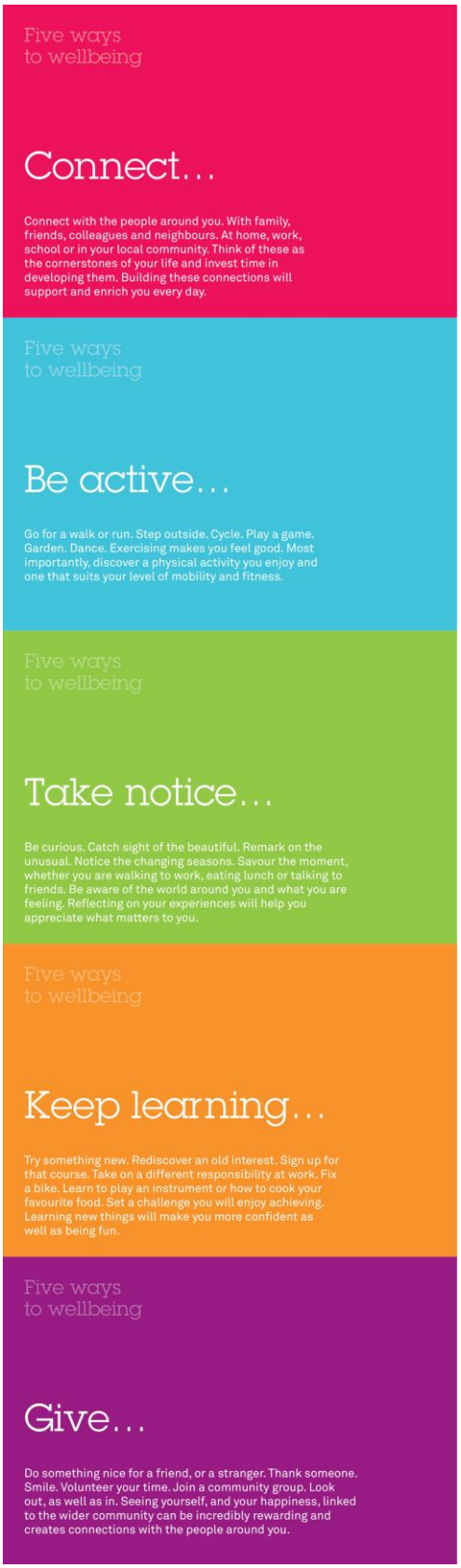

New Economics Foundation, Five Ways to Wellbeing postcards (neweconomics.org/2008/10/five-ways-to-wellbeing-the-postcards)

Mental Health Select Committee

Inquiry into opportunities to improve mental health outcomes for Queenslanders

Anglicare Southern Queensland

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This submission may be quoted in public documents.

Contents

Sidebars and boxes

1.0 Introduction

Anglicare Southern Queensland welcomes the invitation to make a submission to the Mental Health Select Committee's inquiry into opportunities to improve mental health outcomes for Queenslanders, and strongly supports the need to focus attention on this matter.

We bring to this submission the direct experience and expertise of Anglicare Southern Queensland staff in delivering mental health and family wellbeing services to more than 9,000 Queenslanders across a geographic area double the size of the United Kingdom, stretching from Townsville to Coolangatta and across the southwest of the state. Last year, we provided nearly 50,000 hours of mental health and counselling support via intensive counselling, early intervention support, assistance for carers and families supporting individuals (including children and young people) with a mental illness; as well as mental health education and community development activities that increase community knowledge and understanding about mental wellbeing.

As a society, we know that the key supports for maintaining mental wellbeing are meaningful social connection; being active; having sufficient space to be mindful and present in life; learning and purpose; and the opportunity to give and give back.[1] Underlying these are the bedrock structures that support our overall wellbeing — secure and appropriate housing; good nutrition and health; sufficient income; and access to meaningful work and learning.[2]

These structures, and the policy settings that shape them, impact the wellbeing of every Queenslander. As Anglicare Australia noted in their submission to the 2020 Productivity Commission mental health inquiry:

> *The role governments play in mental wellbeing is much more than simply providing a set of specific services; they profoundly influence the quality of our physical, working and social environment, which in turn have a major impact on our wellbeing. Fundamentally we need governments to provide physical and policy settings that support mental health and resilience, not undermine them.*[3]

The terms of reference for the current Queensland Government inquiry hint at this understanding with their interest in economic and social impacts, and in a passing mention of prevention, but they overwhelmingly frame the issue as an individual (though pervasive) problem of mental *illness* rather than enabling a dialogue on how to build mentally healthy and resilient communities, and embed mental health services within them. This latter approach steers away from targeting 'high risk' groups, to position mental health as a universal concern for all community members, supported by a continuum of services that offers early and easy access, reduces stigma and has the flexibility to address the particular needs of individuals and groups to ensure equity of access and culturally appropriate care.

Examples of the economic and societal impact of mental illness in Queensland

Mental illness is the highest contributor (20%) to the Indigenous burden of disease in Queensland, impacting on family and community connectedness.[4]

There were approximately 45,000 informal mental health carers in Queensland in 2019.[5] They provided the equivalent of 34,600 FTE formal support workers, with a total annual replacement cost of $3.3 billion.[6] Yet many mental health carers have insufficient support, resulting in high levels of isolation and loneliness, anxiety, reduced income and poverty, and their own mental health challenges.[7]

Research confirms that mental health stigma and discrimination are significant barriers to participation in the Queensland workforce and many other areas of life.[8]

In this submission, while we briefly address the impact of mental illness in Queensland and the current well-known pressures on the mental health system, our submission emphasises, and urges the Committee to consider, an active, strengths-based and whole-of-community approach that envisages a mentally well community. We look to holistic solutions and opportunities that are informed by the recent *Wellbeing First* report published by the Queensland Alliance for Mental Health (QAMH),[9] and by the on-the-ground experience of our staff as outlined above.

We recognise that this is not a new idea to the Queensland Government. The *Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023*[10] promised to set a "five-year direction for a whole-of-person, whole-of-community and whole-of government approach to improving the mental health and wellbeing of Queenslanders". We are however nearly at the end of this five year span, and our system remains as fragmented and underfunded as it was in 2018, buckling under ever-increasing demand.

We need to address this crisis urgently: to re-imagine a system based on solid evidence and the expertise of people who have lived experience of what works and what doesn't; and to make a real and significant financial investment in Queensland's mental wellbeing.

2.0 The Queensland mental health system

2.1 Impacts on the system

2.1.1 System design

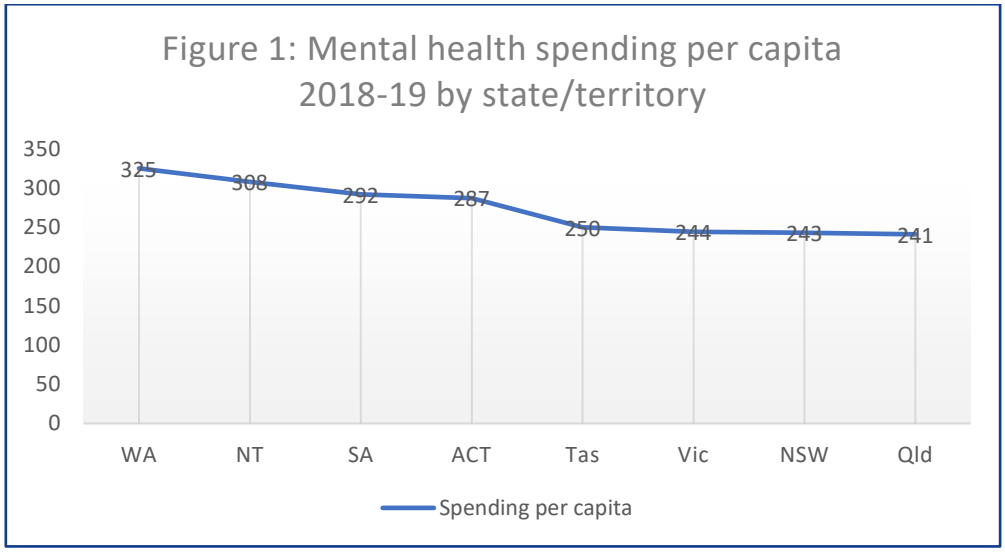
There is little need to outline again the stresses faced by the Queensland mental health system. As the QAMH notes, the current system has been repeatedly identified as "struggling with demand, fragmented, siloed and difficult for the public to navigate".[11]

The design of the system contributes significantly to this situation. Focusing almost solely on those with severe and persistent mental ill health creates a system that is reactive, crisis-driven and shaped by a medical model of care. This leaves it without capacity to support either those showing early signs of distress, or people in what the Productivity Commission calls the 'missing middle': those too unwell to be treated in the primary care system but not yet (though very likely to be) sick enough to be treated by acute services.[12]

2.1.2 Underfunding

Queensland spent $1.2 billion on mental health funding in 2018–19. This was the lowest sum per capita of all states and territories at $241 per person (compared to $325 per person in Western Australia and a national average of $257 per person) (see Figure 1 below).

The most recent 2021–22 State Budget continued this trend with peak bodies such as the Royal Australian and New Zealand College of Psychiatrists (RANZCP) noting the lack of investment and prioritisation of mental health services, even with the impacts of the pandemic taking their toll on individuals, communities and workforces.[13]



Source: AIHW. 2021. Mental health services in Australia. (Updated 8 Dec). www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services

2.1.2 The geographic context: rural and remote Queensland

The vast geographic spread of Queensland creates additional challenges for the system in rural and remote areas of the state.

Attachment A provides an excerpt from Anglicare SQ's (2018) submission to the Australian Senate Community Affairs References Committee inquiry into the accessibility and quality of mental health services in rural and remote Australia.[14] The submission drew directly from the input of our rural and remote Queensland staff, and highlights a range of additional challenges for our state's mental health system, including:

- infrastructure issues that create a barrier to accessing services, including the need to travel long distances for appointments, no or very limited public transport services in most rural areas, and technology issues that can undermine tele-health solutions;
- workforce issues such as high staff turnover and unfilled positions; the lack of psychologists and counsellors outside urban areas; a preponderance of inexperienced, newly qualified staff; and the pressing need for more mental health professionals and workers from Aboriginal and Torres Strait Islander backgrounds;
- social and cultural factors, including perceived stigma, a feared loss of privacy and confidentiality in small communities, and impacts from the constant turnover of mental health workers, which can affect the level of understanding service providers have about local cultural issues as well as making it difficult for clients to build trusting relationships.

2.1.3 Covid impacts

What was already a system under pressure in both rural and urban environments is now staggering under the weight of unparalleled demand from the mental health impacts of the COVID pandemic. Our staff have seen first-hand the effects first of lockdown, and then the ongoing impacts of constant anxiety for both adults and children exacerbated by issues such as reduced social support and connectedness; employment challenges such as reduced or lost hours; rental stress; and education challenges for children, young people and the parents and carers who support them. The box on the next page highlights some of the effects of COVID-19 and related areas of need identified by our staff, all of which impact the mental health and other service sectors.

Examples of mental health impacts of Covid-19

- Carers and parents experience the same pressures with regards to home schooling children as the wider community. However these challenges are often amplified given that children in care and children who are at risk generally exhibit more challenging behaviours than the general population. There was insufficient support available for parents to cope with the new demands of home schooling.
- Mental health issues emerged during lockdown for carers and parents with small children. The availability of free childcare for a period was extremely helpful in addressing some of these pressures.
- With limited access to external services and sporting recreation, there was a deterioration in young people's wellbeing and for some young people a regression in their mental health. Usual social protective activities were not available, or not continued because of anxiety etc; family routines and systems were upset; and online bullying and loneliness has been apparent.
- We are seeing evidence of babies and young children with decreased socialisation. Some families remained in relative seclusion due to fear even after lockdown finished, and we are seeing 3-4 year-olds entering kindy with limited social skills due to extended isolation.
- COVID has influenced a downward trend in schooling attendance and it has been challenging to re-engage our young people in their education.
- Financial hardship and stress has increased for carers and parents who have lost work due to COVID. They are now competing with a larger population of people who may have more education, more access to resources (such as computer access, childcare), and are only newly unemployed.
- Cultural services supporting our young people's connection to community Elders have been more restricted.
- Rising anxiety/depression is widely evident and there is increased strain and stress on relationships. Specialist children's counsellors reported an increase in anxiety about COVID both at school and home.
- A sense of hopelessness has been exacerbated, particularly for clients in emergency housing.

Anglicare SQ staff consultation 2021

2.2 Needs of the Queensland mental health system

There is no doubt that people are in distress, and the system is under unparalleled pressure. Mental health experts however agree that not all distress requires a clinical intervention.[15]

Expanding the scope of the Queensland mental health system to encompass a whole-of-community 'mental wellbeing' approach would substantially reduce the pressure on existing clinical services, as well as offer significant social and economic benefits to Queensland as a whole. As the QAMH notes:

> *For the individual, early intervention will build social and economic participation. For communities, it will increase resilience to common life challenges. For clinical mental health services, it will alleviate many of the current demand pressures. And for the nation [and for Queensland], it will foster mental wealth.*[16]

Further discussion of this point and some practical points of leverage to contribute to a whole-of-community mental health system can be found in section 6.0.

3.0 Opportunities to improve economic and social participation of people with mental illness through comprehensive, coordinated, and integrated mental health services

3.1 A cautionary note regarding the 'economic participation' driver

Research has shown that good quality, suitable employment provides mental wellbeing benefits. The opportunity to work is an important aspect of social inclusion and, in our society, contributes to an individual's identity, self-esteem, and the respect they are afforded by others.[17] Employment is therefore a core pillar in a whole-of-community approach to mental wellbeing.

Consistent with this fact, Mental Health Australia advises that early intervention is an effective way to support people experiencing mental ill-health back to work. Many people experiencing mental ill-health are younger people in their working and earning prime, so support in the early stages of mental illness can generate significant benefits at an individual and community-wide level.[18]

At the same time, we have concerns where economic participation is seen to be a criterion for individual recovery or program success. Anglicare Western Australia explained this clearly as follows:

> *Greater economic participation can be a positive by-product of increasing mental wellbeing, but should not be the driver of community services and/or mental health programs. While securing and maintaining paid employment may be part of a person's recovery, it should not be the measure of their worth and whether they, or the program supporting them, are deemed to be successful.*

> *In our experience … some people will require long term financial and social support to achieve a basic standard of living. The provision of such support should be based on respecting the rights and dignities of all people, rather than measured by the speed with which they can be removed from income support or the extent to which they contribute to national economic growth.*[20]

We further address issues of workplace mental health in section 5.5.

3.2 Social participation and a whole-of-community response

In the introduction to this submission, we highlighted well-known supports for maintaining mental wellbeing including meaningful social connection and reciprocity, or the opportunity to give and give back.[21]

Many submissions to the recent Queensland Government inquiry into social isolation and loneliness made an explicit link between these factors and mental health; and the Committee's report quoted the Productivity Commission as follows:

> *Loneliness and mental ill-health are mutually reinforcing — loneliness may increase an individual's likelihood of developing mental illness, but people with severe mental illness are particularly likely to be lonely. Part of the relationship between mental illness and the propensity to feeling lonely may be explained by social factors — people living in areas with low incomes, high unemployment, and poor access to transport and healthcare are likely to have higher levels of loneliness and are more likely to experience mental ill-health.*

George's story

Having no option but to live in inadequate housing, where public transport was limited and there were few opportunities for social contact, George became isolated from his family and the communities where he had previously belonged. Without connection to family, employment or a community, he experienced a profound loss of social participation; not only was his housing inadequate, but he had lost his home - a place to belong….

Once George found temporary accommodation in the community of his choice, he developed relationships and found opportunities that helped him to find a home. In his new home, George has cultivated an environment of situated care. He invited me to visit his new house, his horses, his Harley and his new partner, who has offered to be an ongoing support for George's literacy. He now also returns this care to his community as a volunteer with a local charity.[19]

In our own submission, we noted that quality social networks and a sense of belongingness[22] are at the core of a socially connected life, and are key protective factors against loneliness and mental ill-health. 'Quality' relates both to the strength of relationships, built on such things as shared meaning, interests and events; and to diversity, where mixed friendship networks can help to buffer against loneliness or disadvantage by providing different kinds of resources (actual physical resources, as well as knowledge, opportunities and support).[23]

An Anglicare community-based mental health initiative, A Place to Belong, highlighted this point in research about their literacy program, explaining that we need a 'thick' understanding of social participation and inclusion rather than the narrow view that often informs policy frameworks. This includes an understanding of social participation and mental health that engages with factors such as:

- gaining power over one's life in both big and small ways
- gaining power and control over one's own mental health
- having the opportunity to be respected and valued as part of the group/community
- connection with family and friends
- the opportunity to develop creative, employment or education pathways.[24]

Opportunities to build these networks are strongly influenced by interactions between individuals and the environments in which they live, work, and play.[25] While governments cannot prevent people ever feeling lonely or isolated, they can help to shape the environment and reduce structural barriers in ways that support social connection and mental wellbeing. As a 2009 Queensland Government project on reducing the social isolation of older people pointed out: "Simply bringing people together for short-term group activities may not be enough to build community capacity or to reduce social isolation in the long term". [26]

Building mental wellbeing through social participation requires a whole-of-community strategy that builds skills, support and connections more broadly in the community. Strategies that enable people to 'get around', for example, and increase the accessibility of green space in urban areas have been shown to increase social participation and act as protective factors against loneliness, social isolation and mental ill-health (see boxed text on next page).

Further discussion of this holistic, integrated approach to mental wellbeing is taken up in section 3.3.

Examples of structural factors related to social participation and mental wellbeing

Ability to 'get around'

Mobility is a key protective factor in enabling people to participate in their communities. Research supports the observations of our staff that for older people, the loss of the ability to drive is often associated with a decrease in social activity and an increase in social isolation and feelings of loneliness. This is also the case for people who live in rural or outer suburban areas, where there are fewer alternative transport options.[27]

Socioeconomic stress can have a similar effect for people of all ages, even where public transport exists. There is considerable research on the way in which reducing the cost of public transport can support older people to engage in their communities, much of which is equally applicable to people on low incomes.[28]

An expert workshop at a 2017 international conference on the nexus between transport and health further identified a range of public transport-related factors that can impact positively or negatively on mental health.[29]

Green space and mental health

Research internationally has demonstrated the benefits of green space for mental wellbeing.

An Irish review of 25 relevant studies revealed that 23 of these showed positive associations between mental health and green space characteristics.[30] In the UK, researchers found that greenspace programmes are successful in improving mental health due to seven interacting factors: the feeling of escape and getting away; having space to reflect; physical activity; learning to deal with things; having a purpose; relationships with programme leaders; and shared social experiences.[31]

Australian research also shows that green space is an important protective factor against loneliness. People living in neighbourhoods where at least 30% of nearby land is green space have 26% lower odds of becoming lonely compared to people in areas with less than 10% green space. For people living alone where there is 30% or more green space, the odds of becoming lonely halve.[32]

3.3 Comprehensive, coordinated, and integrated mental health services

3.3.1 Prevention and early intervention in a whole-of-government, whole-of-community approach

Establishing and maintaining preventative and early intervention mental wellbeing supports is not solely the province of health departments and organisations but, as noted above, is a whole-of-government, whole-of-community responsibility.

There is, as mentioned previously, a range of environmental factors that are recognised as risks for mental illness, such as unstable formative environments for children, low educational completion, homelessness, drug misuse, poverty and exposure to violence.[33] Mental Health Australia notes that preventative and early intervention options should also reflect changes in our social and demographic profile that impact on healthcare requirements and shifting risk factors at a population level: the ageing of our population, changes in settlement and household formation patterns, and the level and composition of our migrant intake. They point out that where such risk factors intensify, this can signal where preventative and early intervention have the potential to yield significant payoffs to the community.[34]

In their work on wellbeing, the UK-based New Economics Foundation (NEF) make a solid argument for:

> *moving away from an understanding of mental health that focuses solely on the provision of targeted help for vulnerable groups, towards an approach that balances promotion and prevention of mental health and wellbeing at a population level together with care and treatment.*[35]

It is worth quoting NEF at some length on this point, given their extensive work on wellbeing and the priority that mental health and wellbeing issues have been given by UK Government over the past decade. NEF point out that:

> *[F]ocusing attention just on those people who are experiencing mental health difficulties does not, in itself, help to reduce the overall incidence of deficits and vulnerability in the population. This argument is summarised in Figures 2a and 2b [below]. Figure 2a shows a hypothetical distribution of mental health across a population. At the right-hand side of the distribution are those people experiencing significant mental health difficulties, to the extent that they would meet the criteria for diagnosis of a mental illness. Next to this is a group who are described as languishing – people experiencing some difficulties and distress in their daily lives but at a 'sub-clinical' level. The majority of the population are assumed to have moderate mental health; at the left-hand side of the scale is a small group of people who are truly flourishing.*
>
> *This model is a simplification and recent work suggests that mental wellbeing and mental illness may in fact be better conceptualised as two correlated but essentially separate dimensions. Nonetheless, it makes*

explicit that the opposite of mental ill-health is not merely its absence, but rather the presence of positive psychological states. Whilst a subtle change, this is extremely significant; it suggests a new area of interest for activity promoting mental health, namely developing interventions and strategies to shift people upwards from languishing and moderate mental health to flourishing…. Strategies and interventions that succeed in shifting the whole population *will lead both to a significant increase in the number of people flourishing and moving to moderate mental health but also, crucially, to a significant* decrease *in the number of people experiencing troubling mental health problems.*[36]

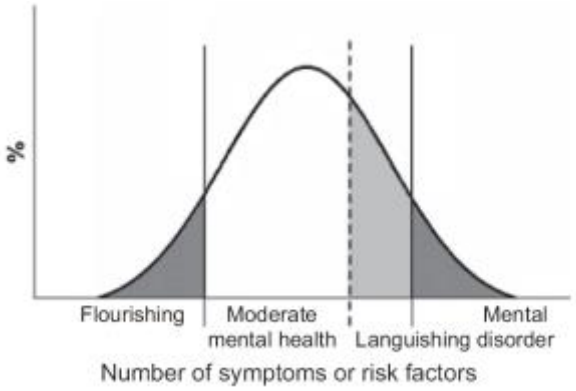


Figure 2a: The mental health spectrum in a population

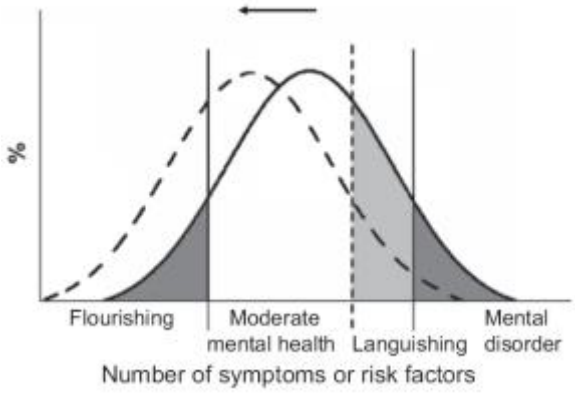


Figure 2b: The impact of a positive shift in the population mental health spectrum. Note the marked reduction of people in the 'mental disorder' category.

Thus, whole-of-government, whole-of-community supports that operate at a population level such as initiatives that foster social connection; family support and childcare; an increased wellbeing and resilience focus embedded within all levels of the education system, from childcare on; appropriate education and skills training that leads to meaningful work or volunteering; and housing strategies that ensure people have a secure place to live (see also our case study below) are all integral to mental wellbeing.

In addition to this 'early intervention in life' approach, the QAMH notes the efficacy of 'early intervention in illness or episode' in ensuring better outcomes for people dealing with occurrences of mental illness. Both approaches are currently profoundly underfunded.

> *We know that just one per cent of public health funding is spent on prevention (Christensen, 2020). In the mental health context, most of this goes to early intervention in life as opposed to early intervention in illness or episode. However, early intervention in episode would ensure better outcomes for people with severe and complex issues and for those described as the "missing middle". It would also prevent the bottle necks and demand that currently plague the acute system.*[37]

3.3.2 Crisis response, harm reduction, treatment and recovery

Examples of good practice

Hospital to Home provides 6 weeks of follow up care in the community following a mental health admission to hospital. While some people need much more than this, the service is an effective support in helping individuals successfully transition back into the community.

ADHOT – The Alcohol & other Drugs Homelessness Outreach Service visits Anglicare's HSWF homelessness service onsite to provide ongoing assessment and support to women experiencing both mental health and AOD challenges. With the service user's consent, they will liaise with HSWF staff to ensure the continuity and support of plans between visits, and are highly responsive to emails/calls from our service.

Transforming Life in Change (TLC)[38] is a private psychology, counselling and support service that offers call out services. In a recent example, they worked collaboratively with HSWF to visit onsite and make plans for future support of a service user who had a significant trauma history and would have struggled to afford or attend a psychologist with a mental health care plan.

1300MHCALL provided effective support for an HSWF service user who expressed acute suicidal intent. They had a safety plan on file and worked with both her and HSWF staff to encourage her to use previously identified strategies to address her mental health. This kept her safe and out of hospital for longer.

There is nothing new about a call for integrated, person-centred care for people experiencing high levels of need in coping with mental illness.[39] The word 'relational' appears in every discussion as a core element of system reform. However, as noted previously, service systems often continue to be fragmented, responding to specific aspects of need in isolation from other challenges impacting on people's lives, and without a holistic wellbeing focus that encompasses meaningful connection and life experience of trauma, poverty and exclusion.

Mental health services need to be readily available as part of a service response that is integrated across sectors. Examples of effective practice such as those in the sidebar to the left need to be more intentionally embedded in a more holistic **community mental health system** which is strengths-based and inclusionary. The alternative is a situation where people in need fall through the cracks due to systemic failures, such as in the examples provided on p. 16.

The Trieste (Italy) model of mental health service provision has drawn worldwide attention for a proven approach that includes person-centred/relational, easily accessible, community-based intervention and close links with housing, employment and social reintegration, supported by highly skilled recovery-focused specialist mental health services. (Significantly, the Trieste approach is underpinned by a view that the mental health of the community is everybody's responsibility, as we argue above.)

The QAMH report, *Wellbeing First*, describes community-based mental health services, or the 'community mental wellbeing sector', as those services that have emerged to provide largely non-clinical aftercare to people diagnosed with a moderate to severe mental illness, with a focus on preventing relapse or readmission.[40]

The report argues that this is grossly underestimating the potential of the sector to contribute to Queensland, and Australia's 'mental wealth' — that is:

> *the collective cognitive and emotional resources of citizens, [that] include people's mental capital, their mental health and well-being which underpins the ability to work productively, creatively and build and maintain strong positive relationships with others.* [41]

The current crisis represents an opportunity for government and the community to pivot toward this relational, wellbeing approach. Appropriate levels of longer-term funding, supporting workforce skill building, attraction and retention in the community mental wellbeing sector, would complement high-need mental illness services and better address the needs of those showing early signs of distress or in the 'missing middle'. As the QAMH report comments: the impact of languishing or poor mental wellbeing is as expensive and detrimental as the experience of serious mental illness. [42]

We would also argue that an important opportunity exists for the **broader community sector** to be more strongly acknowledged and supported in its contribution to mental health at all points of the continuum.

The experience of Anglicare SQ, and the other 35+ affiliated organisations in the national Anglicare Australia network, is that every community service is at least in part, a mental health service. Any support service can be a door for people needing help with their mental health, interwoven as it is with all aspects of a person's life.[43] Approximately 90% of the women at Anglicare's Homeless Services Women and Families (HSWF),[44] for example, present with diagnosed or undiagnosed mental health issues. More than half (53%) the young people attending our INSYNC youth homeless services in 2017–18 identified as having mental health histories.

Trauma-informed, recovery-oriented approaches taken in areas such as housing, family, substance misuse and foster care programs are not separate to mental health measures: they are integral to them.[45] There is increasing and deeper cross-sectoral understanding that trauma can manifest in multiple ways, and that working toward recovery from, for example, substance misuse, can only be achieved in tandem with mental health and trauma treatment (rather than, as was historically common, requiring people to be sober or clean *before* addressing mental health concerns). A focus on recovery in any of these areas includes establishing and maintaining connective pathways of support:

> *… being able to "create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues". For services, that means collaborating with people, their families and communities. It means focusing on wellbeing and helping to build positive links between people and the society around them. And it means offering people "a life in the community not defined by their mental illness."* [46]

A relational approach to mental health

We make sure that women experiencing homelessness are seen. People go days with people avoiding eye contact or avoiding engagement. The little things go a long way to show respect and to include people. We make time to notice people, their affect, how they're going. We remove the invisibility that people who are homeless experience. We also advocate for people's visibility, all of the ways that homelessness impacts the biopsychosocial elements of a person's life. We see the whole person, not just a person to be avoided, because they're experiencing homelessness (Recovery Practitioner).

It's important to be there as someone people can rely on. Our role can be to provide stability and connection, to use our rapport to build relationship for people. We walk beside them, help them research their options and help them find somewhere to connect (Family Support Worker).

Relationships come about through mutual respect, trust and reciprocity. People haven't had someone they trust is their lives. They can be quite isolated so sometimes my support can be just being there and listening, assuring someone that I'm on their side (Client Care Coordinator).

1300MHCALL provided effective support for an HSWF service user who expressed acute suicidal intent. They had a safety plan on file and worked with both her and HSWF staff to encourage her to use previously identified strategies to address her mental health. This kept her safe and out of hospital for longer.

Much of the community sector therefore already works relationally. The quotes from our staff in the sidebar show this clearly.

The boxed text on pp. 17-18 provides a case study of an Anglicare SQ women's homelessness service that demonstrates the key role that community services such as ours play in the mental health space. As can be seen in 'Amy's story' below, we work with our service users to achieve increased capacity and independence; to help women to safely explore and address the social determinants that have contributed to their homelessness, and obtain sustainable housing by improving their community inclusion and connectedness; to recognise our service users' inherent worth and uniqueness and their right to quality service provision; and to ensure that our services are underpinned by the principles of equality, confidentiality and respect for the individual's right to self-determination.

As the QAMH notes:

> *People with lived experience of the mental health sector often report their best experiences as those which challenge them to try new things, learn new skills and engage in full community life. Services that adapt to meet the needs of participants rather than offering a one-size-fits-all approach can achieve even greater results.* [47]

Falling through the cracks in the system: stories from HSWF staff

I recall once sitting with a person in ER who was telling me that he was so tired of waiting for assessment that he wanted to run out into traffic (literally, due to his sense of hopelessness, not just expressing frustration). I had to leave him there after hours of waiting, and he eventually left without being seen. The person had an alcohol problem and rarely presented anywhere entirely sober, so his depressive symptoms were usually seen as being only related to intoxication. He used alcohol and other drugs to manage enormous anxiety, and later depression, following a significant trauma history of childhood sexual assault. He eventually died from an accidental Valium overdose.

> *I had one young person aged about 20 years who was told he was 'too complex' for a youth mental health service because he was not considered to be 'early intervention', but not complex enough for adult mental health. The two services kept referring him back and forth. He had anxiety, depression and a likely brain injury causing significant executive dysfunction.*

We have had instances of women exiting prison with complex physical conditions turning up without access to the medical records from when they were diagnosed and treated in prison — no scripts or plans for how to access their medication. The effects of having their usual medications withdrawn at the exact moment that they are exiting prison and returning to the community can have significant effects on both mental and physical health eg anxiety goes through the roof, side effects of withdrawal from mental health medication, or dizziness from withdrawing blood pressure medication, not remembering their diagnoses and having to start again at ER with life-threatening physical symptoms.

> *Some women whom we know will need ongoing mental health support in the form of case management cannot access it without being admitted to hospital or programs that they may be too unwell to attend without support. This means that some women exiting our service have to wait until they relapse so badly that they are re-admitted before they can be eligible for ongoing support. This is very difficult given that the hospital then may not have capacity to assess or admit them despite significant mental concerns.*

One woman who was released to homelessness was re-admitted with endocarditis in another hospital less than a week later, after being held hostage and injected with dirty drugs by someone who had robbed her. This woman had been on and off many medications for mental health, and was quite up front about the fact that she could not manage them herself, often taking more than she should in the hope that she would 'get better faster'. She would take too much and experience significant side-effects, then run out of medication and enter withdrawal, over and over, decreasing their effectiveness overall. They were not even addictive drugs, but anti-depressants like Mirtazapine. An admission to allow her to experience a period of stable mental health and well managed medication could have had great benefit. She was seeking this treatment, but she was still unable to get herself admitted despite diagnoses of anxiety, depression, bipolar disorder, PTSD, panic disorder with agoraphobia, and BPD; and the fact that she wasn't well enough to engage meaningfully in community treatment.

Case study: an integrated care approach to secure housing and mental health

The link between mental health, housing and homelessness is a complex one, interwoven with factors such as domestic violence, physical health and disability, addiction, social isolation and trauma. Where housing is addressed in isolation from these other issues, people will often cycle in and out of insecure tenancies or homelessness because their underlying challenges remain a constant and are, in fact, often compounded by their housing insecurity.

People experiencing homelessness, or discharged into insecure housing from institutions such as hospitals or correctional centres, often also have experience of trauma that relates to mental illness, social isolation and/or addiction. Associated challenging behaviours may have 'burnt bridges' in accessing some mainstream systems, such as housing supports.

At this level of acute or sub-acute need, effective person-centred care depends on **highly skilled, holistic support**. Services such as the Homeless Health Outreach Teams and hospital-based social workers are a critical link in facilitating and coordinating housing and other supports, as are organisations such as Anglicare. The best outcomes for service users come about when workers can collaborate across sectors and coordinate care, as in this recent example from Anglicare's Homeless Services Women and Families (HSWF):

> *A service user from HSWF was struggling with depression, and suicidal. With the permission of the young woman, the Queensland Health Early Psychosis Team and HSWF Recovery Practitioner worked collaboratively with her to establish a joint safety plan (rather than two individual plans) and a communication plan to ensure a coordinated cross-agency response when assessing for risk of harm. In one situation, the team drew upon the knowledge, resources and strengths of both agencies and the service user herself to liaise with the hospital mental health clinician and the Queensland Ambulance Service in response to specific wellbeing concerns. The outcome was a much more thorough assessment for the service user, and a clear communication path to ensure all parties were in accord about actions required to effectively monitor her safety plan.*

Services are however **profoundly under-funded to meet need**. This is an issue right across the continuum of service, from prevention to acute care. However, simply funding more services to refer high-need clients to the same number of crisis and transitional beds, and the same number of support workers, changes little.

Workers at our INSYNC youth homelessness service often struggle with accessing care for young people who are a risk to themselves or others. Expanding the number of live-in, mental health-supported facilities to support people, including young people, with high needs is a pressing issue; but such facilities need to be recovery-oriented, connected in positive ways to the community around them.

Amy's story

Eighteen-year-old Amy entered Homelessness Services Women and Families (HSWF) from the mental health ward of the Sunshine Coast hospital following a suicide attempt. She had spent approximately a week in hospital. Prior to that she had slept rough, after a violent incident which ended her foster care placement.

Amy had no contact with her family, whom she identified as dangerous. She had significant safety concerns around her family being able to find her, and she had no friends and no support other than a cat, which she identified as her most significant support. We supported Amy to engage with 'Guardians of Animals in Crisis', who found a foster placement for her cat until she had found appropriate housing.

Amy identified having borderline personality disorder, PTSD, depression, anxiety, and dissociative identity disorder, significant self-harm and daily suicidal ideation. Initially, she received intensive case management support 3-4 times per week. She also had access to support workers over night and she frequently reached out and engaged in this support. She developed positive relationships with staff and engaged in all onsite activities which were offered – art, music, cooking etc.

We linked Amy with the Homeless Health Outreach Team (HHOT) and the Brisbane Rape and Incest Survivors Support Centre (BRISSC) for support with her mental health and to develop further strategies. She met with a psychiatrist and mental health registrar, and received some mental health case management through HHOT. Amy was also linked with 'Talk Suicide' to further explore her suicidality.

As Amy's mental health stabilised, she shared concerns around how she would manage living on her own, as she had never lived alone before. We supported her with daily living skills and continued to develop self-care and coping strategies to manage her triggers. Amy began to settle in the HSWF environment and make some friends. She benefitted from sharing the cooking and meals, engaged in communal chores and took on extra responsibilities where possible.

As we explored housing options with Amy, she identified a wish to live in the community, with supports. She transitioned to an Anglicare community property where she continued to engage in case management. This was initially a turbulent time for her as she experienced triggers around isolation but, with support, she eventually settled.

She identified that she would like to return to school and complete year 12, and we supported her to enrol in a local flexi-school. This supported her engagement in the community and reintegration with her peers. She made friends and developed a social circle which was of further support to her.

Amy identified however that she was still 'getting back on her feet' and that she would benefit from longer term supports. As we explored options with her, Amy identified interest in the Anglicare INSYNC programme which provides transitional housing for young people under 25. We worked with INSYNC to create a collaborative plan to make this a smooth transition for Amy. She stayed with INSYNC for 12 months, engaging positively with her new case manager and identifying the move as a positive outcome for her.

Amy has now transitioned out of intensive Anglicare services completely and secured a community housing property. She continues to have the support of an outreach mental health service and other support networks.

3.3.3 Clarifying roles, building skills, and improving communication pathways

In a whole-of-community model, it is important however to be clear about roles and responsibilities and the nature of expertise that each service has capacity and funding to contribute. While community mental health services, and other services such as Anglicare's Homelessness Services (Women and Families) or INSYNC Youth Services, are vital contributors in the mental health sector, many agencies face challenges taking on a level of support and risk for which they may not have suitable training or sufficient funding. One staff member describes for example the disjunction that can occur when people are discharged from hospital after an episode of mental illness:

> *What is not working well is discharging patients from hospital when they are not ready or well enough to be discharged, and then there is poor post-discharge care and planning when risk assessments are being made — both from the hospital, or Accident & Emergency. This is particularly so when people are being discharged into a homelessness service.*
>
> *This has been an ongoing issue for the many years I've worked in this sector — the practice of hospitals has never changed. There have been so many occasions where we have had to explain to hospitals that we are not a clinical mental health service. So the level of risk has not really been addressed or diminished, just shifted from one service to another.*
>
> *If the responsibility for people who are not ready to be discharged was to be formally shifted, it would be beneficial if the mental health clinicians provided suitable training to their NGO partners on managing that level of risk.*

Liaison with General Practitioners (GPs) can also be problematic due to supply and demand issues. While access to bulk billing GPs and obtaining a Mental Health Care Plan is usually straightforward, GPs then face difficulties identifying bulk billing, timely mental health care services to which they can refer patients. This is part of the 'bottle neck' identified above: under-funded, limited numbers of mental health services operating under pressure already have extensive wait lists, such that patients are sometimes expected to research services for themselves and attend the GP consultation with a referral in mind. With months of wait-time expected, some GPs will prescribe medication as an interim or ongoing treatment; or even 'gate-keep' resources (such as psychiatric referrals) in an attempt to reduce the pressure on the system.

The fragmentation of the system also creates other barriers to integrated service provision. Service providers currently make use of formal structures such as regional interagency and Mental Health Network meetings, as well as informal communication between staff and agencies involving collaborative problem solving of issues, warm hand overs and client referrals. One of the biggest issues faced by providers however in a constantly changing environment is maintaining their knowledge about other services within the sector, what they do, their availability (including catchment limitations as well as wait times) and how to source these. There are limits to how much individual workers and agencies can do in a siloed system to make their own communication pathways.

Reconceptualising the mental health system as a community-based, holistic, Trieste-like 'mental wellbeing' model would not only benefit individuals who access the system, but also create a multi-disciplinary network of shared knowledge, information and relationships across agencies, workers and people with lived experience of mental illness. Learnings from the Ipswich and Toowoomba Floresco service model trials would be key in rolling out such a model.[48]

A day in the life of Trieste

TRIESTE, Italy — An old mental hospital sits in Trieste's San Giovanni Park alongside a large rose garden that stretches up a hill over the city. The facility closed over 40 years ago, but its ocher pavilions are filled with activity.

In one building, Radio Fragola (Strawberry Radio) broadcasts news and public services information. Next door is Il Posto delle Fragole (Strawberry Patch), a café and meeting point. (Their names are a nod to Ingmar Bergman's *Wild Strawberries* film.) Down the hall, workers are busy sewing ties, bags and clothing.

Helping staff these operations, as well as cafés, museums, libraries and other workplaces throughout the city, are people with mental illnesses who belong to a social cooperative called La Collina (the Hill).

This is all part of what's known as the Trieste model, an approach dating back to the 1960s that is recognized by the World Health Organization as one of the most advanced, community-based mental health care systems. Unlike in the past when psychiatric patients were confined in institutions where they faced abuse, the Trieste model set out to treat people with mental illnesses with dignity, including them in the community and in daily activities.[49]

4.0 Experiences and leadership of people with lived experience

> *Our thinking begins with the phrase: "Nothing about us without us". This is a claim for the active involvement of people in the decisions that affect them. More deeply, it is a call to create a society where we are all recognised and valued as whole people, not as problems to be solved.*[50]

We are pleased to see recognition of the lived experience and leadership of people with mental illness in the Terms of Reference of this inquiry. Such a view is consistent with a whole-of-community approach that values the strengths of the individual, the choices people make and, as mentioned above, supports the development of what the QAMH call the 'mental wealth' of the community.[51]

An Anglicare Australia research project called *Our Better Selves* sheds significant light on the value of inclusion, acceptance, respect and opportunities for leadership. In a small group, Anglicare's *A Place to Belong* participants, volunteers and staff explored what the 'ripple effect' meant for them: how did 'ripples' go out into the community as individuals' capacity increased? As people grew in their own confidence and connection, it also became clear that they were having positive effects in their communities, activating local and social change.[52]

The boxed text below provides examples from *Our Better Selves,* but the following poignant comment from John provides perhaps the deepest insight into the therapeutic value of actively engaging with people as experts in their own lives:

> *For mostly all my life I have lived with the ideas that I am a waste of space, a good for nothing, unlikable, unlovable, person who cannot connect. Now I can shift these thoughts with the experience of attending regular meetings, where there was much discussion of meaningful, thoughtful ideas, and I was able to understand, formulate my own thinking and contribute in a manner which leaves me feeling good about myself and others. This is a major shift for me.*[53]

Stories of leadership and contribution

Donna's story

[I took part in] a group of people with mental illness to write about how people live with the memories of acute care and what recovery looks like. This included an academic article to explain to nurses how we are still human beings and want to be treated as such.

'Martin's' story

A man who has lived with chronic mental illness learnt that walking assists him. For some years now he has walked miles across Brisbane to be part of various community events. He is now volunteering, and has been part of an informal Circle of Support around a vulnerable man. He said, 'People have put me back together after I've suffered schizophrenia. Now is a chance to give back to others. I needed the context of other healthy people to be able to do that — when we band together and work together.'

Deborah's story

Deborah, a woman with a range of disabilities and challenges, who some years ago had been semi-homeless, is now on the casual payroll at the University of Queensland and she regularly contributes to different classes. A lecturer shared feedback from participants in a workshop where Deborah had told her story. One student commented …'[It] definitely changed my perception of people who seem like they've had a bit of a complicated life. I think it's made me more accepting and considerate regarding mental health.' Deborah is educating future professionals. Now there's a ripple!

Neil's story

Ian, Donna and John are service participants who have been at the heart of Our Better Selves inquiry. As an indicator of their leadership capacities, they co-presented a paper about the Ripple Group process at a recent Australian and New Zealand Mental Health Services conference in Brisbane – without any staff support from our agency. [54]

5.0 Mental health needs of people at greater risk of poor mental health

A common thread throughout this entire submission has been the value of a whole-of-community approach that positions mental health as a universal concern for all community members, and is based on an understanding that structural factors and barriers in society put people at higher risk of mental illness. Initiatives addressing 'high risk' groups therefore do not occur in a policy vacuum. Nor should they target individuals in these groups in a service delivery silo but as mentioned above, as part of a continuum of services, offering access to both 'early intervention in life' and 'early intervention in episode' support[55] within an environment that reduces stigma, and ensures equity of access and culturally appropriate care.

Causes and risk factors for social isolation and disconnection

- Socioeconomic disadvantage, which restricts social activities and leads to the breakdown of social networks
- Living alone
- Loss of relationships eg relationship breakdown, death of a partner
- Disability and/or chronic health conditions, largely due to environmental and structural barriers that restrict people's participation in activities outside the home.[56]

That said, it is completely appropriate to consider the particular needs of groups of individuals who deal with social and environmental factors that put them at higher risk of mental illness. Many of these challenges diminish people's capacity to establish and maintain meaningful social connection (see sidebar and section 3.2), which is a major protective factor against mental ill-health. Researchers have noted the reciprocal relationship between social isolation and loneliness, and negative consequences such as poor physical and mental health — for example, 'where loneliness is associated with an increased risk of mental illness, but individuals with mental illness also tend to be lonelier'.[57]

Consistent with our whole-of-community, whole-of-government focus in this submission, we highlight below some groups who are particularly vulnerable to social isolation and disconnection. Prevention and early intervention strategies and policies that help to increase quality social networks and a sense of 'belongingness'[58] for individuals in these groups are critical to support mental wellbeing.

5.1 Young adults

Since around 2013, an increasing proportion of young Australian adults aged 15–24 years have agreed with the statement that, 'I often feel very lonely' in the HILDA longitudinal survey.[59] This is consistent with a recent Victorian survey that asked 1500 young Victorians aged 12–25 years about their experiences of loneliness and social isolation.

The Victorian research found that young adults aged 18–25 years reported higher levels of loneliness, social isolation, social anxiety and depressive symptoms than adolescents in the younger age bracket; and indicated the impact of the pressures facing young adults as they negotiate major life events and transitions such as leaving school, moving out of home, and

starting employment or higher education.[60] COVID is a further source of stress and concern about the future for many young people (see also sidebar on p. 26).[61]

5.1.1 Young people leaving care

For young adults facing such challenges without the support of a family, such as those transitioning from state care, the mental health risks are even higher. Recent AHURI research found that within four years of leaving care, 11% of young people had a hospital admission for mental health and 8% for self-harm. More than one fifth (22%) made an emergency presentation for mental health, and 20% for self-harm.[62]

A 2018 UK survey, *Our Lives Beyond Care*, found that one in five care leavers feel lonely most or all of the time (see above) and nearly a quarter have low life satisfaction – seven times higher than among young people in the general population.[63] The voice of care-leaver Louise Hughes is poignant:

> *I've felt lonely and isolated for most of my life … To this day, as a 23-year-old, I struggle to form friendships, which has led to a constant feeling of loneliness.*[64]

Figure 3: Data from Our Lives Beyond Care

In Queensland, state support for care leavers finishes at 18 (for residential care and self-placements) or 19 years (for foster and kinship care). In addition to the myriad challenges faced by all young people transitioning to adulthood, when social connections are often disrupted or severed and identity can be dislocated,[65] these young people are less likely to have the support of traditional support structures such family, friendship circles and community. This limits the social support young people transitioning from care can leverage to address social isolation and disconnection.

A recent benefit–cost analysis undertaken by Deloitte Access Economics identified the significant wellbeing and financial benefits that would accrue if extended care and support was offered to Queensland care leavers to at least the age of 21 years. The analysis estimates the wellbeing costs of mental health disorders for care leavers using a burden of disease methodology developed by the World Health Organization, and found that for every $1 invested by the Queensland Government in extended care, the expected return to the state would be $5.90.[66]

Extending care to the age of 21 years is a simple and fiscally responsible way to increase the mental wellbeing of the approximately 500 young people who leave care in Queensland each year.

5.2 Older people

While ageing is not *in itself* a risk factor for social disconnection and mental illness, isolation and and its associated risks among older people tend to increase because they have greater exposure to structural risk factors such as those in the side bar on p. 23.[67]

Anglicare staff in our respite centres note that people tend to feel more isolated as their functionality decreases and barriers to mobility increase — when they are unable to walk or drive, become incontinent, or lose the ability to eat normally, and their coping behaviour may be perceived by others as less socially acceptable. People's awareness of this gradual distancing from others can contribute to their feelings of isolation and disconnection. This is often exacerbated when siblings, friends and acquaintances die, leaving older people without the comfort of a peer network. Younger family members — the 'sandwich generation' — face pressures managing work, commitments to their own children, and spending time with their parents. Even in situations where an older person lives with family, they are often alone for much of the working day. Geographic (including rural or remote) or cultural isolation (including older people from culturally and linguistically diverse backgrounds) can exacerbate the issue.

Older women and older men have both been identified in the literature as groups at risk of social isolation and disconnection. Older women are more likely to have lost a partner and live alone than older men,[68] and are among the family types at highest risk of poverty[69,70] — all risk factors for loneliness. Older men with limited social networks, low socioeconomic status, poor levels of community participation, and low sense of purpose in life, have also reported high levels of loneliness.[71]

The COVID pandemic has also intensified the mental health risks for many older people due to enforced isolation (see sidebar on p. 26), resulting in a range of publications internationally providing advice on strategies for reducing anxiety, depression and agitation.[72] A recent review of studies looking at the effects of social isolation or quarantine on older people came to the conclusion that social isolation, particularly in epidemics and pandemics, increases rates of psychological problems such as feelings of loneliness, abandonment, social exclusion, stress, anxiety and depression. [73]

Examples of the isolating impacts of COVID 19

Fear of infection, particularly among older people, has led some people to withdraw from activities, potentially making them more vulnerable to loneliness. In our respite centres, older people are showing increased anxiety and distress about masking and social distancing; and respite services have been periodically reduced to meet limits on inside gathering numbers.

Anxiety and depression related to job security and finances, the length of the pandemic and prolonged uncertainty have contributed to a sense of meaninglessness and concern about the future for many younger people. Staff have seen a deterioration in young people's wellbeing and mental health, as their access to socially protective activities such as sport is limited, and external services such as Anglicare's have been curtailed during periods of high alert or lockdown. Increased online bullying and loneliness has been apparent.[74]

5.3 People with a disability

Macdonald et al. call loneliness and social isolation 'the invisible enemy' for people with a disability, who are significantly more likely to experience social isolation and emotional loneliness than the rest of the population;[75] and to be more at risk of higher levels of psychological distress than those without disability.[76]

Consistent with the discussion above in relation to ageing, it is important to note that key risk factors for people with a disability are largely structural barriers to participation and connection, rather than related to the physiological nature of an individual's disability. In Macdonald et al.'s UK study, around 70% of participants who experienced loneliness and isolation also experienced environmental barriers within their communities; and they reported that disabling barriers impacted on their accessing leisure activities outside the home.

The difference that connection makes to people with a disability is evident in the words of one of our respite clients, Louise, who was unable to access any leisure activities for a long period after a stroke. The support of Anglicare staff overcame the barriers around her return to our bus trip outings:

> *When I came back I nearly cried because people told me how much they'd missed me when I wasn't there."*

Louise also faced trauma when a family member died, but the care and support of her bus trip friends gave her the support she needed:

> *I didn't want to be home alone but I broke down on the bus. People just put their arms around me and I got through the day.*

Inaccessible communities, structural barriers to employment and insufficient social care are among the factors that cause people with a disability to be over-represented among those who are isolated and disconnected[77] — a fact which further strengthens our argument for a whole-of-community, whole-of-government approach to mental wellbeing.

5.4 People in financial stress

Research strongly indicates a correlation between poverty and psychological distress, a key marker of mental ill-health. Australian research shows that among the poorest one-fifth of Australians, both within and outside capital cities, 1 in 4 people have psychological distress at a high/very-high level, compared to about 1 in 20 people among the richest one-fifth of Australians.[78]

Limited resources can curtail opportunities to initiate or maintain personal relationships (as discussed previously, a significant protective factor in mental wellbeing); and poverty can generate feelings of shame or inferiority that might induce people to withdraw socially.[79]

This submission has repeatedly highlighted the role of structural factors in contributing to mental health or ameliorating mental ill-health. The work over the past decade of the Anglicare network, for example, on affordability in the private rental sector provides a telling example of some of the social and personal wellbeing costs that accompany poverty and inadequate housing. University graduate Luke, relocating to Brisbane for work, for example, told us:

> *You just can't live on [JobSeeker] if you have to pay rent. I only have me to look after – I don't know how anyone could do it with kids. You can't afford to spend time with your friends, or even to leave the house sometimes. It's very isolating.*[80]

Luke's words are consistent with the substantial research linking poverty and social marginalisation, with its related impacts on mental health.

5.5 Workplace mental health

One in five Australians (21%) have taken time off work in the past 12 months because they felt stressed, anxious, depressed or mentally unhealthy.[81] The cost of poor workplace mental health is significant: a report commissioned by Beyond Blue estimates that untreated mental health conditions cost Australian workplaces approximately $10.9 billion per year: $4.7 billion in absenteeism, $6.1 billion in presenteeism (workers who are underproductive due to illness, stress or injury) and $146 million in compensation claims. [82] The Productivity Commission estimates the cost as even higher, at $17 billion p.a.[83]

The issue of workplace mental health has been exacerbated by the pandemic, with factors such as mandatory lockdowns and isolation, the fear of getting sick, potential loss of income and anxiety about what the future may hold playing a part in new levels of upheaval and workplace stress.[84] With the spread of the Omicron variant, staff shortages across almost every industry as people isolate or recover have impacted those still at work, with many staff carrying double or more workload.[85]

In workplaces that employees consider mentally healthy, however, the impact of mental health-related absenteeism almost halves (13%).[86] The Productivity Commission noted in the 2020 Mental Health Inquiry report that mentally healthy workplaces focus on psychological

safety as much as physical safety, and recommended that workers should have access to early treatment funded through workers compensation schemes.[87]

Other research has found significant positive returns on investing in evidence-based workplace mental health initiatives. A return-on-investment analysis commissioned by SafeWork NSW found up to a $4 return for every dollar invested in various workplace mental health interventions.[88]

LeadingWell Queensland is a solid foundation for continued attention in this space. Providing project funding for organisational mental health programs and initiatives (complementing community grants for Mental Health Week events) would help raise the profile of mental health in the workplace, expand knowledge of the resources available, and could help to address stigma.

6.0 Investment at all levels of government

An holistic, whole-of-community approach to mental wellbeing, integrated across government agencies and sectors, could purposefully activate supports such as those mentioned above.

We submit that strategies and action plans developed across almost every government portfolio should include explicit mention of how they contribute to individual and community mental wellbeing, in the same way that it is now required that new legislation addresses the implications of the Human Rights Act.

There are many existing points of leverage. As a report commissioned for Mental Health Australia (MHA) notes, because mental health and the experience of mental illness is influenced by everyday life, sectors such as (but not limited to) education, housing and family support, child protection, sports and recreation, disaster relief and criminal justice and corrections can all play a role.[89]

Almost every Queensland Government department has an opportunity to contribute to the development of meaningful social connections, for example, through existing programs and initiatives. Neighbourhood and community centres, with their reach into rural and regional as well as metro areas, are an obvious connection point, but further connections should be explored with diverse strategies and initiatives such as those in the sidebar on the next page.

Investment in areas where a rigorous evidence base already exists, such as the extension of state care for young people to the age of 21 years, should be implemented immediately; as should increased investment to address the pressing mental health challenges facing rural and remote Queenslanders. Attracting professional staff to rural and remote locations requires urgent consideration of financial incentives (eg increased remuneration, subsidised housing or assistance with relocation fees); as well as increased focus on significant, innovative professional development opportunities.

There are also opportunities to connect across jurisdictions, with federal programs such as the Community Visitors Scheme; and the community development activity supported by Brisbane City Council and other councils across the state.

Existing levers for a whole-of-community 'mental wellbeing' approach

- The *Queensland Plan*, with its diverse approaches to building cohesive and inclusive communities, where people 'look out for each other'[90]
- opportunities offered by the new *Queensland Women's Strategy*, currently in its development phase[91]
- The inclusion of social connection as a measure of success in future iterations of and activity related to *My health, Queensland's future: Advancing health 2026*[92] and the *Queensland Youth Strategy*[93]
- Expanding the initiatives under 'Reducing the cost of transport for households' in the *Queensland Transport Strategy* to explore more fully the potential for expanded concessions, supporting people on low incomes at risk of disconnection to connect more actively with their community[94]
- reviving the *Queensland* Greenspace Strategy 2011-2020,[95] and including a focus on the social benefits of green space for social connection and the reduction of isolation and loneliness
- exploring further options for individuals on community service orders that focus on building relationships as well as completing tasks[96]
- actively linking with community arts initiatives in *Creative Together: A 10-year Roadmap for Arts, Culture and Creativity in Queensland*[97]
- opportunities offered through Skilling Queenslanders for Work programs[98]

Every program has its costs, and the MHA report also outlines key components that underpin cost effectiveness, particularly of prevention and early intervention initiatives. It suggests, in summary, that the success of such programs is based on:

- solid evidence that addresses key determinants and/or risk and protective factors;
- adequately resourcing to ensure interventions are properly followed through;
- a longer term view, recognising that positive health outcomes can take 3 to 5 years, and sometimes beyond a decade to materialise; and
- leveraging cross-sector contact points, with collaboration between various service providers and agencies.[99]

7.0 Service safety and quality, workforce improvement and digital capability

The *Mental Health Commission National Report 2020*[100] provides valuable insight into workforce and access issues.

Much of the report's commentary on workforce improvement echoes points made earlier in this submission about the need for a collaborative, whole-of-community approach that values the contributions of professionals outside the clinical sphere. The report recommends:

> *A multidisciplinary workforce should extend beyond the clinical disciplines to appreciate the contributions from a wide range of professionals across all types of care in the stepped care model, from frontline prevention and identification through a range of treatments to recovery support and research.*

> *This workforce includes a wide range of clinicians (psychological, allied health, general practice and medical), recovery support workers, live experience workers, counsellors, psychotherapists frontline or emergency responders, and people working in community institutions more broadly, including sporting, cultural and religious organisations.*

We also support the findings of the Commission regarding the success factors required for such a diverse workforce:

- clearly identified roles and responsibilities that encourage professional recognition, with flexibility in scope, and a culture of collaborative practice and team approaches
- recruitment and career pathways in mental health specialisation across all aspects of the workforce
- appropriate mental health training, from primary qualifications to ongoing or specialised professional development and in-role training
- retention of trained workers and incentives to take up mental health specialisations
- resourcing to enable professions to work to their full scope of practice.[101]

Comprehensively addressing and resourcing the factors above is also key to service safety and quality, ensuring appropriate workforce skills, experience, mentoring, retention and development that supports quality service provision.

The National Report also highlights the potential for digital mental health services to offer new ways for people with lived experience, and their carers and families, to access services across all levels of care, overcoming geographic, stigma, privacy and financial barriers. At the same time, it notes a range of issues that need to be considered as digital mental health services expand, including accessibility of the internet (both bandwidth and cost) and low digital literacy.

These are among issues raised by Anglicare staff in a previous Commonwealth inquiry into mental health in rural and remote Australia, provided for consideration in Appendix A. Our staff also noted that for many people, telephone or video is a poor replacement for face-to-face contact with a service provider, and that online channels for communication often need to complement rather than replace real world interaction.

8.0 Mental health funding models in Australia

A comprehensive overview of mental health services in Australia, including expenditure and funding models, is provided in a regularly-updated report by the Australian Institute of Health and Welfare.[102]

Temporary COVID-related changes to Medicare-subsidised mental telehealth services have recently been made available on a continuing basis.[103] This is a positive but insufficient move to address the explosion of demand. As noted previously, workforce shortages mean people are on long wait lists for appointments with psychologists and psychiatrists.

Anglicare SQ recently joined Queensland Mental Health Commissioner Ivan Frkovic and the Royal College of Psychiatrists in supporting the push to widen Medicare benefits to counsellors and mental health nurses. We base this position on our experience providing counselling and support to more than 8,000 Queenslanders annually. In many of these instances, early intervention and support at the right time is more effective than a medical solution. As Mr Frkovic notes:

> *a person in 'situational crisis', such as suffering a relationship breakdown or adjusting to becoming a new parent might just as easily be treated by a counsellor or nurse trained in mental health.*
>
> *That would free up psychologists to deal with the patients who needed their specialised expertise.*[104]

We urge the Queensland Government to join us in advocacy to the Federal Government on this issue, to help ensure that Queenslanders have the mental health support they need, when they need it.

9.0 Relevant national and state policies, reports and recent inquiries

The Committee is very familiar with the pivotal Mental Health Inquiry report from the Productivity Commission. While we strongly support many of the recommendations of the report we also highlight, with Anglicare Australia, a number of gaps and flaws that need to be addressed. These same considerations should inform the Queensland Government's next steps, and we refer the Committee to the following Anglicare Australia submission into the Productivity Commission inquiry, and in particular pp.5–6:

> Anglicare Australia. 2020. Submission to the Productivity Commission's Draft Report on Mental Health, February. Submission 1206. Canberra: Anglicare Australia. At: www.pc.gov.au/__data/assets/pdf_file/0010/252100/sub1206-mental-health.pdf

We also strongly recommend the following reports and resources for consideration by the Committee:

> Queensland Alliance for Mental Health. 2021. *Wellbeing First.* Brisbane: QAMH.
>
> *Victorian Government. 2021-22 Victorian State Budget* — mental health highlights. See www.health.vic.gov.au/mental-health-reform/2021-22-victorian-state-budget-mental-health-highlights
>
> National Mental Health Commission. 2021. *Monitoring Mental Health and Suicide Prevention Reform: National Report 202*0. Sydney: NMHC.

10.0 Conclusion

In its final Mental Health Inquiry report, the Productivity Commission makes a statement that effectively summarises the many strands of the above submission. We take the liberty of adapting their comment to the Queensland context:

> *[Queensland] needs a mental health system that places people at its centre. In a person-centred system, people would be empowered to choose the services that are right for them across a full spectrum of clinical and non-clinical needs.*[105]

With a firm focus on *people* at the centre rather than processes, the system can be re-imagined in a way that defines individuals less as burdensome 'consumers', 'clients' or 'dependents'[106] and instead asks (to borrow from a Swedish model of person-centred care): *what's best for Esther?*[107]

To circle back to where we started in this submission: for individuals, families and communities to prosper in the long term, we need to provide an environment and supports that empower people to flourish. This is a whole-of-community responsibility — enabled, allowed, supported and resourced by all portfolios of government.

Attachment A

Rural and remote Australians access mental health services at a much lower rate

The experience of Anglicare's rural staff suggests that the reasons behind rural Australians' lower rates of access to mental health services are multi-pronged.

- Rural communities struggle with infrastructure issues that create a barrier to accessing services:
    - A defining feature of remoteness is isolation and distance. The issue of limited services in many rural areas (addressed below) is compounded by the geographic spread of individuals and families living in rural districts. Even where services exist, access may necessitate travelling long distances with implications for time, costs and managing family responsibilities. Many clients find telephone counselling a poor substitute for face-to-face contact with a service provider.
    - The above situation is exacerbated by no or very limited public transport services in most rural areas. For individuals and families experiencing complex disadvantage, including poverty, the difficulties related to attending appointments (even in the same town) can be a significant obstacle to obtaining services.
- Social and cultural factors often have greater impact because of the multiple, interwoven personal connections that are characteristic of relationships in rural communities:
    - Mental illness continues to be a source of shame for many people. In a small community, accessing support can be a source of stigma; and people may fear a loss of privacy and confidentiality when local service providers are the same individuals they come across at the supermarket, school event or church.
    - The turnover of professional staff in rural communities is high (see below). Constant staff change can make it difficult for clients to build trusting relationships with service providers, and necessitate retelling their stories (and potentially revisiting trauma) over and over.
    - High staff turnover also impacts the level of understanding service providers may have about local cultural issues, particularly in relation to Aboriginal and Torres Strait Islander clients who may have vulnerabilities resulting from generational trauma and embedded disadvantage.

The higher rate of suicide in rural and remote Australia

Rural Australians face economic, social and emotional burdens that are often distinct from those living in urban locations. These include the following:

- Financial pressures may result from drought, higher costs of living, limited opportunities for employment, or unemployability because of illiteracy and the decrease in available manual work.
- Fly IN, Fly Out (FIFO) roles, where workers are isolated and detached from their families and community, create particular social and emotional pressures. Farmers facing the prospect of off-farm life, particularly where properties have been handed down through generations, may also be under significant pressure.
- Without falling into the trap of myth-making and stereotyping rural communities – there may be more traditional gender expectations (eg Mundy 2013) that play into male stereotypes about failure and 'weakness' associated with needing or accessing help or support. Similarly, social understandings of rurality that emphasise self-reliance and stoicism might influence the low therapeutic engagement and unwillingness to seek help that characterises some rural Australians.
- For individuals from Aboriginal and Torres Strait Islander backgrounds, culturally appropriate assistance and care is even more limited.

Issues that arise in both urban and rural locations, such as the following, may be further exacerbated in rural and remote communities by isolation, disconnection and lack of access to services:

- the reality of embedded intergenerational disadvantage, often co-existing with family dysfunction characterised by drug and alcohol use, family violence, children in state care, gambling and/or poverty; and
- the severance of Indigenous young people from culture and kin, and the struggles many face in finding employment and maintaining the hope of a good life.

The nature of the mental health workforce

The particular challenges associated with rural and remote communities require skilled and experienced mental health professionals. The workforce, however, suffers from the following characteristics:

- Staff turnover is high, often due to lack of peer support (with fewer colleagues to draw upon for support and mentorship), and the difficulties of accessing professional development.
- Positions may be unfilled for long periods of time, partially due to expensive rents and the high cost of living.

- While there are generally sufficient mainstream support workers to meet demand, the number of psychologists and counsellors is inadequate to address the compelling need for mental health professionals outside urban areas, and declines with increasing remoteness (see Figure 4 below).

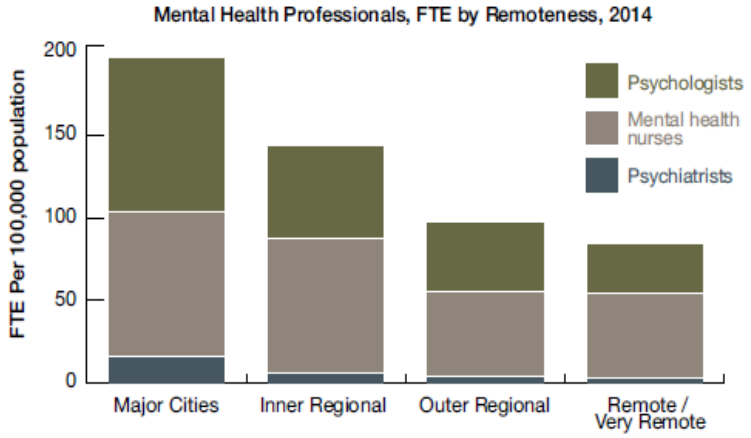


Fig 4 Numbers of mental health professionals decline with remoteness (Hazell et al 2017)

- Where professional staff are available, there is a preponderance of newly qualified staff who are enthusiastic but lacking in experience, and who require significant support from already-stretched colleagues.
- There is a pressing need for dedicated strategies to support more trained mental health professionals and workers from Aboriginal and Torres Strait Islander backgrounds into employment in rural and remote areas.

Attracting professional staff to rural and remote locations requires more serious consideration of financial incentives (eg increased remuneration, subsidised housing or assistance with relocation fees); as well as significant, innovative professional development opportunities.

The challenges of delivering mental health services in the regions

In common with other service providers, Anglicare SQ faces challenges in delivering rural and remote mental health services. These include the following:

- Geographic distance — for example, a 1400 km round trip to service a remote community. Such distances put workers themselves at risk of isolation and burnout.
- There is often a lack of collaboration between services, resulting in inconsistent client referrals; and there are limited appropriate venues to offer counselling services in many communities. Anglicare is addressing such issues by building partnerships and linkages with other organisations and services such as local councils or the local Aboriginal health service.
- There may be difficulties in engaging clients and gaining the trust of both communities and clients because of the constant turnover of staff.

Attitudes towards mental health services

As noted above, to be seen accessing mental health services in a rural community can be perceived to be a sign of weakness and a significant source of stigma.

Concerns about privacy and confidentiality add to this resistance. Word travels fast in small communities and privacy can be a key concern, particularly if staff are 'locals'. People may worry about being 'labelled' by local gossip.

Fig 1 GP mental health encounters (Hazell et al 2017)

For Aboriginal and Torres Strait Islander Australians, access to help may be tied in with the fear or reality of finding oneself in an alienating clinical environment among strangers and far from country (eg Commonwealth of Australia 2006).

Opportunities that technology presents for improved service delivery

PC- or mobile-based videoconferencing has been frequently suggested as a possible channel for rural clients to engage with city based professionals such as psychiatrists, and there have been many trial projects in Australia and internationally exploring these possibilities. While Anglicare staff support such initiatives, we note there are very pragmatic issues that sometimes hinder their success, and thus need to be considered in tandem with technology solutions.

For example, rural clients may have unreliable internet or mobile access, with connections that 'drop in and out' and interfere with the flow of communication between counsellor and client. Clients experiencing hardship (or simply on limited data plans) may not have sufficient data or credit to make contact with the worker at an agreed time, or complete a planned session. Clients may also find it hard to find a quiet, confidential place to speak on the phone or via internet. If home is not suitable, there are few other locations in rural communities that meet this criteria.

Conclusion

The mental health workforce plays a critical role in supporting the wellbeing of rural Australians. Despite the challenges noted above, Anglicare and other mental health professionals are valued resources in their communities. They work in difficult circumstances, with a keen awareness that individual therapeutic responses need to be supported by enhanced community capacity, capability and understanding of mental health issues.

We strongly recommend, therefore, that strategies at **both individual and community level** need to be considered by the Committee in its report. As the Centre for Rural and Remote Mental Health note in their position paper:

> *Building strong resilient rural communities is an important investment to ensure that such communities can support the most vulnerable in times of adversity and those who may experience suicidality (Hazell et al 2017, p. 7).*

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