The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Western Australian Branch

10 07 2020

Mr Chris Tallentire MLA
Chair, Joint Select Committee on Palliative Care in Western Australia
Legislative Council Committee Office
18-32 Parliament Place
WEST PERTH WA 6005

Submission via: www.parliament.wa.gov.au/subportal

Dear Mr Tallentire,

Re: Inquiry into Palliative Care in Western Australia

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) WA Branch welcomes the opportunity to contribute to the Joint Select Committee's *Inquiry into Palliative Care in Western Australia*.

The 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 WA Branch has over 500 members including almost 400 qualified psychiatrists and around 120 members who are training to qualify as psychiatrists. 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.

In our brief response to the Joint Select Committee, the RANZCP WA Branch would like to highlight three areas of particular concern regarding palliative care in WA – the availability of integrated mental health care to alleviate suffering in palliative care, the impact of the lack of consultation-liaison services on desire to access and access to voluntary assisted dying, and the lack of access to palliative care services for people with serious mental illness.

Mental health care as a component of palliative care

In designing palliative care it is helpful to consider Saunders' concept of 'total pain' – the suffering that encompasses all of a person's physical, psychological, social, spiritual and practical struggles (1). Responding to the physical pain and challenges of life-threatening illness is but one element of the provision of palliative care. Good mental health care in the palliative setting requires an integrated approach that is able to balance biological, psychological and social factors.

Treatment for mental health issues can help to relieve the experience of physical pain, due to the interaction of biological and psychological systems (2). Co-occurring mental illness or disability may overshadow other diagnoses, or may mean that some treatments need to be provided differently to be tolerable or to accommodate interactions between different treatments.

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While all psychiatrists have training in working with co-morbidity, consultation–liaison psychiatrists specialise in the treatment of mental illness in the context of physical illnesses. An important component of the consultation–liaison role is in supporting medical services and staff in providing treatment that encompasses mental health.

The integrated nature of consultation-liaison psychiatry means that despite the evidence demonstrating the reduction in cost of treatment for people with co-occurring physical and mental illness, it is vulnerable to cost-cutting as it sits uneasily between the physical and mental health funding and governance models.

RANZCP WA Branch members working in consultation-liaison settings have reported that baseline availability of consultation–liaison psychiatry has deteriorated in recent years the impact of which has included the loss of outpatient clinics for people managing the psychiatric and psychological impacts of cancer, neurological disorders, cardio-respiratory disorders, renal failure and organ transplants. Consultation–liaison is not only underfunded in major metropolitan public hospitals, it is practically inaccessible in other service settings.

This means palliative care patients in regional or remote areas, and those cared for at home or in a hospice setting do not have access to care that includes consultation-liaison psychiatry. This is significant as a large portion of these patients have either untreated mental health comorbidities or psychiatric side effects of their terminal illness or the treatments provided for these illnesses.

A second significant group of psychiatrists providing integrated care of particular relevance to palliative care are the sub specialists in Psychiatry of Old Age. Psychiatrists who specialise in working with older adults are experts in mental illnesses that emerge later in life, and co-occurring illnesses and conditions of ageing as well as the transitions social connections and supports in this age group. A push to ageless services can be administratively attractive, but disenfranchises older people who have complex psychiatric, medical and psycho-social needs that differ significantly from younger cohorts. It is therefore important that palliative care services also have mental health expertise relevant to this age group available to them.

The RANZCP WA Branch recommends that the Joint Select Committee on Palliative Care investigate and support measures to ensure the availability of consultation-liaison and older adult mental health services as a consistent component in palliative care.

Impact of limited availability of consultation liaison psychiatry on end of life choices

Adequate support for consultation–liaison services is essential in ensuring people with chronic and terminal illnesses are able to alleviate or manage psychological suffering. It is arguable that patients are currently able to fully exercise choice regarding end of life care where such services are unavailable or poorly understood.

The RANZCP WA Branch also recommended that where there was doubt around capacity in the context of accessing voluntary assisted dying (VAD), assessment should be undertaken by a specialist. It is not the case that mental distress is the inevitable outcome of ageing or terminal illness. There is a risk that symptoms of mental ill health may be mistaken by a doctor not trained in psychiatry for an ‘understandable’ reaction to their condition. In the case where mental illness may potentially be influencing capacity, this specialist should be a psychiatrist (2).

It is of ongoing concern to the WA Branch that consultation–liaison services are underfunded and are therefore not sufficient to meet the needs of the population. As the RANZCP WA Branch identified in submissions to the End of Life Inquiry, early intervention with consultation liaison psychiatry can significantly reduce suffering, and in some cases facilitate

medical treatment that is life-saving but may previously have been experienced as intolerable by patients (2).

The RANZCP WA Branch notes that in the implementation of VAD there has not been provision for any additional consultation-liaison capacity that would be able to support such assessments, meaning that any such capacity would be diverted from the already resource-strapped and potentially life-saving services working to intervene earlier in care pathways.

The RANZCP recommends that the Joint Select Committee on Palliative Care investigate the availability of mental health services, and consultation-liaison psychiatry in particular, to services and patients in the context of voluntary assisted dying.

Palliative care for people with mental illness

The other group whose end of life care needs are poorly met are those in residential mental health/psycho-social disability settings It is rare for people requiring palliative care to be accepted and treated if referred to mainstream mental health services as they are often deemed to fall outside the core business of the services or the services feel that they lack the required expertise. People who usually reside in residential care have limited options for palliative care once their psychiatric hostels or mental health services are unable to meet their physical health care requirements. This leads to people going untreated, or alternatively transferred to tertiary hospitals to wait in acute beds until eligible for palliative care hostels.

Likewise, people who are unable to be managed in palliative care settings due to psychiatric symptoms such as agitation, aggression, mood lability, psychotic symptoms, are transferred to tertiary hospitals to access palliative care.

The RANZCP WA Branch therefore recommends that the Joint Select Committee on Palliative care investigate and include recommendations to ensure the availability of palliative care services to people with mental illness.

As a final note, the mental health and wellbeing of carers and the health workforce should be considered in reviewing palliative care. The RANZCP WA Branch notes that supporting the health and wellbeing of carers and the workforce impacts both the quality of care provided as well as preventing an increase in mental ill-health amongst carers and the workforce.

If you have any questions about this submission or would like to discuss further, please contact Zoe Carter, RANZCP WA Branch Policy and Advocacy Advisor, via zoe.carter@ranzcp.org or on 9284 2138.

Yours sincerely

Professor Megan Galbally
Chair, RANZCP Western Australian Branch Committee

References

(1) Ong CK, Forbes D. Embracing Cicely Saunders's concept of total pain. BMJ. 2005 Sep 10;331(7516):576. doi: 10.1136/bmj.331.7516.576-d. PMID: 16150775; PMCID: PMC1200625

(2) Royal Australian and New Zealand College of Psychiatrists [Internet] Perth WA Royal Australian and New Zealand College of Psychiatrists WA Branch Submission to the Joint Select Committee on End of Life Choices; 2017 Oct 18 [cited 2020 Jul 03]. Available at https://www.ranzcp.org/files/resources/submissions/sub_end-of-life_ranzcpwa_final.aspx