January 2022

Inquiry into the opportunities to improve mental health outcomes for Queenslanders

Queensland Mental Health Commission

Introduction

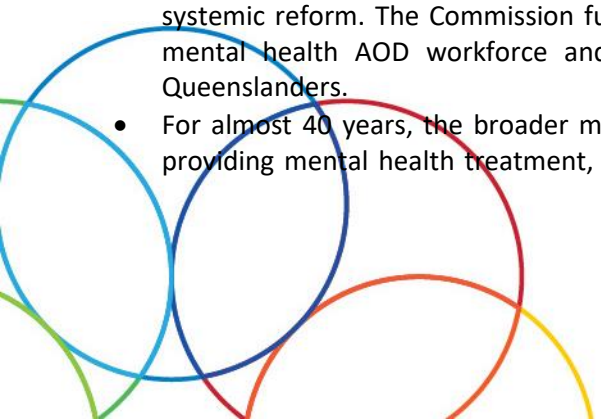
- The Queensland Mental Health Commission (the Commission) welcomes the Mental Health Select Committee inquiry *into opportunities to improve mental health outcomes for Queenslanders* (the Inquiry).
- The Inquiry presents a critical opportunity to understand and assess the performance of the broader mental health landscape to support whole-of-person and quality-of-life outcomes through a contemporary, person-centred, and future-oriented mental health and wellbeing system in Queensland.
- This document outlines the Commission's response to a request on 15 December 2021 for a written brief against the Terms of Reference (ToR), with the purpose of highlighting areas of particular significance within each ToR for further consideration.

Overview of 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, recovery-oriented mental health and substance misuse system.
- Under the Act, the Commission focuses on systemic mental health and problematic issues. In addition, the Commission takes account of the issues affecting people who are vulnerable to or otherwise 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 has four main functions:
    1) develop a whole-of-government strategic plan for improving mental health and limiting the harm associated with problematic alcohol and other drugs (AOD) use
    2) undertake reviews and research to inform decision making, build the evidence base, support innovation and identify good practice
    3) facilitate and promote mental health awareness, prevention, and early intervention
    4) establish and support collaborative, representative, transparent, and accountable state-wide mechanisms, and
    5) monitor, report and review reform implementation and progress
- The Commission promotes policies and practices aligned to the vision of the *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023* (*Shifting minds*) and sub-plan, *Every life: The Queensland Suicide Prevention Plan 2019-2029* (*Every life*), 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 (the Advisory Council), which acts as a champion for people living with mental health issues, problems related to AOD use, or affected by suicide.

Overview of the evolving mental health landscape

- The Commission acknowledges people living with mental illness, problematic AOD use, and those impacted by suicide, their families, carers and support people. We commend their resilience and leadership in driving systemic reform. The Commission further acknowledges the professionalism and dedication of the broader mental health AOD workforce and their concerted efforts to support quality-of-life outcomes for all Queenslanders.
- For almost 40 years, the broader mental health landscape has undergone significant review and reform in providing mental health treatment, care, and support. Such reform has contributed to and achieved many



Queensland Government

positive, long-term and sustainable outcomes for people with lived experience and their families, carers and support people. Examples include:
    - the shift away from large, long-stay institution-based psychiatric hospitals to the growth of community-based services, including the co-location of small inpatient units within general hospitals
    - evolving models of community care
    - evolution of the consumer and carer movement
    - strengthening of human rights
    - innovations in clinical treatments and non-clinical interventions
    - embedding of recovery-based and trauma-informed approaches in mental health service provision
    - workforce diversification and growth of the clinical and non-clinical workforces
    - evolution of mental health governance mechanisms, service accreditation standards, advocacy and appeals mechanisms, and
    - the advancement of digital mental health within the broader landscape.
- Over time, there have been numerous national and jurisdictional policies, plans and strategies to improve outcomes and deliver a quality mental health system[1]. However, the ongoing challenge has been implementing sustainable change[2].
- Despite over thirty years of reform, concerted effort, and growing investment, the prevalence of mental health conditions has not fallen, the burden of disease remains, and there have been no sustained reductions in rates of suicide[3].
- The overarching mental health landscape remains complex and under-resourced relative to other areas of health and relative to the enormous and growing burden of disease it represents.
- It is characterised by fragmentation, limited integration within and across other areas of essential non-mental service provision, with ill-defined pathways between levels of care and services, duplication, and siloed approaches.
- The system is primarily structured to focus responses to areas of high cost, including first responders, emergency department presentations and acute inpatient care, but also criminal justice, homelessness and welfare support.
- Despite the concerted effort and increased investment, the system has become self-perpetuating, requiring sustained and increased investment to respond to the growing demand for late and acute interventions.
- By default and necessity, the emergency department has become the entry point to mental health treatment, care, and support.
- The ongoing effort to improve the effectiveness of treatments and the availability and quality of supports and services is essential. However, a simultaneous focus on mental health promotion, prevention and early intervention is critical to ensure quality-of-life outcomes for all Queenslanders.

The importance of concepts and context

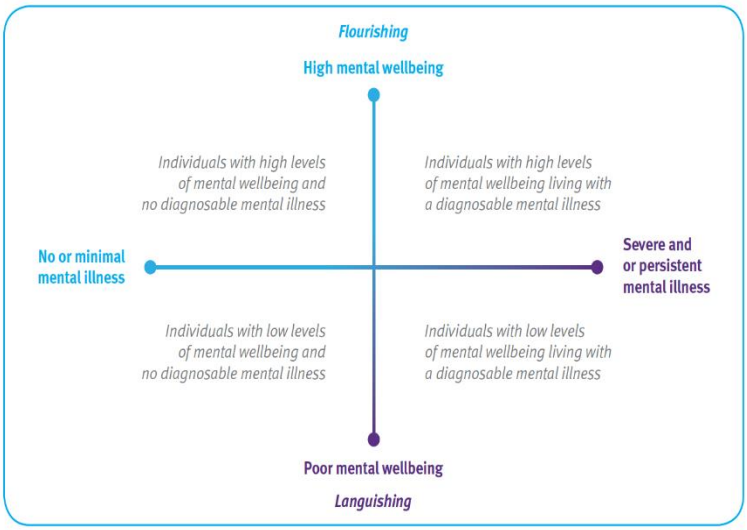
- Mental health and wellbeing are more than the absence of mental disorders and a foundation of flourishing and prosperous individuals, families, communities, and society[4]. This supports our broader economic performance, long-term growth, and sustainability.
- Positive mental health enables us to be resilient in the face of adversity or stressors, participate in education, training, and employment, form and maintain interpersonal relationships, contribute to and remain connected

[1] KPMG and Mental Health Australia 2018, Investing to Save: The economic benefits for Australia of investment in mental health reform, viewed 9 January 2022, https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018
[2] State of Victoria 2021, *Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations*, Parl Paper No. 202, Session 2018–21, viewed 9 January 2022, https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf
[3] Prevention United 2019, Investing Upstream: The Social and Economic Benefits of Promoting Mental Wellbeing and Preventing Mental Health Conditions, viewed 9 January 2022, https://preventionunited.org.au/wp-content/uploads/2019/05/FINAL-PU-PC-SUBMISSION.pdf
[44] World Health Organisation 2018, *Mental health: strengthening our response*, viewed 8 January 2022, https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

to our communities, have a sense of purpose, reach our individual and collective potential, and lead a meaningful and fulfilling life of our choosing[5].

- Positive mental health and wellbeing aids recovery can buffer the impact of mental illness and problematic AOD use and is also a strong protective factor in preventing suicide.
- Mental health, wellbeing, and mental health conditions vary along a continuum[6]. At any given point, a person may experience a level of wellbeing ranging from high to low, and at the same time, a mental health condition ranging from emerging to mild, moderate or severe.
- Individuals can experience poor mental health and wellbeing with or without experiencing a mental illness, and it is possible to live with mental illness and experience positive levels of mental health and wellbeing as illustrated by the dual continuum model (Figure 1).

Figure 1: Dual continuum model of mental wellbeing and mental illness[7]



- Mental health and wellbeing are shaped by a range of social, political, cultural, biological, economic, and environmental factors that operate across the diverse stages of the life course and at key transition points[8].
- It is in the settings that we are born into, where we grow, live, play, learn, earn, connect and age, our mental health and wellbeing, and our vulnerability for experiencing mental health challenges, are greatest. This includes the home environment, kindergartens, preschools and schools, universities and colleges, workplaces, communities, and places for retirement.
- Actions that seek to improve the conditions of everyday life, from prenatal periods to early childhood, to older childhood and adolescence, during family building and working ages through to older ages have a fundamental role in protecting the mental health and wellbeing of Queenslanders, as well as preventing and reducing the impact of mental ill-health, problematic AOD use and suicide.
- An optimally functioning mental health system can only occur within a broader population mental health approach.
- A population mental health approach, establishes mental health as a whole-of-community issue, recognising the importance of attending to the whole population's mental health and wellbeing needs. This includes:
    - supporting and protecting the mental health and wellbeing of all Queenslanders

[5] World Health Organisation 2021, *Comprehensive mental health action plan 2013–2030*, viewed 9 January 2022, https://www.who.int/publications/i/item/9789240031029
[6] Friedl, L & Parsonage, M 2009, *Promoting mental health and preventing mental illness: the economic case for investment in Wales*, viewed 9 January 2022, https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/Promoting_mental_health_Wales.pdf
[7] Iasiello, Matthew & Agteren, Joep & Muir-Cochrane, Eimear. 2020. Mental Health and/or Mental Illness: A Scoping Review of the Evidence and Implications of the Dual-Continua Model of Mental Health. Evidence Base. 2020. 10.21307/eb-2020-001.
[8] Allen, J, Balfour, R, Bell, R & Marmot, M 2014, 'Social determinants of mental health' in *International Review of Psychiatry*, vol.26, no,4, pp.392-407

  - identifying and responding to individuals and groups at greater risk of mental health problems due to individual, social, economic, cultural and environmental circumstances, and
  - ensuring people with lived experience of mental health challenges and illness can live lives with purpose and equality, supported through quality, person-centred and holistic mental health support and interventions while maintaining social and economic participation.
- This is reflected in mental health reform and ensconced in the state, national and international strategies over decades, but the necessary prioritisation or investment has not been matched.
- A population mental health approach also points to the shared responsibilities across sectors to support and protect the mental health of the population. This includes the responsibility to detect and respond to the needs of people at risk of, or living with, mental health challenges or illness.
- In this regard, the mental health sector, including public, private, primary health and non-government sectors, have a critical role in providing a continuum of integrated mental health interventions, support and treatments.
- It also requires collaboration across systems and services to ensure all economic, housing, vocational, educational, social and recreational needs are seamlessly provided.

A whole-of-system and cross-portfolio approach

- Promoting positive mental health and wellbeing is a fundamental responsibility shared across communities, systems and sectors, industries, and governments[9].
- Improving mental health and wellbeing outcomes requires the contribution of systems and services within and beyond the healthcare sector. No one agency, level of government, group or community can improve the mental health and wellbeing of Queenslanders alone.
- The overarching architecture across clinical and non-clinical systems is critical to responding to whole-of-life needs and enabling quality of life outcomes that support people to get well, stay well and maintain a high level of wellbeing to lead contributing lives.
- A compassionate, person-centred, strategically aligned, integrated, and coordinated system supported by whole-of-government and cross-sector effort is key to delivering the outcomes that matter at the individual, population and system levels.
- Comprehensive cross-sector alignment of investment and efforts also recognises the importance of non-health systems, for example, community services, housing, education, employment, training, justice, welfare and informal supports, as critical enablers of positive mental health and wellbeing.
- Queensland Government agencies contribute to and make significant investments in services and programs to prevent and reduce the impact of mental ill-health, problematic AOD use and suicide.
- Queensland drives a whole-of-government approach to improving mental health and wellbeing, reducing the prevalence and impact of mental illness, minimising harms associated with AOD use, and preventing suicide.
- *Shifting minds* states that shared leadership and accountability is required to deliver a system that reflects and supports the optimal design and mix of services commensurate to population need.
- This collective approach is required across all points of the policy, design, planning, funding, program development and delivery processes.
- Robust governance is critical to support and sustain the cross-agency and cross-sector collaboration required.
- The *Shifting minds* Strategic Leadership Group is supported by senior cross-agency representation and provides oversight of the implementation of mental health, AOD and suicide prevention reform efforts.
- The Strategic Leadership Group recognises the importance of working in close alignment with cross-agency planning and governance processes.

[9] State of Victoria 2021, *Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations*, Parl Paper No. 202, Session 2018–21, viewed 9 January 2022, https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf

- The reform ambition is more than improving parts of the mental health system and requires more than system adaptation[10]. Consideration of the relationships and intersectionality of reforms and systems, within and beyond the healthcare system, is required.

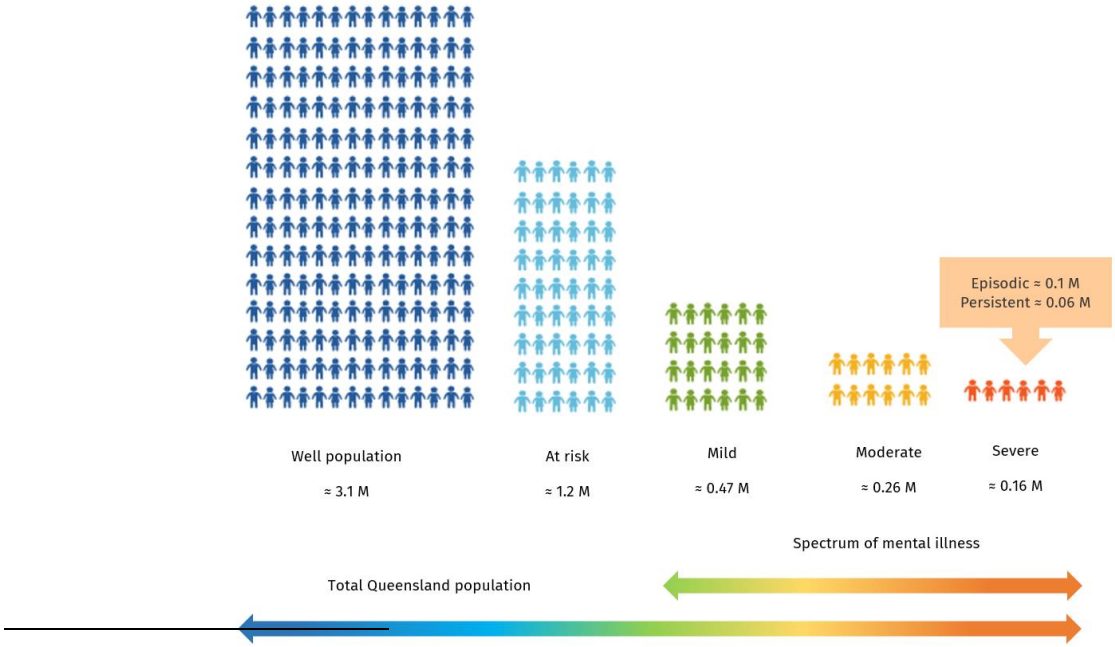
Responses to the Terms of Reference

TOR 1(a): the economic and societal impact of mental illness in Queensland

Prevalence of mental ill-health

- Mental ill-health is common, affecting all Queenslanders directly or indirectly through families, carers, loved ones, friends, colleagues, peers, and the broader community.
- Approximately one in seven children and young people and one in five adults (20 per cent) will experience a mental disorder in any given year.
- Almost one in two Australians will experience a mental illness in their lifetime[11]. At any point in time, there are three groups of Australians:
    - *well population:* approximately 60 per cent of Australians were identified to be in this category in the last twelve months
    - *at-risk population:* 23 per cent of Australians were at risk of experiencing an episode of mental illness because they had symptoms over the past twelve months, had a prior mental illness, or were exposed to another risk factor(s), and
    - *population living with mental ill-health:* an estimated 17 per cent of people experienced mental ill-health over the past twelve months with their condition being mild (9 per cent), moderate (5 per cent) or severe (3 per cent). It is estimated that approximately one-third of persons living with severe mental illness have persistent or complex needs[12].
- On average, people living with severe mental illness die approximately 10 to 15 years earlier, often due to comorbidity issues[13].

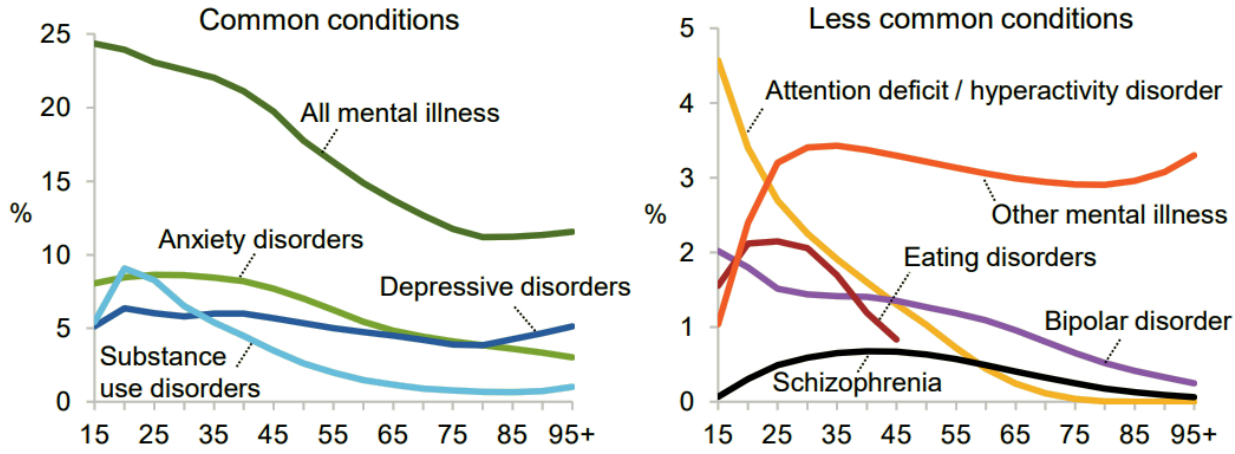
Figure 2: Distribution of mental health across the Queensland population[14]



[10] State of Victoria 2021, *Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations*, Parl Paper No. 202, Session 2018–21, viewed 9 January 2022, https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf
[11] Slade, T, Johnston, A, Teesson, M, Whiteford, H, Burgess, P, Pirkis, J, Saw, S 2009, *The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing*, Department of Health and Ageing, Canberra.
[12] Whiteford 2017, as cited by Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[13] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[14] Calculated for the Queensland population using Productivity Commission (2020) findings

- Despite the prevalence of mental ill-health in Australia, government expenditure is primarily concentrated on providing acute mental health services. Access to timely, quality, and appropriate treatment, care, and support where it will benefit most remains a significant issue.
- Mental ill-health often starts early in life and persists across the life span, with significant onset during adolescence and young adulthood.

Figure 3: Prevalence of mental disorders by age[15]



- Approximately 75 per cent of adult mental health disorders emerge by the time people are 25 years[16].
- While most young people experience positive mental health and wellbeing, mental ill-health is the leading cause of disability for people aged 10–24 years[17]. By Year 9, students with mental illness may be up to five years behind students who do not have a mental illness[18].
- Mental illness can substantially impact the life trajectories of children and young people.
- The prevalence of mental illness is relatively similar across Australia. However, people in capital cities are almost twice as likely to access mental health services in comparison to people residing in remote areas[19].
- The perinatal period is an often-overlooked life stage for mental health challenges.
- Perinatal mental health describes the mental health and emotional wellbeing of parents from conception until two years after the end of pregnancy. For most families, this is a time of excitement and joy. However, adjusting to pregnancy and parenthood can be stressful.
- 'Perinatal mental illness' covers a range of emotional and mental health disorders, from mild and transient to severe and disabling. These can occur at any time during or after pregnancy, including after the termination of a pregnancy.
- The commonly experienced perinatal mental health disorders are anxiety, depression, or a combination of both. Other more serious illnesses such as postpartum psychosis or bipolar disorder can also occur.
- One in five women will experience anxiety and/or depression in the perinatal period, and one in ten men will experience anxiety and/or depression in the perinatal period.
- Based on birthing rates in Queensland in 2020, 11,746 women experienced anxiety and/or depression in the perinatal period. This is a significant number of women and their families – all of whom will require additional support through primary, targeted and indicated mental health services.

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[15] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[16] Kessler et al 2005, Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication, as cited by the Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[16] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[17] McGorry et al 2014, Cultures for mental health care of young people: an Australian blueprint for reform, as cited by the Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[18] Goodsell et al 2017, Child and Adolescent Mental Health and Educational Outcomes as cited by Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[19] Productivity Commission estimate using 2016 ABS data

- Across 2016-17, 37 deaths occurred during or within 365 days of the end of a pregnancy. The single most prominent cause of death was suicide (9) (exceeding malignancy (8) and cardiac (7) issues).

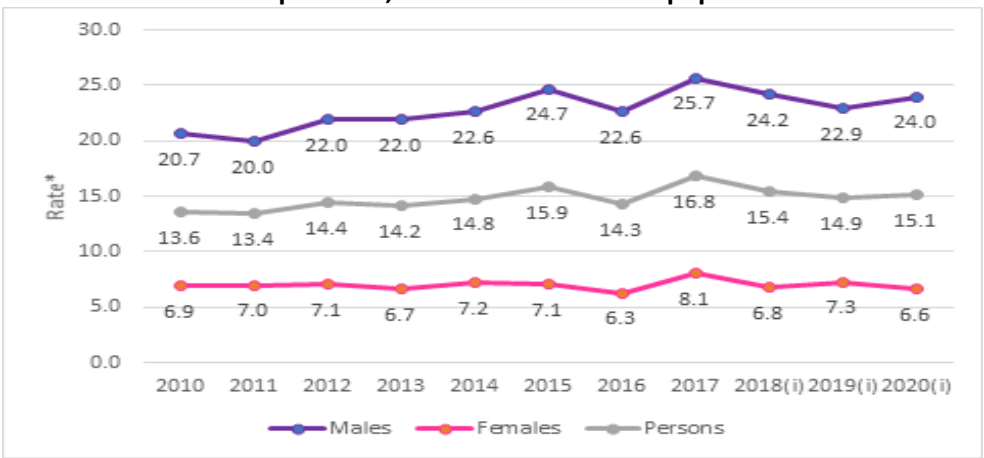
Prevalence of alcohol and other drugs use

- The use of alcohol and other drugs occurs across a continuum, from occasional use to dependence; harmful use can arise at any point, impacting individuals, families, and communities.
- Alcohol use is one of the leading causes of preventable injury and early death in Queensland and is a leading contributor to the burden of disease. Approximately one in five Queenslanders (890,000) exceed lifetime risky drinking[20].
- The *Australian drug harms study* ranks alcohol as the drug that causes the most significant harm to self and others, followed by crystal methamphetamine and heroin[21].
- In 2019, it was estimated that approximately 20 per cent of Queenslanders recently used illicit drugs, while there has been a six per cent reduction in illicit drug use nationally since 2001[22].

Prevalence of suicide and non-fatal suicide attempts

- While mental disorders are known to increase the risk of premature death from suicide and chronic disease[23] , not all people who attempt or die by suicide have a mental illness.
- Suicide remains the leading cause of death for Australians aged 15–44 years, with regional communities reporting a 54 per cent higher rate of suicide than capital cities[24]. Three out of four deaths by suicide are male[25].
- Aboriginal and Torres Strait Islander people are twice as likely as non-Indigenous people to be hospitalised due to mental illness and are twice as likely to die by suicide. Aboriginal and Torres Strait Islander youth (up to 24 years old) are up to 14 times more likely to die by suicide than other Australian youth[26].
- Queensland consistently records suicide rates above the national average and has the second-highest rate of suicide among all states and territories, behind the Northern Territory.
- The Queensland Suicide Register (QSR) shows that while numbers and rates of deaths by suicide in Queensland have generally increased since 2011, they have remained relatively stable following a peak in 2017.

Figure 4: Age-standardised death rate per 1000,00 estimated resident population



*Age-standardised death rate per 1000,00 estimated resident population as at 30 June (mid-year) (i) interim Queensland Suicide Register data 2018-2020

[20] Queensland Health. The health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020.
[21] Bonomo, Y, Norman, A, Biondo, S, Bruno, R, Daglish, M, Dawe, S et al 2019, 'Australian drug harms ranking study' in *Journal of Psychopharmacology*, vol. 33 #7, pp.759-768.
[22] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[23] Walker, E, R, McGee, R E, & Druss, B G 2015, 'Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis' in *JAMA Psychiatry*, vol. 72, pp. 334-341
[24] Australian Bureau of Statistics 2019, *Causes of Death* as cited by the Productivity Commission 2020, Mental Health, Report no. 95, Canberra
[25] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[26] Goodsell et al 2017, Child and Adolescent Mental Health and Educational Outcomes as cited by Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

- Queensland experienced the highest population growth rate in 2020, compared to other jurisdictions, ending 31 December 2020 at 1.1 per cent[27].
- The World Health Organization (WHO, 2014) estimates 20 suicide attempts for every suicide death[28]. This equates to a conservative estimate of 16,000 suicide attempts a year in Queensland.
- It is estimated that between 15-25 per cent of people who attempt suicide will re-attempt; the risk is significantly higher during the first three months following hospital discharge[29].

Impact of COVID-19 and mental health

- The COVID-19 pandemic continues to have broad, variable and changing effects on the mental health and wellbeing of Queenslanders, with insights continuing to be gained on the ongoing impacts. However, there has been a deterioration in mental health at the population level.
- The connection between social and economic circumstances, mental health and wellbeing, and vulnerability for mental health challenges and illness continue to be emphasised.
- The pandemic has shown how uncertainty and intense, prolonged stressors such as physical safety risks, economic hardship, insecure housing, disruption to employment or education, reduced mobility, and social isolation can affect mental health and wellbeing.
- In the early stages of the pandemic, agencies such as Beyond Blue, Headspace, Lifeline and Kids Helpline have reported a 30-60 per cent increase in demand for phone and online support.
- In 2021, Lifeline reported the highest volume of calls for support in the organisation's 58-year history[30].
- ADIS, a 24/7 AOD Queensland Health phone-based service, reported a 15 per cent increase in calls seeking assistance for AOD across Queensland during COVID-19.
- Over 2020-21, existing barriers to mental health treatment, care and support were exacerbated, including:
    - access-related barriers, including cost, waitlists, and lack of service options
    - societal barriers, for example, stigma and social inequity, and
    - disparities in the mental health system result in people falling through the gaps, unable to access timely, appropriate, and quality treatment, care and support when and where they need it most[31].

Social and economic impacts of positive mental health and wellbeing

- The substantial individual, social, and economic benefits of investing in reforms that prioritise positive mental health and wellbeing are clear.
- It is an enabler of social participation and productivity, positive community engagement and cohesion, and is critical to long-term growth and broader economic productivity, sustainability, and development[32].
- Countries including Finland, Iceland, New Zealand, Scotland, Wales[33], and the ACT Government[34] have prioritised the creation of wellbeing economies. This approach recognises that people need to restore a harmonious relationship between society and nature, enjoy a fair distribution of resources and live in healthy and resilient communities[35].
- Focusing on the mental health and wellbeing of Queenslanders represents a critical opportunity to improve outcomes across all life domains and across current and future generations.
- This includes reducing pressure and demand for costly treatments and late interventions, including child protection and youth justice, homelessness services, corrections, corrections, emergency services and

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[27] Population growth, Queensland, December quarter 2020, https://www.qgso.qld.gov.au/issues/3091/population-growth-qld-202012.pdf
[28] World Health Organization 2014, *Preventing suicide: a global imperative*, Geneva, viewed 9 January 2022, https://www.who.int/publications/i/item/9789241564779
[29] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[30] Lifeline 2021, 'More Australians than ever seeking crisis support', Media Release, viewed 10 August 2021, https://www.lifeline.org.au/media/yxab453i/20210804-lifeline-more-australians-than-ever-seeking-support.pdf
[31] Bower M, Smout S, Ellsmore S, Donohoe-Bales A, Sivaprakash PP, Lim C, Gray M, Francis A, Grager A, Riches J and Australia's Mental Health Think Tank 2020, *COVID-19 and Australia's mental health: An overview of academic literature, policy documents, lived experience accounts, media and community reports*, Sydney, NSW
[32] World Economic Forum 2021, *Mental wellbeing is not just beneficial for you – it can also lead to lower healthcare costs*, viewed 9 January 2022, https://www.weforum.org/agenda/2021/05/mental-wellbeing-economic-social-government-benefits-public-spending/
[33] Wellbeing Economy Alliance n.d., *Wellbeing Economy Governments*, viewed 9 January 2022, https://weall.org/wego
[34] Wellbeing Economy Alliance n.d., *Canberra unveils wellbeing framework*, viewed 9 January 2022, https://weall.org/canberra-government-unveils-wellbeing-framework
[35] Wellbeing Economy Alliance n.d., *Wellbeing Economy Governments*, viewed 9 January 2022, https://weall.org/wego

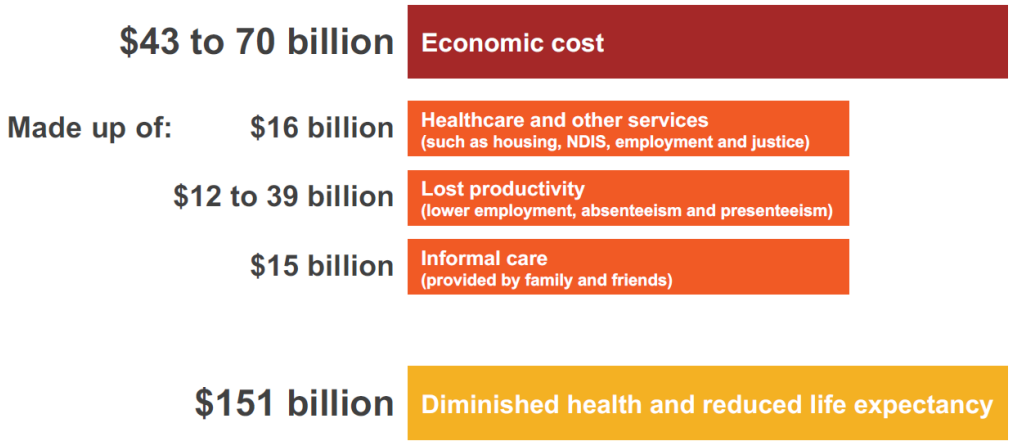
community-based supports, tertiary and specialist health and mental services, including hospital inpatient and emergency department care and emergency service responses.

- The Queensland Government has recognised that economic recovery is not possible without human and social recovery, including mental health and wellbeing. Therefore, in August 2020, the Queensland Government announced $46.5 million for localised mental health community treatment and support services as part of the Queensland Government's Economic Recovery Strategy.

Social and economic impacts of mental ill-health

- The Productivity Commission (2020) conservatively estimated that mental ill-health cost the national economy $200-220 billion per year or between $550-600m per day[36].

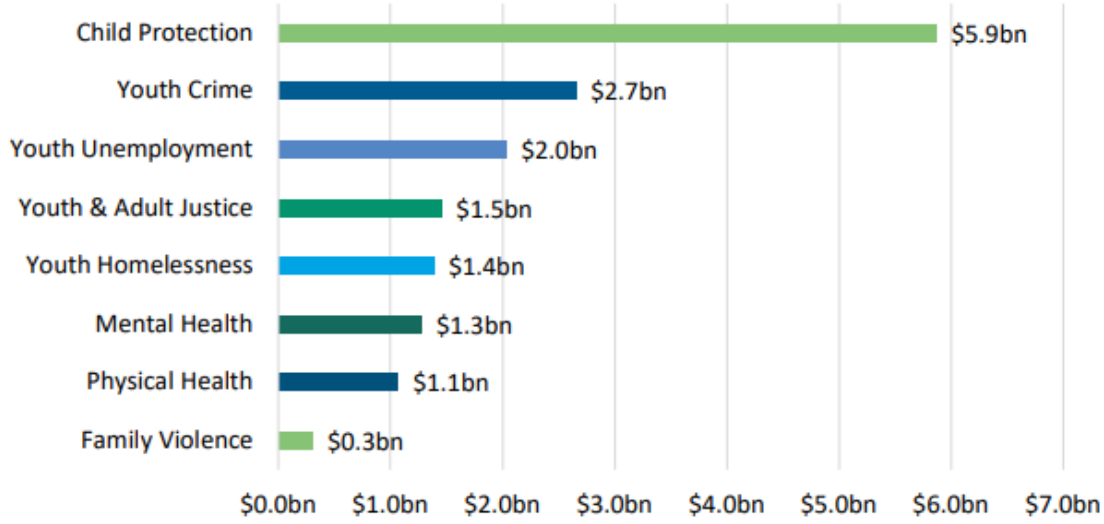
Figure 5: Annual cost of mental ill-health and suicide[37]



- The cost to Queensland can be estimated at 20 per cent of these costs, with widespread impacts for individuals, communities, systems/sectors, and the economy.
- Such costs, however, cannot be understood as just numbers or monetary terms.
- They are highly personal, pervasive, and long-lasting; and are experienced by people with lived experience of mental ill-health, families, carers, support people and the broader community, and governments, industries, sectors, and insurers.
- People living with mental ill-health are more likely to be negatively impacted across multiple life domains.
- This includes poorer academic outcomes, disengagement from school, education or training, low workforce participation and higher levels of unemployment, incarceration, homelessness, co-occurring substance use problems, and poorer physical health and life expectancy compared to people without a mental disorder[38].
- The cost to the government of late intervention in Australia is $15.2billion per year, equating to $607 for every Australian, or $1,912 per child and young person. Late intervention costs include the cost of specialist mental health services, out-of-home care, homelessness, youth unemployment, police, courts, and general health costs of youth crime[39].

[36] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[37] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[38] Prevention United 2020, *Prevention Coalition in Mental Health: Primed for Prevention – a consensus statement on the prevention for mental disorders*, viewed 9 January 2022, https://preventionunited.org.au/advocacy/preventioncoalition/
[39] William Teager, Stacey Fox and Neil Stafford, *How Australia can invest early and return more: A new look at the $15b cost and opportunity.* Early Intervention Foundation, The Front Project and CoLab at the Telethon Kids Institute, Australia, 2019

Figure 6: Annual cost of late interventions in Australia by issue (2018-19, prices, $BN)[40]



- Perinatal mental illness has been identified to cost $877 million in the first year, with an additional estimated lifetime cost of $5.2 billion.
- This lifetime cost is attributable to the increased risk of depression, anxiety, and ADHD in the children of parents with perinatal anxiety and depression, affecting wellbeing, productivity, and health system use[41].

The value of informal care

- The social and economic value of carers of people with lived experience requires explicit focus.
- Informal carers perform a fundamental role in caring for people with mental illness in Australia, providing a substantial number of hours of unpaid support, including practical tasks, emotional support and psychosocial care, and activities of daily living[42].
- As is well acknowledged, system and structural complexities, service gaps, barriers to access and complex navigation have resulted in a high proportion of people with lived experience unable to access quality, timely and appropriate treatment, care and support close to home and in their communities.
- Carers have become the de-facto frontline of service delivery. The absence of such care would result in poorer outcomes, with care needs going unmet or required to be picked up by formal health and social supports at additional cost[43].
- The annual national cost to replace this care with paid staff was conservatively estimated in 2018-19 was approximately $15 billion[44]. A compounded figure when considering the mental health-related expenditure in 2018-19 totalled $10.6 billion[45].

[40] William Teager, Stacey Fox and Neil Stafford, How Australia can invest early and return more: A new look at the $15b cost and opportunity. Early Intervention Foundation, The Front Project and CoLab at the Telethon Kids Institute, Australia, 2019
[41] https://www.pc.gov.au/__data/assets/pdf_file/0017/250811/sub752-mental-health-attachment.pdf
[42] Dominic, S, Heilscher, E, Lee, Y Y, Harris, M, Schess, J, Kealto, J & Whiteford, H, 2017, The economic value of informal mental health caring in Australia: summary report, viewed 9 January 2022, https://www.mindaustralia.org.au/sites/default/files/publications/The_economic_value_of_informal_mental_health_caring_in_Australia_summary_report.pdf
[43] Dominic, S, Heilscher, E, Lee, Y Y, Harris, M, Schess, J, Kealto, J & Whiteford, H, 2017, The economic value of informal mental health caring in Australia: summary report, viewed 9 January 2022, https://www.mindaustralia.org.au/sites/default/files/publications/The_economic_value_of_informal_mental_health_caring_in_Australia_summary_report.pdf
[44] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[45] Dominic, S, Heilscher, E, Lee, Y Y, Harris, M, Schess, J, Kealto, J & Whiteford, H, 2017, The economic value of informal mental health caring in Australia: summary report, viewed 9 January 2022, https://www.mindaustralia.org.au/sites/default/files/publications/The_economic_value_of_informal_mental_health_caring_in_Australia_summary_report.pdf

The social and economic impact of alcohol and other drugs

- Alcohol use carries high social, health and economic costs conservatively estimated at $66.8 billion nationally in 2017-18[46]. This conservative estimation is based on pre-pandemic rates. However, there is an early indication that alcohol-related harm may be increasing through the pandemic.
- In 2015-16, opioid use, including illegal opioids and non-prescribed pharmaceutical opioids, was estimated to cost $15.76 billion. In this same year, the social cost of cannabis use was estimated to be $4.5 billion, and tobacco use was $136.9 billion[47].
- Nationally, Queensland has the second-highest emergency department presentations attributed to alcohol use; and there are 45,000 hospitalisations or over 146,000 patient days.
- In 2015-16, 11,200 hospitalisations or 48,700 patient days attributed to drug use were reported.

The social and economic impact of suicide and non-fatal suicide attempts

- The Productivity Commission (2020) conservatively estimated that the cost of suicide and non-fatal suicide attempts are approximately $30 billion per year[48].
- Each death and attempt can have far-reaching impacts on individuals, families, carers, support people, friends, colleagues, peers, and the broader community. Such impacts are profound, can last a lifetime, and are beyond measure[49].
- Effective aftercare is conservatively estimated to provide a long-term return-on-investment of $2.37 to $6.90 for every dollar invested[50].

TOR 1(b): the current needs of and impacts on the mental health service system in Queensland

- Despite successive national and state/territory reform, investment, and efforts to ensure access to mental health treatment and support, there is still a significant proportion of people living with a mental health condition who are not accessing or receiving a form of mental health treatment, care and support[51,52].
- There is evidence that an increasing number of people have not received an appropriate response when and where required, putting increased pressure on an overly pressured and costly hospital-centric system.
- Access to appropriate treatment, care and support varies across age ranges, locations, and mental health conditions.
- Provision of mental health treatment, care and support, public healthcare funding and service responsibilities are split across federal, state/territory and local levels.
- Mental health services in Queensland are funded by both Australian and Queensland Governments and are provided through public, private, and non-government (NGO) sectors, including the primary health sector.

Public mental health – State-based services

- The public mental health system in Queensland provides:
    - hospital bed-based services (acute and medium secure)
    - community bed-based services (community care units, adult and youth step-up/step-down, older persons non-acute, AOD rehabilitation)
    - community treatment services (child and youth, adult, older persons, AOD)
    - state-wide-wide and specialist services

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[46] Whetton, S, Tait, R J, Gilmore, W, Dey, T, Abdul Halim, S, McEntee, A, Mukhtar, A, Abdul Halim, S, Roche, A, Allsop, S & Chikritzhs T 2021, *Examining the Social and Economic Costs of Alcohol Use in Australia: 2017/18*, Perth, WA, National Drug Research Institute, Curtin University, viewed 9 January 2022, https://ndri.curtin.edu.au/ndri/media/documents/publications/T302.pdf

[47] Australian Institute of Health and Welfare 2021, *Alcohol, tobacco & other drugs in Australia*, viewed 9 January 2022, https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impacts/economic-impacts

[48] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

[49] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

[50] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

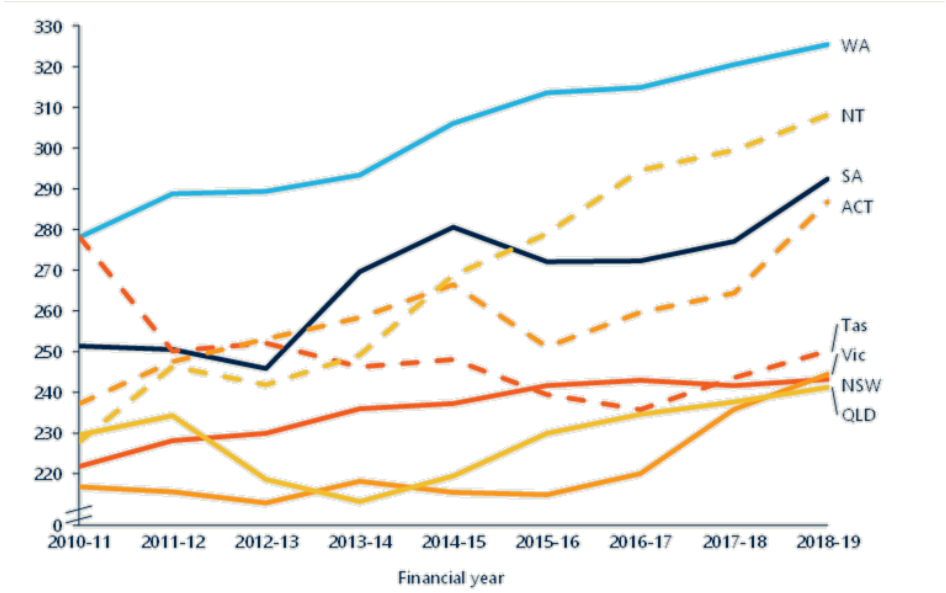
[51] Kaleveld L, Hooper, Y, Clark, K, Dufour, R, Olekalns, A & Elmes, A, *Mental health deep dive: community consultations and final report*, Centre for Social Impact, University of Western Australia, University of New South Wales and Swinburne University of Technology

[52] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

- forensic high secure and extended treatment beds and state-wide community forensic services
- eating disorder services, including beds
- Queensland Transcultural Mental Health
- perinatal and infant mental health services, including mother-infant beds
- suicide prevention crisis services, and
- community-based psychosocial support services through NGOs for those not receiving support through the National Disability and Insurance Scheme (NDIS).

- The lack of available services prevents many people from accessing prevention, primary health care and early intervention services. This means that people present late, are diagnosed with higher levels of acute need, and often are at a more advanced stage of illness, including corresponding physical comorbidities[53].
  - People presenting to emergency departments for treatment, care and support are in the main brought in by first responders. More than 80 per cent of people experiencing a mental health crisis and accessing services via Triple 000 are in a complex, multi-faceted crisis, including suicidal crisis. Informal advice received from the Queensland Ambulance Service identified that of this group, 60 per cent are treated on-site, 40 per cent are transferred to the emergency department. However, only 5-10 per cent of people need to come to the emergency department if other suitable alternatives are available.
  - The emergency department has become the entry point to treatment, support and care for persons experiencing psychiatric and AOD emergencies and suicidal crises.
  - Nationally, the rate of mental health presentations at emergency departments has risen by approximately 70 per cent over the past 15 years[54]. Queenslanders aged 25-34 years had the highest mental health-related emergency department presentations (20.79 per cent)[55].
  - Queensland has the lowest mental health expenditure per capita of all states and territories (figure 7), with the growth in Queensland health expenditure not translating to a corresponding increase in mental health expenditure (Figure 8).

Figure 7: Mental health expenditure per capita ($) by jurisdiction[56]



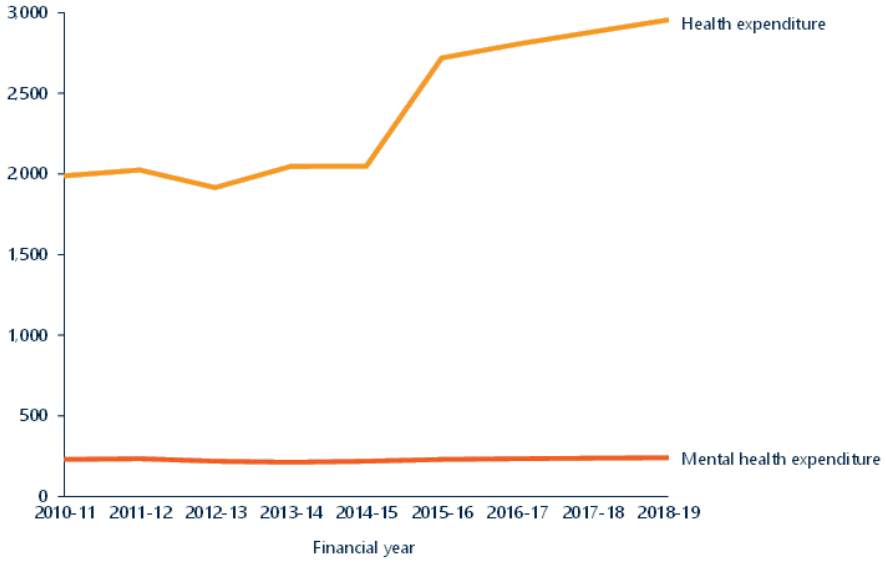
[53] Commonwealth Government 2018, *the* Fifth *National* Mental Health *and Suicide Prevention* Plan, viewed 9 January 2022, https://www.mentalhealthcommission.gov.au/getmedia/0209d27b-1873-4245-b6e5-49e770084b81/Fifth-National-Mental-Health-and-Suicide-Prevention-Plan

[54] AIHW 2019, Mental Health Services in Australia, as cited by the Productivity Commission 2020, Mental Health, Report no. 95, Canberra

[55] Mental Health Services in Australia

[56] Source: Productivity Commission 2021. Report on Government Services 2021: 13 Services for mental health; Productivity Commission 2021. Report on Government Services 2021: 132 Public Hospitals

Figure 8: Proportion of Queensland Health spend on mental health services[57]



- In Queensland, there is an overall shortage of community bed-based services; and at present, Queensland is not meeting the set target for community treatment services in accordance with the National Mental Health Services Planning Framework (NMHSPF).

Alcohol and other drugs services

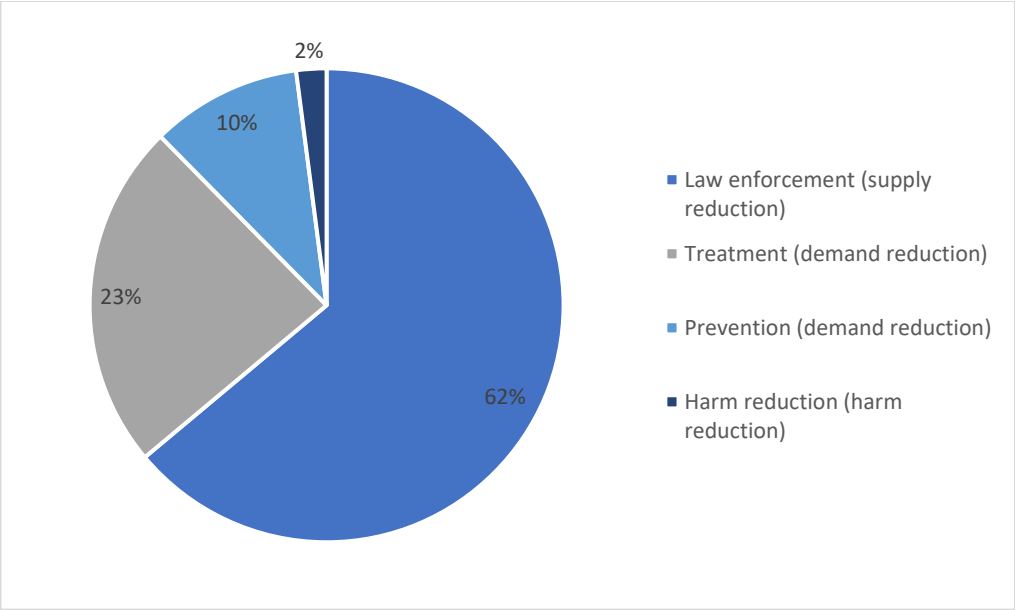
- In Queensland, AOD services are provided through public, non-government and private sectors.
- Funding for AOD services is provided by the Commonwealth and state/territory governments and through user-pay arrangements, including private health insurance.
- Australia's current investment in AOD treatment is estimated at $1.26 billion per annum. Of the $1.26 billion total, the Commonwealth contributes 31 per cent; state/territory governments contribute 49 per cent, and 20 per cent is contributed through private sources such as philanthropy and client co-payments. This estimated expenditure is inclusive of specialist and generalist treatment[58].
- In Queensland, AOD treatment and support services are funded via a hybrid model of Commonwealth, State health and other agency funding, including specific initiatives such as *Action on Ice*.
- *Action on Ice* was released in 2018 to specifically address the impact of methamphetamine (ice) on the Queensland community, with a suite of 56 actions to contribute to reducing supply, demand and harms, and $100 million funding over a five-year period.
- Australia's approach to responding to the harms associated with AOD is based on the three pillars of the *National Drug Strategy 2017-2026*: reducing harm, reducing demand, and supply[59].
- At the last estimate in 2013, the percentage of government spending allocated to the pillars are as follows.

[57] Source: Productivity Commission 2021. Report on Government Services 2021: 13 Services for mental health; Productivity Commission 2021. Report on Government Services 2021: 132 Public Hospitals

[58] Ritter, A, Berends, L, Chalmers, J, Hull, P, Lancaster, K, & Gomez, M 2014, *New Horizons: The review of alcohol and other drug treatment services in Australia.* National Drug and Alcohol Research Centre, UNSW

[59] Ritter, A, Berends, L, Chalmers, J, Hull, P, Lancaster, K, & Gomez, M 2014, *New Horizons: The review of alcohol and other drug treatment services in Australia.* National Drug and Alcohol Research Centre, UNSW

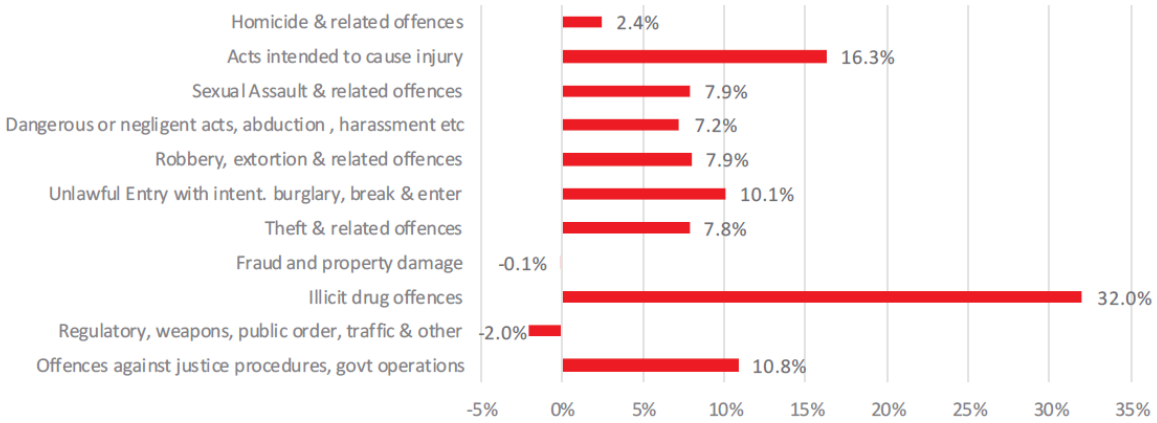
Figure 9: Area of allocation by harm minimisation pillars[60]



- AOD treatment and care services meet an estimated 28-48 per cent of demand in Queensland, resulting in a significant proportion of unmet needs[61].
- There are significant service gaps across the AOD service system in Queensland. These include:
    - population groups with high needs (young people, First Nations peoples, families, parents and carers with children, individuals with comorbid mental health or multiple morbidities such as disability and chronic pain, and those from culturally and linguistically diverse backgrounds), and
    - specific service types, namely residential rehabilitation, withdrawal management, counselling, and other outpatient services.
- The criminalisation of illicit substance use and dependence results in stigma and discrimination, preventing people from engaging and seeking help from support services.
- The notion that alternatives to law enforcement response to the use and possession of illicit drugs are 'soft' on crime is simplistic and is not supported by the evidence.
- Diversion has the dual capacity to maintain community safety and divert people from a criminal trajectory to a health response while better addressing the underlying issues contributing to substance misuse, such as untreated mental health conditions, history of trauma, and domestic and family violence.
- Vulnerable people can be diverted to health responses such as AOD treatment, and those who are occasional substance users can be diverted to credible education and information on illicit substance use as an early intervention measure.
- The most significant contributing factor to the growth in the sentenced population in prison in Queensland is illicit drug offences which accounted for 32 per cent of the increase from 2012 to 2018[62].
- In Queensland, around 50 per cent of prisoners had a prior hospitalisation for a mental health issue or were subject to a child protection order. For female Indigenous prisoners, this figure increases to 75 per cent.

[60] Ritter, A, McLeod, R. Shanahan, M 2013, Monograph No.24: Government drug policy expenditure in Australia – 2009/10. *DPMP Monograph Series*. Sydney, National Drug and Alcohol Research Centre
[61] Ritter, A, Berends, L, Chalmers, J, Hull, P, Lancaster, K, & Gomez, M 2014, *New Horizons: The review of alcohol and other drug treatment services in Australia.* National Drug and Alcohol Research Centre, UNSW
[62] Queensland Productivity Commission 2019, Inquiry into Imprisonment and Recidivism: final report, viewed 9 January 2022, https://qpc.blob.core.windows.net/wordpress/2020/01/FINAL-REPORT-Imprisonment-Volume-I-.pdf

Figure 10: Contributions to the growth in the sentenced prison population in Queensland[63]



- The current illicit drugs policy costs approximately $500 million per year to administer in Queensland.
- The Queensland Productivity Commission *Inquiry into Imprisonment and Recidivism* (2019) found that prohibition encourages the supply of more harmful and addictive substances, including incentivising the production of more harmful substances such as crystal methamphetamine (ice) and supporting a large criminal market[64].

Primary healthcare and private healthcare

- The Commonwealth Government predominantly funds primary healthcare through the Medicare Benefits Schedule (MBS), Primary Health Networks (PHNs), disability services (including the NDIS), employment programs, housing and homelessness assistance, income support and programs funded through the Department of Defence and Department of Veterans Affairs.

General practice

- General practice has formed a central role in treating and providing mental health care[65].
- In the main, General Practitioners (GPs) are at the forefront of Australia's healthcare system and are the primary gateway to clinical, evidence-based, and holistic mental health treatment, care and support that encompasses both physical and mental health needs[66].
- In any given year, over 5 million people see their GPs for assistance with their mental health. In 2021, the *General Practice: Health of the Nation*[67] report by the Royal Australian College of General Practitioners (RACGP) identified that for the fifth consecutive year, psychological conditions were the most reported reasons for patient presentations, with more than 70 per cent of GPs identifying 'psychological' in their top three reasons for patient presentations. A percentage that has increased from 61 per cent in 2017.
- The role of GPs in the provision of mental health treatment, care and support is universally recognised. This role further includes care coordination and referral to specialist services[68].

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[63] Queensland Productivity Commission 2019, Final Report: Inquiry into Imprisonment and Recidivism, Brisbane, QPC
[64] Queensland Productivity Commission 2019, Final Report: Inquiry into Imprisonment and Recidivism, Brisbane, QPC
[65] Royal Australian College of General Practitioners 2020, *RACGP submission to the Productivity Commission Inquiry into Mental Health's Draft Report*, viewed 9 January 2022, https://www.pc.gov.au/__data/assets/pdf_file/0019/251065/sub858-mental-health.pdf
[66] Royal Australian College of General Practitioners 2019, *Submission to the Productivity Commission Inquiry into Mental Health*, viewed 9 January 2022, https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Reports%20and%20submissions/2019/Submission-to-the-Productivity-Commission-Inquiry-into-Mental-Health.pdf
[67] Royal Australian College of General Practitioners 2021, General Practice: Health of the Nation 2021, viewed 9 January 2022, https://www.racgp.org.au/health-of-the-nation/health-of-the-nation
[68] Royal Australian College of General Practitioners 2020, *RACGP submission to the Productivity Commission Inquiry into Mental Health's Draft Report*, viewed 9 January 2022, https://www.pc.gov.au/__data/assets/pdf_file/0019/251065/sub858-mental-health.pdf

- General practice can further provide population-based mental health promotion, stigma reduction, illness detection, early intervention, and detecting and responding to patients determined to be at risk of suicide[69].
- However, there is substantial variability across GPs in their interest and training in mental health, alcohol and other drugs and suicide prevention.
- In 2019-20, or 9.3 per cent (474,697 people) of the population in Queensland, received Medicare-subsidised mental health-specific services provided by general practitioners. Approximately 2.2 per cent (111,045 people) of the Queensland population received a Medicare-subsidised mental health service provided by a clinical psychologist. Queensland is ranked third lowest when compared to other jurisdictions. Finally, 3.3 per cent (168,223 people) received a Medicare-subsidised mental health service provided by 'other psychologists'. This is higher than the national average of 2.9 per cent.

Private healthcare

- In 2019-20, Private Health Insurance (PHI) paid for 53 per cent of all mental health care separations in Australian hospitals (with the private hospitals' sector handling 60 per cent of cases). Benefits paid by PHI for in-hospital mental health care claims totalled $628M (a 3.4 per cent 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 claims for psychology/group therapy services (a 0.2 per cent increase on the previous year).
- Most primary healthcare services, including GPs, are funded through the MBS fee-for-service model and private health insurance. However, the current funding model is not fit for the purpose required in providing quality primary mental health care for patients[70]. In addition, the MBS creates disincentives towards longer consultations and further penalises people with mental health concerns who cannot afford gap fees.
- As highlighted by the RACGP (2019), there is a need to recognise the additional time required to manage patients who may have complex needs, such as persons living with severe mental illness, comorbid conditions, socioeconomic disadvantage, and lack of social support supports[71]. Ultimately, MBS subsidised mental health-related services should reflect the complexity of services provided[72].
- Consumers are required to pay additional out-of-pocket costs not covered through MBS or private health insurance. For example, the gap payments to see a GP (due to scarcity of bulk-billing GPs), private psychiatrist, or an allied health professional can be unaffordable.
- Under the MBS, psychologists and allied health professionals can deliver up to 10 counselling sessions per year (previously a maximum of ten sessions). In addition, in October 2020, the Australian Government expanded the *Better Access Pandemic Support* measure to include ten additional Medicare subsidised psychological therapy sessions for all eligible Australians experiencing a severe or enduring mental health response to the COVID-19 pandemic. This measure is available until 30 June 2022[73].

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[69] Royal Australian College of General Practitioners 2019, *Submission to the Productivity Commission Inquiry into Mental Health*, viewed 9 January 2022, https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Reports%20and%20submissions/2019/Submission-to-the-Productivity-Commission-Inquiry-into-Mental-Health.pdf

[70] Royal Australian College of General Practitioners 2019, *Submission to the Productivity Commission Inquiry into Mental Health*, viewed 9 January 2022, https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Reports%20and%20submissions/2019/Submission-to-the-Productivity-Commission-Inquiry-into-Mental-Health.pdf

[71] Royal Australian College of General Practitioners 2019, *Submission to the Productivity Commission Inquiry into Mental Health*, viewed 9 January 2022, https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Reports%20and%20submissions/2019/Submission-to-the-Productivity-Commission-Inquiry-into-Mental-Health.pdf

[72] Royal Australian College of General Practitioners 2019, *Submission to the Productivity Commission Inquiry into Mental Health*, viewed 9 January 2022, https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Reports%20and%20submissions/2019/Submission-to-the-Productivity-Commission-Inquiry-into-Mental-Health.pdf

[73] Australian Government Department of Health 2020, Additional 10 MBS mental health support sessions during COVID-19, viewed 9 January 2022, https://www.health.gov.au/sites/default/files/documents/2020/10/additional-covid-19-mbs-mental-health-support-additional-10-mbs-mental-health-support-sessions-during-covid-19.pdf

- Long wait times to see a private psychologist or psychiatrists, particularly private paediatric psychiatrists and paediatricians, are significant. Long waitlists can lead to poorer mental health outcomes and adversely impact the continuity of care and therapeutic relationships. The pandemic has exacerbated this issue.
- Private providers are not equally distributed or not available across Queensland, particularly outside of the greater Brisbane area, impacting the service needs of persons in rural and remote locations.
- Many people are not accessing the appropriate support required for their needs, and the treatment drop-out rates demonstrate this. For example, almost half of consumers accessing MBS-rebated psychological therapy used three or fewer sessions, which is generally insufficient to enable recovery[74].
- The Productivity Commission (2020)[75] noted the lack of low-intensity support options available for people who would benefit from low-intensity care and recommended options, which would equally apply to Queensland. This includes supported online treatments and group therapies.
- In terms of the private mental health care system, private health insurers (PHIs) fund mental health treatments delivered within a private or public hospital or through private healthcare providers, including psychiatrists, psychologists, and other allied health professionals.

Pharmacology

- In addition to MBS, the Commonwealth also subsidises the Pharmaceutical Benefits Scheme (PBS) and the Repatriated Pharmaceutical Benefits Scheme (RPBS).
- The cost of pharmaceuticals may be further reduced for concession card holders, people in receipt of the Centrelink pharmaceutical allowance, or those who exceed the annual family safety net threshold ($1542.10 for general patients or $326.40 for general concessional patients).
- Queensland had the third-highest per capita expenditure on mental health-related medications in 2018-19. In the three financial years from 2015-16 to 2018-19, total expenditure on mental health-related pharmaceuticals subsidised under the PBS and RPBS in Queensland remained relatively stable and at the third-highest amount compared to other jurisdictions.
- Evidence suggests that the pressure on the public mental health system in Queensland could be significantly reduced by providing greater access to bulk-billing GPs, private psychiatrists and allied health professionals.

Non-government psychosocial support services

- Whilst the provision of quality and contemporary clinical interventions is essential, recovery is also best supported by holistic and comprehensive approaches that take account of the whole-of-person needs. This includes tailored psychosocial support.
- When delivered through community-based settings, psychosocial support can assist people with lived experience of mental ill-health to establish connections, gain and strengthen skills, obtain secure housing, and meaningfully engage in education, training, and employment.
- Tailored community-based support services that complement clinical mental health services can assist individuals to sustain a living, connect or remain connected to their communities, and reduce the risk of them entering a cycle of acute care, temporary accommodation, unemployment, homelessness, and possibly offending and imprisonment.
- Psychosocial support delivered through community-based settings can further support functional, social, and emotional recovery, provide an alternative to support for people who may not have accessed such intervention, provide complementary interventions for people on a waitlist, or provide ongoing support to people discharged from clinical settings.
- Community-based supports can further provide a more effective approach to intervene where people are experiencing the impact of the social determinants of mental health and reduce pressure off costly tertiary-based services.

[74] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[75] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

- The evidence for the efficacy of psychosocial support services, particularly in combination with other mental health interventions, is considerable. Queensland evidence of this includes but is not limited to the Housing and Support Program.
- Despite the critical role of non-clinical psychosocial supports, there is a vast gap between demand and the provision of support. For example, estimates from the NMHSPF suggest that 690,000 people with mental illness would have benefited from some psychosocial support in 2019-20.
- Among these are 290,000 people with severe and persistent mental illness who are most in need of psychosocial support, while just 88,000 will access support upon full rollout of the NDIS[76].
- Approximately 75,000 people receive psychosocial support directly from other Australian, state and territory government-funded programs[77]. However, there is a significant gap in Australia's provision of psychosocial supports, particularly for those not receiving NDIS support.
- It is estimated that there are somewhere between 551,000 people with *significant mental illness* to 151,000 with *severe and persistent mental illness* who would benefit from psychosocial support, who are missing out[78].
- Community Mental Health Australia has estimated that an additional $610 million per year in Commonwealth Government funding is required to provide psychosocial support services to people with severe and persistent mental illness[79].
- In the 2017-18 Commonwealth Budget, the government committed $80 million over four years for the National Psychosocial Support (NPS) measure funded through the Primary Health Networks (PHNs). This allocation has been extended for two years in the 2021-22 Commonwealth Government Budget ($171.3 million).
- The NPS was designed as an interim transitional means for people previously receiving support through the Personal Helpers and Mentors program (PHaMS), Support for Day to Day Living in the Community (D2DL), Partners in Recovery (PIR), and Mental Health Respite: Carer Support (MHR: CS) to enable the opportunity to test their eligibility for NDIS.
- This investment is non-recurrent and sought to address the gap created when Commonwealth-funded psychosocial programs were cashed out to support the implementation of the NDIS.
- The Queensland Government investment of $267.76 million for psychosocial support services over four years commenced from 1 July 2019.
- Outside of the NDIS, investment into the community mental health sector to provide non-clinical psychosocial support is inadequate to need. This has led to a greater dependence on hospital-based services and services funded through the MBS.
- Contrast this with the New Zealand example, where the target for total HHS spending on psychosocial support is approximately 20-25 per cent[80], contributing to fewer presentations to emergency departments, fewer days in inpatient care, and reduced the rate of admission and readmission.

Service gaps and the missing middle

- The current mental health service system primarily offers support at the two ends of the needs spectrum. Primary and private healthcare services provided by GPs and allied health professionals are designed to support people with mild to moderate needs, while the public mental health system is designed to support people with severe mental health conditions.
- Neither of these service components can meet the needs within their area of responsibility. The pandemic further compounds this issue. As a result, a large and growing group of people have needs that are too 'complex', too 'severe' or too 'enduring' to be supported through primary care alone, but not 'severe' enough

[76] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[77] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[78] Productivity Commission (2020) estimates as cited by Community Mental Health Australia 2021, Community Mental Health Australia 2021-22 Federal Pre-Budget Submission, viewed 9 January 2022, https://treasury.gov.au/sites/default/files/2021-05/community_mental_health_australia.pdf
[79] Community Mental Health Australia 2021, Community Mental Health Australia 2021-22 Federal Pre-Budget Submission, viewed 9 January 2022, https://treasury.gov.au/sites/default/files/2021-05/community_mental_health_australia.pdf
[80] Meadows, G, Farhall, J, & Fossey, E 2020, Mental Health and Collaborative Community Practice 4e eBook: An Australian Perspective, Oxford University Press Australia and New Zealand, Melbourne. Available from: ProQuest Ebook Central. [13 January 2022].

to meet the strict criteria for entry into specialist mental health services. As a result, people receive inadequate or inappropriate treatment, care, and support or remain untreated.

- This group of people is sometimes termed the 'missing middle', and the service gaps here present a significant challenge in Queensland and nationally.
- Service gaps at the ambulatory care and community-based levels are a driver of increased presentations to the emergency department. High demand on emergency departments further means that people may experience lengthy delays in assessment and treatment, particularly if inpatient care is required[81]. In addition, the emergency department can be inappropriate, unsuitable, or harmful environments for people experiencing significant distress[82].
- The current demand for crisis care and support could be reduced by adequate and appropriate resourcing at the non-acute/middle level of healthcare. Adequate and commensurate resourcing at this level would enable support to people whose needs cannot be solely supported through primary healthcare but who also miss out on the more clinical, community and hospital-based mental healthcare and support due to high demand[83].
- Treatment and support available outside of the hospital environment, for example, peer and clinician-led, provided after-hours or through mobile teams, would better support needs, stem the escalation to acuity and reduce pressure on more costly systems.
- In the 2020-21 Budget, the Commonwealth Government announced funding targeting the missing middle. This included establishing a network of community-based centres called Head to Health for adults and children.
- Despite the potential of these service approaches, Queensland is likely to receive a limited number of the Head to Health centres.
- Data shows that less than one per cent of 0–4-year-olds received a mental health service in any one service setting. The consequences of not investing in the mental health needs of children at the earliest stages of life mean denying thousands of children the opportunity to reach their life potential as well as accumulating substantial financial costs, as many of these children eventually become clients of the justice, child protection and disability sectors.
- Access for rural and remote living families to various services across Queensland remains difficult.
- Telehealth service delivery has provided an opportunity for individuals, families and support people in rural and remote locations to access secondary consultations through telehealth systems. However, online connectivity and access to ICT hardware remain an issue in some instances.
- The Queensland Centre for Perinatal and Infant Mental Health's ePIMH service is an example of this service type in Queensland. For the optimal impact of the ePIMH work, it is recommended that the service be combined with face-to-face delivery of consultations and interventions.

Terms of Reference 1(c): opportunities to improve economic and social participation of people with mental illness through comprehensive, coordinated, and integrated mental health services (including alcohol and other drugs and suicide prevention):

a. across the care continuum from prevention, crisis response, harm reduction, treatment, and recovery
b. across sectors, including Commonwealth funded primary care and private specialist services, state-funded specialist mental health services, non-government services and services funded by the NDIS

- To genuinely improve the social and economic participation of people living with mental illness, a wide-angle view is required, well beyond a focus on clinical outcomes.

[81] Duggan M, Harris B, Chislett WK & Calder R 2020. *Nowhere else to go: Why Australia's health system results in people with mental illness getting 'stuck' in emergency departments*. Mitchell Institute Commissioned report 2020, Victoria University, viewed 9 January 2022, https://acem.org.au/getmedia/5ad5d20e-778c-4a2e-b76a-a7283799f60c/Nowhere-else-to-go-report_final_September-2020

[82] Duggan M, Harris B, Chislett WK & Calder R 2020. *Nowhere else to go: Why Australia's health system results in people with mental illness getting 'stuck' in emergency departments*. Mitchell Institute Commissioned report 2020, Victoria University, viewed 9 January 2022, https://acem.org.au/getmedia/5ad5d20e-778c-4a2e-b76a-a7283799f60c/Nowhere-else-to-go-report_final_September-2020

[83] Kaleveld L, Hooper, Y, Clark, K, Dufour, R, Olekalns, A & Elmes, A, *Mental health deep dive: community consultations and final report*, Centre for Social Impact, University of Western Australia, University of New South Wales and Swinburne University of Technology

- This includes taking full account of the context of people's lives and living experiences and providing responses and supports that enable full and contributing lives across the lifespan.
- Through *Shifting minds*, the Queensland Government adopts a policy position that builds a future mental health system on four pillars, timely and quality access to clinical services, psychosocial support, access to affordable housing, and continuation and return to education and employment.
- The actions and strategies to improve social and economic participation need to be matched to age, developmental status, and social and cultural factors.
- Informed by the clear evidence, *Shifting minds* also gives equal priority to improving the mental health and wellbeing of the population, reducing vulnerability among known groups with increased risk of mental illness, and early intervention in the onset of mental health challenges.

Promotion, prevention, and early intervention

- Ensuring early and seamless access to quality and responsive mental health services for people experiencing signs and symptoms of mental health challenges is vital for reducing the severity and duration of episodes of illness and improving quality of life outcomes.
- However, a treatment approach will not reduce the prevalence of mental illness in the population.
- Strategies are required to:
    - support people to stay mentally well
    - prevent the development of mental illness, particularly in high-risk groups, and
    - provide early intervention supports and services.
- Responsibility for promoting wellness, preventing illness, and to a great degree intervening early, is the responsibility of agencies and social networks beyond the health system.
- These interventions occur in settings where people are born, live, play, learn, work and age. This includes families, educational settings, communities, workplaces, and places for retirement.
- Sustained and targeted investment in prevention and early intervention has been minimal over the years and not commensurate to the evidence, clearly showing the potential return on investment. Conversely, funding is prioritised to treatment and late inventions.
- Promoting wellness has received some traction in Queensland and demonstrated positive impacts, including through state and national initiatives such as the partnership with Beyond Blue, Mental Wellbeing Capacity Building (Wheel of Wellbeing), and the *Dear Mind: Your Mental Wellbeing* campaign.
- The evidence suggests that prevention is highly effective with known high-risk groups such as families in contact with child safety, disengagement with education, young people coming to the attention of youth justice,
- Education Queensland initiatives, including dedicated mental health coaches and allied health professions and GPs in schools, are good prevention and early intervention measures occurring outside the health context.
- The Commonwealth Government has rolled out over 150 Headspace Centres nationally to provide early intervention services for young people aged 12-25 years.
- Notwithstanding all the challenges of the funding model that underpins Headspace Centres, this is an example of an effective systemic initiative that provides access to young people experiencing situational crises related to education, family, finances, relationships, and so forth.
- There is no such service equivalent for the under 12 years or the adult population. However, the new Head to Health centres may meet some of this need, noting the current funding will support a few centres across the nation relative to need.

Mental health-promoting communities and social isolation

- A person's mental health and wellbeing are interconnected with the social conditions and the kind of society they live in[84].
- While not discounting the vital role of individual factors, the ordinary spaces and everyday life settings, including community, exert substantial influence over individuals and groups' mental health and wellbeing of individuals and groups. In many respects, people's lives are most acutely influenced at the local level – in their neighbourhoods and communities.
- It is in these environments that mental health and wellbeing can be supported and improved, and the influence of the conditions and factors that diminish our mental health can be reduced.
- A wide range of factors that support good mental health and prevent mental illness operate or can be influenced at the community level, including:
    - being included socially and connected with others
    - having control over one's life
    - having a sense of purpose and future
    - meaningful participation in learning, work, and community
    - having access to housing, income, and other resources and services, and
    - being safe and free from violence and discrimination[85].
- Communities and groups can also negatively affect the mental health and wellbeing of community members.
- Factors such as stigma, racism, persistent socioeconomic disadvantage, loneliness, and trauma can be significant barriers to social participation and are strongly associated with mental ill-health (Productivity Commission 2020 p. 353).
- People with a lived experience of mental illness frequently experience disadvantage, marginalisation, and exclusion. Stigma and discrimination can have an even greater effect on the quality of life and recovery than the mental health problem itself, as stigma can affect people long after their mental health symptoms have been resolved.
- Social isolation and loneliness are experiences of disconnection from others and are generally experienced as negative and painful states. The influence is bi-directional. People experiencing social isolation are more likely to have higher levels of distress and mental ill-health. Additionally, mental ill-health can affect the quality of relationships, which can contribute to social isolation and impedes recovery.
- 196 submissions were made to the 2021 Queensland Parliamentary Inquiry into social isolation and loneliness, demonstrating a strong level of interest in this issue by many organisations and groups.
- Neighbourhood and community centres across Queensland were particularly highlighted in the report for the valuable contribution they can and do to prevent and respond to social isolation and loneliness.
- The Committee recommended that the Queensland Government develop a 10-year state-wide strategy to address social isolation and loneliness[86].
- Implementation of a plan to address social isolation and loneliness would significantly enhance mental health and wellbeing in Queensland.

Supporting children and young people

- Compelling outcome evidence demonstrates the significant and ongoing benefits of early intervention, whether early in life, vulnerability, or early in the onset of illness.
- The perinatal and infant period or the first 2000 days commence at conception to the child's fifth birthday. It is a critical time of life for optimal physical, cognitive, social, and emotional development and growth. In addition, what happens during the first 2000 days has been shown to have an impact across the lifespan.

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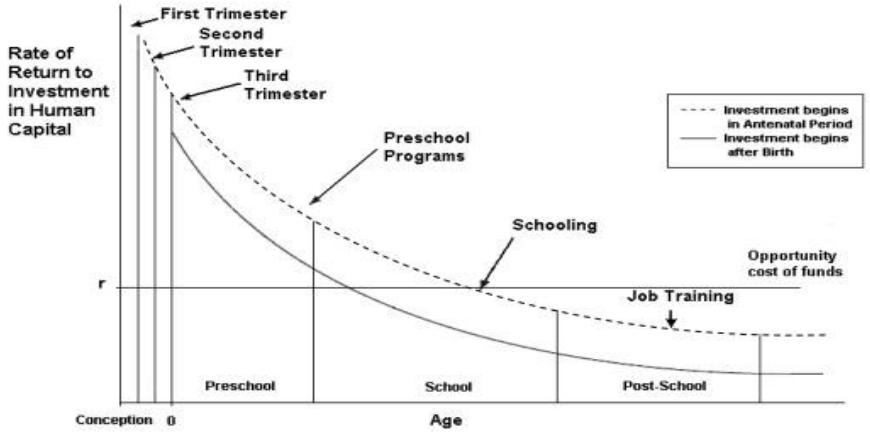
[84] Bacon N, Brophy M, Mguni N, Mulgan G and Shandro A. The State of happiness: Can public policy shape people's wellbeing and resilience? The Young Institute: London. 2010
[85] Cooke A., Friedli L., Coggins T, Edmonds N., Michaelson J, O'Hara K, Snowden L, Stansfield J,
Steuer N, Scott-Samuel A. Mental Wellbeing Impact Assessment Toolkit 3rd ed., London: National
MWIA Collaborative. www.apho.org.uk/resource/item.aspx?RID=95836 .2011
[86] Community Support and Services Committee 2021, Inquiry into social isolation and loneliness in Queensland - Report No. 14, 57th Parliament, viewed 9 January 2022, https://documents.parliament.qld.gov.au/TableOffice/TabledPapers/2021/5721T2070.pdf

- Preventative interventions should begin before conception and pregnancy. The foetal environment and maternal health behaviours have significant long-term consequences for the infant's health and development.
- For example, nutritional intake, problematic AOD use, and domestic and family violence can all have implications for the infant's neurodevelopment and health throughout the life course.
- Nobel winning economist James Heckman (Doyle et al. 2009) argues that where investment in prevention and early intervention services occurs from the first trimester, the return-on-investment rate is the highest and continues throughout the child's trajectory[87].

Figure 11: Rates of return to human capital investment setting[88] - investment to be equal across all ages



Rates of return to human capital investment setting investment to be equal across all ages

- Secure attachment and a positive family environment are fundamental to healthy child development[89].
- The mental health and wellbeing of parents are critically important to their baby's emotional and physical development. If left untreated, parental mental health issues can negatively impact the parents, their baby, and family.
- Parenting support must commence from conception with models of sustained maternal home visiting demonstrating substantial benefits for the infant and parents, as well as the longer-term economic returns.
- Home visitation should include a focus on the infant's early development and supporting responsive caregiving attachment relationships. Despite high-quality maternity and child health programs, expansion, and upscaling of comprehensive maternal home visitation models, is required, particularly for higher needs groups.
- Highly stressful or traumatic early life experiences may have enduring negative impacts on a child or young person's physical, social, and emotional development.
- Adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood. ACEs can include witnessing domestic and family violence, experiencing child abuse (physical, emotional or sexual) and neglect, growing up in a family with parental mental health or substance use problems, or family instability due to parental separation, divorce or incarceration.
- The experience of one or more ACEs and associated toxic stress are linked to increased risk for numerous adverse outcomes, including a wide range of chronic diseases and leading causes of morbidity and mortality such as cancer, diabetes, heart disease, suicide and drug overdose.[90]

[87] Doyle, O, Harmon, C, Heckman, J & Tremblay, R 2009, 'Investing in Early Human Development: Timing and Economic Efficiency' in *Economics & Human Biology*, vol.7, issue.1, pp.1-6
[88] Doyle, O, Harmon, C, Heckman, J & Tremblay, R 2009, 'Investing in Early Human Development: Timing and Economic Efficiency' in *Economics & Human Biology*, vol.7, issue.1, pp.1-6
[89] Prevention United 2020, *Prevention Coalition in Mental Health: Primed for Prevention – a consensus statement on the prevention for mental disorders*, viewed 9 January 2022, https://preventionunited.org.au/advocacy/preventioncoalition/
[90] Centers for Disease Control and Prevention 2019, *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence*, viewed viewed 12 January 2022, https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

- Individuals reporting four or more ACEs/neglect are 7.69 times more likely to have depression than those reporting no ACEs.
- ACEs and their associated harms are preventable. Even one positive, caring relationship can act as a buffer against the effects of toxic stress and substantially improve a child's recovery from stressful life events[91].
- Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full health and life potential.
- Substance abuse during pregnancy can result in structural and neurological deficits in the foetus that have lifelong impacts on function, including physical abilities, cognition, learning and behaviour, and general health and wellbeing.
- FASD is the most common non-genetic cause of intellectual impairment in the western world.
- More children are born each year with FASD than with autism, spina bifida, cerebral palsy and Down Syndrome combined. Between 17 and 42 children are born in Australia each day with FASD, between 3 and 9 of these in Queensland[92].
- There is strong Queensland cross-agency support for a focus on early years, childhood, and adolescence from early prenatal care for mothers to ensuring children get the best start in life, including health, family support, financial wellbeing, education, housing, and disability[93].
- The Queensland Government can strengthen its leadership role to nurture and enhance the mental health and wellbeing of infants and young children across the first 2000 days of life as the backbone of minimising the economic and societal impact of mental illness in Queensland. This investment will create gains not only for the generation of children living in Queensland in 2022 but for future generations as the societal and economic benefits grow and develop.
- Beyond the early years, prevention and early intervention can improve the lives of children and young people and strengthen our communities while reducing pressure on government budgets, enabling more efficient and effective spending, and boosting workforce skills and capabilities[94]. There are many evidence-based approaches and programs that can be supported and upscaled.
- There is no possible better return on investment, with the cost of inaction considerable and far-reaching.

Housing and homelessness

- Access to safe, secure, and affordable housing is a significant contributing factor to keeping people well, preventing mental ill-health and promoting long-term recovery.
- The relationship between housing, homelessness, mental illness and problematic AOD use is strongly interrelated, highly complex and bi-directional[95]. However, integration across the mental health, housing and homelessness systems remain inadequate[96].
- People with lived experience of mental illness and problematic AOD use have greater housing instability, poorer housing quality, variability in housing pathways, less choice of living conditions and neighbourhood amenities, and are highly vulnerable to homelessness. In addition, comorbid physical and mental health issues can undermine the ability to maintain and sustain a home, further impacting the security of tenure.

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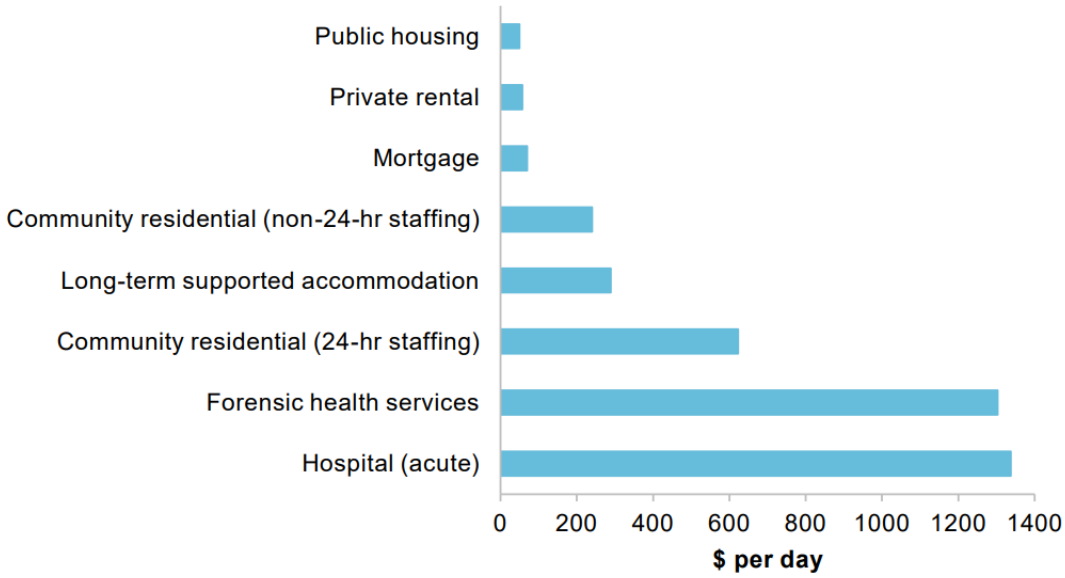
[91] Emerging Minds 2021
[92] https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/qcycn/fasd-pos-statement.pdf
[93] Atkinson, B 2018, Report on Youth Justice - from Bob Atkinson AO, APM, Special Advisor to Di Farmer MP, Minister for Child Safety, Youth and Women and Minister for Prevention of Domestic and Family Violence, viewed 12 January 2022, https://www.cyjma.qld.gov.au/resources/dcsyw/youth-justice/reform/youth-justice-report.pdf
[94] William Teager, Stacey Fox and Neil Stafford, *How Australia can invest early and return more: A new look at the $15b cost and opportunity.* Early Intervention Foundation, The Front Project and CoLab at the Telethon Kids Institute, Australia, 2019.
[95] Australian Housing and Urban Research Institute 2020, *Mental Health and Housing*, viewed 9 January 2022, https://www.ahuri.edu.au/analysis/policy-analysis/mental-health-and-housing
[96] Australian Housing and Urban Research Institute 2020, *AHURI submission to the Productivity Inquiry on Mental Health*, viewed 9 January 2022, https://www.pc.gov.au/__data/assets/pdf_file/0018/251118/sub885-mental-health.pdf

- Mental ill-health may prompt or precipitate homelessness[97]. In the year before accessing support, specialist homelessness services (SHS) clients further were significant users of non-homelessness services, including health, justice, emergency, and welfare services, compared with the broader Australian population[98].
- The effects of homelessness can be far-reaching, affecting adults, families, children and young people.
- For persons experiencing mental ill-health, it is difficult to access and navigate both housing and mental health systems without appropriate support; and are often required to balance their mental health needs and their housing needs due to the incompatibility of the two systems[99].
- There is extensive evidence of diverse models that successfully deliver person-centred and recovery-oriented housing. However, such models cannot meet the current and growing demand, requiring consideration to consolidate what works, scale up, and expand programs to meet current and future demand[100].
- Whilst there is no one-size-fits-all approach, certain elements and principles are evidenced to facilitate positive outcomes. These include:
    - access to affordable, appropriate, and stable housing
    - policy and stakeholder coordination
    - integrated, person-centred support with seamless wrap-around service delivery, and
    - provision of programs to support diverse needs[101].
- The Productivity Commission (2019) found that housing and mental health supports enable people to live in the community 'can also be cost-effective where they help people avoid spending time in relatively higher cost acute settings, such as residential mental healthcare or hospitals'.
- This would make available numerous beds for people who require them and reduce a large percentage of bed blocking in the current system.
- Various jurisdictional surveys have suggested that 30 per cent of admitted patients (about 2000 people or 650,000 inpatient bed days) in psychiatric wards could be discharged if appropriate housing and community services (clinical and psychosocial) were available[102].
- The Productivity Commission (2020, p.44) concluded that 'for each individual retained in an acute hospital bed, who could be treated (at least as well) in a non-acute bed-based service, the health system is overspending'[103].

[97] Australian Housing and Urban Research Institute 2020, *AHURI submission to the Productivity Inquiry on Mental Health*, viewed 9 January 2022, https://www.pc.gov.au/__data/assets/pdf_file/0018/251118/sub885-mental-health.pdf
[98] Australian Housing and Urban Research Institute 2019, *Mental health and housing*, viewed 16 January 2022, https://www.ahuri.edu.au/policy/policy-analysis/mental-health-and-housing
[99] Australian Housing and Urban Research Institute 2020, Trajectories: the interplay between housing and mental health pathways: report for national consumer and carer consultations, viewed 9 January 2022, https://www.ahuri.edu.au/sites/default/files/migration/documents/Consumer-Report-Trajectories-the-interplay-between-housing-and-mental-health-pathways.pdf
[100] Brackertz, N, Davison, J & Wilkinson, A 2019, Trajectories: the interplay between mental health and housing pathways: A short summary of the evidence, viewed 9 January 2022, https://www.ahuri.edu.au/sites/default/files/migration/documents/Trajectories-the-interplay-between-mental-health-and-housing-pathways.pdf
[101] Brackertz, N, Davison, J & Wilkinson, A 2019, Trajectories: the interplay between mental health and housing pathways: A short summary of the evidence, viewed 9 January 2022, https://www.ahuri.edu.au/sites/default/files/migration/documents/Trajectories-the-interplay-between-mental-health-and-housing-pathways.pdf
[102] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[103] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

Figure 12: Average daily ongoing cost of accommodation per person[104]



- Programs that support discharge from acute mental healthcare or prisons can prevent people residing inappropriately within institutional care or discharged into homelessness.
- For example, an evaluation of the Queensland Government's Transitional Housing Team program (Siskind 2014) found that participants experienced significantly fewer inpatient bed days and improved living conditions.
- This reduced the average cost of health service use by about $38,600 per participant, and offset the $31,200 per participant cost of the program. In addition, the program provided an estimated return on investment of about $1.24 per dollar invested.
- Additionally, psychosocial support programs like the *Housing and Support Program* (HASP) decreased the average time spent within inpatient care from an average of 227 days per year to 19 days per year[105]. This program was subsumed into the NDIS as such clients were eligible to receive NDIS. However, this program has not been replaced with an equivalent program for persons ineligible for NDIS.
- Improving housing stability for people living with significant and persistent mental illness has demonstrated improvements in health, community participation, education and employment outcomes, and reduced interactions with emergency, acute and tertiary services.
- The success of integrated supports for people with a mental illness that focus on joint solutions across the complexities of their circumstances, including health, employment, social connection, and family, are well recognised. For example, recent research found that job placements increased by 71 per cent with the implementation of psychosocial interventions[106].
- The *Queensland Housing and Homelessness Action Plan 2021–2025* commits to enhancing the Coordinated Housing and Homelessness Response in priority locations across the state to identify people experiencing homelessness and to coordinate services for people with complex housing and support needs.

Income and employment support

- Employment can be crucial to positive mental health and wellbeing, and there is considerable scope to reduce the barriers to economic participation.
- Sustained unemployment has far-reaching consequences for individuals, families and the broader community.

[104] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[105] Meehan, T, Madson, K, Shepherd, N & Siskind, D 2010, *Final evaluation report of the Queensland Government's Housing and Support Program*, viewed 10 January 2022, https://www.yumpu.com/en/document/read/12188634/housing-and-support-program-hasp-final-evaluation-report
[106] Coppin, D, Ciarrochi, J, Sahdra, B & Rosete, 'A jobseeker segmentation and intervention program' *PsyArXiv,* viewed 9 Janury 2022, https://psyarxiv.com/nmkzw/

- However, workforce exclusion is a complex and enduring problem in Australia. Some job seekers are more likely to be disadvantaged in the labour market than others, contributing to reduced productivity, lower wages, reduced economic growth, lower taxation-based revenue and higher welfare.
- People with a lived experience continue to face additional challenges in obtaining and keeping paid work, particularly employment of their choosing.
- While services exist to support employment opportunities, the complexity of available support services may prevent potential participants from effectively navigating the system to meet their support needs best.
- Employment services are predominantly the responsibility of the Commonwealth Government.
- Programs including Job Services Australia (JSA) and Disability Employment Services (DES) seek to support people with mental ill-health or problematic AOD to enter/re-enter employment.
- The Individual Placement and Support (IPS) model has demonstrated effectiveness and provides the government with a proven intervention with long-term savings implications.
- Queensland Government programs such as *Skilling Queensland* and *Back to Work* are focused on employment readiness and have been relatively successful in helping people with mental ill-health, and problematic AOD use to prepare for entering or re-entering work.
- However, more is needed and specifically targeted at people with mental ill-health and problematic AOD use.
- Both the Commonwealth and State Government have funded the development of various social enterprises focusing on vulnerable Queenslanders, including people living with mental ill-health and problematic AOD use.
- Social enterprises seek to address social concerns, improve communities, or provide access to employment and training. Their income is sourced from trading, with most profits reinvested to support their overarching goal[107].
- Increased investment and resources are required to support the establishment of medium-to-large social enterprises. The social enterprise model of employment for people with mental illness provides an opportunity to create supportive environments for workers that are likely to have the strongest positive impact, help break down stigma and discrimination, and ensure a greater likelihood that workers will remain employed long-term[108].
- Studies in Scotland[109] and Australia[110] showed that social-purpose companies benefitted employees with a mental illness by providing social and vocational skills and a sense of inclusion and distraction from psychological symptoms and worry. Other studies have shown that a pleasurable and supportive environment with positive physical and mental stimuli, combined with strong relationships, are critical to overcoming problematic AOD use[111].

Mentally healthy workplaces

- There are strong correlations between employment and mental health[112]. Mentally healthy workplaces attract and retain skilled staff and enable high levels of engagement, performance, productivity and quality of outputs/outcomes.
- Mentally healthy workplaces can enable economic and social inclusion and participation or cause mental stress.
- Workplaces offer opportunities to support the mental health and wellbeing of the workforce, with strong evidence outlining a significant rate of return from creating and supporting mentally healthy workplaces.
- Conversely, factors relating to poor work design, excessive work demands, and poor psychosocial work conditions can increase the risk of mental illness.
- The national cost of lower economic participation and lost productivity ranges from $12 to $39 billion due to lower employment, absenteeism, and presenteeism[113].

[107] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[108] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[109] Svanberg et al 2010
[110] Williams et al 2012
[111] Hari, 2015
[112] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[113] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

- The national cost of workplace absenteeism and presenteeism due to mental ill-health ranges from $13 billion to $17 billion per year[114].
- On average, it is estimated that people with mental ill-health reported that they reduced the amount that they worked by 14-18 days per year due to psychological distress[115].
- However, it is estimated that the return on investment for every dollar spent creating mentally healthy workplaces is between $2.30[116] and $4.00[117].
- Evidence supports an integrated model for workplace mental health that includes efforts to prevent and reduce psychosocial work-related risk factors, promote the positive aspects of work, and identify and intervene early when mental health issues occur.
- In Queensland, substantial expertise and an extensive program of workplace mental health activities are supported through the leadership of key stakeholders.
- Workplace Health and Safety Queensland (WPHS), Office of Industrial Relations (OIR) provides leadership in setting the workplace mental health policy direction and building cross-sector capacity. This includes:
    - drafting a soon to be released *Managing the risks of work-related psychosocial hazards Code of Practice*
    - development and implementation of the *Queensland Mental Health at Work Action Plan* (currently being revised)
    - *Mentally healthy workplace toolkit*, *People at work* being the only Australian validated psychosocial risk assessment psychosocial tool for workplaces, and
    - the Leading Well Queensland initiative.
- The Queensland Public Service Commission (PSC) contributes by focusing on the public sector workforce.
- Queensland government agencies also develop and implement workplace mental health frameworks and action plans.
- The Commission, OIR and PSC maintain close collaborative links with the National Mental Health Initiative funded by the Australian government and auspice by the National Mental Health Commission.
- In September 2021, the National Mental Health Commission released the first iteration of The Blueprint for Mentally Healthy Workplaces for review.
- The Blueprint aims to define a vision of mentally healthy workplaces that all organisations and businesses across Australia can share. It also defines the core principles and focus areas to create environments that protect, respond, promote and support mental health.
- The evidence demonstrates the potential return on investment of appropriately resourced and evidence-based mentally healthy workplace approaches in Queensland.
- Queensland has available significant cross-agency commitment, leadership, and expertise.
- Greater investment is required in the sectors and portfolios equipped to deliver on this potential, such as the Office of Industrial Relations.
- Current resourcing is not adequate to the need, and the cost of not remedying this is not only short term but also has significant longer-term ramifications.

Older persons mental health

- Mental health and wellbeing are as important in older age as at any other age within the life-course.
- At the population level, the prevalence of mental illness decreases with age, with the prevalence of mental ill-health lowest between 75-85 years[118].

[114] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[115] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[116] Pricewaterhouse Coopers 2014
[117] Yu and Glozier 2017
[118] Australian Institute of Health and Welfare (2015) Australia's Welfare 2015: Feature Article - Mental Health of Older Australians, series no 12. Cat. No. AUS 189. AIHW, Canberra

- The rate of depression in the older population is thought to be between 10 per cent and 15 per cent. This contrasts with the rate of depression among people living in residential aged-care care, approximately 35 per cent[119].
- Older Australians often experience a combination of complex physical illness and mental health problems.
- Experiencing comorbid mental and physical ill-health often involves poorer outcomes for individuals than if they experience mental illness or physical ill-health alone[120].
- Mood disorders are also common in people with dementia. For example, about 20–30 per cent of people with dementia also experience depression[121].
- Suicide rates in men over 85 years are disproportionately higher than those in the remainder of the population[122].
- Older people can have outdated views of mental ill-health, seeing it as a weakness or character flaw, discouraging help-seeking behaviours[123].
- Promoting the mental wellbeing of older adults involves creating living conditions and environments that support wellbeing and facilitate people leading healthy life. Promoting mental health depends largely on strategies to ensure that older people have the necessary resources to meet their needs, such as:
    - secure and appropriate housing
    - social support for older people and their caregivers
    - health and social programs to support vulnerable groups such as those who live alone or who suffer from a chronic or relapsing mental or physical illness, and
    - programs to prevent and deal with elder abuse.
- Integrated services that address physical and mental health problems, and skills in recognising the risk factors for suicide, are central to achieving effective outcomes for older Australians (COAG Health Council 2017).
- The Aged Care Royal Commission Final Report (2021)[124] noted that older people with mental health conditions are not adequately addressed across the aged care system.
- The Royal Commission found it is often difficult for people living in residential aged care to access specialist mental health services, such as psychologists and psychiatrists. Furthermore, many staff members working in aged care are not sufficiently skilled or trained to identify and support people living with mental health conditions[125].

Integrated treatment, care and support

- Over the years, successive state and national governments have identified the overarching goal to ensure effective mental health treatment, care and support, when and where required.
- However, despite this strategic intent, consumers regularly report a patchwork of services that are not commensurate with consumer needs but rather are reflective of historical funding models[126].
- The responsibility is frequently on the individual to navigate and connect with different parts of the mental health system and other service points, such as financial support or housing. The mental health system is complex, with little continuity between providers, settings and types of treatment, care, and support[127].
- Consistently, we have heard from people with lived experience, their families, carers and support people that they seek a mental health system that enables:

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[119] BeyondBlue (2022) Older People, accessed 13 January 2022 at <https://www.beyondblue.org.au/who-does-it-affect/older-people
[120] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[121] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[122] COAG Health Council (2017) The Fifth National Mental Health and Suicide Prevention Plan, Canberra
[123] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[124] Royal Commission into Aged Care Quality and Safety 2021, *Final report: Care, Dignity and Respect*, viewed 9 January 2022, https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-1_0.pdf
[125] Royal Commission into Aged Care Quality and Safety 2021, *Final report: Care, Dignity and Respect*, viewed 9 January 2022, https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-1_0.pdf
[126] State of Victoria 2021, *Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations*, Parl Paper No. 202, Session 2018–21, viewed 9 January 2022, https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf
[127] State of Victoria 2021, *Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations*, Parl Paper No. 202, Session 2018–21, viewed 9 January 2022, https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf

  - access and navigational support to timely, quality and appropriate treatment, care and supports (clinical and non-clinical) across the spectrum of severity
  - a system and services that promote inclusion, as opposed to exclusion, and address the inequities that prevent access to a flourishing and prosperous life
  - access to community-based supports when required and where they will benefit most, and that this be supported by commensurate inpatient care and community residential services, and
  - access to evidence-based, trauma-informed, culturally appropriate, and person-led psychological, pharmacological, and psychosocial interventions, where the person, their families, carers and support are placed at the centre.
- A significant proportion of the mental health system is traditionally planned around clinical interventions that focus on symptom reduction. However, effective responses to enable whole-of-person, quality-of-life outcomes requires the clear integration and coordination of a comprehensive range of hospital-based care, community clinical treatments, community-based psychosocial support, primary healthcare, and non-clinical systems and services, including housing, employment, and education[128].
- A more balanced approach requires a shift towards the community as the critical place where mental health and AOD services and support are provided, with hospital-based care, including emergency departments and inpatient care being a fundamental element but not the front door to mental health treatment, care and support.
- Achieving this balance, however, will require a fundamental shift in the role and structure of the mental health
- Integration needs to occur at diverse levels. However, the concept of integration is commonly misunderstood and regularly and interchangeably used with concepts of partnerships and collaboration.
- Integration has been challenging to achieve in Queensland and Australia for many reasons. This includes having different levels of government funding different aspects of mental health care, lack of joint planning, minimal co-commissioning and policy misalignment.
- Certain service areas traditionally feature more significant challenges to integration. For example, these include integrated models across mental health and AOD services or between mental health and housing and homeless services.
- An integrated system response would eliminate service gaps and inconsistencies between and within public, private and non-government services. In addition, integrated approaches that support whole-of-person, quality-of-life outcomes would further eliminate the need for the consumer, their families, carers, and support people to navigate and negotiate access to services across different service types.
- With this, integrated responses would further address the need for consumers to understand the diverse and often inconsistently applied inclusion and exclusion criteria and the need to understand the divide between clinical and non-clinical care.
- Integration occurs when there is a common purpose, joint governance and accountability, joint planning, co-commissioning of services, co-location of integrated and interoperable services with digital mental health services, and no exclusion criteria. In addition, supporting people with lived experience with their diverse needs requires one overarching client care plan underpinned by one client information management system and a systematic collection of standard outcome measures.
- In Queensland, we have some good examples of co-planning occurring across HHSs, PHNs, NGOs and the private sector. An example of this is the *Health Alliance* between Metro North HHS and Brisbane North PHN.
- Similarly, Queensland has made a small step in the right direction with Queensland Health and PHNs co-commissioning Way Back services for people who present to emergency departments with suicidal ideation.
- Examples of successfully integrated service responses in Queensland and New South Wales include the Floresco Centres in Ipswich and Toowoomba and the Like Minds Centres in New South Wales. Toowoomba has now closed due to the lack of funding.

[128] Nous Group & Medibank 2013, The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design, viewed 9 January 2022, https://www.medibank.com.au/Client/Documents/Pdfs/The_Case_for_Mental_Health_Reform_in_Australia.pdf

- Both Floresco and Like Minds Centres have been independently evaluated and overwhelmingly demonstrated positive consumer and system outcomes.
- The rapid response models that stood up at the commencement of the pandemic have produced examples of effective cross-agency planning and delivery, with positive impacts on consumer lives and improved service provider cooperation and responsiveness. In the main, the pandemic forced the broader systems, clinical and non-clinical, to:
    - be more creative and flexible in the way we conceive, commission and deliver services
    - overcome barriers to information and data sharing to enable informed, real-time decision making
    - increase coordination, collaboration and cooperation across and beyond the mental health and AOD sectors
    - prioritise the need to support people with appropriate, quality and timely responses in situ, and
    - to consider the importance and need to rebalance the system within and beyond the health sector.
- The pandemic resulted in the rapid mobilisation of support within and beyond the mental health, AOD, suicide prevention and related sectors, driving new ways of working together. This is particularly evident through a shift in service delivery models, emphasising community-based support and the integration of telehealth and online support. Our challenge is to review, evaluate and consolidate the innovation, gains and lessons learned from this experience as part of the longer-term reform agenda.

Terms of Reference: 1(d): the experiences and leadership of people with lived experience of mental illness, problematic substance use and suicidality and their families and carers

- Queensland has a long history of consumer and carer engagement, participation and leadership at various levels, including mental health advocacy, service delivery, service provider training, funding, planning and policy.
- In 1977, the Queensland Department of Health established the first *Office of the Patients' Friend*, to the establishment of mental health *Consumer Advisory Groups* (CAG) across several local health districts, and the subsequent establishment of the state-wide Queensland Consumer and Carer Advisory Group to provide advice, feedback and input into service planning, policy and quality processes.
- In response to the *National Standards for Mental Health Services*, specifically Standard 3 (Consumer and Carer Participation), Queensland Health developed the *Consumer, Carer and Family participation Framework* (2010).
- Over the next several years, local hospital districts started employing *Consumer / Carer Consultants* within the mental health settings to assist consumers (and their carers) and advocate on their behalf for service improvements. Queensland Health also developed a state-wide consumer and carer participation reimbursement schedule to ensure that consumers and carers were adequately reimbursed for their time, travel and out of pocket expenses.
- To assist public, non-government and private mental health and AOD services to improve and increase the engagement of people with a lived experience, their families and carers in service delivery, the Commission developed *Stretch2Engage (2015).*
- In 2018 the Queensland Health Mental Health, Alcohol and Other Drugs Branch released the *Lived Experience Engagement and Participation Strategy* (*LEEP Strategy*). The *LEEP Strategy* committed Queensland Health to engaging people with lived experience in state-wide policy and planning development activities across every level of the public mental health and AOD system.
- Recently the Commission released the *Queensland Framework for the development of the Mental Health Lived Experience Workforce*, and the National Mental Health Commission also released the *Lived Experience (Peer) Workforce Development Guidelines.* Both documents aim to inform employers and funding bodies about the benefits of the Lived Experience workforce and assist them in assessing their local readiness and prioritising activities that support successful implementation.
- Actions associated with the *Queensland Framework for Mental Health Lived Experience Workforce* include lawfully creating identified positions for people with a lived experience and advertising and appointing people who have a lived experience to those positions. In addition, the ability to advertise identified lived experience

positions can remove a perceived systemic barrier, enabling more organisations to employ and grow the lived experience workforce in Queensland.

- Developing the lived experience workforce at all levels is critical to building relationships based on a collective understanding of shared experience, self-determination, empowerment, and providing an essential resource for change. Therefore, thriving mental health lived experience workforce is considered a vital component of quality, recovery-focused mental health services.
- Currently, the Commission is auspices the establishment of the *Queensland Mental Health Lived Experience Peak* (the Peak), building on initial scoping work undertaken by Queensland Health with support of Health Consumers Queensland. This is the next step in a long journey to give people with a lived experience independent and meaningful input and engagement at every level and across all aspects of mental health in Queensland.
- Peer organisations have been agents of change in the AOD sector in Queensland and Australia for decades.
- In 1988 Queensland was one of the first states to establish a lived experience organisation representing people who use drugs. This organisation continues to operate today.
- The key findings of a project undertaken by QNADA in 2020 (Queensland Network of Alcohol and other Drug Agencies) on the need to establish an AOD peer peak found that:
    - the population of people who use drugs in Queensland is heterogeneous, and they represent the breadth of diversity of society.
    - the benefits of engaging service users (and potential service users) in service system planning and development are well established. However, there are significant barriers to engaging people who have a lived experience of problematic substance use with adequate representation across the diversity of the population, and
    - the criminalisation of the use and possession of illicit substances, and the stigma and discrimination faced by people who use drugs, acts as a significant barrier in the engagement and participation of these populations.
- In recent years, lived experience has also emerged as a significant innovation in suicide prevention. Again, Queensland is a leader in this area with the establishment of the non-government organisation *Roses in the Ocean* in 2008. *Roses in the Ocean* is Australia's leading lived experience of suicide organisation, with lived experience suicide prevention initiatives locally and nationally.

TOR 1(e): the mental health needs of people at greater risk of poor mental health

- The experience of mental health and wellbeing and mental illness is not uniform and varies across population groups, influenced by the interaction of individual, social, economic and cultural factors.
- To effectively improve mental health and wellbeing and reduce the risk of mental illness among at-risk groups, tailored responses are required that address their specific contributing factors and circumstances commensurate to need.
- Evidence increasingly points to co-design, participatory and place-based approaches as improving impact and effectiveness across all known groups.
- Social inequality, poverty, marginalisation, and discrimination are both a cause and consequences of mental illness. In addition, inequalities in themselves create an increased risk of mental illness (WHO 2014).
- The often entrenched and systemic disadvantage, and barriers to inclusion and participation, must be addressed for genuine and sustained changes to occur to the mental health and wellbeing of known groups with particular and unmet mental health needs.
- Difficulties in accessing appropriate and responsive mental health services are disproportionately experienced by some groups, increasing the likelihood of late action and poorer mental health outcomes.
- The available evidence points to the deleterious and long-lasting effects of toxic stress and trauma, including early in life exposure to ACEs and intergenerational transmission.

Aboriginal and Torres Strait Islander social and emotional wellbeing

- Aboriginal and Torres Strait Islander peoples adopt a holistic concept of social and emotional wellbeing that recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how such connections have been formed and shaped across generations, and the processes by which they affect individual wellbeing[129]. It further recognises the impact of policies and past events upon wellbeing[130].
- Aboriginal and Torres Strait Islander people continue to experience health inequities across diverse health and wellbeing indicators within the context of colonisation, historical and intergenerational trauma, impacts of the Stolen Generations and removal of children, systemic racism, discrimination, economic and social disadvantage[131].
- Aboriginal and Torres Strait Islander people experience a disproportionate burden of mental ill-health compared to non-Indigenous Australians. Aboriginal and Torres Strait Islander adults are almost three times more likely to experience high or very high levels of psychological distress than other Australians, are hospitalised for mental ill-health at almost twice the rate of non-Indigenous people and have twice the rate of suicide than that of other Australians. More than 50 per cent of the differences in outcomes between Indigenous and non-Indigenous Australians is accounted for by social determinants of health.
- Factors that are critical to and enhance the social and emotional wellbeing of Aboriginal and Torres Strait Islander people include connection to country, spirituality, ancestry and kinship networks, strong community governance and cultural continuity, renewal of Aboriginal and Torres Strait Islander culture and knowledge systems, and the capacity for self-determination[132,133, 134].
- In August 2015, the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSIMHL)[135] developed the Gayaa Dhuwi Declaration for Aboriginal and Torres Strait Islander leadership in mental health and suicide prevention.
- Effective mental health responses emphasise early identification and intervention, embed cultural capability into clinical practice, work across service types, including the community-controlled sector, focus on recovery and integrate an understanding of trauma and trauma-informed care into services[136].
- Other groups identified as having increased vulnerability include:
    - ***People from culturally and linguistically diverse backgrounds*, including refugees,** face challenges accessing mental health services due to many issues, including stigma, low levels of mental health literacy and difficulties navigating a complex service system. The limited data available suggests that the overall prevalence of mental illness for people from culturally and linguistically diverse backgrounds is similar to the general population. However, immigrants and refugees exposed to trauma in their country of origin are likely to experience higher rates of mental illness and exposure to traumatic experiences in their transition to Australia. Barriers to mental health treatment, care and support include a lack of cultural considerations and trauma-informed approaches within service delivery, language barriers and lack of translation services, privacy, issues of stigma and discrimination associated with mental ill-health[137].

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[129] Dudgeon, P, Walker, R, Scrine, C, Shepherd, C, Calma, T & Ring, I 2014, *Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people*, Issues paper no. 12. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.

[130] Dudgeon, P, Walker, R, Scrine, C, Shepherd, C, Calma, T & Ring, I 2014, *Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people*, Issues paper no. 12. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.

[131] The National Aboriginal and Torres Strait Islander Leadership in Mental Health, Indigenous Allied Health Australia and Australian Indigenous Psychologists Association 2019, *Submission to the Productivity Commission's Review of the Social and Economic Benefits of Improving Mental Health*, viewed 9 January 2022, https://www.pc.gov.au/__data/assets/pdf_file/0004/241078/sub418-mental-health.pdf

[132] Zubrick, S.R, Shepherd, C.C.J. , Dudgeon, P. , Gee, G., Paradies, Y. , Scrine, C. , Walker, R. 2014 Social determinants of social and emotional wellbeing. In Dudgeon, P. Milroy, H. Walker, R. (Ed.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd edition ed.,pp. 93-112). Canberra: Department of the Prime Minister and Cabinet.

[133] Dudgeon, P., Bray, A., Smallwood, G., Walker, R., Dalton, T 2020, *Wellbeing and healing through connection and culture*. Sydney: Lifeline.

[134] Australian Government 2017, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*, viewed 9 January 2021, https://www.niaa.gov.au/resource-centre/indigenous-affairs/national-strategic-framework-mental-health-social-emotional-wellbeing-2017-23#publication_content_type_view-block_2-0

[135] Meadows, G, Farhall, J, & Fossey, E 2020, Mental Health and Collaborative Community Practice 4e eBook: An Australian Perspective, Oxford University Press Australia and New Zealand, Melbourne. Available from: ProQuest Ebook Central. [13 January 2022].

[136] Queensland Health 2016

[137] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

- ***People who identify as lesbian, gay, bisexual, transgender, intersex and queer or questioning*** **(LGBTIQ+)** are over-represented in mental health statistics for anxiety and depression and have an increased risk of self-harm and suicide due to their experiences of stigma, discrimination, prejudice, abuse, violence, exclusion and isolation[138].
- ***Rural and regional communities*** experience the same or similar prevalence of illness as people in major cities; however, the impact of mental illness is greater because mental health professionals are in short supply (COAG Health Council 2017). In addition, service models initially designed for large population groups assume access to specialist providers such as psychiatrists (who are often not available in rural communities) and do not meet the needs of a rural or remote population[139].
- ***Children with parents or family members living with mental illness*** are estimated to be between 40-70 per cent risk of developing their own mental health pathology as adults[140].
- ***Children under the care of the state, including children in out-of-home care*** and those in contact with the justice system, are more likely to experience mental ill-health and have complex needs. These children are likely to have been exposed to trauma such as child abuse or neglect and can also experience trauma within the system, which disposes them to mental health challenges. The National Children's Mental Health and Wellbeing Strategy (2021) note that currently, these children are more likely to be turned away from services than other children because their needs are more complex[141]. In 2020, the Queensland Government designed and established the Evolve service to provide specialist and tailored therapeutic mental health services to children in out of home care.
- ***Children in youth justice*** in Queensland are estimated to have high levels of mental ill-health[142]. Research has also found that generally, more than half of the children detained in youth justice centres are known to child protection services and have a history of traumatic experiences.
- ***People with lived experiences of homelessness*** are among the most socially and economically disadvantaged in Australia. Homelessness can result from many factors, including mental ill-health, exposure to violence and victimisation, long-term unemployment, and mental ill-health[143].
- ***People with eating disorders*** have a complex mental illness that results in significant physical impairment and has a high mortality rate. People with eating disorders also experience higher rates of comorbid mental health problems than the general population[144].
- ***People with co-occurring problematic substance use*** experience specific challenges. There is a complex relationship between mental health and AOD use. A mental illness may make a person more likely to use substances to provide short-term relief from their symptoms, while other people have drug problems that may trigger the first symptoms of mental illness. People with mental health conditions or high or very high levels of psychological distress are more likely to drink alcohol at risky levels than people without these conditions. The combination of problematic substance use and mental illness has historically made diagnostic and treatment decision-making difficult, and successful interventions are often dependent on concurrent responses to both disorders[145].
- ***People in contact with the justice system*** are more likely to have a mental illness than people in the broader population. For example, the National Prisoner Health Data Collection from 2018 found that 65 per cent of women and 35 per cent of men in prison reported a previous diagnosis of a mental illness, including AOD use disorders[146]. The reason people living with mental illness are over-represented in the prison system is

[138] LGBTIQ+ Health Australia 2020
[139] Centre for Rural and Remote Mental Health 2021
[140] Emerging Minds, 2019
[141] Australian Government 2021
[142] Working Together, Changing the Story: Youth Justice Strategy 2019-2023, https://www.youthjustice.qld.gov.au/resources/youthjustice/reform/strategy.pdf
[143] AIHW 2021
[144] COAG Health Council 2017
[145] COAG 2017
[146] AIHW 2019

primarily because of the complex interaction between mental illness and a variety of factors such as disrupted family backgrounds, family violence, abuse, use of drugs and alcohol, and unstable housing[147].

- ***People with disability*****,** particularly people living with intellectual disabilities, experience higher rates of mental health problems and mental illness. People living with intellectual disabilities have significantly lower treatment rates for mental health problems compared with the general population and can encounter barriers that prevent timely access to appropriate supports and services[148].

TOR 1(f): how investment by the Queensland government and other levels of government can enhance outcomes for Queenslanders requiring mental health treatment and support

Rebalancing the system upstream

- Optimising the use of current and new investment requires strengthened integrated planning, co-commissioning and oversight across all levels of government and sectors.
- There is a critical need to shift investment upstream, to support all individuals and groups to prosper, prevent people from becoming unwell. Investment is needed in mental health promotion, illness prevention and early intervention.
- Heckman (2022) demonstrated that this is more investment in social and emotional wellbeing for children and young people, particularly targeted intervention for those who have experienced or are experiencing ACEs, specifically in the early years[149].
- Every dollar spent on high-quality birth-to-five programs for disadvantaged children delivers a 13 per cent return on investment per year. This is based on providing comprehensive developmental resources to children living in disadvantaged environments from birth to age five; and includes nutrition, access to health care and early learning[150].
- It is vital to appropriately build capacity and resourcing sectors beyond health to design, embed, and drive prevention and early intervention through their core business. This includes workplace health and safety, early years, education, housing, employment and communities. This will ensure evidence-based approaches in everyday life settings that have been demonstrated to have the most significant preventative impact.
- Potential investments may include:
    - initiating a concerted national approach, supported by the states and territories and local community activities, to prompt wellness, that is, maintaining good mental health and staying well
    - initiating a national campaign, supported by the states and territories and local community activities, to reduce stigma and discrimination experienced by people with mental health and AOD problems and their families and carers.
    - preventing the development of mental ill-health, AOD problems, and suicidal ideation amongst at-risk groups through targeted strategies
    - enabling access to early intervention and support services for people experiencing mild to moderate mental health problems, similar to, but better funded than the Headspace services for young people
    - developing a new community infrastructure for children, similar to Head to Health, to provide early intervention support and care for families with children 0-12 years
    - development of a new community service infrastructure for adults similar to Head to Health to support people between the mild and severe ends of the spectrum and meet the needs of the mild-to-moderate and moderate-to-severe groups (i.e. the missing middle).

[147] NSW Mental Health Commission 2014
[148] COAG Health Council 2017
[149] Heckmanm J 2020, Research Summary: The Lifecycle Benefits of an Influential Early Childhood Program, viewed 12 January 2022, https://heckmanequation.org/resource/research-summary-lifecycle-benefits-influential-early-childhood-program/
[150] Heckman, J 2020, Research Summary: The Lifecycle Benefits of an Influential Early Childhood Program, viewed 12 January 2022, https://heckmanequation.org/resource/research-summary-lifecycle-benefits-influential-early-childhood-program/

Services closer to home

- The recent Commonwealth Government investment with support from the State Government could develop new community infrastructure, which should become the new front door for all mental health needs.
- This will enable access to the full range of supports across the continuum of need, strengthen the integration of primary healthcare, and act as a gateway into public mental health services for those with severe, complex and enduring mental illness.
- This approach would further strengthen regionalised planning and service delivery based on population needs.
- This new community infrastructure should co-locate and integrate standardised intake, assessment, triage, interventions, treatment and support across the public, private and NGO service providers, including primary healthcare.
- It should integrate treatment, care and support across treatments and therapies, including physical health, mental health and AOD treatments, wellbeing supports, education and employment, care planning and coordination to enable access to and continuity of care, commensurate to need.
- In addition, this new approach should be integrated and interoperable with digital mental health services to broaden the reach of appropriate and evidence-based treatment, care and support, when and where required.
- Similarly to the Trieste model of community mental health care[151], each centre should cover a population of 50,000-70,000 people. In addition, each centre should provide a hub and spoke model to cover smaller communities across Queensland, operate extended hours, including weekends, and be a service point for first responders.
- The Victorian Government, in collaboration with the Commonwealth Government, are rolling out 60 of these adult community centres across Victoria in response to the recommendations of the Royal Commission into Victoria's mental health system (2021)[152] .
- It is recommended that public mental health clinicians are co-located within the new centres, however as required, they should minimise their case management role and primarily provide a range of treatment and interventions. This is in efforts to support people maintain their mental health and wellbeing in the community, as close to home as possible, and to support persons discharged from hospital with appropriate follow-up community-based support and treatment.
- The role of public inpatient mental health services should continue to target people at the acute phase of mental illness and AOD that requires hospital admission. The gateway into acute hospital bed-based services should be primarily through the new community centres or an alternative to the emergency department, such as the service currently being trialled at the Gold Coast.
- Access to forensic, secure and extended treatment services will be supported by this new community infrastructure where possible but remain largely unchanged from the current processes.

Terms of Reference 1(g): service safety and quality, workforce improvement and digital capability

Service safety and quality

- The primary aim of mental health safety and quality standards is to protect service users from harm and improve quality-of-service provision.
- Standards provide a mechanism to test whether relevant systems are in place and ensure that expected safety and quality standards are met. They also enable consistency in the standard of care that people expect from their mental health service organisations.
- A fundamental principle is that caring for a person's mental and physical health are integrated processes.
- Even though different members of the workforce have different roles, it is everyone's responsibility to collaborate to deliver person-centred care that meets the person's holistic health needs.

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[151] Frances, A 2021, 'Save Trieste's mental health system', in *the Lancet Psychiatry*, vol.8, pp.744-746

[152] State of Victoria 2021, *Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations*, Parl Paper No. 202, Session 2018–21, viewed 9 January 2022, https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf

- Safety and quality in mental health have several dimensions, including clinical governance, medication safety, care standards, communication and partnering with consumers.
- Safety and quality frameworks and standards in mental health have been developed at national and state levels, including specific standards for community mental health organisations and digital mental health services.
- In particular, consumers, families and carers often identify the challenges of services meeting safety and quality standards where a person is involuntarily treated and where seclusion or restraint are employed.
- Compared to other jurisdictions, Queensland has one of the most contemporary mental health legislation instruments with identified safeguards, including Independent Patient Rights Advisors. Despite this, meeting safety and quality standards still appear to be complicated.
- Families and carers similarly identify that safety and quality standards are not met when engaging them in treating and caring for a loved one. For example, a recent decision to lock all acute mental health wards in general hospitals has also bought into question the quality and safety standards and how this decision impinges on an individual's human rights.
- At certain times, the locking of certain beds or sections of a ward is clinically appropriate for the safety of the individuals, staff, and the community. However, feedback indicates that, for example, locking of wards should be a local decision based on the contemporaneous needs and clinical milieu of each individual ward and not a blanket directive.
- Safety, quality, and human rights of people with mental health and AOD problems are critically important, and an ongoing focus on this area is required to optimise client outcomes.
- Another contributing factor impacting the quality and safety of mental healthcare is that clinicians spend approximately 20 per cent of their time with consumers on average. The optimal proportion of time spent on providing direct care is proposed to be between 67 per cent of clinician time as identified in the NMHSPF.

Workforce improvement

- Providing appropriate, timely and quality mental health treatment, care, and support is contingent on the availability of skilled mental health and AOD workforce who are appropriately resourced and supported to provide quality care.
- Recent reports, including the Productivity Commission inquiry into mental health (2020)[153], has identified that quality mental healthcare service provision needs to be trauma-informed, family and carer inclusive, culturally competent, be recovery-oriented, build consistent and continuous therapeutic relationships, and respect individual rights and dignity.
- There is a mental health workforce shortage in Australia and Queensland, and there is a critical need to expand the current workforce mix to include other professional groups such as those holding counselling degrees and peer workers.
- At present, there are existing and projected skill gaps, and this includes:
    - psychiatrists treating children, young people and older Queenslanders
    - mental health nurses
    - allied health professionals
    - mental health workers outside major cities, and
    - mental health workers who provide culturally competent, person-centred mental health treatment, care and support.
- There is insufficient mental healthcare training incorporated into nursing and allied health under-graduate qualifications.
- In Queensland, there are limited opportunities for specialist and generalist AOD education in both the vocational and tertiary sectors, resulting in only a small pool of candidates suitable for the AOD workforce with adequate pre-employment knowledge, skills, and qualifications required to work with people experiencing AOD problems.

[153] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

- More is required to attract more graduates into the mental healthcare space. Pathways that support new graduates into mental health need to be established, including a greater focus on induction, orientation, and ongoing professional development for those that come into the mental health services system.
- Incentives need to be established to attract students in final year placements into rural and regional areas with a job guarantee at the successful completion.

Digital capability

- Digital mental health interventions have an essential role in supporting the closure of the treatment gap, providing mental healthcare, and enabling access to quality, timely and appropriate treatment within the home or as close to home as possible.
- The advancement of digital mental health services into the broader mental health landscape, notably since the onset of the pandemic, is rapidly transforming how mental health treatment, care and support are accessed and delivered.
- Digital mental health proposes an unprecedented opportunity to expand access to and availability of psychological therapies that are location agnostic[154], enable warm distancing to therapeutic support[155] and reduce barriers to treatment, care and support, including overcoming stigma and discrimination.
- Growing evidence has demonstrated the clinical efficacy of digital mental health approaches, including internet cognitive behavioural therapy, in treating psychiatric conditions, reducing psychological and emotional distress, and promoting mental health and wellbeing.
- While digital mental health services are often presented as an alternative to traditional face-to-face treatments, there is growing evidence to support the use of such technology as a complementary approach to blended care. This enables both treatment enhancement and the extension of clinical services within and between sessions.
- However, such approaches must be evidence-based, integration and interoperation within the broader mental health context require further consideration, and the need for rigorous regulatory oversight, governance coordination, privacy and security, responsible and ethical use to ensure patient safety and quality of content is paramount.

TOR 1(h): mental health funding models in Australia

- Responsibility for funding and oversight of the mental health system is predominantly a shared responsibility of Commonwealth and Queensland Governments.
- In 2018-19, $10.6 billion was spent on mental health-related services in Australia, a 1.5 per cent annual average increase in the real per capita spending on mental health-related services from 2014–15 to 2018–19[156].
- In 2020-21, Queensland Health spent an estimated $1.49 billion on MHAOD, equating to $286.17 per person. Most of the expenditure ($1.35 billion or 91 per cent) is for MH, with the remainder being expended on AOD (approx. $139 million)
- Expenditure on mental health-related services represented 7.8 per cent of government health expenditure despite the mental and substance use disorders comprising the fourth largest contributor of total disease burden (13 per cent)[157].
- Despite substantial investment and efforts into providing mental health treatment, care and support, the return on this investment, particularly regarding genuine improvements in the lives of people with mental illness, is not commensurate with the level of investment.

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[154] World Economic Forum & Accenture 2019, Empowering 8 Billion Minds Enabling Better Mental Health for All via the Ethical Adoption of Technologies, White Paper, viewed 9 January 2022, http://www3.weforum.org/docs/WEF_Future%20Council_Mental_Health_and_Tech_Report.pdf

[155] Wind, T, Rijkeboerb, M, Andersson, G & Riperde, H 2020, 'the COVID-19 pandemic: The 'black swan' for mental health care and a turning point for e-health', Journal Pre-proof, in *Internet Interventions*, viewed 9 January 2022, https://www.sciencedirect.com/science/article/pii/S2214782920300464#bb0040

[156] Australian Institute of Health and Welfare 2021, *Mental health services in Australia – expenditure on mental health services*, viewed 9 January 2022, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services

[157] Australian Institute of Health and Welfare 2021, *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2018 - Summary report*, viewed 9 January 2022, https://www.aihw.gov.au/getmedia/c5ea1fc8-5ec9-46f8-a8f3-a297a0df8150/aihw-bod-27.pdf.aspx?inline=true

- This is partly due to the relatively siloed and unyielding demarcation of funding responsibility and a lack of joint planning and commissioning approaches.
- Unbalanced investment across the distribution of needs and interventions has further diminished the impact of the investment. This includes negligible and non-recurrent funding for upstream prevention and early intervention, despite offering the potential for the greatest return.
- The Commonwealth Government subsidises GPs, private psychiatrists and private allied health professionals through the MBS to provide mental health services. Funding is based on mental health and other items prescribed in the MBS schedule, with the length of consultation primarily determining the funding level.
- The Commonwealth Government further block funds a range of clinical and psychosocial support services via the PHNs across Queensland and Australia.
- Private health insurance funds private hospital stays, private psychiatrists, and allied health professional sessions. Both the MBS and private health insurance require a gap payment due to the limited number of service providers that provide bulk-billing arrangements.
- The State Government funds public mental health inpatient and community clinical services, and to a smaller extent, psychosocial support for people who are not eligible for NDIS.
- Public sector hospital services are funded using an activity-based funding (ABF) model, which allocates funds based on the type and volume of services provided, and the complexity of the patient population served.
- Service categories were ABF funded in 2020-21 included emergency department services, acute admitted services, admitted mental health services, sub-acute and non–acute services, and non–admitted services.
- ABF funding in mental health has been assessed as having both positive and negative aspects.
- From a positive perspective, it appears that inpatient ABF funding for mental health care gives a good economic signal of the potential cost of follow-up care for people through public community mental health services, which are currently not ABF funded.
- However, people are also identifying potentially perverse incentives in ABF, such that beds may be occupied for the optimal duration of time to maximise funding, not on clinical need.
- ABF can also negatively impact funding levels and the efficiency of services, as some patients may be difficult to discharge. Such persons may stay longer than the optimal time, which reduces the level of payment under ABF.
- In Queensland, it is difficult to determine how ABF funding is applied to mental health as it appears that a service's historical budgets seem to determine subsequent budgets.
- There is also evidence suggesting that ABF could be a useful methodology for determining mental health funding levels but that the capability to optimise and incentivise the model in mental health is not fully developed.
- At present, public mental health community services are not currently activity-based funded. However, a key recommendation of the Productivity Commission (2020)[158] is that consideration is given to funding these services based on activity rather than the current block funding arrangement.
- Mental health budgets are not quarantined at the HHS level, which may periodically result in mental health funds being reallocated to other health areas within an HHS.
- However, quarantining mental health budgets may also not be the most beneficial for HHS mental health services, as it marginalises mental health from the broader HHS funding pool.
- Alternative options may include improved transparency, monitoring, reporting and independent governance (oversight) of how mental health budgets are allocated and spent at the HHS level.
- Non-government community mental health and AOD organisations are primarily funded through a block funding arrangement; however, NDIS provides funding to the individual rather than the agency and the individual decides which agency they want to purchase their service.
- The individual NDIS funding arrangement is causing significant instability within the NGO sector as there is:

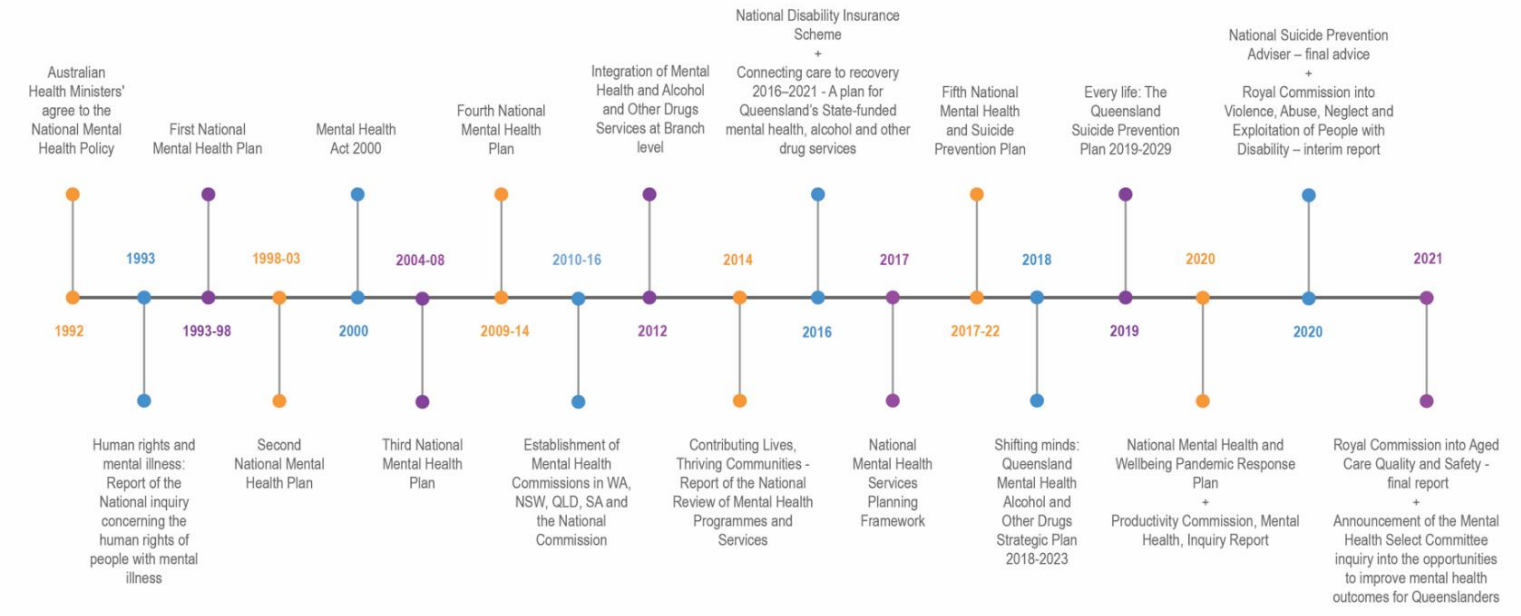
[158] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

  - no guarantee of duration of income
  - workforce recruitment and retention are an issue
  - organisational financial viability and sustainability, and
  - thin markets and provider of last resort.
- These and a range of other issues result in people not spending their total allocated NDIS package.
- The need for appropriate investment and provision of community-based clinical and non-clinical mental health supports, commensurate to population need, is critical to addressing current needs and services gaps and supporting future needs.

TOR 1(i): relevant national and state policies, reports, and recent inquiries, including the Productivity Commission Mental Health Inquiry Report

- Since the *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled* (the 1983 Richmond Report)[159], the mental health landscape has undergone numerous inquiries, reviews, inquiries, and reports at national, jurisdictional, and local levels.
- Such reviews have consistently revealed the considerable size and scale of mental health needs within the Australian population, the significant cost associated with mental ill-health, the level of unmet need and increasing system pressures across the health and human services systems.
- These have each undertaken a deep and comprehensive analysis of the systemic, structural operational and other factors that contribute to inefficiency and ineffective responses, as well as the urgent shifts and priorities required to improve responses.
- Figure 13 provides a high-level overview of the reform journey at the national and state levels.

Figure 13: an overview of the reform journey



- In addition to these significant mental health policies, inquiries and reviews, other state and national developments have impacted mental health, AOD and suicide prevention in Queensland, including:
  - National Drug Strategy
  - Queensland Government's Economic Recovery Strategy – Unite & Recover for Queensland jobs (2021-2022)

159

- Queensland Housing Strategy (2017-2027)
- Skilling Queenslanders for Work Initiative
- Path to Treaty
- Making Tracks Together: Health equity framework
- Working together, changing the story: Youth Justice Strategy 2019-2023
- Supporting Families, Changing Futures 2019-2023
- Queensland Youth Strategy
- Creating mentally healthy workplaces – Healthy minds
- Student learning and wellbeing framework
- Queensland Children's Wellbeing Framework
- Queensland Early Years Plan
- Every life: Queensland Suicide Prevention Action Plan 2019-2029
- Queensland Productivity Commission Inquiry imprisonment and recidivism
- Queensland Productivity Commission Inquiry into the NDIS market in Queensland
- Queensland Sentencing Advisory Council: spotlight on trafficking in dangerous drugs