Queensland Mental Health Commission

Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

Submission to the Health and Environment Committee

December 2021

Introduction

The Queensland Mental Health Commission (the Commission) welcomes the Queensland Parliament Health and Environment Committee's (the Committee) *Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system*. A truly person-centred system enables people to access the assistance they need easily and seamlessly. The Commission supports reform efforts to align the system with this intent.

There have been several inquiries and reviews across Australia in recent years calling for reform of the mental health system. Rather than responding to the broad issues at length the Commission provides this submission for the Committee's consideration, focusing on a few key areas and possible solutions to support strategic reform.

In line with the Commission's remit the submission focuses on issues relevant to the mental health, alcohol and other drug (AOD) service system; however, notes the issues raised and solutions proposed are likely to be applicable across the entire health system.

The Queensland Mental Health Commission

The Commission is an independent statutory agency established under the *Queensland Mental Health Commission Act 2013* (the Act) to drive ongoing reform towards a more integrated, evidence-based and recovery-oriented mental health and substance misuse system. Under the Act, the Commission must focus on systemic mental health and substance misuse issues.[1]

The Commission takes account of the issues affecting people who are vulnerable to or are at significant risk of developing mental health problems and recognises the importance of custom and culture when providing treatment, care and support to Aboriginal and Torres Strait Islander peoples.

The Commission works in four main ways:

- developing a whole-of-government strategic plan for improving mental health and limiting the harm associated with problematic alcohol and other drug use
- undertaking reviews and research to inform decision making, build the evidence base, support innovation and identify good practice
- facilitating and promoting mental health awareness, prevention and early intervention
- establishing and supporting collaborative, representative, transparent and accountable state-wide mechanisms.

The Commission promotes policies and practices aligned to the vision of *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*[2] (*Shifting minds*) for a fair and inclusive Queensland, where all people can achieve positive mental health and wellbeing and live their lives with meaning and purpose.

The work of the Commission is supported by the independent Queensland Mental Health and Drug Advisory Council (Advisory Council) which acts as a champion for people living with mental health issues, problems related to alcohol and other drug use, or affected by suicide.

[1] Section 11(2)(a) of the Queensland *Mental Health Commission Act 2013*
[2] https://www.qmhc.qld.gov.au/2018-2023-strategic-plan

The Advisory Council's functions are to:

- provide advice to the Commission on mental health or substance misuse issues either on its own initiative or at the Commission's request; and
- make recommendations to the Commission regarding the Commission's functions.

Strategic context

There have been a significant number of inquiries and reviews of the mental health system over many years that highlight issues relevant for the Committee's consideration regarding the challenges of providing person-centred, integrated care across the spectrum of all health services including primary, secondary and tertiary services.

Most recently the Australian Productivity Commission's Inquiry into Mental Health[3] demonstrated the substantial cost of mental illness to the Australian economy and provided compelling evidence of the cost and benefits of reform, estimating mental illness is conservatively costing the Australian economy about $200-220 billion per year – or between $550 million and $600 million per day. The economic benefits of the recommended reforms to Australia's mental health system were estimated to be up to $1.3 billion per year as a result of the increased economic participation of people with mental ill-health.

The Australian Productivity Commission called on Australian and State and Territory Governments to develop a new national mental health strategy that comprehensively integrates health and non-health sectors, guides the allocation of resources, and aligns collective efforts of relevant sectors in all jurisdictions. Without this the Australian Productivity Commission believes that there will continue to be a heavy reliance on health-centric solutions and not enough attention to change the wider social, cultural, political, economic, and environmental determinants that lead to poor mental health.

In the recent federal budget, the Australian Government provided an additional $2.3 billion investment into national mental health and suicide prevention over the next four years. In addition, the Australian and state and territory governments are working on a new National Agreement on Mental Health and Suicide Prevention (the National Agreement). The Commission looks forward to seeing the National Agreement when it is finalised and released in the near future. The Commission hopes this will be the first step towards a better integrated, more person-centred mental health system.

The Australian Productivity Commission's recommendations and proposed actions broadly align to the key themes of Queensland's mental health and suicide prevention reform agenda outlined in *Shifting minds*. *Shifting minds* identifies strategic priorities and builds on existing, and ongoing whole of government commitments and actions, across health and human services sectors to improve the mental health and wellbeing Queenslanders through improved services and coordinated approaches. It builds on many years of whole-of-government effort to improve the mental health and wellbeing of Queenslanders. However, there is more to be done to meet the needs of a growing and increasingly diverse population and to address complex societal issues.

Due to the complexity of the related service systems, the reforms proposed most recently by the Australian Productivity Commission Report will not be easy to achieve. It is seeking to change complex systems that are steeped in siloed legislative, policy, planning and funding approaches that are likely to be unique to each jurisdiction and reflect their own reform journey.

[3] https://www.pc.gov.au/inquiries/completed/mental-health/report

Regardless, the Australian Productivity Commission Report and the commitment to a National Agreement can provide an opportunity to strengthen and expand ongoing reform in Queensland. Negotiation of the National Agreement will need to focus on interjurisdictional role and responsibility delineation, actions and additional investment, which align to Queensland's priorities and stage in the reform journey.

As the Committee would be aware, on 30 November 2021, the Queensland Government announced a parliamentary inquiry into mental health services in Queensland. It will look at how the health system is coping with increased demand from the pandemic, as well as a general assessment amid reportedly high presentations. The Health and Environment Committee will conduct the inquiry, which also comes amid reports the health system is being overwhelmed by the needs of people with mental health challenges. The Minister for Health and Ambulance Services, the Hon. Yvette D'Ath said 70 per cent of general practice (GP) presentations in 2021 had been related to mental health, up from 61 per cent in 2017[4]. This inquiry provides another opportunity to reflect on the reform achieved to date and consider what further is needed across the mental health, AOD, and aligned human services sector.

Lived experience led reform

The meaningful and authentic engagement and leadership of people with a lived experience must be central to any consideration of the impact of provision of primary, allied and private health care, aged care and National Disability Insurance Scheme (NDIS) services and its interface and impact on the Queensland public health system.

The Commission considers that this engagement is a human right fundamental to citizenship. This will require increased investment in efforts to systematically embed authentic and meaningful engagement into both Queensland and Australian Government processes.

This includes engaging people with a wide range of lived experience of mental health challenges, problematic alcohol and other drug use and suicide, as well as families, carers and other supporters. Deliberate efforts are required to engage people with different perspectives and experiences across Queensland.

The newly established *Mental Health Lived Experience Peak Queensland* will be a useful mechanism to facilitate this engagement.

Unique Queensland context

Consideration must be given to the unique Queensland context which provides an additional layer of complexity, including that:

- just over 20 per cent of the Australian population lives in Queensland
- it has the fastest population growth of all states and territories
- the population is ageing (due to low fertility rates, increased life expectancy and baby boomers transitioning into the older age groups)
- more than 25 per cent of Australia's Aboriginal and Torres Strait Islander people live in Queensland
- it is the most geographically diverse state with highly dispersed population centres.

The implications of this are wide ranging and one-size-fits-all solutions and approaches can be problematic. Impacts include limited consumer choice and ability to access Australian and State

[4] https://healthtimes.com.au/hub/mental-health/37/news/aap/qld-govt-orders-mental-health-inquiry/6364/

funded services including primary health care, aged care and NDIS providers; thin markets and market failure impacting on service viability; and workforce attraction and retention.

Improving funding approaches between Australian Government and States/Territories

The mental health system has been referred to as a 'patchwork' system [5] that is failing to meet the needs of many Australians rather than a comprehensive and integrated system; and it is well known that the current approach is unbalanced and configured towards a hospital crisis response. As noted previously, numerous reviews and inquires confirm this; and the pandemic has further highlighted the significant issues within our system.

State funded hospital and health services are the safety net Queenslanders rely on; however, these services are stretched beyond capacity which impacts on their ability to provide timely and effective care to people who need it.

There is a limited focus on prevention and early intervention which means that people often don't get support until they are in crisis. This is costly for the individual in terms of their quality of life, social and economic participation; and costly for the system to provide acute services that could have been avoided or lessened with more appropriate early responses.

Responsibility for funding prevention and early intervention efforts across the range of relevant areas including mental health and AOD services lies with both the Australian and Queensland Government.

As the Committee would be aware, the Australian Government funds the primary mental health system of general practitioners, private psychologists and psychiatrists through the Medical Benefits Scheme (MBS), the NDIS and components of the non-government sector. The Queensland Government funds public community and hospital services and some non-government services for people that don't qualify for the NDIS.

There is no doubt more investment by federal and state governments is urgently needed to address long-term, chronic underfunding. Australian Government investment is especially necessary to build a diverse range of community-based services, including for the 'missing middle' who are people whose mental health challenges are too complex for the primary health system but not complex enough for the state acute system. These people regularly fall through the gaps in the patchwork of services.

As mentioned above, the Australian Government provided $2.3 billion last budget for mental health and suicide prevention including Head to Health community mental health centres and a temporary increase in MBS-funded private mental health sessions from 10 to 20 a year. While this is welcome and greatly needed, it is insufficient when spread across eight states and territories. In fact, funding 10-20 mental health sessions a year has exacerbated workforce pressures as there hasn't been a corresponding increase in the number of clinicians to do this work. It has just divided their time among fewer people, increasing wait times and frustrations for people needing support.

The current funding approach encourages siloed service delivery and competition rather than collaborative and integrated approaches to community needs. Significant work is required to create a truly person-centred, integrated and functional system. There is an urgent need to embed

[5] https://www.news.com.au/lifestyle/health/health-problems/former-prime-minister-julia-gillard-makes-bold-proposal-for-mental-health-reform/news-story/33b473676fbe6184f390163d76ab16af

mechanisms to ensure partnerships, joint planning and co-commissioning to provide a better service system, coupled with strong governance and reporting to ensure transparency and accountability.

The Commission notes there are many positive examples of existing partnerships, joint planning and co-commissioning, for example regional planning and commissioning by Hospital and Health Services and Primary Health Networks (PHN) co-designed with community members, and that reforms should build on and strengthen these approaches. Programs like *The Way Back Support Service* co-designed and co-commissioning by local Hospital and Health Services and the PHN's is a small example of what an integrated approach could look like.

The impact of an unbalanced system

The impact of our current unbalanced system can be seen through blockages in our emergency departments (EDs); shortage of hospital beds for people experiencing mental health crisis; and delays and challenges accessing both NDIS and aged care. As noted previously this is costly for the individual in terms of their quality of life, social and economic participation; and costly for the system to provide acute services that could have been avoided or lessened with more appropriate early responses.

Reliance on ED intervention can be considered a sign of system failure. Earlier responses are required to prevent and intervene when mental health challenges arise. Too often the first-time people present for help is to an emergency department, often via ambulance services or accompanied by the police. This additional pressure is exacerbated by the fact Queensland has the lowest per capita spending of any state on public mental health services. Queensland has also the lowest number of mental health inpatient beds per capita in Australia, and people who can't get help in the community often end up in crisis at an ED[6]. With a system already stretched pre-COVID-19 and a pandemic-driven demand increase right across the service spectrum, wait times have blown out, people are struggling to access services, and when they do, putting additional pressure on the public mental health system.

As outlined in the recent Australian Medical Association (AMA) Public Hospital Report Card[7] our EDs and hospitals are already at capacity. Patients are waiting several hours to receive a service and "ramped" ambulances because there are not enough hospital beds or staff to cope. The AMA recommends hospitals should be kept at 90 per cent capacity so there is room for patients to be admitted into wards. Ramping happens when hospitals operate at 100 per cent capacity and patient movement grinds to a halt[8].

The Queensland Government is making significant investment in innovative and contemporary responses that enable crisis responses outside of the emergency department and hospital systems. For example, co-responder models, mental health consultation and liaison models, crisis outreach, safe spaces and the recently introduced Crisis Stabilisation Unit.

These tertiary system responses are supported and should be scaled up and expanded however earlier solutions are required to prevent people experiencing acute distress wherever possible. As such, primary and secondary interventions across the spectrum of human services, which are the remit of the Australian Government and the Queensland Government, should similarly be scaled up and expanded.

[6] https://www.ama.com.au/articles/ama-public-hospital-report-card-2021
[7] https://www.ama.com.au/articles/ama-public-hospital-report-card-2021
[8] https://www.ama.com.au/articles/ama-public-hospital-report-card-2021

Australian Productivity Commission data shows that 30 per cent of people occupying beds don't need to be there for clinical reasons; but the system is currently not able to provide appropriate housing options so people cannot be discharged from hospital.

The Commission believes the pressure on the public hospital system can be reduced by creating improved step-down models; social and affordable housing and accommodation (residential places); psychosocial supports; community clinical support; support to assist people back into the community; and by providing early intervention services before people require treatment in hospital.

Primary, allied and private health care

Primary health care encompasses a large range of providers and services across the public, private and non-government sectors.

At a clinical level, it usually involves the first (primary) layer of services encountered in health care and requires teams of health professionals working together to provide comprehensive, continuous and person-centred care.

While most Australians will receive primary health care through their GP, primary health care providers also include nurses (including general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, and Aboriginal health workers.

Primary health care is the frontline of Australia's health care system. It can be provided in the home or in community-based settings such as in general practices, other private practices, community health, local government, and non-government service settings for example, Aboriginal Community Controlled Health Services.

Primary health care services will also look and operate differently as one moves from metropolitan areas to rural and remote settings. Significant variations may relate to geography, community and population characteristics, socio-economic circumstances, infrastructure, health status, and workforce mix and availability. Health services in rural and remote areas are particularly dependent on primary health care services, especially those provided by GPs.

The Australian Productivity Commission noted that GPs are the 'first port of call' for many people when they first experience symptoms of mental ill-health; with at least one in five people consulting a GP about their mental health; and one in eight GP consultations relating to mental health problems in 2018-2019[9]. It also noted the critical role of GPs, and the skill required, in identifying mental illness, providing an initial diagnosis, prescribing medication, referral to specialist care, and ongoing support and treatment. The Australian Productivity Commission noted the lack of low intensity support options available for people with mental health challenges and made several recommendations for Australian Government consideration, aimed at enhancing choice and options for consumers, for example supported online treatments, and group therapies.

Access and affordability are issues particularly relevant to supporting people with mental illness and problematic AOD use. Queensland is the most decentralised state in the nation and needs Australian Government support getting GPs into the state's regional areas. There is a shortage of GPs in the regions as well as a shortage of bulk-billing generally. If people are not able to see a GP, and they are not looking after their health, their health deteriorates, and potentially results in utilisation of hospital

[9] https://www.pc.gov.au/inquiries/completed/mental-health/report

bed-based services. Additionally, community members that aren't in a critical condition, and unable to afford a visit to the GP, will utilise the public system to seek medical advice.

General practice also bridges the gap between the community and institutions such as hospitals, mental health outpatient services, drug and alcohol rehabilitation facilities, and prisons. For primary care services, including GPs, the major issues are related to:

- understanding and negotiating their role in the continuing care of a person who has experienced mental illness
- ensuring that the physical health needs of people who have been seriously affected by mental illness are met
- providing integrated and seamless continuing care pathways by working in effective partnership with specialist mental health services, other primary care services, allied health services, and providers of psychosocial and psychiatric rehabilitation services; and
- being actively involved in discharge planning and continuing care plans.

Mental health care and shared mental health care arrangements can be complex and the Medicare structure makes it difficult for GPs to viably provide the level of care that is needed.

Pressure on the public health system in the mental health area could be eased by providing options for social prescribing for the primary health care sector. Social prescribing[10] is the practice where health professionals, including GPs, have the resources and infrastructure to link patients with social services – or even social groups – in a bid to address the social determinants contributing to poor health and stave off the epidemic of loneliness and social isolation. The Commission is aware of a community driven social prescribing network pilot in Mt Gravatt. The pilot assist with building individual resilience and community capacity to address social isolation, and prevent unnecessary reliance on primary, secondary and in some cases tertiary health care.

The Commission also notes with interest the recent Queensland *Parliament Community Support and Services Committee Inquiry into social isolation and loneliness* in Queensland, its recommendations, and the relevance of this to the Committee's current inquiry.

Private mental health services delivered by private hospitals and allied health provides are an important part of the health care system. In 2019-20, private health insurance (PHI) paid for 53% (191,428 out of 359,990) of all mental health care separations in Australian hospitals (with the private hospitals sector handling 60% of cases); and benefits paid by PHI for in-hospital mental health care claims totalled $628M (a 3.4% increase on the previous year); under extras or ancillary cover (services for out-of-hospital medical care), PHI paid an additional $31.8M in total for member's claims for psychology/group therapy services (a 0.2% increase on the previous year)[11].

Affordability and access to private hospital and allied health services are significant issues, particularly in rural and remote areas. The cost of private health insurance, and the associated gap payment is a barrier for many people.

[10] https://chf.org.au/social-prescribing
[11] Cited in https://www.privatehealthcareaustralia.org.au/factsheet-mental-health-care-from-a-private-health-insurance-perspective/

Aged care and NDIS

Aged care

Ensuring timely access to aged care and the NDIS also impacts the tertiary, state funded, health care system. AMAQ President Professor Chris Perry said recently that people waiting to get home care or disability packages or into aged care were taking up hospital beds that could be used for other patients – and it was a problem across the state[12]. Timely access to such services provides better outcomes for people and savings for the tertiary system.

Healthy ageing is intrinsically linked to good mental health. Although the majority of older people do experience good mental health, more than nine per cent experience mental illness and almost 11 per cent experience a high level of psychological distress, including depression or anxiety[13]. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) note that mental illness is often unrecognised by individuals, family and health care professionals, who may wrongly attribute symptoms of treatable mental illness to the irreversible effects of ageing or to physical or environmental changes. Additionally, most interventions that are effective in younger people remain effective in later age, including when cognitive impairment is present[14].

Queensland Hospital and Health Services (HHS) Older Persons Mental Health teams support mentally healthy ageing with psychiatrists and registrars, mental health nurses, social workers, psychologists, and occupational therapists delivering recovery orientated framework services for people 65 years and over who are presenting with their first episode of mental illness; diagnosed with dementia with severe behavioural or psychiatric symptoms; and experiencing longstanding mental illness with complication from age-related medical health problems.

Whilst the Older Persons Mental Health teams can assist those requiring support, the *National Mental Health Services Planning Framework* highlights a need to significantly increase older persons community based beds and treatment services to effectively manage the demand.

It's important to recognise those services being provided within the aged care settings including the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (MBS). Unfortunately, this initiative is time limited (December 2020 to June 2022) in response to COVID-19, but the evidence highlights the need for these services to remain in place into the future.

In March 2020 the Commission made a submission to the Royal Commission into Aged Care Quality and Safety. The submission made a number of recommendations relevant to the Committee's inquiry including:

- improving access to appropriate treatment and support through the introduction of mandatory screening for people in residential and community-based aged care, to detect mental illness, including PTSD and early mental health problems;

[12] https://qld.ama.com.au/news/EmergencyTimebomb

[13] Health of older people in Australia: a snapshot 2004-05 [Internet]. Canberra. Australian Bureau of Statistics. 2006a. Catalogue number 4822.0.55.001. [cited 2016 August 13] Available from: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4833.0.55.001

[14] https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/psychiatry-services-for-older-people

- improving access to mental health services by requiring residential aged-care providers to ensure the spectrum of mental health care is available and accessible to residents; and
- improving access to appropriate treatment by ensuring residents of aged-care facilities have equivalent access to mental health treatment plans as the general population[15].

NDIS

The rollout of the NDIS has brought many benefits to those who are eligible but continues to present challenges to the state and Australian Government systems, significantly impacting on people with mental illness.

Psychosocial supports, such as those provided by the NDIS, play an important role in recovery and social inclusion and participation, especially effective when accessed early. Effective psychosocial supports can improve quality of life and reduce the need for more costly interventions.

Revised growth projections within the *Annual Sustainability Report 2021 – projected number of participants with primary psychosocial disability* state there will be 65,835 participants with a primary psychosocial disability in the Scheme by 30 June 2024, and 88,180 by 30 June 2030[16]. The *2018 Survey of Disability, Ageing and Carers* identified 4.6% of Australian (1.1 million people) had a psychosocial disability[17]. Not everyone who needs these supports can access them. The Australian Productivity Commission identified that approximately 154,000 people who need psychosocial support services are not able to access them.

Prior to the implementation of the NDIS, State and Territory Governments withdrew funds for a range of mental health support programs and used this funding to offset part of their contribution to NDIS[18]. People with unmet needs are often forced to seek assistance elsewhere or are left without help until their illness gets worse. This means that unmet or hidden demand for mental health services may manifest in other government services, such as health and homelessness services[19].

The Queensland Productivity Commission's recent report on the NDIS market in Queensland highlighted systemic issues relevant to mental health, including:

- potentially eligible Queenslanders not taking up the scheme
- the scheme is large, overly complex and inflexible
- it creates a costly and inefficient compliance burden
- introduces high policy and regulatory risk for providers – deterring new entrants, investment, employment and innovation, and
- constrained market mechanisms and the effective functioning of the market.

The Australian Government is solely responsible for aged, disability and home care packages, and needs to step in to resolve these issues, in partnership with state funded services where necessary and to facilitate an integrated and seamless system for consumers.

[15]https://www.qmhc.qld.gov.au/sites/default/files/submission_to_the_royal_commission_into_aged_care_quality_and_safety_march_2020.pdf
[16] Annual Sustainability Report 2021 – projected number of participants with primary psychosocial disability
[17] https://www.abs.gov.au/articles/psychosocial-disability
[18] https://www.pc.gov.au/inquiries/completed/ndis-costs/report/ndis-costs-overview.pdf
[19] http://rcvmhs.archive.royalcommission.vic.gov.au/Victorian_Government.pdf

Alcohol and other drug specific issues

Problematic alcohol and other drug (AOD) use is a significant burden on individuals, families, support services and healthcare providers, and is estimated to cost Australian society approximately $55.2 billion per year [20],[21].

The *Australian College for Emergency Medicine* identifies alcohol harm as one of the most significant preventable public health issues facing emergency department across the country, with alcohol-related presentations estimated to cost $630 per patient in Australia – equivalent to more than $789 million in 2018–19 within emergency department alone[22].

A comprehensive, independent review into how the alcohol and other drug treatment sector funded by the Drug Policy Modelling Program at the National Drug and Alcohol Research Centre, published in 2014, found there is significant unmet demand for specialist alcohol and other drug treatment. Unmet demand is based on the number of people in any one year who need and would seek treatment, currently the met demand rate is between 26 and 48 per cent [23] this rate is considered to be significantly higher in some geographic areas.

Funding to the alcohol and other drugs sector needs to be enhanced as alcohol and other drug treatment has proven to be a good investment – for every $1 invested, society gains $7 as treatment has been shown to reduce consumption of alcohol and other drugs, improve health status, reduce criminal behaviour, improve psychological wellbeing, and improve participation in the community. [24]

Australia's current investment in alcohol in other drugs (in 2014) is approximately $1.26 billion per annum, compared to the rate of unmet demand; the prevalence of alcohol and other drug problems in Australia; and the estimated social cost, this equates to a small investment. Of the $1.26 billion investment, it is estimated that the Australian Government contributes 31 per cent, state and territory governments contribute 61 per cent and 20 per cent is contributed via philanthropy and client co-payments.

The rate of unmet demand for services has created service system gaps, which has facilitated the operation of privately funded AOD services supplement the publicly funded services. [25] Many private providers provide an adequate service but due to a lack of standards and accreditation requirements, a number of private service providers are operating unsafe and poor-quality services at a high cost to the individual client. Vulnerable people who are experiencing substance dependence struggling to navigate the service system landscape and encountering substantial waitlists for publicly funded residential rehabilitation programs, are resorting to paying high fees to private sector.

Evidence suggests that alcohol and other drug service providers are managing an increased range of complex clinical presentations due to changes in availability and supply of licit and illicit substances; the ageing population; increased burden of chronic health conditions; rising incidence of

[20] Australian Institute of Health and Welfare. Alcohol, tobacco and other drugs in Australia. Canberra: AIHW; 2020.
[21] Searby A, Burr D. State of the workforce 2020: Mapping the alcohol and other drug (AOD) nursing workforce in Australia and New Zealand. Queensland: Drug and Alcohol Nurses of Australasia DANA; 2020
[22] https://www1.racgp.org.au/newsgp/clinical/one-in-eight-summer-ed-presentations-relate-to-alc
[23] Ritter A, Berends L, Chalmers J, et al. New Horizons: The review of alcohol and other drug treatment services in Australia final report. Sydney: University of New South Wales; 2014
[24] Ritter A, Berends L, Chalmers J, et al. New Horizons: The review of alcohol and other drug treatment services in Australia final report. Sydney: University of New South Wales; 2014.
[25] Health Complaints Commission. Review of private health service providers offering alcohol and other drug rehabilitation and counselling services in Victoria. Melbourne: Health Complaints Commission; 2020.

comorbidities and multiple morbidities. [26] Many private service providers are not equipped with the clinical governance and multidisciplinary team input required to manage this range of complexity which can impact client outcomes.

The Health Complaints Commission report – '*Review of private health service providers offering alcohol and other drug rehabilitation and counselling services in Victoria'* recommendations include establishing a stronger regulatory landscape for privately funded AOD services to bring privately funded services more closely into line with publicly funded services. In increasing the regulation and standards of private operators, an aspect of this is defining the minimum qualifications, professional development requirements and level of experience required for the workforce in AOD treatment services.

Multiple streams of treatment funding add to complexity for organisations managing multiple sets of funding arrangements with different reporting conditions, data collections and timeframes. Opportunities exist to streamline contract management and monitoring. Duplication also exists across Australian Government and state and territory funding.

Workforce issues

AOD

Allied health graduates are entering the workforce without the required skills to work in alcohol and other drugs requiring the State-funded services to provide on-the-job training and in-house professional development.

In Queensland, there are limited opportunities for specialist and generalist alcohol and other drug education in the undergraduate tertiary sector. Nationally, dedicated AOD undergraduate curriculum content in allied health professions such as psychology, social work, medicine and nursing is often not consistent with contemporary practice and doesn't prepare a graduate for entry-level positions in the AOD workforce. [27]

The workforces that provide responses to alcohol and other drugs can be separated into two categories based on the focus and scope of practice. The workforces that provide specialist AOD treatment and harm reduction services require specialised skills in order to provide specific, evidence-based interventions across a range of treatment types. Other workforces that provide early intervention, information and referral to specialist AOD services, are known as the generalist workforce are often based in community services, education, law enforcement, child safety and so on.

A significant, current workforce issue in the aging workforce. Research by the Drug and Alcohol Nurses of Australasia (DANA) into the alcohol and other drugs nursing workforce cohort of people aged 65-74 found that this aged group has doubled since 2013, this age group is working past the traditional retirement age. [28] The workforce in all disciplines is ageing workforce overall, the current estimate this that 16 per cent of the alcohol and other drug clinical workforce in Queensland is aged 55 and over

[26] Queensland Health. Mental Health Alcohol and Other Drugs Workforce Development Framework 2016–2021. Brisbane: Queensland Heath; 2017.
[27] Queensland Health. Mental Health Alcohol and Other Drugs Workforce Development Framework 2016–2021. Brisbane: Queensland Heath; 2017.
[28] Searby A, Burr D. State of the workforce 2020: Mapping the alcohol and other drug (AOD) nursing workforce in Australia and New Zealand. Queensland: Drug and Alcohol Nurses of Australasia DANA; 2020

and almost 70 per cent of the workforce is female, meaning that a significant segment of the workforce will reach retirement age or move to part-time work over the next 10 years. [29]

Mental Health

A well-functioning mental health and AOD system capable of delivering quality care relies, in large part, upon an effective workforce. It is important that consideration be given to a systemic workforce approach, rather than a focus on specific disciplines, as changes made in one part of the workforce will affect other parts. Any additional investment must be underpinned by a comprehensive and innovative workforce strategy to meet demand, cut wait times and reduce pressure on the public system. We need to free up clinicians and workers so they can spend more time meeting the needs of clients, rather than the needs of the system. Queensland's unique context, as highlighted previously, must also be considered.

The Australian Productivity Commission report[30] made several recommendations relevant for the Committee's consideration including:

- finalising the National Mental Health Workforce Strategy
- increasing the number of psychiatrists
- improving training on medications and non-pharmaceutical interventions
- supporting and increasing the peer workforce
- stigma reduction programs in initial and continuing education for all health professionals
- promoting mental health as a career option.

The Commission notes consideration should also be given to building the capability of the non-clinical and non-mental-health workforce to work in a trauma-informed, healing-aware way across all population groups to maximise the potential to address mental distress early, before it requires specialised intervention.

Conclusion

The Commission welcomes the inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system. We support reform to take the pressure off an already stretched public mental health system that is also dealing with the challenges of the ongoing pandemic. We acknowledge the work and sacrifices of a committed and dedicated health workforce dealing with enormous pressures, health risks and often mental health challenges.

As outlined at the public briefing of the Committee reform is urgently needed to ensure all Queenslanders receive the best possible person-centred health care they require in metropolitan areas as well as in the regions and remote communities.

The Commission believes changes to the current funding system between the State and the Australian Government are required to drive reform to increase efficiencies, avoid gaps and enhance system integration and navigation for the benefit of people using services.

[29] Queensland Health. Mental Health Alcohol and Other Drugs Workforce Development Framework 2016–2021. Brisbane: Queensland Heath; 2017.

[30] https://www.pc.gov.au/inquiries/completed/mental-health/report

A focus needs to be the provision of an effective network of GPs and allied health services that can be bulk-billed in the regions – clearly an Australian Government responsibility.

GPs also need to be trained and appropriately equipped with staff to deal with mental illness and AOD issues of patients. The current practice of referring patients to EDs for matters that could be dealt with in GP practices, or in the community, is not sustainable.

A number of reports and commissions have suggested ways for improvement of the mental health system that will lead to better health outcomes for Queenslanders as well as taking pressure of the public health system. The recently announced inquiry into Queensland's mental health services will provide and important and welcomed opportunity to investigate additional solutions to a complex system and to lay the foundation for much needed systems reform.