Inala Primary Care
Excellence in General Practice

A Submission to the Queensland Government Mental Health Select Committee's Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders

Dr David Chua PhD
Research and Collaborations Manager

Dr Jamie Nuttall MBBS FRACGP
General Practitioner

Dr Stephanie Chua MBBS FRACGP
General Practitioner

Dr Suzanne Williams MBBS MSpMed FRACGP
Clinical Director, General Practitioner

Ms Tracey Johnson
Chief Executive Officer

-On behalf of all the General Practitioners and Practice Nurses at Inala Primary Care-

February 2022

Inala Primary Care
64 Wirraway Parade
INALA QLD 4007
Phone: [redacted]

Correspondence to: Tracey Johnson [redacted]

2022 Inala Primary Care

SUMMARY

Mental health-related hospital admissions are the fastest growing type of hospital admission, growing by over 26% or over 30,366 admissions, between 2013-2018. 1 in 5 Australians between the ages of 16 and 85 experienced a mental health disorder in the past 12 months. Mental illness erodes quality of life and leads to premature death in many. The current state of mental health care in Australia has been labelled as being in crisis.

Inala Primary Care's GPs and practice nurses operate in one of the most socioeconomically marginalised urban areas in Queensland. They serve a vibrant, culturally and linguistically diverse population with a substantial representation of people from refugee backgrounds. Through their unique insights, experience and desire to advocate for the most vulnerable, they call for:

1. **Better access to community-based low-intensity mental health counselling and psychology.**
2. **Support mental health and wellbeing for our children, teenagers and younger adults:**
    a. *Better support for children, teenagers and younger adults including access to multi-disciplinary teams inclusive of counsellors, psychologists, nurses and link workers to ensure early intervention and case coordination across the school, health, community service and justice systems.*
    b. *Support childhood trauma services, particularly to address cases of child sexual abuse.*
    c. *Positive parenting programs across all age groups including younger adults.*
3. **Improve suicide support services, especially at the time of crisis.**
4. **Equitable access to psychological therapy for all.**
5. **Better access to mental health and trauma services for culturally and linguistically diverse people.**
6. **Improved, expanded, and integrated care coordination and social work services.**
7. **Better public psychiatry access.**
8. **Other Recommendations including perinatal depression support, improvement in the mental health nurse navigators system and psychiatric discharge process and enhanced funding into healthy neighbourhoods through community-led initiatives, neighbourhood centres and sports and recreation programs.**

We welcome the Queensland Government Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders. Action is needed at all levels of government and across agencies. There are many possible avenues to improve prevention and intervention. Years of continued inaction means we have been living in a crisis state with real human costs. Concerted mental health care reforms will translate into society-wide benefits.

CONTEXT

Mental and substance use disorders is the fourth highest disease contributor to Australia's overall disease burden. 1 in 5 Australians between 16 and 85 years old experienced a mental health disorder in the past 12 months (1). This places a significant burden on the person which contributes to reduced quality of life and premature death (1,2). This also places strains on surrounding members of the community, for example their families and carers.

General practitioners (GPs) are the primary providers of mental health services in Australia (3). Approximately 83% of Australians visit a GP at least once a year; this easy accessibility means that people in distress typically visit a GP first (3–5). Most GPs report psychological presentations as being a common reason for attendance, and this has steadily increased since 2017 (6). GPs provide over 80% of Medicare Benefits Scheme (MBS)-supported mental health services (7). They are trained to detect and manage most mental health conditions and have access to referral pathways to escalate care when required (4).

System Inadequacies, Increased Hospitalisations

People living with mental health conditions have increased rates of chronic disease, medication side effects, reduced help-seeking and lowered accessibility to quality health care along with poorer lifestyles and disadvantage (2,8,9). This leads to increased prevalence of potentially avoidable hospitalisations compared to the wider population (2). Mental health-related hospital admissions are the fastest growing type of admission, growing over 26% (30,366 admissions) between 2013-18 (10). 4.1% of Queensland's emergency department presentations are due to mental and behavioural disorders (11). The National Association of Practising Psychiatrists (NAPP) has labelled the current state of mental health access and support as a system in failure and in crisis (12). The NAPP reported that current mental health services are unable to meet patient needs, and this has led to patients becoming more severely unwell and requiring hospital admissions which could have been avoided through earlier interventions and better community case management and follow-up (12). While we welcome the recent inquiries into mental health at both federal and state levels along with the recognition that interventions take time to plan and implement, we wish to highlight that change is still overdue and there are real human costs every day effective reforms are debated and delayed (13). In Queensland alone, more than half of the unexpected deaths were of patient who were mentally unwell. In Victoria, 42 people under 30 years old committed suicide as a result of inadequate mental health treatment in the past 2 years (12). For each of these deaths, there could be many more untold, unreported harms.

Role of General Practice in Mental Health

A team of Queensland-based researchers discovered that inadequate patient access to services, such as to their GP, increased emergency department presentation rates for individuals with mental or physical conditions (14). We know GPs are trained in diagnosing and managing mental health problems, they are easily accessible and are enabled to escalate mental health care when needed. GPs practice whole-person care and often have rapport with patients in a way that allows them insights into their social circumstances, thus helping them better structure interventions that fit with the patient's past and present contexts. Being in primary care, GPs act as care coordinators and are connected to and interface with a myriad of community-based services including social coordination services, low-intensity psychology and counselling services and welfare agencies such as the NDIS. They are also well-acquainted with the state hospital system and private mental health professionals such as private psychiatrists. GPs have unique insights into the challenges presented to their patients due to inadequacies of the system, resulting in unique ideas on reforms that could work.

KEY RECOMMENDATIONS FROM OUR CLINICIANS

1. **Better access to community-based low-intensity mental health counselling and psychology**
   Our GPs see the following types of services to be either completely unfunded, thus inaccessible to large sections of the population, or severely underfunded, thus lengthy wait times or overly restrictive intake criteria are major barriers to patients:
   - ***Social work and care coordination services.***
     Our physical and mental health and wellbeing is strongly influenced by social determinants, income, education, job security, food security, housing situation, discrimination, childhood development, conflict and our surrounding environment. These are our social determinants of health (15). An oversimplified view but helpful illustration is a person who experiences homelessness simply does not have the personal capacity to worry about their health and wellbeing. This is where social work and care coordination services are vital to ensure that our vulnerable do not "fall between the cracks" as many do at present. Such patients are often frequent attenders at hospital settings with the Royal Brisbane and Women's Hospital recently reporting that more than 10% of presentations to emergency related to recurrent mental health and addiction issues. Such crisis presentations could be avoided by more access to social work and care coordination supports. This is further discussed in Section 6.
   - ***Counselling particularly relating to interpersonal relationship stress.***
     For example, Relationship Australia counselling is not publicly funded or subsidised for marginalised people who are most at risk. It is well established that stressful life events such as transition into parenthood, financial stressors and number of previous relationship breakdowns are predictive of future mental health problems (16–19). From our GPs experiences, early intervention in interpersonal counselling could reduce or avoid escalation. Many patients who present at their GP with relationship problems do not yet qualify for an MBS-funded Mental Health Care Plan and thus do not receive funding to see a public psychologist. In our catchment of Inala, most cannot afford private relationship counselling or private mental health counselling. Perversely, relationship counselling as a form of prevention is likely to be much cheaper than alternatives such as presenting to their GP or one day requiring mental health interventions by highly skilled professionals. Trauma and relationship breakdown has serious cumulative and ongoing physical and mental consequences (18,19).
   - ***Psychological trauma therapy for patients with a history of psychological trauma but have not yet developed a diagnosed mental health disorder.***
     There is very compelling evidence demonstrating past trauma significantly increases the risk of long-term mental and physical health problems, sometimes serious (18–23). Our GPs find that short-term, episodic intervention that is currently the norm and "encouraged" by the structure of the MBS, is neither appropriate nor adequate for such patients. Patients with significant past psychological trauma will benefit from long-term support from mental health nurses and/or adequately trained mental health support workers. Furthermore, past studies have demonstrated that support to patients from these types of professionals can be more economical and effective (23,24).

   There is strong evidence that early access to low-intensity mental health interventions is effective at addressing some of the most common mental health conditions such as depression and anxiety (13,25,26). However, evidence also suggests that ongoing support for these patients are needed as relapse rates can be over 50% within the first 6 months after discharge (27).

Federal government programs such as the Better Access scheme still requires patients to have a psychological diagnosis. This requires access to a psychologist of which Medicare-funded, bulk billed access is already scarce. Alternative pathways and their limitations are:

- ***NDIS***: only eligible for people with disabilities; most cases encountered are not eligible.
- ***Referral to a psychiatrist using MBS item 291***: a once-off, single use annual assessment item number for diagnosis and management advice but does not cover ongoing care.
- ***Use of medication***: not a holistic approach; only appropriate for some mental health illnesses; does not address any underlying social issues; and is likely to address some or many psychological and biological problems. Medications are also not without risk and are also not acceptable for many patients who decline pharmacotherapy. Furthermore, medication commonly prescribed by psychiatrists have a very narrow range of diagnoses where it is funded by the Pharmaceutical Benefits Scheme even though these medicines are proven useful for a broader range of disorders.

We also need to recognise and fund the skills and positive impact that ancillary services can provide (28). For example, programs to address loneliness and social isolation (e.g. Groups for Health) can significantly improve physical and mental health (29). The role of mental health nurses and liaison officers also show benefit to patients and the health system (24,30). There needs to be a more suitable tiered approach to mental health care as suggested by the Australian Psychological Society where patients are provisioned with supportive therapy, psychological therapy or advanced psychological therapy depending on their condition(s) severity (28).

We acknowledge and support the expansion of the Federal Government's *Head to Health* initiative (31). Providing earlier and effective support for self-management, or support for carers, via a convenient web-based media or in familiar settings could reduce the risks of future escalation. However, such a program is suitable only for some as it requires health, language and technological literacy, access to technology and most importantly, an adequate degree of self-efficacy. Thus, support for professional and personalised services is still required.

2. Support mental health and wellbeing for our children, teenagers and younger adults

An analysis of 192 epidemiological studies across the globe revealed that a majority of mental health disorders develop before the age of 25 years (32). Early detection, treatment and management is essential in ensuring that the condition is well-managed in our young people thus leading to a happier more productive society. Furthermore, adverse childhood events (e.g. physical or sexual abuse, neglect, witnessing family break up or violence, incarceration of a parent, a parent with a mental disorder or addiction etc) are well-documented to increase the risk of chronic diseases, mental illness and risk-taking behaviours later in life (18,33). These factors are what sustains growth in health care utilisation of both hospital and primary care systems and cause the untold costs to the individuals who endure such circumstances.

Our GPs call for the following actions to be taken:

a. Better support of counselling and psychology for children, teenagers and younger adults.

Despite knowing that we need to act early and quickly when our young people experience onset of mental health conditions, both our GPs and those across the nation frequently report inadequate access and lengthy wait times in the order of months or longer for their young patients to access Headspace services (34). Increasing caseloads to Headspace combined with the Federal Government's stop on the opening of new clinics are the root cause of access problems (35). For the state, some of this load could be reduced through better support of state-funded drug and alcohol services as Headspace is typically not equipped to manage

complex presentations, particularly ones involving substance misuse (35). Of course, better funding of Headspace is also sorely needed to alleviate wait times and improve patient outcomes.

We also suggest further and ongoing support for high quality school counsellors. We would encourage that school counsellors build relationships with the student and family's general practitioner where there is one. We encourage a nationally standardised training, accreditation and practice framework for all school counsellors.

b. Support childhood trauma services, particularly to address cases of child sexual abuse.

Our GPs have reported upwards of 10-week wait times for survivors of child sexual abuse to access counselling and support services through a commonly utilised child protection charity. Delays in access to vital counselling to that extent erodes effectiveness and greatly increases the risks of further harms. One of our GPs reported that in one case, a family became so frustrated by the immense wait times to access a child protection charity that they decided to abandon trying to engage. Furthermore, counselling services are often bound by area catchments – in Inala, our GPs report that some families have been deemed to be outside the catchment of a commonly utilised child protection charity and were refused counselling as a result. While they were eventually directed to other services, the experience and barriers had caused many of these affected families to not bother pursuing counselling further.

Moreover, our GPs see and do their best to manage past under- or unaddressed childhood trauma in today's adults. We need to provide immediate care and provide services which can help redress the situation and begin the process of recovery. No child should have to wait weeks to months for counselling and support or forego it completely due to barriers to access.

We hope to see better coordinated childhood trauma services that perhaps integrates better with us as GPs, the Education Department and Queensland Government's child safety and child health services. We hope to see services like Bravehearts help refer people in need to the right catchment area and smooth the process to prevent people falling through the cracks and avoiding seeking help. There needs to be support for navigating the legal process when charges are laid as this can alleviate a significant amount of psychosocial stress and, with better coordination with that person's GP, can lead to more efficient and improved care overall. We also need better support for families as often the perpetrator is a member of that family or a close family friend.

We are aware that WentWest (Western Sydney Primary Health Network) has begun a social impact bond program as a way to invest in and deliver services to families and children who have increased adverse childhood experience scores. While not yet published, WentWest have estimated significant returns on investment. We encourage dialog with the Queensland State Government as to whether such a program could work in our state.

c. Positive parenting programs.

We applaud the fact that the Queensland Government funds the Triple P Positive Parenting Program. However, families with specific or higher needs requiring more specialised programs beyond what Tripe P can offer often have limited support. For example, the "Circle of Security" program appears to be only funded for children up to 8 years of age only. Furthermore, we wish to make aware the fact that some marginalised families have a distrust and fear of

Children's Health Queensland services as they worry their family will be reported to Community Services.

Positive parenting programs is a powerful prevention tool for child social, emotional and behavioural problems including for children with developmental disabilities (36). There is evidence that such programs are useful in the prevention of eating problems, anxiety, pain syndromes and even childhood obesity (36). When delivered appropriately though adequately trained convenors, the benefits are realised across cultures, family types, stages of child development and settings (36). Benefits of positive parenting programs are typically long-lasting without the need of follow-ups or refreshers (36).

Our GPs and nurses are medically trained and while they are trained to deliver medical care within the biopsychosocial context of the patient, it is a waste of resources for some of our most well-trained people to deliver parenting advice. Not to mention that "parenting advice" alone is technically not a Medicare-billable service. GPs and practice nurses are not specifically trained to deliver parenting training and the environment they work within does not fund or support them to deliver it even if they were adequately trained.

Our clinicians frequently encounter families struggling to cope. Child and Family Connect offers support to some families at risk of entering the child safety system, but the support is suited for more serious scenarios and thus limited for other families. Poor parenting can disrupt schooling and lead to over-medicalisation of what may have started as simple behavioural problems. Diagnosis and treatment of problems such as attention deficit and hyperactivity (ADHD) disorder is not without consequence or risks and it treats the biological aspects but in itself does not always address the deeper psychosocial aspects (37–39). Support for ADHD also requires paediatric consultation and there is often a long wait in the public system for this to occur. Parenting support is desperately needed to address these issues and to also support parents with children with diagnosed behaviour disorders.

The evidence is convincing, positive parenting programs can prevent either onset of the mental health problems or the factors which increase the risk of such problems. It can even prevent future chronic disease by setting children and families up for success in improving and encouraging better lifestyles. We propose that the Queensland Government engage with general practice, Inala Primary Care is ready, to co-locate the Triple P program in a setting where it is needed most. Triple P currently is only delivered online and we understand the current COVID19 pandemic warrants this action. We would welcome a return to face-to-face support for people when practically possible. We also wish to highlight that self-referral does not work for the most marginalised, vulnerable groups who would benefit most from such programs and would welcome a point-of-care, drop in system to engage people at the best opportunity – when they see their GP. Thus, we believe that a co-location model could serve to increase effectiveness of Triple P in areas of need like Inala and reduce overall health system costs through the reduction of GP-visits driven wholly or partially by parenting stressors.

More generally, there are challenges exchanging information between the schooling and health systems including GPs and other primary care providers (e.g. allied health). Currently, children with developmental delays, including those with underlying mental health issues are sometimes sent to our GPs by schools. They provide limited advice to GPs about the triggers for the visit. The child's parents are also often underinformed about the request to visit their GP, hence they offer little context on why the GP consultation is required. The GP then has a difficult task to unpick the issue within the confines of an already tight consultation time due to well-documented constraints of MBS bulk-billing. This means the families may not receive a timely referral to specialists'

services or paediatricians for diagnosis and treatment and might have to endure more diagnostic testing as the GP tries to figure out the best course of action from scant information. We witnessed an example of this communication breakdown in Inala when local childcare centres were visited by child and maternal health nurses. They identified significant numbers of children with possible developmental delay, behavioural and mental health problems. Parents were told to request attendance at their GP and to obtain a referral back to public paediatric services. However, the nurses' case notes were not available to the GP and most affected parents reportedly did not feel inclined to see their GP to discuss the nurses' recommendation. Hence, potentially vulnerable children who stood to benefit from early intervention were left floundering in a system where privacy and data exchange challenges prevent effective communication and early intervention. As many public child health services cut off at the age of 8 and more at the age of 11, delaying diagnosis could mean many vulnerable children miss out on vital care which could fundamentally change the life trajectory of child and family.

3. Improve suicide support services, especially at the time of crisis

Our GPs acknowledge that hotline services (such as Lifeline, Beyond Blue, and Kids Helpline) and Queensland's confidential mental health triaging service, 1300MHCALL, are useful for suicidal patients. However our GPs report that there is still a significant gap in supporting and managing suicidal patients. Suicide hotlines are useful for some types of patients but are not for others, and even when useful, it is only a way to exit the crisis but does not provide for an adequate treatment of the underlying issues in a patient-centred approach. Even with the uptake in telehealth services, there are many patients who do not feel comfortable talking to a stranger over a phone and specifically seek the help of health professionals face to face. However, appropriate community support for such patients is lacking. Patients are either seen to be 'not sick enough' for community services or 'too sick' and requiring emergency department presentation. Indeed, many community services (e.g. Headspace, Stride) explicitly state that they are not a crisis service and are unable to accept such patients. There needs to be careful re-evaluation of intake criteria and better funding and programs put in place for our most vulnerable so that a full continuum of care exists with "step-up" and "step-down" provisioning in place

Suicidality can range from those with acute active suicidal ideation and intent who certainly do require emergency care, and those who may have chronic, fleeting, or passive suicidal ideation for whom presentation to the ED is superfluous and often not helpful. Patient experience has shown us that being discharged from an ED after presenting for suicide support can feel invalidating for some and does not help them learn functional coping strategies with managing psychological distress. If the patient presents to us after such an episode, the GP will often scramble to find an appropriate community-based pathway, which are limited at best. Amongst all this, the patients often do not "feel any better", and their true problems have not been addressed adequately; largely because they are complex with social aspects beyond the scope of emergency medicine, highlighting the importance of care coordination (discussed in Section 6). Rather, these patients would be better served by timely, accessible community-based support and GPs kept in the loop.

4. Equitable access to psychological therapy for all

Our GPs call for better publicly funded access to psychologists for their patients. Many patients who suffer from chronic mental health problems are very likely to also be disadvantaged

socioeconomically. These factors resonate to further drive disadvantage, increasing the risk of chronic disease, mortality and hospital service use and lowering economic productivity overall.

Australians with depression, anxiety and other mental health conditions were found to have paid 95% more out-of-pocket costs compared to a person with no long-term health care condition (40). The same research found that people with mental health conditions are likely to skip care because of the costs associated with care (40). The risks of skipping care include increased mortality and poorer quality of life, increased socioeconomic disadvantage, development of acute episodes warranting presentation to emergency departments and hospitalisation, and self-harm and suicide (28). The Royal Australian and New Zealand College of Psychiatrists and another international study have reported that cost is still a major barrier to seeking care for people living with mental health conditions (41,42).

Psychiatry, psychology and counselling are each different modalities of treatment for different mental health conditions; they achieve different outcomes via different treatment methods. Depending on the patient's context, condition and its severity, GPs will develop an appropriate management strategy that best fits. Commonly in general practice, psychological therapy is the most appropriate first line treatment. The most common transient and chronic mental health conditions seen in general practice are typically treated or managed successfully by psychologists (43). In Australia, psychologists are allied health professionals and the bulk of the services they provide are privately billed and not covered under the Medicare Benefits Scheme, hence are often out of reach for many who suffer from mental health problems.

The Federal Government's Better Access program does improve access but is still deeply inadequate for many. A white paper prepared by the Australian Psychological Society highlights that the Better Access program's shortcomings include (28):

- The number of publicly funded appointments (typically 10 consultations pre-COVID19 pandemic, now 20 consultations with no guarantee if this will remain) are inadequate for almost all evidence-based treatment regimens. Now that there are 20 funded consultations, access to psychologists has become severely limited as their appointment slots are typically full due to the increased demand.
- Regulatory barriers for psychologists under the Area of Practice Endorsement system means there is a supply-side restriction to the delivery of certain treatment regimens and assessments.
- Our GPs frequently report that finding a psychologist who is willing to and can bulk-bill is extremely challenging. Psychologists who do are often fully booked and often have unfeasibly lengthy waiting times.
- The present Better Access scheme requires a particular type of diagnosis (call Axis 1 disorders covering conditions like dissociative, eating, mood, psychotic and substance use disorders). These are suited to the Better Access funding scheme as these patients then receive a discrete course of psychological therapy. What it is **unsuited** for is personality disorders (an Axis 2 disorder). Personality disorders take a disproportionate amount of GP time and are at much higher risk of hospital admission for a variety of mental and physical conditions (44).

Our practice has found that an embedded psychologist or mental health nurse is an invaluable contributor to team-based care. This is because patients do not feel stigmatised attending a GP practice, patients can mask their visit from family, friends and work as the encounter occurs at a GP practice, the environment is familiar and trusted improving compliance with referrals and shared care is made possible by the ongoing interactions between clinicians sharing the same

space. “Warm handovers”, personal and/or informal handovers between practitioners sometimes with the patient present, in addition to more formal letters may also be occasionally afforded improving the reception of the patient to being introduced to a new face. The challenge is that visiting mental health nurses are funded in such a way that they cannot contribute upkeep and overheads of the practice. This undermines practice viability. Psychologists can share revenues, however, in a catchment with exceptionally high now show rates, psychologists who can bill $240 per hour in other privately billing catchments average just $60 for the work undertake in our premises which is bulk billed.

A one-size-fits-all approach to psychology access does not work. Yet we know that appropriate and effective psychological intervention is one of the most effective strategies to prevent further worsening of mental health conditions, improve overall physical health and quality of life. It has also been identified as a way to reduce costs across the whole health system (28).

Aside from funding, another significant issue facing our GPs is simply access to psychologists. Even patients who are able and willing to pay gap fees are being faced with psychology clinics not taking new patients at all, or having inordinate, months-long wait times. This again leaves the patient without treatment at a time when key intervention could prevent deterioration and allow for early recovery. The result has been that some members of our medical team have undertaken upskilling in short psychological interventions. With groups like the Black Dog Institute and Beyond Blue developing many online interventions which can be self-navigated with a clinical coach, there is real potential for GPs to play a role in supporting mental health disorders more comprehensively. However, all such consultations will be lengthy. The remuneration per minute for a long (≥20 minutes), or very long (≥40 minute) consultation does not pay for the base operating costs within the practice. Hence, GPs will avoid having to bill these item numbers as they are financially unsustainable. With most vulnerable and at-risk patients finding it difficult to accommodate an out-of-pocket expense, doctors with additional skills are thus penalised for offering higher quality and more effective care. Creation of mental health related item numbers beyond mental health care plans and reviews is one way to address this.

5. Better access to mental health and trauma services for culturally and linguistically diverse people

Over 1 in 5 of us were born overseas and over 16% of us report we do not speak English well or not at all (29). We know that a person’s environment, upbringing, cultural context, spirituality and physical wellbeing all play a role in the manifestation of our health, including our mental health – the whole-person perspective. To properly address the mental health needs of people who are of culturally and linguistically diverse (CALD) backgrounds, we need to first understand and appreciate their cultural context and be able to communicate in the language which the patient is most comfortable with.

For non-English speaking mental health patients, their options for psychological therapy are extremely limited. There are a patchwork of not-for-profit providers serving the region, but because the work is time intensive and requires particularly skilled staff, they are often utilised beyond capacity. Wait times become unfeasibly long for many patients. For people living in regional areas, their choice for support is even more limited than in metropolitan areas. This is a particular issue for people who have arrived via the humanitarian settlement program and are being preferentially settled in regional areas. Furthermore, private psychologists do not have access to free interpreting services provided by the Federal Government-funded Translating and

Interpreter Service and for many at risk, paying for their own interpreting service (e.g. patients of a refugee-background) is financially inaccessible (see Section 4 above).

Our GPs are confronted by patient experiences of witnessing atrocities such as war, genocide or having experienced living in refugee camps and being displaced by geopolitical instabilities. Also, many patients present with devastating personal traumas such as torture, domestic and family violence or past physical or sexual abuse. Yes, our GPs do frequently refer patients in need of multicultural mental health services to the Queensland Transcultural Mental Health Centre (QTMHC) and QPASTT. However these services suffer from "incredibly long wait times," a direct quote from our clinical team. This means our patients do not receive the timely care they need to manage their health and be equipped to integrate in their new country.. This lack of access to appropriate support increases their social isolation, poverty and ongoing trauma impact for their families and risking intergenerational marginalisation.

The next wave of mental health issues for this group are associated with dementia and aging. Different cultures view aging, dying and death very differently. Reflecting these cultural considerations in care offered through our aged care system is long overdue. It is well known that lack of purpose, increased loneliness and reduced physical ability, including the pain often associated with old age, cause a marked increase in depression amongst older Australians. Supporting Australians of multi-cultural background to discuss their anxiety and depression in culturally appropriate ways will become of increasing importance and demand. Add to this the rising rates of dementia which lead to patients reverting to their mother tongue and you have escalating complexity in dealing with multicultural patients in residential settings.
There needs to be a nationally consistent approach to addressing the mental health needs of our most vulnerable people. We need to encourage, train and employ more bicultural mental health workers and embed them in both specialised transcultural and mainstream mental health and aged care services. Access to interpreter services needs to be made available nationally to all providers registered with Australian Health Practitioner Regulation Agency (AHPRA) so that nurses, allied health (Dieticians Australia-registered for dieticians as they do not register with AHPRA), and medical team members can all draw in the support they need to serve people of CALD background.

6. Improved, expanded, and integrated care coordination and social work services

The Australian health system is complex and difficult to navigate, even medical professionals can experience difficulties with plotting a care pathway for their patients. As previously discussed, addressing mental health needs a whole-person approach, and thus we need to recognise that a person's social context is deeply influential on their mental health. Hence, our clinicians are calling for better access to care coordination services for their patients. Yes, GPs can help address the physical and mental health aspects of a person's being. However, they are often ill-equipped and certainly not funded to address social aspects of a person's being, even if these are major factors in driving physical and mental ailments. Furthermore, some mental health conditions or the context of the patient (e.g. they are generally disorganised, or are not familiar with how the health system operates) means the patient is likely to forget or fail to attend to appointments. Care coordinators can address these issues.

Care coordinators such as Mater's pilot Multicultural Health Care Coordination Service (M-CHooSe) has been a vital service in our practice as they are able to advocate for the patient's needs, follow up when referrals are stalled, or correspondence has not been forthcoming and are able to link the patient with the most appropriate services when required. All performed in a

culturally sensitive and patient led manner, giving power and self-efficacy back to the patient. Similarly, Footprints Community performs similar roles for eligible patients via a special Brisbane South Primary Health Network funding stream which embed social workers in our practice. They link patients in with the most appropriate welfare, housing and social support services. This means the health system operates at peak efficiency while patients benefit from having their needs addressed and can focus on better managing or recovering from their conditions.

The United Kingdom has embraced the role of link workers and care coordination in general practice. Since 2015, the number of such positions has risen from a handful to many thousands across the country. With the rising tide of mental health presentations created by lockdowns during COVID, this workforce has been identified as vital in ensuring the most vulnerable in the community stays well and accesses the most appropriate services. Proposals in the Australian 10 Year Primary Health Care Reform Strategy to involve all primary health networks in a national pilot of social prescribing using link workers are to be endorsed and accelerated.

The Preventative Health Strategy launched by the Commonwealth in late 2021 also notes that patients with mental health issues need greater care support services. The Strategy also acknowledges that living in a disadvantaged catchment or being multicultural should trigger greater access to such services. We agree and content that definitions of disadvantage need to extend routinely beyond identification with First Nations or gender diverse communities. Simply living in a catchment in the bottom 10% of income earners in the country, is closely correlated with poor levels of literacy, health system literacy and a rising digital divide. Hence, supporting such communities to access services will necessarily involve personal responses by trained coordinators able to match patient need with providers. At a simple level, with more of the population over 65 and eligible to access the My Aged Care System and this population being more vulnerable to loneliness which triggers depression and anxiety, we need navigators to enable this population to make full use of government services to which they are entitled.

7. Better public psychiatry access

Our GPs report that public psychiatry outpatients is presently so overburdened to the point where only the most severe cases are seen. While this may not seem out of place, we wish to outline the following vignette. Suppose we had patient with heart failure, and they were not responding well to any of the therapies being provided by their general practitioner and the person was not coping with their condition and were at risk of more severe disease or death. A GP would refer this patient to the appropriate cardiac outpatients where they will be seen within a matter of weeks or a few months. Take another situation where a patient had reasonably complex diabetes and this patient was having trouble managing their diabetes day-to-day and their GP was not making progress with therapies accessible to them. The GP would refer this patient to the complex diabetes service for specialists' intervention. These patients would be adequately triaged and even if their condition were not very serious, they would eventually be seen, usually in less than three months. Now take a patient with severe anxiety and their condition was not responding to all current treatment modalities available to the GP. Sadly, a patient such as this would have their referral flatly rejected leaving no other option but for the GP to continue trying to manage the patient on their own or attempt referring the patient privately, assuming the patient could afford the expensive care of a private psychiatrist.

Regrettably, our GP's experience with private psychiatry is also less than positive. Even if the patient could afford private care, our GPs frequently report that private psychiatrists can be restrictive with what types of cases they accept and sometimes will not see patients with complex

conditions. Often these are patients already severely marginalised, such as those who have been through or are currently in the criminal justice system.

This type of health care inequity needs to be addressed by reviewing resourcing at public psychiatry outpatients and ensure it aligns with levels of access of other hospital specialities.

8. Other general recommendations

Perinatal/Postnatal Depression Support

Perinatal depression is a hidden crisis affecting 1 in 5 mothers (45). These mothers struggle with the challenges of newborns; bonding, feeding, settling, any developmental problems and sleep disruptions. This is often a silent burden as stigma is associated with a lack of joy or perceived competence post-birth. Sadly the risks of domestic and family violence during this chapter of life is increased (46). Resultantly, many women develop mental health issues or enter crisis. At least two Primary Health Networks (PHNs), Brisbane North and Brisbane South, do fund a perinatal depression and anxiety program and this is welcomed as an intervention and prevention tool. We also recognise that Queensland Child Services do have a Postnatal Wellbeing Support group and we welcome that and hope for expansion and increased accessibility of both services to all. But we see a need for 24-hour crisis support services specific for mothers and their babies. Also, there is a dearth of residential facilities specialising in mother and infant care which enable vulnerable families to reset, upskill and be supported as they navigate an exit from a crisis. We wish to highlight that all these services need a culturally appropriate aspect to service delivery as many of our patients are from CALD backgrounds and when they interact with well-meaning but not culturally or linguistically appropriate services, there is far greater risk of further harm and distrust.

Improvement in Mental Health Nurse Navigators and Psychiatric Discharge Communications

We are of the opinion that while the advent of mental health nurse navigators (MHNN) is welcomed, it has not meaningfully addressed the problem of suicide support and crisis care. We are aware that mental health nurse navigators only able to accept a caseload of 40 patients. There are only two MHNN across the entire Brisbane South region. Their work is hospital-centric and focuses on care supports from public providers only. Resultantly GPs are largely isolated from the care team. Too often, admission occurs when the public community mental health service needs to discharge a patient to manage their lists. At this point GPs are asked to take over an unstable patient often on complex medications with limited provision of history and, sadly, with inadequate discharge summaries. Case conferencing with the team prior to discharge almost never occurs. Access to the treating psychiatrist after discharge is impossible complicating the ongoing dispensing of necessary medications, many of which require a psychiatrist's authority. Where a practice is found to be willing to accept these patients, many of whom have no history with any particular GP practice, require considerable history taking and observations to address all their health matters, public providers then send all future discharges to that practice. The practice quickly becomes overwhelmed. For example, most psychiatrists will only manage a handful of borderline personality disorder patients. Inala Primary Care has a significantly high proportion of people with such disorders and many more with schizophrenia and other complex and chronic mental health diagnoses. We have no greater access to a mental health nurse, occupational therapist, social worker or link worker than any other general practice. Hence, the burden on our medical and nursing team is disproportionate and leads to stress and burnout within our medical and reception teams. This means many of our staff will choose to work part-time or will leave prematurely due to these stressors.

Enhanced funding for neighbourhood centres and sports and recreation programs

Community cohesion is part of the environmental factors that play into our individual social determinants of health and wellbeing. Thus, we would encourage place-based and needs-specific investment into neighbourhood centres and sports and recreation programs. We are aware that the Queensland Community Alliance and Griffith University have been active in Inala driving the Nourish Inala community listening program into developing agendas for innovative, community-led healthier lifestyle interventions (47). We would call for the State Government to listen and support community-driven initiatives. These will not only flow on to better physical health, but also mental health and wellbeing.

CONCLUDING STATEMENT

We welcome the Queensland Government Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders. Action is needed at all levels of government and across agencies. There are many possible avenues to improve prevention and intervention. Years of continued inaction means we have been living in a crisis state with real human costs. Concerted mental health care reforms will translate to society-wide benefits.

REFERENCES

1. AIHW. Mental health snapshot [Internet]. Australian Institute of Health and Welfare. 2020 [cited 2022 Jan 21]. Available from: https://www.aihw.gov.au/reports/australias-health/mental-health

2. Sara G, Chen W, Large M, Ramanuj P, Curtis J, McMillan F, et al. Potentially preventable hospitalisations for physical health conditions in community mental health service users: a population-wide linkage study. Epidemiol Psychiatr Sci [Internet]. 2021 ed [cited 2022 Jan 25];30. Available from: http://www.cambridge.org/core/journals/epidemiology-and-psychiatric-sciences/article/potentially-preventable-hospitalisations-for-physical-health-conditions-in-community-mental-health-service-users-a-populationwide-linkage-study/A0AD5F79F8686B35F6095E8DF227F904

3. Slade T, Johnston A, Oakley Browne MA, Andrews G, Whiteford H. 2007 National Survey of Mental Health and Wellbeing: Methods and Key Findings. Aust N Z J Psychiatry. 2009 Jul;43(7):594–605.

4. RACGP. Mental health care in general practice - RACGP Position Statement [Internet]. East Melbourne, Victoria: Royal Australian College of General Practitioners; 2021 [cited 2022 Jan 21]. Available from: https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/mental-health-care-in-general-practice

5. ABS. Patient Experiences in Australia: Summary of Findings, 2020-21 financial year [Internet]. Canberra: Australian Bureau of Statistics; 2021 Nov [cited 2022 Jan 21]. Report No.: ABS cat. no. 4839.0. Available from: https://www.abs.gov.au/statistics/health/health-services/patient-experiences-australia-summary-findings/latest-release

6. RACGP. General Practice Health of the Nation: Infographic Summary Report 2021 [Internet]. East Melbourne, Victoria: Royal Australian College of General Practitioners; 2021. Available from: https://www.racgp.org.au/getmedia/c6fc787b-9c6e-43a5-a1d9-46847a151615/ID-949-HOTN-21-summary-v4-WEB.pdf.aspx

7. AIHW. Mental health services in Australia [Internet]. Canberra: Australian Institute of Health and Welfare; 2022. Available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia

8. Liu NH, Daumit GL, Dua T, Aquila R, Charlson F, Cuijpers P, et al. Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. World Psychiatry Off J World Psychiatr Assoc WPA. 2017 Feb;16(1):30–40.

9. Lawrence D, Kisely S, Pais J. The epidemiology of excess mortality in people with mental illness. Can J Psychiatry Rev Can Psychiatr. 2010 Dec;55(12):752–60.

10. AMA. Australian Medical Association submission to Select Committee on Mental Health and Suicide Prevention [Internet]. Canberra: Australian Medical Association; 2020 Mar [cited 2022 Jan 25]. Available from: https://www.ama.com.au/media/mental-health-our-fastest-growing-hospital-admission

11. AIHW. Emergency department care activity 2020-2021 [Internet]. Canberra: Australian Institute of Health and Welfare; 2021. Available from: https://www.aihw.gov.au/reports-data/myhospitals/intersection/activity/ed

12. Morris P. The Australian Mental Health Crisis: A system failure in need of treatment [Internet]. National Association of Practising Psychiatrists. 2021 [cited 2022 Jan 25]. Available from: https://napp.org.au/2021/04/the-australian-mental-health-crisis-a-system-failure-in-need-of-treatment/

13. Davey M. 'Like hunting for unicorns': Australians on the search for adequate, affordable mental healthcare. The Guardian [Internet]. 2021 Apr 18 [cited 2022 Jan 25]; Available from: https://www.theguardian.com/australia-news/2021/apr/19/like-hunting-for-unicorns-australians-on-the-search-for-adequate-affordable-mental-healthcare

14. Vecchio N, Davies D, Rohde N. The effect of inadequate access to healthcare services on emergency room visits. A comparison between physical and mental health conditions. Abe T, editor. PLOS ONE. 2018 Aug 23;13(8):e0202559.

15. WHO. Social determinants of health [Internet]. Social determinants of health. 2022 [cited 2022 Feb 1]. Available from: https://www.who.int/westernpacific/health-topics/social-determinants-of-health

16. Halford KW. Australian Couples in 'Millennium Three': A research and development agenda for marriage and relationship education. [Internet]. Canberra: Department of Family and Community Services; 2000 Feb. (National Families Strategy). Available from: https://www.dss.gov.au/sites/default/files/documents/australian_couples.rtf

17. January 2019: Finances and Relationships [Internet]. Relationships Australia. 2019 [cited 2022 Feb 1]. Available from: https://relationships.org.au/document/january-2019-finances-and-relationships/

18. Boullier M, Blair M. Adverse childhood experiences. Paediatr Child Health. 2018 Mar 1;28(3):132–7.

19. McFarlane AC. The long-term costs of traumatic stress: intertwined physical and psychological consequences. World Psychiatry. 2010 Feb;9(1):3–10.

20. Prigerson HG, Bierhals AJ, Kasl SV, Reynolds CF, Shear MK, Day N, et al. Traumatic grief as a risk factor for mental and physical morbidity. Am J Psychiatry. 1997;154:616–23.

21. Substance Abuse and Mental Health Services Administration. Understanding the Impact of Trauma. In: Trauma-Informed Care in Behavioral Health Services [Internet]. Rockville, MD: Substance Abuse and Mental Health Services Administration (US); 2014 [cited 2022 Feb 1]. (Treatment Improvement Protocol (TIP)). Available from: https://www.ncbi.nlm.nih.gov/books/NBK207191/

22. AIHW. Stress and trauma [Internet]. Canberra: Australian Institute of Health and Welfare; 2020 Jul [cited 2022 Feb 1]. (Australia's Health 2020). Available from: https://www.aihw.gov.au/reports/australias-health/stress-and-trauma

23. Cleary M, Hungerford C. Trauma-informed Care and the Research Literature: How Can the Mental Health Nurse Take the Lead to Support Women Who Have Survived Sexual Assault? Issues Ment Health Nurs. 2015 May 4;36(5):370–8.

24. Harmon K, Carr VJ, Lewin TJ. Comparison of integrated and consultation-liaison models for providing mental health care in general practice in New South Wales, Australia. J Adv Nurs. 2000;32(6):1459–66.

25. Dalton H, Read D, Handley T, Perkins D. Low Intensity Mental Health Services: A Rapid Review [Internet]. Orange, NSW: Centre fo Rural & Remote Mental Health, University of Newcastle; 2017 [cited 2022 Jan 25]. Available from: https://www.crrmh.com.au/content/uploads/Low-Intensity-MH-Service-Rapid-Review_CompleteFinal-1.pdf

26. Bower P, Kontopantelis E, Sutton A, Kendrick T, Richards DA, Gilbody S, et al. Influence of initial severity of depression on effectiveness of low intensity interventions: meta-analysis of individual patient data. BMJ. 2013 Feb 26;346:f540.

27. Ali S, Rhodes L, Moreea O, McMillan D, Gilbody S, Leach C, et al. How durable is the effect of low intensity CBT for depression and anxiety? Remission and relapse in a longitudinal cohort study. Behav Res Ther. 2017 Jul 1;94:1–8.

28. Australian Psychological Society. The Future of Psychology in Australia: A blueprint for better mental health outcomes for all Australians through Medicare [Internet]. Melbourne: Australian Psychological Society; 2019 Jun [cited 2022 Jan 25]. Available from: https://psychology.org.au/getmedia/a1c6fc1f-8356-471c-9247-36832da61299/aps-white-paper-the-future-of-psychology-in-australia-june-2019-final.pdf

29. Haslam C, Cruwys T, Haslam SA, Dingle G, Chang MX-L. Groups 4 Health: Evidence that a social-identity intervention that builds and strengthens social group membership improves mental health. J Affect Disord. 2016 Apr 1;194:188–95.

30. Olasoji M, Maude P. The advent of mental health nurses in Australian general practice. Contemp Nurse. 2010 Aug 1;36(1–2):106–17.

31. Department of Health. Head to Health [Internet]. Head to Health. 2022 [cited 2022 Feb 4]. Available from: https://www.headtohealth.gov.au

32. Solmi M, Radua J, Olivola M, Croce E, Soardo L, Salazar de Pablo G, et al. Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies. Mol Psychiatry. 2021 Jun 2;1–15.

33. CDC. Adverse Childhood Experiences - Risk and Protective Factors [Internet]. 2021 [cited 2022 Jan 25]. Available from: https://www.cdc.gov/violenceprevention/aces/riskprotectivefactors.html

34. Tsirtsakis A. Pandemic's mental health impact on young people a 'national crisis'. [Internet]. NewsGP. 2020 [cited 2022 Jan 25]. Available from: https://www1.racgp.org.au/newsgp/clinical/pandemic-s-mental-health-impact-on-young-people-a

35. Higgins I, Collard S. Headspace is 'easy for politicians', but failing Australia's youth, experts say. ABC News [Internet]. 2019 Apr 27 [cited 2022 Jan 25]; Available from: https://www.abc.net.au/news/2019-04-28/headspace-failing-australias-youth-experts-say/11039776

36. Pickering JA, Sanders MR. The Triple P-Positive Parenting Program : an example of a public health approach to evidence-based parenting support. Fam Matters. 2015;(96):53–63.

37. Klasen H, Goodman R. Parents and GPs at cross-purposes over hyperactivity: a qualitative study of possible barriers to treatment. Br J Gen Pract. 2000 Mar 1;50(452):199–202.

38. Merten EC, Cwik JC, Margraf J, Schneider S. Overdiagnosis of mental disorders in children and adolescents (in developed countries). Child Adolesc Psychiatry Ment Health. 2017 Jan 17;11(1):5.

39. Dunlop AJ, Newman LK. ADHD and psychostimulants — overdiagnosis and overprescription. Med J Aust. 2016 Mar;204(4):139–139.

40. Callander EJ, Corscadden L, Levesque J-F, Callander EJ, Corscadden L, Levesque J-F. Out-of-pocket healthcare expenditure and chronic disease – do Australians forgo care because of the cost? Aust J Prim Health. 2017 Mar 15;23(1):15–22.

41. Prins M, Meadows G, Bobevski I, Graham A, Verhaak P, van der Meer K, et al. Perceived need for mental health care and barriers to care in the Netherlands and Australia. Soc Psychiatry Psychiatr Epidemiol. 2011 Oct 1;46(10):1033–44.

42. RANZCP. Keeping your head above water: Affordability as a barrier to mental health care [Internet]. Melbourne: Royal Australian and New Zealand College of Psychiatrists; 2014 Nov [cited 2022 Jan 28]. Available from: https://www.ranzcp.org/files/resources/reports/keeping-your-head-above-water-affordability-as-a.aspx

43. Farrer LM, Walker J, Harrison C, Banfield M. Primary care access for mental illness in Australia: Patterns of access to general practice from 2006 to 2016. PLoS ONE. 2018 Jun 1;13(6):e0198400.

44. Fok ML-Y, Chang C-K, Broadbent M, Stewart R, Moran P. General hospital admission rates in people diagnosed with personality disorder. Acta Psychiatr Scand. 2019;139(3):248–55.

45. AIHW. Perinatal depression: data from the 2010 Australian National Infant Feeding Survey [Internet]. Canberra: Australian Institute of Health and Welfare; 2012 [cited 2022 Feb 4]. Report No.: PHE161. Available from: https://www.aihw.gov.au/reports/primary-health-care/perinatal-depression-data-from-the-2010-australia/summary

46. Campo M. Domestic and family violence in pregnancy and early parenthood [Internet]. Canberra: Australian Institute of Family Studies; 2015 Dec [cited 2022 Feb 4]. (CFCA Practitioner Resource). Available from: https://aifs.gov.au/cfca/publications/domestic-and-family-violence-pregnancy-and-early-parenthood

47. Kennedy D. Nourish Inala Discernment [Internet]. Queensland Community Alliance. 2021 [cited 2022 Feb 4]. Available from: https://www.qldcommunityalliance.org/nourish_inala_discernment