World Wellness Group

Submission to the

Inquiry into the opportunities to improve mental health outcomes for Queenslanders

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Introduction

World Wellness Group Ltd (WWG) is an independent multicultural health social enterprise working to reduce health inequity. Established in 2011, we deliver services within the health system whilst simultaneously working on systemic issues that create and often unknowingly perpetuate entrenched inequity for multicultural population groups. Our work is underpinned by a human rights framework on the basis that health is a human right and the principle of universal access to health care regardless of background, affordability, or visa status. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. These determinants frame our work in health service delivery and advocacy. A focus on the social determinants is critical to reducing the unfair and unjust conditions of living that cause poor health and mental health.

Delivery of our purpose occurs via four strategic priority areas:

1. General Practice & Primary Care Clinic: Delivery of culturally responsive and accessible primary care general practice and allied health wrap around care that provide tailored physical and mental health clinical care in Brisbane and a state-wide telehealth service called the Multicultural Connect Line.

2. Bicultural Lived Experience Voices: Engaging people of multicultural background with lived experience of the healthcare system within our models of care via a substantial multicultural peer support workforce whilst also grounding our engagement of bicultural lived experience voices both in the co-design of our health service models of care and advocacy efforts focused on improving health care access, equity and just outcomes for the multicultural communities we serve.

3. Contributions through Partnering: Galvanising corporate, industry and government partners to contribute towards resourcing, design, and delivery of a more accessible and equitable healthcare system for people of multicultural backgrounds.

4. Knowledge Hub: Building evidence and data about access and equity barriers for multicultural communities, health status and health outcomes for multicultural communities and best practice evidence-based approaches to enable delivery of culturally responsive and accessible physical and mental health services for people of multicultural backgrounds with the appropriate level of funding resources and capacity building around cross cultural clinical frameworks.

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We have a strong track record of cultural capability in health service design, delivery and advice. In the past 10 years we have delivered just under 89,000 primary health care appointments to 10,808 people. 45% of our service contacts are mental health and we currently average around 160 mental health appointments a week and serve people from over 145 different ethnicities. We work with the most vulnerable in the multicultural population: marginalised migrants, newly arrived refugees, people seeking asylum, the elderly and those with mental illness across all age groups. We are acutely aware in our daily work of how these determinants impact on our clients' mental health and are frustrated by the lack of attention to these issues for the multicultural population who comprise a significant proportion of the Queensland population, with 1 in 5 Queenslanders born overseas, and with an increasingly diverse population this remains a significant gap.

Despite our significant work in multicultural mental health we feel we are only scratching the surface and remain on the periphery of the mental health system. As such we are frustrated by missed or limited opportunities to improve mental health care for the multicultural population.

As the inquiry is focused on opportunities to improve mental health outcomes for Queenslanders we propose the following key priority actions and opportunities as the health and wellbeing of the whole population cannot be at an optimum level if sections within our community continue to be marginalised in the health and mental health care system:

1. Real not token representation of multicultural lived experience

Multicultural lived experience is a missing voice in the mental health system due to limited investment in the multicultural lived experience workforce. WWG has over 60 multicultural peer support workers representing over 50 language and cultural groups and we skimp and juggle limited resources to keep this workforce employed. They represent the core of our service model as we cannot overcome language and cultural barriers or engage CALD clients meaningfully in mental health service delivery without them but none of our programs fund the workforce development that is needed to build and sustain this workforce.

Many of us at WWG have been the token CALD representative on advisory or consultative committees or at "co-design" workshops where we not only had to represent our own lived experience but also educate the rest of the committee on CALD mental health issues. Change

starts at the top and unfortunately, we continue to encounter lack of cultural capability nor any real understanding of CALD mental health issues at the highest levels of decision makers in the health bureaucracy.

Opportunity 1 : Invest and scale the Multicultural Lived Experience Framework developed with a small grant from Brisbane North PHN and embed as a strategic priority in workforce development plans at all levels of the healthcare system from support and frontline clinical roles to the highest levels of decision making in the healthcare system in Queensland Health and across government.

2: Mandate tenders to include allocation of investment into priority populations and disadvantaged communities including culturally and linguistically diverse populations.

All of our grant funded mental health programs and services, from Queensland Health and the Primary Health Networks were as a result of significant high-level advocacy as we were left with no other choice in the absence of funding priorities investing in CALD population health needs. There were no funding pathways given that CALD populations were not explicitly stated as a priority population. For example, there is no visible funding stream in Primary Health Networks and the last tender for community based mental health services with Queensland Health proceeded on the basis that mainstream mental health services could adequately provide for the needs of the CALD population. Without significant high-level advocacy on our part there would be no dedicated multicultural mental health psycho-social service such as Culture in Mind which at present only covers the Greater Brisbane region. Dedicated multicultural primary mental health care services are now funded by the Brisbane PHNs following significant advocacy but are yet to be funded outside Brisbane as there is no specific funding stream for CALD.

Opportunity 2.1: Ensure future tenders under the new Queensland Mental Health Plan mandate targeted multicultural mental health services

Opportunity 2.2: Work through the joint HHS/PHN mental health regional planning processes to ensure targeted approaches to the needs of the local CALD population

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3: Funding of recurrent multicultural mental health services not projects

We established WWG as a social enterprise to ensure sustainability as the multicultural health and mental health sector is littered with one-off projects. This lack of strategic approach and direction continues to create a great deal of mistrust and scepticism in the multicultural population who are tired of being consulted by never ending CALD community engagement projects that do not result in any accessible services or systemic changes. We have sustained a multicultural health social enterprise for the past 10 years due to the unpaid dedication of a small group of committed individuals, and several generous donors. There is sufficient evidence such as Queensland Health's own Qld Transcultural Mental Health 2021-2026 Action Plan which articulates the following concerning mental health disparities for Queensland's CALD population:

- More likely to be treated involuntarily
- Three times more likely to be treated on a Forensic Order
- Less likely to have a seclusion event, but more likely to stay in seclusion for longer periods
- Less likely to be followed up after discharge from an acute inpatient unit within seven days
- Less likely to have had contact with a community treatment services within seven days prior to an acute inpatient admission
- More likely to be diagnosed with Schizophrenia or Mood Disorders

Opportunity 3: Scale up multicultural mental health services with a track record of success for greater coverage across Queensland with a focus on regions with a significant CALD demographic and at risk populations such as Cairns, Toowoomba, Central Queensland and Gold Coast

4: Mandate multicultural mental health data collection

WWG raised with Queensland Minister for Health and Ambulance Services in 2019 the invisibility of CALD health and mental health issues in public health policy and planning due to lack of CALD specific data collection and analysis by Queensland Health. This led to a commitment of 3 CALD data roundtables of which 2 have been held and the third deferred due

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to the impact of the COVID pandemic on the Department. These issues are well articulated in a 2013 report commissioned by the National Mental Health Commission: Mental Health Research and Evaluation: Developing a Culture of Inclusion which made a series of recommendations that are yet to be implemented. The pandemic revealed that due to lack of CALD data it was difficult to reach multicultural communities who were disproportionately affected, with targeted public health strategies and communications This lack of data means the issues remain invisible and there is limited ability to develop evidence based data informed service improvements for the CALD population.

Opportunity 4: Direct the Department of Health to hold the 3rd CALD data roundtable to develop an action plan with funding for implementation, to address this significant data gap.

6: Shift the focus to community-based services and promotion, prevention and early intervention

Based on our own experience and in line with the productivity commission's *inquiry into the effect of mental health on people's ability to participate in and prosper in the community and effect on the economy and productivity* recommendations, we strongly advocate a shift in funding to community-based services and a greater focus on promotion, prevention and early intervention. A dedicated promotion, prevention and early intervention stream with investment will be necessary given the continual under representation of the CALD population across mental health services, but over representation in acute mental health services. Given the strong evidence of community-based services such as ourselves, that are able to break down the access barriers and deliver equitable services in less stigmatising environments, consideration must be given to alternative service models. There is currently a large gap between prevention and early intervention and primary mental health care and acute services.

Mental health promotion, prevention and early intervention is very limited in Queensland and non-existent for the CALD community. We are disappointed with the narrow focus of Health and Wellbeing Queensland and a total absence of a multicultural health promotion framework. We have met with the senior leadership of Health and Wellbeing and presented a suggested multicultural health promotion framework and were informed it was not a current priority. The subsequent strategic plan launched by Health and Wellbeing Qld had no targeted strategies for the CALD population.

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Opportunity 6.1: Develop a targeted multicultural mental health promotion, prevention and early intervention action plan for Qld
Opportunity 6.2: Develop a dedicated mental health prevention and early intervention stream in the community service funding that is complementary to, and fills the gap between primary mental health care (Commonwealth) and community-based services (state).

7: Shift the focus from training to innovative collaborative workforce development models to build the cultural capability of the mental health workforce

There is no evidence that one-off cross- cultural training has any impact on the cultural capability of the workforce. Sustained change can only be achieved via multilevel strategies addressing skills, attitudes, confidence and resourcing and supporting the workforce with organisational and system changes to embed cultural capability. This can be achieved with innovative, place based workforce initiatives, joint university- industry led initiatives where students or early career mental health workers are exposed to and working in multicultural settings. A current example is a partnership we have with a HHS addictions service in regards to a specialist mental health and other drugs nurse position we have working with people seeking asylum who is being supervised by a HHS senior addictions specialist nurse. This partnership has led to significant access barriers being broken down as the service gained a deeper level of understanding over time of the barriers faced by our clients.

Given the current mental health workforce shortages and the significant issues of unemployment and under employment in the CALD population, one issue that continues to perplex us, is the under utilisation of overseas trained health professionals due to the skills recognition and registration barriers. Our own workforce contains a high number of overseas trained doctors, nurses and mental health professionals working in administrative or support worker roles due to these barriers. This issue was highlighted in the Queensland Government report 'Seizing the Opportunity', with no solutions actioned in the health industry to date.

Opportunity 8: Explore funding partnerships or brokerage arrangements between specialist services, mainstream services and universities for specialist workforce initiatives to build cultural capability including placement and supervision in primary care settings
Opportunity 9: Fund bridging programs for overseas trained health professionals to gain recognition in the health and mental health workforce in collaboration with relevant

regulatory bodies such as AHPRA and the university sector and reduce the complexity and cost around achieving registration.

9: Fund the gaps and build on existing innovative partnerships models delivering wraparound care

There are many excellent initiatives in the mental health sector that do not fit existing funding streams as they fill the gaps. One such example in WWG is a health justice program we have self- funded via fundraising and donations for several years given the large number of our clients with legal issues falling through the gaps in the justice system which exacerbated their mental health issues. Lack of access to justice is well documented for vulnerable people such as CALD people with mental health issues and the Health Justice Partnership Model is an evidence- based model recognised internationally. Advice from both the Departments of Health and Justice and Attorney General was, whilst we were achieving excellent outcomes, that our work fell between the two departments and that there is no funding pathway as we are filling a gap. We would have thought that such critical gaps require more flexible approaches to funding pathways.

8: Don't miss the opportunity to address the inequalities exposed and disproportionate impact of COVID-19 on the CALD population

The disproportionate impact of the pandemic on the CALD population in Australia has revealed significant social inequalities and failings in the health system in terms of targeted multicultural strategies and communications. In our own clinic we experienced a 200% increase in mental health referrals in 2020/21 which is an indication of pandemic related mental health stressors and issues. Under the immediate COVID-19 support measures in Queensland Health we were able to stand up the Multicultural Connect Line, a state-wide helpline for multicultural communities in Queensland which received a further 2 years funding as the number of CALD people contacting the line continues to rise rather than fall. Via this helpline we have become acutely aware of the limited referral options for CALD people with mental health issues outside Brisbane. In Brisbane we are able to provide more intensive and ongoing support via an integrated approach via the multicultural connect line and the psycho-social support service Culture in Mind

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Opportunity 8: Replicate the Multicultural Connect Line/Culture in Mind integrated care model in key settings with a high CALD demographic in Queensland

Thank you for the opportunity to contribute to the parliamentary inquiry into opportunities to improve mental health outcomes for Queenslanders. We would be pleased to provide more detailed information about any of the issues addressed in our submission.