11 February 2022

Committee Secretary
Mental Health Select Committee
Parliament House
George Street
BRISBANE QLD 4000

By email: mhsc@parliament.qld.gov.au

Dear Committee

Inquiry into the opportunities to improve mental health outcomes for Queenslanders

Thank you for the opportunity to provide feedback on the inquiry to identify opportunities to improve mental health outcomes for Queenslanders (the **Inquiry**). Aged and Disability Advocacy Australia (**ADA**) welcomes the establishment of the Mental Health Select Committee (the **Committee**), and appreciates being consulted on the important issues that are the subject of the Inquiry.

About ADA Australia

ADA is a not for profit, independent, community-based advocacy and education service with nearly 30 years' experience in informing, supporting, representing and advocating in the interests of older people, and persons with disability in Queensland.

ADA also provides legal advocacy through ADA Law, a community legal centre and a division of ADA. ADA Law provides specialized legal advice to older people and people with disability, including those living with cognitive impairments or questioned capacity, on issues associated with human rights, elder abuse, and health and disability legal issues related to decision-making.

ADA Law practitioners regularly assist persons in matters before the Mental Health Review Tribunal (the **MHRT**). ADA advocates and legal practitioners work with identified First Peoples advocates through the Aboriginal and Torres Strait Islander Disability Network Queensland (**ATSIDNQ**), a network established to support mob with disability and provide individual advocacy services for Aboriginal and Torres Strait Islander people with disability.

We provide the following comments for the Committee's consideration.

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ADA Australia acknowledges the Traditional Custodians of this land and pays respect to Elders, past and present.

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Lack of service availability and integration

A significant percentage of ADA clients who seek advocacy assistance have either experienced, or continue to experience, mental unwellness or illness. Adverse mental health experiences usually accompany other intersecting challenges, such as housing insecurity, poverty, clinical co-morbidities, inability to access to support services (including the National Disability Insurance Scheme), as well as other social and economic disadvantage.

Gaps in service provision and insufficient early interventions lead to a compounding of issues for an individual. Untreated mental illness hastens a series of negative economic and societal effects, with a trajectory that significantly increases an individual's exposure to the criminal justice, hospital, and guardianship/child protection systems.

For Aboriginal and Torres Strait Islander persons, efforts to seek assistance for mental illness are hindered by a lack of mainstream service options that provide culturally aware and safe supports. Programs such as the Indigenous Hospital Liaison Service are critically important, however we understand that resources are limited and that the service is not available at all Queensland hospitals. There remains limited cultural competence, acknowledgement and awareness within mainstream services of the impacts of intergenerational trauma experienced by Aboriginal and Torres Strait Islander persons, which is demonstrated in policies, communication and services that have clearly been developed without adequate (or any) regard to the accessibility and impacts of these in relation to Aboriginal and Torres Strait Islander people.

In our experience, when mental health issues are identified, attempts to improve or manage are often carried out in isolation of other factors which are likely to intersect with the presentation of mental illness.

Without integrated systemic support, including a focus on early identification and appropriate interventions for both existence of mental health conditions as well as the factors which are known to precipitate or bring on mental illness, there will be continue to be an over-reliance on public emergency services.

We note the Productivity Commission's report, provided to the Australian Government on 30 June 2020 and released publicly on 16 November 2020 (the **Report**).[1] ADA strongly supports the Report's findings and recommendations. The Report states *"almost half of all Australians will experience mental illness at some point in their life"*.[2]

From our perspective, the volume of current services is grossly insufficient and does not assist a fraction of that number. Approximately 64,000 persons across Australia with severe and persistent mental illness are estimated to be eligible for the National Disability Insurance Scheme (the **NDIS**).[3] Recently proposed legislative amendments to improve access to the NDIS for persons with psychosocial disability are welcome, however, the application process continues to be unreasonably complex, difficult, and lengthy, and presents significant hurdles to obtaining access for many – particularly, for persons in regional and remote areas.

Our advocates consistently report that the complex NDIS application process, which regularly involves multiple rejections and applications for review for applicants with psychosocial disability, has the effect of exacerbating the symptoms of the applicant's mental illness. For clients who are approved, many are informed that their funding will be significantly reduced during annual review (for some, after only one year of support). This causes a relapse to their mental health and a loss of any gains made with the benefit of supports.

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[1] Productivity Commission, Mental Health Inquiry Report, Actions and Findings, No. 95, 30 June 2020, 3 <https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-actions-findings.pdf>.
[2] Ibid, finding 2.1 'The State of Mental Health in Australia'.
[3] Disability Support Guide, *Mental Health and the NDIS*, <https://www.disabilitysupportguide.com.au/information/article/mental-health-and-the-ndis>.

If an application is approved, the NDIS will not fund therapies that address mental illness, but will provide funds for functional support for daily life. Supports such as these may include transportation to attend medical appointments, assistance in finding housing or preparing meals and so forth, all of which are essential care components. However, without availability of and integration between the NDIS and mental health services, an approved participant may still not be able to access key therapies that are essential to improvement and recovery.

As mentioned, accessibility is further reduced for people in regional or remote areas, for Aboriginal and Torres Strait Islander persons for whom culturally appropriate supports may not be available, for persons from culturally and linguistically diverse backgrounds, as well as for persons residing in aged care or disability accommodation.

Public and private services and capacity limitations

Our advocates report significant difficulty in locating mental health services with capacity to take on new patients, or to provide the necessary amount of support for existing clients.

Whilst this has increased noticeably over the course of the COVID-19 pandemic duration, demand for supports far exceeded supply before the pandemic's onset. Wait lists have increased exponentially for both public and private services – ADA clients report an average wait time of 6 months. Bulk-billing practices that provide mental health support are very rare. Telehealth practitioners may be more likely to offer bulk-billing, but clients often report that it is more difficult to engage with a therapist through telehealth than in person. For some, inability to see a therapist in person will be a barrier to receiving treatment at all.

Lack of available practitioners and services increases reliance on the public system and emergency acute care. ADA advocates report that mental health units in hospitals across Queensland are at capacity. For many hospitals – including Gladstone, Gold Coast University Hospital and Robina – it is an 'open secret' that patients who experience a mental health episode but do not report feeling suicidal or demonstrate suicidality during a presentation to the emergency department, are denied admission. This is a result of mental health units being so overwhelmed that such a high bar is set for admission. Once admitted, a patient is usually given access to psychiatric care. It is understood that mental health staff and units are under significant pressure, as they try to service increasing numbers of people who have not been able to access support in the community.

It is a similar scenario for community mental health services. It is our view that the critical work undertaken by the Child and Youth Mental Health Services (**CHYMS**) should undergo urgent and sizable expansion. Demand for paediatric mental health support far exceeds current service capacity, resulting in a triage framework that turns away children with mental illness that are assessed as 'not sufficiently unwell' to have reached the requisite bar. Our advocates provided examples where children whose mental health deterioration has caused them to self-harm could not gain access to the service. In these cases, the only option for crisis care is presentation at an emergency department.

Although many prefer in-person treatment, digital and telephone services such as the Kids Helpline, continue to play a vital role in providing safe, private and accessible counselling for children and young people.

Opportunities to improve outcomes for people with mental illness

A whole of government approach should be implemented, to identify and integrate existing systems which support mental wellness. This must recognised intersecting needs and corresponding systems, including:

- A comprehensive framework of early intervention, including early childhood supports that are widely available. The current model of waiting until children are 12 to access key services, such as Headspace, does not support positive outcomes.

- Increased cooperation and integration of health and education systems, with measures introduced to better identify children experiencing or at risk of mental illness in primary schools, and offering of support programs in schools, increasing the number of in-school guidance counsellors, and appropriate referral pathways.
- NDIS participation for children, young people and adults with psychosocial disabilities should be readily available. Disability advocacy services must be prioritised and adequately funded to assist persons in gaining access to the NDIS, reducing overreliance on mainstream emergency services.
- Mental health plans under Medicare with increased numbers of sessions should be retained, and accessibility improved with a strategy to increase the number of bulk-billing services. For many families, counselling services under a mental health plan will still not be accessible outside of bulk-billing practices;
- Destigmatising attitudes towards mental health conditions has improved, but significant progress is still needed. Disclosure of mental illness in the workplace remains low, with limited assistance sought in the earlier stages, leading to an escalation of symptoms requiring more complex treatment. This has a negative effect on job retention.
- Expansion of community mental health services to service all of Queensland, including increasing the number of metropolitan, regional and remote service locations, and with a sizeable increase in Aboriginal and Torres Strait Islander led services and supports;
- Increasing mental health supports in residential aged care facilities and disability accommodation. In our observation, very few facilities employ any services to provide mental health support for residents.
- Significant improvement is needed to address the significantly increased risk that persons who experience mental illness will be exposed to the criminal justice system. ADA understands that educational programs to assist police and correctional staff in identifying and responding to persons with mental illness have been introduced. It is our view that these programs must be comprehensive and mandatory, with a requirement for ongoing learning. People with disabilities, in particular, persons with cognitive or psychosocial disability, are especially overrepresented in the criminal justice system, comprising almost 50% of people entering prison.[4] The relevance of this statistic can not be overstated. It represents a failing of every aforementioned system.

Thank you again for the opportunity to comment. ADA would be pleased to further assist the Committee with its inquiry. Should you wish to discuss this submission, please do not hesitate to contact Vanessa Krulin, Solicitor and Senior Policy and Research Officer on or via

Yours faithfully

Geoff Rowe
Chief Executive Officer

[4] Human Rights Watch, *I Needed Help, Instead I was Punished: Abuse and Neglect of Prisoners with Disabilities in Australia*, 2018, 1 <https://www.hrw.org/sites/default/files/report_pdf/australia0218_web.pdf>.