in” the hours required. Doctors also reported experiencing bullying and harassment from early on in their studies and generally reported a lack of adequate supervision, or safe mechanisms to report concerns.

*This research project was conducted by **Everymind** as part of The Prevention Hub: Australia’s first integrated research initiative into preventing anxiety and depression. This research is funded by the Federal Department of Health and has been approved by the Hunter New England Human Research Ethics Committee of Hunter New England Local Health District.*

Themes related to Secondary Prevention

There are substantial barriers to medical professionals seeking help.

There was a strong focus placed on the need for confidential and effective pathways to care to overcome the substantial barriers to seeking help across the profession. Those interviewed indicated that doctors and medical students would be reluctant to ask for support in the current environment, partly due to mandatory reporting concerns and partly because doctors are fiercely competitive, which means asking for help could be detrimental to their career prospects.

There is a need for tailored support that is suitable for doctors.

In their interviews doctors and medical students emphasised the need for tailored support for medical professionals. Doctors reported that they were unlikely to access the health service

or hospital Employment Assistance Programme (EAP) as they believed it to be too generalist for doctors and as it was not seen as confidential. When discussing the type of assistance they would prefer, participants expressed a preference for face-to-face consultations over online options.

Information and training on how to support colleagues would be valued.

Doctors and medical students revealed a desire for improved access to information and training about mental ill-health, suicidal behaviour and how to respond to a colleague. Medical professionals are still uncomfortable talking about mental ill-health and suicide with each other.

Themes related to Tertiary Prevention or Postvention

Mental ill-health and suicidal behaviour is stigmatised in the medical profession.

Doctors and medical students indicated that mental ill-health and suicidal behaviour was still stigmatised in the medical profession, which impacted on doctors from the start of their university degree through to specialist positions. They reported that it was not uncommon to be exposed to inappropriate comments or 'jokes' about patients or colleagues, and more commonly, a general disinterest in talking openly about the issues. While advocates within the medical profession have talked about their own experiences, it is more common for people to stay quiet for fear that disclosing challenges will have a negative impact on their job and career prospects.

There is a need for effective responses following a suicide.

Doctors and medical students spoke of the impacts that losing a colleague to suicide can have, but remarked that this was very poorly handled in the medical profession. Doctors are often expected to "just get on with it" following the death of a colleague. Often the "duty of care" to patients is prioritised over their own self-care and care for their peers. Many talked about needing effective communication and support following a suicide.

Themes related to Mental Health Promotion

Many doctors and medical students experience isolation.

One of the most prevalent themes that emerged from consultations was the multiple experiences of isolation – this included geographic isolation, professional isolation from peers, and isolation from family and friends because of workloads and hours. It was noted that many doctors-in-training move away for work, which often means they remove themselves from their cultural, religious and familial supports. Disengaging from these supports and social activities can create a combination of different types of isolation: social, intellectual and geographic.

Competition and private practice reduce opportunities for peer support.

The sense of competition between doctors and doctors-in-training was highlighted as a challenge, because it reduces the capacity for peer support and connection with others who are experiencing similar stressors and challenges. This starts early in university and is carried through a doctor's career. Many doctors working as specialists, especially as GP specialists, can also be very disconnected from professional supports.

References

1. Tynan, R.J., et al., Help-seeking for mental health problems by employees in the Australian Mining Industry. *BMC Health Serv Res*, 2016. 16(1): p. 498.
2. National Mental Health Commission, *The National Review of Mental Health Programmes and Services*, 2014.
3. NSW Mental Health Commission, *Living Well: A Strategic Plan for Mental Health in NSW*. Sydney, NSW Mental Health Commission, 2014.
4. Harvey, S.B., et al., *Developing a mentally healthy workplace: A review of the literature*. 2014
5. Australian Medical Association/beyondblue. Roundtable: The Mental Health of Doctors and Medical Students Melbourne, 6 June 2014
6. beyondblue. (2013). *National Mental Health Survey of Doctors and Medical Students*. Melbourne: beyondblue.
7. Elliot L, Tan J, Norris S. (2010). *The Mental Health of Doctors: A Systematic Literature Review*. Beyondblue
8. Rotenstein, L., Ramos, M., Torre, M., Segal, J., Peluso, M., and Guille, C. et al. (2016). Prevalence of Depression, Depressive Symptoms, and Suicidal Ideation Among Medical Students. *JAMA*, 316(21), 2214. doi: 10.1001/jama.2016.17324
9. Bailey, E., Robinson, J., and McGorry, P. (2018). Depression and suicide among medical practitioners in Australia. *Internal Medicine Journal*, 48(3), 254-258. doi: 10.1111/imj.13717
10. Prinz P, Hertrich K, Hirschfelder U, de Zwaan M. (2012). Burnout, depression and depersonalisation— psychological factors and coping strategies in dental and medical students. *GMS Z Med Ausbild*, 29(1), 10.
11. Supe AN. (1998). A study of stress in medical students at Seth G S Medical College. *J Postgrad Med*, 44 (1), 1-6.
12. Mata, D., Ramos, M., Bansal, N., Khan, R., Guille, C., Di Angelantonio, E., and Sen, S. (2016). Prevalence of Depression and Depressive Symptoms Among Resident Physicians. *Survey Of Anesthesiology*, 60(4), 146. doi: 10.1097/sa.0000000000000237
13. Milner, A., Spittal, M., and Bismark, M. (2017). Suicide by health professionals: a retrospective mortality study in Australia, 2001-2012. *The Medical Journal Of Australia*, 206(11), 506. doi: 10.5694/mja16.01372
14. Kölves, K., and De Leo, D. (2013). Suicide in Medical Doctors and Nurses. *The Journal Of Nervous And Mental Disease*, 201(11), 987-990. doi: 10.1097/nmd.0000000000000047
15. Hawton, K. (2001). Suicide in doctors: a study of risk according to gender, seniority and specialty in medical practitioners in England and Wales, 1979-1995. *Journal of Epidemiology and Community Health*, 55(5), 296-300. doi: 10.1136/jech.55.5.296
16. Rich CL, Pitts FN Jr. (1980). Suicide by psychiatrists: a study of medical specialists among 18,730 consecutive physician deaths during a five-year period, 1967-72. *J Clin Psychiatry*, 41, 261-3.
17. Swanson SP, Roberts LJ, Chapman MD (2003). Are anaesthetists prone to suicide? A review of rates and risk factors. *Anaesth Intensive Care* 31, 434-45.
18. Rossouw, L., Seedat, S., Emsley, R., Suliman, S., and Hagemester, D. (2013). The prevalence of burnout and depression in medical doctors working in the Cape Town Metropolitan Municipality community healthcare clinics and district hospitals of the Provincial Government of the Western Cape: a cross-sectional study. *South African Family Practice*, 55(6), 567-573. doi: 10.1080/20786204.2013.10874418
19. Fox, S., Lydon, S., Byrne, D., Madden, C., Connolly, F., and O'Connor, P. (2017). A systematic review of interventions to foster physician resilience. *Postgraduate Medical Journal*, 94(1109), 162-170. doi: 10.1136/postgradmedj-2017-135212
20. Witt, K., Boland, A., Lamblin, M., McGorry, P., & Robinson, J. (2018). *Tackling Mental Ill-Health of Medical Doctors and Students*. Orygen.
21. Petrie K, Dean K, Baker S, Crawford J, Christensen H, Harvey S. (2018). Improving physicians' mental health: A systematic review and meta-analysis of interventions to reduce symptoms of common mental disorder amongst physicians. The Blackdog Institute.
22. Sharma, V., Sood, A., Prasad, K., Loehrer, L., Schroeder, D., and Brent, B. (2014). Bibliotherapy to decrease stress and anxiety and increase resilience and mindfulness: A pilot trial. *EXPLORE*, 10(4), 248-252. doi: 10.1016/j.explore.2014.04.002
23. Kemper, K., Lynn, J., and Mahan, J. (2015). What Is the Impact of Online Training in Mind-Body Skills?. *Journal of Evidence-Based Complementary and Alternative Medicine*, 20(4), 275-282. doi: 10.1177/2156587215580882
24. Farrell, A. and Cook, V. (2018) *Mental Health Initiatives Guide*. Australian Medical Students Association. Retrieved from: <https://www.amsa.org.au/sites/amsa.org.au/files/Mental%20Health%20Initiatives%20Guide.pdf>
25. Australian Medical Association National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors <https://ama.com.au/article/national-code-practice-hours-work-shiftwork-and-rostering-hospital-doctors>
26. Glasgow, N., Bonning, M., and Mitchell, R. (2014). Perspectives on the working hours of Australian junior doctors. *BMC Medical Education*, 14(Suppl 1), S13. doi: 10.1186/1472-6920-14-s1-s13

The draft framework is subject to further consultations, professional design, refinement, layout and formatting to ensure it is fit for purpose for external delivery and dissemination.

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