The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Queensland Branch

Queensland Government

Parliamentary Inquiry into Mental Health Services in Queensland

February 2022

RANZCP Queensland Branch Submission to Parliamentary Inquiry into the opportunities to improve mental health outcomes for Queenslanders

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The Royal Australian and New Zealand College of Psychiatrists | Queensland Branch

Submission to Parliamentary Inquiry into Mental Health Services in Queensland

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental healthcare. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has over 6700 members, including more than 5000 qualified psychiatrists (Fellows) and more than 1600 members who are training to qualify as psychiatrists (trainees). The RANZCP Queensland Branch represents 902 Fellows and 382 trainees.

The RANZCP Queensland Branch submission has been prepared in consultation with the Queensland Branch Chair and Committee, as well as other members of special interest groups. The RANZCP Queensland Branch would like to thank everyone that contributed to this submission.

Acknowledgement of Country

The RANZCP Queensland Branch acknowledges the Turrbal People and Yuggera People, the Traditional Owners and Custodians of the land. We honour and respect the Elders past and present, who weave their wisdom into all realms of life.

Acknowledgement of Lived Experience

We acknowledge the significant contribution of all people with lived experience of mental illness, and the people who care and support them, to the development and delivery of safe, high-quality mental health services.

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Introduction from the RANZCP Queensland Branch Committee Chair

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Queensland Branch welcomed the announcement on 1 December last year of a parliamentary inquiry into mental health services in Queensland. This is such an important development, as there has never been a comprehensive external review of the state mental health system in Queensland. Previous reviews were related to specific clinical sites, for example Ward 10B in Townsville and the closure of the Barrett Adolescent Centre.

The RANZCP Queensland Branch has been calling for an in-depth review of statewide mental health services for the past 18 months. We have been highlighting the historic and chronic underfunding of state mental health services and the massive impact of COVID-19 on mental health services in Queensland.

Following two days of *The Courier-Mail's* "Through the Cracks" campaign, the RANZCP Queensland Branch welcomed the release of the terms of reference that would shape this parliamentary inquiry, to be undertaken by the Mental Health Select Committee.

The RANZCP Queensland Branch hopes that this parliamentary inquiry will provide a comprehensive review of the state mental health system to identify service gaps, determine exactly where the state and Commonwealth funding shortfalls exist, and provide innovative solutions to bridge these gaps.

As an outcome of this parliamentary review, the RANZCP Queensland Branch hopes to see the development of a five-to-seven-year mental health plan, and bipartisan financial commitment to fund the many improvements needed to provide Queenslanders with quality mental healthcare.

Since the COVID-19 pandemic started, presentations to emergency departments and general practitioners have substantially increased, many private psychiatrists across Queensland have closed their books and community mental health services have struggled to cope with increasing demand.

Following the Royal Commission into Victoria's Mental Health System, the Victorian Government announced an investment of $3.8 billion, or a $950 million increase per year for state mental health services in Victoria.

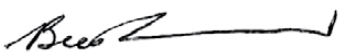
The RANZCP Queensland Branch calls for an immediate funding increase of $88 million per year to bring Queensland mental health spending up to the national average.

The RANZCP Queensland Branch also calls for a recurrent annual funding increase of up to $750 million per year on a pro rata basis (total new expenditure required) in the longer term, to match the Victorian Government funding.

Our submission is not a detailed, comprehensive mental health plan but a summary of the key areas which require funding and further development in Queensland over the next five to seven years.

The RANZCP Queensland Branch welcomes this parliamentary review by the Mental Health Select Committee, and hopes that this inquiry will report on opportunities to improve mental health outcomes for Queenslanders living with mental illness, their families and carers and the broader community.

To discuss the contents of this submission please contact me via Ms Nada Martinovic, Policy and Advocacy Advisor (Queensland Branch), at [redacted] or on [redacted]



Professor Brett Emmerson AM
Chair, Queensland Branch Committee, The Royal Australian and New Zealand College of Psychiatrists

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Key messages

The RANZCP Queensland Branch calls on the Queensland Government to:

Planning and funding

- Develop a five-to-seven-year mental health plan
- Make a bipartisan commitment to funding the improvements needed to provide Queenslanders with quality mental healthcare
- Immediately increase funding to at least the national average, which in 2019 was $88 million per year to bring Queensland mental health spending up to the national average[i]
- Commit to recurrent funding to increase the mental health budget to $750 million per year (total new expenditure required), in the longer term to match the Victorian Government funding, following the Royal Commission into Victoria's Mental Health System

Community mental health

- Strengthen the focus on community-based mental healthcare, this will require an additional 3,000 community mental health staff (taking into account shift work penalties)
- Increase the funding budget for the non-governmental organisations (NGO) sector by 300 per cent
- Increase funding for alcohol and drug treatment services across the state, including the NGO sector

Beds

- Provide for 500 new public acute and sub-acute psychiatric beds, and 250 bed refurbishments, including acute beds, psychogeriatric beds and long-stay psychogeriatric beds, step-up / step-down beds, mother-baby beds, eating disorder beds, and child and adolescent beds
- Develop an additional 25-bed inpatient unit for complex, high-risk persons at "The Park", centre for mental health, treatment, research and education at Wacol (as "The Park" can only accommodate a proportion of very high-risk persons and persons on forensic orders)

Support mental health and wellbeing in people with intellectual and developmental disability

- Develop a new statewide specialist inpatient and integrated community service to support mental health and wellbeing in people with intellectual and developmental disability, operated by the Queensland Government Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships
- Revise the *Mental Health Act 2016*, with respect to existing forensic disability provisions, which currently enable health services to act as parole services for individuals

Workforce

- Expand the mental health workforce significantly, especially in rural and regional areas
- Fund education and training programs to improve the mental health workforce capability, and enhance the capability of state mental health services to provide evidence-based interventions
- Increase the number of peer workers (sometimes referred to as 'lived experience workers'), as part of the workforce within the Queensland public mental health system and community health service
- Develop a workforce strategy (and a central alcohol and other drugs workforce unit) to grow the workforce, in partnership with universities and tertiary institutions

System governance

- Broaden the role of the Queensland Mental Health Commission (QMHC) to monitor, advise on and evaluate the mental health reforms implemented as an outcome of this inquiry
- Develop regional mental health planning committees, which would involve mental health services, primary health networks (PHNs), non-governmental organisations (NGOs) and consumers and carers to oversee the new reforms at the local level (consistent with the Productivity Commission recommendation)

[i] In August 2020, the Queensland Government announced an additional $46.5 million in funding allocated for mental health services, to support a COVID-19 response. However, this funding will be discontinued in June 2022 and the RANZCP Queensland Branch is advocating to the Queensland Government for ongoing recurrent investment of $88 million per year to support mental health services across the state, given the still evolving COVID-19 pandemic and the unprecedented public health challenges associated with this pandemic.

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Cracks in the Queensland state mental health system

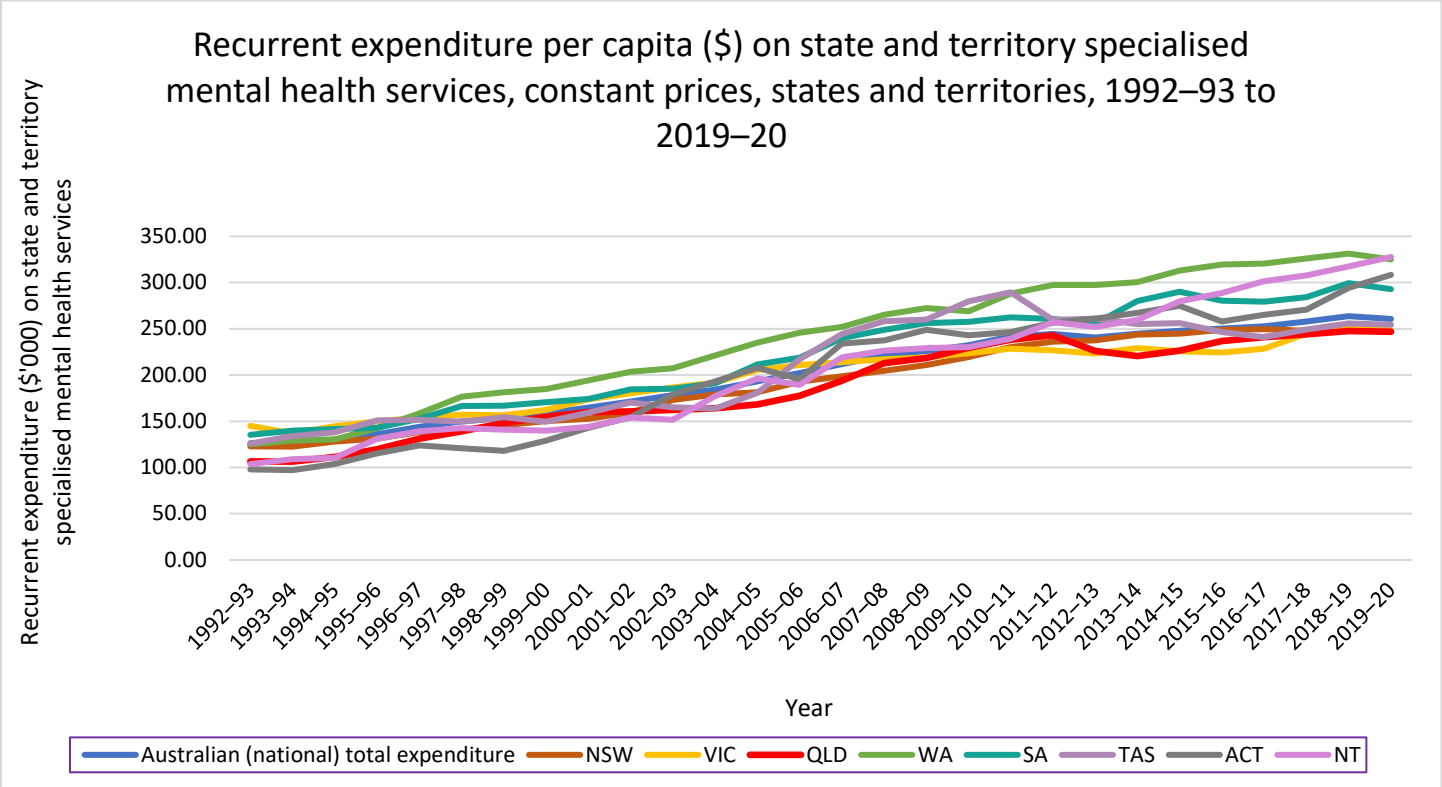
The RANZCP Queensland Branch advocates for people affected by mental illnesses, people with intellectual and developmental disabilities, their families and carers and provides advice to the Queensland Government on mental healthcare.

Our submission is a summary of the key areas which require funding and further development in Queensland over the next five to seven years, with the aim of delivering high-quality care to Queenslanders living with mental illness and services to support mental health and wellbeing in people with intellectual and developmental disability, by implementing evidence-based clinical pathways for various mental health interventions.

Late last year, *The Courier Mail* launched a "Through the Cracks" campaign calling for a broadscale review of mental health services in Queensland. The RANZCP Queensland Branch had been calling for an in-depth review of statewide mental health services for the 18 months prior to *The Courier Mail* campaign.

This campaign highlighted that wait times to access private psychiatry mental health services have blown out to between 12 months for adults, and 18 months for children, exacerbated by increasing presentations to emergency departments and primary care settings. The evolving COVID-19 pandemic has now pushed mental health services to the brink in Queensland.

Queensland has the lowest per capita spend in the country, and mental health accounts for only 7 per cent of the state health budget overall.[1] Decades of underfunding have led to Queensland having the worst mental health workforce staffing levels and least number of beds to service its population.



Notes: As indicated by the graph above (red line), Queensland has had some of the lowest per capita ($'000) spending on mental health services, dating back almost 30 years, compared with other states and territories in Australia.[2]

In the Public Briefing of the Mental Health Select Committee (part 1 of 2), held on 20 January 2022, Associate Professor John Allan, the Executive Director of the Mental Health Alcohol and other Drugs Branch at Queensland Health, provided a verbal submission and said [quoted]:

> *Queensland has one of the lowest per capita expenditures on public specialised mental health services across Australian jurisdictions. Additionally, while there has been a growth of 62 per cent, per capita expenditure on public hospital health services between 2009 and 2010, and 2018 and 2019 in Queensland, comparatively mental health per capita expenditure has only increased by 10 per cent during the same time period, despite significant recent investment.*[3]

The RANZCP Queensland Branch advocates that Queensland, Australia's lowest funded jurisdiction per capita, needs a recurrent $88 million per year, to match the national average which in 2019 was precisely $88 million per year.[4] This should include making permanent the $46.5 million dollars in funding allocated for a COVID-19 mental health response, in the last two years.

On a pro rata basis, the RANZCP Queensland Branch also calls for recurrent annual funding of up to $750 million per year (total new expenditure required) in the longer term to match Victorian Government funding, following the Royal Commission into Victoria's Mental Health System (of $3.8 billion, or an $950 million increase per year for Victorian mental health services), and to keep pace with mental health funding in other states and territories across Australia. We would not like to see funding sidelined pending the outcome of this parliamentary inquiry.

The RANZCP Queensland Branch advocates that it is not sufficient to provide funding and investment for public mental health (hospital) services, which has historically been the case. Rather, it is important that a broadscale and statewide parliamentary inquiry takes a whole-of-system approach (public, private, primary care services, hospital (ED) services, community mental health services, intellectual and developmental disability services, alcohol and drug services, non-governmental organisations, primary health networks and forensic and disability services).

Improving mental health outcomes for Queenslanders is predicated on appropriate and adequate resourcing of an array of related health (and other) services - this includes effective funding of Indigenous health services, culturally responsive mental health services for culturally and linguistically diverse Queenslanders, and culturally competent services for people identifying as LGBTIQA+, as well as safe housing and homelessness services for persons with a mental illness and / or disability.

Queensland's mental health system has reached breaking point and the RANZCP Queensland Branch believes that urgent reform and investment is needed to ensure that every Queenslander has access to high-quality mental healthcare.

Defining important terms, 'mental health', 'mental illness' and 'mental wellness'

Terms like 'mental health', 'mental illness' or 'mental wellness' give rise to certain confusions and vagueness.

The *Mental Health Act 2016* (Queensland) defines *mental illness* as a condition characterised by a clinically significant disturbance of thought, mood, perception or memory (section 10, Mental Health Act).

Broadly speaking, people with mental illness could be categorised into two broad groups:

- the "low/moderate intensity mental disorder" group, representing common but less disabling conditions like depressive and anxiety disorders, with a prevalence of around 20 per cent in most population cohorts

- the "high intensity mental disorder" group, representing rare and more disabling conditions like schizophrenia and bipolar disorder (type I), with a prevalence of around 1 per cent each in most population cohorts.

While members of these broad categorisations may overlap, for example some people with severe anxiety disorder may have a significant psychosocial impairment while others with schizophrenia may function perfectly well, the division between the two groups as outlined above is useful in considering the nuances of mental health care provision.

Notably, some concepts like 'intensity' of illness can be hard to define. Equally, it is important not to confuse and conflate concepts like 'prevalence' of a condition, 'severity' of the condition, 'disease burden' and 'disability'. It is important to understand also that it is not just the symptoms of mental illness which can cause disability, but also the secondary effects arising from the underlying mental illness such as loss of employment, loss of income, loss of housing and loss of important family, social or romantic relationships.

The RANZCP Queensland Branch also acknowledges that many people who seek support from state mental health services would not meet any particular diagnostic criteria for a defined mental disorder. This group could be broadly termed the 'subthreshold mental distress' group, and has a stronger focus on 'mental wellness' than treatment of specific 'mental illness'.

Despite its limitations, clinical diagnoses are quite significant in the context of a person's healthcare journey. It is difficult to access the right treatment services, at the right time, and in the right setting without an accurate diagnosis. For the treatment and/or mental health support service to be effective, it has to be provided at the right time (early intervention is best practice), and by the right health professional (psychiatrists for example diagnose illness, manage treatment and provide a range of therapies for complex and serious mental illness).

The setting of care is also equally important. Most people with low/moderate intensity mental disorders are cared for outside of the public mental health sector, for example by general practitioners instead of the hospital inpatient setting. On the other hand, people with high intensity mental disorders are cared for by private psychiatrists, the primary care sector as well as the public mental health sector, especially if their disease burden requires higher intensity care, then the hospital setting may be the most clinically appropriate setting for their care.

The missing middle

As the Productivity Commission *'Inquiry Report on Mental Health'* (June 2020) highlights, one in five Australians experience mental ill health each year.[5] Many of these people do not receive the treatment or support that they need.

In Queensland and across many other states and territories of Australia, there are few services between the general practitioner (primary care) and emergency crisis care. This means that many Queenslanders living with significant and disabling mental illnesses who would benefit from a comprehensive psychiatric assessment, may be unable to access the care that they need, because they are on the one hand, not unwell enough to be admitted to hospital, and on the other too unwell to be treated and managed by a general practitioner alone.

These persons living with mental illness represent 'the missing middle'[6], a newly coined term to describe persons whose needs are too complex for primary care responses but who are unable to access specialist mental health services.

Pressure on emergency departments in Queensland

Most recent data shows that the mental health of three out of four Australians has been affected by the COVID-19 pandemic.[7] Against the backdrop of the evolving pandemic, the extended wait times for private mental health services in Queensland (like private psychiatrists) is shifting the pressure to emergency departments, and general practitioners, and many Queenslanders currently miss out on the care that they need.

There is broad national consensus that action is needed both *inside* and *outside* the ED. We support the recommendation of the Productivity Commission *'Inquiry Report on Mental Health'* (June 2020), as noted in the Australian Medical Association Queensland (AMAQ) submission to this parliamentary inquiry, that each state and territory should provide more and better alternatives to EDs for people with mental health problems.

The Australasian College for Emergency Medicine (ACEM) in 2020 launched *'Nowhere Else to Go'*[8]*,* a report examining why Australia's mental health system is failing people presenting to the emergency department (ED) in mental health crisis, and the urgent reforms needed. In the *'Nowhere Else to Go'* (2020) report, access block was identified as a significant issue. Specifically, assessment and treatment delays can exacerbate the distress of a person in the ED (with associated effects on other patients, hospital staff and carers, including a heightened risk of occupational violence).[9]

Despite the considerable attention which has been given to it, the incidence and impacts of occupational violence against healthcare workers, including those employed by Queensland Health, remains problematic.[10] This was also noted by AMAQ in their submission to this inquiry. Occupational violence is a significant issue for staff in psychiatric inpatient units, as well as community settings, and more needs to be done in Queensland to capture data on the incidence of occupational violence and to then devise strategies to address this issue.

Apart from access block in ED, it must also be noted that Queensland has a lack of acute psychiatric beds (and back-up extended care beds) across the state, and this often facilitates early discharge of inpatients. In addition to this, inadequate community follow-up and case management of persons recently discharged from the ED means that too few persons are managed closely in the community and present again to ED for care in acute mental health crisis (often referred to as 'revolving door admissions').

The RANZCP Queensland Branch advocates that ED staff should have appropriate levels of mental health, alcohol and other drugs training, training in complex intersectional areas like intellectual and developmental disabilities (having an intellectual disability is second only to alcohol and other drug comorbidity in determining presentations to ED, following inpatient mental health stays), and transcultural competence for the reception, assessment and stabilisation of all persons presenting to ED needing mental health help, within a delineated treatment area that affords safety, privacy and dignity.

There is a strong need for separate assessment units across Queensland public hospitals, to assess persons presenting to hospital with complex neuropsychiatric disorders and connect them with appropriate services on discharge, to prevent repeated presentations to ED and recurrent inpatient admissions. Fellows of the College report anecdotally that it is people with complex intersectional issues (autism spectrum disorder, intellectual and developmental disability, personality disorders, behaviours of concern, offending behaviours, drug and alcohol use disorders) that are the most frequent and recurrent users of public hospital services.

Across Queensland, there are mental health staff appointed to provide services to persons presenting in mental health crisis to the ED, unfortunately these have not been funded and have come out of existing community-based staffing levels, which has contributed to a reduction in the availability of mental health staff in the community.

Recent initiatives to triage mental health presentations from EDs include diversion to non-clinical assessment and supports (e.g. 'Safe Spaces')[11], short-stay mental health units attached to ED[12], and establishment of focused care pathways in mental health inpatient units to support brief admissions ('Short Stay Pathways' (SSP)).[13] However, none of these 'add-ons' reflects a genuine alternative to acute inpatient care, which remains relevant to people whose mental health crises cannot be supported in the community or less restrictive care environments (for example those in the 'high intensity mental disorder group' requiring treatment in public in-patient facilities).

A new $11 million Mental Health Crisis Stabilisation unit has recently opened at Robina Hospital (to provide an alternative to emergency department (ED) care for psychiatric emergencies).[14] The RANZCP Queensland Branch acknowledges that there are different models for crisis stabilisation services (some hospital-based and other community-based models) and advocates that crisis stabilisation services need to be developed in major centres across Queensland.

Pressure on primary care settings and primary health networks across Queensland

General Practices

The pandemic-related economic downturn, as well as restrictions on social interactions and the stress of moving to remote working, have all adversely affected the mental health of millions of Queenslanders.

Since the start of the COVID-19 pandemic, there has been a slow and steady increase in wait times to see a private psychiatrist in Queensland (currently nine to 12 months wait for adults, 18 months for children), and many private psychiatrists have closed their books to new patients, particularly in rural and regional areas of the state, due to existing workforce shortages.

This has put significant pressure on general practitioners to manage increasingly complex needs of persons presenting with mental health issues in primary care settings. In the AMAQ submission to this parliamentary inquiry, the AMA Queensland Council of General Practice reported increases of between 30 per cent and 50 per cent for persons presenting with mental health issues of all ages, since the COVID-19 pandemic began.

Likewise, the RACGP *'General Practice: Health of the Nation'* (2021) report[15], highlights that increasingly people present to their general practitioners for management of mental health concerns:

> *Ask any GP and they will likely report more and more patients presenting with mental health concerns. This is part of a longer-term trend. For the fifth consecutive year, psychological conditions, including sleep disturbance and depression, were the most reported reasons for patient presentations. Over 70 per cent of GPs selected 'psychological' in their top three reasons for patient presentations, a number that has risen steadily from 61 per cent in 2017.*

Since most people suffering from common, but less disabling conditions ("low/moderate intensity mental disorder" group), like depression and anxiety are managed in primary care settings, the RANZCP Queensland Branch recommends that greater connection and liaison between the primary healthcare sector and private psychiatrists is needed to facilitate coordinated care.

The RANZCP Queensland Branch acknowledges that there are different models of coordinated care. As foreshadowed at the outset, our submission is not a detailed mental health plan but a summary of the key areas which require funding and further development in Queensland over the next five to seven years. We recommend that the Queensland Government explore better integrated models of care, such as

consultation-liaison psychiatry models, in which a psychiatrist acts as a consultant to primary care physicians by advising on psychiatric diagnosis and facilitating the overall medical care of persons living with a mental illness.

An example is the Consultation and Liaison in Primary Care Psychiatry (CLIPP) program initiated by Professor Graham Meadows in Victoria. The CLIPP model has three components: regular psychiatric consultation, liaison and education for general practitioners to assist them to recognise and treat mental health problems; shared care of specific persons living with serious mental illness transferred from specialist mental health services; and mechanisms to encourage active follow-up.[16]

Primary Health Networks

The Federal Government has recently made some significant investments in mental health initiatives in primary care settings, such as the SANE Australia pilot for people with complex mental health needs (2021–2023). The RANZCP Queensland Branch would like to see the Queensland Government invest in initiatives which bridge the gap between federal and state funding, map pathways between services and explore models of care that work effectively to support people living with mental illness, their families and carers.

The RANZCP Queensland Branch supports the recommendation to stablish regional mental health planning and coordination organisations, to plan, monitor and evaluate regional mental health plans and services. These would involve public mental health services, primary health networks (PHNs), non-governmental organisations (NGOs) and consumers and carers. Referred to as 'regional commissioning bodies' (at page 33) of the Productivity Commission *'Inquiry Report on Mental Health'* (June 2020).[17]

A consultation and liaison model between mental health professionals, mental health nurses and general practitioners, and coordinated by the PHNs rather than state mental health services, is an effective model to explore. This model would allow a mental health professional (like a psychiatrist, or psychologist or mental health nurse) to provide less intensive intervention to a much wider cohort of people with low/moderate intensity mental disorders, in a cost-effective manner. The main service providers for mental health needs of these individuals would remain their general practitioners. If the treatment needs of the individual consumer however are deemed to be too complex for what can be managed in the primary care setting, then the referral can be made to the public mental health sector, facilitated by psychiatrists.

The RANZCP Queensland Branch recommends that the Queensland Government explore a consultation and liaison model (there are various different models) between psychiatrists and other mental health professionals like psychologists, mental health nurses and general practitioners, which would be coordinated by the Primary Health Networks (PHNs).

This will mean that persons living with mental illness who require a less intense level of care receive low intensity psychiatric, and other mental health support by psychologists and mental health nurses, through the proposed consultation and liaison model.

Persons living with mental illness who require higher level treatment and care would be triaged by psychiatrists, thus reducing the silo between the expectations of care across the two sectors.

Community mental health services across Queensland

The RANZCP Queensland Branch advocates that the mental health system in Queensland would benefit from greater funding and investment into community care, support and treatment. Likewise, AMAQ has argued in their submission to this parliamentary inquiry that there has been insufficient investment in community mental healthcare in Queensland, which is a concern given that community mental health services are increasingly required to support more complex and high-risk persons.

> *We need to shift the balance of mental health services from hospital-centered with community outreach when convenient for staff, to community-centered and mobile, with in-reach to hospital only when necessary.*[18]

Queensland Health community mental health services consist of acute care teams, continuing care teams, mobile intensive rehabilitation teams (MIRT), early psychosis (EP) teams, homeless health outreach teams (HHOT), child and youth community health teams and older persons teams. The chief issue with all these teams is that, apart from HHOT and MIRT, most teams operate Monday to Friday, during standard business hours, and have very significant caseloads, between 30 and 40 persons per clinician requiring care, treatment and support.

According to the *National Mental Health Service Planning Framework*[19], these community mental health teams require a 50 per cent increase in staffing levels, or around 3,000 additional staff, to enable staff to work seven days a week, and take into account penalty rates. An important component of this workforce investment is developing, piloting and evaluating innovative models of care, and the RANZCP Queensland Branch advocates that this should be included as a funded component of this national planning framework for community mental health services.

Only then will these teams be able to manage vulnerable people in the community living with mental illness, with manageable caseloads of under 20 cases per clinician. In the alternative, people living with mental illness in the community have little elsewhere to go, between their general practitioner and presenting to a hospital ED, for treatment and support. As outlined in an earlier section of this submission, the primary care setting and hospital EDs are already under significant strain and pressure, especially due to the evolving COVID-19 pandemic.

The RANZCP Queensland Branch is calling for an additional 3,000 community mental health staff, this takes into account penalty rates. As part of this significant workforce investment, the RANZCP Queensland Branch also advocates that the Queensland Government should develop, pilot and evaluate innovative models of care in the community mental health setting. We advocate that this should be included as a funded component of the *National Mental Health Service Planning Framework* for community mental health services.

Non-Governmental Organisations

Many Queenslanders experience preventable mental distress, disruptions in education and employment, relationship breakdowns and loss of life satisfaction and opportunities, because they are not able to access the mental healthcare that they need, when they need it and from the right mental healthcare provider.

Non-governmental mental health services and supports in Queensland are chronically underfunded. The non-governmental organisations (NGOs) provide a wide range of services. This includes supporting people living with mental illness in the community to effectively manage their illness or condition, by ensuring they

have access to safe accommodation, emotional support, that any physical health issues are treated and that medication intake is monitored.

An excellent example of an NGO mental health service is the H2H 'Hospital to Home' program, developed between Richmond Fellowship Queensland and Metro North Mental Health, which provides support post-discharge from hospital for frequently admitted consumers of inpatient mental health services. Once discharged, regular consumers of inpatient mental health services receive three visits per week for nine months. Then one visit per week, for a further three months. This program has dramatically reduced hospital readmission in this group of persons. Unfortunately, these services are only available for approximately 15 per cent of all persons discharged from general adult mental health wards[20], but the RANZCP Queensland Branch advocates that such a service should be available for up to 65 per cent of discharged persons.

The RANZCP Queensland Branch recommends that the non-governmental organisations (NGO) sector needs recurrent funding to be trebled (a funding enhancement of 300 per cent), to meet population demand for NGO mental health services across Queensland.

Acute shortages of beds across Queensland public hospital mental health units

Queensland psychiatric inpatient units continue to operate at over 100 per cent occupancy. Furthermore, in the last two decades, the availability of acute psychiatric beds in Australia has dramatically declined relative to other The Organisation for Economic Co-operation and Development (OECD) countries.

The RANZCP Queensland Branch advocates for more inpatient beds in public hospitals, to allow inpatient units to operate at the more conventional 85 per cent occupancy.[21] Where public mental health services are operating at capacity, this means that many people living with mental illness will miss out on the right care, at the hands of the right mental health professional and in the right setting.

Concerningly, Queensland now has the lowest number of acute psychiatric beds per capita of all the states and territories in Australia.[22] The profound shortfall in acute inpatient bed capacity drives a reactive and crisis-driven state mental health system, focusing on the availability of beds rather than the optimal treatment of people presenting to hospitals in acute crisis.

The length of stay in adult inpatient units across Queensland is generally shorter than the expected timeframe for the anticipated onset of treatment effectiveness. In the context of inadequate acute inpatient beds, the threshold for admission has become *immediacy of risk*. If a suicide attempt or enacted violence is the threshold for entry to inpatient care, the risk is that clinicians and Queensland public health services will respond too late.

Many people living with mental illness expected to benefit from care in an inpatient environment are excluded from entry, prematurely discharged, or deteriorate in the community while awaiting admission. These factors contribute to increased functional and social impairment associated with mental illness, and a greater burden of disease in the community. A significant disease burden may lead to disruptions in education and employment, relationship breakdowns and loss of life satisfaction and opportunities.

A greater number of beds across Queensland public hospital mental health units would also provide an opportunity for persons living with mental illness in Queensland to be cared for in inpatient units which could be, with more beds, separated by age, illness and gender (to prevent gender-based violence in psychiatric inpatient units).

As a useful guide to estimate how many beds are needed statewide, it may be sensible to extrapolate the Metro North Hospital and Health Service bed data. This health service comprises the Royal Brisbane and Women's Hospital, The Prince Charles Hospital, Caboolture Hospital, Redcliffe Hospital and Kilcoy Hospital, with 340 inpatient beds comprising of 186 acute adult beds, 10 sub-acute beds, 12 adolescent beds, 40 Secure Mental Health Rehabilitation beds (SMHRU), 60 Community Care Unit (CCU) beds, 16 long-stay psycho-geriatric beds (in nursing homes) and 16 statewide alcohol and drug detoxification beds.[23]

The RANZCP Queensland Branch proposes to extrapolate the Metro North Hospital and Health Service bed data, and estimate that statewide Queensland needs roughly an additional 500 new inpatient beds, across state public hospital mental health units. This includes acute beds, extended inpatient beds (sub-acute and non-acute beds), psycho-geriatric beds, long-stay psycho-geriatric beds, step-up, step-down beds and medium-secure beds (Secure Mental Health Rehabilitation Unit).

Also, a significant number of mental health wards across the state were built over 20 years ago and do not provide for contemporary mental health beds. The RANZCP Queensland Branch estimates that 250 of these existing beds need urgent refurbishment.

The RANZCP Queensland Branch acknowledges that health infrastructure funding for public hospitals is a mixture of Commonwealth and state funding, but that ultimately state governments are responsible for making most of the decisions about capital investment in public hospitals.

The RANZCP Queensland Branch advocates to the Queensland Government that an additional 500 new inpatient beds are needed across public hospital mental health units in Queensland, and recommends that the following are included:

- a 25-bed inpatient unit for complex and high-risk persons, and those from custody
- more medium-secure beds
- high-secure beds in North Queensland
- 30 to 40 mother-baby beds across the state
- an additional child and adolescent unit in Central and North Queensland
- more acute psycho-geriatric beds
- at least three (3) long-stay psycho-geriatric beds (as such beds only exist in nursing homes at present)
- additional specialist beds for persons with eating disorders
- more step-up, step-down beds
- gender segregated psychiatric inpatient beds.

The current inpatient bed capacity across Queensland public hospital mental health units fosters sub-optimal care and treatment outcomes for people living with mental illness, their families and carers.

To facilitate best practice, person-centred care, the RANZCP Queensland Branch advocates that Queensland needs an additional 500 new inpatient beds, across state public hospital mental health units. This includes acute beds, extended inpatient beds (sub-acute and non-acute beds), psycho-geriatric beds, long stay psycho-geriatric beds, step-up, step-down beds and medium-secure beds (Secure Mental Health Rehabilitation Unit).

The RANZCP Queensland Branch estimates that 250 beds, of the approximately existing 1,500 beds across the state, need urgent refurbishment.

Locked wards policy for public mental health inpatient units in Queensland

In 2013, the Queensland Government issued a policy directive to lock all acute adult public mental health inpatient wards. The RANZCP, among other stakeholders critiqued the decision of the Queensland Government at the time. The College advocated that vulnerable persons need care and consideration, and there is no cause to lock all vulnerable people receiving mental health treatment away for 24 hours a day. Some persons, say patients under orders from authorities, may need to be restricted and detained but there is no need to make this the standard of care for everyone.[24]

Most recently, *Gill et al*[25] argued in an article published in the *Australian & New Zealand Journal of Psychiatry* (2021) that locked wards are inconsistent with least restrictive recovery-oriented care, and that this policy directive goes against the principles of the 'United Nations Convention on the Rights of Persons with Disabilities', to which Australia is a signatory.

To embed a culture of person-centred care, the RANZCP Queensland Branch advocates that it is necessary for Queensland Health services to reassess unexamined assumptions underlying this existing policy directive, for example that locked wards prevent absconding. *Gill et al* reports that a review of the international literature found little evidence of reduced absconding from locked wards.

Further, *Gill et al* reported that disadvantages for inpatients of locked wards include lowered self-esteem and autonomy, and a sense of exclusion, confinement and stigma. Locked wards are also associated with lower satisfaction with services and higher rates of medication refusal.

On the contrary, *Gill et al* argued that there is significant international evidence that models of care like Safewards and having open door policies can improve the ward environment on inpatient units and may lead to less need for containment and restrictive practices.

Tensions and risks in the blanket use of locked door policies in acute mental health inpatient facilities require striking a delicate balance between respect for human rights and autonomy, clinical utility and public and patient protection. The RANZCP Queensland Branch acknowledges the nuanced complexity of this policy directive but argues that any potential benefits in preventing absconding through locking all mental health inpatient facilities is outweighed by the adverse effects locked wards have on those detained.

The RANZCP Queensland Branch recommends that the Queensland Government review the locked wards policy for public mental health inpatient units, in light of human rights principles and international evidence.

Perinatal mental health services in Queensland (mother-baby beds)

Mental health issues experienced during the perinatal period are a major public health concern in Queensland, as such issues can have serious, long-lasting and potentially intergenerational consequences.[26]

Mother-baby inpatient units form only one component (albeit an important component) of perinatal mental health services.

The RANZCP Queensland Branch recommends that it is best clinical practice that mother and baby remain together during treatment, and that other parents and/or caregivers are involved to provide support. We support admission to mother-and-baby separate psychiatric units, with appropriately trained staff as best practice. General adult psychiatric facilities are not an appropriate environment for infants.[27] The Queensland Mental Health Commission[28] noted that the lack of appropriate mental health beds to which a

mother can be admitted for treatment, without separation from her baby, presented an unacceptable risk for Queensland mothers, infants and families.

In March 2017, the Lavender Mother and Baby Unit, the first public acute mother-and-baby mental health unit was opened at the Gold Coast University Hospital, with four beds.[29] As expected, the low number of beds has proven unable to meet demand. Criteria to be admitted to the Lavender Unit include postpartum psychosis, relapse of schizophrenia or bipolar disorder in the postpartum, severe anxiety and/or depressive disorder, or complex mental health problems. Although the Lavender Unit is a statewide service, its location in the far south of the state makes it practically inaccessible to those not from the Gold Coast or Logan/southern Brisbane areas.

In addition to perinatal inpatient beds, specialist perinatal community mental health services are essential so that mothers can receive treatment and care as an outpatient and therefore hospitalisation may not be necessary. The RANZCP Queensland Branch calls for a funding enhancement of all perinatal mental health services in the community, to ensure that vulnerable mothers and their babies can access care seven days a week, and outside of ordinary working hours.

The AMAQ has equally called for more support and funding of perinatal mental health services in the community, as well as more beds, in their response to this parliamentary inquiry.

The RANZCP Queensland Branch advocates for an additional 30 to 40 mother-baby beds across the state, as well as targeted funding for perinatal mental health services in the community, to ensure that vulnerable mothers and babies (as well as other parents and/or caregivers) are provided with appropriate and timely access to mental healthcare and support.

Eating disorder treatment services in Queensland

At the start of the COVID-19 pandemic in 2020, *The Courier Mail* reported that Eating Disorders Queensland recorded a huge spike in eating disorders, an increase of 98 per cent between January and October 2020, compared with the same time period in 2019. *The Courier Mail* article correctly reported that many people with eating disorders also have a comorbid psychiatric condition.[30]

The RANZCP Queensland Branch advocates that Queensland needs more specialised beds for persons with eating disorders in state public hospital inpatient units. The Butterfly Foundation, an NGO, recently opened Australia's first ever residential treatment facility, the 'Wandi Nerida' on the Sunshine Coast, funded by the Commonwealth Government. This dedicated eating disorder recovery centre accepts people from all over Australia, but even so, there are only 13 beds in the newly opened facility.[31]

In public hospital inpatient units in Queensland, there are currently five specialist eating disorder beds at the Royal Brisbane and Women's Hospital. Many persons with eating disorders are initially admitted to hospital, because they are medically compromised and require re-feeding before their transfer to a general inpatient psychiatric ward.

Whilst in hospital, Consultation-Liaison psychiatrists see the most medically unwell persons presenting with eating disorders. The RANZCP Queensland Branch recommends that each hospital should identify a medical team to work with the Consultation-Liaison psychiatrist to assess and treat these patients. The identified team should be provided with education and training, consistent with the needs of individuals with eating disorders.

At present, there is variable expertise amongst mental health clinicians to manage persons with eating disorders. Most inpatient units lack specialist staff with eating disorders expertise (e.g. psychologists and dietitians), to be able to manage this cohort of patients safely and efficiently.

In Queensland, public mental health services are supported by the consultation-liaison service at the Queensland Eating Disorder Service (QuEDS), and three specialist QuEDS hubs for eating disorders at the Gold Coast (the Gold Coast Eating Disorder Program), and the Sunshine Coast (Eating Disorder Service Sunshine Coast), and also a similar hub at Cairns. The RANZCP Queensland Branch recommends that two or three more eating disorder specialist hubs are needed across the state.

The RANZCP Queensland Branch recommends that more dedicated specialist inpatient beds are needed in public hospital units across the state for persons with eating disorders, as well as specialist community mental health hubs. Furthermore eating disorder specialists, such as psychologists and dieticians, should be employed in all eating disorder public health units and across community mental health teams.

Highly complex and high-risk persons, and those from custody

Queensland's mental health services are tasked with managing increasing caseloads and complex cases, with higher-risk persons with mental conditions. The clinical profile of persons living with a mental health condition, in mental health services, has changed over the past 10 to 15 years. Increasingly Queensland's mental health services receive 'ice' intoxicated persons, violent persons, persons with a combination of disorders (such as mental disorders and substance use disorders) and high-acuity persons transferred from custody.

The RANZCP Queensland Branch supports the recommendation of the Productivity Commission that people with severe and persistent mental illness should receive care coordination services, where this is required to ensure their complex health and social needs are adequately met.

Furthermore, we would support an early intervention approach that would ensure people who are at high risk of coming into contact with the criminal justice system are identified, and provided appropriate support, such as mental healthcare and housing, to reduce their risk of offending.

Queensland has one High Security Inpatient Service, "The Park" at Wacol, for persons on forensic orders, or classified persons who have committed serious offences. However, this service can only take a proportion of high-risk, classified persons. The remainder of this patient cohort are transferred to a general adult mental health ward.

Some Fellows of the RANZCP Queensland Branch have reported that the pressure to treat and be accountable for complex, high-risk individuals, within general mental health wards has an impact on staff safety and morale, recruitment and retention. Furthermore, the therapeutic atmosphere of a ward is impacted when high-risk, complex persons share wards with the general public. Consumers of mental health services in public inpatient mental health units across the state and their families and carers regularly report marked distress at having to share wards with serving prisoners.

The RANZCP Queensland Branch advocates that high-risk persons requiring inpatient care, including those from custody, would benefit from specialist treatment in a purpose-built facility at "The Park", which should have a 25-bed inpatient unit for highly complex and high-risk persons. To be eligible for this specialist treatment, persons would be assessed as beyond the capacity of general adult authorised mental health services, who are not at the offending level for the High Security Inpatient Service, and who are not suitable for rehabilitation in a Secure Mental Health Rehabilitation Unit.

The RANZCP Queensland Branch advocates for a 25-bed inpatient unit for highly complex, high-risk persons at "The Park", at Wacol, to reduce the incidence of serving prisoners being admitted to general adult mental health inpatient units across Queensland's public hospitals.

Older persons mental health services

The *National Mental Health Service Planning Framework*[32] reports that Queensland has a very low number of psycho-geriatric beds, and community-based psycho-geriatric mental health staff.

Most of the current long-stay beds are in Commonwealth-funded nursing homes, that are unable to handle and manage long-stay persons who are complex and violent. This lack of state-funded, long stay psycho-geriatric beds means that many such persons occupy acute mental health beds in general adult mental health wards across Queensland public hospitals, often for prolonged periods of time.

The RANZCP Queensland Branch recommends the development of at least three (3) long stay, Queensland Health funded psycho-geriatric beds (previously covered under 'acute beds') and advocates for an increase in state funding to support community mental health staff with specific workforce expertise to care for psycho-geriatric mental health presentations in the community.

Mental health and wellbeing in people with intellectual and developmental disability

Lack of statewide mental health treatment and support services in Queensland

The RANZCP Queensland Branch advocates that the mental health needs of adults with an intellectual or developmental disability (including autism) are currently underserved in Queensland. People with an intellectual and developmental disability have two to three times higher rates of mental illness than the general population, and persons on the autism spectrum have five times higher rates of mental illness compared with the general population.[33] Also autistic people without intellectual disability have nine times higher rates of suicide than the general population.[34] This demonstrates the significant impact of intellectual disabilities and autism on mental health and wellbeing overall.

Despite the significant burden of disease experienced by people with intellectual and developmental disability, and specifically autism, Queensland has limited treatment services available for this vulnerable population cohort. Mainstream public mental health services lack skills and workforce capacity in this area and often fail to recognise or appropriately care for mental illness presentations in people with intellectual and developmental disability.

Extensive Australian and international research[35], as referenced in 'Statement of Professor Julian Trollor', to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, and lived experience testimony as reported in the '*Interim Report*'[36] of the Royal Commission reveal multiple barriers to accessing mental health services for people with intellectual and developmental disability. These include lack of training and confidence of public mental health staff, an insufficient number of hospital beds, and scarcity of community mental health services to identify people with intellectual and developmental disabilities and refer them to appropriate treatment services, which the Royal Commission concluded all led to persons with intellectual and developmental disabilities experiencing systemic neglect in health care.

The only notable intellectual and developmental disability service in Queensland is a 10-bed facility operated by the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander

Partnerships. This facility is located at "The Park" at Wacol and is permanently operating at capacity, rendering it largely inaccessible to most people with intellectual disability in the state.

While two consultation-liaison services are available in Queensland to meet the needs of persons living with intellectual disability (the Mater Intellectual Disability and Autism Service and the Specialist Mental Health and Intellectual Disability Service), these services cannot adequately address the current level of statewide need. They can only offer assessments and management advice, but do not offer dedicated inpatient beds. This is insufficient to support mental health services to work with this complex cohort effectively, meaning that extended hospital admissions continue, or alternatively persons with intellectual disability who require inpatient mental health treatment and support are often turned away as public health services cannot accommodate them.

It may be useful to demonstrate how people with intellectual and developmental disability utilise state public mental health services, based on New South Wales (NSW) data published last year in *The Medical Journal of Australia*. The RANZCP Queensland Branch would expect that, to extrapolate this data would return similar findings for the state of Queensland. The data from NSW demonstrates that in terms of public mental health service use:

- although persons with intellectual and developmental disability represent just 1.1 per cent of the NSW population, they represent 6.3 per cent of the mental health service user population
- persons with intellectual and developmental disability utilise 8.1 per cent of treatment days in community mental health service settings in NSW, and account for over 8 per cent of all community mental health service costs per year
- persons with intellectual and developmental disability require 14.4 per cent of all bed days in inpatient mental health units, and 14 per cent of all inpatient mental health costs per year (despite representing just 1.1 per cent of the population).[37]

A 2018 study, funded by the National Health and Medical Research Council (Australia), and published in the *British Medical Journal*[38] showed that people with intellectual disability represented 3 per cent of all first presentations for mental health conditions to hospital inpatient units in NSW, and that following discharge:

- having an intellectual disability was the single biggest predictor of presentation to ED in the short, medium and long term
- the presence of an intellectual disability increased the risk of return to the ED threefold, after accounting for all other confounding factors
- having an intellectual disability was second only to drug and alcohol use disorder in predicting the likelihood of re-admission to inpatient mental health units in the short, medium and long term.

Two reports, published in 2006, found evidence of inappropriate models of care for people with intellectual disability in Queensland health facilities:

- *Promoting Balance in the Forensic Mental Health System: Review of the Queensland Mental Health Act 2000* – a Report by Brendan Butler AM SC (Butler Report); tabled in Parliament 11 October 2007
- *Challenging Behaviour and Disability: A Targeted Response* – a Report by William Carter QC (Carter Report), tabled in Parliament 22 May 2007.[39]

Both the Butler and Carter reports noted that people with intellectual and developmental disability, but no mental illness, continued to reside in mental health hospitals in Queensland. This included those persons subject to a forensic order made by the Mental Health Court and those who had neither a mental illness nor were subject to either a forensic order, or an involuntary treatment order.

People with intellectual or developmental disability and challenging behaviours are regularly admitted to inpatient mental health units across Queensland, as there are no other suitable services that can provide adequate care and support for their condition and associated behavioural disturbances. The Butler and

Carter reports found that persons with an intellectual or developmental disability may experience extended stays in hospital and are often mislabeled as having a mental illness. It is the view of the RANZCP Queensland Branch that this is an abuse of the human rights of persons living with an intellectual or developmental disability.

Care for persons with an intellectual or developmental disability on Forensic Order (Disability)

The forensic disability service system is also a source of great concern to the RANZCP Queensland Branch, echoed in reports by the Queensland Ombudsman[40] and Queensland Advocacy Incorporated.[41]

There was an extensive Queensland Government review[42], including a commissioned external review that was tabled in Parliament in 2018, and yet the problems in the state forensic disability system continue.

One of the problems with the forensic disability state system is that the current Queensland *Mental Health Act 2016* places persons with an intellectual or developmental disability who commit crimes on forensic disability orders. These orders tend to be long-term and few people come off them.

A Forensic Order (Disability) requires that the individual placed on the Order is managed by authorised public mental health services, often by staff who do not have the experience to work with people with intellectual and developmental disability. When such persons break their leave provisions, usually through challenging behaviour, they are regularly readmitted to mental health inpatient units of public hospitals across Queensland. There is limited capacity for state mental health services to offer the mental healthcare that this vulnerable cohort needs, such as behavioural interventions or therapies. Thus, the public mental health services are inappropriately forced to act as parole services.

There are extensive recommendations around the roles of public mental health services[43], and the capacity building initiatives that are required to enhance workforce skills shortages and competencies.[44] This includes mandated training for all frontline mental health staff and ED staff, development of designated clinical pathways through all parts of mental health services for people with intellectual and developmental disability and referral pathways to statewide specialist services that operate in a hub and spoke model. It is also necessary to explore emerging methods to identify people with intellectual and developmental disabilities, ensure they are referred to appropriate health services, and to measure and routinely report on health and equity outcomes for this complex and vulnerable cohort.

The RANZCP Queensland Branch recommends the development of a new statewide specialist service to support people with intellectual and developmental disability, and also people on forensic orders (disability). Staff at the proposed new service would be upskilled to ensure that they have the right competencies and expertise to provide best-practice mental health interventions and wellbeing support to people living with intellectual and developmental disability.

We envisage that this service would be operated by the Queensland Government Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships, and staffed by a multidisciplinary team of trained medical specialists, including psychologists, nursing, allied health staff, psychiatrists and disability support staff, and operate in parallel yet separate to community mental health services. This new public facility would provide intensive support to those with complex intellectual and developmental disability and mental illness who require hospitalisation, and would be well integrated with community teams that provide mental health and wellbeing support. As well, this new statewide facility would provide consultation–liaison services for the non-government sector.

The RANZCP Queensland Branch also recommends that the *Mental Health Act 2016*, which currently enables health services to act as parole services for individuals on existing forensic

disability orders, should be reviewed. There has also never been an impact evaluation of the *Mental Health Act 2016* and the RANZCP Queensland Branch recommends a thorough impact-evaluation of the Act, to assess its bearing on forensic mental health services in Queensland, and mental health services generally.

Alcohol and other drug treatment services in Queensland

Increasingly Queensland's mental health services receive 'ice' affected persons, intoxicated persons and persons with a combination of disorders (such as mental disorders and substance use disorders). AMAQ likewise acknowledged, in their submission to this parliamentary inquiry, that many people with mental illness and comorbid physical health problems or substance use disorders do not receive integrated care, leading to poor outcomes, including premature death.

Psychiatric and substance use disorder comorbidity is an especially significant problem in far north Queensland, with a 2016 study reporting that the prevalence rate of comorbidity was 52 per cent in this region of the state.[45]

Whilst all mental health and alcohol and drug services across the state of Queensland are now integrated, there has been very limited Queensland Government expenditure dedicated to state funded alcohol and other drug services, and most of the new funding to date has been directed to NGO services.

As quoted earlier in the submission, in the Public Briefing of the Mental Health Select Committee (part 1 of 2), held on 20 January 2022, Associate Professor John Allan, the Executive Director of the Mental Health Alcohol and other Drugs Branch at Queensland Health, provided a verbal submission and said [quoted]:

> *In 2021 only nine per cent, or approximately $139 million, of state funded mental health alcohol and drug expenditure, was spent on alcohol and drug services, delivered by Hospital and Health Services as an NGO service provider.*[46,47]

There is a solid case for more state funded public sector alcohol and drug services in Queensland. The RANZCP Queensland Branch advocates that it is important that these services be specific to alcohol and other drugs, and that funding enhancements for alcohol and drug services specifically do not become conflated with state government funding dedicated to mental health services more broadly.

The RANZCP Queensland Branch notes that the Queensland Government has also committed to new NGO-operated residential alcohol and drug rehabilitation and treatment services in Rockhampton, Cairns, Ipswich and Bundaberg.[48] This funding commitment is commendable, especially in regions of the state like north Queensland where psychiatric and substance use disorder comorbidity is high with significant health and social ramifications.

The North Metro Hospital and Health Service is a state funded service and currently operates 24/7 Alcohol and Drug Support (Adis), a Queensland statewide service providing a free and anonymous 24 hour, 7 days a week telephone counselling, information and referral service for people in Queensland with alcohol or other substance use concerns, their loved ones and health professionals.[49] We recommend that alcohol and other drug services in Queensland require significant additional growth funding, especially state funded services.

The RANZCP Queensland Branch would also recommend the development and implantation of the consultation–liaison psychiatry services model discussed in the primary care setting in an earlier part of this submission, but of course inclusive of addiction psychiatry expertise. It is expected that such a model may address the issue of unintentional deaths and dependence for some people on prescribed medications and

with alcohol and other drugs substance use disorder, and the associated health and social costs. This would require addiction services to be linked with chronic pain services and clinics across the state.

Furthermore, a highly skilled, competent and sustainable alcohol and other substance use workforce is imperative to effectively prevent and respond to problematic drug and alcohol use and related harms within Queensland. The alcohol and other drugs sector has experienced substantial change in recent decades, and the RANZCP Queensland Branch strongly advocates that it is vital that the workforce has the capacity and skills to be responsive to meet the changing needs of Queenslanders living with addiction.

The RANZCP Queensland Branch recommends that alcohol and other drug services in Queensland require significant additional growth funding, especially Queensland Health state funded services.

The RANZCP Queensland Branch would also recommend the development and statewide rollout of consultation–liaison psychiatry services models, to facilitate coordinated care of persons with alcohol and drug addiction problems, by psychiatrists with addiction psychiatry expertise.

The RANZCP Queensland Branch also calls on the Queensland Government to develop a workforce strategy (and a central alcohol and other drugs workforce unit) to grow the workforce, in partnership with universities and tertiary institutions.

Funding of child and youth services in Queensland (including Early Psychosis teams)

In terms of child and youth mental health services, there are community-based child and youth mental health teams (CYMHS), a child inpatient psychiatric unit at the Children's Hospital, six adolescent inpatient units, three step-up / step-down units and a long-stay residential unit at the Prince Charles Hospital.

At present, there is inadequate funding for these child and adolescent-specific services in Queensland that would provide an opportunity for early intervention, to prevent longer-term functional issues and the societal costs of mental illness such as prolonged unemployment or reliance on social welfare services.

For decades now, investment in youth mental health services has been inadequate to meet demand. The argument that this unmet need is being adequately supported by Commonwealth funding of youth mental health *headspace* centres around the country is no longer tenable. *headspace* has proven to be moderately effective at meeting the needs of young people with mild and moderate mental illness, but has failed to meet the needs of young people with complex conditions and deliver improvements in social and vocational outcomes.[50] Young people in need and at risk of developing severe mental illness are being turned away from public mental health services due to a lack of fit with the available service models and inadequate state government funding needed to expand these and other models of care.

Some Fellows of the RANZCP Queensland Branch have reported that since the mental health field has significantly expanded, some staff have been lost to other parts of the mental health system, and that many CYMHS clinicians are relatively inexperienced, though compassionate and motivated to help young people in distress. Services which prioritise a balanced caseload, access to ongoing professional development and reflective supervision report lower levels of staff stress for staff working in this field.

The anecdote below *(de-identified to protect privacy)* demonstrates that many young people at risk of psychosis miss out on the early intervention and support that they need, falling through the cracks of a state mental health system under significant pressure, with early psychosis services at capacity in Queensland.

Anecdote – gap in provision of early intervention services for early psychosis in Queensland

There are limited Early Psychosis services available in Queensland. These services often get referrals for young people who likely have an emerging psychotic illness. Due to capacity issues, the current service model does not include people at high risk or even ultra-high risk of psychosis. This means that many young people and their families and carers are turned away and redirected to other services which are unlikely to be able to provide the intensity and specialist support (e.g. headspace, GPs) that would be relevant to address modifiable risk factors, reduce the risk of transition to psychosis, and to intervene assertively if and when psychosis emerges. This is a saddening and embarrassing situation. Australia is the country known throughout the world as the leader in early intervention services. Yet in Queensland, this opportunity is missed with enormous personal, family and societal impacts.

Chronic under funding of youth public mental health services, combined with an emphasis on containing risk through community 'case management' has contributed to the deskilling of Queensland's public mental health workforce. Evidence based psychotherapies and other psychosocial interventions expected as part of a minimum standard of care according to the RANZCP Clinical Practice Guidelines are not routinely available.

This creates a two-tiered system where a minority of people with children, adolescents or young people who have substantial financial resources can access the mental healthcare and treatment that they need through the private sector, while the majority of Queenslanders cannot. Children, adolescents and young people presenting to Queensland mental health services in the absence of imminent risk are often turned away, or redirected elsewhere, say with the advice to obtain a Mental Health Care Plan through their general practitioner to access bulk-billing psychological support through the private sector. The reality is that many of these young people will struggle to see their general practitioner promptly, to find a private provider with availability in a timeframe relevant to their mental health crisis presentation, and to identify a provider who is willing to bulk bill. This is part of the 'missing middle' problem emphasised in the Productivity Commission report and illustrated by the case study that follows *(de-identified to protect privacy)*.

Case study – young person in mental health distress navigating the health system

A young man presents to the local ED seeking help. He had woken up this morning with the thought that he could end his life – this frightened him. He had never had this thought before, and while he did not think he would ever do anything, it made him realise he needed help.

His problems started a couple of months ago after a relationship breakup. He has been feeling sad and gradually withdrawing from his friends ever since. He cannot stop thinking that he is no good and gets preoccupied with these thoughts. His work performance has dropped off, and he is increasingly worried about losing his job. The acute care clinician assesses him to be experiencing a major depressive episode of moderate severity.

There are no beds available at the public hospital that night, and several people are already awaiting admission. He is discharged home with his flatmate, who agrees to keep an eye on him over the next couple of days. He leaves the ED with a script for antidepressant medication and is advised to see his GP in the coming days to arrange a mental health plan to facilitate engagement with a psychologist through the Better Access Initiative. The Acute Care Team calls him a couple of days after his presentation to ED to check he is safe and encourage him to contact his GP. He

commits to doing this and his case is effectively 'closed' to the local mental health service. He is told to call the '1300' number if he has any further problems.

He struggles to get an appointment with his GP, and this doesn't happen for a couple of weeks. When he finally sees his GP, he is told he will need to book a longer appointment to complete the mental health plan. Several weeks later, he has his mental health plan and calls several practices to find someone with a booking available, the earliest he can find is three months away but that clinic does not bulk-bill. Realising he does not have the money to pay, he gives up on seeking help for the time being. The thoughts about ending his life keep coming and going, but he is reluctant to seek help – not much came from it the last time.

The RANZCP Queensland Branch calls on the Queensland Government to commit to funding and support of public mental health services to facilitate delivery of evidence-based psychosocial interventions specifically tailored to children, adolescents and young people living with mental illness. We further support expansion of CYMHS and Early Psychosis services, and additional adolescent beds in Central and North Queensland.

Unmet needs of people with history of trauma

Queensland public mental health services are currently oriented towards providing care to people with psychotic disorders and severe mood disorders, where significant risks to self or others are present. There are clear gaps between what is required to support Queenslanders and what is being provided. For example, there is an absence of focused funding commitments to support people experiencing significant disease burden from trauma or say personality disorders highly correlated with traumatic experiences, within state funded public mental health services.

Research has shown that up to 80 per cent of people with borderline personality disorder make at least one suicide attempt in their lifetime, and are more likely to die by suicide, than individuals with any other psychiatric disorder.[51] Studies show that borderline personality disorder has the strongest link to childhood trauma, and that people with this disorder are 13 times more likely to report childhood trauma than people without any mental health problems, according to University of Manchester research.[52]

Anecdote – borderline personality disorder and limited mental health services and supports

When I started training to be a psychiatrist in Queensland over a decade ago, I can remember hearing consumers being told, 'we don't treat borderlines in this hospital' as they were discharged within a day or two of a serious suicide attempt. It is reassuring that we do not seem to convey that same message now. However, sadly, there is little we can offer. Despite the overwhelming evidence for several psychotherapeutic interventions (e.g. Dialectical Behaviour Therapy (DBT), Mentalization Based Therapy, and the Conversational Model), none of these are reliably available to people within the Queensland public mental health system.

While several health services have tried to establish DBT programs, these lack dedicated funding. There is minimal capacity to meet the population need. Waitlists for entry mean that people cannot access care for years. Case managers from continuing care services generally lack relevant skills, and the demands associated with recurrent crisis support can severely limit their ability to provide meaningful support to consumers of mental health services and improve their functioning and independence.

As the above anecdote demonstrates *(de-identified to protect privacy)*, many Queenslanders cannot access mental healthcare services in the community, often this is because they do not meet the criteria for case management, and even if they do the wait times to access community mental health services are prohibitive. This is unacceptable given the risks associated with conditions like borderline personality disorder to cite one example, the demands on acute care and emergency services, and the availability of multiple therapies with a substantial evidence-base (such as DBT for borderline personality disorder) to reduce the risks and service demands associated with these conditions.

The RANZCP Queensland Branch recommends that the Queensland Government should enhance funding support for hospital-based and community services that provide care for persons with a history of trauma, complex trauma and personality disorders.

Deafness, hearing loss and mental health services

The prevalence of hearing loss was estimated to be 3.6 million people in Australia in 2017 and is expected to more than double to 7.8 million in 2060. This indicates that approximately one in every five people by 2060 will have some form of hearing loss, largely due to the ageing population in Australia.[53]

At a minimum, deaf people experience the prevalence of mental illness equal to that of the hearing population.[54]

Despite this, people who are deaf or hard of hearing experience restricted or delayed access to health information and health services. The RANZCP Queensland Branch advocates that there is a need for health professionals to be more aware of deaf culture and the communication needs of deaf or hard of hearing consumers.

The RANZCP Queensland Branch advocates that to meet this need, investment of funding for the Deafness and Mental Health Statewide Consultation Liaison Service (DMHSCLS) is required to build capacity in Queensland's public mental health workforce.

Addressing housing availability as a barrier to improving the mental health and functioning of people living with severe mental illness

The unavailability of affordable accommodation presents an ongoing barrier in the health journey of many people living with severe mental illness in Queensland.

People often wait extended periods of time to access community housing services and spend many years on public housing waitlists. Furthermore, the National Disability Insurance Scheme (NDIS) accommodation funding via the supported independent living (SIL) and special disability accommodation (SDA) programs are only relevant to a small number of people living with severe mental illness who have unmet accommodation needs. For these reasons, people with severe mental illness may find themselves experiencing protracted inpatient or residential care while awaiting accommodation availability and living in sub-optimal Level 1-3 supported accommodation services.

Further to that, some cohorts of people living with a disability in Queensland face specific barriers to accessing NDIS services generally, including supported accommodation services. These cohorts include Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) backgrounds, Queenslanders living in rural and remote areas of the state, and people living with complex and/or psychosocial disabilities.

Anecdote – availability of safe and affordable housing for people living with severe mental illness

The availability of safe, affordable and permanent housing for people living with severe mental illness is critical. Unfortunately, the accommodation crisis has been a constant and worsening factor throughout the 15 years I have worked in mental health.

For the long-stay inpatient and residential rehabilitation services, a significant proportion of the consumers at any time will have completed their planned care and be stuck awaiting discharge accommodation. This impedes their ability to move on with their lives, imposes care in unnecessarily restrictive environments, and incurs substantial costs.

I have met many people desperate to escape the cycle of being stuck in suboptimal supported accommodation services. In these settings, exposure to violence, substance use, and lack of opportunity to undertake and develop the skills they need to live independently in the community can trigger relapse and recurrent crisis presentations.

Better access to accommodation for people living with severe mental illness would enhance their well-being and be accompanied by reductions in mental health services and social services use.

Some excellent supported accommodation services are available in Queensland. However, as the anecdote *(de-identified to protect privacy)* above demonstrates many are ill-suited to support people living with severe mental illness. Lack of safe and permanent housing options contributes to recurrent crises and presents a key barrier to recovery from episodes of severe mental ill health.

The RANZCP Queensland Branch calls for affordable accommodation made available to people with severe mental illness at risk of homelessness following Housing First principles, to facilitate improved mental health outcomes for people living with severe mental illness and people living with a disability that struggle to access supported accommodation services.[55]

The homeless population is made up of a significant number of individuals with serious mental health and addiction disorders[56] and the RANZCP Queensland Branch advocates that there is a need to further enhance the joint mental health and addiction teams across the state, the homeless health outreach teams (HHOT).

Workforce issues

There is a national shortage of all mental health professionals across the country. The RANZCP Queensland Branch is calling for a guaranteed funding pipeline over the next five to seven years, to enable Queensland Health to work with tertiary institutions to grow the mental health workforce. We may also require interstate and overseas recruitment drives. The number of professions that make up the mental health workforce is expanding, to include mental health nurses, peer workers, pharmacists, dietitians, exercise physiologists and various allied health workers. In particular, the number of peer support workers needs to be expanded and supported.

At present, Queensland has only 60 per cent of the mental health workforce that is needed in the community, as per the *National Mental Health Service Planning Framework*[57] and Queensland public mental health services are struggling to recruit, retain and develop the mental health workforce.

Investment in mental health workforce development must be increased, particularly for regional and rural areas of the state to address psychiatric workforce shortages in these areas.

The RANZCP Queensland Branch recognises some commendable recent initiatives, for example the Specialist Training Program (STP), an Australian Government initiative that provides funding to health organisations to support specialist medical training across regional, rural and remote areas of Australia, and in settings beyond traditional public teaching hospitals such as aged care, community health and Aboriginal Medical Services.

Initiatives like these are very welcome in rural and regional areas of Queensland, as there is a higher prevalence of mental health and chronic illness in these areas but access to resources is more challenging, with health outcomes for the same illnesses often worse.[58] Around 65 per cent of Aboriginal and Torres Strait Islander peoples live outside major cities. As a result, they are disproportionately affected by social inequality and poorer health outcomes.[59]

Given the well-documented requirement for enhanced psychiatry services and workforce shortages (exacerbated by the COVID-19 travel ban on international medical graduates) during this unprecedented pandemic, the locum psychiatry workforce is now more essential than ever.

The RANZCP Queensland Branch wrote to the Queensland Chief Health Officer, Dr Jeannette Young, in late September last year. We urged the Queensland Government to provide essential worker exemptions to interstate psychiatrists working as fly-in fly-out (FIFO) locums in underserviced areas of the state, where some of our most vulnerable Queenslanders live, including a significant Indigenous population. The RANZCP Queensland Branch also wrote to Professor Keith McNeil, Acting Deputy Director-General and Chief Medical Officer of Queensland Health, on this same issue.

Most recently, the RANZCP Queensland Branch welcomed the opportunity to respond to the policy proposal being progressed currently by Queensland Health to amend the *Mental Health Regulation 2017.* The RANZCP Queensland Branch is satisfied that the overseas specialist training is substantially comparable to that provided in Australia, and endorses the proposal to recognise registrants under the *Health Practitioner Regulation National Law (Queensland) 2018* who hold general registration, and who have specialist training in psychiatry from another country which has been recognised as substantially comparable by the College, as psychiatrists for the purpose of the *Mental Health Act 2016* (the Act). This will enable International Medical Graduates (IMGs) who qualify for general registrant status to practice as a psychiatrist under the Act.

The RANZCP Queensland Branch has recommended in the section on alcohol and other drugs, that we need a highly skilled, competent and sustainable alcohol and other substance use workforce to effectively prevent and respond to problematic drug and alcohol use and related harms within Queensland. Furthermore, we advocate that the Queensland Government needs to establish a central alcohol and other drugs workforce unit. We call on the Queensland Government to develop a five-to-seven year workforce plan, where the funding increases each year are known, to enable Queensland to negotiate with specialist medical colleges, universities and tertiary institutions and ensure a dynamic and responsive workforce is available to meet the changing needs of Queenslanders.

AMAQ, in their submission to this parliamentary inquiry, recommended greater investment in the workforce and the RANZCP Queensland Branch echoes the AMAQ recommendation [re-phrased]:

> *Access to psychiatric care is particularly constrained, with high costs and long wait times in some areas. The profound difficulty of children and adolescents, people in aged care and people in regional areas in accessing psychiatrists and psychologists, needs to be addressed. When these shortages were raised by RANZCP with AMA Queensland in 2021, we called on the Palaszczuk*

Government to commit to allocate some additional 1,500 doctors60 they had promised in their current term of government to psychiatry, and we repeat that call now.

The RANZCP Queensland Branch calls for urgent investment in the mental health workforce, particularly regional and rural areas of the state to address psychiatric workforce shortages in these areas, where some of the most vulnerable Queenslanders reside, including a significant Aboriginal and Torres Strait Islander population. The RANZCP Queensland Government calls on the Palaszczuk Labor Government to uphold its promise to grow the doctor workforce by 1,500 doctors.

Peer workers

Peer workers (sometimes referred to as 'lived experience workers'), are an essential part of the workforce within the Queensland public mental health and community system. A key objective of the Queensland Government *Lived Experience Engagement and Participation Strategy (LEEPS)*[61] is to plan for the development of the lived experience workforce across mental health and alcohol and drug services in Queensland.

When peer workers are integrated into service delivery there is a reported reduction in hospital admission rates, improved social inclusion, reduction in stigma and an increased sense of hope for individuals, carers and their families.[62] Peer workers use the experience of their recovery journey to support people with mental health issues and comorbid alcohol and drug issues, through peer support, positive role modelling, education, facilitating self-advocacy and providing information and opportunities to encourage participation in the public mental health system.

A number of workers, working in the NGO or community mental health setting, have lived experience of mental illness and this role is highly valued by mental health consumers. A lived experience worker *(de-identified to protect privacy)* has provided the following personal story *(published with permission)*:

Lived experience worker personal story

Twenty-eight years ago, I was diagnosed with mental illness and was referred to mental health services. Feeling alone and different from other people my age, I joined two support groups for people with similar experiences. I was awed and inspired by how strong, kind and generous the people I met were. That was my introduction to peer support and the beginning of my journey into systemic advocacy and lived experience work.

I have been working in public mental health as a consumer consultant - providing a consumer perspective for service improvement and development, informed by my lived experience of mental ill-health, service-use and periods of healing – for 8 years now. I have sat on many committees, as a consumer consultant and as a consumer representative, and have been invited on to several research projects. The feedback I get from clinical staff members and students is that they want to hear from consumers and to learn how to engage consumers more effectively.

The RANZCP Queensland Branch has received feedback from community members that at present, the development of the lived experience workforce is hindered by a lack of lived experience leadership roles (lived experience directors, team leaders and educators) to support the growth of this important part of the mental health workforce. Moreover, peer workers have no career progression pathways.

Peer workers can work as educators in universities and within mental health services and provide guidance and advice on personal recovery and the lived experience workforce. Peer workers can also oversee service delivery and manage healthcare teams either alone, or in partnership with clinicians.

Lived experience workers report that they are often viewed as "complementary". The current focus is on embedding a peer worker or two into existing clinical teams and service models. The RANZCP Queensland Branch has received feedback from community members that instead of adding on peer workers into existing service models, the very same mental healthcare service models need to be re-imagined in consultation with peer workers. Lived experience workers should be consulted to provide feedback and advice on workforce planning frameworks.

The RANZCP Queensland Branch supports that employment of people with lived experience across Queensland hospitals and health services would enhance consumer engagement with mental health, alcohol and other drugs services, provide education and support for clinicians, and facilitate peer worker input into existing workforce planning frameworks and service models.

Telehealth

From 1 January 2022, patient access to specialist telehealth services (including those for psychiatry) will be supported by permanent Medicare Benefits Schedule (MBS) arrangements.

Whilst the Federal Government's initiative is a positive development and a landmark achievement to create permanent arrangements for telehealth, the RANZCP has raised particular concerns to the Honourable Greg Hunt, Minister for Health and Aged Care, about MBS telephone items for consultations over 45 minutes, and MBS Item 288 (rural loading) and its removal without a sufficient alternative.

In particular, MBS telehealth item 288 provided a loading for the complexity of telehealth consultations to persons living with mental illness, in rural and regional areas of the state. This rural loading applied to not only psychiatric consultations, but other specialist consultations. It provided access to specialised medical services for large numbers of Queenslanders residing in rural and regional areas of the state.

This specific item number was removed as of 1 January 2022, with two weeks' notice. No telehealth alternative has been put in place. The RANZCP Queensland Branch members have advised the College that, without the loading, most psychiatrists who have been using item 288 will no longer be able to provide bulk-billed services to rural and regional populations, including to a significant Aboriginal and Torres Strait Islander population that resides in rural and regional areas of Queensland.

The implications for Queensland's mental health services and other speciality services are obvious. In systems under increasing strain, having additional pressures due to withdrawn Medicare services will only shift stress and pressure on to other parts of the state health system.

RANZCP has been working closely with the Federal Government to reach a solution and welcomed the recent decision to reinstate specialist telehealth temporary MBS items for longer telephone consultations and private inpatient consultations. However, MBS item 288 has not been reinstated.

Given the pending impacts on states like Queensland, the RANZCP Queensland Branch of the College urges the Queensland Government to advocate to the Federal Minister for the reinstatement of MBS item 288 or a viable alternative, to enable psychiatrists to provide bulk-billed telehealth consultations to rural and regional Queenslanders.

Mental health system monitoring

The RANZCP Queensland Branch has called on the Queensland Government to develop a five-to-seven-year mental health plan, and to make a bipartisan commitment to funding the improvements needed to provide Queenslanders with quality mental healthcare. This calls for a tight governance and accountability funding framework.

At page 2 of the AMAQ submission to this parliamentary inquiry, the AMAQ has likewise acknowledged that a state governance system is lacking, and that there is a lack of accountability and insufficient monitoring of state health funding resource allocation and utilisation.

The RANZCP Queensland Branch strongly recommends that the role of the Queensland Mental Health Commission should be expanded to enable the Commission to oversee the allocation of state funding for mental health services. It is essential to strengthen oversight mechanisms so that Queensland Government funding provided for state mental health services is protected, and allocated and resourced appropriately.

A tight governance and accountability funding framework is critical, to facilitate Queensland's recovery out of this evolving COVID-19 pandemic, by ensuring that state government funding is appropriately allocated to public health services, community services, PHNs and NGOs. It is likewise important to ensure that funding is committed to appropriate resourcing of an array of related services like drug and alcohol services, statewide consultation liaison services, housing for persons living with a mental illness and funding to support Queensland's mental health workforce.

Addressing the mental health needs of vulnerable groups

Aboriginal and Torres Strait Islander peoples

The Queensland mental health system has largely been developed on a medical/biological understanding of mental illness. This framework of understanding is at odds with the Indigenous understanding of social and emotional wellbeing. For Aboriginal and Torres Strait Islander peoples, many mainstream mental health services may be culturally inappropriate, or culturally unsafe.

Improving Aboriginal and Torres Strait Islander mental health and suicide prevention is a key priority area within the *Fifth National Mental Health and Suicide Prevention Plan*.[63] The Fifth Plan highlights the importance of a balance of clinical and culturally informed mental healthcare, and of social and emotional wellbeing services being integrated into culturally informed models of care.

Aboriginal and Torres Strait Islander people often have complex mental healthcare needs. Symptoms of a mental health condition might be one part of the problem. Other problems which might be impacting on an individual could include cultural disconnection, stressors associated with housing, physical illness, trauma, abuse and loss.

Services for Indigenous people need to be structured to holistically meet the needs of each person, including providing support for their families and/or communities. The RANZCP Queensland Branch supports that there needs to be a mix of Aboriginal and Torres Strait Islander community-controlled health services and mainstream services able to deliver culturally safe and appropriate treatment and care.

All services need to be delivered by an appropriately skilled workforce. The workforce needs to be made up of Aboriginal and Torres Strait Islander mental health workers and we recommend that the Queensland Government needs to increase funding to train and develop this workforce, with an appropriate career progression structure. There also needs to be Indigenous leadership in governance structures, preferably

incorporating elders from the community. The RANZCP Position Statement, *'Aboriginal and Torres Strait Islander mental health workers'*, provides further guidance on workforce planning.[64]

Services need to be planned and delivered in partnership with Aboriginal and Torres Strait Islander communities, recommends the RANZCP Queensland Branch. Services need to work collaboratively across generic state health services and Aboriginal community-controlled health services, which are often funded by the federal government National Aboriginal Community Controlled Health Organisation (NACCHO). There needs to be continuity of care across hospitals and community services, and tracking of individuals from metropolitan to rural and remote areas to avoid being lost to follow up services. Special needs groups include youth and forensic and intellectually impaired populations within First Nations people.

There need to be referral pathways and also coordinated sharing of information between general practitioners, Aboriginal and Torres Strait Islander community-controlled services, mental health and alcohol and other drug services, and NGO/community services which support social and emotional wellbeing.

Vulnerable groups

Many communities across Queensland are vulnerable, stigmatised and face significant barriers to accessing mental health services. These include the lesbian, gay, bisexual, transgender, gender diverse, intersex, queer, asexual and questioning (LGBTIQA+)[ii] communities, culturally and linguistically diverse Australians, the Aboriginal and Torres Strait Islander population, regional, rural and remote populations (amongst others like the long-term unemployed, street sex workers, homeless and refugees and asylum seekers).

Socially vulnerable groups tend to have higher rates of mental health conditions than the general population[65] and can be difficult to engage in healthcare. Vulnerable groups in society are often isolated, oppressed and stigmatised populations in our community.

Providing mental healthcare to these groups represents a particular challenge, as there are many barriers to accessing mental healthcare for vulnerable populations. Some barriers are personal, and some are systemic and relate to the way that the state health system functions. Personal factors such as mistrust of services is often reported as a barrier to accessing mainstream health services for the Aboriginal and Torres Strait Islander population. Language barriers impact persons from culturally and linguistically diverse backgrounds and recent migrants, refugees and asylum seekers, as well as cultural stigma associated with accessing mental healthcare services. LGBTIQA+ communities report that health professionals lack knowledge of their healthcare needs, members of this community may avoid or delay accessing mental health support due to experiences of past discrimination, and some persons may be reluctant to disclose their gender or sexual orientation which may mean that they do not receive appropriate care. For communities living in deprivation, like people living in poverty or the homeless, accommodation issues and competing life priorities interfere with these vulnerable groups accessing necessary health services.

The RANZCP Queensland Branch recommends that to address the mental health needs of vulnerable groups, the Queensland Government should prioritise:

- **establishing outreach programs to identify and engage with vulnerable groups with mental health conditions**
- **facilitating access to services that provide different aspects of healthcare, including mental healthcare**
- **strengthening the collaboration and co-ordination between different state health services**
- **disseminating information on how to access services both to vulnerable groups and to medical practitioners across Queensland.[66]**

[ii] Other common variations of this acronym include LGBTI and LGBTIQ. As terminology evolves, this acronym may change in future.

Suicide

Suicide is a relatively rare event; however the impacts of suicide are significant, long-lasting and felt across families, friends and whole communities.

Stable housing, good physical health, connection to friends and community, meaningful occupation, access to psychological and psychosocial support, environments free from abuse, violence and coercive control, are all factors which promote resilience and may reduce the likelihood of suicide.

A person who presents to a service in suicidal crisis requires specialist crisis care, and may also require pharmacological treatment if the person presenting in suicidal crisis also has a mental illness.

Suicide continues to present a key challenge for Queenslanders and was the leading cause of death for young Queenslanders in 2018, with 129 deaths among people aged 15-24 years. It was also the leading cause of death for people aged 25-34 years, with 139 deaths and 35-44-year old's with 149 deaths in Queensland.[67]

The RANZCP Queensland Branch notes that suicide is not always preventable, although there are established strategies which have been shown to reduce the risks of suicide. Studies have demonstrated that restricting access to lethal means (such as firearms and packaging of risky medications), control of analgesics (such as opiates), and addressing hot-spots for suicide by jumping (such as bridges, train tracks and high-rise carparks), as well as school-based awareness programs, and media reporting / partnership guidelines with public health are effective public health measures for reducing the risks of suicide.[68]

From a therapeutic perspective, the RANZCP Queensland Branch strongly supports psychosocial and pharmacological treatment, where this is clinically indicated. Studies show that a suicide attempt is one of the most significant predictors of future attempts at suicide and the RANZCP Queensland Branch strongly advocates that for persons hospitalised due to a suicide attempt, these persons should be assertively supported and followed-up after discharge from hospital. Across Queensland, there are eight (8) NGO groups, offering 'The Way Back Support Service' developed by Beyond Blue[69] that offer support for individuals, families and carers for up to four to six weeks following a suicide attempt, and/or discharge from hospital. Beyond the four to six weeks interval, and following a suicide attempt, the RANZCP Queensland Branch also supports peer-led interventions like 'Alternatives to Suicide' groups.

With the proposed enhancements and funding investments we have advocated for in the context of this submission, we anticipate that state health services will be able to respond more quickly and effectively to persons in mental health crises. The RANZCP Queensland Branch recommends specifically that more funding is needed across the state for suicide support services, like 'The Way Back Support Service' and peer-led interventions like 'Alternatives to Suicide' groups.

Conclusion

The RANZCP Queensland Branch commends the decision of the Palaszczuk Government to hold a parliamentary inquiry into Queensland's mental health system.

The RANZCP Queensland Branch submission has been prepared in consultation with the Queensland Branch Chair and Committee, as well as other members of special interest groups. The RANZCP Queensland Branch would like to thank everyone that contributed to this submission.

This parliamentary inquiry has come about because of the historically chronic underfunding of Queensland mental health services, and the still evolving COVID-19 pandemic which has pushed state mental health services to the brink.

We have also been working closely with the Australian Medical Association Queensland (AMAQ), amongst others, and following consultation with our members we are recommending the Queensland Government to develop a five-to-seven-year mental health plan.

We also recommend an urgent increase to funding to at least the national average, which in 2019 was $88 million per year. We also ask the Queensland Government to commit to recurrent funding to increase the mental health budget to $750 million per year (total new expenditure required), to match the Victorian Government funding, following the Royal Commission into Victoria's Mental Health System.

We agree with AMAQ and the recommendation of the Productivity Commission that each state and territory should provide more and better alternatives to emergency departments for people with mental health problems. The RANZCP Queensland Branch has recommended that Queensland needs an additional 3,000 community mental health staff (taking into account shift work penalties), as well as a 300 per cent funding boost to non-governmental organisations (NGO) and more funding for alcohol and drug treatment services across Queensland.

The RANZCP Queensland Branch has called for 500 new public acute and sub-acute psychiatric beds, and 250 bed refurbishments. We recommend that the 500 new beds should include acute beds, psychogeriatric beds and long-stay psychogeriatric beds, step-up / step-down beds, mother-baby beds, eating disorder beds, and child and adolescent beds. We have also recommended that the Queensland Government develop an additional 25-bed inpatient unit for complex, high-risk persons at "The Park", at Wacol.

To support mental health and wellbeing in people with intellectual and developmental disability, we have called for the development of a new statewide specialist inpatient and integrated community service, to be operated by the Queensland Government Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships. The existing forensic disability provisions of the *Mental Health Act 2016* also need to be revised, as currently these provisions enable health facilities to act as parole services for individuals.

The effective functioning of Queensland's mental health services depends on clinical staff. As already mentioned, state mental health services are on the brink, and the COVID-19 pandemic has greatly aggravated the stress on many state health services and exacerbated existing workforce shortfalls. If our mental health services are to improve, we need to dramatically increase our recruitment of clinical staff, and this can only occur with known funding over the next five to seven years, to enable the tertiary sector to train and graduate the workforce numbers we are going to urgently need. The RANZCP Queensland Branch has called for significant investment to grow the mental health workforce, establish a central alcohol and other drugs workforce unit, and fund education and training programs to improve mental health workforce capability. There is also a significant need to increase the number of peer workers (sometimes referred to as 'lived experience workers'), as an essential part of the workforce within the Queensland public mental health system.

To support optimal mental health outcomes for Queenslanders living with mental illness, their families and carers the RANZCP Queensland Branch has called on the Queensland Government to develop regional mental health planning committees, which would involve mental health services, primary health networks, non-governmental organisations and consumers and carers to oversee the new reforms at the local level.

Lastly, the RANZCP Queensland Branch strongly recommends that the role of the Queensland Mental Health Commission should be expanded to enable the Commission to oversee the allocation of state funding for mental health services.

Thank you again for providing the RANZCP Queensland Branch with the opportunity to provide feedback to the Queensland Government parliamentary inquiry into the opportunities to improve mental health outcomes for Queenslanders.

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