Policy Document

Mental Health and Wellbeing (2025)

Executive Summary

AMSA believes the current and rising rates of mental illness and suicide within Australia and the Australian medical community to be deplorable and unacceptable. The number of Australians having experienced any sort of mental ill-health is one in five. In medical students, nearly one in five have also reported experiencing suicidal ideation or a diagnosis of depression. It is the duty not only of Australians and Australian medical students, but also of the Federal, State and Territory Governments, medical schools, training colleges, and healthcare services to make a concerted effort in tackling the disparities in mental health. Maximising the wellbeing and preventing mental illness of all students and junior doctors should be addressed with utmost urgency.

The purpose of this policy is to address the state of mental health in Australia and Australian medical students, its risk factors, stigma, the unique vulnerabilities and increased risk in medical students, what groups or communities are particularly at risk, and strategies in improving mental health and wellbeing.

Factors such as higher pressures of academic performance, harmful work-related attitudes and cultures, and stigma surrounding mental health in the medical profession are only some examples contributing to the increased risk in medical students. The causes of mental health problems and mental illness are complex and multifactorial, and are also unique to each individual's sociocultural background. Aboriginal and Torres Strait Islander students, culturally and linguistically diverse students, those studying in rural areas, LGBQTIASB+ students, and international students endure unique challenges which further necessitate additional targeted support as well.

AMSA demands at all levels of the Australian Government immediate further investment in the pursuit and support of initiatives that improve and support the mental health and wellbeing of students.

Medical schools are best positioned to support the mental health and wellbeing of their students. However, there is much to be desired. Universities are asked to be responsive to feedback from stakeholders, students and staff, and to position themselves as leaders in this space of eradicating mental health stigma. To address the physical and mental disparities in those living with mental illness, AMSA urges medical schools to provide further access to mental health and psychoeducation, counselling, referral services, student health and mental healthcare, and access to alternative forms of mental health care. Education to both staff and medical students should be provided for the purpose of Mental Health First Aid training and to address

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the needs of high risk communities. Academic support policies such as special consideration and assessment deferrals should not be made arduous and administratively prohibitive to students requesting it. Overall in an academic context, the implementation of a pass/fail system is an approach to reduce comparison between medical students as a way of fostering a collaborative student environment and reducing mental distress over grades. This approach should be approached with caution and requires more research into its efficacy in reducing medical student burden.

Training Colleges and Health Departments are furthermore strongly urged to support medical students and junior doctors, and to address issues of bullying, harassment, sexual harassment, discrimination, and assault within hospitals and health services.

Policy Points

AMSA calls upon:

1. **Federal, State and Territory Governments to:**
    a. Pursue, establish, and support initiatives that improve mental health and wellbeing in students and support those with mental illness;
    b. Fund research in describing the the sociocultural, economic, systemic, and vulnerability factors that influence medical student mental health and wellbeing;
    c. Directly support Aboriginal and Torres Strait Islander communities by designing and developing culturally safe mental health programs; and
    d. Facilitate the ongoing usage of telehealth as a platform to better support remote individuals and particularly isolated communities.

2. **Australian Medical Schools to:**
    a. Implement affordable and accessible student support services including:
        i. Access to mental health clinician services external to the faculty;
        ii. Student healthcare;
        iii. Evidence-based postvention support protocols;
        iv. Access to counselling and referral services for students at risk of drinking at harmful levels and substance misuse; and
        v. Access to alternative non-pharmacological mental health interventions;
    b. Increase accessibility, reduce barriers, and administrative hurdles to academic support policies for students including but not limited to:
        i. Special academic consideration policies;
        ii. Examination deferral policies; and
        iii. Leave of absence policies;
    c. Provide affordable, accessible, and culturally safe education to staff and/or students regarding:
        i. Mental Health First Aid;
        ii. Needs of international students/patients and culturally and linguistically diverse students/patients;
        iii. Needs LGBTQIASB+ students/patients; and
        iv. Needs of Aboriginal and Torres Strait Islander students/patients;
    d. Implement university-based mental health strategies that are integrated into the administration of the wider institution, including its curriculum and its assessment;
    e. Regularly review evidence and be responsive to feedback regarding teaching and support services from students, staff to improve mental health strategies;
    f. Ensure safety in learning activities by providing adequate training for medical students and faculty, support, and policies addressing potentially distressing situations encountered by students such as death, injury, abuse, and suicide;

g. Adopt and destigmatize early recognition and support pathways for identifying and supporting students with mental illness in universities;
h. Ensure that students that attend rural and regional placements have sufficient access to support services, preventative and treatment mental health initiatives that are equal in quality delivery and effectiveness to their domestic and metropolitan colleagues, respectively;
i. Promote awareness of mental health issues, and support student initiatives to do the same such as AMSA Blue Week and RUOK? Day;
j. Account for students' mental health and financial circumstances when reviewing applications for special consideration for rural placements; and
k. Promote involvement in Aboriginal and Torres Strait Islander events of cultural or community significance, including but not limited to: Invasion Day, NAIDOC week and Mabo Day.

3. **Medical Student Councils and Medical Societies to:**
   a. Advocate for and support their peers by providing feedback to and championing improvements in university and faculty structures;
   b. Implement the sharing of mental health experiences in one's personal life as well as as a collective, either through an anonymous system or from professionals to medical students;
   c. Provide access to wellbeing initiatives;
   d. Establish and support initiatives that promote mental health and wellbeing among medical students and the broader student community;
   e. Encourage medical faculties to provide students with access to mental health professionals including GPs, psychologists and psychiatrists
   f. Discourage cultures of risky alcohol consumption and reduce alcohol related harms by implementing harm reduction strategies at medical society events;
   g. Promote involvement in Aboriginal and Torres Strait Islander events of cultural or community significance, including but not limited to: Invasion Day, NAIDOC week and Mabo Day;
   h. Ensure there is sufficient access to international student specific peer mentor programs and social activities; and
   i. Appoint an Aboriginal and Torres Strait Islander Health Officer position, independent from the Australian Indigenous Doctors' Association (AIDA) Student Representative to advocate for the welfare of Indigenous students.

4. **Australian State and Territory Health Departments to:**
   a. Identify and support employees and students with mental illness in health facilities;
   b. Create more transparency when calling upon medical students to alleviate workforce shortages in public health crises by allowing them to assist in assessment and management of patients, including but not limited to; the Students in Medicine (SiM) and then Assistants in Medicine (AiM) paid-work programs;
   c. Acknowledge their role in reducing mental illness and the prevalence of suicide among their medical workplace;

d. Address longstanding issues of bullying, harassment, sexual harassment, discrimination, and assault within the hospital and health services which contribute to poor mental health wellbeing of their medical workforce and the broader medical community; and
e. Promote proactive approaches towards mental health and wellbeing within their medical workforce.

5. **The Australian Medical Council to:**
   a. Ensure that in order to achieve accreditation, medical curricula must include:
      i. Processes and standards for the prevention and management of bullying, harassment and/or discrimination;
      ii. Adequate levels of support for students with mental illness (including but not limited to the provision of free care by a mental health clinician or similar), and;
      iii. Prevention and postvention mental health strategies and initiatives existing within the faculty such as subsidised MHFA and mental health clincian's support; and
   b. Work with the LGBTQIASB+ community to ensure the medical curricula promotes inclusiveness and ensures that teaching does not pathologise the community.

6. **Healthcare professionals to:**
   a. Encourage and help create a compassionate and collaborative environment for work and medical student education, and to discourage practices of bullying, harassment, discrimination and stigmatisation of mental illness;
   b. Advocate for improved mental health support in a workplace setting; and
   c. Acknowledge the impact that their own stigma towards mental health/illness have on the workplace culture and medical student attitudes.

7. **Individual medical students to:**
   a. Identify the risks of their peers' and own mental health and take proactive steps to safeguard their wellbeing, including seeking a regular General Practitioner;
   b. Regularly assess their own mental health and seek support from mental health clinicians as required and encourage others to do the same;
   c. Complete Mental Health First Aid Training; and
   d. Be involved in Aboriginal and Torres Strait Islander events of cultural or community significance, including but not limited to: Invasion Day, NAIDOC week and Mabo Day.

Background

MENTAL ILLNESS & SUICIDE IN GENERAL POPULATION

Mental health is a key indicator of overall health and wellbeing.(1) According to the National Survey of Mental Health and Wellbeing (NSMHW), for the 2020-2022 period, 42.9% of Australians aged 16-85 years old have experienced a mental disorder at some point in their life. Anxiety disorders, including Post Traumatic Stress Disorder (PTSD) and Social Phobia, were the most commonly reported, with 17.5% of Australians reporting one of these conditions. This was followed by depression reported by 7.5% of respondents.(2) Mental health conditions were highly reported in individuals with disability with 48% of individuals reporting an anxiety disorder and 41% reporting an affective disorder.(114) Programs such as the NSW Health Literacy Initiative promote greater mental health literacy and awareness and improved access to services for help.(3) Factors such as lack of exercise, obesity, smoking, misuse of drugs and alcohol all further contribute to the prevalence of these disorders.(2)

The Australian Federal Government is encouraging a national approach towards targeting mental health; aiming to provide equitable access to mental health services alongside improving timeliness of data collection on suicide and suicide attempts to allow for targeted prevention strategies.(4)

MENTAL ILLNESS & SUICIDE IN MEDICAL STUDENTS

Medical students in Australia are at a higher risk than the general population for mental illness and suicide. The 2019 Australian National Mental Health Survey of Doctors and Medical Students highlighted key statistics on the prevalence of mental illness.(6) In medical students, 43% screened as having a high likelihood of a minor psychiatric disorder, namely anxiety or depression. In comparison, rates of diagnosis of mental health disorders are lower, likely due to the reluctance to seek treatment. In medical students, 18.1% report a diagnosis of depression and 12.7% report a diagnosis of anxiety.(6)

The 2019 Australian National Mental Health Survey of Doctors and Medical Students reported that 19.2% of medical students had experienced suicidal thoughts within the previous 12 months, with 4.1% having made a prior suicide attempt.(6) Female medical students report higher rates of suicide and suicidal ideation than their male peers, and notably higher rates than that of females in non-health care occupations.(7)

Despite the research regarding suicidal ideation in medical students(8), the limitations such as underreporting suicide rates due to misclassification, social stigma, and subject bias affects the accuracy of the data and limits institutions' ability to provide better support and implement early evidence-based intervention.(9-11) Furthermore, the stigma surrounding depression makes medical students reluctant

to seek treatment, as only 15.7% of medical students who were diagnosed with depression sought treatment. This is a major concern, especially considering the known association between depression and increased risk of suicide and future depressive episodes.(14)

ISSUES CONTRIBUTING TO MENTAL ILLNESS & SUICIDE IN MEDICAL STUDENTS

The root of mental illness and suicide amongst medical students are multifaceted and require a detailed and equitable approach. Despite further research being required, there are anecdotal experiences of predisposable factors prior to studying medicine that can impact a student's medical journey and career. While only some key contributing factors are discussed in this policy, other issues such as lack of social support, rural placements, chronic diseases, and more (15-16) can promote mental health issues, and must be acknowledged. These predispositions can become a precursor to mental illness and suicide.(15) Due to the complex and correlational nature of mental health problems, sources of these issues cannot be simplified into one cause.(17) Therefore, this calls for a versatile and dependable approach assisting in the prevention and treatment of mental health issues of medical students, involving numerous interventions and stakeholders.(17) In particular, this advocates for the implementation of guidelines and regular mental health check-ups for medical students attending rural placements, evoking a larger appeal to develop more support centres in more isolated and rural communities. This aims to create multifaceted infrastructure capable of delivering quality interventional, supportive and treatment strategies designed for optimising student's mental health in regional areas, alike to their domestic and urbanised counterparts.

BULLYING, HARASSMENT, DISCRIMINATION, & SEXUAL HARASSMENT

For the purposes of this policy, bullying will be framed through the lens of discrimination and humiliation, characterised by its associated verbal and physical acts. Bullying and harassment in medical workplaces are widespread, with 35% of medical trainees experiencing bullying/harassment, and 38% of those reported moderate/severe impacts on training.(20) Reported rates were even higher for Aboriginal and Torres Strait Islander trainees, at 52%.(20)

74% of medical students reported experiencing and 83.6% had witnessed "teaching by humiliation" during their clinical rotations.(4-21) The effects of bullying, harassment and discrimination on mental wellbeing is well established, not only among doctors but also medical students, and is covered in great depth in AMSA's 'Bullying and Harassment in Medicine' (2023) policy.(22) Bullying, harassment and discrimination of medical students and junior doctors is a cultural and institutional problem, where reporting any form of mistreatment may carry the risk of affecting career progression.(24) Targeted attention from medical workplaces is important to create a more respectable and compassionate culture.

Research on sexual harassment and its impacts among Australian medical students is limited, but evidence suggests it negatively impacts mental health, contributing to

depression, PTSD, disengagement from studies, low self-esteem, and self-blame, as further detailed in the Sexual Harassment Policy (2021).(23)

STIGMA IN THE MEDICAL PROFESSION & EDUCATION SPACE

The stigma surrounding mental illness negatively impacts the wellbeing and self-esteem of those with mental health challenges whilst creating barriers for access of treatment and support.(25) This is true within the medical community and schools.(25)

Public stigma refers to negative/discriminatory beliefs that community members hold towards specific minorities. The public stigma towards mental health perpetuates stereotypes regarding those affected, leading to discrimination.(25) Those with mental health conditions, including psychotic and affective illnesses, can be unreasonably labelled as dangerous/unpredictable.(26) These damaging stereotypes impact all areas of an individuals' life, through diminished access to equal employment opportunities, safe housing and medical services.(26)

This stigma impacts medical students and their ability to seek mental health services. One study reported 47.7% of Australian medical students felt they could not access mental health support due to perceived negative career impact. A common misconception maintained by medical students is that depression is 'personal weakness' and is not a real illness.(28) As a result of this, coupled with fear of negative judgement for seeking help, many medical students feel as if stigma is a barrier for accessing mental health support.

Another stigma which impacts mental wellbeing is personal stigma. This is described as the internalisation of public stigmas that one with mental illness believes to be true of themselves.(26) This impacts people's self-esteem, enjoyment, and quality of life. 30% of medical students reported personal stigma as the reason they did not access mental health services.(26)

Programs which increase medical students' understanding of mental illness, such as psychiatry rotations or Mental Health First Aid courses actively decrease the presence of stigmas.(25) Through implementation of these programs, medical schools can decrease the stigma maintained by students to improve wellbeing and patient outcomes.(27)

In the Australian medical profession, historically there has been mandatory reporting in relation to mental health diagnoses. (30) As a consequence of this program, medical students and health professionals have avoided seeking treatment fearing negative career impacts. (30) Although mandatory reporting of mental illness is abolished, the fear surrounding career impacts is prevalent and the stigma surrounding help-seeking remains. (30)

Continually, this stigma can be reduced through inviting certain individuals/organisations (anonymous or named) to come up and share their own experiences with mental health struggles and the best ways to combat this stigma and issue that medical students experience. (31)

SUBSTANCE MISUSE IN MEDICAL STUDENT POPULATION & MEDICAL PROFESSION

Decades of research reveal strong associations between mental illness, psychological distress, and substance abuse; however, the causal nature of these relationships remains complex. Individuals within the medical profession, including students and practitioners, often engage in 'self-medication' using substances to cope with symptoms of anxiety, depression, and burnout, leading to both short- and long-term consequences. The BeyondBlue National Mental Health Survey of Doctors and Medical Students reported that 21% of medical students engaged in moderate-risk drinking, while 4% were classified as high-risk drinkers according to the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT). (32) Mental health challenges are also prevalent in this population. The same survey found that medical students and doctors experience higher levels of psychological distress compared to the general population, with medical students reporting higher rates than their senior counterparts . Factors contributing to this include demanding workloads, long hours, and high expectations inherent in medical training and practice. (33)

WORK-RELATED STRESSORS IN MEDICAL STUDENTS

The most common stressors for medical students are the high academic demands (58.4%), which are strongly linked to mental health issues.

Internships are a significant source of distress. Allocation systems vary between merit-based and ballot-based approaches, with the latter reducing stress in preclinical years. Merit-based systems have been criticized for causing high distress and should be replaced with ballot-based systems (AMSA's 'Internships and Prevocational Framework' (2023) policy). The oversupply of medical students and interns has increased competition for specialty training. Internship numbers must be managed to meet workforce demands and provide opportunities for graduates. International and full-fee-paying students face uncertainty in securing internships after graduation.

Merit-based intern recruitment causes high distress and should be replaced with a ballot system (AMSA's 'Internships and Prevocational Framework' (2023) policy). An oversupply of medical students has intensified competition for specialty training. Internship numbers must be managed to meet workforce demands and ensure graduates can access training. International and full-fee-paying students face added uncertainty as they are not guaranteed internships after graduation.

Medical students and doctors also struggle with exposure to traumatic events, as noted in the National Forum on Reducing Risk of Suicide in the Medical Profession (2017). Many students experience distress during their first encounters with human cadavers. Additionally, witnessing dying patients and confronting difficult situations is unavoidable. These experiences should be opportunities for medical schools to

provide emotional support and coping strategies, helping students manage stress and reduce trauma.

EXPECTATIONS OF ACADEMIC PERFORMANCE

Literature suggests that the terms 'conscientiousness', 'ambitious', and 'perfectionist' are often used to describe medical students, and that the characteristics of conscientiousness, commitment and obsessiveness are common amongst doctors.(48-49) While these traits are generally associated with greater academic excellence and success in their medical career, it could place them at elevated risk for maladaptive perfectionism and impostorism, leading to distorted thinking patterns about academic performance.(50-52) These self-defeating attributes have common features: fear of failure, need for approval, rumination and concern over mistakes.(53) Consequently, these attributes may compromise medical students' ability to cope with stressors they encounter during their degree, which in turn increases the likelihood of experiencing burnout and mental illness.(49)

Cognitive distortions regarding academic performance such as maladaptive perfectionism and impostor phenomenon are strongly associated with feelings of shame, embarrassment, and inadequacy due to individuals' perceived shortcomings. These feelings are in turn associated with symptoms of depression and anxiety.(51) This is consistent with evidence that demonstrated perfectionism and impostor phenomenon as strong predictors of medical student distress, poorer mental health and wellbeing, and increased likelihood of suicide attempts.(50, 53-55)

Medical schools attract students with these patterns of cognitive thinking, given entry into medical programs necessitates outstanding academic achievement, and reinforces these patterns of thinking by denying students personal vulnerability and placing emphasis on a culture of perfectionism as well as delayed gratification.(50) While many medical schools have wellness and resilience programs, these efforts may not have specifically targeted the underlying cognitive distortions medical students experience.(48, 51)

To address these cognitive distortions, medical students could be introduced to cognitive behavioural strategies and productive thinking techniques as a part of their curriculum. By being able to identify and internally dispute common cognitive distortions, students can be encouraged to develop solutions to their negative self-directed emotions.(51) This is supported by a pilot program, where students who met the criteria for maladaptive perfectionism showed significant improvements after cognitive behavioural therapy.(56)

Additionally, participation in an intensive mindfulness, communication, and self-awareness program was associated with reduced psychological distress and burnout in primary care physicians.(57) Therefore, students may benefit from self-awareness interventions and mind-body exercises, which can lead to character development and diminished psychosocial weaknesses.

Aside from implementing a mental health intervention in medical schools, more research is needed to evaluate the efficacy of existing interventions and allow further development of effective interventions.

EFFECTS OF PUBLIC HEALTH CRISES & NATURAL DISASTERS IN MENTAL HEALTH

As previously illustrated in the 2021 Healthcare in Humanitarian Settings and Disaster Medicine policy, natural and man-made disasters hold significant, direct or indirect ramifications on human health.(58) In the past 2 years, significant research has been conducted, investigating how COVID-19 impacted negative mental wellbeing, especially in healthcare workers who are more likely to face poorer mental health than the general population.(59) Mental health has been closely linked towards occupational activities at workplaces, which have been jostled by both public health crises and natural disasters, forming seriously detrimental consequences upon an individual's mental health.(60) Following this, examinations based around the investigation of post-disaster behavioural and psychological changes, concluded that individuals may experience post-traumatic stress disorder, anxiety or depression, spread across the impacted population.(61) Compounding this sombre sentiment, evidential research illustrates the rising consequences of Climate Change on a higher number of natural disasters (62), emphasising the importance of upholding rigorous policies nationally to better support medical students affected in such events.

In the onset of disaster medicine, the student-based surge workforce, facilitated through the 2021 NSW Health Assistant in Medicine (AiM) Evaluation Workforce, was introduced.(63) With the intention to be an effective disaster management response, AiM positions were opt-in and only available for final-year medical students.(63) Whilst the program facilitated the transition for final-year medical students from clinical placements to national internships, greater transparency and refinement of the program are necessary to establish greater interest from students (63). In addition to this, another issue was the lack of clarity in scheduling, with AiM scheduling coinciding with medical school timetables, increasing stress and decreasing work-life balance for students.(63) A similar program was introduced in Queensland called Students in Medicine (SiM), and despite the limited research around it, likely poses similar concerns as the AiM.

MINORITY GROUPS

Medical Students from Rural Areas.

While there is currently a gap in the literature regarding the mental wellbeing of medical students who move to metropolitan universities from rural areas and students attending rural medical schools, individuals living in rural and remote areas have reported higher rates of mental illness, self-harm and suicide as well as reduced access to support services.(65) Research regarding medical students on placement at rural clinical schools has found they face additional challenges regarding their mental wellbeing when compared to students in metropolitan clinical schools.(66) A variety of factors may lead to decreased levels of wellbeing, including social isolation, lack of mental health resources, less academic and financial support

than metropolitan students as explored in the Rural Clinical Schools Policy (2021).(67)

Culturally and Linguistically Diverse Students.

Healthcare courses have higher fractions of students from culturally and linguistically diverse backgrounds compared to other university courses.(68) According to the 2024 National Data Report, about 35% of final-year medical students were born overseas.(69) Current research has focused on either providing training about dealing with patients from culturally and linguistically diverse backgrounds or the general wellbeing of medical students, and so there is scarcity of literature regarding the wellbeing of people who belong to both communities.

Studies show that medical students from culturally and linguistically diverse backgrounds are at higher risk of low academic performance and discontinuation, with problems more distinctly manifesting during clinical years due to ineffective communication between educators and students.(68) These students also experience social isolation (68) and higher chances of being subjected to racial stereotypes.(70) Lack of resources and training for clinical supervisors to recognise difficulties in learning medicine in a different cultural context or second language leads to exacerbation of isolation and academic difficulties, thus contributing to poor mental health.

English as a Second Language (ESL) students are more likely to find interactions with patients difficult contributing to a negative learning experience.(68) For culturally and linguistically diverse students this experience might be exacerbated by discrimination, profiling and entrenched racial stereotypes from supervisors (REF), further discouraging students from building healthy relationships with their supervisors and limiting communication.(70)

International Students.

International medical students are at an increased risk of developing poor mental health and face additional struggles including isolation from their family and friends and financial difficulties.(71) In 2021, there were 2847 International students enrolled in an Australian medical degree; 15.7% of the medical student population. International students are also more likely to experience racism, struggle with language barriers, and lack access to culturally appropriate support.(72)

Many international students do not have family or friends in Australia prior to their tertiary study which can lead to social isolation; 36% of international students reported that social isolation negatively impacts their mental health (71) with international students who are single scoring significantly higher on depression scales than those with partners.(113) Social isolation has been linked to poor sleep, physical inactivity, substance misuse and decreased life satisfaction, all of which are also recognised as risk factors for mental illness.(73) Ensuring there is sufficient access to peer mentor programs, social activities and international student societies

is imperative in maintaining mental well-being and is reinforced by 60% of international students who would like to see more specific support programs.(71)

International students experience a variety of sources of financial stress for international students including higher annual tuition fees, limits on working hours in line with student visas, costs of healthcare and the high costs of living in Australia which increases the financial burden and expectations to succeed. Heightened expectations as a result of financial burden has been linked to higher levels of anxiety and other mental illnesses.(74)

The Australian Government requires student visa holders to maintain course enrolment without remission, and to not exceed 40 hours of work per fortnight. The limit on working hours may add to the financial stress of international students in addition to the mental stress of remission not being an option. Australia also has a higher cost of living compared to many international students' home countries which may cause additional mental stress and increased pressure on family and personal finances.(74) Additionally, international students are not eligible for publicly funded mental healthcare and therefore, mental health interventions and strategies must be made financially accessible.(71)

Academic performance and expectations are critical stressors for international students, with disparities being found amongst different nationalities and subsequent academic perceptions. Chinese international students for example exhibit higher levels of stress compared to domestic students, reflecting the additional cultural adaptations and educational challenges international students face. Furthermore, several studies indicate that age and level of study have significant correlations with rates of depression; with younger international students who are in undergraduate courses experiencing higher rates of depression. (113)

LGBTQIASB+ Students.

LGBTQIASB+ is an acronym that stands for lesbian, gay, bisexual, transgender, queer, intersex, asexual, sistergirl, brotherboy, and those whose identities are not included in the acronym. In Australia, there is a significant lack of research about the mental wellbeing of people who identify with the LGBTQIASB+ community.(76-77) Most available research focuses on the experiences of lesbian, gay and bisexual individuals and thus greater research is required into the experiences of transgender and gender diverse students. Although we underscore that sexual orientation and gender identity are not equivalent constructs, transgender and gender nonconforming people share LGBTQIASB+ people's historically marginalized social status due to their departure from dominant gender norms.(78) It is therefore likely that transgender and gender diverse students similarly experience a greater mental health burden due to transphobia and biological essentialism in medicine than their cisgender (people who identify with their gender assigned at birth) peers.

It has been widely established that LGBTQIASB+ medical students experience burnout and decreased overall wellbeing at significantly higher rates than their cisgendered and heterosexual (cis-het) counterparts. A higher proportion of these

students also report experiences of discrimination and mistreatment compared to cis-het students. A study on graduating US medical students showed that 27% of LGBTQIASB+ students reported public harassment compared to 20.7% in heterosexual students. Additionally, 23.3% of LGBTQIASB+ students reported mistreatment due to their sexual orientation at least once during medical school compared to 1% in their cis-het peers. The same report revealed that the intensity and frequency of perceived abuse has a dose-dependent relationship with risk of burnout. Even after adjusting for perceived mistreatment, LGBTQIASB+ medical students were 30% more likely to experience burnout than heterosexual students. Internalised stigma, blatant homophobia and microaggressions contribute to building a negative learning environment.(80)

Secrecy around concealment of sexual identities is reported by medical students due to a fear of repercussion and discrimination from peers and supervisors. The discrimination is often covert, for example, witnessing other queer people being harassed, doctors making offensive remarks at queer patients, and peers and educators making similar remarks at other students who are suspected to belong to this community. Queer medical students are subject to verbal abuse and are overlooked for important career steps. LGBTQIASB+ people are often only mentioned when discussing diseases such as HIV which causes a negative connotation to be attached to queer people. These factors cause these students to adhere to heteronormative expectations and force them to be cautious during interactions with people in the medical community. Due to secrecy, these medical students are more prone to suffering from isolation, experience difficulty accessing support groups and networks, and find a lack of mentorship.(77, 81)

In a number of cases, there are intersections between one's identity of being a person-of-colour and being a part of the LGBTQIASB+ community; racial discrimination adds to the oppression the students already face for not being heterosexual and cisgender.(81) As an act of self preservation, these students are forced to adapt to heteronormative expectations.(77)

Aboriginal and Torres Strait Islander Students.

Mental illness is an area where Indigenous and non-Indigenous Australians experience different burdens of disease; there is a difference not only in prevalence of conditions, but also in causes, manifestations and lived experiences. Although increasing, Aboriginal and Torres Strait Islander medical students are a significant minority; with only 412 total Aboriginal and Torres Strait Islander students enrolled as of 2021.(115) As of writing this policy there is a lack of research that describes the mental health and wellbeing of Aboriginal and Torres Strait Islander medical students. This is a cause for concern as they are an extremely vulnerable group.

The most recent Australian Aboriginal and Torres Strait Islander Health Survey revealed that 30% of Indigenous adults had experienced high or very high levels of psychological distress in a four week period; a rate 2.7 times an age standardised rate in non-Indigenous adults.(82) Diagnosable conditions are also thought to be more prevalent in Aboriginal and Torres Strait Islander people than non-Indigenous

people, for example, depression is estimated to affect 12% of Indigenous Australians compared to 9.6% of non-Indigenous Australians.(83) The diagnosis of certain psychological conditions is hindered by using culturally incompatible assessment tools, which decreases confidence in current statistics and highlights the importance of using the widening array of culturally validated assessment tools.(84)

Suicide affects Indigenous Australians at almost twice the rate (1.9 times) of non-Indigenous Australians.(82) The difference becomes more striking when considering youth suicide. An analysis of Queensland's suicide register revealed Indigenous children under 15 are over 12 times more likely than non-Indigenous children to die by suicide.(85) There can be significant variations in suicide rates both geographically and temporally, with many suicides being clustered.(86) With even the youngest Aboriginal and Torres Strait Islander peoples suffering the effects of poverty, racism, intergenerational trauma and the socioeconomic legacies of colonisation, a comprehensive life course approach is necessary for meaningful change in the social and emotional wellbeing of Indigenous Australian medical students.

Parents and Carers.

With the adoption of graduate medical degrees, and a typical minimum of 5 years to complete a medical degree, many medical students often begin or are studying a medical program at a time where they may have already started or are seeking to begin a family. A dependent of a medical student refers to an individual who is dependent for economic support and includes, but is not limited to, biological, expectant, adoptive and foster children. The MSOD National Data Report for 2024 found that the median age of final year medical students is within the 25-29 year old range, with 1.5% aged 40 years and over. A majority (54.9%) of these final medical students identified as having a partner, with 4% reporting dependent children.(69) AMSA's Policy Document on Medical Students with Dependents (2024) discusses in detail the difficulty of parents and carers in managing both their family and careers, citing factors such as sleep deprivation, feelings of guilt and time constraints as key influences on medical students' family planning. Medical students with dependents face further difficulty when accounting for occupational exposures, scheduling of clinical rotations and barriers to breastfeeding. There is currently a significant lack of Australian specific research which examines the experience of medical students who have dependents, particularly in regards to their mental health. However, studies from the United States and Canada have identified that student parents are more at risk for dropping out of medical school and are more likely to suffer from poorer mental health. Despite this, Canadian medical students with dependents have demonstrated that, with the proper support, these students often excel in their demonstrations of clinical skills, particularly in the domains of communication and multitasking. Current institutional support and guidance for medical students with dependents is lacking amongst Australian and New Zealand medical schools with none indicating that they had specific pregnancy or parental leave policies.(116)

Further research into the mental health of medical students who are parents and carers is vital to ensure that the proper support and reasonable adjustments be

offered to meet the competing demands between family and medicine, and ensure that demographic barriers to medicine are mitigated.

STRATEGIES TO IMPROVE MENTAL HEALTH & WELLBEING

Mental health and wellbeing related effectiveness should be a cooperative effort led by external organisations, alongside the government, both federal and state-wide.(90) Despite the significant differing experiences with mental health alongside unique needs (91), structural changes in mental health promotion and prevention can optimise favourable outcomes yielded.(92) AMSA's recommendations to Federal, State and Territory governments to this end can be found in the 2023 policy *Mental Health Support Structure*.(93)

Medical faculties have a tangible ability to facilitate mental health and wellbeing amongst their studies, through preventative responses, crises responses and posthumous care. Awareness programs that focus on mindfulness, wellbeing and stress management are prevalent throughout Australian universities. Despite the significant effectiveness of these institutes in decreasing mental health stigma (94), more directly supportive policies can be more effective (95). These policies include the provision of Mental Health First Aid (MHFA) for both students and staff and ensuring the availability of support services such as counsellors and GPs.

University-based counselling has been proven to be an effective early intervention strategy for supporting student's mental health.(96) The accessibility coupled with integration of these services, have helped reduce stigma of mental health by improving awareness.(96) However, a key disadvantage is that these facilities often operate independently from university institutes, making it unlikely for special considerations or alternative arrangements to occur.(97) These services can be made more effective via the integration with certain universities, alongside being granted for unique considerations. This model provides an intrinsic feedback mechanism such that the faculty can mitigate systemic issues for the benefit of student's mental health.(97) Thus, university-administered wellbeing programs must be continued under the awareness of the aforementioned factors, with given agency for these programs to liaise with universities for special considerations, balancing student confidentiality too.

There is great difficulty in designing a singular service that is both integrated into the faculty and provides confidentiality. Thus, two distinct services - one that is faculty based and able to negotiate student special considerations and one that assists with treatment - have been identified as an ideal model. University treatment services either refer students to the relevant practitioners (such as University of Queensland's Med Student Support Team) (98) or offer clinical support within the service. The University of Melbourne's Dedicated Medical School Health and Wellbeing Service presents an effective model by providing a dedicated Wellbeing Practitioner for medical students (99). This can be perceived as an ideal model, tackling the harmful impacts on students of a lack of engagement support from a GP.(100) Similar models are present at Flinders and Griffith University, and have the capacity to be implemented more broadly throughout Australian medical schools. This is especially important for international students who do not have Medicare or Overseas Student

Health Cover (OSHC). Failing this, medical students should be supported to access GPs nearby, who can compile a database of practitioners committed to supporting their wellbeing issues for reduced cost.(101)

Supporting medical students to develop mental health literacy reduces barriers to vital help-seeking behaviours.(102) MHFA is an evidence-based intervention in which students are taught how to respond to mental health issues.(103) A 2018 systematic review found that MHFA training not only improves knowledge of mental health disorders but also reduces stigma amongst participants.(104) Whilst MHFA is already provided or facilitated in many Australian medical schools to great effect, this should be standardised across all schools and paid for in entirety.

The need for preventative measures for medical student mental health extends to those students with traditionally underserved groups. Medical faculties can create safer spaces for LGBTQIASB+ medical students by normalising the use of personal pronouns in formal education, which has a significant positive impact on the mental health of these students.(105-107) This can be achieved through the simple usage of comfortable pronouns in clinical cases, utilising pronoun pins and including pronouns in email signatures. Furthermore, the provision of education for commencing students and all staff around LGBTQIASB+ identity and experiences removes the burden of medical students having to educate others. The LGBTQIASB+ community has been continually underrepresented and disenfranchised in medical curricula.(108) Medical faculties have the responsibility to remove heteronormative bias from the curricula, eliminating barriers to the mental health and wellbeing of LGBTQIASB+ medical students.

Medical student societies already provide a multitude of mental health and wellbeing initiatives, including meditation sessions, yoga, the provision of free healthy food, mindfulness training sessions, peer mentoring and the promotion of mental-health optimising apps and seminars.(109) Further mental health initiatives and campaigns done by medical student societies can be found in AMSA's 'Wellbeing Toolbox'. In addition to these initiatives, medical student societies are uniquely placed to advocate for mental health support services within their university. Thus, leveraging this policy, they can campaign for improvements to these preventative mental health structures, alongside providing consistent feedback. However, it is worth noting that this responsibility should be a shared commitment by both university faculties and medical societies, fostering a more caring and healthier environment.

Alongside preventative measures, universities and medical faculties require effective crisis response structures in order to best protect the mental health of their students.(8-97) The ANU mental health strategy is an example of a comprehensive mental health strategy, outlining a structured methodical approach that incorporates cultivating a fully supporting environment and adequate crisis management for students.(110) Postvention support also forms part of a holistic mental health strategy.(111) In facilitating healthy grieving for suicide loss survivors, the risk to these individuals of severe and lasting adverse mental health effects is mitigated.(112) There is a dearth of research on postvention models in tertiary education, which must be addressed in the near future. Support is also provided by

organisations external to faculties, such as Drs4Drs, state-based doctor's health organisations and other telehealth providers. These external services provide accessible and confidential services, mitigating stigma as a barrier for students accessing help.(101)

CONTINUING & IMPROVING THE USAGE OF TELEHEALTH

Telehealth is a productive tool that involves the usage of technological tools, such as the Internet, mobile phones and/or other devices to attend and proceed with remote medical consultations and psychological assessments. The service has especially been beneficial for rural Australians, due to its innate ability to access specialist staff, including nurses, who are typically not on-site.

Rates of suicide and depression across the rural and regional community have posed gaping and stark concerns, questioning the availability of medical services across such areas. Whilst the 2023 age-standardised suicide rate for residents residing in metropolitan data was around 10.0 deaths per 100,000 population (below the national average of 11.8 individuals per 100,000 population), such rates for more remote and isolated communities were much higher.(117) Categorically "very remote" areas had a rate of 21 deaths per 100,000, which was almost 2.1 times their metropolitan counterparts, and exceeded the national average. In addition to this, data from the AIHW's National Hospital Morbidity Database (117) also illustrated that the total rates of hospitalisations for intentional self-harm was significantly higher in very remote, remote, outer regional and inner regional areas as compared to major or metropolitan cities, within the 2022 to 2023 period. The increasingly alarming and gaping disparities amongst the mental health and wellbeing between rural and urban localities has raised further questioning into factors contributing to this divide.

As outlined in AMSA's 2025 policy, there are numerous factors contributing to insufficient mental health and wellbeing support for people residing in remote areas, with greater emphasis on the lack of access to clinical medical psychiatrists, psychologists and other allied health staff. According to the Mental Health Commission on Mental Health Services in Rural and Remote Areas, selected findings from 2016, though still relevant, illustrated that almost 3 in 5 people situated in remote/very remote areas said not having a specialist nearby stopped them from seeing one, whilst they were also more likely to walk into an Emergency Department due to no GP being available.(118) Moreover, as remoteness increased, people reported reduced sharing and transparency of information between patients and health providers.(118) This increased stress on Emergency Departments in such areas, without adequate staff trained particularly in dealing with patient's Mental Health, is coupled by a joint 2017 rural and remote survey by the National Farmers Federation, and The Royal Flying Doctor Service (RFDS). It found that for people living in remote areas, most wanted better access to mental health and medical services as their top two areas of additional funding from the Australian government to improve wellbeing outcomes.(118) Therefore, with higher demands on improving mental health and wellbeing outcomes of residents in rural and remote communities, Virtual Health (Telehealth) has been enhanced to mitigate this issue

The NRHA Mental Health Factsheet published in July 2021 concluded that mental

health disorders and illnesses, especially for the youth residing in rural areas, can be successfully diagnosed and treated with time and sufficient intervention from mental health specialists.(119) The Better Access Telehealth Initiative, which operates regardless of location provided the patient can access a video or telephone, can help services to be delivered by eligible health practitioners such as but not limited to clinical and registered psychologists, occupational therapists, social workers, general practitioners and other prescribed medical practitioners.(120) In many of these instances, family and other support networks can also bolster and provide comfort based on any outlined treatment plan advised by an eligible health practitioner. As of 2020, during the peak of the COVID-19 pandemic, all residents across the country were eligible to gain access to Telehealth and other virtual care outlets, where previously, the patient had to be from an area located in the Modified Monash Model area 4 to 7. Healthdirect also noted the increased usage of virtual care networks, which allow for nurses to have 10 minute consultations (disregarding triaging) for patients in hospitals, increased fluidity and improved treatment of acute-care patients (121). The Better Access Telehealth services are beneficial for patients for diagnosed mental health disorders, allowing them prompt and immediate access to registered psychologists and medical specialist teams who can provide a robust mental health assessment and treatment plan.(120) Moreover, virtual health can deliver group mental health therapy sessions, which is particularly crucial for rural residents who may otherwise not be able to access such sessions.(120) These services can also be effective for patients who may be comfortable conversing in another language other than English, being more culturally and linguistically compatible with all communities (120) and access services from the comfort and privacy of their homes. The Medicare benefits, provided by the Better Access Telehealth initiative, can also prompt more eligible health practitioners listed above, to provide wellbeing care towards rural and remote regions.

Whilst Telehealth services can be refined to accommodate for chronic and acute conditions (digital prevention programs), to allow for seamless transfer of regional and rural patients to nearby emergency departments, the AMSA calls upon the program to be continued to bridge the gap in mental health and wellbeing service access between rural and metropolis localities. This will be able to better complement the various virtual services such as those targeting Indigenous and Rural residential mental wellbeing, including BeyondBlue, KidsHelpline and Lifeline .(121)

For More Information

To learn more about the prevalence of mental health disorder and factors that predispose junior doctors to worsened mental health, we recommend you read this article. It is an Australian study that was conducted in 2013 on the modifiable workplace variables impacting junior doctor mental health.

> Petrie K, Crawford J, Shand F, Harvey SB. Workplace stress, common mental disorder and suicidal ideation in junior doctors. Intern Med J. 2021 Jul;51(7):1074-1080. doi: 10.1111/imj.15124. Epub 2021 Jun 22. PMID: 33135841; PMCID: PMC8362052.

For a more recent discussion, this opinion piece written in 2024 played a pivotal role in guiding what ideas to explore while writing this policy. This paper discusses mental health stigma in the medical workforce and its key drivers. It also discusses some ways in which we can address this stigma. It goes in much further depth than was possible in this policy regarding this issue.

> Ng IK, Tan BC, Goo S, Al-Najjar Z. Mental health stigma in the medical profession: Where do we go from here? Clin Med (Lond). 2024 Jan;24(1):100013. doi: 10.1016/j.clinme.2024.100013. Epub 2024 Jan 17. PMID: 38382183; PMCID: PMC11024831.

Another perspective piece on stigma is the below opinion piece written in 2021 by a professor of psychiatry at the University of Michigan. Mental health stigma is a significant barrier to improving mental health across medical students and the medical workforce, and this paper discusses what systemic issues are at play that continue to drive mental health stigma.

> Brower KJ. Professional Stigma of Mental Health Issues: Physicians Are Both the Cause and Solution. Acad Med. 2021 May 1;96(5):635-640. doi: 10.1097/ACM.0000000000003998. PMID: 33885412; PMCID: PMC8078109.

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Category: C - Supporting Students

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