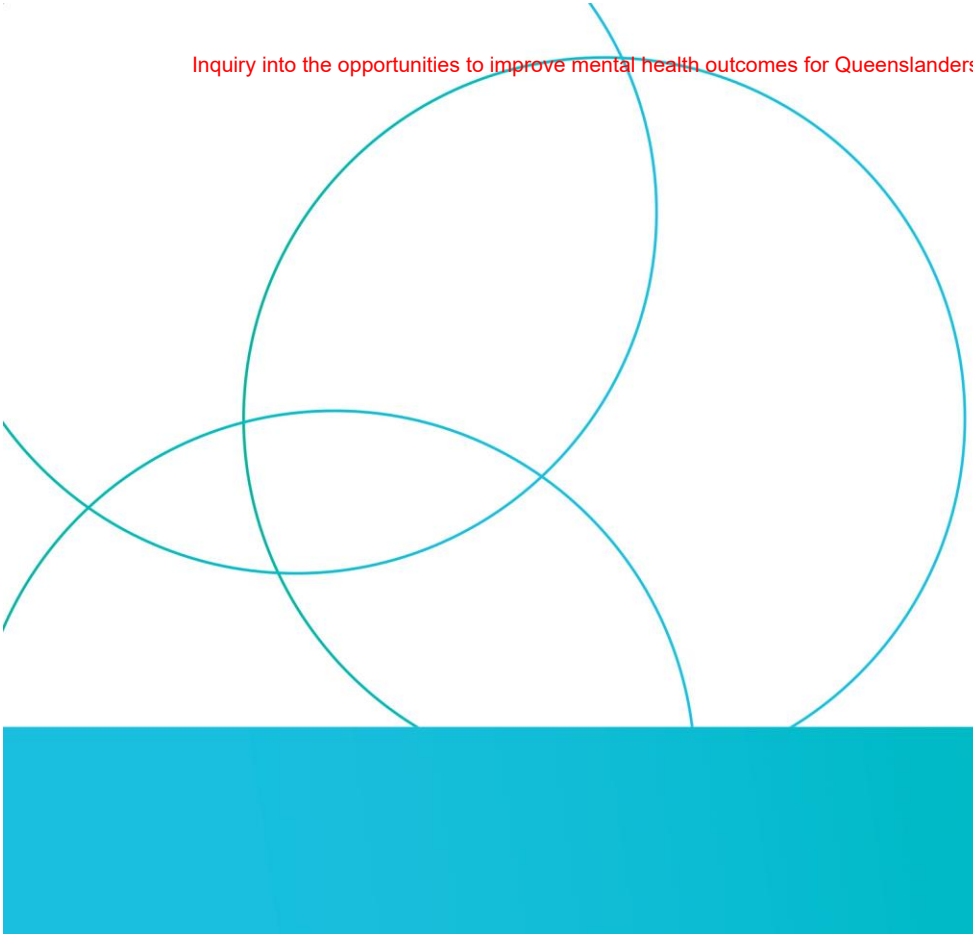

Queensland Alliance for Mental Health

Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders

Submission

4 February 2022

Who is QAMH?

Queensland Alliance for Mental Health (QAMH) is the peak body for the Community Mental Health and Wellbeing Sector in Queensland. We represent more than 100 organisations and stakeholders involved in the delivery of community mental health and wellbeing services across the state.

Our role is to reform, promote and drive community mental health and wellbeing service delivery for all Queenslanders, through our influence and collaboration with our members and strategic partners.

At a national level, we have a formal collaboration with Community Mental Health Australia and provide input and advice to the work of Mental Health Australia and the National Mental Health Commission where appropriate. Locally, we work alongside our members, government, the Queensland Mental Health Commission and other stakeholders to add value to the sector and act as a strong advocate on issues that impact their operations in Queensland communities.

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A note on language

QAMH intentionally refers to the community managed mental health sector as the Community Mental Health and Wellbeing Sector to emphasise the unique contribution and preferred future direction of the sector as outlined in our Wellbeing First Report. This includes non-government, not-for-profit, community-based mental health organisations that provide psychosocial supports and access to natural supports in the community.

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Our Response

QAMH welcomes the opportunity to provide input into the Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders (the Inquiry). We believe this Inquiry is an important opportunity to fundamentally reform a mental health system which is currently failing to provide appropriate care to those seeking help for mental illness, and to make lasting changes that other reviews have been unable to actualise. It is a chance to implement structural reforms which actively improve the wellbeing of all Queenslanders, rather than funding more of the same services that simply respond to illness once it has reached crisis point. Tweaking around the edges of a fundamentally flawed system or injecting more money into the same traditional models of care will not bring the systemic changes required. We look forward to this opportunity to redesign and reimagine a mental health system that can deal with the escalating demand, offer the right services at the right time, build economic and social participation and, most importantly, invest in the mental wellbeing of all Queenslanders.

This Inquiry is the latest in a long line of reviews, reports, plans, investigations and roadmaps that have been conducted over the past three decades. The Productivity Commission's inquiry into mental health was a watershed moment in documenting Australia's mental health crisis. It confirmed what previous reports had alluded to – that the nation is facing a mental health emergency, the system is not fit for purpose and radical change is needed. While QAMH is pleased to be part of this current Inquiry, we are cognisant that the sector is battle-weary, accustomed to contributing to reviews that make short-sighted recommendations, and dispirited by providing frontline stories that fall on deaf ears. It is time for governments, federal and state, to step up and transform the mental health landscape. We retain hope that the Mental Health Select Committee (the Committee) will deliver meaningful and lasting recommendations to improve the lives of people living with mental distress, and more importantly, that these recommendations will be acted upon.

Our response to this public consultation has been informed by the feedback our members provided in focus groups and in one-on-one interviews, and our extensive knowledge of the Community Mental Health and Wellbeing Sector in Queensland. Despite this broad consultative process, QAMH does not consider that adequate time has been provided for stakeholders to consider the terms of reference and gather all necessary evidence. We feel that the issues seeking to be addressed as part of the Inquiry are enormously complex, involving various government agencies at all jurisdictional levels, independent statutory bodies, non-governmental organisations (NGOs) and most importantly those with lived experience. QAMH would expect that an Inquiry of this nature, which has potentially significant implications for generations of Queenslanders to come, would necessarily involve adequate time for broad consultation.

We have structured our response to this Inquiry around the terms of reference. Part of this involves highlighting the problems inherent in the current system, however we have also deliberately accompanied these with cost-effective and achievable solutions. Specifically, QAMH believes the

Community Mental Health and Wellbeing Sector lies at the heart of this solution. The sector is an under-utilised and under-resourced element of the mental health ecosystem with huge potential to transform the system into a sustainable one offering high-quality, evidence-based and accessible services.

What are community mental health and wellbeing services?

Community mental health and wellbeing services encompass a broad range of NGOs that primarily deliver psychosocial and wellbeing supports in the community. These supports:

- Operate through the entire mental health spectrum, with a particular focus on supporting people to live well in their communities.
- Believe that the best outcomes occur when responses are offered early in distress through an early intervention and preventative lens.
- Draw on "community" at the heart of their work providing opportunities for people to re-engage with their relationships and natural community.
- Deliver person-led services which provide targeted opportunities for people to foster personal agency and self-leadership.
- Work to fit their resources to individual need rather than a one-size-fits-all approach.
- Use recovery-oriented, trauma-informed knowledge in working with people to reestablish their lives beyond illness.
- Employ people with lived experience in peer worker roles, who draw upon their personal life-changing journey of mental health challenges, service use and recovery to coach others on their recovery journey.
- Use coaching as a framework to assist people to build their capacity for social, emotional and psychological wellbeing.
- Take a whole of life approach supporting people to navigate and respond to their broader needs including housing, employment, legal issues, family support and alcohol and drug challenges.
- Recognise and uphold a human rights approach which values least restrictive practice.

The Productivity Commission highlighted the importance of these services as a critical part of the mental health system, saying there has been a "disproportionate focus on clinical services".[1] It is essential that the system shifts to greater reliance on community mental health and wellbeing services which are comparatively flexible, cost effective, accessible and have demonstrated success in assisting people with mental distress. QAMH strongly encourages the Committee to consider the Community Mental Health and Wellbeing Sector as central to any future strategy to combat Queensland's mental health crisis.

[1] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p8.

Key Recommendations

- That QAMH is formally provided an opportunity to present on behalf of the Community Mental Health and Wellbeing Sector at one the Committee's upcoming public briefings and hearings.
- That the Committee makes recommendations to both state and federal governments outlining the need for fundamental reform in Queensland, including a pivot to a whole-of-community wellbeing approach.
- That significant and ongoing funding is provided to support realistic community alternatives to emergency departments for those experiencing acute crisis. These services must be co-designed and have lived experience at the heart of their delivery models.
- That the Committee specifically provides for those Queenslanders currently locked out the system (the 'Missing Middle') and recommends funding for assertive community responses to fill this service gap as a matter of priority. This must include open access to support people early in distress, without the need for diagnosis or medical referral.
- That there is investment in the development of contemporary education and training qualifications for the community mental health and wellbeing workforce, with the intent to build a workforce for the future. This includes both peer workers and the broader community mental health and wellbeing workforce. QAMH would be prepared to work with government and other relevant stakeholders to design the educational content and plan for implementation.
- That significant investment in research and evaluation of all components of the mental health system is needed with lived experience at the heart of this.
- That strategies are developed which address the protective factors needed to sustain wellbeing for all Queenslanders including housing, employment, social connectedness and community participation.
- That there is a review of the reporting relationships for the Queensland Mental Health Commission to allow independence, and a remit to influence all sectors in a whole-of-government approach.

Responses to Terms of Reference

(a) The economic and societal impact of mental illness in Queensland

Mental illness is increasing in prevalence across the country and unfortunately Queensland's experience is consistent with this trend. One in five Queenslanders will experience mental illness in any one year and while most will have mild or moderate symptoms, approximately 3.1% will experience severe mental illness.[2] In 2020, Queensland had the third highest suicide rate in Australia, trailing only the Northern Territory and Tasmania.[3] Suicide remains the leading cause of death in Queenslanders aged 15 – 44yrs and the rate of suicide in Queensland's Aboriginal and Torres Strait Islander population is double that of the general population.[4]

While it is difficult to quantify, the Covid-19 pandemic has increased the prevalence and severity of mental illness in Queensland, due to anxiety about contracting the virus itself, physical isolation, separation from family, loss of employment, uncertainty about the future, and disrupted schooling at critical points in the emotional development of young people. The Australian Institute of Health and Welfare (AIHW) has gathered evidence which reveals the heightened psychological distress during the pandemic, such as Lifeline's record high daily call volumes (33 per cent higher in 2021 compared to 2019), increased use of MBS mental health-related services (22 per cent higher in 2021 compared to 2019) and an increase in the number of dispensed mental health-related prescriptions (19 per cent higher in 2021 compared to 2019). Interestingly, this increase in psychological distress during the Covid-19 pandemic has not translated into a rise in deaths by suicide.[5]

While this evolving mental health emergency is a blight on the nation's health record, translating statistics on incidence, prevalence and morbidity into socio-economic impact has eluded policy makers until recently. In 2020, the Productivity Commission released its landmark review of the economic impact of mental illness in Australia. While not specific to Queensland, it is reasonable to conclude that its findings could be extrapolated across all states and territories. It indicated that in 2018-2019 the annual cost to the Australian economy of mental ill-health and suicide was as much as $70 billion. This consisted of direct expenditure of $15.5 billion on mental health care, $39 billion on lost productivity and absenteeism, and $15 billion on lost economic participation by carers. It went on to say that the

[2] Queensland. Queensland Mental Health Commission. (2018). *Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*, p11.
[3] Australia. Australian Bureau of Statistics. (2021). *Causes of Death, Australia*. Causes of Death, Australia, 2020 | Australian Bureau of Statistics (abs.gov.au)
[4] Queensland. Queensland Mental Health Commission. (2019). *Every Life: The Queensland Suicide Prevention Plan 2019-2029*, p8.
[5] Australia. Australian Institute of Health and Welfare. (2022). *Mental Health Services in Australia*. Mental health services in Australia, COVID-19 impact on mental health - Australian Institute of Health and Welfare (aihw.gov.au)

cost of disability and premature death due to mental illness, suicide and self-inflicted injury was equivalent to a further $151 billion per year.[6] With such a damming report, policy makers now had the data to make an economic rationale for combatting the mental health crisis facing Australia.

The social impacts of mental illness have been more difficult to quantify. Living with mental illness affects every aspect of a person's life and therefore has significant societal impact, extending far beyond the person. When people do not receive support to manage their mental health, their capacity to lead a contributing life is diminished, along with their wellbeing and the wellbeing of their carers, family and friends.[7] The social impact of mental illness is far-reaching and includes the following:

- **Housing**: People living with mental illness are more likely to experience housing instability. Figures from the AIHW on the delivery of specialist homelessness services to nearly 14,000 Queensland clients in June 2021 reveal that 3,395 had a mental health issue and 871 reported a problematic alcohol or drug issue.[8] In Queensland, 15 per cent of households on the Housing Register waiting for long-term social housing were assessed as having difficulty accessing housing due to a member of the household having a mental illness.[9]
- **Employment**: People with lived experience of mental illness are less likely to hold stable employment. Approximately 37 per cent of people with lived experience of mental illness, or 67 per cent with severe mental illness, are not in the workforce compared to 22 per cent of people without mental health conditions.[10] Even when they are employed, employees with mental ill-health are more likely to be absent from work, and less productive when at work.[11]
- **Justice system**: Those with mental illness are known to be over-represented among those in contact with the criminal justice system. In Australia, results from the 2018 National Prisoner Health survey, indicate that 40 per cent of prison entrants report having a history of mental illness and 23 per cent report current use of mental health medication.[12]
- **Physical health**: People with a mental illness continue to have poorer health than other Queenslanders, with much higher rates of heart disease, diabetes, cancer and other chronic

[6] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p11.
[7] KPMG and Mental Health Australia. (2018). *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*, p1.
[8] Australia. Australian Institute of Health and Welfare. (2021). *Specialist Homelessness Services: Monthly Data*. Specialist Homelessness Services: monthly data, Monthly data - Australian Institute of Health and Welfare (aihw.gov.au)
[9] Queensland. Queensland Mental Health Commission. (2018). *Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*, p13.
[10] Queensland. Queensland Mental Health Commission. (2018). *Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*, p13.
[11] KPMG and Mental Health Australia. (2018). *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*, p1.
[12] Australia. Australian Institute of Health and Welfare. (2018). *The Health of Australia's Prisoners*, p38.

conditions. They are twice as likely to have cardiovascular disease, respiratory disease, metabolic syndrome, diabetes and osteoporosis, and six times as likely to have dental problems.[13]

- **Social isolation and loneliness**: The Productivity Commission's report highlighted how "loneliness and mental ill-health are mutually reinforcing – loneliness may increase an individual's likelihood of developing mental illness, but people with severe mental illness are particularly likely to be lonely".[14] The Australian Psychological Society (APS), in collaboration with Swinburne University, produced the Australian Loneliness Report in 2018, based on a national survey of adults in Australia. The report concluded that there is strong evidence that loneliness has a negative impact on health and wellbeing, educational attainment and economic outcomes. It also stated that compared to non-lonely people, lonely people are more anxious about social interactions, express more symptoms of depression, have less social interaction with family, friends and neighbours, have poorer physical health, have more negative emotions and fewer positive emotions and have poorer overall quality of life.[15]

These long-term societal trends were problematic prior to 2019, but the Covid-19 pandemic has significantly amplified their impact. Certainly, homelessness and housing affordability, job insecurity and social isolation have been burning issues over the past two years and, while it is difficult to predict how long the effects of the pandemic will last, we can be sure its consequences will be profound. The above statistics should be a clarion call to policy makers that mental illness does not just affect the individual. Its destruction is far more wide-reaching, profoundly affecting the social and economic fabric of Queensland. It is clear that there is a social and economic imperative to improve the mental health and wellbeing of Queenslanders and QAMH encourages the Committee to put forward a set of ambitious and meaningful reforms that will transform the lives of people living with mental distress.

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

Culture and Stigma

The overwhelming barrier to change within the mental health ecosystem is its own culture, which largely explains the difficulty enacting the recommendations from other reviews. Culture is formed by the explicit and implicit values and customs of how we collectively do things. The mental health system's culture is the 'elephant in the room' when examining the failure to embrace reform. The

[13] Queensland. Queensland Mental Health Commission. (2018). *Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*, p13.
[14] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *2*(95), p380.
[15] Australian Psychological Society and Swinburne University. (2018). *Australian Loneliness Report: A survey exploring the loneliness levels of Australians and the impact on their health and wellbeing*, p5.

current culture stems from a paternalistic model of caring which ultimately values the expertise of the clinical professional over the experience of the person living with an illness. People with lived experience of the system talk about a culture that promotes fear and powerlessness and low expectations placed on their recovery.

A similar power imbalance is experienced by different services in the mental health ecosystem, stemming from entrenched beliefs about what different parts of the system can and should contribute. For the Community Mental Health and Wellbeing Sector, there are low expectations from other elements of the system of its professionalism and ability to manage risk and support complexity. This is due to its evolution and limited resources, and despite the positive outcomes being achieved by many community mental health and wellbeing services.

Alternatives to Emergency Departments

Emergency departments remain one of the most common points of entry to the mental health system. Unfortunately, they are also one of the most distressing places for people experiencing mental illness and are not conducive to trauma-informed care. People with lived experience have outlined the distress of overcrowding, noise, long waits and the use of restrictive practices in emergency departments. The Productivity Commission reported that "the typical ED experience too commonly exacerbates the distress of those with mental illness, frustrates and diverts emergency clinicians, paramedics and police, and is an entry point that is very expensive for the community".[16]

There is an urgent need to establish alternatives to emergency departments that are located in the community, separate from clinical services and staffed primarily by people with lived experience. These crisis centres would be more approachable and less daunting for people in distress, providing welcoming spaces for private conversations conducted with dignity, and an environment conducive to de-escalating people's distress. Benefits include a strong focus on early intervention leading to less hospitalisations, reduced police presence, promotion of social connections, and increased access to other community organisations which would reduce the burden on acute services.

In Queensland, there have been a range of initiatives in partnership with community mental health and wellbeing services, many of which are in their early stages of implementation and as such have not yet undergone formal evaluation.

- The Brisbane North Primary Health Network (PHN) has received funding to establish four safe space hubs and a safe spaces network in the Brisbane North and Moreton Bay Region. While still in their infancy, these hubs were co-designed with Roses in the Ocean, a peer-led suicide prevention organisation. The hubs intend to provide a peer-led alternative to emergency

[16] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p28.

departments for those experiencing emotional distress and suicidal crisis, offer support outside of normal business hours, and provide individual safety planning, sensory modulation and other therapeutic activities. They also offer outreach and in-reach services to and from local emergency departments.

- Queensland Health has recently funded eight pilot crisis support spaces across the state as an alternative to emergency department care for people experiencing mental distress. These centres employ lived experience workers and are co-located on hospital grounds. At this stage, funding is available until 2023.
- Eight federally-funded pilot Head to Health centres are currently being established across the country, including one in Townsville. QAMH welcomes the co-design process that was part of their establishment, their open access, 'no wrong door' philosophy and the emphasis on lived experience in staffing ratios. We are also pleased to see the Community Mental Health and Wellbeing Sector leading this initiative, due to the unique knowledge and skills we bring to the mental health landscape.

QAMH supports the intent of all these initiatives, which is to provide alternatives to emergency department care for people who are experiencing acute crisis. Many of these initiatives borrow from 'The Living Room' model[17] which is based on:

- Locating care in non-clinical environments with a warm and welcoming atmosphere, maximum privacy, and low levels of visual and auditory stimulation;
- Utilising lived experience staff first and foremost, with any clinical staff positioned in a space away from the main area;
- Employing active listening, de-escalation strategies and development of coping skills;
- Providing recovery-oriented, trauma-informed care with a focus on autonomy, respect, hope, empowerment and social inclusion;
- Ensuring safety is considered at all stages, with the development of safety plans and provision of follow-up.

We are cognisant that the intention of service delivery in the initial planning phase can undergo transformation during the implementation and rollout phase. For this reason, we look forward to the formal evaluation of these initiatives, in particular how they interact with emergency departments, whether they are funded for extended opening hours, the balance of non-clinical to clinical staff and

[17] Heyland, M., Emery, C., & Shattell, M. (2013). The Living Room, a Community Crisis Respite Program: Offering People in Crisis an Alternative to Emergency Departments. *Global Journal of Community Psychology Practice*, *4*(3).

whether they can cope with demand. We also watch with interest whether governments will fundamentally acknowledge the need to divert people experiencing mental distress away from emergency departments and provide greater long-term funding for the rollout of peer-led community crisis centres across Queensland.

The Missing Middle

While it is indisputable that there has been a steadily escalating demand for mental health services across Queensland, it is the 'missing middle' in particular who are locked out of the system. The term 'missing middle' has gained widespread use and refers to the large and growing number of people whose situation is considered too complex or severe to be treated in the primary care system but are not deemed unwell enough to be treated by acute services. They have been singled out by successive reports and inquiries, most significantly the Productivity Commission's report, the final report from the House of Representatives Select Committee into Mental Health and Suicide Prevention, and the Royal Commission into Victoria's Mental Health System.

A number of factors have contributed to the emergence of the missing middle:

- Increasing demand against a background of long periods of underinvestment in the mental health system by all levels of government;
- A system which is designed around responding to crisis rather than actively supporting wellbeing or responding early in distress;
- Policy decisions that have channelled funding and resources into supporting specific cohorts, leading to people falling through the gaps in care;
- A system which is notoriously difficult for the public to navigate due to service fragmentation and lack of integration within the system;
- A lack of innovation and diversity with a narrow focus on clinical services to the exclusion of the Community Mental Health and Wellbeing Sector;
- A lack of consumer confidence in the types of care on offer which are all too often described as traumatising and retraumatising leading to people avoiding the system altogether;
- High out-of-pocket costs associated with GP and psychologist visits, making it too costly for the vast majority of people; and
- A demarcation in responsibilities between state and federal governments has created a gap in services with no one taking full responsibility for this group of people.

Consequently, the missing middle have fallen between the cracks of various government funding models and cannot necessarily afford to access private services. They do not meet the strict entry criteria for accessing state funded mental health services or the National Disability Insurance Scheme (NDIS) but require different supports to those which can be accessed through a GP or a psychologist. It is a difficult group to quantify, but the Productivity Commission estimates that as many as one million Australians are missing out on access to mental health services.[18]

While we understand that the state government sees its role managing the acute end of the system, it does have a responsibility for the wellbeing of all Queenslanders and therefore a duty to collaboratively work with the federal government to achieve the best outcomes for the population. QAMH urges the Committee to develop recommendations to fill this service gap as a matter of priority and ensure that the National Agreement prioritises these issues. Too often, government responses to calls for action have resulted in more funding for hospital beds in acute mental health units or more subsidised psychology sessions under the Better Access Initiative. While welcome to some, these measures are missing the mark because they are not necessarily the right services for the cohort of Australians who have the most difficulty accessing appropriate services - the missing middle.

QAMH believes that the Community Mental Health and Wellbeing Sector should form part of the solution to addressing the missing middle. As an accessible, evidence-based, relatively cost-effective sector, with an ability to be scaled up on demand, it is perfectly positioned to fill this service gap, freeing up the hospital system for more acute presentations. However, this would require a significant restructuring of funding models to an emphasis on supporting community mental health and wellbeing services, redesigning entry points and referral pathways to shift away from GPs and hospitals, and a recognition from governments that not all human distress needs a clinical response. This is undoubtedly a fundamental shift, but one that would effect real change in the system and improve the lives of many Queenslanders living with mental distress.

Gated Entry Points

Currently, people enter the system through a variety of channels, with the most common entry points being attendance at a GP clinic, presentation to an emergency department, or calling 1300 MH CALL. The result is that people remain within very narrow (clinical) pathways, usually involving prescription of medication, referral to a psychologist under the Better Access Initiative, or transfer to one of the state-funded Hospital and Health Services (HHS). While some people get referred to a community mental health and wellbeing service through one of these channels, direct entry into these community services is not part of the current funding arrangements for the majority. For some grant-funded services there is an established pathway into community-based services but referral directly from GPs

[18] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p29.

is not widespread. This may be because of a distinct lack of knowledge of the existence of these services by clinicians and historical practices established within the Better Access Initiative. Very often, people experiencing mental distress do not need medication or psychology sessions, but rather practical help and problem-solving strategies for the issues they face. These services are core functions provided by the Community Mental Health and Wellbeing Sector. There is a strong argument for the establishment of an alternative front door where people can access the system, receive initial information about the suite of clinical and non-clinical services available and associated out-of-pocket costs, and help connecting them to these services. This will prevent, in many instances, the unnecessary medicalisation of mental distress which does not always need a clinical response and take the pressure off a hospital system struggling under the weight of demand.

Another flaw of the current system is that, with its reliance on eligibility criteria, it is designed to exclude people. The 'no wrong door policy' that underpins the National Mental Health and Suicide Prevention Plan refers to the expectation that all people who make contact with the mental health system will either receive a direct response or be linked to an appropriate service in a timely manner. In reality people with lived experience report that despite 'reaching out' and making contact with the mental health system, they remain locked out of services whose funding models are attached to excessive exclusion criteria. The NIDS requirement that people must have a psychosocial disability which is both permanent and causing significant functional impairment is well known. Other examples include Queensland Health funded services being available only to those referred by the HHS, PHN funded services requiring GP referrals, or psychologists needing mental health care plans to be completed by a GP. When one understands how difficult it can be to ask for help in the first place, it becomes apparent that a system designed to put up administrative hurdles for people to jump is not one conducive to recovery.

QAMH is calling for a redesigning of entry points, in particular less reliance on eligibility criteria, allowing self-referral to be a valid entry to the system, and a recognition that clinical pathways are not the default journey to recovery. It is essential that community mental health and wellbeing services become more natural places to access help early in a person's journey. When designing such a system, careful attention must be paid to ensuring it remains easy to navigate and focused on local services rather than providing standardised, one-size-fits-all solutions. The federally-funded Head to Health centres, if scaled to demand, could potentially fill this role as community-based, easily accessible gateways to the mental health system and community wellbeing supports. QAMH acknowledges the intent of these centres, which is to provide a direct entry point and service the missing middle early in distress by providing short-term supports. We also appreciate the importance that has been placed on lived experience workers in the Head to Health centres, with the philosophy that 'Wellbeing Coaches' support people from when they arrive to when they are ready to leave, and clinicians are not the default providers of care. We keenly await the evaluation of these pilot centres, in particular whether they are able to reach the missing middle and cope with demand, how they balance clinical versus non-clinical care, whether they can provide targeted wellbeing responses, and whether there are adequate funded services available for onward referrals.

An Integrated Mental Health System

The current fiscal landscape, which is based on grant funding through Queensland Health and PHNs or individual fee-for-service funding through the NDIS and Medicare, encourages services to operate as silos. This fragmentation has resulted in services evolving into discrete units that compete fiercely with each other for funding. While this arrangement provides administrative simplicity for funders and lucrative funding channels for some health professionals, it is not operating in the best interests of people experiencing mental distress.

The rollout of the NDIS radically transformed existing funding arrangements. Because it is not a sustainable model and its pricing arrangements do not reflect the complexity of the work performed, competition for grant funding has become super-charged. This is an abrupt change from the pre-existing environment where services operated more collaboratively in networks of community-based care. Prior to the NDIS, service providers would refer people to each other's programs, draw on each other's strengths and knowledge, and work together to provide the best outcomes for people in distress. QAMH strongly advocates for funding models that foster collaboration and integration within the mental health landscape.

This fragmentation has also partly arisen because funding streams come from individual government agencies at various levels of jurisdiction. It is not only the impasse between federal and state funding, but also the intersection of health, housing, employment, disability and justice which creates a labyrinthine web of responsibility. Amidst all this confusion, no one steps up to take responsibility for funding adequate services for people living with mental distress and the age-old game of passing the buck continues.

QAMH has long been advocating for a whole-of-government approach to mental health funding Importantly, a person's mental health difficulties do not exist in a vacuum – there is usually a multitude of complex issues which need addressing. The Productivity Commission stated that "housing, employment services and services that help a person engage with and integrate back into the community can be as, or more, important than healthcare in supporting a person's recovery".[19] Similarly, the House of Representatives Select Committee into Mental Health and Suicide Prevention noted that "clinical interventions, in the absence of broader measures to address social determinants of health, cannot resolve growing mental health concerns in Australia".[20] We recommend a future system where funding models incentivise cooperation between services to provide collaborative care delivered by multidisciplinary teams.

[19] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p2.
[20] Australia. Select Committee into Mental Health and Suicide Prevention. (2021). *Mental Health and Suicide Prevention: Final Report*, p 316.

The two-year Mental Health Demonstration Project which commenced in 2015 is a good example of collaborative service delivery. To combat the risk of eviction for social housing tenants with mental illness, it trialled a new integrated housing, mental health and welfare initiative. The Project was a collaborative approach between Queensland Heath, the (then) Department of Housing and Public Works and NGO partner Footprints Community. Clearly there have been some pockets of excellence, but unfortunately most are pilot programs with no long-term funding or rely heavily upon a few committed individuals rather than a systematic approach to collaborative service delivery.

Housing

Housing deserves special mention here as it is central to a good mental health system. It forms one of the four pillars in Shifting Minds, the Queensland Mental Health Commission's strategic plan for mental health services in Queensland. It was also one of the Productivity Commission's priority reforms, including the commitment to "no discharge from care into homelessness".[21] Having the security of safe and affordable housing is a major factor in preventing mental illness and an important first step in promoting long-term recovery. Moreover, there is an economic argument for addressing homelessness, with the Productivity Report suggesting that about 30 per cent of admitted patients in psychiatric wards could be discharged if appropriate housing and community services were available.[22]

QAMH, together with Q Shelter, has been calling for the Queensland Government to commit to increased investment in housing and housing support programs as a fundamental component of a mentally healthier Queensland. Queensland has recently experienced a significant reduction in the availability of affordable housing with vacancy rates reduced to less than one per cent in most regional towns.[23] This has severely impacted the availability of suitable housing options for people living with a mental illness who are at risk of homelessness. It is critical that the Queensland Government ensures access to safe, supported and long-term housing for people with lived experience of mental illness by:

- Making increased funding available for head-leased housing options for targeted access by people with lived experience of mental illness;
- Funding support programs that focus on tenancy sustainment;
- Providing growth funding for subsidised housing options aimed at addressing the needs of people with lived experience of mental illness; and

[21] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p41.
[22] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p44.
[23] Real Estate Institute of Queensland. (2021). Extremely low vacancy rates endure across 80% of Queensland. Media Release: REIQ. https://www.reiq.com/articles/vacancy-rate-report-mar-21/

- At a national level, putting pressure on the federal government to ensure the intersection of mental health and housing services is clearly articulated in the upcoming National Mental Health and Suicide Prevention Agreement.

The NDIS

Since its rollout in 2016, the NDIS has provided a life changing opportunity for many Queenslanders living with psychosocial disability. In many instances, it has allowed them to access supports and services they require to exercise choice and control and effectively participate in society. NDIS statistics indicate that in September 2021, there were 9,377 participants with psychosocial disability in Queensland who had an individually funded plan under the NDIS.[24]

However, the NDIS has not been without problems. To receive funding under the NDIS, a person needs to demonstrate that their psychosocial disability is both permanent and significantly impairs their functional capacity to carry out activities in at least one of the six domains (mobility, communication, social interaction, learning, self-care or self-management). Only a fraction of the people living with mental illness will ever meet these criteria to receive funding from the NDIS. According to the Productivity Commission, two million Australians are living with moderate to severe mental illness at any given time. But just 64,000 (three per cent of these people with psychosocial disability) will meet the strict eligibility criteria to access the scheme.[25] When services underwent the major transition to NDIS funding, they were forced to focus on service provision for those with approved packages. This has left a gaping hole in the system, with many people ineligible for an NDIS package unable to access any programs at all. QAMH urges the Committee to properly consider alternative funding channels to provide services for these people, and specifically recommends the Community Mental Health and Wellbeing Sector to fill this gap.

The NDIS' fee-for-service model also fails to address the ancillary costs associated with employing staff. Pricing arrangements are grossly inadequate and make it impossible to offer secure and satisfactorily remunerated employment. They also inhibit provision of adequate training and supervision and do not cover the costs associated with staff recruitment and onboarding. The inevitable result has been a shift to casual employment, significant increases in staff workloads and costs of training being absorbed by the organisations themselves, which is clearly not a sustainable model. The sector discusses a "divide" that exists between its NDIS services and those that are funded through other sources. A large national organisation and QAMH member recently ceased providing NDIS services altogether due to unsustainability of the cost structure.

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[24] Australia. National Disability Insurance Scheme. (2022). *NDIS Data and Insights*. https://data.ndis.gov.au/explore-data

[25] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p40.

In addition, QAMH members have regularly expressed concern regarding the interface between funding provided by the NDIS and healthcare provision, including Medicare, Queensland Health and PHNs. Participant plans do not provide sufficient funding to cover costs associated with ongoing psychosocial needs. When participants try and fill these gaps by accessing mainstream services, they find them difficult to access. Members report participants are being denied access to the NDIS if they have periodic interaction with clinical services within Queensland Health. That is, the National Disability Insurance Agency (NDIA) shifts responsibility for funding to state-provided services. Practically there is significant overlap between these services. For instance, navigating access to a Queensland healthcare provider for clinical services will often require NDIS-funded assistance. Unfortunately, an individual's interaction with a particular service does not divide neatly between NDIS and non-NDIS categories. The NDIA's failure to consistently recognise the complex interface that exists between health and psychosocial disability leaves some member organisations concerned that vulnerable people are missing out on accessing the care they require.

Finally, it is important to note that the disability model that underpins the NDIS is diametrically opposed to a wellness and recovery framework. This focus on disability and permanent functional impairment is stigmatising and does not align with how the sector sees mental distress and the recovery journey. QAMH welcomes the recent introduction of a Psychosocial Disability Recovery-Oriented Framework and appreciates the NDIA's acknowledgement that people with psychosocial disability have different needs to those with physical and intellectual disability. However, the fact remains that the NDIS was initially established to address the needs of people living with physical and intellectual disability. Psychosocial disability, with its fluctuating/episodic nature and ongoing attempts to achieve personal recovery, was retrofitted into the scheme and providers constantly struggle to provide services in this poorly funded, rigid, dependency-based model.

Geographic Disparities

Queensland's unique geography, including vast distances and areas of remoteness, have impacted the mental health landscape. Servicing all corners of our disparate state while ensuring that remoteness is not a barrier to accessing care has been a constant challenge for Queensland's policy makers. While telehealth and fly-in fly-out services can provide some benefit, they are not the whole solution. We need to ensure that people in remote regions are still able to access affordable, face-to-face services.

Once again, the NDIS has played a significant role in shaping the community mental health and wellbeing services available in rural and remote regions. Specifically, thin markets have developed, with providers lacking financial incentives to provide services there. Pricing arrangements under the NDIS do not reflect real world operating costs of delivering services in remote and very remote areas, including things such as travel, training, and other incentives required to attract appropriately trained staff. This limited workforce means that people with psychosocial disability living in these areas miss out entirely on critical supports and a lack of choice and control, a fundamental principle of the NDIS.

The state government needs to ensure that it advocates strongly with the federal government around the pricing structures of the NDIS to accurately reflect the challenges associated with delivering services in rural and remote areas.

In addition, resources should be made available to support grant funding for local initiatives to address this gap. QAMH members report that there is no organic, local, place-based service delivery that is culturally appropriate for people's needs and call on governments to support establishment of such services. It is crucial that we equip local communities with resources to support the wellbeing of their communities. This is particularly important in Aboriginal and Torres Strait Islander communities, where suicide rates are unacceptably high. "People in these communities should be empowered to design and implement programs that address the specific needs of their local community and are grounded in its culture and concepts of social and emotional wellbeing."[26] Our current system relies so heavily upon conventional one-size-fits-all clinical services such as psychology sessions under the Better Access Initiative, which have very little relevance or suitability in remote communities. The Community Mental Health and Wellbeing Sector is well-placed to offer services tailored to local needs, however this requires flexibility in funding models. It is essential that grant funding rewards local design and innovative solutions created by communities themselves, and central models of care are designed in such a way as to allow local adjustments and customisation.

Research and Evaluation Framework

QAMH strongly advocates for work to be done on developing a research and evaluation framework that is system-wide, co-designed with people with lived experience and used to drive evidence-informed policy. Adequate evaluation should be built into all funding contracts, with a focus on outcomes and value for money in order to justify the billions spent on the mental health system per year. A coherent framework would allow comparison of the Community Mental Health and Wellbeing Sector with other areas of the mental health system and support policy makers in directing resources across the entire sector.

The importance of a robust evaluation strategy was emphasised in the Final Report from the House of Representatives Select Committee on Mental Health and Suicide Prevention which recommended:

> "The Australian Institute of Health and Welfare convene a cross-jurisdictional working group, including Commonwealth, state and territory authorities, researchers, clinicians, and service delivery organisations, to establish a national collection framework for data on mental health and suicide prevention. The national collection framework must include:

[26] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *2*(95), p182.

- A central repository of current, harmonised and comparable data from all jurisdictions which is broadly available for research and service delivery planning; and
- Harmonised data reporting requirements for inclusion in service delivery contracts."[27]

Currently, evaluation either occurs in an ad hoc and siloed fashion without a systemic view to informing larger policy and investment decisions, or simply not at all. Better Access is a good example of a government initiative that has been allowed to operate with little or no accountability at the practitioner or national policy level. It is reported that "GPs only review 50 per cent of the mental health plans they write"[28] and even then their reviews are cursory at best. Successive governments continue to increase funding for Better Access, including most recently an expansion from 10 to 20 Medicare-subsidised psychology sessions during the Covid-19 pandemic. This is despite the lack of evidence that it improves outcomes for people experiencing mental distress. This may partly be due to what the Productivity Commission refers to as "a lack of measurement and evaluation of what works, and in part due to a culture of superiority that places clinicians and clinical interventions above other service providers."[29] QAMH welcomes the federal government's recent announcement that the Better Access Initiative will undergo a robust and independent evaluation process in 2022, but feels that this would have been more useful before the rapid expansion of the program to the exclusion of other services. We need a stronger focus on outcomes which can only occur with in-depth data collection. This evidence needs to inform commissioning processes and ongoing decision making about policies and investment.

In calling for a research and evaluation framework, QAMH would expect that all sectors are equally represented, including the lived experience sector. Without this condition, we feel that the framework may morph into one where vested clinical interests are able to commission research projects to validate clinical therapies as opposed to objectively comparing all available programs and services, including those in the Community Mental Health and Wellbeing Sector. QAMH would also argue that the burden for such evaluation does not fall upon individual service providers but is supported by a centralised system which would promote evaluation practices, issue guidance and facilitate access to evaluation expertise. We would expect that, when awarding contracts, the costs to organisations of evaluating and demonstrating effectiveness is included.

[27] Australia. Select Committee into Mental Health and Suicide Prevention. (2021). *Mental Health and Suicide Prevention: Final Report*. p xxiii.
[28] Rosenberg, S., Lawson, K., & Hickie, I. (2021). Building Support for GPs to Help Mental Health Consumers, *Insight+*. Building support for GPs to help mental health consumers | InSight+ (mja.com.au)
[29] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p8.

The Queensland Mental Health Commission (QMHC)

Established in 2013, QMHC has played a key role in positioning mental health reform across the sector, as evidenced in Shifting Minds, its strategic plan for 2018-2023. It has been actively involved in building collaboration across the sector and has been a driving force in moving towards a more integrated, evidence-based, recovery-oriented mental health system. However, in order to continue this important reform agenda, QAMH believes the existing legislative framework within which QMHC operates needs to be reviewed.

The rationale for the establishment of the QMHC as an independent statutory agency which was separate to the Department of Health was to provide greater capacity to influence across different government agencies and the wider sector, and leverage systemic reform. This cross-sector engagement is emphasised in Shifting Minds: "The plan deliberately stretches beyond the health sector, to seek commitment and action across all levels of government, portfolios, sectors and the broader community".[30] However, QMHC's ability to execute this broad engagement and influence is somewhat impeded by its allegiance to Queensland Health and the health minister, to which it directly reports. The state government claims responsibility for supporting the mental health needs of only three per cent of Queenslanders who access acute services run by HHS's, and therefore attributes the needs of all others as a federal responsibility. The Commissioner's advocacy for more community-based services to support people earlier in their distress is impeded by this clear demarcation in responsibility.

To realise its full potential and position itself as a genuine player in system reform, the QMHC needs to be a truly independent entity, separate to Queensland Health.

[30] Queensland. Queensland Mental Health Commission. (2018). *Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*, p2.

(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):

Economic Participation

The links between employment and good mental health are well established. There are a number of ways that employment can improve mental health:

- "Working can give people a sense of identity, and provide regular interaction and shared experiences with people outside of an individual's immediate family;
- The collective effort and purpose of work can provide a sense of personal achievement;
- Structured routines associated with work help give direction to the day and promote the need for prioritisation and planning; and
- Increased employment of people with mental illness can reduce the stigma of mental illness throughout the workforce."[31]

The Productivity Commission specifically recommended that people with mental illness have access to Individual Placement and Support (IPS) programs as a priority reform. These are supported by a large body of evidence and involve rapid job search for competitive employment, on-the-job training and ongoing case worker support. IPS programs are delivered by a number of QAMH members, with excellent results. WorkWell is a program run by NEAMI, which fuses the principles of IPS with the Collaborative Recovery Model (based on a person's strengths, values and ongoing search for meaning in life, and an enduring hope for recovery). A recent evaluation conducted by the University of Sydney and La Trobe University demonstrated its success. Almost half of participants gained a competitive employment position. Average employment duration was 21.6 weeks and average weekly wage was $478. The findings underestimated the job tenure period because at the end of data collection 29 of the 48 people who had gained employment were still working.[32]

Stepping Stone Clubhouse is another QAMH member who provides a range of employment services to people experiencing mental distress, including transitional, supported and independent employment

[31] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p49.
[32] Scanlan, J.N., Feder, K., Ennals, P., & Hancock, N. (2019). Outcomes of an Individual Placement and Support Programme Incorporating Principles of the Collaborative Recovery Model, *Australian Occupational Therapy Journal*, *66*(4), pp519-529.

programs. In 2020, they supported 88 people in employment. Their transitional employment program, where people work in part-time roles for six months to gain confidence and reintegrate into the workforce, has been particularly successful. The ultimate goal is to transition out of these roles and into the competitive workforce, a process which is further supported by their independent employment programs.

Based on a significant body of evidence, QAMH encourages the Committee to consider allocation of funding for employment programs to improve the outcomes for people living with mental distress who are currently looking for work.

Social Participation

The association between social isolation and mental illness is well documented. It is a bidirectional relationship, with both social isolation being a strong risk factor for mental illness, and mental ill-health leading to reduced social connectedness.[33] Research shows that social isolation and loneliness are associated with lower workplace productivity, poorer health outcomes (including mental distress and suicidal ideation) and reduced quality of life.[34] Initiatives that promote social connectedness must be central to any strategy addressing mental illness in Queensland and QAMH believes that the Community Mental Health and Wellbeing Sector, with its focus on accessible community-based programs which operate within a wellbeing and early intervention framework, is perfectly positioned to tackle this issue.

There are many examples of successful initiatives in the Community Mental Health and Wellbeing Sector which improve social participation in Queensland:

- **Upbeat Arts** fosters social connectedness and overall wellbeing by delivering arts and cultural programs including creative writing, song writing and choirs. Educators work together with marginalised communities to build upon the capabilities of participants, encouraging them to take their own personal creative journeys, connect with the community and meet new people. This provides an opportunity to nurture new creative skills while breaking the cycle of social exclusion.
- **Ways to Wellness** is a collaboration between the Mt Gravatt Community Centre, Mt Gravatt Men's Shed, Queensland Community Alliance and the University of Queensland. It aims to tackle social isolation and loneliness with a whole-of-community approach. People in the

[33] Sarei, A.K., Cruwys, T., Barlow, F.K., Stronge, S., & Sibley, C.G. (2017). Social Connectedness Improves Public Mental Health: Investigating Bidirectional Relationships in the New Zealand Attitudes and Values Survey. *Australian & New Zealand Journal of Psychiatry*, 52(4), pp365-374.
[34] Australia. Australian Institute of Health and Welfare. (2019). Social Isolation and Loneliness. Social isolation and loneliness - Australian Institute of Health and Welfare (aihw.gov.au)

community who are experiencing social isolation can self-refer to the service or be referred by their GP or allied health worker. Once referred, a Community Link Worker connects these socially isolated members of the community to meaningful group programs and activities.

- QAMH has partnered with QSport the peak body for organised, affiliated sport across Queensland to support more people living with mental health challenges to access community sport. Community sport fosters a sense of social cohesion and inclusiveness and is linked to positive mental health outcomes.[35] Under this agreement, local connections between community mental health and wellbeing services and sporting clubs will be forged, encouraging more people to play sport and/or volunteer in community club activities. The program also aims to raise awareness of mental health challenges, risk factors, early signs and symptoms, and the supports available.
- QAMH has commenced discussions with the Australian Council for the Arts to pilot an 'Arts on Prescription' program, which encourages participation in arts and cultural pursuits to address the social determinants and social isolation that contribute to mental illness. Arts on Prescription acknowledges that resources already exist in the community to improve our wellbeing beyond the traditional health system. The program aims to tap into these resources and give health professionals, including GPs, new ways of connecting people with arts and cultural endeavours.

It is important to note that all these initiatives could be utilised in a social prescribing framework to address social isolation and its associated mental health challenges. Social prescribing is becoming increasingly popular as an evidence-based, affordable, non-clinical adjuvant to more conventional treatments such as prescription medications and referrals to psychologists. The Royal Australian College of Practitioners have noted that many GPs are already incorporating social prescribing into their day-to-day practice and are now calling for it to be officially included in the Federal Government's 10-Year Primary Health Care Plan.

QAMH strongly supports such non-clinical initiatives that recognise human distress does not always need a medical response. We encourage the Committee to recommend expanding social prescribing structures in Queensland to provide more opportunities for people to connect with local community services. The Community Mental Health and Wellbeing Sector, which already looks for opportunities to engage people with naturally occurring community resources, would be a cost-effective conduit to a social prescribing model, reducing the burden on our acute mental health system.

[35] Street, G., & James, R., (2007). The Relationship Between Organised Physical Recreation and Mental Health. *Health Promotion Journal of Australia*, *18*(3), pp236-239.

(d) The experiences and leadership of people with lived experience of mental illness, problematic substance use and suicidality and their families and carers

QAMH strongly believes that people with lived experience are an essential component of a thriving mental health workforce in Queensland. People with lived experience utilise their personal life-changing journey of mental health challenges, service use, periods of healing and recovery to coach those living with mental illness.[36] Importantly, people with lived experience bring unique knowledge, insights and expertise which makes them distinct from other sectors of the mental health workforce. By employing coaching skills and operating within a recovery-oriented framework, they assist people to build on their strengths, increase their capacity to live a full and meaningful life and provide a living example of hope and recovery.

In addition to this function, people with lived experience are organisational 'change agents', significantly contributing to reducing discrimination and prejudicial attitudes by helping service providers understand everything in mental health care through the lens of lived experience and recovery.[37] The voice of lived experience has driven much of the contemporary reform agenda, articulating the need for a focus on wellbeing, greater self-determination and less restrictive care. People with lived experience hold vital knowledge about what is needed from the system, both for individual care and at broader levels. Engagement of people living with mental illness and those supporting them can lead to healing of historical traumatisation within services and promote cultural change.[38]

The following examples illustrate the life-changing work being performed by those with lived experience and put forward a strong case for further embedding lived experience as a central component of the mental health workforce in Queensland.

- Peach Tree Perinatal Wellness is a Brisbane-based not-for-profit organisation that provides support for parents, partners and families who are experiencing perinatal mental health challenges. Peach Tree is a 100% peer-led organisation, meaning all staff and volunteers have their own personal experiences of perinatal mental illness, each with unique stories of hope and recovery. Their goal is to work in partnership with perinatally-focused professionals and health practitioners to provide compassionate support and services to parents and families within the community. Peach Tree's "Just Peachy" Program is a weekly program for mothers

[36] Queensland. Queensland Mental Health Commission. (2019). *Queensland Framework for the Development of the Mental Health Lived Experience Workforce*, p8.
[37] Australia. National Mental Health Commission. (2021). *Lived Experience (Peer) Workforce Development Guidelines*, p4.
[38] Australia. National Mental Health Commission, (2017). *Consumer and Carer Engagement: A Practical Guide*, p4.

experiencing perinatal mental health challenges. It is facilitated by peer support workers with lived experience and aimed at improving mental health and wellbeing. A rigorous evaluation process was conducted between 2019 and 2021, which showed participation in this program resulted in statistically significant improvement in symptoms of depression and anxiety, and an increase in wellbeing, parent-infant bonding, social support and parenting confidence.[39]

- Brisbane North PHN is committed to lived experience on a strategic level through the creation of the Lived Experience Engagement Coordinator role, which is responsible for developing capacity and supporting opportunities for people with lived experience to actively participate in reforms. This has seen recognisable benefits to the organisation, as people with lived experience are leading change, and becoming active partners in co-designing, delivering and evaluating services.[40]

- Brook RED is a lived experience governed, managed and operated community mental health organisation operating in South Brisbane since 2000. Brook RED delivers a range of services that include four mental health community centers offering formal (e.g. DBT, Hearing Voices and Smart Recovery) and informal (e.g. art, social and cookery) groups. Other services include flexible individual support and counselling services; suicide prevention including an aftercare service taking referrals from local emergency departments and a Crisis Support Space within the Princess Alexandra Hospital; and NDIS Support and Specialist Support Coordination. All of Brook RED's services are delivered by peer practitioners. Brook RED also delivers external training and supervision for peer workers and organisations who want to best support their peer workforce.

QAMH encourages the Committee to incorporate lived experience as a central component in any future design of the mental health landscape in Queensland. In particular, we call for:

- A requirement for authentic partnership with lived experience to be integral to all mental health service design, commissioning and implementation. This is in keeping with the lived experience philosophy "nothing about us without us". QAMH is strongly of the view that nothing should be decided or delivered without direct leadership and collaboration with those affected, in this case people with lived experience. We note that embedding lived experience engagement in the commissioning cycle has been set out in guidelines developed by the National Mental Health Commission's 'Practical Guidelines for Consumer and Carer Engagement' which provides a clear framework for lived experience participation.

[39] Staneva, A., (2021). *Peach Tree Perinatal Wellness Evaluation Report*.
[40] Brisbane North Primary Health Network and Metro North Hospital and Health Service. (2018). *Planning for Wellbeing.*

- Further recognition of and support for the new peak body for mental health consumers - Mental Health Lived Experience Peak Queensland (MHLEPQ). With adequate resourcing, this has the potential to be an active and engaging peak body which would inform policy decisions, ensure lived experience is at the forefront of governance structures, and advocate on behalf of people living with mental illness.
- Real work to be done on strengthening and growing the lived experience workforce. The lived experience workforce is now recognised as a crucial element of change but still faces specific challenges such as constructing a recognisable identity within the mental health landscape, reducing the stigma faced by lived experience workers, developing skill sets and engaging with the non-lived experience workforce to increase their understanding of how lived experience contributes to a thriving mental health system. The Queensland Framework for the Development of the Mental Health Lived Experience Workforce was released in 2019 and provides some strategic direction. However, we feel that the establishment and resourcing of a formal body or peak to progress this piece of work is necessary to ensure its aims are fully realised. Queensland Lived Experience Workforce Network (QLEWN) already has some experience in this space. QAMH strongly believes that the lived experience workforce is the workforce of the future and, as such, the Committee needs to put forward a concrete plan to support the strengthening of lived experience within the mental health ecosystem.

(e) The mental health needs of people at greater risk of poor mental health

QAMH welcomes the Committee's focus on people at risk of poor mental health. The current mental health system is designed to respond to people who are in crisis: The NDIS funds services to those with 'significant psychosocial disability'; emergency departments provide care to people experiencing acute mental distress; many commissioned services are only available to those who are unwell enough to have come through the hospital system. Services operating at this acute end of the illness trajectory are expensive and resource intensive. Moreover, they are becoming overwhelmed by the tsunami of mental health presentations that are upon us due to there being limited alternatives. Over the past 15 years, people presenting to emergency departments with mental distress have increased by 70 per cent.[41] The NDIS provides psychosocial supports to a small fraction of people who need them. It is not uncommon to wait many months to access a psychologist, with even longer waiting periods to see a psychiatrist and no direct pathway into other support services. Clearly a new approach is needed, one that will stem this flow by investing in preventative and early intervention services. The Productivity Commission's assessment is scathing:

[41] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p28.

> "Australia's mental health system does not focus on prevention and early intervention. Too many people are treated too late. Young Australians at risk and their families cannot easily access support. And those with developing mental health problems can face a bewildering array of unpredictable gateways to care: They know what services they need, but timely access is not possible. Our recommendations aim to refocus the mental health system, recognising the truth in the adage that 'prevention is better than cure'." [42]

Much of the important work performed by the Community Mental Health and Wellbeing Sector focuses on prevention and early intervention. This sector is perfectly positioned to play a crucial role in reducing the burden on the acute system, by delivering services which focus on mental wellbeing and flourishing and provide active intervention early in an episode of mental distress. This will obviously provide better outcomes for the individual, whose risk of progressing to crisis is reduced, but also relieve the burden on our acute services.

Some examples from QAMH members providing innovative preventative and early intervention services include:

- Accoras is a not-for-profit organisation providing a range of services in South-east Queensland, with a particular focus on prevention and early intervention. Attachment and Biobehavioral Catch-up (ABC) is one of their programs which targets infants aged six to 24 months who have experienced some degree of trauma (usually abuse and neglect) that could place them at risk of requiring the involvement of the child protection system. This type of trauma impacts the developing brain and has lifelong social, emotional and health consequences. The 10-session, home-based early intervention program aims to improve infant distress levels and social-emotional development, as well as parental sensitivity, stress, and confidence. Outcomes include previously traumatised infants returning to a more typical developmental trajectory with improved attachment to the primary caregiver, improved language ability, improved impulse control and caregivers who report reduced stress and more settled infants. It has been the subject of multiple randomised controlled trials and has a substantial research evidence base supporting its effectiveness.
- Mind Blank is an evidence-based mental health promotion service that empowers people to implement mental health strategies and have conversations that save lives. They focus their efforts in the child and youth sector space as they find it is the best area to see a return on investment. Mind Blank engages participants through an interactive theatre experience and builds skills to deal with issues such as cyber-bullying, consent culture, anxiety, depression and suicide prevention. Rather than employing a didactic approach, they use experiential learning

[42] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p6.

where participants are given a range of scenarios and discuss possible pathways. This approach has proven to cut through traditional barriers to learning and gives children and young people practical skills such as identifying risk factors and early signs of mental illness, how to stop and think about behavioural choices, and where to seek help in a time of need.

QAMH specifically calls for:

- A recognition from government that not all distress requires a medical response, and intervention early in illness stems the flow into all aspects of the mental health ecosystem and is ultimately a cost-saving.
- Funding allocation specifically for preventative and early intervention services provided by the Community Mental Health and Wellbeing Sector.
- A focus on specific at-risk groups such as LGBTIQ+, culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander communities. As documented in the Productivity Commission's Report, these populations are grossly over-represented in data on mental illness and suicide. It is crucial that preventative and early intervention services are directed at these groups to interrupt their trajectory to more acute levels of mental distress.

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

The fiscal environment in which community mental health organisations operate is one plagued by short-term funding cycles, inflexibility, fragmented funding streams, and a focus on funding acute (clinical) services to the detriment of more community-based care. QAMH advocates for the following changes to mental health funding in Queensland:

- A reimagining of the mental health ecosystem and the funding arrangements underpinning it so a diversity of services is on offer. Currently, the lion's share of funding goes to GPs and psychologists under the Better Access Initiative. Between November 2006 and June 30, 2019, GPs wrote 31 million mental health care plans costing $2.75 billion, clinical psychologists provided sessions costing $2.45 billion and registered psychologists provided sessions costing $2.6 billion.[43] Despite this vast outlay, there is little evidence to suggest this investment has decreased the prevalence of mental illness. The system is costly for the taxpayer, with no accountability attached to funding, and simply not producing desired outcomes. It is heavily weighted towards the acute (crisis) end of the mental health spectrum, rather than investing in preventative / early-in-illness treatments. In contrast, the Community Mental Health and

[43] Rosenberg, S., Hickie, I., & Rock, D. (2020). *Rethinking Mental Health in Australia*, Brain and Mind Centre.

Wellbeing Sector is vastly under-resourced and under-funded, and yet is perfectly positioned to provide services for people who are yet to reach crisis point. Investing in these community services would stem the flow into the more expensive clinical streams of funding. Most importantly, people living with mental illness want an array of treatment alternatives, rather than the very limited option of seeing a GP for a script and mental health care plan followed by 20 sessions with a psychologist. There is a strong argument for shifting the focus from the reliance we have developed on the Better Access Initiative to redesigning funding models that include a suite of services, including those offered by the Community Mental Health and Wellbeing Sector.

- Longer funding cycles which won't inhibit longer term planning and workforce development. Both the Productivity Commission's report and the House of Representatives Select Committee's final report recommended that funding transition to five yearly cycles (up from 1-3 yearly). This would include funding of PHNs themselves and mental health and suicide prevention services they commission, as well as NGOs. The relationships between contract length and sustainable service delivery, service quality and workforce attraction, are interconnected. Without longer funding cycles, community mental health organisations will continue to be plagued by high staff turnover, lack of permanent employees, and inability to implement any lasting service delivery changes.

- More flexibility in funding pools to be creative, innovative and responsive to local needs rather than a top-down, one-size-fits-all approach. As discussed in detail in our section on *Geographic Disparities*, this is especially important in Queensland where there are distinct regional differences. A mental health service appropriate for an Aboriginal adolescent in a remote Cape York community will have different needs to one servicing farmers living in western Queensland or those living in inner-Brisbane. It is essential that our funding models reflect this need for local, place-based solutions to mental distress. Unfortunately, the current system relies on inflexible, centralised funding models which presume that every person's experience of mental distress is uniform and therefore funnels them into the same kind of treatment pathway.

- Greater cooperation and interconnectedness within the funding models rather than the current situation where a service operates as a silo and needs to compete for funding (as discussed previously in our section on *An Integrated Mental Health System*).

(g) Service safety and quality, workforce improvement and digital capability

Service Safety and Quality

The Australian Commission on Safety and Quality in Health Care (the Commission) has recently released Draft Mental Health Standards for Community Managed Organisations. We believe these standards are an important step towards providing safety and quality assurance for people accessing these services and those caring for them, and best practice guidance for service providers. We welcome the standards' purpose and intent to provide a nationally consistent statement about the standard of care people can expect from a community mental health and wellbeing service.

QAMH was involved in the consultation which led to the development of these draft standards and are pleased to see some of our feedback incorporated into the document. We feel that the Commission has been largely responsive to the sector's needs and look forward to the release of the final standards in 2022.

Importantly, there are currently various competing standards which community mental health organisations are required to meet: The NDIS Practice Standards, the National Safety and Quality Digital Mental Health Standards, and now the Mental Health Standards for Community Managed Organisations. We are advocating for a marrying of these standards so our service providers are not required to meet the standards multiple times, which only serves to add an extra layer of administrative burden.

Workforce Improvement

Addressing workforce challenges must be central to any fundamental reform of Queensland's mental health system. Clearly the large and ever-increasing number of people in the missing middle are not going to be able to access supports without growing our mental health workforce. Recent reviews such as the Productivity Commission's report have focused on strategies to strengthen the 'big five' health professions – doctors, nurses, psychologists, occupational therapists and social workers. This approach fails to appreciate the highly skilled community workforce that is already providing a diversity of services and achieving positive outcomes in the community. It also ignores our fundamental argument, which is to pivot from managing illness in the acute system to supporting people staying well in the community.

Part of investing in the community mental health workforce will necessarily involve a focus on developing education and training opportunities. Compared to the clinical professions, the community workforce requires a different skill set that is not currently adequately provided for in the tertiary education system. A recent Workforce Report released by QAMH indicated that the Community Mental Health and Wellbeing Sector draws from a range of educational and training backgrounds. 96 per cent of workers were found to hold formal qualifications. Demonstrating the diversity of the sector,

60 per cent had vocational qualifications and 74 per cent held university qualifications, ranging from a Certificate III to Masters level. But despite the high percentage of staff holding formal qualifications, nearly two thirds of service managers surveyed did not believe that formal qualifications currently on offer adequately train the workforce. They reported concerns that courses did not provide the opportunity to translate theoretical knowledge into practical experience and identified specific workforce knowledge gaps such as trauma-informed care, responding to complex needs, provision of culturally appropriate services, managing risks, establishing professional boundaries, the intricacies of the NDIS, recovery-oriented practice and leadership and management training.

QAMH is calling for the design and implementation of tertiary-level training opportunities that are specific to the community mental health workforce. We are happy to work with the Queensland Government to explore how this might work in practice. Investing in training pathways that are contemporary, affordable and relevant to the work performed by the sector must be a priority recommendation for this Committee.

Another significant workforce challenge is the high levels of stress and burnout experienced by the Community Mental Health and Wellbeing Sector. The recent surge in COVID-19 cases, whilst significantly impacting service delivery across the mental health ecosystem, has highlighted the fragility of the already fatigued sector. Frontline workers and their managers have identified reduced job security, casualisation of their roles, increased workloads and unachievable productivity requirements as contributing to high stress levels and burnout. Experiences of vicarious trauma, the intensity and complexity of the work, and inadequate support and supervision was also reported by frontline workers. Supporting staff and promoting their mental wellbeing must be a priority for the Committee. QAMH calls for the Committee to explore sector wide approaches to supporting staff wellbeing, which may involve identifying and collaborating with service providers who are currently succeeding in this area and dispersing knowledge of these programs. In addition, consideration needs to be given to providing adequate funding and longer contracts, which would ease pressure on staff and lead to improved mental wellbeing. Building robustness and resilience of the sector needs to be a priority.

Digital Capability

In 2021, QAMH was commissioned by the Mental Health, Alcohol and Other Drugs Branch (MHAODB) of Queensland Health to investigate the sector's experiences of the Covid-19 pandemic. This process highlighted several issues concerning digital capability within the Community Mental Health and Wellbeing Sector, which were amplified during the pandemic due to social distancing requirements. In particular, the report commented on the need to reduce the digital divide both from a hardware accessibility perspective and digital skills. QAMH strongly encourages the Committee to reflect on the need to explicitly address barriers to digital access and include specific actions for reducing this digital divide.

(h) Mental health funding models in Australia

The funding of mental health services in Queensland is best described as labyrinthine. Services are funded at both a state level (through Queensland Health) and a federal level (through the NDIA, Better Access, Medicare and PHNs).

- The state, through **Queensland Health**, funds specialist mental health clinical services as part of its HHS. These can be either outpatient or residential services and are designed to provide support to those with a more severe or complex mental illness or those in crisis. Queensland Health also funds community support services which provide individual recovery and peer support programs, group-based peer support, programs for people at risk of homelessness, and people transitioning from acute mental health wards or correctional centres. These services provide up to 12 months of support and are only available to those who access support through HHS mental health programs. The fact that these services rely on referrals from within the clinical system means that they are only ever going to be accessible by those who have already reached crisis point. The consequence of this blinkered approach is that services are simply not funded for the prevention and early intervention programs they are capable of providing. Moreover, after the rollout of the NDIS, these services underwent major transformation which resulted in a reduction in choice of providers, smaller pockets of available funding and stricter eligibility criteria.
- The staged roll-out of the **NDIS** across Australia brought significant changes to the funding of the Community Mental Health and Wellbeing Sector. The NDIA funds supports for people who are assessed as having a psychosocial disability likely to be lifelong and causing significant impact on their ability to carry out day-to-day activities. As mentioned earlier in this submission, this definition precludes vast numbers of people living with mental distress from accessing services.
- The **Better Access Initiative** provides Medicare benefits to people who wish to access care provided by clinical or registered psychologists, occupational therapists or social workers. It requires a person to have a mental health care plan completed by their GP. Introduced in 2006, the Better Access Initiative has continued to expand, costing more than $800 million per annum.[44] Previously, Australians living with mental illness were able to receive up to ten Medicare-subsidised sessions each calendar year. However, since the Covid-19 pandemic, this has been expanded to 20 sessions. An unintended consequence of this increase was the blow-out of waiting periods for people entering the system for the first time. Despite Better Access appointments being partly covered by Medicare, out-of-pocket costs remain a significant

[44] Hickie, I., & Rosenberg, S. (2019). The Runaway Giant: Ten years of the Better Access Program. *Medical Journal of Australia*, *210*(7).

barrier for many people, excluding those most in need. As discussed previously in our section on *Research and Evaluation*, Better Access has not been subjected to rigorous evaluation despite considerable investment from the federal government.

- **Medicare** also underpins funding for GPs who are often the first port of call for people seeking help when experiencing mental distress. At least five million Australians every year see their GP for assistance with their mental health[45] at an enormous cost to taxpayers. While some GPs do an excellent job, many lack knowledge and skills in mental health, and rely too readily on medication as a treatment option. In fact, six in 10 people presenting to GPs with mental health problems are prescribed medication, in comparison to only three in 10 who receive some counselling, education or advice.[46] This reliance on prescribing medication is likely related to being time-poor and a lack of training in providing non-pharmacological supports. Moreover, GPs can be difficult to access, unaffordable when they charge out-of-pocket fees and not incentivised by the Medicare funding structure to spend longer periods of time with people.

- **PHNs** across Australia have adopted the Stepped Care model, which offers a spectrum of service interventions. The PHN Guidance document, produced by the Department of Health, defines stepped care as "an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, which can be matched to the individual's needs".[47] Commissioned services are provided by NGOs based in the community and offer a range of psychosocial supports, including peer support and services with a resilience-building and wellbeing focus. Many of these services require a clinical diagnosis of mental health condition, level of severity and strict referral pathway for access. Without a structured navigation system to support connections and referrals from GPs, these services are often under-utilised. Moreover, funding contracts to individual service providers are usually small in size, short-term and narrow in scope which creates limitations to what can be delivered and stifles innovation in service delivery.

- In addition to these services, there are a range of state and federally funded online and telephone-based supports such as Lifeline, Beyond Blue, Kids Helpline, SANE Australia Helpline, Parent Line, PANDA and Diverse Voices.

[45] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p34.
[46] Australia. Productivity Commission. (2020). *Mental Health Inquiry Report*, *1*(95), p34.
[47] Queensland. Department of Health. (2019). *PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance: Stepped Care*. p6.

(i) Relevant national and state policies, reports and recent inquiries including the Productivity Commission Mental Health Inquiry Report

Over the past 30 years, there has been a multitude of inquiries, plans, reviews, roadmaps and reports into mental health. The following list is by no means exhaustive, however it is comprised of relevant and contemporaneous documents QAMH regularly uses in its day-to-day work in the community mental health landscape. The sheer number of reviews is testament to the size of the challenge and the impacts mental health has across the Australian community. Unfortunately, concrete actions by various levels of government have not followed from the recommendations contained in these reviews. It is essential that governments commit to implementing these recommendations and dedicating funding and resources to alleviate the unprecedented pressures on our system and bring life-changing benefits to those living with mental illness.

QAMH

- Wellbeing First Report – this was produced out of frustration with the Productivity Commission's report which largely overlooked the key role the Community Mental Health and Wellbeing Sector could play in reform.
- Community Mental Health Workforce Report
- Mental Health Service System Changes: Experiences of Covid-19 Project

Queensland

- Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023
- Every Life: The Queensland Suicide Prevention Plan 2019-2029
- Connecting Care to Recovery 2016–2021: A plan for Queensland's State-funded Mental Health, Alcohol and Other Drug Services
- Queensland Housing and Homelessness Action Plan 2021–2025
- Inquiry into Social Isolation and Loneliness in Queensland: Final Report
- Queensland Framework for the Development of the Lived Experience Mental Health Workforce
- Planning for Wellbeing: A Regional Plan for North Brisbane and Moreton Bay focusing on mental health, suicide prevention and alcohol and other drug treatment services 2020–2025

National

- Productivity Commission's Final Report into Mental Health 2020
- The Fifth National Mental Health and Suicide Prevention Plan 2017–2022
- National Aboriginal and Torres Strait Islander Leadership in Mental Health: Gayaa Dhuwi (Proud Spirit) Declaration (2018)
- Mental Health and Suicide Prevention – Final Report - House of Representatives Select Committee on Mental Health and Suicide Prevention
- Draft National Safety and Quality Mental Health Standards for Community Managed Organisations
- National Lived Experience (Peer) Workforce Development Guidelines
- Consumer and Carer Engagement: A Practical Guide

Thank you for the opportunity to contribute to this important Inquiry. We look forward to reviewing the recommendations put forward by the Committee. Please do not hesitate to contact QAMH should you require any further information.