SUBMISSION

Mental Health Select Committee:
Inquiry into the opportunities to improve mental health outcomes for Queenslanders.

Committee Secretariat

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Introduction

Lived Experience Australia is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. Our core business is to advocate for systemic change, empowerment of consumers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

LEA is represented in Queensland by our Director and Coordinator Mr Norm Wotherspoon together with the Queensland State Advisory Forum and as such, we are providing this Submission to inform the Mental Health Select Committee's Inquiry into the opportunities to improve mental health outcomes for Queenslanders.

This Submission comes from the perspectives and experiences of people with lived experience of mental health issues, their families, and carers.

Our responses are below:

(a) the economic and societal impact of mental illness in Queensland.

Mental ill-health brings many challenges which impact on the wellbeing of individuals. This means that many lose employment, connections and relationships with families, friends, and society in general. Much needs to be done in Queensland as well as more broadly, to ensure mental ill-health has the least possible impact on people's lives.

This means timely access to evidence-based treatment and supports, when they are needed, and as close as possible to where people live.

(b) the current needs of and impacts on the mental health service system in Queensland.

There are issues within the mental health system that need to be addressed. LEA has made some recommendations below which go some way to addressing those issues.

- Community mental health facilities are a key point of contact for people with lived experience and are needed for those with serious and complex mental ill-health. Having connections to a mental health team is crucial for people on their recovery journey.

- Staffing is also a crucial issue. If Queensland is to provide the best possible holistic care in these settings, a mix of multi-disciplinary clinicians offers the best possible choice.

- Queensland GPs provide that pivotal role in identifying those needed specialist mental health care beyond that which they can provide.

- Emergency Departments also are a first port of call for people in crisis and having access to mental health clinicians is a real need. Furthermore, training in aspects of mental health crisis presentations is needed so that people can be treated in a respectful and dignified manner.

- Mothers who have mental ill-health as either an existing condition, or develop mental ill-health such as post-natal depression, anxiety, etc need access to specialist care. This is a very important time in both the mother's life and also the bonding needed between mother and baby, to ensure baby has the best possible start in life from an emotional and mental wellbeing.

LEA makes the following recommendations:

1. Increase staffing in community mental health care facilities. The National Mental Health Framework recommends that this staffing be increased to 80% by 2024. Current Queensland rates are 55% of the recommended, while older persons services operate at only 30%

2. Provide incentives to recruit mental health staff (psychiatrists, psychologists, mental health nurses, allied health therapists and lived experienced peer workers to rural areas. Currently the costs of living and accommodation, social isolation and lack of peer support deters workers from moving to rural areas.

3. Provide funding for GPs to receive mental health training and education

4. Provide training for Emergency Department staff in mental health, suicide training and how to interact with people with lived experience and their carers/families.

5. Increase the number of mother and baby beds in Queensland. (Currently three 8 bedded wards in public hospitals in Queensland).

(c) opportunities to improve economic and social participation of people with mental illness through comprehensive, coordinated, and integrated mental health services (including alcohol and other drugs and suicide prevention):

LEA believes that one of the key issues for people with lived experience is integrated, whole of person, mental health care. This addresses the full needs of people on their road to recovery, i.e., mental health, physical health, housing, education and training, employment, and social connection.

All aspects are key to a true person-centred approach to treatment and support.

Communication, cooperation, and collaboration between clinical settings is crucial and LEA's research[1] has clearly shown that people disengage from mental health support leading to crisis when this does not occur. This includes alcohol and other drug dependence, tobacco use, and suicide early identification and prevention.

From a very recent survey of LEA in partnership with Equally Well[2], we found that:

- Over half of consumers said that a mental health professional (other than a GP) had asked them about their sleep (65.48%, n=165) as well as exercise and physical activity (54.48%, n=137). The least likely areas that mental health professionals talked to consumers about included lung function (4.05%, n=10) and cancer screening (6.88%, n=17).

- Also consistent with consumer respondents, the least likely areas for a mental health professional to have asked about, according to carer respondents, were lung function (9.90%, n=10), cancer screening (9.90%, n=10), sexual health (13.86%, n=14), cholesterol (14.85%, n=15) and diabetes (15.15%, n=15).

- From consumer and carer responses, it was apparent that approximately 45% - 60% of consumers smoked cigarettes. However, less than one-quarter of consumers said their GP had asked about their smoking in the past 12 months (21.79%, n=39). Men were more likely

[1] The Missing Middle, Lived Experience Perspectives; Kaine C, Lawn S. (2021)

[2] Review of Physical and Mental Health Care in Australia, Kaine C, Lawn S, Roberts R, Cobb L. (2022)

to be asked about smoking by the GP (26.19%, n=11) than women (12.26%, n=19) and this difference was significant ($p<0.05$).

While mental health providers appear to ask about some physical health needs such as sleep, exercise and physical activity, other physical health needs such as smoking, drug and alcohol use, cancer screenings, etc., are often not discussed, even though there is the likelihood of approximately half of consumers being smokers and at risk. Almost half of mental health professionals did not show an interest in a consumer's whole health (e.g., social connection/engagement, lifegoals, etc). When consumers raised concerns about their physical health or medications, only half of consumers reported being taken seriously by their mental health professional.

These findings are concerning given that we know 28% of Australian deaths are due to cancer and that cigarette smoking is leading cause of cancer in Australia[3]. We also know that people living with mental illness are more likely to smoke tobacco and smoke more heavily than the general population, have high levels of nicotine dependence and are less likely to be offered treatment to stop smoking.

The management of tobacco smoking is one the most useful preventative strategies for improving health outcomes for people who experience mental health issues [4]. It is one of the most important activities GPs and other mental health service providers and other specialists (such as cardiologists) can undertake to improve physical health outcomes for this population, including their rates of cancer.

Evidence reported in the National Mental Health Commission's Equally Well Consensus Statement indicates that people with a serious mental illness are particularly important to consider in any Cancer Strategy. They are:

- Six times more likely to die from cardiovascular disease
- Five times more likely to smoke
- Four times more likely to die from respiratory disease
- Likely to die between 14 years and 23 years earlier than the general population and account for approximately one-third of all avoidable deaths [2].

Discrimination and stigma, diagnostic overshadowing, service cultures and workforce practices, reliance on psychiatric medications as the main or only form of treatment provided, financial barriers preventing people from seeking healthcare support, and the many social issues (e.g., unemployment, poverty, marginalisation) impacting people's lifestyle options are all significant concerns for this population that impact their physical health[4] , including whether they are supported with cancer screening. This is concerning, given prostate, Breast and Trachea/Broncus and Lung Cancer are 3 of the top 4 causes of mortality for people with serious mental illness [5].

LEA makes the following recommendations:

Develop clear protocols for information sharing (communication), collaboration and cooperation between **all settings** which provide mental health treatment and/or support to consumers.

[3] Lawrence D et al;. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: Retrospective analysis of population-based registers. BMJ. 2013;346.

[4] National Mental Health Commission. Equally Well Consensus Statement. Improving the physical health and wellbeing of people living with mental illness in Australia. Sydney: NMHC, 2016.

a. across the care continuum from prevention, crisis response, harm reduction, treatment, and recovery.

As above

b. across sectors, including Commonwealth funded primary care and private specialist services, state funded specialist mental health services, non-government services and services funded by the NDIS.

As above

(d) the experiences and leadership of people with lived experience of mental illness, problematic substance use and suicidality and their families and carers.

Leadership is essential in creating a culture of respect and dignity toward people and their families and carers. Mental illness is not a choice, rather it can be caused by several things, i.e., environmental, trauma experiences, family wholeness, and genetic factors.

COVID 19 has had consequences on people's mental wellbeing and much of the responsibilities of the Minister for Health and Ambulance Services, Hon Yvette D'Ath MP has been dominated by responding to the pandemic.

Since the implementation of the NDIS, many federal and State-funded services (such as PHaMS, Partners in Recovery) have been de-funded. Sadly, NDIS does not cover many of those requiring psychosocial support.

Furthermore, our research findings clearly show those who cannot afford treatment, those who have been disillusioned by how they have been treated, those who don't know or for whom it is too hard to access services, and those for whom services are either neither accessible nor affordable.

LEA makes the following recommendations:

Establish a network of peer workers to consult with and inform the Department in relation to relevant issues.

1. Create a dedicated position for a Minister for Mental Health
2. Train all staff to consider holistic needs of people – housing, education, training, and employment – as well as their mental health needs.
3. Establish community centres (many more needed that the 5 centres and 7 satellite services to be funded under Head to Health program) around the State.
4. Fund non-government community support services for those who cannot access specialist mental health support
5. Provide outreach services to the missing middle –those who have disengaged with mental health support because of various reasons.

(e) the mental health needs of people at greater risk of poor mental health;

There are many disadvantaged people across Queensland that are at greater risk of poor mental health outcomes. These are people who are homeless, Aboriginal and Torres Strait Islander people, those from CALD communities, as well as rural and remote communities.

Suicide risk for farmers, first responders, police, ambulance officers and increasingly because of COVID 19 exhausted health practitioners is high.

LEA makes the following recommendations:

1. Expand promotional work addressing mental health, suicide, and stigma/discrimination.

2. Expand identification, early intervention, and suicide prevention activities in rural and remote communities, ATSI communities, with funding to local government to promote good mental health and wellbeing and suicide prevention.

3. Expand programs targeting first responders to maintain their mental health and wellbeing as well as identification, early intervention, and suicide prevention.

4. Target specific programs for the CALD community.

5. Increase the mental health resources to people with intellectual disabilities and other disabilities who also experience mental illness.

(f) how investment by the Queensland government and other levels of government can enhance outcomes for Queenslanders requiring mental health treatment and support;

COVID 19 has highlighted the need for a whole of government approach to mental health and wellbeing. Now is the time to develop funding models to support not only the emergence of mental ill-health amongst the Queensland community, but also those with existing mental health conditions and mental illness. LEA is concerned that with the focus nationally and in Queensland of the fall out of mental ill-health from COVID 19, that the mainstream specialist mental health system will be overshadowed.

Clear funding is needed to ensure people with existing or emerging mental ill-health or mental illness are catered for by the Queensland government.

(g) service safety and quality, workforce improvement and digital capability;

Provide specialist mental health care in a safe environment, by experienced mental health clinicians is crucial. The Australian Government has developed the 'Head to Health' website which contains numerous online or digital programs which should be promoted.

LEA makes the following recommendations:

1. Increase funding to the department to address the increasing numbers of people moving from private to public health care.

2. Move the Mental Health Department from a hospital-centric approach to one where community-based services are at the centre.

3. Focus more on early intervention and prevention, whilst retaining the services for those in need of acute services

(h) mental health funding models in Australia;

There are numerous funding models across Australia, but one area LEA considers important given the current wave of anxiety and depression:

LEA makes the following recommendations:

Negotiate with the Psychology Board of Australia to increase the opportunities for supervision for psychologists. Wait times for supervision are too long.

(i) relevant national and state policies, reports and recent inquiries including the Productivity Commission Mental

The suggestions and recommendations in this Submission are based on material from several sources:

The initial 4-hour public hearing of the Committee on 20th January, where the Committee questioned a panel from Queensland Health and the Ambulance Service (a.m.) and the Queensland Mental Health Commission.

'PLANNING FOR WELLBEING' A Regional Plan for North Brisbane and Moreton Bay focusing on mental health, suicide prevention and alcohol and other drug treatment services Revised 2020–2025 (Brisbane North PHN and Metro Health Brisbane North); and

'PROMOTING LIVED EXPERIENCE PERSPECTIVE: DISCUSSION PAPER PREPARED FOR THE QUEENSLAND MENTAL HEALTH COMMISSION' (Queensland Branch of RAANZCP, July 2021)

Contact

LEA has been pleased to provide this Submission for consideration. We would welcome the opportunity for further clarification on any points raised and Mr Norm Wotherspoon would be the first point of contact for you.

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