phn QUEENSLAND
An Australian Government Initiative

Mental Health Select Committee Inquiry QLD PHN Submission

Overview

The Primary Health Networks (PHNs) of Queensland have jointly prepared this submission for the Mental Health Select Committee Inquiry into the opportunities to improve mental health outcomes for Queenslanders ('the Inquiry'). Given the alliance between Queensland and Northern Territory PHNs, Northern Territory PHN provided additional perspective and information for the development of this document, however the focus of this submission will remain on the role of Queensland PHNs in supporting the mental health outcomes of Queenslanders.

The contents of this document are aligned with the Terms of Reference of the Inquiry, as indicated in the boxes to the left of section headings and are summarised in Appendix 4.2.

Recommendations from PHNs to improve mental health outcomes for Queenslanders

Queensland PHNs acknowledge the importance of improving the mental health outcomes of Queenslanders and the vital role that PHNs can play in achieving this. The key recommendations that have been identified to support the optimisation and expansion of the role that PHNs play in supporting the mental health outcomes for Queenslanders are listed below:

1. **Enhance alignment of governance frameworks** between various levels of healthcare services, government, allied health bodies, and NGOs to facilitate joint commissioning.
2. **Co-design stepped care that is responsive and flexible to patient needs**, including cohort-specific requirements, with a focus on integration with existing services and engagement with relevant stakeholders.
3. **Support workforce expansion and retention** particularly in rural and regional areas, including through alternative workforce models.
4. **Develop evaluation processes to determine effectiveness and impact of services** in addition to service safety and quality.
5. **Support building digital capability across primary healthcare** including telehealth services and the use of digital health technologies to enable data/records and prevention and hybrid delivery models.
6. **Secure ongoing funding and resourcing to improve mental health outcomes** to supplement existing service offerings and partnerships.

Associated actions for Queensland PHNs in the short, medium and long term for each of these recommendations have been developed and are outlined within this submission in Section 3. Where possible and appropriate, these actions are intended to align with broader national approaches to mental health and will involve collaboration with the Australian Government and other States and Territories to avoid duplication and assist with progressing a nationally consistent approach.

Submission structure and terminology

This submission contains four sections, namely:

1. Background and role of PHNs in the healthcare system (pp. 3-4)
2. Current state mental health impacts and needs in Queensland (pp. 5-14)
3. Recommendations for PHNs to improve mental health outcomes for Queenslanders (pp. 15-23)
4. Appendix (pp. 24-26)

The following terms are used throughout this submission, with supporting definitions to provide clarification on the context in which they are used in provided below:

- *Consumers* refers to individuals who are experiencing mental illness and are seeking services to support their mental health needs and has been used as an alternative to the term 'patients'.
- *Mental illness* refers to 'a health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people. It is diagnosed according to standardised criteria.'[1]
- *Stepped care* refers to 'an evidence-based, staged system comprising of a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as linear steps, but rather offer a spectrum of service interventions. Stepped care is a different concept from 'step up/step down' services.'[2]

For questions or further information, please contact:

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[1] *What is mental illness?* 2007, Department of Health, accessed 31 January 2022, https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-w-whatmen-toc~mental-pubs-w-whatmen-what
[2] Carey, T A, 2018, *'Stepped care for mental health treatment. A system in need of psychological expertise'*, InPsych, vol. 40, no. 6.

1. Background and role of PHNs in the healthcare system

The 31 PHNs across Australia were established by the Australian Government in 2015 and were designed to:[3]

- improve the efficiency and effectiveness of health services for people, particularly those at risk of poor health outcomes
- improve the coordination of health services
- increase access and quality support for people.

Since 2015, PHNs have grown to be an integral part of the delivery of primary care in Australia. PHNs bring strengths in their understanding of local community needs and services, and a regional approach to commissioning that is responsive to local settings to enhance population health outcomes. They engage with general practitioners, other primary health care providers, secondary care providers, consumers, carers, allied health, Hospital and Health Services (HHS) and Non-Government Organisations (NGOs) to deliver targeted services, provide wrap-around care that suits the needs of consumers, and more broadly, facilitate transformational and system change.

To achieve the intentions and goals of providing healthcare services, PHNs:[4]

- assess the health needs of their region using a people-centred approach
- commission health services to meet the prioritised health needs of the people in their region
- work closely with providers to build health workforce capacity and ensure they deliver high-quality care
- connect health services for people to encourage better use of health resources and avoid duplication.

The work of PHNs is underpinned by six national priorities established by the Australian Government which include mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, digital health, aged care, and alcohol and other drugs.[5] As one of the key pillars to the national priorities, mental health has been a central focus of PHN work since their establishment. PHNs have two main roles in mental health and suicide prevention, namely regional planning and commissioning of services.

The programs delivered by PHNs for mental health follow and advocate for a stepped care approach, which is a staged approach to mental health services, delivering care across the range of mental illness needs. The intention of the stepped-care model is for individuals to receive different methods and forms of care matched to the severity of their mental illness, providing a holistic approach to services across the spectrum of need.

The role of PHNs in mental health is underpinned by a broader national strategic context, and informed by recent Inquiries, including (but not limited to):

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- The National Health Reform Agreement (available here): Identifies PHNs as the primary health care partners of HHSs to support and enable better integrated and responsive services.
- The National Agreement on Mental Health and Suicide Prevention: Established in November 2021 between Commonwealth and State/Territory governments, which identifies the responsibilities for service delivery, funding, monitoring, reporting and evaluation.
- The Fifth National Mental Health and Suicide Prevention Program (available here): Proposes regional planning to develop joint regional mental health and suicide prevention plans to provide coordinated delivery of services, particularly for those with severe and complex mental illness and for those in specific cohorts. Identifies the need to develop evidence-based services, which are all ultimately underpinned by national guidelines and frameworks.
- The Productivity Commission Inquiry Report into Mental Health (available here): Assesses the role of mental health in supporting economic participation, enhancing productivity and economic growth, and identifies a range of recommendations to improve the mental health of Australians.
- Submission by the Queensland Mental Health Commission (QMHC) - response to the Productivity Commission Inquiry into Mental Health Draft Report (available here): Identifies the QMHC's response to the report which is supportive of the strategic intent of the recommendations and proposes further

[3] Department of Health 2021, *What Primary Health Networks are, Australian Government | Department of Health,* accessed 31 January 2022, https://www.health.gov.au/initiatives-and-programs/phn/what-phns-are
[4] Ibid.
[5] Department of Health 2021, *How we support Primary Health Networks, Australian Government, Canberra,* accessed 31 January 2022, https://www.health.gov.au/initiatives-and-programs/phn/how-we-support-phns#key-priorities

consideration and translation for the Queensland context, including integrating community-based services with housing, employment, parental supports, community building, justice and other services across the continuum of care, and greater investment in prevention and early intervention.

In Queensland, the changing nature of mental health support needs, as well as the need for alignment with these broader national strategic intentions have resulted in the development of a range of state strategic documents and plans which establish the approach to delivering services in the short, medium and long-term. These documents include:

- Shifting minds – Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023 (available here): Establishes a five-year direction for a whole-of-person, whole-of-community and whole-of-government approach to improve the mental health and wellbeing of Queenslanders through a comprehensive and coherent approach to legislation, policy, planning, funding and service delivery.
- Connecting care to recovery 2016-2021 (available here): Builds on the broader strategic plan of *My health, Queensland's future: Advancing health 2026* and strengthens collaboration and effective integration across the mental health system for those with severe mental illness or problematic substance misuse, to ensure coordination of care to promote better outcomes.
- HHS strategic plans (available here): Identifies each of the strategic plans of the 16 HSSs in Queensland, which articulates their core pillars, objectives and strategies to address the challenges and needs of their region, and the interaction between the services available.
- PHN and HHS Joint Regional Plans (see individual PHN websites): Under the Fifth National Plan, all PHNs and HHS have worked together to produce foundational Joint Regional Plans and are now implementing the agreed actions in the plans. In some regions, reviews of the original plans have been conducted and a refreshed plan published. The level of active involvement of stakeholders (especially HHSs) varies across regions and should be strengthened going forward.

The role of PHNs in supporting mental health at present, as well as the challenges in delivering care and alignment with these strategic intentions are detailed further in Section 2.3 and 2.4.

2. Current state mental health impacts and needs in Queensland

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2.1 Health, social and economic impacts of mental health

Almost half of all Australian adults are impacted by mental health issues, and the impacts of mental illness on society, economy and the community are large. The Health of Queenslanders 2020 Report highlights that:[6]

- 85% of adults considered themselves to be in excellent, very good or good health in 2020
- 23% of adults self-reported a long-term mental or behavioural problem in 2017–18,
- in 2018, there were 767 suspected suicides by Queensland residents—a rate of 15 per 100,000 population,
- in 2020, Queensland adults averaged 2.6 days in the past 30 days when their usual activities were limited due to poor physical or mental health.

The Productivity Commission Inquiry into Mental Health estimated that the quantifiable economic cost of mental illness and suicide in Australia ranged from $43 billion to $70 billion (2018-19), and the cost of diminished health and reduced life expectancy for those with mental illness, self-inflicted injury and death by suicide totalled approximately $151 billion.[7]

The significant need for financial investment into mental health is also reflected in Queensland. State-funded mental health services in Queensland cost approximately $934 million in 2016,[8] and the number of Medicare items processed between July 2020 and June 2021 for GP mental health treatment (Medicare Benefits Schedule (MBS) item 2715) in Queensland was 195,283.[9] Furthermore, those who experience mental illness may require prescriptions for mental health medication, with 10.8 per cent of people living in Queensland dispensed with mental-health related subsidised medications in 2019-20 and 19.0 per cent of people living in Queensland dispensed with mental-health related subsidised and under co-payment medications in 2019-20.[10] Those who experience mental illness may also require more care from family members and their community, creating additional indirect costs.

Social impacts of mental illness, which are more difficult to quantify, include: direct and indirect caring duties, social isolation, absenteeism and presenteeism and potentially limited labour market opportunities and career progression. These issues are particularly pertinent if mental illness is experienced during childhood or youth, where these impacts can accumulate over time, as limited opportunities in one area, such as education, can then further impact their development in the workplace, community and social circles.[11]

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2.2 Risk factors and needs associated with mental health

The severity of mental health ranges from well and at-risk, to those with severe and complex needs, warranting a range of interventions that address the spectrum of care requirements. The Productivity Commission Inquiry into Mental Health identifies that a large proportion of individuals are at-risk of mental illness, and the provision of early intervention and prevention initiatives can be invaluable in preventing the development of more complex illness in the future and lessening long-term impacts. The report identifies that currently, there is a stronger focus by Australian, State and Territory Governments to invest in more acute services, rather than lower-intensity services on the stepped-care continuum.[12]

In Queensland, compared to previous years, the proportion of the population with self-reported mental or behavioural problems has more than doubled since 2001.[13] However, this may be partly attributable to increased awareness, reduced stigma, improved mental health literacy or increased rates of reporting as opposed to a direct increase in prevalence. There are a range of risk factors for Queenslanders that can lead to mental illness, detailed further below.

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[6] Queensland Health 2020, *The health of Queenslanders 2020. Report of the Chief Health Officer Queensland*, Brisbane.
[7] Productivity Commission 2020, *Productivity Commission Mental Health Inquiry Report no. 95*, Productivity Commission, Canberra.
[8] Queensland Health 2016, *Connecting care to recovery 2016–2021: A plan for Queensland's State-funded mental health, alcohol and other drug services*, Brisbane.
[9] Services Australia 2022, *Medicare Item Reports, Australian Government, Canberra,* accessed 31 January 2022, http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp
[10] Australian Institute of Health and Welfare 2021, *Mental health services in Australia: Mental Health related prescriptions, AIHW, Canberra,* accessed 31 January 2022, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-related-prescriptions
[11] Productivity Commission 2020, *Productivity Commission Mental Health Inquiry Report no. 95*, Productivity Commission, Canberra.
[12] Ibid.
[13] Queensland Health 2020, *The health of Queenslanders 2020. Report of the Chief Health Officer Queensland*, Brisbane.

2.2.1 Geographic distribution

Those who live in regional and remote areas are more likely to experience higher rates of self-harm and suicide, reduced help-seeking behaviour, lower service provision, less access to specialised mental health care such as psychologists, psychiatrists and mental health nurses, and with rates of hospitalisation from mental health conditions increasing with remoteness.[14] Queensland's population is uniquely distributed, with 16 per cent of Queenslanders living in outer regional, remote or very remote areas, compared to 10 per cent across Australia in 2020.[15] Given the higher proportion of the population living in regional and remote areas in Queensland compared to other states and territories, it is likely that these issues mentioned above are of a greater magnitude in this state.

2.2.2 Impact of natural disasters

Queensland is one of the States and Territories most affected by natural disasters. Since 2011, the state has been affected by more than 80 significant natural disasters including floods, bushfires, cyclones and monsoons.[16] Experiencing natural disasters can result in a range of mental health problems and mental disorders and may require care for post-traumatic stress disorder.[17] As natural disasters also tend to disproportionately affect rural and regional areas, the mental health needs of Queenslanders living in these areas are further increased. Furthermore, given the societal and economic impacts of climate change, the impacts of these challenges accumulate over time, creating larger impacts on the mental health of Queenslanders living in disaster-impacted zones.

2.2.3 COVID-19

The wide-ranging impact of COVID-19 on the economy, society and community within Australia has had drastic effects, particularly with the need for lockdowns to curb the spread of disease. Lockdowns have reduced the opportunity for individuals to interact with their families and communities, reducing the availability of necessary supports particularly for mental health. The need for lockdowns and limited social interaction also impact the employment of many Australians, which has further effects on wellbeing as employment is often identified as an important part of wellbeing and life satisfaction, and associated with access to economic resources and financial stress.[18] Consequently, the significant uncertainties and changes in various aspects of everyday life can generate significant feelings of anxiety, distress and concern, which can also increase an individual's risk of developing mental illness.

2.2.4 Demographic composition

Aboriginal and Torres Strait Islander populations

The composition of the Queensland population is also unique, with a higher proportion of Queenslanders identifying themselves as Aboriginal and/or Torres Strait Islander (5 per cent) compared to the corresponding national proportion (3 per cent) according to the 2016 Census.[19] Aboriginal and/or Torres Strait Islander people are more likely than non-Indigenous people to experience mental health concerns, particularly high or very high levels of psychological distress, and have particular mental health needs that stem from disadvantage and discrimination, grief and trauma from past systematic removal of children and destruction of communities, and continuous experience of loss.[20] Furthermore, given the high proportion of Aboriginal and/or Torres Strait Islander people living in rural and remote areas, these issues are compounded and further

[14] National Rural Health Alliance Inc. 2017, *Mental Health in Rural and Remote Australia*, National Rural Health Alliance Inc., Canberra, accessed 31 January 2022, https://www.ruralhealth.org.au/sites/default/files/publications/nrha-mental-health-factsheet-dec-2017.pdf
[15] Australian Bureau of Statistics 2020, *Regional population 2019-20 Population estimates by selected Non-ABS Structure, 2010 to 2020,* Canberra
[16] Queensland Reconstruction Authority 2018, *Resilient Queensland 2018-21: Delivering the Queensland Strategy for Disaster Resilience*, Brisbane.
Queensland Government 2019*, Types of Disasters, Queensland Government, Brisbane,* accessed 31 January 2022, https://www.getready.qld.gov.au/understand-your-risk/types-disasters
[17] The Royal Australian & New Zealand College of Psychiatrists 2020, *Addressing the mental health impacts of natural disasters and climate change-related weather events*, RANZCP, Melbourne, accessed 31 January 2022, https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/addressing-mental-health-impacts-natural-disasters
[18] Biddle, N, Edwards, B, Gray, M, & Sollis, K, 2020, *Tracking outcomes during the COVID-19 pandemic (August 2020) – Divergence within Australia,* ANU Centre for Social Research and Methods, Canberra
[19] Australian Bureau of Statistics 2018, *Estimates of Aboriginal and Torres Strait Islander Australians*, ABS, accessed 31 January 2022, https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release
[20] Mental Health Commission of New South Wales 2014, *Aboriginal Communities,* Mental Health Commission of New South Wales, accessed 31 January 2022, https://www.nswmentalhealthcommission.com.au/content/aboriginal-communities

exacerbated by the concerns regarding mental health of Australians living in these geographic regions, as discussed earlier.

Consequently, it is necessary that the services provided via and by PHNs are aligned to the particular needs of the population. As outlined below, Northern Queensland PHN provides place-based psychological therapies specifically targeted for the needs of Aboriginal and Torres Strait Islander people living in the region's remote communities.

Case Study: Place-based (remote) Psychological Therapies (Northern Queensland PHN)

The Northern Queensland Place-based Psychological Therapies are a response to the specific needs of Aboriginal and Torres Strait Islander people living in the region's remote communities. Through a regional needs assessment and co-design process, a total of seven mental health and wellbeing services were established and are delivered through the Northern Queensland PHN. The tailored response provides a much more targeted service delivery model than the mainstream Stepped Care Mental Health Care Services model to meet remote community's needs. Under the place-based initiative, services are delivered through: Aboriginal Community Controlled Health Organisations based in a Discrete Community, (e.g. Gurriny Yealamucka delivers services in Yarrabah), specialised remote mental health providers, (e.g. Royal Flying Doctors Service Queensland) and indigenous mental health service providers e.g. Wakai Waian Healing for Torres Strait Island communities). Collectively these initiatives provide culturally appropriate mental health and wellbeing services that are both embedded in the community and integrated with Queensland Health services.

Young Queenslanders

It was reported that in 2015, 14.4 per cent of Queenslanders aged 0-24 years had a mental or behavioural problem, which is not significantly unique compared to the national averages.[21] Young people who experience sexuality and gender issues, alcohol and drug misuse, homelessness, living in out-of-home care, involvement with the youth justice system, Aboriginality, disability, refugee status or having a parent with a mental illness have increased risk of and burden of mental illness.[22] Often, young people can experience multiple issues concurrently, and without the appropriate care and support, may result in requiring government services such as police, ambulance, youth justice, domestic and family violence, drug and alcohol, housing, and child protection services.[23]

Further, projects in the childhood and youth mental health space have been undertaken by Brisbane South PHN, specifically the Commonwealth Psychosocial Support Program (CPSP), as outlined below.

Case Study: CPSP for children and young people (Brisbane South PHN)

The CPSP for children and young people is being delivered across identified priority areas of Beaudesert, Browns Plains, Beenleigh and Eagleby and focuses on the delivery of holistic early intervention capacity building for children, young people and their families/ community. During the first full year of the program, (1 January – 31 December 2021), 286 children and young people accessed the service, with 4151 service contacts delivered.

During the pilot implementation the CPSP program worked closely with key partners across the service system, developing integrated referral pathways between services including CYMHs, local schools and other community organisations. Brisbane South PHN, secured additional non-recurrent funding to incorporate clinical care and coordination to further enhance the program. The outcomes of the enhanced model are currently being evaluated, however initial findings indicate positive outcomes across both clinical and psychosocial measures.

New parents

New parents can also be at risk of developing mental illnesses such as perinatal depression and anxiety (PNDA). Risk factors of developing PNDA include past or current personal/family history of mental health problems or substance use issues, past or current trauma, abuse or other stressful experiences, relationship

[21] Queensland Family and Child Commission 2019, *Submission to the Productivity Commission – Mental Health Inquiry: The Social and Economic Benefits of Improving Mental Health*, Brisbane.
[22] Health Victoria 2021, *Risk factors for children and young people*, Health Victoria, Melbourne, accessed 31 January 2022, https://www.health.vic.gov.au/mental-health-services/risk-factors-for-children-and-young-people
[23] Queensland Family and Child Commission 2019, *Submission to the Productivity Commission – Mental Health Inquiry: The Social and Economic Benefits of Improving Mental Health*, Brisbane.

difficulties and social isolation, compromised attachment from one's own parents, previous perinatal/pregnancy loss or conception difficulties, birth of twins or multiples, financial difficulties and limited access to social and practical supports, LGBTQI+ parents who face discrimination and lack of support, and Aboriginal or Torres Strait Islander or CALD individuals without access to culturally aware support systems.[24] By identifying the need for and providing appropriate care as early as possible during parenthood and by ensuring that specific risk factors for cohorts are addressed, the impacts of PNDA can be reduced for the parent, child, family and community.

Aged care residents

For Australians experiencing ageing, those who live in aged care communities and other supported accommodating settings are more likely to experience mental health problems, with life events such as bereavement or physical ill health as significant contributors to mental illness. People experiencing ageing are also more likely to face social isolation and reduction of engagement with peers.[25]

Services tailored for aged care communities, such as Compassionate Communities, were developed in the Central Queensland, Wide Bay and Sunshine Coast PHN, as outlined in the case study below.

Case Study: Compassionate Communities (Central Queensland, Wide Bay and Sunshine Coast PHN)

Compassionate Communities aims to improve the ageing and end of life experience for people by empowering everyday citizens to draw upon their existing knowledge and networks. Social approaches to palliative and end of life care, and to grief and bereavement, are a proven way to build strength and resilience in communities and are growing in popularity around the world.

The establishment of the Compassionate Communities project in Australia is courtesy of The Groundswell Project, which runs educational workshops, develops innovative programs and advocates for a better end of life experience for all. The Community Connector program activates everyday citizens to draw upon their knowledge of local services and groups to play a stronger, more confident role, in the care and support of people with life-limiting illnesses, at the end of life, or those who are bereaved and grieving. They can identify and signpost others to groups, services and other supports that either formally or informally address end of life care, grief and bereavement, like palliative care, hospice care, support groups, social clubs and community services.

A total of nine Train-the-Trainer Lead Community Connectors' workshops were held across Central Queensland, Wide Bay and Sunshine Coast in 2020/21, with the Compassionate Communities initiative formally launched with an event in Maroochydore.

LGBTIQA+ communities

LGBTIQA+ Queenslanders are also at higher risk of requiring mental health care. Experiences of stigma, abuse, discrimination and harassment negatively impact their mental health.[26] Furthermore, these experiences may also create barriers in help-seeking behaviours as well as access to services, due to concerns around stigma or past negative experiences when accessing services.[27]

Refugees and migrant groups

Refugees are at particularly larger risk of experiencing mental illness. Often, life events such as emotional distress from leaving family and friends and losing their social support, unemployment, language barriers, isolation from their communities and experiences of traumatic events can increase the risk of developing

[24] Gidget Foundation Australia 2022, *Risk Factors*, Gidget Foundation Australia, accessed 31 January 2022, https://www.gidgetfoundation.org.au/about-pnda/risk-factors/

[25] Department of Health 2006, *Pathways of recovery: preventing further episodes of mental illness: Older Adults*, Australian Government, Canberra, accessed 31 January 2022, https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-p-mono-toc~mental-pubs-p-mono-pop~mental-pubs-p-mono-pop-old#:~:text=Common%20risk%20factors%20for%20mental,(US%20Surgeon%20General%201999)

[26] Department of Health 2013, *A national framework for recovery-oriented mental health services: guide for practitioners and providers: Lesbian, gay, bisexual, transgender and intersex people*, Australian Government, Canberra accessed 31 January 2022, https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-recovgde-toc~mental-pubs-n-recovgde-10~mental-pubs-n-recovgde-10-les

[27] Rainbow Health Victoria 2020, *Research Matters: Why do we need LGBTIQ-inclusive services?, Rainbow Health Victoria*, accessed 31 January 2022, https://www.rainbowhealthvic.org.au/media/pages/research-resources/research-matters-why-do-we-need-lgbtiq-inclusive-services/3898382955-1614819704/research-matters-lgbtq-inclusive-services.pdf

mental illness or exacerbate existing mental illnesses.[28] This experience of leaving their home country behind and moving to a new country results in a complex range of needs. Consequently, refugees are more likely to experience mental health conditions such as post-traumatic stress disorder, anxiety, depression and other disorders.

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2.3 The role of PHNs in supporting mental health

The Queensland health system's treatment of mental illness has shifted considerably in recent years, from delivering acute care for severe and complex mental illness, which emphasises the role of psychiatric hospitals, towards a greater focus on lower-intensity and preventative care, with the locus of treatment moving to community and primary care.

With mental health as one of their key national priorities, PHNs play a critical role in supporting the commissioning and delivery of community and primary care services that are tailored and responsive to their regions' needs. These services include care planning, delivery of lower intensity interventions and preventative services to reduce the need for more acute services later on. The core roles and service delivery priority areas for Queensland's PHNs in delivering mental health services include:[29]

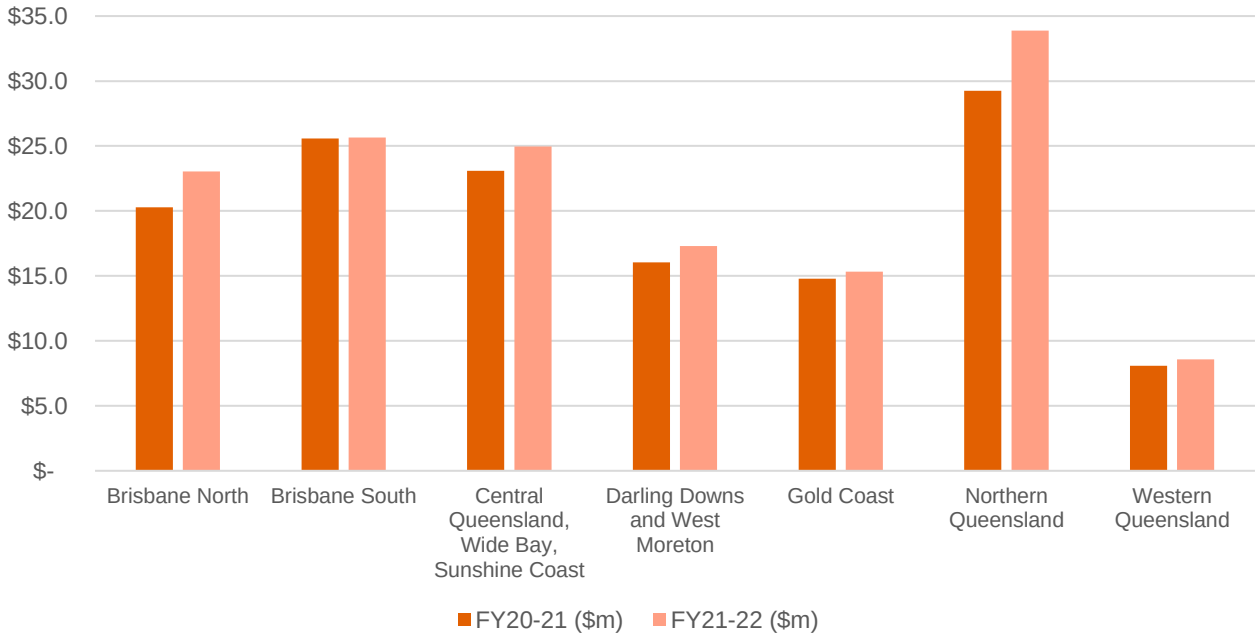
1. developing and/or commissioning low intensity mental health services
2. developing region-specific, cross sectoral approaches to early intervention for at risk cohorts
3. addressing service gaps in the provision of mental health care in underserviced and/or hard to reach populations
4. supporting clinical care coordination and psychosocial support for people with severe and complex mental illness
5. encouraging and promoting a regional approach to suicide prevention
6. commissioning drug and alcohol treatment services for communities at risk of or currently affected by substance misuse
7. improving commissioning capability across the state
8. facilitating systems change at a regional level
9. enhancing and better integrating Aboriginal and Torres Strait Islander mental health services at a local level.

Across all Queensland PHNs, 54,017 individuals engaged with mental health services including psychosocial in FY 2020-21, totalling 464,331 occasions of service with mental health services including psychosocial across the year.[30] Funding accordingly reflects such service provision, and with the high demand for services, mental health funding represents an increasing proportion of the total funding allocation to PHNs. Across the seven Queensland PHNs, funding allocation for mental health services on average increased by 8 per cent, from $137.1 million in FY 2020-21 to $148.7 million in FY 2021-22.[31] Northern Queensland PHN received the largest increase in funding (16 per cent), followed by Brisbane North PHN (14 per cent) and Central Queensland, Wide Bay, Sunshine Coast PHN (8 per cent).[32] The funding received by each PHN in Queensland across the two years is displayed in Figure 1.

In addition, Qld PHNs contribute a combined $24m of funding per annum to the Queensland alcohol and other drugs non-government sector. The majority (64%) of PHN funding was allocated to psychosocial treatment, 11% to residential treatment, 11% to low threshold, 8% to harm reduction, 4% to withdrawal management, and 3% to other.

[28] Healthy WA n.d., *Migrant and refugee mental health*, Healthy WA, Perth, accessed 31 January 2022, https://www.healthywa.wa.gov.au/Articles/J_M/Migrant-and-refugee-mental-health
[29] PHN Cooperative 2021, *Submission to the House Select Committee on Mental Health and Suicide Prevention*, Brisbane. Queensland PHN 2021, *DRAFT Mental Health Joint Regional Planning and Commissioning in Queensland,* Queensland. A more detailed list of mental health service activities conducted by PHNs is listed in Appendix 4.3.
[30] Data provided by Queensland PHNs.
[31] Ibid.
[32] Ibid.

Figure 1: Mental Health Funding Allocation ($m) by PHN (excluding one-off COVID-19 funds)

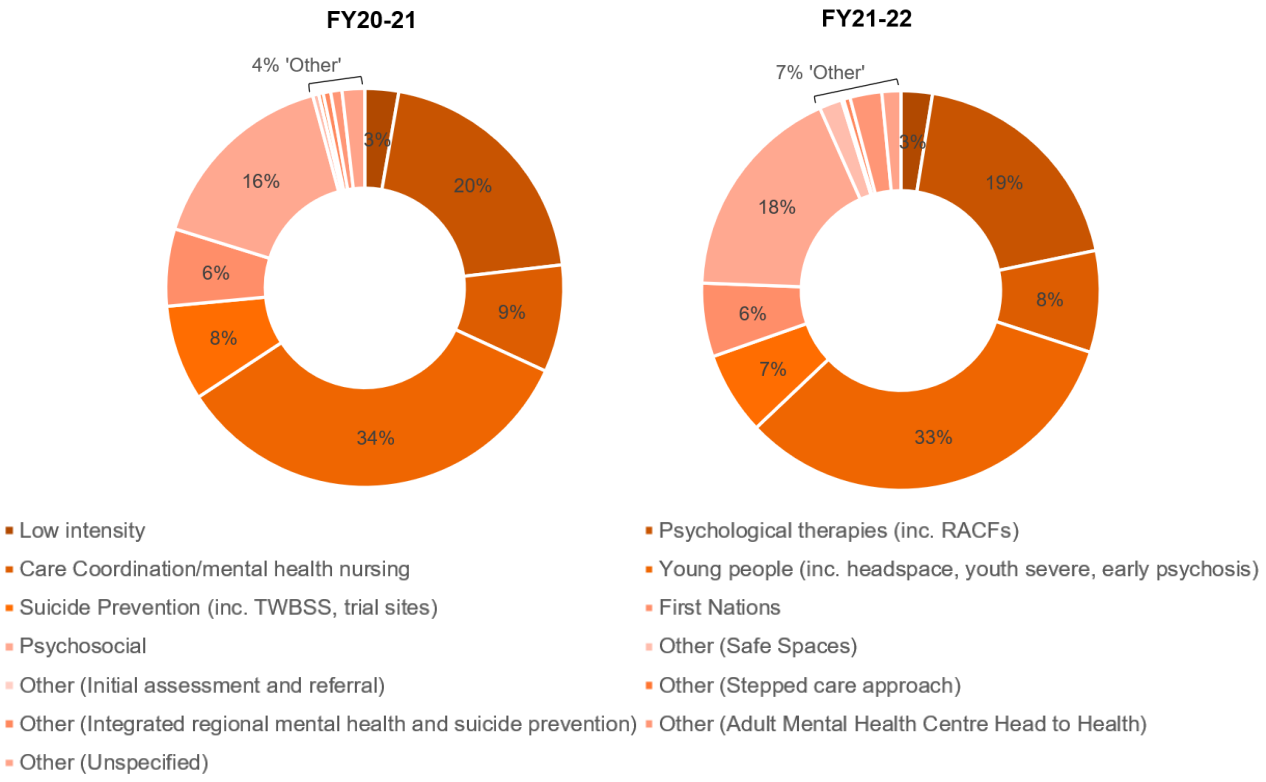


Depending on need and availability of services, Queensland PHNs fund a diverse range of operations. The categories of mental health services include:

- low intensity
- psychological therapies (including therapies delivered in Residential Aged Care Facilities)
- care coordination/mental health nursing
- young people (including headspace, youth severe, early psychosis)
- suicide prevention (including The Way Back Support Service, trial sites)
- Aboriginal and Torres Strait Islander
- psychosocial.

Of these services across all PHNs, for both FY20-21 and FY21-22, services for young people (including headspace, youth severe and early psychosis) received the most funding (34 per cent and 33 per cent for respective years), followed by psychological therapies (including RACFs) (20 per cent and 19 per cent for respective years) and psychosocial (16 per cent and 18 per cent for respective years). A further breakdown of the allocation of funds for mental health services can be found in Figure 2.

Figure 2: Breakdown of Mental Health Funding Allocations for FY20-21 and FY21-22 (excluding one-off COVID-19 funds)



2.4 Challenges of supporting mental health services

While PHNs are a vital access point to mental healthcare in Queensland, challenges still remain to ensure that care is delivered to those who need it, and that services generate positive mental health outcomes. Further, despite the locus of moving to community and primary care particularly delivered by PHNs, the expenditure for mental healthcare is still heavily weighted towards servicing acute and hospital support in the system, and system-wide challenges remain that limit the ability of PHNs to operate in and coordinate care throughout the mental health sector.

2.4.1 Delivery of care across the stepped-care continuum

While the intention across the mental health sector has been to reshape mental healthcare to align with the stepped care model, there are concerns that this model can still result in some consumers not receiving the appropriate care required. For example, those who have a moderate degree of mental illness, may find that they are inappropriately treated in hospitals and/or acute care as they are not sufficiently unwell, but are too unwell for community and primary care, this group of which is termed as the 'missing middle.' It is likely that these individuals do not receive the care that is required for their stage of illness, resulting in them eventually needing to receive more acute care without the appropriate early interventions.[33] Furthermore, the definition for those with severe and complex mental illness has evolved over time and differs across the sector, which can impact the delivery and navigation of services according to the stepped-care continuum.

2.4.2 Cohort-specific care

The challenges articulated in Section 2.4.1 are additionally exacerbated by those who identify with specific cohorts, as they already experience barriers in accessing appropriate care, limiting their ability to engage with appropriate services for their unique circumstances. Ensuring that information is translated and adapted to be culturally and linguistically appropriate adds additional costs to implementing and delivering services.

[33] Orygen n.d., *Defining the Missing Middle*, Orygen, Parkville, accessed 31 January 2022, https://www.orygen.org.au/Policy/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/Defining-the-missing-middle/orygen-defining-the-missing-middle-pdf.aspx?ext=

Furthermore, specific sensitivities, such as desire for privacy by groups such as refugees, need to be catered to in order to ensure they do not become a barrier to accessing services.

Further, it is not only the adaptation of mental healthcare that is required to reach certain groups, but also the provision of specialised and tailored services that is needed. Without the appropriate services for certain groups, such as those impacted by domestic and family violence, by guiding these consumers to more generalist services results in the suboptimal provision of care and addressing of need. Consequently, the unavailability of specific cohort-based services results in support being delivered that is not most suited to their needs.

This issue is also relevant for children and youth, where a lack of family-focused supports prevents wraparound and holistic mental healthcare. Furthermore, for children who do not meet the threshold for access to specific services, it is difficult to know where they can receive appropriate support. There needs to be a greater geographic dispersion of services across Queensland, which can be accessed without needing to engage with acute services first.

Gold Coast PHN, as outlined in the case study below, offers a program that provides a culturally safe approach to care and referrals for specific cohorts. This example focuses on improving navigation and providing tailored information to overcome cohort-specific barriers, which has potential for expansion across a range of other cohorts.

Case Study: Community Pathway Connector (Gold Coast PHN)

The Community Pathway Connector program provides a culturally safe connection point and referral service for people who have specific cultural needs, including those who identify as Aboriginal or Torres Strait Islander and those who are from culturally and linguistically diverse backgrounds. The program is a low to medium intensity service that seeks to assist people through tailored information and one on one support to navigate the service system to best meet needs, working with interpreters and linking with cultural awareness education as needed.

2.4.3 Workforce training and retention

More broadly, there are difficulties in recruiting and retaining a workforce that provides mental health services. This is particularly problematic in relation to more specialised skillsets, such as those experienced in alcohol and other drugs disorders.[34] Workforce availability is particularly problematic in regional and rural areas, where there are insufficient numbers of staff to service the communities, and where staff turnover is also high. Mainstream services also may not necessarily be effective for cohorts in these remote communities, as they have different needs, which often requires more tailored mental health service provision.[35]

Specialised mental health workers report experiences of physical violence at work, as well as disengagement, exhaustion, burnout and stress, which results in high turnover rates.[36] Additionally, the impact of COVID-19 on fewer skilled workers entering Australia to provide services further limits the pool of available staff, with greater reliance on domestic skilled staff. Therefore, there is a strong need to develop initiatives to attract and keep the workforce employed.

Further, at present in Queensland, there is insufficient use of the lived experience (peer) workforce. This workforce comprises of people who have had experience of mental illness and apply their personal understanding of life-changing mental health challenges, service use and recovery to support those who are experiencing mental illness. While this workforce can work across a range of services in the care continuum, they are currently insufficiently engaged due to challenges surrounding employment conditions, wages and guidelines, with the supply of staff particularly limited in regional and rural areas. The existing workforce is currently not fully optimised to its full potential. Concurrently, the peer workforce can be expanded to develop an emerging workforce, so that the capabilities and skills are available to meet increasing demand.

An individual's mental health can be impacted by a range of societal, economic and environmental factors as outlined in Section 2.2, which increases the complexity in effectively providing the appropriate care as services need to be tailored. Those with moderate to high levels of need can often experience fragmented

[34] Queensland PHN, *Productivity Commission – Brisbane Hearing Qld PHNs Statement*, Queensland.
[35] Brisbane North PHN, *PHN feedback on the Report from the Mental Health Reference Group (Better Access MBS review),* Brisbane
[36] Productivity Commission 2020, *Productivity Commission Mental Health Inquiry Report Volume 2 no. 95*, Productivity Commission, Canberra.

care due to the need to receive care from a number of healthcare providers to address psychological, social and behavioural factors of mental health.[37] Furthermore, particular population groups can be underserviced, such as those who identify as CALD, LGBTIQA+, Aboriginal and Torres Strait Islander, and children, and workforce expansion and specialisation can increase access and deliver services to these groups.[38]

As outlined in the case study below, cohort-specific training for the mental health workforce to provide services to Aboriginal and Torres Strait Islander communities can support the delivery of appropriate care.

Case Study: Professional Development Supervision Mentoring Selfcare (PDSMS) (Central Queensland, Wide Bay and Sunshine Coast PHN)

The PDSMS Program is designed to enhance workforce capacity, by including elements of professional development, professional supervision, supportive mentoring and individual and group selfcare. The first round of students in the innovative mentoring program from Indigenous mental health and drug alcohol workers in Central Queensland graduated from the program at the end of 2020.

The training initiative was developed by Rockhampton-based psychological service Wakai Waian Healing to bolster the Aboriginal and Torres Strait Islander health workforce. The project was driven by the high demand for the Wakai Waian Healing service, and lack of supply of services in Central Queensland providing culturally specific mental health and alcohol and other drug clinical therapies.

Several participants in the training initiative are now continuing their studies, enrolling in the Diploma of Counselling and tertiary studies in psychology. Following the success of the 2020 program, the PDSMS Program ran again in mid-2021.

At a governance and strategic level, there are a range of strategies that exist to support the mental health workforce, including:

- Mental Health Alcohol and Other Drugs Workforce Development Framework 2016-2021 (available here): Articulates strategies for HHSs to manage workforce planning and development in the Mental Health Alcohol and Other Drugs (MHAOD) sector, that responds to shifts in service delivery, demand and optimal response mechanisms.
- Queensland Framework for the Development of the Mental Health Lived Experience Workforce (available here): Identifies strategies and action items to embed people with lived experience of mental health challenges into the provision of mental health services.
- National Mental Health Workforce Strategy (in development): Will aim to address the quality, supply, distribution and structure of the mental health workforce, and identify approaches to attract, train and retain the workforce required to ensure that the future demands of the mental health system are met.

Despite this, additional support and commitment from government and associated health bodies are required into the future to ensure that the intentions and goals of these strategies are met, and actions implemented accordingly in a coordinated and integrated way at the regional level.

2.4.4 Delivery of digital services

Since the COVID-19 pandemic, there has been significant discussion on the value of digital services in providing remote healthcare services. However, a prerequisite for the successful delivery of digital services is the establishment of appropriate infrastructure, particularly internet and data. Often in rural and regional areas, the benefits of digital services are not realised because of inadequate infrastructure, with insufficient data and areas that are termed as 'dead spots' with no connectivity. Investment mains a challenge in this space to expand and deliver sufficient infrastructure, and allow for the delivery of digital services.

Furthermore, since digital mental health services are a relatively new method of interaction, some consumers may be apprehensive in adopting this mode of receiving care. Whilst it is generally assumed that younger people are adept and comfortable using digital technologies, in some cases, this cohort may be reluctant to choose remote and digital services if they had not received mental health support in the past and prefer traditional face to face services. Consequently, acceptance of digital services remains a challenge in addition to increasing digital literacy, access and supports for mental health.

[37] Agency for Clinical Innovation 2022, *Consumer Enablement Guide: Care coordination*, ACI, Sydney, accessed 31 January 2022, https://aci.health.nsw.gov.au/resources/primary-health/consumer-enablement/guide/how-to-support-enablement/care-coordination
[38] Brisbane North PHN, *PHN feedback on the Report from the Mental Health Reference Group (Better Access MBS review),* Brisbane.

2.4.5 Governance and funding

A range of governance challenges remain for Queensland PHNs to deliver coordinated and responsive mental health care. Overall, coordination between national, state and regional plans is an ongoing barrier, with positive relationships at a local level between PHNs and HSSs not always reflected in state-wide approaches to planning and distribution of funding and resources. Similarly, differing priorities and approaches between the Queensland and Australian Governments can lead to misalignment and duplication at a local level.

Developing funding models and strategies to reflect these activities and relationships between stakeholders remains a challenge. Whilst the National Mental Health Service Planning Framework has been established, further work is needed to distribute funding based on the local level of need and requirements across the continuum of care as opposed to service-based funding. While there are significant opportunities to leverage funding between PHNs and the Queensland Government, challenges in shared service planning and funding inhibit effective joint commissioning.

In particular, despite Queensland PHNs having undertaken joint regional planning activities with their HHS partners, opportunities for joint commissioning are yet to be fully realised. There is a spectrum of shared activities from joint commissioning that may be considered, from shared service planning through to shared funding contributions. Challenges in realising joint commissioning opportunities stem from the uneven funding contributions available, differing funding cycles between agencies and levels of Government, and unaligned system priorities. In addition, PHNs and HHSs are not funded to collaborate and co-design strategies and services together, despite joint collaboration and planning requiring significant resourcing and investment.

2.4.6 Evaluation

Evaluation is a fundamental aspect of understanding the impact and benefits of mental health services. However, there is limited funding dedicated to research and evaluation of projects. Limited data and information to support decision-making limits the ability to generate informed decisions into investing in mental health services, which can incur significant costs to the system.[39]

Even with the existing mechanisms that are in place to collect data, such as the Your Experience of Service (YES) survey, there are still concerns that data collection methods are not consistent between services and stakeholders, as well as between regional, State/Territory and Commonwealth levels. This lack of data-linkage limits the ability to make comparisons between services and health outcomes at a state-wide level.

This challenge of mental health data collection is further compounded by consumer privacy concerns, with the perception of stigma or identification deterring individuals from opting into sharing data or their experiences – both of which are fundamental to evaluation.

[39] PricewaterhouseCoopers 2020, *Scoping and development of a National Digital Mental Health Framework: Current State Assessment Report*, PwC Australia.
Productivity Commission 2020, *Productivity Commission Mental Health Inquiry Report Volume 3 no. 95*, Productivity Commission, Canberra.

3. Recommendations for PHNs to improve mental health outcomes for Queenslanders

This section presents the six recommendations and their associated actions proposed by Queensland PHNs to improve the mental health outcomes of Queenslanders. Although these recommendations and actions are being proposed in the context of the Mental Health Select Committee Inquiry, where possible and appropriate, it is the intent that these should and will be aligned to broader national approaches to mental health and involve collaboration with other States and Territories to avoid duplication and assist in achieving national consistency.

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3.1 Recommendation One: Enhance alignment of governance frameworks between various levels of healthcare services, government, allied health bodies, and NGOs to facilitate joint commissioning

The unique position and capabilities of PHNs lie in their tailored provision of services that deliver care based on what individual regions and communities need. Underpinned by their region-specific focus, is the need to align with State/Territory and Commonwealth strategies and frameworks for mental health, to ensure coordination and cooperation with the activities of other States/Territories and the Commonwealth.

A single joint regional plan, from which funders procure services independently according to this plan, would assist to overcome inconsistencies in the intentions and the implementation of current strategies across local, state and federal levels. As outlined in the case study below, Northern Queensland PHN, in partnership with the Torres and Cape Hospital and Health Service (TCHHS), Cairns and Hinterland Hospital and Health Service (CHHHS), Townsville Hospital and Health Service (THHS), and Mackay Hospital and Health Service (MHHS), developed a Joint Regional Mental Health and Wellbeing Plan for Northern Queensland to support place-based suicide prevention.

Case Study: Joint Regional Mental Health and Welling Plan for place based suicide prevention **(the Joint Regional Plan)** (Northern Queensland PHN)

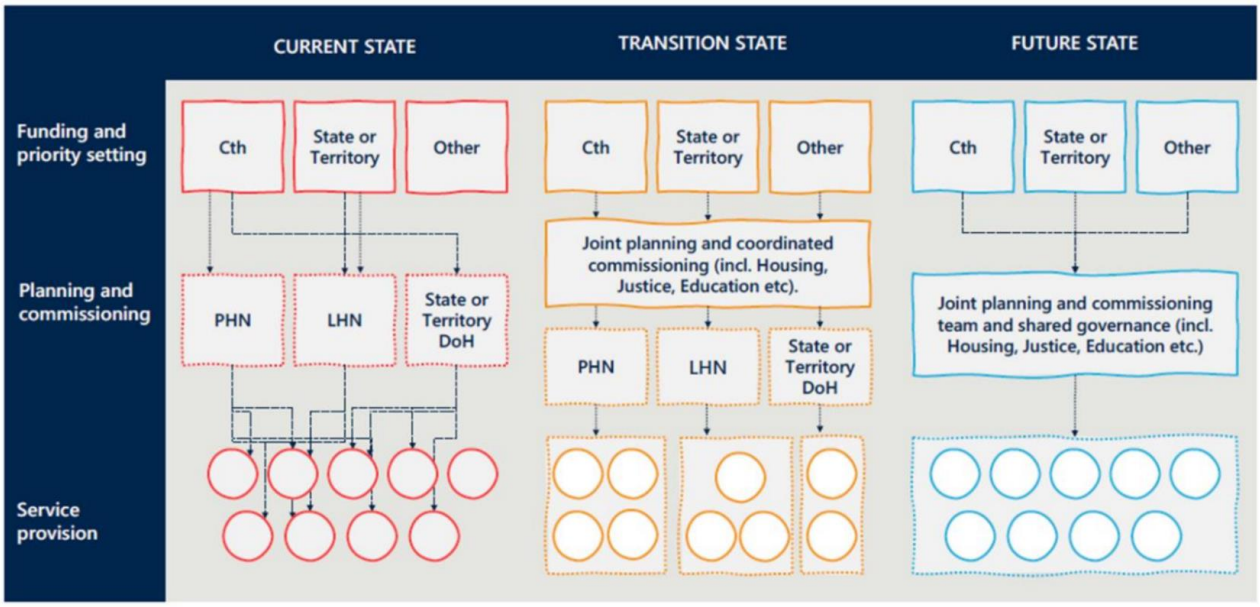
Northern Queensland PHN collaborated with TCHHS, CHHHS, THHS and MHHS to leverage joint regional planning to develop a place based suicide prevention strategy. Development of the plan included input from HHSs, individuals with lived experience, service providers, and the broader community.

The governance arrangements and partnerships developed through this process are now being leveraged for the work of place based Suicide Prevention Community Action Plans (SPCAPs). SPCAPs are playing an important role in operationalising the Joint Regional plan, identifying ongoing improvements and coordinating essential suicide prevention activities delivered by a range of agencies and service providers who understand their local region.

Using a respected governance arrangement is assisting implementation and ensures that all parties are focused on the same goals and are clear on the vision and objectives to be achieved.

Figure 3 displays the expected evolution of the joint commissioning model. This approach to governance would replace the current arrangement where funders procure services independently without coordination or collaboration. Included in this plan would be a coordinated and stepped approach to mental health, suicide prevention and alcohol and other drugs. Further, state government attendance at local planning would benefit the process to ensure coordination between levels of government. Funding decisions, as outlined in Recommendation Six, should also be developed in-line with this recommendation.

Figure 3: The expected evolution of the joint commissioning model[40]



To enable efficient and effective commissioning, there is a requirement for a clear demarcation of responsibilities between regional, state and federal stakeholders. A single joint regional plan would assist to facilitate this and govern ongoing joint commissioning between PHNs and HSSs to deliver services based on local need. This would also support greater alignment and reduced duplication as a result of different approaches and priorities at state and federal level. These processes may involve leveraging existing frameworks to reformulate goals and aims or creating new structures. As the case study below outlines, the relationship between PHNs and HHSs is integral in delivering appropriate and tailored care to consumers.

Case Study: The Way Back Support Service (Central Queensland, Wide Bay and the Sunshine Coast PHN)

Beyond Blue's suicide aftercare initiative, The Way Back Support Service, which provides critical support for people after a suicide attempt, became available in 2020/21 in Central Queensland, Wide Bay and the Sunshine Coast. The service is delivered in Central Queensland by AnglicareCQ, in the Wide Bay by Richmond Fellowship Queensland (RFQ), and on the Sunshine Coast by Open Minds. People are referred to The Way Back by the Hospital and Health Service in their local area and are assigned a support coordinator to guide them through their recovery.

The Way Back Support Service is just one example of how the federally-funded PHN and state-funded HHSs work together to achieve positive health outcomes for the community, as outlined in their Mental Health, Suicide Prevention and Alcohol and Other Drugs Joint Regional Plan 2020-2025.

Furthermore, as a new National Agreement on Mental Health and Suicide Prevention was agreed between Commonwealth and State/Territory Governments in November 2021, it is necessary that at the state level, an agreement between Queensland Health and Queensland PHNs is (collectively) developed, which sets out how the National Agreement will be implemented in Queensland and the role of PHNs and HHSs in joint regional planning and commissioning, which may include agreements on data sharing and in-scope funding. This agreement may also include the Queensland Mental Health Commission, National Disability Insurance Agency, Queensland Aboriginal and Islander Health Council and other relevant stakeholders. Furthermore, at a local level, governance agreements should be developed between the PHN and HHSs and other relevant stakeholders, either through building off existing agreements or creating new plans.

A further initiative that should be developed is the National Primary and Community Care Recovery Framework, which would guide service planning through the identification of evidence-based clinical and psychosocial services in the community available to individuals. The challenges mentioned in Section 2.4 would also need to be addressed. There would be a particular focus on the needs of specific cohorts, such as Aboriginal and Torres Strait Islander people, CALD groups, LGBTIQA+, those living in regional and remote

[40] Queensland PHN 2021, *DRAFT Mental Health Joint Regional Planning and Commissioning in Queensland,* Queensland.

settings, certain age groups, and Australians with specific conditions such as schizophrenia, personality disorder, problematic drug and alcohol use or suicidality. The framework should also be aligned with the National Mental Health Service Planning Framework and the National Alcohol and other Drug Treatment Framework.

To achieve this recommendation, a range of actions that can be achieved with varying time frames are listed in Table 1.

Table 1: Recommendation One - short, medium and long term actions

Short (1-2 Years)	Medium (2-5 Years)	Long (5+ Year)
• **Identify governance frameworks** that are currently being used, and assess their effectiveness and areas for improvement • **Engage relevant stakeholders** to evolve existing governance frameworks where appropriate • **Improve governance** between PHNs, Commonwealth and State/Territories through ongoing conversation and attendance at meetings where appropriate	• **Determine areas of alignment between PHN, HHS and state mental health plans** to assess level of consistency in priorities • **Establish a single joint regional plan** from which funders then commission local services to ensure increased coordination	• **Align with relevant national and state-based plans and agreements at the regional and local level**, such as the National Agreement on Mental Health and Suicide Prevention • **Evaluate governance mechanisms** in joint regional planning and commissioning to support ongoing improvement • **Develop a Primary and Community Care Recovery Framework** for regional commissioning agencies to guide service planning in line with the National Mental Health Service Planning Framework

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3.2 Recommendation Two: Co-design stepped care that is responsive and flexible to patient needs, including cohort-specific requirements, with a focus on integration with existing services and engagement with relevant stakeholders

Key to improving the mental health of Queenslanders is the availability of a stepped care model that is responsive to individual needs and requirements. Stepped care refers to 'an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as one directional steps, but rather offer a spectrum of service interventions. Stepped care is a different concept from 'step up/step down' services.'[41] A stepped care approach also highlights the need for greater coordination and integration between acute and lower intensity community-based services.

As outlined below, Darling Downs and West Moreton PHN has engaged with Momentum Mental Health to provide consumers opportunities to receive low-intensity and community care services such as group and 1:1 coaching services.

Case Study: Momentum Mental Health (Darling Downs and West Moreton PHN)

Momentum Mental Health provides 1:1 and group coaching to those experiencing mental illness. 1:1 coaching focuses on building personal boundaries and routine, while group work can involve working with art groups led by an art therapist, building self-confidence groups, cooking for Tony's Kitchen group, and trying new social group programs to meet new people and practise skills. The program supports consumers in finding employment, the development of financial and personal independence, and encourages them to be active in their community and within society.

Learning from existing services in addition to using a comprehensive co-design and consultation process and re-visiting these insights where required to ensure relevance is fundamental to designing this stepped care model. This process should engage a diverse range of stakeholders to develop a model that addresses varying levels and types of need and embeds services across the care continuum, including: HSSs, the lived experience workforce, consumers, allied health, NGOs and peak bodies. This process would ultimately allow

[41] Carey, T A, 2018, *'Stepped care for mental health treatment. A system in need of psychological expertise'*, InPsych, vol. 40, no. 6.

for the identification of key pain points and potential solutions, and allow for the application of a human-centred approach that seeks to trial and test innovative approaches to resolve challenges as they arise. However, unintentional consequences of innovative service delivery should be assessed and mitigated against to ensure that the benefits of such an approach are fully realised, particularly for large population groups outside of major cities.

PHNs play a pivotal role in the commissioning of mental healthcare services. In this way, PHNs also play an important role in building the overall capability of the healthcare system to adopt and engage with a commissioning approach to the design and delivery of healthcare services. This means taking an evidence-based approach to understanding needs and drawing on the strengths of the most appropriate commissioners and providers in the system to deliver services. The involvement of service providers and other stakeholders in the co-design of mental health services can support the collective capability of the system to drive an evidence-based contemporary approach to mental health primary care.

For example, Western Queensland PHN developed guidelines for the patient journey through stepped care within their local context, using the Kessler Psychological Distress Scale (K10) to identify and provide appropriate and coordinated care according to need, as outlined below.

Case Study: Patient Journey through Stepped Care (Western Queensland PHN)

Using the K10 scale, GPs and mental health practitioners assess consumers to identify the most appropriate form of care. Those on the lower end of the K10 scale are directed to low intensity services, and those with higher K10 scores are provided a mental health treatment plan through their GP. The GP also engages with services of PHN commissioned care coordinators to assist in managing complex needs, with the potential need for a case conference with the consumer, GP, low intensity worker and care coordinator.

Follow-up is also an important aspect of care after treatment, which can be conducted after four weeks to assess the effectiveness of interventions. Maintenance sessions, community groups and self-directed online services also support the provision of low intensity care.

Further, consumer (across a range of cohorts) and carer involvement throughout the co-design process will be essential to understand the barriers that individuals face when accessing care throughout the stepped care continuum and leverage solutions and services that have been well received in the past. Through this consumer-led and person-centred approach, models of care can be developed to be responsive and flexible.

Additionally, cohort-tailored approaches to care should be developed to ensure that the needs of at risk cohorts are met. As detailed in Section 2.2, this may include representation from regional and rural communities, Aboriginal and Torres Strait Islander peoples, CALD communities, those prone to being impacted by natural disasters, children and young people, new parents, LGBTIQA+ individuals and refugee communities.

Across the spectrum, the lived experience workforce should be embedded throughout the co-design process and across the accountability and governance structures established to implement and evaluate services. This may be achieved through consultation with individuals and networks with these experiences and associated knowledge, for example Peer Participation in Mental Health Services Network, outlined in the case study below.

Case Study: Peer Participation in Mental Health Services (PPIMS) Network (Brisbane North PHN)

The PPIMS Network, focussed on the Brisbane North region, is a membership of people with a lived experience of mental health issues as a consumer or carer who would like to actively participate in the development, implementation and review of mental health services.

The network regularly participates in both State-wide and national issues in relation to mental health services, for example: members participated in the Productivity Commission review of mental health in Australia, the establishment of a peak body for consumers in Queensland and the development of the mymentalhealth.org.au website for Brisbane North service delivery.

Over the five years of its operation to date, the network has assisted many of its members through providing monthly meetings with guest speakers, notifying individuals of opportunities for training and participation and sharing information on employment opportunities to become involved in the lived experience workforce.

To achieve this, a range of actions that can be achieved with varying time frames are listed in Table 2.

Table 2: Recommendation Two - short, medium and long term actions

Short (1-2 Years)	Medium (2-5 Years)	Long (5+ Year)
• **Engage with stakeholders (i.e., peak bodies, allied health, NGOs, consumer representatives)** to identify current challenges and determine design requirements for future models of care • **Conduct a needs assessment** to identify consumers who are not receiving the appropriate services across the care continuum, and the factors that impact their access to appropriate care	• **Identify and implement areas of reform across existing models of care across the stepped care continuum,** by bringing together diverse care services to collaborate and support implementation • **Increase focus on service planning** for new care innovations and delivery models	• **Continually improve the primary stepped care model** for all levels of mental health care • **Reinforce care coordination processes** through maintaining partnerships across the mental health sector • **Accommodate cultural safety** through cohort-led services and guidance for providers

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3.3 Recommendation Three: Support workforce expansion and retention particularly in rural and regional areas, including through alternative workforce models

As aforementioned in Section 2.4.3, the shortage of a skilled, specialised and cohort-specific workforce results in misaligned service provision to consumers. As a result, it is vital to support the expansion of workforce availability and ensure the retention of workers, as high turnover rates can hamper the effectiveness of ongoing service delivery. Short-term funding, contract cycles and regionality of demand may contribute to workforce retention challenges, given the significant uncertainty this creates for the workforce. By ensuring that there is sufficient and continuous availability of care, Queenslanders will have appropriate access to care when required, particularly in the less severe spectrum of needs, and reduce dependence for more acute services through early intervention.

Furthermore, in line with the transition to the stepped care model and the increased focus on preventative mental health care, the skills of the present mental health workforce need to be reformed, so that mental health support staff can provide preventative and low-intensity services, to prevent consumers from presenting to hospital and to reduce the reliance on psychology and psychiatry services.

It is important, however, that underpinning workforce expansion is the appreciation of culturally appropriate and considerate care. As outlined in the case study below, Northern Territory PHN in partnership with Central Australia Aboriginal Congress (CAAC), commissioned the recruitment of a Mental Health Nurse to support clients accessing acute mental health services and connecting them in with local ACCHO and community services, as it was recognised that there was lack of coordination and integration between acute and lower intensity community-based services for Aboriginal clients as they transition from acute care to community care. This program has now been in place for three years.

Case Study: Mental Health Nurse Program (Northern Territory PHN)

The program supports the transition from acute care to community care for Aboriginal clients. The aim is to deliver clinical care and coordination via a credentialed mental health nurse to support clients to effectively manage their symptoms, avoid unnecessary hospitalisation or reduce length of stay in hospitals where admission has occurred. The support can be delivered within a clinical setting, the community and in the client's home environment, with no set time or session limitations. Whilst the position is primarily based in the Alice Springs township, travel to or to accept short term deployment to a CAAC managed clinic in a remote community can be arranged as required.

Feedback from stakeholders include clients expressing that the program has provided a culturally safe adjunct or alternative to mainstream Mental Health Services. Government and NGO organisations have indicated that the CAAC Mental Health Nurse co-ordination has provided, increased access to Aboriginal Health Worker services/cultural brokerage; insight into function and objectives of Aboriginal Community Controlled Health Organisations; and insight into the imperative around cultural safety.

Alternative workforce models, including the peer workforce, are an important source of support for consumers seeking help. Peer workers leverage their lived experiences to provide advice and guidance throughout the

consumers' mental health journeys. However, the challenges mentioned in Section 2.4, surrounding employment conditions, wages, accountability, and perceptions of peer worker roles, warrant greater formalisation and structure for the workforce. For example, it is recommended that the Queensland Lived Experience Workers Network (QLEWN) is further developed to act as the professional peak body for the peer workforce to enhance their capacity and capability across Queensland.

To achieve this recommendation, a range of actions that can be achieved with varying time frames are listed in Table 3.

Table 3: Recommendation Three - short, medium and long term actions

<table>
<tr><th>Short (1-2 Years)</th><th>Medium (2-5 Years)</th><th>Long (5+ Year)</th></tr>
<tr><td rowspan="2">Evaluate the impact of funding and contract models on workforce recruitment and retention
Conduct review of existing workforce strategies, engaging with peak bodies as appropriate and reporting findings to Queensland Health and other stakeholders to determine consolidation requirements
Consider MHLEEN frameworks to establish the gaps and opportunities for the delivery of services by the lived experience workforce</td><td colspan="2">Move towards full funding based on the needs and evidence-based National Mental Health Service Planning Framework at a regional level, taking into account the specific needs of local populations</td></tr>
<tr><td>Extend the minimum contract length to encourage retention of staff, particularly in regional and remote areas[42]
Develop a Mental Health Workforce Plan (including lived experience and peer support workers) to provide targeted and holistic care, and more points of access to services in addition to capability development opportunities
Engage relevant peak bodies to develop the plan, particularly in relation to supervision and specialist services
Fund QLEWN as the professional peak body for lived experience (peer) workers in Queensland
Support transition of workforce into and out of regional settings to expand workforce in these areas</td><td>Increase the supply of training programs and degrees that allow individuals to deliver low-intervention and preventative mental health services</td></tr>
</table>

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3.4 Recommendation Four: Develop evaluation processes to determine effectiveness and impact of services in addition to service safety and quality

As identified in Section 2.4.6, the limited ability to assess the effectiveness and impact of programs, particularly due to inconsistent data collection methods between stakeholders remains a challenge in Queensland. The development of appropriate evaluation processes and supporting data requirements is therefore a key role of PHNs moving forward.

The development of these processes should be centred on existing best practice nationally and encapsulate the elements of the Quadruple Aim Framework including patient experience, clinical experience, outcomes and cost. In addition to considering clinical experience, it is important to assess workforce retention, sustainability, and whether current workforce and operational models are fit for purpose. By including the structural aspects of delivering mental health support, these broader and system-wide issues can also be assessed and evaluated to further improve on the delivery and operations of services.

Further, central to developing evaluation processes is the establishment of data collection methods to map data assets, understand current gaps and challenges, ensure that current instruments will enable intended aspirations and support evidence-based regional planning. These activities establish shared measures,

[42] Queensland PHN, *Productivity Commission – Brisbane Hearing Qld PHNs Statement*, Queensland.

embed ongoing monitoring evaluation and learning, and support predictive impact modelling to assess a future supply and demand.

Assessing the safety and quality of services is particularly important for vulnerable cohorts such as those in aged care. As outlined in the Psychology in Aged Care Wellbeing Program case study below, a level of impact assessment has been completed, showing that individuals who participate in the program benefited greatly from this tailored approach to mental health care.

Case Study: Psychology in Aged Care (PAC) Wellbeing Program (Brisbane North PHN)

Brisbane North PHN commissioned Change Futures to deliver psychology services to residents of aged care through the PAC Wellbeing Program. The program offers services based on the stepped care continuum of primary mental health care with a particular focus on providing mild to moderate psychological therapies to residents in aged care. During 2020-21, Change Futures supported over 720 residents in aged care across Brisbane North, with the majority of these patients experiencing adjustment difficulties including symptoms of depression and anxiety. An outcomes report developed by Change Futures in 2021 showed that outcomes from the program include a significant reduction in psychological distress, depression and anxiety (as measured by the K-5), as well as an increase in quality of life (as measured by the QOL-AD).

A consistent approach to evaluation is necessary as it allows for comparison between health services and stakeholders of the effectiveness of services, and ultimately supports decision-making of the distribution of resources and funding. To achieve this goal, a standardised method and framework for collecting data, as well as a standardised evaluation framework would need to be established that is adopted and committed to by all relevant parties. By establishing a common method of data collection and evaluation, the system would move towards an evidence-based and outcomes-based approach that can inform value for money and ensure that services create tangible impact.

To achieve this recommendation, a range of actions that can be achieved with varying time frames are listed in Table 4.

Table 4: Recommendation Four - short, medium and long term actions

Short (1-2 Years)	Medium (2-5 Years)	Long (5+ Year)
• **Conduct review of mental health data collection and management processes** to determine areas for improvement • **Expand use of PREMs and PROMs surveys** to capture consumer experience using a variety of tools to measure outcomes and effectiveness • **Review service planning activities** to determine gaps in current processes with regard to safety and quality	• **Establish an evaluation framework using the Quadruple Aim** to provide a standardised approach to evaluation across PHNs • **Develop guidelines for a common minimum data set** that is aligned with existing data collection methods to be adopted by PHNs, HHSs and other key service providers to facilitate a consistent reporting and evaluation evidence-base	• **Integrate additional available datasets into planning tools,** to allow for a broader contextual evaluation of services • **Continue to refine the evaluation framework** in line with best practice nationally

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3.5 Recommendation Five: Support building digital capability across primary healthcare including telehealth services and the use of digital health technologies to enable data/records and prevention and hybrid delivery models

Given the cost effectiveness and accessibility of digital services, delivering care through these innovative methods has the potential to expand service accessibility across the entire care continuum. This has particularly larger benefits for those who live in rural and remote areas, where face to face services, exacerbated by workforce shortages, can be limited. To ensure the benefits of these services can be realised, connectivity is key in these areas across Queensland, therefore establishing and developing reliable and cost effective infrastructure is required.

Furthermore, digital support services can be especially useful for those who are, although not exclusively, on the lower-spectrum of needs, and receive care through self-help apps and websites, which can expand the availability of low-intensity and preventative services. There are also supported digital programs, such as Mindspot, that are digitally delivered programs which combine self-guided learning with support from skilled

mental health professionals. There is currently an evaluation occurring to review the effectiveness of these supported digital programs.

As outlined in the Head to Health case study below, PHNs in Victoria have successfully implemented a digital mental health 'gateway' for their populations in response to the significant challenges within Victoria's mental health system. The model is based on an integrated intake and service delivery approach and was developed through co-design and collaboration between all six PHNs, leveraging capacity across federal and state services in Victoria – resulting in a mechanism to drive the most effective and targeted use of available resources within the system.

Case Study: Head to Health (Victoria)

Head to Health was developed as a digital mental health gateway that displays a range of telephone-based and online mental health services, with some self-directed and some guided by clinicians. Types of services include informational, telephone and web counselling, online support forums, and online treatment programs. Services are free of charge or low cost, ensuring that care is available and accessible. Given the wide range of services listed on the site, consumers with specific needs can filter and tailor their search results, to identify the care that most suits them. As a central repository of digital mental health services in Australia, the site serves as a central access-point for consumers to receive care.

This model in Queensland can only be achieved through sufficient digital infrastructure, which can be limited in certain regions, as aforementioned. Therefore, assessment of what is needed to implement digital services for mental health should be conducted, to identify gaps and establish remote service provision as standard practice in the longer term. Furthermore, programs targeting and resolving hesitancy in using digital services as an alternative means of receiving mental health care should also be expanded to increase acceptance and deliver the benefits of remote mental health care.

To achieve this recommendation, a range of actions that can be achieved with varying time frames are listed in Table 5.

Table 5: Recommendation Five - short, medium and long term actions

Short (1-2 Years)	Medium (2-5 Years)	Long (5+ Year)
• **Evaluate past and current successful applications of digital services** in delivering positive mental health outcomes, and areas of improvement • **Consult with the State Government** to understand digital health priorities, strategic vision and identify infrastructure gaps and requirements • **Identify consumer barriers to uptake of digital services** through consultation with consumers, peak bodies, and advocacy groups	• **Expand telehealth mental health services and education and prevention programs** to improve mental health awareness and literacy, and to encourage uptake of digital services • **Integrate self-help apps and websites, as well as low-intensity and preventative online services** into models of care • **Assist in broader industry implementation of digital health initiatives** at a local level	• **Embed digital services as a core part of mental healthcare**, on par with traditional face-to-face services, so that mental health service delivery operates as a hybrid model • **Provide guidance to broader industry for ongoing infrastructure development** to facilitate improvements to digital health offerings

1h

3.6 Recommendation Six: Secure ongoing funding and resourcing to improve mental health outcomes to supplement existing service offerings and partnerships

As mental health service models move toward being based on the stepped care continuum, it is important that funding and resourcing provisions reflect this model and accommodate the requirements of joint commissioning. Joint commissioning will become increasingly important as PHNs and their partners seek to align system priorities, reduce duplication and leverage the impact of shared investment in services. PHNs operate within a transparent and accountable funding and governance framework, with fixed overheads and any surpluses returned to government. This is supported by annual reporting obligations.

Into the future, to accommodate the stepped care model in funding, it is likely that there will need to be a redistribution of funds between stakeholders so that resources are used more efficiently and appropriately.

Rebates currently available for mental health under the MBS also play an integral role in the way in which services are delivered and made accessible to Queenslanders.

Flexibility in budget and funding that aligns with emerging needs will help to ensure that services can deliver support where needed, and that there is a reduction in perverse incentives to only deliver certain forms of care. Specifically, given population mental health is dependent on a range of differing determinants, and frequently shifts and changes, it is important that funding can adapt to different region-specific needs, for example sudden and high-impact events such as natural disasters and region-based crises.

The Integrated Mental Health Hubs case study outlined below provides an example of an innovative approach to funding – pooling resources and funding to provide a range of services in a single location to deliver integrated and holistic care. Positive results have been reported from this approach, however integration between the three hubs and the wider local service system remains a challenge and future approaches to pooled funding and resourcing should focus on mitigating this.

Case Study: Integrated Mental Health Hubs (Brisbane North)

In 2019, Brisbane North PHN established three integrated mental health service hubs to provide a seamless approach for people needing access to clinical and non-clinical mental health supports in relation to their complex and/or severe mental illness. The idea for this integrated service model was born from co-design and consultation, and based on the needs identified, the PHN reconceptualised its funding of this 'step' of the mental health service continuum, with the intent to provide alternatives to hospital care which offer holistic, integrated support. The pooling of funds to commission an integrated service, and the subsequent commissioning of a Hub model was a new activity and was intended to provide better outcomes for participants in comparison to siloed funding for programs and providers.

Over the first two years of operation, evaluation results showed that across the three hubs, 2,200 referrals have been received, resulting in 1651 episodes of care and more than 38,000 service contacts. Results also show that people with severe and complex mental illness accessing the hubs reported positive experience and improved recovery outcomes when they remained engaged, and that the pooling of resources enabled integration of clinical and non-clinical supports in one place. However, integration with the wider local service system remains challenging.

Underlying the success of funding generating positive health outcomes is the establishment of relevant governance mechanisms as aforementioned in Recommendation One that are based on the clear demarcation of responsibilities between stakeholder groups whilst working toward a common plan for the region. To achieve this recommendation, a range of actions that can be achieved with varying time frames are listed in Table 6.

Table 6: Recommendation Six - short, medium and long term actions

Short (1-2 Years)	Medium (2-5 Years)	Long (5+ Year)
• **Map current funding resources** received by PHNs, HHSs and other mental health service providers to identify gaps and opportunities for reallocation • **Identify the frameworks that govern funding responsibilities** between stakeholders, in line with Recommendation One	• **Advocate for reform of MBS rebates** by co-funding MBS-related allied health, and continuing MBS rebates for telehealth • **Evaluate how funds are used and its impact on mental health outcomes**, in line with Recommendation Four • **Review how program funding could be reallocated, to support outcomes focussed allocation** of funding to better support PHN and HSS joint commissioning activity • **Establish the single joint regional plan** as the key guidance for funding services for all Queensland PHNs and HSSs, in line with Recommendation One	• **Support greater flexibility in use of funds,** including pooled funds and move to joint regional planning to support culturally appropriate co-design of services

Appendix

4.1 Mental Health Select Committee Inquiry into the opportunities to improve mental health outcomes for Queenslanders Terms of Reference[43]

Terms of Reference

1) A select committee, to be known as the Mental Health Select Committee, be established to undertake an inquiry and report on the opportunities to improve mental health outcomes for Queenslanders. In undertaking the inquiry, the committee consider:
   a) the economic and societal impact of mental illness in Queensland;
   b) the current needs of and impacts on the mental health service system in Queensland;
   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):
      i) across the care continuum from prevention, crisis response, harm reduction, treatment and recovery;
      ii) 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;
   d) the experiences and leadership of people with lived experience of mental illness, problematic substance use and suicidality and their families and carers;
   e) the mental health needs of people at greater risk of poor mental health;
   f) how investment by the Queensland government and other levels of government can enhance outcomes for Queenslanders requiring mental health treatment and support;
   g) service safety and quality, workforce improvement and digital capability;
   h) mental health funding models in Australia; and
   i) relevant national and state policies, reports and recent inquiries including the Productivity Commission Mental Health Inquiry Report.
2) The committee have power to call for persons, documents and other items;
3) The committee report to the Legislative Assembly by 31 May 2022;
4) The committee consist of eight members of the Legislative Assembly: four members (including the Chairperson) appointed by the Leader of the House and four members appointed by the Leader of the Opposition;
5) That, notwithstanding anything contained in standing orders, the appointment of members to the committee shall be by the Leader of the House and the Leader of the Opposition in writing to the Clerk with their appointments by 10 December 2021. The Clerk to table the letters of appointment.
6) If the Leader of the Opposition does not appoint all required members as outlined in 4. by the date in 5., the select committee is still a fully constituted committee with the members appointed by the Leader of the House.

[43] Queensland Parliament 2021, *Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders*, Queensland Parliament, Queensland, accessed 30 January 2022, https://www.parliament.qld.gov.au/Work-of-Committees/Committees/Committee-Details?cid=226&id=4143

4.2 Alignment of Terms of Reference (1) with document sections

Section	Related Terms of Reference
1. Background and the role of PHNs in the healthcare system	1i) relevant national and state policies, reports and recent inquiries including the Productivity Commission Mental Health Inquiry Report.
2. Current state mental health impacts and needs in Queensland	
2.1 Health, social and economic impacts of mental health	1a) The economic and societal impact of mental illness in Queensland
2.2 Risk factors and needs associated with mental health	1e) the mental health needs of people at greater risk of poor mental health;
2.3 The role of PHNs in supporting mental health	1b) the current needs of and impacts on the mental health service system in Queensland;
2.4 Challenges of supporting mental health services	
3. Future opportunities for PHNs to improve mental health outcomes for Queenslanders	1c) opportunities to improve economic and social participation of people with mental illness through comprehensive, coordinated, and integrated mental health i. across the care continuum from prevention, crisis response, harm reduction, treatment and recovery; ii. 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; 1d) the experiences and leadership of people with lived experience of mental illness, problematic substance use and suicidality and their families and carers; 1f) how investment by the Queensland government and other levels of government can enhance outcomes for Queenslanders requiring mental health treatment and support; 1g) service safety and quality, workforce improvement and digital capability; 1h) mental health funding models in Australia; and

4.3 Detailed description of PHN funded mental health services

To supplement the summary of the role of PHNs in providing mental health services in Section 2.3, a more detailed overview of their activities includes:[44]

1. Improve targeting of psychological interventions to appropriately support people with mild mental illness at the local level through the development and/or commissioning of **low intensity mental health services.**
2. Support region-specific, cross sectoral approaches to early intervention for **children and young people with, or at risk of mental illness** (including those with severe mental illness who are being managed in primary care) and implementation of an equitable and integrated approach to primary mental health services for this population group.
3. Address service gaps in the provision of **psychological therapies** for people in underserviced and/or hard to reach populations, including rural and remote populations and residents in aged care facilities, making optimal use of the available service infrastructure and workforce.
4. Support **clinical care coordination** for people with severe and complex mental illness who are being managed in primary care including through the phased implementation of primary mental health care packages and the use of mental health nurses.
5. Encourage and promote a **regional approach to suicide prevention** including community-based activities and liaising with Local Hospital Networks (LHNs) and other providers to ensure appropriate **follow-up and support** arrangements are in place at a regional level for individuals **after a suicide attempt** and for other people at high risk of suicide.
6. Enhance and better integrate **Aboriginal and Torres Strait Islander mental health services** at a local level facilitating a joined-up approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol and other drug services.
7. Support people with a severe mental illness and associated **psychosocial functional impairment** who are not receiving support through the National Disability Insurance Scheme, including former clients of ceased Commonwealth community mental health programs.
8. Improve health and social outcomes for individuals, families and communities at risk of or currently affected by substance misuse through **drug and alcohol treatment services**.

[44] Queensland PHN 2021, *DRAFT Mental Health Joint Regional Planning and Commissioning in Queensland,* Queensland.