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Submission to the Mental Health Select Committee: to improve the mental health outcomes for Queenslanders

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Introduction

Thank you for the opportunity for the Zero Suicide Institute of Australasia (ZSIA) to make a submission to the Mental Health Select Committee to improve mental health outcomes for Queenslanders.

The ZSIA is a leading advocacy agency for the development of the *Zero Suicide Healthcare (ZSH)* and *Crisis Now* frameworks in our region. These global initiatives focus on the relentless pursuit of excellence to reduce suicides & improve the care for those who seek help from healthcare systems.

ZSIA works with healthcare systems to enhance the quality and safety of those who are in crisis and those who live with suicidality.

A critical component for individuals and their families and for those working in mental health care is to have effective pathways to care that do not begin and end in the emergency department of a local hospital. In the latest AIHW report on mental health services it noted in Queensland that six out of every ten people who present to emergency with a mental ill-health condition are not admitted to hospital.[1] This is neither effective for the person nor cost effective for the hospital system.

A new approach has been developed in the United States that provides an effective alternate pathway to care. *Crisis Care Now* framework has four key elements that when implemented in full have demonstrable benefits for the individual, for the health system and for the staff working in mental health and suicide prevention.[2] The critical elements of crisis care are:

1. A Crisis Call Centre Hub that connects people in crisis with health professionals to ensure timely access and maintains a detailed data collection
2. Mobile crisis workers who can be deployed to the location of the person to de-escalate the crisis and connect the person and family or carers to ongoing community-based services
3. A stabilisation unit where the mobile crisis worker can take the person for more comprehensive support and assessment of the need for inpatient services
4. Evidence based treatments and supports available 24 hours per day.

Partners in this approach operate a crisis continuum and include law enforcement, ambulance and hospitals. Where the model has been implemented it has demonstrated a 40-45% reduction in costs to the health services and to demands on partner services.

This 3-minute video provides an overview of the crisis care system and demonstrates the benefits to individuals and partners involved in its implementation:

https://www.youtube.com/watch?time_continue=12&v=GWZKW8PLIgQ

In 2020 the global movement for mental health reform released the first International Declaration for Mental Health Crisis Care supported by this short animation explaining its benefits

The Promise of 988: Crisis Care for Everyone, Everywhere, Every Time - YouTube

[1] AIHW Report on Mental Health Services accessed 1 February 2022 Mental health services in Australia, Emergency department mental health services - Australian Institute of Health and Welfare (aihw.gov.au)

[2] Crisis Now diagram retrieved from www.zerosuicide.com.au. https://docs.wixstatic.com/ugd/443c3b_e29e70fdb987421c9a25700a583d1900.pdf

Terms of Reference relevance

This submission has particular focus on the following in the Terms of Reference:

1. 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):
   a) across the care continuum from prevention, crisis response, harm reduction, treatment and recovery
   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
2. service safety and quality, workforce improvement and digital capability;
3. mental health funding models in Australia; and
4. relevant national and state policies, reports and recent inquiries including the Productivity Commission Mental Health Inquiry Report.

Suicide prevention

Zero Suicide Healthcare

The Zero Suicide Healthcare framework is a continuous improvement model, comprising seven elements, which when fully integrated into a health service has demonstrated success in reducing suicides and suicide attempts in several countries across the world, including Australia.

Queensland Health has adopted this framework as it provides a comprehensive evidence-based approach that has been demonstrated nationally and internationally to reduce suicides for those who enter the healthcare system.

The Gold Coast Mental Health Specialist Services is the flagship health service in Australia having implemented the framework for some five years. Results published in 2020 showed almost a 25% reduction in suicides among people within their care and a 35% reduction in the number of re-admissions from people who had been placed on their Suicide Care Pathway.[3]

As can be seen within the ZSH framework transitions from healthcare are an important element of the ZSH approach and linking individuals to other support services is essential.

There has been significant investment through PHNs to provide aftercare services. However, focusing on aftercare is too limiting. ZSH offers a more comprehensive and integrated approach for reducing suicides while a person is under the care of the health system. Aftercare is only one element.

Policy practices supporting prevention

There is clear evidence that those who live in areas of employment stress and financial disadvantage are more susceptible to mental ill-health. The ability to bring together those areas of government that address the social determinants of health and design policy initiatives that seek to alleviate disadvantage, including homelessness, low levels of education and unemployment is an area of great need.

ZSIA recommends that the Mental Health Select Committee adopt *Suicide Prevention Impact Statements* be a standard part of policy development.

> The health system is not the only provider of services that can support and prevent individuals from taking their own life. It requires a comprehensive, multi-pronged approach that addresses the social determinants of health as well as the health requirements. There are many areas of government that could be brought together to collaborate on suicide prevention in consultation with local hospital and health services and Commonwealth Government funded Primary Health Networks.
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> To facilitate this *Suicide Prevention Impact Statements* should be standard practice across all areas of government when developing policy or assessing programs and services for funding. This would strengthen the role of the social determinants of health in suicide prevention and provide agencies with insight into the impact of their decisions. It would also provide an avenue to facilitate interagency cooperation in areas such as employment, education, justice, social services, finance and others alongside health.

The inclusion of impact statements on suicide prevention at the design stage of policy and program development would help to ensure that employees who are vulnerable to suicide, and who do not

[3] Turner K et al: Efficacy of the Zero Suicide framework in reducing recurrent suicide attempts: cross-sectional and time-to-recurrent-event analyses; The British Journal of Psychiatry (2020)

enter the healthcare system, have a pathway to confidently access service support through their agency as staff will be informed about working with and managing people experiencing suicidality.

Mental Healthcare for people in crisis

Access to a continuum of integrated services is a critical component of early management of mental ill-health. Providing ready access to qualified health professionals can assist individuals and families gain knowledge and understanding of how to manage mental ill-health and provide linkages to other services which can assist the individual.

There are four elements that form such an integrated system to manage crisis response care tailored to an individual needs at the time they experience crisis. The International Declaration for Mental Health Crisis Care states that:

> A comprehensive and integrated crisis network is the first line of defence in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. Effective crisis care requires a systemic approach that incorporates the established core elements of crisis care:
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> - A Crisis Call Centre Hub that connects people in crisis with health professionals to ensure timely access and maintains a detailed data collection
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> These programs use technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems. At the same time, they provide high-touch support to individuals and families in crisis.
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> - Mobile crisis workers who can be deployed to the location of the person to de-escalate the crisis and connect the person and family or carers to ongoing community-based services
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> Mobile crisis offers outreach and support where people in crisis are. Programs should include contractually required response times and medical backup.
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> - A stabilisation centre where the mobile crisis worker can take the person for more comprehensive support and assessment of the need for inpatient services. These centres have a 100% acceptance policy – no wrong door
>
> These programs offer short-term “sub-acute” care for individuals who need support and observation, but not medical inpatient stay, at lower costs and without the overhead of hospital-based acute care.
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> - Essential crisis care principles and practices including trauma informed care
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> These must include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

It should be noted that stabilisation centres cited above do not need to be co-located with a hospital removing the stigma that many experience when presenting to emergency departments. The stabilisation unit is staffed by trained health professionals including mental health nurses, social workers, psychologists and peer workers who are also linked directly to localised community-based services. This ensures that when a person leaves the centre, they do so connected to community-based services that support them and help keep them safe.

Workforce service safety and quality

It is generally understood that among the current cohort of practising psychiatrists they have not had specific suicide prevention training. Currently it is still too common to treat suicide as a by-product of a mental health condition. This has been negated by research and treatment of suicidality should be a direct action and then address any underlying mental health condition.

Training in suicide prevention should be a priority action for all healthcare workers, including psychiatrists, that is commensurate with their roles and responsibilities. However, currently there is no national curriculum for training undergraduate and graduate professionals in suicide prevention. The current approach to achieve inclusion in a degree curriculum is university by university. This is both challenging and time consuming.

To deliver quality and safety in mental health and suicide prevention the current workforce strategy should be reviewed and redeveloped with an implementation plan that includes the development of key competencies in suicide prevention. This may provide the opportunity for universities and other training institutions to design and deliver courses that develop the competencies.

There is little credence paid to the role of unpaid carers and their needs in relation to the workforce strategy. Understanding what services are available and what is appropriate for the individual needing care and support is a perennial problem for family members and carers. A recent Lancet Psychiatry article highlighted the extensive role of unpaid carers and the costs savings that flow from their work. This should be another priority area given consideration in the next workforce strategy.

> "Ensuring that family carers are not left socially isolated and have opportunities to safely connect with peers should be a priority, and policy makers need to learn from the experiences of caregivers during the COVID-19 pandemic."[4]

For many years breast cancer patients have had the active support of other women who have been successfully treated for breast cancer. Patients are matched to a person of similar age, treatment type and location. Having access to someone who can show that recovery is possible and who understand the challenges of dealing with the healthcare system has been shown to have a positive impact on the treatment outcomes for patients. The Cancer Councils' Breast Cancer Support Service is an early forerunner of what we understand today as peer support.

[4] COVID-19 and UK family carers: policy implications - The Lancet Psychiatry accessed 1 February 2022

The same positive outcomes could be achieved with the inclusion of peer workers as a standard appointment within mental health services helping to navigate, and where required advocate, for the individual and the family.

The challenge of retention is a key consideration. The consequence of not retaining experienced and qualified professionals is that of low capability to deliver quality and supportive supervision. This lack of expertise at a senior level in all aspects of the mental health system is a significant barrier to building a restorative and just culture that is focused on recovery and learning rather than compliance and retribution.

Operating under a culture of blame and retribution places healthcare professionals at increased risk of suicide. They have access to means & operate in environments that create abnormal levels of distress. Among women in US, suicide for nurses is 17.1/100,000 vs 8.6/100,000 in the general female population. Risk of suicide among female physicians was considerably higher than the general female population (Davis 2021)

A restorative, just culture fosters a psychologically safe work environment. It builds a culture of trust, learning & forward-looking accountability. Developing a healthcare system that is based on the principles of restorative just culture should be a priority and will make a significant contribution to attracting and retaining staff.

Reforming the mental health care system so that it delivers integrated care in a way that is responsive to the consumer and carer needs and supports and cares for staff is of paramount importance. Such reforms would provide better career pathways for the workforce, lead to improved opportunities for career supervision and deliver more diverse treatment pathways for the people using mental health services.

The workforce strategy must reinforce the recommendations of the Productivity Commission report by speaking to the importance and need for reform and positioning the strategy in this context.

Funding models

The Global Burden of Disease Report shows 140,000 years of life are lost to suicide annually in Australia. The Productivity Commission estimated that the cost of mental ill health and suicide to the national economy is between $43 billion and $70 billion per year, including the costs of providing treatment and supports and loss of economic participation and productivity.

Our universal health system enables us to identify those who present to health services with suicidal behaviours. Therefore, we have the ethical and moral responsibility to respond to their needs in both a competent and compassionate way. Research indicates between 15% and 30% of people who suicide have connected with health systems. If this is averaged at 20% potential national savings, based on the Productivity Commission estimates, would be between $8.6 and $14 billion annually.

It should be noted that by developing a system that responds to the needs of the person, options are provided that can re-direct people to care that is fit to need. In this infographic it illustrates that less than 5% of the original cohort of people requiring crisis care were admitted to in-patient care. Each of the previous options was able to meet the care needs of a proportion of the original cohort. In the US, the business case for this model has demonstrated costs savings of more than 40%, satisfaction with care increased and demands on emergency services significantly decreased.

Conclusion: Everyone …. Everywhere …. Every time

A mental health crisis cannot be planned. It is however possible to plan how we organise services to meet the needs of those individuals who experience a mental health crisis. That planning must be available to everyone, everywhere, every time it is needed.

ZSIA supports the concluding statement from the International Declaration, developed at the IIMHL Washington DC *Crisis Now* meeting in September 2019…..[5]

> All major institutions in society, whether those be places of employment, government agencies, health systems, faith communities or social and educational organisations, **must** support a crisis response system so that access to compassionate, person-centred mental health crisis care is affordable, accessible, accountable, comprehensive and rooted in best practices.
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> Mental healthcare must be moved out of the shadows and into mainstream care focused on the whole person. Parity should be the norm and that means, for individuals experiencing a mental health or substance use crisis, access to timely and effective care based on the person's needs must be equivalent to that of a person with a physical health emergency.
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> Finally, our mindset and culture must be one of a recovery-oriented approach to crisis care. The risks of harm to self or others are recognised, but the basic approach is fundamentally different. When crises are managed in comfortable and familiar settings, people feel less alone and isolated with their feelings of anxiety, panic, depression and frustration. This creates a sense of empowerment and belief in one's own recovery and ability to respond effectively to future crises. A recovery-oriented approach to crisis care is integral to transforming a broken system. Not only must we expand crisis care, but we must forge a better approach to crisis care by ensuring implementation of fidelity to best practice standards.

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[5] Personal communication. IIMHL Crisis Now meeting; Washington DC; September 2019.