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Submission to the Royal Commission into Victoria's Mental Health System

June 2019

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand, including more than 4,000 physicians and 1,850 trainee physicians in Victoria. The College represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

The Royal Australasian College of Physicians (RACP) is grateful for the opportunity to make this submission.

RACP Paediatrician and member of the College's Indigenous Child Health working party, Dr Niroshini Kennedy, has been asked by the Royal Commission to provide evidence regarding Aboriginal and Torres Strait Islander youth mental health. Dr Kennedy will be providing evidence as an individual, not representing the RACP.

As such, the RACP agreed in May that we develop a submission to the Royal Commission to support Dr Kennedy's testimony and to further existing RACP Indigenous youth mental health and suicide advocacy. Given these specifications, the RACP submission addresses the following terms of reference for the Royal Commission into Victoria's Mental Health System:

Term of Reference

4. How to improve mental health outcomes, taking into account best practice and person-centred treatment and care models, for those in the Victorian community, especially those at greater risk of experiencing poor mental health, including but not limited to people:

    4.1. from Aboriginal and Torres Strait Islander backgrounds;

    4.4. in contact, or at greater risk of contact, with the forensic mental health system and the justice system.

    5. How to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches.

Consultation questions

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

No comment.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

The following recommendations can assist with encouraging early treatment and support:

- Provide secure and long-term funding to Aboriginal community-controlled health services (ACCHSs) to expand their mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drugs services, using best-practice trauma-informed approaches
- Increase funding for ACCHSs to employ staff to deliver mental health and social and emotional wellbeing services across the lifespan, including psychologists, psychiatrists, speech pathologists, mental health workers and other professionals and workers including appropriately qualified and credentialed non-teaching staff in schools;
- Increase the delivery of training to Aboriginal health workers to establish and/or consolidate skills development in mental health care and support, including suicide prevention
- Fund and support the ongoing implementation of Victorian Aboriginal suicide prevention strategies and mechanisms such as Balit Murrup Aboriginal social and emotional wellbeing framework 2017-2027. The framework must be implemented in collaboration with Aboriginal and Torres Strait Islander communities and the community-controlled health sector.

Holistic models of care used in Aboriginal community-controlled health organisations (ACCHSs) are an important means of preventing mental health issues and encouraging early treatment. For Aboriginal and Torres Strait Islander people, 'health' is often defined broadly and holistically. Health is conceptualised as not merely the absence of disease. Rather, it is a complex and multi-faceted concept, which encompasses the physical health of individuals, social, emotional and spiritual health, and the wellbeing of whole communities. ACCHO models of care incorporate social and emotional wellbeing into core business.[1] Connection to country, family, culture, language and community are considered protective factors that contribute to mental wellbeing.[2]

3. What is already working well and what can be done better to prevent suicide?

Suicide prevention is a complex area. Factors that can contribute to Indigenous suicide, over and above drivers of non-Indigenous suicide, include but are not limited to: poverty, homelessness, intergenerational trauma, mental illness, lack of opportunity (employment and education), impacts of colonisation, and societal inequality. Indigenous health professionals have evaluated Indigenous youth suicide prevention programs; the findings are outlined in the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report.[3]

To better prevent suicide the RACP recommends long term investment in culturally appropriate mental health services. Indigenous suicide is a national crisis that requires immediate attention. Thirty five Indigenous people died by suicide in the first three months of 2019.

The RACP issued a series of national recommendations which are also applicable to Victoria. Our joint statement with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and National Aboriginal Community Controlled Health Organisation (NACCHO) on Aboriginal youth suicide calls on the Federal Government to make addressing Indigenous youth suicide a national health priority and implement a coordinated crisis response.

This needs to be short-term as well as long-term and must include:

- Secure, long-term funding to ACCHOs to expand their mental health, social and emotional wellbeing, suicide prevention, including increased funding for employing staff.
- Increased training to Aboriginal health practitioners to build on their skills in mental health care and support, including suicide prevention.
- Government commitment to timely follow-up on discharge plans for Indigenous mental health patients, including referrals to other health practitioners and social services.
- Increased culturally safe community mental health teams.
- Better transitional arrangements for mental health care of (a) people taken into custody (police and corrections), and (b) people released into the community. Specifically referring to timely access to medications when entering and leaving custody.

Victoria should support self-determination including through processes such as the Victorian Treaty process. Long-term Aboriginal and Torres Strait Islander self-determination requires commitment to the Uluru Statement from the Heart, including by states and territories. Victoria can lead the way by supporting and advocating the constitutional reforms sought by the Uluru Statement from the Heart.

Youth incarceration – raise the age of criminal responsibility:

The RACP has serious concerns about the over-representation of Aboriginal and Torres Strait Islander people especially children and young people who are incarcerated, as outlined in our position statement on The Health and Wellbeing of Incarcerated Adolescents.

The RACP urges action and funding to improve Indigenous mental, social and emotional wellbeing, focussing on education, counselling, community development and empowerment. We also support the Australian Law Reform Commission's recommendation on justice reinvestment – diverting money spent on imprisonment to community-based initiatives to reduce crime and strengthen communities with a focus on supporting families. Groups with expertise in justice reinvestment should be consulted to determine an appropriate approach. Community led justice reinvestment and diversionary models should be expanded.

There is a recognised connection between children in out of home care having a higher likelihood of interactions with the criminal justice system, related to this is the higher rates of mental illness of incarcerated people[4]. Additionally, incarceration impacts negatively on mental health.[5]

Medical evidence shows that children aged 10 to 14 years lack the emotional, mental and intellectual maturity to have a full understanding of their decisions and complete control of their impulses.[6] The health needs of children in detention are greater than adolescents in non-custodial settings. Accordingly, we support the recommendation in the Royal Commission's report on the Protection and Detention of Children in the Northern Territory (NT) to raise the age of criminal responsibility. We support raising the age to at least 14 years in line with children's neurological and cognitive abilities. Raising the age will avoid children under 14 experiencing the negative health impacts of detention.[7] The aforementioned justice reinvestment programs can assist with diversionary mechanisms.

Any approach to addressing the mental health of children who have been in contact with the criminal justice system, must be culturally safe and have the input of expert Aboriginal groups. Further, we join the NACCHO in their call for the reduction in the proportion of Indigenous children and young people in out-of-home care and detention.

Children in out of home care (OoHC)

Children and young people in the child protection system experience high rates of mental health issues and distress.

RACP paediatricians and physicians are increasingly being asked to manage the complex trauma, attachment histories, and behavioural and mental health issues of children in out-of-home care.

Both the Australian Government's National Clinical Assessment Framework (2011) and the RACP's 2008 position statement on the Health of Children in OoHC call for routine, proactive, multi-disciplinary health screening to establish and plan for ameliorating the complex effects of trauma on these children. The Royal Australian and New Zealand College of Psychiatrist's position statement on the Mental Health Needs of Children in OoHC (2015) calls for priority access to multidisciplinary developmental and mental health services for children in OoHC.

However, in spite of these recommendations, there are significant and severe service gaps in Victoria in the provision of services to Aboriginal children in OoHC, a group who are being removed into OoHC at around 10-15 times the rate of non-Aboriginal children in Victoria. These children and young people have high needs. A 2016 audit at the Victorian Aboriginal Health Service of 103 children in OoHC showed that 66% of these children had mental health problems; 37% had hearing problems and 46% had developmental delay. These service gaps have meant that an alarmingly low number of Aboriginal children have received the recommended multi-disciplinary health assessments. Services for these children have been underfunded, poorly targeted, run in mainstream services rather than ACCHOs, and have not been culturally safe. As with many children in OoHC, or with complex behavioural problems, the majority of these children need prompt access to well-resourced paediatric services. The two paediatric services in Melbourne (one in an ACCHO, and one in a tertiary paediatric hospital) who have been seeing the majority of these children have appealed to the State Government to develop, resource and implement an integrated, trauma-informed and culturally safe model of care.

We recommend investment in the provision of adequate psychological assessment, psychological, long term trauma informed support and management of medication by psychiatrists for children in child protection system, particularly those in out of home care. A comprehensive mental health team of psychiatrists, community paediatricians, general-practitioners, psychologists and youth workers is needed.

Our position statement on the Health of Children in Out-of-Home Care (2008) outlines a number of recommendations to improve the overall health and wellbeing of children in out-of-home care including: mental health screening using accessible and validated tools; promoting the use of fast tracking therapeutic services, (given the small window of opportunity available due to transient care placements). These services need to be provided for all health needs and in particular mental health needs.

Over a decade has passed since our position statement, however, the recommendations remain relevant, and we call for urgent implementation of the suggested approaches. We express concern that there are no publicly funded dedicated paediatric services for Indigenous children in out-of-home care in Victoria.[8]

Investment in the health of young people:

We believe supporting children and young people's mental health is crucial to overall population mental health. Investing in the mental health and wellbeing of children and young people is a cost-effective way to improve their long-term social, physical and mental outcomes.

The current capacity of mental health services for children and young people is limited, making referral difficult and often excluding children with disabilities. Children and young people with mental health problems require coordinated and comprehensive care involving general practitioners, paediatricians, child psychiatrists and other mental health professionals. Due to limited specialised mental health services, especially in rural Victoria, the role of the paediatrician is particularly important.

The RACP position statement on the importance of the early years of childhood emphasises how critical healthy infant behaviour and emotional development are for adolescent and adult mental health. It also recognises the infant mental health depends on parental mental health. Addressing a parent's health needs, including substance use, can positively impact a child's health.

Accordingly, our key recommendations in this area are a home visiting program providing support to all parents for the first ten days after birth and a focus on the early identification of parental antenatal and postnatal depression. Parents with substance use issues will require specific support, noting that trauma has a lifelong impact on mental health.[9]

Further, our position statement on The role of paediatricians in the provision of mental health services to children and young people recommends that governments capitalise on the knowledge and experience of paediatricians, and other child and adolescent health professionals, to develop effective models of mental health care service delivery for children and young people.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

No response.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

Social determinants of health are drivers of poor mental health outcomes. Studies have shown that inequalities in health are mirrored and caused by inequalities in society. These social inequalities in the conditions into which children are born, grown, live and work and age affect not only material resources and access to health care, but also their relationship to power structures and the control that they have over their lives, including overrepresentation in the justice system.[10]

The Dunedin longitudinal study that shows that the most disadvantaged are overrepresented in many negative indices. A segment comprising 22% of the cohort accounted for 36% of the cohort's injury insurance claims; 40% of excess obese kilograms; 54% of cigarettes smoked; 57% of hospital nights; 66% of welfare benefits; 77% of fatherless child-rearing; 78% of prescription fills; and 81% of criminal convictions.[11]

All of these factors have a direct and profound influence in health outcomes, mediated by complex processes that influence health along the life course. Those with higher socioeconomic positions have better health outcomes on average, and that there is a gradient in the relationship between socioeconomic position and health.[12]

The social inequalities affecting health far outweigh the impact of other determinants of health, such as genes, biology or medical care. Socioeconomic position accounts for between one-third to one-half of the health gaps between Indigenous and non-Indigenous Australians.[13]

Aboriginal and Torres Strait Islander people are more likely to have a lower socioeconomic position, and the factors underlying these inequalities need to be addressed in a fair society. Addressing the root causes of these inequalities are the most effective way of addressing health inequalities. This requires sustained political and economic policy changes, and an intersectoral approach. The principles of proportionate universalism – reducing the steepness of the social gradient in health with action that is universal but proportionate to the level of disadvantage – address the tendency for good medical care to vary inversely with the need for it in the population served, and are described in the RACP Inequities in Child Health Position Statement. Marmot outlines six domains to target: “(i) give every child the best start in life, (ii) improve education and life-long learning, (iii) create fair employment and jobs, (iv) ensure a minimum income for a healthy standard of living, (v) build healthy and sustainable communities, and (vi) apply a social determinants' approach to prevention”.[14]

6. What are the needs of family members and carers and what can be done better to support them?

Children of parents with mental illness are commonly in the situation of caring for their sick parents as they become older. In order to provide care for these children, a holistic approach is required that includes consideration of the caring responsibilities through providing adequate support.

Similarly, the children of parents who use substances face in general, a poorer academic experience; emotional, behavioural, and social problems; and an earlier onset of substance use, faster acceleration in substance use patterns, and higher rates of alcohol and drug use disorders. A holistic approach is needed to address the needs of the children of parents who use substances.

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

No response

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

No response.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

RACP Victorian paediatricians noted that there is a reluctance to refer their patients with complex mental diagnoses (possibly in addition to intellectual disabilities and/or Autism Spectrum disorder) to Child and Adolescent Mental Health Services due to the long wait list and view that their patients are not likely to be seen. For this reason, we understand the waitlist may indicate not only the duration of the period prior to consultation, but the existence of people who are not even referred because they are unlikely to be seen. Increased capacity of Child and Adolescent Mental Health Services would assist with increasing access to necessary services.

Victorian paediatricians are skilled in providing mental health care to their patients, however there are numerous barriers including minimal practical or professional supervision, limited abilities to interface with psychiatrists and psychologists due to time constraints. Outpatient psychiatric care is difficult for many patients, specifically because of patient homelessness.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

No response.

11. Is there anything else you would like to share with the Royal Commission?

The RACP is a signatory to the statement developed by Thorne Harbour Health, Rainbow Health Victoria, and Switchboard Victoria calling for the Royal Commission to address Lesbian, Gay, Bi-Sexual and Transgender Victorian Mental health.

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[1] The Royal Australasian College of Physicians, Medical Specialist Access Framework 2018.

[2] Australian Government, Department of Prime Minister and Cabinet, Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report.

[3] University of Western Australia, Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report, 2016.

[4] The Royal Australasian College of Physicians, Health of Children in Out-of-Home Care (2008).

[5] The Royal Australasian College of Physicians, The Health and Well-being of Incarcerated Adolescents 2011.

[6] The Royal Australasian College of Physicians, Submission to the Royal Commission's report on the Protection and Detention of Children in the Northern Territory 2016.

[7] Ibid.

[8] RACP Victoria Election Statement 2018.
[9] The Royal Australasian College of Physicians, RACP position statement on the importance of the early years of childhood 2019.
[10] The Royal Australasian College of Physicians, Health in all policies, 2016.
[11] Dunedin Multidisciplinary Health and Development Study, New Zealand.
[12] The Royal Australasian College of Physicians, Health in all policies, 2016.
[13] The Royal Australasian College of Physicians, Health in all policies, 2016.
[14] The Royal Australasian College of Physicians, RACP Inequities in Child Health Position Statement 2018.