QLD State Government
2020-21 Pre-Budget Submission

January 2020

Making mental health a priority

The Royal Australian & New Zealand College of Psychiatrists

Queensland Branch

Your Health in Mind

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has over 6700 members, including more than 5000 qualified psychiatrists (Fellows) and more than 1600 members who are training to qualify as psychiatrists (trainees). The Queensland Branch (RANZCP Queensland Branch) currently has 852 Fellows and 317 trainees.

Our members hold positions in public and private psychiatry and may specialise in a range of psychiatry subspecialties including child and adolescent psychiatry, consultation–liaison psychiatry, rural and remote psychiatry, and forensic psychiatry. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

Key recommendations

1. Guarantee ongoing investment in community mental health services:

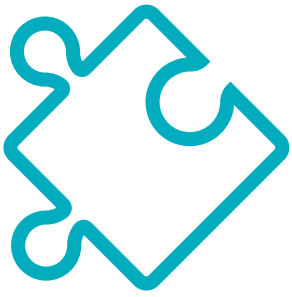
- Commit to target of 80% of the National Mental Health Framework funding in community mental health services by 2024 at a rate of 5% per year.
- Implement a central workforce unit and a state-wide mental health workforce strategy unit.

2. Inpatient unit for complex, high-risk patients

- Establish a dedicated inpatient unit in south-east Queensland for patients who are assessed as complex and high-risk.
- Direct additional resources to improve mental health services for high-risk, complex patients, and provide appropriate, on-going treatment.

3. More mother-baby inpatient units and perinatal mental health community services

- Increase the number of mother-baby inpatient units across the state.
- Invest in perinatal mental health community services.



4. State-wide intellectual and developmental disability (IDD) service

- Develop and operate new state-wide specialist inpatient and integrated community service to support and treat people with IDD and people on forensic orders (disability).
- Improve access for people with IDD to quality mainstream health care services and improve integration and collaboration between health and disability services.

Introduction

Mental health care remains a serious issue for Queensland. The vision that Queenslanders imagined following deinstitutionalisation has not been realised and the road to recovery for our most vulnerable remains very difficult. With Queensland's high suicide rate and high rate of mental disorder never has there been a more important time for our state leaders to stand up and create a 21st century mental health system that leads the nation in delivering economic and social participation for those with a mental disorder.

As psychiatrists, our aims are to prevent and treat mental disorders, and to support and promote good mental health. We are committed to providing the highest-quality treatment and care for people in need. For this, we need a first-class mental health system where people can access the right type and level of care, when they need it.

Queensland's mental health system requires a transformative change, and a government with the vision to see that future and bring it to life. We have been working with the Queensland Mental Health Commission and strongly support the direction outlined in 'Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018-2023'. We call upon the government to prioritise mental health and provide the resources necessary to deliver the Commission's strategic plan.

Professor Brett Emmerson AM
Chair, Royal Australian and New Zealand College of Psychiatrists, Queensland Branch

The state of Queensland's mental health

Mental disorders are responsible for almost one-quarter of the non-fatal burden of disease in Australia – more than any other disease group – and 12% of the total burden of disease.[1] Mental disorders are a leading cause of disability burden in Queensland. The impacts of mental disorders in Queensland are multiple and overlapping, and incur substantial costs on individuals, families, communities and the economy. In Queensland, a greater incidence of people report mental or behavioural problems (3.4%) compared to nationally (2.8%).[2]

Queensland consistently has a high suicide rate. Queensland's rate of suicide per capita (15.8 per 100,000) is second to the Northern Territory (19.5) and has steadily been increasing from 13.2 per 100,000 persons in 2008 to 15.8 per 100,000 persons in 2018.[3] Queensland accounted for 49.6% (130 deaths) of the overall national increase in deaths by suicide from 2016 to 2017, with rates increasing from 13.9 to 16.3 deaths per 100,000 persons nationally.[4]

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
NSW	8.7	9.3	8.4	9.8	9.5	10.8	10.8	10.3	10.9	11.1
VIC	10.5	10.1	9.2	9	8.9	10.9	10.9	9.9	9.6	9.1
QLD	12.1	13.4	12.9	13.9	14.6	14	15.9	13.9	16.3	15.8
SA	11.5	11.8	12.9	11.7	11.9	14.4	13.2	13.3	12.8	12.0
WA	12.3	13.6	12.9	15	13.5	14.5	15.6	14.4	15.8	14.7
TAS	15.4	13	14.1	13.7	14.2	12.8	16	17	15.6	14.5
NT	17.4	18.8	18.5	19.1	14.2	21.8	20.6	19.3	20.3	19.5
ACT	8.9	11.3	9.3	6.2	9.6	9.8	11.4	7.2	14.1	11.0
Australia	10.7	11.2	10.5	11.2	11.1	12.3	12.7	11.7	12.6	12.1

Table 1: Standardised death rates for suicide, state/territory of usual residence, 2009-2018[5]

The state experienced the largest increase in deaths by suicide from 674 persons in 2016 to 804 persons in 2017 (see table below).

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
NSW	623	674	617	727	718	832	829	805	880	899
VIC	576	558	526	514	533	658	668	624	621	593
QLD	525	588	578	631	676	658	757	674	804	786
SA	185	197	212	198	203	243	232	225	224	212
WA	279	313	309	367	336	367	400	371	409	383
TAS	79	64	74	71	74	69	83	92	80	78
NT	37	45	44	48	33	56	49	46	51	47
ACT	32	41	33	24	37	38	46	28	58	47
Australia	2337	2480	2393	2580	2610	2922	3065	2866	3128	3046

Table 2: Number of deaths, state/territory of usual residence, 2009-2018[6]

During the period of 2012–16, Queensland had the highest number of suicides by children aged 5–14 years, and the second highest rate of suicides by children aged 15–17 years. Aboriginal and Torres Strait Islander Queenslanders also fare poorly. The state had the highest number of suicides by Aboriginal and Torres Strait Islander peoples from 2012–16.

In terms of concurrent mental health and physical health conditions, Queenslanders are worse off compared to the rest of the nation. In 2011–12, 12.9% of Queenslanders were living with both a mental disorder and cardiovascular disease, whilst the national rate was 9.5%, and 7.2% were living with both a mental or behavioural problem and diabetes compared to 6.6% nationally.[7] Queensland also has higher rates of lifetime risky alcohol consumption than the national average and compared to most other jurisdictions.[8] As the most de-centralised state in Australia, Queensland has a significant maldistribution of mental health professionals outside of the South-East and major provincial centres.

Queensland's mental health budget

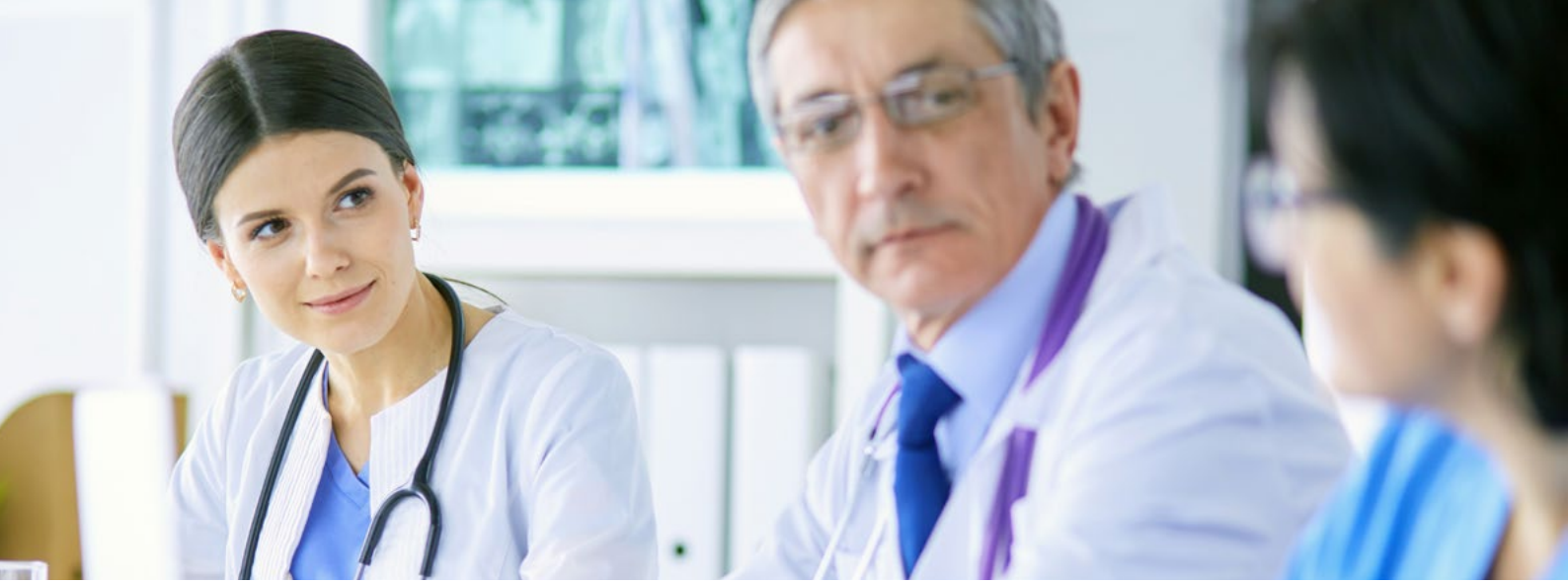
Queensland has a long history of spending less per capita on mental health services than other states and territories.[9] According to the latest data on mental health expenditure in Australia, Queensland had the second lowest spend per capita in 2015-16 and since 1995-96 has consistently spent lower on mental health services than the national average.[10]

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	National average
1995–96	118.15	132.08	108.56	133.59	128.56	137.02	106.10	118.66	122.50
1996–97	124.78	135.62	118.76	148.63	137.20	137.66	113.79	125.79	129.84
1997–98	126.79	138.31	126.05	165.44	149.62	135.74	111.10	129.06	135.09
1998–99	131.27	137.89	133.98	170.03	150.06	140.02	108.64	127.35	138.49
1999–00	135.31	143.01	140.12	173.03	153.40	135.79	118.68	126.43	142.87
2000–01	137.45	152.85	144.73	181.81	156.43	144.43	131.31	130.20	148.45
2001–02	143.68	158.60	145.52	190.52	165.86	154.19	141.81	139.28	154.23
2002–03	156.03	164.28	147.01	194.19	166.42	149.53	164.53	136.93	160.71
2003–04	161.06	168.70	148.44	207.04	171.99	148.44	177.55	160.46	165.88
2004–05	163.67	181.05	152.32	220.34	190.05	163.58	190.84	177.53	174.00
2005–06	173.92	185.50	160.76	230.32	196.46	196.73	188.36	183.91	182.43
2006–07	179.16	188.25	175.62	235.83	215.39	221.56	215.08	198.02	190.93
2007–08	184.43	190.97	192.76	248.34	223.57	234.18	218.24	204.56	199.04
2008–09	189.83	192.98	197.73	255.21	230.25	235.65	228.82	207.04	203.78
2009–10	197.81	196.82	207.67	251.93	231.41	253.61	223.18	207.90	209.41
2010–11	207.41	201.12	215.51	269.79	235.43	262.43	226.42	216.28	217.70
2011–12	212.91	199.39	219.67	278.60	233.73	235.24	235.73	232.82	220.45
2012–13	214.06	196.60	204.64	277.72	229.10	236.41	239.81	227.10	216.78
2013–14	219.58	201.45	199.17	280.90	250.94	231.03	245.34	233.97	220.59
2014–15	220.43	198.29	204.67	292.71	260.10	231.97	252.23	252.18	223.34
2015–16	224.19	197.30	213.70	298.75	257.65	222.96	263.22	260.43	226.52
2016-17	229.80	206.21	222.89	304.64	254.28	223.40	250.07	280.57	232.64

Table 3: Recurrent expenditure per capita ($) on mental health services, 1995-2017[11]

The RANZCP Queensland Branch advocates for a reconceptualisation of the discourse around mental health spending in Queensland. We believe that directing government funding towards mental health care should be understood as an investment, with the potential to generate high returns through improved productivity and social participation. Studies have shown that the productivity costs of mental disorder are up to twelve times more than the healthcare costs.[12] Mental disorders disproportionately affect working age Australians, with 15-24-year olds hit the hardest. The importance of good mental health to economic participation and productivity is well-recognised.

As psychiatrists, we aim to prevent and treat mental disorder, and to support and promote good mental health. In order to achieve this, we need a mental health system that is responsive to the needs of our community across the life span.



1. Increase funding to community mental health services

The twentieth century saw the closure of the asylum system with the intention of providing mental health care in community settings. However, there has been insufficient investment in the community-based model, and our public sector remains mainly institution-based with more funds spent on hospital services than community services and public health programs combined.[13]

Community mental health care refers to government funded and operated specialised mental health care provided by community mental health care services and hospital based ambulatory care services, such as outpatient and day clinics. Community mental health services are free to the public. They are generally available for people with severe forms of mental illness. They usually have a range of different types of mental health professionals, including case managers, psychiatrists, social workers, occupational therapists, psychologists and drug and alcohol workers. Community mental health services can offer specific services such as:

- acute care teams
- home based acute care teams
- continuing care teams
- early psychosis teams
- intensive rehabilitation teams
- child & youth mental health teams
- older persons mental health teams.

In the 2018-19 state budget, the Queensland Government allocated $32.5 million for community mental health services. The following year recorded the first decrease in the Queensland suicide rate for several years.[13 (a)]

To provide optimal mental health care the state's mental health services must be equipped with appropriately staff. There needs to be a 'back-to-basics' focus on building up core services in community mental health services, rather than just on specialists. A central workforce unit and a statewide mental health

workforce strategy unit are required. Increased staffing to the level of 80 per cent of the National Mental Health Framework (NMHF) recommendations by 2024 is required, at a rate of five per cent per year. Current staffing for adult facilities is at 55 per cent of the NMHF recommendation level, while older person services currently have only 30 per cent. The workforce unit should also focus on addressing the maldistribution of mental health professionals in rural areas.

Community mental health services in Queensland have been under intense strain, as prior to the 2018-19 budget there had not been any growth in funding for the past decade. Community mental health services have also experienced an increase in case complexity and are required to treat more high-risk patients than before. Community mental health services require ongoing investment in acute care teams, staff training and program development in order to address the increase in high risk-patients and case complexity. Community mental health in Queensland requires funding growth of five per cent per year for the next five years.

Research consistently shows that community based treatment is superior to hospital centred care for the vast majority of people with acute and long term mental illness.[14]

The funding of community mental health services for adults, children and youth and older persons across the continuum of care is currently below the level of need in the population, and needs to increase relative to the proportion of the population experiencing mental health issues. As outlined earlier, Queensland has a higher prevalence of mental disorders than the national average, and the suicide rate is markedly higher than the national rate.

The RANZCP Queensland Branch recommends:

- Government commit to a target of 80 per cent of the National Mental Health Framework staffing in community health services by 2024 at a rate of increase of five per cent per year. This includes Children and Youth, Adults & Older persons
- Government implement a central workforce unit and a statewide mental health workforce strategy.

2. Establish inpatient unit for complex, high-risk patients

Queensland's Mental Health Services are asked to manage increasing caseloads and complex cases with higher risk patients. The clinical profile of patients in mental health services has changed over the past 10–15 years as patients present to services who are more high-risk, for example 'ice' intoxicated patients, violent patients, patients with a combination of disorders (physical and mental) and high-acuity patients transferred from custody. An example of a complicated case is a person who may present to services who has schizophrenia, who may also require treatment for intermittent drug use, and concurrently have an acquired brain injury and a history of violence.

Some Fellows have reported that the pressure to treat and be accountable for such complex, high-risk individuals, within general mental health services has an impact on staff safety and morale, recruitment and reputation. Despite the considerable attention which has been given to it, the incidence and impact of occupational violence against health workers, including those employed by Queensland Health, remains problematic.[15]

We have also received feedback from consumers and carers who consider the therapeutic atmosphere of a ward may be impacted when high-risk, complex patients share wards with the general public. Without disregarding the rights of high-risk patients, the consumers and carers are concerned their presence may induce discomfort and anxiety amongst general adult patients and their families and carers. For instance, a vulnerable first-presentation psychosis young woman may find it intimidating to be a co-inpatient with a psychotic and antisocial classified male patient.

Queensland has one High Security Inpatient Service in Wacol for patients on forensic orders or classified patients who have committed very serious offences.

However, this unit can only take a proportion of high-risk, classified patients. The remainder of this patient group are transferred to a general adult mental health ward.

Queensland has had consistently less forensic inpatient beds than the national average since 2009-10.[16]

The RANZCP Queensland Branch considers that some high-risk patients presenting in mental health crisis, including those in transition from places of custody, would benefit from specialist treatment in a purpose-built facility. To be eligible for this specialist treatment, patients would be assessed as beyond the capacity of general adult Authorised Mental Health Services, who aren't of the offending level for the High Security Inpatient Service, and who are not suitable for rehabilitation in a Secure Mental Health Rehabilitation Unit. The proposed unit should have 25 beds and would also help relieve the strain on acute inpatient units which experience competing demands for beds from emergency departments and the community.

The RANZCP Queensland Branch recommends:

- Government establish a dedicated 25-bed inpatient unit in South East Queensland for patients who are assessed as complex and high-risk.
- Government direct additional resources to improve mental health services for high-risk, complex patients, and provide appropriate, on-going treatment for this patient group.

3. Increase mother-baby inpatient units and perinatal mental health community services

Mental health issues experienced during the perinatal period are a major public health concern as they can have serious, long-lasting and potentially intergenerational consequences.[17]

The Queensland Maternal and Perinatal Quality Council[18] found that approximately 1 in 6 maternal deaths in Queensland are due to suicide.

The Queensland Maternal and Perinatal Quality Council notes that delays in access to public mental health professionals have been identified in some maternal deaths by suicide and that timely access to specialist perinatal mental health services and/or advice is a matter of serious concern. It is now widely accepted that women requiring inpatient treatment have improved outcomes if accompanied by their babies.

Mother-baby inpatient units form only one component of perinatal mental health services. Specialist perinatal community mental health services are essential so mothers can receive treatment and care as an outpatient so hospitalisation may not be necessary.

The RANZCP Queensland Branch advises that it is best clinical practice that mother and baby remain together during treatment, and that parents and/or caregivers are involved to provide support. We support admission to mother-and-baby psychiatric units with appropriately trained staff as best practice. General adult psychiatric facilities are not an appropriate environment for infants.[19] The Queensland Mental Health Commission[20] noted that the lack of appropriate mental health beds to which a mother can be admitted for treatment, without separation from her baby, presented an unacceptable risk for Queensland mothers, infants and families.

In March 2017, the Lavender Mother and Baby Unit, the first public acute mother-and-baby mental health unit was opened at the Gold Coast University Hospital, with four beds. As expected, the low number of beds has proven unable to meet demand. Criteria to be admitted to the Lavender Unit include postpartum psychosis, relapse of schizophrenia or bipolar disorder in the postpartum, severe anxiety and/or depressive disorder, or complex mental health problems.

Postpartum psychosis affects approximately 1 to 2 in every 1000 mothers and will almost always require admission to hospital.[21]

In 2016, 61,876 mothers in Queensland gave birth. Between 61 and 122 of this number could have required admission to hospital for postpartum psychosis alone.

Although the Lavender Unit is a state-wide service, its location in the far south of the state makes it practically inaccessible to those not from the Gold Coast or Logan/southern Brisbane areas. A significant number of women admitted to specialist mental health units in the first year postpartum are separated from their babies. In 2015/16 220 mothers were admitted to a mental health unit at a Queensland public hospital, of this number 182 were admitted and had a minimum overnight stay.[22] These figures have altered little since the opening of Lavender Unit. In 2016/17 the number of mothers admitted to a public mental health unit (excluding the Lavender Unit) with a minimum overnight stay was 186.

The Lavender Unit's four beds are clearly not enough to meet the demand for one of the many serious mental illnesses which can impact mothers. It is evident that a substantial increase to the number of mother-and-baby units is required throughout Queensland.

The RANZCP Queensland Branch strongly recommends the Government increase the number of mother-baby inpatient units across the state and invest in perinatal mental health community services.

4. Establish a state-wide specialised intellectual and developmental disability service

The RANZCP Queensland Branch is concerned that Queenslanders with intellectual or developmental disability (IDD) are not being afforded the same opportunity to access services, nor have a choice of relevant services that respond to their needs, compared to the general population. People with neurodevelopmental disorders (intellectual disability and autism) make up about 2 to 3 per cent of the population.[23] In Queensland 35,500 people with intellectual disabilities have profound or severe core activity limitation.[24]

People with IDD often have poorer health than the wider population. Evidence demonstrates that they experience higher mortality rates compared with the general population and a poorer quality of life.[25] People with IDD also experience high rates of mental health problems, difficulties in diagnosis and management, decreased capacity for self-advocacy and representation, high levels of stigma and discrimination, and lack of training and expertise in health services.[26] This vulnerable group experience unique obstacles in accessing health care, and in Queensland there is limited specialised health care to meet their needs.

The National Health and Hospitals Reform Commission reported in 2009 that access to specialist medical services is a major gap to be addressed for people living with IDD.[27] There is a particular lack of services for people with IDD who exhibit challenging behaviours. When challenging behaviours result in involvement with the criminal justice system, there is a dearth of secure, therapeutic community options. The Queensland forensic disability service system is unable to address the growing numbers of people on forensic orders (disability) and relies upon placing these people in mental health inpatient units due to a lack of alternative placement options.

The RANZCP Queensland Branch has long considered that it is not appropriate to place people with a sole diagnosis of IDD, including those on forensic orders (disability), in a mental health inpatient unit. This population has a right to be provided with appropriate care and management for their condition. Mental health inpatient units have been designed and staffed to accommodate the clinical needs of people with acute mental illness rather than those with IDD.

Many people with complex IDD or on forensic orders (disability) require care from specialist IDD trained staff and stable, long-term supported living arrangements which inpatient units are not designed for.

Queensland has two state-wide specialist health/mental health services for people with IDD. These are the Mater Intellectual Disability and Autism Service and the Specialist Disability Services Assessment and Outreach Team, whose future is uncertain due to the funding being returned to the National Disability Insurance Scheme.

Community services provides this group with essential support and rehabilitation, while inpatient treatment remains a necessity for some patients with IDD who cannot be assessed or treated in the community. Xenitidis et al[28] study shows how this patient group benefits from admission to a specialist IDD inpatient unit rather than a generic mental health unit. Significant improvements were demonstrated within the specialist unit cohort on measures including psychopathology, global level of functioning, behavioural impairment and severity of mental illness. Charlot and Beasley[29] note that whilst individuals with mild intellectual disabilities and mental health problems benefit from admissions to generic mental health inpatient units, specialist IDD inpatient units can have greater capacity to treat individuals with greater developmental challenges, in addition to offering planned admissions which may help to prevent severe relapse.

The RANZCP Queensland Branch recommends the development of a new government operated state-wide specialist inpatient and integrated community service to support and treat people with IDD and also people on forensic orders (disability). We envisage that the service would be staffed by a multidisciplinary team including disability, health and mental health expertise (including specialist psychiatrists). It would be equipped with appropriate facilities and trained specialist medical, nursing, allied health and disability support staff, and operate in parallel yet separate to mental health services. Inpatient units would provide intensive support to those with complex IDD who require hospitalisation, and integrated community teams would provide both direct care and support, plus consultation–liaison services for the non-government sector.

This proposed state-wide specialised service could help fill the gap in services where the NDIA is unable. For, when the NDIS becomes fully operational it is questionable whether it will be able to provide adequate support services or service options to the forensic disability cohort and people with complex IDD and challenging behaviours. This cohort's needs are unlikely to be able to be met in the private sector. The recent Queensland Government funded report, 'Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System'[30] noted there is a very real potential for people with complex and high-risk needs to find it difficult to engage a willing or suitable NDIS service provider. The report states that 'market failure' may occur for people with complex and challenging behaviours as costs to provide a service may be too great, or specialist expertise or infrastructure is lacking. The report goes on to say that while previously state-based disability services would have stepped in to address these service gaps, under the NDIS this safety net has been removed.

The RANZCP Queensland Branch recommends:

- Government develop and operate a state-wide specialist inpatient and integrated community service to support and treat people with IDD and people on forensic orders (disability).
- Government improve access for people with IDD to quality mainstream health care services and improve integration and collaboration between health and disability services.
- Government allocate funding for enhanced training of all frontline health and disability workers in neurodevelopmental disorders.

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