Submission to the

Community Affairs Committee - Inquiry into Mental Health Services in Australia

The Royal Australasian College of Physicians

145 Macquarie Street, Sydney, NSW 2000, Australia ■ Tel: (61 2) 9256 5444 ■ Fax: (61 2) 9256 3310 ■ Email: samatha.edmonds@racp.edu.au ■ Web: www.racp.edu.au

1. About the RACP

The RACP is the professional organisation responsible for the training, assessment and ongoing professional development of consultant physicians and paediatricians in Australia and New Zealand.

The RACP comprises of more than 9,000 Fellows who work in the areas of adult medicine, paediatrics and child health, public health, rehabilitation, occupation medicine, palliative care, addiction and sexual health. In addition the RACP encompasses a range of affiliated speciality societies representing the spectrum of practice in Internal Medicine and Paediatrics across 31 sub-specialty areas.

2. The Inquiry

The RACP welcomes the Commonwealth Government's commitment to mental health as a national health priority. It is positive to see that State and Territory Governments are working with the Commonwealth Government to address unmet need in mental health service delivery through the Council of Australian Governments (COAG). The RACP is also very supportive of the additional funding that is being made to mental health programs and services. This will go some way to addressing the consistent shortfalls in mental health funding that has been so common in the past.

The RACP strongly advocates for improving mental health service delivery in Australia, and thus people's mental health. However, the timing of this Inquiry seems to be too soon after the endorsement of the COAG National Action Plan on Mental Health (COAG Plan). The Plan was only endorsed in July 2006 and many of the programs covered by the plan have only commenced in the last 6 – 12 months. Therefore it is difficult to comment on the effectiveness of the plan, let alone the programs that it funds. It should also be noted that the COAG plan is predominantly a funding commitment document rather than an implementation document.

The Inquiry terms of reference also ask those writing submissions to compare and comment on three different documents. These are the COAG National Action Plan on Mental Health, The National Mental Health Strategy and the National Approach to Mental Health – from Crisis to Community. There is also a need to include State and Territory based mental health plans within this comparison. The RACP believes that such appraisals should be undertaken by COAG or delegated to a review committee to include State, Territory, Commonwealth representatives as well as representation from key health and mental health bodies.

The Inquiry terms of reference and the National Action Plan currently do not acknowledge the great and unmet need in relation to social and emotional well-being and mental health for Indigenous Australians.

Recommendations:

a) That a review of the COAG Plan occurs again in 12 months time, when it is more likely that the effectiveness of the programs can be evaluated.

b) That the comparison of the three documents referred to in the Inquiry (in conjunction with State and Territory mental health plans) is conducted by COAG or delegated to a review group consisting of State, Territory and Commonwealth representatives and representatives from key health and mental health bodies. This comparison will be made public.

c) That consideration is given to considering within the scope of this Inquiry, the social and emotional well being, and mental health needs of Indigenous Australians.

3. Shortfalls and Gaps in Funding and in the range of services available for people with a mental illness

The COAG plan covers a broad range of programs, which have the potential to make significant changes to people's lives. The RACP also supports the way in which the COAG Plan draws together separate Commonwealth, State and Territory mental health plans. This means that the COAG Plan does not impose a single response to mental health but rather meets the different needs and priorities for each area.

However, in terms of program implementation, the COAG Plan falls short of ensuring consistency in the delivery of Commonwealth funded programs by States and Territories. There is no guidance in the document as to how States and Territories should implement Commonwealth programs and how these decisions are informed. For example in NSW the Personal Helpers and Mentors Program has been implemented differently to Victoria. In NSW referrals to this program have been interpreted as needing to go through Area Health Services rather than General Practitioners.

3.1 Mental Health Promotion, Prevention and Early Intervention

It should be noted that the COAG Plan is equating removing mental illness with meaning good mental health. While there is a relation between the two they are two different areas of need and need different ways of addressing these needs.

The COAG Plan also predominantly presents mental illness as a biomedical issue that needs 'treatment'. While mental health promotion, prevention and early intervention programs are mentioned, to some extent, these areas do not have the funding and the focus that the treatment programs have.

Recommendation

d) That there is additional funding, and a realignment of the COAG Plan, to prevention, promotion and early intervention.

3.2 Alcohol and other Drugs

Alcohol and other drug (AOD) issues are framed in relation to mental illness. However, there is no evidence base that can determine if AOD are the cause or the effect of a mental illness. Programs aimed at treating AOD and mental illness must be carefully

targeted to treat both these issues, not just one or the other. This intent does not come through in the COAG Plan.

Recommendation

e) That those programs aimed at AOD and mental illnesses are reviewed to ensure that they address issues of both mental illness and AOD, not just one or the other.

3.3 Rural and Remote Issues

Many of the programs covered by the COAG Plan rely on the ability to refer people to psychiatrists and psychologists, but in rural and remote areas this is not a feasible option. There are also issues of availability of services, distance to services, transport and limited numbers of practitioners.

Health transport is a significant concern for Aboriginal people and other people living in rural and remote areas. Barriers to health transport arguably contribute to poor health outcomes such as reducing people's ability to seek treatment when needed. Many people located in rural and regional areas who do not own a motor vehicle are likely to face significant difficulties travelling to specialist services which may be located hundreds of kilometres from their home. Therefore there is a need to fund transport services in rural and remote areas under programs such as the Health Related Transport and Isolated Patients Transport Accommodation Assistance Scheme in NSW.

There is also a need to fund infrastructure and resources, not only for hospitals, but for community based services. This includes human resources for already over-stretched services. For example some community based services have received no COAG funding for regional, rural and remote programs. Of particular concern is the lack of funding to counselling services, especially for adult survivors of child sexual assault.

Recommendations

f) That COAG also considers issues of access to services for rural and remote communities and addresses funding needs in areas that impact on this, such as transport.

g) That COAG considers funding for infrastructure and resources for community based services.

3.4 The Social and Emotional Well Being and Mental health needs of Indigenous Australians

At the outset, there is a need to acknowledge the great and unmet need in relation to social and emotional well being and mental health needs of Indigenous Australians. *The Social and Emotional Well Being Framework: A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009* provides a framework for national action to address the high incidence of social and emotional well being problems and mental ill health of Indigenous Australians, The framework highlights a holistic, coordinated and intersectoral, properly

resourced response is required in order to meet the social and emotional well being and mental health needs of Indigenous Australians.

Other issues that need to be taken into consideration include:

Trans-generational trauma i.e. impact of grief loss and trauma - 30 % of Indigenous people in prison who have mental illness have had parents removed as part of stolen generation; impact of stolen generation separation on child and adolescents;

Mental illness patterns in Aboriginal populations usually higher.(e.g. In 2004-05 there were around two times as many hospital separations of Indigenous Australians for 'mental and behavioral disorders' in Queensland, Western Australia, South Australia and the Northern Territory, than would be expected, based on the rates of other Australians. (AIHW/ABS The Health and Welfare of Australia Aboriginal and Torres Strait Islander Peoples 2005);

Deaths by suicide accounts for a much higher proportion of all deaths among Aboriginal people than non-Aboriginal people. In 2004, suicide accounted for 4.2% of all Aboriginal deaths compared with1.5% of deaths for other Australians. (Source: http://www.livingisforeveryone.com.au/files/updates/lifestats240406.pdf)

There are a number of workforce issues that need to be taken into consideration including the need to protect those involved from burnout.

Increased co morbidities with mental health patients e.g. higher risk of developing cardiovascular and endocrine disorders. There is a need for this to be addressed. From a chronic disease perspective, Indigenous Australians with mental illness can also be suffering from at least three other disease patterns other than mental illness:

- Cardiovascular, endocrine, renal disease- which in turn has implications as to how people are treated from a pharmacological perspective;

- The disability suffered from up to four illness patterns. The disability of mental illness alone e.g. untreated schizophrenia is a disabling as quadriplegia, and untreated depression is as disabling as cardiac failure).

Recommendation:

h) That COAG takes into account the social and emotional well being and mental health needs of Indigenous Australians in the review of the National Action Plan.

3.5 Referral to Psychiatrists and Psychologists

There is better access to psychiatrists and psychologists through the use of MBS item numbers. However, concerns have been raised in regards to issues of duty-of-care once the 6 -12 treatment sessions have been completed and the person still requires ongoing care. Many people cannot afford to pay to see a psychologist or psychiatrist. Therefore this is a gap that needs addressing, for example by allowing additional consultations under the MBS if needed. This can be decided on a case-by-case basis by the person with the mental illness, the psychiatrist or psychologist and their GP. There is also a role for other community based mental health services to be a part of this process.

Recommendation

i) That COAG reviews the number of consultations provided under the MBS, so that those who may need additional treatment are able to receive this.

3.6 The Homeless

Another gap in the COAG Plan relates to support services for homeless people, many of whom may have been long-term homeless and who frequently have a mental illness and/or co morbidity with substance abuse and intellectual or physical disability. There is little or no coordination of the various programs available to this group of people. For interventions to be effective long-term, programs must be put in place that present the best opportunity to prevent a person with mental illness falling through the gaps in service delivery and ending up back on the street.

There is also a need for pre and post release programs for people with a mental illness, or who have developed a mental illness, and who have had interactions with the criminal justice system. Frequently these people end up homeless and living on the streets and require services that not only address the person's mental illness, but which provide housing, food, community engagement, living skills and ongoing support.

Recommendations

j) That COAG address the gap in service delivery and coordination for people who have a mental illness and are homeless.

k) That funding is targeted at pre and post release services to reduce the likelihood of released prisoners with a mental illness and forensic patients in the community becoming homeless.

3.7 Inclusion of Physicians and Paediatricians

One gap in the COAG Plan that the RACP is particularly concerned with is the lack of inclusion of physicians and paediatricians. Physicians and paediatricians should be active participants in coordinated care plans for people with a mental illness. The COAG Plan should also include funding for training physicians and paediatricians in mental health issues (current training is only targeted at general practitioners).

Recommendation

l) That the role of physicians and paediatricians in mental health care is recognised and funding is provided for education and training around mental illness and mental health issues for this group.

4. Monitoring and Evaluation of the Plan

The most obvious gap in the COAG Plan is the outlined progress measures. They are very unclear and leave more questions than they answer. The measures proposed in the COAG Plan will not provide a good indication of the effectiveness of the programs.

RACP express concerns regarding the following the Outcome / Progress Measures (p.7):

- **The prevalence of mental illness in the community** - there will always be a percentage of the population who will experience a mental illness or mental health problems during their life. The issues centre around reducing the impact on the individual and the community; to maintaining functionality and a quality of life through equal access to measures that reduce onset or treat acute mental illness and support services to maximise recovery.

- **Percentage of people with a mental illness who receive mental health care** – it is not just about receiving care but the right care at the right time, with appropriate follow-up.

- **Readmissions to hospitals within 28 days of discharge** – frequently pressures on acute beds prevents a person being admitted. Such data does not provide an indication of long-term outcomes for the individual or a measure of service efficacy. Measures also need to be taken at 3, 6 and 12 months to determine if the treatment received in the hospital and the care received in the community has long-term benefits.

- **Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities** – people held within Immigration Detention Centres should also be added to this measure.

- **Participation rates by people (and young people) with a mental illness of working age in employment** – the measure does not consider why a program may fail and this may have nothing to do with the effectiveness of the program or the person's mental illness. A range of other factors can reduce participation rates such as a lack of appropriate employment options, lack of transport, lack of support etc.

- **Prevalence of mental illness among homeless populations** – how will this be measured and what will it actually prove?

None of the measures identify the effectiveness of early intervention, promotion and prevention programs. The measures are just counting the numbers of people who have a mental illness or who suicide. To ensure that a program is effective, progress measures need to include if and when a person experiences a relapse, or the length of time the person experiences the mental illness or the impact of the mental illness on the person's quality of life etc.

The RACP is also concerned about the lack of tracking of referrals to psychologists and psychiatrists. For example what is the mental illness the person is experiencing, what is the outcome of the referral, how effective was the referral. Without doing this it is hard to

measure how effective this process is, what the mental health needs of the community actually are and what improvements to service delivery need to be implemented.

Measurement also needs to be made of the effectiveness of the partnership between State, Territory and Commonwealth Governments in fulfilling their obligations in the COAG Plan.

Recommendations

m) That the progress measures in the COAG Plan are immediately reviewed. Consideration should be given to using the evaluation and key direction points raised in the National Mental Health Strategy as a better range of progress measures.

n) That referrals to psychiatrists and psychologists are monitored and reviewed, to track such things as what is the mental illness the person is experiencing, what is the outcome of the referral and the effectiveness of the referral.

o) That an evaluation team is immediately established to set evidence based parameters and bench marks to measure progress from the implementation of the COAG Plan (July 2006). Traditionally this has been done at the last minute, just before a plan is finalised. The evaluation is then rushed and does not effectively measure the outcomes.

5. Conclusion

The RACP welcomes the Commonwealth, State and Territory Governments' commitment to mental health as a national health priority. The RACP supports the additional funding that is being made to mental health programs and services. This will go some way to addressing the consistent shortfalls in mental health funding that have previously been the case. However, the RACP believes that it is difficult to comment on a plan that has only recently been implemented and therefore it is quite difficult to measure its effectiveness.

The COAG Plan still has a number of shortfalls and gaps that need to be addressed. This is especially so in terms of the progress measures proposed in this plan.

The RACP looks forward to the Community Affairs Committee Inquiry report into Mental Health Services in Australia, in which we hope to see responses that address gaps in services gaps identified by consumers, carers, the various sectors, and the community at large collected during consultations across the community and presented in submissions.