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**Recommendations to the Australian Health
Ministers' Advisory Council (AHMAC)
Mental Health Drug and Alcohol Principal
Committee (MHDAPC)**

December 2016

Recommendations to the Australian Health Ministers' Advisory Council (AHMAC) Mental Health Drug and Alcohol Principal Committee (MHDAPC)

Thank you for the opportunity to provide feedback on the draft *Fifth National Mental Health Plan*. The Royal Australasian College of Physicians (RACP) has provided detailed comments below, and in summary we recommend:

- That the 5th Plan be significantly strengthened with inclusion of meaningful prevention and early intervention strategies and actions under all priority areas.
- That a funded implementation plan be developed, underpinned by a series of bilateral agreements between the Commonwealth and each of the jurisdictions.
- That central to the 5th Plan is the recognition of childhood and adolescence as critical stages of mental health development, and that the MHDAPC considers the recommendations of the RACP position statement on 'The role of Paediatricians in the provision of mental health services to children and young people'.
- That PHNs and LHNs include paediatricians as well as other relevant health professionals on their mental health advisory groups, to inform integrated mental health service planning as well as mental health promotion and mental illness prevention initiatives for each jurisdiction
- That the prevalence of maternal mental ill-health is recognised and prevention and treatment strategies implemented to reduce the impact on the next generation of Australians.
- That MHDAPC reports more frequently than once a year to Health Ministers on issues that may arise from the implementation of new mental health reforms and the NDIS, so that issues can be addressed in a more timely and effective manner.
- That MHDAPC gives serious and systematic consideration to the advice provided by the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG), and that this Group continues to be the principal source of advice to Australian Government Ministers on Aboriginal and Torres Strait Islander mental health and suicide prevention.

Prevention and health promotion

It is concerning that the 5th Plan focuses on mental health services for those with symptoms, without considering the need for mental health promotion and illness prevention. On page 14, under the heading "*The mental health environment: systemic issues and a vision for change*", the 5th plan looks at the mental health service system but does not include prevention and early intervention nor does it appear to consider the environmental and socio-economic determinants of mental health.¹

We recommend that the draft 5th Plan be strengthened by including meaningful prevention and early intervention strategies under all priority areas and actions, and including the impacts of housing, education and employment on people's health and wellbeing. There is a firm positive link between improved mental health outcomes and good employment or 'good work.' The RACP has a position statement and a consensus statement on the *Health Benefits of Good Work* which contains useful information and recommendations.²

In the 5th Plan's vision, there appears to be an assumption that mental illness is episodic and if all goes well, results in recovery (see page 3). This assumption is misleading as it does not apply, for example, to Attention Deficit Hyperactivity Disorder (ADHD) where the executive functioning deficits are stable but ongoing.

¹ WHO (2004): Promoting Mental Health. Concepts, Emerging Evidence, Practice. Available at: http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf (accessed on 28 November 2016)

² Australasian Faculty of Occupational and Environmental Medicine (AFOEM) & Royal Australasian College of Physicians (RACP), (2011): *Australian and New Zealand Consensus Statement on the Health Benefits of Work*, Available at <https://www.racp.edu.au/docs/default-source/advocacy-library/realising-the-health-benefits-of-work.pdf?sfvrsn=10> (accessed on 28 November 2016)

Implementation and funding of the 5th Plan

The *Plan* appears to set out desirable policies and aspirations, but without any comment or commitment to these being funded. If this remains the case, we are concerned that this is unlikely to result in significant meaningful action to reduce the mental health burden on Australian society.

Realising the goals of the 5th *Plan* requires a fully funded implementation plan underpinned by a series of bilateral agreements between the Commonwealth and each of the jurisdictions. While we acknowledge that there are challenges inherent in the structure of Australia's federal system, we believe there are many examples of successful outcomes in Australia, such as HIV/AIDS, cancer screening, and immunisation which have involved a collaborative and coordinated approach across jurisdictions. These examples incorporated clearly defined roles and responsibilities for the Commonwealth and each of the States and Territories, as well as funding commitments by all these governments.

This implementation plan should address the mental health system's interactions with other sectors such as housing, employment and education. Due to the impact of the social determinants of mental health, a collaborative government effort cannot focus on the roles and responsibilities of the health sector alone. A holistic, intergovernmental, integrated and coordinated national approach across all public services is required.

The implementation plan should also focus on filling service gaps within mental health. For example, we understand that liaison psychiatric services are under-resourced, and which in turn means many non-psychiatric units that require psychiatric input are unable to obtain these services for their patients.

Child and adolescent mental health

We are very concerned about the draft 5th *Plan's* lack of focus on the mental health of children and young people. This is only briefly mentioned in a case study on school-based programmes (page 53) and the proposed national indicators for priority area 1 (page 67 & 68). Childhood and adolescence is a critical stage of mental health development, and must be central to the 5th *Plan*.

Child and adolescent mental health disorders in Australia are highly prevalent, and associated with significant short- and long-term morbidity. At any one point in time, 14 per cent (560,000) of 4-17 year olds in Australia are experiencing mental health disorders.³ The onset of disorders in childhood is now known to have adverse effects across the lifespan^{4,5} with 50 per cent of all mental disorders beginning before the age of 14 years.⁶ The financial costs alone of childhood mental disorders for education, social services, and justice, and also for individual families, are very high.^{7,8} Early intervention and prevention of mental health problems in all Australians including in children and adolescents must be a priority for Australian governments.

Paediatricians and the vital role they play in delivering mental health care do not appear to have been considered in any part of the plan. Concerns about development and behaviour make up a substantial part of the workload of paediatric practice. We have enclosed a copy of our position statement 'The

³ Lawrence D, Hafekost J, Johnson SE, Saw S, Buckingham WJ, Sawyer MG, Ainley J, Zubrick SR. Key findings from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Aust NZ J Psychiatry. 2016 Sep;50(9):876-86, first published on December 6, 2015. <http://anp.sagepub.com/content/50/9/876>

⁴ Bosquet M, Egeland B. The development and maintenance of anxiety symptoms from infancy through adolescence in a longitudinal sample. Dev Psychopathol 2006; 18: 517-550.

⁵ Bor W, Najman JM, O'Callaghan GM, et al. Aggression and the development of delinquent behaviour in children. Trends and issues in crime and criminal justice series, No 201. Australian Institute of Criminology 2001.

⁶ Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. Archives of general psychiatry. 2005;62(6):593-602

⁷ Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, Erskine HE, Charlson FJ, Norman RE, Flaxman AD, Johns N, Burstein R. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. The Lancet. 2013;382(9904):1575-86.

⁸ Knapp M, McDaid D, Parsonage M. Mental health promotion and mental illness prevention: The economic case. London: Department of Health; 2011.

role of Paediatricians in the provision of mental health services to children and young people'.⁹ It emphasises that strategic frameworks are needed to address the unmet needs of children and young people with mental health problems. Paediatricians should be involved in all stages of strategic planning and policy development concerning the prevention and treatment of children and young people with mental health problems.

Vulnerable populations

The priority areas and actions should detail how the specific mental health care needs of all vulnerable populations are being addressed. The *5th Plan* should address the needs of:

- children and young people
- people living with physical and/or cognitive disability
- people with addiction issues (drugs, alcohol and gambling)
- people living with chronic disease
- people in the justice system
- lesbian, gay, bisexual, trans and intersex people
- asylum seekers and refugees
- older Australians
- culturally and linguistically diverse populations.

For example, elderly people suffering from delirium, dementia and dementia related behavioural issues, and psychosis can be caught between the health and aged care systems, and the place of care may not be appropriate for their needs.

Refugees and asylum seekers have unique and complex physical and mental health needs that require specific and comprehensive health care attention.¹⁰ The refugee experience is marked by conflict, upheaval and forced migration. Many refugees face persecution, suffer torture, lose family members and endure physical or sexual violence. This trauma often causes long-term mental health problems requiring sustained mental health support and treatment.

The negative mental health impacts of immigration detention are well-documented. Asylum seekers in held detention face profound uncertainty, hopelessness and fear for their future. This, in combination with the detention environment and lack of meaningful activity, contributes to high rates of mental health problems, self-harm and attempted suicide.

MHDAPC should also carefully consider the submission by the NSW Council for Intellectual Disability (NSW CID)¹¹ which provides recommendations on how action on the mental health of people with intellectual disability can be incorporated into the *5th Plan*. We support the NSW CID's recommendation that the *5th Plan* includes people with intellectual disability.

Feedback on the consultation questions

Question B1:

Do you agree that the seven main areas proposed in the draft Fifth Plan should be national priorities for action over the next five years?

All priority areas require a greater commitment to prevention and to consumer/community input. Ideally, the *5th Plan* would articulate better integration of mental health care into general health care. A holistic approach to Priority Areas 2 (*Coordinated treatment and supports for people with severe and*

⁹ RACP (2016): The role of Paediatricians in the provision of mental health services to children and young people. Available at: <https://www.racp.edu.au/docs/default-source/advocacy-library/racp---the-role-of-paediatricians-in-the-provision-of-mental-health-services-to-children-and-young-people.pdf> (accessed 28 November 2016)

¹⁰ RACP (2015): Refugee and Asylum seeker health position statement. Available at: <https://www.racp.edu.au/docs/default-source/default-document-library/refugee-and-asylum-seeker-health-position-statement.pdf?sfvrsn=2> (accessed 28 November 2016)

¹¹ NSW CID (2016): Submission on the draft 5th National Mental Health Plan, page 2

complex mental illness) and 5 (*Physical health of people living with mental health issues*) would be far preferable to the largely separate manner in which physical and mental health are treated currently.

Question B2:

Are there any other major areas that should be the focus of national priority action over the next five years that are not included in the current draft Fifth Plan?

As above, childhood and adolescence are critical stages of mental health development, and should be a priority area. The seven priority areas should also be used to promote action for vulnerable populations.

The 5th Plan should include a major focus on mental health promotion and mental illness prevention. In 2004, the Victorian Health Promotion Foundation worked with the World Health Organisation (WHO) to develop an excellent framework for successful mental health promotion and mental illness prevention.¹²

Drug and alcohol misuse also deserves national priority action and should be represented in the priorities. Alcohol, tobacco, cannabis, stimulant drugs and new (novel) psychoactive substances present serious challenges to the mental well-being of children, adolescents and young adults. This should be addressed through integrated, coordinated and appropriately funded care models identified in consultation and collaboration with addiction medicine specialists as well as the specialised drug and alcohol sector.

We are also concerned about the 5th Plan's lack of attention to eating disorders, particularly anorexia nervosa with its high mortality rate amongst young people in Australia.¹³ The complexity of ensuring patients with complex mental illness and comorbidities, such as an eating disorder and a drug addiction, can access appropriate treatment is not sufficiently addressed in this 5th Plan.

Part 3 - Our views on the 30 proposed actions

The 30 proposed actions lack detail on implementation, as well as which levels of government are responsible for which actions.

Feedback on the priority areas

Priority Area 1: Integrated regional planning and service delivery

The role of health practitioners and specifically paediatricians in service planning

Paediatricians are central to service provision for child and youth mental health and must be involved, along with other mental health professionals, in all strategic planning and policy development around mental health service provision for children and young people.

The 2013 *National Child and Adolescent Survey of Mental Health and Wellbeing* found that the most common mental health disorders identified in children aged 4-17 years were ADHD, anxiety, and depression affecting 7.5%, 6.9% and 2.8% of children, respectively.¹⁴ The survey found significant variation in the use of mental health services by children and adolescents with mental problems, suggesting inequity in care. Of those receiving any services, parents reported that, in the preceding 12 months, general practitioners (GPs) provided care for 35%, psychologists for 24%, and paediatricians for 21%. Only 7.1% of children had been seen by a psychiatrist working independently, and only 3.3%

¹² WHO (2004): Promoting Mental Health. Concepts, Emerging Evidence, Practice. Available at: http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf (accessed on 28 November 2016)

¹³ The National Eating Disorders Collaboration. (2012b). Eating disorders in Australia. Sydney: NEDC.

¹⁴ Lawrence D. et al (2015), Hafekost J, Johnson SE, Saw S, Buckingham WJ, Sawyer MG, Ainley J, Zubrick SR. Key findings from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. ANZ J of Psychiatry. 2015 Dec 6:0004867415617836.

had accessed a specialist child and adolescent mental health service. Thus paediatricians are key partners in the provision of care for children with mental health disorders.¹⁵

Parent reports of paediatricians as key service providers for children and youth with mental health problems are confirmed by the Australian Paediatric Research Network's prospective casemix audits. Evidence suggests that the top conditions managed by Australian paediatricians are ADHD and autism, with anxiety as another common diagnosis.¹⁶

On action 1, we recommend that PHNs and LHNs include physicians and paediatricians as well as other relevant health professionals on their mental health advisory groups. This will help inform integrated mental health service planning as well as mental health promotion and mental illness prevention initiatives for each jurisdiction.

Actions lacking detail, meaningful benchmarks and targets

Action 1 and 2 listed under this priority area, lack detail on implementation and allocation of responsibility around coordination of integrating regional planning and service delivery. Co-design statements between PHNs and LHNs should be strengthened by clearly delineating responsibilities between PHNs and LHNs. We recommend clear targets are developed which each entity has to achieve when implementing this priority.

Priority Area 2: Coordinated treatment and supports for people with severe and complex mental illness

We support developing an integrated and sustainable service system that provides tailored clinical and community supports, at the right time, for people with severe and complex issues. We are concerned that, as the 5th Plan states, it is estimated that only 64,000 people with severe and ongoing psychosocial disability will become NDIS participants by 2019-2020. Modelling by Mental Health Australia estimates that about 200,000 people with severe and complex mental illness currently need integrated sustainable support and treatment. It is problematic that there is a lack of clear funding pathways for non-NDIS eligible people with severe and complex mental illness.

While the RACP welcomes action 4 (page 28) under this priority area, we are concerned that the MHDAPC will only report once a year, through an annual report to Health Ministers on issues that may arise from the implementation of new mental health reforms and the NDIS. Given that the NDIS roll out is currently generating a lot of change in the disability sector, such reporting should take place more frequently, allowing the MHDAPC and health ministers to address issues raised in a timely and effective manner.

Prevention and early intervention for low and moderate mental illness in the population needs to be considered under this priority area. A key aim should be preventing a person going on to develop severe and complex mental illness which is not only extremely harmful to the person, but places an additional and avoidable strain on the mental health system.

Priority Area 3: Suicide prevention

The RACP welcomes the priority area on suicide prevention. However, we note that preventing mental illness is itself a means of preventing suicide.

¹⁵ RACP (2016): The role of paediatricians in the provision of mental health services to children and young people.

¹⁶ Hiscock H, Danchin M, Efron D, Gulenc A, Hearps S, Freed G, Perera P, Wake M. Trends in paediatric practice in Australia: 2008 and 2013 national audits from the Australian Paediatric Research Network. *Journal of Paediatrics and Child Health* (in press).

Priority Area 4: Aboriginal and Torres Strait Islander mental health and suicide prevention

Priority area 4 is largely a set of positive but unfunded policies or aspirations. As referenced above, it requires the development of a fully funded implementation plan with a series of bilateral agreements between the Commonwealth and each of the jurisdictions. It should be noted in the 5th Plan that the recent Australian Burden of Disease Study found that mental and substance use disorders were the single biggest contributors to the burden of disease for Aboriginal and Torres Strait Island people.¹⁷

On page 39 and 41, the 5th Plan makes reference to a 'new intergovernmental advisory group that includes Aboriginal and Torres Strait island representation to advise Health Ministers.' The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) reporting to Australian Government Ministers responsible for the Aboriginal and Torres Strait Islander portfolio as well as the health portfolio has already been established. This Advisory Group should continue to be the principal source of advice to Australian Government Ministers on Aboriginal and Torres Strait Islander mental health and suicide prevention. We understand that this Advisory Group has already made detailed comments on priority area 4 of the 5th Plan which are not yet reflected in the current version. Advice from ATSIMHSPAG needs to be considered systematically and seriously by the MHDAPC.

A new advisory group with representation from ATSIMSPAG would be required to develop an implementation plan for priority area 4 underpinning the envisaged mental health and suicide prevention for Aboriginal and Torres Strait Islander people.

We fully support the recommendation on page 44 of the draft 5th Plan that "a clearinghouse will be established to support the dissemination of relevant and high quality information and other resources through a single portal."

Priority Area 5: Physical health of people living with mental health issues

While it is important to focus on the physical health of people living with mental health issues, this section should also explicitly consider that physical illness is associated with greater risk for mental illness. For example, people with serious mental health issues face increased likelihood of physical illness such as metabolic syndrome, diabetes and osteoporosis¹⁸. Adult medicine specialists and paediatricians have a prominent role in detecting and treating physical health conditions in people living with mental health issues.

While a definitive causal relationship has not yet been established, smoking is associated with an increased risk of suicidality.^{19, 20, 21} In addition, Australian men with mental illness live 15.9 years fewer and women live 12 years fewer than those without mental illness and this difference continues to widen.²² About two thirds of the excess morbidity and mortality is due to smoking related diseases.

Therefore, the RACP recommends that the 5th Plan considers novel approaches to preventing the uptake of smoking in children and young people are required and should be considered under this priority area.

Further, we believe that a new approach is needed to consider the whole-of-person, whole-of-life approach to screening, treatment and care of people living with mental illness (see page 47). Suitable

¹⁷ Australian Institute of Health and Welfare (2016). Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. BOD 4. Canberra: AIHW. Available at <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129555476>. Accessed on 6 December 2016.

¹⁸ De Hert et al. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, 2011 Feb; 10(1): 52–77

¹⁹ Li, D. et al (2012): Cigarette smoking and risk of completed suicide: A meta-analysis of prospective cohort studies. *Journal of Psychiatric Research*, 2012-10-01, Volume 46, Issue 10, Pages 1257-1266.

²⁰ Covey LS, Berlin I, Hu MC, et al. (2012): Smoking and suicidal behaviours in a sample of US adults with low mood: a retrospective analysis of longitudinal data. In: *BMJ Open* 2012;2:e000876.doi:10.1136/bmjopen-2012-000876

²¹ Prochaska JJ (2011): Smoking and Mental Illness – Breaking the Link. *NEJM* 365(3):196-8.

²² Mendelsohn CP, Kirby DP, Castle DJ (2015). Smoking and mental illness. An update for psychiatrists. *Australasian Psychiatry* 23(1):37-43.

guidelines and resources for health services suggested under action 16 should consider issues such as setting up psychiatric wards for medical assessments i.e. availability of ECG machines, online drug databases and references such as MIMS as well as results available online for physician and specialist's access, and setting time frames by which a physical health review occurs for an inpatient.

Priority Area 6: Stigma and discrimination reduction

This section should acknowledge that stigma and discrimination can also cause or exacerbate mental illness.

There should be more emphasis of early intervention programs on stigma and discrimination reduction in the education sector as currently included in the 4th *National Mental Health Plan*. Retaining the cross-sector working and integration of programs started under the 4th *Plan* in the 5th *Plan* is important.

Priority Area 7: Safety and quality in mental health care

This priority area should encapsulate an action for identifying and reducing low value interventions in mental health care. This would allow the health system to continually ensure that best value interventions and treatments are being implemented.

Further, the RACP recommends that this priority area should include a review of the practice of prescribing of psychotropic medicines (antipsychotics, antidepressants, psychostimulants and the benzodiazepine class of medicines) in the treatment of mental illness in young people, given the increasing evidence of limited benefit when prescribing without careful consideration of all of the biopsychosocial factors impacting on the young person's presentation, and the medical risks associated with prescribing these medicines. The RACP recommends establishing mechanisms for clinical governance led by skilled clinicians to review, provide advice and support to medical practitioners in treating mental illness in young people.

Reporting on the progress of mental health reform (page 65-70) is essential to monitoring the implementation of commitments in the 5th *plan*. We support the addition of the indicator 'rate of access to early childhood support programmes' (see page 68) in addition to the currently available indicator 'proportion of children developmentally vulnerable in the Australian Early Development Index (AEDI)'. However, we would like to see more detail on which of the 30 priority actions outlined in the 5th *plan* will be linked to the AEDI indicator. We recommend providing examples in the implementation plan on how priority actions will be satisfactorily measured through the AEDI indicator.